

Thank God it's just COVID!

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Abstract

We have been lucky with the COVID-19 pandemic: it got the attention of the first world, yet (unlike other pandemics) has not threatened the very existence of humankind. COVID-19 has given us a chance to see how well we were prepared for something that was predictable.

Keywords: COVID-19 · Canada · pandemic · response · preparedness

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Graduating in medicine 55 years ago, I have lived through many epidemics. As a practicing psychiatrist watching what people say (or do not say) and using that information to make meaning, I know we have been lucky with the COVID pandemic [1-5]. It got the attention of the first world, yet (unlike others) has not threatened the very existence of humankind. It has given us a chance to see how well we were prepared for something that was predictable.

Epidemics occur regularly. In just the past 20 years, we have had SARS, MERS, swine flu, Ebola, H7N9 influenza, Zika, while dengue, malaria, measles, AIDS and TB continue and increase [2, 4, 6]. COVID morphed into a pandemic which affected us as well [4]. Some recent epidemics had a mortality rate of up to 40%; if they had spread like COVID, we would be facing the

modern equivalent of the Black Death [7]. From most, Canadians have been protected by our geography, or poor viral human to human transmission, but with 6 such threats in the past 18 years, will luck protect us again from the next one due in 2025 or 2030 [8]?

Frankly, our response has shown many flaws that would be disastrous with a more malignant infection. To start, we avoided acknowledging it and being clear about the danger. If the Chinese government waffled, and it did, Canadian federal politicians also dithered to avoid bad news [9]. Other countries (and my province of BC) were calling for border closures and quarantining of travelers long before the feds acted. The Federal Minister of Health accused those asking about data reliability from China of pushing conspiracy theories, and later stopped Chief Public He-

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alth Officer Dr. Tam from answering questions about whether Ottawa had been warned that the national emergency stockpile, including PPE, had been underfunded - after we already knew that supplies were not rotated properly nor replaced [10]. Front line workers knew that supplies were scarce; the refusal to answer how long those supplies would last, and knowing they were unavailable in many care homes gave rise to legitimate fears which were not assuaged by political leaders of all stripes appearing like groundhogs sticking their heads out of their burrows, saying "We're here for you" and then disappearing again. This false reassurance was of little comfort for workers not only at an increased risk, but contributed to a continuing worry about workplace safety, which in some care homes led to the abandonment of their charges [11].

There was a gross lack of systemically collected important data. Some confusion is unavoidable with a new disease. But we know that the numbers of cases reported are unlikely to be the numbers infected, just those tested and found positive. Daily publication of deaths from around the world, while of great shock value, is even more suspect; we don't know how many extra deaths occurred without the infection being identified [12]. Deaths are clustered amongst those who are older, sicker, poorer and living in closer quarters, just as they are for any infection. In Canada, care homes for the elderly provide 80% of the fatalities; of the other 20%, greater numbers are amongst health care and personal service workers [11, 13]. We don't know why: working as they do, do they get increased viral exposure, and does this mean more serious illness? Is the lack of proper PPE a factor? Is it because of gender, or that many are from ethnic minorities? Is ethnicity a proxy for social disadvantage, or are there biological differences beyond melanin production [14]? Previous refusals to identify ethnicity in Canadian hospital data for purposes of virtue-signaling means we can only now start to ask [15].

Will there be a single second wave this fall or, like influenza, recurring waves? The long term trajectory of the illness – and our society – today is not in our hands: recurrences will depend on an as yet undiscovered successful vaccine, on how long immunity lasts and the level of immunity persisting in the herd [16]. With fewer compromised elderly left, previous epidemics have become less class or age conscious the second time around. Bending the curve has protected Canadian healthcare resources so we don't have the mass graves of Italy, New York or Brazil, scenes which would be familiar to a 14th century caller of "Bring out your dead". Yet our 14th Century response of closing the city gates, isolating the pest houses and avoiding those who might be affected (we call it lockdown and

social distancing) has left us with deaths in solitary isolation, without family comfort or dignity [17].

If a second wave comes, as seems to be happening in Europe, the public health measures started three months ago will again flatten the curve, protecting health care services, but again at a great cost to society [18]. This playbook was written long ago, even before SARS. So, in 5 or 10 years' time, when COVID-19 hopefully becomes a memory, will we deal with the next plague better? We don't know what will cause it or exactly when, just that it will occur. If 10 years ago we knew what to do and had a negligent, ramshackle response, will we avoid it the next time?

As a 76 year old overweight physician, I do not want to die. Nevertheless, I prefer that COVID-19 affect me than my 46 year old child or my 16 year old grandchild. I have led my life, but if I die, I do not want to die alone, isolated, hungry, thirsty and in unchanged diapers. The deficiencies of the care home system have been well known for years; if the public report by the Canadian Armed Forces on the level of care came like a gut check, then the people in power were burying their heads in the sand [19]. For over 15 years, I have heard stories about colleagues visiting relatives in care homes daily to ensure care and that meals were eaten. Notwithstanding the calls from unions and politicians of the left, the care in the publically administered or non-profit institutions was only less inadequate than that in private ones. People of all political persuasions are advocating different solutions which reflect more their political world views than the reality of the data [20].

Here we come to the crux of this whole response problem: the first role of government must be to ensure that clinically appropriate standards, whether in public health, care homes or hospitals, are set in a transparent manner, and secondly to monitor and enforce those standards. This all governments, including many outside Canada, failed to do, including such simple standards as consistency of caregivers, time for care and adequacy of supplies [2, 21]. The dereliction of this important role by politicians of all stripes will not be solved by nationalization alone.

Not just business, but routine healthcare in Canada was been shut down due to a total lack of surge capacity. Every epidemic, including the annual flu outbreaks, produces a surge demand on the system [2]. For COVID, no-one can quarrel with the emptying of the beds to prepare for an unknown threat. What is obvious is that the system has been ground down so that this is the only way to deal with any surge, even seasonal flu. In 1970, Canada had 7 hospital beds per 1,000 population. By 1990, this had been reduced to 6, but by 2012, this number had been cut to an asto-

unding 2.7 [20]. This reduction occurred in spite of the fact that many patients today have more complex illnesses, or require more complex treatments which contribute to our greater lifespans. As a physician who practiced in 1970, I know that many conditions are dealt with more efficiently now: however, this enormous reduction in bed capacity has been not been driven by lower clinical demand but by the drive of politicians of all political parties to reduce taxes [22]. The court cases by the clinicians of the Cambie Clinic and the patients in the Chauoulli decision in Quebec arguing against the governmental health care monopoly were not about wanting to pay more, but to have reasonable access to care, and what to do if that access was not available [23]. While unions and politicians cast these cases as private versus public, at their core they are a discussion of what the standards should be, and how should they be upheld? Governments surreptitiously bury standards, dismiss clinicians' concerns and avoid collecting the data for the necessary public and transparent discussion about accountability.

Our response to COVID has been enormously expensive [24]. Small business owners have been pillaged, bankruptcies and financial distress have left proud people in tears. Routine healthcare was shut down and non-COVID deaths increased [25]. The future tax burdens to pay back the increased public debt are currently unknown. While an epide-

mic was predictable, preparation was ignored by those in political power, who should have been setting standards and enforcing them. The so-called "public administration" of healthcare enshrined in Canadian law has degenerated into political administration, without transparent accountability or a public source of truth. Five years ago, it may have cost a little more to keep adequate supplies of PPE, or provide good care in care homes. Today, we pay the price for not having done so.

Every unnecessary death is a waste. Every first responder or health care worker in unnecessary mortal fear is a cost. The COVID epidemic is bad enough, with an estimated infection fatality rate much lower than SARS or MERS [1-2]. For those who lost a loved one in isolated circumstances, each is a tragedy. But if we use it to demand three things: transparent accountability in the system; the provision of the essential requirements for a public healthcare system, and the elimination of the political legerdemain, next time we may be thankful COVID-19 came before COVID-25.

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