13 Essential Questions

Introduction

SARS raised serious questions. Thirteen of the most important ones are addressed here. Some answers are terribly clear. Were health workers adequately protected? Clearly not. Other answers are less obvious. Could SARS II have been prevented? If so, how? This section will summarize these answers as they emerge from the Commission's evidence and findings.

It is too easy after a public health crisis to assign individual blame. This is not to say in hindsight that mistakes were not made or that systems should not be blamed. But honest mistakes are inevitable in any human system. There is always more than enough blame to go around if good faith mistakes made in the fog of crisis are counted in hindsight as blameworthy.

The approach of this Commission as set out in its mandate and as reflected in its approach is not to apportion blame but to find out what happened, to figure out how to fix the problems revealed by SARS, to learn from these tragedies and to give a legacy of betterment to those who died, those who fell ill, those who suffered so much and those who fought it with such courage.

1. Why Does SARS Matter Today?

It is fair to ask, in respect of this final report, after so many reports and investigations, the Naylor Report and the Walker Report and the Commission's 2004 and 2005 interim reports, so what? What is gained now by telling in detail the story of SARS?

Why does SARS matter today, more than three years after the event, after the government and the media have moved on to other crises, after those who suffered from SARS have moved on as best as they can?

After every disaster like SARS the years recede and memories fade. There is always pain that has been forgotten, and things we choose not to recall. If we forget the suffering and courage seen in the SARS crisis we diminish the sacrifices of Tecla Lin, Nelia Laroza, Dr. Nestor Yanga and all those who died and those who suffered. Their suffering and courage should not be in vain.

We must remember SARS because it holds lessons we must learn to protect ourselves against future outbreaks, including a global influenza pandemic predicted by so many scientists. If we do not learn from SARS and we do not make the government fix the problems that remain, we will pay a terrible price in the next pandemic.

2. How Bad Was SARS?

The numbers, that 375 people contracted SARS and 44 died, do not tell the complete story of how bad SARS was. They do not reflect the unspeakable losses of families affected by SARS. They do not reflect the systemic failures that permitted these deaths and illnesses.

SARS had Ontario's health system on the edge of a complete breakdown. The wonder is not that the health system worked so badly during SARS, but that it worked at all. SARS also badly hurt Ontario's international reputation, setting up an unfortunate link in the minds of many in other countries between Toronto and a mysterious deadly disease.

Worst of all, SARS demonstrated how many earlier wake-up calls had been ignored, and how few of their warnings had been heeded. Many of the fault lines that appeared during SARS were identified by earlier investigations and commissions, notably the Krever Inquiry into tainted blood and the O'Connor Inquiry into tainted water.

SARS may be the last wake-up call we get before the next major outbreak of infection, whether it turns out to be an influenza pandemic or some other health crisis. That is why we cannot forget how bad SARS was, and how much terrible suffering and loss we must avoid the next time around. The tragedy of SARS, these stories of unbearable loss and systemic failure, give the public every reason to keep the government's feet to the fire in order to complete the initiatives already undertaken to make us safer from infectious disease.

3. What Went Right?

Despite its deep flaws, the system was supported by people of extraordinary commitment. What pulled us through was the hard work and the courage of those who stepped up and fought SARS. What went right in a system where so much went wrong is their dedication in the midst of chaos and enormous workload pressures. It was a tireless fight in the fog of battle against a deadly and mysterious disease. We should be humbled by their efforts.

SARS produced so many heroes that it is impossible to identify them all and no attempt has been made to do so. Some happen to be mentioned in this report when their names are essential to the narrative.

One hero was the public, which rose magnificently to meet the challenge. Any fight against infectious disease depends above all on public cooperation. SARS could not have been contained in Toronto without the tremendous public cooperation and without the individual sacrifice of those who were quarantined. It is essential to ensure that the spirit of cooperation shown during SARS is not taken for granted. It must be nurtured and promoted.

4. What Went Wrong?

SARS took hold because of a confluence of systemic weaknesses in worker safety, infection control and public health. The Commission's first interim report identified 21 deep systemic flaws in public health infrastructure. The second interim report identified serious shortcomings in health protection and emergency management laws. This final report identifies further areas of unresolved problems, particularly in the domain of health worker safety. Because of these systemic weaknesses, SARS was a disaster waiting to happen.

The public health system was broken, neglected, inadequate and dysfunctional. It was unprepared, fragmented, uncoordinated. It lacked adequate resources, was professionally impoverished and was generally incapable of fulfilling its mandate.

Ontario was not prepared for a public health crisis like SARS. It didn't even have a pandemic plan.

There was a grave lack of worker safety expertise, resources and awareness in the health system, a lack whose impact was compounded by a similar lack of infection control expertise and resources. Not only that, but infection control and worker safety operated as two solitudes, and public health and hospitals operated as separate silos. And the Ministry of Labour was sidelined.

Also missing were two key components of a safe workplace: Neither internal responsibility systems nor joint health and safety committees were, in general, fulfilling their intended roles and responsibilities.

The trust of health workers in the ability of government, safety laws, and their employers to safeguard them and their colleagues was broken. Health workers learned that those in charge were poorly informed and inadequately advised to make pronouncements on worker safety and personal protective equipment. A prime example was the lack of awareness throughout the health and hospital system of the legal requirement for respirator fit testing.

5. Were Precautions Relaxed Too Soon?

In May 2003, the government implemented a series of measures that led to the relaxation of precautions on May 13 and to the lifting of the provincial emergency four days later. But SARS had not gone away. How could victory over SARS have been declared when it was spreading undetected at North York General Hospital? Were precautions relaxed too soon?

Knowing when to announce the "all clear" is very difficult. There were similar instances during the Spanish flu pandemic of 1918–1919, when victory was declared too early. Decision makers are in a tough spot during a public health emergency. React too early in a preventive mode and they may be accused of having generated another "swine flu" problem. Lift precautions too early and they may be accused of recklessness and bowing to political pressure.

There is no easy answer to the question of whether precautions were lifted too soon. In hindsight it turned out to be a mistake because as soon as precautions were relaxed the SARS cases simmering undetected at North York General flared up into the second outbreak. But the decision was made at the time in good faith on the best medical advice available and after two incubation periods with no new detected cases did it appear appropriate to relax the precautions and institute the "new normal" with precaution levels higher than they were before SARS.

As noted in the report, one of the underlying reasons for the second outbreak was the lack of any system to ensure surveillance of the kind that would have detected the North York General cases before they spread. Although the relaxation of precautions triggered the second outbreak, its more underlying cause has more to do with the lack of systems to ensure adequate surveillance.

6. Who Is There to Blame?

No one. The evidence throws up no scapegoats. This will disappoint those who seek someone to blame.

It is too easy to seek out scapegoats. The blame game begins after every public tragedy. While those who look for blame will always find it, honest mistakes are inevitable in any human system. There is always more than enough blame to go around if good faith mistakes made in the heat of battle are counted in hindsight as blameworthy.

More important than blame is to find out what happened, to figure out how to fix the problems, to learn something from these tragedies, to give a legacy of betterment to those who died and those who fell ill and those who suffered so much.

This was a system failure. We were all part of it because we get the public health system and the hospital system we deserve. We get the emergency management system we deserve and we get the pandemic preparedness we deserve. The lack of preparation against infectious disease, the decline of public health, the failure of systems that should protect nurses and paramedics and doctors and all health workers from infection at work, all these declines and failures went on through three successive governments of different political stripes. We all failed ourselves, and we should all be ashamed because we did not insist that these governments protect us better.

It is also hard to find blame because blame requires accountability. Accountability was so blurred during SARS that it is difficult even now to figure out exactly who was in charge of what. Accountability means that when something goes wrong you know who to look for and you know where to find them. That kind of accountability was missing during SARS and remains blurred even today. What we need is a system with clear lines of authority and accountability to prepare us better for the next infectious outbreak.

7. Was Information Withheld?

There is no evidence that information was deliberately withheld. But there is much evidence of serious communication failure.

Bad communication is a steel thread throughout the story of SARS. Poor communication exacerbated a confusing and terrible time. This happened again and again. In February and early March 2003, health workers in Ontario, unlike their colleagues in B.C., were not alerted to the emergence of a mysterious new disease in China and Hong Kong. Until mid-May 2003, directives failed to remind employers of their worker safety legal obligations. And over and over when new hospital outbreaks were detected, there were inordinate delays before all workers who might have been exposed were contacted.

Bad communication between governments and agencies and hospitals is evidenced in many cases throughout this report. Although a real effort was made by government and public health to give the public timely and accurate information, performance was mixed. In some instances public communication was excellent, as in the work of Dr. Sheela Basrur, the Chief Medical Officer of Health for Toronto. In some instances, like the disastrous May 23 press conference, public communication was like a train wreck.

8. Did Politics Intrude?

The Commission finds on the basis of the evidence and analysis set out in this chapter that there was no political or economic pressure brought to bear on the health system or public health or hospitals in order to minimize or hide SARS or to say that a SARS case was not SARS or to declare prematurely that SARS was over.

9. Was SARS I Preventable?

There is an element of speculation in any attempt to say whether a disaster could have been prevented by this measure or that measure. History is full of what-ifs. Like every other historical what-if, there is an element of speculation in any attempt to say whether the SARS disaster could have been prevented, by earlier isolation and investigation, by a differently configured emergency room, by different infection control procedures, worker safety precautions or training or alertness.

The short answer is no, SARS I was not preventable. No country escaped SARS entirely. Vancouver certainly did better than Toronto. Although the presentation of the index cases was much different in each case, there are enough similarities to warrant comparison in terms of preparedness and worker safety systems. There was undoubtedly an element of good fortune that saved Vancouver from the devastation that SARS wrought on Ontario. But it must also be said that Vancouver made its own luck with better preparedness and systemic strengths.

It cannot be proven that SARS I could have been prevented if Ontario's systemic weaknesses in preparedness, surveillance, worker safety, infection control and public health had been adequately addressed before SARS. It is likely that SARS I could have been contained more quickly and with less damage had the right systems been in place in Ontario.

In B.C., even if the province was luckier than Ontario in the presentation of its index case, SARS was, nonetheless, more effectively contained in a jurisdiction with better preparation and more robust and more collaborative worker safety, infection control and public health systems.

British Columbia provides a useful example of how well things can work and how well health workers can be protected when there is a strong safety culture. It provides an example of how things can and should work in Ontario.

10. Was SARS II Preventable?

We will never know if SARS II could have been prevented.

What can be said, for the reasons set out below, is that the opportunity was greater to prevent SARS II than to prevent SARS I, and that SARS II could have been caught earlier and its impact lessened had the right systems been in place.

First, as a mostly nosocomial outbreak, SARS spread primarily within the contained space of health workplaces. Unlike a flu pandemic, it did not spread uncontrollably in the community. Second, it spread precisely in the kind of workplaces that should be optimally prepared to protect patients, visitors and workers from infectious diseases. Third, it occurred more than two months after Mr. T presented at Scarborough Grace Hospital. It is one thing to be caught off guard, as Ontario was, at the start of SARS. It is another to have failed to learn enough over a two-month period to prevent a major recurrence.

The problem was that these factors, which should have made it easier to prevent and control SARS II, were undermined by the many systemic flaws revealed by SARS, including insufficient surveillance, inadequate infection control expertise and resources, a lack of worker safety resources and expertise, blurred accountability, and inadequate communication systems between hospitals and public health.

11. Were Health Workers Adequately Protected?

The answer is no. It is tragically clear that health workers were not adequately protected. This is demonstrated by the heavy burden of disease on hospital workers, paramedics and others who worked in Ontario's health system during SARS. Two nurses and a doctor died from SARS. Other health workers fell ill, including paramedics, medical technicians and cleaners, and many of them unknowingly infected their families. Almost half of those who contracted SARS were health workers who got it on the job. It would have been one thing if all had been infected at the start of the outbreak when little was known about the disease. The full extent of worker safety failings during SARS is revealed by the fact that workers continued to get sick in April and up to the end of May, long after the Scarborough Grace outbreak.

Table 1 – Probable and Suspect SARS Cases Contracted in Health Care Settings[1016]

Category	Phase 1	Phase 2	Total Number of Suspect and Probable Cases	Percentage of Total Number of Cases (375)
Health Workers	118	51	169	45%
Patients	23	35	58	15%
Visitors	20	23	43	11%
Total	161	109	270	72%

Many factors contributed to this. There was a lack of worker safety resources and expertise in the health system heading into SARS. The health system generally did not understand its obligations under worker safety laws and regulations. There was a lack of understanding of occupational safety as a discipline separate from infection control. Infection control and occupational safety operated as two solitudes. The Ministry of Labour was largely sidelined during SARS; its ability to play a greater

1016. Presentation of Dr. Colin D'Cunha, SARS Commission Public Hearings, Sept. 29, 2003.

enforcement and regulatory role as required by law to protect workers had been seriously undermined by funding and resource cuts in the 1990s.

12. Are We Safer Now?

The short answer is yes, somewhat safer. The long answer that we are not yet as safe as we should be.

The Commission's first interim report, in April 2004, addressed the deep problems of public health infrastructure in Ontario and what must be done to make us safer. The Commission's second interim report, in April 2005, addressed glaring deficiencies in Ontario's health protection and emergency response laws and what must be done to correct them.

Although the Ontario government and individual hospitals have taken significant steps to improve our level of protection from infectious outbreaks such as SARS, serious problems persist. Much remains to be done. What has been accomplished thus far, though commendable, marks the beginning of the end of the effort to fix the problems revealed by SARS. The end will not be reached until Ontario has a health system with robust and collaborative infection control, worker safety and public health functions.

As the Commission's second interim report said:

> After long periods of neglect, inadequate resources and poor leadership, it will take years of sustained funding and resources to correct the damage.[1017]

13. What Must Be Done?

SARS revealed a broad range of systemic failures: the lack of preparation against infectious disease outbreaks, the decline of public health, the failure of systems that should protect nurses and paramedics and others from infection at work, the inade-

1017. SARS Commission, second interim report, p. 297.

quacy of infection control programs to protect patients and visitors to health facilities, and the blurred lines of authority and accountability.

SARS taught us lessons that can help us redeem our failures. These lessons are reflected in the Commission's recommendations for change.

Perhaps the most important lesson of SARS is the importance of the precautionary principle. SARS demonstrated over and over the importance of the principle that we cannot wait for scientific certainty before we take reasonable steps to reduce risk. This principle should be adopted as a guiding principle throughout Ontario's health, public health and worker safety systems.

If we do not learn this and other lessons of SARS, and if we do not make present governments fix the problems that remain, we will leave a bitter legacy for those who died, those who fell ill and those who suffered so much. And we will pay a terrible price in the face of future outbreaks of virulent disease, whether in the form of foreseen outbreaks like flu pandemics or unforeseen ones, as SARS was.

SARS taught us that we must be ready for the unseen. SARS taught us that new microbial threats like SARS have happened and can happen again. And it gave us a first-hand glimpse of the even greater devastation a flu pandemic could create.

There is no longer any excuse for governments and hospitals to be caught off guard, no longer any excuse for health workers not to have available the maximum reasonable level of protection through appropriate equipment and training, and no longer any excuse for patients and visitors not to be protected by effective infection control practices.

As the Commission warned in its first interim report:

> Ontario … slept through many wake-up calls. Again and again the systemic flaws were pointed out, again and again the very problems that emerged during SARS were predicted, again and again the warnings were ignored.
>
> The Ontario government has a clear choice. If it has the necessary political will, it can make the financial investment and the long-term commitment to reform that is required to bring our public health protection against infectious disease up to a reasonable standard. If it lacks the necessary political will, it can tinker with the system, make a token

> investment, and then wait for the death, sickness, suffering and economic disaster that will come with the next outbreak of disease.
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> The strength of the government's political will can be measured in the months ahead by its actions and its long-term commitments.[1018]

1018. SARS Commission, first interim report, p. 210.