Territorial Epidemiologists in the early 1980s, when Jonathan served as state epidemiologist for New Mexico, our paths did not cross until years later in 1990. Jonathan had reluctantly resigned as director, Global AIDS Activities, World Health Organization, to become full professor at Harvard School of Public Health. I had taken a year's leave of absence from my position in Maine to enroll in Harvard's Master of Public Health program.

In a talk at the Centers for Disease Control and Prevention, Jonathan once outlined many of his hopes and fears for AIDS activities worldwide. Moved by his pleas for global commitment to the epidemic, I sought out Jonathan at the opening reception for new Harvard students. I shared his dreams for public health activism. We believed in inspiring others to careers in applied public health, so we initiated a brown bag lunch series for students and faculty to share experiences about work in public health (1). The common thread throughout these discussions was universal human rights and respect for human dignity.

Jonathan went on to establish the Francis Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health and used his position to promote health as the broad-based core of human values. His lectures on universal human rights centered on the idea that health transcends geographic, political, economic, and cultural barriers. Jonathan drew on his past experiences with the HIV epidemic to argue that the developing world would never achieve economic or political stability unless the health of its people improved. He maintained that, if not addressed, the health problems of the developing world would pose a global threat. "Public health," he wrote, "too often studies health without intruding upon larger, societal, inescapably laden issues…. If the public health mission is to assure the conditions in which people can achieve the highest attainable state of physical, mental and social well-being, and if these essential conditions predominantly are societal, then public health must work for societal transformation" (2).

Jonathan argued that discrimination and other violations of human rights were primary pathologic forces working against the improvement of public health and that if we ignored the plight of those whose rights were violated, we would be less than human ourselves. Jonathan very much admired Eleanor Roosevelt, chair, Declaration of Human Rights Drafting Committee, who on the 10th anniversary of the declaration asked, "Where, after all, do universal human rights begin? In small places, close to home—so close and so small that they cannot be seen on any map of the world. Such are the places where every man, woman and child seeks equal justice, equal opportunity and, equal dignity. Without concerted citizen action to uphold them close to home, we shall look in vain for progress in the larger world" (3).

On Jonathan's desk at Harvard, amidst family photographs, was a framed joker taken from an ordinary deck of cards. When I asked about its significance, he responded that, despite life's challenges, it remains important to smile. So smile we must at the memory of Jonathan and his many accomplishments. Each year, the Council of State and Territorial Epidemiologists remembers by holding a distinguished lecture named in honor of Jonathan M. Mann.

The public health practitioner must respond to the needs of people and yet be sensitive to world politics. In solving difficult issues, the practitioner must understand the interconnection of social values and scientific truths and work collaboratively with the medical community. Moved to the forefront by recent acts of terrorism, public health has achieved recognition as first responder and as integral part of planning for and responding to catastrophic health crises. We cannot promote safety and security if we fail to recognize, and advocate for, people around the globe who do not have access to basic health care, adequate living and working conditions, or education to enlighten their response to life's challenges. The anniversary of Dr. Mann's untimely death serves as reminder to the medical and public health communities of the ongoing need to promote universal human rights and to focus energies and resources on a global approach to public health.

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Mild Severe Acute Respiratory Syndrome

To the Editor: Severe acute respiratory syndrome (SARS) is a recently recognized infectious disease caused by a novel human coronavirus

(SARS-CoV) (1). The first case of SARS, diagnosed as communicable atypical pneumonia, occurred in Guangdong Province, China, in November 2002. Thousands of patients with SARS have been reported in over 30 countries and districts since February 2003.

SARS is clinically characterized by fever, dry cough, myalgia, dyspnea, lymphopenia, and abnormal chest radiograph results (1–3). According to the World Health Organization (WHO) (4), the criteria to define a suspected case of SARS include fever (>38°C), respiratory symptoms, and possible exposure during 10 days before the onset of symptoms; a probable case is defined as a suspected case with chest radiographic findings of pneumonia and other positive evidence.

Although most reported patients with SARS met the WHO criteria, we found two SARS case-patients who did not exhibit typical clinical features. Case 1 was in a 28-year-old physician. He had close contact with three SARS patients on February 1, 2003. After 10 days, he had mild myalgia and malaise with a fever of 37.3°C. He had no cough and no other symptoms. Leukocyte and lymphocyte counts were normal. The chest radiograph showed no abnormalities. He did not receive any treatment except rest at home. His symptoms disappeared after 2 days. He completely recovered and returned to work 4 days after onset of symptoms. After 12 weeks, his serum was positive for immunoglobulin (Ig) G against SARS-CoV in an indirect enzyme-linked immunosorbent assay (ELISA) with inactivated intact SARS-CoV as the coated antigen.

Case 2 was in a 13-year-old boy whose mother had been confirmed to have SARS on February 4, 2003. Fever developed in the boy 20 days after his mother's onset of the disease. He did not come into contact with other confirmed SARS patients during this period. He had a mild headache and diarrhea with a fever from 37.2°C to 37.8°C for 3 days. No other symptoms and signs developed, and a chest radiograph showed no abnormalities. He completely recovered after 5 days. After 12 weeks, his serum was positive for IgG against SARS-CoV, detected with an ELISA.

In both case-patients, SARS had been initially excluded in spite of their close contacts with SARS patients because their symptoms could be explained as a common cold, and no specific diagnostic approaches were considered when they were sick since the causative agent of SARS was not identified until March 2003 (5). However, their serum specimens were positive for IgG against SARS-CoV by ELISA. Those results strongly indicate that both patients had been infected with SARS-CoV, although their signs and symptoms did not meet the criteria for the SARS case definition. Mild SARS-CoV infection may not easily be defined clinically, and such patients may potentially spread the disease if they are not isolated.

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Transmission of Severe Acute Respiratory Syndrome

To the Editor: The worldwide pattern of severe acute respiratory syndrome (SARS) transmission in 2003 suggests that transmission has occurred more frequently in communities that share certain social and cultural characteristics. Of 8,500 probable cases since March, >90% were reported from China (including mainland, Hong Kong, and Macau) and Taiwan. Of the other 27 countries reporting SARS occurrences, 23 reported <10 cases and the others 1–3 cases. The small number of transmissions in these other countries suggests that the close contact required for transmission did not occur, whereas in China, community-based transmission has continued. In contrast, the relatively large number of cases in Canada, the United States, Singapore, and Vietnam (which comprise 7% to 10% of the total SARS cases worldwide) is related to the fact that relatively prolonged contact occurred because of the patients' close cultural ties with China. Why does Japan still have no cases of SARS, despite its geographic proximity to the most affected areas? We suggest that transmission has not occurred because Japan remains a society mostly closed to non-Japanese persons and has a his-