Message from the Editor-in-Chief

The Next Phase in the Management of the COVID-19 Pandemic: A Discussion of Trade-Offs of Different Strategies

The first phase in managing the coronavirus pandemic has largely omitted a discussion of trade-offs of different pandemic management strategies, and rightly so. The strategy enacted by our government leaders under the advisement of public health professionals has been largely unidirectional: to impose widespread – even by wartime standards – societal restrictions that severely limit human-to-human contact while accepting the associated, and in many areas devastating, economic consequences. The target endpoint has been clear: to mitigate infection spread and allow time for health care institutions and systems to prepare for immediate and future “surges” of coronavirus-related infection and hospitalizations. Our society and profession have responded admirably in adhering to these restrictions and in achieving the desired endpoint.

The next phase in managing the pandemic warrants candid, bidirectional discussions of the trade-offs of a broader versus targeted strategy for restrictions to in-person interactions. This discussion is needed because the next endpoint, that is the availability of a coronavirus vaccine, is at least 12 months away from now, probably 24 months away, and possibly longer.¹⁻³

Healthcare professionals can have a pivotal role in this discussion and debate due to the tremendous influence they currently wield to advise institutions and governments on policy decisions. As general internists, we frequently deal with trade-offs when deciding about the benefits and risks of a diagnostic test, an intervention or a treatment; these trade-offs consider NNTs versus NNHs, the impact of events prevented versus caused, QALYs gained versus costs incurred, all alongside patient-centric values and preferences. Engagement by healthcare professionals can occur at a broader level with public health professionals or governments (federal and provincial) for discussions as to the long-term economic consequences of broader versus targeted restrictions to in-person interactions. Closer to home, we can engage our local institutions or provincial governments to discuss and debate trade-offs to managing the next phase of the pandemic; this can occur in at least two areas.

The first is to consider the trade-offs of virtual versus in-person medical care. It can be argued that although virtual care is not new and will continue in an expanded capacity, it should not routinely replace the meticulous attention to detail, personal engagement, and the humanity that can only be fully provided through in-person (but protected⁴) encounters. In terms of balancing risks, this should consider the risks of infection spread in a protected in-person environment against the putatively higher risks of harm or deterioration of health status to patients with a virtual visit-focused approach. It is important to acknowledge that COVID-19 has disproportionately devastating effects on the elderly, especially those who reside in long-term care facilities: overall infection fatality rates of 10.7% in those 60–79 years old, and 31.4% in those >80 years old⁵ – though these fatality rates are likely much lower in persons without comorbidities.⁶ These vulnerable groups need meticulous protection during in-person health assessments.⁴ On the other hand, we are starting to uncover the collateral health consequences of societal isolation and limits on in-person access to health care, which include higher than expected rates of cardiovascular events and overall mortality, even after accounting for COVID-19 deaths.^{7,8}

The second is to consider the trade-offs of virtual versus in-person learning. Herein, it can be argued that we need to get our students and learners – children, adolescents, young adults – back to school and in the

clinical environment ASAP, meaning in September 2020. For this issue, the trade-offs appear more one-sided: the associated benefits of allowing learners to return to school are likely to outweigh the harms done through continued remote schooling and learning for the next 12 to 24 months. In terms of balancing risks of in-person versus virtual learning, COVID-19 appears to disproportionately spare young people: overall infection fatality rates of 0.06% in those <19 years old, and 0.11% in those 20–39 years old⁵ – though these fatality rates are likely lower in persons without comorbidities.⁶ An in-person strategy will come with caveats so that vulnerable contacts are protected. Students in schools will benefit from in-person interactions with their peers and teachers to develop essential socialization and learning skills. Learners in the medical field will reap immeasurable benefits from having (protected) in-person encounters with patients.

There will be counter-arguments and criticisms to such bidirectional, trade-off-based discussions – this is welcome and needed. For example, it might be argued that although coronavirus-related fatalities in otherwise healthy young people are very rare, we are uncertain about long-term infection-related morbidity. Admittedly, an assessment of trade-offs will accept some uncertainty but this goes both ways: we are also uncertain about the negative consequences of long-term remote learning. There is also the overarching uncertainty that a vaccine, if available in 12 to 24 months, will be sufficiently effective to prevent infection.

In the coming days and weeks, medical professionals can have an important role to discuss and debate different strategies and trade-offs in managing the next phase of the pandemic. Let us engage in this discussion in a vigorous, bidirectional, and candid manner to achieve a balanced way forward.

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