# THE MEDICAL PROFESSION AND THE REACTIVATION OF THE PANDEMIC IN SPAIN

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***REPORT #10 CA-COVID-19-OMC regarding THE MEDICAL PROFESSION AND THE REACTIVATION OF THE PANDEMIC IN SPAIN***

## EXECUTIVE SUMMARY

**The second pandemic wave confirms the lack of control of the pandemic in Spain**; evidence that impacts society, the economy, and health, causing disappointment, damage, demoralization, and tension. The prestige and legitimacy capital of doctors and other health professionals must be put at the service of overcoming the deep and complex crisis we are facing. A common strategy is needed, and everyone must contribute to its achievement. For this, a **series of barriers must be overcome**: knowledge gaps, imperfect institutional frameworks, a tense political climate, and an unstable and inconsistent social awareness.

When it rains, it pours in medical care: where there is community transmission, Primary Care is saturated and collapsing; hospitals also lose the capacity to care for non-COVID patients. The morale of healthcare workers is declining. It is possible that the National Health System will not emerge unscathed from the pandemic unless many things are done quickly and well to correct the current course.

The **strengthening of Public Health** has been uneven, and a little discouraging; lack of confidence has led to the summer lethargy of necessary active reinforcement initiatives. There is no good information on tracers or their activity. However, everything seems to indicate that the ability to trace infection chains is very small. Although, there are differences between Autonomous Communities in this regard. The increased availability and types of diagnostic tests are good news. However, its misuse in population screenings promoted by political authorities due to disinformation or image campaigns is not. Only when tests are indicated based on a prior clinical or public health judgment can it be guaranteed that they are effective instruments to combat COVID-19.

So that **non-COVID patients do not continue to be "de-prioritized"**, reinforcement measures need to be included in strategies and contingency plans to address the delays that are accumulating for new patients, and in the management and review of patients with chronic conditions or in their treatment. And also measures to address the **sequelae and mental health issues** that COVID-19 is causing and that will affect many people.

**The social conscience is disoriented and tired faced with the new phase of the pandemic**; the messages from public health arrive badly; political tension produces an adverse climate to generate trust and adherence; the scientific world sometimes does not help with the premature creation of expectations with preliminary and immature research, and the media and social networks generally amplify the existing confusion and irritation and color it with sensationalism and excess.

This situation invites and forces the medical profession to take a step forward in informing patients and citizens.

The medical profession must act on several levels.

- Promote **better organization** of the fight against the pandemic: provide clarity to the action criteria of the authorities, and promote improvements in the legal framework that supports public health decisions.
- Insist on the **importance of implementing measures in which there is consensus, but not enough action**: epidemiological surveillance ("tracing" included) and the strengthening of Primary Care are two clear sources of problems due to the omission of necessary actions.
- **Direct messages to the population**, to use the profession's capital of prestige and legitimacy for behavior changes that facilitate the control of the pandemic, reduce health damage and reduce the social cost. And also combat COVID-19 deniers and/or its effects, especially when they come from health personnel.

Generate messages to the population that show a **tolerant and open attitude**, seeking **cooperation with other health professions** to enhance the discourse.

The following elements should be incorporated in its **contents**: change the story to contribute to **social cohesion** (leave no one behind); not leaving **non-COVID-patients** behind; give a longer time perspective for the population to prepare for a **long-distance race**; advocate for **economic support** of businesses and families affected by the confinement and closure measures; explain that the **most effective and efficient way to control pandemics is through "social treatment" rather than a clinical approach**, to give relevance to the **individual contribution in protecting themselves and others**; convey a realistic but positive message about the **possibilities and limitations** of science and technology, denouncing sensationalism and the generation of false expectations.

This more direct approach from the Spanish General Medical Council to patients and citizens should **recruit the synchronized and harmonized action of the 52 Local Medical Associations**, and be projected to the media and social networks, with clear and repeated messages that help to change the vision and attitude of the population and patients toward COVID-19.

# 1. How do we define the current situation from a pandemic control viewpoint?

## The effects of the second wave.

In Spain, **COVID-19 is not under control.** The second summer wave, which began in July, clearly, and negatively, differentiates us from the rest of the European countries, whose current growth may herald the expected autumn-winter expansion. There is a lot of uncertainty about how the pandemic will evolve, which contrasts with the expectations that had been generated in society after the lack of confidence, both in terms of controllability via public or clinical health, and early access to effective vaccines.

**The marked difference that has existed in the past two months between Europe and Spain is a fact that raises questions about the underlying reasons, and the possible failures in the actions carried out.** Evaluation and research in Public Health and Health Services should respond to these questions as soon as possible to reorient policies.

**The Spanish population is tired** after many months of suffering from the pandemic. It is also disconcerted: an avalanche of data that is difficult to interpret, a lot of news, often sensational, and little appropriate and internalized information. As a result, a **catastrophic perception prevails in the collective, although certain groups feel safe** and have reckless or trivial attitudes in the face of the serious health problem we face.

These months have allowed better knowledge and better clinical management. The most specific epidemiological control measures have inconsistently begun to be generalized. Today, we have a larger buffer for hospitalization and intensive care compared to the first wave, although Primary Care is overwhelmed and saturated. **We know more about what should be done; but the application is fragmented, incomplete, and uncoordinated. And the morale, energy, confidence, and patience of health professionals and workers has clearly deteriorated.**

Looking back, we must confirm that **the measures always lagged behind the epidemic** (and not ahead). There is a part that can be explained by **deficits in knowledge** in the face of an emerging virus, which would justify some "trial and error"; however, much of the general knowledge accumulated on the management of pandemics (or epidemics due to SARS or MERS) could have better oriented the actions. Scientific and professional consensus has not been easy due to the **low weight of the public health perspective**, and the emergence of extravagant and denialist opinions without scientific or rational support that have been amplified by the media and networks.

The **delay in taking action has been clearly influenced by the authorities' fear that they might not be understood**; in situations of intense political rivalry, the vulnerability of the decision-maker is very high and causes suppression and delay. The capital of authority and trust needed to make unpopular decisions is very high. It must be accumulated prior to crises and be consolidated in regulatory frameworks, institutional structures, governance mechanisms, and expert advice, which can be activated when crises are triggered.

## The need for a common strategy.

It is clear that a **strategy** is needed (at the international, European, and Spanish levels) to deal with the pandemic control from a longer-term perspective, **which will possibly include the whole of 2021**.

**The strategy must overcome a series of barriers**: knowledge gaps, imperfect institutional frameworks, a tense political climate, and an unstable and inconsistent social awareness.

- An essential part of the difficulties in designing this effective strategy against COVID-19 stems from the significant **knowledge gaps** about an emerging disease. Gaps that are not just virology or clinical; every pandemic is complex due to the interaction between a wide number and range of factors that determine its spread, the actors involved, and the range of knowledge and skills that must be mobilized to address appropriate responses
- Another dimension that has complicated the establishment of strategies has undoubtedly been the **institutional framework**. Since its construction since 2002, the National Health System has been losing capacities for collective action, which has particularly affected public health. Previous pandemic warnings led to the proposition of regulatory changes (General Public Health Law 33/2011); however, these were practically not implemented. In this second wave, the Autonomous Communities have been affected differently, feeding the divergence of visions and positions.
- **The political climate has not made it possible to compensate for institutional deficits.** On the contrary: electoral and budgetary turmoil may have created additional difficulties for the needed cooperation. COVID-19 has also complicated the challenge by creating a **dilemma between health and economy**; in the first wave it became clear that health was a precondition for the economy: in the second this duality began to dismantle due to the growing economic cost and the difficulty of maintaining solidarity and social cohesion when the damage to collective well-being is very large. Only a virtuous policy, with broad national consensus, and with good institutional governance (technical capacity), would allow management of the two levers of health and the economy; in its absence, “politics” (political confrontation) can become part of the problem and not part of the solution.

- Finally, **social conscience** is what gives legitimacy to a strategy since it determines its real feasibility. And this has been particularly put to the test after the lack of confidence, and more so with the recurrence of this second wave. **Risk perception** is essential, and young people adhere to the story that dominated the first wave—that this was a problem affecting older people or people with many diseases. In the second wave came the additional **concern of business people and workers** who saw their businesses and livelihoods in danger, which feeds an energetic rejection of the measures that cool the economy. Instead of pressing for aid that avoids or compensates for activity closures, the pressure is transferred to blocking regulations that interfere with and limit their activity. It is possible that this second wave of COVID-19 is making us worse off as citizens.

## Open mind and outlook to understand COVID-19, its causes, and consequences.

There has been a lot of short-sightedness in the response to COVID-19 and also tunnel-vision (some look at the economy and others at health): the appearance of this pandemic is connected in its **origins** with social, economic, environmental, mobility, and manufacturing globalization problems; its consequences also test the solvency of health systems and reveal the atrophy of Public Health, the growing de-prioritization of Primary Care, and the minimal buffer capacity in the hospital service.

Despite the austerity and cuts in Spain, we have a good public health system, which contrasts with other very underdeveloped welfare services, evidenced in the discovery of the weakness in resource funding for nursing homes. But we must also assume that we have a country with **greater social inequalities and situations of poverty and social exclusion** than Europe, which are shown in the greater vulnerability to disease risks and lower capacity to respond to **confinement, isolation, or quarantine requirements.**

It seems to be forgotten that the control of an epidemic depends much more on the social sphere than on the clinical one.

A positive and promising aspect lies in the progressive change in **professional awareness in favor of reforms**: it is evident that the succession of reactive measures is exhausted and that the patches must give way to broader and more systemic approaches.

But, perhaps **it would be a mistake to delay the reforms in the National Health System until the pandemic is finished**. We should not wait for the end of the "acute" situation we currently face to launch the needed analyzes and strategic actions, as there are two important risks: a) that the urgent short-term measures are contradictory or even opposed to the strategy of substantive change, and b) that by letting the acute situation pass, the decision-makers “forget” about the structural problems and return to the previous situation of false self-complacency.

## 2. How is the situation of medical services in the face of increased demand for consultations, hospitalization, and intensive care?

The indicators of resources used by COVID-19 patients prove very important to determine confinement actions and economic and social activity restrictions. Given its repercussion, it would be convenient for the **derived data and indicators to be valid, homogeneous, and unequivocally defined**.

The health system's response to COVID-19 continues to be reactive, rather than proactive. However, compared to the first wave, **centers are better prepared**, particularly in the material means necessary to protect themselves, diagnose and care for patients.

In adapting to the second wave, **Primary Care and Public Health** have been clearly overwhelmed in those places where community transmission has reappeared. There are no reliable data on the number of **tracers**, the typology of these figures, or their activity. However, many testimonies from Primary Care denounce **the lack of diligent activation of the necessary follow-up of cases and close contacts**.

**Primary Care** is directly experiencing the impact of this expansion phase of the pandemic. In many Autonomous Communities, it seems that the **reinforcement of personnel has been poor or non-existent**. Consistent efforts for effective communication with the population and with all health professionals are necessary so that they value Primary Care and its essential role in controlling the epidemic. **Hospitals** are better prepared now than in March, both in terms of material supplies, and in the organization of care networks, as well as in the provision of contingency plans that allow a faster and more efficient response. There also seems to be a more fluid and effective relationship between managers and clinicians, which would have reduced the feeling of improvisation and lack of coordination of the first wave.

Although with some differences, **intensive care** is overloaded, and some are overwhelmed. The plans for elasticity and occupation of new spaces in the ICU exist but are still not very mature. In addition, they have their weakness in the lack of trained professionals to care for critical patients.

The main challenge for the hospital network is **to combine care for the new batch of "COVID patients" with acute patients** seeking care (and whose demand does not seem to be blocked as it was in March-April). Moreover, the accumulated demand (formalized and those not on waiting lists) continues to increase and represents an incremental problem that is difficult to solve.

In general, in the medical care network, "**when it rains it pours**". **Stress accumulates in de-capitalized and demoralized services**, pointing to the risk that the intensity of the deterioration of services and professionals in the medium term may deepen. The **National Health System will not emerge unscathed from the pandemic** unless decisive action is taken to prevent it. Spanish society must know that its best welfare service is at risk of deterioration and decline.

## 3. Are there quantitative and qualitative improvements in the public health services response of the Autonomous Communities for the control of outbreaks and case and contract tracing?

It is clear that **there have been improvements in public health services** to develop specific epidemiological surveillance tasks such as case and contact tracing. In relation to the first wave, all health services have launched initiatives with at least organizational tweaks and one-off reinforcement. However, if we consider the harsh reality, it does not seem that these actions have been decisive in avoiding this second wave with community transmission that is forcing non-specific measures (mobility, confinement, reduction of capacity, closure or limitation of sectors and activities...).

From this perspective, it could be said that the **improvements have been made, but they were not sufficient and came late**, and these have been very heterogeneous among Autonomous Communities. At some point, the regional health authorities will have to account for the diligence, commitment, and adequacy of their responses to this crisis.

The general insufficiency of the responses was somewhat to be expected because the underdevelopment of regional public health was broad and deep and difficult to remedy in a four-month period. Predictable, but not acceptable or justifiable, because evidence and experience had already accumulated to indicate that the most effective way to control COVID was through specific and vigorous action to detect cases and control the transmission chains early. **The removal of confinement in summer was accompanied by a false impression of control, which resulted in many initiatives to actively reinforce Public Health devices falling into lethargy.**

**But the story is diverse and heterogeneous**; not all Autonomous Communities have acted in a similar way; some have been able to further strengthen their human resources, capacities, information systems, or coordination with Primary Care... A good base that can endure as long as transmission does not skyrocket, and which, in any case, represents an investment to slow any spread, so that if there is an increase in spread, recovering a balance in the control of the infection chains is easier.

One positive development has been the **greater availability of diagnostic tests**, essential for detecting cases and launching outbreak investigations and the tasks of tracing and managing isolation and confinement.

But the **inappropriate use of the "tests" for screening large populations** has spread; political leaders, with the frequent silence of their health authorities, tend to use them as a one-off initiative to show interest and commitment in their fight against the pandemic. However, **what makes a test effective is the clinical or public health judgment that indicates it.** PCR or antigen screening of the general population (low prevalence) not only involves an inappropriate use of resources, which are more needed for other actions, but also creates a flow of false positives that will increase the workload of the healthcare system.

Even worse if tests are scarce and diverted from use in clinical or public health to be used in dubious population screening. **The greater availability of tests does not always mean that their results are available quickly** or that healthcare providers can trigger the necessary actions in the face of a positive result. **The bottleneck is particularly intense in Primary Care**, where the lack of professional time and incremental resources is experienced with increasing anxiety to assume the tasks after the appearance of a positive COVID-19.

Finally, there has been a lack of capacity to link research and action. It has not been possible to thoroughly investigate the outbreaks of COVID-19 to adequately trace the origin of the infections and the chains of transmission, which would have allowed the adjustment of preventive measures.

## 4. How can we describe the situation of non-COVID patients with check-ups, procedures, or interventions pending and with accumulated delays?

The second wave and the prospect of COVID-19 extending over time increase the **concern regarding the care of non-COVID patients**. The Spanish public health system has a fairly tight balance of resources, at least in comparison with other countries in our environment, so there is little room for movement in medical care for the pandemic without causing a decrease in the assistance to other patients or to the other diseases.

In the **first epidemic phase, there was a quick and expeditious adjustment**. In the areas with the highest incidence, health centers and many hospitals became in practice "monographic-COVID". An important adaptation altered the care capacity throughout the network: the suspension of scheduled surgeries, the transformation of anesthesiology posts to critical care, the enabling of hospital areas to expand hospitalization or intermediate care, and the reallocation of personnel, including the recruitment of professionals to care for patients outside their usual field of specialization or practice.

Hospital doctors were surprised at how **the general demand for medical care shrunk in this exceptional situation**. There are important reflections on the reduction of a part of medical care activity that adds little value or that can be done in another way (rationalize check-ups, use of teleconsultations, etc.); and questions were also raised about the apparent reduction in the presentation of critically ill and urgent patients.

In any case, the first wave brought a temporary reduction in demand that generated **unattended and bottled up needs**; these needs would be expressed within a short period of time in the form of a waiting list for consultations, procedures, and surgery.

**The second wave**, and the possibility that it will link with a **possible third autumn-winter wave**, changes the panorama, as there is no new normal in which to clear up the backlog. In the probable situation where COVID-19 periodically overloads but does not collapse the care capacity during a four-month period, strategies will have to be in place to take on the following:

- The burden of health problems and **patients whose care was postponed**.
- **Non-COVID patients and diseases**, which can be aggravated by the reduction in the diagnosis of new illnesses and by the inappropriate follow-up of chronic patients ("*pandemic of chronicity*")
- And the **repercussions of the pandemic** in the form of **sequelae** in patients and **mental health problems** caused by the disease itself, or by the related family, social and economic suffering.

It is clear that **the non-prioritization of these patients implies a de facto de-prioritization**; unattended needs will not be fully visible, but they will not cease to exist or collect a morbi-mortality fee. **Elective surgery** will be the visible tip of the iceberg, but, even in this, a part will not appear because the referral will be inhibited, or the indication itself will be reduced due to delays in diagnosis or adjustment in the indication criteria.

The preparation of these initiatives for non-COVID patients must take into account the great **heterogeneity of situations**. The pandemic does not affect all populations in the same way, nor does it "kidnap" care resources equally (including the various specializations and services). In addition, we have to see it as a dynamic process, where it will go through times of increased saturation, and others where the pressure can be relieved much more.

The effect on **Primary Care** is particularly worrying, as the attribute of **longitudinality** is strongly affected. In addition, the bureaucratic overload has not only not abated but seems to have flourished (the queue for administrative procedures often exceeds that of the query).

**The effect in Hospitals will be cumulative** and will add pressure in the centers, overloading professionals and complexity to clinical judgment: consultations, elective surgery, orthopedics, oncology, pain unit, subacute patients, check-ups, etc... And having to combine COVID patients and non-COVID with parallel circuits supposes a reduction of the real assistance capacity.

For all these reasons, it would be convenient to **re-prioritize non-COVID assistance, making it visible on the radar of contingency strategies and plans**, and implementing the necessary reinforcement of resources and the optimization of processes in order to minimize the impact of the overload of the pandemic in other patients and diseases.

## 5. How has the population awareness and political and social climate evolved compared to the first pandemic wave?

Compared to the first wave, it seems that there is a **worsening of social awareness in the face of the pandemic**: it has changed from the applause during total confinement to a growing irritation of the population at the inability to return to daily life. As expected, adherence to health-protective behaviors is more complex and difficult with the "new normal", and **commitment weakens with the passing of months and the lack of a credible time period for solving the problem**, for which dose efforts and crystallize expectations.

But these expected difficulties are complicated by **changing and contradictory messages.** Even the most correct and evidence-backed actions fail to arouse trust, nor do they create a climate of security. The **communication challenge** for Public Health is enormous, and the results seem poor.

However, something may be beginning to change as the second wave unfolds. A long-term dimension is being assumed, and many are changing their attitude toward a more sustained effort (long-distance running). But this effort suffers from inconsistencies and biases as it can prioritize some measures (masks in public places) and disregard or undervalue others (distance in family and social environments). The absolute prioritization of masks or, in the first epidemic phase, of the use of gloves over hand hygiene, which is the most effective method both in the case of airborne and contact-borne diseases, is striking.

In addition, it could be said that much of the “personal” fear has been lost, with the belief that the virus is less contagious and harmful. However, at the same time **the fear is increasing that COVID will take us away from the productive and social life that we long for**, and on which our well-being depends. This is the substrate that increases the unpairing of health and economy.

To improve awareness and behavioral change in the population, it would be essential to work on creating and consolidating a homogeneous body of scientific doctrine, which can be systematically and coherently transmitted to society. Within this reflection, adequate information management is essential, considering **the measures and messages to the population**. Activities with a high risk of transmission are often ignored or not emphasized. In contrast, others with low or no risk are insisted on. The hierarchy of recommended measures and the insistence on the messages are essential to order and make the information adequate for the population.

But, just as important as the above would be creating **an appropriate political climate**. The partisan and institutional struggle, or the litigation culture of decisions are going in a direction that is clearly contrary to what is needed and tends to contaminate the relationship and dialog within the scientific and

professional world, widening differences, and increasing hostility and rivalry.

A **toxic combination of political rivalry, ideological fanaticism, and commercial opportunism** is found in the **denialist undercurrents**, the proposals for pseudo-therapies, or the anti-exemplary conduct of public figures who ignore protection measures or advise outlandish or non-validated therapeutic measures.

On another level, the **tendency of the scientific world to anticipate rigorous trials** by publishing advances that create unfounded expectations does not help either; commercial interest, vanity or the gain of reputation, however ephemeral, are fueling **a spiral of trivialization of research**, which results in the discredit of critical thinking and good science.

The problems mentioned above are amplified by the **media** that often distort the perception of reality through **sensationalism or partisan affiliation**, making it difficult for citizens to be aware, eroding their confidence in the measures that can protect them. On the other hand, the **news from Madrid**, a particular vortex of tension among political agents, tends to spread a conflictive image to the rest of Spain, which is a clear exaggeration and distortion of reality. Social networks cooperate effectively in amplifying flashy and provocative speeches and fueling hostility and mistrust.

We have to stop the growing feelings of detachment, estrangement from self-responsibility, relaxation of behaviors, and search for ways to blame others. We also highlight the **inconsistencies in behavior patterns**, which are causing a clear **underestimation of the risks of transmission "indoors" of small family or social groups**.

To compensate for the distrust in the health authorities, **the scientific and professional world should take a step forward** and speak directly to the community, with clear, positive messages that generate adherence based on the authority and legitimacy that scientific medicine has today.

But we must be cautious: we have witnessed a disruptive incursion of experts in the media and of groups of scientists and professionals who have raised their voices in the media and social networks to launch **messages and proposals that are controversial, sensationalist, immature, or with little evidence, circumventing the usual channels where positions are generated, disseminated, discussed, and concreted.** To avoid adding more noise and confusion and mitigate the deterioration of the credibility of science, it is essential to channel positioning statements through a balanced, solvent advisory structure that is a regular reference for the media and the public.

Furthermore, it would be convenient for the **public powers to mitigate the serious and specific economic consequences produced by the measures of confinement and control of social interaction**;

the tension and desperation of companies and workers in the face of the financial and income disaster should be reduced as much as possible, so that the health and economic levers do not block each other.

## 6. What messages should the medical profession disseminate as positioning statements regarding the current scenario that demonstrate worry and indicate action priorities?

There are a wide range of measures that are known, that have been experimented with, and that have been consolidating an arsenal to control COVID-19. Unlike the first wave, the problem has more to do with the effective organization and implementation of actions in this second wave.

### Improving the organizational framework

Among the organizational aspects, it is necessary to point out the need **to have clear and as explicit as possible criteria** to deal with very different and changing epidemic situations in the various regions. A highly decentralized institutional structure can be fuel for permanent disagreement between authorities, fueled by the dominant political rivalry. Knowing who should make each decision, and the criteria for introducing measures of different intensity to control the pandemic, will undoubtedly help political and institutional actors to focus on their difficult task and abandon the easy recourse to endorse responsibilities to third parties.

An important aspect is the **legal framework to support decisions** that imply a limitation of citizens' freedoms. At this point, it would also be advisable to create a legal framework, or a clear interpretation of the current regulations, which would avoid uncertainty and conflict between the decisions of different powers of the State.

### Move to effective implementation.

In addition to organizational problems, we face **decisive implementation challenges**; fundamentally, in all the actions that cannot be done via regulation with the simple publication of a rule in the Official Gazette.

The health authorities know very well by now that it is necessary to create an effective **epidemiological surveillance** system, with resources and

skills for case detection, tracing and monitoring of cases and close contacts, studying outbreaks, and creating the means for cases and contacts to comply with isolation and quarantine (especially when their environment or economic and employment situation make them impracticable).

They also know that **Primary Care** is overwhelmed and needs reinforcements. It must be made more attractive to retain and incorporate professional capital. Administrative tasks must be facilitated and permit broad and effective delegation to free up clinical care time. Finally, it is necessary to **connect the Public Health system with Primary Care** to offload the functions of epidemiological surveillance and take advantage of the capillarity of Primary Care and its proximity to patients and their families.

The list of tasks that require resources, effort, and talent to implement could be very long. Nonetheless, **it is about taking action, abandoning hollow speeches, games of indicators, and the more or less ingenious tricks of the press office.**

The need to improve implementation also leads to questions regarding the causes of its deficiency: What is the cause? Lack of professionals, financial resources, facilities, political will, or other barriers? Perhaps these questions connect with a broader theme, such as the **crisis of governance in public institutions**, which guides us to pursue alternatives for reforming our organizations so that they can act with greater enforcement, alleviating administrative restrictions, and mitigating the costs of interference and influence, both bureaucratic and political.

## The medical professional directly informing patients and citizens.

Along with this message focused on the organization and implementation of well-known and recommended actions, the **medical profession** must also take on a new task: **directly informing the population to compensate for the deterioration of credibility** that the confusing and changing messages of political and institutional leaders.

**Recruiting citizens to be active agents in the fight against the spread of COVID-19** is an essential task to which the medical profession, and other health professions, can contribute significantly. It is necessary to incorporate popular characters in the media and social networks ("*influencers*") who can act by amplifying and adapting the messages for various age and social groups.

In this sense, the great task lies in connecting directly with citizens and patients to **mobilize the prestige capital of medicine and other**

**health professions** to change the vision and behavior of the population and social actors.

**How should these messages be?**

- **A tolerant and open attitude** is required to remove itself from political tensions and express itself with positive and action-oriented messages, avoiding recriminatory tones about what should have been done or who was responsible. This style helps focus attention on what needs to be done and appeals to the possibility that each individual, group, or institution has to collaborate for the common goal of controlling the pandemic.

- **Cooperation with other professions** is another essential aspect because **forces are joined, and it increases legitimacy**. And by unifying messages and avoiding contradictory or divergent discourses, social pedagogy is strengthened. More than ever, it is necessary to **avoid airing aspects of rivalry and inter-professional conflicts**. It is not coherent to ask for unity from political and institutional agents while taking advantage of the crisis to slip proposals or messages belonging to each profession to increase its scope of competence.

**What content should prevail in this reinforced communication of health professions to patients and citizens?**

- It is important to work to **change the narrative and contribute to improving social cohesion**. The view has spread that the first wave was a matter of "*older people*" while the second wave is a matter of "*poor and immigrants*". For reasons of professional ethics and humanity, we must make it clear that "***no one can be left behind***". It is not acceptable that a percentage of the population can be neglected or de-prioritized for the benefit of economic reactivation. Suppose the ethical and solidarity arguments are not enough. In that case, they must be reinforced with those of self-interest. If embers of COVID remain, the haystack can periodically catch fire again and affect society as a whole—its health and its economy. As in the first wave, health continues to be a precondition for economic and social development.

- "**Non-COVID patients**" must enter the conversation; precisely because no one can be left behind, and the usual patients and pathologies have worsened with the saturation and de-scheduling of consultations, procedures and

interventions. We must make the population and social agents aware that COVID strategies must include healthcare reactivation elements for all patients and pathologies, particularly those that accumulate risks and seriousness.

- We must also contribute to **changing the time perspective**: we have inherited a certain vaccine optimism, which led us to believe that in December or in the first months of 2021, we would have an effective and available tool for total victory over COVID-19, which would allow a return to the "old normal". The collective conscience must prepare for a **long-distance race** and do so with resilience and **confidence** that we have public health and health care measures that can help us cross the desert. In addition, the availability of the vaccine alone is a part of a more global solution, in any epidemic the vaccine has to be reinforced with other measures.

- And, in this broader time perspective, the **suffering of the country's productive fabric** is going to require support to avoid serious damage and a large number of families experiencing an unbearable loss of income. **For health and economy to cohabit and complement each other**, public authorities must articulate **intelligent, committed, and effective responses to maintain jobs and income.** And this should also be part of the discourse of the health professions.

- But we cannot be naive. The ability to finance sectors or companies in crisis due to the pandemic and confinement measures, limitations and closures, supposes an increase in debt and a cost that will be weighed in the coming years. However, **the cost can be greatly alleviated**, with **good implementation of effective measures** by health authorities and **active contribution by citizens to protect themselves and others** from transmission. And this is a central argument to gain the adherence of all.

- Complementing the previous message, it should be made clear that **the most effective control in pandemics is done by combining the clinical approach with a preferential social approach**. This affirmation contradicts the dominant technological fascination, and is not easily assumable because it includes accepting unpleasant restrictions and contributing an important individual effort, whose benefits are dissipated in a general picture distant to the nearby experience of individuals. But as difficult as this task is, it is essential to do it, and the capital of trust that medicine and other health professions arouse must be invested in changing the

Perspective. Moreover, we must **give prestige to Public Health actions as the most effective and those that contribute the most social efficiency.**

- It is also important to convey a **realistic message about the possibilities of science and technology**: knowledge and medicine have limitations but also lead to good possibilities if work is done seriously and rigorously. In addition, provide clear signals contrary to spectacular alternatives, investigations and immature interventions that generate false expectations and real businesses, and the whole court of pseudo-therapies or outlandish therapies that take advantage of the confusion to thrive. **Giving prestige to good scientific medicine is essential. Moreover, feeding the population's critical thinking is an investment in the future.** Investing in quality research creates the necessary substrate for it to germinate.

- Finally, the contents of the messages from the profession to the public **should not enter into open controversy with the health authorities** because it is in everyone's interest to restore a level of trust in the institutions. It should also be recognized that expert knowledge is necessary but not sufficient as collective decisions are forged by considering the many vectors that influence them. One can and must contribute and try to influence decisions from the perspective of medical and health professionalism. At the same time, means should be sought so that we do not undermine the meager trust that currently exists. **To this end, it would be essential for the health authorities to have flexible and permanent channels for participation and open consultation.**

**How do we carry out this new direct approach of the health professional world to patients and citizens?**

- **A systematic, articulated and reiterated campaign** should be created. In the case of the Local Medical Associations, they could be messages from the **52 Associations** that periodically (every week?) were transferred to the general and local media.

- These periodic messages should be replicated and flood the **social networks**. A good part of the population receives their information and positioning through these media and we cannot abandon this communication space.

- And, finally, we must appeal to doctors and other health professionals so that they reinforce and personalize these messages when **providing medical care**. The **clinical dialog and the Doctor-Patient**

**Relationship** provide enormous strength in the recommendations that we should use.