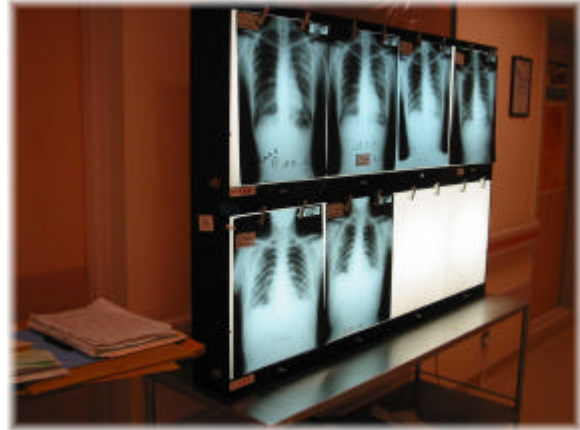


SARS hit Asia

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Dr. Chan recently reported news from Asia in the newsletter of International Association of Hospice and Palliative Care (IAHPC) in June 2003, and shared his experience of working in SARS ward.
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It had been an extraordinary time for Asia in the past few months when Severe Acute Respiratory Syndrome (SARS) spread like plague and hit many countries unprepared. At the time of writing, this infectious disease as caused by a novel coronavirus had infected more than 8400 patients with 800 deaths globally. Among all, 95% of the cases were reported from the Asian countries. The impact of SARS was immense; from individual health to social life, and from the health care system to the economy of the nation. This highly contagious infectious disease with a fatality rate of about 10% had aroused intense fear among the general public. China, Hong Kong, Vietnam, Singapore, and Taiwan, was hit by SARS one after the other. To contain the SARS outbreak, health care systems had undergone rapid changes in the face of crisis. For people who had encountered this illness, the threat of death had never been so real

and close. Moreover, the life of many health care workers were at stake because of the risk of nosocomial spread. The death of health care workers who contracted the disease at work had created a strong social repercussion. The issue of life and death, which used to receive little attention from the public media, was put in the spotlight. Hong Kong had the second highest reported cases after Mainland China. The following paragraphs described how SARS affected Hong Kong and its palliative care service, as an illustration of the impact of SARS.

The outbreak of SARS in Hong Kong occurred since February 2003. Up to date, the reported SARS cases were up to 1755, with 296 people died from SARS, out of which 8 were health care workers. Early in the outbreak, the Prince of Wales Hospital was loaded with SARS patients, of whom many were health care professionals. Very soon, the wave spread to nearly all acute public hospitals in Hong Kong. The roles of hospitals were modified, or even completely altered within a short time frame to fight the battle. All health care professionals, irrespective of their rank, expertise, workplace, were involved in various degrees. To cope with the enormous workload, and to ensure effective infection control measures, non-urgent clinical services were suspended for giving way to SARS battle. Palliative care service in Hong Kong was not exempted from this hurricane, and affected in various ways.

Some palliative care units in Hong Kong, especially those that operated close to the acute wards, were temporarily closed down to vacate more rooms for the SARS patients. Some palliative care units spared their beds

to accommodate the stable patients from the acute wards. Some continued to serve, but the operation was inevitably affected to certain degree. Firstly, infection control measures were generally upgraded, even in wards not catered for admissions of SARS patients. There was a concern that immunosuppressed patients such as advanced cancer patients, when affected by SARS, presented themselves in subtle patterns. It was for the first time that palliative care workers delivered their patient care with masks and gowns on all the time. Visiting hours were restricted as a corporate policy of the Hospital Authority Hong Kong. Families could only visit their beloved ones during a fixed time of 2 hours in the evening. Families and patients were ambivalent, as they were in need of care, and yet they would have less time together, and under a threat of nosocomial SARS infection. Many preferred home visits to hospital care. The home care teams, like the hospital teams, had to visit patients in community with personal protection. This was a difficult time for palliative care workers, who were committed to work under the philosophy of being there, being close, and being with the patients during their last journeys.



In one palliative care unit, advanced cancer patients were put in cohort isolation as one of the staff was diagnosed to have SARS. The following is the sharing of a palliative care consultant whose nurse in the palliative care ward was diagnosed to have suspected SARS:

“ I went to see the hospice staff who was waiting in A&E department for admission to SARS ward. Understandably, she was in fear. The rest of the palliative care team was no better. With a heavy heart, the team had to handle their own emotions, of other colleagues, and that of patients and relatives. All the families were notified about the need for immediate cohort isolation of the hospice ward. Many tasks had to be done within a short time, to name a few: further upgrading the infection control measures, notifying those patients and families who were recently discharged for quarantine, arrangement for coverage of service gaps during the cohort period. Most importantly, we set up a video conferencing system immediately. You could imagine how devastating it could be to have a dying journey in loneliness without the accompaniment of your beloved ones. A minimum of 10 days in cohort isolation – to some of our patients that could mean the rest of their life journeys.

I could still vividly remember one patient who was just admitted on the day before the cohort isolation, and was deteriorating. She recognised me as I approached her, though I was completely different from what I used to be – eyes covered with shield, nose and mouth covered with mask, hair covered with cap, and body covered with a gown. She was in great anxiety of being separated from her family. Even more, she was worried that her

husband could not bear the pain of not able to be with her in the last moment. This was a time of helplessness for all.”

Within a matter of weeks, robust health care workers became sick patients; families were shattered; children became orphans; beloved ones never to be seen again ever since the day they were sent to hospital. Death was at the door before one could realise it. The pain of the patients, families, and that of the health care teams were hammering into each of us. Health care workers from different fields joined in the battle of fighting SARS voluntarily.

Since late March, I joined the SARS team of United Christian hospital at the peak of the community residential outbreak of Amoy Garden which affected over 300 individuals. The impetus for my participation in the SARS team was more than my double credentials in Palliative medicine and Pulmonary medicine, but the compassion that was triggered by so many lives at the risk of dying. In palliative care wards, we live with death and dying; in SARS wards, we fight with life and death. No matter where and how, amidst the fear and loneliness of dying, compassion and human touch is something that will make a difference. Our society had paid heavily for this outbreak, in exchange for a practical session in life and death education for the whole society. Sufferings in many ways are mysterious, we hope our life will ultimately be sublimed.