SA

This image of Yvonne Warner (left) and Niala Kalliecharan appeared in *Chatelaine* magazine in 2003. (Opposite page) Today, the pair, like so many others, have mixed emotions about marking 10 years since SARS.

A DECADE LATER

BY MELISSA DI COSTANZO

PHOTO: (LEFT) NADIA MOLINARI; (RIGHT) JEFF KIRK

This spring marks the 10-year anniversary of Severe Acute Respiratory Syndrome (SARS) in Ontario, a disease that took the lives of two nurses, one doctor and 41 members of the public in the province. These lives were cut short by an illness many health professionals knew little about. In Ontario, and across Canada, health-care workers fiercely attempted to curtail the contagious infection, but the disease's persistent symptoms and relative obscurity proved challenging. The virus, which arrived from Hong Kong in the spring of 2003, turned the health-care system on its head and exposed a number of vulnerabilities. Nurses feared the uncertainty of the disease. They fought to be heard during the outbreak, and felt betrayed by a system that didn't take their concerns seriously. Are nurses' voices heard and heeded today? What lessons have we learned? And just how prepared are we for the next big outbreak?

Ten years ago, Niala Kalliecharan learned the Markham Stouffville Hospital (MSH) 18-bed day surgery/short-stay ward where she worked would be converted into a SARS unit. That decision was made after elective procedures at the hospital were cancelled due to a developing outbreak, freeing up space and staff to care for clients battling a deadly and mysterious disease. Some nurses felt unlucky: this was sudden news in the midst of uncertainty about SARS and its impact. Kalliecharan didn't think twice about her role. "First and foremost, I am a nurse. I care for patients," she says.

A flurry of activity followed in preparation for incoming patients suffering telltale SARS symptoms (fatigue, a fever, muscle pain, a dry cough and breathing problems). Rooms were cleaned, plastic drop curtains were suspended from the ceiling, and negative pressure rooms were created to allow air to flow into – but not escape – isolated areas. Hours after the unit opened, MSH admitted its first SARS patient. It was March 27, 2003, the same day health officials ordered Greater Toronto Area and other hospitals closed to most visitors, and one day after the province declared a public health emergency. Twenty-seven probable cases of SARS were reported.

Kalliecharan, who is now a nurse practitioner in cardiovascular surgery at Southlake Regional Health Centre, says concern for her own safety didn't enter her thoughts back then. That's partly because her knowledge of SARS was limited. In fact, many health professionals were unsure of what they were dealing with. Frequent faxes, telephone calls and emails circulated with emerging information, and often conflicting directions, about symptoms and safety measures.

During the early days of the outbreak, Kalliecharan cared for a woman and her daughter who would later learn of the death of a family member to SARS at another hospital. Kalliecharan wasn't allowed to hug these women after she and other members of the health-care team told them of their loved ones' passing. Nurses were only allowed in patients' rooms for a certain period of time. Much of their contact with clients was done by calling their bedside telephones from the nursing station. It was a "different kind of nursing," she says, adding the lack of contact was the most difficult aspect of the outbreak. Despite this, the experience helped Kalliecharan learn the value of constant communication when it comes to caring for patients. "If you continually talk with (them), provide them with relevant, straightforward information about their illness, they're much more at ease...Communication is everything," she says.

Health professionals working on the front lines during the SARS outbreak needed the same thing, but communication proved a challenge as the government of the day and individual facilities across the province scrambled to understand and communicate correct information. Many practitioners, patients and members of the public felt they were left in the dark as a result. Adding to health providers' practice obstacles were daily and, sometimes, hourly updates to regulations concerning garb. In the beginning, nurses wore a mask and gloves. Days passed, and hats, goggles, shoe covers, face shields and gowns were added to the mix. Doubling up on most items was also common practice. It wouldn't be long before nurses and doctors were advised to don Stryker suits. The "spacesuits" offered total droplet protection, but were cumbersome and claustrophobic.

It was around this time, eight days after she began caring for SARS patients, Kalliecharan began to feel exhausted and was suffering from a severe headache. By now, 144 cases of the disease had been reported in Ontario; 51 per cent of the patients were health-care workers. "I thought: 'I can't have SARS,'" Kalliecharan recalls.

She called in sick and went to a clinic, where she was diagnosed with a nose and ear infection she thought was thanks to the thick,

TIMELINE

March 2003 5 – The first person in Ontario, a woman who recently returned from Hong Kong, dies of SARS at her Toronto home after developing a fever, sore throat, cough, muscle pain and shortness of breath. Eight days later, her son dies after developing the same symptoms.

March 2003 26 – Ontario declares a public health emergency after 27 probable cases of SARS are reported. Toronto hospitals are closed to most visitors beginning the following day.

March 2003 31 – RNAO launches the SARS Nursing Advisory Committee, which brings together senior representatives from major nursing organizations, affected health-care organizations and the Nursing Secretariat to discuss ways of streamlining communication and co-ordinating timely support. The group meets every other day during the height of the outbreak.

April 2003 1 – RNAO cancels its 2003 Annual General Meeting due to the outbreak.

close-fitting N95 mask she was required to wear. When she developed a fever the following day, fear set in. Only two days later, she was admitted to the very floor she had been working on. Kalliecharan wouldn't leave for seven days.

When fellow RN Yvonne Warner learned her co-worker was now a patient, she admits she and other staffers were "scared to death."

"It's always at the back of your mind that one of you could get sick," she says. "You're very fearful of it, and, when it does happen, it's total disbelief."

Ten years after the outbreak, Warner, who now works in day surgery at MSH, is still haunted by the experience. "Every day, we were scared that we were going to become ill and die, or pass it on to our family members and (our) family members were going to die," she says. Indeed, Warner sent her two daughters 150 kilometers away to Burnt River to live with their grandmother during the worst of the emergency. "I remember coming into work, standing outside the closed doors and just leaning against the wall and crying and thinking 'I don't want to go in there. But I have to.'"

Now, when Warner enters MSH's new, four-storey, 385,000 square-foot wing, she thinks "we are more equipped and knowledgeable now, and I think if there was another outbreak, we would probably fare pretty well." The facility boasts a day surgery unit with beds contained within three walls, as opposed to one large room with curtains separating patients, which makes for improved privacy and infection control, Warner says. "I think we would be able to handle (a situation such as SARS) with greater ease and probably a bit more peace of mind if it were to happen again today."

Still, Warner and many other health-care providers will never forget the impact of SARS. It was a troubling reminder that clinical work can be risky, dangerous and sometimes deadly.

Like Warner, many nurses still struggle to come to terms with the emotional toll of the outbreak, which came in two waves: the beginning of March and mid-May. They watched colleagues, friends, and family members fall ill or die from the disease, and provided care in the midst of fear and doubt. They spoke out about the dangers of complacency – only to be silenced – towards what is deemed the end of the first wave, and endured public shunning from people who feared contracting the highly contagious virus from nurses.

The profound imprint the epidemic left can also be seen in the way nurses have changed their practice post-SARS. Many say the experience helped them to become more vocal advocates for health promotion and/or illness prevention. They can also attest to playing a big part in ramped up infection control efforts over the last decade.

Yvonne Warner (centre) suits up with fellow Markham Stouffville Hospital RNs Sandi Collard (left) and Anita Villote during the SARS outbreak in 2003.

"SARS was a tragedy, and we should never forget any tragedy," says RNAO Chief Executive Officer Doris Grinspun. "Yes, we learned a lot, but it was a catastrophic time. We were unprepared, we lost patients and health-care professionals, and the outbreak polarized politicians, the media, and the public, which, during a crisis, is disastrous because everyone needs to stick together."

In Grinspun's view, RNAO was instrumental in providing the glue that would hold the profession together. The association stepped up to the plate when nurses and members of the public began calling home office for help. Anxious and exhausted nurses called with concerns about everything from the fit of their masks to their treatment as SARS patients. Some wanted to quit their jobs; most wanted advice, support or to simply vent their frustrations about being discounted.

On June 1, 2003, RNAO called for a full public inquiry. The association would also renew its call for whistle-blower legislation that would ensure nurses and other health-care workers could express their concerns without fear of reprisal from employers. Eight days later, RNAO delivered its formal request for an inquiry by hosting a press conference at Queen's Park. Nurses attended wearing masks with the words "ignored," "silenced" and "muzzled" printed in heavy ink.

June 2003 9

RNAO delivers a written request to then-Premier Ernie Eves, asking his government to order a full public inquiry into the epidemic. The association's then-President Adeline Falk-Rafael and Executive Director (now CEO) Doris Grinspun host a press conference at Queen's Park, joined by RNs and RPNs who are wearing masks conveying three powerful statements: muzzled, silenced and ignored.

June 2003 10

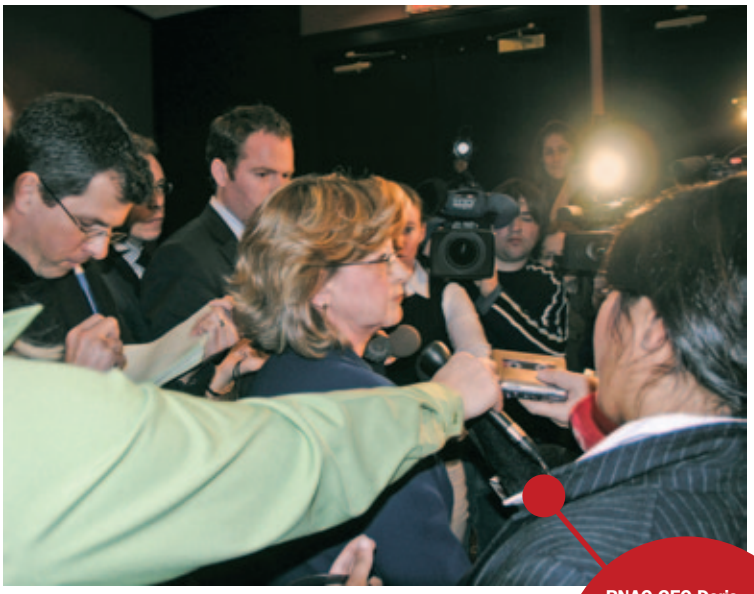
Eves announces an independent investigation into SARS. RNAO says this falls short of a full public inquiry.

August 2003 11

RNAO announces the launch of a voluntary electronic registry of nurses willing to be redeployed in the event of health emergencies. The *Voluntary Immediately Available Nurse* program (VIANurse) is expected to help Ontario cope with future health crises.

August 2003 12

Health Canada releases statistics on the total number of reported SARS cases in Ontario: 375. This number represents about 86 per cent of all Canadian cases of SARS.



RNAO CEO Doris Grinspun is surrounded by media and asked to respond to the SARS Commission report, *Spring of Fear*, in 2007.

Within the following 24 hours, then-Premier Ernie Eves announced an independent investigation, leading to the creation of the SARS commission, chaired by the late Justice Archie Campbell. The commission's report was released in three installments, and completed by 2007. It examined how the virus came to Ontario, its spread, and how the issues were handled. RNAO provided expertise and insight that helped to fuel some of the report's findings, including its call to address staffing issues in health care.

SARS drew attention to low staffing levels in the nursing workforce, demanding workloads and an overreliance on part-time, casual and agency staff – issues that still plague the profession. Though improvements have been made over the years when it comes to full-time employment (the measured share of full-time employment for RNs rose from 59.3 per cent to 68.6 per cent between 2004 and 2012), workload and staffing still remain troublesome. Ontario has the second lowest RN-to-population ratio in Canada. Many RNs resort to working more than one job, or picking up extra shifts, both of which aren't sustainable in the long term.

The strongest message *Spring of Fear,* the commission's final report, delivered was that of the precautionary principle: "...Reasonable efforts to reduce risk need not await scientific proof. Ontario needs to enshrine this principle and to enforce it throughout our entire health system." This was also one of RNAO's key recommendations during the public hearings, and in the association's *SARS Unmasked* report, the final revision released in June 2004.

"If you are not absolutely certain that an epidemic or any other public health risk doesn't exist anymore, you need to continue to act as if it exists to protect people – not only health professionals," says Grinspun. "RNAO insisted on that during SARS and still does today." In the wake of public health scares such as H1N1 and the ongoing H7N9 bird flu outbreak in China, RNAO and other key health stakeholders are now called on to participate in routine conference calls with Ontario's Ministry of Health. The association is also asked to distribute updates to members. The ministry launched a 24/7 telephone hotline to field stakeholders' questions and concerns, and provides briefings – sometimes daily – about any important developments.

In light of the commission's report, pandemic planning has become top-of-mind post-SARS, with the province updating the *Ontario Health Plan for an Influenza Pandemic* (RNAO is a member of the steering committee) that delineates the roles and responsibilities of various organizations, such as Local Health Integration Networks (LHIN) and Public Health Ontario, and communication principles such as timeliness, transparency and credibility.

Ten years after SARS, many agree other crucial changes have been made. Hospitals have added more negative pressure rooms, and a fever/respiratory illness tool that tracks symptoms is completed upon patients' trips to the emergency department. The latter helps to monitor dips and peaks in influenza cases.

All hospital staffers are required, every two years, to undergo mask fit testing, and if participants don't do so within a certain amount of time, they are not permitted back at work. If a staff member is sick, they will receive a call from an occupational health representative who ensures anyone off for more than three consecutive days in a row is clear to return to work. Many hospitals have also beefed up infection prevention and disease control programs. It's clear that good hand hygiene is more prominent than it used to be. Many facilities have introduced multiple stations where staff and patients can either wash their hands or pump out sanitizer.

August 2003 14 – One patient remains hospitalized due to SARS.

September 2003 29 – RNAO presents to the independent *Commission to Investigate the Introduction and Spread of SARS*, providing recommendations for the government, health-care organizations, and the nursing profession that would allow nurses to provide quality patient care at all times.

November 2003 17 – RNAO again appears before the independent *Commission to Investigate the Introduction and Spread of SARS*, this time on occupational health and safety.

June 2004 29 – RNAO releases *SARS Unmasked: Celebrating Resilience, Exposing Vulnerability*, a final report on nurses' experiences during the outbreak. The association honours the commitment and dedication of front-line nurses during the epidemic, and marks the one-year anniversary of the loss of RNs Nelia Laroza and Tecla Lin to SARS, hosting a private gathering for the nursing community.

But when it comes to hand washing, Mary Ferguson-Paré, former RNAO president and retired vice-president of professional affairs and chief nurse executive at Toronto's University Health Network, says health-care professionals just aren't doing it enough. As of 2010, Ontario hospitals have had to report publicly on nine patient safety indicators, including hand hygiene compliance. Data from April 2012 to March 2013 indicate the provincial average is 86 per cent compliance before patient contact, and 91 per cent after.

A less-than-perfect compliance rate is one of the reasons Ferguson-Paré thinks the health-care system will struggle when a crisis like SARS surfaces again. She was one of two nursing voices on the expert panel behind *Learning from SARS – Renewal of Public Health in Canada*. Led by David Naylor, then Dean of Medicine at the University of Toronto, the panel's report, released in 2003, contained a number of key recommendations, many centred on making more investments in public health spending and resources. Public health has "suffered tremendously over the years. The investment in health promotion and disease prevention is what we need to get in order for us to try to have a strong system of preparedness for (something) like another SARS," says Ferguson-Paré.

She also calls for stronger monitoring of antibiotic prescriptions. "(Over-prescribing) is creating tremendous difficulties in the entire system, because people are now dealing with antibiotic resistant superbugs," she says. "The danger is not over. We're dealing with C. difficile, CPE and, to a lesser degree, MRSA – all of these are very concerning infections. We need to be sure (to this day) that there are strong infection prevention and control programs in every area of health care."

For Anne-Marie Malek, SARS was a tough teacher that highlighted yet another vital factor to consider during emergencies. "I couldn't emphasize enough the importance of keeping staff informed and engaging them in responding to the issues at hand," says the president and chief executive officer of West Park Healthcare Centre, a Toronto hospital that opened the first SARS unit in the province. "It was through suggestions and observations of staff we were able to respond more effectively to the outbreak," she says, adding the same would hold true today.

In 2003, Malek was VP of programs and chief nursing executive at West Park, where Tecla Lin, a 58-year-old respiratory services RN, would die from SARS. "For an organization to lose a staff member in this way was emotional, tragic and quite devastating in regards to bringing home the risk associated with health-care delivery in circumstances like this," Malek says. She believes SARS left Ontario better prepared to face a future pandemic, saying greater attention across the health-care system has been given to listening to those closest to the patient: nurses.

Unlike the management structure in hospitals in 2003, legislation now mandates chief nurse executives have a seat on hospital boards and chief nurse officers have a place in all public health units. Both of these changes were spearheaded by RNAO, and announced by then-Premier Dalton McGuinty at RNAO's 2011 annual general meeting. Nurses also have a seat on infection control committees. Toronto Public Health RNs and inspectors meet monthly with these committees, forming an initiative called the *Communicable Disease Liaison Unit* that was born directly out of SARS. All health-care professionals meet to trade information and monitor communicable diseases in Toronto. This allows for a smoother flow of information, and helps to establish and maintain relationships with facilities so that when the next outbreak occurs,

SARS turns once fearful RN into forceful advocate

Ten years ago, Saverina Sanchez (left) was ready to quit nursing for good. Today, she's a clinical manager and has her baccalaureate as well as her master's degree in nursing, all thanks to the strength she was able to build during the deadly SARS outbreak in Ontario in 2003.

SARS pushed many nurses and health-care providers to the brink of their personal and professional capacities. And Sanchez was no exception. "We lost the ability to act on our own volition," she recalls. "(SARS) was probably my darkest moment in nursing."

She looks back with a mix of anger and distress at how nurses at the Toronto facility where she worked during the outbreak were forbidden from speaking to one another. Security guards would measure the distance between nurses snacking in the cafeteria to ensure they were sitting at least a metre apart to prevent the spread of rumours. She and her colleagues were warned that if they didn't report for duty, they would be terminated. Health professionals at her organization were also urged to restrict contact with family and friends.

Each constraint left Sanchez feeling less and less in control. It wouldn't take long for her to begin thinking: "I can't do this anymore. I'm quitting nursing." But before she could leave the profession for good, Sanchez felt compelled to tell someone what nurses had to endure. This mysterious disease was still in its early days, and the public wasn't aware of the turmoil health-care facilities were undergoing as it spread. "I knew in my heart that…I couldn't continue in the state that we were in. Somebody needed to know that something was wrong," she says.

Crying, she dialed RNAO and was connected to then-Executive Director (now CEO) Doris Grinspun, who assured the distraught RN that the situation would improve. Grinspun called the hospital's chief nurse executive and CEO to demand nurses not only receive the respect they deserve, but also the basic necessities they were being denied. According to Sanchez, health-care providers were discouraged from making trips to the grocery store for water or food, or to the bank.

The strength she drew from RNAO was invaluable, Sanchez recalls. The association "supported (nurses) without judgment, and actually listened…and helped solve the problem(s)." This gratitude soon led to her involvement as a media spokesperson.

The experience helped her to see the power of speaking out. Sanchez became one of only a handful of front-line RNs who would share their experiences publicly at the height of the outbreak, helping to expose the tumult at the time.

SARS also "taught me that even in my darkest moment, I was born to be a nurse, and I couldn't give it up," she says. That's why she persevered and went on to pursue her degree and then her master's. "I realized I could make a difference as a manager, respecting the people that I report to, but always with the safety of patients and staff at the forefront."

Despite the traumatizing effects of the outbreak, Sanchez recognizes how the experience shaped her. "If it wasn't for SARS, I wouldn't…have had the conviction and the drive that I needed to get me where I am today."

For more stories about SARS, including magazine features from 2003, visit www.RNAO.ca/SARS

the channels of communication are already open and active.

Former emergency department RN Karen Ellacott wishes nurses' voices were heard louder throughout SARS. During the outbreak, she cared for SARS patients at North York General Hospital (NYGH), the facility at the heart of the second cluster of cases. She says precautions were lifted too soon after the first wave of illness, and felt ignored when she shared her concerns at the time.

Sixty-two days after the first SARS case was reported in Ontario in 2003, the World Health Organization rescinded its controversial travel advisory for Toronto. Almost three weeks later, the provincial emergency was lifted. Ontario began to announce the epidemic was over. Preventive measures at health facilities across the province relaxed, and some nurses were told they didn't have to wear masks anymore. Yet, nurses were still seeing and reporting new cases of the disease. RNs frantically tried to meet with administrators, attempting to get the message across: SARS has not disappeared. Instead, they were ignored and, in some cases, outright dismissed.

When pre-emptive protective measures began to loosen before the second wave became apparent, Ellacott recalls how, on the orthopedic floor at NYGH, nurses were told they no longer required protective gear, even though patients with SARS symptoms were still being admitted. That is how Ellacott thinks Nelia Laroza, a 51-year-old orthopedic nurse at NYGH, fell ill – and later died – from SARS. "In and of itself, it was a devastating reality to see, but, at the same time, it was a frightening mirror," Ellacott says. "There was a nurse, just like me, a mother of a 17-year-old, just like me, who...was now critically ill...it was just tragic and...possibly unnecessary."

By August of that year, the number of SARS cases finally started to dwindle. So, too, did Ellacott's passion for nursing. SARS "knocked the professional wind out of me," she says, adding "nurses went through hell." Her hairdresser refused to cut her hair. Friends kept their distance. And given the level of exhaustion at work, "everything was done in silence," adding to the eeriness of the situation. Ellacott remembers passing a sobbing physician in one of the hospital's corridors. Numbness prevented the RN from comforting her distraught colleague. "It was surreal," she says.

She began having nightmares, developed an ulcer, felt anxious and depressed, and lost all of her hair – all signs she chalks up to post traumatic stress disorder, something many nurses, post-SARS, can relate to. "Counseling and supports were provided, but a lot of us did not avail ourselves of (them). There was that sense that you are in the middle of something incredibly intense that no counselor is going to understand...I realize now that's not a helpful mindset."

Ellacott thought of leaving the profession, but having already nursed for 20 years, she wasn't sure she wanted to embark on a new career. Instead, she signed up for travel placements. After a handful of stints in ERs and ICUs throughout B.C., she took a job in a remote First Nation community in that province. This past April, Ellacott finally returned to her Ontario home for good. "The fact that I've reached (the 10-year anniversary of SARS) feels like the end of...that era, and the beginning of a new one," she says.

SARS patient and Newmarket RN Kalliecharan's personal journey post-SARS was also trying. She spent a week in hospital when she had the disease, followed by two weeks of quarantine at home. After her month-long confinement was over, she felt hesitant to leave her home because she had a residual, non-contagious dry cough. She was off work for five months, and returned to a modified schedule with reduced hours on different units. She often felt anxious as she reached for masks and isolation gowns, saying it took a while to overcome this unease. Nevertheless, returning to work was "awesome. I felt really lucky to go back because some nurses still struggle," she says. "This was my way of saying I had won. I can do this."

Kalliecharan says she is forever grateful to her health-care colleagues who helped to restore her health and confidence when returning to work. "When I was wheeled up to the SARS unit, and the doors opened and I entered as a patient, it was a low moment," she says. "When I started seeing (my colleagues), it gave me strength... and comfort...Because I knew the eyes and the smile behind the mask, I didn't feel as afraid. When someone smiles behind a mask, you know they're smiling because you see that crinkle in the eyes. I can never forget that." **RN**

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