

Reflections on the 2020 Pandemic from Ontario, Canada by Dr. Nicholas Pairaudeau. July 5th 2020

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I was asked to write something that might reflect of the challenges and the possible direction that Gynecology will take in the new world of the novel virus COVID -19 or Sars-COV-2 that is ravaging our population and has brought to a halt economies that have never been locked down for so many months and now just beginning to open up.

From the beginning in January 2020 the population has been divided into three groups. The first the alarmist group forecasted millions dying and that every extreme measure should be undertaken to stop its spread including lock downs, testing and a need for a vaccine. The media became hysterical every case being deemed a terrible disaster, unaware that every day people are dying from other viruses as well as other causes. The second and probably the majority were overwhelmed by facts, fake news and an expert opinions covering the problem in excruciating detail. And the third group of head in the sand and hoped it would go away, take chloroquine and hope for the best.

By July 5, 2020 China reported a total number of cases 83,545, and deaths 4,634 and recovered 78,509 (WHO, CDC). World figures are to date 11,093,182 and deaths 525,491 and recovered 5,890,052 (WHO, CDC). This compares with The Spanish flu of 1918 that caused an estimated 50 million deaths. There are apparently 500,000 worldwide deaths attributed to Covid-19 to date and the final figures will inevitably go higher.

I became aware of COVID-19 on January 8th, 2020 as my colleagues in China had picked up from a friend that a pneumonia type flu like SARS was increasing in Wuhan. Doctors and nurses were dying and that the emergency department and the Intensive care units and the mortuaries were filling up alarmingly. Every resource was put into place by the Chinese Government including sending staff from all over the country and placing the whole city of Wuhan under strict lock down. Ontario recorded its first case on January 22 and the patient went to Sunnybrook hospital and later recovered. Events moved slowly, with evidence that the virus was spreading and the next hotspot was Iran with many dying. Subsequently Italy became the hotspot followed by Belgium, France and then Spain. By early March, it was obvious Ontario would not be spared. For those that were travelling at the time, the border controls at the airport were sparse in North America, baffling many that came from abroad. There was a consensus at the airport that this was a disaster in the making, but no one in authority at these places seem to care.

The WHO at the end of January 2020 officially noted that there was a novel Corona virus that was devastating the world population. Every effort was being made to understand, sequence the virus, and manage the possible outcome. The WHO constantly updated us referring to Wuhan, which was closed to the world by intense lock down for everyone.

On March 11, 2020 COVID-19 was deemed a pandemic by the WHO. From the beginning the WHO consensus was that droplet transmission was the major cause, with air borne issues less involved, and contact a distinct possibility, hence hand washing. The controversy has continued with emphasis that crowded areas, close contact and poor ventilation was associated with most of the infected cases. The issue of droplet and airborne focused on what face covering works best, with droplet transmission needing a regular face mask, but air

borne transmission needing N95 mask. Because of the lack of large supplies of N95 masks, every effort was made to use regular masks and only use the N95 in highly infected areas. Medical resources could then hope to handle the increase in the severely ill patient and manage intensive care with the possible use of medical support, drugs and ventilators. Huge efforts were made to provide appropriate PPE.

The alarm bells were ringing after the WHO statement that we had a pandemic and by March 17, the Ontario Government accepted that COVID -19 was probably capable of community transmission and later in the day with numbers increasing a state of emergency was declared by the Ontario Government. This original closing down included a number of sites including private schools, theatres public libraries, but later on March 24, all non-essential business were closed including doctors' offices. Only essential visits were permitted. With negotiation with the OMA and the Ontario Government a plan to keep Doctors funds flowing, top up emergency funds were made available to pay up to 70% of regular monthly remittances, which were to be paid back at a later date. The Canadian Federal Government allowed private business to apply for a \$40,000 loan to be paid back at a later date.

Over the world medical conferences were closed down, and the medical educational needs were transferred to the internet and webinars, as well as such applications of web conferencing. ZOOM and Teams meetings became the standard fare of keeping up with developments. Some welcomed this and others found it difficult to manage with frequent glitches, but every day there were improvements. It is fascinating with new developments over the last few years that the internet infrastructure was able to handle such an explosion of use. Except what was seen to be overloading the system, and slowing flow of data, we have managed very well.

From the practice of Gynecology, the closure of the hospital's ER to only severe cases, the closure of the operating rooms to non-essential cases, refurbishing operating rooms to contain and protect OR personnel were put into place. There was extensive teaching of all staff on safe practices managing the symptomatic patient as well asymptomatic, that might have the disease. Our Hospital went to extraordinary measures to make the environment safer. Unfortunately, as the pandemic expanded it was the realization that at least 15 to 20% of the population was asymptomatic, but with positive Covid 19 testing and could be spreaders. Despite a slow start to testing, gradually most patients were tested before any operations were carried out, and now it is now almost 100%. Recently we have a quick test with results back in 4 to 6 hours but it is more expensive. Thus, testing can be performed on the same day of admission or Operating day. Regular surgery testing with results back within 24 to 36 hours is now the norm.

The hospital surgical team put in daily briefings and all possible cases triaged by an expert team. There were weekly meetings for all surgical staff with frequent updates. This has been curtailed recently as it achieved the goal of not missing urgent cases and appropriate triaging carried out.

Another issue started to emerge both from the UK and the USA that there were groups that seemed to be much more infected than others. The BAME group an UK acronym "Black Asian and minority ethnic "groups were at more at risk from this virus, particularly with worse outcomes and higher death rates. This has been noted throughout the world as the pandemic continues to escalate.

Meanwhile back at the clinic and office challenges were immediately recognized. The initial consultations were being screened over the telephone, and only essential cases were actually seen. Every effort was made to make the office safe with sign in survey, mask and hand washing for all staff and patients. Rooms and equipment were wiped down after each patient. Social distancing was instituted, the rest were telephone triaged, and relevant tests ordered and then reviewed when they were back. Numerous organizations over the world have focused on what is acceptable and what is not acceptable in this reduced medical access environment. For example, we are all agreed that cancer takes priority, but how long should someone be left without treatment for a low hemoglobin and heavy periods? At the moment we are trying to use smart phone apps to make the entry and exit easier for the patients and the staff. We are aware that cancer cases are of utmost importance, but there are many other conditions that have grave implications on patient health. The challenge is to provide good care in limited circumstances.

Fortunately, operating rooms are opening up, patients are being triaged, but the lists are long, and with summer approaching staff have gone on holiday. After this terrible time, you cannot criticize this work expectation of having summer holidays.

Medical schools until recently have not taught telemedicine on a regular basis, and only those with a need to teleconference such as OTN (Ontario Telemedicine Network) would provide the environment and experience. I am amazed however the amount of activity by Universities all over the world, including the University of Toronto with E-learning. I hope that it will bring down the cost of education, but it will need to be validated. However, we have all had to learn the strengths and weaknesses of the so called teleconference, for some it has been delightful, for others it has been disappointing. Meanwhile, clinical medical care is not just taking history, examination, ordering tests, and making a diagnosis, but also human interaction. I wonder what William Osler would have thought?

Focusing on the issue of teleconferencing for clinical use, it really depends on each patient. We are waiting for a standard format with visual access to allow us to better serve our patients. Teleconferencing is a learned art and needs to be taught as well as validated. This is a great opportunity to define what medical care is all about. Having reminded myself that medical care is about quality of life and longevity with a reasonable life. We as a society have not come to terms with the second part of my vision for medical care. Any debate on the implications of my second column, "a reasonable life" is shot down and I will not get involved with a much greater issue of how we are managing old age. It is distressing that most of our lost lives have been with old people stuck in crowded conditions with underpaid and under protected workers. But this pandemic, like all, bring out such issues, only to be put on the back burner till another pandemic happens. We all know the answers, there have been many conferences, government committees, but there are many obstacles to dealing with this recurring disaster. There is a lot of hubris and hypocrisy out there and we do not seem to move on.

As we reach the next step, we need to understand that this maybe a pivotal time for reviewing what medicine, medical care and fulfilling the issue of quality of life and longevity really means. The costs are higher than ever. Older people have been targeted, from 60 to 65 to 70 and then to 80. Many of these people have other co morbidities that also contribute to their vulnerability. As a senior gynecologist, many of my colleagues and friends of my age were told to stay away. We are frankly distressed that we are seen as being very vulnerable and must be locked up. It was interesting when it seemed that many doctors might be needed, it was to the older doctors that were looked at as medical resource for managing the millions of patients that would over-whelm the medical system. Many of my colleagues were quite happy to put themselves on the front line. Some were disappointed that they were not needed after all. Yes, older people have to be more careful, use masks in closed places properly, and socially distance themselves. It maybe that N95 might be the norm, with short time use, for the older population when they go out. But everyone must use the mask correctly. Time and time again, I am seeing Doctors on Television wearing masks under the chin and setting a bad example.

I believe we are not at the end of this medical and economic nightmare yet. But we need to focus on the big picture. We cannot be constantly shown over and over again, ghastly images that only terrify us and depress us. This is an abuse by the media, which should be more responsible. We really need to explore every way we can provide medical care that we can afford but also fulfills our needs as humans and humanity.

It will be interesting to review the situation in 3 months to see what really happens but it will not be business as usual. WE are not out of the woods yet.

Conclusion

The COVID-19 pandemic has provided Gynecologists, who deal with many sensitive areas of medicine, with significant challenges. It is establishing a relationship that is beneficial to take an adequate history, make an examination, order the relevant tests and set the patient on a therapeutic pathway to improving health. Telehealth is a relatively new specialty in itself, that has proven its worth in this Covid-19

pandemic, in many areas of medical care. What we are finding out in Gynecology that Telehealth can be very helpful, but there are areas that there appears to be deficiencies, that cannot be substituted by the new technology. The challenge is to find out what works well and what that does not.

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