After COVID-19, business as usual: is this the right goal?

Roderick J McClure

At a personal and public level, the world is experiencing true devastation. In homes, hospitals, streets and societies, loss is profound. Public health, and what it means in terms of individual and collective responsibility, is forefront in public and political discourse. Expertise (and science) is being recognised as friend not foe, and the technical tools used by public health scientists and practitioners are standard fare in the lay press.

So, what happens next? It is hard to know, and many of us are needing to focus so much on survival that we don’t have the luxury to think about it. However, many of us are hoping that soon things will return to ‘normal’ and that we can again get about our business as usual.

The business world has been quick to point out that whatever we get back to, it will not be business as usual as we currently know it. People will adapt practices to mitigate day-to-day threats of endemic disease, and the structural changes brought about as an acute phase response will become system-level enablers with long-term benefit for national and global economies in ways totally unconnected to the threat of COVID-19.

I am wondering if health practitioners have been thinking so adaptively or have the long-term future of our healthcare system currently in mind. Our healthcare industry is well used to dealing with acute crises. In health, sudden surges in quantity or severity of cases, with consequent frenetic activity, are followed by time to tidy up, replenish stocks and get ready for the next surge. This is the life of Emergency Medicine all the world over and has been for many years. Indeed, it is the life of medicine more generally; that is, wait until a condition develops, diagnose it, treat, close the book on that one and move on to treating the next. Public health is a little better in terms of systemic preparedness and prevention, but as shown by the COVID-19 crisis, it is revealing how much our conversation focuses on vaccine as the cure. The risk for health is that once the COVID-19 pandemic has moved on, we slip back to our business as usual, into health systems not be much changed by the experiences in which we have all invested so heavily.

What does this mean for Injury Prevention in the time of COVID-19 and beyond? If the manuscripts in this issue are an indication, injury prevention is already on the front foot. Success of any COVID-19 induced behaviour change depends on the strength of evidence on which these changes are based. Let’s consider the two methods papers published in this issue of Injury Prevention by Dr David C Schwebel and colleagues to illustrate the point.

Perhaps the most obvious adaptation to COVID-19 isolation measures has been the shift to online modes of worker engagement and online methods of service delivery. This isolation-by-virus is simply a special case of the more general isolation-by-circumstance that includes geographical (rural populations) and economic (price sensitive availability) components. In Study protocol: a randomised non-inferiority trial using interactive virtual presence to remotely assist parents with child restraint installations, Schwebel and colleagues note that probably only 5% of child restraints on roadways in Florida are installed with expert technical support, and that children are at increased risk of injury as a result. Using a rigorous non-inferiority trial, with large sample size, the authors describe an approach to testing the effectiveness an interactive, mixed reality mode, expert supported intervention for fitting of child restraints in vehicles of people where the expert and fitting is independent of the geographical location of either.

The second of the methods papers by Schwebel and colleagues anticipates another issue that has been highlighted by the COVID-19 crisis: the extent to which we have been using only a limited part the tremendous capacity of the technologies we use every day. In Using Bluetooth beacon technology to reduce distracted pedestrian behaviour: a cross-over trial study protocol, the authors identify the risk of technology-distracted pedestrians. They describe a rigorous cross-over trial to evaluate the effect of electronic beacons at traffic intersections that trigger messages in the smartphones of pedestrians approaching the intersection when distracted by their phones. A simple technological solution to a technologically caused problem. Consistent with the principle of optimising use of a technology’s capacity, the study outcomes are collected electronically by the installed app on the study participants’ smartphones.

For me, the highlight of both manuscripts is the author’s attention to methodological detail. At its heart, Injury Prevention is a scientific journal. Scientific rigour can support strong claims and underpin brave action. Scientific exploration is rarely a pursuit of yesterday’s norm. Health, like business, can come through COVID-19 with our sights on the future, and not simply be hoping for a return to business as usual.

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