COVID-19 and Social Distancing Efforts—Implications for Cancer Control

Since the beginning of 2020, the coronavirus disease 2019 (COVID-19) pandemic has altered the landscape of social relationships worldwide. As of November 18, 2020, more than 55 million total cases of COVID-19 infection have been reported. In the absence of a vaccine or proven treatments, mandated and encouraged social distancing (and lockdowns) remain the only effective weapons against this pandemic. Accordingly, patterns of social interaction have shifted dramatically, with increases in social interaction within the household, decreases in broader social interaction beyond the household, and shifts in social isolation depending on the quantity of household members and other social distancing partners. Moreover, interactions outside the household may be hindered by reliance on digital platforms, anxiety about sharing physical space with those outside the household, and use of face masks (which can obscure facial expressions that otherwise facilitate connection and closeness). Social relationships have also been altered by the existential threat of the pandemic, which may facilitate a shift toward valuing relationships over productivity. Although some relationships flourish in times of stress, others may degrade or end.

The importance of considering the consequences of the current pandemic in health policy response and cancer diagnosis and treatment have been acknowledged. Similarly, we argue social shifts may be uniquely consequential for health behaviors and decisions integral to effective cancer prevention and control, for which social relationships are an important determinant. Indeed, several efforts will track the influence of the pandemic and distancing on cancer outcomes. Furthermore, the National Cancer Institute intends to support, through funding awarded later this year, an effort to survey residents surrounding several National Cancer Institute–designated cancer centers to assess the association between social distancing and cancer control-related behaviors. Even beyond studies explicitly examining the influence of distancing on cancer outcomes, however, it is important to consider this social context in all cancer research and practice. As such, if cancer researchers and clinicians do not adjust theoretic frameworks, methodologic approaches, and clinical practice to account for the influence of the pandemic, they will overlook important factors that now play a role in their research and practice.

One domain in which social distancing may be effective for cancer outcomes is via its influence on cancer-related health behavior (eg, smoking, alcohol consumption, eating, activity, sedentariness), which is often concordant within, and influenced by, close relationships. Behavior that increases cancer and recurrence risk, such as alcohol consumption, obesogenic dietary behavior, and smoking have social determinants. People may drink and consume alcohol more or less depending on the frequency of such behavior among their social distancing companions. Individuals who drink or smoke only when socializing may do so less because of bar and restaurant closures—unless their social distancing companions are heavy drinkers or smokers. Moreover, those social distancing alone may drink or smoke more because of loneliness and stress. A similar dynamic may occur with cancer- and obesity-related dietary behavior. For example, people may eat more or less healthfully depending on the eating habits of their social distancing companions. Reduced access to specific food types and grocery stores may also shift household dietary consumption, which may be exacerbated among underserved populations living in food deserts. Furthermore, responsibility for grocery shopping may shift to less-at-risk members of the household, which can alter dietary patterns. As with smoking and alcohol consumption, people who live alone may eat less healthfully as a result of loneliness or stress. Health behavior that reduces cancer and recurrence risk and increases the effectiveness of cancer treatment may also be influenced by social distancing. For example, although some people may have more time to exercise, they may have less (or no) access to exercise equipment or classes, which might exacerbate the role of social relationships for exercise. People who rely on social support or companionship for exercise may exercise less if they are not in physical contact with their exercise companions, whereas those social distancing together who frequently exercise together may be even likelier to exercise as an excuse to leave the house.

Social distancing may also influence cancer outcomes through its impact on the dynamics of patients’ relationships with their health care professionals and informal caregivers, as building trust and rapport in both types of relationships is critical to facilitating positive cancer outcomes. Communication in in-person cancer care may be disrupted by increased mask wearing (which can lower trust and connection); consequences of these disruptions may be more pronounced in racially discordant patient-physician interactions, in which racial bias can already disrupt communication. In addition, patient-physician communication is shifting toward telemedicine, which could widen cancer care disparities owing to racial/ethnic inequities in access to electronic devices and software and inadequate attention to cultural tailoring within some telemedicine programs. Moreover, access to in-person cancer screening and treatment has declined in the pandemic to prevent transmission and ensure adequate clinical capacity for COVID-19 care. Reduced access to care will result in increased...
diagnosis of later-stage cancers and delays in treatment for patients currently diagnosed,\(^9\) which will increase not only cancer complications, multimorbidities, and mortality, but also the burden on informal caregivers. Indeed, reduced cancer care access may leave patients with and survivors of cancer (as well as those with increased risk of cancer) feeling less supported and more stressed, further increasing the burden on informal caregivers and family members. Less access to palliative care, or access to suboptimal telehealth palliative care,\(^9\) may similarly increase informal caregiving burdens. Moreover, informal caregivers may be overburdened by patients’ increased reliance on caregivers with whom they are social distancing and their inability to access additional caregivers from whom they are social distancing (or caregivers who become infected by COVID-19). These consequences for cancer and caregiving outcomes may be exacerbated among those at increased risk for COVID-19 due to structural inequities in society and health care, widening already disparate health and quality-of-life outcomes among racial/ethnic minority populations.

Of note, COVID-19-related social distancing may be consequential for cancer outcomes well beyond the immediate pandemic crisis. Although many places have eased lockdown (but not distancing) requirements, additional infection spikes seem likely. Oscillations between waves of infection and lockdowns, with continued distancing recommendations throughout, are expected to continue until an effective vaccine is developed and administered to a majority of the population (or an effective treatment is developed). When the pandemic has ended, relational shifts produced by the pandemic may persist, given that people will have become accustomed to new social interaction patterns. Moreover, even if social interaction returns to prepandemic patterns for some, the effects of social relationships on cancer control behavior may persist through the effects of habituation on such behavior. As such, the COVID-19 pandemic may shift the landscape of cancer control, via social distancing, long after the actual pandemic has ceased.

Researchers and clinicians must recognize the consequences of COVID-19-related social distancing on health behaviors and to improve health behaviors, access to care, and cancer outcomes in all US residents during the pandemic and beyond. Research not focused explicitly on the pandemic should nonetheless consider its influence on determinants of health behavior and intervention delivery, measuring and accounting for changes in perceived stress, social support, and loneliness. Clinicians should carefully consider how health communication, prevention, and treatment will be affected by less access to health care and racial/ethnic inequalities in care and balance these considerations with infection risk when making screening recommendations and creating care plans.

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REFERENCES