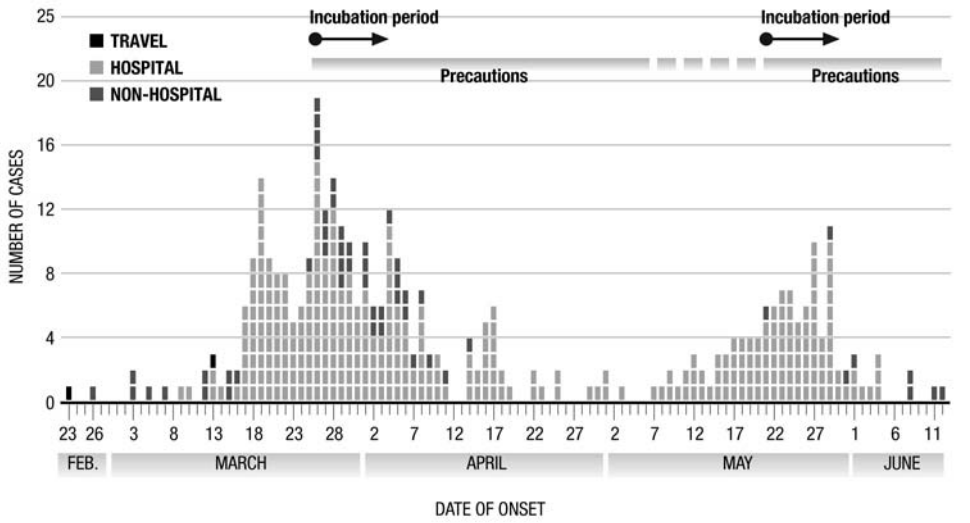
Relaxation of Precautions at North York General Hospital

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 chart[583] 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 directives[584] 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:

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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 directive[588] 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

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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:

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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 Heat 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:

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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	Change in Ministry Directives
	• 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:
	  • 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
		• 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
			• NYGH policy not in contravention of Directives
			• NYGH policy more stringent than Ministry Directives

May 7	No change in directives
	• Remained as they were as of April 14, 2003
		• 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:
		  • 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
			• NYGH policy not in contravention of Directives
			• NYGH policy still more stringent than Ministry Directives

May 13th	• 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	No change to NYGH Policy • Remained as it was as of May 7, 2003.	• NYGH policy not in contravention of Directives • NYGH policy remain more stringent than Ministry Directives
May 15	• No change in directives • Remained as they were as were on April 14, 2003	• 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	• 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.
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> 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.
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> 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.*
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> 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.
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> Question: And that applies to protective equipment?
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> 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 heath 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:

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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.