The many uncertainties of COVID-19

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In politics, certainty is strength, uncertainty is weakness. In the patriarchal model of medical care, now deemed a relic, bringing certainty to a patient consultation was a proxy for professional competence. Public health doctors were no less convinced of the correctness of their solutions. Modern medicine, even before COVID-19, had moved considerably in the opposite direction. Uncertainty, in the shape of risks and benefits, became essential to any patient interaction. Uncertainty became equally palatable in public health.

Over two decades ago, this future might have seemed improbable. The emerging discipline of evidence-based medicine promised answers to every question, at least to the unenlightened. Instead of understanding the uncertainty revealed by a higher quality of evidence, the misguided disciples of evidence-based medicine believed in the certainty of what the evidence revealed. Indeed, uncertainty in clinical practice is an age-old concept overlooked by both the self-deluded patriarchs and the optimistic EBMers.¹

Today, uncertainty is a natural state for clinicians and scientists; a reality that politicians seem unable and unwilling to grasp. This contrast plays out sharply when politicians claim to be ‘following the evidence’ in their response to COVID-19. How can the evidence be so certain that it should be followed? Isn’t it better to accept uncertainty, communicate that uncertainty clearly to the public, but provide a convincing rationale for policy informed by, not following, the best available science and evidence?

Perhaps it doesn’t pay for a politician to think so deeply? In times of crisis people tend to crave strong leadership, but one of the lessons of COVID-19 is that some of the countries that have fared the best, New Zealand and Germany for example, are led by women willing to accept uncertainty and the advice of their scientists – and then take decisive action. Meanwhile, the leaders of the USA and UK have parroted ‘following the evidence’ but chosen a path

informed less by science and more by their own world view, and ended up dithering. The outcomes speak for themselves.

This month’s issue reflects some of the many uncertainties in responding to COVID-19. At what age should we start protecting people? At age 60 years or 70 years?² How can we lessen the inequalities exposed by COVID-19?³ What are some of the clinical effects of loneliness and social isolation?⁴ Was lockdown even the right policy option?⁵ Either way, what are the conditions now required to exit it?⁶ These are difficult questions to answer with certainty and the evidence may be patchy. The solution to how best to move forward may come from an older source, from a closer examination of the experiences of the Spanish Flu of 1918.⁷ When our COVID-19 politics and disagreements are done too, history will judge how well we, politicians and clinicians, served the people.

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