

Clusters of Illness in the Emergency Department

By May 2003, Toronto was claiming a victory over SARS. Directives geared towards a “new normal” were issued and precautions were relaxed. Government and public health officials travelled to China to talk about the successful containment of SARS in Ontario. But SARS was not over. It had never ended. Rather, it lay smouldering in the orthopedic ward at North York General Hospital. While precautions were in place, transmission occurred primarily between patients who shared rooms. Once precautions were lifted, SARS quickly began to spread, among patients, visitors and health workers.

As SARS spread, some of the patients and visitors who had been exposed to SARS and who began to develop symptoms came to the emergency department at North York General Hospital for treatment. Staff in the emergency department became increasingly alarmed in May as they saw cases admitted with respiratory symptoms that could be SARS. Of particular concern was the family of Patient A.⁷²⁵ Patient A had been an inpatient on 4 West and had died on 4 West on May 1, 2003, during the first part of the SARS outbreak. After his death, his wife, daughter, son-in-law and grandchild were all admitted through the emergency department at North York General Hospital. Emergency room staff raised concerns about these cases but, as in the case of the psychiatric patients in April and early May, staff were told that these cases were not SARS. Like the psychiatry staff, the emergency room staff would later learn that their observations and concerns were correct: all of these family members had SARS.

Another family, Mr. and Mrs. O, came through the emergency department around the same time that the fourth family member of the Patient A family cluster (the granddaughter of Patient A) was admitted to hospital. Mr. O had also previously been an inpatient on 4 West. He was discharged home but developed pneumonia and was readmitted to hospital. His wife became ill and was also admitted through the emergency department at North York General Hospital, with pneumonia.

725. As noted earlier, the initials of the patients have been changed throughout the report.

Patient A, the four family members who were admitted to hospital, and Mr. and Mrs. O were all retrospectively classified as SARS after the outbreak at North York General was identified on May 23. On May 20, Ms. N, a former inpatient at North York General Hospital, was identified as part of a cluster of SARS at St. John's Rehabilitation Hospital. Ms. N had gone for rehabilitation following her discharge from North York General Hospital. Concerns about the Patient A family cluster and the link between the index case of an outbreak of SARS at another hospital to North York General Hospital was what led public health officials to North York General on May 23. The story of the investigation on May 23 and the details that led public health officials to North York General Hospital on that day are told later in this chapter.

From the story of these clusters of illness that came through the emergency department during May emerge many of the same system-wide problems as were evident in the story of the psychiatric patients: failure to give attention to the concerns of front-line staff, too much reliance on the epilink, poor communication with front-line staff and poor communication between Public Health and hospitals. The story of these family clusters of illness shows the importance of strong infectious diseases leadership and of proper support and supervision during an outbreak.

But above all, the story of Patient A and his family is a story of family tragedy and loss. Five family members fell ill, and in the end the family lost a husband, father and grandfather.

Patient A Family Cluster

Patient A was admitted to North York General on March 22, 2003, following a fall that resulted in a fractured pelvis and clavicle. He was admitted to 8 West, the ward that later became the SARS unit. Although his admission to hospital predated the formal declaration of SARS and the accompanying requirements for screening of patients, it is known in retrospect that Patient A did not have an epidemiological link to a SARS patient or to a hospital with a SARS outbreak and that he had no history of travel to an area where SARS was endemic.

Although Patient A was on 8 West when Health Care Worker No. 1⁷²⁶ became ill

726. The story of Health Care Worker No. 1 is told earlier in this chapter, along with the stories of four other health workers who contracted SARS while working at North York General Hospital during April 2003.

with SARS, his onset of illness was inconsistent with this potential contact being the source of exposure. The SARS Field Investigation, an investigation into the outbreak at North York General Hospital, concluded:

Incidentally, on March 30, 2003, while patient A was on 8W, a nurse on that ward developed SARS symptoms and later tested PCR positive in stool samples and then seroconverted to SARS-CoV. The nurse's mother was an inpatient at Scarborough Hospital Grace Division (where SARS transmission was occurring) in late March; her serology results were positive for SARS 2 months later but she did not meet the WHO case definition. Evidence of SARS was sought in other patients with whom this nurse had contact on the only known date she was working while symptomatic. Although two additional patients had isolated, unexplained temperature elevations within ten days of this contact, we found no convincing evidence for SARS. She also should have been in full precautions when seeing patients. The 8W nurse had unprotected contact with another nurse on the ward, who subsequently developed SARS 3 days later. She was sero negative. This appears to be the full extent of this transmission chain. Our investigation failed to find evidence for direct contact between the first 8W nurse and patient A or B.⁷²⁷

On April 2, 2003, Patient A was transferred from 8 West to 4 West, the orthopedic ward, as 8 West became the hospital's SARS unit. Because surgeries had been cancelled during SARS, 4 West had a number of empty beds and was filled with medical patients in addition to the usual orthopedic patients who were on the unit.

In early April, Patient A was diagnosed with pneumonia. He was treated with antibiotics and his condition appeared to improve. The retrospective review of his case by the SARS Field Investigation Team determined that this pneumonia was unrelated to SARS. As the report found:

The onset of his [Patient A's] illness was most compatible with the April 19, 2003 date, as his family did not get sick until May 2003.⁷²⁸

727. SARS Federal Field Investigation, p. 16-17. Patient B was a roommate of Patient A while on 4 West. Post-SARS, it remains unclear whether Patient A gave SARS to Patient B, Patient B gave SARS to Patient A, or they were infected from a common, unknown source.

728. SARS Field Investigation, p. 16.

On April 19, Patient A developed another pneumonia. Despite treatment, his condition deteriorated, and he died on May 1, 2003. During his stay in hospital, Patient A had no known contact with a SARS case and his medical illness was not inconsistent with his age, health history and presenting medical problems. A diagnosis of SARS was not considered during his stay, and his case was therefore not reported to public health officials. Until his family began to present to the emergency department, there was nothing about his case that caused alarm bells to ring or that led to a query of SARS.

Patient A's Wife

Patient A's wife (referred to as Mrs. A) regularly visited him while he was in hospital. She became ill on May 3, 2003. On May 9, she was taken by ambulance to North York General Hospital, where she was seen in the emergency department.

The emergency room physician who saw Mrs. A had maintained a strong vigilance for SARS, even during what was thought to be the post-SARS period. He diagnosed pneumonia and thought that Mrs. A's symptoms were consistent with SARS. He requested a SARS work-up and admitted Mrs. A to respiratory isolation on full droplet precautions. His astute, cautious actions most certainly prevented further spread of SARS, as staff who worked with Mrs. A were protected and other patients were not exposed to SARS.

Concerned about this case, this physician told the Commission that he contacted Dr. Barbara Mederski, an infectious disease specialist at North York General Hospital, to request admission to the SARS unit. He said that Dr. Mederski did not feel that Mrs. A had SARS and would not admit her to the SARS unit. This physician told the Commission that the absence of an epilink seemed to be the determining factor:

It was big with her [Dr. Mederski] that we needed an epidemiological link, and if we didn't have an epidemiological link, then it was unlikely to be SARS. And I remember on one occasion I said to her, an epidemiological link is great, but we're dealing with a disease whose symptoms in the beginning are very insidious, how can we track back every person that she may or may not have been in contact with. It wasn't practical, what I was being asked to do. And in the heights of such an outbreak, we have a patient who is coming in with fever, with pneumonia findings, yes, she's elderly but there's no history that she passed out and aspirated, and at that point I was told by one of the nurses that her husband had passed

away on the orthopedics floor, what was it, two or three weeks prior. And in fact at that time, we didn't know what the man had passed away from. In fact, in my notes I wrote, "she is not known to have any specific known SARS contact, but this obviously, at this point in the SARS outbreak, is of limited value. The patient had her husband in hospital for nearly six weeks and he passed away a few weeks ago. He passed away of complications related to a fracture of the left shoulder," end quote, is what I wrote. That's the best information I had at the time because at that time nobody even knew that this man on the orthopedics floor was going to be a central role in the whole outbreak. But it was very suspicious to me and so I decided to admit this patient and I couldn't convince her [Dr. Mederski], so the patient ended up going, still in isolation, but to the medical ward.

This physician identified what many missed during SARS: that the absence of an epilink did not rule out SARS but might mean not that the epilink didn't exist, but that it just had not been found. This emergency room physician also recognized that the cluster of illness among family members with a link to a hospital that had SARS cases in a city with an infectious disease outbreak was cause for concern.

After Mrs. A was seen in the emergency department on May 9, another physician took over her case. By May 13, Mrs. A's condition has worsened and her physician, concerned about her deteriorating condition, also consulted with Dr. Mederski. Mrs. A's physician recalled that Dr. Mederski did not think that Mrs. A had SARS. Although Mrs. A's physician had concerns about her health, she thought the diagnosis of non-SARS-related pneumonia was also plausible, particularly in light of her having just lost her husband:

So I spoke to Dr. Barbara Mederski, our head of infectious diseases, and she thought it was probably a non-SARS-related pneumonia. This is an elderly woman who had been at her husband's bedside every day, very tired and emotionally drained, and so the feeling was that this was likely a non-SARS-related pneumonia but, of course, we were concerned since she had visited him while there was quarantine in effect at our hospital. She [Mrs. A] would have had to wear a mask and gown and such in order go in and sit at her husband's bedside.⁷²⁹

729. Dr. Mederski's response to the recollections of others is noted below.

At that time, there seemed to be a good alternate diagnosis for Mrs. A's illness, and her presentation was not inconsistent with a woman who had lost her husband after a constant vigil at his bedside. Dr. Mederski's consultation notes for May 13 indicate that she did not believe that Mrs. A had SARS. Although she did not think Mrs. A had SARS, Dr. Mederski did order a number of tests for Mrs. A, including a series of SARS tests.⁷³⁰

On May 15, the physician who was caring for Mrs. A contacted her daughter (referred to as Mrs. B) to discuss her mother's condition. At that time Mrs. A seemed to be improving, but her doctor was concerned about her well-being given that she had just lost her husband. When Mrs. A's physician spoke to Mrs. A's daughter, Mrs. B, she became concerned when she learned that Mrs. B, her husband (referred to as Mr. B) and their daughter (referred to as Miss B) were also ill. Mrs. A's physician learned that Miss B had been home for her grandfather's funeral and had since returned to school, outside of Toronto. This physician said that she wrote this all down, because the cluster of illness among the family caused bells to go off:

So I took all this down on a piece of paper. I was sitting there and I must have spent half an hour on the phone and I said, okay, who are your kids, where are they? I'm writing all this because suddenly these little bells are going off. You know, this is not right. So, I wrote it all down and I said, I'm going to speak to Dr. Mederski again.

This physician again spoke to Dr. Mederski, outlined what she had learned and expressed her concern about these cases. She recalled that it was Dr. Mederski's opinion that these cases were not SARS, that they were community acquired pneumonia. Although there was no known connection to a SARS case at that time, this physician continued to be worried and to have concerns about this family cluster of illness. So she took the notes of her conversation with Mrs. B (Mrs. A's daughter) and gave them to the Public Health person who was working in North York General Hospital:

So I then took all this information on my little sheet of paper and I went to the patient's chart to transcribe it all there, as part of the legal docu-

730. Although PCR [polymerase chain reaction] and serology testing were available at this time, the tests had to be sent to the National Microbiology Lab in Winnipeg, Manitoba, and were not quickly available. For example, the lab results for Mrs. A were reported July 17, 2003. As noted earlier the only test that could rule out SARS was convalescent serology, a test to determine whether a patient had developed antibodies to the SARS coronavirus. A convalescent serology test could not be considered negative, or used to rule out SARS, until more than 28 days after onset of symptoms. CDC, SARS Laboratory Preparedness.

ment, and there was a woman there, and I believe she was with the Public Health Department, back at the hospital. I think it's probably the following morning, probably the 16th. So I had my little piece of paper there and the Public Health lady there, I should have gotten her name but I was just so pleased to see someone, she said, I'm from Public Health and I said, oh, thank goodness. I said, I'm really worried about this family. Here's the history, I said, there's a family outbreak, and I said, I'm very, very concerned.

This physician thought that because she had reported her concerns to Public Health, they would now investigate the matter. As will be seen below, Public Health were already aware of this family cluster and were also concerned about their illness.

Mrs. A eventually recovered and was discharged home on May 26, 2003. During her hospitalization at North York General, she was treated on a regular medical floor, albeit in respiratory isolation with precautions, and was not admitted to the SARS unit. Mrs. A was retrospectively classified as probable SARS, on May 25, 2003, after the outbreak on 4 West was identified.

Patient A's Daughter and Son-in-Law

Mrs. A's daughter and son-in-law (Mrs. and Mr. B) had been in contact with Mrs. A when she stayed with them following Patient A's funeral. The family had sat shiva for the week following the funeral. After Mrs. A became ill, Mrs. and Mr. B also became ill and both went to the North York General Hospital emergency department on May 16, 2003. By May 16, Mr. B had already been to see his family physician, where he was diagnosed with pneumonia. He had also previously gone to the emergency department at North York General but was not admitted to hospital at that time.

When Mr. and Mrs. B went to the emergency department on May 16, they were examined by the same emergency room physician who had examined their mother-in-law/mother just a week earlier. Once again, this physician queried a diagnosis of SARS and raised concerns about these cases. He was concerned to now have admitted three family members in one week, all with respiratory symptoms, who had had a relative die while in hospital during the SARS outbreak. As he told the Commission:

So at that point I'd seen now the mother, the daughter, the husband of the daughter, three members of that same family in the course of seven days. I'm also told that the patriarch died on May the 1st ... I have three

people with pneumonia who had visited a father in a time of the SARS outbreak.

The physician ordered SARS work-ups for Mr. and Mrs. B and placed both patients in respiratory isolation on droplet and contact precautions. Again, the cautious diligent actions of front-line staff, maintaining a high vigilance for SARS and ensuring both patients were isolated and handled with precautions, most certainly prevented further spread of SARS.

This emergency room physician told the Commission that he once again contacted Dr. Mederski to consult about the case and to request admission to the SARS unit. He said that Dr. Mederski did not think that it was SARS and once again did not accede to his request to admit these patients to the SARS unit.

Although there was no epilink, there were now three family members, all diagnosed with pneumonia, and a connection to another family member who had died while an inpatient at North York General Hospital, on May 1, during the first SARS outbreak. In his consultation notes for Mrs. B, this emergency room physician wrote that he found it “very suspicious that the patient, her husband and mother had all come down with pneumonia in the last 10 days.” He suggested that SARS should be ruled out. This emergency room doctor described to the Commission his concerns about these cases:

Clearly, all three of them had pneumonia. The pneumonia diagnosis, there’s no discussion about that, that is clear. The x-rays showed it, the lab data supported it, okay. The question was what kind of pneumonia? Pneumonia simply means an infection of the lungs. You can have infection from bacteria, from TB, from viruses. Coronavirus is a virus, which causes SARS. You have three members of the same family with pneumonia. My working diagnosis is that this pneumonia, in all three patients is, as far as I’m concerned, SARS. Why? Because three members of the same family, which is highly, highly, highly irregular and unlikely in any of the bacterial or viral infections that you see, and at a time when SARS was ravaging the health care scene, and at that time I didn’t know what the elderly man, the patriarch, had died of, but he had died in hospital on May the 1st.

This physician explained how it was difficult to diagnose SARS and, in the absence of a quick, reliable test, front-line physicians like him had to rely on their clinical judgment. In the case of Mr. and Mrs. B, his clinical judgment led him to a working diagnosis of SARS:

So essentially, in the case of SARS for instance, a patient comes in with certain symptoms and the big symptoms being fever, cough, usually a dry cough, with a chest x-ray that will, in the beginning, show maybe very subtle abnormal findings and later on becomes more obvious. So, you ask yourself, what else can give you those symptoms? There are many other bacteria that can behave the exact same way, okay, microplasmas, strep-pneumonia, and so on, can behave exactly the same way. So it's very hard to distinguish them from the first instance.

So then you start looking for other clues to help you point towards or away from SARS. If a patient comes in and it's a nurse who has worked on the SARS unit the night before or week before then obviously you tend towards SARS. If you had a patient, and these would happen with chronic lung disease, heavy smokers, who come in for their sixth admission in three years with pneumonia, then you take a little bit of a guess that it's most likely the same type of pneumonia and not SARS. You don't report every case that comes in as, they must be SARS because they came in, in May of 2003, no. There is a lot of clinical judgment that goes into this.

This physician recalled that he spoke to Dr. Mederski about the cases and she offered the opinion that they did not have SARS because there was no epidemiological link:

... when I was asking for a good reason as to why it can't be SARS, tell me why it can't be SARS? And the answer was, very clearly, she said, there's no epidemiological link.

After this emergency room physician saw Mr. and Mrs. B in the emergency department, care for these two family members was turned over to another physician.

Both Mr. and Mrs. B's cases were taken over by an internal medicine specialist. This physician also queried SARS for both patients. He too noted that Mr. B's father-in-law had died while in hospital and that his mother-in-law and wife were also admitted to hospital. This physician told the Commission that when he saw Mr. B and Mrs. B and became aware of the family history, his flag went up:

Question: When you first saw them, what was your understanding of what was the problem with them, what was their presentation?

- Answer: They had a pneumonia-like picture, and the strange thing that occurred to me was why would the husband and wife get sick together, so close in time proximity to the father who was sick and died.
- Question: Were you aware at that point in time that the mother was also in hospital?
- Answer: They told me that, actually, [Mrs. B] told me that. They were wondering if they had something too.
- Question: So what happened to them? With the results of all that information, what did you do?
- Answer: Well, first of all a flag goes up. I need to be really well protected against these people. I don't want to get infected by them. So I wore the N95 mask, gown and gloves and used all precautions to prevent infection to myself and I treated them and monitored them. They needed oxygen and I think I gave them treatment. I can't exactly remember if that was antibiotics or what-not. I got an infectious disease consult on those.

This physician also recalled that Mrs. B raised concerns with him as to whether they might have SARS.

The concerns of this physician were reflected in his consultation notes, which provided that "Mr. B should be considered a person under investigation for SARS until other causes of his pneumonia were ruled out." His consultation notes for Mrs. B stated that she should be managed in respiratory isolation due to a "possible epidemiological link to her father who died in the hospital and potentially may have had exposure to SARS."

Mr. and Mrs. B's physician referred their cases to Dr. Mederski. Dr. Mederski saw Mr. B and Mrs. B the next day, May 17, 2003. Mr. and Mrs. B's physician recalled that at that time Dr. Mederski did not think these patients had SARS, primarily because there was no epidemiological link. As he told the Commission:

My understanding was that there is no epidemiological link. I hope I am not misquoting her [Dr. Mederski]. There is not definite evidence of

SARS, that was the conclusion. Treat it as any ordinary case of pneumonia.

This physician said that although it was his impression that Dr. Mederski did not think these patients had SARS, it was also his understanding that the fact that both Mr. and Mrs. B's conditions improved contributed to Dr. Mederski's belief that these were not SARS cases:

Question: So you discussed the case with Dr. Merderski, and what was the result? You said that there was an issue about the epilink?

Answer: My understanding is that this is not SARS. Don't worry too much about it and she would follow up as an outpatient. She would see the people in followup.

Question: And did she say to you don't worry too much about it?

Answer: I may be paraphrasing her, meaning that they got better, they are okay and don't worry about it. I am not specifically saying that she is saying "don't worry about it that this is SARS." This is a matter of judgment here and that also happens very often when we ask for consultation. The consultation report of the opinion might not be exactly what you think they are, but they are what the experts say and when the patients get better especially, I don't think there is any suspicion or any reason to think otherwise.

Mr. and Mrs. B's physician said that he did not raise concerns with anyone other than Dr. Mederski. He said that he consulted with Dr. Mederski, whose opinion was that they did not have SARS. The patients got better, and that was where the matter was left:

Question: At this time then, is it fair to say in your mind it was a suspicion and you raised it and you consulted with the person in charge and that is where it was left basically?

Answer: Yes, that is how consultation works. You ask for an opinion, it is provided, the patient got better.

Both Mr. and Mrs. B were treated in respiratory isolation, with precautions, on a

regular medical floor.

Mrs. A's physician, who had by the time of Mr. and Mrs. B's admission expressed concerns about the family cluster to both Dr. Mederski and Public Health, recalled being surprised to later learn that Mrs. A's daughter (Mrs. B) had been admitted to hospital but was not on the SARS unit:

So that was the Friday, and I thought, it'll be dealt with. I came in the Monday, which would have been the 19th, and you have to realize that Mrs. A was not in a SARS unit. She was in respiratory isolation, but on a regular medical floor, and in the SARS unit you have that extra level of protection. There's all the plastic sheets up, the extra vestibule where everyone changes, but this was a room with a bunch of stuff on a tray outside the door, so you have masks and everything to go in to see her. I go to the floor and then I see Mrs. A and I said, oh, they've moved her room. They hadn't moved her room, it was her daughter who had been admitted and her daughter was not admitted to the SARS unit, and I'm going, okay, a family outbreak with previous contact with this hospital and they're not in the SARS unit. I just said, okay, strange things happen.

As noted above, both Mr. and Mrs. B improved with treatment. Mrs. B was discharged home on May 22. Mr. B was discharged home on May 26, 2003. Both remained on regular medical units during their hospitalization, under respiratory isolation.

Both Mr. and Mrs. B were retrospectively diagnosed with SARS on May 29, after the outbreak at North York General Hospital was identified on May 23.

Patient A's Grandchild

On May 18, 2003, the granddaughter of Patient A (referred to as Miss B) presented at the North York General Hospital emergency department. The same emergency room physician who saw Mrs. A, Mr. B and Mrs. B also saw Miss B. This physician had now seen the matriarch of the family, the daughter, the son-in-law and the granddaughter. He had raised concerns about three family members, had admitted them all into isolation with full precautions, had ordered SARS testing and had requested admission to the SARS unit. But none of the three patients was admitted to the SARS unit and none was identified as SARS.

This physician told the Commission that when he first saw Miss B, he did not know her connection to the previous three A family members. He said that when he learned of her connection, he got goosebumps:

And then I said to her, do you have anybody who in your family was sick recently? And this girl looked at me and said, what do you mean, you don't know? I said, what? Well, my name is [Miss B] but my parents are [Mr. and Mrs. B] and my grandma is [Mrs. A], in which case, I had goosebumps.

Seeing Miss B reinforced his suspicion that this was a family cluster of SARS. As he told the Commission:

Well, at that point the clouds parted, the sun came out and lightning struck me and I said, hot damn, we've got one more.

The emergency room physician ensured that Miss B was placed in respiratory isolation and felt that she should be admitted for treatment to the SARS unit. He told the Commission that as he had done for the other three of her family members, he asked for admission to the SARS unit but that, as with her three family members, Dr. Mederski admitted her to a regular medical floor.

The internal medicine specialist who took over care of Miss B recalled that she was aware that the emergency physician had raised the question of SARS. This specialist also cared for Mr. O, another patient with a previous connection to 4 West, who was admitted to hospital on Sunday, May 18, and whose story is told below. Mr. O was also questioned as a possible SARS case. Miss B's physician recalled that precautions were taken when caring for both Miss B and Mr. O and that both were treated as possible SARS cases:

The question of SARS had been raised, and the way our system works is there's an internist on overnight who gets the referrals from the emergency physician, admits the patient to one of us, we essentially reassess the patient the next morning and make our own determination. So yes, there was, certainly at least a question of SARS for both of these patients [Miss B and Mr. O] and so they were presented to me as possible SARS patients and I treated them as such.

Both Miss B and Mr. O were referred to Dr. Mederski. Dr. Mederski saw Miss B on Monday, May 19. Her consultation notes report that although many of Miss B's

immediate family members were now hospitalized for pneumonia, other family members remained well. Dr. Mederski's notes show that her opinion at that time was that this was another case of community acquired pneumonia.

Miss B's condition improved with treatment and she was discharged from hospital on May 23. During her hospitalization she was treated on a regular medical unit, in respiratory isolation, with precautions. Miss B was retrospectively diagnosed with SARS after the outbreak at North York General Hospital was identified on May 23.

Mr. and Mrs. O

Around the same time that Miss B, the granddaughter of Patient A, was admitted to North York General, another patient who had ties to the 4th floor at North York General Hospital was seen in the emergency department, along with his wife.

Mr. O was admitted to North York General Hospital on May 7, 2003. He was an inpatient on 4 West until May 11, when he was discharged home. He came back to North York General Hospital via the emergency department and was readmitted to hospital on Sunday, May 18, for pneumonia. The internal medicine specialist who cared for Mr. O recalled referring his case to Dr. Mederski. It was this specialist's recollection that Dr. Mederski was not convinced that he had SARS. The internal medicine specialist recalled that she wrote a note on the file identifying Mr. O's connection to 4 West, the unit where Miss B's grandfather had died. As noted above, the internal medicine specialist was caring for both Miss B and Mr. O on May 19.

Dr. Mederski recalled being asked to consult on his case and recalled that she saw Mr. O on May 19. She recalled that at that time he was a young man who was very ill:

I don't know who asked me to see him [Mr. O], but I was asked to see him in consultation, I don't remember when I was asked to see him, but it was around the time of the Victoria Day long weekend,⁷³¹ because it was based on his findings that I then spoke with the Public Health people about it Friday, and that is that I saw this man looking extremely sick. What was bizarre, he was a young male who had been in the hospital on 4 West, with an appendectomy, but had gone home and came back with symptoms of pneumonia. I was asked to see him as a routine pneumonia,

731. The Victoria Day long weekend was Saturday, May 17 to Monday, May 19.

not as anything else. At that time he was on the 5th floor when I saw him.

Dr. Mederski said that she contacted his wife and learned that she too was ill:

And when I interviewed him, I phoned his wife, because I found it to be very strange that a young man would be so sick. And I got very interesting news, that she thought he got sick from her while she was visiting him in the hospital while he was in for his first surgery on 4 West, because she was sick after visiting him on 4 West, while he was there resting from his appendectomy. So she thought that his current pneumonia was acquired from her. She wasn't bad enough to be admitted. She was at home I was phoning her while he was admitted ... And then she came back and was admitted too, on the same day.

Dr. Mederski told the Commission that after Miss B was admitted on Sunday, May 18, she (Dr. Mederski) was starting to get a little bit anxious about SARS. She said that seeing Mr. O on Monday, May 19, was a turning point:

And then by this time [Miss B's admission], I am getting a little bit anxious, but the real turning point came with Mr. O ... He came in on the 19th. He had been admitted on the 19th but he came to the emerg on the 18th, but I didn't get to know him until he was actually admitted to the floor on the 19th. It was then that I got worried, but I didn't at the time connect him with the [Patient A family]. Looking at his wife who is very mildly ill, very, very mildly ill and making the decision that even though she is mildly ill, she is going to be admitted, again to the regular floor. So as the days go on, I am starting to get more antsy.

Mrs. O was admitted to North York General Hospital on May 20, 2003.

Both Mr. and Mrs. O were admitted to regular medical units, in respiratory isolation. Both Mr. and Mrs. O were retrospectively classified as SARS on May 29, after the outbreak was discovered on May 23, 2003.

Why Not SARS?

It is clear that more than one front-line physician at North York General raised the question of SARS with respect to these patients. Among the physicians who raised

concerns was the emergency room physician who saw four of the five family members and who had strong opinions based on first-hand clinical impressions. Furthermore, this emergency room physician was an infectious disease specialist and a medical microbiologist, although he was not working in that capacity during SARS at North York General Hospital. So why were these patients not identified as SARS?

Part of the problem was the mistaken belief that SARS was over. Victory had been declared. It was time to move on. As one member of the infection control team at North York General said when asked why Patient A's family wasn't considered to have SARS:

Question: During May, there was a family cluster that came through the emergency department, the [Patient A family]. When did you become aware of them?

Answer: We automatically report anyone that comes through, but when they came in, I never thought they were SARS. They were milder cases, my understanding is that the one family member just had a sore throat and that's it.

Question: Were you aware that [Patient A] was in fact an inpatient on 4 West?

Answer: Yes.

Question: And so now his daughter comes in, is admitted. His son-in-law comes in, is admitted. His wife is admitted, and also his granddaughter.

Answer: And I honestly didn't think they were SARS. I mean, the whole message out there was that it was over. I wish I had thought the other way, but I didn't.

The belief that SARS was over was not limited to North York General Hospital. After the travel advisory, the focus was on recovery.

The desire to see the end of SARS was natural. People were tired, it was a frightening experience, and everyone wanted to see the end of the spread of SARS. But at North York General Hospital, notwithstanding the belief of some that SARS was over,

nurses and a number of highly skilled physicians who had experience seeing and treating SARS cases did express concerns about the possibility of SARS.

Each patient was referred for a consult with Dr. Mederski. Yet none of them was identified as SARS and none was admitted to the SARS unit. Those involved with these cases wondered what was going on and were disturbed at what was happening with these patients. As one emergency room physician said:

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

While all these patients were admitted into respiratory isolation with droplet and contact precautions, they were admitted to regular medical units throughout the hospital instead of being admitted to the SARS unit. One physician noted that he and his colleagues worried that this increased the risk of spread of the disease:

When we were seeing the patients with suspected SARS in the emergency room and funnelling all these patients through [Dr.] Mederski, even if she was not the most responsible physician,⁷³² she [Dr. Mederski] was deciding where they were going to be admitted. And we were concerned at that time that we were finding that they weren't being clustered on one floor, such as 8 West, but they were being spread in isolation rooms all around the hospital, thereby augmenting the potential for spread of the disease, because more nurses, more physicians would be coming in contact with them.

Another emergency room physician agreed that it was worrying that these patients were not admitted to the SARS unit, where there was a high degree of caution because the risk to staff was well known:

The other thing was, when you call a unit "SARS unit," everybody goes

732. A medical term to denote the physician primarily responsible for a patient.

in as if they're walking on some other planet, so the height of their protection is maximized, as is their care taken. So on a regular ward, it was almost like, if the patient is on that ward, then this patient can't have SARS, so the guard would not be the same and that is human nature.

Dr. Mederski told the Commission that she contacted Public Health on Friday, May 16, to inquire whether there was anything happening in the city that she should be aware of. She said that she spoke to Dr. Tamara Wallington⁷³³ but that she did not recall how much she said about the Patient A family at that time:

[I asked Dr.] Tamara Wallington, in the role that was [Dr.] Bonnie Henry's, if there is anything else going on in the community. We had been told SARS was finishing, is there something that is happening that I need to know about. Is there anything that I should have on my radar? Are there any people that are being sent to emerg that Public Health has put their eyes on? And that is all I can remember at the moment. This was about [Mrs. A]. Yes, I was calling about the [Patient A] family, but I can't be sure how much in the way of the [Patient A] I spoke to her about, because I didn't have anything at the time about how much she [Mrs. A] was in emerg that day.

Dr. Mederski told the Commission that even after the daughter, Mrs. B, was admitted to hospital on Friday, May 16, she (Dr. Mederski) remained unsure whether she had SARS. She said that her instructions at that time were to dismantle the SARS unit, and so she admitted the patients to regular medical floors, ensuring that they remained in isolation and that staff used full precautions:

In the earlier part of the week when I had first seen [Mrs. A], I was ambivalent about my own instincts. From the time her daughter [Mrs. B], as the third party, presented, I was starting to get enough worried that I ordered the tests and insisted that she come in. So I was fighting with myself, to be honest that is the only way I can put it, I was fighting with myself to say this is interesting, this is very interesting, because it's now a cluster. Now on the other hand, these are very mild illnesses. And the rest of the family aren't sick and from what we know, from the Sunnybrook episode and the other high spreaders in Hong Kong, usually everybody gets sick or it's just a sort of one-on-one transmission pattern.

733. The recollections of Toronto Public Health physicians involved with these cases is reported below.

I was trying to sort of scientifically rationalize. This is me to myself. And that is why, because I had this tremendous difficulty when I was being called by the emerg department, where to put these people, in terms of SARS unit or not.

Dr. Mederski said that unlike earlier cases, such as the psychiatric patients, which she was confident were SARS, with the A family cluster she was uncertain about these cases over the weekend. She said that they were not following the usual path of a SARS illness and that there were no connections to other possible SARS cases:

Question: Now I just put this as a reaction for your comment. The Barbara Mederski you are describing over the weekend doesn't sound like the same Barbara Mederski a few weeks before, when you were dealing with the psych patients. You seemed more hesitant, maybe a bit tentative, a bit on the one hand, on the other hand, whereas before you seemed very definite in your conclusion, maybe because of different presentation, different symptomology that they had, but is that accurate and were there other factors that played there other than just the symptoms?

Dr. Mederski: Yes, the fact that cases that I thought were definitely SARS, I'm now being told to me and agreed by others that they are not SARS and I have even less to go on that these cases are SARS. I have even fewer connections. I have even fewer progressive symptoms that would suggest these are SARS cases. They are not coming along the trajectory of getting worse, worse, worse quickly. So clinically they are not behaving like the typical SARS. I would later learn that, I later thought we had different presentations of SARS, the range was huge. Now that was the other thing: I had actually been on television to discuss my theory about SARS having a variant of presentations and I was told by others that I was crazy, that others heard me on this television show, it was an interview by [name of interviewer] where I had said that we can't be complacent in thinking that SARS is only this rapidly galloping, quickly progressing respiratory infection. We have to actually think of it perhaps as a larger cloud of subclini-

cally infected patients, meaning they don't demonstrate symptoms, that these may be the people who transmit and I was summarily taken to task on that.

Dr. Mederski said that because of the way the Patient A family cluster was presenting, she thought she could safely manage them on a regular medical floor:

So these patients, this cluster, was actually very similar to what I was alluding to. There is no, there's this, you know, you are sitting shiva, there are hundreds of people coming to your home, this is going over 48 hours, people are getting infected very quietly, very subtly, and that was what I was trying to say. And that was all in that mind. I don't think the public needs to be worried, because these people have a good outcome, they are not going to die, they are going to be like any other respiratory illness. And that's why, as well, in my thoughts, I was not as concerned about moving these individuals into the SARS unit and I thought that I could still deal with them appropriately in isolation, protecting them, treating them on the regular floors, because I thought that was what some of SARS was, that it was going to behave like other regular respiratory infections.

Dr. Mederski said that she was not admitting patients to the SARS unit. Although she could not remember specific details of conversations, she did recall that Mr. and Mrs. B's physician asked about admitting them to the SARS unit and she said that it was possible that someone else did as well:

Question: Now, could it be, you have mentioned [Mr. and Mrs. B's physician], could it have been [emergency room physician who saw all four family members] who spoke to you about Mrs. A, and Mr. B, from emerg?

Dr. Mederski: It could be. I am trying to think of some experience that I had with him saying something like, if it was me I would do such and such, but I don't remember when or where. So if you said that we have evidence that he was there on that weekend and spoke to you, I wouldn't be surprised, that could be. I doubt it was more than [the doctor caring for Mr. and Mrs. B] for sure.

Question: And if he, in speaking to you, wanted them put into the

SARS unit, or recommended that, would that be consistent with your recollection about the SARS unit and why you were not using the SARS unit?

Dr. Mederski: It could have been because [Mr. and Mrs. B's physician] for sure asked me. And it may have been him and it may have been somebody else who asked me to move somebody or just asked me, where are we going to put these patients, SARS unit or not? And if I was going to be consistent, I was going to have to be consistent, and so the conversation would have been something like, oh, I have spoken to the Public Health, they feel that SARS is not an issue, that these are respiratory cases in the community, yes I know, blah-blah-blah, but I don't think we need to, I can't, or actually I've got a mandate to downsize, I don't have the nursing staff, so I'm going to have to put them on the floor. And they may not have been happy with that.

Dr. Mederski said that she felt that because her mandate was to take the SARS unit down, as long as she could isolate the patients in a private room she could watch them and move them if it became necessary. She said that she normally admitted patients directly to the SARS unit and that the fact that she didn't with these cases was reflective of her ambivalence about these cases as the weekend progressed. Dr. Mederski did not recall anyone challenging what she was doing:

Question: They wanted them in the SARS unit?

Dr. Mederski: Well, they didn't say so. Nobody protested when I put them on the floor. Nobody said, oh, they should have been put in the SARS unit.

Question: Not to you?

Dr. Mederski: Not to me, which would have been the case before. In other words, they would make their case very quickly, like, what are you doing, this is insane. Nobody did that. [Mr. and Mrs. B's physician] did ask me if I would put [Mr. B] in the SARS unit and [Mrs. B]. And I said, you know what, I don't think so because I have been given a mandate that I have to try to take the SARS unit down

and not the other way, and there is no staffing and as long as I get them into a private room and isolate them, I can watch them and if there is a problem then I'll move them.

Dr. Mederski said that her instincts about these cases [the A family] were less intense than they were for other SARS cases, until she saw Mr. O come back to hospital on Sunday, May 18, having been discharged home after being an inpatient at North York General Hospital. She said that after she saw him on Monday, May 19, she contacted Toronto Public Health and asked to speak to the physician on call. She said that Dr. Elizabeth Rea contacted her and they discussed the cluster of respiratory illnesses. Dr. Mederski said that she and Dr. Rea discussed the absence of an epilink and that fact that these patients could have other, non-SARS explanations for their illnesses:

... [Dr. Rea] listened to what I had to say, and was listening to everything and then she asked me if there was an epilink. And I told her that there wasn't, but that intriguingly there were these two cases that just happened to be in 4 West. So she said, well you know it is community acquired pneumonia season, it could be atypical pneumonia, these were all younger people and they weren't sick particularly, and it could be like a microplasma, much as we had said with [Patient No. 2] and others.

Dr. Mederski told the Commission that she also mentioned Mr. O during this conversation. It was her understanding based on the conversation that because there was no epilink, these cases were not SARS. Dr. Mederski also recalled mentioning that Mr. O and Mrs. A had connections to 4 West, although at the time she was unaware that there were unidentified cases of SARS on 4 West and did not know the significance of their link to 4 West. It is important to note that Toronto Public Health at this time was also unaware that there were unidentified SARS cases on 4 West.

Dr. Mederski's consultation notes for Mrs. B for May 19 report that she spoke to Dr. Rea of Toronto Public Health, that Dr. Rea concurred with Dr. Mederski that Mrs. B did not have SARS and that she told Dr. Mederski there were "numerous such cases here and there in the city." The notes of that conversation, recorded in Mrs. B and Miss B's Public Health charts but dated May 20, outline Mrs. B and Miss B's current clinical status and conclude with the following notation:

Imp: not SARS
Plan: continue to follow while in hospital. Contacts do not need to be hospitalized.

Dr. Mederski said that she again spoke to public health officials on Tuesday, May 20,⁷³⁴ shortly before her meeting with the emergency room staff. She said that at that time she was trying to find out if they were following the Patient A family. She described her view of that call:

And then on the final call, which I made, which was on the 20th, which was to [name of Toronto Public Health physician⁷³⁵] and [Dr.] Tamara Wallington.⁷³⁶ It was on a Tuesday, the 20th, where I repeated more about the same cases and the fact that I was having a meeting that evening with the nurses from emerg at their request, with [Dr.] Glen Berall. On that day, on the 20th, when I spoke to Tamara [Dr. Wallington] and to [name of Toronto Public Health physician], I was asking them specifically questions about the Patient A family, as well as the questions that I was going to be speaking to the nurses about from emerg.

However, I was trying to find out during that long weekend if there was a Public Health file on the Patient A family, because the statements made by Mrs. B, daughter of Mrs. A, suggested to me that Public Health might be trailing them in some fashion or had them on their radar. I couldn't find out. She wasn't clear and I wasn't clear and no one else was clear and it was a weekend. The reason I had it is that one of the nurses in emerg thought that she heard from somebody when they came in through emerg saying Public Health had told these people to come in.

734. As noted below, Dr. Wallington recalled speaking to Dr. Mederski on one occasion before May 23, and that was May 15 or 16. According to Dr. Wallington this conversation involved her and Dr. Rea. This is also consistent with Dr. Rea's recollection. While there is clearly confusion about the specific dates of the conversations, there is agreement that Dr. Mederski spoke to Public Health doctors on three separate dates in the week leading up to the second outbreak. The recollections of the Public Health physicians in respect of these conversations are reported below.

735. Although Dr. Mederski recalled speaking to a particular Toronto Public Health physician, the recollection of that physician, as well as her employment records, show that she did not participate in a conversation with Dr. Mederski on May 20. This second physician told the Commission that she did not speak to Dr. Mederski before May 23 about the Patient A case or any other case. As noted below, Dr. Elizabeth Rea recalled speaking to Dr. Mederski on May 18 and May 20.

736. As noted below, Dr. Wallington's recollection is that she spoke to Dr. Mederski once on or about May 15 or 16 and that she did not speak to her on May 19 or 20.

Well, we always took that very seriously. If Public Health said you come in, you have to make sure you talk to those people especially carefully. So that was a sort of a rumour behind these people being admitted.

Dr. Mederski said that she also called Public Health on May 20, to ensure she was going to give the right information to emergency room staff, with whom she was meeting later that day. She said:

Question: And then on the 20, when you talked to [Dr.] Tamara Wallington and [name of TPH physician], what was the added feature that caused you to call on the 20th?

Dr. Mederski: I called for two reasons, one is I was still seeking a more comfort zone in that, given that I am now watching these patients for 72 hours, I wanted to verify with somebody whether indeed any of them had been on the radar screen with Public Health and told to come in. I am talking about Mrs. B, I was still trying to get to the bottom of that because I kept hearing this rumour that she had been actually sent in by Public Health. And she herself was vague about it, the patient. And I was trying to understand who knew and it turned out [name of Toronto Public Health physician] knew something. But I still never understood what it was [name of Toronto Public Health physician] knew, whether she had just heard or she was part of that file of the patients that they get every day by fax. So they both reassured me that SARS was over.

The other reason for my calling was to find out to what level we could downgrade with our PPE, with our protective equipment, because other hospitals that I had phoned by the way over the weekend, the week before and that day, I was calling Sunnybrook, I was calling Toronto General, I was calling Mount Sinai, I was speaking to different people, what are you doing, what are you doing, what are you doing, despite the directive coming down from the Ministry, what are you actually doing in terms of who was not wearing PPE, what are you doing in emerg, what are you doing on the floors?

And I was told that everybody was downgrading. The only hospital that wasn't was Scarborough Centenary with [Dr.] Ian Kitai, who said, we're not so quick.

And so I was doing this because I was preparing for this meeting with the nurses, but I was also asking about these cases that came in and I was basically told, I said, am I being hysterical that I am so worried? And there's a silence that I interpreted as, yes, I guess I am. I am meeting with these nurses, I want to hear from you, what do I say, what do I say. They are worried, and what do I say. I know what is written out there but what do I really say. And they both reassured me that SARS was over, that the directives were there, and that basically there was no need to be concerned and that was it for me.

When asked if she expressed an opinion to either Dr. Rea or Dr. Wallington, on either the 19th or 20th, that these patients might be SARS, Dr. Mederski said:

Question: Did you express any opinion to them on the 20th or when you spoke to Dr. Rea on the 19th, did you express any opinion to them about your own feelings, your own thinking about what these cases were?

Dr. Mederski: Well, I was concerned enough to personally call them and nobody had asked me, the hospital administration had not asked me, nobody else had asked me. My concern was manifested by definition in the fact that I phoned these two individuals to ask about, an open-ended question effectively to say I have these cases, should I be concerned? The staff are concerned, these are mild cases, except for [Mr. O], they look like some of the SARS cases we've had. But I didn't say, oh, I have five SARS cases. I was more, it was a rhetorical type of open-ended mulling about, and the fact that I was uneasy about it because I was reflecting the uneasiness of the staff. I did say that I had actually not admitted them to the SARS unit, because there had been no ability to get the staff in for these patients, because we were trying to close.

And that was one of the other things that I asked, should I be admitting these patients to the SARS unit or can I actually keep them out in isolation and I was given the nod for that. So that was more or less the discussion that we had overall. With [Dr.] Elizabeth Rea, I was more concerned about it being SARS just in the sense that I was worried that these cases were clustering, but she basically had felt that there wasn't an epilink and there wasn't to be much concern.

I have to just say that, of the different people I spoke to, [Dr.] Elizabeth Rea held, with me, the highest credibility of the lot. Prior to that Bonnie [Dr. Henry] knew who I was, I knew her, I knew her thinking. When Tamara [Dr. Wallington] was introduced to me on Friday, I understood her background to be fairly junior, so I didn't really think that she had as much ability to make an opinion. Elizabeth [Dr. Rea], on the other hand, was a seemingly a scientist, had researched this, was on the continuous teleconferencing with us, and heard my opinions. I felt that I could run things by her with a greater depth and that she would be a better person to really get some input from when she was actually there on the phone. With her, I voiced more concerns.

This was on the 19th, with [Dr.] Elizabeth Rea I actually specifically alluded to these clusters and I specifically alluded to the fact that we had concerns because we had a similar story with the psych patients that I had been told these weren't SARS cases but I still think they are SARS cases, and you remember me, I said to her, saying this to her on the phone, and she said, yes, I remember you saying that. So, with her I was more pointed about that.

With these other two [Dr. Wallington and another TPH physician] it was more, I am now going to be facing the staff, I am nervous about doing that, what do you think? I have already phoned my colleague equivalent for nursing staff at other hospitals, to see what they are doing and to try to have my preparation for this meeting, but what else

should I do to be comfortable about what I am saying?

Dr. Mederski said that the discussion with Toronto Public Health focused primarily on relaxation of precautions and that she didn't discuss the cases in detail. She said that she could not find out whether Public Health viewed these patients as "something special":

When I spoke on the 20th, it was more like, okay, this is my third phone call now, I know I am being apologetic before I even open my mouth, but I have to ask you again, do we or do we not have a reason to be concerned? The vibes I am getting from everywhere from the City are, we don't. The staff are worried in this hospital. I didn't go back and discuss these cases in the detail that I had with Dr. Elizabeth Rea. It was more in line of what are they supposed to do in the way of downgrading the equipment, how far should they go? Is it reasonable for us to do what they are doing at the other hospitals, because we are doing it slower? And I had this whole discussion with [a Toronto Public Health physician] about [Mrs. B], was there something special about the [Patient A family] because I am getting the feeling that there is something special about the [Patient A family], both in terms of how they are now presenting and also because I am getting these messages that they had been picked up by Public Health for review, but I didn't get any corroboration from Public Health.

Dr. Mederski said that the main point of the conversation was to ensure that the staff were safe and that they were safe in downgrading as they had. Dr. Mederski said that when she went to the meeting, despite her personal beliefs, she understood that Public Health was not concerned that these patients were SARS, that SARS was over, and that the staff were safe. This was a message she repeated to the front-line staff, at a meeting held with the emergency department. Dr. Mederski said:

Question: Did you report back, I don't mean in a formal sense, but did you tell people, okay, I have spoken to Public Health and they are not concerned, they really think SARS is over, we manage them in this way, but it's not SARS? And who would you have told that to?

Dr. Mederski: Well that weekend I spent a lot of time in emerg, the Saturday and Sunday in particular, and up to Monday. And I remember [physician treating Mrs. B] that I said he was concerned, and I said to him, I have actually

spoken to Public Health about [Mrs. B] and they are not worried. This was from the discussions that I had had with [Dr.] Tamara Wallington on the Friday, the 16th.

Question: Of course the [Patient A family] were not all in [name of hospital] by then.

Dr. Mederski: No, they weren't all in but I was already aware of [Mrs. B] because her mother had said to me that, my daughter is coming down with an illness, so it was just mentioned, that was it. I didn't think it was anything at the time, but I had just been speaking to Tamara [Dr. Wallington] and I had mentioned [Mrs. A] because [her treating physician] had been concerned. I guess the thing is that if people were very strongly opinionated and had a concern, I would share that with Public Health. Whether I felt equally concerned was another story. But if I could, if I had opportunity to speak to these people, I would.

So, at this stage now, I am more voicing other people's concerns rather than my own, in the first part of that weekend. And when they were phoning me over that weekend, the nurses from emerg, and [Mr. and Mrs. B's doctor] I said, you know, I have spoken to Public Health and we have discussed this during our SARS Task Force and we have the directions from the POC [the Provincial Operations Centre], that SARS is over, that for sure it is over, even [Dr.] Bonnie Henry has gone off to the Orient to teach and so on, to get experience.

Question: And [Dr.] Jim [James] Young?

Dr. Mederski: And [Dr.] Jim Young, and they feel strongly that they don't even have to worry about this anymore and we are supposed to be downgrading our hospitals and that we are one of the last holdovers. That was my message to the staff.

More will be said below about the May 20 meeting with emergency department staff and with communication with front-line staff.

Dr. Mederski said that by this point, May 20, although she continued to consult with Toronto Public Health, she had her own opinion about these patients:

Question: But as the clinician responsible, were you looking for their input as just a piece of further information to help you in coming to a diagnosis, or in deciding what course of treatment?

Dr. Mederski: No. My opinion, clinically, no, definitely not. I already had my opinion by then. If anybody, I would have looked to [Dr.] Elizabeth Rea. By then I had already realized that I wasn't going to get any, so I made my own mind up and proceeded to do what I did with these patients.

Question: Did you make your mind up that these were probably SARS patients?

Dr. Mederski: I think by then I was.

Question: You said, by?

Dr. Mederski: By the Monday [the 19th]. By the Tuesday [the 20th]. By the Tuesday, by the Monday night.

Question: At the meeting or after the meeting?

Dr. Mederski: No, before the meeting ...

Whatever Dr. Mederski's level of suspicion or her belief about the status of these patients as of May 20, she did not express concerns to front-line staff at the May 20 meeting:

But then I couldn't backpedal. And I couldn't move them to the SARS unit if they weren't there, because then I would be looking as talking from two sides of my mouth. I had just finished telling [Mr. and Mrs. B's doctor] and the staff in emerg that I am not sure these are SARS, I don't

think so, I have every reason to believe they are not, based on the criteria we have, and suddenly turn around days later and move them out. That was the way I felt about myself.

Dr. Mederski said that in the absence of an epilink she understood that these patients could not have SARS. She said that once again she felt that she had to maintain what she perceived was the position of Public Health. She said that she was not trying to hide anything and that she did not feel she could voice her own opinion, in the face of what she believed was a consensus among outside experts and in the face of what she perceived as previous rebukes for attempting to clinically diagnose SARS without an epilink.

As noted below, Public Health officials say that they did not rule out SARS for the Patient A family and that the family was a source of great concern that they were investigating. The Public Health physicians did not recall Dr. Mederski reporting to them that it was her clinical opinion that these patients had SARS, and there is nothing in the Public Health charts of any of the family members to suggest that she did provide this opinion.

The Role of Toronto Public Health

Prior to May 12, 2003, Toronto Public Health had never heard of the A family and had no knowledge of Patient A and his death while in hospital or of his wife's illness and admission to hospital. Toronto Public Health learned of the Patient A family cluster on May 12, 2003, when Mrs. B (the daughter of Patient A) phoned Toronto Public Health looking for guidance with respect to entering another health care facility.

When Mrs. B spoke to the Toronto Public Health investigator, she reported that she had a fever and a cough but that a chest x-ray had been normal and that as of that day, May 12, she was starting to feel better. During her call she also mentioned that her mother was ill and had been admitted to North York General, that her father had died while an inpatient in North York General Hospital and that her husband (Mr. B) was also unwell and had also been to see a doctor. Mrs. B told the public health investigator that her mother (Mrs. A) had regularly visited her father while he was hospitalized at North York General but that she always wore a mask. Mrs. B said that she and her husband (Mr. B) had not visited her father while in hospital at North York General.

Dr. Wallington, a Toronto Public Health physician, said that although they worked hard to follow up and obtain information about the family, the description by Mrs. B of symptoms and of her husband's condition did not immediately raise the SARS alarm:

I think the reason that this came to our attention initially was because [Mrs. B] was looking for some direction around should she go to [another hospital] or not. Because otherwise, [Mrs. B] had been diagnosed with strep throat. She had a fever and a sore throat and her husband [Mr. B] had a fever and some back pain, and his sugar was out of control. So, although we say that the way in which SARS presented was very vague and mimicked other diseases, the symptoms that [Mr. and Mrs. B] complained of didn't even mimic the vague symptoms of SARS. A fever and a sore throat was generally not how SARS presented. And [Mrs. B] had been treated with antibiotics for strep throat and was feeling better. So I don't believe that the investigator was alarmed about [Mrs. B's] clinical complaint, it was more, I'd better take this to a physician and make sure we give her the right information on whether or not she could go [to another hospital].

Dr. Wallington explained that because of the information provided by Mrs. B and the uniqueness of the scenario, the information was discussed among the physician group at Toronto Public Health, where it was decided that the case needed to be further investigated, in particular to try to understand what was happening with Mrs. A and Mr. B.

On May 13, Dr. Lisa Berger, a Toronto Public Health physician, phoned Mr. B's family physician to try to determine what was happening. She explained that at this time, Public Health was still investigating anything that came to their attention:

At this point we are still working full out and investigating everything that comes to our attention. If our investigator gets a call from the hotline or a report in any fashion, we are still investigating, the same way we investigated right from the beginning. So, typically, if I don't have enough information, if the information was through a spouse and it was unclear what was going on, if I needed to make a determination as to what is going on, I would go to whatever source of information I needed. Sometimes that involved calling physicians, sometimes that involved calling the coroner, it would depend. So this was a story about someone from a spouse, I decided I would call the physician and understand what

was going on and really what the husband had. So I called the family physician the next day, to speak to him as to why he had seen the husband and what he had found.

Dr. Berger said that the family physician described Mr. B's symptoms, including a previous fever, chills and muscle pain. He told Public Health that the chest x-ray did show pneumonia and so he was prescribed antibiotics. Toronto Public Health followed up with Mr. B the following day, at which time Mr. B reported that he had no shortness of breath and that he was feeling better.

On May 15, Mrs. B contacted Public Health to report that her husband was unwell. Toronto Public Health suggested to Mr. B that he return to his family doctor or visit an emergency department. Although he went to the emergency department, he was not admitted to hospital on that date. Dr. Wallington told the Commission that Toronto Public Health continued to be concerned about this family but that at that time the clinical picture still wasn't looking like SARS:

Because this was a family cluster, we made a decision to keep following. Again, this wasn't really a picture that even vaguely looked like SARS. And in fact, [Mr. and Mrs. B] had not even been to North York [General Hospital].

Also at this time, Dr. Wallington contacted the physician of Mrs. B's mother (Mrs. A) to try to determine what was happening with Mrs. A's illness. Dr. Wallington told the Commission that on or about May 15, she spoke to the physician who was caring for Mrs. A and that after speaking to the physician, she was reassured that Mrs. A's case was being managed with precautions:

We talked. SARS came up, in terms of, are you worried about this pneumonia, do you think it could be anything other than just a community acquired pneumonia or an atypical pneumonia? And again, the answer was, no, there are a lot of good reasons for her to have this pneumonia. She is frail, she is sick, she has suffered a major loss. But she is nonetheless being treated in precautions. So she was being treated appropriately. The other thing that I did verify with [the physician] was whether or not it was her understanding that [Mrs. A] wore a mask, an N95, every day that she walked into the hospital. And [the physician] said she did ask that of [Mrs. A] and [Mrs. A] did verify that yes, she wore a mask every day. So again, this was a family and a case that was on our radar, but there was a lot of reassurance that she was being treated appropriately, she had

a good reason for having this pneumonia, she had no epilink, and on top of that, she was very reassuring about the fact that she had worn this N95 every day she went into the hospital.

As noted above, although Mrs. A's physician did not initially worry that it was SARS, shortly after this conversation she became concerned to hear that other family members were ill, which caused her to be concerned about the possibility of SARS. She reported that information to a Toronto Public Health nurse who was on site in North York General Hospital, providing detailed notes of the information she was able to obtain about the family cluster.

Although Public Health officials were monitoring these cases, they still did not initially think they were SARS. For example, despite Mr. B's illness, Public Health determined that it was unnecessary to place him under quarantine prior to his admission to hospital. This meant that even though Mr. B was ill, he was not required to remain in his home. This fact alone suggests that Public Health officials did not consider these cases to be SARS at this stage.

It is important to recall that Public Health officials were unaware of the cluster of respiratory illness on 4 West or of illness among staff on 4 West. They had no idea that there were unidentified cases of SARS in North York General Hospital. To their knowledge there was no link between any of the Patient A family members and other SARS cases or contacts.

But Mr. and Mrs. B continued to be ill, and both returned to the North York General emergency department. Mr. B was admitted on Friday, May 16, 2003, while Mrs. B was admitted in the early morning hours of Saturday, May 17, 2003.

On or about May 16th, Dr. Mederski phoned Toronto Public Health and spoke with Dr. Wallington and Dr. Rea. Dr. Wallington told the Commission that she did not recall Dr. Mederski asking if there were new cases of SARS in Toronto and she did not recall speaking about the Patient A family cluster during that telephone call. Dr. Wallington described her recollection of the conversation:

I recall having a phone conversation with Dr. Mederski around mid May, so around May 15th, 16th, and I recall that Dr. Elizabeth Rea was on that phone conversation with me and my recollection of the sequence of events is that Dr. Mederski contacted us before going into a meeting, that she was going to have with North York General Hospital staff. So she was in her car, on her way to the hospital, to attend this meeting, she

called us from her cellphone, and again I recall that Dr. Elizabeth Rea was on that call with me, we had Dr. Mederski on speaker phone, and there were a couple of issues that she wanted to discuss with us. The reason that I ended up speaking with Dr. Mederski, is primarily I believe because Dr. Bonnie Henry was away, at that point, she was in China, and up until that time Dr. Henry had been the main contact for Dr. Mederski, primarily because of her involvement with the 7 West cluster. So Dr. Mederski called us to talk about this meeting that she was going to be attending, it was going to be, from what I recall, a meeting that she would have with the staff and other senior administrators would be there to talk about the new normal directives that had been released by the province on May 13th, and that were going to take effect on May 16th. So there were apparently some questions that staff were going to have around those directives, and I was left with the impression that staff may have had some concerns with the new directives and would have questions around what it would mean for their practice, and some of the other questions and concerns that Dr. Mederski felt might come up would be around the 7 West cluster.

So the main subject of that particular conversation was primarily about the 7 West cluster. And what I had said to Dr. Mederski in the context of that conversation was pretty much a reiteration of what already happened in the adjudication process. And Dr. Henry had given me an update before she left for China on this cluster, because it was a complicated cluster and Public Health had been following it very closely. And my impression was, Dr. Henry felt that there would likely be followup phone calls because of the complexity of the cluster, my impression was this was one of the followup phone calls that we were expecting and I reiterated what had been discussed with respect to the adjudication process and this cluster. It was determined by the adjudication team that this could not be labeled as SARS, but this cluster would be treated as SARS. It would be treated in full precautions, the contacts would be quarantined and followed. So it was pretty much a reiteration of the decisions of the adjudication team.

Dr. Wallington said that she did not recall reassuring Dr. Mederski that there were no new cases of SARS in Toronto or that SARS was over and that she would not have said or insinuated that there were not people being followed or under investigation for possible SARS:

A reasonable comment to make would have been that we were investigating many individuals, that there were many persons under investigation in the city at that time. That there were individuals who we were concerned about and who we were following closely, but at that time there were no individuals that meet the case definition for a suspect or a probable case of SARS. I certainly wouldn't have insinuated that we weren't worried about people or that people were not being followed. There were in fact many persons under investigation.

Dr. Wallington did not recall Dr. Mederski expressing any concerns about the Patient A family and said that such a statement would have been important to Public Health at that time, as they were closely following the Patient A family. As noted above, she did not recall the Patient A family cluster being discussed at all during that telephone call. Dr. Wallington also told the Commission that at no time during this conversation did Dr. Mederski raise concerns with Public Health about unidentified cases of SARS in hospital.

On March 17, Toronto Public Health learned of Mr. and Mrs. B's admissions to hospital when the Public Health investigator had tried to reach them at home on May 17, and, upon being unable to do so, tried calling the emergency department at North York General Hospital to see if they were there or if they had been admitted to hospital.

After learning that Mr. and Mrs. B had been admitted to hospital, Dr. Berger spoke to the internal medicine specialist who was caring for both Mr. and Mrs. B, on May 17, 2003. She told the Commission that the physician told her that Dr. Mederski was aware of these cases and that Dr. Mederski had seen Mr. B's wife, Mrs. B, and would be seeing Mr. B. He also told Dr. Berger that Mrs. B had been diagnosed with atypical pneumonia. Toronto Public Health officials were again assured that both patients were in respiratory isolation and were being managed with precautions, and no one raised concerns at that time to Toronto Public Health that these patients were SARS.

Dr. Rea recalled being contacted by Dr. Mederski on Sunday, May 18, about the Patient A family cluster. Dr. Rea told the Commission that on that date Dr. Mederski conveyed the opinion that she did not think the A family had SARS. As she told the Commission:

I spoke with her on Sunday, so that would be May 18th, she'd actually called about another issue, about them decommissioning the SARS unit at North York General and we had a side-conversation about the [Patient

A] family cluster, at that point. You'll remember there were conversations back and forth about that cluster, the family cluster from the 12th, earlier that day, the 18th, [Dr.] Lisa Berger had spoken with [Mr. and Mrs. B's doctor] at North York General and they'd had a conversation about it again and raising the issues around SARS. So what Dr. Mederski was saying at this point on the 18th was, despite that conversation and what [Mr. and Mrs. B's doctor] had talked about with [Dr.] Lisa Berger, that she felt pretty strongly it was not SARS, that the mother, so that would be [Mrs. A], was already getting better, that none of them were that sick even though the son-in-law, which is [Mr. B], was diabetic, because at that point we already knew that diabetes was a risk factor for SARS, that the so-called source which came with [Mrs. A] who had been visiting her husband in precautions, that he [Patient A] had an explainable course of illness, a fall with fracture and pneumonia is a complication which is a very, very well characterized scenario. So that from her end, it was not hanging together as looking like the clinical picture of SARS that we had sort of accumulated or got to know to that point in the outbreak. So that was the Sunday [May 18].

Dr. Rea told the Commission that at that time the family was classified as persons under investigation and that her view of the telephone call was that Dr. Mederski wanted to be clear about her opinion on these patients, which was that they did not have SARS:

Basically the way I remember it, because we kept from our end handling that cluster as SARS, and following up on them and conversations and other clinicians at the North York end quite, quite appropriately. People coming in with fever and maybe respiratory symptoms, raising a concern about SARS, keeping it on a differential. So I think she wanted to be clear what her take on it was.

On May 20th Dr. Elizabeth Rea again spoke to Dr. Mederski about Mr. and Mrs. B.⁷³⁷ At that time she learned that the granddaughter (Miss B) had also been admitted to hospital, into isolation, and was being managed with precautions. Dr. Rea's notes report that based on this discussion with Dr. Mederski, that the impression was "not SARS."

737. Dr. Rea advised the Commission that although she had no specific recollection of how the contact was initiated, she had no reason to dispute Dr. Mederski's recollection that she contacted Toronto Public Health on Monday, May 19, and asked to speak to the physician on call and that Dr. Rea telephoned her, in response to that request.

Dr. Rea described her recollection of that call, supported by notes she made at the time of the call:

The first part of it was Dr. Mederski saying that [the onsite Public Health nurse] was at North York General telling the [Patient A] family contacts to be in quarantine, now what on earth was she doing, because again Dr. Mederski's consistent impression was that this cluster was not SARS, so what was [the onsite Public Health nurse] doing going around telling people that they needed to be in quarantine? From our end, she wasn't actually telling them to be in quarantine, what she was doing was completing the standard 10-day history and contact lists, we weren't pursuing quarantine for contacts but we were going right up to that point so finding out who all the contacts were and the risk areas if they should turn out to be SARS, and that's what [the onsite Public Health nurse] was actually doing ...

My interpretation on that and consistent with what we've been over, the charts to back it up, is that she [the onsite Public Health nurse] wasn't telling people they had to be in quarantine, she was completing the standard documentation for PUIs, including getting the contact information. So then following that, there was another sort of update on the status of the group, the family members. And the notes that I have from that conversation, my own notebook are a first mention of [Miss B], that she and [Mrs. B] both have sore throats, that Dr. Mederski's, again, take on it was that three of the four in that cluster would never have been in hospital prior to SARS, that they just weren't ill enough to need hospital-level care. That [Mrs. B] had been at that point afebrile for 48 hours and became afebrile after only 24 hours in hospital. That the granddaughter [Miss B] had a sore throat, was on penicillin, that tests were pending for influenza RT adenovirus that would be part of the standard work-up. And corresponding with that are the part from my notebook which would have been my notes during the conversation, so following that, I would have gone to the chart and written up this note. So there's a bit more explanation there about [Miss B] had a sore throat, she was first seen at [local clinic where she lived], put on Biaxin, came back to Toronto and was admitted at North York General, so at that point Dr. Mederski hadn't seen [Miss B] herself but had heard about her chest x-ray and gotten this much of the history and then, the update on [Mrs. B] and [Mr. B]. So again, her

impression was not looking like SARS, not looking like the pattern that we had been building up of what SARS clinically looked like. And the update on the testing, that the samples had been done but all the tests are still pending at that point.

Dr. Rea said she did not recall specifically being asked her opinion about these cases and the notation “imp Not SARS” represented her net impression of the case at that point in time:

Question: Okay, so when this note is written on the chart, “imp: Not SARS,” whose impression is that?

Dr. Rea: That’s my net impression of where we are at this point in time. So it’s not a diagnosis. It’s kind of a what’s currently at the top of the differential, if you like. So that’s from my end, that’s taking into account what information is available about the clinical picture about laboratory stuff to back it up, so serology, stuff about RSC influenza, chest x-rays that support one way or the other what information is there about epidemiology, about establishing an epidemiological link to a known case of SARS. So at that point where we were with that family cluster, the working impression at that time was not SARS. But, of course, we are still following them as persons under investigation. So, there are precautions, we are still pursuing the diagnosis, we are still making sure that [the onsite Public Health nurse] has got all of the contact stuff, and the 10-day history and everything is ready to go, if that impression clicks.

Dr. Rea said that in all these conversations, Dr. Mederski was consistent in her opinion that these patients did not have SARS. Dr. Rea told the Commission that it was not clear that these patients had SARS because they did not fit the clinical picture of SARS as it was known at that time because they were minimally ill compared to other SARS patients and they had no epilink. But Dr. Rea said that at no time did she ever say to Dr. Mederski these patients were definitely not SARS or that SARS was ruled out.

Toronto Public Health officials told the Commission that they were calling to get information on these patients. They said that it was not that they were being

contacted to provide their opinion about these patients, but rather that they were having to follow up regularly to try to obtain as much information as they could about these cases.

Toronto Public Health officials said that they were concerned about this family. Although they were reassured by the fact that all of the hospitalized family members were in isolation and being managed with precautions, their illness was a source of “great angst.” As Dr. Wallington said:

This was a family that was on our radar, so the one thing that was very reassuring and that we did verify again and again was that they were being treated in precautions. So that they were being treated appropriately, from an infection control point of view. They were being treated in isolation. But again, the cluster itself, it caused us great angst as we were trying to work through what was going on. And it wasn't always easy to get the clinical information we needed to think through this cluster and what was happening. It was sometimes very difficult to get that clinical information.

Toronto Public Health said that there was enough back and forth between them and the hospital and enough efforts on their part to follow these cases, including speaking to physicians involved in their care, that it should have been clear that the members of this family cluster were of concern.

All three of the Toronto Public Health physicians involved in the Patient A family cluster told the Commission that Dr. Mederski did not report to them that she felt these patients had SARS. Based on their discussions with Dr. Mederski, they understood that it was Dr. Mederski's clinical opinion that these patients did not have SARS. The Public Health physicians who were following the Patient A family told the Commission that they did not overrule or dismiss any concerns about these patients and that they were concerned about this family and that at no time did they suggest otherwise. It was their understanding that Dr. Mederski's clinical opinion was, and remained until the full extent of the outbreak was identified on May 23, that these patients did not have SARS.

Communication Breakdown

Retrospective accounts of the contact and communication between Toronto Public Health and Dr. Mederski with respect to the sequence of events and opinions held and shared about the Patient A family cluster differ. In fairness, both parties were asked to reconstruct the events long after the outbreak was finished. The Commission does not doubt that both sides were truthful when they spoke to the Commission and that both recounted the events to the best of their abilities.

But the different perspectives of each of the respective parties underscores the importance of clarity in communication and of ensuring there are strong support systems in place to ensure effective communication.

Although Toronto Public Health told the Commission that they were constantly having to seek out information about this family, there is evidence that those within the hospital did try to make their concerns known to Public Health officials. For example, the notes prepared by the physician caring for Mrs. A, which the physician said she provided to a Public Health nurse on May 16, were in the Toronto Public Health patient files, obtained by the Commission.⁷³⁸ This document included detailed information about each family member's illness, including Miss B, the granddaughter of Mr. and Mrs. A.

The consultation notes for Mrs. B reflect that Dr. Mederski did speak to Public Health officials about her case. And notes in the Public Health charts report that Dr. Mederski did communicate to Public Health officials concerns of front-line staff about relaxing precautions and that there were concerns among front-line staff about the opinions she was giving. Notes taken by Dr. Barbara Yaffe, Director of Communicable Disease Control and Associate Medical Officer of Health, Toronto Public Health, discussing the North York General situation some time before May 22, included an update of the status of Patient A family members, as well as the following notation:

ER nervous re POC directives – not our bus. We'll – keep PHN in hosp.

...

Ask Bonnie to call Barb Mederski next week

738. All Toronto Public Health records and files were obtained under the power of summons, issued under the *Public Inquiries Act*.

...

issue – even when Mederski says it is not SARS, rest of hosp. still think it's SARS.

Dr. Yaffe was asked to explain what these notes meant:

Question: In the notes, it appears that on that day, in addition to everything else that was going on, there was a discussion again about the [Patient A family] and case updates.

Dr. Yaffe: Yes.

Question: Was that part of what was happening in connection with St. John's or was this sort of a separate case update?

Dr. Yaffe: A separate case update.

Question: Okay, and now by the 22nd, in the case update notes, we have gone through some of it, but halfway down the page "ER nervous re: POC directives not our business we'll keep" ...

Dr. Yaffe: PHN in hospital ...

Question: So "ER nervous re: POC directives" – do you remember what the discussion about that was?

Dr. Yaffe: No.

Question: Presumably they are talking about the emergency room at North York.

Dr. Yaffe: Yes. They must have been nervous about something going on with directives and we were saying that, I was saying that they need to talk to the Province, we are not in charge of the directives.

Question: Will keep PH ... ?

- Dr. Yaffe: Oh, will keep Public Health nurse in hospital.
- Question: In hospital, okay.
- Dr. Yaffe: Yes, we had nurses in each hospital .
- Question: Okay and then down near the bottom of the page, “ask Bonnie to call Barb Mederski next week: issue even when Mederski says it is not SARS rest of hospital still thinks it is SARS.” Do you recall where that information was coming from?
- Dr. Yaffe: I really don’t. One of the physicians must have been saying that to me, obviously.

But whatever the contact and whoever the initiator, as noted above, there is nothing in the Public Health records to suggest that Dr. Mederski clearly conveyed concerns of front-line physicians or her own opinions, at whatever point she began to think SARS. On the contrary, as noted above, the Toronto Public Health records have repeated references to the clinical opinion of Dr. Mederski that these patients did not have SARS. This is consistent with the message she gave to front-line staff and other physicians at North York General and with her consultation notes with respect to these patients. Whatever Dr. Mederski’s private beliefs about these patients, she did not share them with colleagues at North York General Hospital or with front-line staff. Moreover, given her own accounts of conversations with Toronto Public Health, it is unclear in what way and how strongly she expressed her views. More will be said about the communication between Toronto Public Health physicians and Dr. Mederski below.

There were also problems with reporting the A family cluster. Although the matriarch of the family, Mrs. A, was admitted May 9, she was not reported to Toronto Public Health officials. As subsequent family members came to hospital, Public Health officials report that they were constantly having to seek out information about the family.

As noted above, Toronto Public Health said that they were constantly having to seek out information about these patients and that their admission to hospital was not always reported in a timely manner. It was through their own investigation and on-site person they were aware of each of these patients and that they were able to monitor them from the time of admission. Each member of the Patient A family became a person under investigation for SARS from the date of his or her admission until

classification as a SARS patient after May 23, when an epilink was identified:

- Mrs. A: May 12 to May 25 PUI
 May 25 classified as probable
- Mr. B: May 18 to May 25 PUI
 May 25 classified as suspect
 May 29 classified as probable
- Mrs. B: May 18 to May 25 PUI
 May 25 classified as suspect
 May 29 classified as probable
- Miss B: May 21 to May 25 PUI
 May 25 classified as suspect
 May 29 classified as probable

Public Health officials report that based on their followup with respect to these cases it would have been clear these patients were of concern and were being followed. In addition, infection control practitioners completed SARS Report Forms for Mr. and Mrs. B and Miss B, all of which were dated May 20th.

But the fact that these patients were under investigation for SARS and that they were being monitored daily by Toronto Public Health does not appear to have been clear to North York General Hospital senior officials. As noted above, Dr. Mederski told the Commission that the status of these patients and of Public Health's involvement with these patients was unclear to her.

Based on the earlier actions of the hospital, the Commission does not doubt that had senior hospital officials and those in charge of the SARS response known that these patients were classified as persons under investigation for SARS, hospital officials would have communicated that fact to staff, via staff updates. As noted earlier, although the communication with staff was not always effective, the hospital clearly made an effort to report to staff whenever a case became a concern for public health officials. And there is no mention of these patients being under investigation for SARS in the SARS Task Force minutes, a place where their status with Public Health would have most certainly been discussed.

But the story of North York General Hospital underscores the importance of communication. Time and again throughout SARS, the importance of having an on-site

public health presence in hospitals, particularly during times of an outbreak or public health risk, and of having strong relationships between public health physicians and hospital physicians and infection control staff, is glaringly obvious. Public health was only as effective as the information it received. In turn, hospital officials often turned to public health for guidance on the management of cases and risk to staff, visitors and patients. Yet for the most part, communication between public health physicians and hospital physicians occurred over the telephone. As one infectious disease specialist noted, telephone opinions and consultations run the risk of miscommunication and misunderstandings:

It was easy to talk over the telephone and say, I don't believe it. But if you are in charge of an epidemic, where it's so important, why wouldn't they send somebody down to actually look at the patient and go over the records? I mean, I know they have a nurse there, but sometimes there's nothing like being on site to actually see what's going on. People may emphasize the wrong thing [in a telephone conversation] or somebody may take away from a conversation something that, that's why we go and see patients ... Sometimes when you see the patients, it's a completely different story. You know, there's a completely different interpretation from hearing it over the phone.

The story of North York General is rife with systemic communication problems, like the entire story of SARS. But when Public Health physicians were on site, things were much better. On May 23, the problems became clear and decisions were made in consultation with the on-site Public Health physicians. After May 23, Public Health physicians continued to work on site at North York General, providing valuable advice on the epidemiology of the outbreak and helping to identify and track cases.

During SARS, Toronto Public Health lacked the resources to regularly have physicians on site in key hospitals. As noted earlier in this report and in the Commission's first interim report, the public health capacity for on-the-ground assistance must be strengthened. No system can continue to rely so heavily on the volunteerism and goodwill of outside experts, and it is clear from SARS that the most effective support is an on-site presence.

May 20 Meeting with Emergency Room Staff

By May 20, front-line staff had seen Patient A's family and Mr. and Mrs. O come in through the emergency department at North York General Hospital. They knew that both families had connections to the hospital, back to when there were known SARS patients in the hospital. They knew that other doctors, whom they respected and trusted, thought these patients had SARS. That, combined with their own experience, led them to question why these cases were not being identified as SARS cases, why they were on regular medical units and not on the SARS unit, why precautions had been relaxed and why the message they were getting was that SARS was over.

By May 20, worry and fear in the emergency department had reached a boiling point. On that date, emergency room staff asked to speak to someone in authority about what was happening and what had taken place with the family cluster. That afternoon, an impromptu meeting was held with the staff of the emergency department and hospital officials, at North York General Hospital. Much like the meeting between senior hospital officials, including Dr. Mederski, and the psychiatry staff, the meeting with the emergency room nurses seemed focused on convincing them that they were wrong, that SARS was gone.

The Naylor Report describes the meeting:

In mid-May physicians and nurses in the emergency department assessed family members of the 96-year-old man with symptoms suggestive of SARS, and they were increasingly anxious about a continuation of the outbreak. Radiologists also expressed concerns to colleagues about sets of suspicious x-rays. Taking their cue from public health officials and citing the epidemiology uncertainty about how all these cases could be linked to each other, the hospital's infection control director and vice president of medical affairs tried to reassure emergency physicians and nurses at a tense meeting on May 20th.⁷³⁹

But nurses who attended the meeting did not describe a sense of reassurance. Rather, descriptions from some of the nurses who were at the meeting conveyed to the Commission a sense of dismissal and disregard for their opinions and legitimate concerns.

739. Naylor Report, pp. 39-40.

One nurse described the meeting as tense and said that there was anger and frustration on the part of the nurses:

There was great tension in the room, and there were some very angry, very frustrated nurses. One of the nurses, actually stood up and said to Drs. [Glen] Berall and [Barbara] Mederski, you're all lying, I don't believe any of you. Many of the nurses said that they would just like to know at least then, can we have our masks, if you say it's not SARS. And then when Mederski said, well we see these things often, you know, we do see them only we just don't look for them and now we're looking for them so we're going to see them.

And one of the nurses said, well, it's interesting because I've been a nurse for about 20 years, and maybe you've seen them, but I've never seen acute viral ailments written down as the diagnosis so many times. And if these patients aren't SARS, why are we doing the SARS work-up, the kit, and that's when they said, oh, we mean to change the name, it's going to be the CAP kit, the CAP [community acquired pneumonia] work-up, because there is no real test for SARS and it's just community acquired pneumonia and you're just going to have to get used to seeing this. And that it's just not SARS. Over, and over, and over again.

Emergency room staff told the Commission that the message conveyed at the meeting was that they should listen to the infectious disease specialist:

And one of the clerks asked and said, well, you have to understand I've worked here for a while and there's a lot of physicians I've worked with, who I respect, over the years. And they're telling me that it is SARS, so whom do I believe. And Dr. Berall says that you ask the infectious disease specialist, and the infectious disease specialist is telling you that it's not SARS, so then it's not SARS. That she is the expert, not them and not you. It wasn't even, our considerations weren't even, unfortunately, there were physicians there; however, none of the physicians spoke up.

One emergency room nurse described the message of the meeting as follows:

There is no SARS. We don't have a problem, there is no epilink, we don't see clusters. Normally there would be 20 or 30 people with SARS and I've been doing this for months, I know everything about it. At that point, they weren't even admitting the psych patients were SARS.

Another nurse described the meeting to the Commission:

I sat in at the meeting with emerg when Dr. Mederski said, they did not have SARS. It was a family and she gave reasons for the contagiousness to its spread, said it was definitely not SARS and SARS was over. The nurses were telling her this is SARS; if it smells like SARS and it looks like SARS and acts like SARS, it's SARS. She said no, it was community acquired pneumonia and they should stop it. You know, stop talking like that.

Health workers who saw these patients and knew about their cases simply did not believe what they were being told. They did not believe that SARS was over. As the above-quoted nurse told the Commission:

I happened to sit in on a meeting at the emergency department, just prior to SARS II breaking out. I wake up to CFRB every morning and there was an announcement on the radio "SARS is over in Toronto." An hour later I called my father in [name of city]. I said, you're going to hear that SARS is over in Toronto, you're also going to hear in a few days that it's not true because five people were admitted with it from one family.

One physician who attended the meeting agreed that the message was SARS was gone. He said:

So here's how the meeting went, right. We were told basically there are no new cases of SARS. Two incubation periods have passed, assuming we knew what the incubation periods were, and there was thinking about seven to 12 days, seven to 14, those were about the figures, and SARS basically was no longer present in the hospital. That's a pretty profound conclusion. Not based on known information nor a history of knowledge about the disease called SARS.

During the meeting, people were asking, some of the people, nurses in particular, were asking, in fact, nurses exclusively asked questions like, how can you be sure, this is a new disease, are you sure the definitions are appropriate? And we were given, those who gave information made the same statements again and again. The disease doesn't exist anymore, we've now had two incubation periods. This isn't just our opinion, it's the opinion of all the experts. Period. Further questions were asked, the same statement was repeated. I think if we were in the same situation in 2016,

people wouldn't dare be as blunt about it. At least not everybody. You know, we've been wrong before ...

Many nurses felt that their experience and judgment were being overlooked and belittled in favour of applying a strict case definition. As one nurse told the Commission:

She [Dr. Mederski] said that she's going by the guideline that was set out by the Ministry of Health. The definition that says it has to have a link and that they've done tons of research and all the epidemiologists in the city and all the epidemiologists over the world and all the ID [infectious disease] people, they talk, and they're all experts and written papers, and they know so much more about this disease and I mean, come on, girls, really, I mean, really, that's how you felt, like, come on, please, don't insult us.

Dr. Mederski told the Commission that she thought the thrust of the meeting would be to talk about the new normal. As noted above, Dr. Mederski told the Commission that by the evening of May 19, her private opinion was that these were probably or maybe SARS patients. But as in the meeting with the psychiatry nurses earlier in May, she did not express this opinion to staff. Instead, she, along with Dr. Berall, the co-chair of the SARS Management Committee, repeatedly told staff that the cases were not SARS and dismissed their fears. Dr. Mederski said that she did not feel that she dismissed concerns and that it was not her intention to do so. She felt confident that the patients in question posed no risk to staff, as they were all being treated in respiratory isolation. Based on her discussion with Public Health, she felt that they did not think these cases were SARS and that it was safe to continue to relax precautions. As noted above, Public Health officials say that they never said these cases were not SARS, that they were concerned about these cases; they understood that it was Dr. Mederski's opinion that these patients were not SARS and that decisions with respect to precautions fell to the Province through the Provincial Operations Centre.

Dr. Mederski described her view of the meeting to the Commission:

Question: Now as you went into it, you in your own mind had some people in mind that you thought were maybe SARS cases, was that [Patient A] and [Mr. O]?

Dr. Mederski: Yes.

Question: Anyone else?

Dr. Mederski: That's all I can say now. Oh, no, no, no. There was one other lady whose name I don't remember right at the moment at all, who was extremely sick with a respiratory problem. And she was on the main, on the regular ward, and I treated her, and we eventually did do SARS testing and it came back negative but for a while at first she sure looked like a SARS case, and so I also had this one other patient who is not on your list.

Question: But certainly you had the [Patient A family] and Mr. O?

Dr. Mederski: And [Mr. O] in particular. As I said, the thrust of the meeting was not to say yes or no, these are SARS cases, but it was to allow the hospital to proceed with the new normal and as I said, I was hoping subliminally nobody would ask me whether or not these cases were or were not, because I would have to toe my line starting Saturday morning, 6:30 in the morning, when I had the first call about these cases coming through.

Question: You would have to essentially say they weren't SARS?

Dr. Mederski: And I did speak to this indirectly at that meeting.

Question: All right, so now you attended the meeting and who was at it and what was the tone, and what's your recollection of the course of the meeting?

Dr. Mederski: It was a very difficult meeting. I came in with Glen [Dr. Berall], it was a small room in the emerg department, in the nurses' lounge area. It was packed to the rafters. It was noticeably absent of physicians, who were walking outside of the room in the hallway, not wanting to show their faces, almost as if, you are in for it, we are not ...

... It was all the nurses and some administrators and some clerks, like ward clerks, and the atmosphere was

very tense. It was very, you could tell, really, it was tense in the air. Two nurses came in, two nurses who work regularly, two senior nurses there, who basically fired off some questions during the course of the meeting and one of that of them had to do with the SARS kit, that was no longer the SARS kit, but it was this other kit, that I had designed.

Question: The Respiratory Infection ...

Dr. Mederski: Respiratory Infection Specimen Kit. I coined it and I thought I was being so brilliant when I thought this one out.

Question: Respiratory Infection Specimen Kit?

Dr. Mederski: Yes. So somebody said, are you hiding something from us. You are still collecting these specimens for SARS. And I said, yes I am, and I will continue to do so in appropriate cases and this is a perfect opportunity to carry on this way as part of our new normal forever in this hospital, that when patients come in with respiratory symptoms, we should be doing this anyway. This is something that we should be doing forever, not just now, not this year, but forever.

And you know, that bothered me, that somebody would somehow imply that I was lying because I am changing the word from the SARS kit to RISK kit, when I was actually trying to be a good Samaritan and do something the right way for the hospital to get the specimens identified the way we have always dreamed of doing. And the other had to do with all these people coming in that I had mentioned earlier, that there was this feeling among the nurses that there was a huge number of patients coming in with respiratory infections. So I did say that I had spoken to [Dr.] Tamara Wallington, that I had spoken to [a TPH physician], that I had spoken to [Dr.] Elizabeth Rea, that I had also spoken to other hospitals, that I had spoken to my professional

colleagues, some of them, and that outside of the Centenary [Hospital], everybody else had already downgraded, before we were even talking about it. And that I felt it was safe to do so.

Then they proceeded to say, we are having our equipment taken away from us, do you agree with that, our protective equipment? And I had been already primed by [the two nurse managers] that what they were going to do was make the PPE a little less strategically available. So instead of having a parked cart on every single doorstep on emerg, they were going to move these carts away, a little bit further so there was less ease of grabbing another mask or grabbing a gown, just willy-nilly getting all gowned up at any time, that it would have to be thought out. Yes, they would still have access to equipment, but it would not be at every corner. They were going to ease out this way. This was their strategy. And so I said, I know that nothing is being taken away, I know that it's available to you, and yes, I totally agree that in emerg you should have availability of all this as you need it, and triage is the most vulnerable area, but we still have to proceed forward even along the lines of what the MOH [Ministry of Health] said, the Ministry said is the new normal.

Then I gave little lecture on atypical pneumonia and microplasma pneumonia and how they present and how they have a very high contagious rate in families, this is well known, and I think that's the comment that may have turned off some people because as I later heard that I was "putting people down" and something like that. And it may have been that "was well known" concept that I alluded to. But I said frankly it is well known. Respiratory infections of this nature are highly spread amongst families, it's just that they are mild enough that people usually don't bother and people go home and they sniffle and they take care of themselves and that's the end of the story. But from time to time people get very sick and crash and it looks just like SARS. So I was sort of rationalizing out loud why the

cases that they had seen over the weekend were actually meeting the case definitions.

Dr. Mederski told the Commission that after the second outbreak was announced, she felt able to voice her true opinion about the cases and that she had a private meeting with the emergency room nurses to explain what had happened. Dr. Mederski said:

Dr. Mederski: I repeated all that. I repeated everything. And I think I also said, you don't realize what pressure I've been under. Feeling one thing, being told differently, repetitively over the last two months. There comes a point when you finally just have to say what you're told to say, or what you're expected to say. And at no time have I been upset at anybody in particular, other than the fact that I was upset when somebody mouthed off about my RISK kit, about being a hiding effort on my part, to hide something, activities going on. And the part that bothered me first thing was when they said that I was trying to hide information from them or that the information that I was hiding, just period, everything to do with SARS information, that I was hiding SARS cases. I think the thing that crossed my mind over that whole period of time was, was I hiding these cases, or was I just so ambivalent or schizophrenic that I just didn't know what to do anymore and what to say, and proceeded to do what I did, treat them and whatever, but wasn't comfortable in speaking in the same way I did when I spoke about the psych cases. I was hurt.

Question: Did you feel the second meeting went better than the first meeting?

Dr. Mederski: Yes I did. And I felt that there may have still been some people that were maybe still not convinced but nevertheless I felt much better and the one nurse that had been very angry came up to me later and said, you know, we did feel that you were not being fair with us etc., but I feel a little better now.

Question: Tell me if this is accurate, the second meeting, seeing that the 23rd had happened, the hospital had closed, you were able to share with them ...

Dr. Mederski: Yes.

Question: ... then your feelings about the pressures you were under ...

Dr. Mederski: Honestly.

Question: ... which included the pressures you've described, to sort of say what you were expected to say?

Dr. Mederski: It was definitely more easy. But when the question came, well, why didn't you tell us this earlier, because it did come up, you know, it was very hard to give an answer to that, because I said, there comes a point when you can't say something definitively because we don't have a definitive test, and you know, we've been doing this now for three months, I'm exhausted, and I have to say I did the best I could at that point. And I feel badly if somebody was offended, but it was definitely not intended to offend anybody, or belittle anybody's concerns. That was really what the whole intent was, to indicate that I wasn't belittling anybody's concerns, but that I too was offended by their offense, at my seemingly being, lying, coy, whatever the words are that come to mind.

Dr. Berall, the other hospital official at the meeting, described the meeting from his perspective:

Question: That was a May 20th meeting, I think you were at that meeting?

Dr. Berall: Yes.

Question: Dr. Mederski was there?

Dr. Berall: That's correct.

Question: That was a meeting where concerns were expressed. It's been suggested perhaps that it was pretty categorically told to those who were expressing concerns that the cases they were concerned about were not SARS. Do you recall that meeting?

Dr. Berall: Yes I do.

Question: Do you recall that sort of descriptive suggestion of how the concerns were being addressed?

Dr. Berall: I recall lots of questions about the cluster or clusters of patients that arrived in the emerg that prior weekend. And I recall Dr. Mederski answering questions about the clusters and hearing people's concerns and informing them that the clusters were reviewed with Public Health. There were considerable discussions and questions back and forth on that, and she informed them about the discussions with Public Health and that they were discussed and ensured that each of the cases they had in mind were discussed and identified, that some of them had different illnesses that were proven by diagnosis and that Public Health had deliberated, considered the cases and determined that they weren't SARS.

And she answered the questions about how they were addressed, that they were isolated, that they were still in isolation, that they were in respiratory droplet precaution. Because the emerg protocol had had the triage nurses in PPE and all respiratory droplet patients streamed into a PPE protective stream, that nobody had had any exposures. The emerg staff knew how to wear their PPE and they were following the policies. And so that those things had been done. Public Health was the one that made the call is it or isn't it. The infectious diseases specialist ensured that they were addressed in proper precautions as probably so did the opinions of the other health care professionals as a team. People all agreed that they should be in respiratory precautions.

What was debatable was the diagnosis, but Public Health said it was not SARS.

Dr. Berall told the Commission that at the time he had no reason to doubt what he understood from Dr. Mederski was the opinion of Public Health, that these people were not SARS:

If it was obvious, something different would have been done. It wasn't obvious. At least, it wasn't obvious to us, and based on the knowledge at the time, it wasn't obvious to apparently Public Health either, and they were considering more than just North York General. They had the bigger picture. But based on the knowledge at the time, they judged that it was not SARS and according to the directives, it didn't fit the diagnosis of SARS. What do you tell those people? I don't know what you're referring to when you're saying that they're being told it's gone. I guess you might be referring to the directive that said we're in the recovery phase.

But because of staff concerns expressed at the meeting, Dr. Berall said, at the end of the meeting he once again asked Dr. Mederski to consult with Public Health, to ensure that the message they were giving staff was correct:

... after the May 20th meeting concluded, I asked Dr. Mederski to call Public Health once again and just check with them once again. Tell them that our staff was concerned and convey that concern and ask them the question that were raised and they gave the same answer as they had given before.

Dr. Berall said that he thought that staff questions were answered, that the tension in the room had seemed to come down and that, after the meeting, he sincerely understood that staff concerns had been addressed and that staff had felt heard. This understanding was supported by an email he later received from one of the emergency room managers, expressing thanks for the meeting. He said that later accounts of the meeting were inaccurate and that it was not his impression of the meeting that Dr. Mederski was saying SARS was gone:

Dr. Berall: ... I certainly didn't come away from the meeting with the impression that Dr. Mederski had said that SARS is gone. I didn't get that impression from that meeting.

Question: But that she was answering specific questions about specific cases.

Dr. Berall: Yes, she definitely did that. Was there a little bit of tension in the room? At the beginning, there was tension in the room and Dr. Mederski was the first person to answer questions because the first questions were about clinical cases. So, you know, in a room full of a bunch of people who are anxious or concerned or whatever, it starts off with interpretation. I have an e-mail that I wrote to the clinical chiefs the day after that meeting that, sort of speaks to my perspective on that meeting. I know the *Toronto Star* article said something about people storming out of the meeting. They weren't at the meeting that I was at because nobody stormed out of the meeting. People seemed to be calmer at the end of the meeting and I actually got a thank-you note from the unit administrator from emerg for coming and speaking to the nurses, that they felt it was helpful. So, I don't know why she would thank me for coming to a meeting and creating an atmosphere where people would storm out. That doesn't make sense.

Dr. Berall said that staff were listened to but that there was a divergence of opinion and that the hospital went with the opinion that they understood reflected the consensus among the experts:

I think there's a difference between being listened to and sharing the same opinion. And I think that whenever there was a concern raised, that we were aware of, we would meet with the staff and have a discussion and hear what they had to say, listen to their concerns, provide them with information pertinent to their concerns, any information that they wanted, and we answered all their questions and then took whatever steps seemed appropriate in response to that. So I have a lot of respect for my health care professional colleagues. I don't share the opinion that they weren't listened to. They were listened to, they were heard, I feel, but you know, the steps were taken that I think were appropriate in response to that.

Although some staff continued to be upset after the meeting, not everyone felt that way. As noted above, an email sent the following day, May 21, 2003, from one of the nurse managers in the emergency department thanked Dr. Berall and Dr. Mederski for their assistance and said that staff reported their appreciation for the meeting. The email promised:

I wanted to take a minute today to thank you for your assistance yesterday as we struggled with the new directives and moving forward. Friday, staff were so excited to be able to lighten the restrictions and yet throughout the weekend fear seeped in again. Today the staff expressed appreciation for the opportunity to ask questions, share their fears and discuss how we move forward. Personally I thank you for your support yesterday and throughout the past weeks.

Dr. Tim Rutledge, Chief of Emergency Medicine, was away on the long weekend and returned to work on Thursday, May 22. He said that he heard about what was happening and became aware that there continued to be anxiety among staff. He said he spent much of the day trying to understand what was happening. He said that although the use of precautions was no longer required, equipment was still available and its use was optional. As noted below, this was a key feature of the emergency department story, the fact that although these patients were not SARS, staff were given the means to use their own judgment to protect themselves and could continue to use protective equipment.

Whatever the intention of those who presented at the meeting, despite the differing perceptions between Dr. Berall, Dr. Mederski and those nurses and doctors at the meeting who reported as quoted above, it is clear that some of the staff came out of that meeting feeling that they had been dismissed. The problem was that, much like in the meeting with the psychiatry nurses, this meeting seemed focused on placating or calming the nurses rather than on acknowledging their legitimate concerns. As one emergency room nurse said:

If there had not been the denial that SARS was still around, when it very obviously was. I know it was a new disease, but you know, if it looks like a duck, it walks like a duck, and it quacks like a duck, it's got to be a duck. And what they kept saying is, no, no, no, it's a figment of your imagination. And if someone comes in with symptoms of typhoid and tests positive for typhoid, whether there's an epilink or not, that patient has typhoid ... When are you people going to learn to be up front with us. "We don't know if it's SARS, we want you to protect yourself," that

would make sense to me.

This was a group of highly trained, diligent health workers who had provided front-line care for SARS patients for almost two months. Concern about these patients was shared among the emergency room physicians and internal medicine specialists who were involved with them. Even if the doctors did not attend or speak up at the meeting, their actions, in ordering tests, in placing the patients in isolation and especially in requesting admission to the SARS unit, clearly conveyed their concerns. Moreover, their concerns were captured in the consultation notes in the respective hospital charts. It is difficult to understand why, notwithstanding any beliefs about opinions from Public Health, the concerns of front-line staff were not acknowledged as possible. It appears that there was no system to ensure that the physicians' concerns came to the attention of anyone other than Dr. Mederski and no way to ensure that all relevant front-line informed opinions were systematically assessed and considered in an organized fashion.

Nurses and other health workers were receiving mixed messages. Dr. Berall and Dr. Mederski were telling them it was safe to remove the protective equipment, that the cases were not SARS, yet emergency room physicians, with whom they had a long-standing working relationship, whom they respected and trusted, were still wearing full protective equipment at all times and were voicing their concerns to staff and advising them to do the same.

The emergency room physician who saw all four of the Patient A family members said that he was upset because he felt that if they had treated the SARS patients as suspect until proven otherwise and had maintained precautions, people might not have gotten sick:

If you look at who got sick in the end, by far most of the nurses that got sick were the 4th-floor nurses. The one that died was from the 4th floor. They all, the majority were from the 4th floor, because they had no more protection. Had they continued protection, had they treated everybody as suspect till proven otherwise, many of these people would not have gotten ill, that's for sure. So, I was very, very, very upset because in this particular case, this coincidence of me happening to see four patients, and I was working so many shifts because nobody else was coming to work, that I happened to be in a unique position where I actually saw four of these patients on the days they came in.

And when you have all that, and she [Dr. Mederski] knew about every one of these patients, she could not say, wait a minute, guys, something is happening here, four people, same family, all with pneumonia, it's suspicious, at the very least it's suspicious, let's play along with this paranoid guy and let's pretend they have SARS, but let's prove him wrong, let's wait for the blood test ... but no, that's not what happened. She went around, in fact at that period, telling the nurses in the emergency room, pooh-poohing us, me and [another emergency physician], that we were perhaps being a little paranoid and as proof she was there in her own little civilian uniform, eating lunch in the nurses' lounge, while all of us were walking around garbed, listening to her telling them not to be concerned and that there is no problem.

The Role of Dr. Mederski

It would be unfair to blame the second outbreak on Dr. Mederski. No one person could be responsible for the second outbreak. As one infectious disease expert said:

I have known Barb [Dr. Mederski] for a long time and I think that there were mistakes but I don't think we can blame it on just her. We all sort of blew it, but she sort of was unfortunately right in the middle of it.

There were many factors that occurred that were totally beyond Dr. Mederski's control and knowledge, among them the outbreak of respiratory illness on 4 West and the knowledge that there were sick staff on 4 West. It would be unfair to expect Dr. Mederski to have figured out what so many others also missed: that SARS had never left. Dr. Mederski explained to the Commission that the 4 West connection did not come together before May 23:

Question: I do get the sense though that, having regard to the way your antennae worked when you were seeing psych patients and [Patient A Family], that had you seen that information that was tabled on the 23rd about 4 West, that you would have reacted differently.

Dr. Mederski: You know, I don't know what I would have done. I have no idea, because I wasn't in that position, and hindsight is always great. Had I been able to extend the link from Mr. O on the previous long weekend and follow a

thread, had I had energy and my usual inquisitiveness, which I usually do, maybe I would have tweaked to something earlier.

Dr. Mederski did not know that there was an unidentified outbreak in the hospital, or that there were unidentified patients, not isolated, being cared for by staff without protection.

It is clear that Dr. Mederski sincerely cared for the well-being of patients, visitors and staff at North York General Hospital. Whatever decisions she made, the Commission accepts that they were made in good faith. Many physicians interviewed by the Commission described her as a conscientious physician who worked extremely hard during SARS. As one North York General physician said:

Dr. Mederski worked terribly long hours. She's an extremely conscientious physician.

The problem is that Dr. Mederski was simply one overwhelmed individual, left largely on her own, without professional supervision or systemic support to manage an enormous responsibility that required a level of management and communications experience to which she had not been exposed.

Underneath everything that happened at North York General, there is a clear picture of a tired, overworked physician who lacked supervision and whose clinical judgment and personal views had somehow become overborne throughout the course of SARS.

One Toronto Public Health physician said that the workload imposed on Dr. Mederski and the other members of the infection control department was huge, and that it probably prevented her from seeing the bigger picture of what was happening:

There were sick people and overworked clinicians looking after very sick people and the infectious disease department appeared very strained in terms of resources and who knows if they had a huge volume of cases and very few people could see them, one of whom [Dr. Mederski] appeared unwell, and whether that person ever had a chance to step back and try and see a big picture, and I think it required to be able to have a look at a big picture.

This physician also noted that when they were on site on May 23, Dr. Mederski appeared exhausted and unwell:

She appeared not to be well and exhausted and was being called all the time from all over the hospital while we were there. I think it was exhausting to look at, how one person could possibly manage all this. Her beeper was going off all the time. Everybody was asking her to see consultants all over the place. It is very difficult in that kind of a situation, you're seeing all the trees, you're missing the forest.

As noted earlier, there are differences of recollection between Dr. Mederski and those with whom she dealt at Toronto Public Health. This is one area of the Commission's investigation where recollections differ in respect of important facts. The Commission process lacks confrontation and cross-examination and lends itself well to getting frank and open evidence but less well to the resolution of disputed recollections. Because the Commission makes no adverse findings of fact against any witness and no criticism of any individual or organization arising out of these disputed recollections, no confrontation or cross-examination was required. Wherever there is a significant difference of recollection between witnesses in respect of a material fact, each witness, as fairness requires, was given the gist of what was said by those whose recollection differed.

Because the root problem with the undetected family clusters was systemic and not personal, it may in one sense not matter very much whose recollection is better.

It would however be unfair to Dr. Mederski and to those whose recollections differ to leave the difference of recollection entirely up in the air. It is obvious that Dr. Mederski and all those whose recollections differ from hers gave the Commission their best recollections of what happened.

Dr. Mederski was largely on her own with a huge personal burden of responsibility and no backup in the sense of ongoing organized professional supervision and support, especially in May, when the hospital concentrated its attention on the return to normal operations. Unlike those who worked in Public Health, she was not part of an organized and closely supervised system with vast experience in the timely and effective recording of epidemiological data and evidence. It is only natural in the circumstances that her recollection should be more impressionistic and less exact than that of those in the investigative business of systematically noting and logging and charting and recording and reporting and verifying, as they arose, the contemporaneous conversations and pieces of evidence that bore upon the question of whether the patients had SARS.

The Public Health witnesses worked within a system that required them to note and log and chart and record significant conversations and pieces of evidence contemporaneously.

raneously without having to rely on their memory months or years later to reconstruct what they thought must have happened. Unlike the Public Health witnesses, Dr. Mederski lacked the advantage of such a system.

These profound contrasts in their respective working environments and information logging systems give the Public Health witnesses a great advantage over Dr. Mederski in their respective abilities to recollect accurately what was said.

For this reason alone, the recollection of the Public Health witnesses is on balance likely to be preferred to Dr. Mederski's best attempts to recall and to reconstruct what happened in that time of enormous pressure and responsibility when she was so alone and under great stress and indeed ill.

This likelihood is reinforced by the manner in which Dr. Mederski expressed her recollection, in language sometimes vague, tentative, unsure and occasionally characterized by circular interior dialogue with herself, in contrast to the direct and objective recollection expressed by the Public Health witnesses.

Dr. Mederski in some areas relied not so much on her actual recollection but on her later rationalization ("trying to rationalize") of what she thought must have happened. At times she relied more on her intuitive interpretation of what she thought someone meant instead of relying on what they actually said ("the vibe I am getting," "I am getting the feeling").

Dr. Mederski was openly tentative and unsure about significant aspects of her evidence ("I can't be sure," "it could be," "I am trying to think," "it could have been," "it may have been," "I don't remember," "I would not be surprised that would be," "the conversation would have gone something like," "I was trying to understand," "but I still never understood what it was"). This quality in Dr. Mederski's evidence makes it difficult to prefer her evidence over the direct and focused evidence of the Public Health witnesses.

It may be that she sometimes focused more on her own subliminal interior monologue than on what was actually said by her to others and by others to her ("that was all in my mind," "I was hoping subliminally no one would ask me," "was I just so ambivalent or schizophrenic that I just didn't know what to do anymore and what to say").

Dr. Mederski's answers to the Commission's questions sometimes tended towards indirection, and it appears from those answers that she was not always direct in what

she said to the Public Health witnesses. The following question and answer furnish an example of both problems:

Question: Did you express any opinion to them on the 20th or when you spoke to Dr. Rea on the 19th, did you express any opinion to them about your own feelings, your own thinking about what these cases were?

Instead of saying “no,” Dr. Mederski said this:

Dr. Mederski: Well, I was concerned enough to personally call them and nobody had asked me, the hospital administration had not asked me, nobody else had asked me. My concern was manifested by definition in the fact that I phoned these two individuals to ask about, an open-ended question effectively to say I have these cases, should I be concerned? The staff are concerned, these are mild cases, except for [Mr. O], they look like some of the SARS cases we’ve had. But I didn’t say, oh, I have five SARS cases. I was more, it was a rhetorical type of open-ended mulling ...

Although this lack of directness in answer to the Commission’s questions and the lack of directness in her discussions with Public Health officials do not detract from her honesty or her best efforts to assist the Commission, it does detract from the reliance one can safely put on her recollection as opposed to that of the Public Health witnesses.

A strong reason to scrutinize Dr. Mederski’s evidence closely is the fact that Dr. Mederski decided on May 20 to tell the nurses the very opposite of what she thought. She told the Commission that she assured the nurses on May 20 that the family cluster did not have SARS when she in fact believed they probably or maybe had SARS, and she set out in detail her reasons for telling the nurses the opposite of what she thought. Whatever one may make of her rationalization for her conduct, this regrettable incident suggests that this hard-working, compassionate and overwhelmed physician laboured at the time under a measure of internal conflict and perhaps an element of confusion about her role and her accountability that made it difficult for her to communicate accurately and directly at all times what was in her mind. Dr. Mederski’s ability to talk herself into telling the nurses something she thought was wrong is a further reason to prefer the evidence of the Public Health witnesses when it conflicts with that of Dr. Mederski.

There is another reason to prefer the evidence of the Public Health witnesses: the greater plausibility of their evidence with regard to its harmony with the undisputed facts and surrounding circumstances at the time.⁷⁴⁰

It is implausible that Toronto Public Health, concerned about the A family cluster, following them closely and looking closely for any evidence or reasonable suspicion of SARS, would ignore or fail to record any suggestion by Dr. Mederski that she suspected that any family member had SARS. It is implausible that Toronto Public Health, at a time when they were actively investigating many cases to see if there was evidence of SARS, would give Dr. Mederski a blanket assurance that SARS was gone and that she need not be concerned about suspicious cases.

Because of the advantages enjoyed by the Public Health witnesses over Dr. Mederski in respect of contemporaneous records and the systems that support the accuracy of their current recollection, and because of the inherently greater probability associated with the recollection of the Public Health witnesses, and because of the often tentative nature of Dr. Mederski's recollection and the other difficulties with her evidence noted above, the recollection of the Public Health witnesses is preferable to the attempts of this hard-working, compassionate and overwhelmed physician to reconstruct and recall what was said during a period of enormous personal stress.

There is no evidence that Dr. Mederski or anyone at North York General withheld information from front-line staff for any improper purpose. Both Dr. Mederski and the authorities thought that the patients in question posed no risk to others because they were isolated and handled with precautions although not diagnosed as SARS cases.

The evidence reviewed above does, however, disclose serious systemic failures.

Having accepted the evidence of the Public Health witnesses in preference to the evidence of Dr. Mederski for the above reasons, the finding of fact follows that there was a breakdown in communications at Dr. Mederski's end between North York General and Toronto Public Health in respect of the A family cluster and the O family and the evidence of the re-emergence of SARS at North York General Hospital in May. There was no system to supervise Dr. Mederski and ensure effective

740. As a great judge once said,

The most satisfactory judicial test of truth lies in its harmony or lack of harmony with the preponderance of probabilities disclosed by the facts and circumstances in the conditions of the particular case.

R. v. Pressley (1948), 94 C.C.C. 29 per O'Halloran J.A. at p. 34.

communication between the hospital and Toronto Public Health with respect to the growing evidence that SARS had returned.

Dr. Keith Rose, Vice-President, North York General Hospital, when asked about Dr. Mederski's supervision, said this:

Question: To whom was Dr. Mederski accountable?

Dr. Rose: To whom at the hospital?

Question: Yes.

Dr. Rose: First there was the Chief of Medicine, Dr. David Baron, and then through the Chair of the MAC [Medical Advisory Committee] and then through the Board. From a medical practice, medical quality.

Question: Who was her supervisor?

Dr. Rose: That is difficult to say. Dr. Baron, indirectly, but he wasn't in infectious specialities, so his supervisory capacity would be limited, so he may not be able to assess her medical quality of care, he could assess some other aspects of her practice.

Neither was there any system to ensure that the clinical judgment of the front-line physicians who strongly suspected SARS at the time was noted, received, analyzed, investigated and assessed in an organized fashion. In the absence of such a system, their crucially valuable evidence suggesting the return of SARS went into a black hole.

It is most regrettable that Dr. Mederski did not communicate to anyone in the hospital or to Public Health her concerns that the clusters of patients in May may have SARS and doubly regrettable that the accurate concerns of the nurses to the same effect were denied by Dr. Mederski and dismissed by hospital authorities.

The nurses who were present at the meeting on May 20 feel that the hospital did not listen to them, and the hospital feels that it did listen to them but simply happened to disagree with them. The difficulty with the hospital's position is that, unbeknownst to the hospital, Dr. Mederski agreed with the concerns of the nurses, as did a number of experienced front-line physicians whose suspicions and concerns never got past Dr. Mederski. There was no system of supervision or communication or support to ensure

that all the appropriate evidence, including Dr. Mederski's actual views and the views of the front-line physicians, were investigated, weighed in the balance with the perceptive and accurate concerns of the nurses, and then considered by someone other than Dr. Mederski, who at the material time bore almost single-handedly the overwhelming and unsupervised burden of decision making in relation to SARS diagnosis and investigation at North York General Hospital.

This topic cannot be left without a final word about Dr. Mederski.

Dr. Mederski carried a huge burden with very little support. She worked hard to the point of exhaustion and beyond, ill and under great personal stress. The hospital, especially in May, when it focused on its return to normal operations, relied on her entirely, with no system to supervise her or back her up. She was the hospital's sole gatekeeper for SARS in the sense that it was she and she alone who decided who went on the SARS ward and who did not and she had the sole effective say within the hospital as to who was diagnosed with SARS and who was not and the sole responsibility to communicate at a working level with public health. This was an enormous responsibility, an overwhelming responsibility for one person to bear.

Enough has been said above about Dr. Mederski's decision to reassure the hospital and the nurses on May 20 that the family clusters, which so alarmed the nurses and front-line physicians, did not have SARS when Dr. Mederski in fact thought they probably or maybe had SARS. Enough has been said about the reasons for preferring the evidence of the Toronto Public Health physicians to that of Dr. Mederski and enough has been said about the breakdown in communications at Dr. Mederski's end between Toronto Public Health and North York General Hospital.

To some at North York General, Dr. Mederski personified the problems associated with the second outbreak. To others she was the exemplar of a dedicated physician working impossibly long hours beyond the call of duty.

It was Dr. Mederski's misfortune to be saddled with enormous responsibility without an office, without dedicated time, without the support of a comprehensive surveillance programme and without the support of supervision and backup. To this was added a unique professional burden as the solitary gatekeeper, the only physician in the hospital authorized to make a formal SARS diagnosis and admit patients to the SARS ward. As noted earlier, the Naylor Report described her situation as an example of the general systemic weakness in Ontario of systems to prevent the spread of infectious diseases within hospitals:

Although infection control practitioners attempted to institute comprehensive surveillance programs in some hospitals, such a program alone requires approximately 2 full-time staff members for a 500-bed hospital, more than the majority of hospitals have on staff for all infection control tasks. At North York General Hospital, for example, one full-time and one part-time infection control practitioner were responsible for 425 acute care beds. The infection control director⁷⁴¹, Dr. Barbara Mederski, occupied the role without any salary, protected time, or even an office.⁷⁴²

Dr. Mederski was not a free agent. It would be too easy to make her the scapegoat for systemic failures in the prevailing provincial machinery of outbreak management. It is speculative whether someone else might have listened more carefully to the concerns of front-line doctors and nurses, whether someone else might have taken the evidence at North York General as an opportunity to investigate further and more systematically.

The problem at North York General, shared by other hospitals and the entire apparatus of outbreak management, was that there was no system to scrutinize the application of the case definition, to look into concerns that it might miss cases and to require immediate investigation of any credible evidence suggesting that undetected cases were spreading throughout the hospital. There was no system of surveillance to pick up the unusual number of deaths or the sick staff or the family clusters and thus trigger an immediate epidemiological investigation.

These things cannot be left to happen on their own. It is not enough to hope that someone in Dr. Mederski's position might sense the fact that something was wrong and might have the personal initiative and entrepreneurial drive to buck the system and insist that something further happen by way of investigation. Public safety from disease cannot be left to the accident of personal initiative. Public safety requires adequate systems. Public safety cannot depend on the unsupervised and unsupported private initiative of whoever happens to fill a particular job at a particular time. What is needed is a system to ensure that danger signs are picked up and promptly investigated. What is needed is a system to ensure effective supervision and communication under clear lines of authority and accountability within hospitals and between hospi-

741. In fact, although her role and responsibilities suggested that she occupied the role of the director of infection control, Dr. Mederski was not in charge of the program. She was an infectious disease specialist during SARS and, while her work as such involved overlap with infection control, she was not in charge of infection control. Dr. Mederski described her role as providing ad hoc, informal advice for infection control on an as-needed basis. She did not have dedicated office space, time or support and did not have supervisory authority over the infection control staff or their program.

742. Naylor Report, at p. 39.

tals and public health.

It would, as noted above, be unfair to scapegoat Dr. Mederski, a caring and conscientious physician who was overworked, unsupervised, overwhelmed, ill and unsupported by the kind of systems that should have been in place throughout the province. The second outbreak, as noted earlier, could have erupted at any other SARS hospital and it was the misfortune of North York General that it happened to strike there. The tragic mistakes and failures that led to the second outbreak were systemic, not personal to Dr. Mederski or to anyone at North York General Hospital. The task ahead is not to search for scapegoats but to improve the systems that defend us against infectious outbreaks and to ensure that this horrible tragedy does not happen again.

SARS Is Over

As noted above, the backdrop to the Patient A family cluster is that by the middle of May, 2003, the message in Toronto was that SARS was over. One North York General Hospital emergency room physician agreed that after the travel advisory was imposed and subsequently lifted, it seemed that the focus shifted away from looking for new SARS cases:

Question: Some doctors have suggested that there seemed to be a shift in the mindset of people after the WHO issued its travel advisory, that the focus went from finding SARS cases to trying to get rid of SARS. Any observations or thoughts on that? And not that it was a deliberate thing but it was always something that weighed at the back of people's minds.

Answer: I think I kind of share that feeling as well, because it is so financially damaging to the economy, probably not just to the city, but even to Canada. So I think the case definition kind of shifted to include less of those potential cases.

Another physician said that he thought that there was pressure to relax restrictions to get Toronto off the WHO travel advisory. He said it seemed that there was pressure to have SARS go away:

If you were aware of the media there was pressure because of the way it affected Toronto coming into the summer, to get Toronto off the WHO

travel advisory because of the, if you will, the political/economic effect it was going to have. There was this will to have SARS go away and be declared resolved. And the impression was that started at a public health/governmental level rather than within a particular hospital.

He said that he was not aware of any evidence of actual political pressure but that it seemed that it was there:

... a will, if you will, a general will in the community to have Toronto declared SARS free.

Another North York General physician said that in their view, the May 20 meeting was an attempt to convince staff that SARS was winding down:

My impression was that at the time the hospital was trying to reassure the emergency department that SARS was winding down.

As one North York General emergency room nurse said, she thought there was tremendous pressure to downplay SARS but that they should not have downplayed it with staff:

... there was a tremendous pressure on the politicians from the business community, or perceived pressure, to downplay the danger of SARS. But the danger was to downplay it to the staff who were looking after the patients. And to put the staff at risk. And to put all of the community at risk, because you're not containing it strictly.

None of the physicians, experts, provincial or public health officials interviewed by the Commission reported any pressure to not call a SARS case SARS. More will be said later in the report about the question of whether there was political interference during SARS.

But there clearly was a change after the travel advisory, a change that did not go unnoticed by front-line physicians who felt that the focus became more on convincing everyone that SARS was over and that the recovery of the city and of the economy was now the priority.

The problem was that no one could say that SARS was over or that SARS was gone. It was a disease that was still new and about which much remained unknown. With new cases being identified as under investigation in the city, cases that could not be

quickly ruled out as SARS, no one could say with any certainty that it was over. No one could say with any certainty that there were no new cases of SARS when the possibility remained that there might be unidentified cases.

The story of the second outbreak underscores the importance of being cautious in moving forward in the face of a new and unknown disease. It also showed a disconnect between front-line health care providers and the decision makers at higher levels. Those front-line physicians who did not believe SARS was gone, who continued to use protective equipment, who continued to see patients whom they thought were SARS, were not asked what they thought. In the face of new directives, a move to a “new normal,” the guard came down. And SARS came back.

Listening to Front-Line Health Workers

Emergency room staff had concerns about the family clusters that were coming through the emergency department in May. They did not believe, based on what they were seeing come through the emergency department doors, that SARS was gone. One emergency room physician recalled physicians’ overall frustration at how these cases were being handled and physicians’ disbelief in assertions that these patients did not have SARS:

The other situation that I wanted to bring up was what went on when we had that cluster of five on the May long weekend [May 17th to 19th]. All of us in the department were anxious and discussing what was going on and without a question, we felt that that family had SARS. And we were frustrated that the people that were admitting, looking after those patients were not taking the concerns of the staff seriously, or at least that’s what we felt. I heard the whole story from all the staff. I remember [the admitting physician] saying to me and others that if this isn’t SARS, then this is an incredible coincidence. She was the fifth member of that family.

Based on their own suspicions, concerns and beliefs, they were able to take matters into their own hands and continue to wear protective equipment and to continue to have a high level of suspicion for new SARS cases.

Front-line staff, including physicians, had serious concerns about these patients, so why didn’t hospital officials react to these concerns?

Dr. Rose said that he learned of concerns among emergency department staff on Tuesday, May 20, after he came back to the hospital following the long weekend. He

said that although he did not attend the May 20 meeting, it was his understanding that Public Health did not think these cases were SARS and he was aware that there would be a meeting with staff to discuss the cases later that day:

So, I knew the concern when I went to the hospital on the morning, Tuesday, May 20th, after the long weekend. I was in the emergency department. I talked to the assistant director because Tim [Dr. Rutledge] was signed out and there appeared to be a lot of confusion. Staff were wearing protective devices, despite my understanding that they stopped doing it the previous Friday. They were concerned about potential cases. I also had been told that Toronto Public Health investigated and there was a difference of opinion and that there wasn't a new alarm for SARS. The emerg director, the assistant, was looking for direction on what he should do. As the day unfolded, they had more conversations with Dr. Mederski and Public Health, and there was an agreement that there would be a meeting with the staff that night to discuss staff's concerns as well as the findings of Toronto Public Health and the issues around the weekend and this so-called cluster of people. As I said, I was not at that meeting.

Dr. Rose said that he understood that the patients were being treated in isolation with all the precautions but that at that time there were no alarm bells going off that this was a new SARS epidemic. He said that none of the front-line physicians approached him to say that they were wrong, that these cases were SARS. Dr. Rose said:

Question: I guess really the issue, the two issues in May, if people didn't speak to you about it, they didn't speak to you about it, but our information is that at the treatment level, at the level of admission and treatment, front-line health care workers are saying both with respect to psych patients and [Patient A], we thought it was SARS, it's going up the way it was supposed to. Dr. Mederski is involved along with Toronto Public Health and others and what's coming to you is the opinion that it is not SARS.

Dr. Rose: Correct, although we have pretty good relationship with our medical staff. We are available and visible. We did hold public meetings with the staff if they felt strongly, the medical staff I am talking about particularly, with their own chief of medicine, with me, our doors were

open for people to come and say, look things are bad, you have got your eyes closed, and they did not come to us and do that.

Dr. Rose said that there were other avenues of communication in addition to raising concerns with him or with other senior administrators, if they had concerns about outside opinions or about Dr. Mederski's opinions:

So we had another infectious disease specialist who people could have consulted with and said let's take a closer look. We had another sideline of communication through the Chief of Medicine. The Chief of Medicine was there. I talked to the Chief of Medicine on the 20th of May. We went through some of this. So even if those two things have been true, why weren't other sources used to raise the alarm bells? How sure were they of the diagnosis? In retrospect, yes the family of what appears to be many individuals, it all comes together very clearly now, but at the time ...

Whether it was uncertainty about the diagnosis, hesitation to speak out, a concern about being a voice of dissent among what to many seemed to be a consensus among outside experts, or even just individual personalities that were not of the type to approach senior officials or to second-guess a consult by an infectious disease expert, the opinions of front-line staff were not made clear to senior officials. One physician who was involved in these cases said that although he was worried, he did not approach senior management with his concerns because he felt that he had raised them with Dr. Mederski and she was the expert. He said that it was not his personality to push at higher levels and that because there was no test to say it was SARS, and because the patients did get better, he left it with Dr. Mederski. As he told the Commission:

I am that kind of person. I bring up my concerns and that is the end of it. I don't go up and beyond as some people otherwise would have done, you know, go to the higher levels and keep pushing. I have no evidence at that point in time that this is SARS either. There is no good diagnostic test. And they got better, that's the end of the issue.

Dr. Rose said that concerns of staff were heard:

Question: But there are those who would say their concerns about the [Patient A] family were ignored. Do you agree with that? Disagree with that?

Dr. Rose: I think the concerns were heard. The actions in retrospect were not. What were the best decisions? So you can listen to people, hear what they have to say, balance that with other information from other experts, then you make the decision. You do listen to them. You may not make the decision that they want you to make, but you do listen to it. I actually think that we handed you a copy of an email from [the nurse manager] from the emergency department following the first May 20th visit that was one of the first ones, who is actually pretty reassuring that she felt staff were heard. I will tell you I was personally out of the hospital on May 20th. I was [out of town] that night. Knowing that this was a problem, I was available. I came back to the hospital on the 21st. I actually took [a family member] to the emergency department on the 21st because he fell and cut his foot or something, and I was in the emergency for two or three hours waiting with [the family member]. I did not hear concerns expressed. I was there. I was available.

One physician, who was involved in the Patient A case, said that the problem was that the disease was so new and that no one knew how serious it was. He said he did not sense a huge disconnect between front-line staff and hospital administrators; rather, no one knew for certain what these cases were. He said:

Question: Some people have suggested and some of the doctors have suggested that one of the lessons from SARS is that there seemed to be a disconnect, if you will, between what the front-line doctors were seeing and some of the decisions that were being made. They said that that was a lesson learned from SARS?

Answer: I think it is difficult to say. It is a brand-new disease, so to speak. We never had that before, with no experience and we don't know how serious this illness is, potentially. So, again I think it comes down to human nature, how serious it is. I don't know. I don't have a strong sense of disconnect between administration and front-line workers.

The Commission accepts the evidence of senior hospital officials that they were not unwilling to listen to front-line doctors and that they sincerely believed that there were communication lines that were open between front-line staff and senior-level officials.

But the importance of strong systems of communication from those on the front lines to senior officials and those in charge of decision making about the SARS response cannot be overemphasized. It is not enough to hope that a physician will risk censure or ridicule should he or she raise an alarm. It is not enough to hope that a physician who goes to work, does his or her job, cares for patients and focuses on that will step outside that role to involve himself or herself in higher-level decisions. It is not enough to hope that colleagues will second-guess or raise concerns about decisions by other colleagues. Particularly in a case like SARS, where no one knew for certain if their opinion was right, it is not difficult to imagine that front-line physicians who had concerns, whether minor or great, would feel reluctant to voice them. Even Dr. Mederski, in her role as the infectious disease specialist in the hospital, did not have that level of comfort in the face of what she perceived to be a consensus among experts and in the face of previous criticism from outside experts that she could not diagnose SARS cases on the basis of clinical judgment alone.

SARS taught us that with a new disease, no one can claim to have all the answers. It is hard to say that someone is an “expert” on a disease that has been around for two months. There are no right and wrong opinions, and the perspective of those on the front lines must be brought to the table. They must be sought out, they must be encouraged to be voiced, and there must be no fear of consequences for speaking out. The dialogue must be open and free from fear of ridicule and censure.

Communicating with Front-Line Staff

In a case like SARS, a new disease with no quick, reliable diagnostic test, it is understandable that opinions may differ between front-line physicians. An emergency room physician thinking a patient had SARS while the infectious disease specialist thinks the patient did not is not an unusual event.

The problem was not so much that the opinions provided to staff that these patients were not SARS turned out in hindsight to be wrong or that there wasn't a consensus of opinions among physicians. The problem was that no one could give an absolute opinion about SARS: without a reliable test to prove SARS or not SARS with any degree of certainty, one physician's opinion could not completely rule out another. In

other words, there was no correct opinion; there were only differing opinions.

With a new disease, it is not unrealistic to think that the experts will not have all the answers. The problem is that no one acknowledged this uncertainty. No one acknowledged to staff that no one really knew anything for certain about SARS. No one acknowledged the possibility that staff concerns might be right. Even if hospital officials, those in charge of the SARS response, and Dr. Mederski did not feel it appropriate to voice their uncertainty in the public domain, the message to staff that these cases were not SARS, that SARS was over, displayed a confidence that no one could have. Without a quick, reliable test that could rule out SARS, no one could rule it out with any certainty. And in the face of concerns by front-line staff, among them nurses and doctors who had seen more than their share of SARS cases, the opinion that these patients were not SARS could not be put forward with any certainty or confidence.

Without acknowledgment of the possibility that staff concerns may be right, that no one had all the answers to SARS, that no one could rule out a case with any certainty in such a short period of time, many staff felt betrayed and angry when it turned out that the assurances to staff were, as we now know, false.

Not only did the emergency department staff know something was wrong, but word spread to other parts of the hospital. Staff outside emergency began to hear rumours about what was happening, adding to the level of fear, anxiety and mistrust in the hospital. As one nurse who worked on the SARS unit told the Commission:

I had heard rumours that there was problem. And that emerg nurse came up and brought me a patient one day, and she was isolated or whatever and she said, well, that's just the very beginning, because she said, the same people keep coming back and they're sicker each time.

Of those who did hear about the cluster of patients, many wondered why they weren't being told anything about these cases. Even though the psychiatric patients were not called SARS, staff were still told about them through the minutes and updates to staff. But there is no mention of the family cluster in the minutes of the SARS Management Committee, nor was there an update to staff about them.

As one nurse said:

I'm hoping that they've really learned this and I'm hoping they've really learned also that it is much, much more of a loss to the economy to have

to close a whole hospital than just being up front with the staff in the hospital and saying this is what we're dealing with, this is the line that is going out to the press, but we want you to know so you can protect yourself and protect the public and we want you to keep it quiet. It would have been far better, it would not have been such an insult to our intelligence. It would not have had the bad impact it's had on the nursing profession, on our feelings towards the profession. We're at a state now where we're pretty well desperate for staff already and it's going to get worse. 60 to 70 per cent of the nursing staff is aging staff. Within the next 10 years they're all going to be gone, and how are we going to attract young people to a profession that thought that we were so stupid we would follow that kind of party line. How can we recommend a profession to them where people are treated pretty well like, as far as I was concerned we were treated like disposable cannon fodder.

It is a lesson that North York General seems to have learned post-SARS. After the second outbreak, communication with staff changed to include a category of cases identified as "CRO": "can't rule out" SARS. To many staff, this signalled a major improvement and was a positive change post-SARS. As one North York General emergency department nurse told the Commission:

The big thing that's changed since then is, then you didn't have SARS until it was absolutely proven that you had SARS. Now it's, you've got SARS until we absolutely know you don't. And that's the one big, good thing that's come out of this.

The Commission finds no evidence that hospital officials, including those in charge of the SARS response, deliberately withheld information about the patients who were coming through the emergency department in May or that they lied about these patients. The Commission accepts that hospital officials sincerely believed that these cases were not a concern to public health officials and that they repeated that to front-line staff.

The Commission does find, however, that in conveying these messages and in communicating with staff, hospital officials, including those in charge of the SARS response, conveyed a confidence that we now know was misplaced. The Commission finds that the communication with staff, although well intended, was ineffective and failed to acknowledge legitimate concerns on the part of front-line staff, but rather dismissed them in the face of what was believed to be the opinion of outside experts.

Caution and Leadership in the Emergency Department

As noted earlier, precautions in the emergency department at North York General Hospital began to relax on May 16, 2003. This was consistent with provincial directives.

But the staff in the emergency department, uneasy about the admission through the emergency department of a number of patients who had a previous association with the hospital, such as the Patient A family cluster and Mr. O and his wife, were cautious about following hospital notices that advised them they no longer had to wear precautions at all times.

Front-line staff were told, on the one hand, that it was safe to remove protective equipment, that there were no new cases of SARS. On the other hand, they kept seeing patients coming in the emergency department, like the Patient A family cluster, whom they knew front-line physicians, whose opinions they respected and trusted, thought had SARS. They also saw these front-line physicians continuing to wear full personal protective equipment at all times. As one physician told the Commission, there were mixed messages that left some unsure how to proceed:

Later in May when we received recommendation that Code orange was being dropped ... we were told that we no longer needed to wear personal protective equipment and there was a big discussion, a lot of anxiety in the emerg regarding the decision to remove our personal protective equipment and we weren't sure what to do. There were differing opinions from different sources. There were faxes coming on an ongoing basis from the OMA, from the Ministry, we would read one thing and, the descriptions of what steps to take in personal protection were not always the same from the different agencies. We weren't even getting the same instruction from our infection disease people in our own hospital.

The one infectious disease consultant, Dr. Mederski, was telling us, take off your masks and don't worry, and I remember going up to Barb [Dr. Mederski], I think it was right after the long weekend and we had a cluster of five from the 19th to the 20th, and I said, Barb, tell me that I don't need to wear my mask and tell me why. And Barb went into this

whole dissertation about why it is not SARS and there is no epidemiologic link.

And then I go into the department to work and there is another doctor, who is our part-time infectious disease consultant, completely covered in a gown, mask and goggles ... there were nurses going back and forth deciding whether to wear it or not, I was deciding whether to wear it or not. Our two internists that worked in the emerg most of the time in those days were both walking around with masks and goggles on and here I am without my mask going, why am I listening to the hospital who's telling us to remove our masks?

Another emergency room physician described the varying use of equipment and said that he and other emergency room physicians encouraged staff to continue to use personal protective equipment because they were not convinced SARS was over:

It was a completely ludicrous sight. I'd be up on the 4th [floor] because I'd get called to put out a little medical fire here, I'd go up fully dressed, [another physician] if she was around, she was also fully dressed and we'd be on a ward, we'd have nurses walking around us completely in regular nursing uniforms and we'd be almost like Martians, completely out of context on these wards. And I spent a lot of time preaching to the ER nurses, where I spend most of my time and maybe on one or two occasions on the 4th floor, saying, I'm not convinced that this thing is over, I've admitted a few patients in the last few days, does it hurt to continue wearing this stuff for a few more days until we see where it goes?

Virtually nobody on the orthopedics floor heeded what I said. A lot of nurses in emerg did heed what I and [the other physician] said. They saw a lot of us frequently down there, in fact that's where we spend most of our shifts when we work and in fact several of the nurses continued to wear full uniform as long as they kept seeing us wearing full uniform. I'd say maybe two or three nurses on any shift were not protected, but something like seven or eight, the balance of the team, were always fully protected.

Another physician who consulted in the emergency department said that he continued to wear protective equipment throughout May, because he was paranoid that SARS was not over:

I suppose when SARS I kind of hit, so that's the outbreak at Scarborough Grace, everyone is suddenly very excited and very worried and what is it, how do we get this illness or what can we do to avoid having the illness? And I think for some time we were very vigilant about it, you know. Before seeing any patient, we would have gowned and gloved and washed our hands, before and after and things like that. And I suppose when that period was gone, around April or the first part of May, people kind of said, "okay so that's great, no more new cases, don't get too excited about it." I think that's the kind of general feeling I see in North York General Hospital, and I was the one who was kind of the paranoid, and I have been wearing an N95 mask even when I am not in patient care areas. And people sometimes joke about it, they laugh at me and say you don't want to be choked to death and suffocated, but I don't care, I just do my own stuff.

This physician said that he never had problems getting equipment and that he didn't recall a time when he wanted equipment and could not get it. When he was asked if he ever felt any pressure to remove the equipment, he said:

No, absolutely not. In fact, let's say that Dr. Baron made it clear that it was your own personal choice. Even if the directive comes out that now you can stop wearing the mask and if you choose to do it, be my guest, just do it, whatever you are comfortable with.

Although precautions were relaxed, emergency room staff were cautious and followed protocol guidelines to use protective equipment with all cases of respiratory illness. As noted above, some of the staff and physicians continued to wear equipment at all times.

One emergency room physician said that the fact that SARS wasn't spread in the emergency department before May 23 was a testament to staff's adherence to good infection control procedures and policies that were in place in the emergency department. He credited the leadership of Dr. Rutledge and other hospital executives for ensuring that the emergency department was as safe as possible:

Question: One of the interesting things is that it doesn't look as if anyone in emergency, physicians, nurses, others, got SARS after the relaxation of the precautions. Yet people in the rest of the hospital got it. Why did no one in emergency get it?

Answer: The patients who came into the hospital who may have transmitted SARS, in spite of exceptions to the rule, generally speaking had respiratory symptoms or fever. In spite of the existence of exceptions, we immediately put them in isolation as Tim [Dr. Rutledge] had ordered. We wore masks, full outfits, gloves, and washed our hands. I'm very upset and concerned about the nurses, but don't get the belief that the emergency department wasn't extremely carefully educated, that would be a false belief. Actually apart from what I pointed out, you know, that I wasn't thrilled about, apart from that, everything else was superb. The tabletops were cleaned all the time, we were taught time and time again not to take our fingers and touch our mouths and so forth.

What happened on the 4th floor was a little different. There was a patient who was a super-spreader. We know these viruses are found on tabletops in the hall, and all you have to do is touch a virus and touch your hands to your mouth a few times and you increase your likelihood of getting a disease. We didn't do that in emerg. The hand washing, the scrupulous cleaning of tabletops, the administration was really very careful about making sure we followed the intelligent practices of communicable diseases ...

Question: And to whom do you attribute that good leadership?

Answer: Oh, [Dr.] Tim Rutledge was great. Also Dr. Keith Rose and the hospital execs ... Those people with whom I didn't totally agree on a couple of items, on most items I agreed with totally. I have worked at [other hospitals] and I can tell you that the engineering, and the training, and the attention to all the details was absolutely superb, absolutely superb.

Another emergency room physician said that staff were diligent and strictly followed protocols. This physician said that it was a team effort, not only by nurses and doctors.

He described the important role that a woman from environmental services had as part of that team effort:

I was aware of it being an individual choice on my part but most people, when I say “most people,” nursing staff, were quite consistent that way. And I referred to it earlier, the emergency department in the time in March and into April, there were certain doors that were not the normal access point into the emergency department but patients used to be moved out through those doors on beds going to diagnostic imaging. But in fact they held to the protocols very strictly, but there was a woman who was in housekeeping, environmental services, who took it upon herself, she was wonderful that way, it didn’t matter who you were, if anybody tried to use that door or deviated from what the protocol was, and she always made sure the supplies were stored, clean, adequate, separated. And she’d be standing there and, it was never an issue in my circumstance, but there were some people that needed to have some direction as to, I mean from time to time, but she was probably the most effective form of maintaining accountability and enforceability of what the protocols were and she was there – the approach she took was tremendous. It’s that sort of an individual that can make the substantial difference. I think the nursing staff were aware that the protocols were in place for very good reasons and followed that.

This physician said that the nurses were also very diligent about ensuring that procedures and precautions were followed by visitors:

The nurses in the emergency were very consistent. There would be times where patients, if they were in a cubicle, any time in May, if you went into the emergency department, there would patients who, if they said, well, you should have a mask on, the patient says, but I don’t like this, and they take it off, but they [staff] would insist. They were very consistent.

And, importantly, front-line staff in the emergency department reported that they had the support of their nurse managers. As one nurse told the Commission:

Our manager was very vocal in saying that, they were talking about the isolation and the idea of isolation and the idea of only certain nurses wearing the garb. Because eventually they got beat down a little bit and

they said, fine, you can wear your garb, okay, we get it. But maybe only certain nurses can wear it in this certain section and then these other nurses can stay in the other section. And our manager was saying, you don't understand the way the emergency department works, it doesn't work that way. You've got nurses in and out of everywhere. If a group of nurses here are going to wear it then everybody's going to wear it, if you think that it might be necessary and so it's going to be all-or-nothing sort of thing down here.

Another nurse described the unique position of the emergency room staff in the hospital and how that position affected their insistence on wearing protective equipment:

Emergency nurses and physicians have a little more of a relationship so we kind of spearheaded amongst ourselves. We're a pretty strong group down there. I don't think anybody would have told us to take it off and you have to push very hard to get us to take it off.

Fortunately, because of their refusal to remove their protective equipment and because of their adherence to strict isolation precautions, the emergency room staff and the emergency room physicians who admitted the Patient A family cluster members in May did not contract SARS. Had they been less firm in their belief in precautions or less confident in their own professional instincts, it seems likely that SARS would have spread within the emergency department, infecting not only staff but other patients and visitors. The hospital and the community owe a debt of gratitude to the skill and dedication of these individuals who held their own and refused to believe what they were being told by hospital authorities. They personify the wisdom of the precautionary principle. And it is a testament to the leadership in the emergency department that the emergency room at North York General had an environment where intelligent, able health workers were able to think on their feet and make effective decisions to protect themselves, patients and visitors.

By May 20, 2003, staff in the emergency department at North York General were concerned that SARS was still around and that there were patients admitted to the hospital for whom SARS could not be ruled out. The same day that staff were meeting with Dr. Berall and Dr. Mederski to express concerns about these cases and to discuss the relaxation of precautions, St. John's Rehabilitation Hospital was reporting to Public Health that they had a cluster of respiratory illness among four

patients and a health worker. In the days that followed, as the St. Johns' Rehab cluster was investigated, the trail began to lead back to North York General Hospital. Emergency room staff would learn on May 23 that they were right: SARS had never left.