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 unit[533] 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.

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able 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 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.
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> At that point there was a decision made that we should move 7 North and 7 West to a Level 2[543] 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 advisory[548] 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 Adjudcators 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:

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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 noncompliant 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:

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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 <u>partially</u> incorrect and that they misconstrued <u>some of</u> 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 of 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 legionnella 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 teleconference[578] 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 epilink 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 lookout, 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.