

CHAPTER FOUR: The Second SARS Disaster

May 23 Bombshell

Rough Day at North York General Hospital

On May 23, the news emerged at a disastrous press conference that the victory declared over SARS was false. SARS was back with a vengeance.

With the ministry announcement on May 22 of the St. John's Rehabilitation Hospital closing came a notice to the media of a "technical briefing for SARS update" to be held on Friday, May 23, at 7:00 p.m. in the Macdonald Block at Queen's Park. It was at this press conference that the news emerged, but only under media probing, that SARS was back. Toronto was in the grips of a major second outbreak of SARS.

What the May 23 press conference showed was complete official disarray. It was clear that no one was in charge of the flow of information to the public. The worst aspect was that the devastating news of the second outbreak was not volunteered by those supposedly in charge. The news had to be pried out by reporters. As Helen Branswell of the Canadian Press noted the next day:

Inexplicably, neither Health Minister Tony Clement nor Ontario's chief medical officer Dr. Colin D'Cunha nor Dr. Barbara Yaffe from Toronto Public Health volunteered the information about the new cluster during formal presentations at the beginning of the scheduled news conference.

It was only when the floor was opened to questions that the bombshell was dropped.⁴⁵⁷

457. Helen Branswell, Canadian Press, May 24, 2003.

No one had told the Minister of Health or the Chief Medical Officer of Health about the second outbreak.

Towards the beginning of the press conference on the evening of May 23 the Chief Medical Officer of Health, Dr. D’Cunha, warned those who had recently visited North York General or St. John’s Rehab to monitor themselves for symptoms of SARS⁴⁵⁸ and announced a telephone hotline.

D’Cunha’s message was upbeat, that steps were being taken towards:

... having that 150 percent certainty that we’ve wrestled this new episode, if it turns out to be that, completely to the ground.

His reassuring message, which turned out to be terribly wrong, was that the system was working:

I want to stress that our system of early detection and quick containment is working ...

Despite these apparent new cases, if I may call them that, I believe that we continue to make our progress well known, and better, against this disease. I know that we have some unanswered questions about these cases, we’re not even 100 per cent certain at this time that we can call them SARS in terms of meeting the definition. That having been said, we continue to determine whether there is an epidemiological link, we’re making use of all available public health tests, medical tests to help us nail this one down. We will continue to advise the media and the public when we have more information.

The trouble with this assurance is that it was wrong. The system of detection and containment had failed completely. Officials had more information, shocking information, than that announced by Dr. D’Cunha. This became apparent after a question from a journalist:

Are any people under investigation?

458. He said: “These symptoms include the rapid onset of fever greater than 38 degrees, that is accompanied by respiratory problems such as a dry cough, shortness of breath, and difficulty breathing”.

Dr. D’Cunha replied dismissively⁴⁵⁹ that there were a couple of people under investigation:

There are a couple of persons who are under investigation. I’m going to request my colleague Dr. Low to get into some detail. Don’t

The media spotlight then turned to Dr. Low. In contrast to the upbeat demeanour of Dr. D’Cunha, Dr. Low appeared sombre and halting, shaken by the news he was about to deliver.

Yes, it’s been a rough day at North York. I don’t have all the answers for you tonight but what we’ve essentially identified is a cluster of cases that occurred on one ward at North York General ... That there has been a likely transmission to health care workers. That there has been transmission to family members. And that there’s probably been transmission to other patients.

The unanswered question was how many people were under investigation. A journalist asked immediately for an “estimate of how many people are in this cluster.” Only then, and only after this further probing by Helen Branswell of the Canadian Press, came the big surprise. Dr. Low said:

We’re talking probably in the twenties.

The cat was now out of the bag. It was immediately apparent that Dr. D’Cunha’s earlier statement, that there were only a couple of people under investigation, was inaccurate.⁴⁶⁰ This was not lost on the media. A journalist said:

In the twenties. Okay. Why did you just go through this whole presentation for 20 minutes and we had to get it in a question? Why didn’t you tell us that at the start?

459. There is no suggestion that Dr. D’Cunha knew he was misleading the public. The problem was not deliberate deception but the broken system. The system was so broken that the man in charge of public health did not know what was going on.

460. As noted below, there is no suggestion that D’Cunha was deliberately misleading. It became apparent that he had not made it his business, before speaking to the public, to find out what in fact was going on at North York General.

Although Dr. D’Cunha did his best with the incomplete information he had,⁴⁶¹ the journalists kept coming back to the key fact, which was originally withheld from the public:

So we’re looking at a minimum of 25 cases of SARS now?

And Dr. Low acknowledged that a number of possible SARS cases were still under investigation.⁴⁶²

Officials said that 34 paramedics were in quarantine, as were several hundred people named by St. John’s, that that total in quarantine at that time amounted to just over 1,000 people, depending on how the list was defined, and that the number was growing.⁴⁶³

461. Dr. D’Cunha: Well, keep it in mind that right through the period middle of March, every person who presented with any one of the signs and symptoms consistent with SARS made it to that list. What was looked at as a person of interest or a person of investigation different jurisdictions use different terms. My understanding, from what I know in the clinical case conferences that I participated in, the five persons that we spoke to are more likely towards being SARS, these other 20 are at the lower end of the spectrum, and they may well drop off the list, and I think Dr. Low has made it very clear, in the case of the one death that he’s looked at the chart, this person didn’t even ... he feels very confident it was not. There are others if they progress, because some of them are some of the staff as best as I understand it, they may come closer to these five. I think what you are trying to get us to do is to start to draw cuts in this category of persons of interest or persons under investigation. The key message here, Helen, is anyone who presents with respiratory symptoms, particularly in the last 10 days, automatically are going to be people of interest or persons under investigation for us. And that’s exactly why yesterday we asked people to come out and identify. We put staff in isolation, to name just a few, and, Don, I don’t know if you want to elaborate a little more.

Dr. Low: No. I mean, it’s just what I said.

462. By May 24 the number under investigation was 33; two had died, 25 were in hospital, and six were recuperating at home. Seven of the 33 were health workers. It was thought that the St. John’s cluster was sparked when a woman in North York General Hospital on the same ward as the 96-year-old man was transferred to St. John’s on April 28. (Helen Branswell, *Canadian Press*, May 24, 2003.)

463. By the next day, Saturday, May 24, the numbers were clearer:

About 500 people in Toronto have gone into quarantine, said Dr. Barbara Yaffe of Toronto Public Health. Another 2,000 who were in the affected hospitals during key transmission dates have reported to public health but, because they have gone through the disease’s incubation period without symptoms, have been given the all-clear.

Helen Branswell, *Canadian Press*, May 24, 2003.

The disastrous communication of the May 23 press conference was reviewed in the Commission's first interim report. As the Commission found:

The confusion that marked the May 23 press conference exemplified the lack of any coherent communications strategy and the lack of any clear lines of accountability for the communication to the public of vital news about the status of the outbreak ...⁴⁶⁴

... The problems of public communication during SARS are addressed thoughtfully in the Naylor Report and the Walker Interim Report. The Commission endorses their findings and their recommendations for the development of coherent public communication strategies for public health emergencies.

There is no easy answer to the public health communications problems that arose during SARS. On the one hand, if there are too many uncoordinated official spokespeople the public ends up with a series of confusing mixed messages. On the other hand, as Mr. Clement points out above, any attempt to manage the news by stifling important sources of information will not only fail but will also lead to a loss of public confidence and a feeling among the public that they are not getting the straight goods or the whole story. What is needed is a pre-planned public health communications strategy that avoids either of these two extremes.⁴⁶⁵

Adding to the communication disaster was that this new SARS outbreak was reported during this press conference before North York General Hospital had told its own staff any details of the investigation or conveyed to them that there were a large number of cases of SARS under investigation at the hospital, many of them ill staff.⁴⁶⁶ More will be said later about communication with staff.

464. SARS Commission, first interim report, p. 63.

465. SARS Commission, first interim report, p. 64.

466. In an update to staff at 5:10 p.m. on May 23, 2003, the hospital reported, "We have patients with undiagnosed respiratory symptoms including some health care workers. They are being assessed as 'persons under investigation' until a more definite diagnosis is determined." The hospital announced the implementation of full barrier precautions at the Leslie site, effective immediately. SARS Update #43, May 23, 5:10 p.m.

SARS II sickened 118 people, almost a third of the total for both outbreaks. By the time SARS II was over, 17 more were dead, including Nelia Laroza,⁴⁶⁷ a North York General Hospital nurse. The emergence of SARS II at North York General, coming after official assurances that the outbreak was over, shook the confidence of the public and the media in the accuracy of what they had been told by the authorities.

The public announcements of victory over SARS in mid-May were followed quickly by a press conference on May 23, 2003, which revealed the re-emergence of SARS at North York General Hospital. The news came as a bombshell because officials had assured the public that SARS was under control and that the outbreak was over. A shocked public found it hard to understand why they had been told that SARS was under control only to learn that it was back with a vengeance.

Three weeks and two days earlier, on April 30, the World Health Organization, after protests from Ontario, had removed its travel advisory against Toronto. Ten days earlier, on May 13, the province had declared the “new normal,” which established the precautions to be taken as the outbreak ended. Nine days earlier, on May 14, the World Health Organization had removed Toronto from the list of areas with recent local transmission of SARS. Six days earlier, on May 17, Premier Eves had lifted the provincial emergency.

We now know that while precautions were being relaxed in a mood of relief, SARS was in the orthopedic ward at North York General Hospital and in family clusters and in health workers associated with that ward. We also know that an earlier cluster of patients identified in the psychiatric ward at North York General Hospital and reported to staff as “not SARS” were in fact SARS cases. As April and May unfolded and Toronto tried to return to normal, there were unidentified SARS cases in North York General Hospital. As precautions were relaxed in early May, those cases spread, infecting other patients, visitors and health workers.

How could the public be assured that SARS was under control, only to learn almost by accident through a blurted comment in a press conference that it was back?

467. Because Ms. Laroza's name is in the public domain as a result of intensive media coverage, her name is used here as an exception to the general rule that individual SARS patients are not identified personally in this report.

The sense of public surprise was summed up in Michael Enright's introduction to a series of CBC interviews in June 2003:⁴⁶⁸

For a time we thought we had it licked. The battle with severe acute respiratory syndrome was over. Toronto health officials shut down their containment teams. Nurses and doctors took off their protective masks and gloves. Hospitals went off high alert, politicians declared Toronto to be clean and exhausted health care workers booked some much-needed time off. But it wasn't over. SARS wasn't beaten. Suddenly with a new cluster of cases SARS was back ... The return of SARS indicates that somewhere in the system of public health protection there was a breakdown. The system somehow failed. Medical professionals who have been tracking the outbreak since March 1st let down their guard. This morning an examination of what went wrong and why with some of the key players.

I want you to help me a bit with chronology here. As I understand around the middle of April, around the 25th, public health officials said that the outbreak was pretty much under control 20 days after that there had been no new cases and then by May 16th or so everybody thought that it was over. Some of the contamination teams were disbanded, some of the workers were told that they don't have to wear protection and so on, and then on the 22nd of May a new cluster is found.

What happened? How did we feel that it was over and then it was not over?

This sense of a breakdown in our system of public health protection, that the system somehow failed and medical professionals had let down their guard, was aggravated by the way the bad news emerged. The sense of public shock was fuelled not only by the unexpected nature of the announcement but also by the curious way that it slipped out towards the end of the May 23 press conference.

Despite warnings from nurses and doctors at North York General, hospital officials had dismissed evidence that SARS was back.⁴⁶⁹ But an independent review of hospital records by Toronto Public Health during the day on Friday, May 23, made it impossible to deny any longer that SARS had been spreading in the hospital for weeks.

468. CBC interview June 2003: Michael Enright, Dr. Sheela Basrur, Dr. Richard Schabas, Barb Wahl.

469. The complex reasons for this good faith mistake are recounted in detail below.

The news was devastating to all those who had fought SARS, especially to the nurses and patients and all those at North York General who had thought they were safe only to find that they were seriously at risk. And those who raised the alarm that SARS was still around, that it had not left, felt ignored and then angry, as they later learned that they were right. As one North York General physician said:

But I'll tell you, SARS II never existed, SARS I just kept going. And when you see this happening and you turn a blind eye to this, either because you have other motives, you want make the hospital look like it's recovering and let's get back to business and so on, or because your level of suspicion, or what we call your index of suspicion in medicine, is not high enough, then it's very disturbing. It's very disturbing that this kind of thing can happen with so many people around seeing it, people discussing it, raising concerns, and yet the power being given to that one person who can make these decisions.

As noted in the quotation above, although everyone speaks of the first outbreak (SARS I) from April 7 to mid-May 2003 and the second outbreak (SARS II) from May 23 to July 2003, there was in a technical sense only one outbreak, because even after victory was declared in May, SARS continued to incubate and spread at North York General.⁴⁷⁰ Because the two phases of the fight against SARS were clearly separated in time it is logical to follow the common understanding and to refer in this report to SARS I and SARS II, and these terms have been used throughout the report.

Although there were in hindsight clear signs that SARS was spreading in the hospital, it was not detected because there was no system to put together all the evidence that now points so clearly to the re-emergence of SARS at North York General during April and May. Before May 23, there was no epidemiological investigation at North York General Hospital to bring together for the hospital management and the outside experts the scattered pieces of information that show so clearly in hindsight that SARS never went away at North York General and that it simmered undetected for weeks until its existence could no longer be denied.

470. North York General now recognizes this:

North York General Hospital has been described as the epicentre of SARS II. In truth, for North York General Hospital there was no SARS I or SARS II. We never really got out of SARS I, so, there was no break. For us, SARS lasted almost five (5) months. (Bonnie Adamson, CEO, North York General Hospital, SARS Commission Public Hearings, September 30, 2003)

North York General Hospital

Introduction

The shock of the disastrous May 23 press conference was followed by questions. How could SARS be back, just after the government said it had gone and declared victory? How long had SARS simmered at North York General? Why did the hospital and the authorities not realize what was going on?

As more facts emerged, the questions became pointed. It soon became known that nurses at North York General had warned the hospital that SARS had returned and that their concerns culminated in a meeting with hospital officials on May 20, when the nurses were told incorrectly that they were wrong and that SARS had not returned at North York General. In fact it turned out that the nurses were exactly right and the hospital's assurances were exactly wrong.

Did North York General listen to the nurses who said SARS was back? Why did the hospital dismiss as wrong the warnings, which proved to be so tragically correct? Were there other warnings? The questions were mixed with rumours. Was there a cover-up? Did the hospital and the government hide SARS in order to lift the economically devastating World Health Organization travel advisory? Who knew what, and when did they know it? As it became more clear that SARS had simmered undetected at North York General since April, these questions and rumours became even more pointed.

Because of these questions and these rumours, because North York General was the epicenter of the second wave of SARS which sickened 118⁴⁷¹ and killed 17 in addition to the casualties from the first wave, and because the failure to detect SARS at North York General shook public confidence in official assurances, there was much to investigate and there is much to tell the public in this report.

471. 118 is the estimated number of cases associated with the second phase of SARS. Source: Dr. Colin D'Cunha, SARS Commission Public Hearings, September 29, 2003.

As Dean Naylor pointed out, the impetus for this Commission came largely from issues arising out of the second outbreak at North York General:

Mr. Justice Campbell's mandate arose in meaningful measure from events around the second wave or "SARS II" ...

... On June 10, largely because of the tangled chain of events at North York General Hospital, but also because of mounting pressure from nursing associations and unions, opposition politicians, and the media, the Province of Ontario announced a formal arm's-length investigation into the SARS crisis, headed by Ontario Superior Court Justice Archie Campbell.⁴⁷²

The North York General study is the longest section in the Commission's story of SARS because this second outbreak raised the most troublesome questions: how and why SARS was undetected and misdiagnosed with such tragic results after the province had declared that SARS was gone.

Based on confidential interviews with over 150 individuals associated with North York General,⁴⁷³ and on hundreds of documents, this chapter will trace the story of the second outbreak at North York General. This is not the story of SARS at North York General, merely the account of how the second outbreak came to pass, so far as it will ever be known.

This chapter seeks to answer a single question: how did North York General become the epicentre of SARS II? This single-minded focus limits, of necessity, the scope of the story told here.

The story includes the hospital as SARS initially found it in March of 2003, the first three nurses who came down with SARS in April, two other nurses who fell ill, the mysterious illness of three psychiatric patients in April and May, the consultations with Toronto Public Health and outside experts, the presentation of a cluster of five family members who turned out to have SARS, the belated discovery on May 23 that SARS was back at North York General, and the immediate steps taken to deal with the disaster.

472. Naylor Report, p. 23.

473. In most cases witnesses are quoted without personal attribution. In some cases witnesses agreed to be quoted by name.

Outside the scope of this chapter is the story of how North York General coped with the return of SARS with such excellence as one of the four “alliance” hospitals that took the second outbreak cases. Outside the scope of this focus are the many improvements since SARS in infection control and prevention and disease surveillance. Reference will be made later to the state-of-the-art infection control and surveillance system now in place at North York General, a system referred to by some as the gold standard.

Outside the scope of this chapter is a scientific question that will probably never be answered: the question of the exact pathway through which SARS entered and initially spread at North York General. Various theories, not all of them consistent, have been advanced by various authorities from time to time. Dean Naylor said it is doubtful that we will ever know for sure exactly the precise transmissions of infection through which SARS spread undetected at North York General. As Dean Naylor said:

Despite extensive investigations by Toronto Public Health, Health Canada and the CDC [Centers for Disease Control], the exact chain of events leading to the second wave of the SARS outbreak remains a mystery. In fact, a definitive link between the first outbreak and the cases on the orthopedic unit (4 West) has yet to be established, although officials have suggested different possibilities. How the psychiatric patients fit into the overall picture is also unknown, and may never be definitively solved.⁴⁷⁴

Although further scientific investigation after Dean Naylor’s report has produced a plausible working theory that makes sense to those who have studied the problem, an element of the unknown will probably always remain. This theory is discussed later in the report.

Outside the scope of this chapter is much of the work of the administrators and physicians and nurses and health workers who displayed such skill and dedication and courage at North York General during SARS. The hospital told its own story of SARS during the Commission’s public hearings, and that presentation is set out in the public hearing material on the Commission’s website.⁴⁷⁵

North York General is home to some of the finest and most dedicated physicians, administrators and health workers in Canada. Many of those doctors and nurses

474. Naylor Report, p. 40.

475. www.sarscommission.ca

worked tirelessly on the front lines during SARS, putting their lives at risk to help others. Nothing in this chapter detracts from its present distinction as a fine hospital. To tell the story of how North York General tragically missed the return of SARS is not to point fingers or assign blame: it is simply to tell what happened without any findings of civil or criminal liability and without any adverse finding against the hospital or anyone associated with it.

Although the second outbreak happened to occur at North York General, it is possible that given the deep systemic province-wide inadequacy of preparedness, infection control and worker safety systems, it could have struck any other hospital. Those who wish to prevent similar disasters in the future, instead of pointing the finger at North York General, should focus on system-wide weaknesses illustrated by the insidious spread of SARS that happened to occur at that particular hospital. The lesson from North York General is not that the hospital deserves blame. The lesson from North York General is that because of systemic weaknesses, what happened there could, but for good fortune, have happened at almost any other hospital in the province.

All that being said, the failure to detect the return of SARS at North York General was a tragedy of enormous dimensions. It sickened 118, killed 17,⁴⁷⁶ caused unspeakable loss and suffering, shook public confidence in the ability of authorities to inform and protect the community, and shook the faith of health workers in the ability of their employers to keep them safe from harm.

We owe it to those who died and those who suffered to learn how this happened, to correct the mistakes that led to the tragedy and to build systems to make sure it does not happen again. That is why the North York General story is so important to us all.

The outbreak at and from North York General became known as “SARS II.” For many this was a misnomer, as it suggested two separate outbreaks, each with a distinct beginning and end. In reality there is no clear dividing line to demarcate two separate outbreaks. SARS never left.

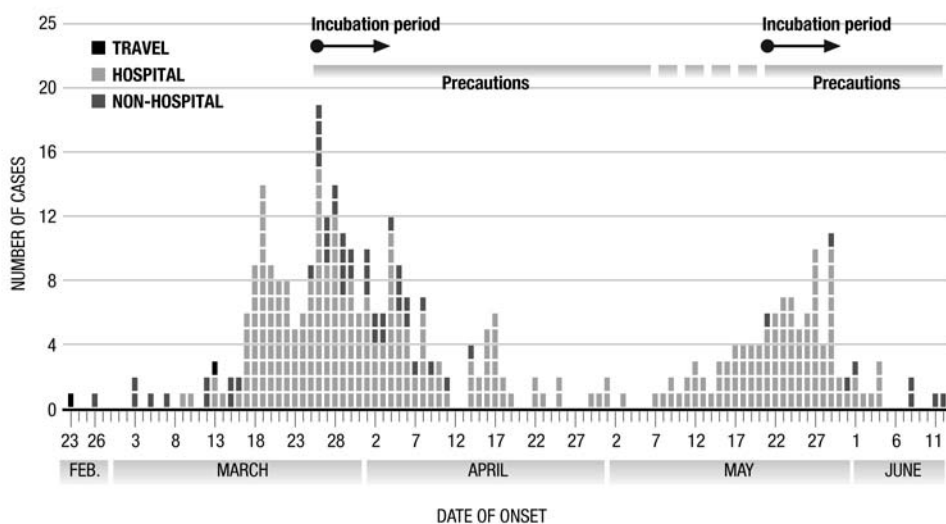
SARS simmered throughout North York General Hospital during April and May until, cautiously and according to provincial directives, the hospital relaxed precautions in May. As soon as precautions were relaxed, SARS sprung up quickly at North York General. Simmering since April, it spread remorselessly with ever increasing speed leading to widespread infection in the hospital and to its sudden closure on

476. Presentation of Dr. Colin D’Cunha, SARS Commission Public Hearings, September 29, 2003.

May 23, 2003. The SARS cases that simmered undetected and misdiagnosed in North York General since April remained stable in number until North York General complied with provincial directives and relaxed precautions in early May. The chart shows what happened next. As soon as precautions were relaxed, SARS started to spread rapidly within one incubation period. Then as soon as precautions were reintroduced on May 23, SARS declined just as rapidly within one more incubation period.

Nothing is clearer than this relentless relationship between SARS and precautions. As the chart⁴⁷⁷ below shows, precautions down, SARS up. Precautions up, SARS down.

The Distribution of Cases in the Severe Acute Respiratory Syndrome (SARS) Outbreak in Ontario, Canada, from February 23 to June 12, 2003.



The second outbreak was devastating. In the end 118⁴⁷⁸ people contracted SARS. Seventeen of them died, including Nelia Laroza, a highly respected and much-loved nurse who worked on 4 West, the orthopedic unit where SARS simmered undetected and undiagnosed. For those who fell ill and for those who lost loved ones, the cost of SARS II is immeasurable.

477. Dr. Donald Low and Dr. Allison McGeer, “SARS – One Year Later”, *NEJM*, 349:25, December, 2003.

478. 118 is the estimated number of cases associated with the second phase of SARS. Source: Dr. Colin D’Cunha, SARS Commission Public Hearing, September 29, 2003.

Whenever one speaks of cost – the cost to the government to protect us better, the cost to hospitals of better infection control, surveillance and worker safety – we should never forget the cost of SARS in sickness, pain, suffering and unspeakable loss.

The second outbreak also had a terrible impact on the morale of health workers. Many lost faith in the system and the ability of their employers to protect them. It was not only the public who had been led to believe that SARS was gone. Nurses and health workers were told that SARS was contained and that there were no new cases of SARS. SARS was over. Nurses at North York General, concerned about outbreaks of staff illness and clusters of SARS-like illness, were told again and again by the hospital “Not SARS” when it turned out that these cases were in fact SARS.

On May 23, 2003, nurses and others at North York General learned, along with the rest of the world, that SARS was not in fact over. It was not contained. There were new cases of SARS right in their midst. Many of their colleagues were ill with SARS, and in the coming days more would become ill and be admitted to hospital.

But once again these nurses and doctors and clerks and technicians were asked to step into danger. And once again they did. Once again they risked their lives and health for the sake of others. What is it in their character and their professional culture that produced this courage? Will they heed that call the next time if they lack confidence that governments and hospitals will do better next time to protect them? More will be said later about the need to restore the faith and to build trust with those health workers who no longer trust the system.

The challenges we faced during SARS were overcome only through the hard work, dedication and sacrifice of people too many to identify in person. Everyone did their best, from the front-line staff, to hospital managers and administrators, to the experts who volunteered their time, to public health, to those within the government. They all worked hard, always with the best intentions. But they could not repair in a day or a week or a month the gaps and cracks in the system, the lack of preparedness, the lack of infrastructure, the lack of basic resources. You cannot change tires on a car traveling at 80 miles an hour.

As a North York General nurse said so eloquently:

Valiant efforts were made, I think we have to acknowledge that, but effective efforts were not made. They weren't organized, they weren't fast enough, they weren't cohesive.

SARS was unforgiving. It did not pause to wait until the system got its act together. SARS was a wake-up call – a chance to see where things went wrong, what needs to be fixed, and what cannot happen again. The problems that arose during SARS must be fixed. If we do not fix them, we risk that those who worked so valiantly to save us from SARS the last time will not be willing to step once more into danger. Why would anyone step into danger again without confidence that everything reasonable has been done to protect them? Without the willing support of the health workers in the face of a system that let them down so badly during SARS, we will have no one to save us next time around. It behooves us to do everything reasonable to secure their confidence that we will protect them better next time. If we do not fix the systems that let them sicken and die, we cannot reasonably ask them to step forward into danger when the next outbreak strikes.

This is why the lessons from SARS, in particular from the second outbreak, are so important to our health system and to the Province of Ontario as a whole. It would be a grave error for any hospital to view the story of North York General as something that happened to someone else. It would be unfair to scapegoat North York General for the general systemic failures that came home to roost in that particular hospital. North York General cannot be blamed for the fact that Ontario, like some other jurisdictions, had too low a standard of surveillance and systemic protection against the spread of infectious disease. The take-home message from North York General is that every hospital must prepare better and must develop systems to ensure effective surveillance of hospital-spread diseases.

The problems that arose at North York General were not unique to that hospital. They reflect seven systemic problems that run like steel threads through all of SARS, through every hospital and every government agency:

- Communication
- Preparation planning
- Accountability: who's in charge, who does what?
- Worker safety
- Systems: infection control, surveillance, independent safety inspections
- Resources: people, systems, money, laboratories, infrastructure

- Precautionary principle: action to reduce risk should not await scientific certainty

As the narrative unfolds during April and May, right up to the belated discovery of the outbreak on May 23, 2003, these seven themes underpin the story of how the re-emergence of SARS at North York General Hospital was missed by the hospital and by all the outside experts upon whom it relied.

Every other hospital was similarly vulnerable to the spread of SARS. The story of North York General has lessons for everyone. We must all learn from the story of North York General, so that whatever infectious disease follows SARS, we are all better prepared.

“Infections, pandemics, epidemics, they’re not going to happen”

North York General Hospital is a multi-site hospital. The main site is located at 4001 Leslie Street, at the corner of Leslie Street and Sheppard Avenue, in North York (now part of Toronto), Ontario.⁴⁷⁹ It is a busy community teaching hospital with approximately 420 beds. In 2001-2002 it had approximately 65,000 emergency visits and 175,000 outpatient visits.⁴⁸⁰

Like most other hospitals in Ontario, infection control at North York General was not given a high priority before SARS. Unlike programs with higher profiles and more obvious results, the benefits of a robust infection control program were not readily apparent. Its lack of resources and priority become apparent only in the face of an outbreak or crisis, as it did during SARS.

North York General was no exception to this. When SARS hit, North York General Hospital, like most other hospitals in Ontario, did not have enough infection control resources to deal with a major infectious outbreak. The hospital had

479. It also has a site at 555 Finch Avenue West, known as the Branson Division, as well as Senior's Health Centre, located at 2 Buchan Court (Leslie and Sheppard). The Senior's Health Centre is a 192-bed long-term care home.

480. SARS Field Investigation, p. 8.

one full-time infection control practitioner at the General site as well as one at the Branson site. One hospital official described the makeup of the infection control program pre-SARS:

Pre-SARS, we had an infection control program. We had a leader designated and she had one full-time person working with her and another person who was training to be an infection control practitioner. We did not have a designated medical leader for infection control. The role was assumed by Dr. Barb Mederski, who on an informal basis was an advisor to the infection control program. Her primary responsibility was as an infectious disease specialist. That was about 50-60 per cent of her activity, although she did do some work as an internal medicine specialist. That is her background. She provided advice and counsel when we got into outbreaks. She provided advice around standard infection prevention and control issues within the hospital. We had one other infectious disease specialist ... There was not a formal sign-out system between the two of them, but they looked after the majority of patients in the hospital who required an infectious disease specialist.

There was a third member of staff with a specialty and certification in both infectious diseases and medical microbiology, but he worked in the emergency department during SARS and was not utilized in an infection control capacity. As noted above, although there were two physicians with infectious disease specialties. Dr. Mederski assumed primary responsibility during SARS. There was no formal division of responsibilities between Dr. Mederski and the other infectious disease specialist. As the other infectious disease specialist explained to the Commission:

Before SARS there was no formal infectious diseases call schedule, and so there would be people who called me to see the patient in consultation for infectious diseases, but there were people who would call Dr. Mederski. There was nothing formal, whoever decided to call me or call Dr. Mederski, so there was never really on-call or not-on-call.

More will be said later about the role of Dr. Mederski and the responsibilities she held during SARS. Regardless of the division of responsibilities, the inadequate resources became apparent when SARS hit. As one physician described the problem:

Infection control personnel were totally overworked. It was just one of those things that has never received a lot of priority, I guess, and we've taken it for granted up until now. Not just we, meaning North York, but I mean everybody.

Another senior physician at North York General, described how infection control had simply ceased to be a priority not only for health care institutions but also for those working inside them:

We believed, in all institutions, that infections had gone away ... [Pre-SARS] I would say NYG was no different than any of the other hospitals in which I had privileges, and it was cursory, we really weren't very concerned about major problems ... Infections, pandemics, epidemics, they're not going to happen. So you would get your training in medical school and do your residency about hand washing and changing your clothes, but it had become lax.

Not only were infection control resources not in place, but structurally North York General was not equipped to deal with an influx of infectious patients. This problem was in no way unique to North York General Hospital. Prior to SARS, few hospitals imagined that they would need large numbers of negative pressure rooms or isolation facilities. When SARS hit at North York General, it, like most other hospitals, had to scramble to increase its capacity to isolate and care for infectious cases. It was not enough simply to designate a room as an isolation room; it had to be properly ventilated, and negative pressure rooms had to be created. When SARS hit North York General, there were only two proper negative pressure rooms in the entire hospital, both located in the emergency department. One ICU physician described the challenge:

Pre-SARS you could essentially make any room an isolation room just by closing the door and putting a sign out and using appropriate barrier precautions ... We didn't have a proper negative pressure room in the ICU, the old ICU. And I don't think there were any floor rooms that were actually negative pressure. We had very few negative pressure rooms pre-SARS. The ones that we needed during SARS we generated for the most part until our new ICU opened.

Prior to SARS, most health workers had never heard of, much less used, protective equipment such as the N95 respirator or a Stryker suit. All of a sudden, proper use of this unfamiliar equipment, including very precise care in its application and removal, could mean the difference between becoming ill with SARS and remaining safe. Overnight, health workers were expected to apply and maintain precautions of a type and level that they had never used before. This too was not unique to North York General Hospital, as other hospitals in the Greater Toronto Area were in a similar situation of having never used this level of precautions before.

When SARS hit North York General, much of the senior administration was relatively new. Although senior management stepped up to the task and devoted countless hours to managing the SARS outbreak, there was no long-standing relationship between front-line staff and those in charge. There was not the same established foundation of trust as existed in other institutions.⁴⁸¹ As one physician said:

Senior management is so new, there's not yet any buildup of trust. I don't think that's their fault, except for timing, they should've chosen a better time for SARS, after they'd been there for five years, right. So I find them workable and approachable, but the president and the vice-presidents, most of them had been there less than a year when this hit, and it takes much longer than that to build trust.

The trust of staff at North York General became a key issue during the outbreak and remains the source of anger for many of the staff even years after SARS. More will be said later in the report about communication with staff, listening to staff, and the feeling of some that their trust was misplaced.

Despite the systemic problems identified throughout this report, North York General Hospital remains home to many fine nurses, physicians and other health workers. They worked tirelessly during SARS, often in the face of frightening unknowns. Those who worked at North York General during SARS, and particularly those who cared for SARS patients, exemplify the ultimate of selfless sacrifice and public service. They went to work every day knowing that they might become ill. Ever present was the fear that they might infect their families with a deadly illness. As one nurse said:

481. For example, at Scarborough Grace Hospital, the Vice-President during SARS was Ms. Glenna Raymond, a former nurse who had worked her way up through management. She was well known to staff, and many of those interviewed, including many nurses, expressed a deep trust and confidence in her leadership abilities.

There's one thing with becoming ill yourself at work, and then there's another thing coping when you could potentially bring that home to your family. It really had a huge impact on me in that way. I would get up in the middle of the night checking the doors and the windows making sure everything was locked. Check on my children all the time. If my husband was out with the kids and I had expected them home at a certain time and didn't hear from them, I would be in a panic thinking that something awful had happened. It really shook my foundation of safety that I had, and that I thought that my family had.

Another nurse who worked on the SARS unit described how suddenly her job became a potential source of danger to her family:

I never thought in my whole world of nursing that I would ever potentially bring something home to my family. When my son went into quarantine and it impacted my family like that, I genuinely questioned whether or not I should go get a job at A&P, and it came that close, very close, very, very close.

Nothing in this report should be taken as any criticism of those at North York General who worked so hard and so selflessly on the front lines of the war against the deadly disease that was SARS. They fought bravely in the face of a new and unknown disease, never knowing what the next day might bring, always wondering if they and their families were safe. As will be seen in the story of North York General, even when the second outbreak became evident, in the face of anger, fear, despair and overwhelming disappointment, they continued to work and provide care for those infected with SARS. Everyone in Ontario owes a debt of gratitude to these front-line heroes. Whatever mistakes were made and whatever lessons are identified from SARS have been learned through their efforts and tragically, in some instances, at their expense.

“Like Drinking Water from a Firehose”

North York General became involved in the SARS outbreak towards the end of March when it began receiving patients who had contracted SARS from the outbreak at Scarborough Grace Hospital.

Dr. Tim Rutledge, the Chief of Emergency Medicine at North York General, recalled that quite early it became apparent that this was a serious illness requiring a serious response:

I can tell you first step we took. We started, I think because of our proximity to Scarborough Grace, we were seeing quite a number of cases. We were quite impressed that it was a very aggressive disease. I remember seeing one case myself where in the middle of night a patient had a very minor pneumonia, the next morning her lungs were whited out, she was an elderly lady and she was getting very ill. We knew she needed to go to the ICU. She was in one of our rooms that was an isolation room. We didn't have any room in our ICU. Somebody had to transfer her down to 3A ... We were able to get a bed for her at St. Mike's [Hospital]. Somebody had to transfer her down to the ICU. I did it. I put on a mask, hat, gown and gloves and bagged her all the way down in the back of the ambulance. It was pretty impressive to all of us as to how sick she got, so fast. By March 25th we had seen enough, and myself and the program director made a call early that day that we would put everybody in mask, gowns and gloves whether they were taking care of ankle sprains. That was really radical at that time because it was alarming to patients coming in. The next day the provincial emergency was declared and there were directives for all emergency departments to do that.

On March 26, 2003, the Province declared a provincial emergency. Following the declaration of the provincial emergency, all hospitals in the Greater Toronto Area were directed to activate their Code Orange emergency plans. This meant suspending elective surgeries, restricting visitors, suspending non-essential visits by hospital staff, suspending volunteer work in hospitals, and restricting overall access to hospitals to essential services only.⁴⁸²

North York General, along with other hospitals in the GTA, was asked by the Ministry of Health and Long-Term Care to set up a SARS unit. North York General's first SARS unit was established on 3 North (then pediatrics) at the Leslie site.⁴⁸³

On March 26, 2003, North York General issued its first SARS Update to staff. This marked the first of 96 updates to staff, distributed via the hospital's internal email system.

482. MOHLTC Fact Sheet, March 2003.

483. The units previously on 3 North also moved. The pediatrics unit moved to the old labour and delivery unit on 2 West, and eating disorders moved to 8 North.

By March 28th, 2003, the hospital had established a Logistics Command Centre at the General site, to serve as a central point of contact to respond to SARS-related issues.⁴⁸⁴ The hospital also established the SARS Task Force Steering Committee.⁴⁸⁵ The Steering Committee comprised 21 people representing various parts of the hospital. The group met daily throughout March and April. The minutes of the meetings were posted on the hospital intranet. The Steering Committee focused on day-to-day management issues such as hospital status, census of patients, changes to directives and communications with staff. Branching out from the Steering Committee were a number of subgroups, focusing on a wide range of SARS-related issues.⁴⁸⁶

North York General Hospital, like other hospitals in the Greater Toronto Area, scrambled to institute precautions, develop and adopt new policies and protocols that complied with the constantly changing directives from the Ministry of Health and Long-Term Care, and communicate this information to front-line staff. One member of the SARS Steering Committee spoke of the difficulty of keeping up with the directives and the enormous amounts of information coming out in the early days of SARS:

Information was coming at us from it seemed all sides and from a few different sources. Some from the Ministry of Health and Long-Term Care and some from the Provincial Operations Centre. Early on it seemed as if we were drinking water from a firehose. We were getting information that was very important from world literature and World Wide Web. All that stuff had to be taken in and considered and integrated into practice.

As the directives came out, they had to be reviewed, understood, changed into hospital policy and communicated to staff. As one member of the SARS Steering Committee told the Commission, this was no small task:

484. SARS Update #5, March 28, 2003.

485. At the end of April, the SARS Task Force Steering Committee changed its name to the SARS Management Team. The last meeting of the SARS Task Force Steering Committee took place on April 28, 2003. The SARS Management Team began meeting on April 30, 2003.

486. "Such as administration, the Branson site, staffing and human resources, building issues, patient – including ER [emergency room], infection control and discharge and followup, supplies, communication – staff/external and physicians, policy and directives, command centre, and front door." NYGH SARS Task Force, minutes, March 31, 2003, at 1600-1730.

Some of them [the directives] were complicated ... There were times when they didn't make sense. There were times when it seemed that we were changing direction from what we had been taught the day before. One of the roles of our Task Force was to try and make them useful for the front-line staff. Some were very clear and direct and explicit, and those we basically passed on to the staff and educated them right away. Others were vague and tough to interpret, so our job was to try to make them something that could be put into practice.

At times it took hours to go through the directives. For many, it seemed like an inordinate amount of time was spent trying to figure out how the directives had changed and what those changes meant within the hospital.

And time was a precious commodity in the early days of SARS, as there were many competing issues that needed to be resolved. As noted above, one of the early challenges of SARS was to establish a number of isolation rooms with negative pressure. This was particularly key for the emergency department and for any areas that would admit and provide care to suspected SARS patients. It was a difficult task, compounded by the fact that they still did not know everything they needed to know about SARS. One physician explained the challenge they faced as they established negative pressure rooms to care for SARS patients:

We were using negative pressure wards that we had generated through the help of our engineering and building people. And that's how we looked after the SARS patients. During SARS I we looked after them on wards that were completely isolated and completely negative pressure. They were basically an entire ward that was designated to serve that purpose, and then we sort of retrofitted them to become negative pressure using our ventilation system. It wasn't ideal probably, initially. And we didn't know everything in SARS I about how the virus was transmitted. So, some of the rooms were very hot. For example, one of the nurses had a fan in there. Obviously we knew through SARS II that that's really not a good thing. We didn't necessarily know that in SARS I. There were things that we didn't know ... we obviously didn't do later on when we knew how things were actually transmitted. And part of it is just because we were all scrambling to do the best we could for the patient, to make it as safe as we could. Because what we did was better than having that patient put in a non-isolated room and a non-negative pressure room. But was it a perfect negative pressure room? No.

Another big issue North York General and many other hospitals in the Greater Toronto Area faced early into the outbreak was a shortage of personal protective equipment. By March 31, 2003, the hospital had only enough N95 respirators in stock to last two days. The Task Force Steering Committee grappled with the problem of locating sufficient supplies, in a market that was being tapped by every hospital in the province. As the minutes noted:

NYGH has enough N95 masks in stock to last two days. Directives state that N95 masks should be given to staff in all patient care areas. As more stock becomes available to us, we will filter the N95 masks to all areas. [Name] cautioned that with the current stock we cannot give everyone an N95 mask. [Name] says he will continue to try and get more masks from the MOH supply, but to date they are not sending us enough N95's.

As the requirement for precautions increased, the hospital, like other institutions in Toronto, rushed to obtain personal protective equipment for its staff. The SARS unit, emergency department, front-line staff, direct patient care workers, community care centre staff and labour and delivery staff were the only units who would receive N95 respirators. Anyone else who wanted to wear a respirator had to use yellow procedure masks.⁴⁸⁷

By April 2, 2003, the Ministry of Health and Long-Term Care warned the hospital that, from an epidemiological perspective, it should expect to see more cases that week.⁴⁸⁸ This meant that the hospital would need a greater capacity to isolate and care for SARS patients. In response, the hospital announced to staff that a new SARS unit would be established on 8 West. The capacity of the new SARS unit was to increase from the current 23 beds on 8W to 38 beds for SARS patients, including beds in the existing unit on 3N, if needed.

This would be one of many changes to the location of SARS patients over the course of SARS I and II. The changes were as follows:

March 27, 2003 – April 2, 2003	1st SARS unit was created on 3N
April 2/3, 2003 – May 22, 2003	2nd SARS unit was created on 8W
May 22/23, 2003 – June 2, 2003	3rd SARS unit was created on 5SE
June 2/3, 2003	4th SARS unit was created on 6SE ⁴⁸⁹

487. Follow-up of Discussions and Decisions, Monday, March 31, 2003 – 10:00 a.m.

488. SARS Update #9, April 2, 2003.

489. Wong et al., SARS Field Investigation at North York General Hospital, June 1–June 28, 2003 (SARS Field Investigation).

On April 2, 2003, the policy on personal protective equipment changed significantly as all staff in the hospital were now required to wear an N95 respirator at all times.⁴⁹⁰ This directive would remain in place at North York General until May 7, 2003, when they began to relax precautions in some areas of the hospital. More will be said below about the changes in precautions in May and their connection to the second outbreak.

On Friday, April 4, 2003, North York General announced that because ten days had passed since the unprotected encounter with a SARS patient in the emergency department on March 23, 2003, the hospital's designation was changed from Level 2 to Level 1, under the hospital classification system established by the Provincial Operations Centre.⁴⁹¹

The classification system established by the Provincial Operations Centre at the end of March⁴⁹² identified four levels to designate health care facilities, depending on whether or not they had SARS cases and if there was any unprotected exposure to staff or patients. Those levels were:

- | | |
|------------|---|
| Category 0 | Healthcare facility has no known cases of SARS (suspect or probable) |
| Category 1 | No unprotected SARS exposure – staff and/or patients. Healthcare facility has one or more cases of SARS (suspect or probable) |
| Category 2 | Any unprotected SARS exposure within the last 10 days but without transmission to staff or patients. The healthcare facility may or may not currently have one or more cases of SARS (suspect or probable). |
| Category 3 | Unprotected SARS exposure with transmission to HCW's [health care workers] and/or patients. The healthcare facility may or may not currently have one or more cases of SARS (suspect or probable) |

The classification system was significant because it determined things such as restric-

490. SARS Update #9, April 2, 2003.

491. SARS Update #11, April 4, 2003.

492. Directives to GTA/Simcoe County Acute Care Hospitals, Saturday, March 29, 2003.

tions on patient transfer, quarantine for patients discharged from the facility, level of protective equipment required in various areas of facility, restrictions to visitors, and movement and management of patients within the facility.⁴⁹³

Hospitals with SARS patients paid a big price if they were upgraded from Level 1 to Level 2 or, even worse, to Level 3. Moving to a Level 2 or Level 3 designation had profound consequences on the day-to-day workings of the hospital, for everyone at the hospital, such as:

- Level 2 & 3: Visitors prohibited except in special circumstances (and then on full droplet and contact precautions);
- Level 3: Closed to admissions and no new clinical activity permitted; Level 2: Emergency and urgent cases and admissions only;
- Level 3: Use of full droplet and contact precautions for all direct patient contact and use of a N95 mask or equivalent for all staff in the facility; Level 2: Use of full droplet and contact precautions for direct patient contact in all area(s) affected by the unprotected exposure;⁴⁹⁵
- Level 2 & 3: No transfers to long term care facilities and no admissions from long term care facilities unless there were no other alternatives;⁴⁹⁵
- Level 3: Working quarantine for essential staff only, all other staff on home quarantine; Level 2: Essential staff only in areas affected by the unprotected exposure. Staff must work in the affected areas only and cannot work at other facilities and are on working quarantine.⁴⁹⁶

In contrast, a Level 1 facility was permitted a gradual return to normal clinical activity, could permit visitors as per hospital discretion, had no requirements in respect of quarantine of staff, did not require all staff to wear protective equipment and could transfer patients out to long-term care facilities.⁴⁹⁷

It is evident from North York General Hospital records that the SARS Task Force

493. Description of Activity for Acute Care Facilities by SARS Categories, April 14, 2003.

494. And use of full droplet and contact precautions in any area with a patient who failed the SARS screening test or had respiratory symptoms suggestive of an infection, and for taking care of suspect or probable SARS cases. This was the required level of precautions in a Level 1 facility.

495. Directive Regarding Transfer of Individuals from Hospitals To Long-Term Care Facilities (LTCF).

496. Description of Activity for Acute Care Facilities, April 14, 2003. The above is a summary of the key points in the document. To see all the differences between the four levels, reference should be made to the original source document, the Description of Activity for Acute Care Facilities, April 14, 2003.

497. Description of Activity for Acute Care Facilities, April 14, 2003.

worked hard throughout both outbreaks and did its best under very difficult circumstances. It was a remarkable achievement for the hospital and everyone in it that no staff or patients contracted SARS during these early days despite the infectious nature of this deadly disease and all the challenges it brought.

As evidenced by the updates and the recollections of front-line workers, this was a terrifying period for everyone, as the course of the outbreak remained uncertain and directives from the Province changed almost daily. The hospital struggled to respond to the emergency in the face of so much that was new and unknown, while front-line workers struggled to work in an environment where the direction they were getting in respect of protective equipment and management of SARS cases seemed to be constantly changing.

The change to a Level 1 designation on April 4, 2003, signified a return to a more normal working environment. It looked as if things were under control, as there were no known unprotected SARS exposures.

But on the weekend of Saturday, April 5, and Sunday, April 6, just after the hospital was downgraded from Level 2 to Level 1, things changed drastically. On April 6, 2003, North York General reported to staff that for the first time, staff members were under investigation for SARS.⁴⁹⁸ As April progressed, five nurses were investigated for SARS. With the exception of one, who was initially reported to staff as not SARS then later as SARS, all of these cases remained under investigation. Three were eventually classified by Toronto Public Health as “does not meet case definition,” while the fourth remained classified as a “person under investigation” until after the second outbreak. All five nurses were subsequently classified as SARS, four of them probable cases, and one a suspect case.

With the exception of one nurse whose story will be told in greater detail below, there appears to be no link between the illness of staff in April and the second outbreak. That being said, the story of the second outbreak must be told in light of their illness. The fact that health workers were becoming ill in April weighed heavily on the minds of those who went to work in the hospital. It brought home the risk they all faced simply by going to work, and underscored the importance of ensuring worker safety through strong precautions. It also marked the first time the hospital had to commu-

498. To protect the privacy of these health care workers, they will be referred to in the report as simply Health Worker No. 1, Health Worker No. 2, Health Worker No. 3, Health Worker No. 4 and Health Worker No. 5.

nicate with the staff about the illness of one of their own while simultaneously trying to assure staff that they were safe.

In the days and weeks that followed, as more staff and patients became ill, those working within the hospital and those with family members in the hospital would come to question not only their own safety but also the truth of continuing reassurances from the hospital that it was safe and that certain individual cases that looked like SARS were not SARS. No one could anticipate the events that unfolded at the hospital throughout April and May, and no one could foretell the lasting impact that SARS would have on North York General Hospital, its patients and its staff.

Five Sick Nurses

As April unfolded and it appeared that the outbreak was being contained, hospitals and the community at large anticipated a return to normal. No one wanted to see more SARS cases. Everyone wanted it to be over. But at North York General, illness among health workers would cause some staff to question their safety and to worry that perhaps not all cases were being properly identified.

In retrospect, we now know that one of the ill health workers, not classified as SARS at the time, was connected to the second outbreak at North York General Hospital, as her likely source of exposure was a patient on 4 West (the unit later identified as the epicentre of the second outbreak) whom she cared for in the intensive care unit (ICU). At the time of his illness he was not recognized as a SARS case; he was diagnosed with SARS retrospectively after the outbreak at North York General was identified on May 23, 2003. The other four nurses appear to have no direct link or connection to the second outbreak.

However, the stories of the ill health workers reveal problems seen throughout the story of SARS: tensions between clinical diagnosis and the strict case definition, requiring a known link before a case could be identified as SARS, lack of clarity around communication with staff, lack of clarity around the meaning of a classification of a patient as a person under investigation, the importance of education and training on the use of personal protective equipment, and poor communication in cases involving more than one hospital.

Three Sick Nurses

By April 6, 2003, three nurses, all from the same unit, were under investigation for possible SARS.⁴⁹⁹ The transmission to three nurses was frightening for all those who went to work in the hospital each day, hoping that they were safe.

499. NYGH SARS Task Force Steering Committee, Minutes of Meeting, April 7, 2003, 1600 hours, Main Boardroom – General Site.

Health Worker No. 1 developed a temperature on March 30, 2003, while at work. She continued to be unwell for the next few days. She told the Commission that when she reported to occupational health, she was told to stay home and, if her condition continued to deteriorate, to see her family doctor. She made three visits to family physicians over the next three days, the final visit including a chest x-ray. On April 5, she received a call from the hospital inquiring about her condition. When she reported that she remained unwell, she was told to come to the emergency department. She was admitted to hospital on April 5, 2003.

Health Worker No 2 had worked with Health Worker No. 1 during the time when Health Worker No. 1 first began to feel unwell. She recalled that Health Worker No. 1 had complained to her that she felt unwell and that they had not been wearing their masks when they were on break together. Health Worker No. 2 began to develop symptoms on Monday, March 31, 2003. On April 4, she saw a family doctor, who suggested she go to the emergency department. She did so, and was admitted to North York General Hospital on Friday, April 4, 2003. At the time of her admission she reported that her colleague, Health Worker No. 1, with whom she had been in contact, was also unwell.

A third colleague, Health Worker No. 3, began to feel unwell on Thursday, April 3. By Sunday, April 6, 2003, Health Worker No. 3's condition had worsened, and she was admitted to hospital later that day.

All three nurses worked on 8 West, which was then an acute geriatric and medicine floor. At that time there were no known SARS cases on the unit and there was nothing to suggest that any of these three nurses had been in contact with a SARS patient while working in North York General. While they were clearly connected to each other, their epmlink to a SARS case was unclear. Public Health and the hospital commenced an investigation in an effort to account for this unexplained transmission. One hospital official described the news of their illness as a "huge concern."

On April 6, 2003, the hospital issued an update advising of the admission of the three ill staff under investigation for SARS and said:

There is no evidence that SARS was passed on to these nurses when they were wearing protective SARS gear and caring for patients. None of these nurses were caring for SARS infected patients at NYGH. We know that these cases have caused concern among staff; we would like to remind everyone that proper protective gear and SARS precautions in all areas at all sites are very effective in stopping the spread of the disease. To

date, we have done a good job of protecting ourselves and we will continue to aggressively protect staff and our patients.

Infection Control and Occupational Health are working with Toronto Public Health to further investigate the above mentioned cases. Occupational Health will be contacting all known staff who had contact with these nurses between March 29 and April 4. We recognize that all of our staff need access to medical services and we are working setting up an assessment area. We will update you as soon as we know more information. If you are exhibiting symptoms of SARS, please contact Occupational Health [number provided].

There is a suggestion that the nurses under investigation for SARS could have contracted the disease while they were having a break together in a staff lounge with their masks off and sharing food.

At this time we would like to reinforce the Food Policy. The full Food Policy should be available in your SARS binder on your unit. Some key points of this policy are as follows:

- Staff must sit at least one metre apart from other staff and stagger seating arrangements.
- Do not share food.
- Ensure you wash your hands before and after every meal.

We also want to remind you when changing clothes before and after your shift, please maintain precautions by wearing your mask at all times.⁵⁰⁰

Initially, the source of their transmission was a puzzle. Dr. Barbara Mederski recalled speaking to Health Worker No. 1 in an effort to find out how she got SARS and said that although there were theories, the possible source of transmission was not clear at that time:

[Health Worker No. 1] indicated that her mother had been at the Grace Hospital on the cardiac floor getting some kind of cardiac procedure. Her mother was completely well. She had absolutely no symptoms despite her age, her frailty or medical condition. She was perfectly well. So the fact

500. NYGH SARS Update, #12.

that [Health Worker No. 1] was sick with a well mother, albeit had been at the Grace a few weeks earlier, was bizarre. [Health Worker No. 2] in turn had the connection of having shared food with [Health Worker No. 1], who we now realized probably, in retrospect, had already been ill by the time of that luncheon. So it made more sense that the two of them would be ill. And at that stage, because of the constellation of symptoms and the link with the Grace, albeit through a healthy party, I essentially labelled them as persons under investigation, probable SARS. That was in my own mind.

The hospital established a clinic to screen those staff members who had been in contact with these nurses, under investigation for possible SARS. Arrangements were also made to have the family of Health Worker No. 1 come to the hospital to be examined and have x-rays taken, to determine if they too were ill. Although the rest of the family was well, one family member was admitted under investigation for SARS.

Over the next few days Public Health, with infection control and the occupational health department at North York General, worked on identifying possible contacts of these nurses. Toronto Public Health sent a field epidemiologist to the hospital to review the cases and put together an epidemiological picture of who had contact with whom and how SARS may have been transmitted between these sick nurses. Potential contacts were identified to monitor them for symptoms and to place them in quarantine. In total nine nurses were identified as potential contacts. Fortunately, none of these contacts developed SARS.

On April 8, 2003, the hospital reported to staff that Toronto Public Health and the hospital continued to investigate a possible link back to Scarborough Grace Hospital. At this time they also reported that Health Worker No. 3 was not believed to have had unprotected contact with the other nurses, and that she did not have SARS-related symptoms.⁵⁰¹ They reiterated this message the following day.

On April 9, 2003, they provided the following update to staff:

We currently have seven patients on the SARS Unit. The three staff members that remain under investigation for SARS are stable. As stated yesterday, it has been determined that the third staff member had no

501. NYGH SARS Update #14.

unprotected contact with other staff, and does not have SARS related symptoms.⁵⁰²

Public health officials believed that the chain of transmission went from Health Worker No. 1 to Health Worker No. 2. Investigation to that point revealed that one of the nurses, Health Worker No. 1, had a connection to the Scarborough Grace Hospital, as her mother had been an inpatient between March 14 and March 18, at a time when SARS was spreading throughout the hospital. Health Worker No. 2 had unprotected exposure to Health Worker No. 1 in the staff lounge.⁵⁰³ Throughout April, Health Worker No. 1 and Health Worker No. 2 remained under investigation for possible SARS.

Health Worker No. 3 told the Commission that she had contact with Health Worker No. 2 when neither was wearing a mask or other personal protective equipment. Health Worker No. 3 was initially classified as a person under investigation, but on April 22, her case was closed with Public Health as she was classified as “does not meet case definition.” This meant that she did not meet the case definition for SARS, either suspect or probable, or for a person under investigation for SARS. Infection control and those involved in her care at North York General agreed with the determination that Health Worker No. 3 was not SARS. As Dr. Mederski, who was involved with all three cases, said:

She had also worked on 8 West but not at the same time as the other nurses and actually did not have contact with them. And, in fact, her duties, shift duty was not very extensive, so she was just sort of coming in and out briefly and there was no clear link with either of the two other ladies or with any other epilink and neither were her symptoms compelling, but just by virtue of the fact that she was on 8 West and this coincided with both [Health Worker No. 1] and [Health Worker No. 2], we decided to bring her in as a person under investigation. And I think the few of us who saw her did not feel that she had SARS at that time but we still felt compelled to investigate to a point.

After the last update about these ill nurses to staff on April 9, 2003, their status was never clarified or updated again. Beyond the above information provided to staff, that they were ill and under investigation, it was unclear what the result was. Was it SARS,

502. NYGH SARS Update #16.

503. NYGH SARS Update #16.

not SARS, or could be SARS but was still under investigation? There was no further explanation provided in the updates to staff, then or later, as to how these three nurses became ill, beyond the “possible link back to Scarborough Grace,” and their exposure to each other while unmasked during breaks.⁵⁰⁴

Health Worker No. 1 was neither reported to staff as SARS nor ruled out as SARS. She remained under investigation as a possible SARS case throughout April and May. Health Worker No. 2 was neither reported as SARS nor ruled out as SARS, even though she remained a person under investigation until May 3, 2003, when she was classified as “does not meet case definition.” The third nurse was reported to staff as early as April 8 as not SARS, even though she remained under investigation for possible SARS until April 22, when she was classified as “does not meet case definition.” Throughout April and, in the case of two of the nurses, into May, Public Health monitored their symptoms, identified their contacts and monitored their contacts for symptoms. Public Health had not ruled out the possibility that these cases could be SARS.

The following chart provides an overview of the classification and communication to staff in respect of these ill nurses:

	Date Admitted to Hospital	Classification by TPH	What Hospital Staff Were Told	Post–May 23 Classification by TPH
Health Worker No. 1	April 5/06	Remained PUI ⁵⁰⁵ until changed to SARS on June 23	Under investigation	Probable SARS
Health Worker No. 2	April 4/06	Remained PUI, until classified as DNM on May 3	Under investigation	Probable SARS
Health Worker No. 3	April 6/06	Remained PUI, until classified as DNM on April 22	Not SARS	Suspect SARS

504. NYGH SARS Update #12.

505. PUI is the classification category “person under investigation.”

Even after SARS, despite the fact that infection control and occupational health were actively involved in the investigation into this cluster of staff illness, and despite it's involving three staff members, hospital officials remain unclear about the outcome of the investigation. Dr. Keith Rose, when asked to describe the investigation into this cluster of illness, said:

There would be two parts to the investigation. Number one, how they got SARS, how they contracted it, what were their other contacts, what else needed to happen. And then there would have been the medical investigation of the patients to understand what disease did they really have. And my understanding was that the experts felt that these nurses, it was unlikely that they had SARS, and they had a rational explanation that they may have had another respiratory disease of which I don't know the details about. My understanding was that they felt very clearly that this was not SARS.

One member of the SARS Steering Committee, when asked what they understood to be the SARS status of these nurses, said:

At that time I don't think they could actually say they were or say they weren't because of the wishy-washy epilink. Because I would have thought if they thought it was SARS, they would have closed us down.

The report of the Joint Health and Safety Committee at North York General made the following comments, highlighting the continued lack of information among front-line staff on the cause of this cluster of illness:

The epidemiological link (the epilink) responsible for this mini-outbreak on the original 8W has not been identified and the situation remains unexplained. Whether this may have led to the spread of SARS to any other areas of the hospital is unclear.⁵⁰⁶

All three nurses were retrospectively classified as SARS: two as probable cases and one as a suspect case. To date the prevailing theory among public health officials remains that Health Worker No. 1 contracted SARS through contact with her mother, who contracted it on the coronary care unit (CCU) at Scarborough Grace

506. North York General Hospital, Joint Health and Safety Committee, Report, p. 37 (JHSC Report).

Hospital, and that Health Worker No. 1 spread SARS to the other nurses through unprotected contact that occurred primarily during staff breaks.

The story of these three nurses is also important because it underlies a later theory about the origin of the second outbreak of SARS, a theory that was developed in hindsight, after the second outbreak, and that was announced by Toronto Public Health on June 13.⁵⁰⁷ According to this theory, Health Worker No. 1 contracted SARS from her mother, who had been a patient at Scarborough Grace,⁵⁰⁸ and then passed it on at North York General to Patient A, a 96-year-old patient on 8 West. When 8 West became the SARS unit, Patient A was transferred to 4 West, the unit we now know was the epicentre of the second outbreak. This theory has since been rejected and the source of Patient A's exposure remains unknown. Patient A's story and the story of 4 West are told later in this chapter. An investigation into the outbreak at North York General found no evidence of any link between Health Worker No. 1 and the second outbreak.⁵⁰⁹

While no one knows with any certainty what caused the second outbreak at North York General, public health officials no longer consider that Health Worker No. 1 or the other two nurses had any connection to the second wave of SARS at North York General Hospital. Their story does not impact on the second outbreak as an early warning sign, a causal link or a missed alarm.

Their story is nonetheless an important part of the history of SARS at North York General. Not only did three health workers become ill, impacting their health, their fears of infecting their families⁵¹⁰ and their concern for their own lives, but their illness underscored to other staff the risk they faced just by coming to work.

By mid-April, with confidence that the contacts of these nurses had been identified and that the cluster of illness did not appear to be extending beyond these nurses, the matter appeared to have been put to rest. Although these nurses had not been clearly identified as SARS nor had SARS been ruled out, if they were SARS there appeared

507. Toronto Public Health, Daily Technical Briefing to the Press, June 13, 2003.

508. Toronto Public Health SARS Document, August 25, 2003, reported that Health Worker No. 1's mother was a roommate of two patients at Scarborough Grace Hospital, both later identified as SARS. Health Worker No. 1's mother's serology tested positive for SARS antibodies.

509. SARS Field Investigation.

510. A close family member of one of the ill health workers was hospitalized under investigation for SARS and was later classified as a probable case.

to be no further spread of the disease and a plausible explanation for its transmission and spread had been identified.

By April 11, 2003, the hospital was preparing for an anticipated return to Level 1 status and planning for an increase in activity,⁵¹¹ but as April progressed, the reality of the danger of SARS would resurface, as there would be further cases of staff illness. Two more nurses would be investigated for SARS, but both would be misdiagnosed and misunderstood, adding to the anxiety of those front-line staff who wondered just how safe they were and if they knew what was really happening in the hospital.

An Infected Nurse on the SARS Unit

On April 22, 2003, North York General staff were told in an update that a nurse from the SARS unit was under investigation for SARS.⁵¹² This transmission was alarming, as it occurred in an area of the hospital that, while at great risk, was supposed to be the most protected in terms of worker safety.

Health Worker No. 4 began working in the SARS unit towards the end of April. On one particular occasion, she recalled working with a patient who was thought to be a probable SARS case. He was quite ill and was having difficulty breathing. Health Worker No. 4 spent more than 30 minutes in the room with him before he was transferred to the intensive care unit. She began to feel unwell and went to the emergency department at Scarborough Centenary Hospital late in the evening on Friday, April 20. Early the next morning, April 21, she was transferred to North York General Hospital, where she was admitted to the SARS unit.

Health Worker No. 4's case was brought to the attention of the North York General Hospital SARS Task Force, whose minutes report that her illness was "believed to be most likely community acquired pneumonia" but that "the possibility of SARS had to be investigated."⁵¹³ The minutes also reported that the case was under investigation and proceeding as rapidly as possible.

511. North York General Hospital, SARS Task Force Steering Committee, Minutes of Meeting, April 11 and 12, 2003, 10:00 a.m., Main Boardroom – General Site.

512. North York General Hospital, SARS Update #23. The staff illness was also referenced in the April 21 SARS Steering Committee Minutes.

513. North York General Hospital, SARS Task Force Steering Committee, Minutes of Meeting, April 21, 2003, 10:00 a.m., Main Boardroom – General Site.

Later that same day, just a few hours after the Task Force Committee meeting whose minutes noted that the case was “under investigation,” an update was sent to staff advising them that the staff member who had come down with symptoms of respiratory illness and been admitted to the SARS unit had been investigated by infection control and that the investigation concluded that the “staff member does not have SARS.” The update said:

A key topic of discussion this morning was about a NYGH staff member who has come down with symptoms of a respiratory illness and was admitted to the SARS Unit. A detailed investigation by Infection Control and Public Health revealed that the staff member does not have SARS. We are treating anyone with respiratory illness with extreme precaution to ensure that we clearly identify and treat suspected or probable SARS cases as quickly as possible.

As a result of this information, we will continue on to function on Level 1 status.⁵¹⁴

The minutes from the Task Force Committee meeting the following day, April 22, reflected this:

Sunday night: nurse from NYGH Sars unit asymptomatic, remains on SARS unit, not SARS.⁵¹⁵

But this conclusion would change.

On April 28, 2003, the Task Force minutes reported that the same nurse who had previously been reported to staff as not SARS was now in the ICU at North York General Hospital, diagnosed with suspect or probable SARS. The minutes also reported that Toronto Public Health had investigated the matter previously and was doing so again, but the only epilink they found was 8 West, the SARS unit at North York General Hospital.⁵¹⁶ On the other hand, the minutes report that there were “no

514. NYGH SARS Update #23.

515. North York General Hospital, SARS Task Force Steering Committee, Minutes of Meeting, April 22, 2003, 10:00 a.m., Main Boardroom – General Site.

516. North York General Hospital, SARS Task Force Steering Committee, Minutes of Meeting, April 28, 2003, 10:00 a.m., Main Boardroom – General Site.

apparent breaches in precautions.⁵¹⁷ The precise cause of the transmission remained unclear. The update provided that day told staff:

A main topic of discussion this morning was about a staff member under investigation whose illness had progressed since being admitted eight days ago. Infection Control and Public Health interviewed all known contacts of this staff member when the investigation first got underway, and spoke with them again yesterday. Everyone is in good health. This situation is being carefully monitored.⁵¹⁸

The following day, April 29, 2003, staff were given the following update:

We also have an update to share with you about the staff member whose illness has progressed. It was confirmed last night that the staff member has probable SARS. A full, aggressive investigation into the possible source of infection continues.⁵¹⁹

In that same update, on April 29, hospital officials reported to staff that two patients on 7 West, the psychiatry floor, had been diagnosed with probable SARS.⁵²⁰ More will be said about the psychiatric patients below.

For some staff, this apparent flip-flop concerning Health Worker No. 4 was troubling, as they wondered if they were being given the right information or if those in charge really knew what they were doing. How could someone be ruled out so definitively, so quickly, and then later turn out to be SARS?

But those closely involved in the case explained that it was not unusual to identify a SARS case after the clinical picture deteriorated. As one doctor who treated many SARS patients explained:

It may look odd now in 2006, but at the time I think SARS was a new disease and the presentation of SARS was fever, fatigue and achiness, which had nothing specific compared to the rest of any other viral illness, and we were really learning at the time as opposed to knowing

517. North York General Hospital, SARS Task Force Steering Committee, Minutes of Meeting, April 28, 2003, 10:00 a.m., Main Boardroom – General Site.

518. NYGH SARS Update #27.

519. NYGH SARS Update #28.

520. NYGH SARS Update #29.

what the illness is all about. So, again, I don't have any recollection of seeing this patient or whatever, but looking back it would not be a surprise to say that somebody maybe decided not to label as SARS initially but as time goes by see that the patient has become more and more like SARS and then to change the diagnosis afterwards. It was not impossible, at that time.

Dr. Mederski recalled that although Health Worker No. 4 clearly had a potential epilink through her work on the SARS unit, Health Worker No. 4 was adamant that she had not breached protocol and that her illness may have other explanations:

When she first presented, again without the clinical chart, I can't remember if she did or did not have chest x-ray findings. She had a potential epilink insofar as she had been working on the SARS unit. Now this would have been obviously a major, major thing. We are talking breach of protocol in terms of potentially getting infected. The patient herself was adamant in all questioning that she had never breached protocol, that she had never done anything that could possibly have rendered her contaminated by SARS, and she was adamant that she had chronic recurring respiratory infections, of which this was merely another bout, and was adamant emphatically that she wanted to leave the hospital. She was quite stable the first few days, and I would guess then, in retrospect, this may have been what was happening in terms of the definition of whether she fitted SARS, because if she was adamant that she did not breach any barriers, then how could she have gotten infected with SARS. There was no other way she could have become infected. She didn't leave, she didn't go anywhere except home and to the SARS unit, home and to the SARS unit. So that's, I think, the way it was viewed by the investigators at that time, when we were feeding the information. There would be Public Health getting information from us and the daily update which they did, and making decisions around that, as well as my own clinical impression and those of my consultants who would have seen her.

So I guess at this point that her clinical condition definitely worsened by around the third day. She came in on a Sunday and, I think, by the Wednesday she was quite ill and by then she had developed clear-cut infiltrates on her chest x-ray and was clearly showing a rapid progression

that was quite different from the earlier days. And so, that may have then led to, hey, you know what, notwithstanding the apparent absence of contact, this is progressing now like a SARS case.

However, saying that she might be SARS but that they could not find a source of exposure was different from saying with certainty, as was done in the early days of this case, that this was not SARS. Even in the early days, those involved in Health Worker No. 4's case thought this could be SARS. So how did the message become so emphatic that it was not SARS?

At play in this case, and what will be seen as a recurring problem at North York General in the days leading up to the second outbreak, was a lack of clarity around the roles of hospital clinicians, infectious disease experts, Public Health and the Provincial Operations Centre: that is, the difference between a clinical diagnosis of SARS, or a clinical belief that a patient had SARS, and the formal classification of a patient as having SARS. Dr. Mederski reported that clinically, Health Worker No. 4 appeared to be a case of SARS, but that it was initially ruled not to be SARS:

Question: Such a definite statement, a detailed investigation by Public Health revealed that the staff member does not have SARS. Now I am presuming that this kind of a message, this is going out to the hospital in the present, doesn't get said unless that is what the report is to the Task Force, and it just seems so definite, that somebody has gone in, they have done a detailed investigation and they are saying this patient does not have SARS. And as we see within some period of time that she does have SARS, it's raising the question, who was making the call?

Dr. Mederski: This is case number four, five or six, or maybe even seven, but I am having, my personal opinions are SARS and my adjudicators are feeling probably not or possibly not at that point.

Question: Or definitely not?

Dr. Mederski: Or definitely not.

Question: The adjudicators were Public Health?

Dr. Mederski: Well, Public Health worked in concert with the Scientific Advisory Committee and POC's [Provincial Operations Centre's] scientific physician leaders, and I know for a fact that they always went to them for any dubious cases or questionable cases. And again, I would have called the POC. I had most of the time encountered [one of the doctors taking calls at the Provincial Operations Centre] answering the phone, because they had sort of a roster, and he then would in turn say to me, well I have to speak to Dr. [Donald] Low, or you have to speak to Dr. Low, or I'll talk to Dr. Low and then somebody will get back to you. I also know that that's where I was channelling through to Bonnie [Dr. Henry], to try to get to other physicians who had knowledge of these cases, because again it was kind of repertoire sequence, and asking them what was going on, and the decision would come either in the form of a discussion over the phone together as we did on the other cases or, as later, we had them actually come on site.

Also at play throughout the story of North York General Hospital was the breakdown in communication between Dr. Mederski, the infectious disease specialist who was in charge of communication with Public Health, and others. Although Dr. Mederski expressed the view, quoted above, that she was overruled with respect to this case, Toronto Public Health records dated April 21 report her as saying that she was "confident [that Health Worker No. 4] has community acquired pneumonia – Not SARS!"⁵²¹ This is consistent with Dr. Mederski's own evidence that the case was not at the outset an obvious case of SARS.

When case adjudicators came on site on April 27 to review this nurse's case and the case of two ill psychiatric patients, whose story is told below, they determined that Health Worker No. 4 was SARS.

521. Toronto Public Health case files for Health Worker No. 4, SARS Program Progress Notes, dated April 21, 2003.

Toronto Public Health officials said that their role was never to determine a clinical diagnosis of the patient and that they never overrode a clinical diagnosis of SARS. Their role was to decide if a patient met the case definition and to provide epidemiological support. As Dr. Bonnie Henry explained:

There are two parts, there is the clinical diagnosis and how you manage a patient, then there is the whole part of our responsibility at Toronto Public Health to report on numbers of SARS to the federal level and the Province and Health Canada, and that was a different issue altogether. That was much more about, do you meet this very narrow WHO [World Health Organization] definition that's adopted, and if you don't have an epidemiological link, then you don't officially meet that definition and it's a numbers game in a sense, which is a little bit separate from the individual picture that we were involved with. And certainly in April, North York was not the only facility we were involved with. There were daily discussions with multiple facilities about multiple patients who were on the SARS units. I think we had 19 SARS units at one point where we had contact daily with them, about all of the cases. So if something was misinterpreted perhaps, by Barbara [Dr. Mederski], if we said we are not going to include this person in, or they don't meet the case definition for probable SARS, maybe we had said something like that, she may have interpreted that as us saying she [Health Worker No. 4] doesn't have it, I don't know. I am just speculating that those are the types of things that could have happened.

As many doctors pointed out to the Commission, regardless of the actual classification of a person as SARS or not SARS, those cases at North York General where there was a suspicion of SARS were put in isolation and handled with precautions. Treatment decisions were not affected by a patient's classification according to the case definition. As Dr. Mederski told the Commission:

We did not know what to treat SARS with. The direction about how to treat these patients was, do essentially what you would do with any other respiratory-infected patient. So, give them all the different antibiotics you think they may need, do this and that, but additionally, if you really think it is, consider using steroids and ribavirin. So, those would really be the only salient differences between treating a sick respiratory case of other sorts and a SARS case. The isolation would technically be the same or should be the same. The degree of isolation, although if it's

somebody who's well, it should be the same, basically. But the actual issue of the epilink then, or not having it, doesn't change how you treat them because you are still going to treat them with everything you have at your hands, if it's a very ill patient. You are also allowed to just observe. You can just sit by and watch a patient depending on how stable they are. You don't have to treat, there is no such thing as treat right from the day they walk through the door, unless the treatment is indicated. So, whether the patient was identified as SARS or not, if they had nebulous findings, were not terribly ill, one would just sit back and observe and watch them closely, monitor them, do investigations to what was available to us at the time and watch what happened. And then, with the notion that this may end up being a SARS case, have a much lower threshold for charging in with the steroids and the ribavirin, which at that particular time were the only thing that differentiated SARS from non-SARS treatment.

While the medical treatment may not have been impacted by the formal classification or description of a patient, this misunderstanding of the respective roles had profound consequences for the information that was provided to staff. As will be seen time and time again at North York General, where Public Health determined that a case was not SARS for classification purposes because it did not meet the case definition, the conclusion taken by hospital officials and provided to staff was that the case was not SARS. But simply because a case did not meet the case definition at that time did not mean it could be ruled out as SARS. A person under investigation, and even one who did not meet the case definition at that time, could later end up being classified as SARS.

Although Health Worker No. 4 was initially determined as not SARS because she did not meet the case definition, she was under investigation for SARS and remained a person under investigation by Public Health from the time she was admitted to hospital until she was ultimately classified at the end of April as probable SARS.

The illness of Health Worker No. 4 caused concern for both the hospital and public health. Because of the protective environment of the SARS unit, they quickly determined that there appeared to be no unprotected contact with other patients or staff. But it was still unclear how Health Worker No. 4 contracted SARS. While she was hospitalized, battling SARS, she was repeatedly interviewed in an effort to understand how she had become infected. She recalled how frustrating the experi-

ence was because she was so ill and she was unable to provide an easy explanation for how she got SARS.

There are many possible explanations for her illness and no one will ever know with certainty precisely when and how Health Worker No. 4 was exposed to SARS.⁵²² Like the three health workers who became ill in April, Health Worker No. 4 appeared to have no connection to the second wave of SARS at North York General.

Around the same time that staff were hearing that Health Worker No. 4 did have SARS, some would also learn about the illness of yet another nurse. This fifth sick nurse appeared to fall under the radar completely, as both hospital officials and staff at North York General seemed unaware of her case. Significantly, had Health Worker No. 5 been identified as SARS at the time, her case would have represented transmission of SARS within the hospital, from a completely unknown and unidentified source, in an area where SARS was not believed to be present. And, as we now know, her illness, had it been identified, may have been an important early signal that there were unidentified cases of SARS on 4 West at North York.

522. Health Worker No. 4 reported that when she worked on the unit, she did wear the personal protective equipment as required by hospital policy. She told the Commission that she had not been fit tested, and she wore a respirator that she later discovered did not fit her. Also potentially reducing her level of protection was the fact that she was in the habit of wearing a surgical mask underneath the required N95 respirator, as she thought this would offer a higher level of protection. Because she had not been fit tested and had not been trained on how to properly apply the N95 respirator and ensure a proper seal, she was unaware that by wearing a surgical mask underneath, she was potentially preventing a proper seal being made by the N95 respirator. Although, as noted above, when and how she was exposed to SARS remains unknown, her story underscores the importance of proper training and use of personal protective equipment.

A Fifth Sick Nurse

On April 30, 2003, another nurse from North York General was admitted to hospital under investigation for SARS.⁵²³ Like the three nurses who were investigated earlier in April, Health Worker No. 5 had not worked with any known SARS cases.

Although it turned out in the end that she had SARS, a series of systemic failures together with the inherent difficulty of diagnosing SARS led to a failure to identify SARS.

Health Worker No. 5 recalled working during a night shift on April 27, 2003, with a patient who had previously been a patient on 4 West, the orthopedic floor that was the epicentre of the second outbreak. This patient developed respiratory problems and was transferred to the intensive care unit on the 6th floor at North York General Hospital. Health Worker No. 5 recalled that at that time it was believed that the patient had pneumonia, and that no one suspected SARS. She recalled taking a sputum sample from him, and she also recalled using suction on him and that there was some spray. Health Worker No. 5 could not recall whether or not she was wearing a mask when she cared for the patient. She reflected that at that time it was her understanding that if the patient was not suspected as SARS, staff did not have to wear a mask. Hospital policy, however, required that all staff wear N95 respirators in all patient care areas.⁵²⁴ Like Health Worker No. 4, her misunderstanding as to the use of protective equipment underscores the importance of training and education for everyone working on the front lines of patient care.

The following day, April 28,⁵²⁵ she began to feel unwell. She went to Toronto General Hospital, where she was put in isolation. She was told by doctors that they did not think that she had SARS. She reported that she continued to have a fever, muscle aches and a headache. She recalled that even regular doses of Tylenol would not break the fever. She worried that she had SARS and openly expressed this concern while in hospital. But they did not consider her to be a SARS case. As she told the Commission:

523. Health Worker No. 5 went to the emergency department on April 29, and was admitted to hospital on April 30.

524. North York General Hospital, SARS Task Force, "Droplet and contact precautions for staff," April 25, 2003.

525. Toronto Public Health records report the date for her onset of illness as April 29, 2003, but it was her recollection that she began to feel unwell on April 28.

All the time they didn't believe that I had SARS. I think it was because they thought I wasn't looking after diagnosed SARS patients. I was just working on a regular unit, so they didn't think I could have it.

While Public Health and doctors did not ultimately classify her as SARS, Health Worker No. 5 remained under investigation for SARS for some time. A May 6, 2003, x-ray report included the notation:

History: Rule out pulmonary embolism. Query SARS.⁵²⁶

The report also included the following summary of findings:

These findings are inherently nonspecific. It could be caused by an inflammatory process as SARS, but also by any other infectious agents. The wedge-shaped opacity in the right lower lobe could also represent an infraction.⁵²⁷

Initially, her clinical picture was unclear. As a Toronto Public Health report noted:

Her clinical picture also remains unclear (ie not following a SARS pattern) despite being 2 weeks into her illness now. She has had a fluctuating fever throughout, mild intermittent cough beginning May 7, some intermittent subjective SOB despite good O₂ sats, and occasional pleuritic-type chest pain. She had multiple normal CXRs, then a CT May 7 showing LIL and RLL infiltrates. Her radiologic picture has not progressed. She is clinically improving on azithromycin, ceftriaxone, and steroids.

She has had a negative stool PCR for coronavirus, other SARS work-up negative so far with more lab tests pending. Current clinical diagnosis is "unlikely to be SARS", persuing ? atypical presentation of TB and considering bronchoscopy.⁵²⁸

526. Report, dated May 9, 2003.

527. Report, dated May 9, 2003.

528. Email from Toronto Public Health to MOHLTC re: Urgent Canada SARS, May 12, 2003.

The physician in charge of her case at Toronto General Hospital said that while SARS was questioned from the outset, he was repeatedly assured that there was no possible epilink. As he told the Commission:

So initially I thought that her symptoms were compatible with SARS, but we thought she had not had any contact with SARS-infected patients or a staff member, and that was based on information from Public Health. So initially, before we were able to contact Public Health and have it worked out, I thought, well, maybe she had had some contact, but then after that it was vigorously denied that she would have had any contact with them.

Her physician said that it never became clear during the course of her illness that she had SARS. In addition to not having an epilink, her clinical presentation was not clear and lab tests suggested a possible alternative diagnosis.

Compounding the difficulty of diagnosing SARS was the fact that there was still no quick, reliable test to confirm or rule out SARS. Although Health Worker No. 5's physician sent specimens to the National Microbiology Lab for antibody testing on April 30, on May 13, and again after her discharge on May 23, results of convalescent serology testing were not available until after the second outbreak was discovered, at which time an epilink to a SARS case was also discovered.⁵²⁹

Health Worker No. 5 remained classified as a person under investigation for her entire admission to hospital, from April 29, 2003 until May 16, 2003. Toronto Public Health reported that during this time they did extensive investigation of her case and could find no evidence to support any exposure to SARS. When she was

529. The problem with a lack of timely and reliable lab testing would plague the SARS response. Without a reliable lab test and timely access to results, treating physicians and public health had to diagnose SARS on the basis of clinical presentation and the existence of an epilink. Because the clinical presentation of SARS was similar to so many other diseases, including pneumonia, the epilink became an important part of the diagnostic too. However, as noted throughout this report, as we now know in hindsight, the epilink could not always be identified. It is critical during future outbreaks that lab testing be coordinated and communicated in an effective and timely manner. The Commission endorses the many thoughtful recommendations of Dr. Naylor and Dr. Walker, as well as reiterates its own recommendations, which underscore the importance of improved information systems to allow the exchange of necessary information between local health units, hospitals and provincial laboratories and to ensure that the provincial labs have the capacity and the resources to perform vital scientific research and testing that is critical during a health crisis.

released from hospital on May 16, 2003, she was released on home quarantine, and she recalled that Public Health spoke to her repeatedly while she was in hospital and continued to monitor her after her release from hospital, while she was on home quarantine.

Public health officials report that doctors at Toronto General Hospital did not believe she had SARS and that they agreed with that assessment. As in many cases that went undiagnosed in the days leading up to the second wave of SARS, her lack of an epilink appeared to be a key factor. As Dr. Henry told the Commission:

They [Toronto General] didn't feel she had SARS, they didn't feel she was very sick. We carried out an epidemiologic investigation with North York, trying to figure out when she worked and was she on the SARS unit and was she around anybody who we knew was SARS. And there was something about the emerg, I don't remember the details. And in my discussions with Toronto General [Hospital], who were managing her, I think it was equivocal whether she had been anywhere that might have exposed her. We followed up with all of her contacts, of which there were not many as I recall. None of them became ill, and in some cases that was an indication that there was actually something that was going on, including her co-workers who we followed up with. Nobody else became ill. And my understanding was that the hospital's final decision was they didn't feel that she had SARS.

Health Worker No. 5's treating physician told the Commission that his opinion as to whether she had SARS fluctuated. One of the key factors was the repeated assurance that she had had no contact with a SARS case:

Question: Do you recall if you ever expressed an opinion to Toronto Public Health that you ruled out SARS, or this is not SARS?

Answer: I can tell you that my opinion fluctuated from time to time, but I don't think I ever was convinced at that time that it was SARS, but it would have varied because, of course, it was very normal basically, and later on she did develop infiltrates.

Question: So you weren't convinced it was SARS because the course was wrong and she didn't have infiltrates?

Answer: I think the big problem here is the lack of an apparent, according to them, the definition of an actual person that, if you look through the case definition, it is pretty specific, requiring a contact. They denied that there was any contact. In that sense, I can't say "SARS," but I have to ...

Question: "They" being Toronto Public Health?

Answer: Yes, everybody. I think it's the same situation, there were people that were questioning whether there was SARS. I wasn't aware of that. I think I talked to [Dr.] Bonnie Henry, who was up there, who was looking after the psych patients I think, and that's why I wondered about microplasma ... So the message we were getting from North York General, from the public health people at North York General, was, it was looking like all these people that might have been SARS were having an alternate explanation.

Although she was a nurse from a hospital that was treating SARS inpatients, there was no evidence that she had been in direct contact with a SARS case, hence there was no epilink. More will be said about the reliance on the epilink later. When SARS II hit, it would become apparent that experts' inability to identify an epilink did not mean a case could not be SARS. But at the time that this nurse was diagnosed, the epilink was still a key component of the case definition and simply being a visitor, patient or health worker in a hospital that had SARS patients was not considered an epilink.

Although Health Worker No. 5 was not classified as SARS, doctors and public health officials in May were unable to rule SARS out. She remained a person under investigation for SARS. So what was happening during this time at North York General Hospital concerning this case? Was North York General involved in discussions about the case, given that it involved a staff member and a possibility them having SARS? Even the possibility that she might have SARS was significant. If she did have SARS, it meant that there was an unidentified source of exposure in the hospital, a fact that should have been of considerable concern for those managing the outbreak at the hospital and for those on the front lines of the hospital who were treating patients and were to be on heightened surveillance for new SARS cases.

But no one at North York General seemed to have a good awareness of Health Worker No. 5's case. At the time of her admission and hospitalization, little was said about this case at North York General Hospital. The only reference to it can be found in the Task Force Minutes of May 1, 2003, which reports simply that a North York General Hospital nurse had been admitted to Toronto General under investigation for SARS.⁵³⁰ Nothing further was said about her case in any later updates or Task Force minutes.

Dr. Mederski, the infectious disease physician at North York General who had assumed responsibility during SARS I, recalled hearing about this case through the hospital grapevine, as nurses working in the ICU had heard about their colleague's admission and had asked Dr. Mederski about it. She recalled contacting the treating physician at Toronto General Hospital and being assured that they did not believe that Health Worker No. 5 had SARS.⁵³¹ She took this message back to the hospital and other staff, reassuring them that it was not SARS. She told the Commission:

I went back to the hospital staff, who were obviously concerned again for their own safety, and said, no, no, they do not think this is a case of SARS at all, but because she happens to be there, they are just putting her under investigation and so on and so on.

When Dr. Rose, vice-president at North York General Hospital, was asked about his knowledge of this case or any investigation into this case, he said:

And other than one of them being recognized in the SARS Task Force, and one of them being noted in the minutes of the Management Committee, my understanding was that we had very little to do with those. There was contact tracing, there was no suggestion of transmission at the hospital. In particular, the nurse that went to the Toronto General was not SARS or they didn't feel she was SARS and therefore it had very little impact on us.

It was no secret among Health Worker No. 5's colleagues that she was off sick and that she was in hospital. When some of the ICU staff learned that Health Worker No. 5's condition was deteriorating, they again raised the issue with Dr. Mederski.

530. North York General Hospital, SARS Task Force Steering Committee, Minutes of Meeting, May 1, 2003, 08:00 a.m., Main Boardroom – General Site.

531. The treating physician could not recall the specifics of conversations with Dr. Mederski and, although he said it was possible he spoke to her, could not confirm her recollection of the conversation. But he said that it is possible that he told her that Health Worker No. 5 did not have SARS.

Again Dr. Mederski contacted the treating physician at Toronto General for information, but the diagnosis or classification of SARS remained unclear.

North York General seemed unaware of Health Worker No. 5's case, and no alarm was raised over the possibility that she might have SARS. Dr. Mederski reported that once the nurse became a person under investigation, her understanding was that the investigation would be done through occupational health and infection control and that she was not part of this process:

Once this patient was now declared a possible, under investigation case, then the normal processes would advise whom, then in place, to investigate from our end. But that would be funnelled through occupational health and infection control and I wouldn't be privy to that information necessarily.

But the coordinator of occupational health was not aware of Health Worker No. 5's case and was not involved in the investigation. As she told the Commission:

Question: The next staff member was [Health Care Work no. 5], who was admitted to Toronto General at the end of April under suspicion for SARS. Were you involved at all in her case?

Answer: I wasn't.

Question: Do you recall if there was an investigation into her illness?

Answer: I don't.

Question: Did you ever review or receive a report regarding her illness?

Answer: No.

Infection control, which was aware of her case, reported that they could not get a diagnosis for Health Worker No. 5 but that Public Health determined she had no contacts. That appeared to be the extent of their knowledge about the case. As one member of the infection control team said:

Question: There was another health care worker, who was admitted to Toronto General Hospital at the end of May. Do you remember when you became aware of that?

Answer: I know that we couldn't get a diagnosis from her. I know about her. I know that I even called the infection control practitioner down there, and they didn't know for sure, but again, that epilink, because she worked in the ICU, she didn't work with known SARS patients, that I understand. Certainly, we wondered if maybe with her cultural background, that maybe she came into contact with someone out in the community. And it wasn't until afterwards that they found that, indeed, one of the patients from 4 West went to ICU, and she looked after that patient ... But as I say, it was all put together afterwards.

Question : When she was admitted to hospital, what was your understanding of what she was in hospital for?

Answer: Well, with fever and respiratory illness, I guess. And you know, they have to rule out SARS, but they couldn't we couldn't get a diagnosis from them.

Question : So was there an investigation done at that time within North York as to her possible source of illness?

Answer: Well, I guess that's when they determined that she didn't work with SARS patients, so once there would have been a link, the Public Health person that was assigned to our hospital was aware of that and she probably was involved with looking at potential [links].

No one at North York General Hospital seemed aware of the details of Health Worker No. 5's case and of the possibility of unexplained transmission, potentially through an unidentified source.

Yet during this time, Health Worker No. 5 was being treated in a SARS unit, in isolation, with precautions. While she was not classified as a suspect or probable case, she was considered a person under investigation. She remained under investigation until May 16, 2003, when she was classified as "does not meet case definition." This did not mean that she did not have SARS or could not have SARS; it meant that she did not meet the case definition for SARS. Between April 30 and May 16, 2003, Public Health was actively monitoring her case and attempting to identify her contacts and

any possible exposure. As Dr. Henry told the Commission:

And then she [Health Worker No. 5], I think, was designated as “does not meet the case definition” at some point. But in terms of the outbreak management, she was treated in isolation, she was managed as if she had the disease. We followed up on all of her contacts. She did not transmit to anyone else.

The problem was not the failure to categorize her as suspect or probable SARS or even the failure to diagnose her as SARS; it was the lack of information provided to North York General and the mistaken impression that North York General had that she had been ruled out as SARS. For public health classification purposes, she was ultimately ruled out because she did not meet the case definition. But practically speaking, that is very different from saying she did not and could not have SARS. The key feature that precluded her from meeting the case definition was the lack of epilink. But as we now know, the epilink wasn't missing; it was simply not identified at the time.

Because Health Worker No. 5 was not classified as SARS for public health purposes, this was mistakenly taken to mean that she was 100 per cent not a SARS case. There appeared to be no recognition within North York General that they may have a staff member who had contracted SARS through an unknown, unidentified exposure. Had they considered this, however remote the possibility, and had there been an extensive investigation into all of her contacts, would they have identified Patient B, the orthopedic patient from 4 West? Would that have led to an earlier detection of SARS on 4 West? It is impossible to answer these questions in retrospect.

It would be speculative to suggest that had Health Worker No. 5 been properly diagnosed, her case alone may have led investigators earlier to the simmering outbreak on 4 West. The link became obvious in retrospect, once associated with a cluster of illness on 4 West. It is impossible to know if and how the result would have been different had officials at North York General Hospital known that she was a SARS case.

What can be said, however, is that if the hospital had known there was a staff member under investigation for SARS and that, while there was no known epilink, this staff member was being managed and treated as a SARS case, it should have alerted them to the possibility of unexplained transmission within the hospital. This in turn might then have factored into their decision to relax precautions six days later, on May 7, 2003, in most areas of the hospital. It also might then have factored into the level of

awareness and heightened vigilance within the hospital to look for other possible SARS cases.

This is not to ignore the real and human possibility of a misdiagnosis or misidentification of SARS. As many doctors point out, SARS was very difficult to diagnose. Its symptoms resembled many other illnesses, including common pneumonia, and there was no test to establish whether someone actually had SARS. Added to all this, it was a new disease, about which experts were learning more and more as time passed.

The problem was not one of requiring perfection. The problem was that the inability to slot a patient into a very specific case definition, defining a new disease about which everything was still not known, somewhere along the way got translated into meaning that a case could not be SARS or that there was no possibility of SARS. As will be seen later in the story of North York General, staff, including physicians who were seeing patients with respiratory symptoms in May, operated under the erroneous belief that there had been no new SARS cases since early April and that SARS was no longer around.

The case of Health Worker No. 5 yet again reveals confusion around the role of public health and the role of the hospital. That those within North York General were so uninformed about the status of one of their staff members also reveals weaknesses in the chain of protection. No hospital should be left in the dark while one of its staff is being investigated for an infectious disease that could have safety ramifications for patients and other staff, as was the case in SARS.

As noted above, after the second outbreak was announced on May 23, 2003, and a review of cases related to North York General was begun, Health Worker No. 5 was retrospectively diagnosed with SARS. Later investigation revealed that her likely source of exposure was the patient in the ICU, a patient from 4 West, the unit that later became the epicentre of the second outbreak.

As April came to an end, things yet again appeared to be returning to normal. Although five⁵³² health workers from North York General had contracted SARS during April, it seemed to the hospital that their illnesses were isolated events and that, on the whole, the hospital had been successful at continuing to treat patients, including SARS patients, without transmission to staff and other patients. But the

532. Health Worker No. 3 is classified as a suspect case by the Ministry of Health and Long-Term Care.

question of whether there was unidentified exposure to SARS in North York General Hospital would be raised again, when three patients on the North York General psychiatric ward developed symptoms consistent with SARS.

The Outbreak on the Psychiatric Unit

Introduction

One of the most troublesome stories is the mystery of how three psychiatric patients at North York General Hospital contracted SARS. This is the story of three patients who in fact had SARS but were mistakenly said not to have SARS. The staff on the psychiatry unit registered concerns in April and early May that the three could have SARS. The hospital consulted outside experts and sought guidance from Public Health officials. The three patients were treated in the SARS unit⁵³³ and their cases were managed as if they were SARS, but they were not classified as suspect or probable cases because they did not conform to the case definition at the time, because there was no known epilink or connection to another case or to a SARS-afflicted area such as China.⁵³⁴ Under the rigid case definition,⁵³⁵ which required an epilink, a

533. Two of the psychiatric patients were transferred within North York General Hospital to a medical unit for treatment when they became ill, prior to being transferred to the SARS unit.

534. SARS Clinical Decision Guide (Ontario), April 23, 2003.

535. To define the diagnostic category for patients suspected to have SARS, health care professionals were directed by the SARS Clinical Decision Guide (Ontario) issued by the SARS Provincial Operations Centre (POC). A patient diagnosis would be made by a hospital clinician. But the classification of a case as either suspect, probable or a person under investigation, was determined by whether the patient met the criteria for those prescribed categories. The categories as of April 23, 2003, were defined as follows:

Probable Case: Clinical Symptoms: A person meeting the suspect case definition together with severe progressive respiratory illness suggestive of atypical pneumonia or acute respiratory distress syndrome with no known cause.

Epidemiological Link/Contacts: One or more of the following:

- Close contact within 10 days or onset of symptoms with a suspect or probable case OR
- A recent visit, within 10 days of onset of symptoms to a defined setting, or encounter with a group that is associated with a cluster of SARS cases OR
- Recent travel within 10 days of onset of symptoms to a WHO reported 'affected area' outside of Canada

Suspect Case: Clinical Symptoms: Fever (over 38 degrees Celsius) AND One or more respiratory symptoms including cough, shortness of breath, difficulty breathing.

Epidemiological Link/Contacts: One or more of the following:

- Close contact within 10 days or onset of symptoms with a suspect or prob-

patient could qualify for a SARS diagnosis if he had travelled to China but not if he was a patient in a SARS hospital. Staff were told the patients did not have SARS. In fact, as discussed later, all three had SARS.

The SARS diagnosis and classification was understood by hospital officials to mean the patients did not have SARS. On this basis, hospital officials repeatedly told a very troubled and concerned group of staff that these patients did not have SARS or, in the short form used, were “not SARS.”

But even as these assurances were being given, Public Health officials continued to monitor the three patients and their contacts. All three of the patients remained under investigation well into May, two of them remaining “persons under investigation” right up until May 23, the day the outbreak at North York General was announced to the public. Public Health classified them as “PUI,” persons under investigation. For those in the psychiatric unit, the repeated denial that these patients had SARS led to feelings of disbelief and mistrust, feelings magnified when it later became clear that they were right in their fears. All three of the patients had been infected with SARS.

probable case OR

- A recent visit, within 10 days of onset of symptoms to a defined setting, or encounter with a group that is associated with a cluster of SARS cases OR
- Recent travel within 10 days of onset of symptoms to a WHO reported ‘affected area’ outside of Canada

Persons Under Investigation

Clinical Symptoms: Fever over 38 degrees OR One or more of chills, rigors, malaise, headaches, myalgia

Epidemiological Link/Contacts: One or more of the following:

- Close contact within 10 days or onset of symptoms with a suspect or probable case OR
- A recent visit, within 10 days of onset of symptoms to a defined setting, or encounter with a group that is associated with a cluster of SARS cases OR
- Recent travel within 10 days of onset of symptoms to a WHO reported ‘affected area’ outside of Canada

OR

- Clinical Symptoms: Pneumonia clinically compatible with probable SARS
- Epidemiological Link/Contacts: No known epidemiological link

Community Acquired Pneumonia Or other respiratory/flu like illness

Clinical Symptoms: Clinical picture unlikely SARS
 Epidemiological Link/Contacts: No epidemiological link

Two Psychiatric Patients Become Ill

In April 2003, the psychiatric unit at North York General was a busy, vital part of the hospital, with many inpatient beds and outpatient services. Staff became concerned when, in mid-April, two inpatients who had been known to have contact with each other on the unit between April 13 and April 18 developed respiratory symptoms.

The first patient in question, Patient No. 1, a 31-year-old man, was admitted to the psychiatric ward at North York General Hospital on April 1, 2003. On April 17, 2003, he had a fever and was denied a weekend pass to leave the unit for Easter. He signed himself out against medical advice the following day, Good Friday, April 18, 2003, but returned to North York General Hospital via the emergency room on April 21. He had a fever and cough, and a chest x-ray showed pneumonia. The physician who saw him in emergency recalled being concerned that it might be SARS and he expressed that concern to the internist who took over caring for Patient No. 1. Although SARS was questioned, the diagnosis was not clear, as the internist explained to the Commission:

He had come back into the emergency room with some shortness of breath and then when it was recognized that he possibly could have picked up SARS within the hospital, was moved to a more appropriate room. And I was very impressed that his chest x-ray showed only a single lung infiltrate, but even when I went, and with that poor knowledge, specifically tried to see if there were any clinical findings that went with it, I couldn't find any. So his only point of contact as far as I could tell had been the clustering in the hospital recently.

Patient No. 1 was admitted to 3 North, a medical ward, under respiratory isolation, and started on antibiotics. In the early afternoon on April 28, 2003, he was transferred to the SARS unit, where he remained until his case was closed by Public Health on May 16, 2003.

By April 29, 2003, Patient No. 2 was also being treated on the SARS unit. She was admitted to the North York psychiatric ward on April 13, 2003. She went home for five hours on April 17, 2003. Her family recalled to the Commission that she was not feeling well while at home. She returned to the psychiatric unit on 7 West that evening. The following day she had a fever and a chest x-ray showed lower left lobe pneumonia. Dr. Mederski, who became involved in her case on April 18, recalled that although she questioned the cause of Patient No. 2's illness, the diagnosis was not

clear at the outset:

I was questioning a respiratory infection that wasn't getting better after two days in a person who otherwise was well, but I wasn't establishing in my mind necessarily that it was SARS.

Patient No. 2 remained febrile on the psychiatric unit until April 23, when she was moved to 3 North and placed on respiratory isolation. The following day she was transferred to the North York General SARS unit but was returned to a second medical ward, 5 West, later that same day, in respiratory isolation.

Public Health Becomes Involved

Although a SARS diagnosis was not initially clear for either of these patients, from the outset physicians involved in their care questioned whether it was a possibility. Dr. Barbara Mederski, an infectious disease specialist at North York General Hospital, told the Commission that she was very concerned about these two cases and that by around April 21, 2003, she was marking them on her SARS working list:

As I recall I was very concerned about this whole development. I had no evidence that this was SARS, but it was coincidence that there were these two patients with similar trajectory of events in terms of where they have been and how they got sick and the timing. Because the one of them was deteriorating, I felt that it was something that needed to be considered as serious. My note to myself, which is the only way I can really see what I felt at the time, is that, officially I had label of PUI, person under investigation, as I was directed to have, but I put down P, which meant, in my mind, probable. As I said, I had my own notation that was just for me.

Dr. Mederski said that as early as April 23 she contacted Public Health and expressed concerns about these cases, and that they contacted the Provincial Operations Centre.

A report by Toronto Public Health says that North York General infection control reported these cases to Toronto Public Health on April 27, 2003. Because SARS was a reportable and communicable disease, the hospital was required under the *Health Protection and Promotion Act* to report patients who may have SARS to public health

authorities.⁵³⁶

Dr. Mederski said that she went away between April 23 and April 28 but that while she was away she continued to worry about these patients and whether they could have SARS:

I then disappeared to Jamaica, where I am venting left, right and centre about these cases to objective physicians, saying, am I being completely ludicrous here, asking for input from objective bystanders? Coming back to Toronto to find that now I have, on the 28th, both patients are now on the SARS unit and saying, okay, I have this teleconference, I am now going to talk about this. Because I came back somewhat rejuvenated.

When she returned to work on April 28, both patients were being cared for on the SARS unit. She told the Commission that at that time she again discussed the cases with Public Health. Dr. Mederski said that it was not unusual for her to consult with Public Health about cases that could be SARS, but the diagnosis was unclear. When she discussed the case with Public Health and outside experts on April 28, it was decided that there would be an on-site visit to review the cases:

My usual protocol would be to call [Dr.] Bonnie Henry and [Dr.] Don Low and anybody else I could get a hold of. In this case [the two psychiatry patients], I called Bonnie Henry and I gave her the cases of the psych cases. I described what was happening. I told her that it was a much more complicated story this time because there was no evidence of epilink, but there was a link between two patients coming down with respiratory symptoms, suspiciously, one a well patient medically and another one not too bad either. Both of them were reasonably healthy people actually, so there was no good reason for them to become suddenly sick. And nobody in their families was ill so this wasn't easy to understand, why just they would be ill. But no epilink, to the normal epilink, as defined at that point. And so I ran that by Bonnie and she then proceeded to run it by Don and that's when we eventually got the

536. Section 27(1) provides:

The administrator of a hospital shall report to the medical officer of health of the health unit in which the hospital is located if an entry in the records of the hospital in respect of a patient in or an out-patient of the hospital states that the patient or out-patient has or may have a reportable disease or is or may be infected with an agent of a communicable disease. R.S.O. 1990, c. H.7, s. 27 (1).

coming to our site of Don Low, [Dr.] Tony Mazzulli and Bonnie Henry, to actually review this on site.

That evening, April 28, Dr. Bonnie Henry of Toronto Public Health, Dr. Don Low and Dr. Tony Mazzulli, both physicians from Mount Sinai Hospital, went to North York General Hospital. One of the adjudication doctors recalled being asked to go to the hospital to consult on these cases:

... I got called by [Dr.] Bonnie Henry. Bonnie used to phone me up quite a bit about trying to adjudicate cases, could this be SARS, and one thing I have learned from this whole outbreak is it is impossible clinically to tell whether, and this makes sense in hindsight, but it is impossible clinically to determine whether somebody has SARS or not. You might as well flip a coin. And to think that somebody who has had clinical experience with these patients is any better at it than the next person is madness ... There was concern at North York about three patients. One was a nurse that had looked after patients and was now sick, had looked after SARS patients, and two psychiatric patients that now had developed pneumonia. So Bonnie asked if I would go out to North York Hospital with her to look at these cases to try to decide whether or not they were SARS. I felt that I was going to be biased because I had made such a big noise about the fact it was going away ...

This doctor told the Commission that they reviewed the case of the two psychiatric patients and the case of an ill health worker, Health Worker No. 4, the SARS nurse whose story is told earlier in this report. At that time it was felt that these patients did not have SARS but that the health worker (Health Worker No. 4) did. As one of the adjudication doctors told the Commission:

... that night we sat out there and went through these cases. The nurse, it was clear that she had, there is no question she had SARS, and she had been admitted to the ICU. She was a ward nurse that had worked on the SARS unit and become sick. The two psychiatric patients were interesting ...⁵³⁷ The reason that they were kind of interesting, they spent a lot of time together on the psych ward and the psych ward is a

537. A short portion of the quotation, which referenced the patients' mental health diagnosis, has been edited out to ensure the privacy of these two patients.

real lockdown unit, you don't wander around the hospital if you are on the psych ward. In any event, these two people had spent time together. They both had been discharged before the Easter weekend. One was Jewish and had gone out for six hours and come back, and the other was a Christian who had gone home for Easter weekend but came back on the 21st. In any event, the week of the 21st, they both developed pneumonia and the question was, could these patients have SARS? They both came back with pneumonia and we talked about them and at the end of it all felt that we couldn't rule out that they didn't have SARS and that we didn't feel – there was no epilink, there was no way to explain either airflow or something, and so at the end of the day we treated them as if they had SARS. Subsequently there was another psych patient that developed pneumonia, that we never saw, but we heard about later, but in any event we reviewed the cases and made the decision that the nurse has SARS; the two psych patients don't so they wouldn't be included in the registry, but we would treat them as SARS, and put them in isolation.

This doctor said that although they were not classified as SARS cases, they were handled with respiratory precautions for the duration of their hospitalization.

Question: So they wouldn't be included in what registry?

Answer: Wouldn't go into the count as a SARS case in Toronto with the Ministry and Toronto Public Health.

Question: But you treated with SARS precautions?

Answer: Yes.

Question: In an ICU [intensive care unit]?

Answer: One of them ended up going to ICU for a short period of time, and so they were treated with respiratory precautions the whole time that they were sick.

A summary of the visit and findings prepared by Dr. Henry and later forwarded to North York General Hospital, described their role as “to review the charts” and “to assist the hospital in making decisions about the need to restrict staff or quarantine

staff or patients.”⁵³⁸ After both cases were reviewed, the two psychiatric patients were classified by Public Health as “persons under investigation, category 2.”⁵³⁹ According to the case definitions at that time, this meant that they had pneumonia clinically compatible with probable SARS but no known epidemiological link.⁵⁴⁰

Hospital officials, including Dr. Mederski, understood the position of the adjudicators to be that they did not feel these were SARS cases. In a followup email to the Provincial Operations Centre, Dr. Mederski wrote:

Please note that neither of the clinical cases in question has been defined as SARS – in fact the term specifically used is PUI – Category 2. Furthermore, both Drs. Low and Henry favoured NOT calling these pts [patients] SARS based on their clinical presentation.⁵⁴¹

Although Public Health may not have favoured calling these patients SARS, they had not ruled out SARS. As Dr. Bonnie Henry told the Commission:

So we had this discussion and the bottom line from that discussion was that these very possibly could be SARS and we needed to manage them as if they were. So again, from my point of view, the whole issue was, was anybody else sick? Is anybody else incubating this disease and how to make sure that they don't transmit to anybody else. So by the time that we heard about these patients, they had actually been ill for a period of time and actually I think Patient No. 1 was well on the road to recovery and hadn't got all that sick. [Patient No. 2] was the other person as I recall and she got quite ill for a while. I know they had been transferred between wards and there were issues around locking the doors and a lot of angst. So we had decided with the hospital again, they would look after their staff that were either on work quarantine or needed to be monitored at work. They would look after the inpatients. We would get a list of all the patients who had been in the psych ward at any period of time or the other wards that they were on ... and Toronto Public Health would follow up with all the outpatients. We would do all the contact

538. Summary of North York General Hospital investigation, April 28, 2003 prepared by Dr. Bonnie Henry.

539. Toronto Public Health Records and Summary of North York General Hospital investigation, April 28, 2003, prepared by Dr. Bonnie Henry.

540. SARS Clinical Decision Guide, April 23, 2003.

541. Dr. Barbara Mederski, email to Allison Stuart, Provincial Operations Centre, April 29, 2003.

tracing in the community, so the families of the patients. We also did a really concerted effort to see if anybody had been on that ward who had worked on the SARS ward, if they had cross-covered, if there was any of the family physicians, we went through a whole list of anybody who had been on the psych ward who might have passed it on. The way the three of them got sick within a very short period of time, it seemed to us from the epidemiologic connections that there was a point exposure.

They were all probably exposed around the same time by somebody or something, so we tried to put a lot of effort and one of the things that we were looking at was most of the smoking areas in the hospital were shut down because SARS precautions were used everywhere. But the psych ward still had a smoking area. So was there somebody who worked somewhere else who went up to the smoking area? We could not find anything. They were treated in isolation. They were managed as if they had SARS because we had this concern.

The clinicians were equivocal, [Dr.] Barb Mederski wasn't sure, [Dr.] Don [Low] thought they absolutely didn't have it, [Dr.] Tony Mazzulli said he thought they might. The answer was, if there is any doubt, we need to treat them as if they have the disease. So that's how we managed it and that's how we agreed to manage. There was no transmission from those patients. We followed up with everybody and couldn't find any other cases. We also followed up to see if there is, one of the thing about SARS was it was a diagnosis of exclusion, if there was sort of no reason for them to have it. So we did a bunch of testing for a variety of things including microplasma, legionella. The hospital had construction going on in one area, so that was a possibility. And I know Patient No. 1, and I think perhaps one of the, the third person tested positive for microplasma, so that was a compounding factor. It was a really very tricky trying to figure out what was going on. It was worrisome and we didn't have a good handle on how they could have got infected.

As described by Dr. Henry, after the adjudication and classification of the patients as persons under investigation, category 2, Public Health developed a plan of response, to ensure that the patients were monitored and that all possible contacts were identified and investigated:

Staff who had close contact without a mask with Patient 1 [referred to as Patient No. 2 in this report] between April 18 to 20 are sent home on

quarantine until May 1. Those who worked shifts on the ward from April 18 to 20 but who did not have close unprotected contact are to remain at work. They are to monitor themselves closely for symptoms and are placed on quarantine when at home. All other staff on the psychiatric ward are placed on active surveillance by occupational health (daily phone call and symptom check for those days staff were not at work) until May 1.

Patients on 7N who were on the ward between April 18 and 20 are to be monitored twice daily for fever and symptoms. Any patients who were on the ward between April 18 and 20 and who have been discharged must report to TPH. They are placed in quarantine at home until 10 days from their last contact on the ward.

NYGH and TPH assess all patients, visitors, physicians and staff who were on the Psychiatric ward between April 7 and April 17/18 to determine if anyone is unwell, to assess if anyone has an epidemiological link to a SARS case and to assess if anyone may have passed another illness on to the two psychiatric patients. No source of infection is found.⁵⁴²

Dr. Mederski told the Commission that the Public Health plan was in response to the concerns of the hospital, including herself, about these patients:

... the fact that they were being treated as if they had SARS, because the formal setup is that they're being investigated to the extent where the staff are being put into quarantine, so the contact of contacts are now being treated with concern. So if you were a worker on 7 West you would be put into quarantine. There was a lot of discussion as to how far to go with this, and if I am correct in recalling, this was not following the routine type of approach, because if you really felt they were not SARS you would not be bothering to put people into quarantine. There would be no point, if you're following the way it was laid out up to that point by the ministry, what to do. So, this is, I believe, more in response to our own, meaning the hospital's, concern that had been voiced over and over again and the staff concerns that we're not willing to say that these aren't cases. We are worried enough that we are going to do something about it, a

542. Summary of North York General Hospital investigation, April 28, 2003 prepared by Dr. Bonnie Henry.

little more than perhaps was expected at that stage, and so you have this meeting of halfway, that you are going to take precautions that you would normally do with people with SARS.

Dr. Keith Rose, the Vice-President responsible for the infection prevention control program at North York General Hospital, told the Commission that the illness among the psychiatric patients was of great concern to senior management and those handling the SARS response:

There was some discussion over the weekend. On the evening of Monday, April 28th, [Dr.] Don Low and [Dr.] Bonnie Henry and an infectious disease guy by the name of [Dr.] Tony Mazzulli, I think he was from Mount Sinai, I hadn't met him before, came to review x-rays and the history of two psychiatry patients. We had the entire psychiatry staff come in, not the entire, but the leaders and the managers in the psychiatry area, come in, because I remember calling them in. And it had to have been 10 or 11 at night by the time we left that meeting, it was quite late, in terms of assessing what those patients actually looked like and what precautions should we take.

At that point there was a decision made that we should move 7 North and 7 West to a Level 2⁵⁴³ and treat it as if there was potential transmission. Interesting, those patients, at the time of their diagnosis, were on medical floors. Their exposure to 7 North or 7 West had been some time back around the middle of April and they were there for a very short period of time. The manager of 7 West and 7 North was there. People knew what they needed to do in terms of advising the staff of why this had happened and what had gone on. At that point we were still in full precaution for all our patients, so in terms of our management it actually made little difference to the 7 North and 7 West. There was still a protocol, with direct care to treat patients with gowns and masks, there was still screening and all the other things that were going on that were relevant to SARS.

543. On April 30, 2003, the psychiatric unit (7 West) and 7 North were moved to a Level 2 status. The rest of the hospital remained at Level 1 status. The later confusion about the hospital's SARS status level is discussed below.

What Level 2 did, at that point was, the Chief of Surgery actually cancelled surgery – it was that date he cancelled surgery. Yes, because my log date was kept on Wednesday, April the 30th, because we were just starting to ramp up on new activity. And the concern was lack of information. Nobody knew the extent of how seriously ill they were. Whether, if this really was potential transmission, then would we go to a higher level? People were concerned that we would unknowingly bring patients into the hospital and therefore potentially create a home quarantine situation for them and that would not be acceptable. Therefore, the Chief of Surgery actually cancelled some clinics and cancelled surgery ... he did that late in the day on the 29th, because at that point they were doing the contact tracing and trying to understand where the patients had come from.

Meanwhile, Patient No. 2 remained unwell and she was transferred back to the SARS unit on April 28. Her condition continued to deteriorate. On April 30, the patient was moved to the intensive care unit. The doctor caring for Patient No. 2 spoke to her husband and told him that she would be intubated later that day. Intubation was an advanced life support step which involved inserting a tube into the trachea to provide an open airway to assist the patient in breathing.⁵⁴⁴ The gravity of her condition was explained to her husband, prior to the procedure:

Dr. Mederski called me at noon, told me my wife was in serious condition, deteriorating. She told me that a team of doctors, including Dr. Low, had examined her x-rays the night before and that her lungs were showing a worsening pneumonia and that is how the intubation decision had been made. Dr. Mederski explained intubation to me and told me as well they were going to put a feeding tube into her stomach and that they were going to operate soon. This was Wednesday at noon. She told me intubation meant putting a tube down her throat into her lungs. It was not a good day for me.

Later that day, Patient No. 2's husband spoke to the physician who performed the surgery and was told that they were unable to feed the intubation tube down his wife's lungs and a result they had to do a tracheostomy. A tracheostomy is an emergency procedure to surgically open the trachea to provide and secure an open airway.⁵⁴⁵ Patient No. 2's husband recalled that the physician told him that it was not certain

544. *Taber's Cyclopedic Medical Dictionary*, F.A. David Company, 2001.

545. *Taber's Cyclopedic Medical Dictionary*, F.A. David Company, 2001.

that his wife would survive and that only time would tell. He told the Commission that at that time he also asked the physician whether his wife had SARS, and he was told yes, she did.

Probable SARS to PUI

On April 29, at 9:30 a.m., the hospital reported to staff that two patients on 7 West, the psychiatric unit at North York General Hospital, had been diagnosed with probable SARS:

This morning, we have news to share with you regarding a few new developments that occurred late last night. Two people who were patients on 7 West have been diagnosed with probable SARS. Public Health and Infection Control are interviewing all staff and other patients who had contact with these patients. All at risk patients and staff who had unprotected contact with these patients on 7 W from April 18 to April 21 will be identified and carefully monitored.⁵⁴⁶

Later that same day, at 4:24 p.m., the hospital revised this statement, providing the following information:

We would like to share some new information with you about the two people who were patients on 7 West. We would like to update this morning's statement with the fact that those patients are classified by Toronto Public Health as people under investigation, and not probable SARS cases.

Both patients were immediately put on respiratory precautions once they exhibited symptoms. To alleviate some rumours, we would like to clarify that the patients remained on their unit and did not walk around the Hospital. All staff in contact with these patients followed all the appropriate precautions, and were wearing protective gear. One patient's incubation period is now complete and the second patient's incubation period will be complete on Thursday, May 1.

546. NYGH, SARS Update #28.

Public Health and Infection Control are continuing the investigation to determine the source of their infection.⁵⁴⁷

For some, this quick change was difficult to understand. How did the cases move from probable SARS back to being persons under investigation in the same day? Was the initial report correct and the second report an attempt to hide or minimize concerns?

In fact the classification of the patients did not change. At no point were the psychiatric patients classified by Public Health as suspect or probable SARS, until after May 23, when the second outbreak was announced. The psychiatric patients remained persons under investigations from the time of their being reported to Public Health until after May 23. Dr. Rose explained that the initial update to staff on April 29 was not meant to report a formal classification. The formal classification of these patients was not reported from Public Health until that day, at which time the update was amended to reflect the classification by Public Health as “persons under investigation.” He said:

Two patients admitted to the SARS unit, I don’t think at that point, that we had our PR people honed to call people, “suspect SARS, probable SARS, patients under investigation, category 1, category 2 under investigation.” I don’t think we had them defining that in our messaging. And so, I would’ve read this as, “you were admitted to the SARS unit, possible SARS,” and later in the day, recognizing that there was an official classification, that classification was officially “people under investigation” and that misconception was corrected.

But concerns that cases were being hidden was fuelled by the fact that the World Health Organization travel advisory⁵⁴⁸ was a big issue in Toronto. Municipal and provincial officials were heading to the WHO’s Geneva headquarters to argue against the advisory. Dr. Keith Rose was asked whether the travel advisory, or any other outside influences, weighed on the decisions of the hospital in respect of these or other cases:

547. North York General Hospital, SARS Update #29.

548. The World Health Organization issued a travel advisory against Toronto on April 23, 2003. The advisory was rescinded effective April 30, 2003. For more on the travel advisory, see “WHO Travel Advisory” in this report.

On my radar screen I don't have any time frame when there was travel advisories, when they travelled to Geneva, it doesn't even register on me, those dates. So, at the hospital we were not focused on what was going on externally in terms of travel advisories. That was not impacting our decision making at the hospital level in any way.

The Commission accepts that the change in status from probable to under investigation was not the result of an attempt to minimize or hide cases. There is no evidence that there was anything sinister, suspicious or improper in the changes in the communications described above. The reasons are fully and plausibly explained. The actual categorization of the patients did not change.

But the change in classification reveals the importance of clarity of communication. The hospital, in a sincere attempt to update the staff as soon as possible, released the first update before it had the benefit of the decision of the adjudicators, who classified the case as "person under investigation." Unfortunately, the reasons for the change from probable to persons under investigation were not clear to staff at the time. The communication left some wondering if these patients were believed to be SARS but were not being reported as SARS.

The miscommunication problem was not deliberate but rather the product of a system unprepared for a new disease like SARS, unprepared for any major infectious disease outbreak, a system without plans or protocols for effective communication. This problem is at the root of much of the difficulty that arose during SARS.

Hospital Remains Level 1

Now that these patients were considered "persons under investigation," the question arose as to whether the hospital should retain its Level 1 status or be elevated to Level 2. As noted above, Level 1 meant that a hospital had no unprotected SARS exposure to staff and/or patients but that it had one or more cases of SARS (suspect or probable). Level 2 meant there was unprotected SARS exposure within the last 10 days but without transmission to staff or patients. The designation of a hospital as Level 1 or 2 had implications for visitors, admissions, patient transfers and admissions from long-term care facilities, and clinical activity.⁵⁴⁹

549. "Description of activity for acute care facilities," April 14, 2003 (summarized in above text).

Following the April 28 adjudication, Dr. Bonnie Henry prepared a written summary of the investigation. She wrote:

The hospital remains Level 1 with the psychiatric ward considered a Level 2 area.

The hospital provided this information to staff the following morning, April 29, in an update. They reported to staff that the hospital would remain at a Level 1 status and that only 7 West and 7 North would move to Level 2 status. That same day, the chief of psychiatry corresponded with other psychiatry chiefs at other area hospitals, to report that North York General had two psychiatric patients currently under investigation for SARS and that the psychiatric unit was closed.⁵⁵⁰

MEMORANDUM

To: Chiefs of Psychiatry at
Sunnybrook & Womens College Health Science Centre,
Scarborough General Hospital, Trillium Health Centre,
Toronto East General Hospital, York Finch Hospital, Humber
River Regional Hospital, York Central Hospital, Markham
Stouffville Hospital, The Toronto Hospital, Mount Sinai
Hospital

From: Dr. Brian Hoffman, Chief of Psychiatry
North York General Hospital

Re: Closure of Psychiatric Inpatient Ward at North York General
Hospital Until (at least) Saturday May 3rd, 2003.

Date: 29 April 2003

550. Dr. Brian Hoffman, Chief of Psychiatry, memorandum to all psychiatrists and physicians, Re: Closure of Psychiatric Inpatient Unit, April 29, 2003; Dr. Brian Hoffman, Chief of Psychiatry, North York General Hospital, memorandum to: chiefs of psychiatry at Sunnybrook and Women's College Health Science Centre, Scarborough General Hospital, Trillium Health Centre, Toronto East General Hospital, York Finch Hospital, Humber River Regional Hospital, York Central Hospital, Markham Stouffville Hospital, The Toronto Hospital, and Mount Sinai Hospital, Re: Closure of Psychiatric Inpatient Ward at North York General Hospital until (at least) Saturday, May 3rd, 2003.

Dear Colleagues:

You may have heard that North York General Hospital has had two ... patients admitted to the psychiatric inpatient unit who developed respiratory symptoms. Both patients are now under investigation for SARS.

Accordingly, we are closing the ward to admissions until at least Saturday May 3rd, 2003 (assuming there are no new cases).

We would appreciate your help if any patients in our emergency room require admission. Please let your intake staff and on-call psychiatrists know of these developments.

Thank you kindly.

As an aside, this communication from the chief of psychiatry was an example of effective communication between hospitals. This communication from the chief of psychiatry to other hospitals was important, not only because it put other hospitals on notice that they might now get psychiatric patients who would normally be at North York General, but also because, as a result of this notification, other chiefs of psychiatry would have been on alert if a psychiatric patient with respiratory illness who had previously been at North York General Hospital came into their hospital. As will be seen throughout the story of SARS, hospitals can best protect themselves from a potential source of infection or a potential problem if they are informed about what is happening in the community and in other health care institutions. More will be said about the importance of communication between hospitals later in the report.

The designation level of the hospital was unclear. The Provincial Operations Centre felt that the entire hospital should go to Level 2. On April 29, Dr. Mederski sent an email to Allison Stewart at the Provincial Operations Centre, asking them to “reassess” the situation at North York General in light of the adjudication of the cases. In support of the hospital’s position that it should remain a Level 1 facility, Dr. Mederski reported the following information to the Provincial Operations Centre:

In reference to the very recently received document from POC identifying North York General Hospital as a Level 2 facility and with this attachment I wish to appraise you urgently of the final opinion of the POC Adjudication Team consisting of Drs. Don Low, Tony Mazzulli and Bonnie Henry after their on-site visit at our (NYGH) request yesterday evening April 28, 2003.

- 1) Please note that neither of the two clinical cases in question has been defined as SARS – in fact the term specifically used is PUI Category 2. Furthermore both Drs. Low and Henry favored NOT calling these pts SARS based on their clinical presentation.
- 2) there has been no epi link/risk identified for the “respiratory” cases thus far
- 3) The 7 W Psychiatry unit was in Full Precaution mode since the beginning of the epidemic
- 4) The patient in question was in full isolation in a locked total isolation unit with no breach of precautions from 12:30 hrs (afternoon) on April 20th and in Full isolation similarly but in another unit with a shared bathroom (but NO sharing patients) since April 19th 22:30 hrs. Yet in good faith we elected to “round off” the “quarantine range” to April 21st thereby identifying our 10 period as finishing on May 1st rather than April 29th ie. today. During initial discussions with the Adjudicators it had not been clear what precautions the psych unit employed. Later it was firmly clarified that indeed other than occasional patients wandering out of rooms not always fully masked there were absolutely no breaches in precautions from staff.
- 5) We EXPLICITLY REQUESTED this adjudication in order to establish our hospital’s status and were firmly reassured that – as in the case of many other institutions before us, only the psychiatry unit involved would be involved in any quarantine step as this did not affect any other area of the hospital
- 6) It is to be noted that there have been no instances in staff nor patients of illness during this quarantine period.
- 7) Finally, it has been suggested by the Adjudicators that the contact for these pts may well have been any patient on the psych unit – now discharged – who could have passed any resp’y infection on to our two patients. As an aside, these two patients are behaving “clinically” quite differently from each other and one of them is clearly improving at this time.

We trust your sound and prompt re-assessment of our situation in light

of the recommendations of the Adjudication group.

Thank you.⁵⁵¹

The April 30 minutes of the SARS Management Committee reported that the “POC’s suggestion that the whole hospital be Level 2 was being debated.”⁵⁵² But later that day, the Provincial Operations Centre clarified the SARS status for North York General, allowing the hospital to remain at Level 1 and only 7 West and 7 North move to Level 2.⁵⁵³

The change of status was confusing, and on April 30, at 9:15 a.m., the hospital sent the following update to staff in an attempt to clarify things:

Yesterday there was considerable confusion relating to the change in status for NYGH. This email is to notify you that the current SARS status for NYGH is Level 1. However, 7 North and 7 West (psychiatric units) will remain at a Level II category until May 1, 2003 due to a possible exposure which occurred April 18 to April 21.⁵⁵⁴

The classification of a unit within the hospital was unsettling to some, as it seemed illogical that a floor within the hospital could have a distinct classification, as if it were a self-contained unit without the possibility of access or exposure to the rest of the facility. As one nurse told the Commission:

What I found odd is that the hospital made it [the 7th floor] Level 1 but we didn’t realize that you could have a unit within the hospital that was a Level 2.

Particularly frightening was the knowledge that if these patients were SARS, no one could say where they got it. One physician experienced in the care of SARS patients explained that although the symptoms were consistent with SARS, they could not figure out how the patients were exposed:

551. Dr. Barbara Mederski, email to Allison Stewart, Ministry of Health and Long-Term Care, April 29, 2003, 5:48 p.m.

552. North York General Hospital, SARS Management Committee Minutes of Meeting, April 30, 2003, 0800 Hours, Main Boardroom – General Site.

553. Dr. Keith Rose, email to Allison Stuart, Ministry of Health and Long-Term Care, April 30, 2003, 13:29.

554. NYGH, SARS Update #30.

I remember multiple times discussing the issues of the psych patients that had syndromes that we thought were consistent with SARS, and not being able to identify how these people could possibly have been connected and infected with it, and going back and forth about that.

As noted below, the psychiatric patients were not always compliant with precautions, they were not easy to isolate and there was some concern about the ability to track their movements since the tracking relied on self-reporting.

Some within the hospital wondered why they weren't classified as a Level 3 facility. As one physician said:

If he [Patient No. 1] was SARS, we should have gone to Level 3 right then. It was hospital transmission.

Part of the confusion was the uncertainty over what the category definitions meant. Level 3 meant there was unprotected SARS exposure with transmission to health workers and/or patients. The health facility may or may not currently have one or more cases of SARS (suspect or probable).⁵⁵⁵ Did the unprotected SARS exposure mean that, having identified a new SARS case, the question was whether any other patients or staff had had unprotected exposure to that patient? Or did the unprotected SARS exposure include a new patient who may have contracted SARS from an unidentified source? Was unexplained transmission in a hospital enough to move to a Level 3 category?

Dr. Mederski explained her understanding of the categorization as meaning secondary transmission while unprotected:

This was in line with what were the directives at the time, that if there was a categorization of possible breach of precautions with secondary spread to a staff or patient, that would render that area a Level 2 area. That was following along the categorization that we were already experiencing right from the beginning of the outbreak, with our first emergency patient that [name of doctor] had seen. And the Grace Hospital was the precedent for the whole Level 3 and the closure of the hospital. So essentially this acknowledged the fact that there may have been

555. "Description of activity for acute care facilities by SARS categories," April 14, 2003.

transmission of SARS to a patient in breach of precautions. That's what that means.

Because we were trying to fathom whether this was truly only at the level of the psych unit, given that by this point, there had been no apparent transmission elsewhere within the hospital to any other patient, and therefore are we comfortable in closing only the psych unit. And that would have been done with the direction from Public Health. That wasn't the hospital's decision. And I know that there was a lot of thought put into that because clearly if there was this notion of patients wandering up and down, then one would argue that it could be a breach of precautions throughout the entire hospital. But I think that was where this whole discussion came around well, did these patients really leave the unit, did they really wander?

The categorization of the hospital had no impact on how these patients were managed. However, a change in category had significant consequences for the management of the hospital. For instance, a move to Level 3 would have closed the hospital to admissions and closed the emergency room and clinics. There would have been no new clinical activity permitted. All staff other than essential staff would have been placed on home quarantine, with essential staff on working quarantine.⁵⁵⁶

A move to a Level 2 facility would have permitted emergency and urgent case admissions only. Non-essential staff would have been permitted to work but staff would have been on working quarantine and not allowed to work in another hospital. By remaining at Level 1, the hospital was permitted to continue a gradual return to normal. There were no restrictions on admissions and clinical activity, except that guidelines with respect to transfers and discharges had to be followed.

One of the most significant aspects of changing a hospital's status was the impact it had on personal protective equipment. A Level 3 facility required the use of full droplet and contact precautions for all direct patient contact and the use of an N95 respirator or equivalent for all staff in the facility. A Level 2 facility required the use of full droplet and contact precautions for direct patient contact in all area(s) affected by the unprotected exposure. A Level 1 facility required the use of full droplet and contact precautions in any area with a patient who failed the SARS screening test or

556. "Description of activity for acute care facilities by SARS categories," April 14, 2003.

had respiratory symptoms suggestive of an infection, and for taking care of suspect or probable SARS cases.⁵⁵⁷

However, a change in level at North York General would not have impacted the use of personal protective equipment (PPE) in late April and early May 2003, as the hospital was requiring all staff to wear personal protective equipment. In effect, they were adhering to the protective equipment precautions required of staff in a Level 3 facility.⁵⁵⁸ But, as Dr. Rose pointed out, an important consequence of changing the level of the unit, in addition to no new patients, was the increased awareness:

No new patients. Full precautions were already in place, so the PPE didn't change, and increased awareness to the staff. One of the reasons that you do it is because you want that ten day period, if any staff becomes ill that could've been exposed during the 18th or 19th or 20th of April, when they figured the potential exposure might have occurred, is there any staff or any other patients might have come down with an illness. It was a heightened awareness.

There is no evidence of any hidden or improper motive with respect to the categorization of the hospital. The hospital had been told following the adjudication that these patients were not likely SARS. It had been approved by the Provincial Operations Centre to remain a Level 1 facility, with the exception of 7 West and 7 North. Hospital officials believed there had been no unprotected exposure to staff, and the absence of any staff illness supported this belief.

The problem with the categorization of hospitals was that it depended on the identification of SARS cases. The psychiatric patients were not identified as either suspect or probable patients. And the categorization did not explicitly address the situation of the psychiatric patients: a cluster of ill patients, under investigation for SARS, who, if they were SARS, had an unidentified source of exposure.

By remaining at Level 1, the hospital was permitted to return to normal, including admissions and clinical activity. It also sent the message that the hospital was safe. The

557. And use of full droplet and contact precautions in any area with a patient who fails the SARS screening test or has respiratory symptoms suggestive of an infection, and for taking care of suspect or probable SARS cases. This is the required level of precautions in a Level 1 facility.

558. However, no one had been fit tested on the use of N95 respirators and many staff reported that they had no training on how to apply and remove the protective equipment, how to get a proper seal or how to properly use the N95 respirator.

classification of the hospital as Level 1 suggested that any transmission was an isolated, contained event. Making the psychiatric unit Level 2 sent the message that any transmission was confined to the psychiatric unit and that the rest of the hospital was safe. But if the psychiatric patients had SARS, where had they gotten? No one knew.

And with a change in status came a heightened awareness. But by limiting the change to the psychiatric unit only, the heightened awareness was not emphasized throughout the hospital. As May progressed, many health workers, including many physicians, believed that SARS was over and that there had been no new cases. The belief that SARS was over lowered the general index of suspicion. In the result, a respiratory illness was no longer viewed by everyone with the same level of suspicion as was the case in March and April.

The impact of the mistaken diagnosis is impossible to calculate. But we do know from many witnesses that a lower index of suspicion leads to less vigilance in protective measures, just as a heightened index of suspicion increases vigilance. One part-time doctor explained how decisions about patients were impacted by the information on what was happening in the hospital, in particular about whether there were new SARS cases or exposure in the hospital:

Had I been one of the doctors who worked there every day and been awfully suspicious, and I know who those doctors are, who already had their antennae up, they're the ones who had not relaxed their precautions. I might have went, "hmm, I wonder." I might have done a little more investigation, more consulting.

It is safe to conclude that had the psychiatric patients been correctly diagnosed as SARS cases, the level of vigilance and protective measures would have been higher. Whether this heightened vigilance would have prevented the second outbreak is impossible to tell.

The confusion over the designation of the hospital also contributed to the worry that cases were being dismissed or ignored. By the end of April, there had been unexplained staff illness, confusion about the classification of the psychiatric patients (changed from probable SARS to not SARS but classified by Public Health as persons under investigation) and confusion over the designation of the hospital. None of this created a sense of trust and confidence in how cases were being handled.

Was SARS Contained?

As April ended, the psychiatric patients remained on the SARS unit and remained classified by Public Health as persons under investigation. Working with hospital infection control staff, Public Health identified and monitored contacts of these patients to determine whether there had been any unprotected exposure, and through the hospital, they closely monitored the health of these two patients.

By April 29, rumours swirled in the hospital about whether there was a new outbreak of SARS among the psychiatric patients. The psychiatric unit was closed to admissions.⁵⁵⁹ Of particular concern to staff was the question of whether patients had broken isolation and wandered off their unit, possibly exposing others while ill.

The hospital tried to respond to these rumours and to alleviate fears by telling staff:

Both patients were immediately put on respiratory precautions once they exhibited symptoms. To alleviate some rumours, we would like to clarify that the patients remained on their unit and did not walk around the Hospital. All staff in contact with these patients followed all the appropriate precautions, and were wearing protective gear.⁵⁶⁰

But in doing so, they expressed a measure of control and certainty that on review was not so clear. If the hospital could not say how the psychiatric patients got ill, how could they say that the exposure was limited to 7 West? How could anyone be certain that these patients did not move outside their unit and that they had no unprotected contact with staff or others? From the various interviews and documents provided to the Commission, it appeared well known that these patients were difficult to isolate and that the patients were not always compliant with precautions.

One of the physicians who first saw Patient No. 1 in the emergency department recalled that he was not isolated immediately when he entered the emergency department and that Patient No. 1 did not always keep his mask on:

557. Dr. Brian Hoffman, Chief of Psychiatry, Department of Psychiatry, memorandum to all psychiatrists and physicians, Re: Closure of Psychiatric Inpatient Unit, April 29, 2003.

560. Dr. Brian Hoffman, Chief of Psychiatry, memorandum to all psychiatrists and physicians department of psychiatry, Re: Closure of Psychiatric Inpatient Unit, April 29, 2003.

Both patients first became febrile while on the psychiatric unit and both spent time on medical units. Although staff did a remarkable job keeping them isolated and protecting themselves and other patients, their illness made them difficult to manage.

Although the psychiatric unit was a locked unit, it was not impossible for a patient to leave the unit. As one 7 West physician told the Commission:

Occasionally people manage to get out of the unit even when it's locked. They just sneak out. We try to avoid that as much as possible.

The April 29 memorandum to other chiefs of psychiatry from the chief of psychiatry at North York General reported that the two psychiatric patients “would not comply with respiratory precautions.”⁵⁶¹

A physician from 7 West remarked that they were very lucky that they did not have further spread, given the problems of isolating Patient No. 1 and Patient No. 2. He described both of them as being “totally noncompliant with protection.”

Dr. Mederski recalled how difficult it was to isolate Patient No. 1 while he was on a medical ward and that there were concerns that he might have wandered off the unit:

Patient No. 1 was found wandering all over the place, when he was on the medical ward. Some people say that they thought they saw him even downstairs. We don't know that for a fact. But there are statements to that effect that he had gone to the joint pantry, the communal pantry for patients on the ward, and so on and so on. So once this kind of thinking got clicked in and he started evolving more respiratory symptoms, we moved him right into the SARS unit.

Difficulties with isolating these patients were not restricted to the psychiatric unit or to the medical units. One of the physicians who worked with Patient No. 2 on the SARS unit recalled that her illness made it difficult to conform with isolation protocols:

561. Dr. Brian Hoffman, Chief of Psychiatry, memorandum to all psychiatrists and physicians department of psychiatry, Re: Closure of Psychiatric Inpatient Unit, April 29, 2003.

I remember trying to isolate her [Patient No. 2] and because of her psychiatric illness we had trouble isolating her because she'd walk out and disregard all the rules and so forth.

This inability to comply with precautions and isolation resulted in Patient No. 2 being transferred four times before April 28, as she moved from psychiatry, to 3 North, to the SARS unit, to 5 West and finally back to the SARS unit. Dr. Mederski told the Commission that the psychiatric patients posed a challenge from an isolation and containment perspective. When Patient No. 2 became ill she was moved to a medical floor and then later to the SARS unit. Once she was on the SARS unit, it was difficult to isolate her, so a decision was made to move her off the SARS unit. As Dr. Mederski explained:

She [Patient No. 2] was walking outside of the room in the SARS unit, essentially in all the areas where the nurses worked, within the SARS unit ... and the SARS nurses were really frustrated with that, the SARS unit nurses, because they did not feel this was right, and they couldn't keep her in the room ... This is a fully conscious person. So I asked them to move her back up to the psych unit, because although that room was not negative pressurized, it was locked, under full glass observation, so you could see if the person could do something to themselves, and didn't even have half the paraphernalia that the medical rooms had that could be endangering her. And that she was stable enough to go there. In other words, there was no need for any higher-level medical care at that point.

Staff were understandably concerned when they were told by the hospital that the patients had been immediately isolated and did not move around the hospital. A more cautious message to staff would have been more in line with the observations and concerns of those on the front lines who had worked with these patients. It appeared to some that there was a disconnect between what was being reported to staff and what was actually happening with these patients. As one nurse described the message from the hospital:

... basically have no fear, whether they were seen as SARS or not, they were isolated and treated. And that's not necessarily true. They tried to isolate them in their room but they remained on psychiatry for a period of time until they became medically unstable and then they had to move them from a medical reason. But there was a period of time, be it days, I

don't know, that they were on the psychiatric ward being treated by the psychiatric nurses, trying to contain them in their state ... but the frustration was, how do we contain these people. We are a psychiatric floor. They can't be contained.

Another worry for staff was whether these patients could be relied upon to be accurate historians of where they went and with whom they had contact. Another physician who worked with Patient No. 1 recalled how difficult it was to obtain a history from him. Knowing this, this physician was skeptical about the focus on contacts:

It was not possible because of his psychiatric illness to get an adequate contact history from him. One of the subsequent conclusions that I drew was that there were certain types of patients from whom a contact history would never be obtainable. The very young, the very old, the demented and those with psychiatric illness. So, all this intense focus on contact breaks down when you look at some of the subsets of patients that we see. And I think at that time, given the second case, the one that had the asymptomatic contact, and then the psychiatric case, all this public posturing over contacts made me very skeptical and very dubious.

The staff working on 7 West struggled under difficult circumstances. As one outside observer told the Commission:

The one-to-one nurses, the nurses that were assigned to the floor were scrambling to do everything to detect its cause, to see where it was coming from, to protect the patients, to institute anything they could to prevent further spread. But it was sort of like doing it blindfolded because nobody knew exactly how it was getting in there and what was happening.

One physician who worked on 7 West noted that, although the patients were non-compliant with their requirement to wear masks, staff were very careful:

One of the problems we clearly had was that too many of our patients were noncompliant. That led other parts of the hospital to think the staff were noncompliant. Once we had the two infectious cases, the staff were really good. And it was unbelievably uncomfortable, that gear, and in mental health, how do you interview anybody with masks and sometimes gowned and gloved? It's one of the most bizarre situations I've ever been in.

Fortunately, the nurses on the psychiatric unit, the medical units and the SARS unit did their best to isolate the patients, despite the difficult circumstances. They were vigilant in the use of precautions themselves. It is important to note that there was no known transmission from the psychiatric patients to other patients, visitors or staff. Clearly the cautious approach of staff and the adherence to their own use of protective equipment was critical. It is reasonable to assume that their extra attention to precautions prevented even further spread of SARS.

The two ill psychiatric patients remained under investigation for SARS by Public Health, but there were still no clear answers. As Dr. Mederski explained, one patient was getting better but the other remained quite ill and despite extensive investigation no one could determine an epilink:

By this time, by that last week of April, both of them now, he was remaining quite stable, she on the other hand was getting worse. And her clinical condition was a worsening respiratory picture but again we had no link with any epilink. The link seemed like between these two patients, but [there was] no link to any other epilink that anybody could come up with. We went to the extent of having occupational health review all the nursing staff on that floor, had any of them been on the SARS unit, had any porters been on the SARS unit, some communal shared services go into the psych floor, and then down to the SARS unit. The thought that a lot of people kind of said was, maybe Patient No. 1, because he was known to be a wanderer, maybe he stepped out of the psych unit and ended up on the SARS unit unbeknownst to us, at some stage, got infected and then came back to the psych unit and infected her. So there was all these perambulations were being discussed, but no firm epilink ever came of it at that point.

No one was calling them SARS but no one could rule SARS out. And, if it was SARS, no one could say where or how they were exposed to the virus.

A Third Patient Becomes Ill

By May 5, a third patient was under investigation at the hospital for possible SARS.⁵⁶² Patient No. 3 had been admitted to the psychiatric unit on 7 West at North York General on April 22. She developed symptoms on May 5 and was transferred to the SARS unit the following day. The minutes from the May 6 meeting of the SARS Management Team reported that the case was “unlikely SARS.”⁵⁶³ The May 7 minutes reported that the patient was under investigation and that Public Health was to be involved.⁵⁶⁴

Although it was not believed that Patient No. 3 had had contact with Patient No. 1 or Patient No. 2, she had stayed in two rooms on the ward, both of which were used by Patient No. 2 while Patient No. 2 had respiratory symptoms.

Dr. Mederski again phoned Public Health for guidance. She recalled that there was great fear among the staff and more questions than answers:

I’m on the phone to [Dr.] Bonnie Henry to say we’ve got now a third psych patient. Now, this is the very interesting case because you look at time frames. This is way out of keeping with the other two. They’re already either gone home or have got better or whatever. Time incubation is way out of line, this is weeks later. Out of the woodwork comes the [another] psych patient. Well by now the fear is unbelievable. We thought we’d cleaned 7 West enough, didn’t we.

Dr. Mederski told the Commission that when Patient No. 3’s condition deteriorated and the patient had to be transferred to the intensive care unit, Dr. Mederski thought it might be SARS and she expressed her opinion to the family of Patient No. 3. Dr. Mederski said that she believed the physician who took over the care of Patient No. 3 also thought it was SARS. Patient No. 3 rapidly deteriorated; by May 11 her condition was critical and she required intubation.

562. North York General Hospital, SARS Management Team Minutes of Meeting, May 5, 2003 – 0800 Hours, Main Boardroom – General Site.

563. North York General Hospital, SARS Management Team Minutes of Meeting, May 6, 2003 – 0800 Hours, Main Boardroom – General Site.

564. North York General Hospital, SARS Management Team Minutes of Meeting, May 7, 2003 – 0800 Hours, Main Boardroom – General Site.

On May 7, the hospital reported to staff that another psychiatric patient, the third to raise SARS concerns, was under investigation for SARS:

This morning we have some news to share with you. Last night, an inpatient on 7 West developed a fever. The patient is now under investigation and has been transferred to the SARS Unit. As a result of this situation, 7 West is going to Level 2 status, and will not be admitting patients.

It has been determined that staff were following all precautions and had no unprotected contact with the patient. Infection control is investigating.

Later today, we will update you on changes to policies and this situation.⁵⁶⁵

Again, the hospital remained a Level 1 facility, changing the level in one area within the hospital, as opposed to the entire hospital. It is difficult to understand how the entire hospital was permitted to remain a Level 1 facility in light of the fact that they had now a third case of a patient under investigation for SARS from an as-yet-unidentified and unknown source. This time, the Provincial Operations Centre felt that even 7 West did not have to move to a Level 2 category. Out of caution, the hospital independently decided to move the 7th floor back to Level 2. As Dr. Rose told the Commission:

This patient was an inpatient on the psych ward. So, the previous two psychiatry patients had been on psychiatry, April 18th, 19th, 20th. Now we're at May the 7th, and this is an inpatient on their own ward. So, beyond the exposure of the other ones, and an inpatient. So, much more heightened awareness of staff, potential problems related to this patient because they had been cared for all along on that floor. The patient had been isolated and had been under appropriate precautions, and that's why the hospital didn't change levels. Even at the time the POC said we didn't need to change the level of the ward because we had done all the appropriate precautions. But we closed the ward on our own.

Also that day, May 7, Chief of Psychiatry Dr. Brian Hoffman sent another memorandum to all chiefs of psychiatry in the GTA hospitals telling them that there was

565. NYGH, SARS Update #34.

another patient under investigation for SARS, that the previous two patients remained under investigation on the SARS unit and that the psychiatric unit was being closed to admissions.⁵⁶⁶

May 7 was a key date in the second outbreak. Not only were staff learning about a third psychiatric patient under investigation with SARS, but this was also the date that the hospital, in accordance with overall provincial directives, relaxed universal precautions throughout the hospital.⁵⁶⁷ Some staff saw this as a welcome respite from the stress and strain of wearing personal protective equipment at all times. For others it was a controversial decision that signified a disconnect from the concerns of those who believed the psychiatric patients were SARS and that there was an unidentified SARS exposure. More will be said later in the report about the relaxation of precautions at North York General Hospital. It also will be noted that the hospital relaxed precautions no earlier than other hospitals and did so in compliance with provincial directives. Also addressed below is the disconnect which appears between the May 7 announcement of a new case of SARS and the May 7 relaxation of precautions.

The following day, May 8, staff were told that 7 West was to be thoroughly cleaned and that infection control continued to investigate the situation. Although precautions were relaxed in other areas of the hospital, they were to continue on 7 West and the unit was once again closed to new admissions.⁵⁶⁸

The May 8 SARS Management Committee minutes included the following notation:

566. The memo provided:

The Department of Psychiatry at North York General Hospital has had another inpatient develop a fever and cough. This patient has been transferred to the SARS unit and is presently under investigation for SARS. As with the previous two psychiatric inpatients, there was no known contact with an epicenter or a SARS patient. The other two patients are still under investigation on the SARS unit.

We are closing admissions to the psychiatric unit at this time.

I appreciate any assistance you are able to offer our crisis team and psychiatrists if they have to contact your unit for admissions or transfers. Please feel free to contact me if you require further information.

567. NYGH, SARS Update #35.

568. NYGH, SARS Update #36.

The Clinical Chiefs have registered concerns about the 7th floor situation. They view it as a cluster of SARS cases with unexplained etiology and feel we need to respond from a risk management perspective. They are requesting an external evaluation, and that 7 W should be treated as a level II.⁵⁶⁹

Dr. Glen Berall, co-chair of the SARS Management Committee, told the Commission that they took this concern by the clinical chiefs seriously, and that they responded to it:

There was discussion with Health Canada, and I think that's because they were at the time there, they had the discussion all together by phone, and reviewed the information and the data on the cases and decided that it was not SARS. And not only that, it's the federal government that calls in the CDC [Centers for Disease Control], as I understand it, that's what I was told, and Health Canada didn't feel that they needed to call in the CDC at this point in time so they weren't being called in. And I reported that in the meeting because that was what I was told, but that they were running the data that they had taken from the environmental samples on 7 West previously, and that we'd have our answers back. So what I did with the concerns of the clinical chiefs was, I brought their information forward, they ended up being discussed with Public Health again, with Health Canada as well. The request for the CDC was put forward and we followed up on the environmental samples.

Dr. Berall told the Commission that he understood that the clinical chiefs were satisfied with the response and the followup:

They were satisfied that we had discussed it with the experts. They were satisfied to hear that they were getting the environmental sample results back. They were satisfied to hear that Health Canada had been involved in the discussions. That was their [the clinical chiefs'] response.

569. North York General Hospital, SARS Management Team Minutes, May 8, 2003, 0800 Hours, Main Boardroom—General Site.

Also that day, the chief of psychiatry issued a memorandum to all staff psychiatrists and physicians, as well as the unit administrator, the program director and other middle managers. The memorandum provided the following information:

As you know a female patient from 7 West has been transferred to the SARS Unit the night before last. She is still under investigation.

Nevertheless, we have asked the hospital to re-do a thorough cleaning of the south side of 7 West, including the air vents. We have also asked the hospital to investigate the cause of the water stains on the outside walls of some of the rooms on that side of the building.

In addition, there will be a discussion with Public Health to discuss the process for a complete investigation of any possible air or droplet circulation between 8 West and 7 West.

The province has not directed us to Level 2. Nevertheless, we are going to take Level 2 precautions and avoid admissions to 7 West and 7 North.

We will follow the clinical state of the new patient very carefully and will keep you informed if there is any evidence for the development of SARS.

With respect to the previous two 7 West patients who developed symptoms two weeks ago, one developed microbacteria that would explain his symptoms. The other patient is currently being treated as a probable SARS case and remains with a tracheotomy in the ICU. She appears to be making some positive progress.⁵⁷⁰

The news that a third psychiatric patient had developed respiratory symptoms was of great concern for the psychiatry staff. Many of the staff believed that the previous two ill psychiatric patients had SARS. For them, the question was not whether these patients had SARS, but where was it coming from? They worried whether the ventilation was safe or whether something was leaking through the ceiling. As one health worker told the Commission:

570. Dr. Brian Hoffman, Chief of Psychiatry, memorandum to: all staff psychiatrists and physicians, Saul Goodman, Jean Smyth, Marilyn Ferguson, Helen Ross, re: SARS Update, May 8, 2003.

... they [the three patients] were all in the same seclusion room at different times, an inpatient unit has rooms and it's a locked unit, and then we have a special care unit that has three separately locked, contained, walled seclusion rooms that are very small with an outside window. And this is where we would keep our patients who are most ill and they had all been in the middle seclusion room at different times ... The staff were concerned, as to this type of ceiling, that there was leakage from the ceiling. And that was directly under the SARS unit above that had a patient room right above it, because the layout of the floors, of course, is the same. Our reconstruction was that rather than having one patient room, we made it into three small cubicles. So they said, well there must be something wrong, there's something coming through the ceiling, which was denied ... The staff were bringing up all kinds of possibilities, you are doing all this construction, there is a new mechanical room being built, how do we know what's coming through the air vents, how do we know what's coming through the water pipes, whatever.

The stains were investigated and ruled out as a possible source of SARS exposure. As the SARS Field Investigation noted:

7 W was directly below 8 W, a SARS unit, and there were concerns related to water stains on ceiling tiles in multiple rooms on 7 W. Capt. Ken Martinez, an industrial hygienist/environmental engineer from NIOSH [National Institute for Occupational Safety and Health], concluded that the sewage pipes were on the opposite side of the room of the ceiling stains and were not the source of these stains. Rather, the stains were leakage from previously disconnected closed loop ventilation induction units between 7 W and 8 W that were improperly capped or represented drainage of residual water out of those units. Environmental samples taken in the vicinity using viral culturette swabs tested negative for SARS-CoV by PCR. There was no evidence that the ceiling stains contained infectious material from SARS patients.⁵⁷¹

In the meantime, the staff on 7 West, convinced they had three patients who had contracted SARS while inpatients on the unit, tried to understand how SARS could be getting on their unit. The hospital, also worried about this third ill patient, was again consulting with Public Health officials and outside experts for guidance.

571. SARS Field Investigation, p. 23.

May 8 Conference Call

On May 8, during a meeting/teleconference involving physicians from all levels of government, outside experts and Dr. Mederski, the psychiatry cases were presented. After a discussion about them, the consensus was that the patients did not meet the definition of SARS, primarily because there was no epilink.

Although the psychiatric patients were not called SARS or classified as SARS, it was decided that out of caution they would be managed and treated as SARS cases.

One expert who participated in the conference call recalled that there was a lot of concern about these patients. He described the problem with the epilink and the conference call as follows:

So you had some people that were popping up with atypical pneumonia in a cluster fashion, and Barb [Dr. Mederski] knew that and Toronto Public Health, I believe, knew that. There was actually a teleconference call on May 8th. But there was a teleconference call which I was part of and several physicians from the greater Toronto area were on that. Basically around the room it went, do you think these psych patients have SARS? And there was actually even a vote taken and the general consensus from the clinicians – and it wasn't just Barb Mederski, there were others – I think what I heard from Barbara Mederski was a lot of concern at this time, but other people were concerned too. I think they were giving honest evaluations, the other clinicians who were part of this. And they're giving honest evaluations and because they didn't see an epilink they decided that it probably wasn't SARS. On May 8th on that call we knew about the three psych patients and the onset dates that I had in my notes were the 18th for one, the 17th for another and the 23rd for another. There was a cluster of atypical pneumonia in these psych patients and there weren't real good lab tests as you know. There's no lab test that immediately can tell you but one of those had a weekly positive stool PCR for SARS. And that was then repeated and it was negative. This is the one who had an onset, I think on the 17th. And the feeling was it was a false positive. We know false positives occur with these tests. And there was nothing that really stuck out. You've heard about the low white count, the low white blood cell count, the low platelet count. None of those things were really sticking out there,

although none of those are that specific anyway. But they did have atypical pneumonia, and they were a cluster.

Toronto Public Health files indicate that on May 1, there was a positive test result for SARS coronavirus in the stool of Patient No. 1. This was later followed by a negative result. Although the first positive result added to concerns, it was not determinative of anything and the second negative result suggested that the first result was a false positive. As Dr. Henry explained:

Question: So when the discussion ... was the issue of a positive stool sample on the table?

Dr. Henry: I believe so.

Question: It is not something that got just overlooked?

Dr. Henry: No, gosh no. The testing was so uncertain at that time, it was unclear, what a positive or a negative meant. A negative was occasionally helpful, if you had multiple negatives you were pretty sure, but if you had multiple tests done and one was positive weekly, it didn't tell you anything. So it's just so hard to know if you don't know what the tests parameters are. You don't know what the false positive grade is and what the false negative grade is. So testing was extremely unhelpful in multiple cases. The only testing that became helpful was the serology testing eventually, but we found out that most people didn't develop antibodies until several weeks after infection, so that wasn't helpful in making the initial diagnosis. We did do a look back at all of the PCR [polymerase chain reaction] testing we had, because most of the PCR testing, there are two types of PCR tests done. There was a nested PCR, which is a way of basically amplifying small pieces, like very small amounts of RNA, in this case, and it is much more susceptible to false positive. And then there is RT, or reverse transcriptors, PCR, which is much more specific but you need to have more nucleic acid available for it to be accurate. So if I recall, Patient No. 1's stool was a nested PCR and the RT PCRs were all negative, so it kind of made it, who knows. The RT PCR is what got the ... I don't know if you recall, but there was the nursing

home respiratory outbreak in B.C., and the National Micro Lab had done this nested PCR and said, oh, my God, it is a SARS outbreak, and then these people weren't sick and it caused a great deal of angst. It is still to this day not a very accurate test, and they are certainly putting money into developing a test. They are putting a lot of money into a vaccine and things.

Although one participant in the call recalled that the Centers for Disease Control and Prevention suggested that they consider serology testing to rule out SARS, serology tests took weeks to perform and did not always provide conclusive results.⁵⁷²

In the meantime, the psychiatric patients remained in this uncertain place – treated as SARS, not classified as suspect or probable SARS, but not ruled out as SARS either. But staff were not aware of this uncertainty and were not aware of the behind-the-scenes consultations and discussions with outside experts. Questions remained about the psychiatric patients, and staff continued to be concerned about the unexplained illness of these patients.

NYG 7 West Cover-up?

One unsettling question about North York General is whether the hospital was completely open about the outbreak of SARS in its psychiatric unit in late April and early May.

On May 7, concerns that there may be a third psychiatric patient with SARS closed the psychiatric ward to new admissions. The closure of the unit was reported by the chief of psychiatry to other area psychiatric units in the following memo:

The Department of Psychiatry at North York General Hospital has had another inpatient develop a fever and cough. This patient has been transferred to the SARS unit and is presently under investigation for SARS. As with the previous two psychiatric inpatients, there was no known

572. The most accurate form of testing involved convalescent serology testing. This required that a sample be taken at multiple stages of the illness, to determine if the patient developed antibodies to the SARS coronavirus. In some cases antibodies did not develop until more than 28 days after the onset of illness. Source: CDC Fact Sheet, SARS Laboratory Diagnostics.

contact with an epicenter or a SARS patient. The other two patients are still under investigation on the SARS unit.

We are closing admissions to the psychiatric unit at this time.

I appreciate any assistance you are able to offer our crisis team and psychiatrists if they have to contact your unit for admissions or transfers. Please feel free to contact me if you require further information.

The same day, the hospital sent an update to staff saying a 7 West patient was under investigation and had been transferred to the SARS unit. Staff were told that 7 West was going to Level 2 status; there had been unprotected exposure to SARS in the last 10 days, but no known transmission to staff or patients.

On Thursday, May 8, the hospital reported to staff that the psychiatric unit was being cleaned and was not admitting patients:

This morning the SARS Task Force started the meeting by discussing the situation on 7 West. The unit is being thoroughly cleaned and Infection Control continues to investigate. We will continue to take precautions on 7 West and will not be admitting patients.

On Friday, May 9, the SARS management team minutes noted:

7 W will not be officially declared Level II and CDC will not be called in.

By Sunday, May 11, the news media were onto the story. Telephone calls to 7 West were referred to other parts of the hospital but the media had no success in reaching anyone. The *Toronto Star* reached Dr. Glen Berall, co-chair of the SARS Management Task Force, on his cellphone, while he was on a family outing. On May 12, the *Toronto Star* reported about a possible SARS scare at North York General:

Also yesterday, despite reports that a North York General Hospital floor is closed due to a SARS scare, Dr. Glenn Berall, co-chair of the hospital's SARS task force, says the ward has always been open for business as usual. Toronto Public Health and provincial operations committee officials were asked to investigate when a patient developed a fever in the psychiatric department last week, but doctors have since diagnosed the patient as SARS-free.

The floor was not formally closed and guests were still allowed to enter, although nurses and doctors were “still taking normal isolation and infection precautions,” says Dr. Berall.⁵⁷³

Dr. Berall denied saying that it was business as usual at North York General. In his interview with the Commission, he said that he did, however, try to explain that while the unit was not accepting new admissions, it was not formally closed:

I had an interview with them. They didn't get that right. I don't know how they managed to get that. The interview, as I recall, happened in the following fashion. And I remember this interview because it was a bit of a frustrating interview because I felt that I was trying to get them to understand and I couldn't quite, but I was also at a movie with my kids and I got the phone call that the *Toronto Star* reporter would like some information. So I stepped out of the movie into the hallway in one of these large movie houses where they've got bells ringing and noise like crazy, on a cellphone, and you know what that's like in one of those movie theatres. So I'm not sure whether or not the communication was ideal. Regardless of that, the *Star* reporter managed to get the message at the very bottom of that page which is the last line, “the floor was not formally closed.” That sentence, that phrase which they got, doesn't fit with “open for business as usual.” “Was not formally closed” isn't “open for business as usual,” and I was trying to get the reporter to understand that we were doing a heavy cleaning, the admissions were constrained. No, we weren't formally closed. We hadn't been told to be formally closed. But we were being cautious while we were looking further into the situation. And I don't know quite where that piece of information came out like that.

Nothing would be gained at this stage by an inquiry into any competing recollections of Dr. Berall and the reporter as to exactly what words were used. The bottom line is that the public got the wrong message and the hospital did nothing to correct it. Although Dr. Berall explained to the Commission that the unit was not in fact closed, that it was simply suspended to new admissions, the precise status of the unit is immaterial. The distinction between closed and suspended was not clear to those involved in the case of the psychiatric patients and remains so today. Whatever precise language one uses to explain the status of the unit, the reality was that it was not busi-

573. “Canada scorns Finn link to SARS,” *Toronto Star*, May 12, 2003, Ontario edition.

ness as usual, yet the opposite was communicated to the public.

The closure of the unit, notification of other Toronto hospitals of a problem, investigation by infection control staff, and the confusion over whether 7 West should be Level 1 or Level 2 certainly are not evidence of business as usual. Serious steps were being taken to investigate serious concerns that SARS was back at North York General Hospital and was spreading. On May 12, there were only eight patients on the unit, when there were normally around 25 patients. Three patients remained under investigation for SARS, two in serious condition. If these patients had SARS, no one knew how they got it. There was in fact a SARS scare at North York General and the public was not told about it.

Whether or not the phrase “business as usual” was used, this was, unfortunately, how the message was understood by the media and that was what was reported to the public. There was nothing to report what was happening: that there were in fact three patients under investigation for possible SARS, that all three of them had been treated on the SARS unit, that two of them were still being treated on the SARS unit, that staff and contacts had been investigated and some quarantined and that for a second time in two weeks, the psychiatric unit was closed to new admissions and had undergone heavy cleaning.

It is understandable that staff working at the hospital who were aware of what was happening with these patients wondered what was going on when they saw the media coverage. This incident, when viewed in light of the recent World Health Organization travel advisory, the devastation of SARS on the Toronto economy, and high-level political efforts to convince the World Health Organization that SARS was not spreading in Toronto, aroused suspicions that North York General was hiding, or at least downplaying, the new SARS outbreak. It fed staff concerns that they were not being told the whole story.

There is no reason to doubt Dr. Berall’s account of his intention when he talked to the media and no evidence that the hospital or anyone in the hospital deliberately tried to cover up the 7 West outbreak. However, the public was given the wrong impression and the hospital did nothing to correct it. The hospital and the public would have been better served if there had been more openness in respect of the events of 7 West.

One lesson of SARS, repeated time and time again, is that anything less than full and frank openness will return to haunt public institutions and their spokespersons. During any public crisis, there is no forgiveness for spin or obfuscation. Some people might reason that shaping and softening messages to the public lessens anxiety. In

public crisis we all must face the threats together and to do that we all must have the facts.

It's really simple: The public is entitled to the clear, unconfused facts.

May 13 Meeting with Psychiatry Staff

Throughout this period, staff on the psychiatric unit continued to worry that these three patients in fact had SARS. Psychiatry staff were understandably upset when they became aware of the press report claiming that it was "business as usual" at North York General. They knew otherwise.

On May 12, the hospital issued an update to staff about these reported comments to the media, and an update on the status of the three psychiatric patients:

This morning's discussion centered on the announcements made in the media on Sunday evening and this morning about the psychiatric unit in the Hospital being closed due to SARS. We realize that it is very important to outline and clarify the facts for you.

1. As reported in SARS Updates #35 & 36, a patient on 7 West became ill last week with a fever. The decision was made to close some beds on the unit to allow for heavy cleaning of the unit as an extra precaution while the case was being investigated.
2. Public Health and Health Canada have reviewed the case of the above-mentioned patient. They have determined and reassured us that this patient does not fit the criteria of a SARS case.
3. This patient is now being treated for another respiratory illness, but remains on the SARS Unit. A decision was made early on in the SARS Emergency that all patients admitted to the SARS Unit would only be discharged home and not to other units. This explains why some patients who are being treated for other medical conditions remain on the SARS Unit.
4. On April 29, two other patients from 7 West fell ill. Both patients were immediately put on respiratory precautions once they exhibited symptoms. These cases were reviewed by Toronto Public Health and

Health Canada and it was determined that both did not meet the criteria for SARS. One has since been discharged and the other remains on the SARS Unit and is being treated for another medical illness.

We realized that this situation caused concern for our staff. To the best of our ability, we will continue to try to provide you with the most up-to-date information in an accurate and timely manner. We hope that the above facts answer any questions you may have. However, if you have any questions about this situation, please e-mail the command centre at [email and extension provided] during regular business hours.⁵⁷⁴

Again the message to staff conveyed a confidence about what was happening that was misplaced. While it was true that the patients did not meet the case classification for SARS, they were all still under investigation for SARS and two of them remained on the SARS unit. There was no explanation to staff about what was ailing these patients, if they did not have SARS.

Psychiatry staff, upset by the confusion surrounding these patients, demanded a meeting with hospital officials. The meeting took place on May 13.

At the meeting, Dr. Berall told the staff that the media reports were partially incorrect and that he had been misconstrued. In the meeting, staff were told the patients did not have SARS.⁵⁷⁵

According to the minutes of the meeting, staff were told:

Dr. Glen Berall was introduced as co-Chair of SARS Task Force. We discussed the 3 patients from Mental Health that have been on the SARS unit. One has gone home and the other 2 have atypical pneumonia but not SARS. Public Health has cleared all 3 patients as Non-SARS after consultation with the experts. Dr. Berall indicated that the media reports recently are partially incorrect and that they misconstrued some of his comments. [original emphasis]

There have been no new SARS cases identified in the city since the 19th of April. The mental health inpatient units will reopen today. That means

574. North York General Hospital, SARS Update #38, May 12, 2003.

575. North York General Hospital, Mental Health Department, SARS Staff Meeting, May 13, 2003.

that we do not have to wear gowns and masks. Dr. Hoffman assured staff that we are justified and supported in our concerns for patients and staff. The precautions over the last few days were justified to ensure that the proper investigation and cleaning was done.

Staff are encouraged to continue to wear precautions that make them feel safe & comfortable but that we can return to normal working conditions. The staff and SARS team support the need to continue with some precautions once this crisis is cleared. It was suggested that we continue with antibacterial washes being placed in hallways and in various places throughout the units.⁵⁷⁶

For some staff, especially for those who felt that the minutes did not represent what actually took place at the meeting, the meeting simply made things worse. One nurse described her view of the meeting:

The staff came out feeling very frustrated. They'd been talked down to as if they were stupid. They felt disappointed, confused and frightened, and they definitely had absolutely no faith in the management or the way they were being dealt with. They felt they were being lied to and felt information was being withheld.

Another nurse described the meeting and how staff felt that their concerns were not heeded:

It sort of reached the point one day that we had a meeting with Dr. Berall and the coordinator, I'm trying to remember who else, they were the main two, with the nurses from 7 West, 7 North, day hospital, and myself, basically to tell us that we're way off base. And that there was no need, and I think at this point it was the question of protection, that we were being, they didn't say hysterical but much to that effect, that this was not likely SARS ... The impression they left was they were concerned but they didn't think it was SARS and they didn't think it was necessary to move the patients from the floor. These were all patients who were very hard to contain. I can understand moving them to another floor was very difficult, but at that point SARS had proven to be a pretty

576. North York General Hospital, Mental Health Department, SARS Staff Meeting, May 13, 2003.

deadly thing, you don't fool around. So, we kept saying, if it looks like a duck, quacks like a duck, then consider it to be a duck before you say that it isn't. And we didn't feel that was happening at all. So what happened was, a great deal of frustration, a great deal of anger. We were talked to, I would say talked down to, and talked to very rudely.

One hospital official who was at the meeting sympathized with front-line staff. He reflected that in hindsight the opinions were too definitive in the face of uncertainty but that, at the time, management was doing their best to manage the situation:

I think they're real. I think people felt this very strongly and I have said, I guess in early conversation, that I think trust was a big issue in the hospital all the way through, trust of management. And I think the other thing would be there was, so I'm going to call it a bit of an arrogance I suppose on our part, certainly the medical staff, to say we have the answers and you don't have the answers, and I think the staff found that very, very frustrating. All that probably would have gone away had SARS, in fact, gone away as well because it would have vindicated the medical opinion. In actual fact, in that grey area of that time, it would have been difficult to give as definitive statements as seemingly were given at these meetings. On the other hand, I think there was a general fear that you needed to manage the situation appropriately. So I don't question the motivations of any of the doctors or any of the administrators that were there. I think it was a question of trying to manage the situation to the best possible way. But I can understand the staff's reaction as captured here.

Dr. Mederski told the Commission that at the meeting she repeated the views of outside experts that these cases were not SARS. She told the Commission that although she privately did not agree with the outcome of the adjudications, in the face of what appeared to be consensus among the experts, and with no test or clear indicator to say whether these patients were SARS, she felt that she was left in the position of having to bow to the consensus and repeat the opinion of the experts who had adjudicated the case. She said that she felt very uncomfortable at the meeting with the psychiatry staff:

Dr. Mederski: This was the meeting that was fairly needed because of what I alluded to earlier, a very high level of concern on the 7th floor. As well, it was for the rest of the hospital staff, as to how the heck did this patient, the third one, come down with an illness that is looking for all the world like SARS,

behaved badly because she's now intubated, and yet we have been told by others that this is not SARS. And so ... I was directed to go up, with Dr. Berall, to speak to the nurses and to the staff about this as some person who ostensibly has some, dare I say, authority or opinion about it.

And my role, that I saw, was that I would have to say what was said to me by the adjudicators, which were [Dr.] Don Low and others. And so there you go, you have the comment, one had gone home, that would have been Patient No. 1, and two others have atypical pneumonia but not SARS, I shouldn't say that too quickly as to who went home, because I am not sure who made the decision of atypical pneumonia. This would have been my statement or Glen's [Dr. Berall's] statement to the effect that this is what we were told by the adjudicators after the specimens were sent out to the other labs outside.

Question: So did you express your own views at that meeting?

Dr. Mederski: I remember sitting in the corner, on something, and being extremely uncomfortable at that meeting because I didn't feel comfortable about saying anything either way. But I felt that I was in a position that I had to say something because, in fact I think I had even maybe had something to say to Glen, like I am not going to say very much, but I don't know. Anyway, I really tried to say as least as possible.

I had to say something because one of the nurses was pretty aggressive and basically put it to us that, you know, how can you be so blind to this whole thing when you are seeing two cases. And then I paraphrased what Glen had said. Like being the scientist, say, well, you know, you have atypical pneumonia that for all the world looks like SARS or SARS looks like an atypical pneumonia, so it is not unusual that these could be – and they transmit the same way because the data is there for centuries that they do, and yes, it can happen that people get sick at this time of the year with these things and that it's transmissible, and it makes sense, you know, community acquired pneumonia, it does

happen. I've been doing this for many years, so I think it can happen.

Question: In paraphrasing all that, there was something that you weren't saying, or didn't feel that you could say, in that setting?

Dr. Mederski: Well, I think that the staff knew that I had an opinion in this regard. I think people had sort of word of mouth spread that I was treating them as SARS. They were in the SARS unit. So it would have been hard to keep that away from the staff up there. This was a pretty cosy group that knew what was going on. But I would have had to defer to the higher lines, and when we were asked to come and speak to them it was with the idea of placating them and settling them down and making sure people didn't go off the deep end with nervousness and so on. So, basically I was in the position of being able to paraphrase others' opinions. I don't seem to recall somebody asking me, so what do you really think. Not at that meeting, I don't think.

When asked by the Commission what she would have said if someone at the meeting had asked her what she really thought, Dr. Mederski said:

It would have been difficult. It was difficult to be there, though, it was very difficult.

Dr. Mederski told the Commission that in the face of a consensus among experts that these patients did not have SARS, she did not feel comfortable speculating about the cases, notwithstanding her own personal views:

Well, the staff had been worried sick about the psych unit being a source of SARS. To them, it meant everything. On one hand, we're being told we're protecting our staff on the other hand, there's people becoming sick, none of them staff, mind you, just patients, but still, it happens. So after that, those two cases of Patient No. 1 and Patient No. 2, there was a huge, huge effort to clean the psych unit, we went to Level 2 there. Environmental services came in, they even repainted areas, they looked at duct cleaning, they looked at drips on the wall, all kinds of things. So there was now a lot of activity around the psych unit, and assuming that

finally everything is now clean. And that's the way the word went out, to all of us, that we were okay.

So suddenly, two weeks later or three weeks later, to have another patient, ironically from that same room, which I had focused on, that room, come back with symptoms that were not dissimilar to the others, was really scary, because it suggested that some transmission perhaps of this, whatever, in spite of the cleaning, or where else was it happening. On one hand we are sure that it has been cleaned properly, but on the other hand there is somebody coming down with symptoms. There is a fear factor that paralyzes individuals from working properly in those circumstances. People don't think logically when they are afraid. And even though there are means to protect ourselves and they know at this point they have no evidence of staff transmission, there is still a fear factor, which will inhibit the way people work.

So, I mean, [name of nurse] was one my best nurses on the SARS unit, and I would speak to her candidly, and she's probably one that may or may not remember me telling her how I was very worried about [Patient No. 3] possibly having SARS, but I wasn't speaking the same way to all the other nurses. They had to, by definition, protect themselves, and do the right thing anyway, technically they should have, but to tell them would mean that they could tell the rest of the hospital, would mean everybody would be worried. It would make everybody furious at the hospital, that they did something wrong up at the psych unit, that maybe they didn't clean it properly, that maybe there is something going on up there. I didn't feel comfortable that that should be immediately speculated. Although later on, I was quite open about it.

Dr. Mederski said that she knew staff were worried, that they thought these patients could be SARS, and that they wanted to know where it was coming from and whether they were in danger. But she said that she had definite opinions that the disease was not airborne and that staff were not at a higher risk, and said that she communicated that message to staff at the meeting. She said:

Dr. Mederski: I think that at the time of this meeting, I am talking about the 13th, anything to do with the psych unit, I believe, myself, I would have said at some point to whoever would listen, that I did not think this was an airborne disease that was coming from the 7th floor to the 8th floor, or from the

8th floor. I made a very strong point about that. There was a concern about ventilation spread, you know, this was the anthrax theme, that this was happening and the vents were, the drips that were going down the walls were somehow related. And I would have stressed my opinions about that and I would have said no, I don't think that's what it is, and I don't think this is an airborne-spread disease. And that's where the focus of the hospital was, from the top administrators down, airborne, airborne, airborne, airborne, negative pressure, negative pressure. And by this stage, we already had data from Singapore or China or Hong Kong that this disease had a significant element of contact in and adhesiveness to surfaces. Which was after [that whole apartment] outbreak that occurred with the flushing of toilets in Amoy Gardens.

And the way this outbreak was spreading, the way I was working this out in my own head, and reading everything I had and listening to the WHO, was that this was not in my mind at any point a huge respiratory issue like influenza. And I kept trying to say that to the staff, this is not influenza, this is not anthrax, this is the type of disease where the surfaces you touch, where you cough, where you spit, where you have your bowel movements, that's important, not so much the vents on 8 West and on psychiatry.

I even went to the building director and I asked him to give me the blueprints, or to discuss the blueprints about the ventilation system, the way it goes. And I was assured that it was totally independent of the SARS unit end of the hospital and that there is no human way that it could have at all had anything to do with that. I tried to explain that, because that was where everybody's fears were.

I was more concerned that it was the environmental cleaning of the surfaces that left "unchecked points." But that didn't seem to, people were more enamoured by the notion of it being a ventilatory thing, which is why I am saying that I wasn't worried about closing, about allowing other areas of the hospital to open, because it didn't make sense to me

scientifically or epidemiologically, what I was gleaning up to this point, two months of looking at new cases, that that's really where the problem lay. I have to say that because if I don't then you won't understand what I am trying to say later.

Question: At the time of this meeting on the 13th, the context of the staff concern was, whether they were at risk from the psychiatry patients, and when you gave the official view to which you deferred, you did so in the context of your confidence that these patients did not pose a risk to the staff?

Dr. Mederski: I did it in the context of what Public Health had told us was the final adjudicated opinion. That was my formal position. My informal position was that even up to this point we had no ill staff, or for that matter other patients, but certainly staff, and that I don't believe this is an airborne disease. I don't believe they had a higher level of risk, period. That's my personal view.

Another feature of the May 13 meeting that angered staff was the "almost ceremonial" way in which senior management at the meeting removed their masks during the meeting in what was perceived as an effort to encourage staff to remove their personal protective equipment. As one nurse manager told the Commission:

I remember the meeting in the boardroom. They said everything was okay. To take off our masks. It was an almost ceremonial taking off of the masks. I didn't, a number of people didn't. We felt that it was too soon. We went back to our unit and I told staff that if they wanted to wear the mask to feel free. A number took them off and a number kept them on. I took mine off periodically from the 7th to the 23rd. We got braver. More took them off. Some of my staff wore them throughout.

But those representing management at this meeting told the Commission that they believed the assurances they were giving staff and believed that staff were safe. As Dr. Rose told the Commission:

The unit had been identified of a potential SARS patient, even though we had reassured them that that patient, at that point, as far as we were aware did not have SARS. I think the minutes are pretty self-explanatory.

One's gone home, two have atypical pneumonia. Public Health has cleared all three patients, after consultation with all the experts. There had been some media reports on the weekend, I think the *Toronto Star* had said SARS is back or they had done something, I don't have the article with me, but it had not been particularly positive. And Glen [Dr. Berall] had made some statements which he felt were incorrect and he corrected them. Dr. [Brian] Hoffman was there. The only thing that is not written in the minutes here that I can tell you is, we made a conscious decision, Brian Hoffman, Glen Berall and I, to walk into that meeting and take our masks off. That's not in the minutes, but we did it because we felt it was safe, based on the classification that the experts had made, based on the history after a week of seeing what had happened with the patients and that there were other diagnoses that were plausible and that they hadn't progressed and got a whole lot worse.

Despite what was said at the meeting, some staff continued to doubt what they were being told. They worried that their concerns were being ignored unless a clear epilink was proven. One nurse said:

What was not listened to, is that we all knew that they may not have an identified link with the epicentre, but that the protocols around personal protection were being broken left, right and centre.

Some nurses could not accept that these patients did not have SARS and could not understand how three otherwise healthy individuals, all in the same unit, in a hospital that had SARS, could be ruled out as possible SARS cases. As one nurse said:

But the issue was that demographically you don't get atypical pneumonias very often in psychiatry. So the bells should have gone off. And this was not in the depths of winter either when everybody's sick. They all presented the same way and they all had mental health problems but they were relatively healthy.

One nurse described there being an "impending sense of doom" at this time, as they simply did not believe that these patients did not have SARS:

I guess over that time, we certainly were being filled with a more impending sense of doom about all this, in that when we learned that patients on the inpatient psychiatric unit were suffering from respiratory problems, we felt that it defied any kind of logic, that all of a sudden

these patients would be ill, that it would be SARS, and in none of our experiences had we seen any more patients develop a hospital-acquired, unit-acquired pneumonia or problems.

The problem was not that hospital officials were unaware of staff concerns. The problem was they believed that the experts had ruled SARS out. They thought that they needed to convince the staff that their concerns were unfounded and make them understand that it was safe. As Dr. Rose told the Commission:

I knew that the staff was concerned because that is why we held the meeting. We were told the staff was concerned. They don't understand, they just don't have enough information to know for sure that what we're telling them is that it's okay to take off your garbs. There is no SARS here.

Hospital officials felt that they had the advice of experts, that the experts knew what they were doing and that they were doing the right thing by convincing staff that the experts were right. The hospital felt that they were safe due to the assurances they had understood from Public Health. They understood that these patients did not have SARS. They were confident that there had been no transmission to staff or other patients.

Hospital officials, including Dr. Mederski, said that they went into the meeting to convince the nurses that they were wrong, that these patients did not have SARS. As noted above, Dr. Mederski told the Commission:

... when we were asked to come and speak to them, it was with the idea of placating them and settling them down and making sure people didn't go off the deep end with nervousness and so on.

This is what angered so many nurses. In the face of what appeared to be a consensus among the experts, their concerns, which turned out to be well founded, were dismissed. As the unit administrator said, the communication and the focus on the return to normal were disconnected from the front-line staff concerns:

The whole thing was a disconnect. Everything was a disconnect. She's sure one day, one thing and you do. Six days later they can say it's not SARS. So, first it is and then it isn't. So, picture yourself, this is how you have to put yourself in the position of a staffer, you're a casual staff nurse who works maybe every other weekend or three shifts every two weeks.

So, you come in and you look and you see all these minutes that you want to catch up on. You see the ones from the 7th saying it's SARS, then you see the one from the 13th saying it's not SARS, back to normal, and then you go and read what's going on in the hospital, relaxing things. The confused messages that people were given was just incredible. And it wasn't just senior administration, it was also coming from Public Health. They waffled. Everybody was waffling constantly because it was new territory, they didn't know. If it happened again, I think the thinking now would be, "let's use every precaution that we think is necessary in order to prevent outbreak," but three years ago it was, "let's not alarm people; let's not close up; let's not affect our position and what's the spin that we can put on it?" "What can we do to get things back to normal as quickly as possible." I think the attitude of all hospitals and Public Health would be different if this happened again. That's what should come out of it, that you use as many precautions as are required to ensure that staff and patients are safe. And you go overboard with prevention.

Despite the sense of dismissal and dissatisfaction among some of the staff after the meeting, the message sent to hospital officials after the meeting was that things were back on track. A May 13 email from the unit administrator of the psychiatric unit to a senior hospital official said:

... thanks so much for the meeting with my staff. I know it made a difference for them.

A followup in this series of emails also included the following description of the meeting by the unit manager:

It went very well and I thank you for your help and support. I know the staff felt heard ...

Based on these emails, the message that went up the chain of command was that the meeting and the messages provided at the meeting were well received. Again, there was a disconnect between the front-line staff and upper management. The front-line staff still thought these cases were SARS and were concerned about the hospital's handling of these cases. The hospital thought that the matter had been resolved and that it was time to move forward to a return to normal.

However, as the unit administrator explained, the email was intended to thank

management for meeting with the nurses, not to signal an end to the concerns of nurses. As she told the Commission:

[The email was saying] thank you for coming and I think the staff does feel heard, but that doesn't end: you can't just have one meeting and dispense with all feelings, of months. Although I am sure that administration would like to think that that was the answer, it just doesn't go like that.

She told the Commission that even after the meeting, staff continued to believe that these cases were SARS and they continued to wear masks.

As May progressed, hospital officials continued to plan a gradual return to normal, under the belief that there were no new cases of SARS. As Dr. Rose explained to the Commission, he truly believed the information he provided to staff and that there was nothing more they could have done in terms of the investigation of the psychiatric patients at that time:

I had some reassurance that these patients were treated as if they had SARS. So that was important to me, to know that even if they had been wrong, they were treated, they were isolated, they were all put on the SARS unit, they were all given an extensive work-up and their history followed. They were aggressively worked up. And so that yes, even if we had been wrong, worst-case scenario, we wouldn't have done anything differently in terms of the staff and the other patients on 7 West or the other patients in the hospital. So that was reassuring, number one, to me. How many consultations of experts do you need? In retrospect, yes, you could say we should have had another consultation, but I had no reason to believe that [Dr.] Bonnie Henry was misinformed. I had no reason to believe that her experts would give her the wrong advice. I had no reason to believe that [Dr.] Don Low would be wrong. I mean, these were the experts. Do I go and yet ask for another expert opinion at a hospital? In retrospect, yes, I guess so, but at the time I thought we had done enough consultation with enough outside experts. And I had the documentation right there. I had emails from [Dr.] Bonnie Henry, I know the work that she went through to make sure that there was full consultation on these things. It is easy in retrospect to look back and piece it together and say, "Oh, yeah, one here, one here, one here ..." Blood tests were all positive, now those people really did have SARS, it all made sense. I didn't know at the time.

The Commission accepts that Dr. Mederski, those in charge of the SARS response, and North York General Hospital senior hospital officials told staff what they understood to be the decision of Public Health and the consensus among experts. There is no evidence that the hospital, in communication with its staff, made any attempt to hide SARS cases or to mislead staff.

The Commission also accepts that senior hospital officials, those in charge of the SARS response, and Dr. Mederski sincerely believed the matter had been investigated thoroughly and that there was no risk to hospital staff, other patients or visitors.

But hospital officials, those in charge of the SARS response, and Dr. Mederski dismissed legitimate and in hindsight accurate concerns of nurses about the psychiatric patients. Although hospital officials and Dr. Mederski acted upon the advice of others, the assurances given to staff turned out to be not only wrong but insensitive to legitimate staff concerns. There was nothing to prevent a more open dialogue with front-line workers about what was happening on the psychiatric unit. Concerns raised by the clinical chiefs were addressed immediately, until they were satisfied with the response. Concerns of front-line nurses, on the other hand, were approached differently and seemed to be given less weight and consideration. Although they turned out to be correct, nothing was done to resolve the outstanding and indeed accurate concerns of nurses.

In particular, the Commission finds it unfortunate that Dr. Mederski did not feel that she could openly voice her own views about the psychiatric patients to staff at the meeting of May 13. Whether her concerns about voicing her opinion and disagreeing with what she perceived as a consensus among experts were well founded or not, it reveals a major communication problem in the hospital: that the internal expert at a hospital does not believe she can voice her opinion or express disagreement with outside advice and expertise. The disconnect between what Dr. Mederski reported to the Commission as her views and opinions about these patients at the time and what the hospital, both senior management and staff, believed was a consensus between her and Public Health represents a major breakdown in communication.

Even if, as Dr. Mederski reports, some staff were or should have been aware of her unexpressed opinions about these patients because these patients were being managed and treated as SARS patients, her advocating on behalf of the position of others created distrust, disbelief and anger among the front-line staff.

Why Not Classify as SARS?

Why did the authorities, in hindsight, mistakenly decline to classify these patients as SARS patients?

For Public Health officials, the absence of an epidemiological link was the key factor that prevented them from classifying these patients as SARS. Although the patients had clinical symptoms compatible with SARS, and although the nurses and doctors who treated them thought they had SARS, these patients were not formally classified as SARS patients. According to the case definition, if someone with SARS symptoms had been to Hong Kong, that was enough to classify them as SARS, but it was not enough if they had been at a Toronto hospital with SARS patients. As one physician told the Commission regarding Patient No. 2:

We didn't have a test that we could use to say this person has SARS and this person doesn't. So, what has been devised and implemented by Public Health essentially were a cluster of signs, symptoms and epidemiology that would sort of label someone as probable SARS or definite SARS, and there's whole different categories. I don't think we and they were necessarily always right. We thought certain patients had SARS, but we are looking at the clinical scenario. If they didn't strictly meet the definition because, for example, they couldn't trace an epidemiologic link back to someone with SARS, then they were not SARS, according to their definition. But, clinically, we thought that she [Patient No. 2] had SARS.

The problem was that these patients were not classified as suspect or probable SARS cases because there was no known epilink. Even today, no one has been able to identify how and from where the psychiatric patients contracted SARS. As one expert described the problem:

As you know, these psychiatric patients had fever onset on the 18th of April, another with the onset on the 17th of April and then a third with, I think, an onset not until early May. But you could argue right there that if those had been recognized to have been SARS right away, there should have been red alerts that there was something going on in this hospital. But the big reason they were not recognized is because it was not sensed that they had had any contact with other SARS patients. We still don't know where they had that contact.

But many staff recognized the frailty of relying on the epilink: just because you did not know the link did not mean one did not exist. This overreliance on the epilink was difficult to understand. Staff working with these patients saw that they were being treated as SARS. They knew the clinicians considered these cases to be SARS. Yet they were repeatedly told that SARS had been ruled out. As one physician said, they were told that the patients were not SARS “with conviction.”

Faced with contradictions between what they were being officially told and what they saw and believed from working on the front lines, many staff worried that they weren’t being given the full story and that their fears were being overlooked. As one health worker told the Commission:

So we felt a big cover-up was done at this time. [They] were saying there was no epilink, we were trying to say psychiatric patients are not good historians. Who knows where they were, who knows anything? But they were still saying they were definitely atypical pneumonias. And you know what, in all my years of nursing, I never saw three psychiatric patients get atypical pneumonia so bad that one needed a tracheotomy – it just doesn’t happen.

The failure to classify the psychiatric patients as suspect or probable SARS was not the result of any scheme to minimize new SARS cases or any cover-up on the part of Public Health, experts or hospital officials. Rather, it was a strict application of the case definition at the time, which we now know relied too heavily on the need for an epilink before a case could be classified as SARS.

Communication Breakdown

All three of these psychiatric patients were classified as persons under investigation for SARS. Patient No. 1 remained under investigation until May 16, at which time he was classified as “does not meet case definition” and his Toronto Public Health file was closed. Between April 21 and May 16, Public Health monitored his symptoms and those of his contacts.

Both Patient No. 2 and Patient No. 3 remained under investigation throughout May and were never “ruled out” as SARS. Both remained on the SARS unit through May. Patient No. 2 was discharged on May 23, while Patient No. 3 remained in hospital until June 12. During their admission, Patients No. 2 and No. 3 were both

critically ill. Throughout their admission to hospital, their symptoms were monitored daily by Toronto Public Health, and their contacts were also identified and monitored.

Staff were told it was not SARS, but there was no explanation provided beyond “other respiratory illness.” What did that mean? How could they rule out SARS? By May 12, Patient No. 3’s condition was “critical.” Patient No. 2 had undergone an emergency life-saving procedure on April 30. There was no clear diagnosis for either patient. No one knew what they had. So how could anyone say the psychiatric patients did not have SARS?

As was seen in the case of the ill staff in April, the classification for Public Health purposes took on an importance and meaning that was misleading and that diminished the index of suspicion at North York General Hospital. Because these cases did not fit into the defined categories of suspect or probable due to the absence of an epilink, they were mistakenly taken to mean “not SARS,” when in fact no one could rule SARS out.

An investigation by the North York General Hospital Joint Health and Safety Committee post-SARS reported:

TPH [Toronto Public Health] did investigate these cases and declared that they were not SARS but nevertheless did not explain why they had respiratory symptoms.⁵⁷⁷

But did Public Health rule them out as SARS? Or was there yet again a miscommunication and misunderstanding about the meaning of Public Health’s categorization of the cases and about the possibility that they could nonetheless be SARS cases? Was it clear to hospital officials what a classification of person under investigation meant? When asked about the practical implications of a person under investigation classification, Dr. Berall, the co-chair of the SARS Management Committee, said:

577. North York General Hospital, Joint Health Safety Committee, Report, p. 38. The Commission notes that although this was what was communicated to staff and was the understanding of the hospital and staff within the hospital, the Commission found no document by Toronto Public Health stating that these patients were “not SARS” and, as noted in this section, Toronto Public Health told the Commission that it did not say the patients were “not SARS.”

Question: How did it work that on 7 West it was determined [Update 39, May 14th] by Toronto Public Health and Health Canada that the two 7 West cases mentioned previously were, do not meet the criteria for SARS? However, they are still listed as persons under investigation. What did that signify? That they weren't out of the woods yet?

Dr. Berall: I think it signifies that they didn't yet have a diagnosis that was definitive but they were felt not to be SARS. So they still have undiagnosed, I don't know the answer to that question since I wasn't involved in that. They were still, they didn't meet the criteria for SARS, but they were still not diagnosed as to the underlying cause. But I don't know how long it takes to get a legionella sample back, but I understand it takes some time. Microplasma is a little faster. Some of the virology can take a while. Some virology can take weeks, so it become an issue of how do you make a diagnosis. You can have pretty much every patient with pneumonia as a PUI until you get your diagnosis.

Question: And would, they're still listed as persons under investigation, does that signify that Toronto Public Health and Health Canada are still involved?

Dr. Berall: I don't know the answer to that question.

Question: They're saying, they don't meet the criteria for SARS, however they are still listed as persons under investigation. Is that listing by Public Health or the hospital?

Dr. Berall: I actually don't know that. If there were a further development, there would be a discussion with Public Health and if they were cleared off the list, there would be a discussion with Public Health. So they were still kept up to date anyway. Any case that was discussed with them was followed up on.

But the "person under investigation" label did not signify that SARS had been ruled out. It was simply a technical classification that slotted the patient into a predefined category. It was wrong to take this as a declaration that the patients did not have

SARS. In the case of the psychiatric patients, they were slotted into the category of persons under investigation, Category 2, because there was no epilink.

Dr. Bonnie Henry, who was the Public Health physician most involved with the psychiatric patients, said that Public Health never ruled out SARS:

Question: There is a note on the 8th saying, “Toronto Public Health has ruled out SARS.”

Dr. Henry: Toronto Public Health never ruled out SARS in that case [Patient No. 3].

Whatever words were used to describe these cases, Dr. Henry told the Commission that Public Health never suggested that this meant that everything was okay and that SARS was gone:

Most of us were in the room at the Courtyard Marriott on Yonge Street. [Dr.] Barb Mederski was there by teleconference⁵⁷⁸ because she wasn't able to make it down, so [Dr.] Allison McGeer, [Dr.] Andy Simor, [Dr.] Mary Vearncombe, [Dr.] Shirley Paton, there was a bunch of us there and we presented the case, everybody who had worked with the core group of people that had been involved. There were other people there, I don't recall who. So we went around the room and asked what people thought, what they thought was the answer with the psych cluster. I asked individually, every person, do you think this is SARS, and around the room, unanimously they said no. And we put a plan in place to do testing for other things to try and get a better handle on it. And they recommended environmental testing to be done as well. So after that, I reported this back to Barbara [Dr. Mederski] and said yes, in this specific case, the consensus of the clinical people is it doesn't seem to be consistent with what we are seeing with SARS. I did say to her, these three people probably didn't have the disease. I am not one who talks in they did or they didn't probably didn't have SARS, but we managed them as if they were. At that point, it was a moot point, and she told me that the psych nurses were, she said to me a couple of days later, that was before I went to China, so it is around that period of time, she said the psych

578. This is a reference to the May 8 teleconference, during which the psychiatric patients were discussed, as described above.

nurses are really on my case and they want to know that it's safe to still work on the psych ward. And I said that we have no reason to believe that there is any risk on the psych ward now, or you know, this may not have been SARS in the first place. I would reassure them, but they are safe to work on the psych ward now. The patients weren't there anymore, there is nobody else ill. And subsequently I have heard that that has been translated into, Toronto Public Health told us that everything is fine, which is absolutely not what I said. And I had passed on that the consensus was that this probably wasn't SARS and that yes, I felt that the psych ward was a safe place to work.

Dr. Barbara Yaffe, Director of Communicable Disease Control and Associate Medical Officer of Health for Toronto Public Health, explained to the Commission that as far as Public Health was concerned, "person under investigation" (PUI) did not mean "not SARS." She said:

Dr. Yaffe: You know, I think it has to do with how people interpret PUI. To me somebody, as I explained before, PUI didn't mean they didn't have SARS.

Question: Right.

Dr. Yaffe: It just meant they didn't meet the case definition.

Question: At that time?

Dr. Yaffe: Yes, but we were treating as if they did.

Question: Am I right, I'm getting the impression that others may be taking it as PUI is not SARS?

Dr. Yaffe: Yes, but we never said that, I certainly never said that.

Question: Did it ever get to the point where Toronto Public Health was saying it is not SARS?

Dr. Yaffe: Yes, we did have cases where we called them, DNM:⁵⁷⁹ do not meet.

Question: And that meant not SARS?

Dr. Yaffe: Not SARS.

Question: But I assume before you got to that level your threshold ...

Dr. Yaffe: We had to be pretty sure.

Question: ... it was pretty high.

Dr. Yaffe: Absolutely.

But this is not the message that hospital officials understood. Hospital officials sincerely believed that Public Health had cleared these cases as “non SARS.” As Dr. Keith Rose told the Commission when asked about the decision making around these patients, particularly after the third patient was under investigation:

We took this patient very seriously. When I have a really serious problem in the hospital, I am not going to rely on one individual to make the decision, particularly on an area like this which is so grey. So, expertise from Toronto Public Health and whomever they deemed appropriate to call in was welcomed. And so if I have experts telling me that this is not SARS then I believe them.

As noted above, whatever the precise language used by Public Health and others, whether it was “not SARS,” “not likely SARS” or “probably not SARS,” it is clear that North York General Hospital sincerely believed that the consensus among experts was that these patients did not have not SARS.

The other problem was the lack of clarity around the role of Public Health and the meaning of a classification of a patient as a person under investigation. To Public

579. Patients No. 2 and No. 3 were never classified as DNM, does not meet case definition. They remained classified as PUI, persons under investigation, until after May 23, 2003, when they were retrospectively classified as probable SARS cases. Patient #1 was classified as PUI from April 21, 2003, until May 16, 2003, when he was classified as DNM and his case was closed. He was retrospectively classified as a probable SARS case, after May 23, 2003.

Health, a designation of a patient as a person under investigation did not rule out SARS. But that was not clear at the time and unfortunately that was not made clear to the staff at North York General, who were told with confidence that these cases had been cleared by Public Health and others and that the psychiatric patients did not have SARS.

The importance of clear communication and a clear understanding of respective roles and responsibilities is obvious in the story of the psychiatric patients. Public Health felt that they were providing sound advice with the right blend of caution. Although the patients were not classified or called SARS, they were treated as persons under investigation and were investigated and monitored. Outside experts who provided opinions, gave their best, good faith opinions based on their knowledge and understanding of SARS at the time. They understood that the patients were being managed as if they were SARS and that they posed no risk to others. The hospital, in good faith, accepted the opinions of outside experts and sincerely believed that SARS had been ruled out. They repeated this message to staff and tried to convince staff they were safe. They spoke with conviction. They too believed that there was no risk to staff, patients or visitors and that the matter had been thoroughly investigated and all precautions taken.

There is no evidence of any hidden motive underlying the actions of Public Health officials, outside experts who consulted on the patients, or the hospital. The decisions and actions were based on the best medical understanding at the time, constrained by the rigid requirement for a known epilink before SARS could be diagnosed. As noted below, there is no evidence that these decisions were tainted by any motive to minimize SARS for economic or political reasons.

The problem was not one of intention. The Commission accepts that everyone involved was doing what they thought was right. The problem was one of communication. Staff were given assurances and told the patients did not have SARS with a confidence that was not warranted in the circumstances. The message given to staff was that there were no new cases of SARS and that SARS was over. As one expert told the Commission:

They probably had community acquired pneumonia, but we couldn't rule out that they possibly could have SARS, so we would just manage them as if they did. And in hindsight, so what was wrong with doing that? Well, I think what was wrong is that if we had included them as SARS, maybe we would have searched harder for where they got it from and that might have helped us. It might have provided more fodder for the argument that we still had a problem at North York.

The problem was not that the expert opinions or message to staff were wrong. As Toronto Public Health told the Commission, they investigated approximately 2,000 cases that turned out not to have SARS. It is not unimaginable that experts would get some cases wrong. And, as Public Health points out, they got many cases right. There was no quick and easy test for SARS. It was a difficult disease to diagnose. It was a new disease about which not everything was known. The problem was that the opinions expressed conveyed a certainty about these cases that was not available at the time, absent a timely and reliable test that could rule out SARS. It was not that an epilink did not exist, it was that it was not known. Just because no one could say how these patients might have got SARS did not eliminate the possibility that they could have been exposed to SARS in a hospital that had SARS cases.

One of the lessons from SARS is that, especially in the case of a new infectious disease, it is dangerous to believe that anyone has all the answers. As one physician said:

I think what SARS did is it humbled us and it also made us realize that even when we think we know everything, we don't. And that diseases can – the changing nature of disease emerges gradually, and we have to be very attuned to the clues that come from the ground up, not necessarily from the top to the bottom, so I think humility makes the better nurse and doctor. I would always err on the side of caution.

It is especially dangerous and unfair to front-line staff to provide reassurance or to dismiss or placate their concerns where there is not scientific certainty and where much remains unknown. As one infectious disease expert so eloquently said:

The worst kind of reassurance is false reassurance.

Role of Public Health, Outside Experts and the Hospital

Throughout April and May, North York General Hospital repeatedly went to Public Health and outside experts, through the Provincial Operations Centre, for advice on the psychiatric patients. In good faith, the hospital and infection control turned to Public Health and outside experts for answers. But what was the role of Public Health, the Provincial Operations Centre and outside experts? Were they simply classifying cases for reporting purposes? Were they helping to diagnose patients, with implications for treatment? Who had ultimate responsibility for managing the outbreak and for containment measures in the hospital? What was the hospital's role? Who was making the decisions about these patients and about measures that were

being taken to ensure the safety of other patients and staff in the hospital? Who was in charge of what? Who had responsibility for what, including responsibility for decisions and for the outcome and impact of those decisions?

Dr. Barbara Yaffe described the role of Public Health as follows:

I think the clinician is responsible for the patient. The clinician is responsible for the diagnosis of the individual patient. And if, hypothetically, we said we don't think it is something and they think it is, if they think it is, they should deal it, that's their responsibility as a licensed physician. But in this instance, as I said before, we called these people [the psychiatric patients] persons under investigation. We didn't say they don't meet the case definition. That's a different category. We had a lot of people called DNM, does not meet. They were people we were seriously investigating. Now, they didn't have the epi-link and the clinical picture is so nonspecific, it's not helpful, and the lab tests were not helpful. It was a very complicated, unclear situation, which is why we brought in lots of people, consultants, locally and from Health Canada, and from CDC and NIOSH, and everybody was consistently saying, it doesn't look like SARS. But we still said, no, we're not making them DNMs. We're not saying they don't meet. We're just saying we don't feel they clearly meet the case definition to put them on a line list and report them in statistical ways. But they were still supposed to be treated as if they had SARS, which is what we said with all PUIs, and should be the standard anyway at that point with anybody with a febrile respiratory illness. At that point, I think we were not the final authority.

But for many in the hospital it seemed unclear who was making decisions about cases and who was the final authority. One physician told the Commission:

And I couldn't figure out whether it was [Dr.] Barb's [Mederski's] decision or CDC, and you talk to [Dr.] Glen [Berall] and you talk to Barb [Dr. Mederski], and you know we've been given our directives. Now to be fair to everyone, we treated them like SARS. We isolated them, we got them off the ward. But there's some sense that the staff were left in jeopardy when they weren't told the true diagnosis, because we had patients all over the place who weren't wearing masks.

Another physician who treated one of the psychiatric patients told the Commission:

There was a whole behind-the-scenes process going on where I believe that she [Dr. Mederski] was taking the cases that were coming in and having them reviewed by at least some form of a committee and I do not know who sat on that committee. But I know that Dr. Don Low was there and they were very rigidly applying the WHO criteria. So these patients were sometimes initially being classified, then declassified and then subsequently reclassified, depending on what results came back.

Even those working within the SARS response system at the hospital were unclear as to the roles of Public Health and the hospital. One member of the SARS Management Committee, when asked who made the decision on how to classify SARS patients, responded, “Probably Dr. Mederski, I don’t know.”

Dr. Mederski told the Commission that she felt that she had to accept the decisions of outside experts and adjudicators. With respect to the first two psychiatric patients, whose cases were adjudicated on April 28, she thought that Dr. Low was the decision maker, not Public Health. She said:

I want to make it clear for the record, that that meeting of the 28th, it was not Bonnie Henry’s opinion, Bonnie Henry was the scribe, and I would like to make that clear, it was Dr. Low’s opinion that it was not SARS, she [Dr. Henry] was very much neutral and waiting for input.

Dr. Low did not have a formal employment relationship with North York General or with Public Health. He was an available expert who was generous with his time and his expertise. He was not in charge at either the Public Health level or the hospital. He was not involved in the day-to-day running of the outbreak at North York General.

One of the members of the SARS Management Committee, when asked about the response to staff concerns about the psychiatric patients, said:

I think staff were very anxious but we could only go with what the Public Health ruling was.

Dr. Berall, the chair of the SARS Task Force, when asked about the classification of the third psychiatric patient as “unlikely SARS,” said:

Question: What information would be given about that classification of unlikely SARS?

Dr. Berall: We may not have had any further discussion about it than that. You know, the patient was discussed with Toronto Public Health. They're the ones who considered the information, not us. It's redundant for us as non-experts, without that being our function, to consider all the information. We're not going to make a determination on it. But to hear that Public Health has considered it, discussed it with the infectious diseases specialist and made a determination and we're given the information that they're not likely SARS.

Even Dr. Mederski, the infectious disease specialist involved with all three of these cases, felt that she had to support the opinions of those who said these cases were not SARS. Dr. Mederski told the Commission that she did not agree with the conclusion that these patients did not have SARS. Toronto Public Health records dated May 7 report that Dr. Mederski had previously described Patient No. 2 as a patient "who developed SARS." When Dr. Mederski spoke to a Public Health nurse about Patient No. 1, Dr. Mederski said she was "diagnosing client as probable SARS although no epilink." Dr. Mederski told the Commission that at the end of April she worried that these patients might have SARS, so she decided to try to get testing done on the patients:

Question: So when you have an adjudication and the bottom line by the adjudicators is no, not SARS, not probable SARS, and you feel you don't agree with that, is there anything left for you at that point? You don't agree, they have come to this conclusion. You still have to see patients, you still have issues about how to manage their treatment, but what's left for you as the treating physician at that point?

Dr. Mederski: To get a definitive answer with the SARS PCR tests. This is where it became really incumbent to get these results. That's when I started pressuring my colleagues, as I said, at Sunnybrook to do us a favour and I managed to do that through the actual physician that was doing these tests. She was actually materially involved with the tests themselves. And again there was the lag phase in reporting them back because they batch them. These were the first patient samples that I gave, including [Health Care Worker No. 4]. I could give them, I think I could submit three, and those were the ones I gave, [Health Care Worker No. 4, Patient

No. 1], and I am not sure who the third one was, it could have been [Patient No. 2], but I just can't recall. Because I had really no other way of proving it when there was no epilink.

Dr. Mederski told the Commission that although she had her own views about the psychiatric patients, she felt put down and chastised when communicating her concerns outside the hospital, but that she continued to discuss the cases and express concerns with colleagues. She said that by May 9, she was firm in her mind that these patients had SARS and she was beginning to feel desperate:

Yes, and I have to think that, I think by this point I was getting rather desperate and I didn't care anymore about what anybody else thought, if you don't mind me putting it that way. Because I was just so desperate that it didn't matter what I said, everybody was constantly telling me differently and it kind of had to be, do what you can do, under the circumstances and just keep on at it. And in fairness, in fairness, you know I was exhausted and I was just hanging in there.

But, as noted earlier, when Dr. Mederski participated in the meeting with psychiatry staff, she did not voice her own personal beliefs about the cases but felt she had to advocate the position of the experts in front of staff:

You have to kind of keep the front. You can't look like you're totally out to lunch, otherwise your own credibility gets undermined. If you start saying, I think this, they don't think so, but they have the final say, your own credibility really looks pretty bad at that point. Nobody's going to believe you about anything after that. And so I think that I would probably say, this has been my approach, this is what we're doing with these patients, because I can tell you that the ambience of the hospital would be that it's better to err on the side of caution anyway, so go ahead and do that. Nobody would fault you for that. Nobody would say, oh well, you know, you're overreacting. Even if they thought so, but they wouldn't. They would be always a preference to be the other way. And then to reconcile that with what the ultimate adjudications were. And so there was a lot of skepticism in the hospital amongst the staff about these adjudications.

Now these staff that were skeptical weren't sitting at these meetings unfortunately because these meetings tend to take in the hierarchy who

don't see these patients in the first place. So I did have a bit of a challenge to try to explain to [Dr.] Keith Rose and to [Dr.] David Baron, who were really the main physicians involved, that this is how I feel, but this is what they're saying. And in fact, I would have to sometimes be very forceful to say, Public Health investigated this and this is what they feel. And actually, almost take their side because I'm representing now more Public Health in some ways and the infectious disease specialists behind them who are making these decisions than I am myself. I'm now trying to be in allegiance with them.

Does that make sense? I'm really caught but I have to tell you at some stage, especially if there was a lot of what I thought was unwarranted concern in the hospital, I have to use the word "hysteria," or some people were getting really, really worried. It almost helped to say, look, something's going on but the world isn't falling flat, so they feel that the very best experience and they've got the whole city to look at, that their experience says this is not likely. Maybe they're right, but this is what we've done. Try to tell people they're still safe because we're still perceiving to be safe about managing these patients, but acknowledging that Public Health has a say with these experts behind Public Health backing them up.

Because don't forget, these same experts were on television every day, and they were all saying, there's nothing going on, there's nothing going, or there is something going on, there is something going on. So the media and the public and the physicians were hearing this and they heard what they said. They didn't hear all the stuff that was going on at our place and if somebody from our end was going to start saying differently, it wouldn't look very good.

Dr. Mederski said that she felt that the only way she had credibility, even when dealing with hospital officials, was if she had consulted Public Health:

... as we were going on, every day would be an update day, and every day I would be sitting there going, well I think these are interesting cases, they can be SARS, but there is no epilink and I've run this by Public Health, so before I opened my mouth, I would always preface by saying, I have already spoken to Public Health, because that would be the only way I would have some credibility at the table. And then I would basically say, this is what I thought, this is what they felt, here we are.

When asked if it was a case of having to defer to higher expertise, Dr. Mederski said:

I had to because the one thing that couldn't happen was that there was going to be, Mederski says this, I say this, the rest of the hospital says that, and have the hospital at odds. It would cause a lot of chaos at the administration level and that became a frightful thing to me. I felt very, very nervous by the time May rolled around as to my position and that of what was the common parlance at the time and when the hospital would consistently get the expertise of [Dr.] Don Low and other people who said otherwise, who was Mederski to say differently. This was my deep frustration.

When Dr. Mederski was asked by the Commission if, in the face of this frustration, she abandoned her view or desisted from expressing her view, she said:

I became less vocal internally for sure as time went on, meaning in the hospital itself, and I didn't talk to too many of my colleagues at this point. The only person I actually spoke to at any length was [name of doctor], more on the scientific aspects of the disease and anything new that was happening in the world and what was happening in China and what was the information that was going to help us make more diagnoses. But I felt that I had an ear from this outside group and therefore I had an outlet that I could share it with, my frustrations, my feelings and my opinions. And also [name of doctor], I shared with him some of these cases and I felt that he had my ear, that he listened to what I had to say and wasn't going to be dismissive, so my only interactions had been the Ministry of Health, [Dr.] Don Low, [Dr.] Bonnie Henry and all the internal people at Toronto. So I ultimately did what I did with these patients clinically, but as time will show, as the month of May rolled on I started to question the later cases as to what they might be and, we'll get to that, I'm sure. So that did have an interference with my way of thinking, but from a clinical point of view I would still continue to view the fact that if something came in we continued to treat them as a respiratory case that needed isolation or protection or respiratory precautions, I wouldn't necessarily say isolation in the negative pressure way.

When Dr. Mederski was asked about her concerns of creating chaos within the administration, she said:

Well, I am sitting around a SARS Task Force meeting and I have [Dr.] Keith Rose, and I have [Dr.] David Baron and [Dr.] Stan Feinberg and others, and I have the infection control nurses and so on, and there is nursing representatives and I am going to say, I think they're crazy bringing in Public Health/Don Low, but I believe that I am right. In the beginning I would have alluded to that, but in the end I would have eventually got softer and softer, in my vocal opinions, because there has to be a tabulation of an opinion. There has to be an action and a reaction on these memos. The hospital had to have some direction and I wasn't the one providing that direction, I was only providing feedback, which would eventually maybe have some impact on the direction. If I was completely off to left field, one of two things would happen, I would either be told to go home, which I was really afraid might happen, or, because my clinical judgment is so far off, and therefore I wouldn't be able to take care of these patients that I felt very strongly that I had to, because I felt that if I didn't, others would miss it. So there is a bit of arrogance there, but that's how I felt. So, no, I wouldn't have desisted from looking after patients and wanting to see more cases. In fact, I felt even more strongly that I should see patients, as many as I could, to get a better feeling of what's happening out there in the community, of wanting to find out what's happening with this disease. So I was really keen to continue seeing patients and deal with them. But when came to it actually verbalizing my opinion, I didn't know what to say anymore at one point. I just didn't know how much I could say beyond what I had already done. You know, get people in, adjudicate, have an opinion and that's it.

Dr. Mederski also said by this time she was overworked, ill and exhausted. She said:

... but at the time I was feeling progressively more frustrated and progressively more, actually concerned about my own ability to make a diagnosis too, because there comes a point when you are so exhausted and I haven't mentioned this to you, but I think for the record it should be that I was in a wheelchair by this point, I was in such health distress with my knee, that I was functioning on a thread. And you sometimes wonder if all that together, and the exhaustion of being up for 24 hours a day for four months doesn't finally addle your brain a little bit, so you do start to wonder when you have experts telling you otherwise.

The thing that kept me going was the fact that my colleagues who were on these teleconferences and the outside voices tended to agree with me,

from what I had shared with them. So that was what sort of kept me feeling that, I always felt very strongly about my clinical expertise, always, for many, many years. So I usually belabour a case, I usually take an extreme time, longer than average, I do it with some thought. And that's why I felt that I wasn't too far off. Anyway, that's only editorial.

Hospital officials told the Commission that they were unaware that Dr. Mederski privately believed these cases were SARS. Both Dr. Rose and Dr. Berall report that if Dr. Mederski disagreed with the conclusions of Public Health, they were not aware of this at the time. As Dr. Rose told the Commission:

My message all along in dealing with Barb [Dr. Mederski] is Barb [Dr. Mederski] was consistent with the recommendations of Public Health, so that they agreed on the diagnosis. And if Barb [Dr. Mederski] had come to me and said, "I don't agree, I think they are wrong," then that would've been an indication for me to do something different. She did not.

Retrospective accounts of the relationship between Dr. Mederski, Public Health, outside expert adjudicators and the hospital differ among all the parties. Public Health did not see themselves as decision makers telling the hospital how to run things. Dr. Mederski thought that she had to bow to the opinions of others, that she could not speak up openly about her views to senior management and staff within the hospital. The hospital's understanding was that the views of Public Health and Dr. Mederski were consistent. They told the Commission that they were unaware that there was a divergence of opinion between Dr. Mederski and the advice from others. Dr. Low was not in charge or accountable at either the Public Health level, the provincial level or the hospital level, yet his opinions took on a weight and consequence and de facto authority that he never imagined. The sheer difference in perception of what was happening during this time reveals the massive communication breakdown that surrounded the psychiatric patients and underscores the importance of clarity in roles and responsibilities of public health, hospital infection control experts, outside experts and senior management within a hospital. It also underscores the need for a system of documenting opinions and concerns regarding a possible infectious disease, so that there can be no confusion at the time, and later, as to who thought what.

Public Health was classifying cases for reporting purposes, there were legal reporting obligations, and hospitals were subject to the power of Public Health to intervene and make orders, should the actions of the hospital put others at risk. That did not mean that Public Health had all the answers.

Strangely, the division of roles and responsibilities between Public Health and the hospital seemed clear when it came to the treatment of the patients. Those physicians interviewed by the Commission all agreed that Public Health decisions about classifying these patients had no impact on medical treatment. Treatment decisions were entirely determined by clinical presentation and by medical decisions of the patient's physicians.

While it is true that the hospital was not involved in making determinations with respect to the formal classification of these patients, it was not without a role to play. The hospital was ultimately responsible for the safety of its staff and patients. If hospital officials and those involved in the SARS response, including Dr. Mederski, had concerns, there was nothing that required them to advocate the formal classification by Public Health. There was nothing that prevented the hospital from acknowledging the possibility that staff fears that these cases may be SARS could be right. And there was nothing that prevented them from consulting their front-line staff and maintaining an open dialogue, even in the face of strong opinions by outside experts. Some of the front-line physicians had definite opinions about these patients, but they weren't asked. The nurses had opinions about these patients, but those opinions were dismissed in the face of the consensus of the experts.

No Front-Line Voice

A number of the physicians who worked with these patients privately believed the patients had SARS. The husband of Patient No. 2 recalled after the emergency tracheotomy, asking one of her treating physicians whether his wife had SARS:

I asked if my wife had SARS and she said to me, it looks like it, walks like it. I said does my wife have SARS? And she said, yes.

For those physicians providing care for these patients, once SARS was suspected, the formal classification for Public Health purposes was of little concern. Because they did not have a formal test to rely on, they had to rely on their clinical judgment, and they did so and treated the patients as they felt was appropriate.

As one physician told the Commission, in the case of Patient No. 2, that meant treating her as a SARS case:

I know all the people that I was working with thought she had SARS, or at least we were certainly treating her as if she had SARS. And, in many

of these cases, to us on the front line, we didn't really care, in a way, because if the patient did have SARS or didn't have SARS, we were treating them the same because we thought they had SARS. We also knew that we couldn't necessarily know for sure. Maybe it would be weeks, months, years later before we'd even know for sure. We didn't have our DNA testing and our biology and serology to look at to say, oh yes, in retrospect this patient definitely did have SARS. We didn't have that. And in fact we didn't have that on a lot of patients, even in retrospect. We had to go by our clinical judgment and from my recollection, clinical judgment at the time was that she had SARS, and we treated her as if she had SARS.

The technical classification of SARS or not SARS did not impact patients' treatment. Some did not even recall reading or being aware of the day-to-day updates regarding the patients' status. These physicians were concerned with the immediacy of providing care for these patients. The impression of others in respect of the patients' classification did not mean much. As the above-quoted physician told the Commission:

There was a lot of discussion about who had SARS and who didn't. And various people may have been classified as SARS or not SARS on paper, but most of the doctors and nurses had their own feelings about which patients they needed to protect themselves from, in the isolation sense of that expression, and did their own thing.

Another physician who cared for SARS patients agreed that their focus was on caring for the patients and taking precautions to be safe:

Everything was, this is your impression, it wasn't somebody's else impression. You have to be open-minded. Maybe you think it is SARS, but maybe it is not. It is just a matter of take one day at a time. Watch, see what happens to this patient. Take all the precautions. Look after the patient. Keep them alive ...

This physician explained that by the time these patients were being treated on the SARS unit, the official classification had little significance as they focused on their job, saving lives:

I did not have a discussion that they might not be SARS, with them in the intensive care unit with febrile illness and with chest infiltrates and in respiratory failure. We looked after them, ventilating them, keeping their

oxygen level to keep them alive, basically. So, SARS or no SARS, it is looking after the patient, making sure that they don't die on us. So we treat everybody the same in the sense that if they have acute respiratory failure, we give them maybe antibiotics, maybe not antibiotics, just in case it's a bacterial infection. There was no specific treatment for SARS anyway. There were things to be used at that time, but if used we don't know whether it works or not. They were treated like somebody with acute respiratory failure, SARS or no SARS ... They were all in special control, meaning that they were all isolated, N95 masks, etc., etc., they were all isolated as if they had SARS, whether they had SARS or not, although yes I think we were treating them as though they had SARS and we were doing all the precautions in terms of personal protective devices.

Another physician who worked on the SARS unit with Patient No. 1 explained how, regardless of the official classification, Patient No. 1 was treated as if he was a SARS case:

He was in isolation, he wasn't on the SARS ward but we were treating him as if [he had SARS] and he was receiving all the antibiotics that he would have had he been considered SARS, so it really wouldn't have changed anything other than his location.

Regardless of what the experts were saying, those working on the unit, including the physicians, knew that something was very wrong. One physician said:

Dr. Don Low, Toronto Public Health ... who were consulting with CDC, and they were in the building, so these were the best experts in the world in our building, making the diagnosis. But they never discussed it with me, nor the nurses. That's the way we saw things unravelling, but it turns out they were wrong and some of us knew it. And there was a real paradox, eventually my attitude had to be, when we became suspicious we started using isolation, we called up infectious diseases, we insisted the patients be transferred, we closed the ward, we washed it twice, against their recommendations, they said no need. We washed the ward twice, and then finally we said we're reopening, we're safe and we're going to go back to business because we're no longer at risk. And fortunately, the staff were superb at wearing the protective gear, unfortunately other patients on the ward were not. Psychiatric patients were quite noncompliant and we were very lucky that we didn't have some further spread.

But other than discussions between colleagues, the observations of front-line physicians were not a key part of the decision-making process. Those physicians who provided care to the psychiatric patients while they were on the SARS unit were not part of the daily meetings within the hospital, and they did not speak directly to Public Health or to officials within the hospital who were making decisions as to how to manage the outbreak. When the adjudication committee came on site to assess the situation with respect to the first two ill psychiatric patients, they did not speak to the front-line nurses and physicians and other care providers who were responsible for their day-to-day care on the SARS unit.

That is not to fault this group of capable and dedicated physicians. They were busy saving lives. However, the result was that the opinions of many of these physicians, highly trained and skilled individuals, were not considered in the mix of expert opinions. There was no system to ensure that their views and their clinical observations were brought to bear on the questions delegated to the adjudicators.

A confusing and contradictory message was sent to those nurses and other health workers who worked with these patients on the SARS unit at North York General Hospital. They were hearing and seeing something different, often from front-line physicians whom they respected and whose opinions they trusted. One nurse who worked with Patient No. 2 recalled that, despite the fact that the hospital updates were saying that this patient did not have SARS, one of the doctors on the unit said she did have SARS:

I had her about the third day, the doctor says, "I'm sure she's SARS." Because I was having a problem, I can't remember what, but the doctor said, be careful because I'm sure she has SARS. I know for sure that the doctor told me in that room, about the third or fourth day, "I know she's SARS." Now maybe nobody else agreed with the doctor, but [the doctor] said, "I know she's SARS."

Like the physicians, the nurses who worked on the SARS unit with these patients believed that these patients had SARS and knew that whatever official classification these patients were given, they were being handled and treated as if they were SARS cases. As one nurse told the Commission:

We would treat them as a SARS precaution. And not all the staff in the hospital is aware of that. Because a few people would come and approach me; did you have SARS patients from the psych unit? I said, yes, we get patients from there.

But outside this small circle of nurses and physicians who were involved in the care of these patients, for others in the hospital, the source of information about these patients was a combination of rumour and hospital updates. Rumour said there was SARS on 7 West. Hospital updates said there wasn't.

There seemed to be a lack of connection between what the front-line nurses and doctors saw and what the hospital told its employees. Hospital reports said there had been no new cases since Health Worker No. 4 was confirmed as a case at the end of April. To many, what the hospital told them about these patients was critical, as it meant the difference between SARS is back, be worried, be cautious, be on the look-out, and SARS is not back, SARS is gone. As will be seen later in the report, a physician who saw a nurse on May 21 did not consider her illness to be SARS, because she believed, based on what she had been told through hospital reports, that SARS was gone. When patients on 4 West, the unit that later became the epicentre of the second outbreak, became ill, the flag was not raised for possible SARS because no one was looking for undetected cases of SARS.

But as we now know, it turned out that all three of the psychiatric patients did have SARS. The front-line nurses and the treating doctors were right. The hospital and Toronto Public Health and the outside experts who said they did not have SARS turned out to be wrong.

The problem was that in all the consultations and decision making, there seemed to be no voice from the front lines. Despite the fact that many front-line physicians reported to the Commission that privately and among their colleagues they felt these cases were SARS, those views were not communicated to those in charge of decision making at the hospital. As Dr. Keith Rose told the Commission:

Nobody had come to me in terms of the other areas around the psychiatry patients, so I think some of them were seen in consult with the critical care physicians and I was not aware. And my door is open, so I should've been aware if there was a concern that we were wrong.

Dr. Rose said he knew that the chief of the psychiatry department was concerned, but that other physicians did not approach him with concerns. He said:

Certainly Dr. [Brian] Hoffman, the Chief of Psychiatry, was concerned because there were three patients on his floor and a psychiatry floor is not a floor where we usually deal with infectious patients or people that get pneumonia. So, he was very concerned of that association with the

psychiatry floor. Did other infectious disease specialists approach me, did any of the interns in the hospital? No.

Dr. Berall likewise reported that he was not aware of disagreement by the clinicians and that had he been aware of such disagreement it would have been cause for concern and he would have acted, as he did when the clinical chiefs registered their concerns about the psychiatric patients:

Question: Did any of the physicians who were treating the patients ever come to you and express to you their own private concerns that these may be SARS patients?

Dr. Berall: No, I wasn't approached by other clinicians treating the patients. The only one that I had discussion with was Dr. Mederski, who was involved in all of these cases.

Question: Do you know to what extent she was talking to the people caring for them?

Dr. Berall: I was under the impression that she was in discussion with them on a continuous and regular basis. And I don't know who was the primary, I don't know who was the MRP, the most responsible physician. It might have been her and it might have been another physician. I don't know the answer to that question.

Question: Did she ever pass on to you, as part of the information, that the physicians who were dealing with them felt that they may have been SARS patients, that they were treating them as SARS patients?

Dr. Berall: I'm not aware of that information. I don't recall her ever saying anything like that. But again, you know, they have the discussion at clinical chiefs, and clinical chiefs raised their concerns and we look into it. So if she had said that to me, my inclination would have been to report it at the SARS Management Team and to ask her to re-discuss it with Public Health and indicate to them we have clinical views here that differ, because whenever that happens, that's what we did.

North York General Hospital placed huge reliance on Dr. Mederski. There was no machinery to ensure that this one crucial “point person” was regularly debriefed and supervised. There was no system to ensure that any relevant concerns she might have from time to time were expressed, considered and addressed by management. The lack of a system to oversee and support this crucial lynchpin in the hospital’s SARS response is evident in the lack of clarity around the question of supervision. Dr. Rose said:

Question: To whom was Dr. Mederski accountable?

Dr. Rose: To whom at the hospital?

Question: Yes.

Dr. Rose: First there was the Chief of Medicine, Dr. David Baron, and then through the Chair of the MAC [Medical Advisory Committee] and then through the Board. From a medical practice, medical quality.

Question: Who was her supervisor?

Dr. Rose: That is difficult to say. Dr. Baron, indirectly, but he wasn’t in infectious specialities, so his supervisory capacity would be limited, so he may not be able to assess her medical quality of care, he could assess some other aspects of her practice.

This is not to suggest that disagreement among physicians would be unusual or inappropriate. The problem was that the disagreement of opinion was not brought into the open, so that the differing opinions could be weighed. As Dr. Rose told the Commission:

In a disease that is unknown, does it surprise me that there might have been people that disagreed? No. Without a blood test, as you’ve said, we couldn’t make a definitive diagnosis. Even with a blood test it was hard to make the diagnosis. But it wouldn’t surprise me that one expert might have a different opinion from nine other experts. I was not aware that [Dr.] Barb Mederski was one expert telling nine other experts that they were wrong, or felt that she was right and they were wrong. I was not aware of that. It’s always a risk in general in medicine.

The problem with this approach is that it meant that there was a circle of staff with privately held opinions about the psychiatric patients, by nature of the fact that they were caring for these patients. They could make their own decisions about personal protective equipment, vigilance for new SARS cases and relaxing precautions. But the rest of the staff were kept in the dark, because there was no system to ensure that front-line clinical experience was brought to the attention of the ultimate hospital decision makers. As one doctor said:

I think what was happening at North York and what some of the nurses and doctors were suspicious of was on one side of the spectrum. On the other side, you had the powers that be like Dr. Low and Dr. Mederski who said, we're cool, everything's okay. And that's tricky. So I guess we have to learn from the bottom up and from the top down. You need a feedback loop and a better dissemination of information. Because I believe we will be faced with another serious illness in the not too distant future. Toronto is particularly vulnerable because of our population profile, so avian flu may be our next dreaded epidemic and I'm hoping that we would handle it differently because, again, health care workers, there probably will be a 30 per cent attack rate on them.

No criticism can attach to the front-line physicians who were busy caring for the patients and saving lives. The Commission finds that there was an ineffective process and system to provide a path for communication and consult with the front-line staff who were providing care to these patients. In the end, the patients, the hospital and the public are fortunate that these physicians and health care providers acted on the strength of their professional judgment and that they provided the care in the manner that they did.

SARS After All

The hospital, Public Health, government experts and outside experts, in hindsight, mistakenly declined to classify these patients as SARS, largely due to the absence of an epilink. As summarized in the Naylor Report:

Between April 20 and May 7, three psychiatric patients developed pneumonia. All had been on the seventh floor of North York General Hospital. One had come back to hospital through the emergency department. He was placed in a waiting area with a mask, but paced constantly and, to the concern of the staff, frequently removed his mask. All three patients were

isolated and managed as potential SARS cases, although no epidemiological link to other cases could be identified. The assessment team had divergent views as to whether the clinical picture was consistent with SARS – but in the end, chiefly because there were no epidemiological links to known SARS patients and negative laboratory tests, they ruled out a new cluster.⁵⁸⁰

Instead of saying “these psychiatric patients have all the symptoms of SARS, we treat them as SARS patients, they are in a hospital with SARS, let’s be cautious and assume they have SARS until proven otherwise,” the message to staff was that these cases were not SARS.

The unexplained appearance of this SARS-like cluster of patients, treated by the hospital as if they did have SARS, was a cause of great concern. The degree of concern, the depth of SARS suspicion, is reflected in the high-level consultation with Toronto Public Health and other outside experts. Despite this high level of suspicion, no one ever explained to staff how a cluster of three physically healthy patients in the same unit could come down with atypical pneumonia around the same time. The cluster remained unexplained. And, as noted earlier, the SARS-like illness of the nurses in April also remained unexplained.

Some point to the case of the psychiatric patients and suggest that although they were misidentified, in the end there was no known transmission from these cases to other staff or patients. They argue that the cases were investigated, that precautions were taken on the unit and that the cases were handled as SARS. Even if they had been identified as SARS at the time, nothing could have been done differently.

It is impossible to say in hindsight how things would have been different had the North York General psychiatric patients been identified as SARS or at least as possible SARS to staff. But had the psychiatric patients been identified as SARS, hospital officials may have reconsidered the decision to relax precautions on May 7. It might have caused everyone to look harder for the source and for other possible undetected cases of SARS. The acknowledgment of new SARS cases may have elevated the index of suspicion among staff and physicians. Instead, as May progressed, those nurses and doctors who did not have their own beliefs that SARS was still around, based on their involvement with cases such as the psychiatric patients and the ill health workers in April, believed that there were no new cases of SARS. As will be seen in the case of the outbreak of respiratory illness among patients and health workers on the orthope-

580. Naylor Report, p. 39.

dic floor, decisions about the use of personal protective equipment and the overall vigilance of staff were impacted by the belief that SARS was gone.

The staff would later find out that their suspicion and fears were correct and that the assurances given to them by the hospital were wrong. These psychiatric patients, all three of them, had SARS. To date, the source of infection for the psychiatric patients has not been found. All three patients are listed by Public Health and the Province as probable SARS cases.

The investigation by the Joint Health and Safety Committee at North York General noted in its report:

As it turned out, all three of these patients did have SARS and no epi-link has ever been established. Even as TPH initially dismissed these cases, they provided no explanation why this cluster of patients had these symptoms to the knowledge of this subcommittee. We believe that the appearance of this cluster was a strong warning that SARS was not contained and it is particularly alarming in light of the fear expressed by the Clinical Chiefs that we had an unexplained cluster.⁵⁸¹

The SARS Field Investigation into the second outbreak at North York General Hospital made the following findings in respect of the psychiatric patients from 7 West:

Around the same time in mid April, a cluster of 3 SARS cases appeared on a locked psychiatric unit, 7 W. These 3 patients were never co-roomed. Each of the three did stay in the same isolation room but separated in time by at least several days. Extensive investigation by TPH did not identify any family members or unit staff with SARS symptoms. The first 2 cases (a 34-year-old man and a 50-year-old woman, both admitted from the community) developed SARS symptoms on April 17 and 18, 2003 respectively. Although these 2 individuals did not consistently wear masks, and shared the public telephone on the ward with other patients, only one other patient on the ward came down with SARS. All 3 patients were subsequently found to be SARS-CoV seropositive. They were placed on SARS isolation while the investigation was underway. Case

581. North York General Hospital, Joint Health and Safety Committee, p. 39. This is a reference to the concerns registered by the Clinical Chiefs in early May, which is discussed earlier in this section.

finding on the ward for other unrecognized symptomatic SARS patients only identified a smoker with cough but no fever in late April. CXR was uncertain for an early infiltrate.

Work assignments of mobile hospital workers identified a consultation nurse who saw patients on both 4 W and 7 W during the incubation period of the 4 index cases. However, she had no direct contact with SARS patients and did not consult on roommates of these patients. She did have fever, diarrhea and myalgia in late March and early April 2003 but her convalescent SARS-CoV serology taken 2 months later was negative.

The early cases on the orthopedics and the psychiatry wards were not recognized initially as these patients had no travel history or known contact history. In addition, nosocomial SARS transmission among patients had not yet been reported at NYGH. How SARS was first introduced to 7 W and 4 W remains an unresolved issue.⁵⁸²

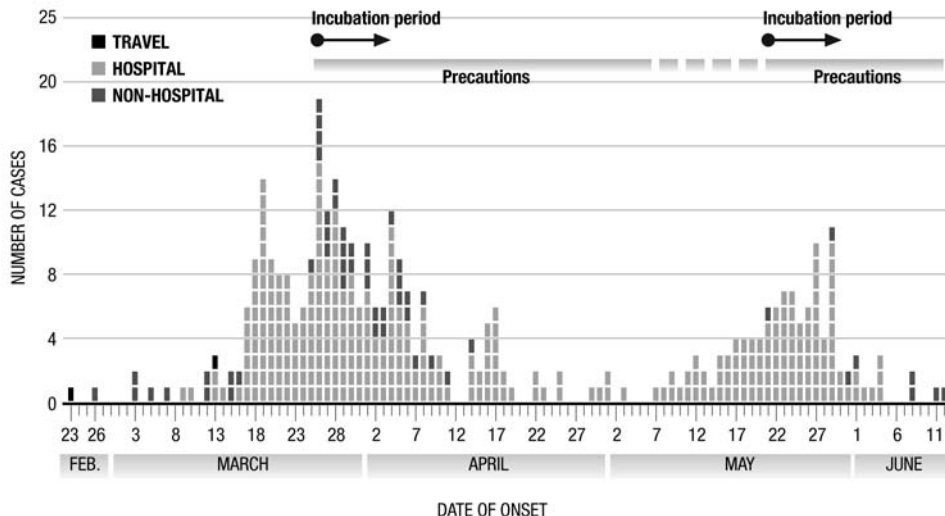
The psychiatric patients were the second, but not the last, undetected sign that there was unexplained SARS transmission at North York General Hospital. An outbreak was spreading on the 4th floor, an orthopedic floor. However, unlike for the psychiatry patients, the illness on the 4th floor was neither identified within the hospital nor reported to Public Health officials. As precautions were relaxed, the outbreak began to spread throughout the hospital.

582. SARS Field Investigation NYGH.

Relaxation of Precautions at North York General Hospital

During April and May, unidentified cases of SARS smoldered at North York General Hospital. When precautions were relaxed in May, SARS spread there quickly, among patients and health workers. Hardest hit were health workers, who worked unknowingly with SARS cases without protective equipment. When precautions came down, SARS spread; when precautions came back up, SARS was contained. The following chart⁵⁸³ shows a spike in the number of cases, approximately 10 days after the relaxation of precautions:

The Distribution of Cases in the Severe Acute Respiratory Syndrome (SARS) Outbreak in Ontario, Canada, from February 23 to June 12, 2003.



583. Dr. Donald Low and Dr. Allison McGeer, "SARS – One Year Later", *New England Journal of Medicine*, 349:25, December 18, 2003.

One of the most controversial issues surrounding the outbreak of SARS at North York General is the question of whether the hospital relaxed precautions too soon. Did the hospital breach existing directives⁵⁸⁴ regarding the use of protective equipment? Did it prematurely relax precautions, before the Provincial Operations Centre had given the green light to do so? If the hospital was in compliance with the provincial directives, should it have delayed the relaxation of precautions until a later date, in light of what was happening inside the hospital, with the illness among staff in April and the illness among the psychiatry patients in April and May?

Also from the story of the relaxation of precautions at North York General Hospital emerges a key lesson seen time and time again throughout the story of SARS, not only at North York General Hospital but also at other hospitals: the necessity to ensure that whatever the policy of the day, staff are encouraged and supported to wear

584. The Commission, in its second interim report, *SARS and Public Health Legislation*, recommended amendments to the *Health Protection and Promotion Act*, to clarify and strengthen the power to issue directives to hospitals. As the Commission observed:

Even now that SARS is over, the question remains: under what legal authority were these directives issued and under what authority are they continued and replaced by new directives? Many directives were issued across the board to all hospitals whether they had SARS cases or were even within the Greater Toronto Area. How would those hospitals without SARS cases, remote from the Greater Toronto Area, fit the requirement under s. 22 that a “communicable disease exists or there is an immediate risk of an outbreak of a communicable disease in the health unit”? Legal arguments can be made for and against the authority of the Chief Medical Officer of Health to issue such directives under s. 86 of the *Health Protection and Promotion Act*. It may be that a generous reading of the *Health Protection and Promotion Act* could support the legal authority for the directives issued to hospitals during and after SARS.

There is too much at stake to leave this vital issue to a debate between lawyers about strict and generous interpretations of the *Health Protection and Promotion Act*. The law must be clear. The Chief Medical Officer of Health must have the clear power to issue directives to health care facilities and institutions on issues related to the prevention and control of infectious diseases to ensure a uniform and adequate standard of public health protection within the health care field as a whole. One undetected or unreported case of an infectious disease may have disastrous consequences for the public’s health. One health care facility with substandard procedures or poor infection control could be the site where the index patient of a new disease seeks treatment and spreads the deadly virus. The province, through the Chief Medical Officer of Health after appropriate consultation with the appropriate experts and health care communities, must have the authority to direct and ensure an appropriate level of institutional protection against infectious disease. (pp. 152-153)

Also in the Commission’s first and second interim reports, it discussed problems with authority, transparency, accountability, and clarity of the directives. See *SARS and Public Health in Ontario*, April 2004; and *SARS and Public Health Legislation*, April 2005.

the protective equipment and use the approved infection control and worker safety procedures they believe are necessary to protect themselves.

It is also important to remember that regardless of the hospital's policy in respect of the use of protective equipment, North York General, like most other hospitals in Ontario, had not trained its staff prior to SARS to ensure they understood how to safely use personal protective equipment and were aware of its limitations. And North York General, like most other hospitals in Ontario, did not routinely use N95 respirators and did not have a fit-testing program in place prior to SARS. Consequently, when SARS hit, it had to scramble to train approximately 4,000 staff in the midst of an outbreak.⁵⁸⁵ Many health workers from North York General reported to the Commission that they were not properly trained on how to use personal protective equipment and were not fit tested during the first phase of SARS. Whatever protocols were in place with respect to the use of personal protective equipment, staff were not fully protected without proper training, including fit testing as required by law.⁵⁸⁶

Compliance with Provincial Directives

In the aftermath of SARS at North York General Hospital, some question whether the hospital relaxed precautions prematurely and whether it breached provincial directives in doing so. One physician, who did not work at North York General, said to the Commission when speaking about the second outbreak at North York General Hospital:

... I don't personally know of any other hospital, with the exception of Sick Kids, which was a different issue, who reduced their precautions prior to May 13th.

On the other hand, North York General Hospital has repeatedly asserted it they did not relax precautions prematurely. As Ms. Bonnie Adamson CEO of North York General Hospital said during her presentation at the Commission's public hearings:

585. As Ms. Bonnie Adamson said at the Commission's Public Hearings, September 29, 2003:

Mask fit testing for our staff quickly became a major issue. We had to fit four thousand (4,000) staff, a time-consuming process and we certainly didn't have a lot of time to spare.

586. *Occupational Health and Safety Act* and the Health Care Regulations 67/93.

Even as the first SARS crisis appeared to be over, we continued our vigilance. The reason we were so cautious is that we still had SARS patients in our hospital. We could not and did not return to business as usual.⁵⁸⁷

The simple answer, that North York General Hospital did not relax precautions prematurely, emerges from a chronological analysis of the complex, jerry-built system of provincial directives. Directives were put in place by the hard work and dedicated efforts of the members of the Scientific Advisory Committee and the Provincial Operations Centre, who had to step forward and make the directives up as they went along, in a system totally unprepared for a major health emergency such as SARS.

The first provincial directive⁵⁸⁸ to hospitals, outlining the required use of protective equipment, was issued March 27, 2003. That directive provided:⁵⁸⁹

All staff in GTA and Simcoe County hospital emergency departments and clinics to wear protective clothing (gloves, gown, eye protection and mask – N95 or equivalent).⁵⁹⁰

The directive also provided that all patients and individuals accompanying patients

587. SARS Commission Public Hearings, September 30, 2003.

588. Prior to this, a letter dated March 18, 2003, from the Chief Medical Officer of Health, Dr. Colin D’Cunha, to all physicians in Ontario, provided:

Staff precautions:

Health care workers who have direct contact with a **suspect case of SARS** must observe the following:

- Good hand hygiene before and after contact with the patient and after removing gloves
- Wear gloves, gowns, for patient contact
- Wear an occlusive seal, high filtration mask (e.g. TB mask – N95)
- Wear eye protection if spraying or aerosolization of secretions is anticipated

[emphasis in original].

589. This section contains key portions from a number of directives issued during SARS. The directives are not reproduced in their entirety and portions are summarized. For the entire directive, reference should be made to the actual directives, as cited.

590. Provincial Directives to all Acute Care Hospitals, dated March 27th, 2003, issued by Dr. James Young, Commissioner of Public Safety, and Dr. Colin D’Cunha, Commissioner of Public Health.

entering a hospital emergency department in the GTA must apply a surgical mask prior to entering. It also required that all visitors to a hospital be registered and wear a surgical mask while in the hospital.

On March 29, 2003, the scope of precautionary measures broadened considerably. Under this directive, all staff in any part of an acute care facility in the Greater Toronto Area were required to wear an N95 respirator and other protective equipment (as outlined in the directive) for direct patient contact. The directive provided:

In order to contain the spread of SARS (severe acute respiratory syndrome), the Ontario Ministry of Health and Long-Term Care advises that all hospitals in the GTA and Simcoe County must undertake the following procedures **effective immediately**:

10. Undertake the following precautions for all hospital staff:

For all staff when in any part of the hospital:

- Use frequent hand washing techniques
- Use an N95 (or equivalent) mask (ensure mask is fit tested)

For hospital staff who are required to visit a patient care unit:

- Use frequent hand washing techniques
- Use an N95 mask (ensure mask is fit tested)
- Use an isolation gown

For direct patient contact:

- Use frequent hand washing techniques
- Use an N95 mask (ensure mask is fit tested)
- Use an isolation gown
- Use gloves
- Use protective eyewear

Masks and gowns may be reused but must be changed:

- Following contact with a SARS patient
- When wet or soiled

Gloves must be changed, hands washed, and eyewear washed with soap and water following each patient contact.⁵⁹¹

Only essential staff were to go to work, and all staff were to be screened for SARS symptoms prior to entering the hospital. Also at this time, provincial directives restricted visitation, except on compassionate grounds.⁵⁹² Visitors who were permitted in the hospital on compassionate grounds had to undergo a symptom clearance evaluation and had to wear a surgical mask at all times while in the hospital.⁵⁹³

On April 14, 2003, the requirements for the use of protective equipment were significantly changed, as the Provincial Operations Centre issued revised directives to all acute care hospitals in Ontario. This directive no longer required that N95 respirators be worn by staff in all areas but specified their use in certain areas and/or situations.

The directive required the use a N95 respirator by staff and visitors when entering the room of a patient who had specified respiratory symptoms:

HCW's [health care workers] should maintain a high index of suspicion when assessing any patients for new onset of fever or respiratory symptoms. Any person developing the following symptoms or signs after admission – cough, unexplained hypoxia, shortness of breath or difficulty breathing – must be treated as follows:

- a) Transfer to a single room if available. If a single room is not available, cohort similar case presentations (e.g. congestive heart failure cases with other patients with congestive heart failure) and maintain at least one metre spatial separation between beds. If there is more than one patient in the room, the curtains must remain closed between beds to minimize droplet transmission.
- b) Patient activity should be restricted ie. patients should remain in their room with door closed until SARS is ruled out.
- c) All visitors and health workers must wear a N95 mask or equivalent when entering the room.

591. Directives to GTA/Simcoe County Acute Care Hospitals, March 29th, 2003, issued by the Ministry of Health and Long-Term Care, under the signature of Dr. James Young, Commissioner of Public Safety and Security.

592. Such as palliative care, critically ill children or visiting a patient whose death may be imminent.

593. Directives to GTA/Simcoe County Acute Care Hospitals, March 29th, 2003, issued by the Ministry of Health and Long-Term Care, under the signature of Dr. James Young, Commissioner of Public Safety and Security.

- d) Where possible, diagnostic and therapeutic procedures (e.g. imaging, hemodialysis) must be done in the patient's room.
- c) Patients should be out of the room for essential procedures only and wear a surgical mask during transport.⁵⁹⁴

The April 14 directive also included a number of attachments that further specified precautionary measures. One attachment, titled "Emergency Department Barrier Precautions," provided an algorithm for screening patients and for the use of protective equipment in emergency departments. Based on that, emergency room staff were required to wear N95 respirators and other protective equipment for direct patient contact where a patient:

- fails the SARS Screening Tool, OR
- the SARS screening tool cannot be completed, or
- has fever greater than or equal to 38 C or any history of fever, OR
- has any respiratory symptom ...

Also at that time, an attached document titled "Description of Activity for Acute Care Facilities by SARS Category" correlated the level of precautions to the level of a facility. The key changes with respect to the use of protective equipment by staff were:

Level 3 Facility

- N95 mask or equivalent for all staff in the facility.
- Full droplet and contact precautions (gowns, gloves, N95 masks or equivalent, protective eye wear) for ALL direct patient contact

Level 2 Facility

- Full droplet and contact precautions (gowns, gloves, N95 mask or equivalent, protective eye wear) for:
 1. direct patient contact in all area(s) affected by the unprotected exposure
 2. direct patient contact in any area of the hospital with a patient who fails the SARS Screen or has respiratory symptoms suggestive of an infection
 3. for taking care of suspect or probable SARS patients

594. Directives to All Ontario Acute Care Hospitals, Directive 03-04, April 14, 2003.

Level 1 Facility

- Full droplet and contact precautions (gowns, gloves, N95 mask or equivalent, protective eye wear) for:
 1. direct patient contact in any area of the hospital with a patient who fails the SARS Screen or has respiratory symptoms suggestive of an infection
 2. for taking care of suspect or probable SARS patients.⁵⁹⁵

Visitors to the emergency department were required to wear surgical masks if accompanying a patient who failed the SARS screening tool, could not complete the screening tool, had a fever greater than or equal to 38°C, or who had respiratory symptoms.⁵⁹⁶ Visitors to the room of a patient who had developed cough, unexplained hypoxia, shortness of breath or difficulty breathing were to wear an N95 respirator at all times.⁵⁹⁷ Like the use of protective equipment by staff, visitation and the use of protective equipment by visitors were tied to the level of the health care facility. For example, in a Level 3 hospital, visitors were not permitted except for special circumstances,⁵⁹⁸ and in such a case the visitor had to follow full droplet and contact precautions. A Level 1 hospital could allow visitors at the hospital's discretion. Visitors had to comply with protective equipment as described above and also had to comply with full droplet and contact protection if visiting a SARS patient.

Ten days before this April 14 directive, on April 4, North York General Hospital had been upgraded to a Level 2 classification, following the identification of three staff members as persons under investigation for SARS. The story of these three health workers is told earlier in this chapter. On April 14, 2003, after 10 days with no evidence of further transmission from these three ill health workers, North York General Hospital was downgraded in terms of SARS risk, from a Level 2 facility to a Level 1 facility.⁵⁹⁹

595. Directives to All Ontario Acute Care Hospitals, April 14th, 2003, and Description of Acute Care Facilities by SARS Categories, April 14, 2003.

596. Directives to All Ontario Acute Care Hospitals, April 14th, 2003, and Description of Acute Care Facilities by SARS Categories, April 14, 2003. Attachment, "Emergency Room Barrier Precautions."

597. Directives to All Ontario Acute Care Hospitals, April 14th, 2003, and Description of Acute Care Facilities by SARS Categories, April 14, 2003.

598. Critically ill patient, palliative care patient, labour partner or parents (one at a time) of a child. See Description of Activity for Acute Care Facilities by SARS Category.

599. NYGH SARS Update #17, April 14, 2003.

As per the directives issued April 14, outlined above, staff were not required to wear N95 respirators or even surgical masks in all areas at all times unless the hospital was classified as a high risk Level 3 facility. Nor were visitors required to wear masks at all times when in all areas of the hospital.

According to North York General policies, as of April 14, 2003, the hospital was still requiring staff to wear N95 respirators when in any part of the hospital.⁶⁰⁰ In effect, the hospital was adhering to the more stringent standards for a Level 3 hospital, even though it was classified as a lower-risk, Level 1 facility.⁶⁰¹ To put it simply, North York General Hospital adhered to a higher standard of protection than that required by government directives.

On April 25, 2003, the hospital issued this chart,⁶⁰² summarizing the requirement for protective equipment across the hospital:

600. SARS Task Force, SARS Precautions For NYGH Staff, April 4, 2003, revised April 10th, 2003.

However, it would appear there were exceptions to this. One exception was in the psychiatry unit, where interviewing mentally ill patients while wearing an N95 respirator, and trying to enforce the use of a mask by the patient, posed a challenge for staff and physicians. A memo dated April 23, 2003, from the Chief of Psychiatry to all physicians and senior staff in the department, said that masks could be removed during mental health interviews provided both patient and staff agreed, staff had a degree of trust in the patient whom they had assessed as reliable in answering questions to the screen, staff and patient maintained a 2 metre distance from each other, and staff and patient washed hands with alcohol wash after interview and washed down furniture and other surfaces after each interview. The memo was clear, however, that staff were not required to remove protective equipment for mental health interviews if they were at all uncomfortable.

601. Droplet and Contact Precautions for NYGH Staff, April 4, 2003, revised April 10, April 16, April 15 and April 25.

602. Droplet and Contact Precautions for NYGH Staff, April 25th, 2003. The chart, titled “Isolation Precautions,” is reproduced to fit the format of the report. The chart also included the following information:

- **High Risk Patients:**

1. Patients with – Congestive Heart Failure with/without pneumonia
 - Exacerbation of COPD
 - Exacerbation of Asthma
 - Patients with pulmonary infiltrates and presumptive diagnosis (not SARS)

Note: These patients will have precautions discontinued as per defined criteria – see policy

2. Patients transferred from a Level 3 hospital
3. Intubation of high risk patients (for all areas of the Hospital, except the O.R.). All staff involved in the intubation procedure should wear the following: N95 mask, double gown, double gloves, head cover, goggles and face shield.

- **High Risk Areas:**

1. Front door screening (no booties)

Isolation Precautions	Probable or Suspect SARS or Person Investigation	Emergency Dept.	ICU	High Risk Patients and Areas* (Droplet/Contact)	All Other Patient Care Areas
Hand Hygiene	•	•	•	•	•
N95 Mask	•	•	•	•	•
Gown					
Front and Back	•				
Front Only		•	•	•	If in contact with blood or body fluid
Gloves					
Double	•				
Single		•	•	•	If in contact with blood or body fluid
Face Shield	•				
Goggles	•	•	•		
Shoe Covers	•	•		•	
Head Covers	•	•		•	

The accompanying written policy, revised April 25, 2003, required all staff to wear the N95 respirator when in any part of the hospital. Visitors to the hospital were required to wear a surgical mask at all times while in the hospital.⁶⁰³

North York General Hospital continued this level of precautions until May 7, 2003, when it instituted the first relaxation of precautions by the hospital since the beginning of the SARS outbreak. The chronology shows that this measure was taken carefully, and is in line with provincial directives.

On May 7, 2003, the hospital significantly changed its policy in respect of the use of protective equipment. Staff were no longer required to wear N95 respirators in all patient care areas. The only areas that had to continue to follow the use of N95 respi-

2. Outpatient departments

NOTE: SARS PATIENTS IN OTHER AREAS, e.g. EMERGENCY ROOM ARE TREATED WITH SARS PRECAUTIONS
HIGH RISK PATIENTS IN ANY DEPARTMENT ARE TREATED WITH CONTACT/DROPLET PRECAUTIONS

S:\Policies\Staff\Droplet & Contact Precautions for Staff REV April 25.doctor Created on 03-04-25 5:24 PM Page 5 of 5 [emphasis in original].

603. SARS Management Team, SARS Visitor Issues – Staff Directives, Issued April 2nd, 2003, revised April 10, 2003.

rators at all times were the emergency department, the intensive care unit, the critical care unit, and the SARS unit. This change in protocol was communicated to staff via an update, which provided:

Effective immediately, the Mask Policy has been revised and some staff are no longer required to wear masks. Masks are no longer required in common areas including elevators, Cafeteria, etc.

Staff must wear masks in the following areas:

SARS Unit

Emergency Department

ICU/CCU [Intensive Care Unit/Critical Care Unit]

Outpatient areas/clinics (only in areas that require a staff member to be in direct patient contact), front door screening checkpoints, in rooms where patients are under respiratory or droplet precautions, in other specified areas (eg 7 West)

Staff who are required to wear masks in their work area because they fall into one of the above categories can either pick their mask up at the front door or on their unit. All staff who are still required to wear masks must be fit tested as per provincial directives. Occupational Health will be arranging mask fitting education sessions for all nurse clinicians and any other department who wishes to learn how to properly fit a mask. Please call [contact name and number provided].

Staff who work in areas that are not listed above are not required to wear masks. If you wish to still wear a mask, you may pick one up at the front door on our [your] way in.

All visitors and patients will still be required to wear surgical masks.⁶⁰⁴

The policy changes expanded visitations but required all visitors to wear a surgical mask while in the hospital.

The decision to relax precautions in most areas of the hospital commencing May 7, 2003, was not intended to alter the level of precautions taken in areas that were

604. NYGH SARS Update #35.

perceived to be at greater risk of exposure, such as the emergency department. One physician who worked in the emergency department and the intensive care unit explained that this change had no effect on the precautions taken by front line workers who cared for SARS patients or saw patients from off the street:

Whether the entire hospital policy is being reduced and wound down, in the intensive care unit we were still looking after SARS patients at that time. So from that point of view, I didn't even pay attention to what the policy was, you are looking after SARS patients now. You do whatever you have to do, and going into the emergency department on call for medicine is the same thing, you are actually seeing patients fresh off the street. You don't know where they are coming from.

In that sense, we were doing precautions all the time, just because it pertains to my work. So, there is that thing in the background that the hospital policy is reducing the precautions, but I think with my work, working in the emergency department or working in the intensive care unit, it was not relevant whether it [the set of precautions] was used everywhere else or not.

Hospital policy also continued to require the use of droplet and contact precautions by staff working on the SARS unit, providing care to suspect or probable SARS cases, caring for patients who had failed a SARS screen, and caring for patients who had a respiratory illness suggestive of infection, on droplet and contact precautions, or during contamination-prone procedures.⁶⁰⁵

Dr. Berall, co-chair of the SARS Task Force, said that the decision to relax precautions was done after a great deal of thought and discussion. He said that they did not relax precautions until weeks after the April 14, 2003, directive:

April 14th there was information from the POC [Provincial Operations Centre] on SARS categories that identified the level of precautions

605. SARS Management Team, Precautions for Staff Caring for SARS Patients, issued April 23rd, revised April 25, 2003. SARS Task Force, Droplet and Contact Precautions for NYGH Staff. Also note, the Hospital had a separate policy for staff caring for SARS patients. The policy, which set out the precautions to be used when on the unit and when having direct patient contact or entering a patient room, continued to remain in effect on the SARS unit. See NYGH SARS Management Team, Precautions for Staff Caring for SARS Patients, issued April 23rd, 2003, revised April 25, 2003.

appropriate to each SARS category of institution. And we continued to keep our precautions at a level above the minimum required for the level that we were at. We delayed bringing any relaxation into place and even this relaxation doesn't bring it down to what we could have according to those descriptions but we delayed this because of an abundance of caution.

He told the Commission that the North York General Hospital SARS Management Committee understood that other hospitals had relaxed the use of precautions in all areas of the hospital, and that they were receiving pressure to do the same. Dr. Berall said that despite this pressure, they continued to be cautious:

By their descriptions and the implications of their descriptions, they were saying that, and other institutions had relaxed before us. In fact, there was some article in the media referring to that factor as well. Although I don't recall the article and the date, I remember seeing it referred to.

So there was a general sense that other institutions were relaxing and we were actually getting requests from our staff, you know, can we relax the precautions somewhat. Is it needed everywhere? Should we only have it where we're facing these issues? And we resisted those sorts of pressures and went slowly. I think it's absolutely ironic that when we were more conservative than most, that SARS II involved North York General to the degree that it did.

The hospital relaxed precautions on May 7, 2003, in accordance with Ministry directives at the time. Even with the changes to precautions on May 7, 2003, North York General Hospital continued to require the use of precautions at a higher level than required by the current directives. As of May 7, there was no requirement in Ministry directives that staff wear protective equipment at all times in areas such as the intensive care unit, critical care unit, emergency room, and outpatient areas and clinics. As noted above, the use of protective equipment outlined in the directives was tied to a hospital's level and related to the screening of patients and their symptoms (that is, failed screen, patient with fever, respiratory symptoms, etc.).

On May 13, 2003, the Provincial Operations Centre again revised the directives to all Ontario acute care facilities. These directives, known as the "new normal," were intended to set out the use of protective equipment in what was believed was now the post-SARS period. These directives marked another significant change in the use of protective equipment. Staff in emergency departments and critical care settings were

no longer required to take SARS precautions, including wearing an N95 respirator, for all patient contact. SARS precautions were required only when caring for a suspect or probable case. Precautions such as gowns, gloves, N95 respirators or equivalent and protective eyewear were required when entering a room of a patient who had respiratory symptoms suggestive of an infectious disease, until SARS was ruled out.

The May 13 directives, like the April 14 directives, linked the required level of protection required to the SARS level of the hospital. The key provisions with respect to the use by staff of protective equipment can be summarized as follows:

Level 3 facility – Staff:

- SARS precautions (gowns, gloves, N95 mask or equivalent, protective eye wear) for all direct patient contact in areas defined by the hospital outbreak investigation team in consultation with local public health unit.

Level 2 facility – Staff

- Full SARS precautions (gowns, gloves, N95 mask or equivalent, protective eye wear) must be used for:
 1. Direct patient contact in all area(s) affected by the unprotected exposure;
 2. Direct patient contact in any area of the hospital with a patient who fails the SARS Screening Tool or has respiratory symptoms suggestive of a transmissible respiratory infectious disease; and
 3. Taking care of PUI, suspect or probable SARS, continued to follow Directive 03-06(R) May 13, 2003, entitled Directives to All Ontario Acute Care Hospitals For High-Risk Procedures in Critical Care Areas During a SARS Outbreak.

Level 0 or 1 facility – Staff

- For care of suspect or probable SARS patients use SARS precautions. Refer to the Directive 03-05(R) April 24, 2003 for information on staff personal protective equipment, SARS patient room requirements and patient care activities.
- For entry into a room of a patient who has respiratory symptoms (unexplained cough, hypoxia, shortness of breath or difficulty breathing) suggestive of an infectious disease, use precautions (gowns, gloves, N95 mask or equivalent, protective eye wear) until SARS is ruled out.

By May 13, 2003, North York General Hospital no longer required the use of N95 respirators in all patient care areas. As noted above, this was consistent with Ministry directives issued April 14, 2003. However, North York General Hospital policy still required the use of masks in the emergency department, the critical care unit, the intensive care unit, and outpatient clinics and areas where staff had direct patient contact. Staff working on the SARS unit, staff providing care to suspect or probable SARS cases, staff caring for patients who had failed a SARS screen, staff providing care to a patient who had a respiratory illness suggestive of an infection and put on droplet and contact precautions or during contamination-prone procedures, were still required to use droplet and contact precautions as per hospital policy.⁶⁰⁶

May 15, 2003, was the second stage for the relaxation of precautions at North York General Hospital. On that date, the hospital removed the requirement that all staff in the emergency department and the community care centre wear N95 respirators at all times. The policy provided:

Staff with no contact with patients with respiratory symptoms suggestive of an infectious disease are not required to wear caps, eye shield, masks, gowns, shoe covers or gloves [original in capital letters and in bold].

Also on May 15, 2003, the hospital revised its policy with respect to use of protective equipment by visitors. It no longer required visitors to wear masks in all areas of the hospital. The changes to the policy were outlined to staff in an update issued that day. It provided:

Visitors and patients will no longer be required to wear a mask while they are in the Hospital unless they fail the screening tool or are in areas under special precautions (Emergency, SARS, ICU/CCU).⁶⁰⁷

The hospital announced the changes in an update to staff, dated Friday, May 16, 2003:

606. SARS Task Force, Droplet and Contact Precautions for NYGH Staff. Also note, the hospital had a separate policy for staff caring for SARS patients. The policy, which set out the precautions to be used when on the unit and when having direct patient contact or entering a patient room, continued to remain in effect on the SARS unit. See NYGH SARS Management Team, Precautions for Staff Caring for SARS Patients, issued April 23rd, 2003, revised April 25, 2003, June 5, 2003, and June 16, 2003.

607. NYGH SARS Update #39. The changes were announced on May 14th, 2003, but were not effective until May 15th, 2003.

This morning, we talked about moving towards the new normal and the changes that need to be made in order to do that. By next Friday, you should see a number of changes to existing SARS policies.

A significant change that has taken place today is the removal of protective gear in the Emergency Department and Community Care Centre. Triage nurses will continue to wear protective gear during the initial screening of patients in both these departments.

All patients presenting to the Emergency Department (ED) and CCC with respiratory symptoms suggestive of an infectious disease will be placed in specific rooms and all staff in contact with these patients will take the appropriate precautions.

As we move forward with the removal of protective gear, everyone must remember that it is still very important to wash your hands frequently throughout the day.⁶⁰⁸

The hospital continued to screen patients and visitors as they entered the hospital. The May 20, 2003, minutes of the SARS Management Team note that screeners were to remain at the front door of the hospital, at least until July.⁶⁰⁹

The following chart provides an overview of the key Ministry directives with respect to the use of protective equipment by staff, in comparison with hospital policies during April and May 2003:

608. N YGH SARS Update #40.

609. North York General Hospital, SARS Management Team, Minutes of Meeting, May 20, 2003, 0800 hours, Main Boardroom – General Site (referenced in this section as “SARS Management Team, Minutes of Meeting”).

DATE	MINISTRY DIRECTIVE	HOSPITAL POLICY	COMPARISON
April 14	<p>Change in Ministry Directives</p> <ul style="list-style-type: none"> • Use N95 respirator when entering room of patient with respiratory symptoms or fever • In ER full droplet and contact precautions if patient failed SARS screen, SARS screen could not be completed, fever of 38°C or greater, or has respiratory symptoms • Level 1 facility – full droplet and contact precautions for: <ul style="list-style-type: none"> • Direct patient contact in any area of the hospital with a patient who fails the SARS screen or has respiratory symptoms suggestive of an infection • Taking care of suspect or probable SARS patients 	<ul style="list-style-type: none"> • No change in hospital policy • Staff still required to wear N95 respirators in all patient care areas and in any part of the hospital. • Droplet and Contact Precautions for staff working on SARS unit 	<ul style="list-style-type: none"> • NYGH policy not in contravention of Directives • NYGH policy more stringent than Ministry Directives
May 7	<p>No change in directives</p> <ul style="list-style-type: none"> • Remained as they were as of April 14, 2003 	<ul style="list-style-type: none"> • NYGH Policy changed – first relaxation of precautions • Staff no longer required to wear masks in common areas or in all patient care areas • Staff must continue to wear masks at all times in: <ul style="list-style-type: none"> • ER • SARS unit • ICU • CCU • Outpatient areas/clinics where staff member required to have direct patient contact • Front door screening • Rooms where patients under respiratory or droplet precautions • Droplet and Contact Precautions for staff working on the SARS unit 	<ul style="list-style-type: none"> • NYGH policy not in contravention of Directives • NYGH policy still more stringent than Ministry Directives

May 13th	<ul style="list-style-type: none"> • N95 respirator and SARS precautions no longer required for all patient contact in emergency department and critical care settings • Only required use of SARS precautions, including N95 respirator, when caring for suspect or probable SARS case • Precautions, including an N95 respirator, required when entering a room of a patient with respiratory symptoms suggestive of an infection until SARS is ruled out 	<p>No change to NYGH Policy</p> <ul style="list-style-type: none"> • Remained as it was as of May 7, 2003. 	<ul style="list-style-type: none"> • NYGH policy not in contravention of Directives • NYGH policy remain more stringent than Ministry Directives
May 15	<ul style="list-style-type: none"> • No change in directives • Remained as they were as were on April 14, 2003 	<ul style="list-style-type: none"> • Staff no longer required to wear PPE in at all times in the emergency dept and Community Care Centre • PPE required for contact with any patient with respiratory symptoms suggestive of an infectious disease • SARS precautions still required when caring for suspect or probable SARS case 	<ul style="list-style-type: none"> • NYGH policy not in contravention of Directives

North York General Hospital policy required the use of a N95 respirator in all areas of the hospital until May 7, 2003. This was almost one month longer than required by provincial directives. Between May 7 and May 15, 2003, the hospital maintained precautions in the emergency department, intensive care unit, critical care unit, SARS unit, and outpatient areas and clinics where staff had direct patient contact, even though provincial directives no longer required the use of protective equipment, in particular the N95 respirator, in those areas at all times. Provincial directives permitted discontinued use of SARS precautions for all direct patient care in the emergency department as of May 13, 2003. North York General relaxed precautions in its emergency department on May 15, 2003.

The Commission finds that North York General Hospital did not breach provincial directives in the relaxation of precautions. On the contrary, North York General

Hospital policy continued to require staff and visitors to use personal protective equipment beyond what was required by Ministry directives.⁶¹⁰

May 7 Disconnect

Although North York General did not relax precautions before permitted by provincial directives, the question remains: in light of what was happening at North York General during April and May, with ill health workers and the ill psychiatric patients, should the hospital have delayed the relaxation of precautions?

By May 7 the hospital had, within the past 10 days, identified to staff one nurse who had contracted SARS (Health Care Worker No. 4) and three psychiatry patients who were under investigation for SARS. Also, a nurse from the ICU at North York General was in another hospital, also under investigation for SARS (Health Care Worker No. 5). Of particular concern were the ICU nurse and the three psychiatry patients, because if they were SARS, no one knew how they got it, meaning there were one or more unidentified sources of transmission.

On its face, one of the most striking disconnects appears on the date that North York General first relaxed precautions. At 10:45 a.m. on May 7, the hospital announced to staff that they had a third psychiatry patient under investigation for SARS. At 5:00 p.m., the hospital issued an update to staff, advising them that precautions were being relaxed. As noted above, the May 7 update told staff that effective immediately, other than the emergency department, critical care unit, intensive care unit and SARS unit, staff no longer had to wear N95 respirators in all areas of the hospital. The two updates seem to reflect a disconnect between the possible discovery of a new case of SARS in an area not expected to have SARS, with an unknown source of exposure, and the relaxation of precautions throughout the hospital. There was no test that allowed SARS to be ruled out within the hours between the morning announcement and the afternoon update relaxing precautions. Patient No. 3 was still under investigation as of 5:00 p.m., and if she had SARS, no one knew where she got it.⁶¹¹ And, as

610. Although, as the Commission notes above, notwithstanding compliance with the directives, if staff were not trained how to safely apply and remove the respirator and were not fit tested, they were not fully protected.

611. As seen earlier in the report and as seen in the chart outlining the communication in respect of ill patients and staff in April and May, including the ill psychiatric patients, there was considerable uncertainty and confusion about the status of the patients and whether they were or were not SARS.

noted earlier, as of May 7, Patient No. 1 and Patient No. 2 also remained under investigation and, like Patient No. 3, if they had SARS no one knew there they got it.⁶¹²

Dr. Keith Rose was asked by the Commission to explain the apparent disconnect. He said:

Question: The question really revolves around the SARS update of 5:00 p.m. on the 7th, which is at Tab 34. And the issue really is, was there some sort of a disconnect going on at that particular point in time in as much as you've got, under the mask policy, a step taken towards relaxing the requirement for personal protective equipment, at the same time as there is concern about 7 West, concern about a new case on 7 West and the clinical chiefs now have concerns about there being a cluster.

Dr. Rose: Okay, so let me try and recreate the situation at North York around the beginning of May, May 6th, May 7th. The issue of how much protective equipment was to be worn in the hospital had been discussed for at least three weeks. You'll see varying, as you go through the SARS Task Force Minutes, varying discussion on "was it necessary?" In fact if you go back to the directives as early as the beginning of April, you could, according to directives, discontinue the use of personal protective equipment in non-clinical areas and for direct patient contact except for isolation patients, ER's, triaging areas and ICUs. And our own staff had lots of conversation with their colleagues at other hospitals where precautions had been relaxed. And it's not easy to wear the protective equipment. It's not something people line up to do. You have to do it, you have to do it, okay. So, in many areas of the hospital, this was welcomed.

We did not initiate it until over a month after the directives said we could. We actually went out and canvassed staff. I remember this discussion about, "Are you ready to put down

612. A May 7, memo from the Chief of Psychiatry reported to staff that all three patients remained under investigation for SARS.

protective equipment?” and several areas were not ready to do so in terms of direct patient care. And so we held off in initiating this until the 7th and this had been planned for quite some time, to initiate it at this time. Discussion the previous Friday on how we would do it, a couple of options developed, so it was not an overnight fleeting thought. At the same time, after this decision had been made, the same day, a patient was admitted to the SARS unit from 7 West. So the decision had been already made about protective equipment. So the decision on 7 West was, what we applied to the rest of the hospital in terms of relaxation of precautions, did not apply to 7 West. 7 West was closed to new admission. People continued to wear protective equipment in direct contact with patients and what applied to the rest of the hospital, did not apply to 7 West.

There was a full investigation by [Dr.] Bonnie Henry and Toronto Public Health again. A discussion that [Dr.] Bonnie Henry had with members of the CDC around the psychiatry patients: “Should we have more environmental testing; should we do anything different?” They felt that all three patients weren’t SARS patients and in particular this one wasn’t. There should be more investigation of the patient around microplasma and some other things and they should get on the patient to see if this patient had another disease. The emphasis we should make is on finding another disease that this patient might have and that they didn’t feel environmental testing was warranted at the time, Public Health. And Bonnie [Dr. Henry] had done some work on a conference call with some experts from the CDC.

But, as Dr. Berall pointed out, although precautions were relaxed, there remained an expectation that cases would be handled with precautions, and keeping 7 West as a Level 2 facility meant that precautions remained in place on that unit, the unit where Patient No. 3 became ill. He said:

This memo has the POC [Provincial Operations Centre] telling us that we don’t need to do this. In an abundance of caution, we decide to keep 7 West and 7 North on Level 2. So we’re restricting any potential transmission on 7 West and 7 North. But because the POC has said, you don’t

need to do that, that's over what's necessary, and yet we're taking that abundance of caution, we then step down in the rest of the facility where appropriate. Not where there are patients with fever and infectious diseases, not where there are patients who are under respiratory droplet precaution. People who have respiratory droplet issues are being dealt with in isolation like they should be. People in the emerg are being dealt with in isolation like they should be. But, we keep 7 West and 7 North in an abundance of caution in a higher level of protection. We do the heavy cleaning and we consider it to be sort of Level 2 kind of status anyway. And then I have a discussion with the clinical chiefs and they want more than we've done. So we do that.

The decision to relax precautions was welcomed by many. A number of physicians and other health workers interviewed by the Commission said that the relaxation of precautions in most areas of the hospital on May 7, 2003, was a relief. Wearing the mask made working conditions difficult and, at times, unbearable. The May 2 update to staff shows the hospital officials and those in charge of the SARS response aware of apparent pressure from staff, who wondered why precautions were not being relaxed sooner. The update provided:

There was also discussion about newspaper and television reports that many health care workers at various institutions are now being allowed to relax the use of protective gear in some areas. The SARS Task Force will review our Staff Precautions Policy on Monday. We are gathering information from other Hospitals for comparison.⁶¹³

One health worker described the reaction she and many of her colleagues had when they were finally told they could remove the protective equipment:

I mean we were literally taking the masks off and we were throwing them because we couldn't breathe in them. And it was hot and everybody was getting ridges across our nose, it was raw across the bridge of our nose.

It is also important to note that provincial officials and public health officials were aware of the cases of ill staff in April and ill psychiatric patients in May. The Provincial Operations Centre did not direct North York General Hospital to move to Level 3, or even Level 2, in late April or early May, as new cases were identified.

613. NYGH SARS Update #32.

Instead, it permitted them to remain Level 1, aware of the precautions and directives that were attached to that designation. It required only the psychiatric unit, where the patients under investigation for SARS had been, to go to Level 2 status at the end of April. When the third patient was announced on May 7, it was the hospital that decided to move the unit back to Level 2, as the Provincial Operations Centre had determined that the hospital did not have to change its designation, even on that specific unit.

The hospital's decision to relax precautions, criticized by some in the aftermath of SARS and which as we now know led to the spread of SARS among patients, visitors and staff, was not questioned or challenged at the time by provincial officials. As noted earlier in this chapter, the classification of hospitals did not seem to address the situation where a hospital had cases under investigation for SARS, where there was no known transmission to other patients, visitors or health workers, but where if the cases were SARS, their source of exposure was unknown. The risk of the unknown source of exposure was that it could still be in the hospital, unidentified, waiting to spread to others, when protective equipment was removed. As one health worker said:

What I want to say is that in terms of the directives, they had directives that went to all hospitals. It wasn't very discrete in terms of how it was done. There were different hospitals that had different circumstances that maybe shouldn't have had the all clear.

North York General was still seeing patients who, although not identified as SARS, could not be ruled out as SARS either. Until those cases were ruled out, the possibility of an unidentified source of exposure remained. And the key thing that prevented them from being identified as SARS was that the epilink could not be found. But what if the epilink could not be found because it was somewhere, unknown, in the hospital, as we now know was the case?

Although everyone agreed that wearing the equipment was difficult and uncomfortable, despite the discomfort and the desire to return to normal, for many staff at North York General Hospital the decision to relax precautions was troubling in light of what had been happening in the hospital. As one nurse said:

I feel that we were told to take our masks off too soon without having any concrete evidence to why we should be doing that.

One physician said the changes in May that led to different levels of protection between areas of the hospital made little sense:

As the weeks went into May, things started becoming more lax. Sometime by mid-May, barriers were being dropped ... certain wards were deemed wards that you had to be gowned and gloved and masked. Other wards you didn't have to have anything ... To start separating wards into different rules when you have no meaningful barrier between those wards and you have free flow of personnel back and forth, how can you designate certain wards to be high risk, and other wards would be free of risk? ... From an infection control point of view, it actually makes no sense whatsoever. For example, the 4th floor, the famous 4th floor now, people were told it was no longer a high-risk area, you did not need any more isolation, except when you went into the room of a patient.

By May 7, five health workers and three patients had been investigated for SARS. The contradictory and confusing information about these patients can be summarized in the following chart:

Case	Communication to Staff	Public Health Classification	Retrospective Classification
HCW#1	April 7 – PUI ⁶¹⁴ Nothing further reported to staff	PUI ⁶¹⁵	Probable SARS
HCW#2	April 7 – PUI ⁶¹⁶ Nothing further reported to staff	PUI DNM (does not meet case definition) ⁶¹⁷	Probable SARS
HCW#3	April 7 – PUI ⁶¹⁸ Nothing further reported to staff	PUI DNM (does not meet case definition) ⁶¹⁹	Suspect SARS

614. SARS Task Force Steering Committee, Minutes of Meeting, April 7, 2003.

615. Health Worker No. 1 was admitted to hospital on April 5, 2003. She was classified as a person under investigation (PUI) and remained such until her classification was changed to probable SARS, on June 23, as part of the retrospective review of cases.

616. SARS Task Force Steering Committee, Minutes of Meeting, April 7, 2003.

617. Health Worker No. 2 was admitted to hospital on April 4, 2003. She was classified as a person under investigation (PUI) and remained such until May 3, when she was classified as “does not meet case definition.” She was retrospectively classified as a probable SARS case, in June 2006.

618. SARS Task Force Steering Committee, Minutes of Meeting, April 7, 2003.

619. Health Worker No. 3 was admitted to hospital on April 6, 2003. She was classified as a person under investigation (PUI) and remained such until April 22, when she was classified as “does not meet case definition.” She was retrospectively classified as a suspect SARS case, in June 2006.

Case	Communication to Staff	Public Health Classification	Retrospective Classification
HCW#4	April 21 – Not SARS ⁶²⁰ April 22 – Not SARS ⁶²¹ April 28 – suspect or probable SARS ⁶²² April 29 – probable SARS ⁶²³	PUI DNM (does not meet case definition) Probable SARS ⁶²⁴	Probable SARS Probable SARS
HCW#5	May 1 – PUI ⁶²⁵ Nothing further reported to staff	PUI DNM (does not meet case definition) ⁶²⁶	
Pt#1	April 29 – Probable SARS ⁶²⁷ April 29 – PUI ⁶²⁸ May 7 – under investigation ⁶²⁹ May 8 – reported as having alternate diagnosis ⁶³¹ May 9 – not SARS ⁶³² May 12 – did not meet criteria for SARS ⁶³³ May 13 – Not SARS ⁶³⁴ May 13 – cleared as Non-SARS ⁶³⁵ May 14 – do not meet criteria for SARS, PUI ⁶³⁶	PUI DNM (does not meet case definition) ⁶³⁰	Probable SARS

620. NYGH SARS Update #23, April 21, 2003.

621. SARS Task Force Steering Committee, Minutes of Meeting, April 22, 2003.

622. SARS Task Force Steering Committee, Minutes of Meeting, April 28, 2003.

623. NYGH SARS Update #28, April 29, 2003.

624. Health Worker No. 4 was admitted to hospital April 21. She was initially classified as a person under investigation, then said to be “not SARS” (April 22), then suspect or probable SARS (April 28) and finally probable SARS (April 29). She was ultimately classified as a probable SARS case.

625. SARS Management Team, Minutes of Meeting, May 1, 2003.

626. Health Worker No. 5 was admitted to hospital April 28, 2003. She was classified as a person under investigation (PUI) and remained so classified until May 16, 2003. On May 16, 2003, she was classified as does not meet case definition (DNM). She was retrospectively classified as probable SARS.

627. NYGH SARS Update #28, April 29, 2003.

628. NYGH SARS Update #29, April 29, 2003.

629. May 7, 2003, memorandum from Chief of Psychiatry to Chiefs of Psychiatry GTA Hospitals

630. Memorandum from Chief of Psychiatry NYGH, to All Staff Psychiatrists and Physicians.

631. SARS Management Team, Minutes of Meeting, May 9, 2003.

632. NYGH SARS Update #38, May 12, 2003.

633. Meeting with psychiatry staff, May 13, 2003.

634. Minutes of Mental Health Department SARS Staff Meeting, May 13, 2003.

635. NYGH SARS Update #39, May 14, 2003.

636. Patient No. 1 was classified as a person under investigation from April 21 until May 16. On May 16 he was classified as does not meet case definition (DNM). He was retrospectively classified as probable SARS.

Case	Communication to Staff	Public Health Classification	Retrospective Classification
Pt#2	April 29 – Probable SARS ⁶³⁷ April 29 – PUI ⁶³⁸ April 30 – PUI ⁶³⁹ May 7 – under investigation ⁶⁴⁰ May 8 – reported as being treated as “probable SARS” ⁶⁴¹ May 9 – not SARS ⁶⁴² May 12 – did not meet criteria for SARS ⁶⁴³ May 13 – Not SARS ⁶⁴⁴ May 13 – cleared as Non-SARS ⁶⁴⁵ May 14 – do not meet criteria for SARS, PUI ⁶⁴⁶	PUI ⁶⁴⁷	Probable SARS

637. NYGH SARS Update #28, April 29, 2003.

638. NYGH SARS Update #29, April 29, 2003.

639. SARS Management Committee, Minute of Meeting, April 30, 2003.

640. May 7, 2003, memorandum from Chief of Psychiatry to Chiefs of Psychiatry GTA Hospitals

641. Memorandum from Chief of Psychiatry NYGH, to All Staff Psychiatrists and Physicians.

642. SARS Management Team, Minutes of Meeting, May 9, 2003.

643. NYGH SARS Update #38, May 12, 2003.

644. Minutes of Meeting with psychiatry staff, May 13, 2003.

645. Minutes of Mental Health Department SARS Staff Meeting, May 13, 2003.

646. NYGH SARS Update #39, May 14, 2003.

647. Patient No. 2 was classified as a person under investigation on April 27, 2003. She remained so classified until she was retrospectively classified as probable SARS.

Case	Communication to Staff	Public Health Classification	Retrospective Classification
Pt#3	May 5 – under investigation ⁶⁴⁸ May 6 – PUI, unlikely SARS ⁶⁴⁹ May 7 – under investigation ⁶⁵⁰ May 8 – under investigation ⁶⁵¹ May 9 – not SARS ⁶⁵² May 12 – did not meet criteria for SARS ⁶⁵³ May 13 – Not SARS ⁶⁵⁴ May 13 – cleared as Non-SARS ⁶⁵⁵ May 14 – do not meet criteria for SARS, PUI ⁶⁵⁶	PUI ⁶⁵⁷	Probable SARS

All of these patients were managed as if they were SARS. Some point to this and question the significance of their misidentification and of the communication to staff that these patients were not SARS. But the problem was that health workers' continued use of personal protective equipment, strict adherence to infection control practices, and heightened awareness for new SARS cases were directly impacted by the understanding that there were no new cases of SARS. Many health workers interviewed by the Commission reported that if they had known there may be new cases of SARS in the hospital, they would have chosen to continue to use personal protective equipment.

As one nurse said to the Commission:

Question: What did you think about the way the hospital communicated with staff during SARS? Did you feel like you were being told what was going on?

648. SARS Management Team, Minutes of Meeting, May 5, 2003.

649. SARS Management Team, Minutes of Meeting, May 6, 2003

650. SARS Management Team, Minutes of Meeting, May 7, 2003; May 7, 2003, memorandum from Chief of Psychiatry to Chiefs of Psychiatry GTA Hospitals; and see SARS Update #34, May 7, 2003.

651. Memorandum from Chief of Psychiatry NYGH, to All Staff Psychiatrists and Physicians.

652. SARS Management Team, Minutes of Meeting, May 9, 2003.

653. NYGH SARS Update #38, May 12, 2003.

654. Meeting with psychiatry staff, May 13, 2003.

655. Minutes of Mental Health Department SARS Staff Meeting, May 13, 2003.

656. NYGH SARS Update #39, May 14, 2003.

657. Patient No. 3 was classified as a person under investigation on May 5, 2003. She remained so classified until she was retrospectively classified as probable SARS.

Answer: No. If I knew, I would have never taken off the mask and gown.

Question: If you knew that there was still SARS in the hospital?

Answer: Yes.

Question: Even if you had known that it was on another floor, would you have still kept wearing the mask?

Answer: Yes.

Those physicians and nurses who were actively involved in these cases or who were aware of these cases and suspected they might be SARS were able to make informed decisions about the use of protective equipment. They recognized new cases as they came through the door, and they were skeptical when they were told that SARS was over, that there were no new cases of SARS. But this knowledge was not shared across the hospital. Most health workers believed that SARS was gone, and willingly discontinued using protective equipment based on that belief and the understanding that they were safe.

Assurances to staff that SARS was gone or that there were no new cases of SARS turned out to be false. As one infectious disease expert said to the Commission:

The worst reassurance is false reassurance.

We now know that the reassurances about the psychiatric patients and the ill health workers, although well intended and believed at the time they were given, turned out to be false. And when staff made decisions about protective equipment based on those reassurances and then became ill, it undermined their sense of trust and sense of safety.

The Commission finds no evidence that the May 7 decision to relax precautions in the emergency department at North York General Hospital was made in bad faith or with disregard for patient, visitor and staff safety. The Commission accepts the evidence of senior hospital officials that the decision to relax precautions in May was made under the mistaken belief that there had been no new cases of SARS in the hospital. The Commission further accepts the evidence of hospital officials that the decision to relax precautions was made with the belief that doing so did not pose a risk to patients, visitors or health workers.

The Commission does find that the decision to relax precautions in the face of the discovery of a new case under investigation for SARS, which could not be ruled out as SARS, was a disconnect that emphasizes the problems of using the formal classification system for cases to determine risk. Time and again throughout SARS the importance of communication to and from front-line staff is evident. Nurses on the psychiatric unit were concerned these patients had SARS. They expressed those concerns openly and repeatedly. And these concerns were dismissed.

Although the psychiatric unit remained under precautions on May 7, as the hospital decided to keep the unit at Level 2, the level of concern from staff about these patients was not reflected in the decision to relax precautions on the same day that a new case was announced. And it lacked a strong communication system to allow input from front-line care providers, including those physicians who were caring for these patients, to influence the decisions of those in charge. For example, although hospital officials did not believe that Patient No. 3 had SARS, treating physicians did. Her family was told she had SARS.

The story of the relaxation of precautions also underscores the importance of the application of the precautionary principle. When risk is uncertain, always err on the side of caution. As one infectious disease specialist so eloquently said:

If you are not sure, act with the greatest caution to maximally protect health care workers and providers.

May 15 – Disconnect

On May 15, 2003, North York General Hospital announced that precautions were relaxed in the remaining areas of the hospital that had not been part of the initial relaxation of precautions on May 7. Areas such as the emergency department no longer had to wear protective equipment at all times.

Although the hospital's decision to relax precautions in the emergency department was in compliance with the provincial directives, not all staff were convinced that it was the cautious and safe thing to do. There appeared to be another disconnect, as emergency room staff raised concerns about patients coming to the emergency department with respiratory symptoms that they believed were consistent with SARS but at the same time they were being told that SARS was gone and that they no longer had to wear protective equipment.

Emergency room staff were alarmed in May when four family members of Patient A, who had died while an inpatient on 4 West, were admitted to North York General Hospital, all through the emergency department, all with respiratory symptoms. Their story is told later in this chapter. Staff raised concerns to hospital officials that this was a family cluster of SARS. Their concerns were dismissed. Also at this time, Mr. O, another inpatient from 4 West, had come back into hospital, through the emergency department, with pneumonia. Two days later, his wife was admitted to hospital, also with respiratory symptoms.

The admission of these patients did not go unnoticed by emergency room staff. When case after case was admitted but not identified as SARS, those staff involved with these patients or aware of the family cluster took matters into their own hands, continuing to wear personal protective equipment at all times, despite the relaxation of precautions. As one physician told the Commission:

But clearly the biggest family was the [Patient A family], where five members were involved, in ample time to have started raising a flag that SARS was not over and not to put down our precautions. And I'm convinced that most of the North York staff that got infected, would not have gotten infected had they not stopped all their protections. It wouldn't have happened. All the people that got infected were all from the, almost all were from the 4th floor ... Why not a very high proportion from the emergency room? Because those people continued to wear their full protection, right through. I personally never let down my guard, the only time I stopped wearing my uniform was when I left I hospital ...

One emergency room nurse said that concerns about removing equipment were discussed between nurses and physicians:

There was extensive concern among both the nursing and the physician population in our hospital and there were both nurses and physicians who refused to remove any of their gear when the directive came down that it was time to relax precautions.

From the perspective of those emergency room staff who were involved with the patients who were coming into the emergency department with symptoms that they believed were SARS-related, it was difficult to understand the push to remove equipment. Many wondered whether it was tied to concerns about the economy and the need return to normal as quickly as possible. As one emergency room nurse said:

And it seemed to happen very suddenly and it seemed to happen concurrently with a turn in media coverage from SARS, SARS, SARS, to, you know we're dying here and our tourism is falling to pieces and the WHO has slapped us with an advisory and our team went over to Switzerland and the next thing we knew, that was it. Travel advisory is lifted, SARS is over, you can take your stuff off. And yet what we were seeing at the patient level in the department didn't reflect that. And so there were a lot of people who were concerned. And some were sort of partially relaxing restrictions, maybe not wearing the gowns and the goggles but keeping their masks on, and others took all their gear off.

But in the emergency department, we tended to have the choice to ignore the directive, whereas on the floor in some other units in the hospital, those nurses weren't given the choice and their masks and gear were removed from the unit, particularly the 4th floor, which became the epicentre of the second outbreak. And there were many informal discussions between nurses and physicians about this thing not being over and then isn't it interesting how it's all changed overnight.

Dr. Tim Rutledge, the hospital's Chief of Emergency Medicine, said that the decision to relax precautions was done with caution and that he felt they were being more conservative than most other hospitals. He said:

Dr. Rutledge: So May 15th, we drafted a much-anticipated policy and procedure for the emergency department, that was approved by the SARS Management Team, that we implemented on May 16th, on the morning of May 16th. And it was totally consistent with Ministry directives, and it was a relaxing of precautions that lagged behind most other emergency departments in the Greater Toronto Area. It was very conservative, but what it did was make the wearing of PPE [personal protective equipment] optional for those staff that were caring for patients that had no signs of any respiratory illness.

Question: Were you part of the process that led to relaxing of those measures?

Dr. Rutledge: Yes, oh yes. I was one of a few people that drafted this and presented it to the SARS Management Team and I was, myself and my program director, were the people that went

into the emergency department and announced that this was the case. I can tell you that the vast majority of the staff were very happy about it. It was a relief to be getting out of the hot clothes and the masks for taking care of patients with sprained ankles, etc.

Dr. Rutledge said that the relaxation of precautions was directed at patients who did not have respiratory illnesses:

What we were doing in the emergency department was we were being prepared to deal with any patient that presented at the emergency department with febrile respiratory illness in that state, whether we were aware if they had SARS or not. We were simply saying to the staff that were taking care of patients that had nothing to do with respiratory illnesses that they were safe to step down and this pertained to the emergency department.

Dr. Rutledge also told the Commission that he was not aware of concerns by physicians or nurses that it was too early to relax precautions. He speculated that had he been aware of such concerns, he probably would have gone even slower:

Question: Once, in that period between the 7th and the 16th, the memo goes out on the 7th, it's now safe to relax precautions except in emergency and with SARS, etc. Were you aware of any physicians or nurses commenting that it was too early to be relaxing precautions in that way?

Dr. Rutledge: I don't remember being aware of that. I will just, if you don't mind, refer to my MAC [Medical Advisory Committee] minutes to see if there was any such anxiety mentioned. I don't see any mention of any anxiety being mentioned on the MAC minutes of May 13th.

Question: Was that your primary source of information at that time?

Dr. Rutledge: No, it's my primary source of information at this time. I don't remember three years ago being aware of anxiety in that week prior to us opening. In fact, I think that if I was aware that there was a hospital angst, that I would have been much slower even. We were perceived by the commu-

nity of emerg people as being very cautious in our relaxing of precautions. I suspect that if I was aware of hospital anxiety about stepping down, that I probably would have even gone slower. But I'm speculating.

The Commission finds no evidence that the May 15 decision to relax precautions in the emergency department at North York General Hospital was made in bad faith or with disregard for patient, visitor and staff safety. The Commission accepts the evidence of senior hospital officials and Dr. Rutledge that the decision to relax precautions in May was made under the belief that there had been no new cases of SARS in the hospital. The Commission further accepts the evidence of hospital officials and Dr. Rutledge that the decision to relax precautions was made under the belief that doing so did not pose a risk to patients, visitors or health workers.

But some emergency room staff, including a number of front-line physicians, still had concerns that SARS was around. They were continuing to see cases that they felt were SARS and were not convinced that it was safe to remove the protective equipment. As we see time and again throughout the story of SARS, health workers' ability to protect themselves from risk was dependent on the information they had about their risk. So those health workers who believed there were no new cases of SARS removed their protective equipment. And they did not have the same level of suspicion as other health workers who, based on their own observations or through discussions with their colleagues, believed that SARS was still around and that there were still new cases coming into the emergency department.

Those physicians and nurses who were actively involved in these cases or who were aware of these cases and suspected they might be SARS were able to make informed decisions about the use of protective equipment. They suspected new cases as they came through the door, and they suspected that it hadn't been 20 days since the last new case of SARS. But this knowledge was not shared across the hospital. Most health workers believed that SARS was gone, and willingly discontinued using protective equipment based on that belief and the understanding that they were safe.

Pressure to Remove Protective Equipment

As precautions came down, staff took varied approaches to the use of protective equipment. Some staff, most notably a number of the emergency room staff, continued to wear equipment at all times. Other staff, like some of the nurses on 4 West, chose to wear the equipment when providing patient care but removed the equipment

when outside of a patient's room. Other nurses and doctors removed the equipment completely, believing that SARS was over and it was safe to work unprotected. As one doctor told the Commission:

Question: Now on May 16th, the precautions were relaxed in the emergency department at North York General. Did you remove your equipment at that time pursuant to the directives? Everybody seems to have had a different approach.

Answer: It was a bit loose, the approach. It was not a strong directive. People said that we were approaching, that we were between two and three incubation periods, perhaps, without any new cases, so they felt it was safe to relax the precautions. A lot of the nurses did not. Certainly the triage nurses did not. Probably 50 per cent of the doctors did not. I was one of them that relaxed under certain circumstances. Anyone with anything respiratory, I use precaution. But if it was like a sprain, whatever, I was relaxed in my approach to that. I was feeling confident.

Question: But if a patient came in, they didn't have any respiratory symptoms, you'd use your normal precautions, which would be gloves ...

Answer: Yes, and I did not have my N95 on, which I loathed.

Hospital policies about the use of precautions also advised staff that they could wear protective equipment as they felt appropriate. The May 7 update to staff, notifying them of the relaxation of precautions in most areas of the hospital, said that staff who were not required to wear masks could still do so:

Staff who work in areas that are not listed above are not required to wear masks. If you wish to still wear a mask, you may pick one up at the front door on our [your] way in.⁶⁵⁸

The May 7 minutes of the SARS Management Team reported that every unit was to maintain a supply of N95 respirators, for use as required.⁶⁵⁹ Clearly there was an

658. NYGH SARS Update.

659. SARS Management Team, Minutes of Meeting, May 7, 2003.

intention on the part of hospital officials and those in charge of the SARS response to continue to make masks available.

Despite these written policies and communications, a number of health workers interviewed by the Commission reported feeling pressure to stop using protective equipment. In the story of the 4 West nurses, some, but not all, said that after May 7, equipment was difficult to obtain and that there was subtle and, at times, not-so-subtle pressure to remove the protective equipment, including the N95 respirator.

As noted earlier, not everyone felt pressure to remove their equipment. Many physicians and nurses continued to wear their equipment after precautions were relaxed and many reported to the Commission that they were not discouraged to do so. As one physician said:

We were never discouraged in the emergency department. I had heard anecdotally that the nurses on 4 West were discouraged and that patients could find it alarming and frightening, so we were told that basically there were no new index cases, two incubation periods, it was okay to relax if we wanted to. We were given free rein.

For those who did report feeling pressure to remove the equipment, the pressure came from a number of sources, even at times other health workers. And the perception of some health workers that there was pressure to discontinue using protective equipment was not restricted to those working on 4 West. Other health workers, from other areas of the hospital, made similar reports to the Commission. For example, one nurse said that there were concerns expressed about frightening others by continuing to wear the mask:

We heard a lot of how it appeared to people to see us wearing masks, how it frightened them off. You know you walk into a hospital and see people with masks, people get frightened. It just seemed like they were more concerned with what we looked like to the community, how we appeared. Okay, SARS is completely under control so there is no need to worry when in fact there was still high risk to us as it later showed, there was a high risk. Because I thought it was ridiculous that they cared more about what we looked like to the general public than they cared about how we could have been exposed, and we ended up being exposed. You would hear that we want to get back into the normal, we want to get rid of these masks. That was at the first outbreak.

This nurse told the Commission that although no one said this to her directly, it was a general sense at the time among her and her colleagues. She told the Commission that it was her view that there was pressure to remove the masks to show that things were “under control” and that “everything was okay.”

Another nurse recalled the pressure she felt to remove her equipment and return to “normal”:

At the time when the WHO had put a ban on and the time that we were in, I guess it was into May when the city was suffering, I felt there was a concerted effort to get us back to normal and to get the gear off of us and that there was a great deal of pressure. Now, I don’t remember the exact timing in that, it was probably early May, because we went into quarantine on the 23rd ...

At times the pressure came from other colleagues, most well meaning, who also wanted to return to normal and forget about SARS. For example, one health worker who contracted SARS after precautions were relaxed recalled receiving well-meaning encouragement from a colleague to remove his mask and feeling relieved at being able to do so:

There was still the fear of SARS. It was in the basement and I remember [a colleague] saying, “What are you wearing your masks for? Everything is okay. It’s done, don’t worry about it.” I guess he was confident on that matter. Okay, fine. And to tell you the truth, I was actually relieved because those things are not actually comfortable. I breathe better without it. So it was actually a relief to not to wear it, not to have to wear a mask without any expectation of getting sick. Like I said, I was a pretty fit guy. I thought I could handle anything.

At other times, staff who wanted to continue to wear equipment came up against resistance from others who did not appreciate or understand their continued desire to do so. For example, one emergency room nurse recalled having difficulty obtaining equipment after the precautions were relaxed:

That weekend [May 17-18, 2003] I worked and I had a very hard time getting gowns, getting the supplies, because the stress was no longer there on the team attendants to bring it. And again, we’re dealing with people who don’t have the knowledge of isolation technique, don’t have the knowledge of disease, who have been told it’s safe now, you don’t need this stuff. And they’re no longer willing to go and get it and supply it.

And I had one scene on my second-last shift where I asked the team attendant, I said, there's no gowns in there and I need to go in and I'll need a gown to come out. And she said, well, we don't have to wear them anymore. And I said, if you choose to believe that, that's okay, that's your decision. But I said, I have enough knowledge that I know that it's still not safe. And she got really quite angry with me.

And then the next one, the next scene I had the next day, I went to the area where we would take all our PPE off before going into the lounge, and one of the team attendants came, took her gown off and threw it up on the clean table where the clean supplies were. And I said, you just contaminated all those things. And she just got so angry, she just grabbed this gown, threw it into a corner on the floor and said, there, are you happy now, and stomped off. At one point there were no gowns in the lounge and I just refused to come out. I just called the charge nurse and said, there's no gowns in here, they're refusing to bring them and I am not going out there without one. And then they threw a bunch through the door at me and it turned out they came from outside rooms D and E.

This nurse told the Commission that this was not the message that came from the manager, and that her manager would not have permitted that behaviour. But the problem was, in the face of the official position that personal protective equipment was no longer required except for specific circumstances, those who chose to continue to wear the masks were seen by some as going against the official position. As she said:

... they [the equipment] were thrown at my feet. And this is the message ... I know our manager did not tell them to behave like that. It's just that they felt I was being unreasonable because the management said it wasn't necessary. Who was I to countermand it? And so, it put me in a difficult situation.

It is important to note that in the psychiatry unit and the emergency department, two areas where we now know there were cases of SARS, there was no evidence of transmission to staff, visitors or other patients, beyond the cases identified earlier in this report.⁶⁶⁰ Some of this can be attributed to the fact that although these patients were

660. In the psychiatry unit, SARS spread between three patients, whose stories are told earlier in this report. There is no evidence of transmission of SARS in the emergency department. Rather, as will be seen later in this chapter, patients and visitors who had been exposed to SARS through their contact with the 4th floor of the hospital, an area we now know had many unidentified cases of SARS, were admitted through the emergency department and treated in respiratory isolation, on medical units in the hospital.

not classified as SARS, because concerns about the possibility of SARS were identified they were isolated and managed with precautions. However, it was the vigilance and high index of suspicion of front-line staff that brought these cases to the attention of hospital infection control and it was the ongoing use of precautions that ensured that there was no transmission before the cases were identified and isolated.

There is no evidence to suggest that senior management or those in charge of the SARS response discouraged the use of protective equipment after the two phases of relaxing precautions at North York General on May 7 and May 15.

There were clearly different experiences among health workers with respect to the availability of equipment and to the support from colleagues and superiors for continuing to use the protective equipment if they chose to do so. However, as noted earlier, the reports from those health workers who felt they did not have a choice, whether through lack of equipment or whether through pressure from others to remove their equipment – subtle, direct, well-meaning, or otherwise – are troubling.

During a public health crisis, no health worker should be denied the opportunity to use or be discouraged from using approved protective equipment and infection control and worker safety procedures she believes are necessary to protect herself. As one physician who cared for SARS patients told the Commission:

Front-line health care workers should be allowed to exercise their own kind of caution, and I understand that there would be guidelines provided. But they should have unlimited access to personal protective equipment. Let's say if there is a next epidemic, avian flu or whatever, then health care workers should be allowed to feel safe when they come to work and not to feel that they are the guinea pigs or whatever to see if they would come down with this disease with this kind of protection.

The stories of those health workers who felt they were pressured to remove protective equipment underscore the important responsibility that senior managers have to ensure a safety culture in which no one is discouraged, directly or indirectly, from protecting themselves.

Conclusion

In the new disease that was SARS, no one knew for certain when it was over. And in a hospital, like North York General, that continued to have ill staff and ill patients pop up under investigation for SARS, with the missing link for diagnosis being simply that they could not connect it to a source, reassurances that SARS was over, that there were no new cases of SARS, directly impacted decisions about relaxing precautions, whether at an institutional level or at an individual level, as well as vigilance for new cases of SARS. As will be seen in the following section, the story of 4 West, precautions were relaxed and a cluster of illness among patients was not suspected to be SARS because everyone thought SARS was over.

As the report of the Joint Health and Safety Committee at North York General eloquently said:

While the exact manner in which SARS presented and spread among workers at North York General Hospital remains unanswered, it is clear that this occurred where the presence of SARS went unrecognized and, almost exclusively to staff who were not caring for known SARS patients. The outbreak declared at NYGH in of May 23, 2003 occurred more than two full incubation periods after an apparent victory in the SARS battle and the relaxing of PPE measures. In fact, NYGH was one of the last facilities to move to a relaxing of such measures.

However, there was no SARS I and SARS II – SARS had never left us. In May of 2003 NYGH continued to care for SARS patients at its General Division. The presence of SARS represents a risk, a risk that can be greatly diminished by our ability to recognize it and respond appropriately. The use of PPE and infection prevention and control measures in caring for our SARS patients and patients in other areas considered to be at high risk, such as the Emergency Department, was quite effective. *Our ability to recognize this new and emerging disease, of unknown etiology, was our point of weakest defense; a defense that could have been greatly strengthened.*

POC Directives continually emphasized the need to “maintain a high index of suspicion” for SARS. Prophetically, when the battle against SARS appeared to be over in late April of 2003, the MOL Directives emphasized the need to remain vigilant in this regard. With the benefit

of hindsight we can see evidence of a failure to maintain a high index of suspicion and failure to capitalize on mechanisms which could have enhanced our ability to do so.⁶⁶¹ [emphasis in original]

In hindsight it appears likely that if the precautionary principle had been applied, and precautions had been maintained until the unexplained cases had been fully investigated and definitely ruled out as SARS, the spread of SARS could have been prevented.⁶⁶² As one physician said:

Answer: I think what SARS did is it humbled us and it also made us realize that even when we think we know everything, we don't. And that diseases can, the changing nature of disease emerges gradually and we have to be very attuned to the clues that come from the ground up, not necessarily from the top to the bottom so I think humility makes the better nurse and doctor. I would always err on the side of caution.

Question: And that applies to protective equipment?

Answer: Yes, until they're ... it's very difficult. We were told there's absolutely nothing to worry about and then we did have something really to worry about, so I don't know when one can ever relax, but I would, as I said, I would err on the side of caution and use the most protective equipment I could until I had an absolute assurance that a modification was safe. Especially if you're dealing with someone's life.

North York General Hospital did not make the mistake of believing it was over too soon alone. As noted earlier, in the section titled "Victory Declared," it was a mistake made by many as Toronto celebrated the end of SARS. Unfortunately, in the rush to recover from SARS, in the rush to say that SARS was gone, assurances were given to health workers and precautions were scaled back at a stage that we now know was premature. As one health worker said, the problem was that everyone wanted to believe it was over and no one wanted to go back on the WHO list:

661. JHSC Report, p. 54.

662. As noted earlier in this report, the only test that could rule out SARS was convalescent serology. This test required taking samples from the patient approximately 30 days after the onset of illness, to determine if they had developed antibodies for the coronavirus. Alternatively, the 20-day waiting period (two incubation periods) could have been applied to those cases under investigation for SARS, such as Patient No. 3, who developed symptoms around May 5.

It was a decision of the hospital to keep them on, so we actually had kept them on longer, and we look at, it looks like a prudent thing to do, but in hindsight, we should have had them on even longer because if you go back to the fact that they never really identified how did those people on 8 West get ill, then those patients on 7 West, they didn't have the epilink there either.

And yet, so you have these cases without an epilink, you don't know how they got it but it looks like it's over so you now have all of the masks off. So we'd had a couple of incidents of it, we still had active patients that we were treating, we probably should have kept them on even longer. But if you put yourselves in that time context, everybody was really happy about getting their masks off. Everybody was saying it's over. Everybody wanting to think it was over. And at that point, honestly, the WHO [World Health Organization] was the enemy.

4th Floor – The Orthopedic Floor

In hindsight, the unexplained SARS-like illness of the psychiatric patients in April and May and the unexplained SARS-like illness of the Patient A family cluster in May, discussed below, were signs at North York General Hospital that SARS was not contained. We now know that there was another sign of the re-emergence of SARS at North York General: problems on the 4 West orthopedic ward during April and May, including an unusual number of deaths, respiratory illnesses, and illness among staff.

Eighty-three per cent of cases associated with the second outbreak at North York General were epidemiologically associated with 4 West.⁶⁶³ SARS simmered undetected on 4 West throughout April and May and spread rapidly once precautions were relaxed in early to mid-May. But the evidence of how SARS got a foothold on 4 West and how it spread there in April and May is diffuse and problematic. Answers to questions such as how SARS got on 4 West remain unknown. As the Naylor Report found:

Meanwhile, unbeknownst to the hospital administration, several elderly patients on the orthopedic ward (4 West) had been fighting what were at first believed to be typical post-operative lung infections. Among them was a 96-year-old man with a fractured hip. Through means still unknown, illness spread from 4 West over the next few weeks to other patients and to several visitors and staff.⁶⁶⁴

While it remains unknown how SARS came to 4 West at North York General, public health officials believe that it originated with one of two patients, both admitted to the 4th floor in the early part of April 2003.

The first patient, Patient A, was admitted to North York General Hospital on March 22, 2003. Patient A was 96 years of age and had been admitted for treatment of a fractured clavicle and hip, caused by a fall. He was first admitted to 8 West, which was

663. SARS Field Investigation, p. 19.

664. Naylor Report, p. 39.

not at the time the SARS unit.⁶⁶⁵ He was transferred to 4 West on April 2, 2003. On April 3 he developed a fever. A chest x-ray on April 4 showed bibasilar infiltrates.⁶⁶⁶ The SARS Field Investigation, an extensive investigation led by Health Canada into the second outbreak, reviewed Patient A's case and found that he had:

... multiple episodes of fever and radiographic findings of pneumonia throughout his hospital stay (March 24, April 3, and April 19), initially responding to antimicrobial therapy.⁶⁶⁷

He died on May 1, 2003, while a patient on 4 West. During his hospitalization at North York General he was not identified as a possible SARS case and was not investigated for SARS. Four members of Patient A's family were admitted to hospital during May 2003, after his death. They all had SARS, although as noted in the previous section, they were investigated as possible SARS cases but not classified as SARS until after May 23, 2003. Although Patient A had multiple episodes of fever and radiographic findings of pneumonia throughout his hospital stay, his onset date for SARS is believed to have been April 19, 2003.⁶⁶⁸ As the SARS Field Investigation concluded:

...the onset of his [Patient A's] SARS illness was "most compatible" with the April 19, 2003, date, as his family did not get sick until May.⁶⁶⁹

A second patient, Patient B, was a 56-year-old man who was admitted on April 11, 2003, to the same four-bed room on 4 West as Patient A. Patient B had a fever, cellulites and a leg abscess.⁶⁷⁰ The SARS Field Investigation also reviewed his case history and described his progress after his admission:

He [Patient B] was treated with antibiotics, diarrhea developed on the 15th, and fever returned on the 17th along with respiratory symptoms and infiltrates on chest x-ray.⁶⁷¹

Patient B improved while hospitalized and he was discharged home.⁶⁷² He was iden-

665. 8 West became the SARS unit on April 2nd, 2003.

666. SARS Field Investigation, p. 16. In June 2003, a team of experts investigated the outbreak at North York General. The SARS Field Investigation team, reviewed charts and other sources of patient information, such as radiographic reports.

667. SARS Field Investigation, p. 16.

668. SARS Field Investigation, p. 16.

669. SARS Field Investigation, p. 16.

670. SARS Field Investigation, p. 16.

671. SARS Field Investigation, p. 16.

672. SARS Field Investigation, p. 16.

tified as a SARS case retrospectively, after Public Health and outside experts reviewed medical charts on and after May 23, 2003.

Although these two patients are believed to have been the first patients with SARS on 4 West, it is unknown who passed SARS to whom, or whether there was an unidentified SARS contact with whom both patients had contact. The SARS Field Investigation in June 2003 found that:

Patient B could have passed SARS to Patient A, or the two patients could have been infected from a common, as yet unidentified source. These two patients had no SARS travel risk, no visit to another “SARS-affected” hospital or prior close contact with known SARS patients other than themselves.⁶⁷³

The SARS Field Investigation concluded:

How SARS was first introduced to 7W [the psychiatry unit] and 4W remains an unresolved issue.⁶⁷⁴

We will never know all the twists and turns of the path of SARS while it simmered on the 4th floor of North York General during April and May until it broke out with a vengeance once precautions were relaxed, starting May 7, 2003. Given the scientific

673. SARS Field Investigation, p. 16. Although Patient A was a patient on 8 West when Health Care Worker No. 1, whose story is told earlier in this report, was working on the unit, post-SARS studies have not found any connection between the two cases of SARS. As the SARS Field Investigation found:

Incidentally, on March 30th, 2003, while patient A was on 8W, a nurse on that ward developed SARS symptoms and later tested PCR positive in stool samples and then seroconverted to SARS-CoV. The nurse’s mother was an inpatient at Scarborough Hospital Grace Division (where SARS transmission was occurring) in late March; her serology results were positive for SARS two months later but she did not meet the WHO case definition. Evidence of SARS was sought in the other patients with whom this nurse had contact on the only known date she was working while symptomatic. Although two additional patients had isolated, unexplained temperature elevations within ten days of this contact, we found no convincing evidence for SARS. She also should have been in full precautions when seeing patients. The 8W nurse had unprotected contact with another nurse on the ward, who subsequently developed SARS 3 days later. She was sero negative. This appears to be the full extent of this transmission chain. Our investigation failed to find evidence for direct contact between the first 8W nurse and patient A or B. (at p. 17)

674. SARS Field Investigation, p. 18.

impossibility of telling with precision who gave SARS to whom and when on 4 West in April and May, the retrospective evidence of the spread of SARS on 4 West must be approached with caution.

This caution is underlined by the fact that it is all too easy to see things clearly, now that we know SARS was spreading on 4 West, a fact far from clear at the time. It is difficult even to pin down in hindsight the precise details of evidence such as staff illness and unusual levels of death and respiratory illness. This evidence was not systematically investigated and recorded because there was no surveillance system in place at the time. This points clearly to the need for surveillance systems to ensure that these vital pieces of evidence are not missed in the future. But the lack of systems at the time to ensure that such crucial information was recorded, monitored and investigated makes it impossible to draw firm conclusions now from data that were not systematically recorded at the time.

Why did SARS simmer undetected on 4 West in April and May? Why were the cases of SARS, so clear in hindsight, not detected at the time?

It is impossible to prove exactly how the course of events would have been different had all the systems and checks been in place that we now know might have identified SARS on 4 West. It is impossible to speculate with any certainty that any single measure would have detected and stopped the spread of SARS on 4 West. But the clusters of respiratory illness, increases in mortality rates, and staff illness on 4 West were all signs that something was wrong on the unit. These were all signs that were either missed altogether or, when they were noticed, were not reported to or investigated by hospital officials or public health authorities. While it is much easier with the benefit of hindsight to look back and identify the failures in Ontario hospitals' infection control systems, that does not negate the importance of examining the events in April and May 2003 on 4 West, to ask how the signs of SARS were missed and to determine how to prevent an outbreak of the kind that occurred on 4 West from happening again.

Tragically, these lessons were learned at the expense of those who became ill, those who died and those who lost love ones: patients, relatives, visitors and health workers. We must never forget the heroism and sacrifice of the front-line health workers who became ill in the line of duty. We must never forget Ms. Nelia Laroza, an orthopedic nurse who contracted SARS and later died. Ms. Laroza and the other health workers on 4 West went to work every day, unaware of their risk, to care for others. As one physician from 4 West said:

Nobody was as close and as intimate with the patients, and I use that in the broad sense of the word, than the nurses were. Changing them, in those rooms for long periods of time, nobody got “nuked” more than the nurses. Showering them, cleaning them and their soiled clothing. The risk that the nurses took unknowingly ... they could never be repaid for what they went through.

Respiratory Illness and Death on 4 West

It is now known that during the months of April and May, there were cases of unrecognized SARS on the 4th floor of North York General. There was a cluster of respiratory illness on the unit among patients who were later identified as SARS. There was also an increase in deaths on the unit during April and May 2003.

The number of cases of respiratory illness began to escalate after precautions were relaxed in most areas of the hospital on May 7, 2003. By May 23, 2003, patients, visitors and health workers were ill with SARS. As the SARS Field Investigation found during a retrospective review of the onset of illness on 4 West and the spread of SARS to patients, visitors and health workers during April and May 2003:

Cases began to escalate in the second week of May, shortly after enhanced precautions were selectively relaxed in low-risk settings. Although only 6 additional individuals developed symptoms before then, 8 more developed symptoms in the 2nd week of May, 20 in the 3rd week, and 29 in the 4th week.⁶⁷⁵

Post-SARS, the Joint Health and Safety Committee at North York General reviewed information about the number of deaths on 4 West in April and May 2003, and noticed a significant increase. They found:

We then obtained, from the hospital, information regarding the number of deaths on 4W during the months of April and May, 2003. (Appendix) There were 6 deaths in April and 7 deaths in May 2003. Two of the deaths would occur on May 1; the 96-year-old patient, possibly the index

675. SARS Field Investigation, at p.18.

case, was among these deaths. Another two deaths would occur on May 9 for a total of 4 deaths in the first two weeks of May. We also looked at the trend of the number of deaths over a five-year time period from 1999 to 2003; the period from March to June was examined. (Appendix) We discovered that the number of deaths from March to June 2003 was 14. This was almost double the number of deaths recorded for the same time period compared to the previous years examined. Recall that 13 out of these 14 deaths occurred in the months of April and May, 2003. Clearly, this is a significant increase.⁶⁷⁶

During the one-month period of April 19, 2003, until May 19, 2003, four patients on 4 West who we now know had SARS died. Their deaths were in addition to deaths from other causes on the unit.

The cluster of respiratory illnesses and any increase in mortality rates on the unit was not identified to Public Health or provincial officials at the time. SARS-related respiratory illnesses and deaths on 4 West were also not identified to Public Health as such at the time. Consequently, there was no investigation into deaths or respiratory illnesses, and cases were not investigated as possible SARS until May 23, 2003, when public health officials and outside experts began to review cases at North York General. At that time they were investigating a possible link to an outbreak at St. John's Rehabilitation Centre. More will be said about the outbreak at St. John's Rehab later in this report.

North York General senior management and the SARS Management Committee were also unaware of the cluster of illness on 4 West and were unaware that there were possible SARS cases on the unit. Senior hospital officials, including Dr. Keith Rose, Bonnie Adamson (the CEO of North York General), and the two co-chairs of the SARS Management Committee, Sue Kwolek and Dr. Glen Berall, all reported to the Commission that they were unaware of any problems on 4 West until May 23, 2003.

Dr. Keith Rose, the administrative vice-president responsible for SARS, told the Commission that the first he knew of problems on 4 West was on May 23, when Public Health was on site to review files. He told the Commission that when he initially heard about St. John's Rehabilitation Centre, he thought that the concern was whether St. John's Rehabilitation Centre might have spread SARS to North York General. He did not know that the opposite had occurred:

676. JHSC Report, p. 43.

On May 23rd I was on call overnight, I was in the hospital. I was called to go down to see the emergency around 2 or 3 o'clock in the morning. A breach of precautions intubating a patient from St. John's and therefore a decision to close the emergency department from a lack of staffing and to send staff home on home quarantine and to wait to receive more information about St. John's. It wasn't until 9 or 10 o'clock in the morning that I became aware that there was a link between St. John's and North York. I had no idea, in fact my impression was St. John's had the problem and had potentially spread it to North York through the incident in the emerg department overnight. And then the day unfolded at that point. [Dr.] Don Low was there, along with Public Health. Chart reviews, it became clear by mid-afternoon that 4 West was a very problematic centre, that the staff that had been identified as sick that day were sick and needed to be assessed and we needed to make major changes for the hospital.

Ms. Sue Kwolek, co-chair of the SARS Task Force, when asked when and how she learned of the problems on 4 West, said:

Not until May 23rd when Dr. Low came to review some of the charts of patients in the organization. This was, you will recall, the St. John's thing, on May 22nd there was an announcement that St. John's had patients under investigation for SARS. I came in early that morning and was advised of the St. John's situation. There was a pre-scheduled meeting with [Dr.] Donald Low at 11:00 that morning. I remember this day very clearly. It's etched in my brain. Eleven o'clock, he came in and started reviewing the charts, and sometime in the afternoon, the manager of Occupational Health and Safety came up to the boardroom where the command centre was and she said, there are quite a number of staff on 4 West who are reporting in ill. And that's the first time that, as a SARS management team, and it was me at that point, there was nobody else on the SARS management team there, that I became aware that there was an issue on 4 West.

There is no mention of the orthopedic floor or any problems associated with the floor in any of the SARS Task Force/Management Committee minutes between April 1 and May 23. Toronto Public Health said that they received no reports about potential SARS patients on 4 West, or about a respiratory outbreak on that floor, prior to May 23, 2003. Hospital administrators, had they known of the problems on 4 West, would

have been required to report not only SARS cases, but any respiratory infection outbreak.⁶⁷⁷

Although senior hospital officials and Public Health were unaware of the problems on 4 West, we now know there were signs that something was wrong on the unit. A cluster of respiratory illness, an increase in deaths on the unit, and staff illness were all signs that something was wrong. The question that remains in the wake of SARS is, did anyone see the signs? If so, what was done to raise the alarm? And, if the alarm was raised, why didn't it reach senior hospital officials or Public Health?

Identification of SARS on 4 West – Did Anyone See the Pattern?

During the SARS outbreak, directives from the Ministry of Health and Long-Term Care stressed the importance of heightened suspicion for any new SARS cases. For example, a directive issued by the Ministry of Health and Long-Term Care on April 14, 2003, provided:

Health care workers should maintain a high index of suspicion when assessing any patients for new onset of fever or respiratory symptoms.⁶⁷⁸

This message was repeated in later Ministry directives.⁶⁷⁹ If this heightened suspicion was supposed to be in place, how were so many SARS cases on 4 West missed?

None of the orthopedic surgeons from 4 West interviewed by the Commission reported being aware of a cluster of respiratory illness or an increase in deaths on the unit. Similarly, none of the physicians who were involved with patients from 4 West and interviewed by the Commission reported being aware of a cluster of respiratory illness on 4 West or an increase in deaths. Unlike the psychiatric patients, where front-line physicians had their own opinions that the patients had SARS, none of the

677. *Health Protection and Promotion Act*, R.S.O. 1990, c.H.7., s.27; and see Ontario Regulation 559/91, amended to O.Reg, 365/06, Specification of Reportable Diseases.

678. Directive to Acute Care Facilities in the Greater Toronto Area (Toronto, York, and Durham Regions), Directive 03-04, April 14th, 2003. Full text of bullet #8 quoted below in report.

679. See Directives to All Ontario Acute Care Hospitals, Directive 03-04(R), May 1, 2003.

physicians from North York General who were interviewed by the Commission reported suspicions of SARS in respect of any of the orthopedic patients prior to May 23, 2003.

Many of the 4 West nurses who were interviewed by the Commission reported an awareness of an increase in deaths or respiratory illness on the unit, either through their own observations or as a result of discussions with colleagues on the unit. Not all of the nurses, however, reported this, and some said that they were unaware of an increase in deaths or respiratory illness on the unit until on or after May 23, 2003. Even those nurses who told the Commission they were aware of an increase in respiratory illness and/or deaths said they did not know it was SARS. For example, one nurse, who recalled a meeting where concerns about illness and death were raised with the unit administrator, did not recall any discussion about the possibility of these cases being SARS at that meeting or any other time:

Question: Did anyone ever raise the possibility that SARS was in your unit during that meeting or during that time period? Did those patients have SARS?

Answer: I don't think so.

Question: Did you or your colleagues ever wonder if they had SARS? Is that something that you thought of at the time or did everybody just think that the patients just had respiratory illness?

Answer: Just maybe respiratory illness.

Question: Did you or anyone else to your knowledge ever raise in April or May the possibility that those patients might have SARS?

Answer: No, I don't think so.

It would be easy in hindsight to say that the problems of 4 West should have been obvious, but it is clear that they were not.

By mid-April, SARS seemed to be under control. 4 West was a unit that was not expected to have SARS cases and no one imagined it would be the entry point for a new SARS case. Many health workers, including physicians and nurses who worked

on 4 West, believed SARS was gone. As one nurse from 4 West told the Commission:

As far as we were concerned, SARS had left the city.

When the psychiatric patients became ill, they weren't classified as SARS because there was no epilink. Hospital officials believed that SARS had been ruled out by Public Health and outside experts. Health workers at North York General were told that the psychiatric patients did not have SARS and that there were no new SARS cases. Many of the staff working on 4 West, including the physicians, did not know about Patient A's family cluster, the family that came through the emergency department in May 2003: they did not know that four family members of one of their patients, who had died in hospital on May 1, 2003, had subsequently admitted to hospital with respiratory symptoms. For those who did know about Patient A's family, the information provided about this cluster of illness was that they were not considered SARS. Many of the nurses and doctors who did not have their own beliefs that SARS was still around, based on their involvement with cases such as the psychiatric patients or the Patient A family cluster, believed that there were no new cases of SARS. In their mind SARS was gone. As one physician from 4 West said:

Everyone assumed it [SARS] was over, I'm sure you've heard this already, and then all of a sudden more cases appeared.

Decisions about the use of personal protective equipment, the overall vigilance of staff, and their suspicion for SARS were impacted by the belief that SARS was gone. For example, one physician who worked on the 4th floor and who later developed SARS recalled hearing about the psychiatric patients but understood that there was a gastrointestinal illness on the unit. This doctor, like many others, did not know that the three psychiatric patients remained under investigation for SARS throughout April and May, and did not know that four family members of Patient A, an inpatient who died while hospitalized on 4 West, had been admitted through the emergency department, all with respiratory symptoms, during May 2003. As this physician remarked:

Now, knowing that there were other potential cases, that would have been useful information, but to my knowledge the situation had been cleared so I felt comfortable removing the protective equipment.

Other factors also contributed to the failure to identify the respiratory outbreak or to identify SARS cases on the unit. In late March, Toronto had been hit by a particularly nasty ice storm, resulting in a large number of slip and falls. North York General ended up with a large number of orthopedic patients who came to the hospital through the emergency department, as they picked up spillover resulting from the closure of Scarborough Grace Hospital and York Central Hospital. Because elective surgeries had been cancelled in the wake of the first outbreak in March, 4 West had available bed space, which was used to accommodate patients from 8 West, a geriatric unit that had been cleared to become a SARS unit.

As one orthopedic surgeon told the Commission:

We had a large number of patients through the emergency department. Part of that was because Scarborough General emergency and, I think, York Central emergency were closed because they had SARS in those hospitals, so we were seeing more than our usual number of emergency cases, and then we had the ice storm and, if my memory serves correctly, we had, in a 24-hour period, about 70 patients that had fractures of various kinds that required surgical treatment. So our floor became full with injured patients during that period of time, many of which had fractured hips and more alarming management problems ... At that time we also had a number of bed-spaced medical patients and we didn't have our usual complement of younger elective orthopedic patients that would normally be there. So we had more than our usual number of elderly patients with strokes and other problems apart from orthopedic problems because they were there for other reasons.

When asked about the higher number of deaths on the unit, this surgeon explained how the makeup of the unit was not what it normally was:

The context of that [the higher number of deaths] is after and during SARS I, during the period that you're referring to [April and early May 2003], we were not allowed and we were not having elective admissions to the floor. Those patients in general, many of them are healthy, otherwise well patients who just have an orthopedic problem. During that period of time, we were only admitting to the emergency department, which meant that we had many bed-spaced patients. 8 West was closed because it was a SARS unit. [8W] is normally a medical floor. So we were taking overflow on our floor. We had patients who were only admit-

ted through emerg because of injury. These tend to be the less well elderly patients. So it was not our usual patient mix during that period of time.

Many, but not all, of these patients were elderly and were believed to have developed pneumonia, not uncommon in elderly people who are injured or post-operative. As the orthopedic surgeon quoted above told the Commission:

It's [developing post-operative pneumonia or respiratory illness is] not uncommon. As one of my professors used to say, rarely but not uncommonly. It occurs, and elderly people are prone to develop this, but we're aware of that so now we make every effort to get them up and try to avoid that happening. So it isn't as common as it once was, but it still is the issue, and going back to the years in the early part of the century when a fractured hip meant it was likely that you would get pneumonia and die. That's no longer the case, but there's still the same risks. And so yes, elderly people are prone to get if not pneumonia, certainly adolecticis, that is, collapse at the base of the lung, where they get a little low-grade fever and don't eliminate the secretions from that part of the lung as well as they should, and that usually clears up once they are a little more mobile and can do some deep breathing and coughing, within a day or so. It's not pneumonia, but it is sort of a precursor if you like. It's sort of the stage perhaps before pneumonia, before they necessarily get a bacterial infection, but it does produce a fever, it does produce some respiratory symptoms.

Pneumonia in an elderly post-operative patient did not by itself raise an alarm. When a post-operative patient or a medical patient, especially one who was elderly and had other underlying medical problems, developed respiratory symptoms, there was no clear leap to the possibility of SARS. None of these patients were believed to have had contact with a SARS case or to have a travel history that would put them at risk of being in contact with a SARS case. And, as noted above, among these patients there were good alternate diagnoses. As one physician said:

Those clinical assessments are very, very difficult to do. The program for SARS is no different from the program for any other infectious disease, influenza or cold, you can't tell. And all you go on is the balance of probabilities. So you had a hip patient who gets a normal post-operative pneumonia, and is 90 years old, nobody could be expected to think that would be SARS. Turns out it was.

Post-SARS, the SARS Field Investigation into the outbreak at North York General Hospital noted that seasonal illness may also have made the identification of new SARS cases difficult:

The occurrence of seasonal respiratory infections such as influenza may further compound the difficulty in identifying a SARS case, which then may escape early detection by clinical and public health systems.⁶⁸⁰

It was the clusters of illness that in retrospect signalled there was a big problem on 4 West. But individual physicians providing day-to-day care could not easily see the overall patterns in illness or identify clusters of illness. At play was the fact that there was a group of physicians providing care for a group of patients on a rotational basis. No one physician saw each of the patients who developed SARS symptoms on 4 West. One physician who was regularly on the orthopedic unit explained how the shift cycle of picking up medical cases on the unit did not lend itself to identifying patterns of illness on the unit:

The way it used to work before was, a patient would have a fever of 38, 38.5 and then staff would call the orthopedic surgeon saying, this is so and so, fever of 38.5, has a bit of a cough. And the specialist would most often, some handled their own, some didn't, would order some tests. They would get a chest x-ray and a blood count, which is what surgeons are programmed to do, or some would say, call the internist on call. So the internist on call would come see the patient, maybe within 10 minutes, maybe within six hours, maybe the next day, would see the patient, make recommendations and pass it on to another internist the next day. So you've got this fragmented care. And you've also got some orthopedic surgeons who would call a specialist, some wouldn't, and I think the nurses didn't know what to do.

Another physician, who also was involved with some of the 4 West patients, described how the shift cycle of physicians did not permit for surveillance of patterns of illness:

As a clinician, I walk in to do my shift, and I go home and maybe a day later or two days later, I go in to do another shift, and I go home. If I am

680. SARS Field Investigation, at p. 26.

on call on the ICU, I do, that week, seven days straight and then I sign out to somebody else. Before that seven days, I didn't look after these people, after seven days later, I wouldn't look after them again, until my next time on call, maybe a month later. So probably it is a fragmented view of globally what happened at that time.

The “fragmented care,” as these physicians described, was not conducive to detecting patterns among patients. As Dr. Tamara Wallington, a Toronto Public Health physician who was part of the investigation into the outbreak at North York General, observed, 4 West had “individual patients who were being managed according to their clinical diagnosis.”

The patient makeup of the unit at the time, the similarity between the presentation of SARS and other respiratory illnesses, the belief that none of the patients had been in contact with a SARS case, the availability of plausible alternate diagnoses, the fragmented care, and the prevailing belief that SARS was over, all made it difficult for any one physician to identify the cluster of SARS illness on 4 West.

After the second outbreak, the importance of heightened awareness and vigilance was painfully clear. The Ministry issued new, stronger directives that reinforced the need for vigilance. The directives finally clarified that the absence of the epilink did not rule out SARS:

Health care workers should maintain a high index of suspicion when assessing any patients for new onset of fever or respiratory symptoms.

Fever alone must be considered as a sign of potential infection and should be considered even in the absence of other signs of an epidemiological link. Therefore, any person developing the following symptoms or signs after admission – fever, dry cough, unexplained hypoxia, shortness of breath or difficulty breathing – must be treated as follows ... [emphasis in original] [isolation and precaution procedures follow].⁶⁸¹

The SARS Field Investigation, referred to above, identified the importance of considering the possibility of nosocomial acquired SARS, even in the absence of an epilink:

681. Directive to Acute Care Facilities in the Greater Toronto Area (Toronto, York and Durham Region), Directive 03-09, May 31, 2003.

In a febrile post-operative hospital patient in the absence of known epidemiological links, it is important to consider the possibility of nosocomial SARS acquisition in addition to the usual causes of post-operative fever. This is especially true if the hospital still houses SARS patients or has unusual fever or pneumonia clusters within the institution. Suspicion for SARS should not be limited to community acquired pneumonias.

A standardized assessment for SARS (e.g. clinical, radiographic, and laboratory criteria) might be used among all hospitalized patients with new-onset fever, especially for units or wards in which clusters of febrile patients are identified.

All acute care hospitals should have a low threshold for consideration of SARS in their patients and report this possibility immediately to their Infection Control service and the local public health unit. Risk-based SARS associated infection control precautions should be instituted promptly and SARS-CoV testing performed.⁶⁸²

No Provincial or Local Surveillance

While everyone wanted to believe SARS was gone, scientists and experts knew that in the aftermath of an outbreak, it was important to continue to look for cases. In an article published May 9, 2003, the Centers for Disease Control recognized the need for ongoing surveillance to find suspect cases:

In Singapore, suspect and probable cases are identified and reported using a modification of the WHO case definition that expands contact to include any health care setting. Surveillance for suspect cases includes any fever and/or respiratory symptoms among HCW's, clusters of cases of community-acquired pneumonia, unexplained respiratory deaths, and individual cases with no contact but that are clinically suspicious for SARS.⁶⁸³

682. SARS Field Investigation, at p. 27.

683. CDC, MMWR, Severe Acute Respiratory Syndrome, Singapore, 2003.

The importance of surveillance was not unknown, but the responsibility for surveillance for new and undetected cases of SARS was left to individual institutions and to front-line practitioners. Neither local public health nor the Province was involved in this type of surveillance. As Dr. Naylor found:

Provincial directives required hospitals to isolate patients with fever and respiratory symptoms in either the hospital or the emergency department until SARS had been ruled out, but there was no recommendation for formal, hospital-based surveillance programs. The SAC [Scientific Advisory Committee] had actively discussed the need for heightened surveillance. Its functions, however, were being wound down. Public health officials viewed syndromic surveillance as a matter for institutional infection control and outside their mandate; they lacked resources to implement such a program in any case.⁶⁸⁴

Officials from Toronto Public Health told the Commission that they emphasized the need for robust surveillance within health care institutions and that they fully expected that individual institutions would take steps to ensure possible cases of SARS or clusters of illness were identified and reported to them.

At the provincial level, officials emphasized the importance of maintaining a high vigilance for SARS. The SARS Clinical Decision Guide (Ontario) from the Provincial Operations Centre, dated April 23, 2003, provided:

The diagnosis of SARS remains a challenge as the identification of a link to a known probable case becomes more complex. Although the epidemiological link will always be important when it is present, it may not always be identified initially. This link may not be found for several days, or it will become evident in several days if other close contacts of the patient become ill. It is for this reason that high vigilance for SARS needs to be present for every case of pneumonia.⁶⁸⁵

Although Public Health continued to investigate new possible cases, there was no surveillance system to look for SARS throughout the health care system. Early into

684. Naylor Report, p. 38.

685. Ministry of Health and Long-Term Care, SARS Provincial Operations Centre, SARS Clinical Decision Guide (Ontario), April 23, 2003.

the outbreak there seemed to be an attempt at a form of surveillance through the Office of the Chief Coroner, begun on April 5, 2003.

On April 5, 2003, a directive was released from the Office of the Chief Coroner through the SARS Provincial Operations Centre. The directive provided as follows:

As a result of the recognized overlap in clinical and radiological findings between SARS and other clinical conditions and in an effort to better identify patients who may have died as a result of SARS or while infected with the SARS virus, hospitals in the GTA should, effective immediately and retroactive to March 14, 2003 report the deaths of all patients who appear to have died as a result of (or while diagnosed with);

1. Congestive heart failure,
2. Pneumonia (typical or atypical),
3. Respiratory failure,
4. Adult Respiratory Distress Syndrome

to the Office of the Chief Coroner (OCC). The coroner will review the clinical information available and make a decision as to whether the case will be accepted for a coroner's investigation.

Hospitals should refer these cases to the Dispatch Office of the OCC at [number provided].⁶⁸⁶

The directive appeared to signal a recognition that the danger as the number of new SARS cases abated was that new cases would go undetected. The memo appeared to be an attempt at surveillance of hospitals in an effort to identify potential unidentified SARS-related deaths. But just 10 days after it was issued, the directive was rescinded.

Dr. James Young, then Commissioner of Public Safety and Security and Chief Coroner for Ontario, explained the decision to rescind the directive:

At the time this directive was issued, the SARS outbreak was in its early stages and the clinical, laboratory, and epidemiological features of the

686. SARS Provincial Operations Centre, From the Office of the Chief Coroner, April 5, 2003.

disease were poorly understood. There was concern that cases of SARS may be missed because of confusion with other diseases, and the directive was intended to capture all possible cases.

This directive resulted in a large number of cases being sent for review, with considerable additional workload for hospital staff and reviewers. This process did not, however, identify any additional cases of SARS. It was apparent that the medical staff in GTA hospitals were keeping abreast of the developing body of knowledge regarding SARS as the outbreak progressed, and that they were able to identify potential cases with the assistance of public health officials as required.

As a result of this experience, it was decided that there was no added value in reviewing the very large number of patients who appeared to have died as a result of (or while diagnosed with) congestive heart failure, pneumonia, respiratory failure or adult respiratory distress syndrome, where SARS was not already being considered by clinical staff or public health officials.

Therefore, on April 15, 2003, Dr. [Barry] McLellan issued a directive to all hospitals in the GTA that they no longer needed to report these “potential” cases to the Office of the Chief Coroner. This decision was made following consultation with the SARS Scientific Committee that was providing advice to the government at that time. Hospitals were, however, instructed to continue to report all SARS deaths.⁶⁸⁷

In hindsight, the assumption that “medical staff in GTA hospitals ... were able to identify potential cases with the assistance of public health officials as required” turned out to be optimistic.

The Joint Health and Safety Committee of North York General Hospital, which conducted an internal investigation into the death of Ms. Nelia Laroza and the illness among health workers, questioned another assumption that underlay the cancellation of the directive:

687. Letter from Dr. James Young, April 14, 2004, to Joint Health Safety Committee, North York General Hospital.

It is certainly questionable whether we were so much more knowledgeable about SARS in the space of ten days (April 5 to April 15).⁶⁸⁸

SARS continued to be difficult to diagnose. There was still no quick test to determine whether a patient had SARS or some other respiratory illness such as pneumonia. Even where the clinical impressions of front-line physicians and nurses who were admitting and caring for patients identified a case as possible SARS, their clinical impressions were discounted where there was no epilink to a SARS case or a SARS region. We now know that the ability to diagnose SARS cases with accuracy was not progressing as well as it was thought at the time, and that the assumption which underlay the April 15 cancellation of the Chief Coroner's directive turned out to be incorrect. This is clear from the number of patients at North York General who had SARS but were not identified as possible SARS cases and from those cases who were identified as possible SARS who were said not to have SARS when we now know they did.

Post-SARS, some health workers wonder, if the April 5 Coroner's protocol had remained in place, would the deaths on 4 West have been recognized as an unusual cluster that warranted further investigation, which would have uncovered the simmering SARS on 4 West? As the Joint Health and Safety Committee at North York General concluded:

... the subcommittee believes that if the April 5 directive had been left in place for hospitals who had SARS patients, the unusual number of deaths on 4W might have been seen to be suspicious by the Coroner and subsequent events might have unfolded differently. Recall, that there were 4 deaths on 4W in the first two weeks of May; possibly two of them either in the same room or closely located in terms of room number and possibly with a similar diagnosis. To us, this important directive represented a valuable check and balance within the health care system. In hindsight, it is very clear that patients with SARS on 4W/S went unrecognized and undiagnosed despite the retrospective assurance of Dr. James Young that, "the medical staff in GTA hospitals ... were able to identify potential cases with the assistance of public health officials" ... (Personal Communication, Dr. James Young, April 14, 2004).⁶⁸⁹

688. JHSC Report, p. 45.

689. JHSC Report, p. 45.

One physician who worked with SARS patients thought it would have made no difference at all:

We have so many patients with ARDS [adult respiratory distress syndrome] and respiratory failure and congestive heart failure. I think they would have just been totally inundated and it would have been the same problem, too many cases that they wouldn't have been able to wade through and sort out anyway. So, no, I don't think that would have made any difference.

Because it was cancelled so soon after its implementation, it would be speculative to suggest that the Coroner's directive might have identified problems on the orthopedic floor at North York General. An obvious limitation of the Coroner's directive is that it was intended to catch deaths only, but as we now know there were many patients who were ill with SARS before May 23, 2003, who had not died and who ultimately survived the illness. These cases would not have been captured by the Coroner's memo, even if it had remained in place.

What can be said is that provincial or local surveillance initiatives might have made a difference. We now know that the diagnosis of SARS was not clear and that cases were missed. There was nothing system-wide to ensure that undetected cases were caught. Any system that might have identified clusters of illness or death could have been helpful and might have prompted a look into what was happening on 4 West.

Whether or not the Coroner's directive would have made a difference, physicians agreed that a strong surveillance system could have helped. As the above-quoted physician said:

Question: If there were a system in place that required the question to be answered, what do these clinical indications of SARS, that we're not calling SARS, mean? In other words, instead of asking itself the question, do these patients have SARS, if the hospital had asked itself a different question: What does this show is going on? Maybe we better take a look at mortality rate here, a cluster there? In other words, let's do an epidemiological investigation, would that make sense?

Answer: I think if we had the infrastructure and the expertise to do that on an ongoing basis, then, sure, because we probably

would have picked up that in March there were, you know, five orthopedic deaths, and in April there were 25, hey, what's going on. But nobody that I'm aware of had that kind of top-notch, or very few anyway, had that kind of a top-notch epidemiologic surveillance infrastructure and system set up to track that kind of thing on a reasonable time basis. And if we did, sure, we might have picked that up that there was a funny blip in the mortality rate on that floor.

Another physician who argued that surveillance would have made a difference, as was evidenced in other areas, said:

One of the things that happened after the hospital closed, was I went back and started reading the CDC Atlanta's Morbidity and Mortality Weekly Reports, and discovered that there was one dated May the 9th, that was in the library where the authorities, I think it was in Singapore, had started tracking nosocomial pneumonia regardless of contact history, beginning as early as late March. And this was then reported in May the 9th. If we had been tracking the literature appropriately, or what was happening in other centres, that whole clustering on 4 West, the orthopedic floor, potentially could have been avoided.

It turned out that the pattern of illness was not hard to see as soon as one focused on 4 West. When experts went in on May 23, 2003, they knew within a matter of hours that they were looking at a cluster of illness within the hospital. As Dr. Tamara Wallington told the Commission:

We continued to review the charts anyway, and I would say after about an hour, we realized that we were dealing with a major outbreak. We reviewed these charts and realized that there was a serious, a significant clustering of febrile respiratory illnesses associated with deaths, all in one small ward. [All between] the 17th and May 23rd. And again, the numbers are significant, and I mentioned 23 health care workers and patients to you between April 17th and 23rd, and that's less the Patient A family [five family members]. That's less some of the people we already knew about. So the numbers were very significant, and these were names that were completely unfamiliar and unknown to us.

By that evening Dr. Low was announcing to the public, under media cross-examination, that it was a significant cluster and that the focus was on the orthopedic unit of the hospital.

As one physician pointed out, when Public Health came to the hospital on May 23, 2003, to review charts, the pattern of illness was much easier to see, as they knew what they were looking for:

They were looking for it. They had a preconceived idea, and a reasonable one, that's why they came looking to North York General. It wasn't that it was so simple ... They knew that there was this funny cluster of cases at St. John's, and they figured out that, well, isn't it funny that a lot of these patients actually started out at North York General. So, they knew what they were looking for, and they went right to it, and it doesn't take long to find something when you know what you're looking for. So, when it's happening sort of in a scattered, very obscure, somewhat occult way around you, and you're living in real time, it's not always that obvious.

While it is no doubt true that the discovery of the outbreak on 4 West was much easier with the knowledge that they were looking for SARS and that there had been a patient associated with 4 West who was now believed to have SARS, Public Health officials did not go to the hospital expecting to find a large cluster of illness. They thought they were going to review the chart of Ms. N, the patient who had been transferred to St. John's Rehabilitation Centre from North York General and who later developed SARS, to look at the chart of her roommates, and to look at Patient A's chart. Public Health officials did not know going into North York General on May 23, 2003, that they would discover a cluster of ill patients and ill staff on 4 West. As Dr. Wallington said:

We had no reports at all of any febrile respiratory illnesses at 4 West from the hospital. We were completely unaware of what was happening on 4 West until we went in on May 23rd. And, in retrospect, it would have been helpful to have known about what was happening on that unit. So, no, 4 West would not have been considered a place where someone would be epilinked.

The pattern of illness became clear only when the files were reviewed as they were looking for possible unidentified SARS cases. But that is the point of surveillance: to look for SARS even in places where you might not expect to find it. And that was not happening.

Surveillance would have also required greater infection control resources. As Dr. Wallington said when asked if she would expect any hospital with a SARS unit to have active surveillance throughout the hospital:

That's a really good question, and I think in an ideal world that would have been and should have been happening. I think that hospitals would probably tell you that there would've been real difficulty with that since for many, many years, infection control has been ignored, it's been under-resourced. And in order to do that, which I think is a really good point, and it's something that should exist, in order to do that you need to be resourced to do it. It is not a simple task. It takes a high level of expertise and commitment to do this. So, you have to have the right people with the right training in place to do that.

Speculation is a slippery slope. But it is certainly possible that the simmering SARS cases on 4 West might have been detected earlier had an independent review of the kind envisaged by the April 5th Coroner's memo or some other kind of system-wide surveillance sparked a review of the 4 West cases.

Surveillance Within North York General

Without a provincial or local surveillance system, surveillance for new or undetected SARS cases was left to the infection control program of individual hospitals. Consequently, the level of surveillance and approach to surveillance varied among hospitals. But many hospitals, including North York General, did not have a robust program and did not have the infection control resources to implement such a program during SARS. As Dr. Naylor found:

Hospitals responded by treating all patients admitted with community-acquired pneumonia as potential SARS cases until proven otherwise. Most took special precautions with inpatients who developed respiratory symptoms suggestive of infectious disease. Some hospitals also did "fever surveillance." For example, at York Central Hospital, all inpatients had their temperature checked twice daily. Chest x-rays were ordered for all York Central inpatients with fever and respiratory symptoms and they were isolated promptly; and until SARS could be ruled out, a specialist in lung diseases assessed and treated all pneumonia patients in isolation. Similar measures were used in Singapore health care facilities.

Although infection control practitioners attempted to institute comprehensive surveillance programs in some hospitals, such a program alone requires approximately 2 full-time staff members for a 500-bed hospital, more than the majority of hospitals have on staff for all infection control tasks. At North York General Hospital, for example, one full-time and one part-time infection control practitioner were responsible for 425 acute care beds. The infection control director, Dr. Barbara Mederski, occupied the role without any salary, protected time, or even an office. In the absence of a directive, and with ongoing budgetary concerns, instituting full syndromic surveillance was not seen by most hospitals as necessary or feasible.⁶⁹⁰

Identified SARS cases or cases under investigation for SARS were required to be reported to infection control, who, along with Public Health, monitored the status of these cases daily and were required to report daily lists to the Ministry of Health and Long-Term Care. During SARS I, in accordance with Ministry directives, the hospital had initiated and maintained screening of anyone entering the hospital, whether they were patients, visitors or health workers. Hospital resources were directed at screening for new cases of SARS to enter the hospital. What was missing was a strong surveillance system to look for unidentified cases of SARS in the hospital.

Surveillance was especially important in areas like 4 West, a unit that was vulnerable because it was a place no one expected to find SARS. Unlike the emergency department, where staff maintained vigilance for new cases because they knew they might have a new SARS case come through the emergency department doors, the staff on 4 West did not expect that SARS could be on their floor. And, as noted above, health workers were led to believe the outbreak was over.

As one 4 West nurse told the Commission when asked about surveillance:

Question: Was there anyone during this time whose job it was to monitor these things [respiratory illness and deaths] on your unit? For example, to keep track of the number of deaths and keep track of the number of respiratory problems.

690. Naylor Report, pp. 38-39.

Answer: Not really. Because we all thought it was going to be temporary. SARS was going to disappear and these people [the medical floor patients] are going to go back to their floor and then we would be normal again.

Another nurse reported that although they noticed that there seemed to be more deaths, there was no system to report or investigate those deaths:

Because I know one of my concerns was that when Mrs. X [a 4 West patient] passed away, I remember at the nursing station I said, there's eight deaths, and my question was if these people are in the nursing home and this person had come to us from the nursing home and the person died, we'd have to contact them and find out what number is she on their list. Because if it becomes 10 deaths, then we have to do an inquiry. So we were up to eight at that point, and that was my concern, that we have eight deaths. I wasn't even thinking of SARS when I was thinking of that. My concern was that if the nursing home reached 10 deaths, we have to call. Whenever a person comes from a nursing home and died, we have to call to find out what number is this person on your list, because there has to be an inquiry after 10 deaths in a certain space of time. And here we are up to number eight, what is the policy for our floor? That was my concern.

One physician who worked on 4 West and provided care to SARS patients in both SARS I and II, when asked about reporting of respiratory infections, said:

Question: Were there any rules or procedures in place about reporting infections, respiratory infections in particular?

Answer: Not that I am aware of.

Question: What about a procedure for reporting patients that might fall under the category of persons under investigation?

Answer: If there was, I was not involved.

Had the cluster of respiratory illness been identified, even without a link to a possible SARS case, it should have raised the alarm and it should have been reported to Public Health. As Dr. Wallington told the Commission:

Question: If you had been in that room for some other reason that morning and the ICPs had started bringing in the charts and saying we need a second opinion? So everything the same, except nothing from St. John's. Can you explain what it would look like?

Dr. Wallington: I would still be very concerned. This was clearly a clustering of febrile respiratory illnesses with deaths.

Question: Coming out of 4 West?

Dr. Wallington: Coming out of 4 West, and so this is an outbreak that we would take very seriously.

Question: Even forgetting about St. John's and the tests?

Dr. Wallington: Yes. Absolutely. This was an outbreak that was happening in a hospital, an acute care facility which still housed SARS patients. So this was an outbreak that we would have to take very, very seriously.

Unfortunately active surveillance for infectious respiratory illness was not mandated at the time by any provincial directives and there was no clear standard of surveillance that had to be met by hospitals.⁶⁹¹ It was not until weeks after SARS II hit that the Provincial Operations Centre issued a SARS surveillance program directive. On June 16, 2003, Directive 03-10, Directive to Acute Care Facilities in the Greater Toronto Area (Toronto, York, and Durham Regions), required the following:

All hospitals must institute active surveillance for infectious respiratory illnesses as outlined in the appended document Active SARS Surveillance Program.⁶⁹²

691. Although, as noted above, hospitals were required to report to public health any outbreak within the institution of respiratory infection. *Health Protection and Promotion Act*, R.S.O. 1990, c.H.7., s.27; and see Ontario Regulation 559/91, amended to O.Reg. 365/06, Specification of Reportable Diseases.

692. Directive 03-10, Directive to Acute Care Facilities in the Greater Toronto Area (Toronto, York, and Durham Regions), June 16, 2003.

The appended document outlined the importance of surveillance. It provided:

Active surveillance is an important epidemiological tool that serves a variety of purposes, both during active outbreak situations, and during times when specific outbreaks are not declared.

The ability to identify cases early in an outbreak, or in anticipation of an outbreak, offers enhanced protection to patients, staff, visitors and the community at large. It also identifies the need for appropriate infection control precautions and prevents transmission of disease.

The presence of an Active Surveillance Program in acute care hospitals is important for the early identification of “clusters” of cases requiring investigation. Regular attention by clinical nursing and hospital staff to the combination of certain symptoms (e.g., “fever and respiratory symptoms”) in a systematic fashion across the hospital environment also provides continuous opportunities for staff education on both infection control practices and other SARS-related information. An Active Surveillance Program minimizes the possibility that SARS cases will be missed.

Further, an appropriately resourced Active Surveillance Program will build and maintain public confidence in the public health and hospital care systems, both during periods of transition and over time.

Ultimately, an efficient system will significantly reduce costs to both human and other resources.

An Active Surveillance Program is not meant to replace Infection Prevention and Control practices already in place in acute care hospitals, but rather to supplement them.

The program was to be applied to all inpatient units, with the exception of critical care units.⁶⁹³ As part of the program, unit staff were to monitor and record on a surveillance sheet if any of their assigned patients had unexplained fever, cough,

693. The program provided that “Another method of case finding will be developed for Critical Care Units.”

hypoxia and/or shortness of breath. An assigned surveyor was to be responsible for going to all inpatient units daily to review the patient lists and speak to staff and/or review charts as necessary. The surveyor and infection control practitioner were to review all information provided by the surveillance to enable infection control staff to quickly determine if there were gaps in the identification of at-risk patients and their appropriate isolation.⁶⁹⁴

Post-SARS, the need for strong surveillance systems and strong infection control programs to support such systems is clear. As the SARS Field Investigation found:

Enhanced surveillance is needed, including for the following:

Absenteeism among hospital workers

Unusual fever or pneumonia clusters among patients and hospital workers within health care facilities, particularly in facilities providing care to SARS patients

Abnormal death patterns within health care facilities and pneumonia deaths

Significant increase in laboratory testing for respiratory pathogens or SARS Co-V

Patients discharged from hospital with pneumonia of unknown etiology

Community acquired pneumonia in areas with recent SARS transmission⁶⁹⁵

The SARS Field Investigation emphasized the importance of strengthening the infrastructures, both in a hospital and in public health, to support disease surveillance systems:

It is critical that hospital infection control, disease surveillance systems and public health be strengthened with increased resources

694. Paraphrasing Directive 03-10, Directive to Acute Care Facilities in the Greater Toronto Area (Toronto, York, and Durham Regions), June 16, 2003.

695. SARS Field Investigation, p. 27-28.

across Canada. There should be increased staffing and the infection control medical director should be compensated for the time devoted to infection control issues.⁶⁹⁶

Tragically, strong disease surveillance systems and resources necessary to support those systems were not in place prior to SARS II. Although some hospitals had limited forms of surveillance, North York General was not out of step with the generally prevailing surveillance standards. Had Ontario's surveillance standards been higher and mandated in all hospitals, the systems better and the resources more available, the cluster of illness on 4 West should have been detected before May 23.

Isolation of Febrile Cases

One of the big questions that remains in the wake of the second outbreak is, even if the patients were not identified as SARS, if they had respiratory symptoms, were they handled with droplet and contact precautions? If so, how then could SARS spread so widely on the unit?

On April 16, 2003, North York General Hospital issued a revised policy for droplet and contact precautions. The revised policy included the following:

Criteria for Full Droplet and Contact Precautions are required:

3. When a patient has respiratory symptoms suggestive of an infection and have been put on droplet and contact precautions (i.e. CHF, CAP, Vented, Pneumonia, Asthma).⁶⁹⁷

At that time, provincial directives required isolation and the use of precautions for any patient who developed fever or respiratory symptoms. An April 14, 2003, directive to all acute care hospitals required:

HCW's [health care workers] should maintain a high index of suspicion when assessing any patients for new onset of fever or respiratory symp-

696. SARS Field Investigation, p. 28.

697. North York General Hospital, SARS Task Force, Droplet and Contact Precautions for Staff, April 4, 2003, revised April 10, 2003, revised April 16, 2003.

toms. Any person developing the following symptoms or signs after admission – cough, unexplained hypoxia, shortness of breath or difficulty breathing – must be treated as follows:

- a) Transfer to a single room if available. If a single room is not available, cohort similar case presentations (e.g., congestive heart failure cases with other patients with congestive heart failure) and maintain at least one metre spatial separation between beds. If there is more than one patient in a room, the curtains must remain closed between beds to minimize droplet transmission.
- b) Patient activity should be restricted i.e. patients should remain in their room with the door closed until SARS is ruled out.
- c) All visitors and health care workers must wear a N-95 mask or equivalent when entering the room.
- d) Where possible, diagnostic and therapeutic procedures (e.g., imaging, hemodialysis) must be done in the patient's room.
- e) Patients should be out of the room for essential procedures only and wear a surgical mask during transport.⁶⁹⁸

The new normal directives, issued May 13, 2003, also stressed the need for isolation and use of precautions for patients who had respiratory symptoms suggestive of an infectious disease, until SARS could be ruled out.⁶⁹⁹

It is unclear the extent to which the North York General Droplet and Contact Precautions policy was followed. Although the majority of staff, including physicians, interviewed from 4 West recalled the policy, few remembered it clearly and most could not recall whether or not they applied it. Most reported to the Commission that if the policy was in place, they would have followed it. As one physician told the Commission:

698. SARS Provincial Operations Centre, Directives to All Ontario Acute Care Hospitals, Directive 03-04, April 14, 2003.

699. Directives to All Ontario Acute Care Facilities, Directive 03-04(R), May 13, 2003.

My observation would be that it was followed pretty carefully. Certainly on our floor it was. I think that, I'm sure there may have been some breaches from time to time, but my observation being on the floor a fair amount was that it was carefully certainly all the surgeons, nurses and so on were very careful with this. I mean, there was significant concern during that time with respect to this illness, so people were observing the precautions that were outlined carefully.

Another physician who worked on the unit agreed with the observation that the policy was followed. He said:

Everybody tried when the policy came about. The nurses were informed. They were pretty good about doing it. I don't think too many corners were cut.

But how then did SARS spread throughout the unit? Even if the patients weren't identified as SARS, if they had "respiratory symptoms suggestive of an infection" or, as per the directives, if they had a cough, unexplained hypoxia, shortness of breath or difficulty breathing, they were supposed to have been put on droplet and contact precautions, which included isolation.⁷⁰⁰

Because there wasn't a strong system of surveillance to focus on the possibility of undetected SARS transmission in all areas of the hospital, including those thought to be "safe" or "SARS-free," SARS cases were not identified when they simmered on 4 West. When possible SARS cases were not identified on 4 West, the problem was compounded by the fact that those cases of respiratory illness, which we now know had SARS, were not always isolated or treated with droplet precautions. As Dr. Wallington told the Commission:

People with febrile, respiratory illnesses were to be managed in precautions, they were to be managed in respiratory precautions. That was the direction. And there was a good reason for that. It was to prevent potential spread of SARS or any febrile respiratory illness. And I think what we're seeing here [on 4 West] is that when you don't put people in isolation, you get this unrecognized, ongoing, low-level, grumbling transmission. And then the health care workers start to take their masks off and they get sick.

700. April 16th NYGH Policy.

One member of the infection control team at North York General told the Commission that when a patient was put on isolation, infection control were supposed to be notified. They recalled later noticing that on May 20, 2003, a date when we now know there were many patients ill on 4 West with SARS, no patients from 4 West were flagged as being on isolation. As they told the Commission:

Any patient who developed fever or respiratory illness was put on isolation and they were supposed to be flagged in the patient care system so that we would have a record of who was on isolation ... I do know, in looking back afterwards, I saw one of those reports from May 20th, and there wasn't anyone's name on it from 4 West. We weren't notified through the system.

Clearly, the policy that was in place was not working.

This is not to blame the health workers or physicians who worked on 4 West, or to suggest that anyone was at fault. Many factors contributed to the failure to isolate all respiratory patients during April and May, including lack of awareness and understanding of the policy, difficulties in complying with the policy, and a general inattention to robust infection control throughout the Ontario health care system.

One physician, when asked how SARS spread so extensively on 4 West notwithstanding the policies that were in place, suggested that either the precautions were not adequate or the precautions were not adequately applied:

... if cases developed while we were taking precautions, and I'm not sure about the time frame here as to when the cases actually became ill, whether it was after we abandoned some of those precautions or not, but if it occurred while we were using those precautions, then that would suggest the precautions weren't adequate or weren't adequately applied. And one would have to, in future, be very careful about instructing staff of the importance of observing these precautions carefully. The other possibility is that if they were observed well, then the precautions weren't adequate, that the sort of use of a simple cotton gown and gloves and mask were not enough to protect you from that particular virus.

The existence and application of the droplet and contact precaution policy was not brought home clearly to all front-line staff. Some nurses did not recall the policy and were not aware of its requirements. Few nurses recalled receiving any training on the policy. One nurse said she was aware of the existence of the policy, but that there was never time to sit and read the policies:

I remember that [the isolation policy], but I think they just put it at the desk and said go and read it if you have a chance. But in nursing, when will you have a chance to do that? It would have been better if they had had a meeting and informed us. There is hardly any chance [to sit and read] with the workload, because 4 West is a heavy, heavy workload floor.

Of those who were aware of the policy, some nurses reported uncertainty about its application and about who could institute the isolation protocols. Even some doctors, while aware that they could isolate patients, were unaware of who else might do so and of the application of the policy outside of their involvement. Who decided initially whether a patient should be put on precautions? Some nurses thought only infection control could put a patient on isolation. Others thought only a doctor could make the decision to isolate a patient. Other nurses thought that only a manager or head nurse could isolate a patient. As one nurse told the Commission when asked about the isolation policy, she understood that a manager had to approve it and that the application of the policy was dependent on bed availability:

Question: And were you aware of a policy in existence during April and May that required that a patient who had a respiratory illness be isolated?

Answer: It rings a bell, but I believe they had to have respiratory symptoms and a fever, when a lot of the patients that were dying in our unit had no fever.

Question: And whose decision would it be to isolate a patient, to put a patient in isolation?

Answer: I think it has to be in consultation with the manager. And also you have to consider if there's going to be an open bed.

Question: That was going to be my next question. What was the situation like on the unit as far as the ability to isolate patients?

Answer: Non-existent really. We were very, very busy in there. Very rarely did we have empty rooms.

4 West was not a place where anyone expected SARS. The resources and emphasis on strict adherence to isolation and use of precautions were not as strong as in areas that anticipated handling SARS cases. As one 4 West physician said when asked how

SARS spread on 4 West despite the policies in place with respect to isolation and the use of protective equipment:

It is hard for me to answer that question. We had a number of patients come to 4 West from other floors during that time when 8 West was closed, to make it a SARS ward. The precautions that were being taken were relatively simple. We were not wearing, at the early stages, N95 masks, for instance. At the time, there was no obvious disease on the floor so these precautions were being observed, but they were pretty simple. And I'm sure that there were some errors of handling something after you took your gloves off perhaps, or I think errors in technique I'm sure were made during that time that could allow it to spread. And then in terms of patient-to-patient, a four-bed room, if one patient gets an illness, it's clear that it can spread to the patient in the next bed without much difficulty, because it was droplet, so I have to assume that's how it occurred.

As the Joint Health and Safety Committee at North York General so eloquently described the problem:

4W was not considered to be the "front lines" and not deemed to be at high risk like other areas, such as the ER, the ICU, or the SARS Unit. Therefore, there was possibly less suspicion and less vigilance. As well, it was common for post-surgical patients to have fever and respiratory complications and patients were not isolated since it was not considered to be unusual. Neither the 96-year-old patient nor the other patient who could also have been an index patient were initially isolated. Both were located in the same four-bed room. The 96-year-old patient was finally isolated but only because he was having diarrhea. Both patients had fever, respiratory symptoms and diarrhea. In retrospect, we saw that SARS would appear in "low risk" areas, such as the original 8W (Geriatric Unit), 7W(Psychiatry) and on 4W/S (Orthopaedics/Gynecology). The reality was that all areas of the hospital were the front lines and were high risk since we had patients with SARS in the building, since we didn't know everything there was to know about SARS (and still don't) and due to the possibility of human error or that things might be missed. Most of the focus seemed to be on the "gate" which was the ER. Viruses, however, will move wherever they are taken. During an outbreak of disease or during the transition period (which turned out to be a very dangerous time), the highest level of vigilance must be maintained

throughout every area of the hospital and concerns from any area must not be dismissed. The problem is deciding when it is safe to relax precautions.⁷⁰¹

Even if a nurse or doctor was aware of the policy and tried to strictly follow it, there were challenges in its application. One nurse from 4 West described to the Commission the challenges they faced when they tried to comply with isolation procedures:

We don't have isolation rooms. These are regular rooms, so our isolation rooms would have to be that if a patient is in the room and two of them [two patients] are in there, you have to take one out. You have to take one out, they clean the room and put the patient in and just pray that whatever one had the other one doesn't pick it up before you do that isolation. We put the other one in a room by themselves ... So if they have a private room that's empty or there's somebody in there that doesn't mind moving, then you take that person out and put them into a room with somebody else, put the isolation patient there ... We have about four rooms that are private. And those are the rooms that act as our isolation rooms, and if these patients refuse to give up their private rooms, to bunk with somebody else, we have nowhere to put these patients.

One physician said that, although there were errors in isolation on 4 West, isolating patients on 4 West was not easy:

Errors that occurred on 4 West were not so much errors of definition of SARS, they were errors of quarantine. People coughing, people with fevers that should have been isolated. Now the trouble is we don't have the resources to do that. You take a 90-year-old person who's got a cough and try to put a mask on them, you need 24-hour nursing to get that mask to stay on, because they'll just take it right back off. It's an unbelievable set of resources that's required to enforce respiratory isolation and, you know, when you call it SARS, suddenly you get all those resources, negative pressure rooms and lots of funding and staffing, but when we go back to our normal surveyance, what you have is policy. This is respiratory isolation policy, we have a sign on the door, and that's very different from staff and funding.

701. JHSC Report, p. 48.

Another physician who worked on 4 West described how many factors, including the type of patients on 4 West, made it difficult to comply with isolation procedures and to minimize exposure and risk to staff:

Question: Some of the staff from 4 West have pointed out that the unit is not conducive to isolating a large number of patients. Any observations on that?

Answer: It's not, because when you have a full unit, a unit has 32 people, 32 beds, and only one, two, three, maybe four or five rooms that you can make isolation rooms.

Question: By isolation, that would mean the patient is in the room alone?

Answer: In the room alone. And that is not the greatest isolation, because you don't have, as far as I know, and perhaps now they do, this negative pressure in those rooms. Is it a perfect isolation room? In the emergency department we have perfect isolation rooms, up to the standard of, whatever standards you would use to make it an isolation, they have, and they probably have it in ICU and CCU, but on the floors, I don't know if the standard is as it should be for a strict isolation, although I assume it is. The other thing about isolation is, these people are orthopedic patients who are recovering from surgery, who need physiotherapy, who need nursing care, they are surgical patients, so there are often people going in and out. During SARS, when you actually had a SARS patient, in the actual SARS unit, there was minimal in and out of that room. It is my understanding that the nurses made their rounds occasionally, did everything at one time, no visitors, this was quarantine and isolation the way it should be. Last week, we had a patient on 4 West that was isolated because of a cough and a bit of a fever. She wore a mask, the patient wore a mask during physio, the physiotherapist had to go in there and give her some physio, the nurses had to go in there, the lab had to go in there, tests had to be done, visitors are allowed in.

In the wake of SARS, the importance of isolation and droplet precautions with respiratory cases became clear. But prior to SARS, isolation of patients and use of protective equipment were not routine. This was not true only on 4 West; it was true throughout the health care system in Ontario. Many physicians told the Commission that before SARS, the only time they isolated patients and used a mask was when they thought the patient had TB. Even then, the mask used was typically a surgical mask. One senior physician, who regularly worked on 4 West at North York General, candidly described a higher level of knowledge and degree of care in respect of isolation and worker safety post-SARS. He explained how SARS changed the way he practised medicine:

Answer: SARS has changed medicine for me unbelievably. Now part of that is not just me, part of it is I am forced to be aware of it, because the minute somebody develops a fever with a respiratory component, they are isolated by the hospitals. There are strict orders to isolate, so I am forced to examine this very carefully.

There is better knowledge of what happened. So that in itself, and I keep stressing this because we are aware of what happened, we are more knowledgeable now. Anybody with a fever and a respiratory, a fever and cough, is isolated, until you sort it out. That's one. If somebody has a fever with no symptoms, the nurses note it and I am notified, because they could just have a urinary tract infection. Then I go through the questions, is it this, is it that. A fever with respiratory illness or respiratory complaints, or probably fever with cough, are isolated. Cough without fever may not be and if you are not sure, 24-hour/7 we have an ID [infectious diseases] team we can call for advice, which the staff use, and they use it wisely. Anybody who has a medication that is delivered by droplet, because there are certain oxygens we give, that happened to me the other day. I had a patient who I am pretty sure we are talking about congestive heart failure, it was congestive heart failure, required high-concentration oxygen to keep their oxygen up, the respiratory therapist came by and decided this oxygen should be humidified. I was not informed, but this was her mandate. As soon as that happened, because it was droplet, the patient was put in isolation. When I came in the next day, I

asked, why was this patient in isolation? When we intubate a patient, I have to mask and gown and glove, something I never did for 25 years. I still, still have difficulty with that. Although the younger doctors do now, it is like seatbelts.

Question: Do you do that for all patients now, or ones with respiratory illness?

Answer: If I'm intubating, you've got three-point protection.

Question: And are these changes that have happened as a result of knowledge since SARS?

Answer: Since SARS – none of this was around before SARS. I can recall doing mouth-to-mouth on patients before SARS, as part of CPR. I was going to say, it's like seatbelts, you know my kids don't think twice about seatbelts. It's their natural reflex.

Where isolation and precautions were strictly followed, it was easy to see how even the most diligent health worker could make an honest mistake in its application or how there could be a breach in protection for those patients on droplet precautions. One physician who routinely cared for SARS patients described how difficult it was to maintain precautions and how the use of the protective equipment was not routine:

Even with a policy that tells you to do this, it was something that we didn't practise on a daily basis up until then. It takes a conscious effort to ask me to remember the sequence. Until you do that, it is difficult to think, but basically it is not a second nature, so you have to remember to wear masks, do this, do this, do this. Once it is finished, take this and this and this and that. All of that is not a second-nature thing. It is uncommon. It is almost like you have to follow – that's why the signs are so big, so that you can actually remind yourself. And even though you do that every day, you still have to remind yourself what to do and at times, you kind of maybe forget about one step. So that is human nature, you don't remember.

We were breathing under the N95 mask. We were breathing our carbon dioxide back into our brain, and working 16 hours under those masks and gowns. It was very difficult to concentrate, to remember what to take off

first, etc. And so even with the policy, sometimes just down to the nitty gritty, it's like okay, the gloves go here, gown here, maybe there is a crack, maybe a droplet goes there and you forget and you wipe your nose.

I think everybody was trying to follow instructions. Nobody wanted to get SARS. We were trying very hard, everybody was trying very hard to follow whatever was there. And myself, working in the intensive care unit, I was intubating these people with a space suit etc. Again, you were taking it off, trying not to contaminate yourself, you have to make a conscious effort. It is a very slow process and it takes you forever. Instead of going in and out, it takes you forever to see one patient. So, you can see that in so many hospitals, there can be cracks.

The nurses on 4 West were hard-working, caring and attentive. They were used to providing close, constant care for the patients on their unit. They were not used to limiting their exposure to patients or leaving them alone and unattended in their rooms. For example, one nurse who contracted SARS recalled working with one of the elderly patients on the unit, who we now know had SARS. This nurse explained to the Commission that she spent a lot of time in this patient's room, not because she was the patient's nurse, but because she spoke Russian and would go in and speak with the patient and provide comfort to her. As she told the Commission:

She wasn't my patient, but the doctor would sometimes ask me to translate because I know Russian and she didn't speak English. I came to her room so many times to help. After she knew I was Russian, she said, come and talk to me, I am so lonely here. So I came to her to talk, whenever I had a minute. I was not wearing a mask.

This type of compassionate patient care is what we all hope for in a health worker. Tragically, health workers, like the one quoted above, were unknowingly put at risk, simply by being good nurses.

It is much easier in hindsight to look back and say what should have happened on 4 West. But at the time, no one working on 4 West believed their patients would have SARS. The hospital had a SARS unit, which was not anywhere near 4 West. They believed SARS was contained. As one nurse told the Commission:

On the 8th [floor], that was suppose to be a SARS unit, but not on our floor. We didn't have any idea there was anyone with SARS.

One physician from 4 West reflected that it was easy to look back now and see what went wrong, but it was not so obvious at the time:

I don't think anything went wrong. It was the demon that was so new and we were learning about it and we had no test and had no treatment. The study cohort is so few. It is easy to look back and say what we should have done. For me what went wrong, looking back, and it is only because I have the knowledge now, is that perhaps everybody, as they had fever and cough, should have been isolated and we should have been more aggressive in isolating them and consider SARS as a cause.

Post-SARS, one of the emergency room nurses reflected on how the different levels of training likely contributed to the difference in the numbers of staff who were exposed and who became ill with SARS:

For some reason, not one nurse in emerg contracted SARS, not one, yet the 4 West nurses did, because that was a little different. Those people who were exposed, I think it was because they had improper education [on] and understanding of isolation.

The story of 4 West underscores the importance of regular, mandatory education and training programs for workers on the use of personal protective equipment and on hospital policies, such as isolation protocols. It shows the challenges associated with isolating and using precautions when treating the very ill, the scared and the elderly. It also shows that during an outbreak of an infectious disease in a health care institution, suspicion for new cases and awareness about the disease must be emphasized in all areas of the hospital. As 4 West showed, there is no such thing as a "low risk" or "safe" area, especially in a hospital that has SARS patients.

Were Concerns Raised by Staff?

Hospital officials told the Commission that they were unaware of any problems on 4 West until May 23, 2003, when news of the second outbreak broke. However, as noted above, many of the 4 West nurses interviewed by the Commission said they were aware of an increase in respiratory illnesses and/or deaths on the unit, either through their own observations or through discussions with colleagues.⁷⁰² Many of these nurses believed that concerns were raised about these patients to management and/or physicians and that nothing was done to investigate their concerns. This has contributed to a feeling of mistrust among staff, as some point to it as an example of senior management's not listening to nurses.

The Joint Health and Safety Committee reported anecdotal evidence that illness on 4 West among staff and patients had been ignored:

Other health care workers on 4W would comment, ... so many patients died of pneumonia on 4W (over 10 in 2mos.) ... they should have investigated for SARS.(Phase 1 –Interview # 23). Another would comment, "Patients were dying with respiratory illness. We were told not to worry, it's not SARS." (Phase 1 Interview #24) Another comment, "*Concerns about why so many patients were dying with respiratory symptoms were not investigated promptly.*" (Phase 1 Interview # 24) "*I had nursed patients with respiratory problems who later died. I was told after I had been admitted into hospital that these patients died of SARS ... Patients with respiratory illness were not investigated properly. There were 6 or 7 deaths in a matter of a few weeks. When concerns were raised by us, nobody listened. We were told they are elderly and what do you expect?*" (Phase 1- Interview #26) Another HCW stated, "*We had approx. 10-11 patients die of pneumonia and we mentioned it to the U.A. who I hear asked DR. and felt it was nothing. Staff began to get sick, 5-6 sick calls a day and U.A. said it was a bug going around. If it had been looked into when patients started to die this would not have been such a big outbreak and people might not have died.*" (Phase 1 – Interview # 39) "*Massive death within short period of time, which had never happened before.*" (Phase 2 – Interview).⁷⁰³

702. As noted earlier, not all of the nurses from 4 West reported an awareness of problems on the unit. Some 4 West nurses said they were unaware of problems on the unit until May 23, 2003.

703. JHSC Report, at p. 46.

Some nurses who did report to the Commission that they were aware of problems on the unit, either through their own observations or conversations with others, said they did not raise concerns with anyone themselves and did not know if anyone had raised concerns with the manager or any hospital official. For example, one nurse reported being aware of problems on the unit but did not know if anyone raised concerns with the manager or anyone else:

I don't know if anybody actually went to her and said it to her. But I know that was one of our concerns, but did anybody go to her and actually say to her that we have so many deaths, what are we doing about it? ... Their connection was just not there ... I didn't know if anyone had actually gone to her [the unit administrator] and said, so and so, so and so. I don't know if anybody had actually gone to her and said it.

However, a significant number of nurses interviewed by the Commission stated a clear belief that concerns had been raised with the manager, although almost all reported that they were not present when the conversation took place. They understood from colleagues that the manager was aware of the problems on the unit. For example, one nurse from 4 West recalled staff being alarmed because of the number of deaths and reported hearing that a colleague had raised concerns with the manager:

I didn't know what the ratio was for patients dying in that area because I came from [another] site, and I could remember the other staff members, they were all alarmed, why we were having so many people dying on the floor. People came in with a fractured hip and broken bones and usually they would recover, go to rehab and be okay. But many of them were dying with respiratory problems. In conversation with one of my co-workers, she said that she had mentioned it to the manager, why so many people are dying, and her response was that they are old ... [The nurses] were concerned.

Another nurse, when asked if she noticed an increase in the number of deaths, reported a similar scenario of awareness and belief that someone had raised it with the manager. She believed that concerns had been raised with a doctor as well, although she did not know which doctor. She said:

Question: At some point during April or May, did you ever notice that there seemed to be a higher than normal number of deaths on the unit?

Answer: Yes, because during my night break, we were kind of talking about it, like “do you remember this patient? She passed away last week.” And they said, “really,” and then during that week, another patient died, again, and then somebody died, and so many deaths.

Question: Did you ever raise that with anybody, your manager?

Answer: My manager was aware at that time and I heard from my colleagues, I don’t know, I can’t remember which colleagues I was talking to, but the doctor knows about it but they can’t find anything. They thought it’s plain pneumonia and they’re on antibiotics and puffer and nebulizer, whatever.

Question: So you heard about it from your colleagues. Did you, yourself, ever talk about it with your manager?

Answer: I was on night shift so I didn’t see her.

Question: So when you say that your manager was aware of it, is that something that someone told you, or is that because you actually talked about it with your manager?

Answer: I did not talk to her. Somebody talked to her about it.

Question: Do you know who that person is?

Answer: I don’t know, because I just heard from, when we were kind of sitting down in the nursing lounge and then somebody said that [the unit administrator] knows and she talked to the doctor.

One nurse recalled a meeting between the unit administrator and staff where the issue of deaths and illness were raised. She could not recall the date of the meeting or who was present but was certain that the issue of increasing deaths and respiratory illnesses on the unit was raised. She said that at the meeting the question of SARS was not raised and that although she recalled concerns about the increase in deaths and illness, she did not remember anyone connecting it to SARS at that time. This nurse reported that she also noted that a lot of patients had respiratory

problems, but post-operative fever or pneumonia was not unusual and SARS did not cross her mind:

I noticed it, but on our floor, surgery, some of them spike fever, post-op. So initially you may not think that it's pneumonia or whatever because it's a complication of surgery, especially if they tend to be feverish, especially when they don't deep breathe and cough.

Another nurse reported discussing the deaths with a charge nurse, but the explanation given was that the patients are elderly and have medical problems:

I heard that some nurses talked to the head nurse and talked to the nurse in charge at the desk about these deaths, because there were just so many pneumonia patients who died. And the charge nurse said that, actually, I was there when one of the nurses told her about it, and she said, well, they're old and they have past medical history, so they're expected to die.

Others nurses reported hearing rumours that colleagues had raised SARS concerns with doctors or that the manager had raised concerns with one or more doctors:

I heard later that the nurses mentioned concerns about SARS, but the doctors they just, maybe wishful hoping, denied it. I didn't hear it from them directly, I just heard a rumour like that.

Another 4 West nurse reported being aware of an increase in deaths on the unit and a belief that concerns were raised with the doctors, although she did not know with whom:

There seemed to be lot of illness and death. To be honest we did talk about it, and I think the nurses did tell the doctors, but that is just what I was told. The main excuse was these patients are elderly and they have problems and that dying is natural. But we said it is unusual. Even on the 8th floor [the geriatric unit] we did not have that many deaths. Here [on 4 West] every time I went in it seemed someone had passed away on the day shift or the night shift.

None of the physicians interviewed from 4 West recalled anyone identifying the high rate of illness and death among patients on the unit prior to the discovery of the second outbreak. Infection control staff also told the Commission that they were unaware of the high rate of illness or an increase in the number of deaths on the unit.

There is no record of anything being raised in respect of 4 West in the minutes of the SARS Task Force/Management Committee. Toronto Public Health reviewed their call logs and did not locate any reports of unusual illness or deaths on 4 West by any staff member at North York General Hospital.

One physician who cared for SARS patients noted that, despite the perception that warnings were unheeded, to his knowledge no one raised the alarm in respect of the patients on 4 West:

Given what we now know about the index case and how it was, I think that would have been a very, very difficult thing. I know there are physicians or nurses that are saying, there was this funny cluster of deaths that we couldn't really explain. But I don't remember hearing anything about that. I don't remember hearing anybody at the time saying, this funny thing is happening on 4 West ... There was no talk about anything at the time that people were worried about. A lot of people I guess have come up retrospectively, I remember thinking, but at the time there was nothing, there was absolutely nothing that I recall being concerned about or worrying about.

The Joint Health and Safety Committee at North York General Hospital investigated reports of health workers that concerns were ignored and found:

It remains uncertain how concerns regarding an increasing number of deaths and possibly numbers of patients with respiratory symptoms and/or pneumonia were escalated by the health care workers on 4W or by the UA [unit administrator]. We have the statements of the staff on 4W that issues were raised with the UA. No one we interviewed from Infection Control, the administration or the doctors claim to be aware of any concerns being raised on 4W prior to May 23rd. During the transition period prior to recognition of the SARS outbreak on May 23rd, the UA's were supposed to be meeting each week on Wednesday. Problems were then reported to the SARS Management Team. There is no evidence from the minutes of the SARS Management Team that there were any problems on 4W. The immediate supervisor of the 4W UA states that nothing unusual was reported to her.⁷⁰⁴

704. JHSC Report, p. 46.

It is difficult to reconcile the perception of health workers that events were reported with the absence of any documentation of such reports or any recollection by anyone that such a report was made. It is difficult to determine with certainty who said what to whom at the time. The difficulty is compounded by the fact that because there was no system allowing for whistle blowing and no record-keeping of concerns raised by front-line staff, accounts of reports to others are based on individual perceptions which may or may not be tempered by the benefit of hindsight and must therefore be approached with caution. For example, one nurse reported to the Commission that she knew a colleague had raised concerns with the manager. When the colleague, who was identified by the nurse was interviewed, she reported that she had not spoken to the manager herself. She was also under the impression that another colleague had raised concerns with a manager, but she was unable to recall which colleague did so.

It is impossible now to say with certainty what was in the minds of all those involved at the time. There is the further difficulty of separating hindsight and rumour from actual recollection.

The unit administrator was unable to be interviewed by the Commission and was therefore unable to respond to any of the comments made about her or to provide her perspective on what transpired on 4 West. But there is no evidence that anyone in charge on the unit, including the unit administrator, knew these patients had SARS and failed to report them as such. While many nurses said they thought the unit administrator was aware of the illnesses and deaths, there is no evidence that SARS cases were identified to her and that she failed to respond. It would be unfair to hold the unit administrator or any other supervisor at fault for what happened on 4 West. No one identified the cluster of SARS cases, including doctors. It would be unfair to suggest that the unit administrator should have known what no one else did, that these were cases of SARS.

Despite rumours that 4 West staff identified and reported suspected SARS cases prior to the second outbreak, the Commission found no evidence of any such report. Nor is there any evidence that any physician detected or failed to report any suspected SARS cases.

There is no evidence that doctors identified cases of SARS on 4 West and then failed to report or raise concerns to hospital officials or to Public Health. The Commission does not doubt that had the doctors who were caring for these patients during April and May suspected SARS, they would have reported their concerns and managed the patients accordingly. They would not have put themselves and others at risk.

Had a physician identified an outbreak of respiratory illness on 4 West, he or she would have been obliged to report such a belief to hospital administrators, to enable the hospital to meet its reporting obligations under the *Health Protection and Promotion Act*. Since SARS was not only a reportable disease but also a communicable disease,⁷⁰⁵ physicians had a legal obligation independent of hospital administration to report to public health if they formed the opinion that a patient is or may be infected with an agent of a communicable disease.⁷⁰⁶ As Dr. Wallington told the Commission:

My understanding is at that time, if SARS was even considered as a diagnosis, it should have been reported. SARS was not considered as a diagnosis in any of these cases and so they weren't reported. It was an outbreak, it was a cluster of respiratory illnesses, so technically, under the reporting requirements, respiratory outbreaks in facilities should be reported. Having said that, when you look at the charts of the individuals on 4 West who were sick before we got there, there were good alternate diagnoses, and so perhaps one could argue that everyone had their own reason for having this pneumonia and maybe they weren't all linked and maybe that's why it wasn't reported as a respiratory outbreak. It would have been very helpful for us, considering the numbers of sick people in one ward and the deaths that were associated, to have known about it.

There is also no evidence that health workers on 4 West identified SARS patients to senior management or those in charge of the SARS response. There is no evidence to suggest that senior management or those in charge of the SARS response ignored reports of SARS cases on 4 West or that they failed to respond to such reports. When Dr. Wallington was asked why the hospital couldn't take steps to control the outbreak earlier, such as steps that were taken to control the outbreak at St. John's Rehab once a cluster of illness among patients was identified, she said:

Question: You made a note on May 21st, four others at St. John's have fever, recommend the ward close, active surveillance of staff and patients, active surveillance of what people were getting sick, contact to inquire about sick staff ...

705. Ontario Regulation 559/91, amended to O. Reg. 365/06, Specification of Communicable Diseases.

706. Section 26. A physician who, while providing professional services to a person, forms the opinion that the person is or may be infected with an agent of a communicable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided. *Health Protection and Promotion Act* R.S.O. 1990, c. H.7, s. 26.

Dr. Wallington: Yes.

Question: ... and actually look after the ill staff, couldn't North York General have taken that kind of step much earlier, as soon as they had questions about sick health care workers – some on 4 West, they had the psychiatric patients, and they had the Patient A family cluster. Why couldn't North York General before May 23rd have taken the steps that you took immediately on May 21, in respect of St. John's?

Dr. Wallington: I think part of the issue, in retrospect, was that they were not aware, I do not think the administration was aware of the outbreak that was occurring. It was an outbreak that went undetected.

Question: The outbreak of febrile respiratory illness on 4 West?

Dr. Wallington: Yes, it was not identified or labelled as an outbreak. They were individual cases, individual patients who were being managed according to their clinical diagnoses, so it was not declared an outbreak. And I think that is why the measures that you are alluding to were not taken, because I know at the senior level they were not aware.

Hospital administration had a legal duty to report not only suspected cases of SARS but also an outbreak of respiratory illness. Senior officials and those in charge of the SARS response at North York General understood their obligations. The Commission does not accept any suggestion that senior management or hospital officials would have ignored cases of SARS or that they would have deliberately put patients, visitors and staff at risk. The Commission is satisfied that had North York General officials and members of the SARS Task Force/Management Committee been aware of the possibility of SARS on 4 West, they would have sought the advice and assistance of Public Health and would have taken measures to ensure the safety of staff, patients and visitors to the unit.

While it is impossible in retrospect to know what exactly transpired on 4 West, the Commission finds that some of the staff who worked on 4 West did have concerns at the time about the number of deaths and respiratory illnesses and that there was no effective system to bring those concerns to the attention of someone who had a clear duty to investigate their concerns, to report back to staff on the results of their inves-

tigation, and to satisfy front-line staff that their concerns were heard and that something was being done to address them. Whatever concerns arose at the time among front-line staff, those concerns did not make their way up the chain of command.

The Commission does not doubt the credible and sincere accounts by the many staff who reported being aware of an increase in deaths or respiratory illness on the unit. But there was nothing in place at the time to capture the concerns of front-line staff in a concrete way. As the investigation by the Joint Health and Safety Committee concluded:

We were never sure of exactly how or when the nurses or other health care professionals on 4W escalated their concerns. It is believed that the UA of 4W took concerns to doctors, but to which ones, we are not absolutely certain although names have been suggested. It is easy to understand why the doctors may not have reacted. This is conjecture but we are thinking that concerns may have been brought in isolation to different doctors at different times and no connection may have been made. Also, it is traditional to bring concerns to doctors, since they are thought of as the ultimate authority in the medical model. However, this emphasizes to us the need to always document concerns in writing and to bring these concerns to the administrative side of the hospital as well as to the medical side, since the consequences immensely affect the administrative side of the hospital.

We must not have medical silos which are separated from the administrative side of the hospital. The administrative and the medical sides of the hospital must become integrated as they are part of the same organization and key people on the administrative side must be kept up to date on all important developments, including medical ones, during or after an outbreak.

As well, we never saw any indication that a specific nurse brought concerns to the attention of a specific individual other than the UA. There is no mention of Infection Control being notified of any problems and they confirmed this in their interview. There were never any “I” statements, such as I did this or I did that. The bottom line is that everyone is responsible for infection control. The question is how do we as an organization enable and empower individuals and how do we encourage leadership at every level within the organization? Tackling diseases, such as SARS, requires immense leadership and co-operation from everyone.⁷⁰⁷

707. JHSC Report, p. 47.

Because there was no system to ensure the effective reporting of concerns to senior officials in the hospital, concerns of front-line staff did not seem to move past the unit level. The SARS Field Investigation into the second phase of SARS also identified and stressed the need for strong feedback mechanisms to address staff concerns as part of a multi-faceted approach to infectious disease control and outbreak prevention and management.⁷⁰⁸

During an infectious disease outbreak, it is important to have strong feedback systems between front-line staff and senior management, but it is also important that front-line staff have the power and protection to report public health concerns to public health officials. As the Commission found in its second interim report, *SARS and Public Health Legislation*, there must be strong protections for employees who report a public health risk:

Any health care worker should be free to alert public health authorities to a situation that involves the risk of spreading an infectious disease, or a failure to comply with the Health Protection and Promotion Act. Public health officials do not have the resources to be present in every health care facility at every moment. While one would expect that a facility administrator, infection control specialist or practitioner would report to public health officials situations or cases that might risk the public's health, the cost of nonreporting or inaction is too high. In the event of such a failure to report, regardless of its cause, it is not enough to hope that public health officials will stumble across the problem eventually. SARS and other diseases clearly demonstrate the importance of timely reporting of a risk to public health. Health care workers can be the eyes and ears of public health and the front line protectors of the public's health. They must be free to communicate with public health officials without fear of employment consequences or reprisals.⁷⁰⁹

The Commission finds that the problem on 4 West was not a failure by senior hospital officials or those in charge of the SARS response to listen to nurses or to heed warnings. It was, however, a failure to have in place a system whereby concerns of front-line staff were documented and reported to someone with the time, resources, authority and responsibility to investigate, take action and report the results of their investigation and any actions taken back to staff, management and senior hospital officials.

708. SARS Field Investigation, p. 28.

709. SARS Commission, second interim report, p. 248.

Spread of SARS Among Health Workers on 4 West

On May 7, 2003, the hospital, in accordance with provincial policies, began relaxing precautions in certain areas of the hospital. This meant that staff were no longer required to wear masks at all times when in the hospital or when providing care to patients. The relaxation of precautions included the 4th floor at North York General, where the orthopedic unit was located. The 4th floor was also home to the short-stay surgical unit. It too was an area of the hospital where precautions were relaxed following the May 7 directive to staff.⁷¹⁰

We now know that as May progressed a number of staff from 4 West and 4 South, as well as a number of physicians who either worked or consulted on the 4th floor during May 2003, became ill with SARS. It is clear from the onset of illness among staff that as precautions came down, the number of SARS cases, particularly among staff, went up.

When precautions were relaxed on May 7, 2003, not all staff on 4 West removed their equipment. However, some staff did remove their protective equipment, trusting what they were told, that SARS was over, and believing that they were safe. As one nurse said:

For weeks we weren't wearing anything ... they told us that we didn't have to wear anything. We had no protection. Because we were told we didn't need to, everything was over ... there were directives from the government, the directives would come up on the email, the hospital sent us things, the supervisors told us.

Wearing the masks made work conditions difficult, at times almost unbearable. Many nurses and doctors said that they were relieved when they were told they could remove their equipment. As one nurse candidly told the Commission:

We were all tired of wearing this equipment, we were all getting headaches every day.

710. See the earlier section titled "Relaxation of Precautions", for a more in-depth review of the relaxation of precautions at North York General Hospital.

One 4 West nurse described how, even after some initial hesitation, she was relieved to remove the equipment and finally did so:

I didn't [remove the equipment] when they first said we could. I probably wore it for another day or two. It was so horrible wearing all of that stuff, I did take it off finally.

One 4 West physician described his relief when he learned he no longer had to wear protective equipment:

I recall that [when masks came off], because we were all so relieved. I don't recall exactly, but I recall a time that it was intimated SARS is over, we can take the masks off, we don't need to have any precautions, and it was just such a relief. You can't imagine how difficult it was, working eight-hour shifts with those masks and gowns on. I couldn't wait to get outside to take it off for a second. The second they told me to, I did.

Others, like Ms. Nelia Laroza, a 4 West nurse who died of SARS, worried that SARS was not gone and continued to wear the equipment.⁷¹¹ Ms. Laroza was exposed to SARS sometime between May 7 and May 16, when she fell ill from SARS. She died on June 30. As one nurse described Ms. Laroza and her approach to protection:

We took our breaks together a lot, and I remember joking with her. I said, oh, Nelia, you will never catch anything. Because she just was covered completely.

Another nurse described Ms. Laroza's precautionary approach:

She was our co-worker, we laughed with her, we cried with her, we nursed together, we did a lot of things together, and she was very afraid that she would get SARS and she double-gloved from the very beginning. And when the memos came around, you don't have to wear a mask, she wore everything. We didn't wear masks. She was very, very protective of herself.

By all accounts Ms. Laroza was a careful, cautious nurse who continued to wear the protective equipment even after the precautions were relaxed in the hospital.

711. Although most SARS victims are identified in this report by anonymized initials, Ms. Laroza's name is used because her tragic death has been widely reported in the public domain.

Ms. Laroza was not the only nurse on 4 West who chose to continue to wear protective equipment past May 7. Other nurses made the same decision, despite provincial and hospital policies that said they were no longer required to do so. One nurse who worked on 4 South, the short-stay surgical unit, told the Commission:

We wore everything. Whenever they told us to start, I can't remember what day we started it, but whenever we were told to start, we did. We wore everything right up until whenever they told us we didn't have to. And lots of nurses wore it after we didn't have to, for a while. And a lot of the nurses on the 4 West side did, more than on our side. I guess they just didn't feel comfortable taking it off.

But there was no consistent approach, as each individual nurse determined his or her own level of protection. As one 4 West nurse said:

I remember I went in one morning and we were told that we were not allowed to wear masks anymore. We don't have the masks, gown, and gloves anymore, and that was told to us as we reached the main entrance to come in. So I said, well, I'm going to still wear it, so I still put my mask on there. I put it on, I put on my things, I went up to the floor and did my normally change as we would, put on your stuff and I went about my duties.

And when I walked on the floor, I saw some of the nurses not wearing a mask or gown or anything and I said, why aren't you guys wearing your stuff. They said to me that we're not required to wear them anymore. I turned to them and I said, I don't think we're out of the woods yet, so if I were you, I wouldn't have jumped and taken off my stuff yet because we're not sure how it's spreading, what's going on. Even though we get the go-ahead from Public Health not to wear our stuff,⁷¹² I think for our own precautions, we should still wear them. Well, their [the other nurses'] reply was that if they don't have to wear, they don't see why should they wear it.

Some 4 West nurses reported that when they wanted to continue to wear protection, supplies were not always readily available. One nurse, who was caring for an ill patient

712. Public health officials said that they were not involved in the decision to relax precautions in the hospital, and that that was an internal hospital decision. See the earlier section titled "Relaxation of Precautions".

on May 22, the day before news of the outbreak was announced, recalled worrying that something was very wrong with the patient. She decided to wear a mask while caring for the patient. But the only mask that was available to her was a surgical mask. Other nurses similarly reported that after the policy was announced to relax precautions, masks and other equipment became scarce on the floor.

Along with concerns about availability of protective equipment, some nurses who continued to wear protective equipment after May 7 reported feeling pressured to remove their equipment. One nurse reported feeling pressure to remove the equipment after May 7:

My boss said to me, why are you still wearing your mask and stuff? I said to her, I don't think we're out of the woods yet. She said, you guys are making yourself sick because you're re-breathing in your carbon dioxide.

Another nurse recalled overhearing a manager admonish a nurse for wearing the equipment:

But I remember specifically being in the hall one day and she said to one of the nurses on their side, when are you going to stop wearing that stuff, because you don't need to wear it, and you're just going to be scaring the patients. So we were really being encouraged to not wear it.

Another nurse described the pressure she felt to stop wearing protective equipment, and her belief that it was safe to do so:

Answer: Things started dying down. As far as we knew, there weren't any diagnosed cases on the floor, anybody in isolation on the floor, and we were told that we could stop wearing our protective gear. Not everybody did immediately. There were some of us, including myself, who were a bit scared to take it off, so I kept it on for maybe a day or two, and then gradually took it off.

Question: So after about a day or two, you followed what everybody else was doing, and took it off?

Answer: Yes, because everybody else was taking it off. Actually, it was kind of getting embarrassing because people would come on the floor and say, what are you still doing in

this, don't you know you are not supposed to be wearing it anymore?

It is important to note, however, that this was not the experience of all health workers on 4 West. Some nurses interviewed by the Commission said that they did not feel pressure to remove the equipment and that the decision about protective equipment was theirs to make. One nurse said the choice of whether to use protective equipment was her own:

It's not really the pressure [that caused her to remove her equipment] but I think it's my own decision.

Another nurse from 4 West who continued to wear a mask when doing certain procedures or close patient care said that she never felt pressure to do otherwise and that she never had trouble finding a mask:

Question: So did you feel at that time that if you wanted to put a mask on you could?

Answer: Yes, I did.

Question: And were there masks available on the unit?

Answer: There were masks available on the unit and I think still in the main entrance because some of the units, they still had the policy [to wear masks at all times].

As noted earlier, the unit administrator was unable to be interviewed by the Commission and was therefore unable to respond to staff reports of unavailability of equipment and of pressure to remove the protective equipment. It is important to note that there is no evidence that the unit administrator was aware of any risk to staff, visitors and patients on the unit, or that she believed there were SARS cases on the unit.

Despite the continued use of protective equipment by some nurses, no one working on the unit was safe from SARS. Even nurses who continued to wear the protective equipment, like Ms. Nelia Laroza, contracted SARS.

Because there was no rule in place requiring the use of masks at all times, and because the nurses on 4 West believed SARS was over and that they did not have any SARS

patients on their unit, even those who decided to continue wearing a mask did not always do so. One nurse explained her approach to the use of protective equipment:

I was wearing my mask, but I know they told us when the first outbreak cleared, and there were no more cases. They said, we've got a directive that masks can be removed.⁷¹³ It's okay not to wear the mask anymore. Everybody was happy because it's so horrible when you're wearing it and you can't breathe. But I did not remove my mask, because during that time some of my patients were coughing and they had pneumonia-like symptoms. I didn't want to get sick.

When asked if she wore the mask all the time, she said:

Out of 100 per cent, I'd wear it [the mask] 80 to 85 per cent. If I removed it, maybe I'm eating, or my patient is really, really stable, they're not that bad and don't have respiratory symptoms.

When asked if she would wear it if she was just at the nursing station, she said:

I wore it but I removed it on and off. Because it gave me, I'd feel light-headed already for the whole 12-hour shift because I'm on 12 hours. So we didn't leave the mask on, but by the ninth hour, I'd be light-headed already.

The varied approach to the use of protective equipment potentially exposed 4 West staff to SARS through contact with patients, visitors or other staff. One nurse, who reported that she, like Ms. Laroza, continued to wear protective equipment at all times when dealing with patients yet contracted SARS, told the Commission that in addition to contact with others, there were many other places where they could have contracted SARS in the unit:

Between me and her [Ms. Nelia Laroza], we wore a mask all the time so my conclusion then is that if we picked it up, then it had to be anywhere between the nursing station, because if it's droplet then mask goes off, people talk. So we could pick it up from there. Or even by the med sheets, because we have to use those med sheets, everybody used them.

713. The directive from the hospital telling staff (in some but not all areas of the hospital) they were no longer required to wear masks was issued on May 7, 2003. See the earlier section titled "Relaxation of Precautions".

So it could be on the med sheets also, or the cardex that people use and stuff like that. The patients charts are on the door, it's outside the room door, so you finish inside and you come out and you just pick it up from there and you do your charting, but that week when there were no masks or anything being worn, and you come out of that room, you could have been coughing and it just landed on the book or whatever you're doing, and then somebody else comes along, picks it up and signs on it or whatever it is that you have to do.

It is believed that droplets can contaminate the surfaces and articles on which they land. As the Healthcare Health and Safety Association of Ontario noted:

... viable organisms may survive long enough in droplets deposited on environmental surfaces to contaminate the hands of caregivers and then be further transmitted.⁷¹⁴

Infectious disease experts recognize the possibility of transmission of SARS through objects contaminated by droplets, known as fomites. A May 2005 article by the Centers for Disease Control and Prevention found:

Epidemiologic features of SARS provide keys to its diagnosis and control. The pattern of spread suggests that SARS-CoV is transmitted primarily through droplets and close personal contact (Seto 2003; Varia 2003). Studies documenting stability of the virus for days in the environment suggest the possibility of fomite transmission.⁷¹⁵

Even those nurses who continued to wear protective equipment after May 7 removed their masks when outside of patient rooms, when interacting with each other, and when on breaks. This meant that a nurse could protect herself when in a patient room only to be exposed to SARS when she took a break with a nurse who had had unprotected exposure to SARS. As one expert told the Commission:

At North York General, don't leave with the impression that everyone took their masks off. Even though the memo came out May 7th relaxing

714. Healthcare Health and Safety Association of Ontario, "Respiratory Protection Programs, Second Edition," (Toronto: 2005), p. 1.

715. CDC, "Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS) Version 2/3", May 3, 2005, p. 20

precautions, many of the nurses were not comfortable doing that. According to a number of nurses and nurse managers, a majority kept their masks on when working with patients. Only a handful took their masks off. But we found out that the nurses were taking their masks off with each other.

On May 16, there was a Nursing Appreciation Breakfast at the hospital. Nurses from 4 West ate their breakfast in the small makeshift lounge described below. They were not wearing masks. Precautions had been relaxed on the unit for over a week by this point and, as noted above, even those nurses who continued to wear masks when providing patient care did not do so when simply interacting with colleagues, as they believed they were safe to interact with each other unprotected. The SARS Field Investigation found that this breakfast was a likely source of transmission:

On May 16th, 2003, staff from 4W took food back from the NYGH Nurses Appreciation Breakfast event to the small staff lounge on 4W and ate there. Two of the nurses on 4W working that day were unknowingly infected with SARS.⁷¹⁶

Of those nurses who told the Commission that they continued to wear the protective equipment after May 7, none had been fit tested or instructed on the proper use of the N95 respirator. This meant that they could have been wearing a mask that did not properly fit their face or wearing the mask improperly, potentially negating the protection afforded by the mask. For example, one nurse reported that although she continued to wear a mask after May 7, she did not learn until her fit testing in September that she was wearing it improperly:

We were told that we didn't need them, but I felt somewhat uncomfortable, so I would kind of wear mine around my neck and then when I went into a patient's room would put it on. But now, as of September [2003], I had the mask fitting test and I'm told that is a total no-no because you're infecting yourself if the outside of your mask has touched with clothing and then going up near your face. So that's another thing, I was never mask fitted and we were never instructed on the proper use of the personal protective equipment.

Another 4 West nurse reported that she wore tissue between the mask and her face,

716. SARS Field Investigation at p. 18.

because she had an allergy to the mask. She too was unknowingly compromising the protection afforded by the mask.

While it is clear that the relaxation of precautions led to the spread of illness among staff, the makeup of the unit also potentially contributed to the widespread transmission of SARS on the unit. During this time the hospital had been under renovations, including the 4th floor, and space was limited. Nurses from 4 West described the unit as cramped and expressed frustration about the conditions of the unit. One nurse described the situation:

This specific unit, 4 West, had two units on it. I think that they were renovating and they had put two units together, and the nurses at one point were sharing one of the patient rooms as a lounge. Then they built them a makeshift room for a lounge in the middle, outside of the unit, with a curtain around it. It was out, it wasn't a room, there wasn't a ceiling, it was just like a little makeshift portable, connected to the unit.

The report of the Joint Health and Safety Committee described the conditions in 4 West:

4W/S was repeatedly described as cramped and cluttered since two units were combined. There were too many people in too small of an area, which would have created an excellent environment for SARS to spread from person to person once PPE precautions were relaxed. Since the nursing station and halls were cluttered, this would have severely hampered efforts to clean surfaces properly, which is absolutely essential in controlling SARS as this virus can live on surfaces for hours. As well, 4W/S had a makeshift staff lounge, approximately 11' by 14' with no sink for people to wash their hands. Staff on the night shift also slept side by side in this small room which provided further opportunity for the spread of SARS.⁷¹⁷

It is important to emphasize that staff on 4 West did nothing wrong by removing precautions and working unprotected. They were told that it was safe to do so. But we now know that it was not safe. As precautions came down among the crowded conditions of 4 West, SARS spread. Health workers became ill. The continued use of personal protective equipment at the discretion of individual health workers on 4

717. JHSC Report, at p. 48.

West did not stop the undetected spread of SARS at North York General. As the investigative report of the Joint Health and Safety Committee concluded:

These “*early 4W cases subsequently ignited a chain of transmission, spreading to other patients, their visitors and hospital workers.*” (TPH/HC Report p.17) This chain of transmission would be directly linked to relaxed SARS precautions. At this point, PPE was optional except when dealing with patients on droplet/contact precautions and people didn’t have to sit a metre apart while eating food. Some of the HCW’s on 4W, such as Nelia Laroza, would choose to continue to wear their masks except while eating. The TPH/HC Report states that: “*Among hospital workers, cases began to escalate within 10 days (one incubation period) of the relaxation of precautions.*” (p.17) The report goes on to add that two nurses on 4W “*unknowingly were developing SARS symptoms*” on May 16. (p.17) It is interesting to note that PPE must have been effective since HCW’s on 4W were not getting sick until after its use became optional.⁷¹⁸

There were clearly different experiences among health workers with respect to the availability of equipment and the support from colleagues and superiors for continuing to use the protective equipment if they chose to do so. But the reports from health workers who felt some measure of pressure, whether through lack of equipment or through pressure from others to remove their equipment – subtle, direct, well-meaning, or otherwise – are troubling. During a public health crisis, no health worker should be discouraged from using the approved protective equipment and infection control and worker safety procedures he or she believes are necessary for protection. While there is no evidence to suggest that senior management or those in charge of the SARS response discouraged the use of protective equipment, the stories of those health workers who felt reluctant to protect themselves underscore the important responsibility that senior managers have to ensure that no one is discouraged, directly or indirectly, from taking reasonable steps to protect themselves.

The story of 4 West also underscores the importance of ensuring that staff are trained in the safe use of personal protective equipment, are aware of its limitations, and, in the case of N95 respirators, are fit tested. These are requirements of the *Occupational Health and Safety Act* and Health Care Regulations 67/93, and they predated SARS. Unfortunately, in a major systemic flaw, few in the health sector were aware of them before and during most of SARS. To compound this problem, not enough was done

718. JHSC Report, p. 41.

during SARS to alert hospitals to their worker safety obligations. It was not until a set of directives was issued on May 13, 2003, that the legal requirement of fit testing was explicitly communicated to hospitals. And, unlike in B.C., where the first proactive inspections were conducted in early April 2003 to ensure that worker safety requirements were implemented, the Ministry of Labour did not proactively inspect SARS hospitals until June 2003. By that time, the outbreak was virtually over.

As precautions were relaxed, health workers on 4 West were exposed to SARS and began to have symptoms. But the illness among staff did not raise alarms until May 23, the day the second outbreak was discovered. In the wake of SARS, the question remains, was the illness among staff detected and, if so, why wasn't anything done about it?

Sick Calls

As precautions came down, SARS spread throughout the orthopedic unit at North York General Hospital. According to provincial records, the first ill health workers on 4 West developed symptoms on May 16. On that day, three nurses from 4 West developed SARS symptoms. By May 19, two nurses from 4 South, a nurse from 4 West and a health worker had developed symptoms. On May 20, three more 4 West nurses were ill. On May 21, two physicians who had been on 4 West and another 4 West nurse developed symptoms. On May 22, another 4 West nurse developed symptoms. This meant that by the morning of May 23, twelve health workers and two physicians had developed symptoms, all of whom were associated with the 4th floor at North York General Hospital.⁷¹⁹

Many health care workers interviewed thought there were a large number of sick calls on the 4th floor leading up to the second outbreak and were angry that nothing was done about it. One nurse said:

I was quite angry at the hospital, 4 West, I don't think they, of course, planned on anything, but they had so many sick calls of the nurses. Eleven sick calls, I heard that day, and how come they didn't think of it. You know, that time with SARS and everything in the public, how come they didn't think of it or suspected it.

719. Ministry of Health and Long-Term Care Line-List Records.

Senior management at North York General told the Commission that they were unaware of the cluster of illness among staff prior to May 23, 2003. Like the clusters of respiratory illness and the increase in deaths on the unit, illness among staff did not raise any alarms among senior hospital officials because they did not know about it. Despite the perceptions of some that senior hospital officials were aware of staff illness, they were not.

Senior management understood the importance of monitoring staff illness. A policy had been developed during SARS that each unit within the hospital was to report sick calls to the occupational health department, which in turn would report to the SARS Management Committee. The Joint Health Safety Committee described the process in their report:

It was current policy at that time that each unit within the hospital was to forward a daily list of their sick calls (an absence due to illness form) to the Occupational Health Dept. This was to be done twice daily at specified times. Even if no one was ill, this form was still to be sent and if no one was ill, this fact was to be indicated. The Co-ordinator of Occ. Health, Sharon Robbins would follow up and report to the Command Centre.⁷²⁰

The coordinator of the occupational health department told the Commission that her department would then follow up with the sick calls to do surveillance.

A significant increase in sick calls was not seen until May 20. This was confirmed by the findings of the Joint Health Safety Committee investigation. As part of their investigation, they accessed pay cards, to determine when there was a noticeable increase in staff illness:

The subcommittee obtained the pay cards from all staff from 4W/4S through the Human Resources Dept. All names were removed, except that of Nelia Laroza, to ensure confidentiality. Nelia's name was left because we had to establish that she had worked on 4W during the critical months of April and May, 2003. From her pay card, we saw that Nelia had worked full-time on 4W during those months and that she had never been ill prior to contracting SARS. We were unable to see a significant increase in the number of sick calls until May 20, 2003 when there was a total of 5 sick calls from the two units, bearing in mind that each

720. JHSC Report, at p. 42.

unit operates independently, having, separate unit secretaries and separate UAs.⁷²¹

Between May 20 and May 23, the increase in sick calls among staff on 4 West failed to raise the alarm. The coordinator of the occupational health department reported to the Commission that they were not notified of any staff illness on 4 West until the morning of May 23, 2003. The occupational health coordinator told the Commission that they did not receive any sick calls for 4 West for the month of May:

Answer: 4 West, I didn't receive any all month.

Question: You did not receive any from 4 West all month?

Answer: Yes.

The Unit Administrator for 4 South reported that prior to May 23, only one staff member had called in sick. She told the Commission that two other staff members were also off work, but one had been off for two months and had previously been cleared as non-SARS-related. The other was on scheduled time off, although she was home ill and was later identified as a SARS case.

The investigation by the Joint Health and Safety Committee at North York General also found:

In an interview with the U.A. of 4S, who had staff off sick with SARS, this U.A. stated that she ensured that this list was being sent daily. If she didn't send it, then the charge nurse would. However, it is clear from the records kept in Occ. Health, that these forms were not always either being sent from 4S or being received by Occ. Health. Either way, there was a problem.⁷²²

The unit administrator of 4 South said she had understood that sick-call reports were being forwarded and she did not know why sick reports from her unit were not forwarded to the occupational health department.

721. JHSC Report, p. 41.

722. JHSC Report, p. 42.

This system for surveillance of staff illness did not work. Had it worked, staff would have understood the importance of ensuring that the reports were made to the occupational health department. The occupational health department would have had the resources to monitor and ensure that the reports were provided, and to report to management instances of noncompliance with the policy.

It is also important to note that the monitoring of sick calls by the occupational health department would not have caught all the cases of the nurses who were at home, ill with SARS symptoms, but who were not scheduled to work and therefore would not be required to report their illness to the hospital.

Surveillance for clusters of illness among health workers during SARS was an important precautionary feature. Particularly in light of the relaxation of precautions, staff illness should have been a sentinel for problems. Any cluster of staff illness should have initiated an immediate, thorough investigation, including reinstatement of protective equipment, until the risk to other staff, physicians, patients and visitors had passed. As one physician from Toronto Public Health remarked:

A large number of staff sick from the floor, regardless of the situation whatever was happening, whether they were sick patients, whether you think there is anything going on, any time you would get a number of health care workers sick on a floor, it would be cause for an investigation.

One of the most troubling things about the story of the nurses on 4 West is that although senior management and the occupational health department were unaware of the incidents of illness among staff on 4 West prior to May 23, the problem did not go unnoticed. How could it? Although sick call reports were not provided to occupational health, the fact remains that nurses did call in sick and that those in charge on the unit had to have been aware of the illness among staff.

One of the nurses who took the sick calls on 4 West the week of May 20 recalled being aware of the high number of sick calls and discussing it with the unit administrator. She told the Commission that no one wanted to think it could be SARS. She said:

Answer: ... I was getting the phone calls. And at first, a couple of sick phone calls, we didn't question them as to what was wrong with them or why they were, but then when we started getting more than one in, one almost every day, we started to phone them and, at that time, we did

ask them if they had a temperature and what their symptoms were, and whether they have a temperature or not, we directed them all to go to the emergency to be seen.

Question: And was this something that you were told to do or was this something you just did?

Answer: We had so many sick calls that we were having a hard time staffing the floor, that it just became that we had to do something and, I guess, deep down you didn't want to think that it was SARS, but somehow or other you suspected that it was.

None of the nurses who were ill the week of May 20 reported being told to go to the emergency department at North York General prior to Friday, May 23, the day the second outbreak was announced. Instead, they went to family clinics, some more than once, which subsequently resulted in the quarantine of hundreds of contacts. When the nurses were finally contacted and told to come to the emergency department for assessment on May 23, no one raised with them concerns that they might have SARS. More will be said about the poor communication with sick or potentially exposed nurses below.

One health worker told the Commission that she became aware of the cluster of staff illness and that she asked the unit administrator about it during the early part of the week of May 20:⁷²³

I told my boss, I told [the unit administrator], I said, we've got 10 nurses sick on your unit, or was it eight, I can't remember how many. I said to her, what's going on? You have so many sick calls. She said to me, oh, it's okay, they're just all stressed out. I said, but that's a high number. I've never, ever seen so many nurses sick, you know, within a week. She said, oh, don't worry about it, everything's been taken care of.

This health worker understood the unit administrator's comments to mean that their illnesses had been reported and investigated. She said:

723. She could not recall the precise date but said it was either the 20th, 21st, or 22nd of May 2003.

I thought that she called the people to see what their symptoms were. The occupational health department must have called them, because when you have this many nurses sick or staff sick on your floor, you want to call them and you find out what are the symptoms. If they all have the same symptoms, you want to investigate it. But if they all have different symptoms, then, well maybe there's something else going on.

Although the above-quoted health worker thought something was suspicious, she candidly admitted that she never thought it might be SARS:

I felt something was not right but I didn't know what it was. But I never thought that this would be SARS in our hospital.

As noted earlier, the unit administrator was unable to be interviewed by the Commission and was therefore unable to respond to the events and comments reported above. It is important to point out that some of the 4 West staff interviewed by the Commission made positive comments about the unit administrator. One 4 West nurse described her as open and receptive to input about what was happening on the unit, and another nurse described her leadership and support as "great." Another 4 West nurse described the unit administrator as a quiet person who did not want to "rock the boat." She said:

She was very, she liked to be in the middle of things. She didn't want to get anybody upset. She didn't want to do favours for anybody. She was just in the middle. She wasn't bothering you but yet she wasn't aggressive about anything, she was passive. And I didn't have any problem with her. I thought she was very good because nobody wants to have a manager who is constantly breathing at your neck and telling you what to do and following you around.

Whatever the unit administrator's role, it would be unfair to suggest that she alone was accountable for the failure to identify ill staff on the unit before May 23, 2003, or to use her as a scapegoat for the problems on 4 West. An important process like the surveillance of ill staff during an infectious disease outbreak should not fall apart because of one person. A system must be strong enough to overcome individual errors and it must encourage communication of concerns by middle managers to senior hospital officials.

Illness among staff, which should have been a sign that something might be wrong on 4 West, was not identified to hospital officials until May 23, 2003. The cluster of staff

illness on the 4th floor, especially among staff working on 4 West, which should have been evident before May 23,⁷²⁴ was not investigated, and important decisions about whether staff were at risk and how they should be protected were not made. Knowledge about the cluster of staff illness was not reported past the unit level. Regardless of whether the illness among staff was suspected to be SARS-related or whether those aware of it thought it was due to any other possible cause, it should have been reported and immediately investigated and steps taken to ensure the safety of staff working in that area. The system to monitor and investigate staff illness did not work. The occupational health department was uninformed about what was happening on the unit and lacked a robust system to monitor and enforce compliance with the policy.

In the end, the failure to monitor, report and investigate staff illness meant that another important step in the chain of protection, surveillance for illness among health workers, had broken.

724. As noted above, the number of sick calls increased the week of May 20, with five nurses calling in sick between the two units. It is important to note that these numbers capture only those who call in sick for work. They do not include those health workers who were at home, ill, but were not scheduled to work and therefore would not be required to call in sick. According to provincial records, by May 20 there were 10 health workers from the 4th floor who had developed symptoms.

Clusters of Illness in the Emergency Department

By May 2003, Toronto was claiming a victory over SARS. Directives geared towards a “new normal” were issued and precautions were relaxed. Government and public health officials travelled to China to talk about the successful containment of SARS in Ontario. But SARS was not over. It had never ended. Rather, it lay smouldering in the orthopedic ward at North York General Hospital. While precautions were in place, transmission occurred primarily between patients who shared rooms. Once precautions were lifted, SARS quickly began to spread, among patients, visitors and health workers.

As SARS spread, some of the patients and visitors who had been exposed to SARS and who began to develop symptoms came to the emergency department at North York General Hospital for treatment. Staff in the emergency department became increasingly alarmed in May as they saw cases admitted with respiratory symptoms that could be SARS. Of particular concern was the family of Patient A.⁷²⁵ Patient A had been an inpatient on 4 West and had died on 4 West on May 1, 2003, during the first part of the SARS outbreak. After his death, his wife, daughter, son-in-law and grandchild were all admitted through the emergency department at North York General Hospital. Emergency room staff raised concerns about these cases but, as in the case of the psychiatric patients in April and early May, staff were told that these cases were not SARS. Like the psychiatry staff, the emergency room staff would later learn that their observations and concerns were correct: all of these family members had SARS.

Another family, Mr. and Mrs. O, came through the emergency department around the same time that the fourth family member of the Patient A family cluster (the granddaughter of Patient A) was admitted to hospital. Mr. O had also previously been an inpatient on 4 West. He was discharged home but developed pneumonia and was readmitted to hospital. His wife became ill and was also admitted through the emergency department at North York General Hospital, with pneumonia.

725. As noted earlier, the initials of the patients have been changed throughout the report.

Patient A, the four family members who were admitted to hospital, and Mr. and Mrs. O were all retrospectively classified as SARS after the outbreak at North York General was identified on May 23. On May 20, Ms. N, a former inpatient at North York General Hospital, was identified as part of a cluster of SARS at St. John's Rehabilitation Hospital. Ms. N had gone for rehabilitation following her discharge from North York General Hospital. Concerns about the Patient A family cluster and the link between the index case of an outbreak of SARS at another hospital to North York General Hospital was what led public health officials to North York General on May 23. The story of the investigation on May 23 and the details that led public health officials to North York General Hospital on that day are told later in this chapter.

From the story of these clusters of illness that came through the emergency department the during May emerge many of the same system-wide problems as were evident in the story of the psychiatric patients: failure to give attention to the concerns of front-line staff, too much reliance on the epilink, poor communication with front-line staff and poor communication between Public Health and hospitals. The story of these family clusters of illness shows the importance of strong infectious diseases leadership and of proper support and supervision during an outbreak.

But above all, the story of Patient A and his family is a story of family tragedy and loss. Five family members fell ill, and in the end the family lost a husband, father and grandfather.

Patient A Family Cluster

Patient A was admitted to North York General on March 22, 2003, following a fall that resulted in a fractured pelvis and clavicle. He was admitted to 8 West, the ward that later became the SARS unit. Although his admission to hospital predated the formal declaration of SARS and the accompanying requirements for screening of patients, it is known in retrospect that Patient A did not have an epidemiological link to a SARS patient or to a hospital with a SARS outbreak and that he had no history of travel to an area where SARS was endemic.

Although Patient A was on 8 West when Health Care Worker No. 1⁷²⁶ became ill

726. The story of Health Care Worker No. 1 is told earlier in this chapter, along with the stories of four other health workers who contracted SARS while working at North York General Hospital during April 2003.

with SARS, his onset of illness was inconsistent with this potential contact being the source of exposure. The SARS Field Investigation, an investigation into the outbreak at North York General Hospital, concluded:

Incidentally, on March 30, 2003, while patient A was on 8W, a nurse on that ward developed SARS symptoms and later tested PCR positive in stool samples and then seroconverted to SARS-CoV. The nurse's mother was an inpatient at Scarborough Hospital Grace Division (where SARS transmission was occurring) in late March; her serology results were positive for SARS 2 months later but she did not meet the WHO case definition. Evidence of SARS was sought in other patients with whom this nurse had contact on the only known date she was working while symptomatic. Although two additional patients had isolated, unexplained temperature elevations within ten days of this contact, we found no convincing evidence for SARS. She also should have been in full precautions when seeing patients. The 8W nurse had unprotected contact with another nurse on the ward, who subsequently developed SARS 3 days later. She was sero negative. This appears to be the full extent of this transmission chain. Our investigation failed to find evidence for direct contact between the first 8W nurse and patient A or B.⁷²⁷

On April 2, 2003, Patient A was transferred from 8 West to 4 West, the orthopedic ward, as 8 West became the hospital's SARS unit. Because surgeries had been cancelled during SARS, 4 West had a number of empty beds and was filled with medical patients in addition to the usual orthopedic patients who were on the unit.

In early April, Patient A was diagnosed with pneumonia. He was treated with antibiotics and his condition appeared to improve. The retrospective review of his case by the SARS Field Investigation Team determined that this pneumonia was unrelated to SARS. As the report found:

The onset of his [Patient A's] illness was most compatible with the April 19, 2003 date, as his family did not get sick until May 2003.⁷²⁸

727. SARS Federal Field Investigation, p. 16-17. Patient B was a roommate of Patient A while on 4 West. Post-SARS, it remains unclear whether Patient A gave SARS to Patient B, Patient B gave SARS to Patient A, or they were infected from a common, unknown source.

728. SARS Field Investigation, p. 16.

On April 19, Patient A developed another pneumonia. Despite treatment, his condition deteriorated, and he died on May 1, 2003. During his stay in hospital, Patient A had no known contact with a SARS case and his medical illness was not inconsistent with his age, health history and presenting medical problems. A diagnosis of SARS was not considered during his stay, and his case was therefore not reported to public health officials. Until his family began to present to the emergency department, there was nothing about his case that caused alarm bells to ring or that led to a query of SARS.

Patient A's Wife

Patient A's wife (referred to as Mrs. A) regularly visited him while he was in hospital. She became ill on May 3, 2003. On May 9, she was taken by ambulance to North York General Hospital, where she was seen in the emergency department.

The emergency room physician who saw Mrs. A had maintained a strong vigilance for SARS, even during what was thought to be the post-SARS period. He diagnosed pneumonia and thought that Mrs. A's symptoms were consistent with SARS. He requested a SARS work-up and admitted Mrs. A to respiratory isolation on full droplet precautions. His astute, cautious actions most certainly prevented further spread of SARS, as staff who worked with Mrs. A were protected and other patients were not exposed to SARS.

Concerned about this case, this physician told the Commission that he contacted Dr. Barbara Mederski, an infectious disease specialist at North York General Hospital, to request admission to the SARS unit. He said that Dr. Mederski did not feel that Mrs. A had SARS and would not admit her to the SARS unit. This physician told the Commission that the absence of an epilink seemed to be the determining factor:

It was big with her [Dr. Mederski] that we needed an epidemiological link, and if we didn't have an epidemiological link, then it was unlikely to be SARS. And I remember on one occasion I said to her, an epidemiological link is great, but we're dealing with a disease whose symptoms in the beginning are very insidious, how can we track back every person that she may or may not have been in contact with. It wasn't practical, what I was being asked to do. And in the heights of such an outbreak, we have a patient who is coming in with fever, with pneumonia findings, yes, she's elderly but there's no history that she passed out and aspirated, and at that point I was told by one of the nurses that her husband had passed

away on the orthopedics floor, what was it, two or three weeks prior. And in fact at that time, we didn't know what the man had passed away from. In fact, in my notes I wrote, "she is not known to have any specific known SARS contact, but this obviously, at this point in the SARS outbreak, is of limited value. The patient had her husband in hospital for nearly six weeks and he passed away a few weeks ago. He passed away of complications related to a fracture of the left shoulder," end quote, is what I wrote. That's the best information I had at the time because at that time nobody even knew that this man on the orthopedics floor was going to be a central role in the whole outbreak. But it was very suspicious to me and so I decided to admit this patient and I couldn't convince her [Dr. Mederski], so the patient ended up going, still in isolation, but to the medical ward.

This physician identified what many missed during SARS: that the absence of an epilink did not rule out SARS but might mean not that the epilink didn't exist, but that it just had not been found. This emergency room physician also recognized that the cluster of illness among family members with a link to a hospital that had SARS cases in a city with an infectious disease outbreak was cause for concern.

After Mrs. A was seen in the emergency department on May 9, another physician took over her case. By May 13, Mrs. A's condition has worsened and her physician, concerned about her deteriorating condition, also consulted with Dr. Mederski. Mrs. A's physician recalled that Dr. Mederski did not think that Mrs. A had SARS. Although Mrs. A's physician had concerns about her health, she thought the diagnosis of non-SARS-related pneumonia was also plausible, particularly in light of her having just lost her husband:

So I spoke to Dr. Barbara Mederski, our head of infectious diseases, and she thought it was probably a non-SARS-related pneumonia. This is an elderly woman who had been at her husband's bedside every day, very tired and emotionally drained, and so the feeling was that this was likely a non-SARS-related pneumonia but, of course, we were concerned since she had visited him while there was quarantine in effect at our hospital. She [Mrs. A] would have had to wear a mask and gown and such in order go in and sit at her husband's bedside.⁷²⁹

729. Dr. Mederski's response to the recollections of others is noted below.

At that time, there seemed to be a good alternate diagnosis for Mrs. A's illness, and her presentation was not inconsistent with a woman who had lost her husband after a constant vigil at his bedside. Dr. Mederski's consultation notes for May 13 indicate that she did not believe that Mrs. A had SARS. Although she did not think Mrs. A had SARS, Dr. Mederski did order a number of tests for Mrs. A, including a series of SARS tests.⁷³⁰

On May 15, the physician who was caring for Mrs. A contacted her daughter (referred to as Mrs. B) to discuss her mother's condition. At that time Mrs. A seemed to be improving, but her doctor was concerned about her well-being given that she had just lost her husband. When Mrs. A's physician spoke to Mrs. A's daughter, Mrs. B, she became concerned when she learned that Mrs. B, her husband (referred to as Mr. B) and their daughter (referred to as Miss B) were also ill. Mrs. A's physician learned that Miss B had been home for her grandfather's funeral and had since returned to school, outside of Toronto. This physician said that she wrote this all down, because the cluster of illness among the family caused bells to go off:

So I took all this down on a piece of paper. I was sitting there and I must have spent half an hour on the phone and I said, okay, who are your kids, where are they? I'm writing all this because suddenly these little bells are going off. You know, this is not right. So, I wrote it all down and I said, I'm going to speak to Dr. Mederski again.

This physician again spoke to Dr. Mederski, outlined what she had learned and expressed her concern about these cases. She recalled that it was Dr. Mederski's opinion that these cases were not SARS, that they were community acquired pneumonia. Although there was no known connection to a SARS case at that time, this physician continued to be worried and to have concerns about this family cluster of illness. So she took the notes of her conversation with Mrs. B (Mrs. A's daughter) and gave them to the Public Health person who was working in North York General Hospital:

So I then took all this information on my little sheet of paper and I went to the patient's chart to transcribe it all there, as part of the legal docu-

730. Although PCR [polymerase chain reaction] and serology testing were available at this time, the tests had to be sent to the National Microbiology Lab in Winnipeg, Manitoba, and were not quickly available. For example, the lab results for Mrs. A were reported July 17, 2003. As noted earlier the only test that could rule out SARS was convalescent serology, a test to determine whether a patient had developed antibodies to the SARS coronavirus. A convalescent serology test could not be considered negative, or used to rule out SARS, until more than 28 days after onset of symptoms. CDC, SARS Laboratory Preparedness.

ment, and there was a woman there, and I believe she was with the Public Health Department, back at the hospital. I think it's probably the following morning, probably the 16th. So I had my little piece of paper there and the Public Health lady there, I should have gotten her name but I was just so pleased to see someone, she said, I'm from Public Health and I said, oh, thank goodness. I said, I'm really worried about this family. Here's the history, I said, there's a family outbreak, and I said, I'm very, very concerned.

This physician thought that because she had reported her concerns to Public Health, they would now investigate the matter. As will be seen below, Public Health were already aware of this family cluster and were also concerned about their illness.

Mrs. A eventually recovered and was discharged home on May 26, 2003. During her hospitalization at North York General, she was treated on a regular medical floor, albeit in respiratory isolation with precautions, and was not admitted to the SARS unit. Mrs. A was retrospectively classified as probable SARS, on May 25, 2003, after the outbreak on 4 West was identified.

Patient A's Daughter and Son-in-Law

Mrs. A's daughter and son-in-law (Mrs. and Mr. B) had been in contact with Mrs. A when she stayed with them following Patient A's funeral. The family had sat shiva for the week following the funeral. After Mrs. A became ill, Mrs. and Mr. B also became ill and both went to the North York General Hospital emergency department on May 16, 2003. By May 16, Mr. B had already been to see his family physician, where he was diagnosed with pneumonia. He had also previously gone to the emergency department at North York General but was not admitted to hospital at that time.

When Mr. and Mrs. B went to the emergency department on May 16, they were examined by the same emergency room physician who had examined their mother-in-law/mother just a week earlier. Once again, this physician queried a diagnosis of SARS and raised concerns about these cases. He was concerned to now have admitted three family members in one week, all with respiratory symptoms, who had had a relative die while in hospital during the SARS outbreak. As he told the Commission:

So at that point I'd seen now the mother, the daughter, the husband of the daughter, three members of that same family in the course of seven days. I'm also told that the patriarch died on May the 1st ... I have three

people with pneumonia who had visited a father in a time of the SARS outbreak.

The physician ordered SARS work-ups for Mr. and Mrs. B and placed both patients in respiratory isolation on droplet and contact precautions. Again, the cautious diligent actions of front-line staff, maintaining a high vigilance for SARS and ensuring both patients were isolated and handled with precautions, most certainly prevented further spread of SARS.

This emergency room physician told the Commission that he once again contacted Dr. Mederski to consult about the case and to request admission to the SARS unit. He said that Dr. Mederski did not think that it was SARS and once again did not accede to his request to admit these patients to the SARS unit.

Although there was no epmlink, there were now three family members, all diagnosed with pneumonia, and a connection to another family member who had died while an inpatient at North York General Hospital, on May 1, during the first SARS outbreak. In his consultation notes for Mrs. B, this emergency room physician wrote that he found it “very suspicious that the patient, her husband and mother had all come down with pneumonia in the last 10 days.” He suggested that SARS should be ruled out. This emergency room doctor described to the Commission his concerns about these cases:

Clearly, all three of them had pneumonia. The pneumonia diagnosis, there’s no discussion about that, that is clear. The x-rays showed it, the lab data supported it, okay. The question was what kind of pneumonia? Pneumonia simply means an infection of the lungs. You can have infection from bacteria, from TB, from viruses. Coronavirus is a virus, which causes SARS. You have three members of the same family with pneumonia. My working diagnosis is that this pneumonia, in all three patients is, as far as I’m concerned, SARS. Why? Because three members of the same family, which is highly, highly, highly irregular and unlikely in any of the bacterial or viral infections that you see, and at a time when SARS was ravaging the health care scene, and at that time I didn’t know what the elderly man, the patriarch, had died of, but he had died in hospital on May the 1st.

This physician explained how it was difficult to diagnose SARS and, in the absence of a quick, reliable test, front-line physicians like him had to rely on their clinical judgment. In the case of Mr. and Mrs. B, his clinical judgment led him to a working diagnosis of SARS:

So essentially, in the case of SARS for instance, a patient comes in with certain symptoms and the big symptoms being fever, cough, usually a dry cough, with a chest x-ray that will, in the beginning, show maybe very subtle abnormal findings and later on becomes more obvious. So, you ask yourself, what else can give you those symptoms? There are many other bacteria that can behave the exact same way, okay, microplasmas, strep-pneumonia, and so on, can behave exactly the same way. So it's very hard to distinguish them from the first instance.

So then you start looking for other clues to help you point towards or away from SARS. If a patient comes in and it's a nurse who has worked on the SARS unit the night before or week before then obviously you tend towards SARS. If you had a patient, and these would happen with chronic lung disease, heavy smokers, who come in for their sixth admission in three years with pneumonia, then you take a little bit of a guess that it's most likely the same type of pneumonia and not SARS. You don't report every case that comes in as, they must be SARS because they came in, in May of 2003, no. There is a lot of clinical judgment that goes into this.

This physician recalled that he spoke to Dr. Mederski about the cases and she offered the opinion that they did not have SARS because there was no epidemiological link:

... when I was asking for a good reason as to why it can't be SARS, tell me why it can't be SARS? And the answer was, very clearly, she said, there's no epidemiological link.

After this emergency room physician saw Mr. and Mrs. B in the emergency department, care for these two family members was turned over to another physician.

Both Mr. and Mrs. B's cases were taken over by an internal medicine specialist. This physician also queried SARS for both patients. He too noted that Mr. B's father-in-law had died while in hospital and that his mother-in-law and wife were also admitted to hospital. This physician told the Commission that when he saw Mr. B and Mrs. B and became aware of the family history, his flag went up:

Question: When you first saw them, what was your understanding of what was the problem with them, what was their presentation?

- Answer: They had a pneumonia-like picture, and the strange thing that occurred to me was why would the husband and wife get sick together, so close in time proximity to the father who was sick and died.
- Question: Were you aware at that point in time that the mother was also in hospital?
- Answer: They told me that, actually, [Mrs. B] told me that. They were wondering if they had something too.
- Question: So what happened to them? With the results of all that information, what did you do?
- Answer: Well, first of all a flag goes up. I need to be really well protected against these people. I don't want to get infected by them. So I wore the N95 mask, gown and gloves and used all precautions to prevent infection to myself and I treated them and monitored them. They needed oxygen and I think I gave them treatment. I can't exactly remember if that was antibiotics or what-not. I got an infectious disease consult on those.

This physician also recalled that Mrs. B raised concerns with him as to whether they might have SARS.

The concerns of this physician were reflected in his consultation notes, which provided that "Mr. B should be considered a person under investigation for SARS until other causes of his pneumonia were ruled out." His consultation notes for Mrs. B stated that she should be managed in respiratory isolation due to a "possible epidemiological link to her father who died in the hospital and potentially may have had exposure to SARS."

Mr. and Mrs. B's physician referred their cases to Dr. Mederski. Dr. Mederski saw Mr. B and Mrs. B the next day, May 17, 2003. Mr. and Mrs. B's physician recalled that at that time Dr. Mederski did not think these patients had SARS, primarily because there was no epidemiological link. As he told the Commission:

My understanding was that there is no epidemiological link. I hope I am not misquoting her [Dr. Mederski]. There is not definite evidence of

SARS, that was the conclusion. Treat it as any ordinary case of pneumonia.

This physician said that although it was his impression that Dr. Mederski did not think these patients had SARS, it was also his understanding that the fact that both Mr. and Mrs. B's conditions improved contributed to Dr. Mederski's belief that these were not SARS cases:

Question: So you discussed the case with Dr. Merderski, and what was the result? You said that there was an issue about the epilink?

Answer: My understanding is that this is not SARS. Don't worry too much about it and she would follow up as an outpatient. She would see the people in followup.

Question: And did she say to you don't worry too much about it?

Answer: I may be paraphrasing her, meaning that they got better, they are okay and don't worry about it. I am not specifically saying that she is saying "don't worry about it that this is SARS." This is a matter of judgment here and that also happens very often when we ask for consultation. The consultation report of the opinion might not be exactly what you think they are, but they are what the experts say and when the patients get better especially, I don't think there is any suspicion or any reason to think otherwise.

Mr. and Mrs. B's physician said that he did not raise concerns with anyone other than Dr. Mederski. He said that he consulted with Dr. Mederski, whose opinion was that they did not have SARS. The patients got better, and that was where the matter was left:

Question: At this time then, is it fair to say in your mind it was a suspicion and you raised it and you consulted with the person in charge and that is where it was left basically?

Answer: Yes, that is how consultation works. You ask for an opinion, it is provided, the patient got better.

Both Mr. and Mrs. B were treated in respiratory isolation, with precautions, on a

regular medical floor.

Mrs. A's physician, who had by the time of Mr. and Mrs. B's admission expressed concerns about the family cluster to both Dr. Mederski and Public Health, recalled being surprised to later learn that Mrs. A's daughter (Mrs. B) had been admitted to hospital but was not on the SARS unit:

So that was the Friday, and I thought, it'll be dealt with. I came in the Monday, which would have been the 19th, and you have to realize that Mrs. A was not in a SARS unit. She was in respiratory isolation, but on a regular medical floor, and in the SARS unit you have that extra level of protection. There's all the plastic sheets up, the extra vestibule where everyone changes, but this was a room with a bunch of stuff on a tray outside the door, so you have masks and everything to go in to see her. I go to the floor and then I see Mrs. A and I said, oh, they've moved her room. They hadn't moved her room, it was her daughter who had been admitted and her daughter was not admitted to the SARS unit, and I'm going, okay, a family outbreak with previous contact with this hospital and they're not in the SARS unit. I just said, okay, strange things happen.

As noted above, both Mr. and Mrs. B improved with treatment. Mrs. B was discharged home on May 22. Mr. B was discharged home on May 26, 2003. Both remained on regular medical units during their hospitalization, under respiratory isolation.

Both Mr. and Mrs. B were retrospectively diagnosed with SARS on May 29, after the outbreak at North York General Hospital was identified on May 23.

Patient A's Grandchild

On May 18, 2003, the granddaughter of Patient A (referred to as Miss B) presented at the North York General Hospital emergency department. The same emergency room physician who saw Mrs. A, Mr. B and Mrs. B also saw Miss B. This physician had now seen the matriarch of the family, the daughter, the son-in-law and the granddaughter. He had raised concerns about three family members, had admitted them all into isolation with full precautions, had ordered SARS testing and had requested admission to the SARS unit. But none of the three patients was admitted to the SARS unit and none was identified as SARS.

This physician told the Commission that when he first saw Miss B, he did not know her connection to the previous three A family members. He said that when he learned of her connection, he got goosebumps:

And then I said to her, do you have anybody who in your family was sick recently? And this girl looked at me and said, what do you mean, you don't know? I said, what? Well, my name is [Miss B] but my parents are [Mr. and Mrs. B] and my grandma is [Mrs. A], in which case, I had goosebumps.

Seeing Miss B reinforced his suspicion that this was a family cluster of SARS. As he told the Commission:

Well, at that point the clouds parted, the sun came out and lightning struck me and I said, hot damn, we've got one more.

The emergency room physician ensured that Miss B was placed in respiratory isolation and felt that she should be admitted for treatment to the SARS unit. He told the Commission that as he had done for the other three of her family members, he asked for admission to the SARS unit but that, as with her three family members, Dr. Mederski admitted her to a regular medical floor.

The internal medicine specialist who took over care of Miss B recalled that she was aware that the emergency physician had raised the question of SARS. This specialist also cared for Mr. O, another patient with a previous connection to 4 West, who was admitted to hospital on Sunday, May 18, and whose story is told below. Mr. O was also questioned as a possible SARS case. Miss B's physician recalled that precautions were taken when caring for both Miss B and Mr. O and that both were treated as possible SARS cases:

The question of SARS had been raised, and the way our system works is there's an internist on overnight who gets the referrals from the emergency physician, admits the patient to one of us, we essentially reassess the patient the next morning and make our own determination. So yes, there was, certainly at least a question of SARS for both of these patients [Miss B and Mr. O] and so they were presented to me as possible SARS patients and I treated them as such.

Both Miss B and Mr. O were referred to Dr. Mederski. Dr. Mederski saw Miss B on Monday, May 19. Her consultation notes report that although many of Miss B's

immediate family members were now hospitalized for pneumonia, other family members remained well. Dr. Mederski's notes show that her opinion at that time was that this was another case of community acquired pneumonia.

Miss B's condition improved with treatment and she was discharged from hospital on May 23. During her hospitalization she was treated on a regular medical unit, in respiratory isolation, with precautions. Miss B was retrospectively diagnosed with SARS after the outbreak at North York General Hospital was identified on May 23.

Mr. and Mrs. O

Around the same time that Miss B, the granddaughter of Patient A, was admitted to North York General, another patient who had ties to the 4th floor at North York General Hospital was seen in the emergency department, along with his wife.

Mr. O was admitted to North York General Hospital on May 7, 2003. He was an inpatient on 4 West until May 11, when he was discharged home. He came back to North York General Hospital via the emergency department and was readmitted to hospital on Sunday, May 18, for pneumonia. The internal medicine specialist who cared for Mr. O recalled referring his case to Dr. Mederski. It was this specialist's recollection that Dr. Mederski was not convinced that he had SARS. The internal medicine specialist recalled that she wrote a note on the file identifying Mr. O's connection to 4 West, the unit where Miss B's grandfather had died. As noted above, the internal medicine specialist was caring for both Miss B and Mr. O on May 19.

Dr. Mederski recalled being asked to consult on his case and recalled that she saw Mr. O on May 19. She recalled that at that time he was a young man who was very ill:

I don't know who asked me to see him [Mr. O], but I was asked to see him in consultation, I don't remember when I was asked to see him, but it was around the time of the Victoria Day long weekend,⁷³¹ because it was based on his findings that I then spoke with the Public Health people about it Friday, and that is that I saw this man looking extremely sick. What was bizarre, he was a young male who had been in the hospital on 4 West, with an appendectomy, but had gone home and came back with symptoms of pneumonia. I was asked to see him as a routine pneumonia,

731. The Victoria Day long weekend was Saturday, May 17 to Monday, May 19.

not as anything else. At that time he was on the 5th floor when I saw him.

Dr. Mederski said that she contacted his wife and learned that she too was ill:

And when I interviewed him, I phoned his wife, because I found it to be very strange that a young man would be so sick. And I got very interesting news, that she thought he got sick from her while she was visiting him in the hospital while he was in for his first surgery on 4 West, because she was sick after visiting him on 4 West, while he was there resting from his appendectomy. So she thought that his current pneumonia was acquired from her. She wasn't bad enough to be admitted. She was at home I was phoning her while he was admitted ... And then she came back and was admitted too, on the same day.

Dr. Mederski told the Commission that after Miss B was admitted on Sunday, May 18, she (Dr. Mederski) was starting to get a little bit anxious about SARS. She said that seeing Mr. O on Monday, May 19, was a turning point:

And then by this time [Miss B's admission], I am getting a little bit anxious, but the real turning point came with Mr. O ... He came in on the 19th. He had been admitted on the 19th but he came to the emerg on the 18th, but I didn't get to know him until he was actually admitted to the floor on the 19th. It was then that I got worried, but I didn't at the time connect him with the [Patient A family]. Looking at his wife who is very mildly ill, very, very mildly ill and making the decision that even though she is mildly ill, she is going to be admitted, again to the regular floor. So as the days go on, I am starting to get more antsy.

Mrs. O was admitted to North York General Hospital on May 20, 2003.

Both Mr. and Mrs. O were admitted to regular medical units, in respiratory isolation. Both Mr. and Mrs. O were retrospectively classified as SARS on May 29, after the outbreak was discovered on May 23, 2003.

Why Not SARS?

It is clear that more than one front-line physician at North York General raised the question of SARS with respect to these patients. Among the physicians who raised

concerns was the emergency room physician who saw four of the five family members and who had strong opinions based on first-hand clinical impressions. Furthermore, this emergency room physician was an infectious disease specialist and a medical microbiologist, although he was not working in that capacity during SARS at North York General Hospital. So why were these patients not identified as SARS?

Part of the problem was the mistaken belief that SARS was over. Victory had been declared. It was time to move on. As one member of the infection control team at North York General said when asked why Patient A's family wasn't considered to have SARS:

Question: During May, there was a family cluster that came through the emergency department, the [Patient A family]. When did you become aware of them?

Answer: We automatically report anyone that comes through, but when they came in, I never thought they were SARS. They were milder cases, my understanding is that the one family member just had a sore throat and that's it.

Question: Were you aware that [Patient A] was in fact an inpatient on 4 West?

Answer: Yes.

Question: And so now his daughter comes in, is admitted. His son-in-law comes in, is admitted. His wife is admitted, and also his granddaughter.

Answer: And I honestly didn't think they were SARS. I mean, the whole message out there was that it was over. I wish I had thought the other way, but I didn't.

The belief that SARS was over was not limited to North York General Hospital. After the travel advisory, the focus was on recovery.

The desire to see the end of SARS was natural. People were tired, it was a frightening experience, and everyone wanted to see the end of the spread of SARS. But at North York General Hospital, notwithstanding the belief of some that SARS was over,

nurses and a number of highly skilled physicians who had experience seeing and treating SARS cases did express concerns about the possibility of SARS.

Each patient was referred for a consult with Dr. Mederski. Yet none of them was identified as SARS and none was admitted to the SARS unit. Those involved with these cases wondered what was going on and were disturbed at what was happening with these patients. As one emergency room physician said:

But I'll tell you, SARS II never existed, SARS I just kept going. And when you see this happening and you turn a blind eye to this, either because you have other motives, you want make the hospital look like it's recovering and let's get back to business and so on, or because your level of suspicion, or what we call your index of suspicion in medicine, is not high enough, then it's very disturbing. It's very disturbing that this kind of thing can happen with so many people around seeing it, people discussing it, raising concerns, and yet the power being given to that one person who can make these decisions.

While all these patients were admitted into respiratory isolation with droplet and contact precautions, they were admitted to regular medical units throughout the hospital instead of being admitted to the SARS unit. One physician noted that he and his colleagues worried that this increased the risk of spread of the disease:

When we were seeing the patients with suspected SARS in the emergency room and funnelling all these patients through [Dr.] Mederski, even if she was not the most responsible physician,⁷³² she [Dr. Mederski] was deciding where they were going to be admitted. And we were concerned at that time that we were finding that they weren't being clustered on one floor, such as 8 West, but they were being spread in isolation rooms all around the hospital, thereby augmenting the potential for spread of the disease, because more nurses, more physicians would be coming in contact with them.

Another emergency room physician agreed that it was worrying that these patients were not admitted to the SARS unit, where there was a high degree of caution because the risk to staff was well known:

The other thing was, when you call a unit "SARS unit," everybody goes

732. A medical term to denote the physician primarily responsible for a patient.

in as if they're walking on some other planet, so the height of their protection is maximized, as is their care taken. So on a regular ward, it was almost like, if the patient is on that ward, then this patient can't have SARS, so the guard would not be the same and that is human nature.

Dr. Mederski told the Commission that she contacted Public Health on Friday, May 16, to inquire whether there was anything happening in the city that she should be aware of. She said that she spoke to Dr. Tamara Wallington⁷³³ but that she did not recall how much she said about the Patient A family at that time:

[I asked Dr.] Tamara Wallington, in the role that was [Dr.] Bonnie Henry's, if there is anything else going on in the community. We had been told SARS was finishing, is there something that is happening that I need to know about. Is there anything that I should have on my radar? Are there any people that are being sent to emerg that Public Health has put their eyes on? And that is all I can remember at the moment. This was about [Mrs. A]. Yes, I was calling about the [Patient A] family, but I can't be sure how much in the way of the [Patient A] I spoke to her about, because I didn't have anything at the time about how much she [Mrs. A] was in emerg that day.

Dr. Mederski told the Commission that even after the daughter, Mrs. B, was admitted to hospital on Friday, May 16, she (Dr. Mederski) remained unsure whether she had SARS. She said that her instructions at that time were to dismantle the SARS unit, and so she admitted the patients to regular medical floors, ensuring that they remained in isolation and that staff used full precautions:

In the earlier part of the week when I had first seen [Mrs. A], I was ambivalent about my own instincts. From the time her daughter [Mrs. B], as the third party, presented, I was starting to get enough worried that I ordered the tests and insisted that she come in. So I was fighting with myself, to be honest that is the only way I can put it, I was fighting with myself to say this is interesting, this is very interesting, because it's now a cluster. Now on the other hand, these are very mild illnesses. And the rest of the family aren't sick and from what we know, from the Sunnybrook episode and the other high spreaders in Hong Kong, usually everybody gets sick or it's just a sort of one-on-one transmission pattern.

733. The recollections of Toronto Public Health physicians involved with these cases is reported below.

I was trying to sort of scientifically rationalize. This is me to myself. And that is why, because I had this tremendous difficulty when I was being called by the emerg department, where to put these people, in terms of SARS unit or not.

Dr. Mederski said that unlike earlier cases, such as the psychiatric patients, which she was confident were SARS, with the A family cluster she was uncertain about these cases over the weekend. She said that they were not following the usual path of a SARS illness and that there were no connections to other possible SARS cases:

Question: Now I just put this as a reaction for your comment. The Barbara Mederski you are describing over the weekend doesn't sound like the same Barbara Mederski a few weeks before, when you were dealing with the psych patients. You seemed more hesitant, maybe a bit tentative, a bit on the one hand, on the other hand, whereas before you seemed very definite in your conclusion, maybe because of different presentation, different symptomology that they had, but is that accurate and were there other factors that played there other than just the symptoms?

Dr. Mederski: Yes, the fact that cases that I thought were definitely SARS, I'm now being told to me and agreed by others that they are not SARS and I have even less to go on that these cases are SARS. I have even fewer connections. I have even fewer progressive symptoms that would suggest these are SARS cases. They are not coming along the trajectory of getting worse, worse, worse quickly. So clinically they are not behaving like the typical SARS. I would later learn that, I later thought we had different presentations of SARS, the range was huge. Now that was the other thing: I had actually been on television to discuss my theory about SARS having a variant of presentations and I was told by others that I was crazy, that others heard me on this television show, it was an interview by [name of interviewer] where I had said that we can't be complacent in thinking that SARS is only this rapidly galloping, quickly progressing respiratory infection. We have to actually think of it perhaps as a larger cloud of subclini-

cally infected patients, meaning they don't demonstrate symptoms, that these may be the people who transmit and I was summarily taken to task on that.

Dr. Mederski said that because of the way the Patient A family cluster was presenting, she thought she could safely manage them on a regular medical floor:

So these patients, this cluster, was actually very similar to what I was alluding to. There is no, there's this, you know, you are sitting shiva, there are hundreds of people coming to your home, this is going over 48 hours, people are getting infected very quietly, very subtly, and that was what I was trying to say. And that was all in that mind. I don't think the public needs to be worried, because these people have a good outcome, they are not going to die, they are going to be like any other respiratory illness. And that's why, as well, in my thoughts, I was not as concerned about moving these individuals into the SARS unit and I thought that I could still deal with them appropriately in isolation, protecting them, treating them on the regular floors, because I thought that was what some of SARS was, that it was going to behave like other regular respiratory infections.

Dr. Mederski said that she was not admitting patients to the SARS unit. Although she could not remember specific details of conversations, she did recall that Mr. and Mrs. B's physician asked about admitting them to the SARS unit and she said that it was possible that someone else did as well:

Question: Now, could it be, you have mentioned [Mr. and Mrs. B's physician], could it have been [emergency room physician who saw all four family members] who spoke to you about Mrs. A, and Mr. B, from emerg?

Dr. Mederski: It could be. I am trying to think of some experience that I had with him saying something like, if it was me I would do such and such, but I don't remember when or where. So if you said that we have evidence that he was there on that weekend and spoke to you, I wouldn't be surprised, that could be. I doubt it was more than [the doctor caring for Mr. and Mrs. B] for sure.

Question: And if he, in speaking to you, wanted them put into the

SARS unit, or recommended that, would that be consistent with your recollection about the SARS unit and why you were not using the SARS unit?

Dr. Mederski: It could have been because [Mr. and Mrs. B's physician] for sure asked me. And it may have been him and it may have been somebody else who asked me to move somebody or just asked me, where are we going to put these patients, SARS unit or not? And if I was going to be consistent, I was going to have to be consistent, and so the conversation would have been something like, oh, I have spoken to the Public Health, they feel that SARS is not an issue, that these are respiratory cases in the community, yes I know, blah-blah-blah, but I don't think we need to, I can't, or actually I've got a mandate to downsize, I don't have the nursing staff, so I'm going to have to put them on the floor. And they may not have been happy with that.

Dr. Mederski said that she felt that because her mandate was to take the SARS unit down, as long as she could isolate the patients in a private room she could watch them and move them if it became necessary. She said that she normally admitted patients directly to the SARS unit and that the fact that she didn't with these cases was reflective of her ambivalence about these cases as the weekend progressed. Dr. Mederski did not recall anyone challenging what she was doing:

Question: They wanted them in the SARS unit?

Dr. Mederski: Well, they didn't say so. Nobody protested when I put them on the floor. Nobody said, oh, they should have been put in the SARS unit.

Question: Not to you?

Dr. Mederski: Not to me, which would have been the case before. In other words, they would make their case very quickly, like, what are you doing, this is insane. Nobody did that. [Mr. and Mrs. B's physician] did ask me if I would put [Mr. B] in the SARS unit and [Mrs. B]. And I said, you know what, I don't think so because I have been given a mandate that I have to try to take the SARS unit down

and not the other way, and there is no staffing and as long as I get them into a private room and isolate them, I can watch them and if there is a problem then I'll move them.

Dr. Mederski said that her instincts about these cases [the A family] were less intense than they were for other SARS cases, until she saw Mr. O come back to hospital on Sunday, May 18, having been discharged home after being an inpatient at North York General Hospital. She said that after she saw him on Monday, May 19, she contacted Toronto Public Health and asked to speak to the physician on call. She said that Dr. Elizabeth Rea contacted her and they discussed the cluster of respiratory illnesses. Dr. Mederski said that she and Dr. Rea discussed the absence of an epilink and that fact that these patients could have other, non-SARS explanations for their illnesses:

... [Dr. Rea] listened to what I had to say, and was listening to everything and then she asked me if there was an epilink. And I told her that there wasn't, but that intriguingly there were these two cases that just happened to be in 4 West. So she said, well you know it is community acquired pneumonia season, it could be atypical pneumonia, these were all younger people and they weren't sick particularly, and it could be like a microplasma, much as we had said with [Patient No. 2] and others.

Dr. Mederski told the Commission that she also mentioned Mr. O during this conversation. It was her understanding based on the conversation that because there was no epilink, these cases were not SARS. Dr. Mederski also recalled mentioning that Mr. O and Mrs. A had connections to 4 West, although at the time she was unaware that there were unidentified cases of SARS on 4 West and did not know the significance of their link to 4 West. It is important to note that Toronto Public Health at this time was also unaware that there were unidentified SARS cases on 4 West.

Dr. Mederski's consultation notes for Mrs. B for May 19 report that she spoke to Dr. Rea of Toronto Public Health, that Dr. Rea concurred with Dr. Mederski that Mrs. B did not have SARS and that she told Dr. Mederski there were "numerous such cases here and there in the city." The notes of that conversation, recorded in Mrs. B and Miss B's Public Health charts but dated May 20, outline Mrs. B and Miss B's current clinical status and conclude with the following notation:

Imp: not SARS
Plan: continue to follow while in hospital. Contacts do not need to be hospitalized.

Dr. Mederski said that she again spoke to public health officials on Tuesday, May 20,⁷³⁴ shortly before her meeting with the emergency room staff. She said that at that time she was trying to find out if they were following the Patient A family. She described her view of that call:

And then on the final call, which I made, which was on the 20th, which was to [name of Toronto Public Health physician⁷³⁵] and [Dr.] Tamara Wallington.⁷³⁶ It was on a Tuesday, the 20th, where I repeated more about the same cases and the fact that I was having a meeting that evening with the nurses from emerg at their request, with [Dr.] Glen Berall. On that day, on the 20th, when I spoke to Tamara [Dr. Wallington] and to [name of Toronto Public Health physician], I was asking them specifically questions about the Patient A family, as well as the questions that I was going to be speaking to the nurses about from emerg.

However, I was trying to find out during that long weekend if there was a Public Health file on the Patient A family, because the statements made by Mrs. B, daughter of Mrs. A, suggested to me that Public Health might be trailing them in some fashion or had them on their radar. I couldn't find out. She wasn't clear and I wasn't clear and no one else was clear and it was a weekend. The reason I had it is that one of the nurses in emerg thought that she heard from somebody when they came in through emerg saying Public Health had told these people to come in.

734. As noted below, Dr. Wallington recalled speaking to Dr. Mederski on one occasion before May 23, and that was May 15 or 16. According to Dr. Wallington this conversation involved her and Dr. Rea. This is also consistent with Dr. Rea's recollection. While there is clearly confusion about the specific dates of the conversations, there is agreement that Dr. Mederski spoke to Public Health doctors on three separate dates in the week leading up to the second outbreak. The recollections of the Public Health physicians in respect of these conversations are reported below.

735. Although Dr. Mederski recalled speaking to a particular Toronto Public Health physician, the recollection of that physician, as well as her employment records, show that she did not participate in a conversation with Dr. Mederski on May 20. This second physician told the Commission that she did not speak to Dr. Mederski before May 23 about the Patient A case or any other case. As noted below, Dr. Elizabeth Rea recalled speaking to Dr. Mederski on May 18 and May 20.

736. As noted below, Dr. Wallington's recollection is that she spoke to Dr. Mederski once on or about May 15 or 16 and that she did not speak to her on May 19 or 20.

Well, we always took that very seriously. If Public Health said you come in, you have to make sure you talk to those people especially carefully. So that was a sort of a rumour behind these people being admitted.

Dr. Mederski said that she also called Public Health on May 20, to ensure she was going to give the right information to emergency room staff, with whom she was meeting later that day. She said:

Question: And then on the 20, when you talked to [Dr.] Tamara Wallington and [name of TPH physician], what was the added feature that caused you to call on the 20th?

Dr. Mederski: I called for two reasons, one is I was still seeking a more comfort zone in that, given that I am now watching these patients for 72 hours, I wanted to verify with somebody whether indeed any of them had been on the radar screen with Public Health and told to come in. I am talking about Mrs. B, I was still trying to get to the bottom of that because I kept hearing this rumour that she had been actually sent in by Public Health. And she herself was vague about it, the patient. And I was trying to understand who knew and it turned out [name of Toronto Public Health physician] knew something. But I still never understood what it was [name of Toronto Public Health physician] knew, whether she had just heard or she was part of that file of the patients that they get every day by fax. So they both reassured me that SARS was over.

The other reason for my calling was to find out to what level we could downgrade with our PPE, with our protective equipment, because other hospitals that I had phoned by the way over the weekend, the week before and that day, I was calling Sunnybrook, I was calling Toronto General, I was calling Mount Sinai, I was speaking to different people, what are you doing, what are you doing, what are you doing, despite the directive coming down from the Ministry, what are you actually doing in terms of who was not wearing PPE, what are you doing in emerg, what are you doing on the floors?

And I was told that everybody was downgrading. The only hospital that wasn't was Scarborough Centenary with [Dr.] Ian Kitai, who said, we're not so quick.

And so I was doing this because I was preparing for this meeting with the nurses, but I was also asking about these cases that came in and I was basically told, I said, am I being hysterical that I am so worried? And there's a silence that I interpreted as, yes, I guess I am. I am meeting with these nurses, I want to hear from you, what do I say, what do I say. They are worried, and what do I say. I know what is written out there but what do I really say. And they both reassured me that SARS was over, that the directives were there, and that basically there was no need to be concerned and that was it for me.

When asked if she expressed an opinion to either Dr. Rea or Dr. Wallington, on either the 19th or 20th, that these patients might be SARS, Dr. Mederski said:

Question: Did you express any opinion to them on the 20th or when you spoke to Dr. Rea on the 19th, did you express any opinion to them about your own feelings, your own thinking about what these cases were?

Dr. Mederski: Well, I was concerned enough to personally call them and nobody had asked me, the hospital administration had not asked me, nobody else had asked me. My concern was manifested by definition in the fact that I phoned these two individuals to ask about, an open-ended question effectively to say I have these cases, should I be concerned? The staff are concerned, these are mild cases, except for [Mr. O], they look like some of the SARS cases we've had. But I didn't say, oh, I have five SARS cases. I was more, it was a rhetorical type of open-ended mulling about, and the fact that I was uneasy about it because I was reflecting the uneasiness of the staff. I did say that I had actually not admitted them to the SARS unit, because there had been no ability to get the staff in for these patients, because we were trying to close.

And that was one of the other things that I asked, should I be admitting these patients to the SARS unit or can I actually keep them out in isolation and I was given the nod for that. So that was more or less the discussion that we had overall. With [Dr.] Elizabeth Rea, I was more concerned about it being SARS just in the sense that I was worried that these cases were clustering, but she basically had felt that there wasn't an epilink and there wasn't to be much concern.

I have to just say that, of the different people I spoke to, [Dr.] Elizabeth Rea held, with me, the highest credibility of the lot. Prior to that Bonnie [Dr. Henry] knew who I was, I knew her, I knew her thinking. When Tamara [Dr. Wallington] was introduced to me on Friday, I understood her background to be fairly junior, so I didn't really think that she had as much ability to make an opinion. Elizabeth [Dr. Rea], on the other hand, was a seemingly a scientist, had researched this, was on the continuous teleconferencing with us, and heard my opinions. I felt that I could run things by her with a greater depth and that she would be a better person to really get some input from when she was actually there on the phone. With her, I voiced more concerns.

This was on the 19th, with [Dr.] Elizabeth Rea I actually specifically alluded to these clusters and I specifically alluded to the fact that we had concerns because we had a similar story with the psych patients that I had been told these weren't SARS cases but I still think they are SARS cases, and you remember me, I said to her, saying this to her on the phone, and she said, yes, I remember you saying that. So, with her I was more pointed about that.

With these other two [Dr. Wallington and another TPH physician] it was more, I am now going to be facing the staff, I am nervous about doing that, what do you think? I have already phoned my colleague equivalent for nursing staff at other hospitals, to see what they are doing and to try to have my preparation for this meeting, but what else

should I do to be comfortable about what I am saying?

Dr. Mederski said that the discussion with Toronto Public Health focused primarily on relaxation of precautions and that she didn't discuss the cases in detail. She said that she could not find out whether Public Health viewed these patients as "something special":

When I spoke on the 20th, it was more like, okay, this is my third phone call now, I know I am being apologetic before I even open my mouth, but I have to ask you again, do we or do we not have a reason to be concerned? The vibes I am getting from everywhere from the City are, we don't. The staff are worried in this hospital. I didn't go back and discuss these cases in the detail that I had with Dr. Elizabeth Rea. It was more in line of what are they supposed to do in the way of downgrading the equipment, how far should they go? Is it reasonable for us to do what they are doing at the other hospitals, because we are doing it slower? And I had this whole discussion with [a Toronto Public Health physician] about [Mrs. B], was there something special about the [Patient A family] because I am getting the feeling that there is something special about the [Patient A family], both in terms of how they are now presenting and also because I am getting these messages that they had been picked up by Public Health for review, but I didn't get any corroboration from Public Health.

Dr. Mederski said that the main point of the conversation was to ensure that the staff were safe and that they were safe in downgrading as they had. Dr. Mederski said that when she went to the meeting, despite her personal beliefs, she understood that Public Health was not concerned that these patients were SARS, that SARS was over, and that the staff were safe. This was a message she repeated to the front-line staff, at a meeting held with the emergency department. Dr. Mederski said:

Question: Did you report back, I don't mean in a formal sense, but did you tell people, okay, I have spoken to Public Health and they are not concerned, they really think SARS is over, we manage them in this way, but it's not SARS? And who would you have told that to?

Dr. Mederski: Well that weekend I spent a lot of time in emerg, the Saturday and Sunday in particular, and up to Monday. And I remember [physician treating Mrs. B] that I said he was concerned, and I said to him, I have actually

spoken to Public Health about [Mrs. B] and they are not worried. This was from the discussions that I had had with [Dr.] Tamara Wallington on the Friday, the 16th.

Question: Of course the [Patient A family] were not all in [name of hospital] by then.

Dr. Mederski: No, they weren't all in but I was already aware of [Mrs. B] because her mother had said to me that, my daughter is coming down with an illness, so it was just mentioned, that was it. I didn't think it was anything at the time, but I had just been speaking to Tamara [Dr. Wallington] and I had mentioned [Mrs. A] because [her treating physician] had been concerned. I guess the thing is that if people were very strongly opinionated and had a concern, I would share that with Public Health. Whether I felt equally concerned was another story. But if I could, if I had opportunity to speak to these people, I would.

So, at this stage now, I am more voicing other people's concerns rather than my own, in the first part of that weekend. And when they were phoning me over that weekend, the nurses from emerg, and [Mr. and Mrs. B's doctor] I said, you know, I have spoken to Public Health and we have discussed this during our SARS Task Force and we have the directions from the POC [the Provincial Operations Centre], that SARS is over, that for sure it is over, even [Dr.] Bonnie Henry has gone off to the Orient to teach and so on, to get experience.

Question: And [Dr.] Jim [James] Young?

Dr. Mederski: And [Dr.] Jim Young, and they feel strongly that they don't even have to worry about this anymore and we are supposed to be downgrading our hospitals and that we are one of the last holdovers. That was my message to the staff.

More will be said below about the May 20 meeting with emergency department staff and with communication with front-line staff.

Dr. Mederski said that by this point, May 20, although she continued to consult with Toronto Public Health, she had her own opinion about these patients:

Question: But as the clinician responsible, were you looking for their input as just a piece of further information to help you in coming to a diagnosis, or in deciding what course of treatment?

Dr. Mederski: No. My opinion, clinically, no, definitely not. I already had my opinion by then. If anybody, I would have looked to [Dr.] Elizabeth Rea. By then I had already realized that I wasn't going to get any, so I made my own mind up and proceeded to do what I did with these patients.

Question: Did you make your mind up that these were probably SARS patients?

Dr. Mederski: I think by then I was.

Question: You said, by?

Dr. Mederski: By the Monday [the 19th]. By the Tuesday [the 20th]. By the Tuesday, by the Monday night.

Question: At the meeting or after the meeting?

Dr. Mederski: No, before the meeting ...

Whatever Dr. Mederski's level of suspicion or her belief about the status of these patients as of May 20, she did not express concerns to front-line staff at the May 20 meeting:

But then I couldn't backpedal. And I couldn't move them to the SARS unit if they weren't there, because then I would be looking as talking from two sides of my mouth. I had just finished telling [Mr. and Mrs. B's doctor] and the staff in emerg that I am not sure these are SARS, I don't

think so, I have every reason to believe they are not, based on the criteria we have, and suddenly turn around days later and move them out. That was the way I felt about myself.

Dr. Mederski said that in the absence of an epilink she understood that these patients could not have SARS. She said that once again she felt that she had to maintain what she perceived was the position of Public Health. She said that she was not trying to hide anything and that she did not feel she could voice her own opinion, in the face of what she believed was a consensus among outside experts and in the face of what she perceived as previous rebukes for attempting to clinically diagnose SARS without an epilink.

As noted below, Public Health officials say that they did not rule out SARS for the Patient A family and that the family was a source of great concern that they were investigating. The Public Health physicians did not recall Dr. Mederski reporting to them that it was her clinical opinion that these patients had SARS, and there is nothing in the Public Health charts of any of the family members to suggest that she did provide this opinion.

The Role of Toronto Public Health

Prior to May 12, 2003, Toronto Public Health had never heard of the A family and had no knowledge of Patient A and his death while in hospital or of his wife's illness and admission to hospital. Toronto Public Health learned of the Patient A family cluster on May 12, 2003, when Mrs. B (the daughter of Patient A) phoned Toronto Public Health looking for guidance with respect to entering another health care facility.

When Mrs. B spoke to the Toronto Public Health investigator, she reported that she had a fever and a cough but that a chest x-ray had been normal and that as of that day, May 12, she was starting to feel better. During her call she also mentioned that her mother was ill and had been admitted to North York General, that her father had died while an inpatient in North York General Hospital and that her husband (Mr. B) was also unwell and had also been to see a doctor. Mrs. B told the public health investigator that her mother (Mrs. A) had regularly visited her father while he was hospitalized at North York General but that she always wore a mask. Mrs. B said that she and her husband (Mr. B) had not visited her father while in hospital at North York General.

Dr. Wallington, a Toronto Public Health physician, said that although they worked hard to follow up and obtain information about the family, the description by Mrs. B of symptoms and of her husband's condition did not immediately raise the SARS alarm:

I think the reason that this came to our attention initially was because [Mrs. B] was looking for some direction around should she go to [another hospital] or not. Because otherwise, [Mrs. B] had been diagnosed with strep throat. She had a fever and a sore throat and her husband [Mr. B] had a fever and some back pain, and his sugar was out of control. So, although we say that the way in which SARS presented was very vague and mimicked other diseases, the symptoms that [Mr. and Mrs. B] complained of didn't even mimic the vague symptoms of SARS. A fever and a sore throat was generally not how SARS presented. And [Mrs. B] had been treated with antibiotics for strep throat and was feeling better. So I don't believe that the investigator was alarmed about [Mrs. B's] clinical complaint, it was more, I'd better take this to a physician and make sure we give her the right information on whether or not she could go [to another hospital].

Dr. Wallington explained that because of the information provided by Mrs. B and the uniqueness of the scenario, the information was discussed among the physician group at Toronto Public Health, where it was decided that the case needed to be further investigated, in particular to try to understand what was happening with Mrs. A and Mr. B.

On May 13, Dr. Lisa Berger, a Toronto Public Health physician, phoned Mr. B's family physician to try to determine what was happening. She explained that at this time, Public Health was still investigating anything that came to their attention:

At this point we are still working full out and investigating everything that comes to our attention. If our investigator gets a call from the hotline or a report in any fashion, we are still investigating, the same way we investigated right from the beginning. So, typically, if I don't have enough information, if the information was through a spouse and it was unclear what was going on, if I needed to make a determination as to what is going on, I would go to whatever source of information I needed. Sometimes that involved calling physicians, sometimes that involved calling the coroner, it would depend. So this was a story about someone from a spouse, I decided I would call the physician and understand what

was going on and really what the husband had. So I called the family physician the next day, to speak to him as to why he had seen the husband and what he had found.

Dr. Berger said that the family physician described Mr. B's symptoms, including a previous fever, chills and muscle pain. He told Public Health that the chest x-ray did show pneumonia and so he was prescribed antibiotics. Toronto Public Health followed up with Mr. B the following day, at which time Mr. B reported that he had no shortness of breath and that he was feeling better.

On May 15, Mrs. B contacted Public Health to report that her husband was unwell. Toronto Public Health suggested to Mr. B that he return to his family doctor or visit an emergency department. Although he went to the emergency department, he was not admitted to hospital on that date. Dr. Wallington told the Commission that Toronto Public Health continued to be concerned about this family but that at that time the clinical picture still wasn't looking like SARS:

Because this was a family cluster, we made a decision to keep following. Again, this wasn't really a picture that even vaguely looked like SARS. And in fact, [Mr. and Mrs. B] had not even been to North York [General Hospital].

Also at this time, Dr. Wallington contacted the physician of Mrs. B's mother (Mrs. A) to try to determine what was happening with Mrs. A's illness. Dr. Wallington told the Commission that on or about May 15, she spoke to the physician who was caring for Mrs. A and that after speaking to the physician, she was reassured that Mrs. A's case was being managed with precautions:

We talked. SARS came up, in terms of, are you worried about this pneumonia, do you think it could be anything other than just a community acquired pneumonia or an atypical pneumonia? And again, the answer was, no, there are a lot of good reasons for her to have this pneumonia. She is frail, she is sick, she has suffered a major loss. But she is nonetheless being treated in precautions. So she was being treated appropriately. The other thing that I did verify with [the physician] was whether or not it was her understanding that [Mrs. A] wore a mask, an N95, every day that she walked into the hospital. And [the physician] said she did ask that of [Mrs. A] and [Mrs. A] did verify that yes, she wore a mask every day. So again, this was a family and a case that was on our radar, but there was a lot of reassurance that she was being treated appropriately, she had

a good reason for having this pneumonia, she had no epilink, and on top of that, she was very reassuring about the fact that she had worn this N95 every day she went into the hospital.

As noted above, although Mrs. A's physician did not initially worry that it was SARS, shortly after this conversation she became concerned to hear that other family members were ill, which caused her to be concerned about the possibility of SARS. She reported that information to a Toronto Public Health nurse who was on site in North York General Hospital, providing detailed notes of the information she was able to obtain about the family cluster.

Although Public Health officials were monitoring these cases, they still did not initially think they were SARS. For example, despite Mr. B's illness, Public Health determined that it was unnecessary to place him under quarantine prior to his admission to hospital. This meant that even though Mr. B was ill, he was not required to remain in his home. This fact alone suggests that Public Health officials did not consider these cases to be SARS at this stage.

It is important to recall that Public Health officials were unaware of the cluster of respiratory illness on 4 West or of illness among staff on 4 West. They had no idea that there were unidentified cases of SARS in North York General Hospital. To their knowledge there was no link between any of the Patient A family members and other SARS cases or contacts.

But Mr. and Mrs. B continued to be ill, and both returned to the North York General emergency department. Mr. B was admitted on Friday, May 16, 2003, while Mrs. B was admitted in the early morning hours of Saturday, May 17, 2003.

On or about May 16th, Dr. Mederski phoned Toronto Public Health and spoke with Dr. Wallington and Dr. Rea. Dr. Wallington told the Commission that she did not recall Dr. Mederski asking if there were new cases of SARS in Toronto and she did not recall speaking about the Patient A family cluster during that telephone call. Dr. Wallington described her recollection of the conversation:

I recall having a phone conversation with Dr. Mederski around mid May, so around May 15th, 16th, and I recall that Dr. Elizabeth Rea was on that phone conversation with me and my recollection of the sequence of events is that Dr. Mederski contacted us before going into a meeting, that she was going to have with North York General Hospital staff. So she was in her car, on her way to the hospital, to attend this meeting, she

called us from her cellphone, and again I recall that Dr. Elizabeth Rea was on that call with me, we had Dr. Mederski on speaker phone, and there were a couple of issues that she wanted to discuss with us. The reason that I ended up speaking with Dr. Mederski, is primarily I believe because Dr. Bonnie Henry was away, at that point, she was in China, and up until that time Dr. Henry had been the main contact for Dr. Mederski, primarily because of her involvement with the 7 West cluster. So Dr. Mederski called us to talk about this meeting that she was going to be attending, it was going to be, from what I recall, a meeting that she would have with the staff and other senior administrators would be there to talk about the new normal directives that had been released by the province on May 13th, and that were going to take effect on May 16th. So there were apparently some questions that staff were going to have around those directives, and I was left with the impression that staff may have had some concerns with the new directives and would have questions around what it would mean for their practice, and some of the other questions and concerns that Dr. Mederski felt might come up would be around the 7 West cluster.

So the main subject of that particular conversation was primarily about the 7 West cluster. And what I had said to Dr. Mederski in the context of that conversation was pretty much a reiteration of what already happened in the adjudication process. And Dr. Henry had given me an update before she left for China on this cluster, because it was a complicated cluster and Public Health had been following it very closely. And my impression was, Dr. Henry felt that there would likely be followup phone calls because of the complexity of the cluster, my impression was this was one of the followup phone calls that we were expecting and I reiterated what had been discussed with respect to the adjudication process and this cluster. It was determined by the adjudication team that this could not be labeled as SARS, but this cluster would be treated as SARS. It would be treated in full precautions, the contacts would be quarantined and followed. So it was pretty much a reiteration of the decisions of the adjudication team.

Dr. Wallington said that she did not recall reassuring Dr. Mederski that there were no new cases of SARS in Toronto or that SARS was over and that she would not have said or insinuated that there were not people being followed or under investigation for possible SARS:

A reasonable comment to make would have been that we were investigating many individuals, that there were many persons under investigation in the city at that time. That there were individuals who we were concerned about and who we were following closely, but at that time there were no individuals that meet the case definition for a suspect or a probable case of SARS. I certainly wouldn't have insinuated that we weren't worried about people or that people were not being followed. There were in fact many persons under investigation.

Dr. Wallington did not recall Dr. Mederski expressing any concerns about the Patient A family and said that such a statement would have been important to Public Health at that time, as they were closely following the Patient A family. As noted above, she did not recall the Patient A family cluster being discussed at all during that telephone call. Dr. Wallington also told the Commission that at no time during this conversation did Dr. Mederski raise concerns with Public Health about unidentified cases of SARS in hospital.

On March 17, Toronto Public Health learned of Mr. and Mrs. B's admissions to hospital when the Public Health investigator had tried to reach them at home on May 17, and, upon being unable to do so, tried calling the emergency department at North York General Hospital to see if they were there or if they had been admitted to hospital.

After learning that Mr. and Mrs. B had been admitted to hospital, Dr. Berger spoke to the internal medicine specialist who was caring for both Mr. and Mrs. B, on May 17, 2003. She told the Commission that the physician told her that Dr. Mederski was aware of these cases and that Dr. Mederski had seen Mr. B's wife, Mrs. B, and would be seeing Mr. B. He also told Dr. Berger that Mrs. B had been diagnosed with atypical pneumonia. Toronto Public Health officials were again assured that both patients were in respiratory isolation and were being managed with precautions, and no one raised concerns at that time to Toronto Public Health that these patients were SARS.

Dr. Rea recalled being contacted by Dr. Mederski on Sunday, May 18, about the Patient A family cluster. Dr. Rea told the Commission that on that date Dr. Mederski conveyed the opinion that she did not think the A family had SARS. As she told the Commission:

I spoke with her on Sunday, so that would be May 18th, she'd actually called about another issue, about them decommissioning the SARS unit at North York General and we had a side-conversation about the [Patient

A] family cluster, at that point. You'll remember there were conversations back and forth about that cluster, the family cluster from the 12th, earlier that day, the 18th, [Dr.] Lisa Berger had spoken with [Mr. and Mrs. B's doctor] at North York General and they'd had a conversation about it again and raising the issues around SARS. So what Dr. Mederski was saying at this point on the 18th was, despite that conversation and what [Mr. and Mrs. B's doctor] had talked about with [Dr.] Lisa Berger, that she felt pretty strongly it was not SARS, that the mother, so that would be [Mrs. A], was already getting better, that none of them were that sick even though the son-in-law, which is [Mr. B], was diabetic, because at that point we already knew that diabetes was a risk factor for SARS, that the so-called source which came with [Mrs. A] who had been visiting her husband in precautions, that he [Patient A] had an explainable course of illness, a fall with fracture and pneumonia is a complication which is a very, very well characterized scenario. So that from her end, it was not hanging together as looking like the clinical picture of SARS that we had sort of accumulated or got to know to that point in the outbreak. So that was the Sunday [May 18].

Dr. Rea told the Commission that at that time the family was classified as persons under investigation and that her view of the telephone call was that Dr. Mederski wanted to be clear about her opinion on these patients, which was that they did not have SARS:

Basically the way I remember it, because we kept from our end handling that cluster as SARS, and following up on them and conversations and other clinicians at the North York end quite, quite appropriately. People coming in with fever and maybe respiratory symptoms, raising a concern about SARS, keeping it on a differential. So I think she wanted to be clear what her take on it was.

On May 20th Dr. Elizabeth Rea again spoke to Dr. Mederski about Mr. and Mrs. B.⁷³⁷ At that time she learned that the granddaughter (Miss B) had also been admitted to hospital, into isolation, and was being managed with precautions. Dr. Rea's notes report that based on this discussion with Dr. Mederski, that the impression was "not SARS."

737. Dr. Rea advised the Commission that although she had no specific recollection of how the contact was initiated, she had no reason to dispute Dr. Mederski's recollection that she contacted Toronto Public Health on Monday, May 19, and asked to speak to the physician on call and that Dr. Rea telephoned her, in response to that request.

Dr. Rea described her recollection of that call, supported by notes she made at the time of the call:

The first part of it was Dr. Mederski saying that [the onsite Public Health nurse] was at North York General telling the [Patient A] family contacts to be in quarantine, now what on earth was she doing, because again Dr. Mederski's consistent impression was that this cluster was not SARS, so what was [the onsite Public Health nurse] doing going around telling people that they needed to be in quarantine? From our end, she wasn't actually telling them to be in quarantine, what she was doing was completing the standard 10-day history and contact lists, we weren't pursuing quarantine for contacts but we were going right up to that point so finding out who all the contacts were and the risk areas if they should turn out to be SARS, and that's what [the onsite Public Health nurse] was actually doing ...

My interpretation on that and consistent with what we've been over, the charts to back it up, is that she [the onsite Public Health nurse] wasn't telling people they had to be in quarantine, she was completing the standard documentation for PUIs, including getting the contact information. So then following that, there was another sort of update on the status of the group, the family members. And the notes that I have from that conversation, my own notebook are a first mention of [Miss B], that she and [Mrs. B] both have sore throats, that Dr. Mederski's, again, take on it was that three of the four in that cluster would never have been in hospital prior to SARS, that they just weren't ill enough to need hospital-level care. That [Mrs. B] had been at that point afebrile for 48 hours and became afebrile after only 24 hours in hospital. That the granddaughter [Miss B] had a sore throat, was on penicillin, that tests were pending for influenza RT adenovirus that would be part of the standard work-up. And corresponding with that are the part from my notebook which would have been my notes during the conversation, so following that, I would have gone to the chart and written up this note. So there's a bit more explanation there about [Miss B] had a sore throat, she was first seen at [local clinic where she lived], put on Biaxin, came back to Toronto and was admitted at North York General, so at that point Dr. Mederski hadn't seen [Miss B] herself but had heard about her chest x-ray and gotten this much of the history and then, the update on [Mrs. B] and [Mr. B]. So again, her

impression was not looking like SARS, not looking like the pattern that we had been building up of what SARS clinically looked like. And the update on the testing, that the samples had been done but all the tests are still pending at that point.

Dr. Rea said she did not recall specifically being asked her opinion about these cases and the notation “imp Not SARS” represented her net impression of the case at that point in time:

Question: Okay, so when this note is written on the chart, “imp: Not SARS,” whose impression is that?

Dr. Rea: That’s my net impression of where we are at this point in time. So it’s not a diagnosis. It’s kind of a what’s currently at the top of the differential, if you like. So that’s from my end, that’s taking into account what information is available about the clinical picture about laboratory stuff to back it up, so serology, stuff about RSC influenza, chest x-rays that support one way or the other what information is there about epidemiology, about establishing an epidemiological link to a known case of SARS. So at that point where we were with that family cluster, the working impression at that time was not SARS. But, of course, we are still following them as persons under investigation. So, there are precautions, we are still pursuing the diagnosis, we are still making sure that [the onsite Public Health nurse] has got all of the contact stuff, and the 10-day history and everything is ready to go, if that impression clicks.

Dr. Rea said that in all these conversations, Dr. Mederski was consistent in her opinion that these patients did not have SARS. Dr. Rea told the Commission that it was not clear that these patients had SARS because they did not fit the clinical picture of SARS as it was known at that time because they were minimally ill compared to other SARS patients and they had no epilink. But Dr. Rea said that at no time did she ever say to Dr. Mederski these patients were definitely not SARS or that SARS was ruled out.

Toronto Public Health officials told the Commission that they were calling to get information on these patients. They said that it was not that they were being

contacted to provide their opinion about these patients, but rather that they were having to follow up regularly to try to obtain as much information as they could about these cases.

Toronto Public Health officials said that they were concerned about this family. Although they were reassured by the fact that all of the hospitalized family members were in isolation and being managed with precautions, their illness was a source of “great angst.” As Dr. Wallington said:

This was a family that was on our radar, so the one thing that was very reassuring and that we did verify again and again was that they were being treated in precautions. So that they were being treated appropriately, from an infection control point of view. They were being treated in isolation. But again, the cluster itself, it caused us great angst as we were trying to work through what was going on. And it wasn't always easy to get the clinical information we needed to think through this cluster and what was happening. It was sometimes very difficult to get that clinical information.

Toronto Public Health said that there was enough back and forth between them and the hospital and enough efforts on their part to follow these cases, including speaking to physicians involved in their care, that it should have been clear that the members of this family cluster were of concern.

All three of the Toronto Public Health physicians involved in the Patient A family cluster told the Commission that Dr. Mederski did not report to them that she felt these patients had SARS. Based on their discussions with Dr. Mederski, they understood that it was Dr. Mederski's clinical opinion that these patients did not have SARS. The Public Health physicians who were following the Patient A family told the Commission that they did not overrule or dismiss any concerns about these patients and that they were concerned about this family and that at no time did they suggest otherwise. It was their understanding that Dr. Mederski's clinical opinion was, and remained until the full extent of the outbreak was identified on May 23, that these patients did not have SARS.

Communication Breakdown

Retrospective accounts of the contact and communication between Toronto Public Health and Dr. Mederski with respect to the sequence of events and opinions held and shared about the Patient A family cluster differ. In fairness, both parties were asked to reconstruct the events long after the outbreak was finished. The Commission does not doubt that both sides were truthful when they spoke to the Commission and that both recounted the events to the best of their abilities.

But the different perspectives of each of the respective parties underscores the importance of clarity in communication and of ensuring there are strong support systems in place to ensure effective communication.

Although Toronto Public Health told the Commission that they were constantly having to seek out information about this family, there is evidence that those within the hospital did try to make their concerns known to Public Health officials. For example, the notes prepared by the physician caring for Mrs. A, which the physician said she provided to a Public Health nurse on May 16, were in the Toronto Public Health patient files, obtained by the Commission.⁷³⁸ This document included detailed information about each family member's illness, including Miss B, the granddaughter of Mr. and Mrs. A.

The consultation notes for Mrs. B reflect that Dr. Mederski did speak to Public Health officials about her case. And notes in the Public Health charts report that Dr. Mederski did communicate to Public Health officials concerns of front-line staff about relaxing precautions and that there were concerns among front-line staff about the opinions she was giving. Notes taken by Dr. Barbara Yaffe, Director of Communicable Disease Control and Associate Medical Officer of Health, Toronto Public Health, discussing the North York General situation some time before May 22, included an update of the status of Patient A family members, as well as the following notation:

ER nervous re POC directives – not our bus. We'll – keep PHN in hosp.

...

Ask Bonnie to call Barb Mederski next week

738. All Toronto Public Health records and files were obtained under the power of summons, issued under the *Public Inquiries Act*.

...

issue – even when Mederski says it is not SARS, rest of hosp. still think it's SARS.

Dr. Yaffe was asked to explain what these notes meant:

Question: In the notes, it appears that on that day, in addition to everything else that was going on, there was a discussion again about the [Patient A family] and case updates.

Dr. Yaffe: Yes.

Question: Was that part of what was happening in connection with St. John's or was this sort of a separate case update?

Dr. Yaffe: A separate case update.

Question: Okay, and now by the 22nd, in the case update notes, we have gone through some of it, but halfway down the page "ER nervous re: POC directives not our business we'll keep" ...

Dr. Yaffe: PHN in hospital ...

Question: So "ER nervous re: POC directives" – do you remember what the discussion about that was?

Dr. Yaffe: No.

Question: Presumably they are talking about the emergency room at North York.

Dr. Yaffe: Yes. They must have been nervous about something going on with directives and we were saying that, I was saying that they need to talk to the Province, we are not in charge of the directives.

Question: Will keep PH ... ?

- Dr. Yaffe: Oh, will keep Public Health nurse in hospital.
- Question: In hospital, okay.
- Dr. Yaffe: Yes, we had nurses in each hospital .
- Question: Okay and then down near the bottom of the page, “ask Bonnie to call Barb Mederski next week: issue even when Mederski says it is not SARS rest of hospital still thinks it is SARS.” Do you recall where that information was coming from?
- Dr. Yaffe: I really don’t. One of the physicians must have been saying that to me, obviously.

But whatever the contact and whoever the initiator, as noted above, there is nothing in the Public Health records to suggest that Dr. Mederski clearly conveyed concerns of front-line physicians or her own opinions, at whatever point she began to think SARS. On the contrary, as noted above, the Toronto Public Health records have repeated references to the clinical opinion of Dr. Mederski that these patients did not have SARS. This is consistent with the message she gave to front-line staff and other physicians at North York General and with her consultation notes with respect to these patients. Whatever Dr. Mederski’s private beliefs about these patients, she did not share them with colleagues at North York General Hospital or with front-line staff. Moreover, given her own accounts of conversations with Toronto Public Health, it is unclear in what way and how strongly she expressed her views. More will be said about the communication between Toronto Public Health physicians and Dr. Mederski below.

There were also problems with reporting the A family cluster. Although the matriarch of the family, Mrs. A, was admitted May 9, she was not reported to Toronto Public Health officials. As subsequent family members came to hospital, Public Health officials report that they were constantly having to seek out information about the family.

As noted above, Toronto Public Health said that they were constantly having to seek out information about these patients and that their admission to hospital was not always reported in a timely manner. It was through their own investigation and on-site person they were aware of each of these patients and that they were able to monitor them from the time of admission. Each member of the Patient A family became a person under investigation for SARS from the date of his or her admission until

classification as a SARS patient after May 23, when an epilink was identified:

- Mrs. A: May 12 to May 25 PUI
 May 25 classified as probable
- Mr. B: May 18 to May 25 PUI
 May 25 classified as suspect
 May 29 classified as probable
- Mrs. B: May 18 to May 25 PUI
 May 25 classified as suspect
 May 29 classified as probable
- Miss B: May 21 to May 25 PUI
 May 25 classified as suspect
 May 29 classified as probable

Public Health officials report that based on their followup with respect to these cases it would have been clear these patients were of concern and were being followed. In addition, infection control practitioners completed SARS Report Forms for Mr. and Mrs. B and Miss B, all of which were dated May 20th.

But the fact that these patients were under investigation for SARS and that they were being monitored daily by Toronto Public Health does not appear to have been clear to North York General Hospital senior officials. As noted above, Dr. Mederski told the Commission that the status of these patients and of Public Health's involvement with these patients was unclear to her.

Based on the earlier actions of the hospital, the Commission does not doubt that had senior hospital officials and those in charge of the SARS response known that these patients were classified as persons under investigation for SARS, hospital officials would have communicated that fact to staff, via staff updates. As noted earlier, although the communication with staff was not always effective, the hospital clearly made an effort to report to staff whenever a case became a concern for public health officials. And there is no mention of these patients being under investigation for SARS in the SARS Task Force minutes, a place where their status with Public Health would have most certainly been discussed.

But the story of North York General Hospital underscores the importance of communication. Time and again throughout SARS, the importance of having an on-site

public health presence in hospitals, particularly during times of an outbreak or public health risk, and of having strong relationships between public health physicians and hospital physicians and infection control staff, is glaringly obvious. Public health was only as effective as the information it received. In turn, hospital officials often turned to public health for guidance on the management of cases and risk to staff, visitors and patients. Yet for the most part, communication between public health physicians and hospital physicians occurred over the telephone. As one infectious disease specialist noted, telephone opinions and consultations run the risk of miscommunication and misunderstandings:

It was easy to talk over the telephone and say, I don't believe it. But if you are in charge of an epidemic, where it's so important, why wouldn't they send somebody down to actually look at the patient and go over the records? I mean, I know they have a nurse there, but sometimes there's nothing like being on site to actually see what's going on. People may emphasize the wrong thing [in a telephone conversation] or somebody may take away from a conversation something that, that's why we go and see patients ... Sometimes when you see the patients, it's a completely different story. You know, there's a completely different interpretation from hearing it over the phone.

The story of North York General is rife with systemic communication problems, like the entire story of SARS. But when Public Health physicians were on site, things were much better. On May 23, the problems became clear and decisions were made in consultation with the on-site Public Health physicians. After May 23, Public Health physicians continued to work on site at North York General, providing valuable advice on the epidemiology of the outbreak and helping to identify and track cases.

During SARS, Toronto Public Health lacked the resources to regularly have physicians on site in key hospitals. As noted earlier in this report and in the Commission's first interim report, the public health capacity for on-the-ground assistance must be strengthened. No system can continue to rely so heavily on the volunteerism and goodwill of outside experts, and it is clear from SARS that the most effective support is an on-site presence.

May 20 Meeting with Emergency Room Staff

By May 20, front-line staff had seen Patient A's family and Mr. and Mrs. O come in through the emergency department at North York General Hospital. They knew that both families had connections to the hospital, back to when there were known SARS patients in the hospital. They knew that other doctors, whom they respected and trusted, thought these patients had SARS. That, combined with their own experience, led them to question why these cases were not being identified as SARS cases, why they were on regular medical units and not on the SARS unit, why precautions had been relaxed and why the message they were getting was that SARS was over.

By May 20, worry and fear in the emergency department had reached a boiling point. On that date, emergency room staff asked to speak to someone in authority about what was happening and what had taken place with the family cluster. That afternoon, an impromptu meeting was held with the staff of the emergency department and hospital officials, at North York General Hospital. Much like the meeting between senior hospital officials, including Dr. Mederski, and the psychiatry staff, the meeting with the emergency room nurses seemed focused on convincing them that they were wrong, that SARS was gone.

The Naylor Report describes the meeting:

In mid-May physicians and nurses in the emergency department assessed family members of the 96-year-old man with symptoms suggestive of SARS, and they were increasingly anxious about a continuation of the outbreak. Radiologists also expressed concerns to colleagues about sets of suspicious x-rays. Taking their cue from public health officials and citing the epidemiology uncertainty about how all these cases could be linked to each other, the hospital's infection control director and vice president of medical affairs tried to reassure emergency physicians and nurses at a tense meeting on May 20th.⁷³⁹

But nurses who attended the meeting did not describe a sense of reassurance. Rather, descriptions from some of the nurses who were at the meeting conveyed to the Commission a sense of dismissal and disregard for their opinions and legitimate concerns.

739. Naylor Report, pp. 39-40.

One nurse described the meeting as tense and said that there was anger and frustration on the part of the nurses:

There was great tension in the room, and there were some very angry, very frustrated nurses. One of the nurses, actually stood up and said to Drs. [Glen] Berall and [Barbara] Mederski, you're all lying, I don't believe any of you. Many of the nurses said that they would just like to know at least then, can we have our masks, if you say it's not SARS. And then when Mederski said, well we see these things often, you know, we do see them only we just don't look for them and now we're looking for them so we're going to see them.

And one of the nurses said, well, it's interesting because I've been a nurse for about 20 years, and maybe you've seen them, but I've never seen acute viral ailments written down as the diagnosis so many times. And if these patients aren't SARS, why are we doing the SARS work-up, the kit, and that's when they said, oh, we mean to change the name, it's going to be the CAP kit, the CAP [community acquired pneumonia] work-up, because there is no real test for SARS and it's just community acquired pneumonia and you're just going to have to get used to seeing this. And that it's just not SARS. Over, and over, and over again.

Emergency room staff told the Commission that the message conveyed at the meeting was that they should listen to the infectious disease specialist:

And one of the clerks asked and said, well, you have to understand I've worked here for a while and there's a lot of physicians I've worked with, who I respect, over the years. And they're telling me that it is SARS, so whom do I believe. And Dr. Berall says that you ask the infectious disease specialist, and the infectious disease specialist is telling you that it's not SARS, so then it's not SARS. That she is the expert, not them and not you. It wasn't even, our considerations weren't even, unfortunately, there were physicians there; however, none of the physicians spoke up.

One emergency room nurse described the message of the meeting as follows:

There is no SARS. We don't have a problem, there is no epilink, we don't see clusters. Normally there would be 20 or 30 people with SARS and I've been doing this for months, I know everything about it. At that point, they weren't even admitting the psych patients were SARS.

Another nurse described the meeting to the Commission:

I sat in at the meeting with emerg when Dr. Mederski said, they did not have SARS. It was a family and she gave reasons for the contagiousness to its spread, said it was definitely not SARS and SARS was over. The nurses were telling her this is SARS; if it smells like SARS and it looks like SARS and acts like SARS, it's SARS. She said no, it was community acquired pneumonia and they should stop it. You know, stop talking like that.

Health workers who saw these patients and knew about their cases simply did not believe what they were being told. They did not believe that SARS was over. As the above-quoted nurse told the Commission:

I happened to sit in on a meeting at the emergency department, just prior to SARS II breaking out. I wake up to CFRB every morning and there was an announcement on the radio "SARS is over in Toronto." An hour later I called my father in [name of city]. I said, you're going to hear that SARS is over in Toronto, you're also going to hear in a few days that it's not true because five people were admitted with it from one family.

One physician who attended the meeting agreed that the message was SARS was gone. He said:

So here's how the meeting went, right. We were told basically there are no new cases of SARS. Two incubation periods have passed, assuming we knew what the incubation periods were, and there was thinking about seven to 12 days, seven to 14, those were about the figures, and SARS basically was no longer present in the hospital. That's a pretty profound conclusion. Not based on known information nor a history of knowledge about the disease called SARS.

During the meeting, people were asking, some of the people, nurses in particular, were asking, in fact, nurses exclusively asked questions like, how can you be sure, this is a new disease, are you sure the definitions are appropriate? And we were given, those who gave information made the same statements again and again. The disease doesn't exist anymore, we've now had two incubation periods. This isn't just our opinion, it's the opinion of all the experts. Period. Further questions were asked, the same statement was repeated. I think if we were in the same situation in 2016,

people wouldn't dare be as blunt about it. At least not everybody. You know, we've been wrong before ...

Many nurses felt that their experience and judgment were being overlooked and belittled in favour of applying a strict case definition. As one nurse told the Commission:

She [Dr. Mederski] said that she's going by the guideline that was set out by the Ministry of Health. The definition that says it has to have a link and that they've done tons of research and all the epidemiologists in the city and all the epidemiologists over the world and all the ID [infectious disease] people, they talk, and they're all experts and written papers, and they know so much more about this disease and I mean, come on, girls, really, I mean, really, that's how you felt, like, come on, please, don't insult us.

Dr. Mederski told the Commission that she thought the thrust of the meeting would be to talk about the new normal. As noted above, Dr. Mederski told the Commission that by the evening of May 19, her private opinion was that these were probably or maybe SARS patients. But as in the meeting with the psychiatry nurses earlier in May, she did not express this opinion to staff. Instead, she, along with Dr. Berall, the co-chair of the SARS Management Committee, repeatedly told staff that the cases were not SARS and dismissed their fears. Dr. Mederski said that she did not feel that she dismissed concerns and that it was not her intention to do so. She felt confident that the patients in question posed no risk to staff, as they were all being treated in respiratory isolation. Based on her discussion with Public Health, she felt that they did not think these cases were SARS and that it was safe to continue to relax precautions. As noted above, Public Health officials say that they never said these cases were not SARS, that they were concerned about these cases; they understood that it was Dr. Mederski's opinion that these patients were not SARS and that decisions with respect to precautions fell to the Province through the Provincial Operations Centre.

Dr. Mederski described her view of the meeting to the Commission:

Question: Now as you went into it, you in your own mind had some people in mind that you thought were maybe SARS cases, was that [Patient A] and [Mr. O]?

Dr. Mederski: Yes.

Question: Anyone else?

Dr. Mederski: That's all I can say now. Oh, no, no, no. There was one other lady whose name I don't remember right at the moment at all, who was extremely sick with a respiratory problem. And she was on the main, on the regular ward, and I treated her, and we eventually did do SARS testing and it came back negative but for a while at first she sure looked like a SARS case, and so I also had this one other patient who is not on your list.

Question: But certainly you had the [Patient A family] and Mr. O?

Dr. Mederski: And [Mr. O] in particular. As I said, the thrust of the meeting was not to say yes or no, these are SARS cases, but it was to allow the hospital to proceed with the new normal and as I said, I was hoping subliminally nobody would ask me whether or not these cases were or were not, because I would have to toe my line starting Saturday morning, 6:30 in the morning, when I had the first call about these cases coming through.

Question: You would have to essentially say they weren't SARS?

Dr. Mederski: And I did speak to this indirectly at that meeting.

Question: All right, so now you attended the meeting and who was at it and what was the tone, and what's your recollection of the course of the meeting?

Dr. Mederski: It was a very difficult meeting. I came in with Glen [Dr. Berall], it was a small room in the emerg department, in the nurses' lounge area. It was packed to the rafters. It was noticeably absent of physicians, who were walking outside of the room in the hallway, not wanting to show their faces, almost as if, you are in for it, we are not ...

... It was all the nurses and some administrators and some clerks, like ward clerks, and the atmosphere was

very tense. It was very, you could tell, really, it was tense in the air. Two nurses came in, two nurses who work regularly, two senior nurses there, who basically fired off some questions during the course of the meeting and one of that of them had to do with the SARS kit, that was no longer the SARS kit, but it was this other kit, that I had designed.

Question: The Respiratory Infection ...

Dr. Mederski: Respiratory Infection Specimen Kit. I coined it and I thought I was being so brilliant when I thought this one out.

Question: Respiratory Infection Specimen Kit?

Dr. Mederski: Yes. So somebody said, are you hiding something from us. You are still collecting these specimens for SARS. And I said, yes I am, and I will continue to do so in appropriate cases and this is a perfect opportunity to carry on this way as part of our new normal forever in this hospital, that when patients come in with respiratory symptoms, we should be doing this anyway. This is something that we should be doing forever, not just now, not this year, but forever.

And you know, that bothered me, that somebody would somehow imply that I was lying because I am changing the word from the SARS kit to RISK kit, when I was actually trying to be a good Samaritan and do something the right way for the hospital to get the specimens identified the way we have always dreamed of doing. And the other had to do with all these people coming in that I had mentioned earlier, that there was this feeling among the nurses that there was a huge number of patients coming in with respiratory infections. So I did say that I had spoken to [Dr.] Tamara Wallington, that I had spoken to [a TPH physician], that I had spoken to [Dr.] Elizabeth Rea, that I had also spoken to other hospitals, that I had spoken to my professional

colleagues, some of them, and that outside of the Centenary [Hospital], everybody else had already downgraded, before we were even talking about it. And that I felt it was safe to do so.

Then they proceeded to say, we are having our equipment taken away from us, do you agree with that, our protective equipment? And I had been already primed by [the two nurse managers] that what they were going to do was make the PPE a little less strategically available. So instead of having a parked cart on every single doorstep on emerg, they were going to move these carts away, a little bit further so there was less ease of grabbing another mask or grabbing a gown, just willy-nilly getting all gowned up at any time, that it would have to be thought out. Yes, they would still have access to equipment, but it would not be at every corner. They were going to ease out this way. This was their strategy. And so I said, I know that nothing is being taken away, I know that it's available to you, and yes, I totally agree that in emerg you should have availability of all this as you need it, and triage is the most vulnerable area, but we still have to proceed forward even along the lines of what the MOH [Ministry of Health] said, the Ministry said is the new normal.

Then I gave little lecture on atypical pneumonia and microplasma pneumonia and how they present and how they have a very high contagious rate in families, this is well known, and I think that's the comment that may have turned off some people because as I later heard that I was "putting people down" and something like that. And it may have been that "was well known" concept that I alluded to. But I said frankly it is well known. Respiratory infections of this nature are highly spread amongst families, it's just that they are mild enough that people usually don't bother and people go home and they sniffle and they take care of themselves and that's the end of the story. But from time to time people get very sick and crash and it looks just like SARS. So I was sort of rationalizing out loud why the

cases that they had seen over the weekend were actually meeting the case definitions.

Dr. Mederski told the Commission that after the second outbreak was announced, she felt able to voice her true opinion about the cases and that she had a private meeting with the emergency room nurses to explain what had happened. Dr. Mederski said:

Dr. Mederski: I repeated all that. I repeated everything. And I think I also said, you don't realize what pressure I've been under. Feeling one thing, being told differently, repetitively over the last two months. There comes a point when you finally just have to say what you're told to say, or what you're expected to say. And at no time have I been upset at anybody in particular, other than the fact that I was upset when somebody mouthed off about my RISK kit, about being a hiding effort on my part, to hide something, activities going on. And the part that bothered me first thing was when they said that I was trying to hide information from them or that the information that I was hiding, just period, everything to do with SARS information, that I was hiding SARS cases. I think the thing that crossed my mind over that whole period of time was, was I hiding these cases, or was I just so ambivalent or schizophrenic that I just didn't know what to do anymore and what to say, and proceeded to do what I did, treat them and whatever, but wasn't comfortable in speaking in the same way I did when I spoke about the psych cases. I was hurt.

Question: Did you feel the second meeting went better than the first meeting?

Dr. Mederski: Yes I did. And I felt that there may have still been some people that were maybe still not convinced but nevertheless I felt much better and the one nurse that had been very angry came up to me later and said, you know, we did feel that you were not being fair with us etc., but I feel a little better now.

Question: Tell me if this is accurate, the second meeting, seeing that the 23rd had happened, the hospital had closed, you were able to share with them ...

Dr. Mederski: Yes.

Question: ... then your feelings about the pressures you were under ...

Dr. Mederski: Honestly.

Question: ... which included the pressures you've described, to sort of say what you were expected to say?

Dr. Mederski: It was definitely more easy. But when the question came, well, why didn't you tell us this earlier, because it did come up, you know, it was very hard to give an answer to that, because I said, there comes a point when you can't say something definitively because we don't have a definitive test, and you know, we've been doing this now for three months, I'm exhausted, and I have to say I did the best I could at that point. And I feel badly if somebody was offended, but it was definitely not intended to offend anybody, or belittle anybody's concerns. That was really what the whole intent was, to indicate that I wasn't belittling anybody's concerns, but that I too was offended by their offense, at my seemingly being, lying, coy, whatever the words are that come to mind.

Dr. Berall, the other hospital official at the meeting, described the meeting from his perspective:

Question: That was a May 20th meeting, I think you were at that meeting?

Dr. Berall: Yes.

Question: Dr. Mederski was there?

Dr. Berall: That's correct.

Question: That was a meeting where concerns were expressed. It's been suggested perhaps that it was pretty categorically told to those who were expressing concerns that the cases they were concerned about were not SARS. Do you recall that meeting?

Dr. Berall: Yes I do.

Question: Do you recall that sort of descriptive suggestion of how the concerns were being addressed?

Dr. Berall: I recall lots of questions about the cluster or clusters of patients that arrived in the emerg that prior weekend. And I recall Dr. Mederski answering questions about the clusters and hearing people's concerns and informing them that the clusters were reviewed with Public Health. There were considerable discussions and questions back and forth on that, and she informed them about the discussions with Public Health and that they were discussed and ensured that each of the cases they had in mind were discussed and identified, that some of them had different illnesses that were proven by diagnosis and that Public Health had deliberated, considered the cases and determined that they weren't SARS.

And she answered the questions about how they were addressed, that they were isolated, that they were still in isolation, that they were in respiratory droplet precaution. Because the emerg protocol had had the triage nurses in PPE and all respiratory droplet patients streamed into a PPE protective stream, that nobody had had any exposures. The emerg staff knew how to wear their PPE and they were following the policies. And so that those things had been done. Public Health was the one that made the call is it or isn't it. The infectious diseases specialist ensured that they were addressed in proper precautions as probably so did the opinions of the other health care professionals as a team. People all agreed that they should be in respiratory precautions.

What was debatable was the diagnosis, but Public Health said it was not SARS.

Dr. Berall told the Commission that at the time he had no reason to doubt what he understood from Dr. Mederski was the opinion of Public Health, that these people were not SARS:

If it was obvious, something different would have been done. It wasn't obvious. At least, it wasn't obvious to us, and based on the knowledge at the time, it wasn't obvious to apparently Public Health either, and they were considering more than just North York General. They had the bigger picture. But based on the knowledge at the time, they judged that it was not SARS and according to the directives, it didn't fit the diagnosis of SARS. What do you tell those people? I don't know what you're referring to when you're saying that they're being told it's gone. I guess you might be referring to the directive that said we're in the recovery phase.

But because of staff concerns expressed at the meeting, Dr. Berall said, at the end of the meeting he once again asked Dr. Mederski to consult with Public Health, to ensure that the message they were giving staff was correct:

... after the May 20th meeting concluded, I asked Dr. Mederski to call Public Health once again and just check with them once again. Tell them that our staff was concerned and convey that concern and ask them the question that were raised and they gave the same answer as they had given before.

Dr. Berall said that he thought that staff questions were answered, that the tension in the room had seemed to come down and that, after the meeting, he sincerely understood that staff concerns had been addressed and that staff had felt heard. This understanding was supported by an email he later received from one of the emergency room managers, expressing thanks for the meeting. He said that later accounts of the meeting were inaccurate and that it was not his impression of the meeting that Dr. Mederski was saying SARS was gone:

Dr. Berall: ... I certainly didn't come away from the meeting with the impression that Dr. Mederski had said that SARS is gone. I didn't get that impression from that meeting.

Question: But that she was answering specific questions about specific cases.

Dr. Berall: Yes, she definitely did that. Was there a little bit of tension in the room? At the beginning, there was tension in the room and Dr. Mederski was the first person to answer questions because the first questions were about clinical cases. So, you know, in a room full of a bunch of people who are anxious or concerned or whatever, it starts off with interpretation. I have an e-mail that I wrote to the clinical chiefs the day after that meeting that, sort of speaks to my perspective on that meeting. I know the *Toronto Star* article said something about people storming out of the meeting. They weren't at the meeting that I was at because nobody stormed out of the meeting. People seemed to be calmer at the end of the meeting and I actually got a thank-you note from the unit administrator from emerg for coming and speaking to the nurses, that they felt it was helpful. So, I don't know why she would thank me for coming to a meeting and creating an atmosphere where people would storm out. That doesn't make sense.

Dr. Berall said that staff were listened to but that there was a divergence of opinion and that the hospital went with the opinion that they understood reflected the consensus among the experts:

I think there's a difference between being listened to and sharing the same opinion. And I think that whenever there was a concern raised, that we were aware of, we would meet with the staff and have a discussion and hear what they had to say, listen to their concerns, provide them with information pertinent to their concerns, any information that they wanted, and we answered all their questions and then took whatever steps seemed appropriate in response to that. So I have a lot of respect for my health care professional colleagues. I don't share the opinion that they weren't listened to. They were listened to, they were heard, I feel, but you know, the steps were taken that I think were appropriate in response to that.

Although some staff continued to be upset after the meeting, not everyone felt that way. As noted above, an email sent the following day, May 21, 2003, from one of the nurse managers in the emergency department thanked Dr. Berall and Dr. Mederski for their assistance and said that staff reported their appreciation for the meeting. The email promised:

I wanted to take a minute today to thank you for your assistance yesterday as we struggled with the new directives and moving forward. Friday, staff were so excited to be able to lighten the restrictions and yet throughout the weekend fear seeped in again. Today the staff expressed appreciation for the opportunity to ask questions, share their fears and discuss how we move forward. Personally I thank you for your support yesterday and throughout the past weeks.

Dr. Tim Rutledge, Chief of Emergency Medicine, was away on the long weekend and returned to work on Thursday, May 22. He said that he heard about what was happening and became aware that there continued to be anxiety among staff. He said he spent much of the day trying to understand what was happening. He said that although the use of precautions was no longer required, equipment was still available and its use was optional. As noted below, this was a key feature of the emergency department story, the fact that although these patients were not SARS, staff were given the means to use their own judgment to protect themselves and could continue to use protective equipment.

Whatever the intention of those who presented at the meeting, despite the differing perceptions between Dr. Berall, Dr. Mederski and those nurses and doctors at the meeting who reported as quoted above, it is clear that some of the staff came out of that meeting feeling that they had been dismissed. The problem was that, much like in the meeting with the psychiatry nurses, this meeting seemed focused on placating or calming the nurses rather than on acknowledging their legitimate concerns. As one emergency room nurse said:

If there had not been the denial that SARS was still around, when it very obviously was. I know it was a new disease, but you know, if it looks like a duck, it walks like a duck, and it quacks like a duck, it's got to be a duck. And what they kept saying is, no, no, no, it's a figment of your imagination. And if someone comes in with symptoms of typhoid and tests positive for typhoid, whether there's an epilink or not, that patient has typhoid ... When are you people going to learn to be up front with us. "We don't know if it's SARS, we want you to protect yourself," that

would make sense to me.

This was a group of highly trained, diligent health workers who had provided front-line care for SARS patients for almost two months. Concern about these patients was shared among the emergency room physicians and internal medicine specialists who were involved with them. Even if the doctors did not attend or speak up at the meeting, their actions, in ordering tests, in placing the patients in isolation and especially in requesting admission to the SARS unit, clearly conveyed their concerns. Moreover, their concerns were captured in the consultation notes in the respective hospital charts. It is difficult to understand why, notwithstanding any beliefs about opinions from Public Health, the concerns of front-line staff were not acknowledged as possible. It appears that there was no system to ensure that the physicians' concerns came to the attention of anyone other than Dr. Mederski and no way to ensure that all relevant front-line informed opinions were systematically assessed and considered in an organized fashion.

Nurses and other health workers were receiving mixed messages. Dr. Berall and Dr. Mederski were telling them it was safe to remove the protective equipment, that the cases were not SARS, yet emergency room physicians, with whom they had a long-standing working relationship, whom they respected and trusted, were still wearing full protective equipment at all times and were voicing their concerns to staff and advising them to do the same.

The emergency room physician who saw all four of the Patient A family members said that he was upset because he felt that if they had treated the SARS patients as suspect until proven otherwise and had maintained precautions, people might not have gotten sick:

If you look at who got sick in the end, by far most of the nurses that got sick were the 4th-floor nurses. The one that died was from the 4th floor. They all, the majority were from the 4th floor, because they had no more protection. Had they continued protection, had they treated everybody as suspect till proven otherwise, many of these people would not have gotten ill, that's for sure. So, I was very, very, very upset because in this particular case, this coincidence of me happening to see four patients, and I was working so many shifts because nobody else was coming to work, that I happened to be in a unique position where I actually saw four of these patients on the days they came in.

And when you have all that, and she [Dr. Mederski] knew about every one of these patients, she could not say, wait a minute, guys, something is happening here, four people, same family, all with pneumonia, it's suspicious, at the very least it's suspicious, let's play along with this paranoid guy and let's pretend they have SARS, but let's prove him wrong, let's wait for the blood test ... but no, that's not what happened. She went around, in fact at that period, telling the nurses in the emergency room, pooh-poohing us, me and [another emergency physician], that we were perhaps being a little paranoid and as proof she was there in her own little civilian uniform, eating lunch in the nurses' lounge, while all of us were walking around garbed, listening to her telling them not to be concerned and that there is no problem.

The Role of Dr. Mederski

It would be unfair to blame the second outbreak on Dr. Mederski. No one person could be responsible for the second outbreak. As one infectious disease expert said:

I have known Barb [Dr. Mederski] for a long time and I think that there were mistakes but I don't think we can blame it on just her. We all sort of blew it, but she sort of was unfortunately right in the middle of it.

There were many factors that occurred that were totally beyond Dr. Mederski's control and knowledge, among them the outbreak of respiratory illness on 4 West and the knowledge that there were sick staff on 4 West. It would be unfair to expect Dr. Mederski to have figured out what so many others also missed: that SARS had never left. Dr. Mederski explained to the Commission that the 4 West connection did not come together before May 23:

Question: I do get the sense though that, having regard to the way your antennae worked when you were seeing psych patients and [Patient A Family], that had you seen that information that was tabled on the 23rd about 4 West, that you would have reacted differently.

Dr. Mederski: You know, I don't know what I would have done. I have no idea, because I wasn't in that position, and hindsight is always great. Had I been able to extend the link from Mr. O on the previous long weekend and follow a

thread, had I had energy and my usual inquisitiveness, which I usually do, maybe I would have tweaked to something earlier.

Dr. Mederski did not know that there was an unidentified outbreak in the hospital, or that there were unidentified patients, not isolated, being cared for by staff without protection.

It is clear that Dr. Mederski sincerely cared for the well-being of patients, visitors and staff at North York General Hospital. Whatever decisions she made, the Commission accepts that they were made in good faith. Many physicians interviewed by the Commission described her as a conscientious physician who worked extremely hard during SARS. As one North York General physician said:

Dr. Mederski worked terribly long hours. She's an extremely conscientious physician.

The problem is that Dr. Mederski was simply one overwhelmed individual, left largely on her own, without professional supervision or systemic support to manage an enormous responsibility that required a level of management and communications experience to which she had not been exposed.

Underneath everything that happened at North York General, there is a clear picture of a tired, overworked physician who lacked supervision and whose clinical judgment and personal views had somehow become overborne throughout the course of SARS.

One Toronto Public Health physician said that the workload imposed on Dr. Mederski and the other members of the infection control department was huge, and that it probably prevented her from seeing the bigger picture of what was happening:

There were sick people and overworked clinicians looking after very sick people and the infectious disease department appeared very strained in terms of resources and who knows if they had a huge volume of cases and very few people could see them, one of whom [Dr. Mederski] appeared unwell, and whether that person ever had a chance to step back and try and see a big picture, and I think it required to be able to have a look at a big picture.

This physician also noted that when they were on site on May 23, Dr. Mederski appeared exhausted and unwell:

She appeared not to be well and exhausted and was being called all the time from all over the hospital while we were there. I think it was exhausting to look at, how one person could possibly manage all this. Her beeper was going off all the time. Everybody was asking her to see consultants all over the place. It is very difficult in that kind of a situation, you're seeing all the trees, you're missing the forest.

As noted earlier, there are differences of recollection between Dr. Mederski and those with whom she dealt at Toronto Public Health. This is one area of the Commission's investigation where recollections differ in respect of important facts. The Commission process lacks confrontation and cross-examination and lends itself well to getting frank and open evidence but less well to the resolution of disputed recollections. Because the Commission makes no adverse findings of fact against any witness and no criticism of any individual or organization arising out of these disputed recollections, no confrontation or cross-examination was required. Wherever there is a significant difference of recollection between witnesses in respect of a material fact, each witness, as fairness requires, was given the gist of what was said by those whose recollection differed.

Because the root problem with the undetected family clusters was systemic and not personal, it may in one sense not matter very much whose recollection is better.

It would however be unfair to Dr. Mederski and to those whose recollections differ to leave the difference of recollection entirely up in the air. It is obvious that Dr. Mederski and all those whose recollections differ from hers gave the Commission their best recollections of what happened.

Dr. Mederski was largely on her own with a huge personal burden of responsibility and no backup in the sense of ongoing organized professional supervision and support, especially in May, when the hospital concentrated its attention on the return to normal operations. Unlike those who worked in Public Health, she was not part of an organized and closely supervised system with vast experience in the timely and effective recording of epidemiological data and evidence. It is only natural in the circumstances that her recollection should be more impressionistic and less exact than that of those in the investigative business of systematically noting and logging and charting and recording and reporting and verifying, as they arose, the contemporaneous conversations and pieces of evidence that bore upon the question of whether the patients had SARS.

The Public Health witnesses worked within a system that required them to note and log and chart and record significant conversations and pieces of evidence contemporaneously.

raneously without having to rely on their memory months or years later to reconstruct what they thought must have happened. Unlike the Public Health witnesses, Dr. Mederski lacked the advantage of such a system.

These profound contrasts in their respective working environments and information logging systems give the Public Health witnesses a great advantage over Dr. Mederski in their respective abilities to recollect accurately what was said.

For this reason alone, the recollection of the Public Health witnesses is on balance likely to be preferred to Dr. Mederski's best attempts to recall and to reconstruct what happened in that time of enormous pressure and responsibility when she was so alone and under great stress and indeed ill.

This likelihood is reinforced by the manner in which Dr. Mederski expressed her recollection, in language sometimes vague, tentative, unsure and occasionally characterized by circular interior dialogue with herself, in contrast to the direct and objective recollection expressed by the Public Health witnesses.

Dr. Mederski in some areas relied not so much on her actual recollection but on her later rationalization ("trying to rationalize") of what she thought must have happened. At times she relied more on her intuitive interpretation of what she thought someone meant instead of relying on what they actually said ("the vibe I am getting," "I am getting the feeling").

Dr. Mederski was openly tentative and unsure about significant aspects of her evidence ("I can't be sure," "it could be," "I am trying to think," "it could have been," "it may have been," "I don't remember," "I would not be surprised that would be," "the conversation would have gone something like," "I was trying to understand," "but I still never understood what it was"). This quality in Dr. Mederski's evidence makes it difficult to prefer her evidence over the direct and focused evidence of the Public Health witnesses.

It may be that she sometimes focused more on her own subliminal interior monologue than on what was actually said by her to others and by others to her ("that was all in my mind," "I was hoping subliminally no one would ask me," "was I just so ambivalent or schizophrenic that I just didn't know what to do anymore and what to say").

Dr. Mederski's answers to the Commission's questions sometimes tended towards indirection, and it appears from those answers that she was not always direct in what

she said to the Public Health witnesses. The following question and answer furnish an example of both problems:

Question: Did you express any opinion to them on the 20th or when you spoke to Dr. Rea on the 19th, did you express any opinion to them about your own feelings, your own thinking about what these cases were?

Instead of saying “no,” Dr. Mederski said this:

Dr. Mederski: Well, I was concerned enough to personally call them and nobody had asked me, the hospital administration had not asked me, nobody else had asked me. My concern was manifested by definition in the fact that I phoned these two individuals to ask about, an open-ended question effectively to say I have these cases, should I be concerned? The staff are concerned, these are mild cases, except for [Mr. O], they look like some of the SARS cases we’ve had. But I didn’t say, oh, I have five SARS cases. I was more, it was a rhetorical type of open-ended mulling ...

Although this lack of directness in answer to the Commission’s questions and the lack of directness in her discussions with Public Health officials do not detract from her honesty or her best efforts to assist the Commission, it does detract from the reliance one can safely put on her recollection as opposed to that of the Public Health witnesses.

A strong reason to scrutinize Dr. Mederski’s evidence closely is the fact that Dr. Mederski decided on May 20 to tell the nurses the very opposite of what she thought. She told the Commission that she assured the nurses on May 20 that the family cluster did not have SARS when she in fact believed they probably or maybe had SARS, and she set out in detail her reasons for telling the nurses the opposite of what she thought. Whatever one may make of her rationalization for her conduct, this regrettable incident suggests that this hard-working, compassionate and overwhelmed physician laboured at the time under a measure of internal conflict and perhaps an element of confusion about her role and her accountability that made it difficult for her to communicate accurately and directly at all times what was in her mind. Dr. Mederski’s ability to talk herself into telling the nurses something she thought was wrong is a further reason to prefer the evidence of the Public Health witnesses when it conflicts with that of Dr. Mederski.

There is another reason to prefer the evidence of the Public Health witnesses: the greater plausibility of their evidence with regard to its harmony with the undisputed facts and surrounding circumstances at the time.⁷⁴⁰

It is implausible that Toronto Public Health, concerned about the A family cluster, following them closely and looking closely for any evidence or reasonable suspicion of SARS, would ignore or fail to record any suggestion by Dr. Mederski that she suspected that any family member had SARS. It is implausible that Toronto Public Health, at a time when they were actively investigating many cases to see if there was evidence of SARS, would give Dr. Mederski a blanket assurance that SARS was gone and that she need not be concerned about suspicious cases.

Because of the advantages enjoyed by the Public Health witnesses over Dr. Mederski in respect of contemporaneous records and the systems that support the accuracy of their current recollection, and because of the inherently greater probability associated with the recollection of the Public Health witnesses, and because of the often tentative nature of Dr. Mederski's recollection and the other difficulties with her evidence noted above, the recollection of the Public Health witnesses is preferable to the attempts of this hard-working, compassionate and overwhelmed physician to reconstruct and recall what was said during a period of enormous personal stress.

There is no evidence that Dr. Mederski or anyone at North York General withheld information from front-line staff for any improper purpose. Both Dr. Mederski and the authorities thought that the patients in question posed no risk to others because they were isolated and handled with precautions although not diagnosed as SARS cases.

The evidence reviewed above does, however, disclose serious systemic failures.

Having accepted the evidence of the Public Health witnesses in preference to the evidence of Dr. Mederski for the above reasons, the finding of fact follows that there was a breakdown in communications at Dr. Mederski's end between North York General and Toronto Public Health in respect of the A family cluster and the O family and the evidence of the re-emergence of SARS at North York General Hospital in May. There was no system to supervise Dr. Mederski and ensure effective

740. As a great judge once said,

The most satisfactory judicial test of truth lies in its harmony or lack of harmony with the preponderance of probabilities disclosed by the facts and circumstances in the conditions of the particular case.

R. v. Pressley (1948), 94 C.C.C. 29 per O'Halloran J.A. at p. 34.

communication between the hospital and Toronto Public Health with respect to the growing evidence that SARS had returned.

Dr. Keith Rose, Vice-President, North York General Hospital, when asked about Dr. Mederski's supervision, said this:

Question: To whom was Dr. Mederski accountable?

Dr. Rose: To whom at the hospital?

Question: Yes.

Dr. Rose: First there was the Chief of Medicine, Dr. David Baron, and then through the Chair of the MAC [Medical Advisory Committee] and then through the Board. From a medical practice, medical quality.

Question: Who was her supervisor?

Dr. Rose: That is difficult to say. Dr. Baron, indirectly, but he wasn't in infectious specialities, so his supervisory capacity would be limited, so he may not be able to assess her medical quality of care, he could assess some other aspects of her practice.

Neither was there any system to ensure that the clinical judgment of the front-line physicians who strongly suspected SARS at the time was noted, received, analyzed, investigated and assessed in an organized fashion. In the absence of such a system, their crucially valuable evidence suggesting the return of SARS went into a black hole.

It is most regrettable that Dr. Mederski did not communicate to anyone in the hospital or to Public Health her concerns that the clusters of patients in May may have SARS and doubly regrettable that the accurate concerns of the nurses to the same effect were denied by Dr. Mederski and dismissed by hospital authorities.

The nurses who were present at the meeting on May 20 feel that the hospital did not listen to them, and the hospital feels that it did listen to them but simply happened to disagree with them. The difficulty with the hospital's position is that, unbeknownst to the hospital, Dr. Mederski agreed with the concerns of the nurses, as did a number of experienced front-line physicians whose suspicions and concerns never got past Dr. Mederski. There was no system of supervision or communication or support to ensure

that all the appropriate evidence, including Dr. Mederski's actual views and the views of the front-line physicians, were investigated, weighed in the balance with the perceptive and accurate concerns of the nurses, and then considered by someone other than Dr. Mederski, who at the material time bore almost single-handedly the overwhelming and unsupervised burden of decision making in relation to SARS diagnosis and investigation at North York General Hospital.

This topic cannot be left without a final word about Dr. Mederski.

Dr. Mederski carried a huge burden with very little support. She worked hard to the point of exhaustion and beyond, ill and under great personal stress. The hospital, especially in May, when it focused on its return to normal operations, relied on her entirely, with no system to supervise her or back her up. She was the hospital's sole gatekeeper for SARS in the sense that it was she and she alone who decided who went on the SARS ward and who did not and she had the sole effective say within the hospital as to who was diagnosed with SARS and who was not and the sole responsibility to communicate at a working level with public health. This was an enormous responsibility, an overwhelming responsibility for one person to bear.

Enough has been said above about Dr. Mederski's decision to reassure the hospital and the nurses on May 20 that the family clusters, which so alarmed the nurses and front-line physicians, did not have SARS when Dr. Mederski in fact thought they probably or maybe had SARS. Enough has been said about the reasons for preferring the evidence of the Toronto Public Health physicians to that of Dr. Mederski and enough has been said about the breakdown in communications at Dr. Mederski's end between Toronto Public Health and North York General Hospital.

To some at North York General, Dr. Mederski personified the problems associated with the second outbreak. To others she was the exemplar of a dedicated physician working impossibly long hours beyond the call of duty.

It was Dr. Mederski's misfortune to be saddled with enormous responsibility without an office, without dedicated time, without the support of a comprehensive surveillance programme and without the support of supervision and backup. To this was added a unique professional burden as the solitary gatekeeper, the only physician in the hospital authorized to make a formal SARS diagnosis and admit patients to the SARS ward. As noted earlier, the Naylor Report described her situation as an example of the general systemic weakness in Ontario of systems to prevent the spread of infectious diseases within hospitals:

Although infection control practitioners attempted to institute comprehensive surveillance programs in some hospitals, such a program alone requires approximately 2 full-time staff members for a 500-bed hospital, more than the majority of hospitals have on staff for all infection control tasks. At North York General Hospital, for example, one full-time and one part-time infection control practitioner were responsible for 425 acute care beds. The infection control director⁷⁴¹, Dr. Barbara Mederski, occupied the role without any salary, protected time, or even an office.⁷⁴²

Dr. Mederski was not a free agent. It would be too easy to make her the scapegoat for systemic failures in the prevailing provincial machinery of outbreak management. It is speculative whether someone else might have listened more carefully to the concerns of front-line doctors and nurses, whether someone else might have taken the evidence at North York General as an opportunity to investigate further and more systematically.

The problem at North York General, shared by other hospitals and the entire apparatus of outbreak management, was that there was no system to scrutinize the application of the case definition, to look into concerns that it might miss cases and to require immediate investigation of any credible evidence suggesting that undetected cases were spreading throughout the hospital. There was no system of surveillance to pick up the unusual number of deaths or the sick staff or the family clusters and thus trigger an immediate epidemiological investigation.

These things cannot be left to happen on their own. It is not enough to hope that someone in Dr. Mederski's position might sense the fact that something was wrong and might have the personal initiative and entrepreneurial drive to buck the system and insist that something further happen by way of investigation. Public safety from disease cannot be left to the accident of personal initiative. Public safety requires adequate systems. Public safety cannot depend on the unsupervised and unsupported private initiative of whoever happens to fill a particular job at a particular time. What is needed is a system to ensure that danger signs are picked up and promptly investigated. What is needed is a system to ensure effective supervision and communication under clear lines of authority and accountability within hospitals and between hospi-

741. In fact, although her role and responsibilities suggested that she occupied the role of the director of infection control, Dr. Mederski was not in charge of the program. She was an infectious disease specialist during SARS and, while her work as such involved overlap with infection control, she was not in charge of infection control. Dr. Mederski described her role as providing ad hoc, informal advice for infection control on an as-needed basis. She did not have dedicated office space, time or support and did not have supervisory authority over the infection control staff or their program.

742. Naylor Report, at p. 39.

tals and public health.

It would, as noted above, be unfair to scapegoat Dr. Mederski, a caring and conscientious physician who was overworked, unsupervised, overwhelmed, ill and unsupported by the kind of systems that should have been in place throughout the province. The second outbreak, as noted earlier, could have erupted at any other SARS hospital and it was the misfortune of North York General that it happened to strike there. The tragic mistakes and failures that led to the second outbreak were systemic, not personal to Dr. Mederski or to anyone at North York General Hospital. The task ahead is not to search for scapegoats but to improve the systems that defend us against infectious outbreaks and to ensure that this horrible tragedy does not happen again.

SARS Is Over

As noted above, the backdrop to the Patient A family cluster is that by the middle of May, 2003, the message in Toronto was that SARS was over. One North York General Hospital emergency room physician agreed that after the travel advisory was imposed and subsequently lifted, it seemed that the focus shifted away from looking for new SARS cases:

Question: Some doctors have suggested that there seemed to be a shift in the mindset of people after the WHO issued its travel advisory, that the focus went from finding SARS cases to trying to get rid of SARS. Any observations or thoughts on that? And not that it was a deliberate thing but it was always something that weighed at the back of people's minds.

Answer: I think I kind of share that feeling as well, because it is so financially damaging to the economy, probably not just to the city, but even to Canada. So I think the case definition kind of shifted to include less of those potential cases.

Another physician said that he thought that there was pressure to relax restrictions to get Toronto off the WHO travel advisory. He said it seemed that there was pressure to have SARS go away:

If you were aware of the media there was pressure because of the way it affected Toronto coming into the summer, to get Toronto off the WHO

travel advisory because of the, if you will, the political/economic effect it was going to have. There was this will to have SARS go away and be declared resolved. And the impression was that started at a public health/governmental level rather than within a particular hospital.

He said that he was not aware of any evidence of actual political pressure but that it seemed that it was there:

... a will, if you will, a general will in the community to have Toronto declared SARS free.

Another North York General physician said that in their view, the May 20 meeting was an attempt to convince staff that SARS was winding down:

My impression was that at the time the hospital was trying to reassure the emergency department that SARS was winding down.

As one North York General emergency room nurse said, she thought there was tremendous pressure to downplay SARS but that they should not have downplayed it with staff:

... there was a tremendous pressure on the politicians from the business community, or perceived pressure, to downplay the danger of SARS. But the danger was to downplay it to the staff who were looking after the patients. And to put the staff at risk. And to put all of the community at risk, because you're not containing it strictly.

None of the physicians, experts, provincial or public health officials interviewed by the Commission reported any pressure to not call a SARS case SARS. More will be said later in the report about the question of whether there was political interference during SARS.

But there clearly was a change after the travel advisory, a change that did not go unnoticed by front-line physicians who felt that the focus became more on convincing everyone that SARS was over and that the recovery of the city and of the economy was now the priority.

The problem was that no one could say that SARS was over or that SARS was gone. It was a disease that was still new and about which much remained unknown. With new cases being identified as under investigation in the city, cases that could not be

quickly ruled out as SARS, no one could say with any certainty that it was over. No one could say with any certainty that there were no new cases of SARS when the possibility remained that there might be unidentified cases.

The story of the second outbreak underscores the importance of being cautious in moving forward in the face of a new and unknown disease. It also showed a disconnect between front-line health care providers and the decision makers at higher levels. Those front-line physicians who did not believe SARS was gone, who continued to use protective equipment, who continued to see patients whom they thought were SARS, were not asked what they thought. In the face of new directives, a move to a “new normal,” the guard came down. And SARS came back.

Listening to Front-Line Health Workers

Emergency room staff had concerns about the family clusters that were coming through the emergency department in May. They did not believe, based on what they were seeing come through the emergency department doors, that SARS was gone. One emergency room physician recalled physicians’ overall frustration at how these cases were being handled and physicians’ disbelief in assertions that these patients did not have SARS:

The other situation that I wanted to bring up was what went on when we had that cluster of five on the May long weekend [May 17th to 19th]. All of us in the department were anxious and discussing what was going on and without a question, we felt that that family had SARS. And we were frustrated that the people that were admitting, looking after those patients were not taking the concerns of the staff seriously, or at least that’s what we felt. I heard the whole story from all the staff. I remember [the admitting physician] saying to me and others that if this isn’t SARS, then this is an incredible coincidence. She was the fifth member of that family.

Based on their own suspicions, concerns and beliefs, they were able to take matters into their own hands and continue to wear protective equipment and to continue to have a high level of suspicion for new SARS cases.

Front-line staff, including physicians, had serious concerns about these patients, so why didn’t hospital officials react to these concerns?

Dr. Rose said that he learned of concerns among emergency department staff on Tuesday, May 20, after he came back to the hospital following the long weekend. He

said that although he did not attend the May 20 meeting, it was his understanding that Public Health did not think these cases were SARS and he was aware that there would be a meeting with staff to discuss the cases later that day:

So, I knew the concern when I went to the hospital on the morning, Tuesday, May 20th, after the long weekend. I was in the emergency department. I talked to the assistant director because Tim [Dr. Rutledge] was signed out and there appeared to be a lot of confusion. Staff were wearing protective devices, despite my understanding that they stopped doing it the previous Friday. They were concerned about potential cases. I also had been told that Toronto Public Health investigated and there was a difference of opinion and that there wasn't a new alarm for SARS. The emerg director, the assistant, was looking for direction on what he should do. As the day unfolded, they had more conversations with Dr. Mederski and Public Health, and there was an agreement that there would be a meeting with the staff that night to discuss staff's concerns as well as the findings of Toronto Public Health and the issues around the weekend and this so-called cluster of people. As I said, I was not at that meeting.

Dr. Rose said that he understood that the patients were being treated in isolation with all the precautions but that at that time there were no alarm bells going off that this was a new SARS epidemic. He said that none of the front-line physicians approached him to say that they were wrong, that these cases were SARS. Dr. Rose said:

Question: I guess really the issue, the two issues in May, if people didn't speak to you about it, they didn't speak to you about it, but our information is that at the treatment level, at the level of admission and treatment, front-line health care workers are saying both with respect to psych patients and [Patient A], we thought it was SARS, it's going up the way it was supposed to. Dr. Mederski is involved along with Toronto Public Health and others and what's coming to you is the opinion that it is not SARS.

Dr. Rose: Correct, although we have pretty good relationship with our medical staff. We are available and visible. We did hold public meetings with the staff if they felt strongly, the medical staff I am talking about particularly, with their own chief of medicine, with me, our doors were

open for people to come and say, look things are bad, you have got your eyes closed, and they did not come to us and do that.

Dr. Rose said that there were other avenues of communication in addition to raising concerns with him or with other senior administrators, if they had concerns about outside opinions or about Dr. Mederski's opinions:

So we had another infectious disease specialist who people could have consulted with and said let's take a closer look. We had another sideline of communication through the Chief of Medicine. The Chief of Medicine was there. I talked to the Chief of Medicine on the 20th of May. We went through some of this. So even if those two things have been true, why weren't other sources used to raise the alarm bells? How sure were they of the diagnosis? In retrospect, yes the family of what appears to be many individuals, it all comes together very clearly now, but at the time ...

Whether it was uncertainty about the diagnosis, hesitation to speak out, a concern about being a voice of dissent among what to many seemed to be a consensus among outside experts, or even just individual personalities that were not of the type to approach senior officials or to second-guess a consult by an infectious disease expert, the opinions of front-line staff were not made clear to senior officials. One physician who was involved in these cases said that although he was worried, he did not approach senior management with his concerns because he felt that he had raised them with Dr. Mederski and she was the expert. He said that it was not his personality to push at higher levels and that because there was no test to say it was SARS, and because the patients did get better, he left it with Dr. Mederski. As he told the Commission:

I am that kind of person. I bring up my concerns and that is the end of it. I don't go up and beyond as some people otherwise would have done, you know, go to the higher levels and keep pushing. I have no evidence at that point in time that this is SARS either. There is no good diagnostic test. And they got better, that's the end of the issue.

Dr. Rose said that concerns of staff were heard:

Question: But there are those who would say their concerns about the [Patient A] family were ignored. Do you agree with that? Disagree with that?

Dr. Rose: I think the concerns were heard. The actions in retrospect were not. What were the best decisions? So you can listen to people, hear what they have to say, balance that with other information from other experts, then you make the decision. You do listen to them. You may not make the decision that they want you to make, but you do listen to it. I actually think that we handed you a copy of an email from [the nurse manager] from the emergency department following the first May 20th visit that was one of the first ones, who is actually pretty reassuring that she felt staff were heard. I will tell you I was personally out of the hospital on May 20th. I was [out of town] that night. Knowing that this was a problem, I was available. I came back to the hospital on the 21st. I actually took [a family member] to the emergency department on the 21st because he fell and cut his foot or something, and I was in the emergency for two or three hours waiting with [the family member]. I did not hear concerns expressed. I was there. I was available.

One physician, who was involved in the Patient A case, said that the problem was that the disease was so new and that no one knew how serious it was. He said he did not sense a huge disconnect between front-line staff and hospital administrators; rather, no one knew for certain what these cases were. He said:

Question: Some people have suggested and some of the doctors have suggested that one of the lessons from SARS is that there seemed to be a disconnect, if you will, between what the front-line doctors were seeing and some of the decisions that were being made. They said that that was a lesson learned from SARS?

Answer: I think it is difficult to say. It is a brand-new disease, so to speak. We never had that before, with no experience and we don't know how serious this illness is, potentially. So, again I think it comes down to human nature, how serious it is. I don't know. I don't have a strong sense of disconnect between administration and front-line workers.

The Commission accepts the evidence of senior hospital officials that they were not unwilling to listen to front-line doctors and that they sincerely believed that there were communication lines that were open between front-line staff and senior-level officials.

But the importance of strong systems of communication from those on the front lines to senior officials and those in charge of decision making about the SARS response cannot be overemphasized. It is not enough to hope that a physician will risk censure or ridicule should he or she raise an alarm. It is not enough to hope that a physician who goes to work, does his or her job, cares for patients and focuses on that will step outside that role to involve himself or herself in higher-level decisions. It is not enough to hope that colleagues will second-guess or raise concerns about decisions by other colleagues. Particularly in a case like SARS, where no one knew for certain if their opinion was right, it is not difficult to imagine that front-line physicians who had concerns, whether minor or great, would feel reluctant to voice them. Even Dr. Mederski, in her role as the infectious disease specialist in the hospital, did not have that level of comfort in the face of what she perceived to be a consensus among experts and in the face of previous criticism from outside experts that she could not diagnose SARS cases on the basis of clinical judgment alone.

SARS taught us that with a new disease, no one can claim to have all the answers. It is hard to say that someone is an “expert” on a disease that has been around for two months. There are no right and wrong opinions, and the perspective of those on the front lines must be brought to the table. They must be sought out, they must be encouraged to be voiced, and there must be no fear of consequences for speaking out. The dialogue must be open and free from fear of ridicule and censure.

Communicating with Front-Line Staff

In a case like SARS, a new disease with no quick, reliable diagnostic test, it is understandable that opinions may differ between front-line physicians. An emergency room physician thinking a patient had SARS while the infectious disease specialist thinks the patient did not is not an unusual event.

The problem was not so much that the opinions provided to staff that these patients were not SARS turned out in hindsight to be wrong or that there wasn't a consensus of opinions among physicians. The problem was that no one could give an absolute opinion about SARS: without a reliable test to prove SARS or not SARS with any degree of certainty, one physician's opinion could not completely rule out another. In

other words, there was no correct opinion; there were only differing opinions.

With a new disease, it is not unrealistic to think that the experts will not have all the answers. The problem is that no one acknowledged this uncertainty. No one acknowledged to staff that no one really knew anything for certain about SARS. No one acknowledged the possibility that staff concerns might be right. Even if hospital officials, those in charge of the SARS response, and Dr. Mederski did not feel it appropriate to voice their uncertainty in the public domain, the message to staff that these cases were not SARS, that SARS was over, displayed a confidence that no one could have. Without a quick, reliable test that could rule out SARS, no one could rule it out with any certainty. And in the face of concerns by front-line staff, among them nurses and doctors who had seen more than their share of SARS cases, the opinion that these patients were not SARS could not be put forward with any certainty or confidence.

Without acknowledgment of the possibility that staff concerns may be right, that no one had all the answers to SARS, that no one could rule out a case with any certainty in such a short period of time, many staff felt betrayed and angry when it turned out that the assurances to staff were, as we now know, false.

Not only did the emergency department staff know something was wrong, but word spread to other parts of the hospital. Staff outside emergency began to hear rumours about what was happening, adding to the level of fear, anxiety and mistrust in the hospital. As one nurse who worked on the SARS unit told the Commission:

I had heard rumours that there was problem. And that emerg nurse came up and brought me a patient one day, and she was isolated or whatever and she said, well, that's just the very beginning, because she said, the same people keep coming back and they're sicker each time.

Of those who did hear about the cluster of patients, many wondered why they weren't being told anything about these cases. Even though the psychiatric patients were not called SARS, staff were still told about them through the minutes and updates to staff. But there is no mention of the family cluster in the minutes of the SARS Management Committee, nor was there an update to staff about them.

As one nurse said:

I'm hoping that they've really learned this and I'm hoping they've really learned also that it is much, much more of a loss to the economy to have

to close a whole hospital than just being up front with the staff in the hospital and saying this is what we're dealing with, this is the line that is going out to the press, but we want you to know so you can protect yourself and protect the public and we want you to keep it quiet. It would have been far better, it would not have been such an insult to our intelligence. It would not have had the bad impact it's had on the nursing profession, on our feelings towards the profession. We're at a state now where we're pretty well desperate for staff already and it's going to get worse. 60 to 70 per cent of the nursing staff is aging staff. Within the next 10 years they're all going to be gone, and how are we going to attract young people to a profession that thought that we were so stupid we would follow that kind of party line. How can we recommend a profession to them where people are treated pretty well like, as far as I was concerned we were treated like disposable cannon fodder.

It is a lesson that North York General seems to have learned post-SARS. After the second outbreak, communication with staff changed to include a category of cases identified as "CRO": "can't rule out" SARS. To many staff, this signalled a major improvement and was a positive change post-SARS. As one North York General emergency department nurse told the Commission:

The big thing that's changed since then is, then you didn't have SARS until it was absolutely proven that you had SARS. Now it's, you've got SARS until we absolutely know you don't. And that's the one big, good thing that's come out of this.

The Commission finds no evidence that hospital officials, including those in charge of the SARS response, deliberately withheld information about the patients who were coming through the emergency department in May or that they lied about these patients. The Commission accepts that hospital officials sincerely believed that these cases were not a concern to public health officials and that they repeated that to front-line staff.

The Commission does find, however, that in conveying these messages and in communicating with staff, hospital officials, including those in charge of the SARS response, conveyed a confidence that we now know was misplaced. The Commission finds that the communication with staff, although well intended, was ineffective and failed to acknowledge legitimate concerns on the part of front-line staff, but rather dismissed them in the face of what was believed to be the opinion of outside experts.

Caution and Leadership in the Emergency Department

As noted earlier, precautions in the emergency department at North York General Hospital began to relax on May 16, 2003. This was consistent with provincial directives.

But the staff in the emergency department, uneasy about the admission through the emergency department of a number of patients who had a previous association with the hospital, such as the Patient A family cluster and Mr. O and his wife, were cautious about following hospital notices that advised them they no longer had to wear precautions at all times.

Front-line staff were told, on the one hand, that it was safe to remove protective equipment, that there were no new cases of SARS. On the other hand, they kept seeing patients coming in the emergency department, like the Patient A family cluster, whom they knew front-line physicians, whose opinions they respected and trusted, thought had SARS. They also saw these front-line physicians continuing to wear full personal protective equipment at all times. As one physician told the Commission, there were mixed messages that left some unsure how to proceed:

Later in May when we received recommendation that Code orange was being dropped ... we were told that we no longer needed to wear personal protective equipment and there was a big discussion, a lot of anxiety in the emerg regarding the decision to remove our personal protective equipment and we weren't sure what to do. There were differing opinions from different sources. There were faxes coming on an ongoing basis from the OMA, from the Ministry, we would read one thing and, the descriptions of what steps to take in personal protection were not always the same from the different agencies. We weren't even getting the same instruction from our infection disease people in our own hospital.

The one infectious disease consultant, Dr. Mederski, was telling us, take off your masks and don't worry, and I remember going up to Barb [Dr. Mederski], I think it was right after the long weekend and we had a cluster of five from the 19th to the 20th, and I said, Barb, tell me that I don't need to wear my mask and tell me why. And Barb went into this

whole dissertation about why it is not SARS and there is no epidemiologic link.

And then I go into the department to work and there is another doctor, who is our part-time infectious disease consultant, completely covered in a gown, mask and goggles ... there were nurses going back and forth deciding whether to wear it or not, I was deciding whether to wear it or not. Our two internists that worked in the emerg most of the time in those days were both walking around with masks and goggles on and here I am without my mask going, why am I listening to the hospital who's telling us to remove our masks?

Another emergency room physician described the varying use of equipment and said that he and other emergency room physicians encouraged staff to continue to use personal protective equipment because they were not convinced SARS was over:

It was a completely ludicrous sight. I'd be up on the 4th [floor] because I'd get called to put out a little medical fire here, I'd go up fully dressed, [another physician] if she was around, she was also fully dressed and we'd be on a ward, we'd have nurses walking around us completely in regular nursing uniforms and we'd be almost like Martians, completely out of context on these wards. And I spent a lot of time preaching to the ER nurses, where I spend most of my time and maybe on one or two occasions on the 4th floor, saying, I'm not convinced that this thing is over, I've admitted a few patients in the last few days, does it hurt to continue wearing this stuff for a few more days until we see where it goes?

Virtually nobody on the orthopedics floor heeded what I said. A lot of nurses in emerg did heed what I and [the other physician] said. They saw a lot of us frequently down there, in fact that's where we spend most of our shifts when we work and in fact several of the nurses continued to wear full uniform as long as they kept seeing us wearing full uniform. I'd say maybe two or three nurses on any shift were not protected, but something like seven or eight, the balance of the team, were always fully protected.

Another physician who consulted in the emergency department said that he continued to wear protective equipment throughout May, because he was paranoid that SARS was not over:

I suppose when SARS I kind of hit, so that's the outbreak at Scarborough Grace, everyone is suddenly very excited and very worried and what is it, how do we get this illness or what can we do to avoid having the illness? And I think for some time we were very vigilant about it, you know. Before seeing any patient, we would have gowned and gloved and washed our hands, before and after and things like that. And I suppose when that period was gone, around April or the first part of May, people kind of said, "okay so that's great, no more new cases, don't get too excited about it." I think that's the kind of general feeling I see in North York General Hospital, and I was the one who was kind of the paranoid, and I have been wearing an N95 mask even when I am not in patient care areas. And people sometimes joke about it, they laugh at me and say you don't want to be choked to death and suffocated, but I don't care, I just do my own stuff.

This physician said that he never had problems getting equipment and that he didn't recall a time when he wanted equipment and could not get it. When he was asked if he ever felt any pressure to remove the equipment, he said:

No, absolutely not. In fact, let's say that Dr. Baron made it clear that it was your own personal choice. Even if the directive comes out that now you can stop wearing the mask and if you choose to do it, be my guest, just do it, whatever you are comfortable with.

Although precautions were relaxed, emergency room staff were cautious and followed protocol guidelines to use protective equipment with all cases of respiratory illness. As noted above, some of the staff and physicians continued to wear equipment at all times.

One emergency room physician said that the fact that SARS wasn't spread in the emergency department before May 23 was a testament to staff's adherence to good infection control procedures and policies that were in place in the emergency department. He credited the leadership of Dr. Rutledge and other hospital executives for ensuring that the emergency department was as safe as possible:

Question: One of the interesting things is that it doesn't look as if anyone in emergency, physicians, nurses, others, got SARS after the relaxation of the precautions. Yet people in the rest of the hospital got it. Why did no one in emergency get it?

Answer: The patients who came into the hospital who may have transmitted SARS, in spite of exceptions to the rule, generally speaking had respiratory symptoms or fever. In spite of the existence of exceptions, we immediately put them in isolation as Tim [Dr. Rutledge] had ordered. We wore masks, full outfits, gloves, and washed our hands. I'm very upset and concerned about the nurses, but don't get the belief that the emergency department wasn't extremely carefully educated, that would be a false belief. Actually apart from what I pointed out, you know, that I wasn't thrilled about, apart from that, everything else was superb. The tabletops were cleaned all the time, we were taught time and time again not to take our fingers and touch our mouths and so forth.

What happened on the 4th floor was a little different. There was a patient who was a super-spreader. We know these viruses are found on tabletops in the hall, and all you have to do is touch a virus and touch your hands to your mouth a few times and you increase your likelihood of getting a disease. We didn't do that in emerg. The hand washing, the scrupulous cleaning of tabletops, the administration was really very careful about making sure we followed the intelligent practices of communicable diseases ...

Question: And to whom do you attribute that good leadership?

Answer: Oh, [Dr.] Tim Rutledge was great. Also Dr. Keith Rose and the hospital execs ... Those people with whom I didn't totally agree on a couple of items, on most items I agreed with totally. I have worked at [other hospitals] and I can tell you that the engineering, and the training, and the attention to all the details was absolutely superb, absolutely superb.

Another emergency room physician said that staff were diligent and strictly followed protocols. This physician said that it was a team effort, not only by nurses and doctors.

He described the important role that a woman from environmental services had as part of that team effort:

I was aware of it being an individual choice on my part but most people, when I say “most people,” nursing staff, were quite consistent that way. And I referred to it earlier, the emergency department in the time in March and into April, there were certain doors that were not the normal access point into the emergency department but patients used to be moved out through those doors on beds going to diagnostic imaging. But in fact they held to the protocols very strictly, but there was a woman who was in housekeeping, environmental services, who took it upon herself, she was wonderful that way, it didn’t matter who you were, if anybody tried to use that door or deviated from what the protocol was, and she always made sure the supplies were stored, clean, adequate, separated. And she’d be standing there and, it was never an issue in my circumstance, but there were some people that needed to have some direction as to, I mean from time to time, but she was probably the most effective form of maintaining accountability and enforceability of what the protocols were and she was there – the approach she took was tremendous. It’s that sort of an individual that can make the substantial difference. I think the nursing staff were aware that the protocols were in place for very good reasons and followed that.

This physician said that the nurses were also very diligent about ensuring that procedures and precautions were followed by visitors:

The nurses in the emergency were very consistent. There would be times where patients, if they were in a cubicle, any time in May, if you went into the emergency department, there would patients who, if they said, well, you should have a mask on, the patient says, but I don’t like this, and they take it off, but they [staff] would insist. They were very consistent.

And, importantly, front-line staff in the emergency department reported that they had the support of their nurse managers. As one nurse told the Commission:

Our manager was very vocal in saying that, they were talking about the isolation and the idea of isolation and the idea of only certain nurses wearing the garb. Because eventually they got beat down a little bit and

they said, fine, you can wear your garb, okay, we get it. But maybe only certain nurses can wear it in this certain section and then these other nurses can stay in the other section. And our manager was saying, you don't understand the way the emergency department works, it doesn't work that way. You've got nurses in and out of everywhere. If a group of nurses here are going to wear it then everybody's going to wear it, if you think that it might be necessary and so it's going to be all-or-nothing sort of thing down here.

Another nurse described the unique position of the emergency room staff in the hospital and how that position affected their insistence on wearing protective equipment:

Emergency nurses and physicians have a little more of a relationship so we kind of spearheaded amongst ourselves. We're a pretty strong group down there. I don't think anybody would have told us to take it off and you have to push very hard to get us to take it off.

Fortunately, because of their refusal to remove their protective equipment and because of their adherence to strict isolation precautions, the emergency room staff and the emergency room physicians who admitted the Patient A family cluster members in May did not contract SARS. Had they been less firm in their belief in precautions or less confident in their own professional instincts, it seems likely that SARS would have spread within the emergency department, infecting not only staff but other patients and visitors. The hospital and the community owe a debt of gratitude to the skill and dedication of these individuals who held their own and refused to believe what they were being told by hospital authorities. They personify the wisdom of the precautionary principle. And it is a testament to the leadership in the emergency department that the emergency room at North York General had an environment where intelligent, able health workers were able to think on their feet and make effective decisions to protect themselves, patients and visitors.

By May 20, 2003, staff in the emergency department at North York General were concerned that SARS was still around and that there were patients admitted to the hospital for whom SARS could not be ruled out. The same day that staff were meeting with Dr. Berall and Dr. Mederski to express concerns about these cases and to discuss the relaxation of precautions, St. John's Rehabilitation Hospital was reporting to Public Health that they had a cluster of respiratory illness among four

patients and a health worker. In the days that followed, as the St. Johns' Rehab cluster was investigated, the trail began to lead back to North York General Hospital. Emergency room staff would learn on May 23 that they were right: SARS had never left.

The Outbreak at St. John's Rehabilitation Hospital

On May 20, 2003, St. John's Rehabilitation Hospital reported a respiratory outbreak among four patients and a health worker. The report and subsequent investigation led to the discovery of the second phase of SARS. When the report was made, no one involved with these cases or with the investigation into them had any idea of what was to come. No one knew that these cases were linked to a large outbreak of undetected SARS at North York General Hospital. No one knew that a second phase of SARS, equally devastating as the first, was waiting to be found.

The story of the outbreak at St. John's Rehab Hospital is a story of both tragedy and triumph. Tragedy, because we now know that the cluster of illness among patients at St. John's Rehabilitation Hospital traced back to a much larger, deadly outbreak at North York General Hospital, infecting patients, visitors and health workers, and spreading to other health care institutions. Tragedy, because three of the patients from St. John's were transferred to other health care institutions for treatment before it was known they had SARS, and at two of those institutions there was further spread of SARS. And tragedy for all those who became ill, especially for those who lost loved ones to the second phase of SARS.

The triumph, however, can be seen in the quick investigation and the collaborative effort of public health, hospitals and infectious disease and medical microbiology experts, which ultimately contained the outbreak at St. John's Rehab Hospital and led to the discovery of the outbreak at North York General Hospital. And triumph in the stories of strong medical leadership, strong infection control, strong occupational health and safety and strong communication on the part of St. John's Rehabilitation Hospital and Rouge Valley Health Centre, which prevented further spread of SARS.

But the story of the outbreak and its investigation also reveals a number of systemic problems, many already identified in the Commission's first interim report, including ineffective systems of communication between public health, hospitals and front-line health workers, a lack of central expertise, lack of public health resources and lack of lab support.

A Cluster of Respiratory Illness

St. John's Rehab Hospital, located at 285 Cummer Avenue in Toronto, is a leading hospital for specialized rehabilitation. The hospital has 160 inpatient beds, serving 2,600 patients annually from across the Province, as well as providing more than 47,000 outpatient visits per year, as part of a comprehensive outpatient rehabilitation program.⁷⁴³

After SARS, St. John's Hospital became a haven of support, both physically and emotionally, for health workers recovering from SARS. Through a program called "All Systems Go," St. John's Rehab partnered with the Workplace Safety and Insurance Board to provide post-SARS rehabilitation. It was the only program of its kind. Countless health workers interviewed by the Commission credited the hospital with helping them in their struggle to recover from the long-term impacts of SARS, including post-traumatic stress and chronic pain. Post-SARS, when hospitals returned to normal, many health workers felt abandoned in their illness and pain. St. John's Rehab Hospital was there for them. As one nurse told the Commission:

I wish to tell you one thing, St. John's hospital, the staff, the physios, the doctors, they have been there more for us than the hospital where I worked for 30 years.

On May 20, 2003, Dr. John Patcai, the medical director at St. John's Rehab Hospital, reported to Toronto Public Health a cluster of respiratory illness involving four patients and a health worker. The ill were three men and two women, ranging from 43 years of age to 68 years of age, each with a unique health history. Their common link was St. John's Rehabilitation Hospital and the onset of fever. A chronology of SARS II, prepared by Toronto Public Health, summarized the case history of these five cases:

[Mr. S],⁷⁴⁴ a 43-year-old male, was transferred to St. John's Rehab from Sunnybrook Hospital on May 9, 2003, following a laminectomy. He had developed fever on May 16 and fatigue on May 18. A portable chest x-ray on May 20, showed a right lower lobe pneumonia. While an inpatient

743. Numbers taken from St. John's Rehab Hospital website.

744. As with other parts of this report, patients referred to in this section have been randomly assigned a letter for reference, to protect their identity.

at St. John's Rehab Hospital, he was treated by health worker Ms. J prior to his onset of illness, and he was also a roommate of Mr. T.

[Mr. T],⁷⁴⁵ a 57-year-old male, was transferred to St. John's Rehab Hospital from Toronto General Hospital on March 19, 2003, following a double lung transplantation operation. His symptoms began on May 16 with a low-grade fever. On May 18, while he was at home on a weekend pass, he developed incontinence, weakness, tremors, jaundice and shortness of breath. He was taken to the emergency room at Toronto General Hospital but was returned to St. John's Rehab Hospital that evening. On May 20, he again developed a fever and complained of nausea, chills and cough, and was transferred back to Toronto General Hospital. While he was an inpatient at St. John's Rehab, he was a roommate of Mr. S and Mr. G and he had contact with health worker Ms. J.

[Mr. G], a 68-year-old male, was hospitalized at St. John's Rehabilitation Hospital on March 20, following a stroke. Mr. G's symptoms began on May 11, 2003 with fever. He was admitted to Scarborough Grace Hospital on May 13, with a diagnosis of fever of unknown origin. On May 20, he was diagnosed with congestive heart failure at Scarborough Grace Hospital. While an inpatient at St. John's Rehab Hospital, he was a roommate of Mr. S and Mr. T and was also treated by health worker Ms. J.

[Ms. N], a 55-year-old female, who turned out to be the index SARS case at St. John's Rehab Hospital, was admitted to St. John's from North York General on April 28, 2003, following a bilateral total knee replacement. On May 1, she developed fever and diarrhea. On May 6, she developed a cough. On May 9, she was transferred to North York General and seen in the emergency department, where she was diagnosed on a chest x-ray with pneumonia. She was returned to St. John's Rehab Hospital the same day. Her fever resolved on May 11, and on May 16, she was discharged home, where she remained well. She was called at home by St. John's Rehab Hospital on May 20. While an inpatient at St. John's Hospital, she had contact with health worker Ms. J.

745. As noted earlier, the initials of patients have been changed. This Mr. T is not related or connected to the index case, Mr. T, whose story is told earlier in connection with the outbreak at Scarborough Grace Hospital and the first phase of SARS.

[Ms. J] was a health worker at St. John's Rehabilitation Hospital. She complained of fever and fatigue starting on May 7 or 8, 2003. She was off work on May 8 and returned to work May 9 for one day only. She was then admitted to Scarborough Centenary Hospital with pneumonia, diagnosed on a chest x-ray. She had contact with all four above-listed patients while they were inpatients at St. John's Rehab Hospital.

The reporting of the cluster of illness at St. John's Rehab Hospital was a key step in the detection of the second phase of SARS. The actions of Dr. Patcai and the hospital reflected a keen understanding of not only their reporting obligations with respect to respiratory outbreaks⁷⁴⁶ but also the importance of heightened vigilance for any unusual clusters of illness. It is a strong example of what went right during SARS and it sets an example for future conduct. Without the actions of those involved in identifying and reporting the outbreak at St. John's Rehab Hospital, it is very likely that the second outbreak would have simmered much longer, spreading even further, before it was detected. As Dr. Rita Shahin, a Toronto Public Health physician, said, in giving credit to Dr. Patcai:

I have to credit the astuteness of the medical director at St. John's Rehab for realizing what he was dealing with. He had no training in infectious disease. He is not a specialist. He was very astute. He picked up on that unusual respiratory outbreak on his own and called it in to Toronto Public Health and that really was the first step in uncovering in the facility the second phase of the outbreak.

Not only did Dr. Patcai report the outbreak, he provided in-depth information to Toronto Public Health about the patients and also reported the case of Ms. N, who was no longer in hospital but was at home, having recovered from her illness. Dr. Tamara Wallington, from Toronto Public Health, told the Commission that the reports to Toronto Public Health, such as those made by the wife of Patient A, the man who died as an inpatient on 4 West at North York General and whose family became ill in May, and the report by Dr. Patcai, were important events in identifying the second outbreak:

So I spoke with Dr. Patcai on the 21st and he told me about four patients and a health care worker, and I'll just go through the brief history he gave

746. *Health Protection and Promotion Act*, R.S.O. 1990, c.H.7., s.27; and see Ontario Regulation 559/91, amended to O.Reg., 365/06, Specification of Reportable Diseases.

me on each one. And again, I think that this, for me personally was another really interesting turn of events. When I think of [Patient A's] family, the fact that they were never reported to us and that we probably wouldn't have known about them if they hadn't called in, it is to me pretty amazing. I'm so appreciative of the fact that she [Patient A's wife] called in.⁷⁴⁷

Something similar happened with Dr. Patcai when he phoned to tell us about this outbreak, because he ended up telling us about a patient who had been admitted to St. John's who was actually already at home and well. And just to give you the context around how outbreaks are reported, usually when facilities call in, a long-term care facility calls in to report a respiratory or even a GI [gastrointestinal] outbreak, they will tell you about the patients who are on the line list. So they'll take people who have the various signs and symptoms and they'll put them on what we call a line list, they'll document their names and that will include dates of onset, etc., and tests that have been ordered. They don't generally tell you about people who were sick a week ago and are now better, and he did that. He took that initiative and it turned out to be a very key person and that was [Ms. N]. And he didn't have to tell us about her and it's pretty amazing that he did ...

Dr. Patcai reviewed the health history of Ms. N with Dr. Wallington, including the fact that she had initially been an inpatient at North York General, that she had been seen in the emergency department at North York General Hospital and diagnosed with pneumonia during her stay at St. John's Rehab Hospital, and that she had been discharged home from St. John's Rehab and was doing well. Dr. Wallington credited Dr. Patcai's judgment in reporting the information and said that Ms. N's case was one of the turning points in the outbreak investigation, as it linked back to North York General:

She [Ms. N] was the first case and she was one of the turning points for us. If he had not told us about her, we would not have had the link back to North York, which turned out to be very significant. So, again, it was a very good judgment call on his part because you don't always hear about patients who were sick and then are better. So it was really excellent that he did that.

747. Patient A was a patient on 4 West, the orthopedic unit at North York General Hospital. He was the patriarch of the NYGH family cluster, admitted to North York General Hospital through the emergency department in May 2003. Their story is told earlier in this report.

St. John's Hospital had not only reported the outbreak and provided helpful details about the patients, those who were in hospital and Ms. N, who had since been discharged home, but they had also managed to contain the outbreak within the hospital. The containment of the outbreak at St. John's Rehabilitation Hospital was due to the hospital's strong approach to worker safety and its robust infection control policies. As one official from the hospital told the Commission:

The one saving grace is that any patient that comes into St. John's and has an elevated temp is put into isolation, and that had been even more strongly reinforced during SARS I, and so when SARS II happened after we'd done the critical incident review through SARS I, anybody that came in was on an automatic 48 hours' isolation, so we don't have any negative pressure rooms but we do have the ability to isolate.

Much like the experience at Vancouver General Hospital, whose story is told earlier in this report, the front-line staff at St. John's Hospital were used to being suspicious and cautious when confronted with a patient with fever or other respiratory symptoms and they understood the importance of isolation and the use of precautions. One official from St. John's Rehabilitation Hospital praised the staff for their strict compliance with precautions, preventing further spread of the outbreak:

... the right thing was that the staff were isolating the right patients and were doing the right thing in terms of their own personal protection, because when the patients were cohorted, you know, isolated, there wasn't any further transmission ...

The Naylor Report described the quick and cautious actions of St. John's Rehabilitation Hospital:

Meanwhile, St. John's Rehabilitation Hospital had a steady flow of patients from other institutions, including a transfer from 4 West at North York General Hospital. During the third week of May, staff at St. John's informed senior management that three patients were exhibiting SARS-like symptoms, and a call went out to Toronto Public Health. The hospital immediately instituted all the appropriate precautions.⁷⁴⁸

With the support of strong medical leadership under Dr. Patcai and a strong working

748. Naylor Report, p. 40.

relationship between management and front-line staff, St. John's Rehab Hospital proved that strong systems, strong leadership and good communication will stand even in the face of crisis and change. As one hospital official told the Commission, even a change in leadership immediately before SARS did not impact the hospital's ability to respond:

... the other thing that happened between SARS I and SARS II is that St. John's had no management team. Malcolm Moffat [the CEO] was hired a month before, just before SARS I. He closed the hospital on his third day of work ... So Mary Grace [Grossi] and some of the other folks really stepped up to be leaders during that. Mary Grace has been there for 20 years so she really knows the organization and I think really galvanized the staff to get them rallied around that first one [the first SARS], because certainly people were. There were very good systems in place that we got up and running for the second time around.

The identification and containment of the outbreak by St. John's Rehab Hospital is even more impressive when one considers that it did not have its own infectious disease specialist and did not have the infection control resources available at some of the large health care institutions in Toronto. St. John's, like many other small institutions in Toronto and across Ontario, had to rely on the help of outside experts for consultation and advice.

Around the same time the report was made to public health, Dr. Patcai, concerned about this outbreak, had also contacted Dr. Allison McGeer, the Director of Infection Control for Mount Sinai Hospital. On the advice of Dr. McGeer, and in consultation with the clinicians who were caring for these patients, a number of lab tests were ordered on the patients who had been transferred from St. John's Rehab Hospital to acute care hospitals, including testing for SARS coronavirus.

Toronto Public Health Responds

The May 20, 2003, report from St. John's Hospital about the cluster of respiratory illness was forwarded by the Toronto Public Health investigator who took the report to a public health physician for review. The physician, who was not on the SARS team at Toronto Public Health but rather was responsible for non-SARS outbreak reports, was concerned by what she was told, and reported it to the SARS team. Dr. Shahin explained how the report came to her attention as a member of the Toronto Public Health SARS team:

Late on May 20th, the medical director had called the west office of Toronto Public Health and spoke to one of the investigators about a respiratory outbreak that he was concerned about. She gathered more information from him. He sent her an email with some summaries of the number of cases and patients he was concerned about. And the next morning she spoke to [Dr.] Megan Ward, who was the physician dealing with everything that was non-SARS at Toronto Public Health, and Megan was concerned about the outbreak. It didn't sound like a typical respiratory outbreak, so she was trying to reach the SARS reporting line, the Toronto Public Health line, and wasn't able to get through, so she called me directly, knowing that I was at 277 Victoria.

The astute actions of Dr. Ward meant that alarms were being raised in a timely way, and with the right people.

Also on May 21, 2003, Dr. Barbara Yaffe, the Director of Communicable Disease Control for Toronto Public Health, became aware of the cluster of illness at St. John's Rehab Hospital while at a meeting of the Naylor Commission. She told the Commission that Dr. McGeer approached her at the meeting and raised concerns about St. John's:

I personally became aware of it May 21st, I was actually at the first meeting of the Naylor Commission, on Sheela's [Dr. Basrur's] behalf, and [Dr.] Allison McGeer was there too, and during a break she said to me that she had been called by St. John's, and she was concerned about it. So we went through together what was going on there, and I called the office right away, and I said transfer this St. John's situation to our SARS team and I asked [Dr.] Rita Shahin to take the role as one of the senior physicians to lead the investigation.

As noted above, on May 21, Dr. Wallington spoke to Dr. Patcai and gathered information from him about the four patients and the ill health worker. The various hospitals where these patients were now being treated were contacted by Toronto Public Health to review the cases with the front-line clinicians. She said that at that time, while it was clear that they were dealing with an outbreak of some kind, it was not clear that it was SARS. None of the patients had an epilink to a known SARS case, all had a possible alternative diagnosis and not all of their symptoms were clinically compatible with SARS. Dr. Wallington described the cluster of illness:

It was a clustering of individuals that had fever. Some, three of them had chest x-ray findings, so there was definitely something happening in the lungs but they didn't all complain of respiratory symptoms.

On May 22, 2003, there were a number of conference calls throughout the day involving Toronto Public Health, the Ministry of Health and Long-Term Care, the Provincial Operations Centre and a number of infectious disease experts and physicians from across Toronto.

It was clear that a number of other hospitals would be affected if these cases turned out to be SARS. The four patients⁷⁴⁹ had come from three different health care institutions in Toronto:

- Two patients had come from Sunnybrook Hospital;
- One patient had come from Toronto General Hospital; and
- One patient had come from North York General Hospital.

And as of May 21, the day the investigation started, three of the patients and the health worker had all been transferred out of St. John's Rehab Hospital to other hospitals in Toronto, where they were receiving medical care:

- As of May 21, Mr. G was at Scarborough General Hospital, having been admitted on May 13, 2003;
- Mr. T was at Toronto General Hospital, having been admitted on May 20, and also having been to the emergency department on May 18, 2003;
- Mr. S was admitted to Sunnybrook Hospital on May 20, 2003; and
- The health worker, Ms. J, was at Scarborough Centenary Hospital, having been admitted on May 16, 2003.

Also on May 22, 2003, staff from Toronto Public Health went to St. John's Rehabilitation Hospital for a meeting of the outbreak management team. The Naylor Report described the events of that day:

Toronto Public Health staff visited the hospital on May 22. Discussion again focused primarily on establishing an epidemiologic link to the patients. None was found.⁷⁵⁰

749. There were five people who were under investigation for SARS: four patients and one health care worker.

750. Naylor Report, p. 40.

Although the patients were being managed with SARS precautions, the absence of an epilink prevented health officials from classifying the case as SARS. As the Naylor Report found:

Still chasing down 30 to 40 possible cases of SARS per day, personnel at Toronto Public Health agreed by telephone that there was a respiratory outbreak, but suggested that SARS was not a likely culprit – as at North York General Hospital, no epidemiologic link could be established.⁷⁵¹

The patients were categorized as persons under investigation, in accordance with the case definition at that time. Public Health understood that the cases were being managed in isolation, with precautions, as if they were SARS. Public Health was investigating the cases and looking for possible epilinks.

Smells Like SARS

Ms. J, the health worker from St. John's, had been admitted via the emergency department, to Scarborough Centenary Hospital, part of the Rouge Valley Health System, on May 16, 2003. Prior to her admission, she had seen two family physicians, and she recalled that both had used precautions.⁷⁵² The cautious use of protective equipment by physicians and health workers likely prevented the spread of SARS within those clinics to patients or staff.

Because Rouge Valley Hospital had not dropped precautions in the period between what are now considered SARS I and II, when Ms. J went to the emergency department on May 16, precautions were taken from the moment she walked in the door. Protective equipment was used both by her and by staff who assessed and provided care to her. Ms. J recalled to the Commission that she was given a mask before she entered the emergency department, and that her husband was not permitted to accompany her. While she waited in the emergency department, a nurse took her temperature. Her temperature had gone up and she was put in isolation. As she described to the Commission:

751. Naylor Report, p. 40.

752. Ms. J went to her family doctor on May 14, 2003. She recalled that he wore a mask when he examined her. She went to a walk-in clinic near Scarborough Centenary Hospital on May 16, 2003. The physician who saw her at the clinic also wore a mask and directed her to go to the emergency department at Scarborough Centenary Hospital.

I don't remember how long I was sitting there but finally somebody came and they took my temperature. Actually it went up a little bit so the nurse put me in isolation because I had a fever. I guess to be sure they had to be put in isolation if somebody had a fever at the time. This is what was explained to me. And I was put in an isolation room, I think it was negative pressure, I haven't been in isolation before. And then the doctor came, he was one of the emergency doctors. He assessed me and he said, I don't know what's wrong with you, it seems like I cannot find anything. So I didn't have stroke, I didn't have headache, actually, my head was quite clear. And I was still complaining about a lot of pain. I was asking them to give me some Tylenol or something. It was difficult for me to sit or lying on the side, anything, any side, especially my right was very, very bad. And again, he was in this mask and he looked at me and said, I really can't find anything wrong with you but we will try to see the blood work, and somebody came and took my blood.

And after, I don't know what time it was, but after they came to me dressed and double-masked and they said that I have viral hepatitis and they don't know if I really have it or not, this is what I was told. And they ordered x-rays and blood work. So they eventually came with again, double gowns and masks, I was actually in the room, and the x-rays. It took a while because I guess they had to find a mask and everything. It wasn't just N95s anymore, it was like they were wearing full gowns. And even the doctor who came the second time I actually had my blood done, she was double-gowned too and double-masked at the time.

Also on May 20, 2003, Mr. S's mother, Mrs. S, was admitted to Scarborough Centenary Hospital with respiratory symptoms. She had visited her son on May 11, while he was an inpatient at St. John's Rehab Hospital. She began to develop fever, headache and myalgias on May 14, 2003. When she was admitted to Rouge Valley Hospital on May 20, 2003, Mrs. S was not known to have SARS. When she went to the emergency department, she was asked about recent travel history and reported that she had recently travelled to China. As a result, she was admitted into a negative pressure isolation room and emergency room staff used precautions. The clinician who saw her was concerned about her condition and reported her case to Dr. Ian Kitai, the medical director for infectious diseases at Rouge Valley Health Centre. Although Rouge Valley was unaware of her connection to St. John's Rehab Hospital, they reported her case as a respiratory illness to Toronto Public Health.

Despite the hospital's not being aware that Ms. J and Mrs. S had SARS, the precautions used and infection control measures taken at the Rouge Valley Hospital with these two patients meant that there was no further spread of SARS to other patients, visitors or staff. Rouge Valley Health System treated 28 probable and 21 suspect cases during SARS. They had no evidence of transmission to health workers, patients or visitors in the hospital.⁷⁵³ Dr. Kitai described the hospital's success as a "team success" and said that everyone, including administrators, senior management and front-line staff, was part of the team effort.

The cautious approach taken by Rouge Valley Health System was rooted in strong infection control and occupational health and safety, both essential to safeguarding patients and staff in a health care institution. Measures such as using their Joint Health and Safety Committee to ensure compliance with precautions and to provide education and reinforcement of policies, fostering and maintaining an open and strong relationship between front-line staff and the decision makers in the hospital, and respecting and valuing the opinions of front-line staff were hallmarks of an environment that promoted both patient and worker safety. Dr. Kitai described his infection control philosophy as follows:

If you are not sure, you act with the greatest of caution to maximize and protect health care providers.

Dr. Kitai was a leader, not only during SARS but also during the legionnaires' outbreak in 2005. His approach and outspokenness during both outbreaks showed strong medical leadership, rooted in an understanding and application of the precautionary principle, that action to reduce risk need not await scientific certainty.

The hospital's strong approach to infection control, a worker safety culture, communication and systems based on the precautionary approach were also hallmarks of the response of Vancouver General Hospital, a hospital that contained SARS when it arrived in the emergency department on March 7, 2003. The story of SARS at Vancouver General Hospital is told earlier in this report.

The infection control team and front-line staff at Scarborough Centenary Hospital were in constant communication with Dr. Kitai. When they expressed concerns, he listened. When they alerted him to the case of Ms. J, he shared their concerns. Here

753. SARS Commission Public Hearings, October 1, 2003.

was a health worker who was young and otherwise healthy and who was suddenly very ill to the point of almost requiring ventilation, and who worked at St. John's Rehab, a hospital that took cases from acute care hospitals in Toronto that had SARS patients. Despite the absence of an epilink, Dr. Kitai was very concerned about her case and felt that it "smelled like SARS." Even before the hospital became aware of concerns at St. John's Hospital, they reported the case of Ms. J, to Toronto Public Health, unaware of the connection.⁷⁵⁴ When Dr. Kitai heard about the cluster of ill patients at St. John's Rehab Hospital, he repeatedly phoned Toronto Public Health to express his concerns.

During one call to Toronto Public Health, on May 22, 2003, Dr. Kitai spoke to Dr. Barbara Yaffe, and expressed his frustration as to why these patients, in particular the health worker being treated at his hospital, were not being called SARS. Dr. Yaffe's notes of the conversation with Dr. Kitai provide:

Physio – smells like SARS – screw the orders re PUI
The epilink will come
Look at NYGH – had 2 psych pts
St. John's Rehab Hosp ? adjacent to NYGH
Get virology
Recording everything I'm saying to everybody
So what if you're wrong – regard as SARS until prove otherwise – isolate,
quar.
Nzes [short for "consequences"] of ignoring it + saying it's not SARS ...

Dr. Yaffe was asked by the Commission to explain what her notes meant:

Question: But then he's got noted, get something ... ology?

Dr. Yaffe: Virology.

Question: Got virology.

Dr. Yaffe: Virology.

Question: Virology, recording everything I am saying to everybody.

754. According to TPH records, Ms. J's case was reported by Rouge Valley Hospital on May 16, 2003.

- Dr. Yaffe: That is him telling me that.
- Question: That's him telling you that. So he is recording everything he is saying to everybody, so what if you are wrong, regard as SARS until proven otherwise.
- Dr. Yaffe: Isolate and quarantine.
- Question: Isolate and quarantine.
- Dr. Yaffe: Risks of ignoring it and saying it's not SARS, he is basically saying if you are in doubt, call it SARS, which is what we're doing.
- Question: Now go back to the top, though. He is saying screw the orders re: PUI.
- Dr. Yaffe: Yes, I don't know what he's talking about, I don't know what he meant by that. I don't know. I didn't write down what I said to him, but I would have explained to him that PUIs [persons under investigation], we do treat them as is if they have SARS and isolate them and quarantine the contacts, but I just wrote down what he was saying to me.
- Question: I am interpreting this and I may be quite wrong, but he's phoning up saying, screw the orders re: PUI, so call it SARS, so what if you are wrong?
- Dr. Yaffe: Yes.
- Question: Call it SARS until proven otherwise and the risks of ignoring it. It sounds like he is saying something to you at that point in time that strikes me as a layperson as just about bang on. So it is, screw the orders re: PUI [persons under investigation], were there orders about?
- Dr Yaffe: No, there were no orders.
- Question: ... and call it SARS.

Dr. Yaffe: You know, I think it has to do with how people interpret PUI. To me somebody, as I explained before, PUI did not mean they didn't have SARS.

Question: Right.

Dr. Yaffe: It just meant they didn't meet the case definition.

Question: At that time.

Dr. Yaffe: Yes, but we were treating as if they did.

Dr. Kitai's words resonate today.

The fact that a patient did not meet the formal classification of a suspect or probable case in a system designed to meet reporting requirements within Ontario and Canada and internationally, did not mean they did not have SARS and it did not mandate anyone to say SARS was gone or that cases were not SARS when it could not be ruled out. "Person under investigation" included a patient who clinically appeared to have SARS but for whom an epilink could not be found. But as we know from the story of the ill health workers from North York General Hospital in April, of the ill psychiatric patients and of the Patient A family cluster, because an epilink could not be identified did not mean one didn't exist, and its absence could not rule out SARS. Time and time again, the problem was that the classification of "person under investigation" did not reflect the reality that the patients "could be SARS" if and when an epilink turned up.

There were strong concerns among front-line clinicians involved with these cases that they could be SARS. And while the case definition did not change how these patients were managed, the identification of new cases of SARS, as suspect SARS until proven otherwise, as opposed to as persons under investigation until proven to be suspect or probable, would have signalled to front-line staff that SARS might be back. The identification of suspicion of new SARS cases would likely have resulted in greater vigilance for additional cases across Toronto and to a reinstatement of many of the precautions that helped contain the early cases of SARS. As will be seen below, at those hospitals not involved in this discussion about the St. John's cluster, front-line staff worked without protection, under the false belief that SARS was gone.

The problem was not that Public Health did not understand the meaning of "persons under investigation"; it was that others didn't. And the strict case definition, seemingly premised on the belief that the absence of an epilink meant not SARS, did not

account for the risk that there would be cases for which no epilink could be found, possibly ever. The classification system, based on this strict case definition, did not accurately reflect the potential risk of a new case that looked like SARS and smelled like SARS but for classification reasons could not be called SARS.

It is important to point out that Public Health did not create the case definition. They were operating with a definition that they were required to use. But SARS showed us that in any future outbreaks, there must be complete clarity around case definitions: what do they mean to public health, what do they mean to the provincial government and what should they mean to the rest of the community, especially health care institutions that must take steps to ensure the safety of staff, visitors and patients.

SARS Is Back

May 22, 2003, was a key date in the identification of the second outbreak. Although the cases from St. John's were being investigated, it was still not known if they were SARS or some other outbreak. But on May 22, 2003, as further information about the patients was learned, the pieces came together that made it clear to everyone that SARS was back.

Toronto Public Health identified four things that became apparent on May 22, 2003, and that solidified to them that this was SARS:

- i) results on the broncho-alveolar lavage for [Mr. T] was positive for SARS associated coronavirus;
- ii) the condition of the ill health worker from St. John's Rehab [Ms. J] had worsened significantly. She is being transferred to the ICU;
- iii) the mother of [Mr. S] fell ill with SARS-like symptoms three days following her visit to him on May 11, 2003; and
- iv) the index case, [Ms. N], had been transferred from the orthopedic floor at North York General Hospital to St. John's Rehabilitation Hospital. She had a mild course of illness and had already recovered and was at home. [Ms. N] was [later] linked to 4W where Patient A was a patient and Patient A's wife [the A family cluster]⁷⁵⁵ visited regularly.⁷⁵⁶

755. The story of the Patient A family cluster is told earlier in this report.

756. Toronto Public Health Chronology, SARS II.

Dr. Shahin described for the Commission how these pieces of information came together on May 22, 2003:

We had I think three pieces of information that came together at the same time. One was the test results on [Mr. T], the other was [Mrs. S] who was [Mr. S's] mother, and [Mrs. S] had gone to China about a month before the onset of her illness, so when she became ill, what everyone was focusing on was her travel and the fact that it had been so far out of the normal incubation period that it didn't fit the picture. What we didn't know about was that she had a son at St. John's Rehab and she visited him on May 11th. That piece of information only came together after we were doing the outbreak investigation for St. John's Rehab. And then the third piece that came a little bit later was [Ms. N], who was the patient at St. John's Rehab that had been transferred from North York General and turned out to be the source of the outbreak at St. John's. So as we were investigating St. John's Rehab, we were looking at all the patients and where they had come from because they had all been transferred from acute care facilities.

Dr. Yaffe agreed that on the afternoon of May 22, things fell into place. During a conference call with experts and with officials from the Ministry of Health and Long-Term Care, it was determined that SARS was back and that the public had to be notified and St. John's Rehab Hospital had to be closed. As Dr. Yaffe told the Commission:

You know that day, May 22nd, it was quite a day. Things started to kind of fall in place very quickly in the afternoon. I had a call that there was a positive PCR on the broncho-alveolar lavage from one of the patients who had been transferred from St. John's to Toronto General. We made a connection finally between, there was a woman called Mrs. S, and her son was at St. John's and we didn't realize, she hadn't named him as a contact. And she had travelled to China or Hong Kong but the time period didn't fit, so we were not sure what was going on with her, and they all of a sudden realized she had visited her son who now was ill, so then we started to make the connection with the physiotherapist, Ms. N, who had been transferred from North York [Hospital].

And meantime, all of a sudden it was all coalescing, as all this happened. So then I spoke to the Ministry, I spoke to [Dr.] Erica Bontovic at the ministry, and we said well we need to do a case review of all this right

away. And then in the middle of all of this, [Dr.] Ian Kitai called me. And then we had a case conference with a lot of people on the phone. I called the Ministry and asked for the, what now they are calling the adjudication, I asked for the ID [infectious diseases] physician on call to consult on a difficult situation, it was Dr. Kevin Goff, and got him on the line, and I got the Ministry, and St. John's, and different sections of the ministry, Public Health, and we went through systematically all the different pieces of the whole thing, and based on that, and I was appointed again, the Acting Medical Officer of Health because Sheela [Dr. Basrur] was away, I said okay, SARS is back ...

Late that evening of Thursday, May 22, at approximately 9:30 p.m., Toronto Public Health held a press conference, where they announced to the public the outbreak at St. John's Rehabilitation Hospital. The press release issued about the St. John's outbreak identified four cases under investigation for SARS. The fifth case, Ms. N, was not identified because she was no longer in hospital and had recovered from her illness, although she was considered a case at that time. The press release provided:

News SARS cases under investigation

Toronto, May 22/CNW/ – Four individuals are currently under investigation for SARS. These patients are all being treated in hospital, and full precautionary measures are in place.

As a result of possible exposure to SARS, Toronto Public Health is asking all individuals who were in St. John's Rehabilitation Hospital between May 9 and May 20 to isolate themselves at home and call Toronto Public Health at [number provided] Friday morning starting at 9 a.m.

These individuals should monitor their temperature, and watch for the following signs and symptoms of SARS: sudden onset of fever (greater than 38 degrees C or 100.4 degrees F), AND respiratory symptoms, including cough, shortness of breath, or difficulty breathing.

Staying at home and limiting your exposure to others is the best way to control the spread of SARS to family, friends, and coworkers.

Anyone in isolation must take the following precautions:

- Do not leave your house, and do not have anyone visit you at home.

- Family members do not have to be quarantined, unless a member of the household is diagnosed with SARS.
- Wear a mask when you are in the same room with another member of your household. Change your mask twice a day. Family members do not have to wear a mask.
- Do not share personal items, such as towels, drinking cups, or cutlery.
- Wash your hands frequently.
- Sleep in separate rooms.

St. John's Rehabilitation Hospital is closed to admissions, visitors, discharges and transfers.⁷⁵⁷

By this time it was clear that there was a connection between the SARS outbreak at St. John's Rehab Hospital and a number of hospitals. While the precise details of the connection may not have been clear, those involved in the investigation knew that all of the patients involved had come from other institutions, and all but one had gone back into hospital since being at St. John's Rehab Hospital.

As noted above, Ms. N was believed to be the index case of the outbreak at St. John's. Although she had since recovered from her illness and was no longer in hospital, she had come to St. John's from North York General Hospital. Also at this time, public health officials were worried about the cluster of illness among Patient A's family, a North York General Hospital case they had been monitoring since May 12, 2003. They were worried that Patient A's family might have SARS, and this, combined with what they were learning about Ms. N, led them back to North York General. Dr. Wallington described the concerns about Ms. N and Patient A and his wife, in the context of what was also learned about Mr. S and his mother and the tests results for Mr. T:

So on the 22nd, things started to come together. [Mr. T's] PCR [polymerase chain reaction] came back positive for SARS. [Ms. N], who was the first case at St. John's, had been a patient at NYGH, where a patient [Patient A], who we had heard about anecdotally, had died, and his family was sick. She [Ms. N] was the first person to be sick in the cluster at St. John's. She was therefore the source case for St. John's. Where was she before that? Where did she get it? She was at North York General Hospital where Patient A had died and his family was sick.

757. Toronto Public Health press release, May 22, 2003.

There was a third piece of information that Dr. Lisa Berger may be able to speak to regarding Mrs. S, who was the mother of Mr. S. I wasn't directly involved in her case, but I believe she also developed SARS. She had gone to China a month before, came home and put herself into a 30-day quarantine. She then visited her son at St. John's, got sick and died. Although she had been to China, she acquired SARS as a visitor at St. John's. That was the third piece of information that came to us on May 22nd.

That evening, Thursday, May 22, 2003, after the press conference that announced the St. John's Rehab outbreak, a decision was made to go to North York General to review case files. As Dr. Wallington told the Commission:

At about 11 o'clock I said to Barbara [Dr. Yaffe], I think we need to go to North York [General Hospital]. Somebody needs to go to the hospital and review her chart [Ms. N], and review the charts of her hospital roommates. We need to review the medical charts because there is something going on at North York General Hospital. She [Ms. N.] is the index case at St. John's [Rehab Hospital]. She had been transferred to St. John's from the hospital where [Patient A] died [NYGH], we didn't have any information on him. I felt we needed to go to North York and start looking at charts to get a better understanding of what was going on. And she [Dr. Yaffe] agreed. Lisa [Dr. Berger] and I would go. Allison [Dr. McGeer] and Don [Dr. Low] were standing there. I turned to Don and asked him if he would come with us to review charts. We were at 277 Victoria, at the office. They were there at the time of the press conference.

Protecting North York General Hospital Staff

The investigation into the St. John's outbreak was reported to Public Health officials on Tuesday, May 20, 2003, and commenced on Wednesday, May 21, 2003. North York General was advised of their possible connection late Thursday, May 22, 2003. When meetings and conference calls were taking place on May 22, North York General was not on the line, despite the fact that one of the patients under investigation had come from their hospital.

Dr. Glen Berall, co-chair of the North York General Hospital SARS Task Force, recalled learning on May 22, that Public Health wanted to come on site the following

day to review patient charts, and recalled that it wasn't until May 23 that everything fell into place:

Dr. Berall: On the 22nd, I was aware that they were coming to look into any possible connection to St. John's and they wanted to go over some charts. So I thought, okay, well, if there's something that I need to facilitate, I should be there. So I was at that meeting.

Question: But you'd never had to do that before when they came in.

Dr. Berall: No.

Question: So was there already sort of a signal that it may have been a bit unusual?

Dr. Berall: I sent an email to Sue Kwolek on the night of the 22nd saying, do we have any patients from St. John's? Because I wanted to make sure that she and I both looked into that the next day. And then we had that meeting and it was being covered. I became aware of that meeting anyway and that was my total email to Sue Kwolek, was exactly that line and nothing else. It just said that. And so we then had that meeting. And at the meeting, as the meeting progressed, it took us until late in the afternoon to put the entire picture together with all of that expertise around the table. And as the day progressed, it became more and more obvious to us that there was a problem right there at North York General Hospital. That's when I became aware of it and apparently, that's when Toronto Public Health and [Dr.] Donald Low became aware of it, or certain of it. They had gone to St. John's Rehab, I gather, the day before and therefore they were coming to North York General the next day. And that's my understanding of how that proceeded. So when did they become aware they needed to come to North York General for these things? It was on the 22nd. They arranged to come the next day and we saw them.

Dr. Keith Rose told the Commission that he had no idea prior to May 23 that Public Health was looking at a possible SARS connection to North York General. He said:

I had no idea. We know that our patient went to St. John's. That was a fairly common source of referral for an orthopedic patient and it was an absolute surprise to me on May the 23rd that there was a link, the link was to 4 West. Understanding the patient that transmitted it now and seeing the Health Canada report, understanding who it was and how it got there, I can see all that now. At that time, I had no idea. But I will say I was surprised that if there was a postulate that North York was involved, that we were only notified on May the 23rd.

Toronto Public Health staff and physicians were working very hard to investigate the outbreak. It is apparent that a lot happened on May 22, and the story that now seems so clear was not so neat and clear at the time. As Dr. Wallington said to the Commission as she was reviewing the story of the outbreak at St. John's Rehab Hospital:

So this all sounds neatly packaged, but it's all in retrospect. I need to give you that caveat.

It is also clear that Toronto Public Health officials and government officials had no idea that an outbreak such as they discovered on May 23, 2003, was spreading through the hospital. When they went there on May 23, they intended to review only the charts of Ms. N, her roommate and Patient A. They did not know that there was a large outbreak among patients, staff and visitors on 4 West.

Dr. Berall, the co-chair of the SARS Task Force, said that everyone, including Toronto Public Health, came to the meeting on May 23, 2003, without any idea of the role that North York General had in the St. John's outbreak:

I think they started to suspect it when they went to St. John's and looked at the key patient who had come from North York General to St. John's and then came to North York General because of that suspicion and then the dawning awareness happened during that meeting. The way I look at the meeting is that it was a period of time during which our jaws sequentially dropped over time, and that's everybody around the table. It wasn't like, I didn't at all have the impression that Public Health, Health Canada and Donald Low came thinking, aha, we've got it and, you know, you guys don't know but this is what we think. But rather, they

were wondering and looked because of the St. John's connection. So I don't think that it would have fallen into place earlier because there wouldn't have been the link.

On May 22, 2003, there were suspicions that there were at least two undetected cases of SARS associated with North York General Hospital: Ms. N and Patient A. It was believed that Ms. N was the index case of the outbreak at St. John's Rehabilitation Hospital, and suspicions that the cluster of St. John's patients did have SARS were confirmed. Toronto Public Health staff told the Commission that it was not until they began to review charts on site on Friday, May 23, that they realized that Ms. N had been on the same unit as Patient A.

As seen time and time again throughout the outbreak, minutes, hours and days made a difference. Health workers could not protect themselves if they did not know they were at risk. Any delay in identifying the outbreak on 4 West and reinstating precautions put nurses, doctors and other health workers at risk of exposure. For example, one nurse was exposed to SARS when she came to work on May 22, ironically to cover a shift on 4 West for a nurse who was off sick. The nurse who covered her shift recalled bathing a very ill elderly patient on the orthopedic floor. Even though precautions had been relaxed on the unit, she recalled that she decided to wear a mask, but the only mask she could find was a surgical mask. The patient was one of the 4 West patients who was later identified as having SARS. This nurse contracted SARS and began to experience symptoms on May 26. Her story shows how every moment counts when it comes to protecting workers and the importance of protecting workers at the earlier signs of risk.

The Commission finds no evidence to suggest that public health officials deliberately kept information from North York General or that they had any knowledge of the risk faced by staff, patients and visitors to 4 West. The Commission accepts that prior to May 23 Toronto Public Health officials did not know that both Ms. N and Patient A were linked to the same area of the hospital: 4 West. Public Health did not know that 4 West staff were working, unprotected, with patients who had SARS. They did not know what was happening at North York General Hospital and in no way could have predicted what they would find when they went to the hospital on May 23, 2003. Public Health officials did not have the knowledge that we have today about what was happening on the 4th floor at North York General.

There was at the time no protocol that required North York General Hospital to be notified of the investigation into St. John's Rehab, nor does the Commission suggest

there was a lapse in existing standards. But there lacked a policy and clarity around reporting of potential infectious disease outbreaks by Public Health to potentially affected health care institutions. North York General and staff were not clearly notified of the potential link to the St. John's outbreak at the earliest possible opportunity. While Public Health officials did not know before May 23 that Ms. N was an inpatient on 4 West, the same unit where Patient A died, had North York General been told of the investigation at St. John's Rehab from the outset, and that a former patient was under investigation as part of the cluster, the hospital might have identified the link earlier than May 23. Had it been able to identify the link earlier, the hospital might have communicated to staff the fact that two patients connected to 4 West were under investigation for possible SARS and reinstated precautions until the risk could be ruled out.

As noted by the Commission in its first interim report, the obligation to report potential public health hazards is a two-way obligation: the hospital must report to public health, but public health must also report risks to hospitals. They should not wait until a risk has been fully investigated or crystallized, but should err on the side of disclosure. Nor should the ability of a hospital to be kept informed of risks in the community depend on their being part of the inner circle of experts who are consulted for advice by public health or Ministry officials. As we saw time and time again, hospitals cannot protect themselves if they do not know the risk they face, and in a health system such as Ontario's, where a patient can travel between multiple health facilities in a single day,⁷⁵⁸ diseases can quickly spread beyond what is thought at the time to be the source. Public health must have policies that support and allow the sharing of information with health care institutions and must have clear legal powers to disclose personal health information to hospitals or any other institution that might be at risk, where necessary to protect the public, which of course includes patients, visitors and health workers within those institutions.

758. For example, in the story detailed below under "Communication Breakdown," we see a patient come from St. John's Rehab Hospital, through North York General emergency, to Scarborough Grace Hospital, on the same day.

Communication Breakdown

Although the diagnosis of SARS was not confirmed until May 22, 2003, with the report of the positive results for Mr. T, five patients from St. John's were identified on May 20, 2003, as under investigation for SARS and the investigation was commenced on May 21, 2003.

Those hospitals that were lucky enough to be in the loop as the cases were discussed and conference calls were held, were in a position where they could ensure that their front-line staff, especially their emergency departments, knew about what was happening and were on the alert for respiratory cases from St. John's Rehab Hospital. North York was not one of those hospitals.

Those physicians and staff working in the emergency department at North York General the night of May 22, 2003, did not know about the investigation into a cluster of illness at St. John's Rehab Hospital or the identification of those cases as SARS. As far as they knew, there had been no new cases of SARS since early April. SARS was over.

That evening, they received a patient from St. John's Rehab Hospital who was quite ill. Unaware of the developments at St. John's, physicians and staff intubated the patient in the emergency department without using protective equipment. The doctor who intubated the patient told the Commission that he first saw this patient around 8:00 or 9:00 p.m. He said that when he performed the intubation, he had no idea anything was wrong at St. John's Rehab Hospital:

What happened was I saw her and we were [not] concerned given, at that point, we had been told, or led to believe, or it was suggested strongly that SARS no longer was a problem in Toronto. Right? We had no information about St. John's, and it happened at that hospital that day. And we had been told she had decreasing levels of consciousness for reasons unknown. She had no fever as well.

Because the intensive care unit was full, a not uncommon event in hospitals across the Greater Toronto Area, the patient was then transferred to Scarborough Grace Hospital. Nursing staff from Scarborough Grace inquired whether there were any concerns that the patient might have SARS. North York General reassured them that the patient did not have SARS. The physician who gave this assurance had no idea that cases of SARS had been identified earlier that day at St. John's Rehab Hospital.

He had no reason to suspect this patient might have SARS and he understood that there were no cases of SARS in Toronto. As he said:

On May 22nd, I knew there was no SARS in Toronto. That's what I had been told by some pretty reliable sources. North York General, [Dr.] Barbara Mederski, [Dr.] Glen Berall, the administration, Province of Ontario, Government of Canada sort of got together on that. I'm not sure about the WHO though.

Later that night, one of the physicians on duty in the emergency department at North York General Hospital received a telephone call from a very angry physician at Scarborough Grace Hospital. The front-line staff at North York General still had no idea about the outbreak at St. John's Rehab Hospital:

... I got a call from Scarborough Grace; a physician from there, he was actually I think the internist on duty that night, asked for me. I came on the line and this guy started yelling and screaming at me. He said, what are you guys doing, you know you just transferred a patient with SARS to us ... I said, excuse me, what patient with SARS, we transferred one from St. John's. He said, don't you guys know anything, haven't you been listening to the radio? And I said, no, I work in the middle of emergency; when am I going to listen to the radio? He said, it's all over the news, there's an outbreak in St. John's.

When he said that, no more goosebumps, just a big hot feeling went down my back, because the first thing I knew was, [the doctor who intubated the patient] is dead, [the doctor] is going to die. In fact I was really very, very, very upset. [The doctor] is a very good friend of mine. I phoned [the doctor] right away. I said before you hear it on the news, let me tell you what's happening, and I told him there is an outbreak, we don't know who's involved, which patients, this patient may or may not be involved, but we don't know, but I'll keep him posted.

The physician involved in the intubation recalled receiving that telephone call described above, in the early morning hours while he was at home:

I went home about one o'clock in the morning and the patient was intubated and [the above-quoted doctor] was looking after her. So I got a call about 3:00 a.m. on May the 23rd from [the above-quoted doctor]. He wanted to know if I was sitting or standing, well, I'd better sit down

again. He said, that patient you looked at from St. John's, St. John's has closed their hospital, they've got some SARS suspects in the hospital. I sent the patient to Scarborough Grace. They just got a call from St. John's saying the patient may have SARS. Doctors at Scarborough Grace were not exactly thrilled about that.

One emergency room physician at North York General described the communication around the St. John's outbreak as "a total breakdown":

I think there is a total breakdown and it shouldn't have happened. If St. John's knew in the morning that they may have SARS cases, and they did the appropriate thing, and that was to call Public Health to investigate by midday, at that point they, of course they had to transfer out a critically ill patient, but why was nobody told in our department when they have sent this patient, that they are the place that may have SARS. And this lady was in the next room to where these cases were found, the next room or on the same floor, whatever, but there was a connection there. And this is why I bring this up, the communication had to improve. Public Health should have just taken control of the situation and said while they were investigating, even though we are not willing to go to the media and say it's St. John's because they hadn't released that information yet, they should have forewarned two hospitals when they were sending these patients out, or at least warn us and then we would have forewarned Scarborough. If she was SARS, God forbid, what would have happened.

Dr. Rutledge, the Chief of the Emergency Department, received a call at 3:00 a.m. on Thursday, May 22, 2003, advising him of the intubation and transfer of the St. John's patient, a hospital where emergency department staff had just learned there was SARS. He told that Commission that at that time he said that the emergency department was to reinstitute the use of personal protective equipment:

As it turned out, that patient did not have SARS but that second, on that conversation, I told everybody, back in PPE. I went back into the hospital early the next day and that was the day our hospital was basically shut down. We basically went into full PPE in the emergency department thinking that we've got SARS back again.

Although it later turned out this patient did not have SARS, the point is, what if she had? Had this patient turned out to have SARS, the failure to notify staff of the events developing outside North York General would have had profound implica-

tions, not just for North York General but also for Scarborough Grace Hospital.

Toronto Public Health told the Commission that an email was sent out the night of May 22, 2003, to emergency room physicians and infectious disease specialists to advise them to be on the alert for patients and health workers from St. John's Rehabilitation Hospital. As Dr. Shahin told the Commission:

It was a general email that went out, so much like the earlier ones that Dr. Henry had sent out to the emergency room physicians and infectious diseases specialists, saying that we have a cluster of cases of SARS associated with St. John's Rehab, and it was really to alert them to the fact that if they had any patients that had been through St. John's or any staff, that they could probably have SARS, possibly, if they have any other symptoms.

The email was sent on May 23, 2003, at 2:28 a.m. from Dr. McGeer to a number of physicians and infectious disease experts in Toronto, including Dr. Tim Rutledge, the Chief of the Emergency Department at North York General. The email provided the following information:

5 cases (1 HCW [health care worker], four patients, one visitor) from St. John's Rehab facility in Toronto with clinical illness compatible with SARS.

No clear epi link (one possible link to a hospital with cases, but at least from current knowledge would require invoking something awful like airborne spread; potential travel link, but is visitor who travelled; her onset was 23 days post-return and one patient and HCW ill first, so not likely).

However, BAL on one patient is coronavirus pos [positive] (SARS by restriction), repeat tests pending. Coronavirus testing on two others so far negative (but no stool results as yet). Other investigations – no pathogen to date.

Not probable cases because of lack of epi link, but we are behaving as if SARS.

The status of the patients is home recovering (1), hospitalized (5 – 2 Centenary, 1 TGH [Toronto General Hospital], 1 SBK [Sunnybrook]). At

all three hospitals, patients were managed in isolation for nearly all their hospital stay, so there are a few staff quarantined, but no major disruption. St. John's is closed – they have very few private rooms and no facility for acute care, so will need to transfer out most of their febrile patients.⁷⁵⁹

These attempts at communication with front-line staff, although well intended, were not timely and did not work. The conference call that confirmed SARS at St. John's Rehab Hospital took place the afternoon of May 22, 2003, almost 12 hours before the email from Dr. McGeer was sent. The news conference was at approximately 9:30 p.m. Shortly after the news conference, at approximately 11:00 p.m., a decision was made to go to North York General to review files. For those working the front lines that night, such as the physicians and nurses in the emergency room at North York General, an email to the Chief of Staff in the middle of the night was of no assistance. Emails and news releases all depend on someone's having the time to see these alerts and read them. In the busy, chaotic environment of an emergency department like North York General, the doctors and nurses were too busy saving lives to sit and check their email or watch television or listen to the radio. And both notifications came too late, as the patient from St. John's Rehab had already been transferred and intubated around the time the press conference occurred and long before the email was sent.

There was no system in place to ensure that front-line physicians throughout Toronto were on the alert for possible cases of SARS, as they should have been, as soon as it was suspected that SARS was at St. John's Rehabilitation. Although SARS wasn't proven until May 22, 2003, between May 21 and May 22, 2003, there were five people under investigation for an outbreak of some kind. Whatever these five people had, it was a cluster of illness, and they had been in a number of health care institutions. Their contacts could be numerous. While the investigation was taking place and experts discussed the possibility of a SARS outbreak among patients at St. John's Rehab Hospital, staff at North York General, the hospital from which the index case of the outbreak came, continued to work unprotected, unaware of the risk they faced.

Even if the link to North York General had not been crystallized or even identified, even if suspicions that these patients were SARS were not confirmed until the afternoon of May 22, 2003, there was no system to ensure that front-line physicians were put on alert, as they should have been, at the earliest sign that SARS might be back, whether or not anyone knew where it came from or where it was, whether or not tests results had confirmed that it was SARS.

759. Dr. Allison McGeer, email to a number of GTA physicians [names not listed in this reference], dated May 23, 2003, 2:28 a.m., RE: SARS Update.

The communication failure was not the fault of Dr. McGeer or any of the outside experts who provided advice during this investigation. It wasn't their responsibility to alert front-line staff across the Greater Toronto Area. The problem was that Ontario and public health officials still did not have an effective means to communicate quickly with front-line staff across Ontario's hospitals. The same weak communication systems that existed in March, that failed to alert all front-line physicians and health workers about concerns about atypical pneumonia cases arising out of China, also failed to alert front-line staff in May 2003 that SARS was back.

Dr. Yaffe, the Director of Infectious Diseases at Toronto Public Health, candidly acknowledged that communication did not always work, as they lacked the resources to keep up with the volume of work and the systems to communicate quickly with the health sector stakeholders:

The third thing I think that went wrong is communication, and I said it went well, but parts of it didn't go well, and I think our ability to communicate quickly with all the stakeholders in the health sector was stymied really, particularly with physicians, as we discussed before. Our ability to communicate, even internally, was difficult because we were just so busy, so much volume of work, and information was just coming flying at us, sometimes we would be saying things on the press conference before our hotline staff hear it, which is terrible, right? So they hear it on the news and so that is something we are working hard at looking at how to correct that.

Knowledgeable, alert and vigilant front-line health workers, especially those working in the emergency departments, were the strongest ally in the fight against SARS. They could not protect themselves, or others, if they did not know there was a risk. Their notification cannot be left to emails, radio, television or faxes. In the busy chaos of an emergency department, they need to be informed promptly and clearly so they can take immediate steps to protect themselves and other patients and so they can be on alert for new cases to come through their doors or for cases already in the hospitals.

The Commission finds that the failure to notify front-line physicians, first, of the investigation into possible SARS at St. John's Rehabilitation Hospital and, second, of the confirmation of SARS at St. John's was a major communication breakdown. The Commission finds that the communication with front-line staff was neither effective nor timely. No adverse finding arises against public health or hospitals because there was at the time no standards or system to ensure timely communication. The Commission recommends the institution of such systems and standards.

Post-SARS, individual health units, like Toronto Public Health, continue to struggle with their ability to quickly communicate with front-line physicians and health providers. The local public health agencies must have the resources and support necessary to allow them to protect the public. It is quite simple: they cannot protect the public without quick and effective access to front-line health providers.

Lack of Centralized Expertise and Support

The story of St. John's Rehab Hospital also underscores the importance of ensuring that there is a clear system of support for smaller hospitals and health care facilities. Few hospitals in Ontario have the resources or the depth of expertise of the major teaching hospitals in our large urban centres. It was fortunate that Dr. Patcai could consult with outside experts such as Dr. McGeer, and that so many experts, like Dr. McGeer, were so generous with their time and knowledge and always answered a call for help.

The problem in Ontario was that the Ontario public health system lacked the critical mass of professional expertise one would expect in a crucial branch of government in a province the size of Ontario. Hospitals such as St. John's Rehab had to turn to experts from other hospitals through their own networks and professional contacts because there was no central agency that could provide the same level of knowledge and expertise. As the Commission found in its first interim report:

SARS demonstrated that our most valuable public health resources are human resources and that Ontario lacked a critical mass of expertise at the provincial level. It is crucial to the success of any public health reform initiatives in Ontario that there be a high level of expertise at both the local and central levels of public health. Ontario cannot continue to rely on the goodwill and volunteerism of others to protect us during an outbreak ...⁷⁶⁰

760. SARS Commission, first interim report, p. 83. An action plan released by Health Minister George Smitherman in 2004 said:

An Agency Implementation Task Force is being struck to provide technical advice on the development and implementation of the Agency. Together with the advice of international and national experts, the Ministry will establish the Agency by 2006/07. (Source: Ministry of Health and Long-Term Care, *Operation Health Protection: An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario*, June 22, 2004, p. 23)

The Final Report of the Agency Implementation Task Force, titled *From Vision to Action: A Plan for the Ontario Agency for Health Protection and Promotion*, was released in March 2006.

One official from St. John's Rehabilitation credited Dr. McGeer for providing advice and help when needed:

... it goes back to saying what we don't have onsite. We sent patients out, but our ability to even do diagnostics just aren't there and [Dr.] John Patcai, who's our Chief of Staff, he's a physiatrist, he sort of acted as our infection control physician. As Chief of Staff he's the chair of the infection control committee and at that point we didn't have an on-site infection control practitioner either. So we didn't have a lot of resources available and John [Dr. Patcai] was able to talk to Dr. Allison McGeer, which was a lifesaver in many ways because she was very, very helpful, but we had no formal links to any kind of infectious disease help ...

Another expert whose assistance proved invaluable was Dr. Raymond Tellier. Dr. Tellier, a microbiologist and senior associate scientist at the Hospital for Sick Children in Toronto, had been working on a diagnostic test for the SARS coronavirus. It was Dr. Tellier's test that rapidly identified the results on the broncho-alveolar lavage for Mr. T as positive for SARS-associated coronavirus. The positive test result on May 22, 2003, was a key piece of information that signalled that the St. John's cases were SARS.

Because the provincial lab lacked the expertise and capacity to meaningfully participate in the struggle to contain SARS, scientists at hospitals such as Mount Sinai, Sunnybrook and the Hospital for Sick Children worked tirelessly to fill the void left by a starved, ineffective provincial lab system. As the SARS Commission found in its first interim report, the central lab capacity must be revitalized and strengthened:

The capacity of a laboratory system to respond to an outbreak of infectious disease must pre-exist any future outbreak because it is impossible to create it during an outbreak. The functions performed by public health laboratories require the work of highly skilled professionals. This work cannot be done by recruiting inexperienced volunteers during an emergency. Nor is it adequate to rely on the hope that the private and hospital laboratories will have the extra capacity when needed. Laboratory capacity is like the rest of public health; its importance is not appreciated, nor the impact of its inadequacies felt, until there is an outbreak and then it is too late.⁷⁶¹

761. SARS Commission, first interim report, p. 96.

A hospital as small as St. John's cannot reasonably be expected to sustain an infectious disease specialist, medical microbiologist, epidemiologist or occupational hygienist. During an infectious disease outbreak such as SARS, they will have to depend on outside help. The ability of a hospital to obtain advice or to get access to a newly developed diagnostic test should not depend on knowing the right person or on the goodwill of busy experts who, during a large-scale outbreak, may not have the time to provide support outside their own facility.

Health care institutions, whether they are big or small, urban or rural, acute care, rehab hospitals or long-term care facilities, must have access to a central body of expertise to which they can turn for help. As the SARS Commission found in its first interim report:

Examples abound of centres of excellence for disease control: British Columbia, Quebec, and Atlanta, among others. Ontario needs to learn from their example. Without a critical mass of the right professionals public health reform, no matter how well-reasoned and well-resourced, has no chance of success.⁷⁶²

A central body of expertise is important to provide support on many levels. The St. John's story also underscores the frailty of public health resources. Public health resources were stretched to the maximum. They had enormous responsibilities, including understanding the outbreak from an epidemiological perspective; investigating, monitoring and reporting SARS cases; identifying SARS contacts and ensuring they were quarantined and monitored; and fielding questions from the public, hospitals and other health care providers, businesses and other organizations, both private and public, who needed advice about SARS. Twenty-hour workdays were not uncommon for the medical staff at Toronto Public Health.

But health care facilities like St. John's, which did not have the same depth of expertise or resources as the larger hospitals, needed help. The absence of a centralized support agency and the lack of capacity within public health to fulfill that role with the limited resources available to them became evident at St. John's Hospital when the second outbreak hit. When SARS II hit, they needed on-the-ground assistance, and they had nowhere to turn to get it. Public Health was swamped; the Ministry of Health Public Health Branch lacked the capacity and depth of expertise to provide on-the-ground support; and infectious disease physicians, infection control practi-

762. SARS Commission, first interim report, p. 83.

tioners and occupational health and safety professionals were needed within their own institutions. There was no agency or organized response system in place by which operational and on-the-ground support could be provided and maintained, wherever it was needed. As one official from St. John's told the Commission:

... Toronto Public Health, they were trying to get information, but what we also wanted was assistance and so we were giving a lot of information but we weren't getting much assistance. And again, I think that they were very stretched. So if there was some kind of a central registry to say these people need help, can you go and help them out. Particularly when we didn't at that time and still only have limited resources available to us onsite. It's different for [a major teaching hospital], which has got six infection control practitioners and a couple of infectious disease docs and a fairly large occupational health and safety group, they've got some internal resources that they can bring to bear that we just don't have.

As the focus shifted to North York General and the size of the outbreak grew daily, St. John's Rehab Hospital found itself working hard to contain the outbreak in its institution without much outside support. As one St. John's official told the Commission:

... the difference between St. John's in the first round and the second round was that, in the first round that was probably all right, the kind of resources that we had and who we were able to get in touch with, but for the second round, because we were sort of an epicentre of a cohort, it would have been nice to have had the resources onsite. A recommendation that we would have liked to put forward was that somehow there's a central agency that has the resources that they can deploy to the organizations that need them that don't have them on a regular basis. We can't sustain having an infectious disease physician or a fleet of infection control practitioners, but if there'd been one available it would have been a great help to have someone come in because in fact John [Dr. Patcai] was very good at sleuthing through, but he's just not an epidemiologist or trained to look for things like that.

It is unrealistic, unsustainable and unsafe to expect the limited expertise available in the private sector, whether it is in infectious diseases, epidemiology, infection control or occupational health, to stretch to fill the gaps in the public health system. The province cannot fight an infectious disease outbreak by hoping that a doctor, scientist or expert might be able to work 21 hours instead of 20. By the end of April 2003

those involved in the fight to contain SARS were overworked and exhausted. SARS was identified and contained in less than five months. What if it had been longer? This province cannot expect tired, overworked, mentally exhausted people to fill the voids in the public health system. In many ways we asked too much of our experts who pitched in to help, at either the provincial or local level, and of those public health staff who also worked tirelessly during SARS. But we had to, because the institutional capacity that existed in public health, at both the local and the provincial level, including the laboratories, was simply not capable of managing the outbreak, and someone had to.

The burden of responding on behalf of the largest province in Canada cannot be placed on outside experts, some of whom may not have the time or the desire when the next infectious disease outbreak hits to fill the voids in the public health system that the government has failed to address – voids that were glaringly obvious during SARS and that have been identified by a succession of reports and investigations post-SARS.⁷⁶³

The importance of a central agency with the expertise and resources to provide support during an infectious disease outbreak was one of the key aspects of the successful containment of SARS in Vancouver. In that case, Vancouver General Hospital was closely linked to and had strong working relationships with the provincial agency, the British Columbia Centre for Disease Control. The B.C. Centre for Disease Control housed the provincial laboratory and epidemiology services. It had the depth of expertise, including expertise in vital areas such as occupational health and safety, infection control, infectious diseases, medical microbiology and epidemiology, to provide support to hospitals and health care facilities big and small.

As noted above, rapid, effective communication with health care institutions and front-line health providers is a vital tool in the fight to protect the public from infectious diseases and other health risks. A centralized public health agency, with the necessary resources and information technology and communication systems, could assist local public health units in communicating information about risks and could provide communication where a health risk is not of a local nature. Infectious diseases do not respect local health unit boundaries. In addition to strong communication policies and systems for local public health agencies, there must be strong communication policies and systems for the central public health agency.

763. Naylor Report, Walker Report, and the SARS Commission, first interim report.

In April 2004, in its first interim report, the Commission recommended:

An Ontario Centre for Disease Control should be created to provide support for the Chief Medical Officer of Health and independent of the Ministry of Health. It should have a critical mass of public health expertise, strong academic links, and central laboratory capacity.⁷⁶⁴

A strong central public health agency was completely lacking in Ontario in 2003 when SARS struck, and is as necessary now as it was then. The commitment to resources and the attainment of a standard of excellence within the proposed agency remains a vital priority. Ontario's ability to effectively respond to future outbreaks remains in serious jeopardy without meaningful reform of our central public health system.

764. SARS Commission, *Interim Report, SARS and Public Health in Ontario*, p. 3.

May 23, 2003 – A Chilling Discovery

The morning of May 23, 2003, two physicians from Toronto Public Health, Dr. Tamara Wallington and Dr. Lisa Berger, along with Dr. Don Low, a medical microbiologist from Mount Sinai Hospital, arrived at North York General Hospital to review a few patient charts. By this time Public Health believed that Ms. N, who had previously been at North York General Hospital, was the index case of the SARS outbreak at St. John's Rehab Hospital. They also were very concerned about the Patient A family cluster, a family whose patriarch had died at North York General May 1, while hospitalized during the SARS outbreak, and who now had four family members in hospital, all with respiratory symptoms.

Hospital officials understood that Public Health was coming on site to review files in connection with the outbreak at St. John's Rehab Hospital. As noted earlier in this report, North York General Hospital did not know that it had sent SARS to St. John's through the transfer of Ms. N.

As Public Health officials reviewed charts on site, it became clear that there was a big problem: there was a large cluster of unidentified SARS cases among patients, visitors and staff, primarily connected with 4 West orthopedic ward. The exact scope of the outbreak was unknown, as was the source. Public Health officials determined that to contain the spread of SARS, North York General Hospital would have to close.

Prior to the closures of Scarborough Grace Hospital on March 24 and York Central Hospital on March 28, 2003, no one had ever had to close a hospital in Ontario because of an infectious disease outbreak. There had been no experience in conducting such an enormous undertaking. It is to the credit of these hospitals that they did their best and got the daunting job done one way or the other. On May 23, 2003, when it was determined that the emergency department at North York General Hospital (and eventually the entire hospital) would have to close, senior administration and the hospital SARS response team worked until the early morning hours and throughout the weekend to try to close the hospital and to ensure that the needs of patients and staff were met.

But as was seen throughout the SARS outbreak, a lack of planning and preparedness led to breakdowns in communication, as people struggled to do their best amidst the uncertainty and confusion of the day. Communication breakdowns occurred on many different levels at North York General: to staff working in the hospital, to staff who were off sick and to staff who were well but not working on May 23, 2003. The story of May 23, 2003, shows that, during a health emergency, the first question that must always be addressed is, are front-line staff safe? Whatever decisions have to be made, whoever has to be contacted to make those decisions, the safety of staff should be paramount.

The story of the identification of the outbreak on 4 West on May 23, 2003, also underscores the importance of regular, mandatory training programs on isolation policies and of the use of personal protective equipment in all areas of the hospital, even those thought to be “low risk.”

As we have seen time and time again throughout the story of SARS, where the system failed, those most affected were front-line staff.

Investigation at North York General Hospital: May 23, 2003

At approximately 11:00 a.m. on Friday, May 23, Dr. Tamara Wallington, Dr. Lisa Berger and Dr. Donald Low met with North York General senior management, infection control and the leaders of the hospital’s SARS Management Committee. Public Health officials explained their concerns and talked about the need to review the charts of Ms. N, her roommate and Patient A. The Public Health team did not know what was about to be discovered: that there was a large cluster of SARS cases in North York General, as well as associated ill staff and visitors. As Dr. Wallington told the Commission:

We went there thinking, or at least I went there thinking, that it would be a relatively short meeting and that I would be there to review three, four charts. And they were very accommodating.

Senior management at North York General still did not know that they had undetected cases of SARS in the hospital. They had no idea of the importance the case review would have or that it would lead to the discovery of a large outbreak of SARS among patients, visitors and staff.

The focus of the Public Health investigation team at that time was where Ms. N, believed to be the index case of the outbreak at St. John's Rehab Hospital, might have contracted SARS. Additionally, Public Health wanted to further investigate Patient A's health history, as they were very concerned about the cluster of illness in four of his family members. As Dr. Wallington told the Commission:

I was looking for a source. As far as I was concerned, Ms. N. was the index case for St. John's, so I was looking for the source case and I thought that I would find it at North York. I thought she had been at North York between April 22nd and 28th. She got sick on May 1st. Someone who got sick as a result of her being the index case at St. John's was diagnosed with SARS. So retrospectively, she was a SARS case and in my mind, when I was at North York, I was there to look for the source. Who did she get SARS from?

And the first place that made the most sense to start was her roommate. Who did she room with at North York? And so we asked for her chart to be pulled and the roommates of Ms. N's and again, in the background there is also the [Patient A family] that we're worried about, that there's a lot of angst about. And so we said we need to review [Patient A's] chart as well. We've now got two people that we're worried about.

Around the same time that this meeting was taking place on the morning of Friday, May 23, the hospital, still unaware of what was to come, released the following update for staff:

This morning we have some news to share with you. Last night, Public Health Chief Medical Officer Colin D'Cunha announced that four patients from St. John's Rehab have been classified as under investigation. Everyone who has been at St. John's Rehab between May 9 and May 20 are being asked to enter voluntary quarantine and contact public health in this morning.

Yesterday afternoon, we had a patient from St. John's Rehab brought into the Hospital's Emergency Department. The patient was brought in with another medical illness, and then transferred to Scarborough Grace. As an extra precaution, the Emergency Department has undergone a heavy cleaning in its resuscitation area and sent staff and physicians who had

contact with this patient home.⁷⁶⁵

Anyone coming to the Hospital will be asked at the front door if they have been at St. John's Rehabilitation from May 9–20, and will not be permitted entry.

We are now reviewing medical charts of patients who have come to the Hospital from St. John's Rehabilitation during the above mentioned time.

Last weekend, we had some patients who were admitted and put on droplet/respiratory isolation. Public Health has reviewed these cases at that time, and along with other health officials they will be reviewing these cases in light of these new developments.

We will provide you with an update after 2 pm this afternoon.⁷⁵⁹

After the initial meeting with the Public Health team, hospital officials left the boardroom, leaving Public Health to review charts. The Public Health investigation team recalled that the infection control practitioners also left the room but returned with a number of charts and asked the team to review them. As one Public Health physician told the Commission:

They left us alone to review these charts after we had our meeting but the ICPs stayed, the infection control practitioners. And the next thing I knew they were carrying more charts into the room. Charts that we hadn't asked for. Names that I wasn't even aware of. And they were putting them in front of us, saying, could you please just look at this chart. We've always wondered about this patient.

765. The St. John's Rehab patient referenced in the update was the patient who came to North York General from St. John's Rehab Hospital the night of May 22, and was intubated in the emergency department before being sent to Scarborough Grace Hospital. The staff and physicians working in the emergency department had not been notified of the SARS outbreak at St. John's Rehab Hospital and were not aware of the risks they faced or of the need to use protective equipment when caring for the patient. They, along with staff and physicians at Scarborough Grace Hospital, were understandably alarmed and angry when they later learned that there were SARS cases at St. John's Rehab Hospital. This story is told in the previous section.

766. NYGH, SARS Update #42, May 23, 2003.

As noted earlier, infection control told the Commission that they were unaware of an outbreak of respiratory illness on 4 West or of an increase in deaths on the unit. When asked how this reconciled with the information from Toronto Public Health that additional charts, including charts of patients on 4 West, were brought in on May 23 for review, one member of the infection control team explained that the charts were charts of patients who had been readmitted to the hospital through the emergency department with respiratory symptoms:

Question: Okay, the question then or what we are trying to clarify is before the morning of the 23rd, or on the morning of the 23rd, were there charts other than those requested by Public Health, or were there patients that you were concerned about on 4 West?

Answer: The thing about 4 West is when I had said I didn't know anything going on on 4 West, I was referring to patients that were on the floor leading up to then. I knew about patients being readmitted, who had either been there or were relatives of those patients and such. I honestly don't remember what other charts were in the room on this ...

Question: When you say you knew about patients who had been there or had relatives, what was the ...

Answer: Ones that were readmitted and such. Like the [Patient A family], [the O family], [Ms. N], I remember her having coming back to emerg ... My having not known about 4 West, that related to just patients who were on 4 West. Because I had mentioned that I can produce a list at any time of the patients who were on isolation in the hospital on their names being flagged in the Patient Care. And when I found the daily reports that we had run off, for May 20th, it didn't have anyone on 4 West. And that's what I was referring to when I said I didn't know about things going on, on 4 West.

Question: Okay. So, other than these patients that you've mentioned, and this is what I am trying to understand, did you know about the cluster of respiratory illness on 4 West?

Answer: I knew about having come back into emerg but I didn't know about a cluster ongoing, going on on 4 West, it was only afterwards when everything was put together.

As noted above, included among those charts were those of the Patient A family members, Mr. O and his wife. Mr. O had been a patient on 4 West during May 2003. He was discharged from hospital on May 11, but was readmitted through North York General's emergency department on May 18. Mr. O's wife had also become ill and was also admitted through the emergency department, on May 20. Ms. N, the St. John's index case whose story is told in the previous section, was admitted to the 4th floor of North York General Hospital on April 28, following a knee replacement. After her discharge to St. John's Rehab Hospital, she developed fever, diarrhea and a cough. She was transferred to the North York General emergency department on May 9 and diagnosed with pneumonia. She returned to St. John's Rehab, where her condition improved, and she was discharged home on May 16, 2003.

Public Health officials told the Commission that while the charts were being reviewed and discussed, Dr. Barbara Mederski, the infectious disease specialist at North York General Hospital, was in the room, that she appeared familiar with these charts and that she offered her view to the Public Health team that these patients did not have SARS.

Dr. Berger told the Commission that as charts were brought in, things happened quickly and that it was clear fairly early that there was a very large problem:

Question: And how did that happen [the charts being brought in]?

Dr. Berger: I think they [the charts] were brought in by the ICP [infection control practitioner]. It is hard for me to recall. A lot of stuff started happening very quickly because as I recall, fairly early on, we realized there was a large problem and people started coming in and out of the room and charts were brought in and decisions started getting made. It was a kind of a rapid process. I just remember seeing a pile of charts on a counter and then we were asked to look at a couple more and then some names were raised as well. I don't remember if the charts were there for every name we were asked about.

Question: And who was asking you about the names?

Dr. Berger: The ICPs, infection control practitioners. I remember discussing the whole [Patient A] family at that point.

The Public Health team realized it was looking at a significant clustering of febrile respiratory illness associated with deaths, all on one small ward, 4 West. It was a very serious cluster of illness. As Dr. Wallington told the Commission:

It was May 23rd that we made this determination that SARS, unrecognized transmission of SARS was happening on 4 West in particular. Patient-to-patient, patient-to-visitor, patient-to-nurse, nurse-to-nurse, nurse-to-patient, and then eventually it just became so convoluted that we couldn't link people anymore. It was the ward. Because we were unaware of how large this outbreak really was, we were unaware of how many cases we were really unaware of. On May 23rd we decided to treat North York General as an exposure site. Early on in the afternoon, the cases that we were reviewing all came from 4 West, so there was definitely a clustering happening on 4 West. But because we didn't know if there were cases beyond 4 West in the hospital, we decided to call the hospital the exposure site. And that is when North York General Hospital was shut down on May 23rd.

The charts were not the only sign that something was very wrong. Also discovered at this time was another key piece of information that signalled that there was a serious problem on 4 West: the identification of illness among staff. As the week had progressed, more and more staff from the 4th floor had called in sick for work. As noted earlier, there was a breakdown in the system intended to monitor illness among staff: sick calls from staff working on the 4th floor were not reported to the occupational health department. Senior administration and those in charge of the SARS response had not been notified that there was a cluster of illness among staff, so there had been no followup or investigation into the staff illness. Although the number of sick calls had been increasing throughout the week, it was not until May 23 that Occupational Health became aware of the large cluster of illness among staff on 4 West. The Occupational Health Coordinator told the Commission that she reported the illness among staff to Sue Kwolek, co-chair of the SARS Task Force. Ms. Kwolek recounted how she learned about the cluster of staff illness that afternoon:

... sometime in the afternoon, the manager of occupational health and safety came up to the boardroom where the command centre was and she

said there are quite a number of staff on 4 West who are reporting in ill. And that's the first time that, as a member of the SARS management team, and it was me at that point, there was nobody else on the SARS management team there, that I became aware that there was an issue on 4 West.

Bonnie Adamson, Chief Executive Officer of North York General, told the Commission that she became aware of the Public Health meeting that morning but that it was not until later that afternoon that she learned there was a problem:

If I could just describe that day, in the morning [a colleague] and I were going to visit David Young, one of our MPPs, a regular visit, we took him all the sheets, everything that had gone on in SARS. And on the way out the door my secretary said to me, oh, by the way, [Dr.] Don Low is coming to the boardroom today. She had received a call from someone, and he's pretty important, maybe you should go into the boardroom on your way back, he's been on the TV. Maybe you should go to the boardroom. And I said, okay, I talked to David, and I came back, went to the boardroom and Dr. Low was there, all these Public Health people, Sue [Kwolek] was there, [Dr.] Barb [Mederski] was there, there were charts all over the place.

So I sat there and I listened for a while and I couldn't figure out what in the world is going on, more charts and more charts. And after an hour I left, I thought, well, I'm not contributing anything here, but I went straight out and I called Keith [Dr. Rose] and I said, Keith, I don't know what's going on, but there's something going on. So I went back upstairs to my office and he was in and out, trying to figure out, no one seemed to know what was going on in there. About three o'clock, Sue [Kwolek] called from down there and said, you've got to come right away, they're going to shut us down. So I gathered up Keith [Dr. Rose] and away we went and we were there, and the rest of that is a bit of a fog. We went from there to the boardroom. We had the Ministry of Health on the phone and something drastically had gone wrong.

The discovery of a large cluster of unidentified SARS cases among patients, visitors and staff took everyone by surprise. One member of the Public Health team described how what seemed like a simple review of a couple of cases turned into a surreal experience as it became clear that they had a large outbreak among patients, visitors and staff on 4 West:

... We traipse off to North York on Friday the 23rd, and we told North York, we're going to meet in the boardroom, be there at 11:30, we will review these cases to see if there is anything going on at all, thinking we'll be there about an hour and a half, and that was probably the most surreal day of my life, being in that place, that Friday, it was unbelievable. You are sitting in the boardroom and people are bringing these charts and you are looking at these charts and it became so obvious what was going on.

It was chart after chart, and while this was going on, health care workers were phoning up the hospital saying they had fever, health care workers were arriving back in the emergency department with fever, the head of the emergency department was coming in to us in the boardroom saying, what am I going to do, should I shut down the emergency department because we've got all these people coming in ...

To contain the outbreak, the hospital had to close. The first area to close was the emergency department, with the hospital closing a few hours later.

The notification of staff and the shutdown of the hospital commencing on May 23, 2003, was a huge task. A hospital the size of North York General Hospital could not stop on a dime, especially when it was full of ill patients who continued to need medical care.

Heroism Amidst Chaos

Although the hospital was closed to new admissions, the emergency department remained open to receive staff and patients who had been exposed to SARS. As well, those patients already in the hospital who were suspected of having SARS or of having been exposed to SARS, who could not be transferred out, had to continue to receive medical treatment. This meant that the front-line staff at North York General had to don protective equipment and provide care to possible SARS cases. These cases included patients already in the hospital as well as new suspected SARS patients, including staff, as they came to the emergency department.

One doctor who was not working that day recalled being paged by Dr. Keith Rose to come to the hospital that afternoon to help. This doctor stayed all weekend, seeing patient after patient, including the ill 4 West nurses who had been told to come to the hospital. As she told the Commission:

We just kind of looked at the list and basically, okay, you do this and I do this ... Then I just went see one after the other.

Emergency room staff and physicians worked long hours, providing medical care to those suspected of having SARS. Less than a week earlier, many had attended the May 20 meeting and had tried to convince senior management that SARS was still at North York General. But they put aside whatever anger or disappointment they felt when they learned they had been right all along, that SARS had never left, and once again they stepped up and put the health and well-being of others first.

Those nurses from 4 West who were not ill had to come to work over the weekend of May 24 and 25, until the unit was put on home quarantine, on May 26, 2003. They knew their colleagues were ill and they were frightened for their own safety. Unlike many of the emergency room nurses, the 4 West nurses did not have the experience of and confidence from having already cared for SARS patients. But they continued to come to work to care for the patients on their unit.

One nurse from 4 West who worked the weekend of May 24 and 25, 2003, recalled how afraid she and her family were, knowing she had to go back to work the next day, in the epicentre of the outbreak:

I remember going Saturday morning and I said to my husband, he was in the other room, and I said, I'm going to go, but I am so afraid, and I saw my husband's face and we both had tears in our eyes because I thought I was the next one to get it. I was just so emotional. I just felt so awful. I have to go in, I'm still standing here, I haven't got SARS – well, to me I didn't have SARS – but I thought I was going to be the next one, because all our nurses were falling down.

When she was asked by the Commission if she ever considered not going to work, she said:

I was one of the ones that could go in, to help my work. I think it's your duty to go in as a nurse, to go to the last, to the very end.

These are the heroes of SARS. It is a strong testament to the dedication and professionalism of the front-line health workers and physicians at North York General that amidst the confusion, uncertainty and fear of that day, they did what they had to do to provide care to those who were ill, among them their own colleagues. Without the commitment of physicians and nurses like those quoted above and so many others

who worked the front lines and provided patient care, SARS could not have been successfully contained.

Closing the Hospital: The Eye of the Storm

Before SARS, it was unheard of in Ontario that a hospital the size of North York General would have to close at all, much less close as quickly as North York General did on May 23, 2003. The decision to close the hospital, although clearly necessary, had huge consequences for the hospital, its staff, its patients and the entire community. It was not a decision that was made easily or lightly. As one physician said:

So what would it do to the hospital is, it would devastate it, and it did. Closing the hospital, rightly or wrongly, it did devastate the hospital for several months, many, many months. And what it would do to the staff, the same thing, essentially, it would be huge, this was a huge, huge decision that had wide-reaching ramifications for thousands of people ...

People were very frightened, they were concerned about their families, their livelihood, their income, their financial security. They were concerned about their colleagues, their future, that was a very devastating thing. There were repercussions and the multiple fingers of events that had to unfold as a result of that are just phenomenal. There were people there all night, all weekend, trying to get things sorted out.

To close the hospital, many decisions had to be made, each one important and with far-reaching consequences. And, as the above-quoted physician pointed out, the hospital had to close but keep running, as had it to care for patients but at the same time ensure that staff were safe:

We had to close it but keep it running, because we still had patients there and we had to transfer patients out and we were bringing patients in, and we were trying to keep people coming to work because we needed them to come to work, so that we wanted to do that in a safe way. And from what we knew, we didn't know everything about SARS at that point, so it was a very difficult balance to maintain, to try and get people to keep coming to work, which is the whole issue with work quarantine, the same thing, home quarantine versus work quarantine. The only reason that we were work quarantined is because they needed us to work and we needed to look after the patients. So we needed people to come in and maintain

the support services and keep doing their jobs, but at the same time we wanted to protect the staff.

This physician described the challenges as they tried to close the hospital but keep it running for the patients who had to remain inside:

I remember sitting in at the boardroom table with Bonnie Adamson and all the senior admin people, and Public Health and most of the clinical chiefs and support staff, and I think it was Public Health that told us, I believe it was at that meeting, that they were going to close everything and quarantine everybody. And we were discussing the wisdom of the quarantine and who should be quarantined and then when it was finally, the clinicians all had their opinions about that and what it was going to do to the staff in the hospital. Then after it was decided that that was the way it was going to be, then we were talking about how we were going to notify people and call people and distribute the workload and how this was going to be done. And we each had our own separate areas of responsibility ...

Although the hospital had to close to new admissions, it also had to ensure that patients who would otherwise come to North York General got the medical help they needed. Dr. Tim Rutledge, Chief of Emergency Medicine, told the Commission that closing the emergency department required huge public notification and that they also needed to ensure that patients who had been at North York General, and had therefore possibly been exposed to SARS, had a place to go to get medical attention:

[The emergency department was] completely shut down to the public. Huge public notifications, but we kept it open for staff and patients of the hospital that were returning, select patients to return. So patients that may be having difficulty accessing care elsewhere because they'd been a North York General patient. Any patient that was even concerned they might have SARS because they'd been at our hospital, we saw. Now, we didn't see that many patients but we were open for those patients.

Alternate care arrangements had to be made for ill patients who would not be able to obtain treatment within the hospital. A patient who had cancer still needed treatment, regardless of what was happening at North York General Hospital. As one physician told the Commission:

Everything got shut down. Even cancer patients that we had scheduled for the following week were put on hold and we were all scrambling to

get them distributed to other centres to get them looked after. Because no new admission was going to come in, unless they were a SARS patient or our own staff.

Another important responsibility was notifying staff. This included those who were working in the hospital, those who were off ill and those who were off work but were not known to be ill. The scope of the outbreak was unknown. Any one of the health workers could have been exposed. Those who were at home could be exposing their families. Those who were in hospital working unprotected could be exposed to SARS that very day.

The task of notifying staff and identifying patients and visitors was daunting in a hospital that employed thousands of people and saw hundreds of people enter its doors on any given day. One physician who was involved in closing the hospital and notifying staff described the enormous task that lay ahead of them:

It was a monumental task to try and contact everyone that had been in that hospital that day and the previous eight days. Just in my own little world, the ICU, we have over a hundred nurses, just nurses. What about all the physicians, all the cleaning staff, all the dietary staff, the RTs [respiratory therapist], the physios, the occupational therapists. When you think of all the people that had come in contact with just our little unit, 24-bed unit, it's huge, and who was going to do all that calling. Myself? The unit manager? A couple of our assistants? We recruited people, we got volunteers, I think everybody did the best they possibly could but it was not comprehensive because it was impossible to be comprehensive, doing the notifications. It was just impossible.

At 5:10 p.m. on May 23, the hospital released an update to staff in the hospital:

Further to our update this morning, Ministry of Health officials, Toronto Public Health and Dr. Donald Low, Chief Microbiologist at Mt. Sinai, were on site.

We have patients with undiagnosed respiratory symptoms including some health care workers. They are being assessed as “persons under investigation” until a more definite diagnosis is determined.

We have decided to undertake extraordinary precautionary measures and the following steps are being **implemented immediately at the Leslie**

site only: [emphasis in original]

- No transfers out
- No admissions
- No volunteers
- Full barrier precautions
- No visitors with the exception of:
 - One parent will be permitted to visit a child;
 - One person can accompany an expectant mother;
 - One person will be permitted to visit a critically ill patient and palliative patients.

We are still accepting patients for obstetrics (Labour and Delivery), but have closed Emergency Department to walk-ins and ambulances.

The Branson site, Senior's Health Centre and Philips' House are being treated as separate institutions. They are to continue business as usual, but be vigilant in monitoring their environment. There will be no transfers between any sites.

The management team continues to work on this throughout the evening with Toronto Public Health and Ministry of Health to obtain additional information regarding our situation and status.

Senior Management will be walking around to speak with staff with this information and to keep you updated. We will provide you with further information as it becomes available.

The Ministry of Health and Long-Term Care will hold a press conference tonight at 7:00 p.m. Bonnie Adamson will represent the hospital at the press conference.⁷⁶⁷

In a communication disaster, details of the outbreak that conveyed the situation as much more serious than what was reflected in the 5:10 update to staff would be announced at the press conference at 7:00 that evening, before the hospital had told staff. Staff would learn from the news that approximately 25 people were under investigation for SARS the evening of May 23, many of them health workers.

767. NYGH, SARS Update #43, May 23, 2003, 5:10 p.m.

It is difficult to imagine the chaos and stress at North York General that day. One member of the Public Health team tried to describe to the Commission what it was like at North York General on May 23. He likened it to the eye of a storm:

... All of a sudden you have this boardroom full, all the hospital administrators were there, and people asking her questions, “What are we going to do?” “Are we going to close obstetrics?” It was like this whole thing was just rolling out in front of us, and trying to get hold of Colin [Dr. D’Cunha] on the phone and couldn’t get anyone in Public Health, at the Ministry, and so finally, early in the evening, we decided we’re closing the emergency department, and then later in the night we closed the hospital. It was ridiculous. It was so bizarre, it was like you are in the eye of a storm.

There is no doubt that the task of shutting down the hospital and notifying staff was huge. Compounding the problem was the fact that no one had ever prepared for such an event. There was no system in place to be kicked into gear, to ensure rapid notification to staff, both in the hospital and out. But while the enormity of the task may explain some of the problems in notification, it does not explain them all. Some key areas in the hospital were left out of the communications loop, not just for a few hours, but in some instances for days.

Notification of Staff in Hospital

After May 23, when the story of the discovery of the second outbreak began to spread among hospital staff, it became known that Public Health and Dr. Low had been on site since the morning reviewing files and that senior management had met with Public Health officials and Dr. Low. Post-SARS, many questioned why they didn’t learn about the outbreak sooner, and why they weren’t protected sooner.

One nurse questioned why it took the hospital so long to warn them that something was wrong:

On Friday, May 23rd, [Dr.] Donald Low and an entourage of people were in our hospital walking through the halls, and at 5:00 o’clock we were shut down. Why were we not warned that day? I just feel there was very poor communication ... The way I see it, they back up that, they did this, they did that. But it’s the timely fashion in which they execute these things and how long it takes them to make the decision to act upon

something. They are always way too late.

One nurse from 4 West who worked on May 23 and was later admitted to hospital with SARS told the Commission that she had no idea that there were concerns about SARS in the hospital on May 23. She worked a day shift, without protection, on a unit that we now know was full of SARS. She finished her shift, went home and was unaware of any concerns about SARS. Later that weekend she developed symptoms, and she was admitted to hospital the following week. While in hospital, she learned that the outbreak was identified on May 23, and she wondered why she and her colleagues weren't told that day. She said:

I found this out after, on the Wednesday, when I was admitted. I spoke to one of my co-workers and she said they suspect there was SARS on that Friday. I said, well I worked the Friday [May 23rd] and nobody told me. It was hush-hush, hush-hush.

Another nurse worked the day shift on May 23, and left for home mid-afternoon. She worked on the 4th floor, without any protective equipment. When she left for home, she had no idea about the outbreak on 4 West and did not learn about it until she received a call at home the following day, Saturday, May 24, telling her she was on home quarantine. As she said to the Commission:

I was surprised it took so long for them to actually close the floor [the 4th floor]. When you have this many people sick on the unit you want to investigate. If something is being spread you want to close the unit immediately ...

Retrospective accounts of when staff were told to reinstitute precautions vary. Some staff who worked on 4 West reported that between 3:30 p.m. and 5:00 p.m., they were told to begin using protective equipment again. Other staff suggest it was later.

By May 22, 2003, Public Health officials knew that they had a SARS case with a link to North York General. They were also concerned about the Patient A family cluster, a family whose patriarch had died on 4 West on May 1 and that had four family members in hospital with respiratory illnesses. Public Health officials were coming to the hospital the following morning to try to identify the source of exposure, as they believed Ms. N to be the index patient of the outbreak at St. John's Rehab Hospital. The night of May 22, 2003, hospital officials were notified that Public Health was coming on site the next day to review files in connection with the St. John's outbreak.

But front-line staff were unaware of these developments.

Although no one knew that there was a large undetected outbreak in the hospital, there were concerns about how Ms. N had gotten SARS and concerns about whether Patient A and his family had SARS. And although Ms. N was no longer in hospital, and although Patient A had since passed away and the Patient A family members were in isolation, being handled with precautions, if these cases were SARS, no one knew the source. As noted earlier, Toronto Public Health told the Commission that the link between Ms. N and Patient A did not become clear until they were on site reviewing charts on May 23. In the meantime, there was one case positively identified as SARS who had been at North York General. But there seemed to be no attempt to investigate or ascertain where exactly she had been in the hospital and to ensure that staff working in that area were put on alert, and no one took a precautionary approach and advised them to don protective equipment until they knew what they were dealing with. There was no system or standard or protocol in place to require this precautionary approach. There should be.

Once Public Health arrived on the scene, they knew very soon that something was very wrong. One member of the investigative team said that within an hour of their arrival it was clear that there was a big problem. Hospital representatives were in the room while files were being reviewed. While there are differing estimates of precisely when it became clear that there were unidentified cases of SARS in the hospital, we know that the chart review began at 11:00 a.m., and that the problem became clear fairly early. Dr. Berger told the Commission that it became apparent that there was a problem very soon after they began reviewing charts:

Question: So you start reviewing the charts. When did it become apparent that there was a big problem?

Dr. Berger: Very soon upon review, because Patient A had symptoms that were consistent with SARS and I think that at that point [another patient name] chart had been brought in and it seemed apparent that he had symptoms consistent with SARS. It became evident fairly soon that there was transmission going on there and that there was a problem. I don't recall the time frames, but it didn't take a long time to figure it out.

Question: Was it in the afternoon, before supper, when?

Dr. Berger: Oh yes, we started at 11:00 and it happened very quickly. I think it was mid-afternoon when we closed the hospital, so it had to have happened between 11:00 and 3:00.

Toronto Public Health officials told the Commission that as part of the response plan put into place that afternoon, they told the hospital to reinstitute precautions. Public Health understood that it was the hospital's responsibility to ensure that that was done and that the information was communicated to staff.

By approximately 2:00 p.m., the cluster of ill staff was being reported to the hospital's SARS Task Force. By 3:00 p.m. the hospital was being told it had to close. One member of the Public Health team recalled that they wore masks while in the boardroom on May 23. Although they could not recall at what time they put the masks on, they thought it was before the decision to close the hospital at 3:00 p.m.

Post-SARS, the failure to effectively communicate with staff on May 23, 2003, about the outbreak, the risks they faced and the need to protect themselves has left some health workers feeling betrayed and angry. Some staff told the Commission that they thought that Ms. Adamson and other senior officials knew about the outbreak that morning but that they did not tell staff about it as the day unfolded.

The Commission accepts the evidence of Ms. Adamson that she was unaware of the outbreak until the afternoon of May 23, 2003. The Commission finds that there is no evidence that hospital officials deliberately kept information from staff about the outbreak, or that they withheld notifying staff about the outbreak for any improper purpose. The Commission further finds no evidence that senior hospitals officials deliberately put staff at risk.

The Commission does find, however, that the health care system was unprepared in the event that it became necessary to close a hospital in the face of an infectious disease outbreak. The systemic failure to plan and prepare for an infectious disease outbreak in hospitals meant that staff were not informed in a timely manner that there might be unidentified cases of SARS in the hospital. In particular, the Commission finds that a system should have been in place to ensure that the staff on 4 West were told sooner about the possibility of unidentified SARS cases on the unit and that precautions should have been reinstated earlier.

The problem was that in all the chaos, while decisions about what to close and how to close were being discussed, staff in most areas of the hospital, including 4 West, were

working without protective equipment. By the time the first update was issued at 5:10 p.m., some staff had worked an entire shift that day without wearing any protective equipment. Although North York General made efforts on May 23 to notify staff of their danger, the warnings in some cases came too late and they did not reach all staff in a timely manner.

Even if the links were not clear, even if the decisions on whether to close the hospital and how to go about doing it were unresolved, and even if there was great uncertainty about the scope and the size of the outbreak, front-line staff should have been told of the risk the minute it was reasonably suspected. Even if this meant overreacting or reinstating precautions temporarily, the protection of front-line staff had to be the first priority. As one nurse said:

Don't you think the CEO should announce there is a problem going on in emerg, we're investigating into it, there is suspicion that maybe SARS has been spread ...

As noted above, Ms. Adamson told the Commission that she did not become aware of the problem until mid-afternoon. The Commission accepts her evidence on this point. But other hospital officials were in and out of the room. Charts were pulled, and the Public Health team reviewed files throughout the morning. The fact that the situation was not made clear to Ms. Adamson earlier did not alter the risk to staff or the need to ensure that they were protected.

This is not to say that hospital administrators, physicians or infection control involved in the May 23, 2003, meetings were unconcerned about staff safety. The Commission does not accept any suggestion that any one of these individuals would knowingly and intentionally put staff, patients or visitors at risk. But the hospital, like most hospitals in Ontario, was unprepared for the news on May 23. Although it had instituted precautions and had been providing care to SARS patients during SARS I, it had never had to ramp back up on a moment's notice.

In the chaos of the day, front-line staff were left in the dark far too long, and were left unprotected. One clear lesson from SARS is that whatever crisis unfolds, whatever decisions have to be made, the number one question that must always be asked is, are measures in place to ensure the safety of staff, patients and visitors? Until that is done, all the resources of an institution should be focused on the single goal of protecting those within the institution. A key part of this is communication with staff. Unless staff know where there is a risk, they cannot protect themselves.

Hospitals must plan for the worst. In the wake of SARS, we now know that a hospital may have to close its doors suddenly, when it is full of patients and with staff on the front lines who must continue to provide patient care. There must be clear policies, tested and evaluated, that ensure that if and when it becomes necessary to close a hospital or to institute precautions, all staff are notified quickly and steps are taken to protect staff at the earlier possible opportunity.

When dealing with an infectious disease, one day can make a huge difference. An hour can make a difference. Had Mr. T, the first index patient at the Scarborough Grace Hospital, been isolated immediately under precautions, the first outbreak of SARS would probably have been stopped in its tracks, as it was in Vancouver. Mr. T's exposure to staff and other patients within the first 24 hours of his admission to hospital had profound consequences.

These examples provide compelling evidence that a few hours of exposure by an infectious patient can spark an outbreak. Every moment that staff at North York General worked without protection put them at risk.

The Scramble to Reinstitute Precautions

As news of the outbreak spread and staff were directed to reinstate full barrier precautions, they faced the challenge of gathering equipment and reorienting themselves to the proper procedures for the application and removal of the equipment. Because precautions had been relaxed earlier in May, some units did not have an adequate supply of the necessary protective equipment. For many, the situation seemed chaotic and confusing, which only added to the level of anxiety among staff.

The 4th floor, the epicentre of the second outbreak, had not previously been considered a high-risk area for SARS. The unit had not previously been used as a SARS unit, and it was not expected that the nurses on the unit would be caring for SARS patients.

As noted earlier in the report, many of the nurses from 4 West told the Commission that they received no training or education with respect to the use of the equipment or the proper isolation techniques prior to May 23, 2003. They had not been fit tested, and a number of them later learned, when they were eventually fit tested, that they had been wearing a respirator that did not properly fit their face. Although 4 West was staffed by senior, experienced, knowledgeable nurses, they had received no special training or education for handling a SARS case. Although safety training and fit test-

ing were required by Ontario law, that requirement was ignored by, and in fact unknown to, most Ontario hospitals.

Imagine, then, the fear of knowing that you had to enter a room and provide care for a SARS patient, worried that you might not have everything you needed for protection and having learned how to apply the equipment only moments before entering the room. With practice comes familiarity and confidence, a comfort that these nurses did not have at this time.

One 4 West nurse who worked in the days after the second outbreak was discovered described the confusion as she tried to gear up to provide care to what was by then known to be a suspect SARS case:

They were slowly collecting equipment. The UA [unit administrator] showed up on the ward early in the morning ... She was there trying to tell us how we were supposed to dress to protect ourselves and how we handle all this isolation. I did isolation downtown many years ago but they never had any reorientation on it ... They were trying to direct us. First they were in the change rooms telling us, now we have to go into this room and put on the scrubs now, this was all happening just on the Sunday morning ... But they first spent at least a good two, three hours finding all the proper equipment for respiratory isolation of a SARS patient ... We needed booties, we needed caps, we needed still more things than just what they were doing on Saturday evening.

One 4 West nurse worked on Saturday, May 24, 2003, and had to transfer a patient to the SARS unit. Another health worker involved in the transfer wore a Stryker suit, which afforded more protection than the protective equipment the nurse was wearing. The nurse had never used a Stryker suit before but thought it seemed like a good idea to have the most protection available:

When I went to work, I remember saying there's an outbreak and we have to wear the PPE and also I remember I had to transfer a patient to the SARS unit. I just came on shift and I was told that this patient had to be transferred, they weren't doing well ... An RN had to go with the patient. The RT was there and the doctor was there and because I guess her sats were low so they were there trying to titrate the oxygen and whatnot, seeing there would have been a problem. And when we were ready to transfer, they said an RN has to go.

So I was basically going to go with my my yellow gown and mask and with the PPE basically. Then I saw the RT all dressed up in this white suit. So I asked him where did you get that from? And then he asked me, do you want one? So he went somewhere and got one for me, a Stryker suit, so I wore that on top of my PPE and so I had that to transfer the patient to the 8th floor.

She had received no training in how to use a Stryker suit and had never seen one on her floor before this. Whether or not the Stryker suit was necessary in those circumstances is irrelevant. It must have been both confusing and frightening to observe varying levels of protection without clear training to educate staff on how and when to use the equipment.

Another 4 West nurse who worked the entire weekend described the fear and confusion as staff tried to help the patients but also to protect themselves:

Every day you'd go in and it was just like a war zone, you thought, uh-oh, you're next. It was just crazy. At that point I know they made us take, get out of our own uniforms and put on the hospital uniforms and to put the high-risk, you've got your goggles, you had to wash in between every step, and that was the directive from Saturday, that Saturday and Sunday, and then Monday was the horrendous day. We were just trying to get people home or get them out of our unit, the ones that were okay to leave.

And so around 7:30 that evening they told us okay. There was only three of us left on the floor and then the SARS nurses came in like robots in full gear, they had their helmets, everything on. We didn't have the helmets or anything, we just had our masks, our goggles, our gloves. They said okay, you go home, you're staying home, you are quarantined now, don't leave the house until you get further notice ... That was the Monday evening, we were given a box of masks to take home and just not to leave our house, and I was worried about my family too but they said they should be okay, just wear a mask and use your own utensils, your own towels, not to sleep in the same room as my husband, they gave us those directives and that was the scariest time of my life.

What makes this nurse's story even more remarkable is that she is the nurse quoted earlier in this report who said she never once thought about shirking work that weekend, even though she was terrified of becoming ill herself or of infecting her family.

This shows the danger of limited training in the use of personal protective equipment. Infectious diseases like SARS do not respect boundaries within hospitals. Infectious diseases can spread undetected in hospitals, and an unidentified case of SARS or any other infectious disease could end up anywhere in a hospital.

As noted earlier, North York General was not the only hospital in Ontario that had allowed infection control standards to decline. Nor was North York General the only hospital to use the N95 respirator without proper training and fitting. Unfortunately, in a major systemic flaw, few in the health sector were aware of requirements under the *Occupational Health and Safety Act* and Health Care Regulations 67/93 that staff must be properly trained and fit tested to use the N95 respirator.

Post-SARS, we now know that strong programs are required throughout the health system to promote and maintain safe work environments: both strong infection control programs and strong worker safety programs. Patient safety and worker safety go hand in hand. One does not exist without the other. Hospitals must support resource programs to provide regular, mandatory training for all front-line staff in proper isolation techniques, precautionary measures and the use of personal protective equipment.

The Ministry of Health and Long-Term Care and the Ministry of Labour must work together to hold health care institutions to the highest standards of patient and worker safety, to ensure that as the memory of SARS fades and as budget pressures loom, infection control and worker safety standards are maintained. Much like public health, if we do not provide the resources necessary to address the gaps identified during SARS, if we allow the system to slip back to the way it was, when the next health emergency comes, we will see the same problems that arose during SARS. This time, however, there will be a greater risk that if workers feel that they are unprepared and unprotected for the risk we ask them to face, they will decide not to work.

Notification of Sick Staff

On May 23, 2003, it was finally brought to the attention of senior administration, occupational health and those in charge of the SARS response that there was a problem of illness among staff. With the discovery of unidentified SARS among 4 West patients, it became likely that the nurses who were sick from that unit were sick with SARS. It was no coincidence that there was a cluster of ill patients and a cluster of ill staff, both from the same unit.

Staff who had been at home sick had to be brought to the hospital to be assessed for SARS. Occupational health and supervisory staff from 4 West began to call those nurses they knew were at home ill, to tell them to come to the hospital for assessment. But the nurses were not told that it was for assessment for possible SARS.

All the nurses interviewed by the Commission who were ill at home with SARS in the days leading up to May 23, 2003, reported that they were not told that they were being brought in to be assessed for SARS or that they were going to be admitted. Post-SARS, many are angry at this lack of communication, and question why they weren't warned what was happening. As one nurse said:

Occupational health calls me, the nurse from occupational health called me and she said a lot of you girls have called in sick in the last one week, at least six or seven of you all, and that Dr. Mederski, she's the infection control doctor, would like to come to assess you all, I was told to assess us. So I dropped everything and then my husband drove me there and I went there and I saw the rest of my colleagues sitting outside the 8th floor. Shortly after that the occupational health nurse came and said you all are going to be admitted for probable SARS. I was very angry. Somebody could have at least said something to me or given a hint that that's what they were calling us for.

This nurse told the Commission that she had no idea what was to come. She said she had just purchased a meal and that she had told her husband to save it, that she would finish eating it when she came back. Her husband drove her to the hospital without a mask, both of them completely unaware that she might have SARS. She described seeing her colleagues and being admitted under investigation for SARS as a "total shock." She also described to the Commission how frightened and angry she was, worrying whether she had infected her family. She said she struggled to tell her family what was happening, knowing that she had possibly exposed them to SARS, and how she especially worried about her husband, who had had health problems before SARS:

I was so angry about whether I had infected him [her husband]. It was a rollercoaster, mentally, whether I had infected him and my [child] who's at home ... So I was admitted and it took me a while before I could even take the phone and call my husband and tell him what happened ... It was a very difficult year for us, and time, and I was just going crazy thinking about my husband. I thought I could have infected him and he could die. And it was a rollercoaster, not only thinking about him, and then me

being in that isolation room, sitting there, being a nurse and knowing that SARS is a new disease and they really don't know how to treat us ... Mentally it has affected us a lot, sitting down there in that room thinking, am I going to go home alive. And I worried about my family too, at the same time, have I infected them.

Another 4 West nurse had been off sick that week, as she had been ill since May 18. She had gone to see her family doctor on May 21. Her family doctor had sent her to the emergency department at the Branson site, but she was sent home, as she was thought to have the flu. She recalled being contacted at home the afternoon of Friday, May 23, 2003, and being told to come to the hospital:

Answer: So we came home [from the emergency department] but my symptoms were present and even worse, I couldn't sleep and I couldn't eat. I remember I was crying and my children, and my husband were staying near me. Nobody called me from work, nobody asked me how I was doing. Just Friday, May 23rd, my manager called me from my floor and she said I am supposed to come to the hospital. So I remember I came around three or four o'clock.

Question: Did she tell you why you were having to come in?

Answer: Yes, I asked her but she said, don't ask me, just come.

Question: Did she say that you had to wear a mask to come to the hospital?

Answer: No. When I came to the hospital, they gave us everything, masks, hat, shoes, gown.

Question: How did you get to the hospital?

Answer: My husband drove me, by car. So I was waiting there, all of us in the hallway, all of us. It was scary, you know, to look, I don't know, the people were very sick, they are just lying down and not talking, not anything, but we were waiting there in the chairs ...

As noted earlier in the report, the unit administrator for 4 West was unable to be interviewed by the Commission and was therefore unable to provide her perspective of what occurred on May 23.

Another 4 West nurse who had been off sick prior to May 23, 2003, had gone to her family doctor to obtain a referral for a chest x-ray. No one had contacted her from the hospital while she was off sick. She did not know that a number of her colleagues were also ill. When she returned home that afternoon, she had a message to call the occupational health department:

So I went to get a referral for the chest x-ray and unfortunately, the lab was closed, so I had to come back Saturday. So I have the referral, I went home and [her child] said, Mom, occupational health called, and they said you have to go report to North York General to see Dr. Mederski. And so I phoned North York General, the occupational health department, and I said, can I please go to Markham Stouffville, which is closer? They said, no you have to come here and see Dr. Mederski. So I went, my husband drove me. And then when I was there, they didn't tell us that I would have to stay in the hospital. I mean, just to see Dr. Mederski and go, she says go to the 8th floor. So I went to the 8th floor, I was gowned and everything now at the entrance. And they said, just wait for somebody to open the door. I had my cellphone with me in my bag. But I was waiting very long at the door and nobody was opening it and I was gowned. I was sweating and everything.

So I phoned the unit, 4 West, and one of our colleagues was in charge. I said, what's happening, can you phone them inside? Then she tried to phone and finally, by chance, there was a lady going in there. The door opened so I went in and to my surprise, in the waiting room, some of us were waiting. Some of them were already in. Nelia Laroza and her son were already in, were already admitted. And I don't know who else was admitted ... I think there were four of them and the rest of us were still waiting. So, are you here too? Why are we coming here? So that night, I think I was admitted around 1:00 a.m. I had told my family, my sister, my husband, I will phone you to come and pick me up, not knowing that I would stay there. And I stayed there for 20 days.

When her husband drove her to the hospital, neither of them was wearing a mask and they did not know that she was going to be assessed for possible SARS.

Another 4 West nurse who had been off ill that week reported that when she received the call that afternoon to report to the hospital, she too had no idea she would be admitted and she did not know that she was going to be assessed for SARS. She took a cab to the hospital. Neither she nor the cab driver wore a mask.

Toronto Public Health told the Commission that when the outbreak was identified on May 23, they understood that the hospital would notify ill staff that day and have them come to the hospital to be examined for SARS. Toronto Public Health understood that the occupational health department at the hospital would be contacting the ill staff.

The occupational health coordinator was asked by the Commission whether there was a script for calling the ill nurses and why the nurses weren't told they were coming to the hospital to be assessed for SARS:

Question: Post the 23rd, was there an investigation into what happened?

Answer: I don't know about an investigation. I know that I became aware about 2 o'clock, well, I think [a colleague] told me a little ahead of time, but there was a meeting at 2 o'clock with the Committee upstairs, and I sort of reported to them, people had been phoning in sick with flu-like symptoms. So it was decided at that point to call them all back and have them come in for assessment and admission, which I did.

Question: And at that point in time, was it clear or were you aware that these ...

Answer: We were suspicious, yes.

Question: The staff were phoned, and was there a decision as to what they would be told, was there a script provided to you? Was that discussed in the meeting?

Answer: Not really, we were just told to call them and say, you know, "we're concerned and we want you to come in. Dr. Mederski will see you and make an assessment and you may be admitted as required." I think everybody at that

point kind of thought that they were probably SARS.

Question: And who was making the calls?

Answer: I was. Well, myself and the Occ. health nurses. And I think that was a Friday as well.

Question: To your recollection was SARS mentioned in the telephone call?

Answer: I can't recollect.

Question: Did you recall if you told them that there were many of them that were sick, would they have been aware that their colleagues were sick?

Answer: I didn't make them aware because that is a confidential thing, but I think they had been talking to each other.

Question: Well, actually, one of the things that has become pretty apparent is that staff that had been called in on the 23rd, in fact almost all of them complained that when they came in they actually didn't know they were coming in as a potential SARS case, they didn't know that their staff colleagues were sick. So what happens is, they get a phone call, they come in, they show up and they see all their colleagues sitting in a waiting room outside 8 West and that that was very shocking to them ...

Answer: That was very shocking, that would be.

Question: Can you understand how that would happen?

Answer: Yes, I can understand, well ...

Question: How did that happen?

Answer: I don't know how that happened, because my understanding was that they were coming in to be assessed. I didn't know they would all meet up together.

Question: Well, was it communicated to them that they were coming in to be assessed for SARS?

Answer: I believe, I don't know if I mentioned SARS but I said they needed to come in for assessment because we wanted to rule out, you know, it's so hard to remember now.

Question: Sure. And you know, certainly not looking to blame anybody but as far as a lesson learned, is there a way to improve on that communication. I appreciate there are patient confidentiality issues, but you can understand if you're a nurse and you get a call and the call is: "I understand you are sick, would you come in for assessment," you might come to a different conclusion if you understand that there are ten of your colleagues who are also coming in for assessment. Is there a way to bridge that?

Answer: Yes, a couple ways, I could probably say, we've had a number of sick calls from your unit and we want you to come in for assessment, along with some other of your colleagues.

Question: Did you develop a script as time passed for contacting staff who were potentially exposed?

Answer: Well, when we put the 4 West staff on home quarantine, yes. We just need to know if there were signs and symptoms that are applicable, and they knew we would be calling. Because we went up and we had a chat with the staff and told them what the expectations were going to be.

Question: Okay. So is it fair to say that when you were phoning the staff on that day on the 23rd, you were just really

going off the top of your head and that you had been given no specific instructions about what to say, you were just using your best judgment.

Answer: No, no, in fact I thought they were just coming in for assessment and then I went back up and they said, no, no, no admissions.

Question: And that was the other thing is a lot of them said they came ill prepared to be admitted. So your understanding was they thought they were going in to be assessed.

Answer: Yes, and then they said, admission, so it was tough.

As noted above, all of the ill nurses who spoke to the Commission said they were unaware that they were going to be admitted and they were unaware that they were going to be assessed for possible SARS. Simple things like being open and clear with ill staff and notifying staff who were at home and may have been exposed were missed in the chaos and confusion of the day.

The lesson from SARS, learned through the pain and suffering of those nurses from 4 West who arrived at the hospital completely unaware of what was to come and shocked by the discovery that they and many of their colleagues were being admitted for treatment for SARS, is clear. Communication with staff must, above all, be open, forthright and clear.

Notification of Staff at Home

When the outbreak at North York General was identified on May 23, 2003, one of the things that became critical, in addition to notifying staff who were in the hospital, was notifying staff who were not working that day but were at home on a scheduled day off. Because there were so many ill patients, staff and visitors, no one knew where SARS might have come from or where it might have spread. Until all the cases and contacts were identified, any employee who had worked at North York General could have been exposed to SARS, either through an ill patient, a visitor or a colleague.

Hospital administration worked very hard to contact staff. Dr. Rutledge described how he and others worked until the early morning hours, phoning doctors and nurses to let them know they were on quarantine:

Later that day [May 23], I guess it was determined that North York General was the source of the St. John's outbreak, and by 5:00 p.m. it was determined that we, all of the members of our hospital community, were to be put on work quarantine. So from 5:00 p.m. until the wee hours of the morning, I was phoning docs and nurses, a number of us were phoning and saying, you're on work quarantine, and explaining to them what work quarantine was.

Hospital officials and managers were aware of the importance of contacting staff and keeping them informed of what was happening. They sent updates via email, there was a press release and efforts were made to contact staff by telephone. Despite these efforts, many health workers told the Commission that they did not get notified about the outbreak but heard about it through colleagues or on the news. They had no idea what their risk was or whether they had put their family at risk simply by being at home.

One nurse who worked on the SARS unit reported that she was not contacted by the hospital to advise her about what was happening, and that she heard about it on the news on Saturday afternoon:

And on that famous Friday, when we were all put into quarantine, more than half of us were not even called to inform us of the quarantine. So a lot of us exposed the community prior to finding out on the news. I never got called. I was driving, Saturday afternoon I was driving home and I heard it on the news. They just said there were too many people to call ...

Even some of the nurses who worked on 4 West, an area that was of particular concern on May 23, were left out of the communication loop. On May 23, it became apparent that one of the key areas for potential exposure to SARS was the orthopedic floor on 4 West. That being the case, one would expect that the staff working in this area would receive priority in respect of focusing efforts at notification. But not all the nurses who worked in 4 West were notified of what was happening. In the all the rush and confusion of this frantic activity, an emergency procedure for which there was no plan and no experience, many of the nurses who had been working on 4 West but who did not happen to be working when the news broke in the hospital were not contacted. This meant that those nurses who were not contacted went about their normal day-to-day lives, in contact with their family and others, potentially putting them at risk, until they learned of the outbreak, to their surprise, through rumour or the media.

One 4 West nurse who had worked the week of the 19th recalled hearing about the outbreak on May 23 on the late-night news. She had not been feeling well and had gone to hospital that day but was sent home. She recalled having to call the hospital to find out what was happening:

I saw on the news that my hospital had been closed, so I checked my temperature and it was 39, so I called my floor and one of the girls told me that a bunch of people I work with were already in emerg and I should go into our hospital, so I drove up to our hospital.

One nurse who had worked on 4 West on May 22, 2003, also recalled hearing about the outbreak on the news. She had worked without protection in the unit now known to the hospital and Public Health officials to be an area where there were previously unidentified cases of SARS. Despite her obvious potential exposure, no one contacted her to advise of her risk and to give her direction on what to do and how to protect herself and family. As she recalled:

On the 24th, I heard the news at six o'clock in the morning, I heard the news about the SARS outbreak in North York. Anybody who was in from 13th to the 23rd, had been quarantined.

Another 4 West nurse who worked May 22, 2003, told the Commission that she learned about the outbreak when she went to work on May 24:

Question: Do you remember when you went in on the 24th, do you recall if you aware that SARS was back by that point? Or did you learn about it when you went into work?

Answer: Learned.

Question: And how did you find out about it?

Answer: I walked into the unit.

Another 4 West nurse who worked May 22 was not contacted and told about the outbreak until Monday, May 26, at which time she was told she had to go into quarantine. She told the Commission that no one from the hospital contacted her between May 22 and May 26, and that she heard about the outbreak from a colleague and from seeing it on the news.

One part-time 4 West nurse, who had worked the previous weekend, May 17 and 18, told the Commission that she did not know that the unit had been shut down until she went to work on Monday, May 26. No one had called her to tell her what was happening, even though she had worked on the unit that was believed to be the epicentre of the outbreak.

Toronto Public Health officials told the Commission that it was their understanding that the occupational health department would contact staff and communicate with them. As Dr. Berger told the Commission:

Dr. Berger: What I recall, is that occupational health was notified, so the division around contacting, I don't know exactly how they did it, but the division was that Public Health would not deal with staff, but that would fall to the occupational health and safety department of the hospital, to follow the staff and communicate with them. Part of the whole press release also was to anybody who had been there, but the actual directives around what we were doing was given to the senior management team, of the SARS Senior Management Team, the senior admin at the hospital, so the chiefs of staff of every department were given all this information and then they had to take it and carry it to their various departments. They were responsible for passing those decisions on.

Question: So, when you do go home at some point on the night of May 23rd, is it fair to say that in your mind, the job of contacting either sick health care workers or health care staff on 4 West was in the hands of the hospital?

Dr. Berger: Yes.

Ms. Adamson, the CEO of the North York General, told the Commission that the hospital did begin to call staff that day and continued into the early morning hours, to tell them to quarantine themselves and to stay away from their families:

It wasn't until later on in the afternoon, the latter half of the afternoon when Sue [Kwolek] called me to the boardroom, and it was realized that we had the staff, their illnesses were presented for 4 West, the patients from 4 West that were in question and we'd have to put everyone into

quarantine. We were taken up to the other boardroom, the Ministry of Health people were on the phone. There was going to be a press conference at seven o'clock that I would need to attend to. It never happened, it was cancelled, so we began to do exactly as they told us to do, call everyone, everyone at home were quarantined. We began to communicate and that's when the greatest trauma for the staff happened. We were there until two o'clock in the morning trying to find people and had to leave messages if we couldn't find them. You would wake them out of their sleep and ask them to leave their families and children. We got back the next morning and just tried to continue to make sure people were safe and understood what they needed to do.

Despite these efforts by the hospital, vital information about their potential risk of exposure to SARS did not get through to many of the 4 West nurses.

The coordinator of the occupational health department was asked by the Commission to describe the process by which 4 West staff were notified of the outbreak:

Question: And do you know what system was in place to contact staff who were not necessarily recorded in sick but were on their time off? For example the 4 West nurses?

Answer: Well, we've got a whole list of the unit names, so we phoned everybody.

Question: Did you call even those who were on their days off?

Answer: Yes.

Question: And was there a way to track to ensure everybody was contacted?

Answer: Yes, we do it through occupational health.

Question: And you made all those calls?

Answer: Our staff did, yes.

Question: So if there were a number of nurses who worked on 4 West who weren't notified until May 26th as to what

was happening at the hospital, was that something that just fell through the cracks?

Answer: That was the weekend?

Question: Right.

Answer: So, we probably didn't work until Monday and that's when we put people on home quarantine.

Question: So, then the calls started on the 23rd and whoever didn't get reached on the 23rd was left until the Monday?

Answer: Yes.

Question: If you were to do it all over again, was that ... ?

Answer: We'd probably do it on Saturday.

Question: Yes.

Answer: And there was, I guess, there was no direction as to ...

Question: Who was giving you direction on how this was supposed to be handled?

Answer: It would have been the SARS Committee.

When asked to explain how someone who worked on 4 West might not be contacted, she said:

Question: So if someone who worked on the 4th floor didn't get contacted, it was because it was the weekend and there was nobody was making those calls?

Answer: Yes, I have to go back and think about that.

Question: There aren't that many nurses on the 4th floor, so wouldn't the priority have been given to them?

Answer: It's more than nurses.

Question: Even if it's just the staff, how many staff on the 4th floor, 40, 50?

Answer: Maybe, I'm not sure.

Question: Maybe not even that many. Was priority given, did you know at that point that the 4th floor was really sort of the epicentre of the outbreak?

Answer: Well, no, I guess I didn't.

Question: So, who was being phoned?

Answer: The eight nurses that called in sick. But I know we came in on that weekend.

Question: But outside of the eight nurses, who was being phoned? That's what I am trying to get at. I'm not talking about eight nurses, I am talking about ...

Answer: Nobody during that weekend, because we came in and we were trying to put contact lists together, because there were 13 ill patients and we were trying to match exposure, so that we could make those calls. So what was decided with Public Health is that this is an onerous task for one or two people to do and they felt that they would self-identify, and that's why they put them on home quarantine on Monday, because they were working on the weekend.

Question: Okay, some of them were working?

Answer: Some of them were working, yes. And the quarantine period would be approximately would be 10 days, 11 in one case, I think. So, Public Health said they would self-identify, so when we went up Monday, we went to the unit, we spoke to the nurses and said, you are all going home on home quarantine. And that was a deci-

sion made by the SARS Task Force and so everybody agreed to that. They staffed the unit with agency nurses. We called every day to make sure they didn't have any signs and symptoms, if they did, they were admitted. If they came into emerg, they were assessed and admitted or sent home or whatever.

Question: These are nurses on home quarantine?

Answer: Yes.

Question: Just so I am clear, the 23rd, the calls you made were to the eight ...

Answer: Just to those eight that they said bring in, because they didn't know.

Question: Okay, fair enough. But on the 23rd, eight ill nurses were called, did anybody call or think to call the rest of their colleagues on those days?

Answer: I think [the unit administrator] may have. I think she did but, I can't answer that. But I didn't.

Question: Certainly there was no process in place to ensure that was done, to your knowledge?

Answer: No.

The lack of any such process, the systemic failure to have such a process in place, is unacceptable and indeed appalling.

Toronto Public Health told the Commission that they understood that the 4 West staff would be contacted. Senior hospital officials told the Commission that they understood that staff were being contacted. The occupational health department understood that the unit manager was contacting staff and that ill staff would self-identify. And the nurses remained in the dark.

This is not to blame those working in the occupational health department. As the

above testimony shows, they lacked direction and clarity over who was to be called and what those called were to be told. They were working hard over the weekend trying to identify exposure and contacts for those who were ill. As noted earlier in this report, the unit administrator was unable to be interviewed by the Commission and so has been unable to shed any further insight into why not all of the 4 West nurses were contacted.

What is clear is that there was no consistent approach to contacting staff and that no consistent message was provided to staff. Whatever confusion was present at the time, whatever challenges communicating with staff presented, it is difficult to understand how the 4 West nurses and health workers could not all be contacted and how such a critical task could be left as it was. By the afternoon of May 23, 2003, it was clear there was a big problem with illness among staff, patients and visitors. The 4 West nurses were at the greatest risk for possible SARS exposure and many of them were already ill. The 4 West nurses, all of them, whether they were working or not, ill or well, were entitled to know that they could be at risk so that they could take steps to monitor their own health and to ensure the well-being of their families.

The horror stories of front-line staff – those health workers who learned about the outbreak on May 23, 2003, and wondered if they should have known sooner; those health workers who scrambled to use precautions, who worried about whether they had the right equipment and if they were using it properly; those health workers who learned about the outbreak from television and then had to wonder if they had just exposed their family to SARS; those nurses who were brought into the hospital on May 23, 2003, having no idea that they were going to be assessed for SARS and admitted and then lying in isolation, wondering if their families were safe – are undeniable.

Post-SARS, it is essential that the lessons learned from the terrible stories of these brave health workers be used to ensure that these communication breakdowns never happen again. It is essential that a system be put in place in all hospitals to ensure that front-line health workers directly at risk from a recently discovered infectious outbreak are informed in a timely fashion of what they need to know to protect themselves, their families and the community.

It must be clear who bears the responsibility for notifying staff at the earliest possible opportunity. There must be a clear plan to effectively communicate risk without delay. There must be clear lines of authority, clarity around roles and responsibilities, and an understanding among all managers and supervisors as to what information must be

conveyed to staff, such as their risk and how to protect themselves and their families. Hospitals must have up-to-date contact lists for staff, and as part of their emergency preparedness there should be a clear plan to let staff know how they can expect to be informed about what is happening in the hospital and how those at risk will be notified and protected.

Conclusion

After the second outbreak was discovered, front-line staff, managers and administrators mobilized to provide care to SARS patients, including their colleagues. Whether they were angry, disappointed, exhausted or afraid, they stepped up and did what had to be done to contain SARS. As one doctor said:

What went right: in a situation where so little was known and when you are in the midst of it, so very little was known, was that the people who were involved, right across the board, the ones that were going to step up, you knew who they were and they did so. And they did so in an open manner and knowing as we went along that it was not without risk. And I'd say the people who were going to step up, it was right across the board because it went on and on, they were a smaller group of people involved in stepping up and are then consistently stepping up. But that's a reflection of professionalism, of human nature.

Another doctor agreed that the response of North York General to the second outbreak was one of the things that went right:

What went right is how North York General responded to SARS II. They quickly shut the hospital down and contained what could have been a really truly devastating epidemic. And that's something that I believe was the right thing to do. They did the right thing and it was a big step. They altered a lot of how they affect and contained infection. We had a complete revamping of our emergency department and negative pressure rooms and directives of how to deal with suspected infectious diseases.

Another doctor said that when the hospital knew it had SARS cases or that SARS was around, it did a superb job:

I've got to tell you, apart from my comments which are somewhat negative, North York did a superb job in every other way. In fact, I can tell you, it's the best job I've seen amongst all the hospitals. Superb job, in terms of training, outfits, and the communication from the staff meetings and the physicians and the administration. They did a superb job.

During the first outbreak and the second outbreak ... North York General did a great job. During those times when we believed as a community, as Canadians, that SARS was around, North York General did a great job.

Since SARS, the hospital has made improvements to many important areas, including infection control, occupational health and safety and communication with staff. Many health workers interviewed by the Commission pointed to improvements in these areas and say that they feel the hospital has learned many important lessons from SARS and, as a result, it is now a much safer place to work.

Ms. Adamson told the Commission that the hospital did learn many lessons from SARS and they have implemented many of the lessons:

Many of the lessons learned from SARS are being implemented right now and we are better prepared to deal with SARS if it should happen again; better positioned to handle new infections or new permutations of existing diseases. We have already made significant changes based on the knowledge gained from SARS. A sophisticated patient screening and triage system in our emergency department is one example of how we are moving forward from SARS ensuring that we continue to provide a high level of protection for patients, staff, volunteers and visitors entering our hospital. We've increased the number of isolation rooms with improved ventilation. We have tripled the size of our infection control team and continue to recruit. We've expanded educational programs in infection control for our staff, including instructions on CD-ROM. We now have the capacity to establish an assessment clinic quickly. Our occupational health policy is now more stringent. We are actively improving communication with our staff, increasing management visibility and accessibility and implementing a new participative committee structure.

North York General should not be remembered for the tragic mistakes and errors that took place there during SARS as a result of a province-wide failure to ensure appro-

priate standards and systems for infection control, worker safety, and communications and accountability.

North York General Hospital should be remembered not for those system-wide errors and mistakes but for the skill, devotion and remarkable courage, as described in this report, of the physicians, nurses, and other health workers and members of the hospital community who gave so much of themselves to help those afflicted with SARS.

Ministry of Labour Sidelined

Introduction

The Ministry of Labour was sidelined during most of SARS. Despite its legal mandate to protect workers, the Ministry was excluded from the higher echelons of the government's response to SARS. No one thought to make the ministry an integral worker safety component of Ontario's SARS response. Ministry safety officials were largely excluded from information links. A senior Ministry safety official found it quicker to go to the nurses' union to get a SARS directive than it was to penetrate the information barriers within government.

After the Sunnybrook disaster on April 13, when nine workers got sick after they did everything they were told they needed to do to be safe, the government called in experts from the Centers for Disease Control and Prevention (CDC) without informing the Ministry of Labour's experts whose job it was to prevent such future safety lapses.

It was only in June, towards the end of SARS, that the Ministry of Labour picked up on its responsibility to ensure N95 respirator use, training and fit testing in hospitals. In hindsight it is clear that the Ministry could have done more, that it could have reminded the hospitals in March of their legal obligation to train and fit test nurses, physicians and other health workers for the N95. It is clear that the ministry in April and May had the capacity to do what it finally did in June by way of proactive safety work with SARS hospitals.

Nurses, with good reason, expected the Ministry of Labour to be more aggressive in its mandate to protect health workers. Although it is puzzling why the Ministry did not act sooner, the answer may lie in its exclusion from the central SARS command, its sad lack of depth in health safety resources, a questionable 1984 government protocol that kept it physically out of hospitals during any infectious outbreak, its assumption that the health system had the resources and expertise to protect its workers, the sharp cuts during the 1990s in its capacity to protect health workers, and the

deep resentment of some hospitals which regarded the Ministry as an unwelcome interloper on hospital turf. It would be speculation to ask whether earlier intervention by Labour could have prevented worker illnesses and deaths. It would be speculation to wonder what might have gone better if the Ministry of Labour from the beginning had been able to rise above these limitations, to flex its muscles and push its way on to the turf of those entrusted by the government with its response to SARS.

Ontario's worker safety system needs a tune-up to ensure that the Ministry is not sidelined the next time we are hit by something like SARS. Workers are entitled to better safety enforcement than they got during SARS from the Ministry of Labour. Worker safety requires an independent inspection and enforcement arm and in Ontario, the Ministry of Labour is that arm. The public is entitled to expect that the government's worker safety arm will be more aggressive next time in its protection of workers. Improvements since SARS have put the Ministry in a much better position to protect workers in the next outbreak. But the turf resentments against the Ministry still remain in hospitals and in the Ontario's health system. Those turf barriers have to be torn down.

The Ministry of Labour Before SARS

SARS found a Ministry of Labour that was poorly resourced and ill prepared for a public health crisis. Its contingent of physicians had been sharply reduced since 1992, when it had 19 physicians. By 1996, they were down to three and one half. It no longer had a laboratory, or air-sampling technicians. Its occupational health and safety nurses had been laid off in the 1990s.

Most inspectors had little or no training on infectious disease issues. None of the inspectors interviewed by the Commission said they had ever conducted an infectious disease-related inspection of health care facilities before SARS.

As a senior ministry official told the Commission, the Ministry had little internal expertise in infection control:

The Ministry did not have, until April of this year, people with specific public health experience working, or people with specific communicable disease experience. Actually, I'll correct that a little bit. We had occasionally some inspectors who were nurses with experience in the field and we also had ... during SARS, at that time, we would have had people with specifically communicable disease or infectious disease experience.

The Ministry of Labour’s Role During SARS

The Ministry of Health led the response to SARS. Labour was given a secondary role, providing:

... advice and support to the emergency response with respect to occupational health and safety issues.

The Ministry of Labour set up an internal command centre. It established a protocol on how Ministry staff would respond to SARS-related worker complaints and work refusals. It assigned an occupational health physician to the Science Committee. It posted information on its website. And it participated in teleconferences with unions, hospitals and the Ministry of Health.

As noted in Table 1, prepared by the Ministry, it also investigated worker complaints and work refusals. In all, the Ministry investigated 54 work refusals during SARS, including 18 by workers in the health sector.⁷⁶⁸ Beginning on June 12, 2003, it conducted a series of proactive inspections of some SARS hospitals.⁷⁶⁹

Table 1 – Summary of Ministry of Labour Responses During SARS⁷⁷⁰

Date of Communication	Nature of Communication	Event Location	MOL Response
24 March 2003	Complaint	The Scarborough Hospital	Complaint received, handled by an inspector
25-26 March 2003	Inquiry	City of Toronto – Ambulance	Handled by phone by medical consultant
31 March 2003	Inquiry	Healthcare Health and Safety Association	Handled by phone by medical consultant
2 April 2003	Work refusal	TS Tech	Reported as work refusal – clarified as inquiry only

768. Ministry of Labour, Submission to SARS Commission, March 15, 2006, p. 16

769. For a complete overview of the Ministry of Labour’s activities during SARS, the reader is invited to review its submission to the SARS Commission’s public hearings. The submission is available on the Commission’s website at the following location: http://www.sarscommission.com/hearings/04Mon.Nov.pdf/Mon_12_00_MOL.pdf

770. Ministry of Labour, Submission to the SARS Commission, March 15, 2006. The Ministry said: “The following table provides a brief summary of SARS related communications received by the MOL during the outbreak, the nature of the communication and the MOL response.”

Date of Communication	Nature of Communication	Event Location	MOL Response
3 April 2003	Inquiry	Hilltop Retirement Home	Closed by Public Health – MOL notification
3 April 2003	Work refusal	Ellis Don/Southlake	Field visit report
4 April 2003	Work refusal	Ellis Don/Southlake	Field visit report
7 April 2003	Complaint	DC Diagnosticare	Handled by phone by MOL provincial specialist
8 April 2003	Inquiry	The Scarborough Hospital	Handled by phone by medical consultant
8 April 2003	Work refusal	Canadian Waste Services	Field visit report
27 May 2003	Complaint	North York General Hospital	Handled by phone by medical consultant
1 June 2003	Complaint	North York General Hospital, St. Michael's, & Mt. Sinai	Teleconference
2 June 2003	Work refusal	Thyssen Krupp Elevator	Field visit report
6 June 2003	Work refusal	North York General Hospital	Teleconference
7 June 2003	Work refusal	North York General Hospital	Field visit report
9 June 2003	Work refusal	North York General Hospital	Field visit report
10 June 2003	Complaint	St. Michael's	Field visit report
11 June 2003	Work refusal	Sayers & Associates	Field visit report – delivered verbally June 19 – handled by MOL manager
12 June 2003	Proactive	St. John's Rehab	Field visit report
12 June 2003	Proactive	Lakeridge Health – Oshawa	Field visit report – teleconference
12 June 2003	Complaint	Hospital for Sick Children	Handled by medical consultant – referral to MOH
12 June 2003	Complaint	Mount Sinai	Mt. Sinai reported no issues – field visit deferred pending worker complaints
13 June 2003	Proactive	Scarborough General	Field visit report
16 June 2003	Work refusal	City of Toronto – Ambulance	Field visit report
16 June 2003	Proactive	William Osler Health Centre	Field visit report
20 June 2003	Complaint	Toronto General Hospital	Field visit report
20 June 2003	Complaint	Lakeridge Health – Oshawa – nurse	Referred to mgmt & JHSC – handled by MOL manager

20 June 2003	Complaint	Lakeridge Health – Oshawa – pathology	Referred to mgmt & JHSC – handled by medical consultant
20 June 2003	Inquiry	William Osler Health Centre	Handled by phone by medical consultant
24 June 2003	Complaint	City of Toronto – Ambulance	Field visit report
24 June 2003	Work refusal	Sayers & Associates	Field visit report – handled by MOL hygienist
26 June 2003	Proactive	Sunnybrook	Field visit report
27 June 2003	Proactive	Toronto East General	Field visit report
4 July 2003	Proactive	Southlake – Newmarket	Field visit report
10 July 2003	Work refusal	City of Toronto – Ambulance	Field visit report
14 July 2003	Proactive	Rouge Valley Health Systems	Field visit report

The Ministry of Labour also continued to carry out its duties and responsibilities in other sectors. It told the SARS Commission:

The outbreak of SARS required the Ministry of Labour to apply considerable resources to deal with the emergency while continuing to carry out its inspections, investigations and enforcement activities in all sectors across the province.⁷⁷¹

Perspective of Representatives of Health Care Workers

Representatives of health workers were highly critical of the Ministry of Labour's response to SARS.

They said it failed to enforce safety laws; recognize the health sector's lack of expertise and awareness on N95 respirators, fit testing and other worker safety issues; ensure directives were consistent with laws and regulations and safety best practices; and respond to workers' concerns.

In their joint submission to the Commission's public hearings, the Ontario Nurses' Association and the Ontario Public Service Employees Union said:

771. Ministry of Labour, Submission to the SARS Commission Public Hearings, November 17, 2003, p. 9.

The large number of HCWs [health care workers] who became ill with SARS as a result of workplace exposures should have led to an investigation by the MOL. If that many industrial workers suddenly developed a life-threatening work-related illness, both unions believe that the MOL [Ministry of Labour] would have launched investigations immediately. The illnesses were constantly in the media, as were reports of shortages of equipment, including respirators.⁷⁷²

Ministry of Labour Excluded

Despite its legal mandate to protect workers, the Ministry of Labour was not given a role during SARS commensurate with its statutory duties. No one thought to make the Ministry an integral component of Ontario's SARS response. This systemic problem demonstrates how little the health system was aware of, and how little it understood, Labour's role and expertise.

There are many examples of this.

When a senior Labour expert tried to participate in Provincial Operations Centre (POC) deliberations, he was effectively invisible. He told the Commission:

I went to the Provincial Operations Centre on several occasions to try and participate ... They were in charge, and they were running the show themselves, and that's the way it was.

When the Provincial Operations Centre issued directives, the Ministry of Labour had no oversight over worker safety content. As a senior Labour official told the Commission:

The Ministry of Health was running the directives. They were their directives.

When POC directives were issued, senior Ministry of Labour staff had trouble getting copies. One official said he often had to get copies from contacts at health worker unions or at other agencies. He told the Commission:

772. ONA/OPSEU joint presentation to the SARS Commission Public Hearings, November 17, 2003, p. 28.

What were we supposed to do? We don't have any information. We can't get any information from the Ministry of Health. We are not getting any directives. How do we get the directives?

When West Park Hospital's old TB unit was reopened in late March 2003, the Ministry of Labour was not notified or consulted, even though it knew first hand the old TB unit's shortcomings and had the expertise to try to mitigate them.

When the Centers for Disease Control and Prevention (CDC) was asked to investigate the infection of nine health workers at Sunnybrook on April 13, no one thought to ask Labour to participate. The Ministry didn't even know an investigation was underway.

When the Ministry of Health set up a restricted access website containing technical SARS information, Labour was not informed until long after the fact. Health unions got access to the site weeks before the ministry.⁷⁷³ Labour didn't find about it until "late April or May," a senior Ministry official told the Commission.

When the Ministry of Labour provided one of its occupational health physicians to the Science Committee,⁷⁷⁴ he attended, not as a representative of the Ministry, but as a researcher. A senior Ministry official told the Commission:

He was there as a scientific professional. He wasn't there representing the views of the Ministry of Labour. He was there as our contribution, as a scientific professional, to the SARS Science Committee. He experienced a lot of frustrations.

When the Science Committee met to discuss respirators on April 9, 2003, Labour sent a leading expert to make a presentation. As an indication of his reputation, he sat on the respirator committee of the Canadian Standards Association (CSA). Instead of being welcomed as someone with high-level expertise from the Ministry with

773. ONA-OPSEU joint presentation to SARS Commission Public Hearings, November 17, 2003, p. 6.

774. Ministry of Labour, Submission to the SARS Commission Public Hearings, November 17, 2003, p. 12:

The Ministry of Labour physician in collaboration with the other members of the Science Group contributed infection control advice for the protection of workers, and provided advice regarding the requirements under the Occupational Health and Safety Act and the regulations for worker health and safety in the health care sector. He was also active in gathering scien-

primary responsibility for protecting workers, he was treated as an outsider.⁷⁷⁵ The Ministry of Labour official said:

I was a visitor. I just listened.

Not only was Labour sidelined, but it also assumed that Health – the lead ministry during SARS – and the health care system it oversaw had the resources, expertise and knowledge to protect nurses, physicians and other workers. The ministry told the SARS Commission that it had:

... an expectation that the health care sector was itself equipped to control the hazards.⁷⁷⁶

A senior Ministry of Labour official told the SARS Commission:

The resources and the expertise in terms of infectious disease control don't reside in the Ministry of Labour. We don't have what the health care system has. We don't have what the public health officials have. So, I mean, it doesn't surprise me that we would say, that's fine. The Ministry of Health has got access to international experts. In other cases, and I've had rock bursts in a mine that killed people. And who's got the lead there? It's not the Ministry of Health, it's the Ministry of Labour, and we have our rock engineers. We hire international experts that come in. Health did the same thing here. So when we ran into issues, they brought in infectious control disease experts from various other institutions in the province, from other jurisdictions to help them deal with it, and that's what I would expect it to be.

In hindsight, we can see that this assumption was flawed, and that the health system was woefully weak in worker safety expertise and resources. This assumption worked hand in glove with Labour's exclusion from the higher echelons of the SARS response to limit its response. To the extent that Labour was sidelined, its ability to determine within government whether its assumptions about the health system were valid was reduced.

775. Minutes of the Epi Science Group, April 9, 2003, p. 2

776. Ministry of Labour, Submission to SARS Commission, March 15, 2006, p. 17.

Ministry of Labour Took a Reactive Approach

During SARS, the Ministry of Labour focused on responding to complaints and work refusals.

The Ministry told the Commission:

The MOL strategy during the SARS outbreak consisted of responding to complaints and work refusals on a priority basis to ensure that the most up-to-date standards for the protection of workers from SARS were in place.⁷⁷⁷

At the Scarborough Grace Hospital, Labour received complaints from nurses' representatives by telephone in late March 2003. The Ministry told the Commission:

On March 24, 2003, the Ministry received the first complaint relating to SARS from a worker representative regarding management's response to the hospitalization of health care workers at Scarborough Hospital – Grace Division. The complaint was assigned to an inspector who contacted a Ministry physician who in turn telephoned the hospital on March 24 advising both the Director of Occupational Health and Safety and a Human Resources representative about the requirements under the *Occupational Health and Safety Act* to notify the Ministry of Labour of occupational illnesses. In addition the Ontario Nurses Association was contacted. The Ministry physician also discussed infection control measures with the hospital. The Ministry of Labour physician was told that they were receiving assistance from both Toronto Public Health and Mt. Sinai Hospital and were also in contact with Health Canada.

On March 25, 2003, the Ministry of Labour physician spoke with a Toronto Public Health physician who confirmed that Toronto Public Health was attending at the Scarborough hospital to assist with infection control measures. On March 26, the physician from Toronto Public Health also confirmed that Toronto Public Health was investigating health care workers exhibiting SARS symptoms.⁷⁷⁸

777. Ministry of Labour, Submission to SARS Commission, March 15, 2006, p. 19

778. Ministry of Labour Submission to SARS Commission public hearings, November 17, 2003, pp. 9-10.

When the Ministry of Labour was contacted by a worker at North York General on May 27, 2003, four days after the second phase erupted, the ministry took the same approach as it had taken at the Grace two months earlier:

On May 27, 2003, a Ministry of Labour physician was contacted by a worker at North York General Hospital who raised a concern about infection controls in the emergency department. The Ministry of Labour physician, after contacting a North York General Hospital occupational health representative, contacted the Director of Communicable Disease at Toronto Public Health regarding this concern. The Ministry of Labour physician was advised that Toronto Public Health was aware of the concern and their inspectors were in the hospital doing contact tracing. The Ministry of Labour physician specifically requested that the inspectors attend at the emergency department to review the worker concerns which had been communicated to the Ministry of Labour. Toronto Public Health agreed to do so.⁷⁷⁹

This reactive approach does not reflect on Ministry staff, who responded to the complaints at the Scarborough Grace Hospital, at North York General and at other workplaces, and simply followed Ministry protocols. But it does reflect a systemic problem in the Ministry of Labour.

At the Scarborough Grace and North York General, Labour had, in effect, deferred its worker safety responsibilities to others. It did this under a 1984 Memorandum of Understanding with the Ministry of Health that established:

... lines of responsibilities where there are suspected outbreaks of infectious diseases in workplaces. This agreement provides that the Ministry of Labour has a general responsibility for investigating hazards in a workplace under [OHSA] and the local Medical Officer of Health has responsibility for the identification, investigation and control of outbreaks of communicable diseases. It also provides that where the local Medical Officer of Health has responsibility for the investigation and control of an outbreak, the Ministry of Labour will assist.⁷⁸⁰

779. Ministry of Labour Submission to SARS Commission public hearings, November 17, 2003, p. 11.

780. Ministry of Labour Submission to SARS Commission public hearings, November 17, 2003. p. 9.

The 1984 agreement was unauthorized by statute, unclear, not disseminated to interested parties like the unions, and arguably illegal to the extent that it might require Ministry personnel to fetter their discretion and so fail to fulfill their duties in workplaces affected by infectious diseases.

A former senior Ministry official said:

The first goal is to contain the outbreak and recover, just like it is in any other emergency. The Ministry of Labour doesn't wade in there and start doing their proactive inspections. We let the emergency workers make it safe and then we'll go in and do our investigations and stuff.

SARS revealed a major flaw in Labour's interpretation of the 1984 agreement.

The Ministry assumed that among the myriad tasks on public health's plate during SARS, from contact tracing to deciding whether to close the hospital, it also had the resources, expertise and capability to give worker safety the same level of attention as the ministry whose primary responsibility it is. It is Labour's job to make sure workers are safe. It cannot, and should not, assume that another agency, whether it is a public health unit or the Ministry of Health, can take over that role, or has the capability to do so.

The idea behind the 1984 agreement was sound: Before a crisis, set out the separate roles and responsibilities of the Ministry of Health, public health and Labour so they can better cooperate during a crisis.

What was not sound, and what must be avoided in the future, was the idea that an agreement meant the Ministry of Labour could defer to another agency the primary responsibility for ensuring that workplaces are safe.

Proactive Inspections Came Late

On June 12, 2003, when the outbreak was on the wane, the Ministry of Labour began conducting proactive inspections of SARS facilities. It told the Commission:

On June 12, the Ministry initiated a series of consultations at other health care facilities that were identified as having a risk of SARS transmission to their workers. The health care facilities were categorized based on potential SARS exposure. The facilities were listed as Category 0 to 3,

with Category 0 being hospitals with no known cases of SARS. During these consultations the Ministry reviewed infection control precautions, use of respirators and respirator fit testing and the function of the internal responsibility system. As a result of the consultations and complaints, a total of 16 orders were issued under the *Occupational Health and Safety Act* and regulations to five of ten health care facilities⁷⁸¹ ... The orders included undertaking risk assessments and providing and fit testing respirators to all health care workers in high-risk areas. No violations of the *Act* or regulations were found in five of the institutions.⁷⁸²

Although it is puzzling why the ministry did not act sooner, the answer may lie in its exclusion from the central SARS command, its too long held assumption that the health care sector was able to protect its workers, its reliance on the 1984 agreement, and its emphasis on a reactive approach.

Regardless of the reasons, the bottom line is that no proactive inspections were conducted during virtually all the outbreak. There were no proactive inspections of SARS hospitals in March 2003, or in April 2003, or in May 2003, even though health workers continued to get sick during each of those months and inadvertently infected colleagues, patients and members of their households. That more and more health workers were getting sick was not a secret. One only had to read the newspapers, watch television newscasts or listen to the radio. As each month passed, the widely available evidence mounted that health workers were not protected and that the system in charge of the SARS response was unable to safeguard them. Yet the Ministry did not act proactively. In April and May it had the capacity to do what it finally did in June by way of proactive safety work with SARS hospitals. This was a missed opportunity, although we will never know what impact that might have had on the SARS response.

As noted earlier, Labour's approach was vastly different to what occurred in British Columbia. When a nurse contracted SARS at Royal Columbian Hospital, the Workers' Compensation Board made five inspections at the hospital to make sure workers were protected.⁷⁸³

781. In contrast, the Workers' Compensation Board in B.C. made 19 separate inspections of nine medical facilities, predominantly acute care hospitals between April and July 2003. Only one order was issued, related to N95 respirator fit testing, and it indicates the depth of worker safety culture in B.C. Source: WCB Communication with SARS Commission, September 13, 2006.

782. Ministry of Labour, Submission to the SARS Commission Public Hearings, November 17, 2003, p. 16.

783. Focus of WCB inspections included officer evaluations of:

In B.C., the workplace regulator regarded the incident at Royal Columbian as an urgent signal that it had to make sure workplaces were safe. In Ontario, the Ministry of Labour missed the opportunity to respond to the many red-flag indicators that workers were not being protected.

It cannot be proven that health workers caught SARS because the Ministry of Labour did not conduct proactive inspections. What can be said, however, is that in B.C. only one health worker got SARS in a jurisdiction where the workplace regulator aggressively conducted proactive inspections beginning in early April 2003.

British Columbia provides a useful example of how well things can work and how well health workers can be protected when there is a strong safety culture. It provides an example of how things can work and should work in Ontario.

Improvements Since SARS

Since SARS, the Ministry of Labour has acted on many of the lessons from SARS, and it is to be commended for this.

Since SARS, it has made a significant effort to address its resource and expertise weaknesses, including hiring 200 more inspectors and developing sufficient in-house health care expertise. It has adopted a more assertive, proactive approach to workplace safety in general, and to the health sector in particular. A case in point was a series of proactive inspections of health facilities in late 2003 and early 2004. As the Ministry of Labour said in a submission to the Commission:

Inspectors issued orders for a variety of contraventions related to infection control including the notifications of occupational illness, Workplace Hazardous Information System (WHIMS), operation of joint health and safety committees, training, ventilation, storage and handling of

-
- The status of exposure control plans related to SARS and the appropriate control measures necessary for the protection of workers potentially exposed to the unidentified agent responsible for SARS,
 - Written policies and procedures specific to the exposure control plans,
 - Implementation of these policies and procedures,
 - Worker education and training,
 - Use of personal protective equipment, particularly on respiratory protection for those workers potentially exposed to the unidentified agent via airborne droplets

Source: WCB Communication with SARS Commission, September 13, 2006.

materials, risk assessment of needlestick/sharp injuries and the use of safety engineered medical devices, handling of waste materials, appropriate use of refrigeration units and the use of personal protective equipment.

All 192 acute care facilities in Ontario were visited and 2,172 orders were issued.⁷⁸⁴

Further proactive inspections in health care continued afterwards. If all proactive inspections undertaken are included, a total of 6,008 orders were issued by Ministry inspectors in the health care sector for the period 2003 to 2005.⁷⁸⁵

The Ministry has also hired six inspectors dedicated to the health care sector. The Ministry said it:

... wants to ensure that it has additional staff with the knowledge and experience required to deal with emerging issues such as SARS, pandemic influenza, avian influenza, and other outbreak situations in the health care and other sectors.⁷⁸⁶

There are also signs of better cooperation between the Ministry of Labour and the Ministry of Health.⁷⁸⁷

The Ministry of Labour told the Commission:

784. Ontario Ministry of Labour, Submission to the SARS Commission, March 15, 2006, p. 21

785. Ontario Ministry of Labour, Submission to the SARS Commission, March 15, 2006, p. 23

786. Ontario Ministry of Labour, Submission to the SARS Commission, March 15, 2006, p. 21

787. It is useful to note that Dr. Sheela Basrur, the Chief Medical Officer of Health, has taken steps to improve this situation. Only time will tell if these steps are effective. She notes in her letter of March 9, 2006, to Ms. Linda Haslam-Stroud, RN, President Ontario Nurses' Association

We recognize the need to ensure that the perspectives of occupational health and infection control receive consideration. In light of this, an occupational health physician is included in the membership of PIDAC (PIDAC is the Provincial Infectious Diseases Advisory Committee) and has been sitting on the committee since the inception of PIDAC in 2004. However, we see the importance in continuing to strengthen our links with the occupational health field and a physician delegate from the Ministry of Labour is now also sitting on PIDAC. This highlights our commitment to ensuring that occupational health and safety expertise is brought to the table during all PIDAC deliberations now and in the future. We are confident that building on this approach will assist in ensuring stronger linkages between occupational health and infection control on matters of science.

The Ministry wishes to advise that it is sharing the services of three of its experts in infection control and prevention in occupational health and safety with the Ministry of Health and Long-Term Care (MOHLTC) as MOHLTC lacks the requisite expertise and/or experience ...⁷⁸⁸

Conclusion

The evidence reveals widespread, persistent and ingrained failures by the health care system to comply with, and by the Ministry of Labour to enforce, Ontario's safety laws, including the *Occupational Health and Safety Act* and Ontario Regulation 67/93, Regulation for Health Care and Residential Facilities.

We must do better next time. The only way to do better is to ensure that the Ministry of Labour is in a position to oversee and enforce, as aggressively as required, Ontario's safety standards. The only way to do this is to break down the turf barriers that prevented this during SARS and to promote in our health system a safety culture that applies the precautionary principle that action to reduce risk need not await scientific certainty.

788. Letter from the Ministry of Labour to the SARS Commission, August 23, 2006.

June 13 Cancellation at Mount Sinai Hospital

Introduction

Allegations of political interference ran high on June 13, 2003, when the Ministry of Labour cancelled an urgent safety meeting under the *Occupational Health and Safety Act* to investigate worker safety complaints at Mount Sinai Hospital and to avert a possible walkout by nurses.

The Ministry's motivation to back off from safety enforcement at Mount Sinai remains unclear to this day. Also unclear is the process by which the decision was made and even the identity of the officials who made the decision. This section will deal with three questions:

- What happened?
- Was there political interference?
- Why was the meeting cancelled?

The Commission investigated this allegation in detail because, in all the rumours and suspicions around the SARS crisis of 2003, it is the only concrete allegation of political interference.

Rumours and Allegations

Rumours abounded that the meeting was cancelled because of political pressure at the behest of the Premier, or the Minister of Labour, or the Deputy Minister of Labour, or someone in government above them, or Mount Sinai. A nursing union representative thought it was one of the first three. She told the Commission:

[The circumstances of cancellation] clearly indicate that problems around the Ministry of Labour not enforcing the Act are coming from above the director level. So it's either from the Deputy Minister's office,

from [the Premier's] office, or from [then Labour Minister] Brad Clark's office, so there's only three offices that it could be coming with.

A Ministry of Labour employee thought it was the hospital itself:

... and my understanding was that the next place to meet with people was going to be at Mount Sinai. My recollection at the time was that we just got told to back off, and the rumour going around, and all I can say is that what I heard at the time is that the CEO at the hospital called somebody at 400 Bay [Ministry of Labour head office] and said back off, and we backed off ... Everybody seemed to be running scared of the hospitals.

The concrete allegation, although hearsay, came from a reliable confidential source:

[...] told me that ... [the] CEO of Mount Sinai called Tony Dean and said we don't have a problem so cancel the inspection. Tony Dean called [Deputy Minister] Paavo [Kivisto] and said cancel it.

Intervention by Mr. Dean, the Secretary of Cabinet, to cancel a statutory safety investigation at the behest of a hospital would raise serious issues of improper interference with worker safety procedures mandated by the *Ministry of Labour Act* and the *Occupational Health and Safety Act*.

The investigation of this allegation is set out in detail below.

The purpose of the aborted June 13 meeting was to avert a threatened walkout by Mount Sinai nurses who were concerned about personal protective equipment, lack of respirator fit testing and other practices they considered dangerous to their safety. One observer said:

People were really scared there.

On June 11, Andy Summers, the Ontario Nurses' Association (ONA) union representative at Mount Sinai, sent an email to the ONA advising that he had held three meetings with Mount Sinai CEO Joseph Mapa and that he had told Mapa that the lack of action on fit-testing issues had forced Summers to support a work stoppage:

I informed him that the three weeks of promising mask testing and to this date not one nurse tested, has forced me to provide all nurses with the necessary tools and support to institute a work stoppage ... and I would be contacting every one of my members via mail to give them information and instructions to do so ...⁷⁸⁹

The ONA brought these concerns to the attention of the Ministry of Labour and in particular of Dr. Leon Genesove, the Provincial Physician, who described the nurses' concern:

... a big concern that the staff of Mount Sinai Hospital, that nurses represented by ONA may walk out of the hospital. It came to the attention of the Ministry of Labour and I was asked if I could address the concerns. I spoke to people – I had been speaking to Erna Bujna, and I was also speaking with the president of ONA at the time. And there were lots of concerns from the staff about respirators and infection control issues and infection.

Dr. Genesove also described the Ministry's response:

What we agreed to then [was] that they, the ONA president, would advise their staff not to walk out and the Ministry of Labour would conduct an investigation. So what I arranged for is a Ministry of Labour inspector and myself, or Dr. Lillian Wong, the Ministry of Labour inspector and myself, we would meet with the Mount Sinai people off-site and deal with the issues. So we're going to have the Ministry of Labour inspector and myself, a management representative from the hospital and worker representatives from the Joint Health and Safety Committee. So we agreed to that, and I reported back to my director, Ed

789. This is a convenient place to note that Mr. Mapa, the Mount Sinai CEO, recalled no such conversation:

I don't recall that, union representatives come into my office all the time. It could have happened, but no.

Neither did he recall anything about the cancelled meeting, nor did Leslie Vincent, the Mount Sinai senior VP of nursing. They both thought they would have recalled any suggestion of a work stoppage and a meeting to deal with the threat of a work stoppage. Without finding against Mr. Mapa, it is clear from other evidence that the possibility of a work stoppage was brought to his attention and that the hospital was formally notified of the meeting that was to take place on June 13.

McCloskey. He had told me about the potential walkout, and so it ended up being scheduled for two days after the telephone conversations.

June 13 at 11 a.m. was the time scheduled for the meeting of the Ministry of Labour, Mount Sinai officials, union officials and representatives of the hospital's Joint Health and Safety Committee. The Ministry did not want its inspectors to go physically into the hospital because possible SARS exposure might force them into quarantine and make them unavailable to carry on their work. It was a common practice for the Ministry, in urgent situations when it was difficult or dangerous to meet in the work-site, to meet offsite, and it was therefore arranged to have the meeting at the downtown Marriott Hotel. Although the meeting was not to be physically in the hospital, it was still a formal field visit under the provisions of the *Occupational Health and Safety Act* and under the safety regulations for health care facilities.

The Ministry, on the afternoon of Thursday, June 12, in an internal email, confirmed the meeting for the following morning at 11:00:

From: Grier, Stephen (MOL)
Sent: Thursday, June 12, 2003 2:51 PM
To: Rae, Robert (MOL); Wong, Lillian (MOL); Genesove, Leon (MOL); Ward, Ian (MOL); Walker, David (MOL); Fliegl, Anna (MOL); Baker, Murray (MOL); Boeswald, Joe (MOL); Kwok, Steve (MOL)
cc:
Subject: Proactive Meetings with Hospital Personnel

The following proactive meetings have been arranged with hospital staff to address the issue of worker health and safety as it pertains to SARS.

Mt. Sinai Hospital

Meeting will take place at 11:00 am on Friday, June 13th 2003 at the Marriott Hotel (Eaton Centre) in the Carlton Room. Arrangements have been made with the hospital's Director of Occupational Health & Safety, Mary Anne Adams, for the cochairs of the JHSC and an ONA representative to be present. Further employer representatives will be identified prior to the meeting.

William Osler Health Centre (Etobicoke General)

Meeting will take place at a Medical Building located at 89 Humber College Blvd. (near but not connected to the hospital) on Monday, June

16th 2003 at 10:00am. The hospital's Director of Occupational Health & Safety, Terry Siriska, will ensure that there is adequate worker and employer representation at the meeting.

FYI.

Steve G.

As a result of the Ministry promise of the June 13 meeting, the Ontario Nurses' Association advised its members at Mount Sinai to stay on the job.⁷⁹⁰

On the late afternoon of June 12, the Ministry abruptly cancelled the meeting and thereby created for itself a serious credibility problem and a loss of confidence among nurses.

Different Versions

Ministry of Labour

The official Ministry explanation for the cancellation is that the meeting was cancelled because there was no problem at Mount Sinai. The Ministry's submission to the SARS Commission in November 2003 said:

The consultation at Mount Sinai Hospital did not take place as scheduled. The hospital had been reclassified to a Category 0 (no known cases of SARS).

Pages 15-17 of the Ministry's March 15, 2006, response to a Commission letter contain a brief summary of SARS-related communications received by it during the outbreak. Page 16 contains the following information under the heading "MOL Response" for Mount Sinai:

790. ONA President Barb Wahl pointed out to the local Mount Sinai union representatives the limited circumstances under which nurses could withdraw their services, even for serious safety concerns.

Mt. Sinai reported no issues – field visit deferred pending worker complaints.

These explanations required further investigation. There were in fact serious unresolved issues at Mount Sinai, issues that led to a threatened work stoppage averted only by the Ministry promise of an inspection into worker complaints.

The fact that Mount Sinai reported no issues is no reason to back off the investigation of serious worker complaints. The whole point of an inspection is to not see whether the hospital reports any safety issues, but to see whether there are in fact any safety issues. The Ministry is supposed to investigate worker complaints independently of the employer. The Ministry is not supposed to cancel an investigation because the employer says there is no problem.

The complaint from the nurses had nothing to do with the hospital's classification. The complaint was that safety directives were not followed and that there were breaches of the *Occupational Health and Safety Act*. The fact that a hospital has a zero SARS classification is no defence to a failure to follow safety directives and no defence to a breach of the *Occupational Health and Safety Act*. And because the Commission has seen no evidence that Mount Sinai's SARS status changed between June 11, when the meeting was scheduled, and June 12, when it was cancelled, it seems implausible to advance the hospital's SARS status as a reason for cancelling the scheduled meeting.

Furthermore, the fact that Mount Sinai reported zero SARS is no reason to take off the table a safety inspection to investigate worker safety in a hospital where seven health workers⁷⁹¹ had already come down with SARS despite assurances that all appropriate safety measures were in place.

The direction to cancel the June 13 meeting came from David Walker, the director of the Ministry's central region, in a telephone call to Dr. Genesove, who had been dealing with the ONA.

Dr. Leon Genesove, Provincial Physician

Dr. Genesove recalls:

Dave Walker is director of central region of the Ministry of Labour and instructed me that the visit to Mount Sinai Hospital should be cancelled,

791. See Ministry of Labour occupational illness investigation, Synopsis of Investigator's Findings, p. 2.

apparently because the issues had been resolved there.

Dr. Genesove recalls that he advised Mr. Walker that there were still concerns at the hospital, and that Mr. Walker said, “Let me give you the phone to Helle and she’ll explain it.” Walker gave the phone to Helle Tosine, the Assistant Deputy Minister. Dr. Genesove said:

I was in the Downsview office at the time and he was somewhere, I guess at our head office. He said, let me give you the phone to Helle Tosine, our ADM, and she’ll explain it. Helle gets on and she said, we have to cancel the visit. I said, this is really a bad idea, why are we doing this? She says, here, speak with Paavo Kivisto, the Deputy Minister; Paavo said we have to cancel the meeting. I spoke to Paavo afterwards.

Dr. Genesove called the ONA to let them know the meeting had been cancelled:

Dr. Genesove: Later on in the afternoon, I phoned up the Ontario Nurses’ Association and spoke to [one of its representatives] and let her know the Mount Sinai Hospital meeting was being cancelled, and of course she was quite upset about that because the issues hadn’t gone away.

Question: So is there someone we should talk to who might know more about this?

Dr. Genesove: To get more information, you have to speak to probably Paavo or Helle about it and get additional information. The visit ended up taking place about two or three weeks later, at least we started it ...

Paavo Kivisto, then Deputy Minister, Ministry of Labour

Mr. Kivisto recalled an issue around Mount Sinai, but not the details. He said that he did not tell staff what to investigate and what not to investigate, that there was no political pressure from the Minister of Labour and that all complaints and refusals were investigated:

Mr. Kivisto: There was an issue at Mount Sinai. I don’t remember the details; I think you’re correct to say that there was a

planned inspection, or a planned something, and then it was discovered that Mount Sinai was not – didn't fit the criteria that the Ministry had established of who we were supposed to inspect. So it was taken off the list. There was some controversy over that. Helle [Tosine] can give you a better understanding around that, because I was not involved in that transaction that I am aware of.

Question: In November of 2003, at the public hearings, the Ministry's comment at that time was that there was a consultation but that it didn't take place because Mount Sinai was classified to a level zero.

Mr. Kivisto: They had no SARS. Because they were focusing on the ones that had SARS. I remember there was some question, some controversy over ...

Question: ONA's complaint to the Ministry was that Mount Sinai was not following all of the directives given in respect of SARS and they had evidence to support it. The complaint was that there was a serious health and safety concern at Mount Sinai, that the employer was violating the Act and the directives. The consultation was cancelled, so you can see, obviously, ONA saying, we went to the Ministry, we said we had evidence, you cancelled it, there must have been some political pressure brought to bear.

Mr. Kivisto: I don't think so, no, not in that matter. I've no recollection of any political pressure in that the Minister – in terms of him, personally, or his office, never took an active hand in determining how to respond, what was investigated. I didn't tell staff what to investigate and what not to investigate. All complaints and refusals were investigated and were expected to be investigated. That one, my recollection was that I thought it was a planned inspection that we were going to do and because it didn't fit the criteria we took it off the list and focused on the ones that fit the criteria. Helle was

on the scene and could give you more detail on that, because I can't ...

***Helle Tosine, Assistant Deputy Minister,
Ministry of Labour***

The Commission put to Ms. Tosine the suggestion that Tony Dean called Mr. Kivisto and the Mount Sinai consultation was off:

Question: At Mount Sinai there was a consultation scheduled for some day in June, I think it was around the 11th or the 12th of June. We have the suggestion that the CEO of Mount Sinai called Tony Dean, the Secretary of Cabinet, who I think, at one point, worked in the Ministry of Labour.

Ms. Tosine: Not then.

Question: Not then, no, no, but in a prior life. The suggestion is that Tony Dean then calls Paavo, and the Mount Sinai consultation is called off.

Ms. Tosine: That's not what happened.

Question: No. Then what happened?

Ms. Tosine: We were, it wasn't a consultation, it was more of a proactive inspection.

Question: An inspection?

Ms. Tosine: Yeah, so those hospitals were categorized into those three levels – into 3, 2, 1, they were. And it was mandatory proactive inspection of all level 3 hospitals. So we got the rankings from Health, I can't remember how frequent it was, but they were pretty critical rankings of whether there was probable or suspected SARS in those hospitals. So, as I understand it, I was trying to check that point, I think the ranking changed,

absolutely nothing to do with the CEO calling Tony Dean.

Question: Why would he call Tony Dean?

Ms. Tosine: Because people do that.

Question: Thinking they can solve a problem by ...

Ms. Tosine: No, they just go on about it. People do that now. You know that happens all the time, you get calls from various manufacturing firms ... There was absolutely no interference from Tony Dean.

Question: So when he calls Tony Dean, it's to what, to complain about the fact that there is going to be a review and say well we're not a Level 3 or 2 or whatever it was, or ...

Ms. Tosine: I don't know what he told him about. I guess you'll have to ask Tony Dean about it. But certainly nobody called me, nobody called me to direct me.

Question: No. Okay. But Paavo spoke to you?

Ms. Tosine: About the call?

Question: Yeah.

Ms. Tosine: Actually I don't remember that, maybe, maybe he did. If he said he did then he probably did, but I actually don't remember that.

Paavo Kivisto, then Deputy Minister, Ministry of Labour

Mr. Kivisto, in a further interview, was asked about the alleged phone calls from Joe Mapa to Tony Dean to Mr. Kivisto to cancel the Mount Sinai inspection. Mr. Kivisto told the Commission:

I would not have cancelled that meeting. Tony would never give me direction ... inspections or investigations. He was formerly a deputy. He

would not ever put that kind of request. If he put that kind of request on me, I'd have difficulty and I'd remember that. I don't take direction from ministers, from other deputies, and CEOs about how we do work at the Ministry of Labour. Never have, never will. A couple of times I thought I was going to be fired for that, stood my ground around investigations of the Ministry because my boss or somebody had given me expectations of what we should or should not do. I guard that jealously. As Deputy, I will not [tell] Operations what to do, what not to do on our investigations or meetings with stakeholders. That's their job. You know, CEOs, I got calls from CEOs. I got calls from unions when I was there. You listen to them but that doesn't influence a decision. The decisions are made on the basis of fact, so if there was a meeting planned and it was a meeting cancelled, talk to the people who planned the meeting or cancelled the meeting. It has nothing to do with any conversations I may have had with Tony Dean. I don't remember him calling me. I don't remember talking to a CEO. I don't remember talking to Helle about it, because I wouldn't. Tony had called me a few times on matters, saying, somebody's called upset about something. All I would do with those calls is, look, Helle, either you call him or I call him, but somebody's going to talk to him, find out what's going on. That doesn't determine whether we do inspections or investigations. That's done by people who are responsible for that job, by the officers and the managers who run the show. I've never had a Secretary of Cabinet ever tell me, stop an inspection, stop an investigation or start one. I've gone the other way as ADM Operations, if anything, I will be giving direction to do more, not less. So that doesn't resonate with me. I don't recall if – I can't believe it happened.

... if he [Dean] called me about any call from a hospital, he would have said I had a call from a concerned hospital, would you look after it. I don't, if there's something about a whole hospital shutting down, I would have, I'd remember it. I don't remember anybody talking to me about a whole hospital being shut down. If there was a complaint, a work refusal, I would expect a field staff to go investigate like we're investigating other work refusals, through investigations and inspections. They're holding meetings off site with unions and hospitals. That did not happen. It would not happen. If it did, I'd know, I'd remember.

And I can't help you. I just don't know. I don't remember being on any phone call around that. I don't remember anything about a meeting at Mount Sinai being cancelled. I would expect that every complaint that

was called into the Ministry was investigated. I know we were having meetings off site to do those investigations done by Helle [Tosine] and her folks.

I don't remember that name [Mapa]. If a CEO calls with any concerns, I'll listen to it. If it's something that alleges improper action by the Ministry, I'll have it investigated. I don't let it influence how we carry out our work.

***Helle Tosine, Assistant Deputy Minister,
Ministry of Labour***

In a later interview with the Commission, Ms. Tosine said:

Nobody called me and I was never made aware of any conversation that happened between the CEO of Mount Sinai and Tony Dean. Tony Dean never called me once during SARS, also Paavo [Kivisto] never directed me on which hospital to go in, or which hospital not to run to.

Well, that's right. So, we never got a formal complaint from Mount Sinai. I recognize that, we don't have a formal complaint from Mount Sinai.

I'm going to assure you again we experienced no interference from anyone around Mount Sinai.

Mr. Walker told the Commission:

I mean, what's clear to me, although I wasn't contacted directly by anyone from the hospital or whatever, it's clear to me there were conversations, that there had been a phone call made at a senior level, like from the CEO, but I think last time I mentioned – actually I remember there being discussion around a call from a hospital CEO and actually the hospital was St. Mike's, but honestly, I think I said it, you know this, but it really could've been Mount Sinai, but I know there had been a call from a hospital CAO, or CEO, I certainly recall that there was a conversation. Not that I was, that I remembered being there, I don't believe that I was, but it certainly was relayed to me that there was a conversation between the Deputy Minister and that CEO from the hospital, but that to me is really clear, clear memory of that. I don't remember specifically

sort of that, sort of conversation, when you said pass the – when Leon [Dr. Genesove] said pass – you need to talk to Helle [Tosine], that does sort of jog me. And I am trying to sort of put my mind to sort of who was in the room at the time. I don't remember the Deputy being in the room that moment, but it is possible he was, right.

I was told that, and I could be incorrect, but I believe that it was Steve Grier that told me, but I believe that, I suddenly remembered being told that there was a CEO that had called, was upset, and that there was a conversation between the Deputy Minister and that person – that, to me, that's very clear memory. I wasn't there for it, and then obviously there were discussions that happened after that in terms of how to respond, in terms of a visit, or no visit, and so ...

Sure, I think, it's clear to me in terms of, in terms of what Leon was saying, the fact that I would have said that, I would have said that here you need to speak to Helle, right, that people were uncomfortable, right, that there was a discomfort with how, how to explain to ONA, that there wasn't going to be a meeting.

... CEO, well, I wasn't directly involved in the conversation ... It was quite clear to me there was a call. Now, whether the call was from the CEO directed to the Deputy or the Deputy called the CEO as a result of another conversation, that was clearly relayed to me that there was a conversation between the Deputy and that person ...

Brad Clark, then Minister of Labour

The then Minister of Labour, Brad Clark, appeared unaware of the cancellation. He was visibly appalled at the allegation that the worker safety mandate of his Ministry had been thwarted by a phone call to his officials from the Secretary of Cabinet. He said with some heat that if they had called him he would never have cancelled the meeting:

It does shock me that there was alleged political interference coming from the centre. I had a real reputation as being a real hard-ass, and rules are rules, and ethics are ethics, and we abide.

... So I had no hesitation about getting involved and ordering the right thing to be done. I was not told, it was never brought to my attention

that orders were not being issued or followed up on, inspections were not being done ...

There can never be a hint of political interference.

... I never wanted to be the person that said, no, you lay charges now. Because, these folks are independent, they know their job. I had complete faith in them. They do their inspection, if they recommended charges, then charges should be laid.

I have reservations that it happened, but if it did happen, I would not be a happy camper. And if it did happen, it doesn't surprise me that they didn't come to me, because they know full well I would have blown the whistle.

The strength of the former Minister's reaction gives force to the proposition that a telephone call from the Secretary of Cabinet to a Ministry of Labour official at the behest of a hospital CEO to prevent a worker safety inspection would be regarded within government as an unacceptable form of political interference with the Ministry's legal mandate to protect health workers.

Tony Dean, Secretary of Cabinet

Mr. Dean told the Commission:

I don't recall talking with Mr. [Joseph] Mapa. Perhaps I did talk with him, I don't recall it. What I can tell you with absolute certainty is that I did not, and I would not, and I never have directed or instructed the Ministry of Labour anything or any deputy of any other regulatory ministry to change or alter any field-level inspection, visit, meeting, or order. So, that would not have happened ...

Having told you what I don't do, it's probably helpful to tell you what I do do on occasion. I do get calls from external parties. Examples that spring to mind are concern that my colleagues at a ministry are perhaps overreaching in the protection of the environment to the detriment of people in the development community. That some have the balances getting out of tilt or whatever. That a trade union president will call me and say, "Do you really understand the implications of this strike?" and that's it. And I certainly would, and do on certain occasions, collect that

information and transfer it to the Deputy Ministers as information. I would say, I've had a call from X or Y and this is what I've been told and this is something you should know. I really need to be clear: I would never, in the course of doing that, infer or suggest that any action of any sort ought to be taken ...

Joseph Mapa, CEO of Mount Sinai Hospital

Mr. Mapa told the Commission:

I wish I could shed light on this. I don't even remember that – I just don't. If it did happen, I'll just complete some probability scenarios for you, although I really don't. If it did happen, it must have happened for a good reason. What I mean by that is I would never, knowing my behaviour, and knowing our relationship with the unions as well, our effort to be very close to the unions, call off something such as that. So, if it did happen, it was probably advised by Dr. [Donald] Low and others who advise me. I was very dependent, very fortunate at Mount Sinai Hospital to have people of that expertise available and, at that time, there was so much ambiguity that we were very lucky to have the kind of expertise and talent to advise me. So I was the luckiest CEO, probably, in the city. So I'm giving you probability. I don't know, it's not my nature to do that unless for those reasons. You know, the meeting is set and it's someone from the outside coming in, even during the crisis. In fact during the crisis we invited people during SARS to come and take a look at the ICU [intensive care unit] procedures.

Later Positions and Explanations

In a letter dated June 18, 2003, to Premier Ernie Eves, Barb Wahl, President of ONA, said:

It is with huge concern for public safety that I am writing to you today. As you yourself have said, Ontario Nurses' Association (ONA) members have been heroic, as they have faced both professional and personal challenges in battling the SARS epidemic in the Toronto area.

The Centers for Disease Control investigations have linked the spread of SARS to improperly fitted masks. There is ample evidence that many of the Toronto-area hospitals have not met the basic health and safety

requirement for mask fit testing as set out in Section 10 of the *Regulation for Health Care and Residential Facilities* made under the *Occupational Health and Safety Act*.

We were encouraged by recent decisions and proactive actions of the MOL to help protect our members from further danger. Last week, the MOL issued orders regarding proper protective equipment in two hospitals after investigating a work refusal and a complaint. Thereafter, the MOL began proactively inspecting other high-risk hospitals and committed to continue to visit *all other* Toronto area hospitals to ensure that health care workers are properly protected. On June 12, 2003, I wrote Ed McCloskey, your director of Occupational Health & Safety at the MOL explaining that it was imperative to conduct and complete these investigations immediately.

On the morning of Friday, June 13, 2003, we were advised that the MOL ordered a halt to all proactive inspections for all Toronto area hospitals. In a slight change of position by end of the day, they further advised that pro-active inspections will only proceed for Category 3 & 2 facilities and no other facilities will be proactively inspected. This is unacceptable. Given the current undisputed evidence, we expect the MOL, to continue to at least issue orders regarding provision of personal protective equipment, fit-testing of respirators, and risk assessment programs, where they are found lacking.

Further disappointment followed when the Ministry of Health and Long-Term Care (MOH/LTC) replaced the May 31, 2003, directives with the revised directives issued on June 16, 2003, which reduced the protection for the majority of health care workers. Given increasing evidence that health care workers need properly fitted masks to protect them from SARS, it is premature to reduce the protection of these workers.

A disturbing memo to all staff dated June 13, 2003 from the CEO of Sunnybrook and Women's College Health Sciences Centre confirms that this employer was working with your Science Committee at the SARS Operations Centre to draft these new directives. Why are employers permitted to work directly with the Science Committee when our organization has not even so much as been given an opportunity for direct input? We question whether it is science that changed the directives, or

convenience and economics for employers?

Your labour ministry has an obligation to ensure that employers are taking all reasonable precautions to protect workers. The MOH/LTC directives may act as a base guideline, but in no way should limit the Ministry's enforcement powers under the *OHSA* to ensure that employers are taking the maximum precautions, not the minimum as set out in the directives.

As you must know, since the original SARS outbreak we repeatedly advised the Ministry of Labour of our health and safety concerns, and of the employers' non-compliance with the *Occupational Health and Safety Act*. On June 7, 2003, your Commissioner of Public Health & Chief Medical Officer of Health and your Commissioner of Public Security sent a letter to all acute care hospitals in Toronto, York and Durham Regions, admitting knowledge of their awareness that several employers are known to be breaching the provincial directives.

ONA has also repeatedly advised the MOL/LTC that the directives did not go far enough to adequately protect our members' health and safety. I ask that you intervene at once and direct the MOH/LTC to re-issue the directive requiring any staff working in patient care areas in the GTA (Toronto, York and Durham Regions) to wear full personal protective equipment. Despite everyone's desire for this crisis to be over, we simply cannot afford to reduce health and safety measures again *unless and until there is conclusive scientific evidence to support such an action*.

In light of the circumstances the Ministry of Labour officials' scaling down of inspections, in our opinion, borders on regulatory negligence. I ask you to direct the MOH/LTC to re-instate precautions in the directives that fully protect all health care workers in patient care areas and ask you to direct the MOL to reinstitute proactive health and safety investigations, with sufficient resources to complete them forthwith. We believe that you, too, have an obligation and duty under the statutory regime. Failure to meet these obligations, in our opinion, would also constitute statutory negligence on the part of this government. We urge you in the strongest terms not to stand back and knowingly aid and abet those employers who continue to put our members' lives at risk.

In a letter dated June 26, 2003, to Ms. Wahl, Premier Eves said:

Thank you for your letter about health care workers in Ontario and the *Occupational Health and Safety Act*.

From the very onset of the SARS crisis in Ontario, our government has been both scrupulous and consistent in issuing directives concerning proper infection control procedures, including the wearing of personal protective equipment. As additional information has become available, and our understanding of the virus has increased, the directives have become more focused. We are doing more to better protect the health and safety of patients and health care workers.

The Provincial Operations Centre provided guidelines dated April 14 on the safe and proper use of masks. On May 2, the Provincial Operations Centre issued a communication containing a list of companies providing mask fit testing services. On May 28, in a communique to providers, the Ministry of Health and Long-Term Care reinforced the importance of fit testing of masks and communicated that health care workers who are most at risk of being in close contact with people who have febrile respiratory illnesses should be fit tested as a first priority.

Directives issued by the Ministry of Health and Long-Term Care on June 16 reinforce the message that people working in SARS units must wear personal protective equipment at all times. Further directives issued on the same date deal with high risk procedures and require a personal protective system that covers the face and head completely.

The directives are drafted by the Ontario SARS Scientific Advisory Committee, which includes two infection control nurses. The directives are predicated on the best available science and the need for caution. They are circulated to a reference group from health care facilities, including infectious disease specialists. The focus of the review is on the clarity and implementation of the directives.

With respect to the Ministry of Labour's actions, I want to assure you that the Ministry will continue to investigate all complaints and work refusals in a timely fashion and issue orders as appropriate. As you have noted, the Ministry has investigated complaints and work refusals and has issued orders to two hospitals. On June 10, the Ministry issued four orders to North York General Hospital following a work refusal investi-

gation. On June 10, the Ministry issued three orders to St. Michael's Hospital following a complaint investigation.

The ministry initially concentrated its proactive efforts on the health facilities that are at higher risk because of SARS. To date, the Ministry has completed consultations and/or investigations in all Category 2 & 3 health facilities. The ministry is now working proactively with all Category I hospitals to ensure compliance with the *Occupational Health and Safety Act* and applicable regulations. To this end, the ministry has already contacted all Category I hospitals and will arrange for a consultation with the workplace parties in the near future. As always, any worker health and safety concern should be brought to the attention of the Joint Health and Safety Committee and the Ministry of Labour should be contacted concerning any unresolved issues.

We will continue to be vigilant to protect the health and safety of patients, health care workers, and the community. We must not let our guard down.

The unprecedented challenge of SARS has placed tremendous strain on health care workers across the Province as they strive, under unique and extraordinary circumstances, to combat this new disease. I recognize that they have all been working tirelessly to protect those in their care, as well as their community, from further SARS infection.

I also recognize that our government could not have succeeded in moving forward with our initiatives to combat the outbreak of SARS without the support of our nurses. It is this steadfast commitment to the health of Ontarians that is assisting health officials at all levels of government to move us towards the successful containment of SARS.

Ontarians are grateful knowing that they can rely on our nurses and other health care workers during this difficult time. We want to assure them that we will continue to support health care workers in treating the sick, in protecting the vulnerable, and in containing SARS.

I appreciate your bringing these matters to my personal attention.

In their joint submission to the SARS Commission public hearings, ONA and OPSEU said:

Mount Sinai Hospital – The MOL was targeting Mount Sinai for a proactive MOL investigation into respirator fit testing and training for June 13, 2003. On June 13th, the proactive inspection for Mount Sinai was cancelled. Prior to this decision, ONA had complained earlier in June to the MOL that Mt. Sinai was not meeting its obligation to fit-test employees as per the directives. Both unions wonder why the MOL decided to cancel this proactive inspection despite ongoing member complaints.⁷⁹²

On the one hand, to schedule or to cancel one of a series of proactive consultations would properly require the policy involvement of senior Ministry of Labour officials. On the other hand, to cancel a formal investigation scheduled under the statutory authority of the Act and regulations in response to safety complaints by workers or their union is an operational decision that should not involve the policy involvement of senior Ministry officials, particularly if the reason given for the cancellation is that the employer says there are no problems.

The suggestion that the Mount Sinai meeting was cancelled because of a call from the hospital's CEO to the Secretary of the Cabinet involves a serious perception of political interference with the Ministry of Labour's legal mandate to protect worker safety. It is one thing for a hospital to consult with government. It is another thing to go over the head of officials responsible for worker safety, not just to their Director or their Assistant Deputy Minister or their Deputy Minister, and not even to their Minister, but directly to the centre of government, the Secretary of Cabinet, who sits at the Premier's right hand and speaks with the authority of the Premier. A direction from the Secretary of Cabinet to any Ontario public servant is understood to be a direction from the Premier.

The Commission found strong evidence of a perception that political interference was at work in the abrupt cancellation without reasonable explanation of the Mount Sinai worker safety initiatives.

Because of its timing and the fact that the decision came from somewhere above in some mysterious way without reasonable explanation, and because of the lack of

792. ONA and OPSEU Submission to the SARS Commission, SARS Commission public hearings, p. 20.

appropriate documentation and the fact that no one is prepared to step up now and take responsibility for the decision, the perception of political interference is natural and inevitable.

The curious thing about the cancellation is that no one in a position of authority, no one in the direct chain of cancellation, seems able to remember what happened or why. Mr. Walker, who directed Dr. Genesove to cancel the meeting, said he could not recall the reasons:

I don't know who made the decision – it wouldn't have been a decision that, as regional director, I would have made, on my own, just to sort of say, oh well, we won't go or we won't do that, right, so it's reasonable to assume that there was some, some direction or some discussion about [it]. If I was a participant in that discussion program about that particular facility, I honestly can't remember whether I was.

Dr. Genesove, who got the direction from Mr. Walker and spoke at the same time to Deputy Minister Paavo Kivisto and to Assistant Deputy Minister Helle Tosine, suggested the Commission speak to Mr. Kivisto or Ms. Tosine:

To get more information, you have to speak to probably Paavo or Helle about it and get additional information.

Paavo Kivisto, the Deputy Minister, in turn suggested we ask the Assistant Deputy Minister:

Question: Mount Sinai? Why was the visit cancelled?

Mr. Kivisto: I don't remember the details. There was a planned inspection. When Mount Sinai didn't meet criterion, it was cancelled. Ask Helle Tosine.

Helle Tosine, the Assistant Deputy Minister, did not recall who made the decision:

I don't know ... personally who made that decision to go to Sinai, on or off, but I was certainly told about it.

Someone made this controversial high-profile decision, but no one in a position of authority remembers who made the decision. This collective lack of recollection becomes more and more pointed with every witness in the direct chain of cancellation

who suggests the Commission speak to someone else in the chain of cancellation, and that person – indeed, each person in turn – cannot recall who made the decision. This jarring lack of recollection adds fuel to the perception of political interference.

The Minister of Labour, as noted above, made it very clear to the Commission that he had nothing to do with the cancellation and knew nothing about it in advance. The strength of his reaction gives force to the proposition that a telephone call from the Secretary of Cabinet to a Ministry of Labour official at the behest of a hospital CEO to prevent a worker safety inspection would be regarded within government as an unacceptable form of political interference with the Ministry of Labour’s legal mandate to protect health workers.

Those involved in the incident use different language to describe the June 13 meeting. There is still some confusion about what exactly it is that was cancelled. Confusing terminology is used to describe the process by which the Ministry of Labour hears about and responds to worker safety concerns, terminology like “complaint,” “formal complaint,” “inquiry,” “proactive field visit” and “investigation.”

In the end, the confusing terminology is not of prime importance, although more will be said later about the need to ensure that nurses and hospitals and the Ministry of Labour understand each other and use consistent language when they describe vital processes such as the investigation of workplace danger in hospitals.

The reason terminology is relatively unimportant is because political interference or improper pressure on the Ministry of Labour to cancel any worker safety procedure is unacceptable, whether you call it an “inspection” or an “investigation” or a “proactive consultation” or a “field visit.”

The evidence of Mr. Mapa, Mr. Dean and Mr. Kivisto is uncontradicted by any direct or circumstantial evidence and there is no reason to doubt it. The evidence taken as a whole makes it clear that there was no phone call from Joe Mapa to Tony Dean to Paavo Kivisto to cancel the Mount Sinai June 13 worker safety consultation.

The Commission finds that Mr. Mapa did not call Tony Dean about the June 13 meeting or about anything else. Although the Commission’s source is honest and reliable, the hearsay relied upon by the source is inaccurate. It may be that in the chain of hearsay transmission, confusion arose over a call from another hospital to Mr. Dean about another matter or over another call from Mr. Mapa to other Ministry of Labour officials about another matter.

Regardless of how the meeting was cancelled, the bottom line is it was called off. If a health and safety inspection is cancelled, the process requires full transparency and accountability. There should be no mystery surrounding its cancellation and surrounding the chain of command that led to its cancellation. Regardless of the terminology attached to the nature of the “inspection,” the prime consideration should be the safety of health workers. The safety of health workers is always paramount. If they are not safe, then neither are patients, visitors or the public.