

Pandemic in the Physicians' Perspective
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Let me express my appreciation to the Archbishop Paglia and the Pontifical Academy for Life for sponsoring this very important workshop and thank you very much for the invitation to participate on behalf of the World Medical Association. Let me give you a little context about the WMA. The WMA is an international association of the national medical associations from 115 countries. Those associations represent almost 10 million physicians worldwide. The WMA was founded in 1947 in the aftermath of World War II and in response to some of the atrocities that occurred in the name of medicine and medical research. The WMA adopted the International Code of Medical Ethics just 2 years later in October 1949. Since then, it has been revised and updated three times and is in the process of another update.

The mission of the WMA is to achieve the highest standards in medical education, science, ethics and health care for all people in the world. The WMA does this, in part, by developing statements and declarations on a wide range of topics. As it relates to this Workshop, the WMA has statements on medical ethics in the event of disasters, on epidemics and pandemics, and we adopted a resolution at our last General Assembly meeting in October 2020 on equitable global distribution of COVID-19 vaccine. I think you can see that the WMA has a deep and longstanding commitment to promoting health and health equity for all people.

I think we can agree, that not since the H1N1 influenza pandemic of 1918 has there been a public health threat of such global proportions as we have faced over the past two years with the SARS COVID-19 pandemic. The importance of carefully assessing how this has impacted the economic, physical and emotional health of individuals and countries around the world -- what we must do now to address the damage that is still ongoing -- and how we can plan a more effective response to the next similar situation cannot be overstated. COVID-19 was not the first pandemic and it will certainly not be the last. This workshop provides an opportunity for us to collaborate, share our perspectives, and offer constructive suggestions to address the ongoing damage and plan a more effective response.

COVID-19 has touched the lives of nearly everyone in our world. It has caused disease in over 200 million people and has caused the death of over 4.5 million men, women, and children worldwide. But even those who have escaped disease and death have been impacted by the loss of loved ones and friends, the loss of jobs and businesses, and separation from church, school, work and community. However, there has been one group that has been uniquely impacted by this pandemic - healthcare workers and physicians in particular. It is the perspective of physicians that I will bring to our discussions.

The physicians' perspective has been informed and shaped not only by the science and research but by personal experience. The experience of standing by the bed of a patient critically ill with COVID and not having the tools or the resources to adequately care for them. The experience of the personal risk they take each time they walk into the room of a patient with COVID knowing this may be the day that this dreaded disease infects them. The experience of seeing their physician colleagues and nurses become sick and die - which has been the fate of thousands of physicians and thousands more nurses and other healthcare workers worldwide who have placed themselves in harm's way to care for their patients.

Although the physicians' perspectives span numerous aspects of this pandemic, I will touch briefly on four significant areas that have produced the greatest challenges and, therefore, provide us with the greatest opportunities as we address this pandemic. I will then elaborate further on an area of great promise: vaccination.

The impact of the COVID pandemic on the physical and mental health of individuals cannot be overstated. Consider again the number directly infected: 200 million cases worldwide and over 4.5 million deaths to date. For those with the disease, the impact was most apparent. While the majority of those who contracted COVID were fortunate enough to have relatively mild or moderate illness, many millions were seriously ill, and those that required hospitalization or critical care also numbered in the tens of millions. Many of those who survived COVID sustained lung and heart damage and continue to experience shortness of breath, chest pain and fatigue. In addition, those with prolonged COVID often had extended absences from work and some have been unable to return. Some of these were physicians and nurses worsening the shortages in an already overextended healthcare workforce.

Although the physical illness was apparent to all, the emotional impact on those with and without COVID was initially less evident, but in many ways has proven to be just as impactful. Those with COVID feared progression of the illness. Those critically ill didn't know if they would survive. Family and friends of those with serious illness often couldn't visit those hospitalized and too often had difficulty getting updates on the status of their loved ones. Their days and weeks of waiting and often not knowing took a significant emotional toll.

Even for those without COVID, many worried and wondered when they would be next. Many were afraid even to leave their homes to get food or other necessities of life and even more were afraid to seek health care. Many put off care necessary to address their severe chronic diseases. Surgeries were delayed or cancelled. Chemotherapy and other treatments were interrupted. Some who were willing to seek health care found that their healthcare providers were unable to continue their care due to the immediate and overwhelming demand of critically ill COVID patients.

From the social perspective, “stay at home” orders, closing of schools, business and restaurants, the resulting social isolation, the economic stress of loss of business and personal income all coupled with the fear of illness took an enormous emotional toll on many. The rates of depression, anxiety and substance use increased significantly during the pandemic while at the same time, the availability of medical, mental health and substance use disorder services to address these increase reactions to the pandemic were often even less available than usual. We must anticipate and prepare to address this effect in future similar situations.

The severity of COVID varied widely, but the disease severity was greatest in three broad categories: the elderly, those with chronic disease, and some of the non-Caucasian populations. When these risk factors are further superimposed on populations already experiencing health care disparities and those with unfavorable social determinants of health, it is easy to see why these groups had much higher rates of severe disease and death. During this pandemic, many in these groups had even less access to early testing, supportive medical care or hospitalization than they did prior to the pandemic. This pandemic shined a very bright light on the health inequities and unfavorable social determinants that exist and must be addressed now.

Our health care workforce was uniquely impacted by this pandemic. In the early days, physicians and other healthcare workers were often expected to care for patients with COVID without the benefit of sufficient personal protective equipment placing themselves at great personal risk. While they continued to deliver care because of their dedication and commitment to patients, many felt unsupported or even betrayed by their hospitals and governments. Many became sick and died as a result of their oath to serve.

Those that continued to serve often found themselves facing shortages of necessary equipment and supplies. The shortage of ventilators and hospital and intensive care unit beds were the most visible, but even common items like IV fluids, antibiotics, corticosteroids, and other medications were often in short supply or unavailable. We have seen this before although on a smaller scale with other regional disasters. We have failed to prepare for longer duration and broader disasters such are the one we are in now. We must find ways for each country to develop stockpiles and supply chains for personal protective equipment as well as medications and supplies needed to care for a surge of patients in pandemics and other natural or man-made disasters.

Another area of opportunity is around the science and research and the sharing and dissemination of information. While the efforts and resources devoted to multi-center vaccine development were unprecedented, the global cooperation and collaboration in research and data sharing especially around treatment approaches was not at a level required to effectively address the pandemic. Early in the pandemic reports of near miraculous response to relatively common medications such as hydroxychloroquine and ivermectin caused an explosion of incomplete or misinformation. Then, as some of the earlier reports were found to be

unsubstantiated or even fraudulent, it seemed to breed an avalanche of misinformation and doubt about the validity of the “science” around those and other evolving treatments. The development of monoclonal antibodies was almost as fast and was embraced by medical experts. The development of other treatments, however, has been less than impressive. So, we find ourselves today, almost 2 years into this pandemic, with controversy and conflicting recommendations about use of antivirals, neutralizing antibodies, immune modulators, corticosteroids and even respiratory support. In this age of high-speed computers, exponential advances in scientific and technologic capabilities, and real-time global communication, we must do better with our scientific collaboration and communication and development of consensus on treatment best practices. Our physicians and our patients should expect no less.

This brings me to my final topic: vaccination. Unless or until a disease can be effectively treated, prevention is critical. Vaccines offer that opportunity for prevention. While the efforts to develop and distribute COVID vaccines have been monumental, vaccination rates, especially in lower income and lower-middle income countries remain embarrassingly low with vaccination rates in dozens of countries still less 3 % of their population. As we all realize, this is a multifactorial problem.

Affordability at both the country and individual levels accounts for much of the disparity. Many higher income countries were able to negotiate advance contracts with major vaccine manufacturers for large supplies. Those contracts spoke for much of the worldwide production of the leading vaccine candidates. The WHO brokered COVAX alliance proposed an acquisition and allocation plan that would have leveled the playing field to some extent. However, many of the higher income countries were not willing to forgo their purchase agreements in favor of more equitable vaccine distribution. This includes countries such as the U.S., Canada and the E.U. Although multiple international funding sources are now available to COVAX, vaccine supply and continued financial constraints in many countries will still prevent many countries from reaching anything close to acceptable levels of vaccination by the end of this year or even middle of 2022.

Beyond access and affordability, inadequate vaccine administration infrastructure including governmental and health system structures as well as distribution logistics contributes significantly to low vaccination rates. If permitted by local governments, much assistance can be available from both in country physicians and healthcare personnel as well as from international non-governmental organizations. Solutions to overcome these and other barriers to distribution of the vaccine must be discussed and adopted.

The final and maybe the most difficult to understand factor is vaccine hesitancy. This is seen to some degree in nearly all countries and is also a multifactorial problem. The speed with which these vaccines were developed and the newer technologies some of them employ, such as the mRNA technology, have caused many to approach the vaccines with some apprehension and

even fear. This has been compounded by the global network of misinformation and distortion regarding the risks and benefits of the vaccine. Breakthrough cases after vaccination, the concern of waning immunity and the likely need for subsequent boosters have all contributed to the hesitancy. Taken together, these have caused skepticism and doubt regarding the “science” around the vaccines and the recommendations of the medical establishment that is unprecedented. Physicians and other health professionals are the most trusted voices. We must continue to promote valid and transparent information, stress the benefits of the vaccine and continue to point out the significantly greater risk of the natural disease.

The tragedy in these and other issues in this pandemic is that many of them were and are either avoidable or correctable. It is said that out of crises come opportunities. If so, a great crisis should lead to even greater opportunity. Again, I commend the Archbishop and Pontifical Academy for Life and all those who are participating in this Workshop for their commitment to capitalize on the great opportunity this gives us to come together to develop solutions and propose concrete actions that can be taken now to address the current crisis and prepare more effectively for the next. Thank you.