LETTER TO THE EDITOR

RE: Commentary by Black et al (2023)

Dear Editor

I am writing regarding a recently published commentary (1) criticizing the Canadian Paediatric Society’s (CPS) pandemic response. Vaillancourt et al. have outlined their concerns about the scientific shortcomings of the commentary and its conclusions, for which we are grateful (2). We want to clarify how the CPS made decisions on clinical guidance and advocacy in the early days of the SARS-CoV2 pandemic.

Our advocacy letters calling for schools to return to in-person learning are erroneously referred to as “position statements” in the JCACAP commentary. CPS position statements are based on the standard of evidence built from years, and often decades, of scientific literature. Advocacy letters written during the pandemic were prepared with expert recommendations based on the best available evidence at a time when there were no available data from long-term surveillance, randomized controlled trials, or longitudinal studies.

We received early and sustained signals from paediatricians across the country that children and youth were struggling. These concerns were raised through the Canadian Paediatric Surveillance Program (CPSP) studies for issues such as eating disorder onset, roundtables with experts, and by personal communications and townhalls with community paediatricians and paediatric subspecialists, including adolescent medicine practitioners and child and adolescent psychiatrists, from across Canada.

Led by paediatric infectious disease specialists, and with guidance from multidisciplinary experts including paediatric psychiatrists and developmental and adolescent medicine specialists, we assessed the risks of a return to school against the potential harms of extended closures. The best available evidence pointed to a low burden of disease in children and youth and significant harms from school closures. In addition to concerns about mental health, we note that millions of children and youth rely on schools for health services, nutritious food, security and support (3).

Through the CPSP and, later, the Canada’s Immunization Monitoring Program ACTive (IMPact), we monitored trends in child and adolescent health and found that the burden of disease was significantly lower than feared when the initial decision to close schools was made (4,5). Had the epidemiological signals changed, so too would our guidance.

Since 2020, the evidence base regarding the impacts of COVID-19 on children and adolescents has grown substantially (6-8). We believe our position has been borne out by the evidence, with ever more studies supporting the understanding that restricting children and youth from in-person learning as well as their social and recreational lives was extremely damaging. While they have safely returned to school, a cohort of children and youth is still struggling from harms related to learning loss, a loss of safe spaces, access to nutritious meals, socialization, and physical activity.

The CPS has been accused of spreading misinformation regarding pandemic-related school closures. This is a serious allegation, for which supporting data are sorely missing. With respect to the CPS’ processes and intentions, Black et al.’s commentary can be seen as a serious type of misinformation. The CPS is a longstanding and well-respected organization representing 3782 child health professionals in Canada. Our only agenda is protecting and improving the health and well-being of children and youth.

Sincerely,

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Conflict of Interest
The author has no conflict of interest to disclose.

References

Re: Response to Letter to the Editor
Dear Editor,

I appreciate the opportunity to respond and am thankful for the author’s letter [1]. My co-authors were not part of this response. I would like to thank the Canadian Paediatric Society (CPS) for their efforts generally, and recognize my paediatric colleagues across Canada for the hard work they do.

In stating “the evidence base… has grown substantially,” the letter cites three articles, two are the subject of our original commentary and we responded to the other in our rejoinder. It is puzzling that the citations for the evidence base growing are the same citations used in our original commentary. Yet, evidence has grown, indeed. New data reflect the heterogeneity we referenced. A report from Greece shows most children maintained stable mood (63%) or had positive mood change (14%) during lockdown [2]. A multinational longitudinal study (with subjects from Peru, Netherlands, and the United States) of 1339 children 8-18 found depressive symptoms increased by 28% but anxiety symptoms remained unchanged during the pandemic [3].

Although learning loss was not a subject of our commentary, it is worth mentioning that there is a lack of Canadian evidence regarding this (for example, no evidence comparing learning loss between provinces, which would be welcome given variable school closure lengths). Data from the United States shows changes in National Assessment and Readiness scores (which are reported on a scale from 0-500) in Grade 4 and 8 mathematics and Grade 4 and 8 reading from 2019 to 2021 in a district with lengthy closures such as Los Angeles (-4, +1, +2, +9, compared to the 2019 baseline, respectively) are similar-to-superior compared with short-closure districts like Duval (-7, -5, -7, 0, respectively) and Hillsborough (-1, -7, +2, -2, respectively), counties in Florida [4-5]. A report highlights positive, negative, and neutral impacts of emergency online schooling in Italy [6]. Another highlights superior outcomes from an American cohort of students enrolled in an online school system that was well established prior to the pandemic, compared to traditional public schools or chartered schools [7].

Finally, being characterized for handling evidence in a way that amounts to misinformation is understandably challenging. Nevertheless, we were specific in defining what we meant by misinformation:

1. asymmetrical presentation of evidence and
2. proclamation of cause where causation evidence is lacking.

I stand by our assessment that the claim by the CPS that “online learning is harmful” did both.

Our commentary warns against jumping to conclusions based on early, incomplete, or potentially low-quality data. It is precisely my respect for the CPS and its 3782 members that I wish it to adhere to the highest standards and scrutiny of evidence interpretation, and I feel in this case they did not do so.
A comprehensive and nuanced understanding will better equip us to develop effective policies and strategies to support the mental health and education of children during the next pandemic or emergency.

Sincerely

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References