THE CHINESE UNIVERSITY OF HONG KONG

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Your Ref:

Our Ref: CLO/0104/05

28th January 2004

Miss Flora Tai
Clerk to Select Committee
Select Committee to inquire into the handling of
the Severe Acute Respiratory Syndrome outbreak by
the Government and Hospital Authority
3/F, Citibank Tower
3 Garden Road, Central
Hong Kong

Dear Miss Tai,

Select Committee to inquire into the handling of the Severe Acute Respiratory Syndrome outbreak by the Government and the Hospital Authority

Enclosed are :

1. my qualifications and experience, and
2. my responses to the questions raised by the Select Committee

Thank you for your help.

Yours sincerely,

SC Sydney Chung
Dean

Enc
SC/cm

RESPONSE TO QUESTIONS RAISED BY THE SELECT COMMITTEE

Professor Sydney Chung

Dean of the Faculty of Medicine, Chinese University of Hong Kong

1. I was informed of the outbreak by Professor Joseph Sung in the morning of 12th March 2003. I attended the meeting on outbreak management at the Prince of Wales Hospital (PWH) together with Dr Ko Wing Man, Dr Fung Hong, Dr Philip Li, Professor Joseph Sung and members of the Departments of Medicine and Microbiology.

2. The decision to stop medical students of CUHK from visiting the medical wards at the Prince of Wales Hospital was made at around lunch time on 12th March 2003. This decision was made by myself as the Dean of the Faculty of Medicine in consultation with my Associate Dean, Professor Fok Tai-fai. The decision was implemented immediately by an email to all Year 3 and Year 5 students and teaching staff at 2:50 p.m. When I became aware that some HCWs other than those from the Department of Medicine were also affected, the decision was upgraded to suspend all clinical teaching at the Prince of Wales Hospital and to declare the Clinical Sciences Building at PWH out of bounds for medical students. This decision was again made in consultation with Professor Fok and implemented by another email on 12th March 2003 at 7:40 p.m.

3. Yes, it was an outbreak. I am aware that the Infection Control Team at Prince of Wales Hospital started investigations on 10th March 2003 and the possibility of spread of infection was considered and control measures were instituted. As new information became available, these protocols were reviewed on a daily (sometimes twice daily) basis during the meeting of senior staff. These measures evolved into Guidelines for Infection Control which were generally adopted by all other HA Hospitals.

4. I am aware that both the Department of Health and the Hospital Authority were informed of the outbreak at PWH at the very early stage. Indeed, Dr Ko Wing

Man of the HA, and Dr Au Tak Kwong of the DH, were present at the meeting at PWH on 12th March 2003.

5. Twice daily meetings to discuss the situation at PWH were chaired by Dr Fung Hong, and attended by senior staff of the Hospital, many of whom were also academics of the Faculty of Medicine of the Chinese University. During these meetings, we were updated on the number of patients with suspected atypical pneumonia, their clinical course, the progress of microbiological and epidemiological investigations, infection control measures, manpower issues, etc. The group also discussed how best to respond to the crisis. From the very beginning, the members were cognizant of the highly infectious nature of the disease and its dire consequences, and the risk of spread into the community was mentioned on numerous occasions. In particular, Professor Clive Cockram raised the need to close the hospital as early as 12th March 2003. The issue of closure of the hospital was repeatedly debated as it was a complex issue, involving not only infection risk to patients and the public, but also whether manpower was adequate as many staff had taken ill, whether the Prince of Wales Hospital had enough capacity to deal with the outbreak, whether other hospital within and without the cluster could deal with increased workload, and whether there were more cases in the community. The issue of closure of the Accident & Emergency Department was again discussed on 18th March 2003 in the presence of Dr William Ho, who agreed to close the A&E Department, initially for a period of three days. As far as I am aware, representatives of the Department of Health did not take part in the discussion.

6. I was not personally involved with the Working Group on Severe Community Acquired Pneumonia. During the meetings on atypical pneumonia in the hospital, my impression was that information flowed from Prince of Wales Hospital to the committee rather than in the other direction.

7. My involvement with the outbreak started on the 12th March 2003. Personally I was not party to the discussion on the closure of Ward 8A on 10th and 11th March. I subsequently learned from my colleagues that the ward was closed to visitors after a meeting chaired by Professor Joseph Sung on the 10th March. Immediate

family members were allowed to visit on the 11th March after we received complaints from relatives. We had no legal authority to detain patients against their wishes and there were concerns that patients might insist on being discharged, even against medical advice, if visiting was prohibited. I understand that HAHO, HA Board, DH and HWFB were not consulted on the closure of Ward 8A on the 10th March.

8. see 7

9. Visitors were discouraged, limited to immediate family and were asked to don a mask. As far as I am aware, no visitors to 8A after 10th March became infected with SARS.

10. I was not involved with the clinical care of patients. In the early days of the outbreak, there was little information on the illness. The incubation period of SARS was not known until later.

11. See 10. In general patients are kept in hospital when they need inpatient treatment. To keep patients in hospital when they are otherwise fit for discharge, for the purpose of containing infectious diseases, constitutes quarantine. The hospital does not have the legal power to do so, and in any case it is not be possible to hold patients against their wishes without the appropriate quarantine order.

12. According to information given to me by the hospital, four of the ten patients discharged from the ward contracted SARS.

13. There was an agreement between the DH and the hospital that contact tracing in the community would be done by the DH, whereas the hospital would be responsible for tracing its own staff and medical students. I did not know much about the contact tracing work by the DH. The DCC of the hospital gave twice daily updates to the meeting of the senior staff on its own contact tracing work.

14. see 13.

15. By 19th March 2003, we were desperately in need of information on whether the infection control measures we had instituted were adequate. Colleagues in microbiology and epidemiology informed me that this would be shown by whether or not there was a substantial "second wave" in the epidemiological curve. Such information was not available. After consultation with Dr Fung Hong I called in my team of research nurses, and put them under the command of Drs Louis Chan and Nelson Lee, who were working in the DCC. I also asked colleagues from the Department of Community and Family Medicine to assist.

16. I was not aware of the contact tracing work of DH until a letter from Dr Margaret Chan to the SARS Experts Committee was made available to me in September 2003. According to that letter no staff or student of the kindergarten became infected.

17. At that time there were quite a number of patients who, despite not having visited the hospital, still contracted the disease. Time did not allow me to compile a full list. I asked Dr CK Li and Dr SF Lui to provide me with three examples to give to Dr Margaret Chan to show her that the disease had spread into the community and that the policy of contact tracing was not good enough to protect the health of the public. (see the attached letter to Dr. Margaret Chan dated 19/3/2003) I urged her to "urgently consider all possible measures including quarantine of patients and contacts to contain the outbreak before it is too late". I phoned Dr. Margaret Chan on 19th March at around 6 p.m. to discuss the matter. However, Dr. Chan did not seem to be convinced. She told me over the phone that she had confidential information from some mainland officials, she and her Department had expertise in epidemiology and that there was no cause for concern. I felt angry and frustrated by her response. I decided to collect further evidence to convince the authorities that necessary quarantine measures were urgently needed to contain the outbreak and to explore other avenues of protecting the public from the danger of the epidemic.

18. By 20th March two general practitioners who had treated SARS patients in their respective clinics were down with SARS symptoms and admitted to hospital. I was gravely concerned that an explosive outbreak in the community might well be imminent. I called the meeting on the next morning (i.e. on 21st March) to collate the collective wisdom of the faculty. After examining the data provided by Dr SF Lui and listening to the views of Professor TW Wong, faculty members agreed that we were dealing with a highly infectious illness with very serious consequence and that not enough advice had been given to the public. The faculty opined that we had the responsibility of informing the profession and warning the public. It was also agreed in the meeting that a "show-down" with the authorities would be counter-productive, as the government, and the government alone, had the machinery to carry out proper measures to control the outbreak. It was decided in the meeting to inform doctors in private practice on the necessary precautions and to send a delegation (Prof TF Fok, Prof Tony Chung and Prof Peter Cameron) to present the case to Dr CH Leong, Chairman of the Hospital Authority the same afternoon.

19. see 5 above.

20. By any standard it was a major outbreak. The source of infection was from the community rather than the ward or the hospital. SARS was a hitherto unknown illness. Measures to combat the illness and to control the outbreak had to be worked out by first principles and modified as new information became available. The large number of patients, resulting in high viral load in the environment, compounded our difficulties. The professionalism and dedication of our healthcare team cannot compensate for the lack of isolation facilities, poorly designed wards, antiquated air conditioning system and overcrowding. Our gallant doctors, nurses and healthcare assistants paid dearly for their dedication and selfless sacrifice.

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CLO/0303/09

19th March 2003

Dr. Margaret Chan, JP
Director of Health
21/F, Wu Chung House
213 Queen's Road East
Wan Chai
Hong Kong

FAXED
DATE: 19 MAR 2003
Sent out on 20/3/03

Dear Dr. Chan,

Re: SARS

Amongst the more than 100 cases admitted I am particularly worried that we are seeing the infection in contacts that have never been to the hospital. For example:

1. Dr [redacted] had symptoms but stayed at home from 11-3-03 to 19-3-03. Both his mother ([redacted]) and brother [redacted]) were admitted with pneumonia on 19-3-03. Dr [redacted] was admitted on 19-3-03 as well and was transferred to the ICU straight away.

2. [redacted] a five year old girl developed fever on 13-3-03, attended school for 2 days before admission on 16-3-03. There were typical chest x-ray changes. Both parents have been admitted with pneumonia, the mother is in the ICU.

3. [redacted] M/2 [redacted] is the nephew of the index case. He has consolidation on CT scan. Five other members of the family are admitted with pneumonia.

This condition is posing a severe threat to our community. I urge you to urgently consider all possible measures including quarantine of patients and contacts to contain this outbreak before it is too late.

Yours sincerely,

SC Sydney Chung
Dean

SC/cm