

COVID-19 lockdown revisionism

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The term “lockdown” has become a powerful and perverted word in the infodemic about democracies’ responses to the COVID-19 pandemic. Lockdown, as used in public discourse, has expanded to include any public health measure, even if it places little to no restriction on social mobility or interaction. For example, a working literature review and meta-analysis on the effects of lockdowns on COVID-19 mortality misleadingly defined lockdowns as “the imposition of at least 1 compulsory non-pharmaceutical intervention.”¹ This working paper therefore conflated mandatory isolation for people with confirmed infections and masking policies with heavy-handed limitations on freedom of movement, and since it gained viral fame, it has helped fuel calls for “no more lockdowns.” This working paper has been highly critiqued and is less convincing than comparative assessments of health measures, like the Oxford Stringency Index.^{2,3}

Here, we discuss the spread of misinformation on lockdowns and other public health measures, which we refer to as “lockdown revisionism,” and how this phenomenon has damaged trust in public health initiatives designed to keep people safer.

“Lockdowns”

Anti-lockdown discourse is common on social media, in political rhetoric and in news articles.⁴⁻⁶ Lockdowns are often framed as a false binary of full lockdown versus no measures. However, democratic governments around the world attempted to strike a complex balance in their implementation of a blend of public health measures to address the threat of COVID-19, which varied as the pandemic and scientific evidence evolved. In some popular discourse, lockdowns have been framed as reckless and unscientific, as junk science, as an excuse to permanently

oppress populations, as gaslighting with ever-shifting goalposts and as elements of various outlandish conspiracies.^{4,7,8} The notion that lockdowns did not work has been internalized by some as a truism. Both paid advertisements about lockdowns and posts on social media have gained widespread engagement.⁹ In news media, proponents of the Great Barington Declaration — an open letter from 2020 that has been scientifically discredited — have vocally disputed public health measures.¹⁰

Some dissatisfaction with public health measures could relate to communication errors made by governments and others, and to the messy way in which scientific evidence accrued during the pandemic. Not every measure was implemented ideally in terms of its costs versus benefits. Competing priorities, such as child development versus risk of infection in relation to school closures, created spaces for reasonable disagreement, and also generated fertile ground for doubt and misinformation to develop. Careful audit of missteps and successes could usefully inform more targeted public health measures, if and when they are needed in the future. However, other powerful forces bear great responsibility for fostering lockdown revisionism. The capacity for social media to allow misinformation to be disproportionately amplified;¹¹ the creation in popular media of platforms for and consequent legitimization of individuals who spread misinformation or disinformation, through false balance or otherwise;¹² and the manner in which some politicians have generated or associated themselves with misleading rhetoric — famously, the convoy that occupied Ottawa in part of 2022 received prominent political support for its anti-lockdown messaging — are examples of such forces.

Measuring the effects of public health measures

Revisionism has been noted on a broad range of topics related to the COVID-19 pandemic. Some actors have disparaged vaccines against SARS-CoV-2 as ineffective, despite incontrovertible evidence that they have prevented many millions of deaths worldwide.¹³ Now that variants have evolved to diminish vaccines’ ability to prevent viral transmission, some have claimed that vaccine mandates — many of which were instituted before the emergence of immune-evasive Omicron variants — were discriminatory in intent and did not support public health. Although vaccine mandates are clearly socially and scientifically complex, evidence has shown that they increased uptake of SARS-CoV-2 vaccine.¹⁴ Furthermore, a study by the National Bureau of Economic Research found that vaccine mandates implemented in American colleges saved about 7300 lives during a period of just 13 weeks in fall 2021.¹⁵

Masking policies have also been reframed by some as a medically useless form of “lockdown,” despite having no impact on freedom of movement. Masking is a complex intervention to study, since the quality of masks and the contexts in which they are worn vary greatly. Masks and masking policies continue to generate much scientific and public debate.¹⁶⁻¹⁹ It is clear, however, that high-quality masks can reduce pathogen spread and prevent infection.²⁰ A case-control study of 1828 participants, conducted by the United States Centers for Disease Control and Prevention and published in 2022, found that self-reported respirator use in indoor public settings resulted in an 83% lower probability of testing positive for SARS-CoV-2 in California.²¹ Moreover, a study comparing English hospitals found that upgrading

personal protective equipment (e.g., surgical masks) to airborne respiratory protection (e.g., FFP3 respirators) for staff caring for patients with COVID-19 was associated with a 33% reduced odds of hospital-acquired infection during the Delta wave.²² In addition, a difference-in-differences analysis of staggered policy implementation, studying school districts in Massachusetts, found that 29.4% of all COVID-19 cases in a 15-week period after the end of its statewide school masking policy in 2022 were linked to ending universal masking.²³

Public health measures largely achieved the goals for which they were implemented, with a few exceptions.^{24,25} Despite claims that they induced widespread economic harms, evidence related to this question is equivocal and further study is warranted. Severe restrictions — which were often relatively short term in democratic nations — clearly adversely affected some business sectors.²⁶ However, concern about broader long-term economic harms from public health measures may be unjustified. One review found that Sweden's relaxed public health response, which led to relatively high rates of hospital admissions and death, did not benefit its economy in the short term, compared with other Nordic countries.²⁷ Moreover, the COVID-19 pandemic caused and arguably continues to cause widespread global economic damage on its own, given the burden of disease and loss of consumer confidence. An economic analysis conducted by the European Central Bank suggested that swift action to reduce the spread of SARS-CoV-2 may have helped economies.²⁸

Addressing the impact of lockdown revisionism

Lockdown revisionism creates a false impression of public health interventions, which can damage trust in public health measures and institutions. Misleading characterizations of individual pandemic measures by some high-profile actors have — explicitly or implicitly — portrayed governments that have implemented these public health measures as autocratic regimes that have suspended rights, strictly controlled mobility and utterly oppressed their populations. They also

misleadingly reframe all public health measures as extreme. In reality, government public health responses have varied along a broad continuum, and most government mandates did not involve shutting down social activities beyond the first year of the pandemic.

Lockdown revisionism has tended to frame public health measures as a form of subjugation by elites, while positioning public health as oppressive and fundamentally anti-individualistic. In this way, it supports binary thinking and eschews a nuanced understanding of freedom in liberal democracies, which acknowledges the need for certain limitations (e.g., speed limits, food safety laws, anti-smoking policies).

The problematic reframing of public health measures on social media, in the popular press and by politicians contributes to real harm and has set a dangerous precedent. If this narrative becomes dominant, it will further reduce confidence in public institutions, and will hamper acceptance of and compliance with measures needed to save lives in future pandemics. Inaccurate historical accounts of public health responses should not be normalized.

Physicians can challenge lockdown revisionism at an individual level. Researchers, clinicians and public health professionals can participate directly in public discourse to both debunk and prebunk misinformation in a timely manner. Public health officials must use evidence-informed strategies to carefully communicate the importance of early intervention during viral surges. Governments could consider strategies — including increased regulatory scrutiny — to address the risks of misinformation being amplified on social media. The popular press should avoid engaging in false balance and take care in selecting the voices it amplifies. Politicians who spread misinformation should be publicly held to account by constituents, journalists and experts. Regulators of health professions should enforce evidence-based standards among their memberships.

People everywhere should be armed with the critical thinking and media literacy skills necessary to see through the noise.

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