Select Committee Question Item 13(a)

(a) Letter, notes or any record written by Dr. William Ho to the Chairman of the Review Panel to explain the closure of the hospital

Please note that in his letter dated July 11, 2003 to the Chairman of the HA Review Panel on SARS, Dr William Ho wrote in the second paragraph: limitations of [the WHO definition of SARS] in the Hong Kong context we had already explained to the panel". He was referring to the early stage where clinicians could only rely on clinical and not laboratory criteria to diagnose SARS. Among the clinical criteria as defined by WHO, fever, respiratory symptoms, radiological findings, and even absence of alternative diagnosis were all commonly encountered among non-SARS atypical pneumonia cases as well. Apart from these, one important criterion to assist diagnosis used in other countries was travel history to places where there were SARS. Since Hong Kong had SARS, this criterion would not be of much use.

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Dr William HO, JP
Chief Executive

11 July 2003

Mr Ronald Arculli, GBS, OBE, JP
Arculli and Associates
2012 Hutchison House
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Dear Mr Arculli,

Following yesterday's meeting with the panel, we felt there might not be enough time for us to fully explain the context of the so-called "closure of hospital" argument that could be one of your focus areas. I would therefore like to supply supplementary information for the deliberation of panel members.

Rewinding back to 15 March 2003, that was when the term SARS had just been coined by the WHO, and even so using a rather vague definition the limitation of which in the Hong Kong context we had already explained to the panel yesterday. Hitherto, the surveillance system in Hospital Authority could only focus on the so-called Severe Community Acquired Pneumonia, i.e. those severe enough to warrant intensive care. A rapid diagnostic test using the PCR technique had not been developed at that time. So the differentiation from background atypical pneumonia cases remained problematic. (Even now, this is problematic because the PCR test is still not sensitive enough for the initial period of illness.) The problem presented to us at that time was therefore one of a large number of healthcare workers and contacts in Ward 8A of Prince of Wales Hospital coming down with the illness, indicating an unknown infection there. The index patient was only identified on March 13, based on which information the hospital and Department of Health were doing the contact tracing.

As far as contingency measures are concerned, the hospital informed HAHO that Ward 8A had been closed for admission since March 10, and there was segregation of staff depending on whether they had contacted 8A patients and other infected cases or not. Every effort had been made since March 11 to call back staff and patients/patient relatives with potential contact, for health check and if necessary admission for observation.

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So what is possibly meant by "hospital closure" and what theoretical advantage could that bring? In the strictest sense, this means compulsory quarantine of both staff and patients, meaning that no one inside the hospital building can leave, and those who had already gone home after a certain defined date and time should be called back to be quarantined say in the hospital quarters. This is akin to the later treatment of the residents in Block E, Amoy Gardens. This entails a number of steps:

- The passage of a law for compulsory quarantine in the Legislative Council (as what happened later for Amoy Gardens residents), as SARS was not a statutory notifiable communicable disease hitherto;
- Arrangement for contact tracing and detention, probably needing the help of the Police;
- Arrangement for accommodation and daily living matters;
- No visiting by relatives of either patients or staff;
- Immediate diversion of all other services to other hospitals, which would be a huge undertaking for this major acute teaching hospital with 1,360 beds.

One can judge whether at that juncture, this was politically and operationally feasible, based on the scanty information about the disease available at that time, and the possible reactions from staff, patients and their families. Even then, had the disease already spread outside the hospital before the quarantine was implemented, the problem still remained. It is also to be noted that spread within the hospital where staff and patients were confined by the quarantine, could still occur.

In another sense short of full quanrantine, "hospital closure" could mean no more new admissions either emergency or elective, except perhaps admission of contacts who had symptoms discovered on the tracing. Staff who had no symptoms could still go home and come back to work, while exercising caution. Such strategy would still entail immediate diversion of all other services to other hospitals, and no visiting policy to be applied to the whole hospital. It still falls short of compulsorily detaining all potential contacts within a confined area. One therefore needs to compare this with what the hospital implemented, namely "ward 8A closure" rather than "whole hospital closure", plus cohorting of potentially exposed staff and patients. There would be little practical difference as far as prevention of disease spread is concerned, provided the closure of Ward 8A and cohorting of potentially exposed staff and patients in other areas (e.g. A&E, ICU) had been effectively carried out, and provided the Department of Health had been effective in tracing all possible contacts in the

community and bringing them all to the hospital system for examination and/or cohorting and treatment.

It could thus be seen that unless we went for full-blown compulsory quarantine, there would not be much material difference between closing the hospital for all admissions, or closing the affected clinical areas. Even the former would not be useful if community spread had already occurred, something we were not sure at the time around March 15. The panel might also note that at the later stages when community spread had definitely occurred, we had also not closed any of the hospitals that had outbreak occurred subsequently. All the while, the consideration on whether to "close services" was under the context of workload vis-a-vis manpower.

I hope this would be of use to the deliberation of the panel. Thank you for your attention.

Yours sincerely,

(Dr William Ho)
Chief Executive