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people has become widespread in Japan. #ChineseDon'tComeToJapan is trending on Twitter, and Chinese visitors have been tagged as dirty, insensitive, and even bioterrorists.⁷

The magnitude of the 2019-nCoV outbreak remains unclear. Estimating the reproduction number and capturing the transmission dynamics are crucial to considering effective countermeasures. Considering that asymptomatic cases in Japan were detected among those who flew back from Wuhan by a Japanese chartered plane,¹ the risk of infection during the pre-symptomatic period needs to be investigated.

The mass media must also take responsibility for providing correct information and creating comprehension among citizens. Journalists have an important role in health communication and should acknowledge that their strong but inaccurate and misleading headlines agitate members of the public, cause fear, impinge on public communication, and diminish countermeasures for the outbreak. Health-care professionals should cooperate with the mass media and help differentiate what is known and unknown. Effective communication will not only contribute to lessening the risk for inappropriate behaviour, such as unnecessary visits to health-care facilities, but also help eliminate fake news and discrimination against patients and Chinese visitors.

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Anti-Chinese sentiment during the 2019-nCoV outbreak

The rampant spread of the 2019 novel coronavirus (2019-nCoV), first identified in Wuhan, Hubei, China, has stirred panic and an unwelcoming sentiment towards Chinese people across the world.¹ Hong Kong, where a social movement triggered by an extradition bill to China has been ongoing since June, 2019, is at the forefront of this crisis. One example is Kwong Wing Catering, a pro-movement restaurant chain, which in a Facebook announcement on Jan 28, 2020, said it would only serve English or Cantonese-speaking but not Mandarin-speaking customers as a public health measure.² The Facebook post garnered the third most supportive reactions and interactions since the Facebook page's inception in September, 2019.

Although the three languages are officially recognised in the Special Administrative Region (SAR) of China,

about 90% of the population in Hong Kong speak Cantonese. Mandarin, on the other hand, is the most common language in mainland China. Mandarin is also the official language in Taiwan. The Facebook post was then updated a day later to clarify that they welcome patrons from Taiwan, despite 16 Taiwanese people confirmed to have 2019-nCoV, as of Feb 8, 2020.³

This anti-Chinese sentiment can be traced back to the general public's discontent with the Hong Kong Government's declining autonomy due to Beijing tightening up its control over the territory, and it was exacerbated by the government's delayed public health response, which fell behind Macau, the other SAR of China, in handling the 2019-nCoV crisis.⁴ As a result, some of the public health precautionary strategies are self-initiated by the community in attempts to influence the government's policies; for instance, health-care staff held a strike to press for a total border closure, which the government was reluctant to endorse. However, we should be cautious about the possibility that public health measures, however well intended, can be tainted by sentiment that is fuelled with prejudice against a certain group of people. If left unexamined, this sentiment could give rise to measures that do not target the real issue accurately and adequately, undermining the effectiveness of any interventions.

Although people generally believe they have a predictive model that can identify high-risk disease carriers, thus justifying their position to alienate anyone associated with mainland China, the reality is that virus does not discriminate based on parameters such as language, regional identity, and political position. Moreover, it can be argued that bias against a certain group of people on the basis of a limited set of probable confounded factors might lead to shame, stress, and stigma that prevent true carriers from reporting their condition to official bodies and receiving timely health-care attention.



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In the face of a public health crisis at a globalised scale, ethical consideration is far from being purely intellectual—it is at the core of any effective measure.

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Early lessons from the frontline of the 2019-nCoV outbreak

The outbreak of the novel coronavirus (2019-nCoV) has been declared a public health emergency of international concern by WHO.¹ 2019-nCoV has spread throughout China and beyond. In China, as of Feb 9, 2020, more than 37 000 people have a confirmed infection, and 812 people have died.² Currently, the severe situation has not been effectively controlled, and many governments have sent special aeroplanes to take their citizens home.

The outbreak of 2019-nCoV has taught me a lot. First, early detection and early reporting were delayed. Early in December, 2019, eight doctors discovered unexplained pneumonia and were warned by the police for

spreading rumours.³ One of them was finally admitted to hospital. Second, although the situation of early human-to-human transmission was described in the scientific literature,^{4,5} local authorities did not inform the public early, allowing more than 5 million people to leave Wuhan to go home for Chinese New Year or travel abroad. As a result, an outbreak occurred in Wuhan with sporadic cases in other cities and countries, and there is an increasing trend. Third, there is a low awareness of the severity of pneumonia associated with 2019-nCoV. Many patients have atypical clinical manifestations⁶ and visit different medical departments. Because patients might be contagious during the incubation period, many medical staff might not be fully protected and could become infected through their contact with patients. Research has shown that, in addition to droplet transmission and contact transmission, 2019-nCoV might be transmitted via the faecal-oral route.⁷ Fourth, the reserves of protective equipment in hospitals are severely insufficient, worsened by the implementation of traffic control. A hospital's protective equipment is mainly supplied to designated infectious diseases departments and intensive care units. Medical staff in general hospitals and other departments are likely to be affected the worst because they do not have adequate protective equipment. Fifth, due to the previous medical custody control, many clinical drugs were identified as auxiliary drugs and their supply to the hospital was stopped. The general department of the hospital does not have the necessary treatment drugs, putting many medical staff at risk of infection. Sixth, because all hospital beds in designated hospitals have been filled, and the new hospital in Wuhan has not been completed, many confirmed patients cannot be admitted to hospital and stay in general hospitals or go home for isolation, inevitably increasing morbidity and mortality. Seventh, in

view of the current situation, to reduce cross-infection, many hospitals have cancelled outpatient appointments (except for emergency and fever clinics). This inevitably affects the diagnosis and treatment of patients with other diseases.

As a doctor working on the frontline of the outbreak in Wuhan, I hope that with the joint efforts of medical staff across the country, we can control the development of the 2019-nCoV outbreak rapidly and reduce the mortality of patients with pneumonia. I also hope the Department of Health will pay attention to the frontline doctors and provide adequate protective equipment to reduce their risk of infection. Only in this way can the outbreak be controlled and patients continue seeking treatment for other health conditions in hospitals.

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