"We jumped in a taxi": Emergency Declared

Introduction

By March 24, it was apparent that SARS had spread further than anyone had initially imagined. Public health and government officials worried about the number of people who might be incubating the virus and feared the worst was yet to come.

Ontario was on the edge of crisis, or, more accurately, already over the edge. On March 24th, Health Minister Tony Clement passed a minister's regulation making SARS a communicable and virulent disease under the *Health Protection and Promotion Act*. This legally required hospitals, clinics and other health care institutions to report SARS cases. It also gave Public Health power to make orders in respect of SARS cases, including quarantine orders.

By March 25, Toronto Public Health (TPH) had the names of approximately 5,000 patients or staff who were possible contacts of SARS. Public Health faced the daunting task of contact tracing to determine who had been exposed to SARS and who was ill. A Toronto Public Health chronology of events, prepared after the SARS outbreak, described the situation at that time:

> The case load is increasing by eight to 10 patients per day. Local area hospitals are reporting patients in their emergency rooms with SARS symptoms. Many patients are health care workers from SGH [Scarborough Grace Hospital].
>
> TPH urges the provincial government to declare a Public Health Emergency given that SARS has now expanded beyond the boundaries of Toronto. TPH urges the implementation of severe control measures.[329]

329. Toronto Public Health Chronology, SARS I.

Young Takes the Initiative

It was on the initiative of Dr. Jim Young, then the Commissioner of Public Safety and Security, that Ontario declared the emergency. From this declaration flowed the jerry-built command structure and the stern measures that ultimately stopped SARS even without preparation and without proper systems. The road was very bumpy. Bad things happened that should never have happened, and the second outbreak was an unmitigated disaster. While Ontario's response was seriously flawed from lack of systems and preparation, it did in the end stop SARS. The wonder is not that it worked badly, but that it worked at all. Starting with nothing, in the face of a deadly new disease, an invisible enemy for which there was no diagnostic test and no knowledge of how it spread, this jerry-built apparatus somehow did stop SARS.[330]

One of Dr. Young's colleagues described for the Commission how the emergency came to be declared. Dr. Young was monitoring the situation through his network in the medical community and with Toronto Public Health. Both he and Toronto Public Health officials were concerned about how far the disease had spread and what was to come as more and more cases were identified. He concluded that there were "a lot of concerns and thought this may be a situation where it's time for a provincial emergency to be declared."

The official described what happened next:

> So then we jumped in a taxi and drove from here up to the health ministry, where [the then Chief Medical Officer of Health] Colin D'Cunha's office was, at Yonge and Finch.

Dr. D'Cunha agreed with Dr. Young that an emergency should be declared. Dr. Young, wasting no time on bureaucratic niceties or political manoeuvres, then went straight to the Minister of Health, the Honourable Tony Clement, and his Deputy, Phil Hassen:

330. In the beginning, nothing at all was known about SARS. It was a disease with no diagnostic criteria, symptoms uncertain, clinical course unknown, incubation period unknown, duration of infectivity unknown, virulence of infectivity unknown, method of transmission uncertain, means to prevent spread uncertain, effectiveness of protective measures unknown, attack rate unknown, death rate unknown, infectious agent unknown, origin unknown, no treatment, no vaccine, no prophylaxis, long-term effect unknown. As time went on, more became known, but most of SARS was a fight against an invisible and unknown enemy.

> So then we jumped in Colin's [Dr. D'Cunha's] car and came back downtown and went to see Tony Clement and the health deputy, Phil Hassen, and said, this is what we have in mind. And they agreed.

Dr. Young, having secured approval from the Minister and Ministry of Health, then raised the matter immediately with the Premier's Chief of Staff, Steve Pengelly, and then spoke to Premier Ernie Eves:

> He then spoke to Eves who was out in Brampton, I think, and Eves agreed.

Paperwork was done and faxed to the premier in Brampton.

> The paperwork was done up here, we faxed it over to the premier's office, they faxed it out to Brampton, he signed it. It was all done in about three and a half hours.

This aspect of SARS worked well. The emergency declaration was quick and decisive without miscommunication or turf wars. It reflected good communication, good cooperation between government departments and timely, decisive action at the public service and political levels. To bring on board within three and a half hours the Ministry of Health and the Deputy Minister of Health and the Chief Medical Officer of Health, plus the political commitment of the Minister of Health and the Premier, was a remarkable achievement that reflects well on everyone involved.

It is a tribute to Dr. Young, Premier Eves, and Minister Clement that the declaration of emergency necessary to cope with SARS was made in such a timely fashion with no bureaucratic or political delay. It is a particular tribute to the Premier and Minister of Health that they acted immediately on the professional advice of Dr. Young without thought to political considerations.

The declaration resulted from good cooperation and mutual trust between senior public servants like Dr. Young and political leaders like Mr. Clement and Mr. Eves and from a good division of political and public service roles. The Premier and the Minister of Health, without involving the political apparatus associated with major government decisions, accepted from Dr. Young politically independent public service advice to declare the emergency. The Premier and the Minister then provided public and political leadership to back up the advice given to them by the permanent nonpolitical public servants.

Part of this success had to do with the unique role of Dr. Young. As Chief Coroner, he was well respected throughout the medical and hospital community. This medical respect provided the credibility vital for a public health emergency manager. His emergency management credibility came from his track record during a number of emergencies, including the 1998 ice storm, and from his public safety achievements in working with coroners, forensic laboratories and police services.

Emergency managers cannot simply give orders. They have to secure the cooperation and support of many people over whom they have no authority: their political masters, other levels of government, independent organizations like hospitals, medical associations, nurses' unions. This is even more so in a public health crisis like SARS. Independent professionals like doctors and nurses and independent organizations like Ontario's hospitals do not respond well to military or police-like leadership. The essence of a public health emergency manager is not so much the ability to give the right orders as the ability to bring people on side and secure cooperation from those whose trust and support is vital.

It was a fortunate that someone with Dr. Young's unique skills happened to be the Director of Emergency Management when SARS struck Ontario. His unusual combination of medical and emergency expertise turned out to be tailor-made for the SARS crisis. But effective emergency management cannot depend on the happy accident that a manager with unique skills and credibility happens to be in charge when disaster strikes.

Because it is unlikely that the next public health crisis will see anyone with Dr. Young's unique skills in the emergency seat, it is all the more important to ensure the right structure and lines of authority, especially the paramountcy of the Chief Medical Officer of Health. Emergency management requires not only the right person in charge but also the right support systems and machinery. Above all it requires clear lines of authority and a clear understanding of who is in charge.

Unfortunately, this was not the case during SARS. The system of divided authority between Dr. Young and Dr. D'Cunha did not always work well. It was sometimes unclear who was in charge. This created serious problems noted in the Commission's first interim report.

Although the lines of authority will be somewhat more clear in the next public health emergency, important work remains to fix the problem of who is in charge. It must be clear that in any medical emergency, the person in charge is the Chief Medical Officer of Health, to whom everyone else, including the Director of Emergency

Management, should defer.

The government, as recommended by the Commission, has given the Chief Medical Officer of Health a measure of independent authority to ensure that medical decisions are insulated from political considerations. The government, however, has not yet implemented the Commission's further recommendation to clarify the roles of the Chief Medical Officer of Health and of the Director of Emergency Management and to ensure that the Chief Medical Officer of Health is in charge. It is essential that medical decisions be made by the Chief Medical Officer of Health and essential that the Emergency Management Director and the emergency management apparatus are there to assist but do not elbow their way into decisions on infectious outbreak management. To leave this recommendation unimplemented is to invite in the next outbreak a repetition of the problems that hampered Ontario's response to SARS.

Grim Situation

The Naylor Report described the grim picture of growing cases before the emergency was declared:

> By March 25th, 2003, Health Canada was reporting 19 cases of SARS in Canada – 18 in Ontario and the single case in Vancouver. But 48 patients with a presumptive diagnosis of SARS had in fact been admitted to hospital by the end of that day. Many more individuals were starting to feel symptoms, and would subsequently be identified as SARS. Epidemic curves later showed that this period was the peak of the outbreak. On March 19, nine Canadians developed "probable" SARS, the highest single-day total. Taking "suspect" and "probable" cases together, March 25 to 27 are the highest three-day period in the outbreak.[331]

Dr. Young often used a forest-fire analogy to describe going into battle against SARS:

> You have to get ahead of the fire so you fly over it and figure out how big it is, where it's going and how fast, and you build barriers in the right places to stop it. After SARS was identified and we learned something about it, we realized that the people who were sick had been infected more than a week before, so the picture we had was already 10 days old.

331. Naylor Report, p. 27-28.

> That's when we asked the Premier to sign a Declaration of Emergency.[332]

The April 2-3 minutes of the Science Committee reveal the seriousness of the situation and the need for a strong centralized response:

> JY detailed past events – lack of recognition of the severity of the outbreak for some time, local response measures inadequate initially, lack of epidemiology to provide the science for the best decision-making, lack of coordinated effort provincially and federally with the city until a few days ago. POC [the Provincial Operations Centre] opened one week ago and MOH [the Ministry of Health] now has taken the lead. Shortly after a provincial health emergency was called[333].

When Premier Eves signed the emergency order on March 26th, it was the first declaration of a public health emergency in the history of Ontario. The declaration was done pursuant to the authority granted to the Premier under the *Emergency Management Act*.[334] Under the *Act*, the declaration of emergency gave the Premier power to direct and control local governments and facilities. It gave government officials the power to direct hospitals and other health care providers.[335]

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332. *Getting Ahead of the Fire*, http://www.networkedgovernment.ca/AheadoftheFireBain

333. April 2–3Minutes of the Ontario Scientific Advisory Committee, 2003.

334. Section 7. (1) of the *Emergency Management Act* said:

> Declaration of emergency
>
> (1) The Premier of Ontario may declare that an emergency exists throughout Ontario or in any part thereof and may take such action and make such orders as he or she considers necessary and are not contrary to law to implement the emergency plans formulated under section 6 or 8 and to protect property and the health, safety and welfare of the inhabitants of the emergency area. R.S.O. 1990, c. E.9, s. 7 (1).

335. See sections 7 (2), (3), (4) and (5) of the *Act*:

> Power of Premier
>
> (2) For the purposes of subsection (1), the Premier of Ontario may exercise any power or perform any duty conferred upon a minister of the Crown or a Crown employee by or under an Act of the Legislature. R.S.O. 1990, c. E.9, s. 7 (2).
>
> Emergency powers

Premier Eves recalled for the Commission the reasons why he decided to accede to Minister Clement's advice and declare the provincial emergency:

> I can't remember the exact words but the message communicated to me was that we would probably want to do this, because we'd want to prevent it from spreading throughout the community and that we would be better to err on the side of caution as opposed to the other way, and so we responded.

When asked if he would make the same decision to declare the provincial emergency, Minister Clement said:

> Question: Again, in hindsight, would this kind of situation necessarily have to be a provincial emergency. Would you declare it again or could you see a way of managing it outside of that, that particular box and all that comes with that?
>
> Mr. Clement: Well, it's a difficult question to answer because in hindsight there were 44 deaths and a lot of very sick people, but remember what we knew at the time, which was not a heck of a lot. This thing could have been airborne, it

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(3) Where a declaration is made under subsection (1) and the emergency area or any part thereof is within the jurisdiction of a municipality, the Premier of Ontario may, where he or she considers it necessary, direct and control the administration, facilities and equipment of the municipality to ensure the provision of necessary services in the emergency area, and, without restricting the generality of the foregoing, the exercise by the municipality of its powers and duties in the emergency area, whether under an emergency plan or otherwise, is subject to the direction and control of the Premier. R.S.O. 1990, c. E.9, s. 7 (3).

Assistance

(4) The Premier of Ontario may require any municipality to provide such assistance as he or she considers necessary to an emergency area or any part thereof that is not within the jurisdiction of the municipality, and may direct and control the provision of such assistance, and the Lieutenant Governor in Council may authorize the payment of the cost thereof out of the Consolidated Revenue Fund. R.S.O. 1990, c. E.9, s. 7 (4).

Premier may designate minister

(5) Where the Premier of Ontario makes a declaration under subsection (1), he or she may designate a minister of the Crown to exercise the powers conferred on the Premier by subsections (1), (2), (3) and (4). R.S.O. 1990, c. E.9, s. 7 (5).

> could have been spread by air as far as we knew, and so based on the information that we had at the time, it was the right thing to do.

As Minister Clement noted, the decision to declare or not to declare a provincial emergency is a difficult one.

Experts and public health officials truly had no idea of the actual magnitude of the outbreak. When the provincial emergency was declared, the outbreak was rapidly spinning out of control as the number of contacts grew in leaps and bounds and the number of ill continued to climb.

It also worth noting that there was no alternative to a provincial emergency. The Chief Medical Officer of Health and local medical officers of health lacked the power to manage the outbreak. As noted in the Commission's second interim report, their power was limited to section 22 of the *Health Protection and Promotion Act*, which dealt primarily with orders against individuals.

The Commission observed that without strong day-to-day powers, the only recourse for public health officials in times of outbreak may be the greater extraordinary powers that come with the declaration of an emergency. Even with greater day-to-day powers, a declaration of a provincial emergency in a public health crisis might still be warranted, as it was in SARS. With stronger day-to-day powers, a lesser crisis could be managed without a declaration of emergency. Stronger day-to-day powers give the government more flexibility and more choices for a graduated response than the present all-or-nothing emergency system.

The Code Orange Order

Once the provincial emergency was declared, the Ministry of Health and Long-Term Care ordered that all hospitals in the Greater Toronto Area[336] and Simcoe County[337] activate their Code Orange emergency plan. The March 29 directive to all GTA/Simcoe County acute care hospitals provided as follows:

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336. The Greater Toronto Area was defined as including "geographic area of jurisdiction of the City of Toronto and the four surrounding regional municipalities of Durham, Halton, Peel and York." (Directives to GTA/Simcoe County Acute Care Hospitals, March 29, 2003).
337. Simcoe County included the City of Barrie and surrounding county (Directives to GTA /Simcoe County Acute Care Hospitals, March 29, 2003).

> In order to contain the spread of SARS (severe acute respiratory syndrome) the Ontario Ministry of Health and Long-Term Care advises that all hospitals in the GTA and Simcoe county must undertake the following procedures **effective immediately**:
>
> 1. Initiate full **CODE ORANGE** emergency response plans.[338]

Code Orange, the external disaster code, meant that hospital disaster plans kicked in. Visitors were restricted, non-essential visits by hospital staff were suspended, visits by volunteers were suspended and overall access to hospitals was restricted. Elective surgeries were suspended as hospitals operated essential services only.[339]

The March 29 directive required that hospitals establish isolation units for potential SARS cases, establish around-the-clock infection control coverage and implement the use of personal protective equipment for staff, including the use of fitted N95 respirators, an issue discussed in the Aftermath section of this report. Patient transfers between hospitals were also restricted: they had to be recommended by the infection control practitioner, approved by the Provincial Operations Centre and managed by the infection control practitioner.[340]

The province-wide Code Orange paralyzed the health care system. On April 1, in a directive issued to all acute care facilities, hospitals outside the GTA or Simcoe County were to "be prepared to implement Code Orange if directed by the Commissioner of Public Security and the Commissioner of Public Health." Although this did not officially put hospitals outside the GTA and Simcoe County on Code Orange status, the directives that followed in the document were directed to "all acute care facilities." Those directives so closely resembled the Code Orange that it was, practically speaking, the same thing.

Some argued that broadening Code Orange beyond the GTA was unnecessary and problematic:

> The issuing of the Code Orange directive at the end of March spun the health care system into a province-wide shutdown mode. It was quite clear to all involved that this was a Greater Toronto Area-based issue.

338. Directives to all GTA/Simcoe County Acute Care Hospitals, March 29, 2003.
339. Ministry of Health and Long-Term Care Fact Sheet, March 2003.
340. Directives to all GTA/Simcoe County Acute Care Hospitals, March 29, 2003.

> But although heightened vigilance would have been more than adequate for outside the GTA, a province-wide directive was issued, with no consideration of patient access or continuity of care.

But government officials pointed out that the need to stay ahead of the invisible outbreak required very strong initial measures. One government official described the need for a strong response:

> The decision was made that we needed to invoke measures and in order to do so and get ahead. My belief was we needed very bold steps. We had to do much more vigorous things than anyone thought we needed to do in order to jump ahead. That meant closing the system down for period of time while we figure out a way to safely transfer, while we educate people as using SARS as a diagnosis of exclusion. Only way to do that was to stop elective surgery, limit movement, etc. For all we knew when declared emergency SARS could have been in every hospital in Ontario. Turned out it was in five to six. We had to wait a week to 10 days to wait to see where it was. We did put patients at risk and we knew that. It was the lesser of two evils. If we waited we could have ended up one by one with each hospital down. We knew it was infecting large numbers of health care workers at that point as well. We also know that we close office around Christmas every year and we manage quite well because it suits us at that time so there was a buffer in the system.

One of the problems with Code Orange was the confusion over what it meant and to whom it applied. On April 3, the Ministry of Health and Long-Term Care had to issue a press release to clarify the previously issued directives:

> Toronto – Today officials from the Ontario Ministry of Health and Long-Term Care clarified SARS (Severe Acute Respiratory Syndrome) directives for all hospitals outside the GTA.
>
> Effective immediately, hospitals outside the GTA are to reinstate all surgical services, including elective, urgent and emergent surgery. To the extent possible, all out-patient clinics are to reopen, following both universal infection control precautions and SARS screening tool protocol.[341]

341. "SARS Clarification: Hospitals outside GTA should continue elective services," Ontario media notice, April 3, 2003.

In hindsight, many in the hospital system question whether Code Orange was appropriate for infectious disease outbreaks. In a thoughtful submission, the Ontario Medical Association made the following observations:

> The move to "code orange" was a critical juncture in the fight against SARS; however, the resultant impact on services was large – what were the pros and cons of this approach, are there better models that could be used in the future?
>
> Pro: Use of code orange was a useful tool to raise awareness in the hospital sector of the emergent and serious nature of this outbreak. It necessitates a comprehensive response and got attention of hospitals; it is, however, very drastic, very resource intensive and does not specifically address the needs to respond to an infectious disease outbreak. Need to develop outbreak specific code that can be used in hospitals to respond effectively to a large-scale infectious disease outbreak in their community.
>
> Con: We really need an outbreak specific "code orange" that covers the actions surrounding an outbreak.

Whether Code Orange was justified and appropriate, no one can dispute that it came at a high cost for many who were ill and for many whose family and friends were ill. Their stories will be told later in the report.

One thing is clear: experts and government officials never intended the Code Orange status to last long. Minutes of the April 2, 2003, Epi and Science Group Committee included a debate as to when the Code Orange status would be lifted in the GTA. On April 3, the Science Committee recommended that hospitals be considered for lifting of the Code Orange status on an individual basis, provided they have the following in place:

> Screening using the SARS assessment tool as per the Acute Care Directives;
>
> No evidence of transmission within the hospital under consideration OR spread by that hospital to another facility for the ten day period following identification of the last SARS case;
>
> Effective on-site infection control (i.e., minimum of 1 FTE trained infection control practitioner per 250 beds as per current CDC guidelines)

> No admission of known suspect or probable SARS cases and immediate transfer of newly identified cases to a designated SARS hospital.[342]

But the lifting of the Code Orange status depended on the identification of SARS hospitals. As early as April 3, the Science Committee noted that "the establishment of SARS hospital(s) is critical in minimizing transmission in the institutional setting. All patients with probable SARS who require admission should be sent to the designated SARS hospitals." This remained a roadblock for the lifting of Code Orange. As the Science Committee noted in its April 4 minutes:

> As stated yesterday, this [Code Orange status] is posing major hardship from the hospitals. The key impediment to lifting the Code Orange is the SARS hospital. However, we still must not limit SARS cases comparing into many hospitals. Wording was suggested to not specify a SARS hospital but to limit the cases going to numerous hospitals, however, it was emphasized that outbreak principles must be adhered. The document [the Draft Recommendation on Conditions for Lifting the Code Orange Status] was redrafted and sent to POC Executive at 1100[343].

The designation of "SARS hospitals" did not occur until the second outbreak. On May 27, government officials announced that the establishment of four SARS Alliance hospitals. More will be said about this later in the report.

The Code Orange status was not revoked until May 14.

342. April 3, 2003, Minutes of the Ontario Scientific Advisory Committee.
343. April 4, 2003, Minutes of the Ontario Scientific Advisory Committee.