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Evolving discourses of COVID-19 and implications for medical education: a critical discourse analysis

L'évolution des discours sur la COVID-19 et leurs incidences sur l'éducation médicale : une analyse critique du discours

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Abstract

Background: The othering of individuals has been identified as a concern during the COVID-19 pandemic. The purpose of this study was to examine public commentary during early stages of the pandemic for: 1) emerging discourses that highlighted population-level inequities, and 2) the implications these discourses may have for medical education.

Methods: Using a critical discourse analysis (CDA) approach, an archive of texts available in the public domain discussing COVID-19 was iteratively created, reviewed, and coded. We used an intersectional framework to analyze how COVID-19 highlighted structural and institutional inequity at the population level.

Results: We found 86 representative texts published from March to June 2020. We focused our analysis on implications within Ontario. The two major discourses that emerged were "COVID-19 as Equalizer" and "COVID-19 as Discriminator." The former emerged in the early stages of the pandemic to mobilize public health recommendations and describe near-universal impacts on the public. The latter followed to highlight new and pre-existing forms of marginalization exacerbated by the pandemic.

Conclusions: This study provides a unique perspective on how structural and systemic responses to COVID-19 were shaped through analysis of public discourse, and therefore, has implications for how the COVID-19 pandemic and future pandemics are framed for future medical learners.

Résumé

Contexte : L'altérisation a été soulevée comme effet préoccupant de la pandémie de la COVID-19. L'objectif de cette étude était d'examiner les réactions du public au cours des premiers stades de la pandémie afin de dégager : 1) les discours émergents témoignant d'inégalités au sein de la population, et 2) les incidences potentielles de ces discours sur l'éducation médicale.

Méthodes : L'approche adoptée est celle de l'analyse critique du discours (ACD). Nous avons constitué une archive de textes du domaine public contenant des commentaires relatifs à la COVID-19, que nous avons examinés, codés de manière itérative et analysés transversalement pour déceler dans quelle mesure la pandémie a mis en évidence les inégalités structurelles et institutionnelles au sein de la population.

Résultats : Nous avons trouvé 86 textes représentatifs publiés entre mars et juin 2020. Nous avons concentré notre analyse sur les incidences en Ontario. Les deux principaux discours qui ont émergé sont « la COVID-19 comme facteur égalisateur » et « la COVID-19 comme facteur discriminant ». Le premier est apparu au début de la pandémie pour inciter au respect des recommandations de santé publique et pour décrire les effets quasi universels sur la population. Il a été suivi par un second discours, mettant en lumière les formes nouvelles et préexistantes de marginalisation exacerbées par la pandémie.

Conclusions : Cette étude offre une perspective unique de la pandémie telle qu'elle est perçue par le biais d'une analyse du domaine public. Elle peut donc éclairer la manière de présenter la gestion des pandémies aux futurs apprenants en médecine

Introduction

The coronavirus disease 2019 (COVID-19) pandemic has been described as one of the greatest public health challenges of this generation,[1] with rapidly unfolding implications for medical training. Crises that have national and international dimensions often exacerbate pre-existing health inequities, disproportionality affecting racialized, gendered, and classed groups within individual health sectors. New forms of health inequities can also occur with outbreaks of previously unknown diseases. Risks to vulnerable populations during such crises demand responsiveness and ongoing commitment to social responsibility by medical educators. As we have learned from past pandemics and epidemics, how we make sense of the sociopolitical dimensions surrounding COVID-19 will ultimately shape healthcare practices for years to come. It is thus imperative that medical curricula introduce informed revisions that address both the biological and social health risks brought on by COVID-19. An important way to prepare medical learners for how patients will respond to medical advice during a subsequent pandemics is to use an equity-informed lens to consider how the general public and medical community responses are shaped or influenced by the media.[2,3] Patterns of emerging discourses in the media have proven to be a powerful way of highlighting how inequities related to past pandemics and disease outbreaks influence the reproduction of discrimination in the practices adopted for current outbreaks.[4,5] The media's role during the COVID-19 pandemic cannot be understated–it has and continues to shape perceptions of the public and front-line workers, including medical learners.

Making visible emerging discourses related to the pandemic, particularly on the topic of systemic inequity, can inform medical education change and contribute to curricular reforms aimed at preparing medical learners to function in a post-COVID reality. Our objectives are thus to 1) identify the discourse(s) that have emerged in the popular press and other public commentaries during the COVID-19 pandemic that highlight population-level inequities, and 2) describe the implications these discourses have for medical education. We begin with additional background to situate the role of medical schools in addressing health inequities and outline lessons from past pandemics that have informed our methodology.

Medical education and social responsibility

While medical training has included a focus on identifying and labelling groups experiencing inequities, it is only recently that medical schools in North America have assumed responsibility for addressing the cultural, structural, and systemic factors that lead to health inequities.[6] This has been facilitated by cultivating values related to social responsibility in their formal and informal curricula[7,8] and encouraging learners to contribute to social change.[9,10] This shift has also motivated institutional commitments to mitigate stigmatizing content in health care curricula, to teach about implicit and explicit biases in medical practice, and to create curricular content and experiences to better prepare learners to treat diverse patient populations.[11] The current pandemic has made it clear that schools must supplement teaching about the mechanics and theories of public health with deliberate instruction on the intersectional and structural underpinnings perpetuating health inequities.[12] Analysis of HIV/AIDS, SARS, and H1N1 outbreaks have documented unique stigmatization and inequities faced by particular groups stemming from practices of exclusion (i.e. 'othering') occurring during government and public health responses.[13-17] Public health education improvement often follows threats to societal well-being at large[18] offering an important opportunity for reform. It is encouraging that current calls to increase public health education[19] are also motivated by efforts to mitigate the disproportionate effects of COVID-19 on vulnerable groups. Our project contributes to these efforts by documenting how need and vulnerability have been defined and operationalized in pandemic responses.

Educating learners on COVID-19

Despite the growing appreciation that medical schools have an important role to play in addressing health inequities, from the perspective of VT and AVB who were medical students at the time of writing, medical schools had not adequately responded to the sociopolitical dimensions of COVID-19.[20-22] In immediate medical school responses, the pandemic was typically referenced in biological terms and educators largely focused their attention on pivoting training and assessment to virtual platforms as COVID-19 social distancing protocols called for less in-person education and care. To prepare medical learners to re-enter the clinical environment after the first wave of the pandemic, educators focused on donning and doffing personal protective equipment, communicating new hospital protocols for COVID-19, and training learners

to contribute to virtual care.[23-24] As COVID-19 continues to unfold, medical schools are provided with an opportunity to enrich their curricula with more fulsome discussions of the structural health inequities emphasized by and arising from COVID-19.[25-26] Our research offers important insights for curricular enrichment and reform.

Methods

Study design

We conducted a Foucauldian critical discourse analysis (FCDA) to document the shifts in public health discourse in Canada, with an emphasis on Ontario, related to the COVID-19 pandemic.[27-29] FCDA premises knowledge to be socially constructed and involves studying texts to understand how language constructs the possibility for making meaning and for experiencing the world.[27,28,30,31] We aimed to identify discourses and deconstruct the use of 'truth statements' about the pandemic; ideas that are institutionalized as naturally occurring. The methodology also helped to identify the objects, subject positions, practices, behaviours, and attitudes associated made possible by these discourses.[29-31] "Objects" refers to institutions and concepts that become legitimized through a prevailing discourse. The term "subject positions" is used to denote the authorized roles individuals or groups can play in contexts where particular discourses dominate.

We also drew on tenets of intersectionality theory, first described by Crenshaw[32] to better understand how language used during the pandemic (re)produced othering. Intersectionality is a framework that seeks to identify the impact of interlocking systems of oppression on the marginalized, rather than viewing those systems as additive or in isolation.[32] This methodological approach has been used during past pandemics to understand how pandemic responses disproportionately impact particular patient groups.[5,33-36]

We documented the subject positions associated with historically vulnerable groups and the implications of occupying these subject positions during the first phase of the pandemic. While this analysis cannot fully capture all forms of intersectionality experienced by vulnerable groups during COVID-19, it does highlight illustrative examples that were brought forward by the popular press.

Sample size and sampling methods

In total, we archived 86 representative texts, with publication dates ranging from March 20, 2020 to June 17, 2020 (Table 1). We focused on collecting texts throughout the "first wave" of COVID-19, starting March 11, 2020 when the World Health Organization declared COVID-19 as a pandemic and ending June 30, 2020 when the "first wave" was ending, marked by economies beginning to open again and lockdowns easing. We were interested in the events unfolding in Canada, with emphasis on Ontario because the writers were situated as medical learners in Ontario at the time of writing. Although our main goal was to understand emerging discourses in Canada, we also included sources that spoke to poignant issues in the United States given the close relationship, proximity, and geopolitical similarities between the two countries. We chose media outlets that provided information from two North American pandemic epicenters, New York and Toronto (i.e. The New York Times, and The Toronto Star) and broader perspectives (i.e. The Globe and Mail). We included newspaper articles, Tweets, blog posts, government announcements, and medical school announcements that were available in the public domain. The inclusion of texts, consistent with FCDA methodology, was intended to be representative of different discursive narratives and not exhaustive. For further information concerning the texts utilized in our analysis, please see Table 1. It was beyond the scope of this project to continue exploring subsequent waves of the pandemic.

Table 1. Characteristics of texts

Characteristic	Number of Texts (%)
Geographic Location	
Ontario	30 (35%)
Canada	34 (40%)
United States	14 (16%)
*Canada & United States**	8 (9%)
Source Type	
Newspaper Article	66 (77%)
Blog Post	4 (5%)
Tweet	7 (8%)
Other (e.g. opinion pieces, organization statements, press releases)	9 (10%)

**Canada & United States as a "Geographic Location" refers to texts that don't necessarily address a specific country, but instead opine more broadly on the geopolitical landscape shared between the two countries.*

Data analysis

The archive was analyzed for patterns of how COVID-19 was evoked to highlight, reinforce, or critique structural inequity at the population level. We documented positive and negative effects reported through the popular press during the first phase of the pandemic that impacted access to health care resources.[26-28,30-31] Texts were processed in an iterative fashion to efficiently delimit the archive. Each text was examined for truth statements about COVID-19, language used, and salient themes.

Analysis continued until a stable description of the discourses was established. All archived texts were given the same "weight" in our analysis, as our interest was in the overarching discourses from the pandemic from all viewpoints. VT and AVB developed the archive, read, coded, and analyzed each text. During regular research meetings, TM reviewed analysis with VT and AVB. In addition, TM reviewed and analyzed a subset of texts selected by VT and AVB. These texts were discussed during research team meetings to ensure consistency in the analysis across the research team. The research team revisited the texts to explore identified discourses and sought additional texts to validate the presence of discourses that were identified during iterative analysis. Throughout the analytical work, all team members noted ways in which they individually gravitated towards certain statements over others and had opportunity to describe their specific interpretations of texts. These insights were revisited during research meetings to ensure that all team members stayed attuned to all relevant truth statements contained in the texts and their applications.

Ethics approval

Ethics approval for this study was not required, as all texts examined existed in the public domain.

Results

The two major discourses that we identified during analysis were "COVID-19 as Equalizer" and "COVID-19 as Discriminator" (Table 2). We describe the truth statements embodied by each discourse as institutions that gain power, and language employed within each discourse. Illustrative example texts have been included for each discourse.

"COVID-19 as equalizer"

The initial discourse, "COVID-19 as Equalizer," was identified when evidence of COVID-19 infections began to be reported in the Western hemisphere. Authors that reproduced this discourse made arguments that COVID-19, as a virus and biological entity, did not and could not discriminate, and therefore, the measures taken should be applied to everyone.[37-39] A viral tweet by Chris Cuomo is credited with starting this language: "I don't care how smart, how rich, how powerful you think you are… this virus is the great equalizer."[37] Another illustrative quote states, "containing the pandemic will require more than heroic measures of our front-line workers: we must all make difficult sacrifices."[40] Many governmental organizations fell upon the same language to justify widespread societal lockdowns, with Canada's health minister stating, "what we're trying to do…is prevent this disease from spreading…everybody has a part to play in that."[41] The discourse was reproduced throughout the media during the earliest stages of the pandemic and was largely responsible for wholesale public compliance with initial public health measures. As a result of framing COVID-19 as an equalizer, media and governmental institutions gained visibility during the earliest stages of the pandemic. This is a typical societal pattern during times of crisis. In the Canadian context, this discourse was identified in statements associated with "working together" to "flatten the curve."[42] It was also utilized by the Ontario government to justify the decision to not collect race-based data, stating, "regardless of race, ethnic, or other backgrounds, they're all equally important to us."[43]

Table 2. Discourses within the popular press on COVID-19 (March 2020-June 2020).

Name or Symbol	COVID-19 as Equalizer	COVID-19 as Discriminator
Concepts/Truth Statements	"COVID-19 is the great equalizer." "COVID-19 is a threat to everyone." "Everyone has a role to play in the prevention of COVID-19."	"COVID-19 highlights pre-existing structural inequities." "COVID-19 unveils new ways in which these inequities operate." "COVID-19 impacts certain groups of individuals in disproportionate ways."
Language	"Equalizer," "equal," "collective," "everyone," "together" etc.	"Challenges," "unique," "disparities," "barriers," "exacerbates," etc.
Practices/Processes	Social distancing, universal masking requirements, Canadian Emergency Response Benefit (CERB), Canadian Emergency Student Benefit (CESB), Wellness Together Canada	Collection of race-based data, limited visitor policies in long term care, triage protocols
Objects	COVID-19 tests, public health graphs, face masks	Maps demonstrating geographical differences in infection rates, race-based data
Institutions that gain visibility and or power	Public Health Governmental Institutions	Marginalized Populations Advocacy Groups

Aside from the use of the discourse as justification for wholesale public action, we also identified application of this discourse to describe the potential, near-universal impacts of COVID-19 on the general public. These challenges included mental health impacts of the pandemic and surges in unemployment rates. One psychologist shared that they were "surprised by the level of Canadians' collective stress." Then again, "none of us have been through something like this before," with comparison made to the mental health impacts of the SARS pandemic.[44] In a Canadian context, this led to sweeping government action. For example, the creation of the Wellness Together platform was designed to acknowledge the widespread impact on Canadian's mental health and the Canadian Emergency Response Benefit was created to provide economic relief to those who qualified.[45,46] These government initiatives were later critiqued for taking a "one size fits all" approach.[44,47]

This discourse of COVID-19 as an equalizer persisted throughout the first wave of the pandemic, largely mobilized by public health and governmental institutions. It attempted to motivate adherence to public health measures by demonstrating that everyone has a role to play in mitigating the spread of the virus.

"COVID-19 as discriminator"

The second main discourse we identified in our archive, "COVID-19 as Discriminator," began to appear towards mid-April 2020 and beyond. This discourse pushed back against posturing COVID-19 as an "equalizer." Proponents of this discourse drew attention to the realities facing populations that have been marginalized and made vulnerable by institutional policies.[48] They argued that COVID-19 has not only highlighted these pre-existing structural inequities but has also unveiled new and unique challenges faced by communities made marginalized and vulnerable. As one author noted:

> *Media advertising and posters encourage collective responsibility…by suggesting that, 'We are in this together.' We are not. Who gets COVID-19 most? The old, the weak, the poor, the underprivileged. Who dies of COVID-19 most? The very same groups.*[49]

This discourse was initially adopted by community advocates responsible for the representation and advocacy of various sectors of society, including Black, Indigenous, and People of Colour (BIPOC) communities and those of lower socioeconomic status. Advocates and thought leaders brought forward the lived experience and unique challenges these communities were facing during the pandemic and attempted to shift the pervasive dialogue that COVID-19 affected everyone equally.[49-59]

These discussions in the public discourse began to appear in part because community advocates and people with lived experience began to bring their experiences forward. Up to this point, governmental and public health messaging was wholly focused on the "equal" effects of the pandemic across all social classes, racialized groups, and other groups experiencing disadvantage. There was almost no nuance from an equity perspective in the initial response:

> *While some provincial public health officers in Canada claim to be concerned about all citizens… they simultaneously declare that now is not the time to address the social determinants of health.*[60]

The power of this "COVID-19 as Discriminator" discourse can be seen in the following example. In the initial stages of the pandemic, public health officials across Canada insisted that collecting race-based data wasn't necessary because everyone was "equally important."[43] They began instituting measures and recommendations such as physical distancing and the closing of non-essential places of employment: the same measures advocated by the first discourse of "COVID-19 as Equalizer" that gave all people in society an assumed responsibility to protect themselves and others. Advocates began to highlight the need for such data by drawing attention to the roles that anti-Black racism and systemic and institutionalized discrimination played in the exacerbation of healthcare inequities faced by Black communities.[50] These inequities, they argued, became even starker in the unfolding of the COVID-19 pandemic.

As a result of this advocacy, which was largely brought to the public sphere via the media, Toronto Public Health committed to start collecting race-based data, and other public health institutions began to follow suit.[61] Once race-based data was collected, evidential "proof" of the inequities community leaders had described became officially "visible." The media highlighted disproportionate infection rates amongst Black Canadians, mirroring trends seen in the United States. While the measures instituted from an "Equalizer" perspective remained, the collection of race-based data and other data related to equity and justice-seeking groups formed the foundations to allow additional public health and governmental resources to begin flowing in their direction.[62]

New vulnerabilities, such as the disproportionate impact of COVID-19 on long-term care residents, also began to enter public awareness around April. One text describes this impact as "tragically predictable," stating that the government "waited until the problems were too big and too public to ignore."[63] As cases in this context began to spike and the media highlighted outcry from frontline workers, family members, and elders themselves, Ontario launched a formal inquiry into the events that occurred during COVID-19.

As the pandemic continued, the conversation shifted to the effects of the pandemic on other equity-seeking groups. Examples of these groups, referred to as the "Forgotten" in one article,[64] included racialized minorities, migrants, people with chronic disease, institutionalized individuals, LGBTQ+ individuals, persons with disabilities, victims of domestic violence, and children and youth (see Table 3). Public discourses began to include more calls to action from institutions, in order to address these inequities. The "COVID-19 as Discriminator" discourse, catalyzed by community leaders and people with lived experience, largely preceded any change in the conversation at an institutional level.

Despite the well-documented, pre-existing systems of oppression that are known to impact these groups, the government showed a reactive rather than proactive response. One text captures this quite bluntly, stating: "The coronavirus has done a great job of highlighting the obvious. The poor and disadvantaged always get screwed… it makes the inequities in our society that lead to death much more starkly visible than usual..."[48] The accounts of new forms of marginalization that emerged as the discourse of "COVID as Discriminator" gained visibility across public media during the first wave of COVID-19 also allowed advocacy groups to advocate for solutions that would allow for a more equitable response to future waves of COVID-19.

Table 3. Examples of new and pre-existing, amplified forms of marginalization highlighted by advocacy groups to motivate an equity-informed government response to COVID-19

	BIPOC (Black, Indigenous, People of Colour)	People with Disabilities	Socioeconomically Disadvantaged	Elderly
New & Reinforced Marginalization in COVID-19	Lack of race-based data, racial bias in healthcare & reduced access to care, disproportionate rates of poverty & comorbidity, lack of infrastructure in remote Indigenous communities	Ableism embedded in triage protocols, social isolation, reduced access to care & public health information	Inability to socially distance, often in "essential" or precarious employment	Social isolation, comorbidity, inadequately resourced living conditions (i.e. LTC)
Illustrative Quote(s)	"Public health has historically been an extension of policing for Black people that has positioned us as suspicious and nefarious in our actions and movements…this union of policing and public health has led to more Black people being arrested, detained, and physically restrained in the name of public health protection. Claims of colour-blind health care and approaches to the COVID-19 pandemic are concerning…"[60] "At a press conference this week, Canada's top public health officer, Dr. Theresa Tam said, "A single case in any First Nations, Inuit or Metis community is high cause for concern. These communities are among the most vulnerable to COVID-19…" Proactive measures can only go so far, particularly in remote communities with longstanding, unmet infrastructure needs."[53]	"Throughout history, in times of difficulty, certain groups identified as "different" (religious, racial, cultural and sexual minorities), have been randomly singled out as "less worthy." Disability is no exception to this phenomenon...On a daily basis, we are told to use caution and limit social interaction in order to protect vulnerable and elderly people. Yet, at the same time, in my opinion, directives are being discussed concerning health care rationing to save those people considered more important."[51]	"Better testing, contract tracing, and ensuring there are hotel rooms for test-positive homeless people to self-isolate are important steps. But the underlying problem is poverty."[59] "New numbers from TPH seem to suggest the COVID-19 pandemic is more adversely affecting people with lower incomes in Toronto, alongside newcomers to the city."[65]	"The COVID-19 pandemic has revealed two different Canadas: one that has done better than many other countries at limiting the spread of coronavirus in the general population; and another that allowed its seniors' facilities to become killing fields…"[66]

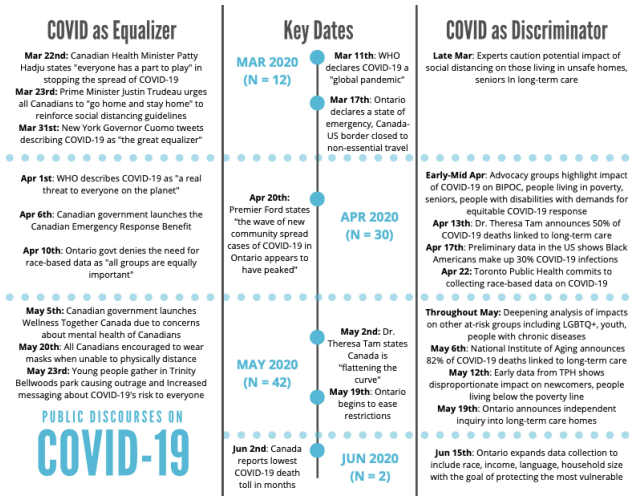

Figure 1. Timeline of emerging discourses during the first wave of COVID-19.

However, the "COVID-19 as Discriminator" discourse elicited governmental responses that appeared to be siloed rather than intersectional. Policy attention was drawn to areas from which there was a public outcry, raising the question of who was left out as governments began to discuss approaching their pandemic response in an equitable way. By placing emphasis on those at elevated risk from COVID-19, there was the potential for the privileged to not see themselves reflected in public health measures, therefore, causing them to disengage from widespread preventative action.[49,67]

Intersectionality

When we analyzed our archive using the concept of intersectionality, we noted that the term "essential workers" was used to describe not only healthcare workers, but also grocery store staff, transit employees, custodial staff, factory and farm workers, amongst others. Advocates drew attention to the notion that Black people are disproportionately employed in these sectors, highlighting the intersectional, exacerbated risk that these individuals faced. An analysis completed by the Canadian Centre for Policy Alternatives' (CCPA) Ontario revealed that "essential workers" earn less than half the national average annual income. Racialized workers make up 21% of the total workforce but are overrepresented in these fields, for example, making up 37% of workers in warehousing and storage, and 30% of workers in food manufacturing.[68] Communities that were allowed the privilege of working at home during the pandemic stood in stark contrast to communities not granted the same privilege due to the nature of their work or socioeconomic standing.[69]

Another example was discussion of the intersection between gender and sexual identity with other marginalized identities. Advocates cautioned that stay at home orders may have disproportionate impacts on those for whom home was not a safe or supportive place. This included victims of family and domestic violence, particularly Indigenous women, and LGBTQ2S+ youth. Texts described victims of domestic violence having to "choose between two pandemics"[70] and the media highlighted a dramatic increase in the number of Indigenous women who reported facing increased levels of violence in their home during COVID-19. A survey revealed that 1 in 5 Indigenous women had experienced physical or psychological violence from March to May 2020,[71] further reinforcing the discourse of "COVID-19 as Discriminator."

Discussion

The COVID-19 pandemic has laid bare not only the gaps in responses to the pandemic, but also the devastating downstream impacts that universal policy can have for a society made up of unique sectors requiring different supports. This is especially true for the populations highlighted in this paper, such as BIPOC communities, those of older age, those with mental health challenges, those who identify as LGBTQ2S+, and those with disabilities.

The devastating effects of COVID-19 on the elderly, particular those living in long-term care homes, has now been well established as subsequent waves of the pandemic have unfolded.[72] An independent investigation was launched in Ontario with the goal of retrospectively understanding the disproportionate impact of COVID-19 on elders living in long-term care.[73] This resulted in tangible, equity-informed recommendations to improve the quality of long-term care homes in the province. Advocates have continued to draw attention to how this investigation and subsequent responses have been reactive rather than proactive.[74] This is an illustrative example of how highlighting emerging discourses in the popular press can serve to make visible the unique challenges caused by the pandemic across our diverse society.

The reality that COVID has disproportionate impact on vulnerable populations exists in tension with the messaging associated with "flattening the curve" which emphasizes COVID-19's potential to universally infect any individual. Nevertheless, the "flattening the curve discourse" continues to play a role as the pandemic response evolves from one of containment to one of

balancing the risks and benefits of opening the economy safely.[75]

While the "COVID-19 as Equalizer" discourse was prevalent throughout the first wave of the pandemic, by the end of May 2020, examples of how the virus affected all populations equally were rarely referenced in the media. Advocacy groups were an integral part of the shift in discourse, as they fostered a greater understanding of the struggles that marginalized communities faced and documented their findings in the mass media. Even though inequities facing marginalized and vulnerable populations have long been present,[50,52,55,56] governmental policy and the response of medical institutions has often been reactive.[43,50,61] This was also the case with the pandemic. The prejudice faced by equity-seeking groups during the outbreak of the pandemic required ongoing advocacy to "prove" need.[50,52,55] This demand on "proof" funneled pandemic response efforts to generate data capture instead of directing resources to address vulnerabilities at their root cause. Requiring data and published literature to act at a time when a rapid response is required perpetuates systemic discrimination.

Nevertheless, the campaign to bring awareness to the unique vulnerabilities caused by COVID-19 did ultimately lead to an influencing of governmental responses. One such example were COVID-19 vaccine rollout strategies, that included Indigenous populations as priority groups, and targeted pop-up clinics in marginalized communities, which was a direct recognition of the disproportionate impact the pandemic was having on these more vulnerable populations.[76-79] The initial recognition of health inequities and advocacy by community organizations has led to a more equitable response during the current COVID-19 "wave." Although public discourse appears to be less focused on this as it has been when the pandemic was first declared, governmental organizations, such as Toronto Public Health, have continued to roll out pandemic-related programs that are mindful of health equity issues, such as the implementation of pop-up vaccine clinics in communities that face barriers to vaccination.[80]

Implications for medical education

Addressing health inequities is a growing priority for medical educators. This project, along with many other efforts to document the immediate disproportionate effects of the pandemic on vulnerable groups, creates an urgency to reconsider how we train health professionals to appreciate the impacts of structural and societal discrimination on health outcomes. It is inadequate for schools to divorce teachings of social justice, health equity, and population health from the more traditional instruction of "organ systems medicine." By segregating the instruction of these topics, the foundational understanding of the social aspects of medicine are drowned out by the overwhelming volume of biomedical curricula learners must absorb. Medical education has already shown its capacity to rapidly innovate in response to the pandemic's emergence by preparing learners to provide virtual care and transitioning to online teaching modalities.[79] In addition, expeditious efforts were also made to re-integrate learners back into the clinical setting, of which one step was instructing learners on the proper use of personal protective equipment.[81] As COVID-19 continues to challenge our health care system, we are provided with an opportunity to center the lived experiences of those hit hardest by the earliest stages of the pandemic in generating equity-informed curricula for managing the care of these patients. COVID-19 provides an opportunity to move beyond framing Black race, homelessness, and poverty as "risk factors" for this virus, and instead, educate trainees on the nuanced complexities that caused these groups to be disproportionately impacted by the disease.[6,9,10]

The primary authors of this work (VT) and (AVB) are now medical residents who have just started their postgraduate residency training. Having just completed medical school, and in their continuing medical training, their interest in this project was to study COVID-19 responses and to reflect critically at the way public health and pandemic response education is delivered to learners. During this research, they have observed a siloed approach to discussions related to COVID-19 with brief, if any, mention of the inequities highlighted and reinforced throughout this pandemic. Their informal education has come from the popular press, which motivated the pursuit of this project. While the opportunity to pursue a research project using an intersectional lens was available to them, they did not receive specific instruction from their clinical supervisors on how to apply an intersectional lens in the care of patients. This omission has long-term effects. Future generations of trainees will see patients that have lived with COVID-19 and its various implications, both medical and social. Some trainees may be living with these implications themselves.

As physicians-to-be, (VT) and (AVB) wish that they had learned about how ageist views shaped the injustice in long-term care homes, how the relationships between

public health and policing has created distrust amongst BIPOC individuals, or how people with disabilities felt targeted by triage protocols. They would also have benefited from instruction on how to address concerns patients may have about receiving vaccines and reluctance to wear masks in vulnerable communities. As current medical learners, they argue that topics of power, privilege, and systemic inequity deserve the same attention as COVID-19's pathophysiology, prevention, and medical treatment. By making visible how the pandemic has been represented in the public press, we can look critically at how the media contributes to public health responses by highlighting gaps in the current pandemic response in education and practice.[20-22,82,83] Only by proactively integrating institutional knowledge with feedback from advocates and community members can a truly intersectional and equity-informed response to COVID-19 and future pandemics be made possible.

Limitations

Our study is largely limited to implications for Ontario. Very few texts were archived from other geographical epicenters and future work would need to significantly expand on the archive to draw conclusions about emergent discourses in other areas of the world. By limiting our timeline, we acknowledge that we have not accounted for discourses that emerged in later phases of the pandemic. We also acknowledge that although our study solely focuses on issues of equity and justice as they relate to the COVID-19 pandemic, the pandemic did not occur in isolation from other current events, such as widespread Black Lives Matter protests in the summer of 2020, that may also have influenced public opinion and therefore discourses at the time.

Conclusions

The findings from this study provide insight into the role of the media in shaping pandemic responses from a government, public health, and general population perspective. The discursive themes of "COVID-19 as Equalizer" and "COVID-19 as Discriminator" highlight a shifting tension between government responses (i.e. emphasis on "equalizer") and lived experiences of those on the front lines, including the most marginalized (i.e. emphasis on "discriminator"). This tension is consistent with past pandemic and outbreak responses, during which a state of emergency justified sweeping government action, making visible new and pre-existing forms of stigmatization and marginalization. Both perspectives are valid and should be integrated in ongoing response efforts to motivate adherence to public health guidelines and mitigate disproportionate effects of the virus. We have argued that integrating an appreciation of discourses shaping pandemic responses can support efforts to move towards more inclusive education and care including learner participation in studentships and experiential learning opportunities aimed at promoting health equity competencies.[82,84-86]

This project represents a first step in documenting discursive relations during the pandemic. Future research agendas should include expanding this work to elucidate dominant discourses in the popular press in other COVID-19 hot spots around the globe. This would help gain a more fulsome understanding of how the media has shaped responses to the pandemic. To further explore the impact of COVID-19 on medical education, curriculum changes implemented by Canadian medical schools should be analyzed with a centering focus on perspective of medical learners and their perceived preparedness to care for patients in a COVID-19 reality.

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