EDITORIAL

COVID Chronicles

COVID-19 and Social Distancing

These days, drafting an editorial which will be of relevance 2 months hence is a daunting task. A planning meeting with our editorial team and publisher inspired us to chronicle our current pandemic anticipating with some trepidation to compare the accuracy of our perceptions with the realities in June. This vision may also be an important archive for future similar events.

On April 7th, the recorded global number of cases was 1.36 million with 76,000 deaths (5.6%), the United States cases were 370,000 with 11,000 deaths (3%) and Canada was at 16,700 cases and 360 deaths (2.15%). On March 1st, Canada had no recorded deaths. We also learned that these numbers very much depended on the extent of population screening performed. In North America, the “apex” of the epidemic curve is still nowhere in sight but people draw solace from the fact that drastic public health measures in China and South Korea appear to have abated the escalation of number of cases and eventually significantly reduced the incidence of new ones. Social distancing in a compliant population has been credited for controlling the epidemic. Drones were even used to monitor behaviour. That experience was contrasted with rapidly escalating European statistics overwhelming the health care system and resulting in a higher rate of mortality, including among health care providers. The difference again was attributed to a culturally freer society with a higher rate of interconnectedness and perhaps differences in vulnerable age groups. Spurred by these experiences, Canada, like other countries, adopted social distancing as its most visible public health measure. Travelling back from the United States, I completed a 14 day period of isolation which I am sure contributed to my choice of topic. Social-isolation as a public health measure highlighted some unintended challenges for our addiction services.

This pandemic demonstrated once more that an essential target of our practices is to rebuild our patients’ positive social connectedness with peer groups, families, worksites, and communities in general. Our detailed assessments aim to establish a rapport with our patients along with motivational interviews to encourage initiation and compliance with treatment programs. These programs largely provide a mix of individual, group, and family activities where interactive professional and peer support is promoted. The frequency of the administration of medication in harm reduction programs aim to encourage regular treatment contact in addition to monitoring. Residential programs emphasize group identification and mutual help fellowship is a pillar of the maintenance of recovery.

It is fully realized that measures to control a lethal viral pandemic aim to keep people alive. In most cases, the epidemic will hopefully resolve in a matter of months and distancing is temporary. Gratitude is due to our colleagues and other first responders who risk their lives by willingly exposing themselves and their loved ones to potentially lethal infection in our midst. Can we however learn from this fresh experience to refine our strategies? As a consumer of North American media, a recipient of a flood of daily emails and listening to experts (CCSA, WHO), I cannot help but draw the following perceptions:

(i) Public health preparedness—Pandemics are a recurrent phenomenon. In the last 20 years, the world has experienced SARS, H1N1, Ebola, Zika, MERS, and now COVID-19. They are salient by their lethality but also occur on top of other more endemic epidemics, such as viral hepatitis, HIV, or West Nile encephalitis among others. This frequent occurrence should dictate education and training in disaster strategies in our curricula. We may have short memories, but we were caught flat footed with very limited inventories in screening tests, pipettes, and protective gear all the way up to ICU beds and ventilators. Social distancing to ensure new cases did not overwhelm limited inventories became the major dilemma.
(2) Isolation and testing—Every pandemic has its own characteristics and predictions can be difficult at the onset. In a few short weeks, we experienced a number of changes in the criteria for entering or leaving isolation, but the relative absence of screening tests and results awaiting 5 to 10 days led to a loss of valuable healthcare resources. Uniformly isolating for 2 weeks, people, many untested, led to the loss of valuable workforce. The risks associated with asymptomatic contacts remain a mystery, as we have so far no reliable prevalence data.

(3) Recognition of addiction and mental health issues as part of an infectious disease pandemic—Perhaps as an indication of stigma reduction, addiction, and mental health challenges are receiving better scrutiny. Social distancing is required but social isolation should be prevented. Of note, the concept of social distancing evolved into physical distancing. Are countless webinars enough? Local epicentres of the disease occurred in nursing homes, shelters, prisons, and the homeless all sharing degrees of isolation. The reaction to the pandemic has been compared to a mass grief reaction, with phases starting with denial, followed by anger, bargaining, and finally acceptance.

(4) Technology as an alternative to personal contact—Predictably, we have been reminded how electronic communication could supplement or replace face to face contact and the empirical evidence for the effectiveness of some of these interventions is rising. I must betray a generational bias by confessing a preference for direct connection between a patient with addiction and a therapist, particularly in the initial stages of the involvement. Not everybody has access to or is just comfortable using a computer, and this certainly applies to some of our most vulnerable populations. Younger generations weaned on computers as their preferred means of communication may be more comfortable with reduced human contact, but a third of our population at least is estimated not to be there yet. Meanwhile, virtual care will get a boost and governments will recognize variations of this modality as a billable service.

(5) Impetus for research—This pandemic raises so many questions on every front! How valid were the assumptions of epidemiological models resulting in a wide range of conclusions and fear of the unknown? Will we get secondary epidemics? What are the determinants of interprovincial differences? The spectrum of addiction and mental health implications of public health measures remain a field in its infancy. Is the knowledge borrowed from natural and war time disasters valid against an “invisible enemy” mutating at regular intervals? Will we need to “flatten the curve” once or several times? A plethora of guidelines from various sources made their integration somewhat difficult. Top of the list was the need for reliable, readily available testing. The uncomfortable interaction of public health policies and politics were on full display. Politics played a major role in denying the recognition of a pandemic in most countries. On the other hand, once recognized, it also played a major role in marshalling resources. Promises of a 15-min test, trials of hydroxychloroquine accepted by FDA in a week, the building of field hospitals in 3 days in several countries were unheard of so far. Closer to home, should liquor and cannabis stores be considered “essential services” to prevent panic buying? Never to miss an opportunity, the internet gaming industry marketed #PlayApartTogether with a pretense of WHO support.

(6) Social resilience and ingenuity—I should conclude by reminding ourselves that pandemics can also bring out the best in us. Heartwarming displays of resilience will be remembered, such as the singing from balconies, the banging of pots and pans to recognize first responders at the end of their shifts as well as the parades of cars in front of the nursing home to celebrate a grandparent’s birthday. Industrial ingenuity in retooling mobile hospitals and trials of vaccines, antibodies, and other therapeutics will have longstanding beneficial implications.
EDITORIAL

Let’s review these perceptions in June. The CJA welcomes more empirically based chronicling of the pandemic. We are all in this together.

Nady el-Guebaly, C.M., MD, FRCP.C
Editor-in-Chief, CJA-JCA

REFERENCE


