# What I Learned From SARS in 2003 That Will Help Me Cope With COVID-19 in 2020

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On March 25, 2003, I was in Vancouver at my niece's bat mitzvah when I saw a picture of my hospital in Toronto on the television news; a story about SARS patients in Toronto. Until then, SARS had been a distant event happening in mainland China and Hong Kong; it had been something that seemed very far away and theoretical. When I returned to Toronto, we had clusters of cases in several hospitals and healthcare workers were falling ill. I was the Physician in Chief at one of those hospitals and was responsible for the clinical care delivered by physicians in the Department of Medicine. So the burden of figuring out what we were going to do fell on me and the other members of the hospital leadership team.

## SARS IN 2003

As the outbreak evolved, we only knew a few things. It was a respiratory infection, likely viral, with a very high mortality rate, compared with most other viral respiratory infections. We learned the hard way that, while it was mostly transmitted by droplets, some patients were able to widely transmit it through the air, and therefore likely through ventilation systems. We knew that most infections were occurring in hospitals but there was also community spread at events like funerals. We had no test to confirm the presence of the virus and, indeed, only figured out it was a coronavirus well into the outbreak. Diagnoses were made using clinical criteria; this uncertainty was a major source of anxiety about potential community spread without direct links to known cases. We had no idea how long it was going to last, nor did we know how it would end. We were entering uncharted territory.

Decisions had to be made. Which patients needed isolation, and which did not? We made mistakes early on that caused hundreds of healthcare workers and people to be quarantined (complete isolation) for 10 days; this was a difficult situation for them, their families, and the people who had to replace them in the workplace.

Within a very short period we changed our way of life in hospitals. We screened everyone who entered with questionnaires and measured their temperatures. Once entering the hospital, we all wore N95 masks in public spaces and when in a room with another person—not just patients. We all got sore throats from wearing the masks 10 hours a day. All patients were placed in respiratory precautions, which meant that, any time we entered their rooms, we had to don all the personal protective equipment (PPE). Yet we didn't run out of supplies. When a member of a provincial leadership team fell ill with SARS shortly after attending an in-person meeting of the committee, all the other members went into quarantine. As a result, we stopped having leadership team meetings in person, and mostly stayed in our own offices, communicating by phone and email.

The hospital took on a bizarre atmosphere: everyone in masks and little face-to-face contact. Yet outside the hospital, life went on mostly as normal. Some people wore masks on the street, but public events and businesses stayed open. Some healthcare workers were shunned in the community out of fear. But I went to another bat mitzvah and even a Stanley Cup playoff game at the height of the outbreak. Only healthcare workers were asked to stop meeting in large groups. The contrast for me was striking.

The Ontario Ministry of Health started a daily noon hour phone conference call; one physician and one administrator from every hospital in the province were on the call. I attended these meetings on behalf of my hospital and, because I knew or taught many of the people on the line, was quickly asked to chair the calls. They were incredibly important and were a source of information exchange and emotional support for all of us. Before each call, I spoke with a person from Toronto Public Health who updated me on the number of cases and deaths. I needed to absorb that information before the calls to maintain my composure when she told the rest of the group. At times I could hear the fear in people's voices as they described the clinical course of their patients.

Because I chaired the calls, I was asked to coordinate the study that documented the clinical outcomes of all the patients in the hopes that we could distinguish it from other common respiratory syndromes. With the help of my colleagues in the 11 hospitals that treated SARS patients, the ethics review boards, medical records personnel who copied the charts, a few medical students, and Christopher Booth, MD, (a second-year resident at the time who headed the study) we were able to go from the idea to do the study to electronic publication in *JAMA* in 30 days.[1] It was *JAMA*'s first experience with rapid review, and the editors there were very helpful. Working on this study was very therapeutic; it allowed me to feel I was doing something that could help.

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I was scared—both for my own health and the health of my family—but also terribly frightened for the health of the people who worked here. When I went home every night, I looked at the people on the street and wondered how many would still be there a few months later. And then it all ended. (Actually, it ended twice; we let up a bit too early because we so wanted it to be over.)

## COVID-19 IN 2020

The COVID-19 pandemic has many similarities, but there are also significant differences. The most obvious is that, because there is more community spread, life outside the hospital is much more severely disrupted. Countries have responded by sliding into more and more practices that try to limit person-to-person spread. First travel restrictions from other countries, then moral suasion to promote social distancing (which is really just physical distancing), then closing schools and nonessential businesses, and finally complete lockdowns.

These events have spurred panic buying of some items (hand sanitizer, toilet paper, masks) and the fear of major disruptions of the supply chain for things like food. SARS was much more limited in its overall economic effect, though the WHO precautionary travel advisory against nonessential travel to Toronto, which lasted for only 1 week, resulted in a long-lasting reduction in tourism and a hit to the theatre business in our city.

The internet and social media have made it easier to disseminate valuable information and instructions, while at the same time made it easier to spread false information. But we had a lot of false information during SARS, too. One of the biggest differences for the United States (which was almost unaffected by SARS) is that the current extreme political divide creates two separate tracks of information and beliefs. A united message is very important.

Finally, the shortage of PPE in some jurisdictions, which was not an issue in Toronto during SARS, has severely heightened the fear for healthcare workers. In 2003, we also had lots of discussion about the tension between our professional duty and the safety of healthcare workers and their families (many of us separated ourselves from our families in our own homes while working clinically). To my recollection, two nurses and one physician died of SARS in Toronto. But when hospitals actually run out of PPE—something that is happening with COVID-19—those discussions take on a much more ominous tone.

## LESSONS LEARNED

In my opinion, SARS was a dry run for us in Toronto and the other places in the world that it affected (Taiwan, Hong Kong, Singapore); one that helped us prepare in advance and will help us cope with COVID-19. But what did I personally learn from my SARS experience?

First, I learned that accurate information in these kinds of situations is hard to come by. We heard lots of rumors from people all over the world. But when I found that it was very difficult for me to figure out exactly what was going on in my own hospital (eg, who was in contact with people who fell ill or went into quarantine, how patients were faring), I realized that figuring out what was happening halfway around the world from news reports was near impossible. I learned to wait for official announcements.

Second, I learned that talking to my colleagues was both therapeutic when we needed emotional support and an outlet for feelings and anxiety provoking when we overreacted to rumors.

Third, I learned that, like others, I was susceptible to exhibiting obsessive behaviors in an attempt to establish control over uncertainty. Constantly washing my hands, checking my temperature, and seeking reassuring facts from others only worked to calm me for a few minutes. And then I felt the need to do it again. This time I find myself checking my twitter account constantly, half afraid I will see something frightening, half looking for good news from people I trust. I now recognize this behavior, and that helps me contain it.

Fourth, I learned that events that occurred remotely had much less effect on everyone than did those that occurred close by. Having two people I knew get SARS, and then learning they recovered, was perhaps the most meaningful event for me during the entire episode.

Finally, I learned that in the end I and the people I care about survived—nothing bad happened to us. The world did not end after SARS. It took me about a year, including some time with a terrific psychiatrist, to realize I was safe after all. And that realization is what I am most hanging on to today.

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