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Editorial

Reminiscing COVID-19: A Perspective from 2030

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Abstract

I'm washing my hands. Looking at the mirror, I notice those red eyes. There is a dull pain in my shoulders and my back. At 8 p.m., I'm exhausted. I get called to the cardiology unit. I touch my face. Hot. Trying to relieve myself, I take a deep breath. Again, my name is called. I wash my hands again. Obsessively. "That can't be. After my last dose of vaccine, my antibody levels were still high in the past week. It is going to be okay.", I mumble to myself. I open the door. "Happy birthday!" they chant together with a big white cake in their hands. We made it. All together.

Keywords: *COVID-19; Vaccine*

We are not that far from developing a vaccine for coronavirus disease 2019 (COVID-19) and there are already discussions about the best approaches to equitably distribute it among populations. One might not easily describe the total scope of afflictions imposed by this pandemic. On October 16, 2020, the number of confirmed deaths by COVID-19 is reported to be more than 1 million [1]. While there are more than 38 million confirmed cases around the world, with some world leaders contracting the infection, there are still some ongoing vague narratives among people who believe that the COVID-19 pandemic might be a hoax. This is a harsh reminder for us, medical advocates, not having done a successful job in conveying the real extent of the damage caused by the outbreak. In other words, communities have not been adequately engaged with medical societies through this period. Experiencing several peaks and fluctuations in daily figures of confirmed cases in various regions, and noticeable changes in the demographics of positive cases towards younger generations, are living signs of people not taking this outbreak as seriously as they should [2].

Again, we, medical professionals, are the ones to take responsibility here. Many factors have affected this chasm to get deeper over the time. Political compass, is one of the main determinants. Trying to control the activities of societies and making efforts to create exemptions from the constitution, have always been present in governmental systems. This trend is even more noticeable during a public health emergency. Defining the situation as an "urgent state" or "emergency" could help the healthcare systems to implement their decrees and policies more effectively. This paternalistic approach, however, could not be further from the correct approach when we lack the support of the main implementers of health policies, the community members. Lack of full transparency, mere economic intentions, and inappropriate care prioritization are some instances that have caused these negative perspectives to erect in the public. Practicing these activities in the long term, can actually imbue basic perspectives about the healthcare systems among the society. This set of beliefs and theories (trusting, conspiracy, etc.) is the main mobilizer of healthcare policies in each population during a public health emergency. Moreover, the role of social stress and anxiety due to the pandemic are previously delineated in the literature [3]. This could further exacerbate the gap between the society and healthcare policy makers.

Consequently, all the contributors to healthcare sectors, must embrace their responsibility to engage with others to warn them about an emergency, and convey the need for solidarity in the most effective, sympathetic, just, and humane way possible. Healthcare, as a pub-

lic matter and not a commodity, should be provided equitably without concerning race, geographical location, religion, or governmental policies. Nevertheless, this cannot undermine the rationale behind resource allocation and care prioritization during the outbreak period. In fact, this reassures that the healthcare is provided more equally and compensates for vulnerable groups that are at increased risk these days. Disadvantaged people, underrepresented minorities, incarcerated individuals, pregnant women, and immunocompromised patients, all belong to this category. This should not be considered as a biased policy or outcome-oriented decision making. Instead, this is the ethical approach of preparedness planning for a public health emergency. Vaccine distribution is not an exception to this and the plans for its equitable access and affordability should be well established. A multilateral collaboration of countries aiming to accelerate the development, production, and equitable access to COVID-19 tests, treatments, and vaccines has already been started, named COVAX. This collaboration is reinforced and co-led by the world health organization. However, once again, this timely intervention needs the social engagement and social support (donations, spread of information, etc.) to result in the expected promising outcomes.

Healthcare advocates, including medical staff, nurses, allied health professionals, and other healthcare facility staff, are encouraged to once more embrace their responsibilities and convey this message that the management of COVID-19 pandemic requires community empowerment and civic commitment. Whether the future generations would remember this era as a "good instance of management and collaboration in the world", or a "bad era", depends on what we have done to halt the pandemic these days. Hopefully, when a nurse is reminiscing the outbreak in 2030, the memory of COVID-19 would be something similar to what was described in the abstract and what relieves the stress, is the thought of effective global collaboration and cooperation that led to the effective management of the pandemic.

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