[redacted]hwfb.gov.hk, 11:56 AM 6/26/2003 +0800, written submission

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Subject: written submission
Cc:
Bcc:
Attached:

Dear Secretariat of the SARS expert committee,

Thank you for inviting me to give a written submission to the committee. Here are some preliminary thoughts which hopefully can contribute to the discussion and review.

1. Known infectious diseases are unlikely to pose a major threat because the behaviour of the disease is already well studied and the government is usually prepared. What has led to the present disaster is that we are facing a previously unknown emerging infectious disease. The first lession is on how we should face the unknown.

2. The only way to gain the upper hand on unknowns is to know it very well before it strikes HKSAR. From now on, the DH (or the new HK CDC) should send field officers to attach to investigative teams in China in any unusal outbreaks(and perhaps other parts of the world) so that they can gain the first hand information of what is happening. These information are sent back to HK by the web so that analysis and formulation of preventive strategy can be done before the epidemic is coming. Such an approach may entail a structural change of DH so as to enhance its flexibility and capability when they are facing unknowns or epidemics of unprecedented scale. This is a fundamental change of mind set.

3. The essence of such an approach is start the process of INTERCEPTION while the disease is still OUTSIDE HK because HKSAR is an ultra-densely populated part of Southern China which in turn has a huge population of human and animals living closely together. The same applies to HA clinicians who will formulate diagnostic and treatment strategy before the disease arrives in HKSAR.

4. The second lession is the strategic position of the hospital as an amplification premise for the SARS and perhaps any other contagious emerging infectious diseases which is serious enough to warrant hospitalisation. The infection control has failed in many HA hospitals which results in massive outbreaks amongst health care workers and patients who subsequently spilled back into the community. Just one patient going into Amoy Garden has produced a historically unprecedented form of outbreak of SARS. In other words, the hospital is the Normandy where any epidemics may land in the coming years. The culture of meticulous infection control must be rooted in all health care workers.

5. Since this Amoy disaster may have been prevented if the hospital infection control is tightend up and the contact tracing process is speedy enough, A detailed investigation into the administration, the infection control processes such as the requiremetns for closure of wards, the architectural design of the HA hospital wards and the adequacy of the staff training should be undertaken. This will identify all the lapses at different levels and will serve to improve hospital infection control of HA. Similarly the speed and accuracy of contact tracing of DH must be reviewed to determine how we could have done better.

6. The third lession is the need for effective communication to both health care workers and the public. During outbreaks involving health care workers, doctors treating their own colleagues are in great

distress and emotional. What they say to the mass media may no longer be based on scientific facts and could be quite inflammable, to the extent that it seriously undermines the creditability of the government, the executive and directors of HA and DH. Similarly, the public start to panic when they saw doctors and nurses coming down with the illness.

7. For the health care workers, teams of experts for rapid response must be sent to any HA hospitals with outbreaks involving health care workers so that objective assessment of the outbreak, sharing of views and discussion with the in charge doctors and nurses, and "conjoint" press conference could be done. This will allow the release of information to the public in an appropriate manner. This will minimise the release of unfounded claims and recommendations which hinder the control of the epidemic, provoke emotions and undermine the creditability of the executives.

Below are some of the details which may worth furthur discussion by the relevant parties of HA:

c. Lectures and practices of infection control are largely ignored in undergraduate days of doctors and nurses. Hand hygiene and other isolation procedures are seldom fully complied. Thus MRSA, ESBL and other multiply resistant bugs are rapidly disseminating in hospitals. **Rebuilding the culture of absolute compliance to infection control measures are top priority: a matter of life and death.** Such a message has to be sent to every health care worker everyday at the start of every shift in the manner of almost a religious ritual. You just do not know which patient is carrying it.

d. To be pragmatic in the practice of hand hygiene, a bottle of **Hibisol(alcoholic based handrub) must be put in permanent holder at every bed table(ward) or consultation table(OPD).** All health care workers must use it to rub their hands after patient contact without soiling. Handwashing is a must if soiling has occurred or the staff feels so. If it is possible at all, all health care workers should have a shower before going home. The shoes and clothing are changed.

e.. A risk assessment form for SARS/contagious respiratory diseases(eg. travel to China, health care worker, elderly people's home, contact with patients with pneumonia, recent visits to hospitals....temperature, myalgia, diarrhea, CXR...) must be filled before ALL admissions at AED/ OPD by experienced nurses and cross-checked by medical officers. This will serve as the basis for admission to triage isolation rooms, triage cubicle of different specialties or the SARS ward. For uncertain cases, they should be seen by senior physicians for decisions.

f. All those with some risk for SARS cohorted in "non- internal medicine specialties cubicles" are monitored daily by senior staff. These cubicles must practise an all-in all-out strategy.

g. Anyone who developed pneumonia after hospitalisation must be isolated or cohorted till considered free of SARS.

h. Anyone who developed hospital acquired fever must be assessed by senior doctors to decide on the need for isolation or cohorting and the workup for SARS.

Thus all febrile or atypical(diarrheal) patients should be checked at designated cubicles for adult or children. Whereas for the elderlies with other acute events, the possibility of afebrile SARS must be borne in mind.

f. All febrile patients undergoing triage should preferably be nursed in single (or double) isolation rooms with self contained toilet/washing facilities so as to prevent cross infection between triaged patients. The rooms should be monitored by CCTV, oximetry and ECG visible at nursing station. In fact all