Food for thought, feeding the medical soul: COVID-19 pandemic lessons and reflections

Dr Ian McWhinney Lecture, 2022

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It has been 2½ years since the emergence of a calamitous pandemic driven by a novel coronavirus. With our counterparts across the world, Canadian public health and health care professionals continue to address the impacts of the longest and most unprecedented emergency response in modern memory and have also supported the most extensive and widest-reaching vaccination rollout in Canada since Confederation.

We have seen trying losses and inspiring advances alongside the best and worst of human behaviour and a seismic shift in how we live, work, and play. It should not be a surprise, then, that we have all derived lessons from the experience. That seems trite to say, given that every day arguably presents new opportunities to learn. But I will say it regardless, because I know that this particular moment in history is unique. That gives us an opportunity to reflect on what we have learned and seen, and to reconsider what we do and how we do it.

We are all connected

The COVID-19 pandemic reminded us that the well-being of communities relies ultimately on how well we are able to collectively protect our most vulnerable members. As I grew fond of saying throughout numerous public appearances as a spokesperson for one of the hardest-hit regions in Canada, it took a novel disease that spread from person to person to remind us that we are all ultimately connected.

Dr Ian McWhinney also notes this about families, writing in his textbook of family medicine that "any change in one part of the family system has repercussions for the entire family."[1] That insight, of course, applies to not only families, but also to the communities in which family physicians practise. Simply put, we ignore the systems that perpetuate inequity at our collective peril.

In quick order, COVID-19 made visible the impacts of day-to-day disparities on the health of individuals and populations. Yet these are the same disparities that often remain invisible and unacknowledged by policy makers as they pertain to other health conditions.[2]

This is perhaps because in many instances the ultimate impacts on health are seen at a point remote from the initial insult or injury.[3] That does not, however, change the clear evidence that inequitable systems, such as those rooted in racism, disadvantage individuals, resulting in lower socioeconomic status, lost opportunities, and chronic disease in later life.[4] As an example, childhood trauma and insecure attachments, which can sometimes manifest from disparities, can result in poor health years down the line.[5]

It was these existing inequities in our communities that in part determined who would face a higher risk of infection and also who would face a higher risk of severe or mortal outcomes if they were met with infection. Some faced both risks together. Of course, you might say that this is no different from any other disease entity that certain members of a community are disproportionately affected by. The key difference lies in what we had to do about it.

Because this virus spread so perniciously, a whole-of-society approach was needed to stop the spread and save lives in the pre-vaccine era. We needed a broad reduction of contacts to keep transmission low, because anyone could catch it and anyone could pass it on.

In a widely susceptible population, COVID-19 was a probability game on a grand scale. The higher the transmission rate went, the greater the chance that this virus would wend its way to vulnerable groups and also to those who might face catastrophic outcomes despite their outward lower-risk profile.

What was most interesting were those who advocated for a "targeted approach" from the get-go—promoting the idea of "protecting" vulnerable groups and letting the rest of society run unimpeded. In response to these people, I ask: do we take a targeted approach when fighting forest fires?

Imagine a forest fire where we told everyone else to, essentially, light more fires—while telling vulnerable people to evacuate if they could and await assistance if they could not. Vulnerable people would remain at home, at greater risk as the intensity of the flames increased. They would still need to receive care and sustenance from the outside community, even as the risk of backdraft grew every time they opened their doors. At the same time, rescuers would be out and about, trying as best they could within their capacity to reach and evacuate them, even as their flame-retardant gear wore down and the fire grew in intensity. They might also have to help a few of the lower-risk folks, too—since some of them would almost certainly set themselves ablaze as they set out to light more fires.

This commentary is based on the 2022 Dr Ian McWhinney Lecture given by Dr Loh at Western University in London, Ont, on September 21, 2022.

This analogy makes one thing clear: less fire means less risk for everyone, especially our most vulnerable. It is for this reason that reducing contacts needed to be an all-of-society thing. In the pre-vaccine era, such measures offered the best protection for all of us, especially vulnerable groups.

Family physicians know that families are similarly complex webs of relationships and history. Many of us saw and still see how COVID-19 spreads through households, disrupting the lives of families. Yet other disease entities have a similar path that affects not only the patient but also their family members—those direct and indirect impacts simply unfold on a different time scale.

It is why Dr McWhinney urges family physicians to "think family" in his textbook.[1] Regardless of the disease a patient has, understanding the family involved allows physicians to determine how a patient's family context might predispose them to or mitigate a disease, and what impacts that disease will have not only on the patient, but also on those closest to the patient. The pandemic reminded us that no one truly lives in isolation—that family doctors treat not solely the patient before them, but also the family in which the patient exists.

Context matters

That brings me to my second reflection. As public health and family physicians deal with these complex systems, we also intuitively understand that none are created the same; communities and families come in different shapes and sizes. Physicians must interpret the overall picture and tailor their advice while carefully accounting for context. We intuitively understand that what works for one family might well be detrimental to or impossible for another. That makes an understanding of context—particularly through information gleaned first-hand—invaluable to a physician's craft.

In his book *A Call to Heal,* Dr McWhinney details his time with the British Army in Malaysia in the late 1940s (then postwar British Malaya)—incidentally, a country that I also share a connection with through heritage and also through having lived there during my high school years in the 1990s.

In his writing, Dr McWhinney reflects that he was "supposed to remain at base camp, leaving the orderlies to accompany the platoons" but instead "asked if [he] could go with the troops [to] experience what [they] were facing."[6] This reminds me of what the English poet John Keats also famously wrote, that "nothing ever becomes real till it is experienced."[7]

During the pandemic, however, a first-hand appreciation for context was regrettably in short supply. This was particularly noticeable among online commentators—including physician colleagues—who would make comparisons between jurisdictions without considering their disparate contexts. Some argued for the pursuit of elimination without accounting for the fact that Canada was not a geographic or geopolitical island. We were dealt a more difficult set of cards than those countries that had the option to close off to the world. And, as those countries have also demonstrated, what was considered "early success" would present different challenges later on in the pandemic.

To illustrate this point, consider that before the pandemic, nearly half a million travelers crossed the United States–Canada border each day.[8] This was equivalent to the total number of international travelers that New Zealand would welcome in a month,[9] putting our risk of importation of COVID-19 cases at a different order of magnitude than that of the remote island nation. Add to this that employing a hard border, as many of the isolated locales did, would have also disrupted critical food, medical, and other essential supply chains with the United States.

Those who argued for targeted protection in the vein of the United States, Sweden, or many African countries also failed to account for contextual differences. These countries, too, saw different impacts from their decisions. In the case of the United States, deciding to remain open resulted in considerable mortality and also saw mass use of their otherwise-high hospital capacity arising from their fragmented health care system—the use of which still cost their economy billions of dollars.[10] Sweden's social compact and trust in institutions made the country unique in seeing the population reduce their contacts voluntarily—recommendations were respected as law, something that precious few other countries could have relied on. Even so, Sweden saw substantial mortality compared with peers.[11] And the relatively young population and limited detection capacity have both been noted as contributing to the trends observed in many African countries.[12]

It should not really be a surprise that different places responded to the pandemic differently. But it is important to assess the outcomes of those responses in their specific contexts, rather than in head-to-head comparisons. It is not surprising, for example, that an earthquake in a large urban area would result in very different impacts than one that occurs in a remote Arctic tundra.

Consequently, what eventuated even looked different across Canada: while northern and Atlantic Canada had the opportunity and necessity to close off to the rest of the world until vaccines arrived, places like Ontario's Peel Region became epicentres. From the start, Peel, where I was serving as the Medical Officer of Health, was never given the opportunity to keep COVID-19 out.

Ontario, in fact, largely saw the same pattern of spread mirrored around the world and in other large jurisdictions. Densely populated, internationally connected urban areas were the first to bear the brunt of community propagation. It then spread to regional centres before finally making it to the more rural and remote parts of the province.

This is what made Ontario's decentralized system of public health units a lifesaver. Following the first lockdown, locally tailored and focused responses in the greater Toronto area and Ottawa helped limit transmission and buy time to vaccinate the province in the spring of 2021. This meant that by the time other Ontario communities further afield started to see widespread transmission, high rates of vaccination coverage helped mitigate health care demand at greater levels of contact.

Skilled family physicians similarly understand that although they might recognize and seek out patterns in their work, they do not typically compare families—and wisely so—nor do they offer one-size-fits-all advice to everyone in their practices. The adept clinician understands that different disease entities manifest differently, exacerbated or hidden owing to one's circumstances, and that comparisons serve little purpose. What is more important, of course, is teasing out each patient's unique considerations and understanding how these influence the decision making in their specific instance.

Eschew the extremes

We have now affirmed that, much like communities in a pandemic, patients exist not on their own but as part of families that are complex systems. We have further affirmed that those complex systems themselves exist within diverse contexts that are difficult to compare.

Now we turn to intervention. Weighing the benefits and harms of any intervention is fundamental to the practice of both family medicine and public health. Throughout the pandemic response, public health officers were often tasked with making recommendations from a plethora of options that ranged from doing nothing to extensive measures—in much the same way that family doctors might help their patients navigate their options to respond to a difficult diagnosis.

These decisions were being made as opinions abounded from across the spectrum, espoused by both physicians and the public. Among physician commentators, the most extreme views often fell into 2 opposing camps with which we are all familiar: elimination, also known as "zero COVID,"[13] and a targeted, rather than population, approach, best ascribed to those who espoused the Great Barrington Declaration.[14]

Now, I am certain many will recall the timeless strategy on multiple-choice examinations where, to find the right answer, you eliminate the extreme options. This remains a good approach even in life.

What became very clear was that a constant adherence to either zero COVID or Great Barrington lacked nuance and did not account for shifting context. The optimal approach—especially in our context in Canada—was more complicated than that: a narrow—if difficult—middle path that shifted between tighter and looser controls as the circumstances dictated. After all, we knew early on that COVID-19 was here to stay. While limiting spread early on was crucial to saving lives by preventing a cascade of severe cases, longer-term elimination was not possible once animal reservoirs were identified.[15]

Even in the short term, Canada faced a different context compared with other geopolitical and geographic islands. Our deep integration with the United States meant that a total elimination and fortress strategy was impossible due to continuous seeding from the essential supply chains that I mentioned earlier. At the same time, I have mentioned how those who advocated for targeted protection did not recognize how Canada's demographic makeup and disparities would render this a death sentence for so many. More to the point, though, was that both sides failed to account for the real trade-offs associated with pursuing their preferred extremes.

Those who advocated for minimal or targeted measures would cite the economic toll of lockdowns without accounting for the very real economic costs of burgeoning COVID-19 hospitalizations, intensive care unit use, and mortality, as well as loss of labour and decreased consumer confidence amid high community rates of transmission. They would cite delays in surgeries and treatments as a harm from lockdown measures, without realizing that those same surgeries and treatments would be delayed if hospitals were overwhelmed. They would talk about the mental health impacts of virtual schooling, without considering the mental health impacts on children losing parents or loved ones.

Meanwhile, those who favoured the most stringent measures and elimination at any cost would fixate precisely on the opposite positions, elevating health care harms over the economic impacts of lockdown measures, pediatric illness severity versus school disruptions, and so on, to defend their own positions.

Both sides would also argue that those left vulnerable by inequities and disparities were being forgotten. This was not the case, of course—those of us in leadership knew that vulnerable groups had to receive targeted assistance where possible. But that moved more slowly, taking time and effort, and it is worth also recalling that emergencies ultimately play out on the ground on which they land. There was no instant fix for decades of systemic inequities that rendered people vulnerable long before the pandemic arrived on our shores.

To be clear, the root cause of all these harms was ultimately the pandemic. Suggestions that the measures were to blame were tantamount to blaming evacuations ahead of a hurricane's landfall for the societal and economic disruption, rather than the hurricane itself. In this context, any decision made was going to be seen as too much or too little by the other side, although I was grateful that the majority of colleagues eschewed the extremes and were supportive, understanding how impossible our role was.

The point I am making, though, is that family doctors thread the same needle every single day. Family

doctors use their best clinical judgment to decide whether to intervene. Sometimes, the choice is easy—send someone to the emergency department to prevent catastrophe, or give a "tincture of time," as my rural preceptor was so fond of saying, to wait watchfully for the disease to declare itself. Most often, patients fall in the mushy middle, which means trade-offs need to be accounted for, considering context, values, and desires.

As Dr McWhinney writes, "[patients] may have their diseases in common, but in their responses to disease, they are unique."[16] Where intervention is being contemplated for patients—and communities—we would do well to remember that any decision is a matter of careful balance that considers the present situation, rather than a constant, unidirectional sledgehammer.

Right decisions at the right time

Once the relationships, context, and trade-offs have been accounted for in diagnosis and intervention, one is left with the actual act of taking a decision. Making decisions is part and parcel of family practice. Write the prescription or do not. Make the referral or send the patient to the emergency department. These decisions are ideally nurtured within a doctor-patient relationship, which in turn is built on the foundation of previous decisions that have fomented trust. It is important to remember, though, that physicians are not called on to make just any decision. At any given time, we are called on to make the best decision that we can at that moment. The right decision, at the right time, for the right context.

As we are people of evidence and judges of the data before us, it can be daunting for doctors to make one decision only to reverse it at a later date in the face of a new situation or new information. But this happens every day. Medications are stopped and changed when they no longer serve their purpose; surgery that was not previously necessary becomes recommended as functional status changes.

Thus was it also with the pandemic response. Wending that middle path meant taking decisions that were appropriate for the moment. These would necessarily change with context: closures to stop uncontrolled spread in a susceptible population before vaccines were available, versus less stringent measures with a highly vaccinated population after several large waves of a no-longer-novel coronavirus.

Communicating this, however, was a supremely difficult task—much as it is, sometimes, to ask patients to change their behaviour. As the nature of risk from COVID-19 infection changed following the first Omicron wave, I told a colleague somewhat tongue-in-cheek that if I had not managed to frustrate everyone in every direction by the end of the response, I had not made the right choices at the right time. He replied that "Consistency is the refuge of a small mind," which, while blunt, served as an important reminder for me of our calling.

As physicians, we are called on to think and assess dynamically. Very little of what we do is ever on autopilot. For family doctors, that means being patient-centred and seeing the ever changing world through their patients' eyes, understanding what has changed internally and how that plays externally amid their relationships and context. To do this well, we must constantly monitor and, with each follow-up encounter, eschew shortcuts, assumptions, and archetypes. We must always be on the lookout for clues, overt and subtle, that might lead us to reconsider or reinforce our previous recommendations.

Returning to the extremes that I previously described, you can imagine my surprise when commentators who pushed for the measures at either end of the spectrum remained committed to their avowed positions even in the face of contrary evidence. In the early days, many who started from the position of "this virus and the measures to control it are overblown" would simply ignore the long list of tragedies from Manaus to Mumbai that acted as counterfactuals in warnings of what would happen here if we also got it wrong. In the later stages of the pandemic, the loosening of restrictions would see them argue that they had been right all along—without any acknowledgment that vaccines and decreased population susceptibility from previous waves had evolved the community's risk.

Notably, the same decisions to recalibrate measures in the face of changed risk would agitate zero-COVID commentators, who have doubled down against tolerating higher levels of transmission without an appreciation for that same evolution of risk.

To understand how one needs to make the right decision at the right time, however, consider how we might respond to another disaster. Imagine, again, a category 5 hurricane coming to an oceanside town ahead of its large annual festival. Those pushing for minimal intervention would recommend that the festival—and society—go ahead as normally as possible despite the storm; vulnerable citizens might consider staying home. Conversely, those pushing for elimination might argue for a total, permanent move of the town to another site altogether.

Reasonable people might agree that the best path forward would result in different decisions at different moments: cancel the festival and evacuate at the height of the storm, with an aim to help those at greatest risk, and then return to the town when weather patterns and the risk of bad weather have returned to manageable levels—and when reasonable adaptations can then be made.

In the pre-vaccine days, we locked down in the face of a new, unknown infectious threat to make contact tracing easier and to buy time—time to shore up health care capacity, learn more about the virus, pursue a vaccine, and teach the population about social distancing and masking. We also saved lives and our health care system by slowing spread and mitigating the cascade of severe cases.

This calculation was clearly different once we had gone through 5 waves and 90% were double dosed against severe disease; suddenly, infection did not hold the same spectre and so the approach changed.

This pandemic dance that unfolded in the community is thus not unfamiliar to family doctors; where necessary, we wean and stop medications or start them anew; we reduce follow-up visits, or refer where we notice things taking a turn for the worse. To that end, we must recall that it is not for physicians to determine a path and stick doggedly to it. Instead, it is for physicians to follow the path, step by step, examining the road before them and making the best decision for the moment based on a careful understanding of data, evidence, context, and the patient's perspective and values. Physicians should also remain open to revisiting these decisions as necessary, giving due consideration at points where things might be new or no longer exist.

Toward effective advocacy

In offering these reflections on relationships, context, trade-offs, and decision making, one common theme you will notice is how much emphasis I have placed on the opinions and perspectives that were shared by other physicians throughout the pandemic response.

To put it simply, I was surprised and disappointed by the extent of vitriol and disregard that emerged from many whom I considered colleagues, often done under the guise of advocacy. It is not clear to me whether this sort of advocacy was effective; amid a once-in-a-century health crisis, our own physician community was fractured by an extremely divisive discourse, which resulted in confusion among the public and policy makers.

In particular, there was a noticeable lack of respect for the specialty expertise of public health physicians. It seemed that many colleagues had forgotten that we were all fighting the same battle; instead of collegiality, the public health community faced barbs, contempt, and insinuations that we did not know what we were doing.

The most effective advocates among our physician colleagues—including family physicians, to wit—were those who did not forget the basic tenets of professionalism and collegiality. Those whom I was most open to working with reached out to public health nonconfrontationally and directly with humility and not hubris. These contributors empathized with the heavy loads that we were all carrying, recognizing that we were all faced with our own circle of hell. They presented their ideas kindly and with respect for our different perspectives arising from mandate and training. They approached us as partners, rather than screaming at us through the Twitterverse.

Now, I am cognizant that physicians of all stripes have faced this vitriol and harassment from the public and each other, as well. Yet, among colleagues, I now wonder how we heal that divide. How do we begin to repair our relationships? How do we reflect on what happened during the pandemic and commit to doing better as colleagues? How do we reconsider how physicians advocate, ensuring that we do so effectively, respectfully, and not at the expense of others, and with an understanding of the breadth and limits of our expertise?

I do not have the answers to these questions right now. But I do know that it is a new day, and that as a physician community as a whole, we must restore what was lost during COVID-19, so that we can better tackle the future challenges we will face together.

Virtual care as a tool

My final reflection on the lessons learned from the pandemic concerns the rise of virtual care. Never has it been clearer than during the COVID-19 pandemic that we might be able to harvest new tools to enhance the practice of family medicine.

As an example, virtual visits appear to be here to stay. We will need to determine how and where they fit into effective practice and what standard we should expect for such engagements.

Insofar as every organization is now figuring out what a hybrid work model looks like for them, family medicine will need to determine what needs to be seen and done in person and what can be done virtually, and by whom—family doctors themselves or the teams they work with.

Amid numerous solutions that did not talk to each other, we also saw the importance and value of digital integration. Do we need to pursue in Ontario what Nova Scotia did, and simply blow up the electronic medical record realm—moving to a single solution?[17] Might this even be considered across the country, so that there is a single digital source of truth for all of our patients' records?

This idea is not new. But the challenges of navigating so many different provincial systems for something as foundational as the COVID-19 vaccine, and the data analysis opportunities that a universal electronic medical record might provide in guiding health policy and health care system decisions—these were fully displayed amid both the successes and the clear challenges that we faced during the pandemic.

Dr McWhinney presciently wrote that "family medicine and psychiatry are … the only branches of medicine without a special instrumental technology," but then goes on to say that "not having an instrumental technology is liberating. It leaves us free to devote our time to our patients in their wholeness."[6] This is perhaps the only moment in this lecture where I might diverge slightly from Dr McWhinney's views.

As family medicine is in the business of relationships—the doctor-patient relationship above all—then in this day and age it is crucial to have wide-ranging, integrated digital solutions that support the cumulative profile of patients as they move through the health care system, and that also facilitate that movement as seamlessly as possible. Effective digital solutions need

to become our special instrumental technology—the special technology that would streamline practice and support Dr McWhinney's assertion that it is important to devote our time to our patients in their wholeness.

Closing thoughts

In its simplest telling, COVID-19 essentially presented us with a capsule summary of not only the challenges but also the solutions to the pressing problems of family medicine. We must always remember that we are treating patients within a complex set of relationships and an overarching context. We must guard against inertia, ensuring that we are making the best decisions we can while accounting for evolving circumstances.

Finally, to effectively tackle the system challenges in the future that will support the vocation of family medicine, it is essential to get collegiality and technology right; COVID-19 has shown us how getting it wrong is truly to our detriment.

We are fortunate in Canada that one of Dr McWhinney's legacies is a strong societal understanding of family medicine as the foundation of the health care system—and, while we face many challenges, I know that we are ultimately building on strength.

As I officially start my role at the College of Family Physicians of Canada, I invite you to let me know how you think we might continue to work together as colleagues and as a community. Let's ensure that Canadians will always think first and fondly of their family doctor as their primary contact for health care, even as they also contemplate health in its broadest sense around how we ultimately take care of each other in our communities.

That is the essence of the primary care business.

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Competing interests
None declared

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References

1. Freeman TR, editor. *McWhinney's textbook of family medicine*. 4th ed. New York, NY: Oxford University Press; 2016.
2. Gravlee CC. Systemic racism, chronic health inequities, and COVID-19: a syndemic in the making? *Am J Hum Biol* 2020;32(5):e23482. Epub 2020 Aug 4.
3. Segal J. Why don't we fund more prevention? [blog]. *Social Finance* 2019 Oct 24. Available from: **https://socialfinance.org/blog/why-dont-we-fund-more-prevention/**. Accessed 2022 Sep 14.
4. Feagin J, Bennefield Z. Systemic racism and U.S. health care. *Soc Sci Med* 2014;103:7-14.
5. Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Health* 2017;2(8):e356-66. Epub 2017 Jul 31.
6. McWhinney IR. *A call to heal. Reflections on a life in family medicine*. Regina, SK: Benchmark Press; 2012.
7. Lau B. *Indolence and disinterestedness. Re: Keats's 14 February–3 May 1819 letter to George and Georgiana Keats*. The Keats Letters Project; 2019. Available from: **http://keatslettersproject.com/correspondence/indolence-and-disinterestedness/**. Accessed 2022 Oct 16.
8. *Canada-United States relations*. Ottawa, ON: Government of Canada; 2022. Available from: **https://www.international.gc.ca/country-pays/us-eu/relations.aspx?lang=eng**. Accessed 2022 Sep 15.
9. *Arriving and departing air passenger movement numbers in NZ, 1 January–December 2020* [information release]. Wellington, NZ: New Zealand Customs Service; 2021. Available from: **https://www.customs.govt.nz/globalassets/documents/oia/air-pax-movements-1-jan-until-31-dec-2020.pdf**. Accessed 2022 Sep 15.
10. Shrestha SS, Kompaniyets L, Grosse SD, Harris AM, Baggs J, Sircar K, et al. Estimation of coronavirus disease 2019 hospitalization costs from a large electronic administrative discharge database, March 2020–July 2021. *Open Forum Infect Dis* 2021;8(12):ofab561.
11. Josefsson KW. Perspectives of life in Sweden during the COVID-19 pandemic. *J Clin Sport Psychol* 2021;15(1):80-6.
12. Adams J, MacKenzie MJ, Amegah AK, Ezeh A, Gadanya MA, Omigbodun A, et al. The conundrum of low COVID-19 mortality burden in sub-Saharan Africa: myth or reality? *Glob Health Sci Pract* 2021;9(3):433-43.
13. Llupià A, Rodríguez-Giralt I, Fité A, Álamo L, de la Torre L, Ana Redondo A, et al. *What is a zero-COVID strategy and how can it help us minimise the impact of the pandemic? COVID-19 & response strategy #26.* Barcelona, Spain: Barcelona Institute for Global Health (ISGlobal); 2020. Available from: **https://www.isglobal.org/en_GB/-/que-es-una-estrategia-de-covid-cero-y-como-puede-ayudarnos-a-minimizar-el-impacto-de-la-pandemia-**. Accessed 2022 Sep 15.
14. *Great Barrington Declaration* [website]. Great Barrington, MA: Great Barrington Declaration; 2022. Available from: **https://gbdeclaration.org/**. Accessed 2022 Sep 15.
15. Shriner SA, Ellis JW, Root JJ, Roug A, Stopak SR, Wiscomb GW, et al. SARS-CoV-2 exposure in escaped mink, Utah, USA. *Emerg Infect Dis* 2021;27(3):988-90.
16. McWhinney IR. The evolution of clinical method. In: Stewart M, Brown JB, Weston W, McWhinney IR, McWilliam CL, Freeman T. *Patient-centered medicine. Transforming the clinical method*. 3rd ed. Boca Raton, FL: CRC Press; 2013.
17. One Person One Record project moves to next phase [news release]. Halifax, NS: Government of Nova Scotia; 2016. Available from: **https://novascotia.ca/news/release/?id=20161206001**. Accessed 2022 Sep 15.

Can Fam Physician 2022;68:874-9. DOI: 10.46747/cfp.6812874