When the disposable mini-toga is used in conjunction with standard PPE, the donning, removal and disposal procedures each take approximately 30 to 45 seconds (see video demonstration at www.cmaj.ca). Because a paramedic can remove the device without assistance before driving, there is no risk of contaminating the driver's compartment and no reason for the paramedic's partner to leave the intubated patient unattended.

In conclusion, the "new normal" PPE standards are inadequate in the prehospital setting. In certain situations a PPS is the only means of achieving the balance between patient care and paramedic safety.

David J. Hutcheon
Advanced Care Paramedic
Toronto EMS
Toronto, Ont.

References

1. Verbeek PR, Schwartz B, Burgess RJ. Should paramedics intubate patients with SARS-like symptoms? [editorial]. *CMAJ* 2003;169(4):299-300.
2. *Directive 03-11. Directive to all Ontario acute care hospitals for high-risk procedures.* Toronto: Ontario Ministry of Health and Long-Term Care; 2003 June 16. Available: www.health.gov.on.ca/english/providers/program/pubhealth/sars/docs/docs2/dir_acute_care_061603.pdf (accessed 2003 Oct 24).

[The authors respond:]

We are not surprised by the wide-ranging opinions expressed in response to our commentary.[1] The 2 physicians suggest that our level of concern for paramedic protection is unwarranted. Although our commentary did not clearly state that our position was in the context of a SARS outbreak as intended, we continue to feel that prehospital intubation of patients with SARS-like symptoms (SLS) in this circumstance poses an unacceptable risk to paramedics. During a SARS outbreak, all patients with SLS should be considered to have SARS until proven otherwise. Schabas' statements regarding ascertainment and the risk of intubation lack insight into the uniqueness of the prehospital environment where occupational and admission histories are frequently unavailable and intubation of a febrile, coughing patient is never straightforward. Moreover, he fails to recognize the evidence that all paramedics who contracted SARS did so by coming into contact with people who were neither hospital workers nor recent inpatients.[2] Interestingly, the situations in which Ovens prescribes risk-taking behaviour for paramedics are areas where efforts to reduce risk are ongoing. These include limitations on the use of lights and sirens and the introduction of safe catheters for intravenous initiation.[3,4]

We feel it is no more acceptable to expect underprotected paramedics to intubate patients with SLS during a SARS outbreak than to have underprotected paramedics enter a building with a suspected Sarin gas release. Would Ovens want to send paramedics headlong into the Sarin fog under the guise of an "occupational hazard"? Who would want to perform an awake intubation, on a patient with SLS lying on a landing between 2 staircases, without having access to the specialized protective equipment he calls for in a recent Canadian Association of Emergency Physicians position statement?[5]

Urszenyi construed our commentary to suggest that all situations requiring airway management pose an identical threat. Our premise is quite the opposite. In the end, the paramedic will make the final decision as to whether to intubate a patient with SLS. Our responsibility is to define potential risk, provide guidance and suggest alternatives. We do not feel it is appropriate for paramedics to be expected to "go it on their own."

We are unaware of any evidence that the "new normal" standard of PPE fails to protect paramedics, as asserted by Hutcheon. Nor are we personally aware of any paramedic who developed probable or suspect SARS once PPE was introduced for all patient encounters. Hutcheon's description of a powered helmet-style PPS is intriguing. We and many others consider this equipment to be necessary but not sufficient to create optimal circumstances for intubation of patients with SARS and SLS.[5,6]

Our recommendations are in no way a disservice to the bravery and commitment of paramedics. Instead they demonstrate that we consider paramedics to be "canaries in the mine" and at higher risk than most other health care workers. Emergency medical services administrators and medical directors understand this and are working to create guidelines that respect the primacy of the "principle of paramedic safety."[4] Our paramedics deserve no less.

Robert J. Burgess
Advanced Care Paramedic
P. Richard Verbeek
Brian Schwartz
Divison of Prehospital Care
Sunnybrook and Women's College
Health Sciences Centre
University of Toronto
Toronto, Ont.

References

1. Verbeek PR, Schwartz B, Burgess RJ. Should paramedics intubate patients with SARS-like symptoms? [editorial]. *CMAJ* 2003;169(4):299-300.
2. Varia M, Wilson S, Sarwal S, McGeer A, Gournis E, Galanis E, et al. Investigation of a nosocomial outbreak of severe acute respiratory syndrome (SARS) in Toronto, Canada. *CMAJ* 2003;169(4):285-92.
3. Peate WF. Preventing needlesticks in emergency medical system workers. *J Occup Environ Med* 2001;43(6):554-7.
4. Kahn CA, Pirrallo RG, Kuhn EM. Characteristics of fatal ambulance crashes in the United States: an 11-year retrospective analysis. *Prehosp Emerg Care* 2001;5(3):261-9.
5. Ovens H, Thompson J, Lyver M, Murray MJ, Innes G, on behalf of the Canadian Association of Emergency Physicians (CAEP). Implications of the SARS outbreak for Canadian emergency departments [position statement]. *Can J Emerg Med* 2003:5(5);343-7.
6. Cooper A, Joglekar A, Adhikari N. A practical approach to airway management in patients with SARS. *CMAJ* 2003;169(8):785-7.

Revisiting Helsinki

Your editorial about the Helsinki Declaration[1] was probably the first indication of unequivocal support from a developed country for the developing countries' cry for justice, even if only (but hopefully just for the time being) in the arena of clinical trials.