專責委員會(2)文件編號 : H35

SC2 Paper No. : H35

(Translation)

Hong Kong Chinese Civil Servants' Association

# Effective Protection: The Key to the Battle Against SARS

--Comments and Recommendations on Hong Kong's Anti-SARS Battle

Hong Kong Chinese Civil Servants' Association

(HKCCSA)

In association with

Nurses Branch, HKCCSA, Enrolled Nurses Branch, HKCCSA

and

Hong Kong Nurses General Union

30 June 2003

Revised

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# 1. Introduction

1.1 The World Health Organisation (WHO) has now not only lifted its travel advisory against Hong Kong, but also removed the territory from its list of SARS-affected areas. This is hard to come by and only made possible with the determination of the HKSAR Government to combat SARS (albeit a bit late or vacillating), by mobilizing massive resources and manpower in collaboration of various sectors in the community. Hong Kong has paid a high price for it —— SARS has claimed 298 lives and inflicted heavy economic losses on us amounting to tens of billions of Hong Kong dollars.

1.2 The Chief Executive, the Secretary for Health, Welfare and Food, the Chairman and Chief Executive of the Hospital Authority (HA), the management of public hospitals, the frontline health care workers and indeed tens of thousands of civil servants from various departments have frantically been engaged in the stubborn fight against SARS since its outbreak in mid-March 2003. They all have exerted themselves to fight the battle.

1.3 On 23 March 2003, at the peak of the outbreak, the Hong Kong Chinese Civil Servants' Association (HKCCSA) together with three nurses unions published an open statement entitled "Two Appeals and Seven Recommendations", in which we expressed our hope that the outbreak could be brought under control as soon as possible and a review of the experiences and lessons learnt be carried out at an appropriate time (Please refer to Annex I). Now it is high time to do so.

1.4 We believe that we should sum up, as appropriate, the experiences, both positive and negative, drawn in the early to intermediate periods of the outbreak, in particular, from early this year. Only then will we be able to build on our success,

overcome our fear, shore up our confidence in fighting the disease, put in place effective measures to prevent future outbreaks and do justice to the 1,755 people infected with the virus, especially the 298 patients and the eight health workers who lost their lives in the battle.

1.5 In achieving this goal, we need to be thorough, objective, frank, scientific, rational and courageous. We should not try to conceal the truth or gloss over wrongs, neither should we claim the credit for ourselves but put the blame on others. It is also inappropriate to be nit-picking, cashing in on the opportunity to air one's grievances or resentment and pan-politicize the issue.

1.6 We hope that the investigation and review this time will show us the way ahead in handling similar crisis in future and finding the right remedy.

## 2. Lesson: A Fall into the Pit, A Gain in Your Wit

2.1 Today, the people of Hong Kong can proudly proclaim that Hong Kong has now put in place a relatively complete set of policies and measures to govern the handling of SARS, both at the government and community levels. We have significantly enhanced our awareness of the risk and prevention of infection, heightened the importance of infection control and environmental and personal hygiene, improved and perfected the measures and facilities to carry out barrier nursing, prevented cross-infection, and attached greater importance to contact tracing. We have even given thought to other specific arrangements such as hospitalization visits by introducing video telephone service (Note 1).

2.2 However, could we be this proud back in March and April?

2.3 Hong Kong was caught off guard and took a stumble despite its self-assurance in respect of a sound health care system, hospital facilities and medical provisions that are modernised and compare favourably with our neighbours. The disease spread rapidly and a large number of health care workers came down with it! (The infection rate was once over 20%. Most of those infected were frontline nurses.)

2.4 In retrospect, the last few months were full of fright and horror. Hong Kong was handed a big and profound lesson.

2.5 We believe the lesson lies mainly in the following areas.

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Note 1: Princess Margaret Hospital (PMH) is the first hospital providing Video Visit Service in Hong Kong.

**(A) Lessons Learned from the Exchange of information on SARS**

2.6 There was an outbreak of SARS in the neighbouring Guangdong Province in January 2003 and the peak was in February. In view of what happened between February and April in Hong Kong (Please refer to Illustration 1), it is obvious that Hong Kong was not completely in the dark then regarding the exchange of information on SARS between Guangdong and Hong Kong as well as our internal flow of information:

- Although no formal mechanism had been set up between the two places, Guangdong did informally report the outbreak to Hong Kong (See item B of the explanatory notes on Illustration 1);

- Certainly the top echelon of the SAR Government was busy addressing some internal problems such as the fiscal deficits and the civil servants' pay cut. But local health authorities and some members of the medical profession (including university professors and senior doctors from public hospitals) were accessible to the major incidents that were unfurling or had already taken place in Guangdong and they were on the alert, and some of them had even had some contacts with the Guangdong authorities (See items C, D, E and F of the explanatory notes);

- Local electronic and printed media carried wide coverage of the epidemic in Guangdong around early and mid-February (See item D of the explanatory notes);

- In mid-March 2003, local media also carried wide coverage of the outbreak of the infectious disease in Prince of Wales Hospital (PWH) and a number of

hospitals subsequently came down with the disease but it seemed that other hospitals still failed to take note and be on full alert;

2.7 Hong Kong got wind of the disease but still paid scant attention to this highly infectious disease. We had no knowledge of its clinical features and syndromes, diagnosis, prevention and treatments, its transmission chain and relevant scientific research about the disease, and its seriousness and outbreak. Neither did we take the initiative to approach the Guangdong Provincial Government to know more about their situation. Even when it came to the stage where outbreaks were reported in some local hospitals, other hospitals still did not bother to find out more about what was going on. The local hospitals were indeed ignorant of this disease. (Note 2)

- The whole community in Hong Kong, from top officials in the government and Hospital Authority to professionals (including university professors, senior medical officers and those who claimed themselves as experts of infection control), as well as various political parties, legislative councillors,

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Note 2: There seemed to be a blockage of information exchange between the various parties mentioned below not only in Guangdong and Hong Kong, but also within the territory. For example there was an outbreak of SARS in PWH from 8 March 2003 to 10 March 2003. Yet in a letter dated 13 March from Dr. Fung Hong, Cluster Chief Executive (New Territories East) to the hospital staff, he had not linked the local outbreak of the infectious disease with Guangdong's Atypical Pneumonia which had wide coverage in local press a month ago. The blockage of information flow was also found in the following:

- between the health authorities(Policy Bureaux and Department of Health) in HKSAR;
- between the health authorities and the Hospital Authority, private hospitals and elderly homes;
- between Department of Health(DH), its offices and clinics;
- between HA and the clusters;
- between the clusters;
- between hospitals within one cluster;
- between departments within one hospital;
- between clinical departments, front-line staff and wards;
- between the universities(including their medical schools and microbiology faculties)

people from different sectors, and the man in the street, had not become vigilant against the outbreak and reacted slowly. They were not aware of the outbreak and took no action, or even they knew the outbreak, they did not take any prompt action. (Honestly, these people included office bearers of health care workers' unions.)

2.8 The results were:

- The Guangdong authorities' knowledge of SARS, their experience and the painful lessons learnt in the fight against SARS had not commanded serious and keen attention of the local health authorities, HA and the health care professionals;

- Some of the local medical professionals including university professor and senior doctors etc. had contacted the Guangdong authorities or were aware of and alert to the epidemic in the neighbouring areas. However, it seemed that they failed to spur the health authorities, HA and frontline staff in February 2003 to exercise vigilance;

- The Kwong Wah Hospital (KWH) failed to share experience they gained from their blunder in the way they treated "AA" [redacted] of Guangzhou Zhongshan Medical University with other hospitals, nor did the hospital sound an alarm to alert the authorities concerned, other hospitals as well as health care professionals;

- PWH failed to contain the spread of the epidemic promptly and on the spot within the hospital at the first instance. It was beyond imagination that other hospitals, including those within the same cluster, e.g. Tai Po Nethersole

Hospital, and United Christian Hospital, PMH, Tuen Mun Hospital (TMH) etc. did not learn from this painful lesson;

- The local health authorities did not have sufficient knowledge of the epidemic in Guangdong Province, including the details on how the disease was brought "under control". They also underestimated the gravity of the problem such as the outbreak in PWH. They were hence unable to make early, comprehensive and effective arrangements for the disease, including the hesitancy to take the drastic decision of closing down PWH;

- The senior management of HA and the relevant authorities of the hospitals were not vigilant enough of the infection within the hospitals under their charge or their own hospitals and underestimated the spread of the disease and the number of patients to be infected.

2.9 Hence, the serious consequences were: the spread of the disease in Hong Kong became out of control and the whole city was thrown into a state of panic.

**(B) Lessons Learned from the Use of Barrier Nursing Measures and Equipments**

2.10 The key to the effective control of infectious disease is prevention and treatment. Prevention, which includes containing the spread of infectious disease and breaking the transmission chain as early as possible, should be put on the top of the agenda. This is a crucial point. In hindsight, something had gone awry in the fight against SARS during the early and intermediate stages. During these crucial stages, barrier nursing measures were not taken promptly and decisively while necessary facilities were not supplied timely and adequately, failing to seize the opportunity to put SARS under control.

**Problem 1: PWH had failed to take strict barrier nursing measures promptly**

2.11 On 4 March 2003, a 26-year-old male staff of an airline company was admitted to Ward 8A of PWH. He was later pinpointed as the index patient infecting PWH. In a short period of 4 to 6 days, he infected quite a number of health care personnel and visitors, including a pastor. Although since 10 March 2003, PWH had taken infection control measures such as advising its staff to wash hands and wear N95 face masks (In the beginning, they were instructed to change masks once a month. Later, they were advised to wear protective gowns —— even though on a one-gown-for-one-shift basis the gowns were still in short supply), the hospital, however, did not take prompt action to shut down the wards or the whole floor, and the wards were as overcrowded as usual. During that period, there was once a patient being transferred from one ward to another to receive renal dialysis treatment (It later came to light that he was the index patient of the "SARS-affected block" at Amoy Gardens.). The management had been advised by nursing staff with professional knowledge in barrier nursing to bar visitors immediately but to no avail. Visitors (many of them were families and colleagues of the health care personnel) were allowed to leave without restriction and go to other wards and departments of the hospital, or the community.

2.12 It came to our knowledge that SARS patients were admitted to a number of hospitals, including Tai Po Nethersole Hospital, PMH, TMH etc., yet these hospitals did not ban or restrict visits of inpatients, nor take any strict isolation measures at the early stage of the outbreak.

2.13 Since medical officers in-charge were not aware of or simply did not realize the necessity of barrier nursing, they had not taken any strict barrier nursing measures at the early stage. Likewise, as the Government had too many reservations about

shutting down the relevant hospital, the decision to close down the hospital came quite late. The immediate results of the inaction were: in the short period from 8 to 15 March 2003, SARS spread rapidly and infected at least 189 people, including 7 people from the index patient's families and friends, 73 health care workers and medical students, 50 patients in the same ward of the index patient and their families (Note[3]). As it turned out, SARS had begun to spread in the community before the relevant hospital put forward its shutdown proposal.

**Problem 2 : Responding to and fighting SARS hastily and in panic**

2.14 Almost all public hospitals were caught off guard and reacted hastily the disease at the early and intermediate stages. Nearly all relevant wards were allowed only one or two days to convert into high-risk SARS wards. Some wards, such as the ward to which the deceased Mr. LAU Wing-kai and Dr TSE Yuen-man, a nurse and a doctor of Tuen Mun Hospital respectively were deployed, moved ordinary patients to make room for SARS patients in a single day. The beds added to ICU were also arranged in this manner.

2.15 Meanwhile, medical wards of these hospitals posted nurses, health care assistants or cleaners nearly on a daily basis as a makeshift measure to the new SARS wards to take care of the SARS patients or be responsible for the cleaning work. Each of them was required to do one or two shifts at most, like playing musical chairs. At the beginning, staff in some wards available to posting to SARS wards were "weak and old", or junior nurses. They did not have enough clinical experience, not to mention the management experience of the wards. Regarding staff to patient ratio,

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Note 3: See a briefing by Dr. S.F.Lui, Service Director (Risk Management and Quality Assurance), NTE Cluster in the "Guangdong/Hong Kong Experience Sharing Conference on Prevention of SARS" held on 3 May 2003.

no consideration was given to the need to strictly practise barrier nursing. Many medical wards that did not handle SARS patients or other wards put up resistance to having their staff posted to SARS wards. It then led to a situation where there was manpower shortage in some wards while in other wards there was sufficient manpower. It was very unfair. GM (N) in the hospital had no authority to transfer nurses from one clinical department to another department. This situation remained unchanged until one to two weeks later. Even the situation had become stabilized, the disinfection of the wards was carried out in a great haste, not much time was given to vacate SARS patients, paying scant attention to the predicament front-line nurses were in.

2.16 Take one hospital as an example : it became the first hospital designated to receive specifically SARS patients on 26 March 2003 and the first batch of SARS patients were admitted three days later. The hospital did not receive many patients at the early stage (from 6-17 March 2003), with only 14 patients at that time, they could handle them with ease. However at the intermediate stage (18-27 March), when a total of 86 patients were admitted, the hospital started to feel the pressure. (See Chart 1 and Chart 2).

2.17 The hospital only opened one more SARS ward at the end of the early stage (also hastily), and three more wards at the intermediate stage. In an attempt to accommodate a large number of patients, 12 general wards were converted into high risk SARS wards (excluding the three ICU wards opened as a makeshift measure) within a span of six days in the peak period.

2.18 At the same time, the number of infected health care workers started to rise. Although the infection rate varied from one hospital to another, most of the health

care workers in the public hospitals were simultaneously infected in these makeshift SARS wards made available in a great haste (See Chart 4), including Mr. Lau Wing Kai and Dr Tse Yuen Man mentioned in paragraph 2.13. This was no coincidence!

2.19 As in the case of public hospitals, no adequate preparation time was given to the designated clinics under DH responsible for tracking the SARS patients and those who had come into contact with them.

**Problem 3: Untimely and insufficient provision of protective equipments**

2.20 As early as 15 February, some hospitals had already reminded ward staff to, among others, report admission of SARS patients, prevent droplet infection and put on personal protectvie equipments (PPEs) such as surgical masks, gloves and protective gowns (See item F of the explanatory notes on Illustration 1). However, at that time the hospitals neither provided specific guidelines to the staff nor took the initiative to supply well in advance the PPEs to the wards. However there were some exceptional cases. In some special workplaces like the ICU of PWH and infectious disease wards of PMH (because they have experience in receiving and treating bird flu patients), staff were already provided with N95 masks and the situation there was better.

2.21 Notwithstanding the alarms raised in Guangdong Province and PWH (in late February and early March), and despite the fact that hospitals were later fully aware of the need to receive and treat SARS patients and had even knowledge of the extremely virulent and the infectious nature of the virus, many hospitals still failed to provide in time PPEs such as surgical masks and N95 masks for their staff. In the meantime, there were problems related to the provision of outfits such as, the sizes of masks were far from complete and often out of stock, thus driving lots of

frontline workers to air their complaints to the media. As for the other PPEs like eye shields and face screens, they were not made available until at a later stage (even some ICUs were no exception). The provision of such PPEs were not balanced in the hospitals, with some having a sufficient supply in relative terms (e.g. university hospitals) while others imposing use restrictions and quota allocation, spawning fear and grievances among frontline workers. Many wards were not provided with such PPEs until late March and short supply was reported as late as mid-April. The four designated surveillance centres under DH also faced the same problem of acute shortage and late supply of PPEs.

2.22 Although frontline workers were working in a harsh environment and staff handling extremely risky procedures (e.g. mucous extraction and endotracheal intubation, etc.) were supposed to be provided with better PPEs, they could not have the gears until a later stage and the supply was also meagre. There was neither any explanation nor demonstration of their proper use. As for the supply of other more user-friendly and enhanced PPEs (See Illustration 2), they were still restricted to a few workplaces (e.g. ICU of PWH) and not open to all!

**Problem 4: Chaotic practices**

2.23 Even at the peak of the epidemic, instances of chaotic practices of barrier nursing measures still abounded, for example:

(1) Policies regarding admission and allocation of beds were not clearly defined and announced:

— How should patients with and without fever in the A&E departments or the wards be segregated for observation?

- Should confirmed and suspected patients be segregated for treatment?

- If isolation wards were full, or no such wards at all with only open wards available, how should the two categories of patients be segregated effectively to avoid cross-infection?

- If a ward was cohorted by all confirmed patients and there was only one single empty bed, how would a suspected patient be admitted?

(2) Demarcation between clean and dirty zones:

Should semi-contaminated areas be designated as a buffer?

- How to solve the problem of PPEs which were relatively expensive and short in supply being locked in dirty zones (inside the wards) because proper storage was not possible in clean zones (communal areas outside the wards)?

- Would the movement with shoes without shoe covers between clean and dirty zones run counter to the idea of demarcation and lead to cross-infection?

(3) Other examples of chaotic cases:

- Some hospitals set a limit on the number of beds in SARS ward at 28, permitting a wider bedspace. Individual wards in the same hospital still catered for 36 beds in case additional beds are required to deal with urgent cases. There were also other hospitals which officially set the number of beds in the SARS ward at 36.

- Once a health care worker was found to have contracted SARS, it was important to find out as soon as possible the cause, background and environmental factors related to the infection to safeguard other colleagues from infection. However, the method of investigation and the tracing of persons who had been in contact with infected patients varied from one hospitals to another, and the questionnaires designed by the infection control units of some hospitals were too simple and general to serve the purpose.

- Confusion in reporting confirmed SARS cases

  - The format of the reports and the information to be provided were changing all the time. This generated much inconvenience to frontline medical workers.

  - In making the reports, many hospitals failed to give a clear definition of what constituted a "confirmed" case at the initial and intermediate stages of the outbreak and even during the early days of the peak period. Neither was there any instruction as to when the report should be made:

    - Once ribavirin was used for treatment?
    - To wait till the microbiological test results were ready?
    - After the consent of the attending doctor had been given?
    - After the senior doctor/consultant had confirmed the case?
    - When it was time to fill out the relevant report form?

- One hospital relieved their phlebotmists responsible for blood taking of such duties in the wards for fear of SARS infection but assigned the job to the nurses.

- HA's newsletter "Battling SARS Update" called on its health care workers to take a shower immediately when they suspected themselves of being infected with the virus. It however virtually turned a blind eye to the fact that most workplaces did not have shower facilities. HKCCSA, in association with several nurses unions publicly appealed to HA as early as April 10 for the prompt provision of additional changing rooms, shower facilities and wash-hand basins in the wards (see Annex I) to no avail, though the idea being technically feasible.

- In the case of Hong Kong's largest psychiatric hospital :

  - No specific measures were adopted in this hospital at early stage notwithstanding that its health care workers were admitted to the hospital as confirmed SARS victims after contacting SARS patients in March 2003 and there were cases where patients had been admitted to SARS wards.

  - The Hospital had taken no isolation measures in its admission wards until suspected cases were reported in Woodbridge Hospital, a psychiatric centre in Singapore (at that time people queried why local psychiatric hospital did not subject its newly admitted patients to isolation).

- One Ward, which had already accommodated 93 patients, was required to introduce isolation measures and to receive new patients. At the same time, the ward was required to transfer patients to other wards. Yet the hospital did not give the ward any instructions and assistance.

- According to standing instructions, there should be a bedspace of 3 feet. But in one ward with a total of 100 beds and bedspace in general measured only 6 inches. In some cases, beds were put together side by side with no space at all. (Some other wards of the hospital were also required to accommodate more beds, and this practically turned the 3 feet bedspace requirement into an "empty talk.")

- How could isolation be possible for a ward with only one toilet to serve 100 patients? The hospital had failed to come up with any solution to this problem.

  - At the peak of the outbreak, the Consultant of the Student Health Service Centre, DH, suddenly required reports to be made to the Nursing Officer when a student was found to have fever and other SARS symptoms. The centre would immediately take the student's temperature as well as his/her parents'. The student would then be diagnosed by the centre's doctor. This was a deviation from the past practice when the patient would be transferred to government general out-patient services. However, these

centres could not spare an appropriate isolation room complete with a wash-hand basin and exhaust fan for students and parents with a temperature. As a result, the operation of these centres had to suspend occasionally for disinfection.

- Nurses from DH could not have access to any shower to clean up before going home.

- The surveillance centre under DH was responsible for taking secretion samples from patients' upper respiratory tract for laboratory test. But the room designed for taking, and temporarily storing, these samples did not have one single exhaust fan. The staff had pointed this out to the senior management but the latter did nothing about it. Some staff did put forward their views on ways to improve these facilities, but their suggestions fell on deaf ears. Senior management seemed to have no sense of crisis at all.

**(C)Lessons concerning manpower resources and deployment**

2.24 Experience showed that ICU support was of paramount importance in the fight against SARS. However, the huge number of infected nurses highlighted the shortage of ICU personnel in various hospitals. Although PMH, for instance, had already deployed nurses by batches to receive ICU training well before the outbreak of SARS, such nurses were still small in number. When the problem came to a crisis scale with a large number of nurses infected, especially when three more ICU

wards had to be opened on top of the original one, the hospital had no alternative but to deploy nurses without relevant training to ICU in order to maintain the critical services.

2.25 Barrier nursing and measures for the prevention of cross infection must be strictly implemented in wards such as ICU or other SARS wards. However, it was almost not until now did public hospitals realize that an absolute majority of healthcare staff, the junior ones in particular, had neither the knowledge nor skills required in this area. The same was true in ward management (Chiefs of Service and Consultants were no exception). As a result, these officers were at a loss when it came to making decisions on matters such as the opening and closing of wards and the movement arrangements. In addition, there were frequent changes of instructions from the management. Frontline workers found this very confusing.

2.26 With regard to deployment such as in the case of nurses, nearly every public hospital had encountered difficulties and serious obstacles at the outset. The main reason was that the General Manager (Nursing) (GM (N)) in each hospital had no authority over the deployment of nurses in the whole hospital. Instead, the authority rest on various clinical Chiefs of Service. (The situation improved with subsequent delegation of power to the GM (N).)

2.27 Uneven distribution of manpower was common in a number of hospitals and DH. For instance, the number of nurses in a Psychiatric Ward, which had to receive new cases, isolate newly admitted patients and accommodate a total of some 100 patients, was no more than similar types of wards with much fewer patients.

2.28 Some regional offices and service units under DH were under pressure from extremely heavy workload and manpower shortage. Nurses working in these

offices/units had to continuously work overtime and felt too exhausted to take it any more. On the contrary, some people (including doctors) could enjoy better treatment. This showed poor manpower deployment! In addition, nurses were required to sort out a lot of investigation materials, surprisingly without any clerical assistance arranged by the management.

**(D) Lessons Concerning the Concept of Infection Control and Communication**

- **Total defeat once the battle started**

2.29 Hong Kong has gradually set up an infection control system since the mid-1980s. At present, each public hospital has its own infection control team, headed by a microbiologist with support from staff such as infection control nurse. Yet, in terms of infection control, it is fair to say that we suffered a total defeat when the anti-SARS battle just started. This was the case at the fronts of many hospitals. One after another, health care workers fell down with the disease! We were not even able to learn from the past mistakes (initially the bitter lessons in PWH)!

2.30 The cause was multifaceted. In terms of infection control, it seemed that there were other factors apart from the above ones.

- **Stressing only on droplet infection**

2.31 During the early and intermediate periods in particular, the authorities concerned (DH and HA) and parties such as the infection control teams all only played up the importance of the droplet infection mode of SARS, including the transmission distance (within a short distance of 3 feet) and the survival period of the virus (as short as 3 hours).

2.32 The lopsided stress had lowered the vigilance of the health care workers, the management staff in particular and undermined the protection measures. However, panic spread when a large number of health care workers contracted the disease. Given the shortage of PPEs, many health care workers bought their own (e.g. face masks and eye shields) but this led to disputes between staff and the management in some workplaces.

2.33 The lopsided stress on droplet infection during the early and intermediate periods had given rise to a situation where even some guidelines failed to underline precautionary measures against contact infection and the ways to handle the vomitus and excreta of patients. As a result, the urine and faeces of patients were flushed down the toilet without first disinfected. Worse still, there was no mention of the extreme caution one should observe when carrying out resuscitation and endotracheal intubation.

2.34 Without the full knowledge and understanding of the toxicity, transmission mode, survival period and other characteristics of the coronavirus, the authorities, to combat this unknown and completely new disease, stressed merely the transmission modes and did not take timely and comprehensive protective measures. This must be one of the main reasons causing the fall at the fronts. (Luckily, many ward

nurses working at the forefront voluntarily practised self-isolation at a very early stage and effectively cut down cases of cross-infection. But some of them had to stay away from their families for weeks and suffered from the plight of separation!)

- **Information and guidelines released were excessive and provided in a haphazard way**

2.35 There had been a deluge of information and guidelines on the control of transmission and SARS. However, for the hard-pressed frontline nurses who had to face the challenge, they could hardly have time to scan and scrutinize all the information especially at the early and intermediate periods of the outbreak. In fact, there had been a chronic shortage of accurate, precise and comprehensive guidelines for the staff at that time. In some cases, nurses working in the wards had to rely on news stories carried in the press for information.

2.36 The flood of information and guidelines so released was confusing, lack of coordination, inconsistent, and contradictory. As the guidelines and information were mainly prepared in English, it was not easy for the message to get through, especially among the minor staff. Some improvement was made to the situation only after mid-April.

**(E) Lessons Learned from the Layout and Provision of Facilities in Wards**

2.37 The fight against SARS laid bare serious defects in the layout of the public hospitals, making it impossible to administer effective barrier nursing.

- **Acute shortage in the provision of infectious disease wards**

2.38 There were hospitals designed specifically for the treatment of infectious disease in Hong Kong before 1970s. These facilities were subsequently scaled down and became the Infectious Disease Unit housed in the Specialty Block of PMH -- the only specialty of its kind in Hong Kong. The Unit took up four storeys of the block. There were dozens of isolation rooms and spacious changing areas with shower facilities. It had its own entrances and exits and was served by independent lifts. Before the mid 1980s, visitors were strictly prohibited. The policy was gradually relaxed when an influx of Vietnamese boat people were admitted to the hospital and the "no visitor" rule was virtually unobserved in the 1990s.

2.39 In the mid-1990s, the hospital carried out renovation to the Specialty Block. To save resources, the Infectious Disease Unit was further scaled down with only three infectious disease wards -- E5 for female patients, E6 for children and F5 for male patients. Only E5 and E6 had each equipped with nine isolation rooms with shower facilities. For F5, there was only one single room and several large cubicles, each of which had eight beds. The changing rooms for the health care workers were relocated to the end of the wards and there were no more shower facilities. The changing rooms had become so small that the staff would rub each other's elbows when changing their clothes. To make matters worse, there was no door between E6 and F6 opposite to it, which was a paediatric ward. Patients of the paediatric ward could roam around the area. It was not until a few years later that a door was added to the isolation rooms of the wards E5and E6 to create negative pressure. However, no improvement was made to F5. As such, male patients in F5 had to be transferred to the female ward E5 should they require an isolation room or a room with negative pressure for barrier nursing. Meanwhile,

the Infectious Disease Unit was merged with the Department of Medicine and Geriatrics and no longer stood alone as a specialty in the hospital.

2.40 After all, the hospital did have isolated rooms with negative pressure control and because the number of SARS patients admitted in the early period was small (See Illustrations 1 to 3). Consequently, no staff in the infectious disease wards of that hospital had been infected for four consecutive weeks, and up to now, which is almost four months later, there had been only two staff members infected (one of them might have been infected in another SARS ward set up as a temporary measure). QMH is another example. As it also has its own isolation rooms and the number of SARS patients admitted was small, zero infection could be maintained for eight weeks in a row.

2.41 If the Infectious Disease Unit of PMH still had retained several dozens more isolation rooms, the first batch of infected health care workers and others patients in PWH could have been transferred to PMH at an earlier stage to receive strict barrier nursing. Perhaps Hong Kong history would have been rewritten!

2.42 Apart from PMH, other public hospitals do not have infectious disease wards. Where necessary, patients contracted infectious diseases have to be transferred to PMH. In 2001, when bird flu broke out in Hong Kong, a majority of patients in the infectious disease wards of PMH, who contracted infectious diseases like viral hepatitis, had to be transferred to other general wards to make room for bird flu patients. At that time, if the government and the management of HA took a serious view of the shortage of infectious disease wards in Hong Kong and made appropriate arrangements well beforehand, perhaps this SARS episode in Hong Kong history could show a different version.

- **Shortage of isolation rooms in general ward**

2.43 Most of the general wards in Hong Kong's public hospitals are short of isolation rooms. Take the medical and geriatric wards as an example, which normally have only one to two side rooms. In the event that patients who need reverse isolation, such as patients with leukaemia, are admitted, the wards will not be able to receive patients with air-borne infectious diseases like tuberculosis or patients in need of barrier nursing. Even if other patients are admitted, these rooms are still not able to achieve effective isolation as they are not negative pressure rooms. This long-standing deficiency touched off a row in matters of occupational health and safety in QEH a few years ago. But unfortunately the incident kicked up only small waves and failed to arouse concerns. No follow-up action was subsequently taken at that time.

- **Poor ventilation in wards**

2.44 After renovation all public hospitals are now enclosed and air-conditioned. For years health care workers from a number of hospitals have been complaining that their wards are stuffy and lack of fresh air. This is particularly the case in terms of medical and geriatric wards which are bursting at the seams with patients. (The wards have been required to accommodate extra beds or even temporary beds on a long-term basis.) Their workers always fell victim to respiratory diseases, but their case had not been taken care of seriously. The situation in a few wards has improved after the installation of some additional exhaust fans.

2.45 Cases of legionnaires' disease are sometimes reported in the offices of enclosed air-conditioned buildings. But this does not arrest the attention of hospital architects and health hazard managers. No guideline for opening windows at a certain

interval for ventilation is developed either. (For security reasons, the windows in many wards are only allowed to open a chink of a few centimeters.) Although air conditioner filters are cleaned up regularly, cleaning work has not been stepped up and intensified in usual days. During the fight against SARS, cleaning of filters was enhanced but still not enough. Clear guidelines are yet to be laid down.

2.46 To minimize the viral load, one of the measures taken by Guangzhou in its fight against SARS was to improve the ventilation in wards. Even though we are very close in terms of geographical location, the relevant authorities failed to pay due attention to this measure taken by Guangzhou, even though the representatives of HKCCSA had highlighted this openly after their return from their exchange trip to Guangzhou. According to the report from the infection control team of QMH after SARS cases first reported in the hospital, the cases might have to do with the increased indoor viral load due to the administration of high concentration oxygen to three patients in a ward at the same time. This mishap showed that the team was not learning from other people's experience and was not taking effective preventive measures. (It is worthy to note that to make up the deficiency, health care workers had worked out some primitive solution by diverting the exhaled air of SARS patients out of the window, thereby reducing the viral load in patient wards and minimizing the chance of cross infection.)

- **Defective ward design and layout**

2.47 Shortage of isolation rooms aside, there is also the problem of wards with defective design and layout, which increases the chance of cross infection. Apart from the aforementioned inadequacy of hand-washing, changing and showering facilities, as

well as the problematic design of contaminated air passing through the nurses station recently came to light, there are also other problems:

— lack of storage space;

— nurses duty room located inside patient wards (the nurses duty room will be inside the contaminated area once the ward has turned into an SARS ward);

— it was absurd to find the place designated for handling and cleaning vomit and excreta, bedpans and urinals as well as contaminated objects (such as clothes and bedding) could be in the space opposite to the nurses station in the middle of the ward, outside the ward, even the space between two wards or a space adjacent to the treatment room and equipment room!

**(F) Lesson concerning the management/system**

2.48 This anti-SARS battle has brought into focus the inadequacy and deficiency of the management/system of the government, HA and hospitals.

- **Bureaucratic and ossified framework**

2.49 The structure of HA is too large. Before the setting up of hospital clusters, there was not much interaction among hospitals. Delegation of power to the lower level resulted in an acute lack of central coordination. Each hospital only minded its own business. The formation of clusters saw closer interface and manpower resources could be properly deployed where necessary. Yet there was still neither frequent communication nor close cooperation between individual clusters. The Hospital Chief Executive of each "Dragon Head" hospital has to take up also the

post of Cluster Chief Executive as well. He/she is responsible for overseeing and managing quite a number of hospitals of various sizes in the cluster. It is really difficult for him/her to take good care of both jobs.

2.50 Even though HA lopsidedly played up the importance of management after its establishment and significantly elevated the status of management staff, and even though each hospital has various sets of so-well-written codes of practice, guidelines, manuals and contingency measures, etc., the management was still at its wits' end in face of the battle against SARS when it found itself in a position to handle an acute crisis. As a matter of fact, people were only good at making empty talk!

2.51 There was a lack of alertness. Hospitals usually had no objective, genuine and sufficient assessment of their capability and readiness to deal with matters such as major incidents and serious epidemic diseases. After the outbreak of SARS, hospitals showed a poor assessment of the spread of the disease and the demand of beds, ICU support and supply of materials such as PPEs. They were reactive and indecisive.

2.52 The lack of coordination among hospital clusters and even in each hospital or clinical department within the same cluster was plain to see. Each unit only minded its own business and there was no strong leadership. In the early period, there was wavering on policies and measures. Frequent changes in such policies and measures were common. On the other hand, the management did not fully appreciate the actual problems and difficulties frontline workers encountered.

When a general ward was converted into a high-risk ward, one could usually see the following:

(1) During the decision making process, frontline nurses' valuable and professional opinions were not listened to;

(2) Failure to anticipate adequatedly the operational problems and difficulties to be encountered during the ward conversion process;

(3) Preventive measures including guidelines on infection control were not issued in time;

(4) Ancillary facilities and PPEs were not made available to tie in with ward conversion;

(5) Relevant policies on admission of patients, the triage system and allocation of beds could not be put in place and made known to staff concerned in a timely manner (The policy guidelines were slow in coming at the start and the situation was still chaotic despite subsequent improvement); and

(6) No full consideration was given to manpower deployment, neither were there clear and written guidelines (most of them were made orally and no written confirmation issued afterwards), while showing insufficient regard for frontline workers' physical and mental health.

- **Out-of-date management culture**

2.53 Since HA's establishment, the management regime and initiatives it introduced have never been in the best interests of the people (not really making the physical and

psychological health and safety of the patients and staff its top priority) or ward service-oriented. To the contrary, the enhancement of its management functions and the dominant role of the doctors-in-charge have seriously undermined the professional status of its nurses and allied health personnel as well as the check and balance between them and the doctors. Team spirit is no more than empty slogan and staff consultation is all for show (some don't even bother to put on such a show). It goes without saying that no rapport can be established in such circumstances. The distribution of internal resources is lopsided in favour of senior doctors and the senior management. Staff relations are always tense, if not getting sour. Deep-seated mutual suspicion can be found between the staff and management at different levels. Staff morale has been consistently low. The senior management of HA has all along played down, ignored and denied the problem.

2.54 Many of the staff, including even senior health care personnel, have a lot of complaints and grievances before and after meetings with the management, but they seldom or never express their views at the meetings. This phenomenon has become all too common.

2.55 With the above in mind, it is understandable why the staff prefer to air their complaints to the media. They hold that to make their complaints publicly will exert pressure on HA to look squarely at the matter. Even though HA later set up a complaint hotline, most of the complainants dare not reveal their real name and office. And some people still continued to choose to voice their complaints to the media.

- **Management, training and deployment of nurses**

2.56 Following the revamp of HA, the formerly rather tightly-knitted top-down nursing management structure has become fragmented (see Illustration 3). With the new management structure in place, GM (N) basically assumes an advisory and auxiliary role in the hospital. His/Her new role does not allow him/her to coordinate the work of the nurses of various clinical departments with the overall care needs of the hospital in mind. Neither can he/she promptly effect appropriate deployment of manpower to cope with the development of the hospital, or emergency cases and additional workload. He/She is also not in a position to map out comprehensive plans for nursing care services, nursing profession and personal career development to equip nurses of various ranks with all basic training and clinical experience in various specialties. In fact, he/she does not have a genuine participation in matters concerning ward management, resource allocation (except the small portion in his/her ambit) and the provision of clinical services. He/She is also denied an involvement even in matters as important as infection control that has much to do with ward management.

2.57 Under the management structure of HA, nurses and doctors no longer collaborate in professional partnership but work as subordinates and bosses. This is the case even at the level as low as the clinical departments. Management culture in HA dictates that nurses of all ranks from GM downwards are not given a chance to get involved on an equal footing, or to voice their views, in matters like ward management, resource allocation and the provision of clinical services. With regard to the communication and collaboration of nurses and doctors, or their discussion about the deployment of beds in wards and the implementation of isolation measures, nurses can only play a secondary role.

2.58 In DH, the Principal Nursing Officer plays only a minor role in the hierarchy of the department. Neither does she have much say in policy making. As for nursing staff at other ranks, they are also denied the chances to get involved or give their opinions in matters relating to clinic management, service provision, isolation measures and PPEs.

## 3. Comprehensive Review of Hong Kong's Medical and Health Services System Required

3.1 Hong Kong lost tens of billions of dollars in containing SARS in the past four months. The financial resources directly allocated to public hospitals and DH in the fight against SARS, and other government departments for support services amount to no less than several billions of dollars.

3.2 The saving achieved by cutting down the number of front-line staff over the years pales in comparison with the loss this time. SARS has consumed all the hard-earned saving. It is high time for policy makers to figure out how to take our medical and health services forward in a holistic, far-sighted, healthy and sustainable way. What strategy should we employ? Do we need to reexamine the short-sighted, profiteering and cost-oriented policy to frantically down size the number of front-line staff? Do we also need to review the allocation of medical resources?

3.3 About two and half years ago, or to be precise, in December 2000, the government released the consultation document on Health Care Reform: Lifelong Investment in Health. However, the government failed to seize the opportunity to take one step forward to embark on a review of medical and health services, especially strengthening the prevention of diseases, the basic medical and health services, breaking away from the practice of hospital-oriented care and the relevant mode of medical financing and assistance, making an earlier development of long term strategic objectives. Should it do the right thing, then the joint effort of all the government departments and social sectors in the fight against SARS would be even more timely, powerful and effective.

3.4 Now the government has decided to set up a Centre for Disease Control and Prevention, which will contribute significantly to the establishment of a mechanism for alarm-raising, and control and prevention of infectious diseases and epidemic diseases. But we hope that the government should consider the views stated in para. 3.2 and 3.3, and the proposal initiated by the Joint Conference of Healthcare Professional Organizations, Hong Kong on 31 March 2001 to set up an inter-bureau and inter-departmental body to promote, handle, coordinate and strengthen the prevention of diseases (see Annex III), and address matters relating to disease control in a more comprehensive and thorough manner.

3.5 The government should also give serious consideration to the following questions:

- How to ensure the establishment of a mechanism for the prevention and treatment of diseases using both Chinese and Western medicine?
- How to strengthen the basic medical and health services and community care services and to ensure their effectiveness?
- How to develop a system for the management and monitoring of the elderly homes to improve their hygienic standard and service quality?
- How to achieve effective communication, cooperation and coordination between the public and private hospital systems?
- How to develop a comprehensive public health system and set it in motion?

## 4. The Anti-SARS Battle Highlighted the Importance of the Public Service

4.1 The Chief Executive Mr TUNG Chee-hwa mobilized an enormous amount of resources and manpower in the fight against SARS. Thanks to the support and co-operation of the public service and the efforts of other parties, Hong Kong has finally brought the epidemic under effective control and has been removed from the list of infested areas.

4.2 Apart from the tens of thousands of health care workers from public hospitals and the Health Department, there are also tens of thousands of civil servants from the Social Welfare Department, the Food and Environmental Hygiene Department, the Home Affairs Department, the Housing Department, the Leisure and Cultural Services Department, the Electrical and Mechanical Services Department, the Architectural Services Department, the Fire Services Department and the Police Force, etc. who provided support services of equal importance (see Annex IV).

4.3 In order to fight against time under the pressing epidemic situation, they often had to work shifts or even performed duty at midnight when being called upon. They had to work overtime during weekdays as well as work during holidays so as to complete their tasks as soon as possible. Some civil servants also had to risk being infected; members of the public sometimes vented their grievances in them and put them in tremendous difficult situation.

4.4 On the other hand, from the intermediate period to the peak of the epidemic, extensive media coverage aroused fear in the community in general. As a result, public hospitals could not recruit minor staff even with the offer of high pay. Some suppliers would rather not earn money than deliver goods to hospitals or take up

outsourcing work. This was a sharp contrast with the public servants who were dedicated to their duties!

4.5 Fortunately, Hong Kong has an efficient, dedicated public service endowed with team spirit. They did not seek extra benefits in the fight against the epidemic when rendering strong support to the government's determination and carrying out the government's measures against SARS.

4.6 The fight against SARS highlighted the importance of the public service when the government was facing formidable challenges and crisis. We cannot imagine what would happen if the government unscrupulously implements the " small government policy" and outsources many public services. Can the Chief Executive easily mobilize such a vast amount of resources and manpower like this time in case crisis happens?

## 5. Conclusion

5.1 The fight against SARS has now achieved impression results. We hope the government, HA, the hospitals and the community would take note of the following:

(1) Infectious disease knows no boundary. Our ties with the Mainland and our links with overseas countries in the process of globalisation have become all the more closer. It is essential for Hong Kong, a densely populated city with heavy passenger traffic moving in and out, to strengthen the early notification system and exchange of information about infectious diseases and epidemics. This must be achieved in an objective, modest, scientific, vigilant, tolerant, rational and holistic approach with the lives and health of people, and the overall interests of Hong Kong uppermost in our mind. (para. 2.6-2.7)

(2) Stringent barrier nursing measures should be taken promptly against infectious diseases and these measures should also be holistic and sustainable. In the event of a new disease, enhanced protective measures should be taken to deal with it prudently. To this end, we should build up knowledge and skills on protection in all aspects and promote a sense of civic responsibility and social solidarity. We should also develop appropriate, comprehensive and straightforward guidelines and provide supporting facilities and equipments in a timely manner. (para. 2.9-2.22; para. 2.30-2.33; para. 2.34-2.35; para. 2.36-2.46)

(3) There should always be sufficient supply of well-trained staff available for prompt, appropriate and fair deployment to meet the needs in war, at ordinary times or during an outbreak. Therefore, training plan should be formulated and carried out by phases in advance of any adversary. It is also necessary to

conduct objective assessments on the manpower level of frontline staff and fill the vacancies as soon as possible. (para. 2.23-2.27; para. 2.55)

(4) The management culture should be one which is people-oriented, with the physical and psychological well-being of patients and staff in mind, so as to give full play to the wit and ability of the staff. Apart from promoting a new culture of partnership, it should be oriented toward enhancing the new culture of partnership cooperation and nurturing a team spirit. Management structure or system should be established to realise this new management culture and to meet three types of needs (patient service need, professional development need and personal career development need). (para. 2.48 – 2.54)

(5) Fully understand the roles and tap the potential of nurses in various ranks (particularly the basic and the front-line nurses) in the defense against diseases and in medical and health services as well. For this reason, changes should be made to clinical departments in hospitals, where nurses are subordinates of doctors, and the structures and systems are threatening the professional independence of nurses. The GM (N) should be empowered to coordinate and manage all levels of nurses engaged in different specialties in hospitals, and the nursing service of the hospital as a whole. In this connection, training provided for each rank of nurse, including that for the GM (N), should be strengthened. As far as its structures and systems are concerned, DH should also ensure that nurses at all levels can have more say, and indeed play a greater part in policy formulation and its subsequent implementation on an equal footing. (para. 2.23 – 2.37; para. 2.52 – 2.57)

(6) A rational public debate on the future development of Hong Kong's medical and health services should be carried out. Importance should be attached to promoting primary and community nursing services, engaging in persistent environmental hygiene improvement activities, and setting practicable targets and clear timetables for such activities. (para. 3.1 – 3.5)

(7) Strengthen an efficient public service which is of high quality, loyal to the government and committed to the community, has a sense of belonging and can be relied on problem solving and crisis management. For this purpose, we should analyze and determine the prerequisites for the Special Administrative Region's public service in order that Hong Kong can respond effectively to both inside and outside challenges as well as make good use of its position. Appropriate policies and systems together with training should also be put in place. Policies such as a "small government", outsourcing and privatization should be re-examined. (para. 4.1 – 4.6)

5.2 The fight against SARS shows that despite blunders (especially at the early and intermediate periods), all of us, from as high as the Chief Executive, SHWF, Chairman and CE of HA, down to the hospital managements, frontline health care workers, civil servants from various government departments as well as various social sectors, have gone all out to do our best and play our respective roles dutifully. More importantly, we have demonstrated the most precious qualities of human nature: care, love, patience, generosity, tolerance, selflessness, dedication, sacrifice, unity and commitment.

5.3 We believe that the whole community should cherish, and join hands to further promote, these invaluable qualities. We should turn them into a driving force to

improve the health care service of Hong Kong and help the government revive the economy of Hong Kong.

5.4 Some say SARS may return this winter. Others say that mankind will face more new diseases and viruses. Anyway, we believe effective protection holds the key to overcoming any diseases.

5.5 The genuinely effective protection requires:

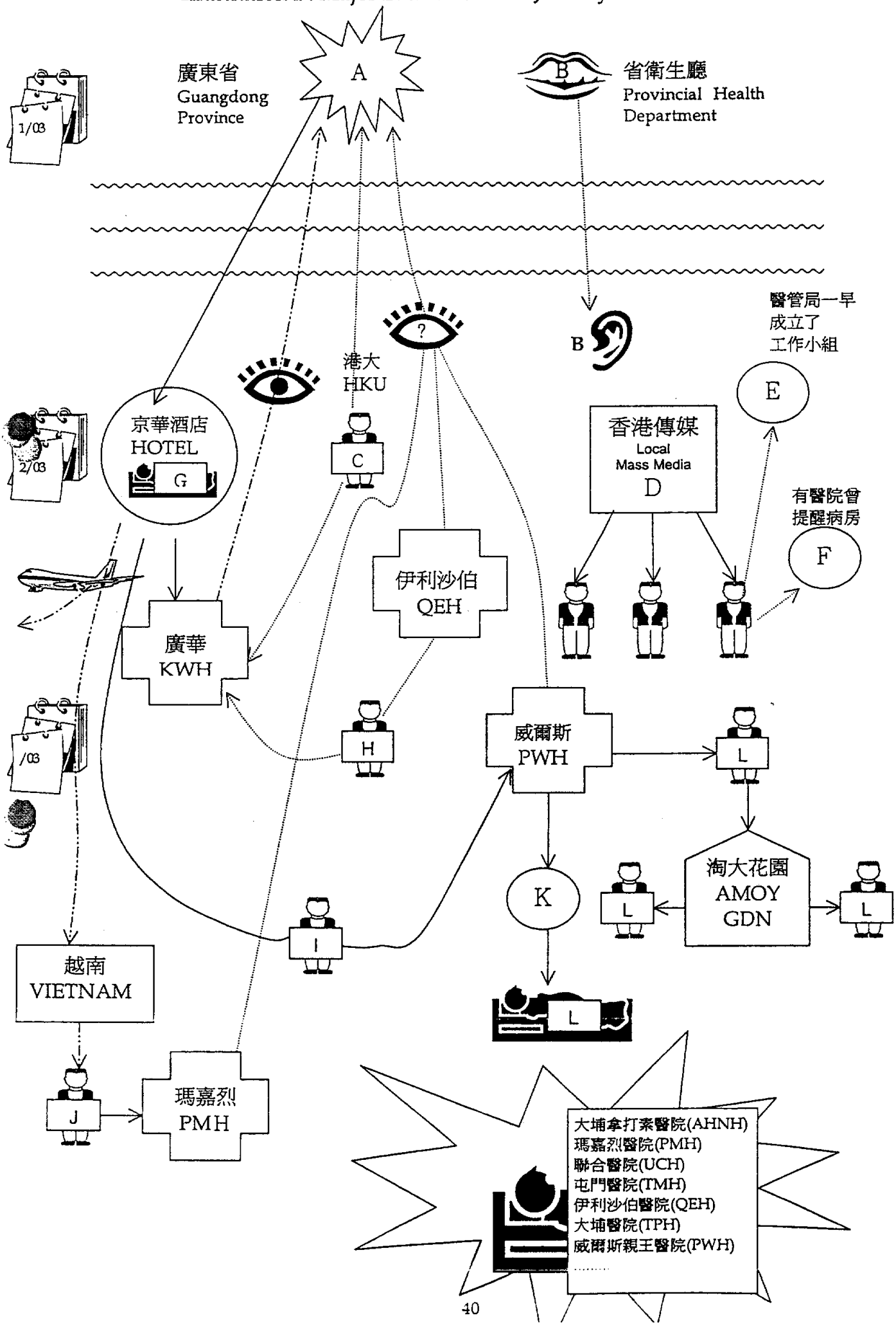
* unity through the ranks and between the government and the people; stick together through thick and thin, cooperation and mutual help and support;

* mutual understanding, tolerance and forgiveness;

* honest, effective communication and consultation;

* partnership cooperation within the health care system and nurturing a new management culture!

Illustration 1 : Major Events between January and March 2003



Legend for Illustration 1

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(A) In January 2003, an outbreak of Atypical Pneumonia (AP) was reported in the adjacent Guangdong province.

(B)

- Ms WANG Zhiqiong, Deputy Director of Guangdong Provincial Health Department clearly stated that she had exchanged views with her Hong Kong counterparts during the early stage of the AP outbreak in January this year (see "AP Files" of Ta Kung Pao, 9 June 2003).

- On 10 February, southcn.com reported for the first time that an outbreak had occurred in Guangdong province. It also described on its symptoms and transmission modes (see Issue No. 151 of Bauhinia Magazine published in May 2003).

- On 11 February, the Guangdong Provincial Health Department held a press conference and announced for the first time details of the outbreak. According to the aforementioned issue of Bauhinia Magazine, the Chinese Ministry of Health reported for the first time the outbreak to the WHO on the same day.

(C) In early February, on the invitation of Dr ZHONG Nanshan, Head of Institute for Respiratory Disease in Guangzhou, Professor KY YUEN, Head of Department of Microbiology of the University of Hong Kong (HKU), visited Guangzhou to trace the origin of the disease. On 12 February, Professor YUEN went to Guangzhou again to sign the cooperation agreement with several Guangzhou medical institutions on behalf of the Department of Microbiology of HKU. Under the agreement, the Guangzhou Collaborative Group on the Research on SARS was subsequently formed to help trace the origin of the disease (see reports in Ta Kung Po).

(D) In early to mid-February, the outbreak in Guangdong province peaked, triggering off a panic buying of vinegar and radix isatidis granules. The Hong Kong media reported this in extensive coverage. On 11 February, Wen Wei Po in its frontpage and inside page reported the following:

-- "Fatal Pneumonia in Guangdong Contained"

-- "Symptoms of Aptypical Pneumonia"

-- "Urgent Control Measures Introduced in Guangdong"

-- "Experts from Central Government sent to Guangdong to Provide Assistance"

-- "Experts : Rare Disease Curable"

On the response in Hong Kong, Wen Wei Po reported that DH was concerned about the development of the "rare disease". The article also noted the following:

-- the SHWF, Dr Eng-kiong Yeoh said that *DH had been in touch with the relevant Mainland authorities on the matter*, and would gauge the need for any appropriate contingency measures. He also called on the public to seek medical consultation as soon as possible if they developed symptoms after returning to Hong Kong, and to inform the doctors of their overseas trips....

-- According to Dr LO Wing-lok, President of the Hong Kong Medical Association, the Association had been in close contact with the Guangdong authorities.

-- Dr TSANG Wah-tak, Associate Professor of Department of Medicine, Faculty of Medicine of HKU, said that further evidence had to be gathered and the type of virus that caused the disease had yet to be identified.... *He called on the public not to panic.*

(E) On 11 February, HA set up a working group to deal with AP, collate cases daily and report them to DH for epidemiological studies and assessment of the spread of AP.

(F) On 15 February, a local hospital passed verbal message to its medical wards that they had to report on the admission of AP patients, prevent droplet infection, use single rooms for isolation, and should wear surgical masks, gloves and gowns, wash hands and disinfect the environment.

(G) On 22 February, [redacted] who suffered from AP was admitted to KWH. He was immediately sent to ICU (On 28 February, [redacted], a nurse of the AE Department of KWH who had no direct contact with "AA" [redacted] came down with the disease and was admitted to the hospital). According to the hospital,

- ICU had immediately requested staff to isolate patients, wear N95 masks, wash hands and wear protective gowns. It was later learnt that family members of this AP patient "AA" [redacted] were infected even only after brief contact. Consequently, staff were advised to have meals or take a break separately and not to get too close with each other.

- KWH had invited a doctor (Professor Y K YUEN of HKU who had just been to Guangzhou) for joint consultation.

- HA was immediately informed.

- According to Dr WATT Chi-leung, officer-in-charge of ICU, as early as the days after the Chinese New Year there were reports that "Hong Kong resident(s) died in Pingtan County in the Mainland.... when reports of panic buying of radix isatidis granules and vinegar were released from the Mainland, I began to look out for atypical upper respiratory tract infection cases."

- On 3 March, the senior management of the hospital held a meeting and decided to take measures to prevent the spread of the disease. (see KWH's " The SARS file", 2 May and 9 May 03)

(H) On 4 March, with the assistance of the thoracic surgeon of QEH, lung biopy was performed for a suspected SARS patient (the brother-in-law of "AA" [redacted]) in the operating theatre of KWH. The sample was then sent to DH and HKU for laboratory tests and analysis. (It was confirmed after ten-odd days that the sample contained coronavirus.) (see the above report) (It was understood that the doctor of QEH was not aware that the patient was a suspected SARS patient. The

instrument borrowed for the surgical procedure was then not subject to any special treatment upon their return to QEH.)

(I) On 4 March (the same day), a 26-year-old airline male employee (who had visited his friend in the Metropole Hotel) was admitted to PWH. Nebulizer had been used to ease his shortness of breath.

(J) On 6 March, a SARS patient who had returned from Vietnam was admitted to PMH. It was the first SARS case of that hospital. On 7 March, the second SARS patient was admitted.

(K) On 7 and 8 March, medical students took an examination in medicine at Ward 8A of PWH.

Between 8 March and 15 March, the above-mentioned young patient infected (more than) 189 persons.

| | |
|---|---|
| – the family members and friends of the patient (1) | 7 |
| – health care workers, medical students | 73 |
| – other patients and their family members | 50 |

(another 40 health care workers contracted the disease from 16 March to 29 March)!

## 表1：某醫院早、中期收治SARS病人情況
**Chart 1: SARS Patients Admitted to A Hospital during Initial and Intermediate Periods**

| 階段 Period | 早期 Initial | 中期 Medium |
|---|---|---|
| | 6-17/03/03 | 18-27/03/03 |
| 收治SARS病人(包括疑似患者)人數 Admission of SARS Pts(inc suspect cases) | 14 | 86 |
| 平均每天收治人數 Daily average | 1.27 | 8.6 |

## 表2：某醫院高峰期收治SARS病人情況
**Chart 2 : SARS Patients Cases Admitted to A Hospital during Peak Period**

| 階段 Period | 高峰期 Peak |
|---|---|
| | 28/3-7/4/03 |
| 收治SARS病人(包括疑似患者) Admission of SARS Pts (inc suspect cases) | 721 |
| 平均每天收治人數 Daily average | 65.54 |

## 表3：某醫院早、中及高峰期收治SARS病人比對情況
**Chart 3 : Comparison of SARS Patients Admitted to A Hospital during Initial, Intermediate and Peak Period**

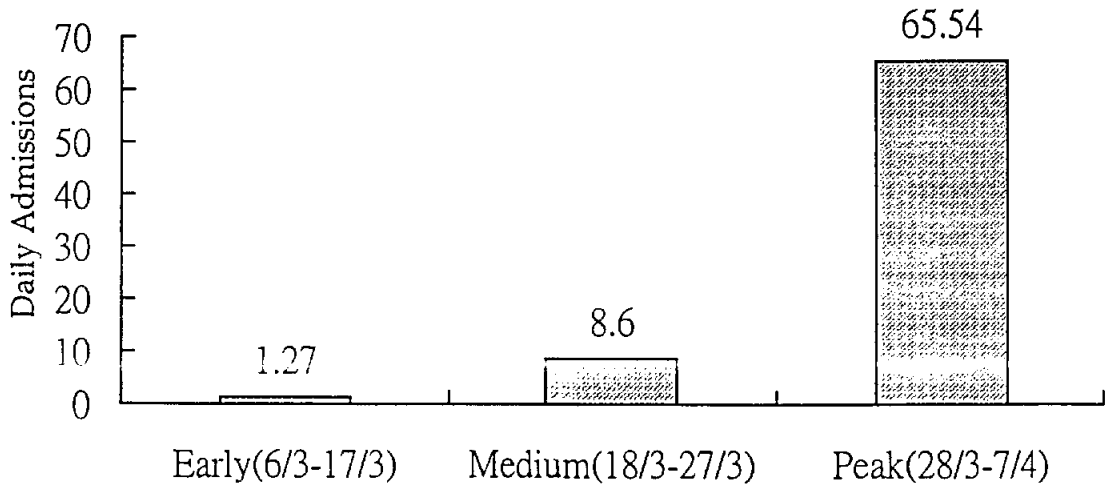

**Chart 4 : The Relations between General Wards of A Hospital Converted to High Risk SARS Wards and Number of Its Health Care Workers Infected**

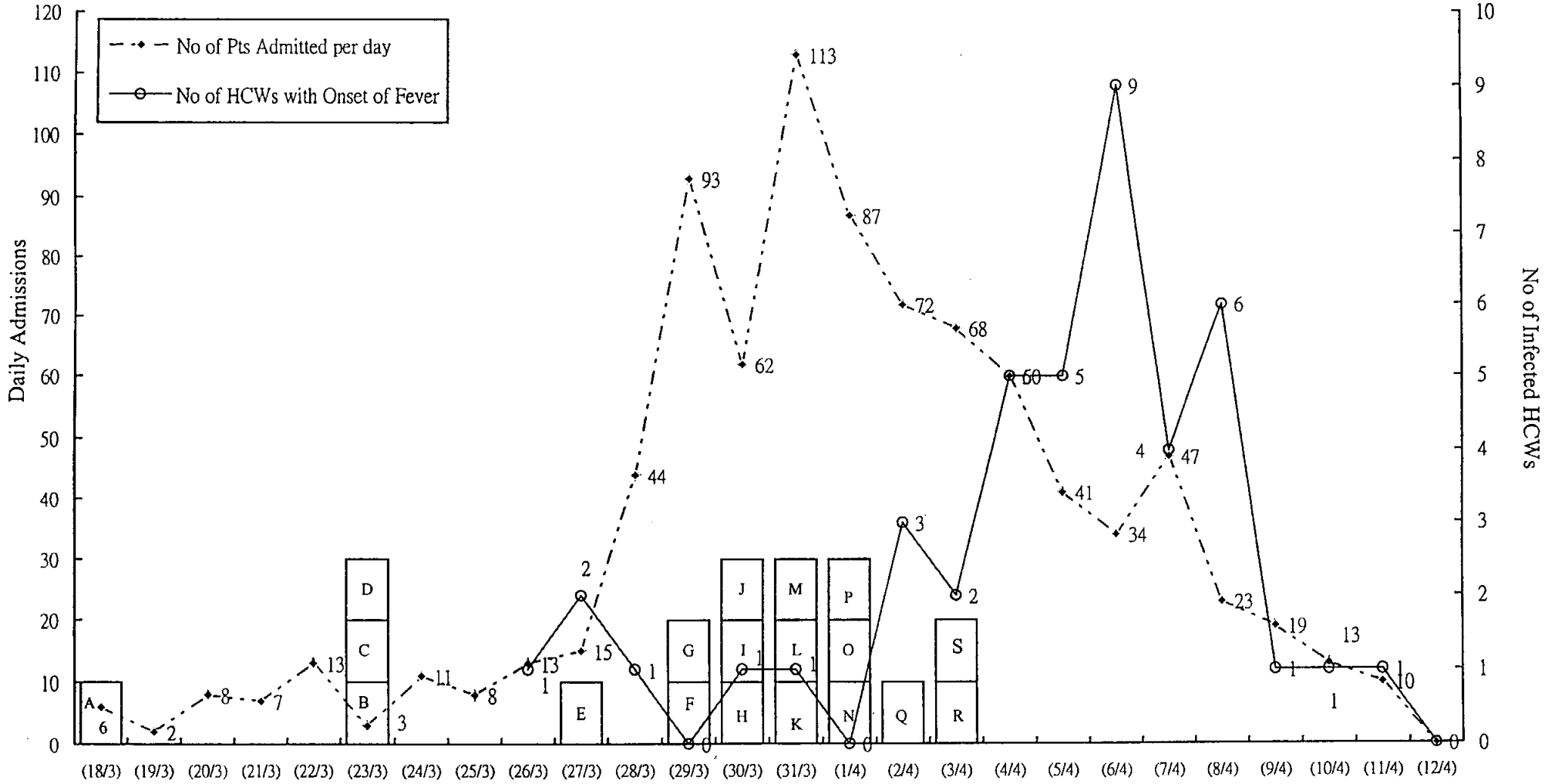




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Illustration 2 : A Waterproof, Chest-length, User-friendly Hood

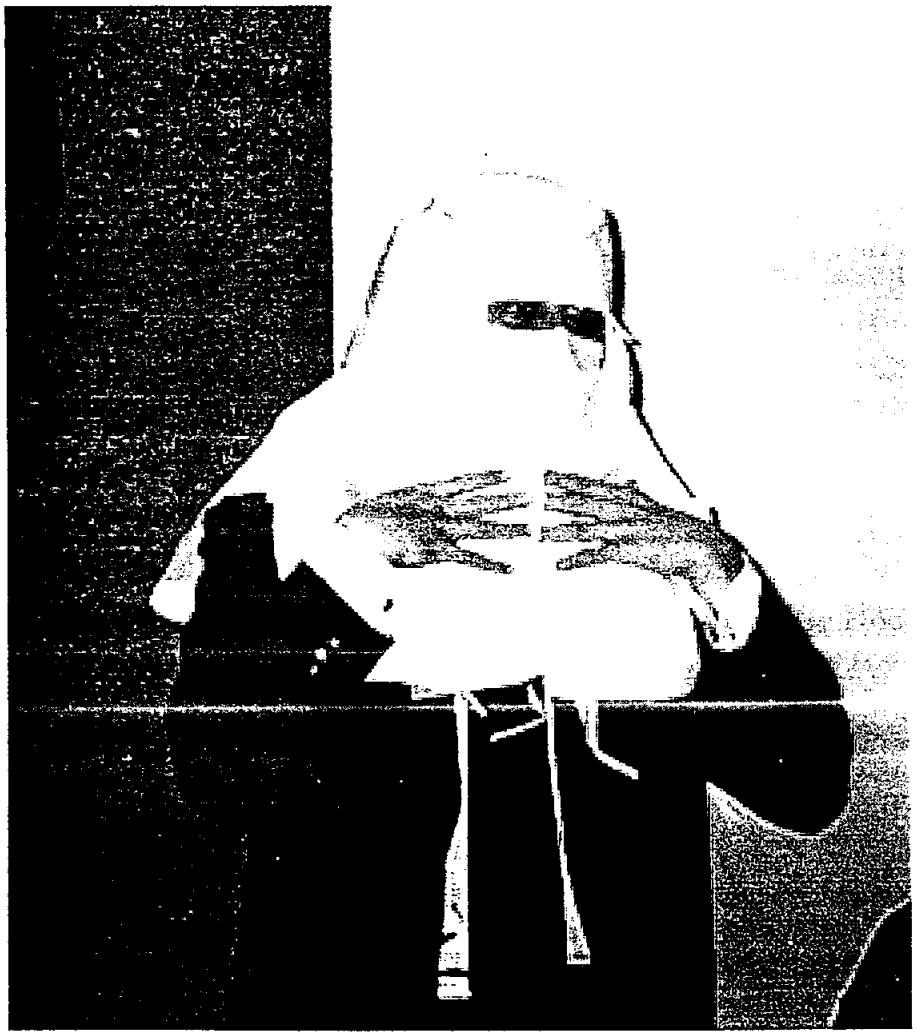
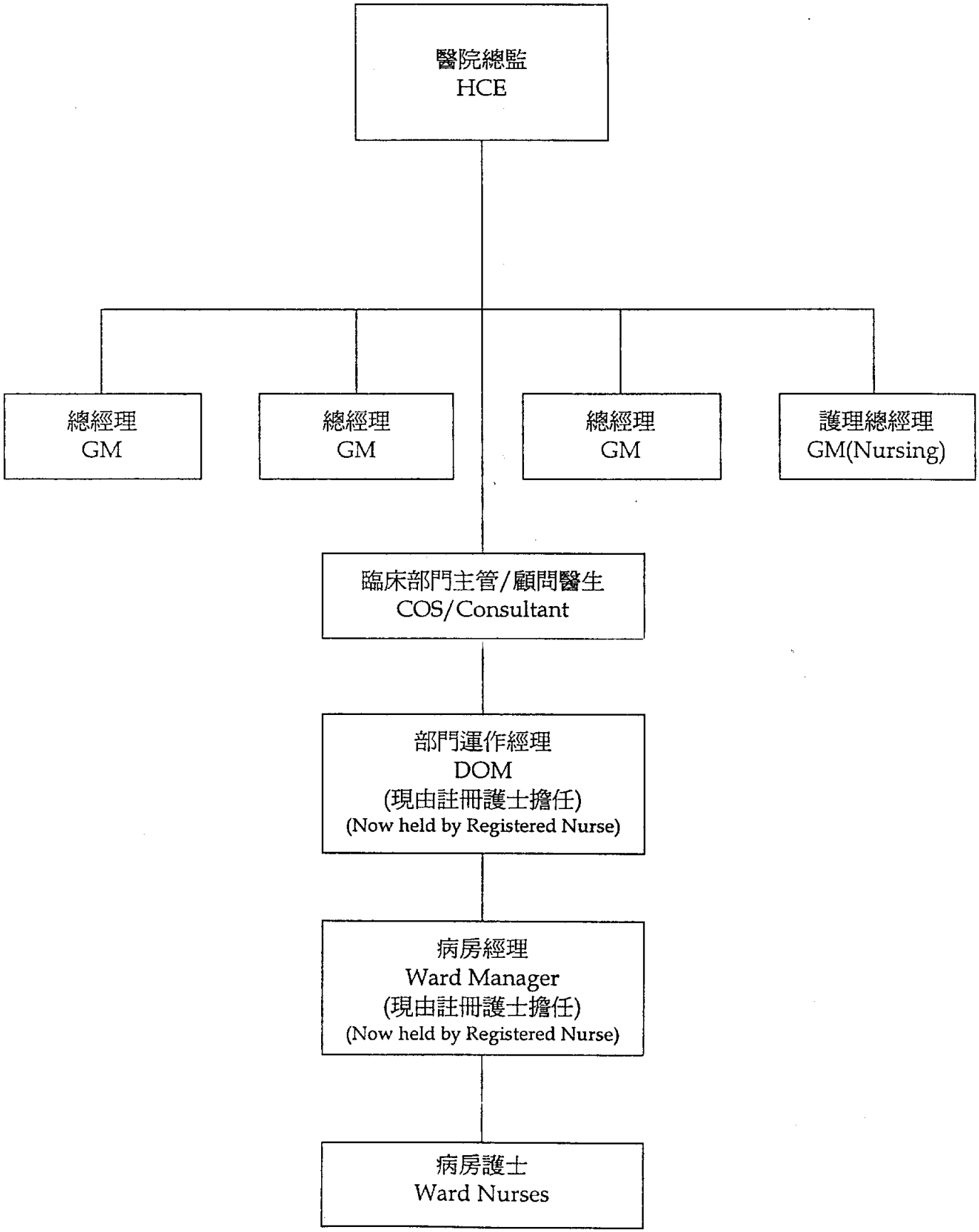


Illustration 3 : The Organization Chart of the Nursing Management in Public Hospitals



Annex I

Special Publication of Hong Kong Chinese Civil Servants' Association

on

Combating Atypical Pneumonia

# Play Our Roles Dutifully in the All-out Fight Against SARS

April 2003

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Annex II

# A Report

on

Guangdong/Hong Kong Experience Sharing Conference

on

Prevention of SARS

(3 and 12 May 2003)

Jointly held by HKCCSA

in association with

Nurses Branch and Enrolled Nurses Branch

and

Hong Kong Nurses General Union

Annex III

Joint Confrerence of Health Care Professional Organizations, Hong Kong

Re: The Establishment of a High-powered Body to Strengthen Disease Prevention Efforts

It is difficult for HWFB alone to line up successfully and effectively the support of all government departments and the general public. The SAR Government must set up a high-powered inter-bureau and departmental body at the Government Secretariat level, to promote, handle and coordinate the efforts. Through support from relevant bureaux such as Education and Manpower Bureau, Environment, Transport and Works Bureau and HWFB, this body may incorporate topics into kindergarten, primary and secondary school curricula on disease prevention, public health, good personal hygiene and personal responsibility at various degrees of complexity. Physical exercise should be designated as one of the compulsory subjects. Other measures should include advice on staying away from unhealthy food (eg salty or fatty snacks with excessively high level of carbohydrate and french fries etc); stepping up education on anti-smoking; organizing programmes in a holistic, persistent and systematic manner for grownups; disseminating information about disease prevention, public health, good personal hygiene, personal obligations and responsibilities; providing education on food and environmental hygiene; reinforcing education and control on pollution-free food, water, air and environment.

This body may also coordinate the work of DH, Education Department, Food

and Environmental Hygiene Department, Social Welfare Department, Environmental Protection Department and Water Supplies Department in respect of education, promotion and law-enforcement and the relevant planning. The guiding principle should be: starting at the source, grass-roots level, frontline and infants as far as possible.

(Extract from the Joint Conference's submission to the government's Health Care Reform Group, Para. 11 (6), 31 March 2001)

Annex IV

**Support Services Rendered by Civil Servants from Different Departments in Fighting against SARS(Part)**

- Execute the isolation order against Amoy Garden residents and help them to move into isolation camps (past mid-night);
- Provide counseling and food and procure daily necessities for members of the public who were observing home confinement order or in isolation camps;
- Render counseling to SARS patients, their families and other members of the public;
- Take care of SARS patients' young kids;
- Enquire about SARS patients' conditions upon the requests of their families;
- Follow up on cases relating to SARS victims and their families;
- Help needy persons to apply for financial assistance;
- Provide care for elderly and handicapped and make arrangements for addressing their special needs;
- Caring Visiting Project : pay visits to hostels for the aged in the territory (including the privately run), day nurseries, child care centres, home for the handicapped to inspect, and assist in putting in place, measures against SARS;
- Caring Action Project : provide home cleaning and simple repairs for elderly and people with special needs in the community. The service has helped create 4,500 temporary posts for cleaners and repairers. Undertake work to liaise, implement and follow up relevant activities;

- Handle applications for Business Community Relief Fund for Victims of SARS and arrange for face-to-face assessment, approval, liaison and referral;
- Handle funding requests for HK Jockey Club Charities Trust by NGOs regarding application, assessment, enquiries and liaison;
- Cleanse streets and villages; supervise street cleansing work by contractors; inspect refuse depots and public toilets (including both aqua privy and flush toilets) and take prosecutions where necessary;
- Provide transport service for colleagues in the public service to visit infected buildings and districts;
- Lend support to Team Clean by taking prosecutions against spitting;
- Draw plans of the sewerage facilities in the light well of Amoy Gardens as part of the open report submitted to WHO;
- Draw plans of extensions to, or improved infection disease wards in hospitals;
- Assist in the inspection of the cleanliness of government buildings to tie in with Team Clean's efforts;
- Furbish 2,016 vacant flats at an interim housing estate, Tin Yan Estate, in Tin Shiu Wai and turn them into confinement camp for SARS patients;
- Install ventilation devices at hospitals such as exhaust fans, adjust the air-change rate of air-conditioners, clean and disinfect air filters.

revised

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# 有效防護：成功對抗SARS之戰的關鍵

## ——有關香港抗炎之役的一些意見和建議

香港政府華員會
暨
護士分會、登記護士分會、香港護士總工會

2003年6月30日

revised

120216

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# 一、 前言

1.1 今天，香港不單已經被世界衛生組織撤銷了旅遊警告，還已從SARS疫區名單中除名。這成果來之不易，是在特區政府展示了抗炎決心(儘管來得稍遲及猶疑)，動員了龐大的資源和力量，並在社會各界的合作下取得的；是香港付出了昂貴的「學費」、沉重的代價——298條人命和幾百億港元的經濟損失換回來的。

1.2 自2003年3月中以來，上自特首、衛生福利及食物局局長，到醫院管理局的主席、總裁，到各醫院當局，以至前線醫護人員，以及多個政府部門數以萬計的公務員，已爲之疲於奔命，付出了極大的努力。

1.3 2003年3月23日，當香港的疫症正邁向高峰之際，華員會聯同3個護士工會向全社會提出了《2個呼籲、7點建議》，除希望香港能儘快控制疫情，還希望在適當時候總結今次的經驗教訓(見附件1)。當前正是此適當時候。

1.4 我們認爲，只有恰當地總結前一段，特別是由年初至抗炎的早、中期階段正面和負面的經驗教訓，才能鞏固已取得的成果、戰勝恐懼的心理、建立必勝的信心，才能爲未來的防疫提供有效的「前車之鑑」，才對得住受感染的1755位人士，尤其是其中不幸逝世的298位市民及殉職的8位醫護人員！

1.5 我們認爲，要達到這目標，需要全面、客觀、坦誠、科學、理性及勇氣，而不是「諱疾忌醫」、「文過飾非」或「諉過他人」，不是功勞、榮耀往自己身上拉，過失、責任往他人身上推，更不是一味挑剔、責罵，藉機發洩自己的怨氣和戾氣，甚至泛政治化。

1.6 我們希望這次的調查、檢討和總結能達到「前事不忘，後事之師」、「對症下藥」、「治病救人」的目的。

# 二、 教訓 —— 「吃一塹、長一智」

2.1 今天，港人可以比較自豪地說，香港在處理SARS疫症上，已有一套從政府到社會的比較完整的政策和措施；我們有關傳染風險和安全的概念、傳染控制的重要性、隔離護理及防止交叉傳染的措施和裝備的提供、對接觸者的追查、環境及個人衛生的重視，已大大提高了、改善了、更全面了；甚至連探病這一細節亦考慮到了，並提供了視像服務(註1)。

2.2 然而，就在2003年3、4月的時候，我們能夠這麼自豪嗎？

2.3 自持有優越於鄰近地區的現代化醫療管理、現代化醫院設備和現代化醫藥水準的香港，竟一時間手足無措，優勢盡失，疾病迅速擴散，大批醫護人員倒了下來(染病率曾一度超過20%，其中大部份是前線的護士)！

2.4 回顧香港在過去幾個月的經歷，可以說是驚心動魄的，帶來的教訓因而亦是極大、極深刻的。

2.5 我們認爲主要有下列幾個方面的教訓。

## (甲) 有關SARS的訊息交流方面

2.6 回顧2003年1月，毗鄰的廣東省爆發疫症，到2月達到高峰，以及香港在2月至4月期間的一些經歷(請參閱圖1)，可知香港對鄰埠以及香港內部，在有關SARS的訊息交流方面，並非一無所知：

- 儘管沒有正式的機制，港粵兩地曾非正式通報過有關疫情(見圖1「說明」的B)；
- 儘管特區政府的高層忙於處理財政赤字、公務員減薪等「內政」問題，本港的衛生當局以及部份醫務人員(包括大學教授、醫院高級醫生)等，對廣東正在或已經發生的大事有所了解和警覺，部份甚至與廣東方面有所接觸(見「說明」的C、D、E、F)；
- 2月上中旬之間，本港電子及文字傳媒曾對廣東的疫情有廣泛報導(見「說明」的D)；
- 2003年3月中，本港傳媒對威爾斯親王醫院爆發疫症，以及其後多間醫院倒下曾有廣泛報導，但似乎並無引起其他醫院足夠的警覺；

註1： 瑪嘉烈醫院是香港第一間提供視像探病服務的醫院。

2.7 儘管有所知悉，但對有關這高度傳染性非典型肺炎(SARS)方面的知識，包括疾病的臨床表現和特點、診斷和鑒別診斷、防護和治療辦法、追縱傳染鏈及有關科研、對疾病和疫情的嚴重性的認識等訊息，香港卻未予重視，亦未與廣東省主動或多些了解實情；香港內部則雖有醫院發生了疫症，其他醫院未能主動或多些了解詳情，以至一一陷入「無知」的「誤區」(註2)。

- 港人上上下下，從政府及醫院管理局的高官到專業人員(甚至包括大學教授、高級醫務人員以及自詡爲傳染控制方面的專家)，到各大小政黨/團、立法會議員、社會各界、普通市民，均警覺性曾甚低，甚不及時，「後知後覺」，甚至「後知」仍不「後覺」。(不容避諱的是，其中亦包括各醫護工會的負責人在內。)

2.8 其結果是：

- 廣東有關SARS的知識、抗炎的經驗及慘痛的教訓並沒有受到本港衛生當局和醫院管理局方面，以及醫護專業人士認真、積極的關注；

- 曾與廣東方面有接觸或對毗鄰的疫情有所了解和警覺的本港部份醫務人員，包括大學教授及高級醫生等，似沒能在2003年2月的時候，及時引起衛生當局、醫院當局以及前線足夠的警覺；

- 廣華醫院醫治"AA"[redacted]的失敗經驗沒能與其他醫院分享，沒能引起當局、其他醫院及醫護專業人員的警覺；

- 威爾斯親王醫院沒能首先、及早、就地阻止疫情在本院內的擴散，它的慘痛教訓竟沒能作爲其他醫院，包括本聯網轄下其他醫

註2： 有關訊息的交流方面，不單在粵港方面，甚或在本港內部，包括下列各環節均似乎出現了堵塞。例如威爾斯親王醫院於2003年3月8日至10日爆發了疫症，但該院行政總監馮康醫生在3月13日致醫院員工的公開信中，仍沒有把疫症與1個月前本港傳媒大肆報導的廣東「非典型肺炎」疫症聯想起來。交流的礙發生在多個環節：

- 特區衛生當局(政策局與衛生署)之間；
- 特區衛生當局與醫院管理局、私家醫院及安老院之間；
- 衛生署與屬下各辦事處、診所之間；
- 醫院管理局與各聯網之間；
- 各聯網與聯網之間；
- 本聯網各醫院之間；
- 本醫院各部門之間；
- 本臨床部門與前線、病房之間；
- 大學與大學(包括彼此的醫學院、微生物學系等)之間。

院，例如大埔拿打素醫院、聯合醫院、瑪嘉烈醫院、屯門醫院等的「前車之鑑」；

- 本港衛生當局對廣東省的疫情(包括「受控制」)的詳情沒有足夠的認識，低估了問題(包括威爾斯親王醫院疫情)的嚴重性，以至沒有能夠作出及早、全面、有效的部署(包括沒能及早對威爾斯親王醫院實行斷然的「封院」措施)；

- 醫院管理局高層、各醫院當局對轄下醫院、本院疫情的發展沒有足夠的預警，低估了疫情的發展和病人的數目。

.....

2.9 由此造成的嚴重後果是：疫情在本港的擴散一發不可收拾，全城陷入恐慌！

## (乙) 隔離護理措施及裝備方面的教訓

2.10 要成功控制疫症，關鍵在「防治」 —— 防護和治療，先行的應該是「防」字 —— 盡早防止傳染病的傳播、切斷傳染鏈，這是關鍵中的關鍵。然而，回顧這次抗炎歷程，正是在關鍵的早、中期階段，在這關鍵中的關鍵環節出了問題，隔離護理措施曾甚不及時、果斷，裝備供應曾甚不及時、充足，致令SARS失控。

### 問題之1：威院沒能及早採取嚴格隔離護理措施

2.11 威爾斯親王醫院8A病房於2003年3月4日收治了26歲航空公司男職員(被視爲該院傳染源頭)。在短短4至6天內，他感染了大批醫護人員及探病者(包括一名牧師)。雖然由2003年3月10日開始，該院採取了控制傳染措施(洗手和戴N95型口罩 —— 初時竟指示要一個月才換一個，稍後穿袍 —— 雖一更一件，供應仍很不足夠)，但並無及早「封房」、「封樓」，病房擠迫情況依舊；其時，有病人還由一間病房轉到另一間病房去洗腎(據了解，他其後被證實是淘大花園「疫樓」的源頭)。儘管曾有護士以對隔離護理的專業認識，向管理層提議應即禁止探病，但未予理會。探病者(其中包括不少醫護人員的家屬及同事)准予探病後可隨便離開，返回醫院其他病房、部門，或返回社區。

2.12 據了解，多間收治SARS病人的醫院，如大埔拿打素、瑪嘉烈、屯門醫院等，在早期均沒有禁止，甚至限制探病，亦沒有採取嚴格的隔離護理措施。

2.13 由於主管醫生方面對隔離護理意識淡薄或欠缺，沒有及早採取嚴格的隔離措施；由於當局對「封院」的考慮顧慮重重，致決定姍姍來遲。「立竿見影」的後果是：單由2003年3月8日至15日期間，疫症迅速擴散，令最少189人，包括探望源頭病人的7名家人和朋友，73名醫護人員和醫科生、50名同病房的病人和探望他們的家人受到了感染(註3)！不待院方提出「封院」的建議，其時SARS已經開始在社區擴散。

## 問題之2：忽忙備戰，倉惶應戰

2.14 幾乎每一間公立醫院在早、中期均曾有　忙備戰，倉惶應戰的共同經歷。絕大多數的病房，只給予1-2天以下的時間，便忽忽忙忙地改爲高危的SARS病房。不少醫院的病房，例如殉職的屯門醫院男護士劉永佳及醫生謝婉雯所在的病房，更是當天調走普通病人，騰出病床，當天便開始收治SARS病人。連加開ICU病床時情況亦差不多。

2.15 與此同時，這些醫院的內科部門幾乎每天臨時抽調護士、健康服務助理，或清潔工人，「走馬燈」似地去新的SARS病房護理SARS病人或負責清潔工作，每位大多只做一、兩更。初時，個別地方可供抽調的人手，屬「老弱殘兵」或大多爲年資淺的護士，臨床經驗不足，更遑論病房管理的經驗；而人手比例則多無考慮工作時須嚴格執行隔離護理的需要。不少非SARS或非內科部門則有抗拒抽調其部門人手的情形，因而出現有病房人手相當緊缺，有病房相對充裕得多的不公平情況。若非授權，醫院的護理總經理(GM(N))亦無權從一個臨床部門調動護士到另一部門。這種情形要經過1-2週才穩定下來。即使穩定後，不少地方在安排清潔消毒病房時，仍是忽忽忙忙，只給予很少的時間去騰空SARS病人，對前線護士的困難考慮得不多。

2.16 以當局於2003年3月26日指定，並於3天後成爲全港第一間專門收治SARS病人的某醫院爲例，該院在早期(2003年3月6日-17日)收治的SARS病人不多，只共有14名，應付得綽綽有餘，但到中期(3月18日-27日)收治了86名，開始感到了壓力。(見表1、表2)。

2.17 某醫院在早期尾只加開了一間SARS病房(同樣是忽忽忙忙)，中期則加開了3間。但爲了收治大量病人，在高峰期短短的6天內則把12間普通病房一下子改爲高危的SARS病房(尚未包括臨時加開的3間ICU)！

2.18 與此同時，受感染的醫護人員開始湧現。儘管醫院各不相同，大多數公立醫院的醫護人員均不約而同地在這段時間，並在這些臨時、忽忙

註3： 見2003年5月3日舉行的《廣州、香港防護SARS經驗交流會》上新界東醫院聯網風險管理及質素保證總監雷兆輝醫生的介紹。

加開的SARS病房(見表4)染病，包括2.13段提過的劉永佳及謝婉雯等。這種情況絕不是偶然的！

2.19 不單是公立醫院，負責監控跟蹤SARS病人及接觸者的衛生署指定診所等，同樣沒有給予較充裕的準備時間。

## 問題之3：防護裝備的供應不及時、不充足

2.20 早在2月15日，有醫院已提醒病房，收治非典型肺炎病人要申報，要防止飛沫傳染，員工應戴上外科用口罩(Surgical mask)、手套、穿袍，等等(見圖1「說明」的F)。但是，在當時，醫院並沒有具體指引，防護裝備亦沒有一早自動提供給病房。比較例外的是，某些特殊的工作場所，例如威爾斯親王醫院ICU及瑪嘉烈醫院傳染病房(因曾收治過患禽流感的病人)，倒是一早就提供了N95口罩，情況較佳。

2.21 儘管已有廣東省及威爾斯親王醫院的教訓(當時是2月下旬及3月上旬)，後來儘管明知要收治SARS病人，甚至已明知病毒的毒性及傳染性極高，但許多醫院仍未能及時供應外科用及N95口罩等防護裝備。其間，既使有供應，口罩的尺碼仍很不齊全，經常缺貨，引致許多前線人員向傳媒投訴。其他一些裝備，如眼罩、面罩等則還要稍遲才有提供(連一些ICU亦沒有例外)。供應情況各院不一致，有較充裕(例如大學醫院)，亦有限制使用、實行配給的情況，引起前線員工的恐慌及不滿。不少地方要到3月底才有供應，4月中仍有不足夠情況。衛生署4個指定監控中心同樣有防護裝備嚴重短缺，供應不及時的情況。

2.22 儘管前線告急，而某些可以在進行極高危程序(例如吸痰、插喉等)時，得較佳保護員工的裝備，則更要遲些才可以供應，並且數量極少，事先又沒有人給予過講解及示範；而一些更輕便的、更佳的裝備(見圖2)，則仍然只局限在極少數地方(例如威爾斯親王醫院ICU)，不能普及！

## 問題之4：執行混亂

2.23 直至疫症的高峰期，許多地方在執行隔離護理措施時，仍發現混淆不清之處，舉例如下：

(1) 收症及床位調配政策不清晰，無清楚交代過：
- 發燒與不發燒病人如何在急症室或病房分隔觀察？
- 確診及疑似病人需否分隔護理？
- 獨立房間床位已滿，或缺乏獨立房間，只有開放式間隔的病房，如何有效分隔兩類病人，而不致發生交叉傳染？

- 如病房全爲確診病人，但只有1張空床，如何收疑似病人？

(2) 清潔與污染區的劃分：
- 需否設立半污染區作爲中間緩衝地帶？
- 較昂貴及供應較緊張的防護裝備，因清潔區(病房外共用的地方)不能妥當儲存，而鎖在污染區(病房)內的問題，如何解決？
- 不穿鞋套的鞋子在清潔區與污染區之間來回有否矛盾，會否引致交叉傳染？

(3) 其他混亂的例子：
- 某醫院的SARS病房病床數定在28張，因而病床之間的距離大大改善，但該院仍有個別病房，擔心會臨時加床，病床數目保留36張。亦有醫院，SARS病房病床數目仍正式定爲36張。
- 醫護人員染病後，其中一件重要的事情是，盡快調查傳染的原因、背景、環境因素等，以防範其他同事「重蹈覆轍」。然而，各醫院調查事實、追查接觸者的做法不一，有醫院傳染控制組設計的問卷，內容簡單，無針對性，難以達到目的。
- 申報確診患者資料的混亂
  - 申報的格式及內容多變，令前線人員不勝其煩。
  - 雖然要申報，但不少醫院在早、中期，甚至高峰期初並無清楚界定「確診」的定義以及在什麼情況下申報，例如：－
    - 是開始使用利巴韋林治療之時？
    - 要等微生物學化驗結果？
    - 等主治醫生的點頭？
    - 等高級/顧問醫生的確認？
    - 等正式填表之時才申報？
- 某醫院擔心抽血員受感染，免去其上病房抽血的職責，卻要叫護士去承擔。
- 醫院管理局的《抗炎日報》叫醫護人員懷疑受感染時應即去沖涼，卻完全無理會大多數工作場所並無淋浴設施的事實。華員會聯同護士工會早在4月10日即曾公開呼籲，醫院應即增添更衣室、淋浴設施，病房加設洗手盆的建議(見附件1)，但未予正視(雖然工程技術上根本不成問題)。
- 發生在本港某精神病院的例子：
  - 醫院起初並無特別措施(儘管該院早在2003年3月已有接觸史的醫護人員染病入院被確診爲SARS；亦有病人入住過SARS病房的例子)。

- 新加坡精神病院(Woodbridge Hospital)爆發疑似病例後(已有人質疑爲何精神病醫院不隔離新入院病人)，才在收症房實施隔離措施。
- 已有93名病人的某病房，既要收新症，又要實行「隔離」，更要自行想辦法安置原病人，院方並無任何指示及協助。
- 照指示，床位相隔距離應有3呎，但因某病房有100張病床，實質一般只有6吋，甚至床貼床，爲零距離。(該院有病房還要再加添病床，令3呎距離成「紙上談兵」。)
- 全病房只有1個廁所，供100個病人用，如何隔離？院方並無提供解決辦法。

- 衛生署學生保健服務中心在疫情高峰時，顧問醫生突規定，如學生有發燒及SARS症狀，要向護士長報告，服務中心會即時爲學生及家長量度體溫，並由中心的醫生診症，而不是根據向來的做法，轉介他們到政府普通科門診去看醫生。然而，中心一直未能騰出一間合適的、有洗手盆及抽氣扇的獨立房間，去處理發燒的學生及家長，以至有時因要停下來消毒，令中心的運作時受阻礙。
- 衛生署護士去「疫樓」調查後，要回家才有淋浴設施；
- 該署監控中心須抽取上呼吸道分泌物標本送化驗，但抽取並暫存標本的房間連抽氣扇亦欠缺。員工雖曾反映過問題，高層無主動協助解決過。亦有員工主動提出改善設施的意見，但某些高層拒絕聽取，似全無任何預警、「未雨綢繆」的意識！

## (丙) 人力資源及調配方面的教訓

2.24 經驗顯示，是次抗炎，ICU的支援十分重要。然而，隨　大批ICU護士染病，突顯了各大醫院並無足夠的ICU人才。儘管例如瑪嘉烈醫院，早在疫症前已在輪調一些護士去接受ICU訓練，但人數不多，因而到了大批ICU護士染病，尤其是要由原來1間，加開3間ICU病房之時，爲支　極其重要的服務，被迫臨時抽調全無接受過訓練的護士到ICU。

2.25 不論是ICU或其他SARS病房均須嚴格執行隔離護理、防止交叉傳染的措施。然而，幾乎每一間公立醫院此時才發現，絕大多數員工在這方面的知識和技巧均甚欠缺，尤以低級員工爲甚。同樣缺乏的是有關病房管理的知識和技巧(部門主管、顧問醫生亦無例外)，以至決定病房的開啓和關閉、搬遷的部署時，失足無措，甚至出現「朝令夕改」，令前線人員疲於奔命的情形。

2.26 但是，即使抽調護士等人手，幾乎每一間公立醫院均曾遭遇困難，初時甚不順暢。主要原因是，每間雖有護理總經理，但並無中央調配全院護士人力資源的權力。權力分割予各臨床部門主管。(其後獲授權始有所改善。)

2.27 多間醫院以及衛生署均出現人手分配不公平的情況，如某精神病院有病房要收新症，要隔離新病人，病人總數接近100之多，然而護士人手與其他同類、但病人數目少很多的病房相同。

2.28 衛生署某些區域辦事處、某些服務面對極大工作壓力，人手相當緊張，護士要長時間超時工作，有不勝負荷之感。但卻可以有人(包括醫生)情況相反，可見人力資源並無得到合理、協調使用！許多調查資料要護士親自整理，高層竟無安排文員協助。

## (丁) 傳染控制概念、訊息方面的教訓

### ● 甫開戰即打大敗仗

2.29 本港自上世紀80年代中起，即已逐步建立了傳染控制的架構。至今，每一間公立醫院均有傳染控制組、由微生物學家擔任的傳染控制組主管及傳染控制專科護士等。然而，抗炎一役，就傳染控制而言，可說是甫開戰即打了一個大敗仗，多間醫院的前線無一例外，「前赴後繼」地，一個接一個地倒下來，「潰不成軍」！前人(最初是威爾斯親王醫院)的慘痛教訓竟不能成爲後人的「前車之鑑」！

2.30 原因有多方面，除上述外，就傳染控制而言，似還有其他一些因素。

### ● 片面強調飛沫傳染(droplet infection)

2.31 尤其是在早、中期，當局(衛生署、醫院管理局)以及傳染控制組等均片面強調疾病的飛沫傳染途徑，包括短距離(3呎之內)、短存活期(3小時)。

2.32 片面的強調降低了醫護人員，尤其是管理人員的警覺性，削弱了防護措施。但在耳聞目睹大批醫護人員染病後，又引起了恐慌；不少醫護人員在供應不足下，自行購買各類防護裝備，例如口罩、眼罩等，卻在部份地方引起了員工與管理階層之間的爭執。

2.33 由於片面強調飛沫傳染，早、中期的時候，一些指引甚至連小心接觸傳染(contact infection)，如何處理病人的嘔吐、排洩物等均不見提

及，致病人的大、小便不經消毒便沖走。搶救病人、插喉時要如何加倍小心防護更不見提及。

2.34 在面對一種不見經傳的新疾病，在對冠狀病毒的毒性、傳播途徑、存活期及其他特性尚未全面認識、掌握的情況下，片面強調其中一個傳染途徑以致沒有及早採取全面防護的措施，應是造成前線失守的主因之一。(倒是許多身處一線的病房護士一早自行採取了自我隔離的做法。他(她)們有些曾有幾個星期未與家人團聚，忍受了分離之苦，但爲減少交叉傳染作出了貢獻！)

### ● 資訊、指引的制訂及發放雜亂泛濫

2.35 有關控制傳染、「非典型肺炎」的資訊及指引曾「滿天飛」。但對尤其在早、中期，倉惶應戰中的前線護士來說，卻大多無時間去翻查細閱全部資料。事實上，那個時期，正確、全面又精簡扼要的指引嚴重不足，以致有病房護士要剪下報章的介紹作爲參考！

2.36 除資訊泛濫外，有關資訊、指引的制度及發放亦「政出多門」、口徑不一、「各自爲政」、各施各法，甚至指引的措施內容有互相矛盾之處。再者，絕大多數的指引、資訊以英文爲主，不利訊息的傳遞，尤以對低級員工而言。這種情況，在4月中以後才逐步改善了多少。

## (戊) 病房設計及設施佈局方面的教訓

2.37 是次抗炎突顯了公立醫院設計方面的嚴重不足，致未能有效執行隔離護理。

### ● 傳染病房嚴重不足

2.38 香港在上世紀70年代以前設有專門的傳染病院。其後規模縮小爲傳染病科，設在瑪嘉烈醫院的專科大樓，爲全港唯一一間。該科共有4層樓、數十間獨立房間，員工有寬敞的更衣室，內有淋浴設施，並有獨立的出入口及升降機。在80年代中以前，該科更嚴格執行不准探病政策，但到大批越南船民入住後，此項政策便日漸鬆弛，到90年代便形同虛設。

2.39 上世紀90年代中，該院改建專科大樓，爲免「浪費」資源，傳染病科規模進一步縮小爲只有3間傳染病房。其一爲E5，爲成人女病房，另一爲E6，爲兒童病房。只有這兩間各有附有淋浴設施的獨立房間9間。F5雖爲成人男病房，卻只有1間獨立房間，其餘爲「大格」，每

格有8張病床。另一方面，員工的更衣室大大縮小至更衣時會互相碰撞的規模，並設在病房的末端，而淋浴設備更全部取消！更甚者，E6與對面F6小兒科病房之間竟無大門阻隔，以至兒科病人可跑來跑去。E5及E6病房的獨立房間則在過了幾年後才加設一道門，制造了負壓的效果。但F5全無改進，以致需要獨立房間或需要負壓來執行隔離護理的男病人，要轉往對面E5的女病房！與此同時，傳染病科合併於內科部門，取消獨立成科。

2.40 儘管如此，由於設有負壓的獨立房間，亦由於在早期收治SARS病人的數目不多，該院傳染病房能連續4周無員工染病，並在近4個月後的今天，仍只有2名員工受到感染(其中1名可能是在其他臨時加開的SARS病房受感染)。另一例子是，瑪麗醫院亦因爲有獨立房間，加上收治SARS病人的數目不多，故能連續8周維持零感染。

2.41 假如瑪嘉烈醫院傳染病科仍有數十間獨立房間，威爾斯親王醫院最早染病的醫護人員及病人能一早轉來並實施嚴格隔離護理，香港的歷史或將會改寫！

2.42 除瑪嘉烈醫院外，其他公立醫院並無傳染病房，需要時要轉介傳染病人至瑪嘉烈。前年，當香港爆發禽流感時，瑪嘉烈醫院傳染病房大部份患有肝炎等傳染病的病人要轉移去其他普通病房，以隨時接收患禽流感的病人。其時，香港缺少傳染病房的情況，假如能受到政府當局、醫院管理局高層的重視，並預作部署，則這次香港迎接SARS挑戰的歷史也或將會改寫。

## ● 普通病房缺少獨立房間

2.43 本港公立醫院普通病房大多缺少獨立房間。以內科及老人科病房爲例，平時僅有的1至2間獨立房間收治了需要逆向隔離(reverse isolation)的病人(如白血病患者)，便無法接納需要防範空氣傳染的肺結核或其他需隔離的病人。即使可以，因房間內並無負壓，亦不能起有效隔離的作用。這種情況長期存在，並曾在前幾年在伊利沙伯醫院出現過涉及職業安全及健康的小風波，遺憾的是，至今仍未能引起各方面的關注及跟進。

## ● 病房的空氣流通欠佳

2.44 本港的公立醫院在改建後全部變爲封閉式的空調醫院。長期以來，不少醫院，尤其是它們的內科及老人科病房甚爲擠迫(因要長期加開額外病床，甚至臨時病床)，員工經常投訴病房空氣差，「焗悶」，常患

上呼吸道疾病，卻一直沒有受到重視。少數病房其後加設了抽氣扇，情況才有所改善。

2.45 封閉式、全空調的大廈辦公室不時引發的「退伍軍人症候群」並沒有引起醫院設計者及負責職業安全及健康風險管理者的注意。病房並無訂定定時開窗流通空氣的制度。(爲安全理由，不少病房的窗戶只能打開一條只有數厘米闊的隙縫。)空調隔塵網雖有定期清潔，平時並無加密、加強。抗擊SARS期間有所改善，仍不足夠，清晰制度仍不足。

2.46 廣州防護SARS經驗之一，是加強病房的空氣流通，減低SARS病毒的濃度。然而，雖屬近鄰，曾有推介，並且在華員會代表與廣州交流返港後公開、 重提出之後，有關當局仍未予足夠重視(見附件2)。某醫院打破零感染的事件，據該院傳染控制組的報告，原因可能與病房內同時給予3位病人高濃度氧氣有關，致室內病毒濃度大大增加。事件顯示，該組顯然並無汲取他人的經驗教訓，因而沒有採取有效改善措施所致！(倒是醫護人員爲爲彌補不足，自行創造出「土辦法」，引導SARS病人噴出的空氣到窗外，減少了病房空氣中病毒的濃度，也減少了傳染的機會。)

- **病房設計及設施的佈局殊不合理**

2.47 除缺少獨立房間外，不少病房的設計及設施的佈局亦殊不合理，增加了交叉傳染的機會。除前面提過的洗手、更衣、淋浴的設施欠缺，以及最近才被發現的有病房，污染的空氣流經護士台的不良設計外，尚有：-

- 儲存物料的空間欠缺；
- 護士辦公室設在病房內(當成爲SARS病房時，即在污染區內)；
- 清倒、清潔嘔吐、排洩物及大便盆、小便壺等器皿以及污染物品被服的場所，竟設在護士台對面、病房的中央，或甚至荒唐地設於病房以外、兩間病房之中，與治療房、清潔器械房爲緊鄰的地方！

## (己) 管理體制方面的教訓

2.48 是次抗疫，突顯了政府、醫院管理局及醫院在管理體制方面的不足、不是之處。

- **架構官僚、僵化**

2.49 醫院管理局的架構過於龐大。沒有成立聯網之前，醫院間的聯繫相當

鬆散，在權力下放後，各自爲政情況嚴重。成立後，關係較前緊密，需要時並可適當調配人力資源；但聯網與聯網之間仍少交流，聯繫並不緊密。而每一「龍頭」大醫院的總監卻須同時兼任聯網內的總監，要監察、管理屬下多間大小醫院，難以兼顧。

2.50 儘管醫院管理局成立後片面強調了管理方面的作用，大大提高了管理人員的地位；儘管每一間醫院都有一套套寫得飄飄亮亮的守則、指引、手冊、危機應變程序.....但到這次迎戰SARS，真正需要處理重大危機之時，卻顯得手足無措，狼狽不堪，有如俗語所謂：「講就『天下無敵』！」

2.51 人們看到的是：缺乏預警。平時，醫院並無對自身應付重大事故、大流行病的各方面能力及不足，有客觀、真實、充分的估計及準備。SARS爆發後，則對疫症的發展，包括對病床數目、ICU支援、防護裝備等物料的供應等等估計嚴重不足，反應不夠迅速、果斷。

2.52 人們看到的是，各聯網，甚至有同一聯網內各醫院以至各臨床部門，各自爲政，缺少統籌及由上至下的強而有力的領導。制定政策、措施，初時搖擺不定，甚至「朝令夕改」，對前線的實況、苦況了解不足。一個普遍的情形是，在普通病房改爲高危病房之時，可看到：

(1) 在決策過程中，前線護士寶貴的、專業的聲音未被聆聽過；
(2) 缺少考慮把普通病房改爲高危病房時，將會碰到的實際問題和困難；
(3) 防護措施，包括控制傳染的指引，沒能同步頒佈；
(4) 配套設施、防護裝備沒能同步到位；
(5) 收症、分流分治及床位調配政策沒有能同時清晰制定並頒佈(起初欠缺，其後雖有，仍引起混淆)；
(6) 人手調配久缺全面考慮，亦欠缺清晰、書面指引(大多只靠口授，事後又不補發)，對前線人員身心健康的考慮不足。

## ● 管理文化落伍

2.53 醫院管理局成立後推行的管理制度和措施，並無真正以人爲本(沒有真正把病人及員工的身心健康和安全置於首位)，無真正以病房服務爲本。強化管理功能及主管醫生壟斷地位之餘，嚴重削弱了護士及專職醫療專業地位及他們與醫生相互間的制衡，團隊精神成了紙上的東西，員工諮詢成了「花瓶」(有些甚至連「花瓶」亦拋棄了)，更遑論夥伴合作關係的建立了。內部資源向高級醫生及高層行政管理傾斜；員工關係長期處於緊張，甚至對立的局面；員工與各級管理階層長期處於互不信任的氛圍之中，致員工士氣長期低落。醫院管理局高層對此輕視、　視、拒不承認已久。

2.54 許多員工，甚至包括高級醫護人員，會前、會後怨言、問題、牢騷甚多，但會上則少說或甚至不說，這種情況，已見怪不怪。

2.55 難怪員工只熱衷於向傳媒投訴，認爲公開投訴才能迫有關方面重視。即使醫院管理局設立了熱線電話，絕大多數致電的員工均不敢透露真實姓名及工作地點，仍有人繼續選擇向傳媒投訴！

## ● 對護士的管理、訓練和調配

2.56 自醫院管理局實行其新的管理架構，原本由上至下，較爲完整的護理管理架構被割裂(見圖3)。醫院的護理總經理在整體醫院架構中基本上處於一個顧問式的、附屬的位置。他(她)不能根據全院護理服務的需要，去協調各不同科目的臨床部門的護士人手，並在需要時去作及時、適當的調配，以回應發展上的、額外的或突發的需求。他(她)亦不能爲了護理服務、護理專業及個人發展所需去爲全院護士制訂通盤計劃，令各級護士均有豐富的基礎訓練及不同專科的實踐經驗。他(她)在涉及病房管理、資源調配(除自己轄下一小部份外)、臨床服務設置等問題上，均無實質的參與權。就連在傳染控制這個與病房管理息息相關的重要問題上，亦是如此。

2.57 由於醫院管理局的管理架構，把低至臨床部門的層面，原來護士與醫生之間的專業夥伴(professional partnership)關係，變爲上司下屬(boss and subordinate)的關係，亦由於管理文化的緣故，總經理級別以下，各級護士在病房管理、資源調配、臨床服務設置等問題上，均缺少平等參與及發言的機會；亦沒能在護士與醫生之間的溝通和配合、病房床位的調配、隔離措施的執行等事宜上去平等商議。

2.58 在衛生署方面，護士總監在整個部門管理架構中所佔的地位不重，發言權亦有限。對其餘各級護士而言，部門並沒有確立夥伴合作的管理文化，沒有制定適當的機制，因而在診所管理、服務設置、隔離措施和裝備等等方面，同樣缺少實質的參與及發言的機會。

# 三、 香港的醫務衛生服務體系應予全面檢討

3.1 近4個月的抗擊SARS的戰役，令香港損失了好幾百億元。直接投入公立醫院、衛生署的抗炎開支以及其他政府部門提供支援服務的開支，加起來恐亦在幾十億元之數。

3.2 多年來削減前線人員所節省下來的公帑，恐怕不及此次損失的零頭。正應驗了「辛苦來，瘟疫去」的說法。由此應該令爲政者反思：如何全面、長遠、健康、可持續發展香港的醫務衛生服務？需要什麼戰略眼光？短視、急功近利、「成本萬歲」、拼命削減前線人員的觀念要不要重新去審視？醫療資源的分配要不要重新去檢討？

3.3 兩年半前，2000年12月，政府公佈了《你我齊參與　健康伴我行》的醫護改革諮詢文件。本來，若能藉機積極跟進醫務衛生服務的檢討，特別是加強預防疾病、基層醫療的工作，擺脫偏重醫院治療和醫療融資及資助問題，及早制定並開始邁向長遠戰略目標，則這次匯合全港各政府部門及社會各界抗炎的力量，或將更及時、更有力、更有效。

3.4 政府已決定成立疾病控制及預防中心，這對於建立對傳染病、流行病的預警、控制、防護的具體機制肯定幫助極大。但我們希望政府應同時考慮上述3.2及3.3段的意見以及香港衛生界專業團體聯席會議於2001年3月31日建議成立的一個跨局、跨部門的機構去推動、處理、協調加強全社會預防疾病的工作(見附件3)，把疾病控制預防做得更全面，更徹底。

3.5 政府亦應積極考慮如下問題：

- 如何確立可開展中西醫結合防治疾病的機制？
- 如何切實加強基層醫療及社區護理服務？作用何在？
- 如何切實制訂護老院的管理及監管制度，改善環境衛生及服務質量？
- 公、私立醫療系統如何有效溝通、合作和配合？
- 如何全面制定及切實執行公共衛生政策？

# 四、 抗炎突顯公務人員隊伍的重要

4.1 行政長官董建華在這次抗炎戰役裏，動員了龐大的資源和力量來抗擊SARS。依靠公務人員隊伍的支持和合作，加上其他方面的努力，香港終於有效地控制了疫症，擺脫了疫區的惡名。

4.2 除了數以萬計來自公立醫院及衛生署的醫護人員外，還有數以萬計、來自社會福利署、食物環境衛生署、民政事務署、房屋署、康樂及文化事務署、機電署、建築署、消防署、警隊等不少政府部門的公務員。後者提供了同樣重要的支援服務(見附件4)。

4.3 由於疫情緊張，時間緊迫，他們往往要輪班，甚至半夜逢召執行工作，平日常要超時工作，假日則還需要工作，以盡快完成任務。部份公務員同樣要冒 受感染的危險；不少人還成爲市民發洩不滿的對象，困難不小。

4.4 另一方面，由疫症的中期到高峰期，由於傳媒的大肆報導，市民普遍存在著恐慌，以至於有公立醫院即使用高薪亦招聘不到低級員工；有供應商寧願不賺錢，不敢送貨到醫院或不敢接外判的工作。這與公務人員堅守崗位的情況有很大的反差！

4.5 幸虧香港還有一支有效率的、堅守工作崗位、發揮團隊精神的公務人員隊伍 —— 他們在抗疫時並無索求額外利益 —— 有力地支持了政府的抗炎決心、執行了政府的部署。

4.6 抗炎突顯了公務人員隊伍在政府面臨重大挑戰、重大危機之時的重要性。不能設想，如政府不顧一切地推行「小政府」政策，把許多公共服務外判出去，一旦有事，行政長官還能夠有如這次般，可以自如地動員龐大的資源和力量嗎？

# 五、結語

5.1 在抗炎已取得重大成果的今天，我們期望政府、醫院管理局、醫院當局以及社會各界能看到：

(1) 疫情是沒有彊界的。在香港與內地的關係越來越緊密、香港與海外因全球化的聯繫越來越緊密，以及香港內部，人口密集、往來頻繁的情況下，加強有關傳染病、流行病訊息的及早通報、交流，十分必要。爲此，須客觀、謙虛、科學、警覺、大度、理性、全面，以人的生命健康爲前提，以香港整體利益爲依歸。(2.6 - 2.7段)

(2) 對傳染病要嚴格執行隔離護理措施，並要盡早、全面、持久。對新的疾病，要採取慎重的態度，加倍地小心防護。爲此，要全面提高防護知識及技巧，以及人人有責、上下一心的意識，制訂恰當、全面、精簡的指引，及時提供相應的配套措施和裝備。(2.9 - 2.22段；2.30 - 2.33段；2.34 - 2.35段；2.36 - 2.46段)

(3) 適當的、有足夠訓練的人力資源得在戰時、平時或突發有需要時，獲及時、恰當、公平的調配。爲此，平時應有計劃地，分期分批地進行培訓。前線人手應客觀評估，盡早補充。(2.23 - 2.27段；2.55段)

(4) 管理文化應真正以人(病人和員工身心健康)爲本，以發揮員工聰明才智，以凝聚、動員員工，發揮團隊精神，弘揚夥伴合作新文化爲依歸。管理架構、制度的設定，應以體現上述新管理文化，滿足3個需要(病人服務需要、專業發展需要、個人發展需要)爲準繩。(2.48 - 2.54段)

(5) 充分認識及發揮各級(尤其是基層、前線)護士在整個防護戰役、整個醫務衛生服務中的角色及潛力。爲此，應改變醫院臨床部門層面，護士從屬醫生管理的、窒息護士發揮專業自主性的架構和制度，應授權予護理總經理統籌管理醫院各級、各科護士及全院護理服務的實權，並爲此應加強對包括護理總經理在內的各級護士的培訓。衛生署方面亦應在架構及制度上，確立各級護士得在政策制訂及執行方面有更平等、實質的參與及發言。(2.23 - 2.37段；2.52 - 2.57段)

(6) 全社會理性探討香港醫務衛生服務發展的方向，大力開展基層及社區護理服務，持之以恆地改善環境衛生，並爲之訂定切實可行的清晰的目標和時間表。(3.1 - 3.5段)

(7) 加強建設高效率、高質素，對政府有向心力、對社會有歸屬感和承擔的，能解決問題、處理危機的公務人員隊伍。爲此，應分析有效回應香港內外部面對的挑戰、發揮所處位置的作用所必備的特區公務員隊伍應有的要素，並以政策、制度、培訓來實現之。爲此，應重新審視「小政府」、外判、私營化政策。(4.1 - 4.6段)

5.2 這次抗炎，我們看到了，儘管有這個那個缺失(特別是在早、中期)，上自特首、衛生福利及食物局局長，到醫院管理局的主席、總裁，再到醫院當局，以至前線醫護人員，以及許多政府部門的公務員和社會各界，整體上能全力以赴，盡力而爲，堅守崗位，盡忠職守。其中，更迸發了人性中光輝的精神 —— 關愛、忍耐、寬容、大度、無私、奉獻、犧牲、齊心、協力。

5.3 我們認爲，全社會應共同努力，珍惜並繼續發揚這些可貴的精神，並把它們化爲動力，以改善香港的醫務衛生服務、協助特區政府盡快復蘇香港的經濟。

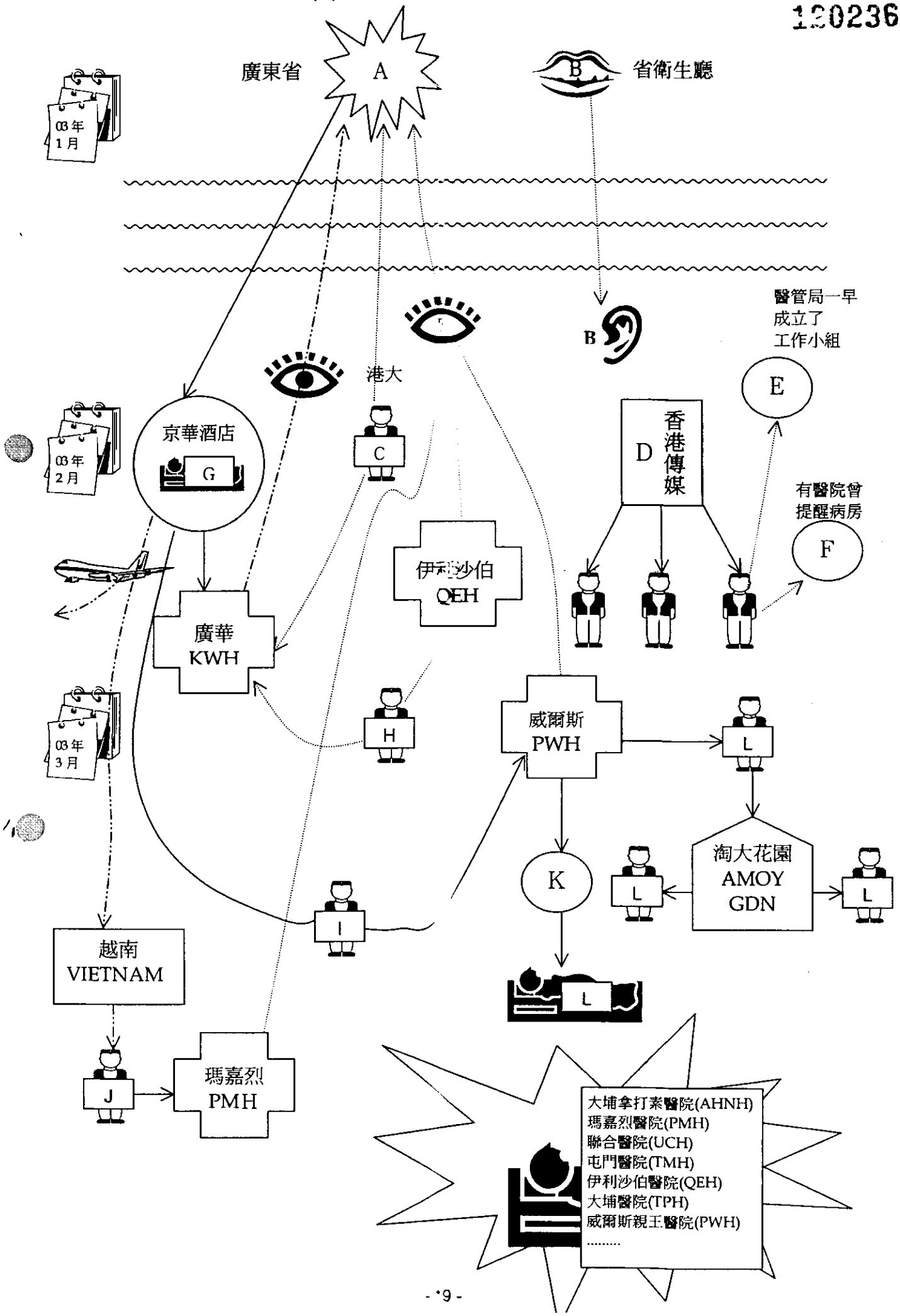
5.4 有人說，SARS有可能會在今年的冬天回頭。又有人說，人類將面對更多新的疾病、病毒。無論如何，我們認爲，有效的防護，是成功對抗疫症的關鍵。

5.5 真正有效的防護，需要
＊上下一心，官民一致，同舟共濟，攜手合作，相互支持；
＊相互理解、包容和體諒；
＊坦誠、有效的溝通和商量；
＊醫療系統內的夥伴合作關係新管理文化的建立！

※ ※ ※

**圖1：2003年1-3月的經歷**

130236



# 圖1說明

130237

(A) 2003年1月，毗鄰的廣東省爆發非典型肺炎(「非典」)疫症。

(B) ● 其間，廣東省衛生廳[redacted]「坦言，今年1月發現「非典」疫症的早期，她個人與香港方面有交流過意見」(見香港《大公報》的《非典檔案》，03年6月9日)。

● 2月10日，南方網首次報導了廣東省發生了疫症以及「非典」的症狀和傳播途徑(見2003年5月出版的總第151期《紫荊》雜誌)。

● 2月11日，廣東省衛生廳召開新聞發佈會，首次公開疫情。另外，同日，據上述《紫荊》雜誌，中國衛生部向世界衛生組織(WHO)首次作了報告。

(C) 2月初，香港大學[redacted]應廣州呼吸病研究所[redacted]的邀請，到廣州研究疫情的病原。2月12日，他再次到廣州，代表港大微生物學系與廣州多個醫療機構簽訂了合作協議，組成「廣州市非典型肺炎研究協作攻關組」，全力協助查找病原(同見《大公報》報導)。

(D) 2月上中旬，廣東省的疫情達到高峰，引起恐慌性搶購白醋、板藍根。對此，香港各大傳媒曾有廣泛的報導，其中2月11日香港《文匯報》頭版及2版載有如下報導：

– 「粵致命肺炎獲控制」、
– 「非典型肺炎症狀」、
– 「粵緊急部署防治」、
– 「中央派專家南下協助」、
– 「專家：怪病可治療」。

在報導香港的反應時，該報說：「衛生署關注『怪病』進展」，內文提到：

– [redacted]表示，*衛生署已就今次事件與內地有關部門接觸*，並會研究是否需要採取適當措施應變。他呼籲市民外遊返港後，如發現(病徵)，要盡快求診，並告知醫生曾經外遊.....
– [redacted]指出，目前正與廣東當局保持密切的聯繫。
– 香港大學醫學院[redacted]醫生指出，暫時仍未有足夠的證據顯示是何種病毒感染的疾病.....*他呼籲市民不用太過緊張*。

(E) 2月11日，醫管局成立針對「非典」的工作小組，以每天收集個案，向衛生署呈報以作流行病學研究，並評估「非典」傳播情況。

(F) 2月15日，某醫院向內科病房傳達口訊：收治「非典」病人要上報；防止飛沫傳染，應用獨立房間隔離、員工應戴上外科用口罩、手套，穿袍、洗手及消毒環境。 "AA"

(G) 2月22日，[redacted]因「非典」入住廣華醫院，即送入ICU(2月28日與[redacted]無直接接觸的廣華醫院急症室護士[redacted]染病入院)。據院方， "AA"

– ICU即已要求同事把病人隔離，戴N95口罩、洗手、穿保護袍，其後了解與病人相處很短時間的家人亦受感染後，要求同事進餐及休息時要分開，勿太接近。
– 廣華醫院曾邀請其他醫院醫生(剛去過廣州的港大[redacted])會診。
– 已即時通知醫管局。
– [redacted]醫生表示，早於農曆新年後「內地平潭縣有本港居民於內地逝世，.....內地傳出搶購板藍根、白醋事件時，我便開始留意一些非典型的上呼吸道感染個案」。
– 3月3日，該院高層開會決定採取防染措施。(見廣華醫院《「SARS」檔案實錄》，03年5月2日、9日) "AA"

(H) 3月4日，廣華醫院手術室，在伊利沙伯醫院胸肺科醫生的協助下，爲受感染的疑似病人([redacted]的妹夫)割取肺組織，交予衛生署及港大作化驗及研究(十多天後證實有冠狀病毒)。(同見上述報導)(據了解，伊利沙伯醫院的醫生並不知病人是疑似患者，有關手術儀器借用後帶回伊利沙伯醫院時並無特殊處理。)

(I) 3月4日同一天，任職航空公司職員的26歲男青年(曾到京華酒店訪友)入住威院，並曾用噴霧器紓緩氣喘。

(J) 3月6日，瑪嘉烈醫院收治一名由越南返港的「非典」病人，爲該院首宗；3月7日又接收第2例「非典」病人。

(K) 3月7-8日，威院8A病房舉行醫科學生內科試。

(L) 3月8日-15日，這位青年病人共感染了189人(或以上)

| | |
|---|---|
| －病人(I)的家人和朋友 | 7名、 |
| －醫護人員、醫科生 | 73名、 |
| －其他病人及其家人 | 50名(3月16日－29日又有40名醫護人員染病)！ |

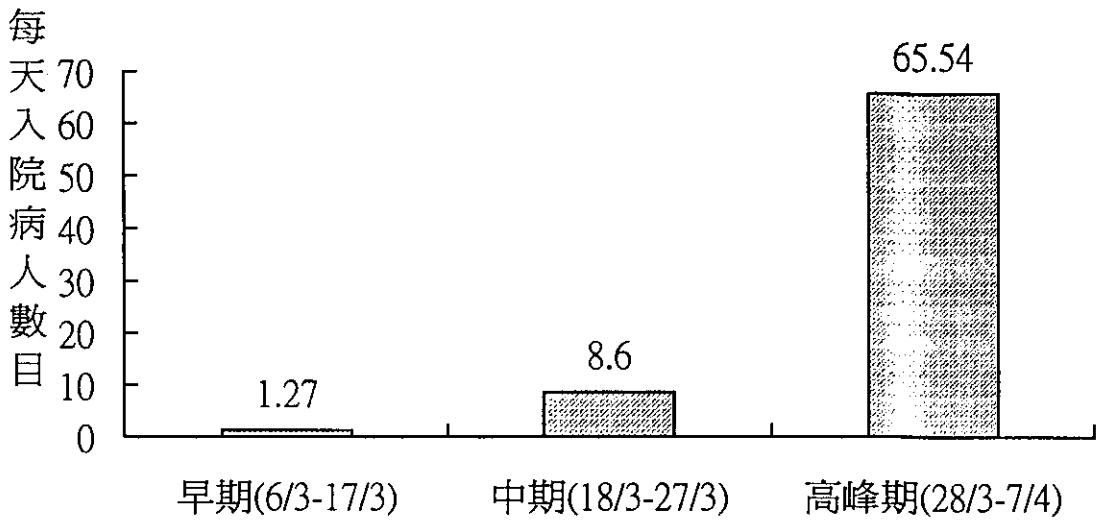
**表1：某醫院早、中期收治SARS病人情況**

| 階段 | 早期 | 中期 |
|---|---|---|
| | 03年3月6日－17日 | 03年3月18日－27日 |
| 收治SARS病人(包括疑似患者)人數 | 14 | 86 |
| 平均每天收治人數 | 1.27 | 8.6 |

**表2：某醫院高峰期收治SARS病人情況**

| 階段 | 高峰期 |
|---|---|
| | 2003年3月28日 － 4月7日 |
| 收治SARS病人(包括疑似患者) | 721 |
| 平均每天收治人數 | 65.54 |

**表3：某醫院早、中及高峰期收治SARS病人比對情況**



## 表4：某醫院普通病房改爲高危SARS病房與受感染醫護人員關係圖

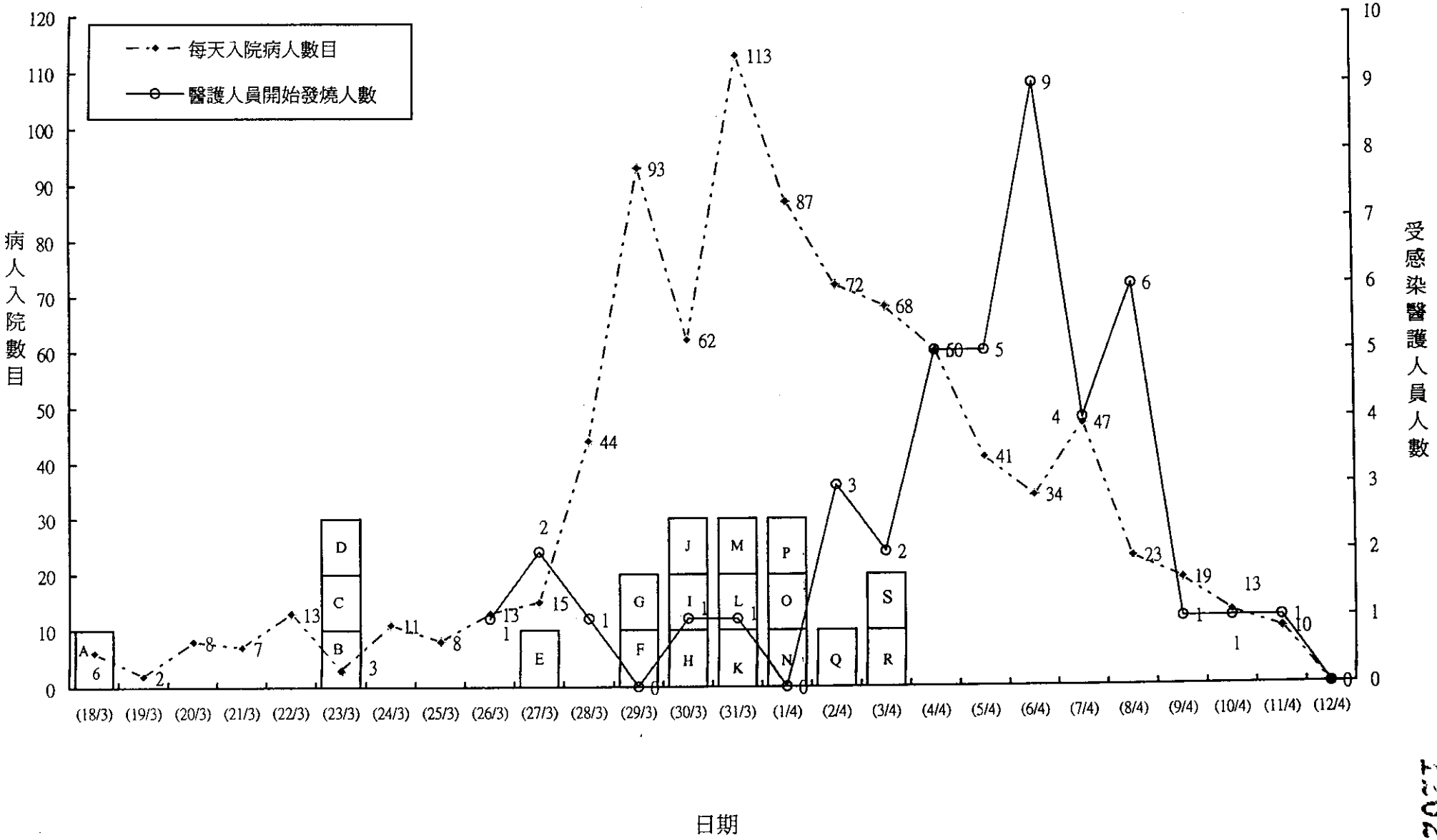
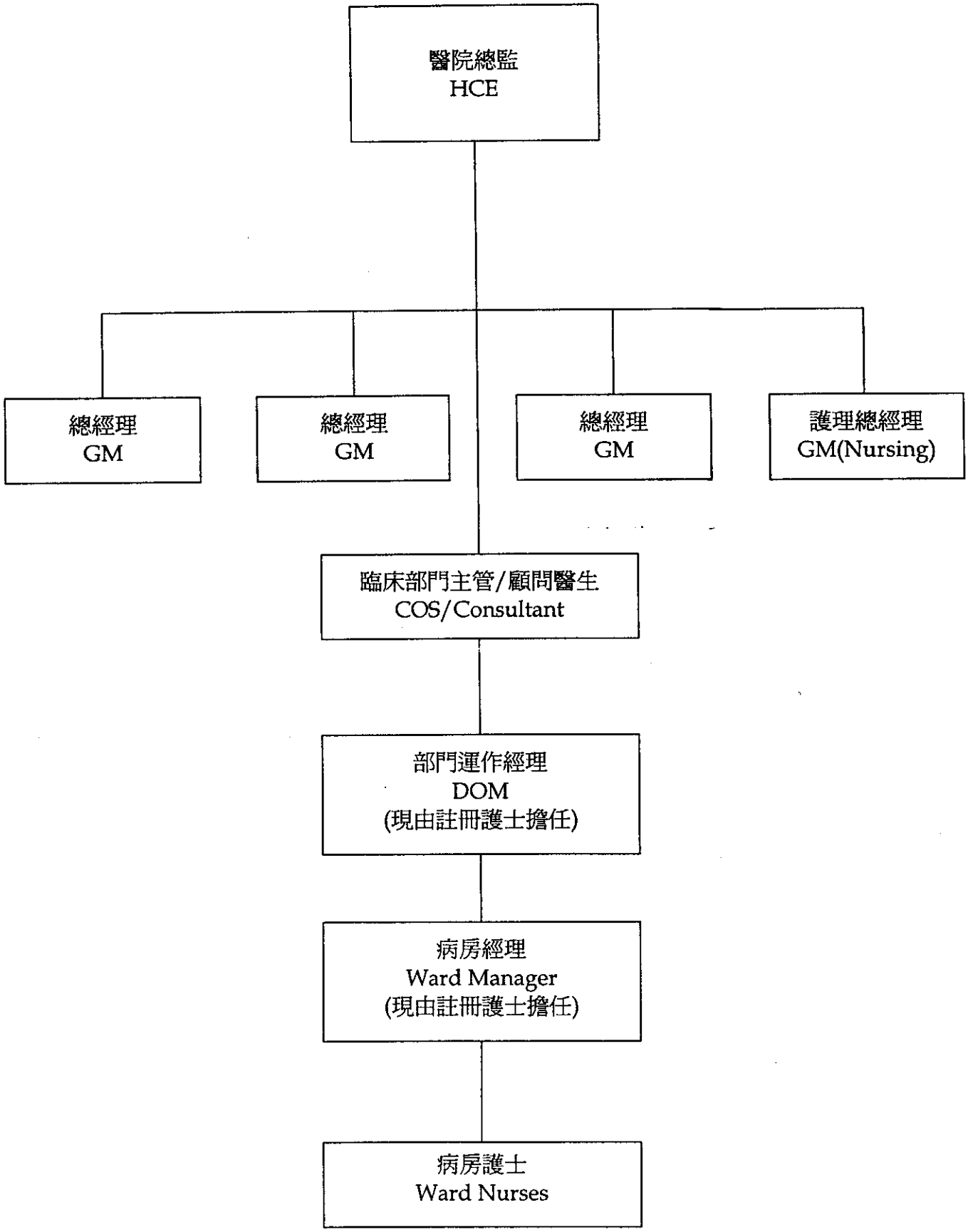


圖 2： 易戴上除下，可防水及遮蓋肩膊以下的頭套

圖3：公立醫院的護士管理架構圖



# 附件 3：香港衛生界專業團體聯席會議
# 有關設立權威性機構去加強預防疾病的工作

要能有力、有效地匯合全港各政府部門及社會各界的力量，單靠衛生福利局一個政策局的努力是不足夠的。特區政府應在政府總部的層面，成立一個跨局、跨部門的權威性機構去推動、處理、協調有關事宜。

這個機構可以透過教育統籌局、食物環境局等相關的政策局，在由幼兒園、小學到中學的課程內增設預防疾病、健康衛生、良好生活習慣、個人負責任意識等由淺到深的科目，以及把體育運動視爲必備、必修科目之一；改變嗜吃非健康食物（例如：含鹽份、脂肪、碳水化合物過高的零食、炸薯片等）；加強反吸煙的教育和措施；廣泛、持續、有系統地爲成人舉辦預防疾病、健康衛生、良好的生活習慣、個人承擔義務及負責任的意識，以及食物和環境衛生的教育；加強反對污染食物、水、空氣、環境的教育和控制，等等。

這個機構可統籌和協調衛生署、教育署、食物環境衛生署、社會福利署、環境保護署、水務署等部門的教育、推廣、執法的工作和計劃。其指導方針是：多從源頭、基層、前線、幼年開始。

（摘自《聯席會議》致政府「醫護改革小組」的意見書
第 11（6）段，2001 年 3 月 31 日）

# 附件 4：不同政府部門公務員爲抗炎提供的支援服務(部份)

- 執行淘大花園隔離令，並協助居民遷入隔離營(時已半夜)；
- 向服從家居隔離令及遷入隔離營的市民提供輔導、供應膳食、購買日用「必需品」；
- 向 SARS 病人、其家人及市民提供輔導；
- 照顧 SARS 病人的幼童；
- 代家屬查詢 SARS 病人的治療情況；
- 跟進 SARS 受害人及其家屬的個案；
- 協助有需要人士申請經濟援助；
- 爲長者、殘疾人士提供照顧及特別需要的安排；
- 關懷探訪計劃：探訪全港老人院舍(包括私營老人院)、幼兒園、幼兒院舍、弱能人士宿舍，檢查及協助執行預防 SARS 措施；
- 關懷行動計劃：爲社區長者及有特別需要人士提供家居清潔、簡單維修工作，爲此，策劃創造了 4,500 個臨時職位予清潔及維修工人，並對有關計劃進行聯絡、實施及跟進進展等工作；
- 處理「工商界關懷非典型肺炎受難者基金」的申請、會面評核、批核、聯絡、轉介等事宜；
- 處理「賽馬會慈善信託基金」所有非政府機構要求撥款進行防炎措施及清潔之用的申請、評核、查詢、聯絡等事宜；
- 清洗街道及圍村，管理承辦商清理街道，檢查垃圾站及廁所(包括水廁和旱廁)以及檢控工作；
- 接載公務員同事往「疫廈」、「疫區」工作；
- 配合全職清潔小組工作，檢控違例、違規吐痰人士；
- 繪製淘大花園天井去水設施圖則，用作向世界衛生組織提交的公開報告資料；
- 繪製加建及改善醫院傳染病房圖則；
- 協助磡察政府樓宇/建築物清潔，配合全城清潔小組工作；
- 爲天水圍天恩　空置的中轉房屋共 2016 個單位，加裝住家設施，使其成爲 SARS 隔離宿舍。
- 爲醫院安裝抽氣扇等通風工具、調校空調機換氣頻率、清潔消毒隔塵網，等等。

120244

附件2

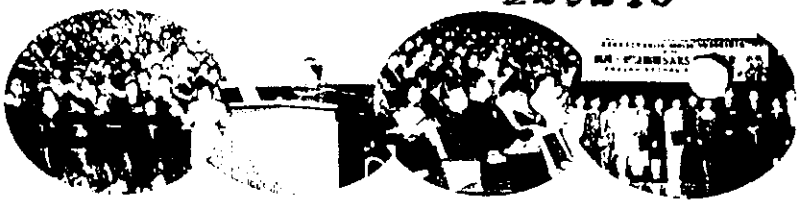
# 廣州、香港防護SARS

# 經驗交流會報告

(2003年 5月3日、12日)

香港政府華員會 暨 護士分會、登記護士分會

NGU 香港護士總工會 聯合舉辦



# 默哀、悼念

全體起立，默哀1分鐘，悼念在抗炎
一役中殉職的屯門醫院男護士劉永佳先生、
西醫劉大鈞醫生、本港市民，以及內地、
台灣及世界各國不幸逝世的人士。

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# 前言

對香港來說，毗鄰的廣州在今年1、2月防護SARS(非典型肺炎)的經歷；對本港其他醫院、診所、醫療機構來說，威爾斯醫院、瑪嘉烈醫院，還有其他一些醫院在今年3、4月的防治經歷，有哪些寶貴的經驗可以汲取？哪些慘痛的教訓可以記取呢？

「他山之石，可以攻玉」，「前事不忘，後事之師」。

只有謙虛地學習廣州的經驗；只有坦誠地、科學地總結本港在防護及治療SARS的經驗教訓，

— 才能為本港以及本港其他醫院、為未來的防疫提供有效的「前車之鑑」；

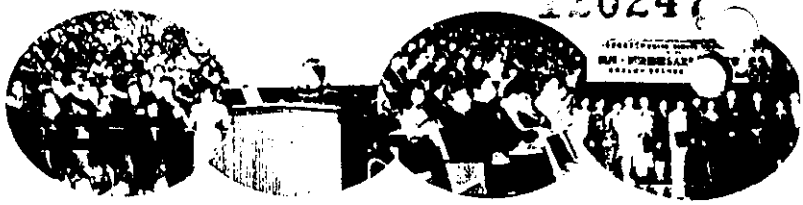
— 才能找出實現「零感染」的辦法；

— 才能鞏固各方面不斷努力和改進下取得的成果；

— 才能戰勝恐懼的心理，建立必勝的信心；

— 才能盡快取得抗炎一役的最後勝利；

— 才對得住因染病殉職的屯門醫院護士劉永佳及醫生謝婉雯、聯合醫院健康服務助理鄧香美，西醫劉大鈞和不幸逝世的市民！



## 蘇肖娟會長致開幕詞：

# 他山之石　可以攻玉

「非典型肺炎在本港肆虐已接近兩個月，迄今仍待有效控制。此症不但威脅着市民和前線醫護人員的安危，更打擊了本已疲弱的經濟，估計本港將損失達數百億元之巨。由於政府為紓解民困，額外增加了百多億的開支，但收入必將大減，本年度財政赤字料將更為龐大；多間銀行、信貸機構正在調低本港的經濟增長數字和評級，情況實在令人担憂。

「鑑於在確診的病人中，約有四份之一是醫護人員(編註：現已降低)，如何確保醫護系統不致崩潰，應為當務之急！為此，本會代表於2003年4月15、16日訪問了廣州和澳門，與兩地醫護人員就防治非典型肺炎措施進行了交流。透過交流，本會認為要打贏抗炎一役的關鍵在：(1)盡早控制疫症的蔓延；(2)保持前線人員的身心健康；(3)提高治療效果。

「雖然本港未能因前有年初廣東省爆發非典型肺炎，後有威爾斯親王醫院的「前車之鑑」，而及時警覺，並在本港及其他醫院採取有效、有力的預防措施，但在政府高層、衛生署、醫管局、各公立醫院等上上下下的共同努力下，近月來，已逐步採取了適當的防護措施，包括隔離患者或疑似患者的行動，疫情開始有穩定的跡象，不過成效仍有待觀察，仍待全體港人加把力，及早控制疫情。

「然而，令人十分憂慮的是，仍有不少前線醫護人員受到感染，日前更有屯門醫院男護士劉永佳殉職*(編註：至截稿時已有屯門醫院謝婉雯醫生及聯合醫院健康服務助理鄧香美女士相繼殉職)*。由於越來越多的公立醫院正在或將收治SARS病人，假若防護措施及意識能進一步加強及改善，院方管理層若能從其他醫院、其他病房汲取到經驗教訓，則情況應不必悲觀！因此，亡羊補牢，未雨綢繆已是刻不容緩！廣州、香港之間及本港各醫院之間，透過坦誠、互相交流以分享經驗教訓便十分必需。

「希望這個《廣州、香港防護SARS經驗交流會》可以起到『**他山之石，可以攻玉**』的目的，透過交流，讓本港醫護人員得以加強防護的警覺及意識，不但令自己盡量減低感染的機會，亦可更有效防止疫症的擴散。


「另一方面，持續加強市民健康教育，提倡並落實清潔衛生由個人做起及推廣到家庭、社區；加強公共環境的清潔衛生，清除環境衛生黑點(隱患)，戒除隨地丟垃圾及吐痰的壞習慣，推行健康運動，倡行港人之間互相關懷、『同坐一條船，攜手創新路』的精神，則此類疫症帶來的壞處，未嘗不能變為好事。『塞翁失馬，焉知非福』！

「當前，抗炎已是由上至特區政府、各有關政府部門、醫管局、下至每一間醫院、每一位醫護人員以及每一位市民之大事。我謹衷心祝願港人齊心協力，共同抗炎，盡快打贏這場世紀之役！」

# 廣州、香港防護SARS經驗交流會報告

**楊永強局長代表、衛生福利及食物局首席助理秘書長陸綺華女士致詞：**

## 我們會更有能力控制蔓延

「嚴重急性呼吸系統綜合症在香港出現了差不多兩個月。一隻我們以前不認識的病毒令全港市民的生活都受到嚴重影響，香港的醫療系統也受到前所未有的挑戰。至今已有超過1,600人受到感染，當中有3百多人是醫護人員。這些數字令人十分痛心。但我們慶幸香港有一班無私的醫護人員，他們願意走在前線，緊守崗位，盡心盡力的照顧病人。我在這裏向所有醫護人員致敬。不幸去世的劉永佳先生，更加是醫護人員的典範。

「劉先生走了，其他的人要繼續打這場仗。我相信隨着我們對這個新病毒的認識日益加深，積累更多的經驗，我們會更有能力控制這個病的蔓延。

「今天的交流會，是一個很好的機會，讓醫護人員交流經驗。希望大家可以更好的裝備自己，更有力量打這場仗。」

**醫院管理局主席梁智鴻醫生致詞：**

## 絕不能鬆懈防炎措施

「非典型肺炎繼續肆虐，作為受疫症影響最大的地區，粵港兩地當前的首要任務當為攜手合作，將對病毒、疫症的所知互相分享，共同抗炎，盡快結束這場來得快且狠的疫症。

「香港每天新增感染個案數目，由疫症爆發初期的三十宗以上減至近期的十多宗*(編註：近日已減為單位數)*，希望這個顯示疫情已走向穩定。但是現在絕不能掉以輕心，鬆懈防炎措施。

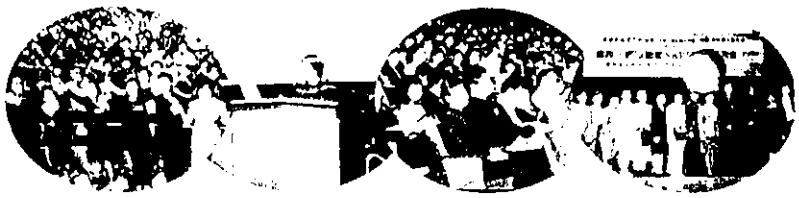
「為了更有效地進行抗炎工作，全力支持前線醫護人員，醫管局已經成立了一個監察工作組及三個專責小組。

「我本人聯同包括醫管局成員更親自參與監察的工作，每日向衛生福利及食物局局長匯報。而三個小組會分別由醫管局總監負責以下三個範疇的工作：

1. 防染控制
2. 臨床治療及資訊
3. 物料供應及環境

我們承諾為前線同事盡一切可能提供最周全的保護，亦會盡力確保每一位同事都有充份的防染裝備和物資。

「最後，我希望粵港兩地繼續加強溝通，交流經驗，使大家盡快戰勝這場非典型戰爭。」



# 上下一心，攜手抗炎

全體手 by 手，結成人龍，
高唱《抗炎歌》

*圖片由《東方日報》提供，版權屬《東方日報》所有，謹此致謝。*

## 抗炎歌

(改編自賣花姑娘曲)

3/4 1=C

粵語・普通話
詞：澳門護士學會

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| SAR S | 嚇 人 | 全 球 | 關 注 | 醫 護 | 人 員 |
| 早 醫 | 早 防 | 相 信 | 科 學 | 保 持 | 冷 靜 |
| 凝 聚 | 力 量 | 團 結 | 一 致 | 持 續 | 抗 戰 |
| 4 3 | 2 — | 2 3 | 4 4 | 3 2 | 3 1 |
| 顯 愛 | 心 | 忘 我 | 獻 身 | 偉 大 | 精 神 |
| 不 恐 | 慌 | 個 人 | 衛 生 | 小 處 | 著 眼 |
| S A R S | | 隔 離 | 病 源 | 自 保 | 互 助 |
| 1 3 | 2 5 | 7 2 | 1 — | | |
| 為 我 | 市 民 | 造 福 | 祉 | | |
| 洗 手 | 清 潔 | 不 發 | 病 | | |
| 健 康 | 安 全 | 大 家 | 創 | | |



# 6位講者與500名參加者
# 分享了穗港防護SARS經驗

2003年5月3日(星期六)下午，來自全港多間公、私立醫療機構和衛生署以及非醫療機構等近500名參加者匯聚浸會大學會堂，參加了歷史性的《廣州、香港防護SARS經驗交流會》。在短短的兩個半小時內，6位講者與參加者分享了他們寶貴的經驗。

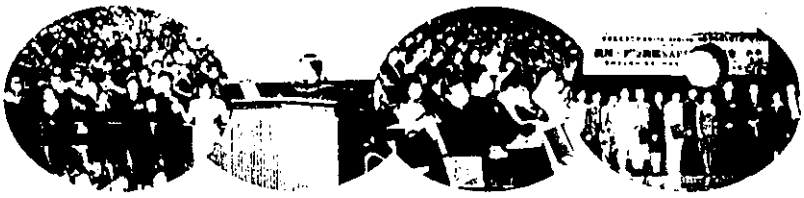
講者中，來自廣州的廣東省中醫院護理部主任張廣清女士的介紹，引起了與會者極大的興趣，受到了熱烈的歡迎。她首先提到了早一天，即5月2日的下午，她參觀了本港首間集中收治SARS病人的瑪嘉烈醫院的觀感。她表示醫院做得非常好，好仔細，在防護方面做了許多工作。

*張廣清主任(左)在瑪嘉烈醫院護理總經理黎雪芬女士(右)陪同下參觀ICU。參觀前先在電梯大堂改裝成的「化妝間」換上全副防護裝備。*

*張廣清主任（中）參觀全港首間醫院提供的視象探病服務，聽取蕭錦綉經理（左）的講解，右為黎雪芬總經理。*

她接着報告，廣東省中醫院早在2003年1月7日開始收治SARS病人。*(編註：該院自1月7日至4月5日期間，共收治112名非典型肺炎患者，除7人死亡外，餘均痊癒出院。)* 起初，因對疾病不認識，結果倒下了一批醫護人員，後來在ICU，因進行插喉、吸痰等高危程序，又令醫護人員染病。

張廣清主任介紹了廣東省中醫院有關非典型肺炎的防治及辨證施護方面的經驗。在首先提到的個人防護注意事項中，她強調了通風透氣的重要性，指出致病微生物一般只有在空氣中積聚到一定的濃度時，才會有傳染的危險，所以保持空氣的流通相當重要，要經常打開所有窗戶，使空氣流通；要避免長時間呆在密閉的空間內，尤其是空調房間。她介紹了非典型肺炎病區的管理及病區，包括空氣消毒的方法和效果，以及救護車的消毒等方法。張主任還介紹了醫院中西醫結合辨證施護，根據早、中、極及恢復期，非典型肺炎患者不同的症狀作出不同的處理，使用不同的中藥及飲食的經驗。



這次交流會邀請的本港講者則從5個不同的範疇介紹了他們的經驗。

新界東醫院聯網風險管理及質素保證總監雷兆輝醫生首先分析了「陳先生的故事」(Mr C's family tree)。這位後來被視為威爾斯醫院感染源頭的病人，起碼傳染給了189人，包括起先的5個家人、73名醫護人員和25名同一病房的其他病人及25名探病人士以及其後這些染病者再傳給他們的親友19人、2名私家醫生及超過40名醫護人員等。雷醫生還分析了威院另一宗個案及大埔拿打素醫院E1、E3病房2位病人又引致近400人受感染的情況，其中包括引致淘大花園集體受感染的教訓。他分析了醫護人員受感染的背景，提出要建立傳染風險及安全的新概念、新文化的需要，還指出隱性病人帶給醫護人員的高危威脅。

ICU經理劉小儀女士則介紹了全港最先接受挑戰的威爾斯醫院ICU，如何從一普通的設計轉變為有隔離設施的病房。她在病房通風、員工調動及訓練、防護裝備、臨床實踐及溝通共5個方面詳述了威院ICU護理SARS病人的經驗。

來自本港第一間集中收治SARS病人的瑪嘉烈醫院的九龍西聯網總經理(社區醫療)、瑪嘉烈醫院護理總經理黎雪芬女士着重介紹了接收非典型肺炎病人的準備，包括停收急症內科病人、停止急症室服務、策劃轉移住院病人、訂定SARS病房及病床數目、病房環境及物料的準備、與員工的溝通、安排感染控制訓練及ICU課程等等。她坦誠地總結了準備時期的經驗教訓，指出初時低估了病人的數目及其嚴重性，準備時間及病房、設備、人手均不足，感染控制意識不足，缺乏簡單、清楚、一致性的指引、庶務員不足及經常轉換、員工訓練時間不足等等。她特別提到了需要時調動人手，尤其護士的困難。黎女士根據這些教訓，提出了她的建議：充分準備、建立制度、高度戒備及經驗分享。

華員會護士分會主席、將軍澳醫院病房經理邵桂鳳女士則從背景、準備、形式3個方面介紹了一間高危病房的產生。她指出學習重點為應先有計劃後行動、行動迅速及針對難題、事前對難題的預知性、預定專責人員以及警覺性要高。她總結成功的要訣在：溝通、準時行動、行動快捷及準備。她最後贈以4句金句：不怕資源不足、無懼認識未深，只要管理開明，定可上下一心。

交流會主持人黃河在介紹最後一位講者前指出，「在整個防護SARS的戰役中，人們往往只把注意力放在醫院，而忽略了一直在並肩作戰的衛生署同事。」

衛生署九龍區辦事處的署理高級護士主任黃倩美女士就此介紹了全港4個分區辦事處負責追查病源、跟進曾與病人接觸之人士。衛生署的同事們曾深入調查威爾斯醫院員工，進行問卷調查，搜集資料作進一步分析；又調查淘大花園、大埔區染病個案；調查環境因素是否引致病毒在淘大擴散的原因。他們又進駐設在渡假中心的隔離營，對被安排入住的居民進行身體檢查；設立4間指定診所*(編註：為石硤尾健康院、沙田圓洲角尤德夫人兒童體智測驗中心及學童牙科診所、西營盤賽馬會分科診所及南葵涌賽馬會分科診所)*，為由SARS病房出院的非SARS病人、親密社交接觸者、身體不適之家居隔離人士提供身體檢查、輔導、轉介社會福利署等服務。他們還在邊境執行防疫措施、舉辦講座、發出健康指引、監察學生健康情況等。

*〔編者按：各講者講稿的詳細內容已全文登錄華員會網頁，歡迎瀏覽（網址：www.hkccsa.org）〕*



# 歷史的影子——記公開討論會

《廣州、香港防護SARS經驗交流會》的公開討論延至2003年5月12日晚上6時半至8時半假伊利沙白醫院M座地下會議廳在紀念國際護士節的氣氛下舉行。除張廣清女士外，全部講者均出席了討論會。

討論會在衛生署同事、業餘歌唱家馮志麗領唱《抗炎歌》、《醫護人員頌》後正式開始。

前理大講師李明珮在講述南丁格爾的貢獻時，表示當時戰地醫院成為傳染疾病的溫床，但南丁格爾用科學精神改革了醫院的管理，運用加強病房環境及個人衛生措施，防止交叉傳染，從而控制了感染。

主持人黃河指出：歷史有相似。南丁格爾當年由於控制了傳染，大大減少了傷病員的死亡率，從而改寫了人類醫學史。然而，今天港人竟差不多面對南丁格爾所面對的同一難題！

自持有現代化醫療管理、現代化醫院、現代化醫藥的香港，竟一時間手足無措、優勢盡失、大批醫護人員倒下來，令全港損失慘重！教訓不可謂不深刻！

控制疫情依靠的是防治，其中最重要的、最先行的是一個「防」字。

而港人的實踐證明，要防疫，靠的竟是最傳統的、早在149年前，即1854年至1856年南丁格爾即已倡導的基本方法：

—隔離及防止交叉傳染的措施(並且要早越好、越徹底越好)；

—病房的空氣流通及環境的清潔衛生；

—個人的清潔衛生，例如用最普通的皂液勤洗手等！

公開討論會用了不少時間交流了有關防護措施和設備方面的經驗。席上，令人詫異的是，時至今天，在多間醫院重蹈威爾斯醫院的覆轍後，竟還有醫院要在防護方面，從頭開始，從頭學起！

*弗羅倫斯．南丁格爾*
*Florence Nightingale*
*(1820-1910)*

與會者還就今次抗炎一役，看到了尚需認真檢討經驗教訓的範疇，涉及不合理的病房(包括瑪嘉烈醫院傳染病房)的設計及設施的佈局；醫管局及醫院層面的管理體制內，有待建立夥伴合作關係新文化，以充分發揮上下一心的團隊精神；護士的發言權及專業功能未被充分發揮；各醫院控制傳染小組未能及早發揮應有作用等問題。應予檢討的還涉及全港醫務衛生服務的發展、全民齊心協力防炎等更宏觀的問題。對此，港人應客觀地予以反思，實事求是地、對事不對人地予以檢討才是。

*示範頭罩的使用*

## 醫護人員頌

(改編自賣報歌曲)

普通話
詞：澳門護士學會

1=F 2/4

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| 5 5 | 5 | 5 5 | 5 | 3 5 | 6 53 | 2 3 | 5 |
| 啦啦 | 啦 | 啦啦 | 啦 | SARS | 害人 | 不用 | 怕 |
| 5 3 | 5 32 | 1 3 | 2 | 3 3 | 2 1 | 6 1 | 2 |
| 醫護 | 人員 | 不怕 | 死 | 戰勝 | 肺炎 | 守前 | 線 |
| 6 | 6 5 | 3 6 | 5 | 5 3 | 23 | 5 — | |
| 全 | 心 | 奉 | 獻 | 精神 | 高 | 尚 | |
| 5 3 | 2 3 | 5 3 | 2 3 | 6 1 | 2 3 | 1 — | |
| 大家 | 敬佩 | 大家 | 學習 | 齊 | 頌 | 揚 | |

# 抗炎進展小結

| 華員會暨護士工會提出過的意見及建議<br>(括孤內為提出的日期) | 防護、防治進展小結 |
|---|---|
| **(甲) 關於防護政策措施方面** | |
| • **有關政策問題**<br>1. 強烈呼籲政府當局、醫管局及各醫院、診所管理階層，用更大力、更實質支援前線工作人員的行動，來更有效地控制疾病的傳播！(03 年 3 月 23 日)<br>2. 當前，醫管局、衛生署應以更有效、儘快控制及對抗非典型肺炎作為其一切要務之重中之重、急中之急！(03 年 4 月 10 日)<br>3. 全面提高全港醫護人員的警覺性，以威爾斯親王醫院為鑑。(03 年 3 月 23 日) | ☞ 在上下努力下，支援行動已大大增加。事實上，在特區政府展示了抗炎決心，並動員了龐大的資源和力量，在醫管局及各醫院各級醫護人員共同努力，並在多個政府部門、社會各界緊密配合下，本港現已控制了疫情，成績令人鼓舞。<br><br>☞ 現時警覺性比 3 、 4 月間有很大程度的提高，當時繼威院有大批醫護人員染病後，又有大埔拿打素、瑪嘉烈、聯合、屯門等醫院步其後塵。若能及時以威院的經驗教訓為鑑，則所有其他醫院以及最近某些醫院均不必從頭開始，從頭學起，甚至走他人走過的彎路！ |
| • **有關全面加大、加強、改善現行預防措施的問題**<br>4. 由單純防止飛沫傳染，一律提升至防止飛沫、接觸及空氣傳染的高度，嚴格、全面執行防止交叉傳染(cross infection)的措施。(03 年 3 月 23 日)<br>5. 全面檢討現行防護措施及指引，摒棄過頭的或改善不足的措施。(03 年 4 月 18 日) | ☞ 早期片面強調防範飛沫感染已足夠，主、客觀上降低了警覺性。其後有所改善，但仍有各院或同一醫院不同病房做法不完全一致的情況。近日，當局新推出的控制傳染指引純從技術角度着眼，無充分顧及實際及操作性問題，無顧及「隱形病人」的傳染威脅，令非「高危」病房有回復至早期輕視感染的「覆轍」之嫌。由於醫學上至今仍未能全面掌握SARS的全部傳染途徑，過早降低警報恐將弄巧反拙，既打擊員工士氣，又令防護行動出現漏洞，不利鞏固目前疫情基本上受控制的成果。【我們已在2003年5月21日會見醫管局主席梁耀鴻醫生時，向他進言。】 |
| • **有關制訂、發放資訊、指引問題**<br>6. 由醫管局參照威爾斯親王醫院的經驗教訓，統一制訂、發放有效預防的指引，避免各自為政、口徑做法不一的情況；並由控制傳染小組(Infection Control Unit)負責指導、示範及監察，糾正不正確使用防護工具或不嚴格執行的情況。(03 年 3 月 23 日)<br>7. 醫管局、衛生署應統一制訂及發放資訊、指引的制度，並由高層根據威爾斯親王醫院、聯合醫院及瑪嘉烈醫院的經驗教訓，儘速統一制訂、發放有效預防、隔離及收症的指引供各院及衛生署參照執行，統一調配人力物質資源，盡快停止各自為政、口徑做法不統一、訊息指引混亂及資源錯配的情況；改變目前資訊「泛濫」、過雜、並不簡潔的情況。(03 年 4 月 10 日)；統一制訂簡明扼要及全面的指引，並必須保證及時提供中文版。(03 年 4 月 18 日)<br>8. 有關資訊、指引可制作視像光碟分發予前線工作人員參照，亦可用作訓練的教材之用。(03 年 4 月 10 日)<br>9. 收集、追查有關資訊，要高層中央有計劃地進行，盡量避免重複及減少對前線工作人員、病人及其家屬的滋擾。(03 年 4 月 10 日)<br>10. 衛生署應即統一制訂、發放宣傳單張、海報、短片，以宣傳有關疾病的危害性及正確預防的知識，加強全港市民的警覺性。(03 年 3 月 23 日) | ☞ — 醫管局已有指引，但各院片面強調彈性(Flexibility)，各施各法，仍各有自己的版本，甚至一間醫院有一套以上的指引；某些控制傳染小組的指引甚至有互相矛盾之處。<br>— 不少資訊、指引仍以英文為主。<br><br>☞ 已制作並分發。<br><br>☞ 有改善。<br><br>☞ 已提供大量訊息。 |

# 廣州、香港防護SARS經驗交流會報告

| 華員會暨護士工會提出過的意見及建議<br>(括弧內為提出的日期) | 防護、防治進展小結 |
|---|---|
| 11. 凡重新調配床位、人手，應改善當前欠缺清晰、書面指引及資源供應短缺的情況。(03年3月23日) | ☞ 不少涉及具體操作層面的指引，仍以口頭為主，欠缺白紙黑字。 |
| • **有關限制、追縱接觸人士問題**<br>12. 嚴格控制、限制探病的人流，呼籲患者親友、市民不要贈送水果、花籃予前線員工。(03年3月23日) | ☞ 已嚴格控制，甚至頒令不准探病，減少了交叉傳染機會；少數醫院其後還設立了視像電話探病的設施，方便了不少病人及家屬。<br>☞ 當局並無呼籲不要攜帶、贈送。捐贈的橙、飲品、食品，不少因醫護人員或無時間，或怕交叉傳染而無享用，致被浪費掉了。 |
| 13. 積極、全面、及時追縱與患者有較密接觸的人士，進行監察，追查來源。(03年3月23日) | ☞ 有跟進，現已能及早追查及隔離，但查詢醫護人員的接觸史尚不全面。若威爾斯醫院能在一發現大批醫護人員染病時，即能全面、及時、果斷地隔離患者和接觸者，疫情或不致擴散到醫院其他病房、部門，或不會傳染給更多醫護人員及其他病人、探病者；其後亦或不致擴散至社區(淘大花園其後成為重災區)。其他醫院若能及早防範，亦將可能有效防止疫症的擴散。 |
| **(乙) 關於防護裝備設施方面** | |
| • **有關口罩等防護裝備問題**<br>14. 不設限制地供應得以更有效控制傳染的、尺碼齊全的口罩及其他有效防護工具。(03年3月23日)<br>15. 各款防護物資，應制訂使用的統一標準，並由醫管局中央統籌、統一供應、減輕各醫院負擔，以騰出人手為前線提供更細緻、實質支援。(03年4月10日)<br>16. 對口罩、眼罩、保護衣、鞋套等防護工具，應統一測試其成效，並確保供應充足，尺碼齊全；凡有需要的均有供應，不論級別。(03年4月10日)<br>17. 為需要為確診病人提供某些高危醫護程序的醫護人員提供有效的防護罩。(03年4月10日)<br>18. 近距離護理、搶救垂危病人，必須加倍提高防護措施，確保絕不鬆懈。(03年4月18日) | ☞ —供應已大大改善，現已很充裕，但各院情況仍不一致，仍有限制的情況。最近甚至重行實施分配制度，限制使用N95口罩，引起前線員工的恐慌及不滿。<br>—為了確保防護措施不致鬆懈，爭取全勝，不致功虧一簣，我們已於2003年5月21日會見醫管局主席梁智鴻醫生，向他建議醫管局高層應督促各醫院繼續提高警覺性，做足防護措施，絕不放鬆。為此各醫院——<br>(1) 應一如較早時候，繼續不設限地向各級前線員工同時提供手術用及N95口罩以及其他必要的防護裝備，並由有關醫護人員自主決定在需要時使用。此舉絕不應被管理階層視為浪費。<br>(2) 在執行高危程序，例如急救病人時的插喉、接駁呼吸機以至一般的抽痰、留取分泌物化驗、插胃喉，甚至普通的餵飼SARS或疑似病人或處理嘔吐物/痰液/糞便時，則除一般防護裝備外(穿戴前當然要確保稱身、適體、無疏漏)，可供應可遮蓋至肩膊以下的簡便、易戴上易除下、可防水的頭罩，以防範近距離大量飛沫的侵襲。 |
| 19. 為在衛生署監控疫情的4間診所同事提供足夠的、合適的防護物資，例如口罩、眼罩、手套、鞋套、衣帽等等。(03年4月10日) | ☞ 3月中仍無口罩供應，護士要自己購買，直至3月底才有供應，但到4月中時仍不足夠。現已改善，不過仍然有配給的情況。 |
| • **有關設施問題**<br>20. 為衛生署4間指定的監控疫情的診所，增設防護設施、淋浴設備。(03年4月10日)<br>21. 為病房增添更衣室及淋浴設備；病房內每一格加裝洗手盆等設備。(03年4月10日)<br>22. 病房內間隔，如尚無裝設門簾者，須盡快加裝，以形成有形的、明顯的隔離區。(03年4月10日)<br>23. 各病房因空間不多，不應挪用治療室、儀器室等地方作儲藏口罩、抹手紙、紙袍、手套等防護物資之用； | ☞ 仍做不到，不少仍無淋浴設備，更衣室甚狹窄，有待進一步改善。<br>☞ 大多無加製洗水盆，更尚未在病房或就近處加設淋浴設備(雖然工程技術上根本不成問題)。<br>☞ 大多無改善。<br>☞ 受原有病房設計限制，大多無改善。 |

| 華員會暨護士工會提出過的意見及建議<br>(括弧內為提出的日期) | 防護、防治進展小結 |
|---|---|
| 為病房增添必要的櫃架等以儲存必要物資；各醫院應增設統一儲存的貨倉並作 24 小時開放，隨時供應有需要的病房。(03 年 4 月 10 日)<br>24. 儘快、切實改善醫院病房擠迫情況，增加病床與病床之間的空間。(03 年 3 月 23 日) | ☞ 大多數 SARS 病房病床數目大幅下降，空間有改善。 |
| • **有關病房空氣流通及清潔消毒等問題**<br>25. 改善空氣流通，裝設抽氣扇、空氣清新機(03 年 3 月 23 日)；改善空氣流通，如尚未裝設抽氣扇、空氣清新機者，須盡快加裝。(03 年 4 月 10 日)<br>26. 即時加強醫院、疫情檢測中心等工作場所的通風，盡量打開窗戶，保持室內外空氣的交換，可以不開空調、盡量不開或減少開空調時間。(03 年 4 月 18 日)<br>27. 加強病房內外的清潔、消毒工作，要做到系統化、制度化，要訂定明確時間表，並有專人負責監督執行及檢查：<br>① 全面、全範圍清潔、消毒，做到每更 1 次 (需要時再加強)；<br>② 工作枱、椅、活動車、電話 (包括話筒)、門把手等，每小時清潔和消毒一次；<br>③ 病人枱、椅、洗手間等，每天清潔和消毒兩次；<br>④ 空調隔塵網、抽氣扇等，每天清潔和消毒一次。(03 年 4 月 10 日)<br>28. 加強清潔消毒病房、空氣、地板、物品 (包括病人使用物品)。(03 年 4 月 18 日) | ☞ — 空氣流通情況有待改善，但並非所有病房均裝設了抽氣扇；絕大多數地方仍無空氣清新機；<br>— 中央空調的封閉環境如何切實改善，有待加強。瑪麗醫院最近打破連續8週零感染的事件，據該院傳染控制組的報告，原因可能與病房內同時給予3位病人高濃度氧氣有關，致室內病毒濃度大大增加。事件顯示，該組顯然並無汲取威院、瑪嘉烈醫院以及更早時廣州的經驗教訓，因而沒有採取有效改善措施所致！【我們已在5月21日向醫管局主席梁智鴻醫生建議：應督促各醫院採取切實措施改善病房的空氣流通，減少室內病毒的濃度，避免再發生瑪麗醫院兩位護士染病的事件。】<br>— 清潔措施有改善，但有醫院仍做不到可以每天消毒清潔隔塵網、抽氣扇(衛生署某些辦公室亦仍然做不到)等清潔措施。有病房在關閉後進行的所謂消毒只是揩抹枱椅、牆壁等表面，並無在角落、間隙等陰暗處噴洒消毒藥水，更沒有消毒過病房內的空氣。 |
| **(丙) 關於人力資源方面** | |
| • **有關提供充足前線人手問題**<br>29. 護士與病人比例不應小於1:4 (不計算當值主管、護士主任)；要預留替假 (包括病假、例假、年假、產假) 人手。(03 年 4 月 10 日)<br>30. 每間病房要編配不少於2名的健康服務助理 (HCA) 以協助護士進行基本護理工作；並要編配不少於2名的清潔工人以負責病房的清潔消毒工作，必要時醫院要予以支援。(03 年 4 月 10 日) | ☞ — 有改善，但仍達不到。(只是因為高峰過後病人數目下降才實際上增加了比例。)<br>— 計算SARS病房人手時，並無計算替假人手。如非染病人數回落，情況堪憂。 |
| • **有關確保前線人員身心健康問題**<br>31. 編配人手要有統籌、有計劃、有系統地進行，停止臨時「拉伕」，忽忙「上馬」的做法；嚴格遵守不臨時周章忽忙加開新病房、不未經訓練便調配的原則。(03 年 4 月 10 日)<br>32. 在調配各類人手去前線之前，要有計劃地統一給予一定時數的、與其職責相應的隔離護理的訓練、傳授有關疾病的知識及治療方法、病房的清潔消毒的知識及技巧及 / 或深切治療、護理的基本知識和技巧等，嚴格做到先訓練、後調配的原則。(03 年 4 月 10 日)<br>33. 每工作3－4小時，容許有半小時的休息；每週額外准許放取 1 天有薪假期。(03 年 4 月 10 日) | ☞ 遺憾的是，多間醫院均重複同一失誤！一聲令下，大多數病房要在 1 天內由普通病房改為高度隔離的傳染病房，不能做到週全，令防護漏洞難以避免。<br>☞ 大多數病房臨時「拉伕」，根本沒有預見，沒有較週全的計劃，藉口是收治 SARS 病人太急促。現在已改善。但對健康服務助理及負責清潔的初級員工的訓練仍需加強。<br>☞ — 大多仍做不到，有醫院容許病房護士有15分鐘的小休(tea)，但不少人怕麻煩(因須更換防護裝備)自動放棄。<br>— 曾給予每週 1 天特別假期(Special Off)，現已退為每 2 周1天，但仍有醫院未落實，引起前線人員的不滿。【我們已於03年5月21日向醫管局主席梁智鴻醫生提出，各醫院應繼續關注員工的身心健康，履行給予額外休假、輪換護理 SARS 病人的承諾。】 |

# 廣州、香港防護SARS經驗交流會報告

## 存好心，說好話，做好事！

| 華員會暨護士工會提出過的意見及建議<br>(括弧內為提出的日期) | 防護、防治進展小結 |
|---|---|
| 34. 容許身體不適、懷孕或有其他疾病的員工放取假期；員工放取假期，不應迫令放取積假，應容許保留有薪年假。(03 年 4 月 10 日) | ☞ 已實行懷孕 13 週有特別假期，一定程度上體現了當局的體恤。 |
| 35. 須為前線人員提供一個離開工作環境的、舒適的休息場所。(03 年 4 月 10 日) | ☞ 大多仍欠缺。有醫院(例如瑪嘉烈醫院)改善了職員餐廳的擺設，以減少就餐時交叉傳染的機會。 |
| 36. 提供足夠留宿設施予有需要的員工。(03 年 4 月 10 日) | ☞ 有改善，但高峰時有不足。 |
| 37. 編配專人加強聆聽員工心聲意見，及時給予更多心理輔導。(03 年 4 月 10 日) | ☞ 有改善，但有不少人仍堅持透過傳媒反映心聲，而致電醫管局熱線電話者，絕大多數不願透露真實姓名，反映員工與當局嚴重缺乏互信！ |
| 38. 提供員工自我檢查身體健康及懷疑有症狀時如何處理、就醫的指引。(03 年 4 月 10 日) | ☞ 有改善。有醫院專門配置獨立房間供發燒員工休息，並接受觀察。 |
| 39. 避免過勞，縮短在深切治療部等護理垂危病人醫護人員的工作時間至每天不超過 4 小時，並切實加強病房人手比例。(03 年 4 月 18 日) | ☞ 仍做不到，工作及休息時間照舊。 |
| 40. 提高前線人員的抵抗力，為全體人員提供預防中藥 (在自願情況下)。(03 年 4 月 18 日) | ☞ 中大中醫中藥研究所、浸大中醫藥學院、廣華醫院等均有提供(但絕大多數醫院並無主動提供)；本會亦已向全港醫護人員介紹廣東省中醫院推介的預防中藥。(見《華員報・抗炎特刊》) |
| **(丁) 關於與內地增加交流，提高治療效果** | |
| 41. 由於本港與內地、海外的交往日益頻繁，應與外地衛生部門加強聯繫，共同追查源頭，相互做好防護措施，並積極應對例如清明節、復活節等高峰期大量人員往來帶來的影響。(03 年 3 月 23 日) 政府應與廣東省當局不但交換疫症的情報，還要交流防治的經驗。(03 年 4 月 10 日) | ☞ — 就SARS疫情等問題，特區衛生部門與廣東省衛生廳的聯繫，已於 03 年 4 月中正式啟動，中央政府已表示大力支持。包含醫管局代表在內的特區政府代表團，已繼我們之後訪問了廣東省中醫院，了解中西醫結合治療非典型肺炎情況。 |
| 42. 充分借鏡廣東省成功治療經驗，不恥下問，可邀請有治療疫症實踐經驗的醫護人員來港，直接交流防治經驗。(03 年 4 月 18 日) | — 廣東省中醫院兩位教授林琳及楊志敏已於 2003 年 5 月 3 日來港，迄今已診治多間醫院共 60 位病人，其中包括 37 名在黃大仙療養院的康復者、 13 名仍在 ICU 的重症患者及 10 名內科(SARS)病房病人(已有 5 人出院)。 |
| 43. 可邀請廣東省中醫院等中醫專家來港進行會診，以充分利用中、西醫各自的長處治療確診及懷疑患者 (在自願情況下)。(03 年 4 月 18 日) | — 《基本法》雖規定特區政府發展中醫藥，但一直沒有訂立任何機制作真正推動。現雖仍嫌不足，但已在實際上向前邁進了一步，作出了有歷史意義的突破。本會促進了此歷史進程。 |
| 44. 為做到上述兩點，須盡快衝破意識上的藩籬、消除現行機制上的障礙，採取果斷措施，勿再猶疑，勿耽誤軍情！(03 年 4 月 18 日) | — 為更有效地配合治療及護理，當局應及時授予相關醫護人員一定的中醫藥知識。 |
| **(戊) 關於公共衛生方面** | |
| 45. 定期推動全民清潔保健行動，使之制度化，並避免「三分鐘熱度」、形式化。(03 年 4 月 18 日) | ☞ 政府已於 4 月 19-20 日舉行「全民清潔保健行動日」，並已決定今後定期舉行(每月一次)。 |
| 46. 充分調動民間力量 (各社會、社區團體) 協助政府推動改善公共衛生，宣傳「同坐一條船，攜手創新路」的精神，並使之制度化。(03 年 4 月 18 日) | ☞ 有改善，政府現正加強中。 |
| **(己)其他方面** | |
| 47. 強烈呼籲全港醫護人員進一步發揮專業精神，全力支持當局共同對付非典型肺炎！(03 年 3 月 23 日) | ☞ 全港醫護人員能堅守工作崗位，發揮專業精神，共同抗炎，贏得了全社會的讚賞及致敬。 |
| 48. 在適當時候總結今次的經驗教訓。(03 年 3 月 23 日) | ☞ 有待全面坦誠、科學地、不「文過飾非」地進行深刻的總結 (但不要「秋後算賬」)。<br>☞ 政府及醫管局已分別決定成立專責委員會以作調查、檢討。 |

# 後　語

- 對這傳染性極高、毒性極強的非典型肺炎新疾病
  - ＊人類確有一個逐步認識的過程，
  - ＊對防護措施確有一個逐步完善的過程，
  - ＊對疾病的治療確有一個學習的過程。

  —— 但要盡快縮短這些過程，

  要盡量減少、避免付出昂貴的代價、「學費」！

- 深刻地總結這次的經驗和教訓，

  並從中學習、積極改善是唯一的途徑！

- 一個寶貴的經驗是：

  當你加深了瞭解，
  - ＊你便會認識這疾病的特性，
  - ＊你便會知所防範，
  - ＊你便會消除恐懼的心理，
  - ＊你便會建立 SARS 是可以被戰勝的信心！

  又一個寶貴的經驗是：應充分認識及發揮各級護士在整個防護戰役中的角色及潛力！

  再一個寶貴的經驗是：

  對付不見經傳的、突發的、傳染性強的疫症，

  有效的、全面的防護以隔絕傳染病、切斷傳染鏈，

  可能比治療更要先行，更加關鍵！

- 真正有效的防護，需要
  - ＊上下一心，官民一致，同舟共濟，攜手合作，相互支持；
  - ＊相互理解、包容和體諒；
  - ＊坦誠、有效的溝通和商量；
  - ＊醫療系統內的夥伴合作關係新管理文化的建立！



# 鳴　謝

- 「香港是我家——支持前線醫護人員」籌款活動基金贊助本經驗交流會
- 香港北區扶輪社贊助「愛心福袋」禮物包
- 衛生署新界東區辦事處贊助「每日運動半點鐘」紀念禮物
- 《華員報》承印商——高寶意念（香港）有限公司贊助本經驗交流會海報
- 馮志麗女士贊助酒精消毒抹紙及手套
- 華員會義工服務隊義工及華員會職員鼎力支持
- 香港浸會大學以優惠價借出會堂
- 伊利沙伯醫院免費借出會場

# 經驗交流會的幕後英雄 — 謝謝你們！

不到兩個星期內，由決定到籌備，到成功舉辦《廣州、香港防護SARS 經驗交流會》，依靠的是不少工會幹事的努力，其中的幕後英雄包括了華員會義工服務隊的義工和華員會職員。他們的辛勞和汗水居功不少。

**謝謝你們！**


# 上下一心，
# 全力抗炎，
# 爭取全勝！

「香港是我家 —— 支持前線醫護人員」籌款活動基金贊助

Special Publication of Hong Kong Chinese Civil Servants' Association Combating Atypical Pneumonia

附件1

2003年4月（非賣品）

# 華員報抗疫特刊

130260


# 堅守崗位
# 全力抗疫

120261

# 華員會理事會

謹向

## 堅守工作崗位
## 發揮團隊精神
## 全力支持抗災

的公務人員

**致謝！**

**致敬！**

# 齊心協力支持有效控制SARS

## 華員會致會員、公務人員同事公開信

120262

# 堅守崗位全力支持抗炎之役
# 同舟共濟積極參與支援行動

面對當前這場前所未有的、嚴峻的疫症挑戰，我們成千上萬公務人員同事正在醫管局、衛生署、社會福利署、食物環境衛生署、民政事務署、房屋署、康樂及文化署、各紀律部隊及不少政府部門，尤其是在各公立醫院，正日以繼夜地協助政府對抗非典型肺炎。我們的承擔和責任得到了全體市民的高度肯定和讚賞。然而，由於蔓延的趨勢尚未遏止，預料「抗炎」之役仍需持續一段時間。

危機當頭，需要全體公務人員及全社會大力發揮「同坐一條船」的精神，全力支持、配合政府行動，才能有效控制疾病的傳播。為此，本會繼3月23日提出《2個呼籲、7點建議，全力支持有效控制非典型肺炎》*(請參閱第8頁)*，再作出如下之呼籲及行動：

1. 呼籲全體公務人員堅守工作崗位，充分發揮團隊精神，全力支持「抗炎」之役。
2. 呼籲會員、公務人員同事從自己做起，加強個人衛生，協助自己的家人、親友、鄰居、同事、社區做好預防工作，並提倡互相關懷、互相體諒(應諒解當前「抗炎」工作緊迫繁重，而引致一些未如人意的情況)、同心協力克服困難的精神。
3. 呼籲有關會員、公務人員同事積極響應衛生署、社會福利署、民政事務署等部門，招募部門員工自願支援後勤工作。
4. 華員會義工服務隊準備為「抗炎」之役提供激勵性及後勤支援服務，現呼籲會員、公務人員同事及其親友加入本會的義工行列。義工服務隊將只為會員、公務人員同事提供精神上的支援，以及為有需要的政府部門、機構提供後勤上的支援，舉例：
   (1) 協助政府部門電話聯絡懷疑患病市民的工作；
   (2) 協助有關部門／機構購買日常生活用品予被隔離的市民；
   (3) 設立「華員會『抗炎』諮詢熱線」電話；
   (4) 協助宣傳正確預防非典型肺炎傳播的知識；
   (5) 協助宣傳行動以鼓勵各前線工作人員保持士氣，繼續奮力作戰，等等。

*【註：有興趣的會員、公務人員及／或其家屬可致電2300-1065索取報名表。為義工安全着想，及避免防礙抗炎行動，義工服務隊將不提供直接前線工作。】*

香港政府華員會理事會
2003年4月9日

**華員會『抗炎』諮詢熱線 電話：2300-1064**

- 對象：會員、公務人員同事；
- 目的：聆聽並反映對政府部門、公共機構「抗炎」的意見和建議；
- 日期：由4月11日至4月30日
- 時間：星期一至星期五晚上6時30分至8時30分；
  星期六上午10時至下午1時
  星期日及公眾假期除外

歡迎諮詢！

**鳴謝**

本特刊部份圖片由政府新聞處及《大公報》提供，版權屬其所有，謹此致謝。

# 華員會就防治SARS與廣州澳門進行交流
# 借鏡廣東省經驗再向當局提最新建議

- 華員會代表於2003年4月15、16兩天訪問了廣州、澳門，與兩地醫護人員就防治非典型肺炎措施進行了交流。
- 代表們會見了廣東省中醫藥局業務處張英哲處長、廣東省中醫院(廣州中醫藥大學第二附屬醫院)副院長羅雲堅主任醫師、澳門護士學會理事長尹一橋、澳門護理人員協進會理事長賈比安以及廣東省中醫院、澳門仁伯爵醫院、鏡湖醫院等醫護人員。

- **交流成果**

透過是次的交流，代表們增加了對廣東省防治非典型肺炎的認識，了解了澳門鏡湖醫院及時提高警覺的情況。(交流心得見另稿)代表們認為，本港應有打贏抗炎一役的信心。關鍵在：

(1)盡早控制疫症的蔓延——全面、及時，適當、有效地加強防護措施及隔離患者或懷疑患者是必備因素。

(2)保持前線人員的身心健康——提高他們的抵抗力、避免過勞，將能極大程度地阻止感染疫症。

(3)提高治療效果——及早中止疾病的發展、減輕患者症狀、縮短病程、減少後遺症及併發症應同時是治療的目標。

- **我們最新的建議**

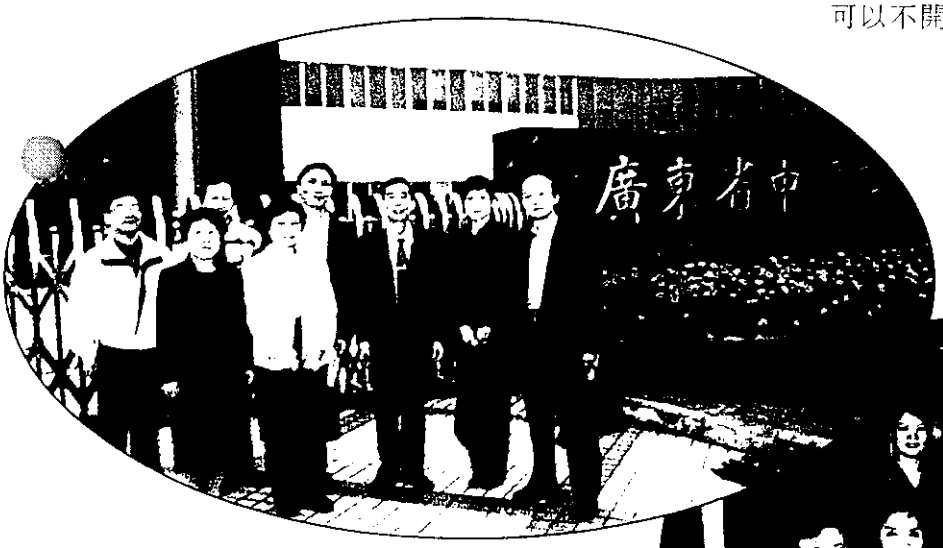
透過是次交流，代表們認為，廣東省防治經驗值得香港借鏡。為此，我們向特區政府及醫院管理局提出最新的建議如下：

**1.關於防護措施**

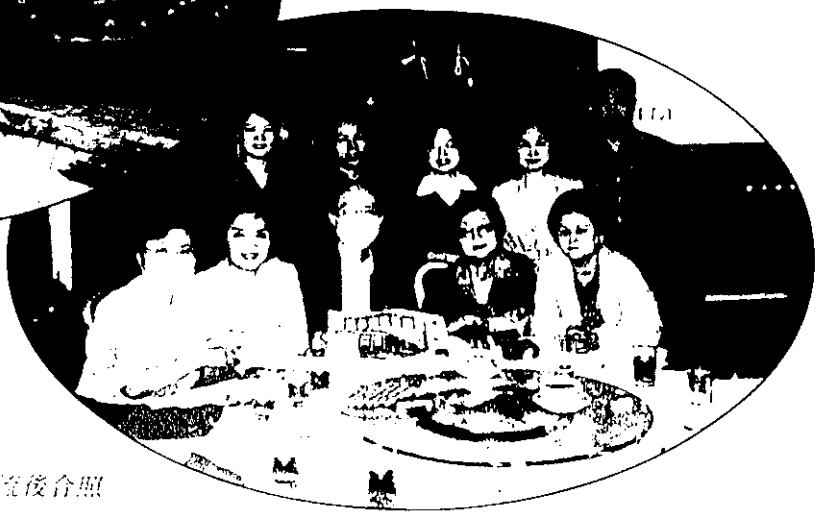
(1)全面檢討現行防護措施及指引，摒棄過頭的，改善不足的措施；

(2)統一制訂簡明扼要及全面的指引，並必須保證及時提供中文版；

(3)即時加強醫院、疫情檢測中心等工作場所的通風，盡量打開窗戶，保持室內外空氣的交換，可以不開空調、盡量不開或減少開空調時間；




本會代表開會廣東省中醫院



本會代表與澳門同業交流後合照



(4)加強清潔消毒病房、空氣、地板、物品（包括病人使用物品）；

(5)近距離護理、搶救垂危病人，必須加倍提高防護措施，確保絕不鬆懈。

**2.關於保持前線人員的身心健康**

(1)提高前線人員的抵抗力，為全體人員提供預防中藥（在自願情況下）；

(2)避免過勞，縮短在深切治療部等護理垂危病人醫護人員的工作時間至每天不超過4小時，並切實加強病房人手比例；

**3.關於提高治療效果**

(1)充分借鏡廣東省成功治療經驗，不恥下問，可邀請有治療疫症實踐經驗的醫護人員來港，直接交流防治經驗；

(2)可邀請廣東省中醫院等中醫專家來港進行會診，以充分利用中、西醫各自的長處治療確診及懷疑患者（在自願情況下）；

(3)為做到上述兩點，須盡快衝破意識上的藩籬、消除現行機制上的障礙，採取果斷措施，勿再猶疑、勿耽誤軍情！

**4.關於公共衛生**

(1)定期推動全民清潔保健行動，使之制度化，並避免「三分鐘熱度」、形式化；

(2)充分調動民間力量（各社會、社區團體）協助政府推動改善公共衛生，宣傳「同坐一條船，攜手創新路」的精神，並使之制度化。

**• 我們的配合行動**

為大力支持政府的抗炎行動，我們已經、即將採取如下配合行動：

(1)向前線人員介紹廣東省中醫院推介的預防中藥藥方（*見第5頁*）；

(2)為前線人員（包括非醫護人員）提供免費預防中藥（正計劃中，希望能盡快推出）；

(3)向醫護人員介紹與廣州、澳門交流的心得（將考慮邀請廣州醫護人員來港直接交流）；

(4)已設立「華員會『抗炎』諮詢熱線」電話2300-1064，聆聽會員、公務人員有關抗炎的意見及建議。


*華員會義工服務隊於全民清潔保健行動日（4月19日）派發抗炎宣傳單章*

*華員會義工服務隊正在接聽「抗炎」諮詢熱線*

# 與廣州、澳門醫護人員交流報告撮要

## (2003年4月15-16日)

**1.高層協調指導及時和有力**

－廣州方面：(1)2003年1月中旬，由於於病例增多，並出現醫護人員受感染現象，引起了廣東省衛生及防疫部門的重視，組織了包括醫學院、呼吸疾病研究所、醫院、疾病控制中心等臨床醫學、流行病學、病毒學等在內的專家小組，進行了交流、調查和研究。小組的治療、預防及病源3個組(內有中醫專家)就治療和預防提出了建議和指導；省、市、區各級防疫站相互協調，接觸並追病人的來源。

(2)省、市衛生當局接着發出了3份分別針對醫院、學校及公共場所指引。

(3)2月上旬召開了廣東省全省疫情防治工作會議，針對社會上出現的流言，作出了緊急部署。

(4)衛生部在2003年2月上旬派出專家調查組到發病地區進行研究及檢測。

(5)廣東省中醫院院方統一指揮、部署、協調全院防治工作及支援行動。

－澳門方面：儘管尚未收治過任何病例，澳門特區政府高層已於2003年3月中與仁伯爵及鏡湖兩院開會，進行專題研究，並在會後不久發出了預防指引。

**2.中藥預防問題**

－廣州方面：自2003年1月中旬發現疫症以來，即研製了預防中藥，供全院醫護人員免費服用。預防療效顯著。

－澳門方面：儘管尚未出現任何病例，鏡湖醫院早已於2003年2月中旬開始向全院員工贈飲抗炎中藥，作為預防措施之一。

**3.防護措施**

廣東省中醫院：(1)在1月下旬即已開始防護措施。省衛生當局亦及時總結了疫情的傳播途徑並發出了指引。

(2)及時總結感染的途徑（近距離飛沫接觸）、場所（急症室、深切治療部、內科）、時機（工作人員疲倦）的經驗，除最初因對疾病傳染性認識不足外，總結了該院其後2次感染高峰期均與搶救危重病人有關。

(3)統一制訂了簡明扼要及較全面的指引，涉及區域劃分及管理、空氣消毒、地面物體表面消毒、病人排泄物及分泌物的處理、病人使用物品的消毒、隔離防護措施

1.強調病房通風換氣及空氣消毒等措施

**4.中西醫結合治療**

廣東省中醫院的經驗顯示，中、西醫結合治療非典型肺炎，可提高患者的療效。例如：－

(1)在早期發病的輕症患者中，及早中止疾病的發展；

(2)明顯減輕患者症狀（例如頭身疼痛、持續高熱、噁心嘔吐、疲乏倦怠、食慾減退、氣短，等症狀），有利治療及康復；

(3)縮短「發燒」時間（現平均只為7天）；

(4)縮短住院日數（現平均只有18天）；

(5)促進肺部炎症吸收，減少肺功能損害的後遺症；

(6)減少併發症及西藥副作用，減少對肝、減少腸胃道反應、腎功能、心臟的損害。

**5.與廣東省的溝通和交流**

由於澳門鏡湖醫院與廣東省衛生當局素有溝通和交流，該院在2003年1、2月間廣東省爆發非典型肺炎的「疫症」後不久的2月10日，該院院長已緊急召集醫護人員，呼籲員工提高警覺，兩天後即已向全院發出有關隔離消毒的指引。

**6.加強公共衛生**

澳門因前年有登革熱，特區政府即連續兩年發動全澳開展大清潔行動（甚至不放過空置的地盤），今年的大清潔已於今日展開。

澳門由80年代開始已設立疾病預防中心，統籌全澳有關工作，其衛生中心為全澳65歲以上老人免費注射抗流感預防疫苗。

**7.廣州、澳門對疫情的反應與香港的緊張有強烈對比**

－廣州方面：

1.醫院內、不論病人或醫護人員甚少戴口罩。醫護人員如常在執行無菌操作時戴上口罩。

2.市面上，戴口罩的人士更少之又少。

3.醫護人員認為只要認識疾病傳染特性，做足針對性預防措施便可。

－澳門方面：情況與廣州相同。

本會代表與廣州醫護人員就[illegible]非典型肺炎措施、交流經驗和心得。為廣東省中醫藥局業務處主任[illegible]長（左三）、廣東省中醫院[illegible]長鄭[illegible]（左四）、[illegible]主任張敬清（左二）及[illegible]（右二）及何德[illegible]（右

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# 本會緊急拜會廣東省中醫院 為本港醫護人員求中藥預防

*編者按：應會員的要求，本會在獲得中央人民政府駐香港特別行政區聯絡辦公室的協助下，已於4月15日到廣州緊急拜會廣東省中醫院，借鏡該院醫務人員服用中藥後成功預防非典型肺炎的經驗。至截稿時，據了解，現正積極考慮介紹給本港醫護人員。*

本會認為，鑑於本港已有越來越多的醫護人員染病（據官方數字，染病人數中，已有超過1/4的病人為醫護人員）或懷疑染病，前線人員正面對越來越大的工作及心理壓力，問題已變得日益嚴峻！故此，如何增強他（她）們的抗炎能力，已急不容緩！本會相信，若能確保他（她）們的身心健康，再配合有效的防護措施（本會已有詳細建議），將能有效對抗疫症，協助特區政府盡快打贏抗炎之役！

**廣東省中醫院推介的、國家中醫藥管理局制定的《非典型肺炎中醫藥防治技術方案(試行)》預防中藥藥方：**

**供與確診或懷疑非典型肺炎病人有接觸的健康醫護人員或其他前線人員服用：－**

生黃芪 15克、銀　花 15克、柴　胡 10克、

黃　芩 10克、板藍根 15克、貫　眾 15克、

蒼　朮 10克、生苡仁 15克、藿　香 10克、

防　風 10克、生甘草　5克

【3碗水(用淨水)煎為1碗，每天煎服一包，可連服3-5天，隔3-5天可再煎服】

*(孕婦、母乳餵飼者、有其他疾病者，請先徵詢中醫師意見有關服用問題。)*

供一般健康人士服用的預防藥方：－

甲：(藥性偏涼、體壯者可服用)

鮮蘆根 20克、銀　花 15克、連　翹 15克、

蟬　衣 10克、僵　蠶 10克、薄　荷　6克、

生甘草　5克

【3碗水(用淨水)煎為1碗，每天煎服一包，可連續服用一週】

乙：(體質較虛、易患感冒者可服用)

蒼　朮 12克、白　朮 15克、黃　芪 15克、

防　風 10克、藿　香 12克、沙　參 15克、

銀　花 20克、貫　眾 12克

【3碗水(用淨水)煎為1碗，每天煎服2次，可連續服用一週】

丙：(舌苔較厚、4肢沉重者可服用)

貫　眾 10克、銀　花 10克、連　翹 10克、

大青葉 10克、蘇　葉 10克、葛　根 10克、

藿　香 10克、蒼　朮 10克、太子參 15克

佩　蘭 10克

【3碗水(用淨水)煎為1碗，每天煎服2次，可連續服用一週】

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# 為有效控制疫症
# 本會聯同護士工會發表兩份聯合聲明

## 4月10日：籲請更有效控制非典型肺炎

1.感謝行政長官董建華昨晚對醫護人員的關懷、支持，感謝他指示醫管局盡最大力提供一個良好的工作環境，保障醫護人員本身的健康。

2.事實上，各高、中、低醫護人員（包括管理及支援人員，尤其是前線人員）長期對抗疫症，正忘我地、竭力地勞累工作；他們之中有些連患病的或需要照顧的家人也顧不上，有些勞碌至自己身體不堪，甚至病倒，不少人甚至不幸地自己本人不幸染上非典型肺炎。

3.自我們於2003年3月23日發出聯合聲明，提出一系列建議以來，我們高興地看到部分建議正在落實中。我們將繼續大力支持政府當局、對抗這疫症。

4.然而，有鑑至今各院仍有多位醫護人員相繼染病（截至2003年4月9日在已確診病例中，有1/4為醫護人員，比例驚人），又根據多間醫管局及護士署會員、同事反映的情況，為更有效地控制、對抗疫症，我們現進一步提出如下建議，希望政府當局及醫管局盡快採納：

(甲)政策前提方面：－

(1)當前，醫管局、衛生署等當務之急是有效、儘快控制及對抗非典型肺炎作為當務之重中之重、急中之急！

(2)政府應與廣東省當局不斷交流疫症的情報，還要交流防治的經驗。

(3)加強、改善高層的中央統籌

1 醫管局、衛生署應統一編訂及發放資訊、指引的制度，並由高層專家從威爾斯親王醫院、聯合醫院及瑪麗醫院的經驗教訓，儘速統一制訂、發放有關預防、隔離及收症的指引供各院及衛生署參照執行，統一調配人力物質資源，並且停止各自為政、口徑做法不統一、容易引混亂及資源錯配的情況；

2 有關資訊、指引可能一式一份分發予前線工作人員參照，亦可能成為教材之用；

3 收集、追查有關資訊，醫管局中央有計劃地

進行，盡量避免重複及減少對前線工作人員、病人及其家屬的滋擾。

(乙)提供充足前線人手：－

(1)護士與病人比例不應小於1:4（不計算當值主管、護士主任）；

(2)要預留替假（包括病假、例假、年假、產假）人手；

(3)每間病房要編配不少於2名的健康服務助理（HCA）以協助護士進行基本護理工作；

(4)每間病房要編配不少於2名的清潔工人以負責病房的清潔消毒工作，必要時醫院要予以支援。

(丙)提供良好工作環境：－

1 加強病房內外的清潔、消毒工作，要做到系統化、制度化，要訂定明確時間表，並有專人負責監督執行及檢查：

(1)全面、全範圍清潔、消毒，做到每更1次（需要時再加強）；

(2)工作枱、椅、活動車、電話（包括話筒）、門把手等，每小時清潔和消毒一次；

(3)病人枱、椅、洗手間等，每天清潔和消毒兩次；

(4)空調隔塵網、抽氣扇等，每天清潔和消毒一次。

2 進一步加強改善防護設備：－

• 防護物資：－

(1)各款防護物資，應制訂使用的統一標準，並由醫管局中央統籌，統一供應，減輕各醫院負擔，以騰出人手為前線提供更細緻、實質支援。

(2)對口罩、眼罩、保護衣、鞋套等防護工具，應統一測試其成效，並確保供應充足，尺碼齊全，凡有需要的均有供應，不論級別；

(3)為需要為確診病人提供某些高危醫護程序的醫護人員提供適當的防護罩；

(4)改善空氣流通，空氣未裝設抽氣扇、空氣清新機者，須盡快安裝；

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5 病房內每一格如尚無洗手盆等設備，須盡快加裝；

6 病房內間隔，如尚無裝設門簾者，須盡快加裝，以形成有形的、明顯的隔離區；

7 為病房增添必要的櫃架等以儲存必要物資；

8 為病房增添更衣室及淋浴設備；

9 各病房因空間不多，不應挪用治療室、儀器室等地方作儲藏口罩、抹手紙、紙袍、手套等防護物資之用，各醫院應增設統一儲存的貨倉並作24小時開放，隨時供應有需要的病房。

• 醫管局方面

1 為4間指定的監護疫症診所，增設防護設施、淋浴設備；

2 為在上述診所工作的同事提供足夠的、合適的防護物資，例如口罩、眼罩、手套、鞋套、衣帽等等。

(丁)確保前線人員的身心健康：－

1 編配人手要有統籌、有計劃、有系統地進行，停止臨時「拉伕」、忽忙「上馬」的做法；嚴格遵守不臨時周章忽忙加開新病房的原則；

2 在調配各類人手去前線之前，要有計劃地統一給予一定時數的、與其職責相應的隔離護理的訓練、傳授有關疾病的知識及治療方法、病房的清潔消毒的知識及技巧及/或深切治療、護理的基本知識和技巧等，嚴格做到先訓練、後調配的原則；

3 每工作3－4小時，容許有半小時的休息；

4 每週額外准許放取1天有薪假期；

5 容許身體不適、懷孕或有其他疾病的員工放取假期；員工放取假期，不應迫令放取積假，應容許保留有薪年假；

6 須為前線人員提供一個離開工作環境的、舒適的休息場所；

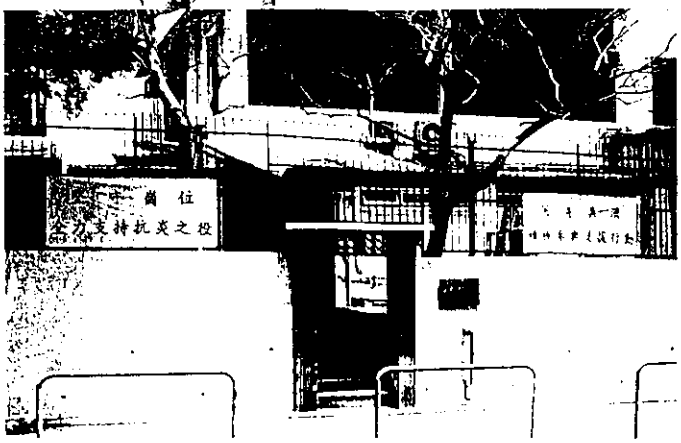
7 提供足夠留宿設施予有需要的員工；

8 編配專人加強聆聽員工心聲意見，及時給予更多心理輔導；

9 提供員工自我檢查身體健康及懷疑有症狀時如何處理、就醫的指引。

5.我們相信，如以上的建議能獲接納，將不但能令前線人員放心、安心，更重要的是，能令疾症得到更有效、更快的控制，防止、減少疫症的進一步傳播，為香港戰勝非典型肺炎打了重要的、堅實的基礎！

華員會 暨 護士分會、登記護士分會、香港護士總工會
第2份聯合聲明
(2003年4月10日)


立法會議員劉千石醫生（中）與本會代表、屬下護士分會、登記護士分會及香港護士總工會代表於記者招待會上（圖中由「大公報」提供，版權屬「大公報」所有），謹此致謝！

華員會全力支持抗炎行動

# 3月23日：
# 2個呼籲、7點建議

現正侵襲本港的非典型肺炎，令本港的醫務衛生服務遭到史無前例的衝擊、公眾的生命健康遭到嚴峻的挑戰，亦令當前積極謀取擺脫經濟困局的本港雪上加霜。

由近個多月以來，非典型肺炎的發展趨勢來看，與患者有接觸受感染的人數在節節上升中，目前尚看不到有紓緩、停止的跡像。為應付巨大的挑戰，近月來，上自衛生福利及食物局局長、醫院管理局總裁，下至醫院當局、前線工作人員已為之疲於奔命，作出了極大的努力。

考慮到問題的嚴重性，我們僅提出2個呼籲、7點建議，希望有利於本港儘快有效地控制這十分危險，但嚴重性或許尚未被人類全面認識的疾病：

- **2個呼籲：**
  1. 我們強烈呼籲全港醫護人員進一步發揮專業精神，全力支持當局共同對付非典型肺炎！
  2. 我們強烈呼籲政府當局、醫管局及各醫院、診所管理階層，用更大力、更實質支援前線工作人員的行動，來更有效地控制此病的傳播！

- **7點建議：**
  1. 全面提高全港醫護人員的警覺性，以威爾斯親王醫院為鑑。

  2. 全面加大、加強、改善現行預防措施——
     ① 由單純防止飛沫傳染，一律提升至防止飛沫、接觸及空氣傳染的高度，嚴格、全面執行防止交叉傳染(cross infection)的措施。
     ② 不設限制地供應得以更有效控制傳染的、尺碼齊全的口罩及其他有效防護工具。
     ③ 由醫管局參照威爾斯親王醫院的經驗教訓，統一製訂、發放[illegible]預防的指引，避免各自為政、口徑做法[illegible]的情況；並由控制感染小組(Infection C[illegible] Unit)負責指導、示範及監察，糾正不正[illegible]使用防護工具或不嚴格執行的情況。
     ④ 積極、全面、及[illegible]進與患者有較密切接觸的人士，進行監[illegible]追查來源。
     ⑤ 嚴格控制、限[illegible]病的人流，呼籲患者親友、市民不要攜[illegible]贈送水果、花籃予患者或前線員工。
     ⑥ 儘快、切實改善[illegible]病房環境，包括
     — 擠迫情況，增[illegible]床與病床之間的空間；
     — 空氣流通，裝[illegible]氣扇、空氣清新機；
     — 增加清潔和[illegible]房以及冷氣系統的次數。
  3. (3) 由醫管局、醫院[illegible]改資訊，改變目前資訊「泛濫」、過雜、[illegible]潔的情況。
  4. (4) 凡重新調配床位[illegible]手，應改善當前欠缺清晰、書面指引及[illegible]應短缺的情況。
  5. (5) 衛生署應即統一[illegible]發放宣傳單張、海報、短片，以宣傳有關[illegible]的危害性及正確預防的知識，加強全港[illegible]警覺性。
  6. (6) 由於本港與內地[illegible]的交往日益頻繁，應與外地衛生部門加強[illegible]、共同追查源頭，相互做好防護措施，[illegible]應對例如清明節、復活節等高峰期大量[illegible]來帶來的影響。
  7. (7) 在適當時候總結[illegible]經驗教訓。

[illegible]

[illegible]華員會 暨 護士分會、[illegible]士分會、香港護士總工會
第1份聯合聲明
2003年3月23日

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# 協助公務員有效預防肺炎 本會要求當局採積極措施

鑑於已有非醫護人員的公務員感染到非典型肺炎，為加強控制此致命肺炎，本會於3月中旬即已要求公務員事務局局長採取積極措施，協助公務員同事有效預防這罕見的疾病。本會要求當局全面加強、加密檢查辦公室空氣質量以及清潔和消毒辦公室環境，包括電話接聽器及冷氣系統的次數。本會並指出，如今辦公室清潔多已外判，要加強、加密清潔，部門管理階層便必須增撥一定的資源，並給予負責清潔的員工必要的指示。

2003年3月28日公務員事務局發出了一份通告，就預防非典型肺炎作出了指引，能向公務員同事傳遞預防的信息，儘管姍來得較遲，仍值得歡迎和讚賞。然而，通告只提到了會加強清潔中區政府合署，灣仔胡忠大廈的辦公室等的措施，但無提及其他地點。為此，本會副會長暨公務員職安健工作小組成員黃河已於當日向當局指出：空氣質量的檢查及清潔和消毒的地方，應包括*所有*政府辦公室(以及*所有*工作場所)！

據公務員事務局局長的回覆，當局已展開如下工作：

- 要求所有部門參考衛生署的預防非典型肺炎指引及按部門運作情況而制定部門指引，向員工介紹預防該疾病的方法。所有部門已制定指引並向員工傳閱。
- 安排所有部門秘書出席簡報會，由衛生署顧問醫生介紹非典型肺炎的特質及預防方法，並解答同事提問。
- 提醒所有部門加強辦公室清潔，保持衛生(當局解釋，並不局限於公務員事務局，而是涉及所有政府部門)。
- 發出處理涉及非典型肺炎個案的病假指引，使有家屬受感染的員工可以休假，減低傳染的可能性。
- 要求部門將懷疑感染個案第一時間向衛生署報告，以便跟進。
- 要求部門按運作情況及需要為員工提供口罩(當局表示員工可自行決定是否在工作時戴上口罩)。
- 提醒身體不適的員工應停止上班。

就涉及有關疾病時如何處理病假方面，當局作出了指引：

- 批准本身沒有病徵，但可能受感染並獲衛生署勸喻離開工作崗位的員工放取病假(長短由衛生署建議)。
- 如家中成員證實感染，但本身並無病徵，可獲特准放取病假最多7天(由上一次近距離接觸受感染家人的翌日起計)。他/她不必提交本身的醫生證明書，但需要提供受感染家人的姓名、患病日期及醫生證明書，供政府轉交有關當局以便跟進。如未能即時提供，管方可先獲准放病假，惟如提供虛假資料或濫用是項措施，將可能面對紀律處分！)
- 非公務員合約僱員亦可特准放取7天，並不會從積存的有薪病假內扣除。
- 懷孕僱員除可申請放取有薪假期外，亦可「借假」，日數不設上限。

# 建議前線櫃枱人員須帶口罩防範

繼衛生署剛向各政府部門發出了預防非典型肺炎的指引，公務員事務局也於3月28日發出了一份通告。此外，衛生署還透過了電子傳媒加強了宣傳。然而，其中的部份信息卻有不足之處。

根據當局的指引和衛生署的宣傳，除醫院、診所外，一般於櫃檯接觸市民最前線的人員「不需要」戴口罩，一般市民戴不戴口罩屬「個人選擇」云云。此言除徒然增加公務員、市民認知上的混亂外，無助紓緩當前緊張氣氛。鑑於非典型肺炎正在向社區蔓延之勢，帶菌/病毒的市民有增加的跡像，因而，協助站在服務最前線的公務員同事積極預防感染致命肺炎實屬必要。為此，在如今環境下，應建議凡提供最前線(包括櫃檯)服務的公務員應戴上口罩。當局有必要修訂有關指引，以負起一個能遵循職安健條例、照顧員工福祉的良好僱主之責。

另一方面，衛生署在宣傳時，不要再講什麼戴不戴口罩屬「個人選擇」這類模稜兩可的話，勿再徒增市民認知上的混亂。向市民講清楚，什麼情形下(例如身邊的親友同事或自己有感冒的症狀時，或在擠迫的公共場所)需要戴上口罩，將大有助於提高全民的警覺，有助於有效地控制疾病的傳播！

*【編者按：目前情況已有改善。】*

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# 非典型肺炎是什麼？如何預防傳播？

■ 有關非典型肺炎(Atypical Pneumonia)

問：甚麼是嚴重呼吸系統綜合症(SARS-Serious Acute Respiratory Syndrome,即非典型肺炎)?

答：這是急性的呼吸道感染而病源不明; 在多過地區包括香港均發現個案。

問：非典型肺炎的病徵為何?

答：發燒、全身乏力、發冷、頭痛、全身酸痛，肺部X光檢驗顯示肺炎象徵，其它病徵包括咳嗽，呼吸急速或困難。

問：感染非典型肺炎的病人是否出現發熱的病徵？

答：是。

問：非典型肺炎與一般感冒有何分別？

答：一般感冒病徵包括發燒、咳嗽、頭痛，病徵在數日後轉好，並且沒有肺炎跡象。

問：非典型肺炎與典型肺炎有何分別？

答：典型肺炎通常是指由肺炎鏈球菌(Streptococcus pneumoniae)等常見病菌引起的肺炎，症狀包括發燒、胸痛、咳嗽、咳膿痰，病徵通常嚴重而且出現得早。

非典型肺炎主要是由流感病毒、支原體、衣原體、腺病毒以及其他未明的微生物所引起的肺炎。

問：非典型肺炎潛伏期多久?

答：潛伏期約為2至7天。

*【編者按：台灣有專家認為可長達14天】*

問：假如懷疑染上肺炎，是否應即時往急症室求診，安排留院觀察?

答：如懷疑染病，請盡早求診，是否需要留院觀察則是由醫生決定。

問：如有懷疑病人感染非典型肺炎，是否必須照X光才可證實感染？

答：懷疑感染非典型肺炎應及早求診，X光檢驗有助診斷。

問：有沒有治療方法?

答：根據本地的個案及經驗顯示，部份病人對類固醇(steroid)及抗病毒藥(anti-viral drug: Ribavirin)治療反應良好。

■ 傳播途徑

問：非典型肺炎由甚麼途徑傳染?

答：非典型肺炎由飛沫(droplet)及分泌物傳染。

問：有什麼根據說明非典型肺炎並非由空氣傳染？

答：根據現有資料及流行病學調查顯示是由飛沫傳染，但不可排除其他途徑。

*【編者按：本會聯同3個護士工會已要求提升預防措施，見第6頁《聯合聲明》；聯合國世界衛生組織及專家則早已建議應當作空氣傳染來預防。】*

問：到公共游泳池游泳是否安全？

答：沒有流行病學資料顯示非典型肺炎經由游泳傳染。現時未有因游泳而感染的報告，如有呼吸道感染的徵狀，不應前往泳池游泳。

問：市民會否因接觸紙幣而感染非典型肺炎？

答：現時資料顯示非典型肺炎是由飛沫傳染，不會經紙幣傳染，但市民應注意個人衛生。

*【編者按：如錢幣已被患者飛沫污染，則不能排除此傳染途徑。】*

■ 預防傳染

問：是否有疫苗預防非典型肺炎？

答：現時病毒還未明確知道，所以暫時沒有疫苗預防非典型肺炎。

問：流行性感冒的疫苗能預防非典型肺炎？

答：不能。

問：一般市民能如何預防非典型肺炎？

答：＊市民應注意個人衛生，如打噴嚏或咳嗽時應掩着口鼻; 雙手被呼吸系統分泌物弄污後(如打噴嚏後)應洗手;用梘液洗手，然後以用後即棄的紙巾拭乾;不應共用毛巾。*【編者按：用後的紙巾不應隨地丟棄。】*

＊培養良好的健康生活習慣。

＊保持室內空氣流通。

＊如出現呼吸道感染病徵，或照顧受呼吸道感染的病人，應該戴上口罩。*【編者按：一般應戴上外科用口罩。】*

＊當感到不適時，應盡盡早求醫。

問：如何避免在辦公室感染非典型肺炎？

答：＊員工如有不適，應及早求診，留在家中休息，不要上班。

＊所有員工要注意個人衛生，培養良好的健康生活習慣。

＊保持室內空氣流通，打開窗戶，如用空調，需經常清洗隔塵網。

＊保持辦公室物件和器材清潔。

問：如何避免在升降機內受感染非典型肺炎?

答：市民應注意個人衛生，打噴嚏或咳嗽時應掩着口鼻。如有呼吸道感染的病徵，須戴口罩，大廈應保持升降機清潔。

*【編者按：市民可戴口罩防範感染。】*

問：如有感到不適，到診所求診會感染非典型肺炎嗎？

答：衛生署已向全港所有醫生發出有關預防非典型肺炎於診所內傳播的建議，求診者應注意個人衛生。戴上口罩有助預防感染。

問：如有家人或朋友證實感染非典型肺炎，應採取什麼預防措施？

答：小童不宜往醫院探訪患者，探訪者亦須採取應有預防措施。

與證實感染非典型肺炎患者有親密接觸人仕，應注意下列事項：－

＊與患者接觸後7天內宜戴上口罩(非典型肺炎潛伏期為7天)。

＊清洗患者家中的家具及玩具(以1:10稀釋家用漂白水清潔)。

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＊留意自己身體狀況，如有病徵請盡早求醫。

＊家中的學童及任職教職員的成員，須留家觀察7天。(非典型肺炎潛伏期為7天)

*【編者按：台灣有專家認為潛伏期可達14天。另外，非必要，成人亦應減少往醫院探病。】*

問：衛生署會否替證實感染非典型肺炎病人的居所消毒？

答：衛生署會建議家人清洗居所及指導清洗方法。

問：曾前往醫院探病的人士穿著的衣服應否即時清洗?

答：應即時清洗。

問：衛生署對於在家中或餐館中與他人用膳時有何建議?

答：衛生署鼓勵市民使用公筷及公匙。

*【編者按：亦要注意用餐時減少說話，避免唾沫橫飛。】*

■有關口罩

問：戴上口罩就可以預防傳染嗎?

答：戴上口罩有助預防傳染。市民仍需注意個人及環境衛生。

*【編者按：仍須注意正確戴口罩的方法，口罩須罩住鼻孔、口腔及下巴，並緊貼鼻樑和面型。】*

問：甚麼人士應戴上口罩?

答：以下人士應戴上口罩:-

＊有呼吸道感染的徵狀的人士。

＊照顧有呼吸道疾病的人士。

＊與証實患上非典型肺炎的病人有親密接觸者，需7天內戴上口罩(由最後接觸起計)。

＊醫護人員。

*【編者按：本會已建議接觸市民最前線的人員，包括提供櫃枱服務者，應戴上口罩；醫護患者的員工則更應提升防護措施。】*

問：什麼類型的口罩能有效預防非典型肺炎？

答：一般外科用的口罩(surgical mask)有助預防非典型肺炎的傳播。

問：是否只有N95才有效防止感染非典型肺炎？

答：一般外科用的口罩及N95口罩同樣有效預防非典型肺炎。

*【編者按：本會聯同3個護士工會已建議有直接觸確診或懷疑患者的醫護人員須加大、加強改善現行預防措施，由單純防止飛沫傳染，一力提升至防止飛沫、接觸及空氣傳播的高度，嚴格、全面執行防止交叉傳染，單純使用外科口罩並不能有效防止感染。】*

問：口罩需要隔多久更換?

答：一般情況下，外科手術用的口罩可持續用數小時。如發現口罩有裂縫或損毀須即時更換。

■有關旅遊

問：現時前往內地安全嗎?

答：根據世界衛生組織的建議，暫時沒有建議任何國家、地區不適宜旅遊。旅客如有不適，應盡早求診。如有非典型肺炎病徵，切勿繼續行程。

問：旅客到香港旅遊安全嗎？

答：香港有優良醫護設施及有效的疾病監察系統，所以香港仍然是一個安全的旅遊地方。

*【編者按：某些國家已忠告其國民暫勿前往數個國家和地區，香港為其中一個。世界衛生組織亦已提出忠告】*

問：旅客到香港旅遊應採取什麼預防措施？

答：旅客應注意個人衛生及避免前往人煙稠密的地方。

(資料由婦女事務委員會、衛生署提供)

# 懷疑染上或接觸SARS怎麼辦？

■問：如果我(你)懷疑染上SARS怎辦？

答：• 求醫，治好自己(已找到特效藥和療法，絕大部份都可治好)。

• 把自己隔離，即到醫院(如果不如此，會傳染給接觸過自己的人——配偶、子女、父母、同事、鄰居、朋友.....)。

• 絕對按照衛生署發出的指引保護自己(盡一個負責任公民的責任)。

■問：如果我(你)接觸過SARS病者？

答：• 留意自己5至10天內，會否發生SARS病徵：發燒、肌肉痛，咳嗽(如自己不能肯定，應請教醫生)。

• 通知衛生署2833 0111或到醫院。

• 接受隔離(因為如果不隔離，果真染病，會傳染他人、擴散社區)。

• 絕對按照衛生署發出的指引，保護自己，保護他人。

• 要保持鎮定(SARS患者，絕大部份，都可以治好)。

■問：如果我(你)的住所/屋/辦公室/工作場所發生証實SARS病者：

答：• 你有機會接觸過患者帶出的病毒，因此要加倍小心，留意發病者徵狀：發燒，肌肉痛，咳嗽。發現時立刻見醫生(如自己不能肯定，應請教醫生)。

• 你不一定接觸過病毒，但你的環境可能令你受感染機會高，因此要特別小心，保護自己，保護家人。

• 是否搬離現場，按自己能力而定。密切注意自己健康變化，有懷疑立刻找醫生，要注意你的搬遷可能把病毒進一步擴散。

• 要保持鎮定(SARS患者，絕大部份都可以治好)。

*註：資料取自威爾斯親王醫院，曾經歷過SARS防治工作的醫護人員的建議，由香港中文大學醫學院梁某中教授提供*

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# 勞工處致僱主僱員
# 《非典型肺炎指引》

當僱員不幸染上此病症，或因其家庭成員感染，或因與患者有緊密接觸而受到影響，我們呼籲僱主要體恤僱員，靈活及彈性處理他們的病假及暫時缺勤的問題。

(A)僱主和僱員在《僱傭條例》下的權利及責任：

(1)如僱員感染嚴重急性呼吸系統綜合症

如果僱員感染此病症，僱主應讓僱員放取病假。根據《僱傭條例》，僱員如符合下列情況，可享有有薪病假(款額相等於僱員正常工資的五分之四)：-

- 僱員能出示適當的醫生証明書；
- 放取的病假不少於連續4天；及
- 僱員已累積足夠的有薪病假日數。
- 僱主不可以在僱員放取有薪病假期間解僱該僱員。根據《僱傭條例》，這會構成可檢控的違例事項。
- 即使僱員未有累積足夠的有薪病假日數，基於這特殊情況，我們呼籲僱主應體恤僱員，同樣給予有薪病假。

(2)如衛生署署長向僱員發出隔離令或要求他們在一段時間內每天接受身體檢查

- 由於衛生署會為僱員簽發病假証明書，(A)(1)段的指引同樣適用。

(3)如僱主因僱員的家庭成員感染嚴重急性呼吸系統綜合症，或因恐怕病毒擴散而關閉工作場所而要求僱員暫時停止上班

- 根據《僱傭條例》，這等同僱主暫停僱用僱員。僱主須按照《僱傭條例》及僱傭合約向僱員支付工資及其他福利。

(B)僱主和僱員在《僱員補償條例》下的權利及責任：

(1)如僱員感染嚴重急性呼吸系統綜合症

- 根據《僱員補償條例》，嚴重急性呼吸系統綜合症並不是法例所指定其中一項可獲補償的職業病。但條例第36條也訂明，僱員若染上疾病，雖然不是指定可獲補償的職業病，如符合條例所指的在受僱期間因工作意外所致的身體受損，則該僱員仍可根據這條例就該疾病追討補償。
- 勞工處在處理非指定的職業病時，會根據醫療紀錄、個案的資料、及《僱員補償條例》的規定，去了解有關僱員的疾病，和是否在受僱期間因工作的關係而意外染病。我們會依照同樣的原則辦理嚴重急性呼吸系統綜合症的個案。
- 如果僱員是在受僱期間因工作的關係而染上嚴重急性呼吸系統綜合症，表面上看來應受到《僱員補償條例》的保障。如果就個別個案有爭議而無法在勞工處協助下解決，法庭擁有最終裁決權。

(C)其他重要事項：

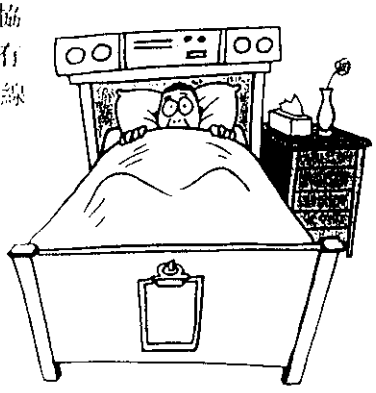
(1)根據《職業安全及健康條例》，僱主均須在合理地切實可行範圍內確保所有在工作中的僱員的安全及健康。倘若工作地點被證實有僱員感染嚴重急性呼吸系統綜合症個案，僱主必須清洗及消毒該工作地點及清潔通風系統。

(2)我們呼籲僱主在適當情況下為員工提供口罩，這將有助對抗此病症。

(3)平等機會委員會提醒僱主及僱員以下事項:

- 若僱員拒絕採取預防措施或拒絕遵守措施以保障公眾健康，則僱主對僱員採取行動便不屬違法。
- 如果僱主因為僱員有家庭成員或親屬染上此病症，或因僱員有類似此病症的徵狀，而安排僱員放取有薪假期在家休息，這並不構成《殘疾歧視條例》及《家庭崗位歧視條例》的違法歧視行為。
- 僱主不可因僱員已染上(或可能染上)此病症，或因他的家人或與其有聯繫人士已染上（或可能染上）此病症，而將其解僱，或令該僱員蒙受不利，否則會構成歧視。

僱主及僱員如需協助，可聯絡勞工處。如有查詢，請致電勞工處熱線2717-1771。



# 家居消毒指引

## 經常接觸的地方及物品

客廳／睡房

- 門柄/窗戶把手/按鈕/電器開關
- 電話/對講機/電腦鍵盤及滑鼠
- 家具表面(如桌面)
- 地氈 • 梳化 • 玩具 • 地板

飯廳

- 餐桌/餐椅 • 地面 • 食具

廚房及廁所

- 水龍頭/花灑頭 • 門柄/窗戶把手/按鈕/電器開關
- 坐廁及水箱把手/坐墊及蓋板 • 浴缸及洗手盆
- 地面及牆壁 • 地面排水口(如有) • 垃圾桶

## 清洗及消毒程序*(也適用於一般工作場所)*

拭抹家具

- 以1:99(即把1份家用漂白水混和99份清水)的稀釋家用漂白水徹底拭抹。
- 如地方骯髒，應用1:49(即把1份家用漂白水混和49份清水)的稀釋家用漂白水清潔。
- 用乾淨毛巾抹乾。

拭抹牆壁

- 以1:99的稀釋家用漂白水徹底拭抹。
- 如地方有污穢物，稀釋家用漂白水的濃度應為1:49。
- 用乾淨毛巾抹乾。

拖 地

- 拖地前先清掃垃圾。
- 用1:99的稀釋家用漂白水徹底拖地。
- 如地方骯髒，稀釋家用漂白水的濃度應為1:49。
- 用清水拖地。

洗刷水廁

- 如廁後，廁紙要放進廁座內。
- 沖廁前要蓋上廁座蓋板，避免污水濺出。
- 沖廁。
- 待沖廁水靜止後，才打開廁座蓋板。
- 用稀釋家用漂白水揩抹廁座邊、廁板和廁蓋，再用清水揩抹。
- 向廁座注入一茶匙稀釋家用漂白水。
- 用皂液徹底清洗雙手，再用抹手紙抹乾。

浴缸及洗手盆

- 用普通刷子和以1:99的稀釋家用漂白水洗刷。
- 以清水沖洗。

排 水 口

- 每天清潔地台排水口一次。
- 為防排水管臭氣隔乾涸，先把半公升左右的清水倒入地台排水口。
- 再把一茶匙稀釋家用漂白水灌入排水口。
- 5分鐘後，用清水沖洗。
- 除非有特別指示，只須使用已稀釋的漂白水，以免損毀喉管。

## 注意事項

- 家居應至少每日消毒一次。
- 清潔電器開關和電腦設備時務必小心。

## 檢查提示

- 確保糞渠及污水渠暢通、無損；如運作不正常，出現洩漏，應立即維修。
- 如發現有蟲鼠為患跡象(例如有老鼠排泄物、蟑螂、積水等)，應立即採取清潔行動，杜絕蟲患鼠患。如有需要，可尋求管理處協助。
- 保持地氈清潔，須每日吸塵及定期清洗。
- 確保通風系統運作正常，定期清洗冷氣機隔塵網。

# 工作場所指引

## 管理層應採取以下預防措施

- 維持空調系統性能良好，並經常清洗隔塵網，定期維修保養。
- 辦公室應不時打開窗戶讓空氣流通。
- 工作地方應保持清潔及衛生，日用設施包括電話應至少每日清潔及消毒一次，用1:99 (即把1份漂白水與99份水混和) 的稀釋家用漂白水拭抹，再用清水清潔。
- 如用具被嘔吐物沾染，應立即以1:49的稀釋家用漂白水清洗，再用清水沖洗及抹乾 。
- 保持地氈、門窗等清潔。
- 確保沖廁設備運作妥當。
- 廁所內應備鹼液、乾手機或用後即棄的紙巾。
- 提醒員工如出現非典型肺炎病徵，應盡早求診，並即時請病假。

# 佩戴口罩須知

## 為甚麼要佩戴口罩？

適當佩戴口罩，對預防呼吸道傳染病有一定作用。[illegible]若受感染，戴口罩有助防止疾病傳播。

## 甚麼人應當佩戴口罩？

- 有呼吸道受感染病徵的人士，以及曾與非典型肺炎患者有過緊密接觸的人士， 都應戴口罩。照顧患者和到醫院探病的人士，也應佩戴口罩。
- 處理食物的工作人員應佩戴口罩。
- 一般市民也可佩戴口罩，以保障個人健康。

## 佩戴口罩要注意的事項：

- 佩戴口罩前後都必須清潔雙手。
- 如口罩的包裝有佩戴指示，應依照指示佩戴口罩。

## 佩戴外科手術專用口罩，一般應注意以下事項：

- 要讓口罩緊貼面部：
  - ➤ 口罩有顏色的一面向外；
  - ➤ 緊緊固定口罩的繩子，或把口罩的橡筋繞在耳朵上，使口罩緊貼面部；
  - ➤ 口罩應完全覆蓋口鼻和下巴；
  - ➤ 把口罩上的金屬片沿鼻樑兩側按緊，使口罩緊貼面部；
  - ➤ 一般情況下，外科手術口罩應每天更換。口罩如有破損或弄污，應立即更換。
- 棄置的口罩應用膠袋封好，才放進有蓋的垃圾桶。
- 佩戴口罩只是預防呼吸道傳染病的方法之一。

*(資料由衛生署提供)*

120275

# 華員會理事會

謹向

堅守工作崗位
發揮團隊精神
全力抵抗 SARS
的醫護人員

# 致謝！
# 致敬！

# 附件 3：香港衛生界專業團體聯席會議
# 有關設立權威性機構去加強預防疾病的工作

要能有力、有效地匯合全港各政府部門及社會各界的力量，單靠衛生福利局一個政策局的努力是不足夠的。特區政府應在政府總部的層面，成立一個跨局、跨部門的權威性機構去推動、處理、協調有關事宜。

這個機構可以透過教育統籌局、食物環境局等相關的政策局，在由幼兒園、小學到中學的課程內增設預防疾病、健康衛生、良好生活習慣、個人負責任意識等由淺到深的科目，以及把體育運動視爲必備、必修科目之一；改變嗜吃非健康食物（例如：含鹽份、脂肪、碳水化合物過高的零食、炸薯片等）；加強反吸煙的教育和措施；廣泛、持續、有系統地爲成人舉辦預防疾病、健康衛生、良好的生活習慣、個人承擔義務及負責任的意識，以及食物和環境衛生的教育；加強反對污染食物、水、空氣、環境的教育和控制，等等。

這個機構可統籌和協調衛生署、教育署、食物環境衛生署、社會福利署、環境保護署、水務署等部門的教育、推廣、執法的工作和計劃。其指導方針是：多從源頭、基層、前線、幼年開始。

（摘自《聯席會議》致政府「醫護改革小組」的意見書
第 11（6）段，2001 年 3 月 31 日）

# 附件 4：不同政府部門公務員爲抗炎提供的支援服務(部份)

- 執行淘大花園隔離令，並協助居民遷入隔離營(時已半夜)；
- 向服從家居隔離令及遷入隔離營的市民提供輔導、供應膳食、購買日用「必需品」；
- 向 SARS 病人、其家人及市民提供輔導；
- 照顧 SARS 病人的幼童；
- 代家屬查詢 SARS 病人的治療情況；
- 跟進 SARS 受害人及其家屬的個案；
- 協助有需要人士申請經濟援助；
- 爲長者、殘疾人士提供照顧及特別需要的安排；
- 關懷探訪計劃：探訪全港老人院舍(包括私營老人院)、幼兒園、幼兒院舍、弱能人士宿舍，檢查及協助執行預防 SARS 措施；
- 關懷行動計劃：爲社區長者及有特別需要人士提供家居清潔、簡單維修工作，爲此，策劃創造了 4,500 個臨時職位予清潔及維修工人，並對有關計劃進行聯絡、實施及跟進進展等工作；
- 處理「工商界關懷非典型肺炎受難者基金」的申請、會面評核、批核、聯絡、轉介等事宜；
- 處理「賽馬會慈善信託基金」所有非政府機構要求撥款進行防炎措施及清潔之用的申請、評核、查詢、聯絡等事宜；
- 清洗街道及圍村，管理承辦商清理街道，檢查垃圾站及廁所(包括水廁和旱廁)以及檢控工作；
- 接載公務員同事往「疫廈」、「疫區」工作；
- 配合全職清潔小組工作，檢控違例、違規吐痰人士；
- 繪製淘大花園天井去水設施圖則，用作向世界衛生組織提交的公開報告資料；
- 繪製加建及改善醫院傳染病房圖則；
- 協助勘察政府樓宇/建築物清潔，配合全城清潔小組工作；
- 爲天水圍天恩邨空置的中轉房屋共 2016 個單位，加裝住家設施，使其成爲 SARS 隔離宿舍。
- 爲醫院安裝抽氣扇等通風工具、調校空調機換氣頻率、清潔消毒隔塵網，等等。