Medical Xpress

'We will not forget our colleagues who have died': two doctors on the frontline of the second wave

December 2 2020, by Tom Wingfield and Miriam Taegtmeyer

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During the first wave of coronavirus in April, we wrote about our experiences as frontline healthcare workers in Liverpool. While working

on COVID-19 wards, we described the stark psychological and health vulnerabilities faced by health workers around the UK. In those early days of the pandemic, our health systems were bogged down by inadequate communication, PPE shortages, and testing limitations.

We also warned of the need to plan ahead to mitigate an inevitable second wave and avoid the negative knock-on effects on routine hospital care. Now, that second wave is here.

After a lull over summer, Liverpool has been at the forefront of the second wave seeing a dramatic increase in COVID-19 cases. The city was one of the first areas to be placed under "very high" alert tier 3 as part of the government's three-tier system of coronavirus restrictions. During November, numbers of hospital admissions for COVID-19 were higher than the first wave and intensive care units were close to capacity.

Around the country, healthcare workers continue to put our lives and those of our families on the line. We arrive at work to face daily, sometimes dangerous, staff shortages but also to see the inherent resourcefulness of NHS healthcare workers. In Liverpool, genito-urinary medicine and palliative care specialist colleagues have again expanded their care to cover or lead COVID-19 wards. Other hospital doctors have "upskilled" to look after people needing ventilators. What is unclear is how long we can keep stepping up.

As frontline workers, we are concerned about the long winter that looms for the UK. Here, we set out the problems we and our colleagues are facing around the country, some lessons we might be able to learn from the first wave, and some positive developments which will make the future a little brighter.

Understaffed and burned out

Health systems are only as resilient as the healthcare workers who dedicate their lives to them.

In August, in a survey of 4,000 doctors by the British Medical Association, a third reported increased stress and anxiety related to coronavirus. Half reported a lack of confidence in their ability to manage patient demand during a second wave. Excess hours, redeployment, and canceled leave have meant that many of us have not been able to look after our own health and wellbeing. We have struggled to reset, are exhausted and, in some cases, fearful.

This is limiting our ability to tackle the second wave. Hospitals are having difficulty recruiting new hires and wards are chronically understaffed. We have seen that even financial incentives are not enough to fill the gaps. Understandably, tired staff value their mental and physical wellbeing more than remuneration.

At risk of infection

Research during the first wave showed variable rates of coronavirus infection in healthcare workers around the world. In the UK, rates were high. Between a quarter and nearly half of frontline UK healthcare workers showed evidence of SARS-CoV-2 infection. Those working in acute medicine, COVID-19 wards or as cleaning staff were at particularly high risk.

In our local area, rates of staff sickness have approached those of the first peak. This is despite previous exposure among healthcare workers, improved use of PPE, and near universal mask-wearing in communal areas.

A number of healthcare workers have also developed long COVID, rendering them unable to work. Worryingly, some healthcare employers

do not recognize COVID-19 as an occupational exposure. This curtails the access to financial protection of those affected. In some cases, this has cost employees their jobs and forced them to claim benefits.

High rates of COVID-19 in badly affected areas indicate that community transmission could represent the highest risk of exposure for healthcare workers. This is the case in places like Liverpool, as it was in London during the first wave. This clearly demonstrates the inextricable connections between community, health systems, and healthcare workers.

Mourning our colleagues

Deaths among healthcare workers tell their own, grim story.

The pandemic has killed thousands of our colleagues globally. A disproportionate number of those deaths have occurred in the UK, where the majority (63%) have been healthcare workers from Black, Asian and minority ethnic (BAME) groups. Another significant proportion of deaths globally has been among older workers and re-hired retirees.

There is currently a review of healthcare worker deaths in England and Wales underway. However, it is unclear whether the results will be made public. These unacceptable deaths are a clarion call for better protection of healthcare workers, especially those from vulnerable groups, during this second wave. We will not forget our colleagues who have died.

Facing the second wave

The second wave of COVID-19 is not a mere repeat of the first.

The UK government initially responded to rising infections by locking

down parts of the country through its tier system, which was reintroduced on December 2. This meant that regions with high rates of COVID-19, such as Liverpool, were treated as "outliers".

An outlier narrative, whether directly or indirectly, put a political squeeze on hospitals to continue necessary routine activities. This impeded formal recognition that hospitals and health systems in our region were becoming overwhelmed. So, with an alleged lack of backing from regional or national NHS bodies, hospitals were forced to struggle on with a "business as usual" response. This regional response lacked the necessary mobilization of staff and resources to deal with escalating admissions.

Meanwhile, the health system at large has still not recovered from the first wave. In July, Sir Simon Stevens, the CEO of the NHS, urged healthcare facilities to accelerate non-COVID services to make use of a window of opportunity before cases rose again in winter. Although it could have come earlier, this was the right response.

But the plan has been hampered by low staff numbers and inadequate resources to clear the backlog in non-COVID care. This includes a waiting list for routine operations that is at its highest level since 2008 and predicted to expand from four to ten million people by the end of 2020.

Coronavirus in winter

There is no doubt that we are staring down the barrel of a harsh and challenging winter. In recent winters, NHS bed capacity has regularly exceeded 95% and emergency attendances continue to drive upwards. The reality is that many hospitals, including those in our area, have already been working at capacity due to COVID-19 since September.

Even with adequate PPE practices, hospitals working at capacity increase the likelihood of in-hospital COVID-19 transmission and deaths . This is compounded by the UK's low per capita hospital bed capacity, which makes it very difficult to separate people with and without COVID-19.

Subsequent outbreak investigations should be cautious to dissect system failures rather than apportion blame at the doors of healthcare workers. In the current scenario, any fault-finding missions are misjudged, misplaced, and only serve to further undermine staff morale.

Influenza season will soon begin in earnest. The interaction of flu and the novel coronavirus is still unclear. Social distancing and mask wearing could contribute to reducing flu transmission. However, it appears people who are co-infected with flu and SARS-CoV-2 are twice as likely to die as those with COVID-19 alone.

Overlapping flu and COVID-19 symptoms will create difficulties for diagnosis and may overwhelm an already underperforming national trace and test system. To combat this, we should continue to urge those who are eligible to get their flu vaccinations.

The good news

Amid all this doom and gloom, it can be hard to see the huge, positive advances made towards addressing COVID-19. Although clap for carers has long fallen silent, the health workforce continues to be an integral part of this response.

Locally, we have seen many examples of good leadership, teamwork, transformation, and clear guidance. This has had a positive impact, empowering clinician leaders and beginning to sweep away some of the ingrained bureaucracy and hierarchy that exists within the NHS. It has

highlighted the importance of communication and trust both within and outside of the health system. And it has also led to improvements in how we safely use, share, and relay health system and trials data in real time.

Procurement and distribution of PPE has improved. There are currently few instances of PPE shortage. However, rates of hospital transmission of COVID-19 in our region and more widely are concerning. It is essential to maintain the regular staff training, support, and championing of high PPE standards that we achieved during the first wave.

There have been huge steps forward in our understanding of COVID-19. Indeed, scientific progress has been so fast that it is hard for frontline healthcare workers to keep abreast of developments.

Multiple vaccine studies have shown promising efficacy and safety results. We are proud in Liverpool to have been a major recruiterto the Oxford vaccine trial, which has also shown highly favorable interim results. This week, it was announced that the Medicines and Healthcare products Regulatory Agency has approved the Pfizer/BioNTech coronavirus vaccine for use in the UK. We look forward to the roll-out of this and, potentially, other vaccines during the course of 2021. If the efficacy of these vaccines is maintained during large-scale use, this will be one giant leap forward in gaining control of COVID-19.

The factors associated with severe disease and death from COVID-19 are also now much clearer. We have new tools to predict the risk of hospital admission or, in those already hospitalised, death from COVID-19. Such scores are hugely useful for the pandemic planning carried out by modellers, epidemiologists, and policymakers. They are also useful to us as healthcare workers to discuss risk and prognosis with patients and their families.

And there have been major breakthroughs in COVID-19 treatments.

These include the UK-led RECOVERY trial, to which our city is a big recruiter. RECOVERY found that the steroid dexamethasone reduced the likelihood of death in people with COVID-19 requiring supplemental oxygen. On the wards, we are seeing firsthand the positive effects of dexamethasone on our patients' outcomes. The results for remdesivir, another potential treatment, have been less impressive and accompanied by rationing issues.

Our knowledge concerning non-invasive ventilation for people with COVID-19 and respiratory failure is also increasing. Specifically, our unit shared encouraging early data about the potential role of continuous positive airways pressure masks to avoid having to put patients onto mechanical ventilators.

Despite these advances, feedback from people with COVID-19 and their families about the care they have received has been broadly overlooked. This is a shortcoming we are trying to rectify by surveying our patients about their experiences.

Better strategies

As the second wave progresses, we need strategies that support healthcare workers who have been exposed to COVID-19 – this will be vital to rebuild trust among a demoralized workforce.

This should involve suitable clinical monitoring of staff, access to rapid testing and transparent policies regarding staff removal or return to work . We also need specific strategies that respond to the needs of at-risk groups, including health workers from Black, Asian and minority ethnic backgrounds. Finally, it is only right that, alongside other risk groups, healthcare workers are prioritized to receive a COVID-19 vaccine first.

In Liverpool, it is hard not to consider the impact on infection

prevention and control efforts of the hugely delayed opening of a new, state-of-the-art hospital. The new hospital opened briefly to look after people with COVID-19 in May but has since closed again and is not due to properly reopen until 2022. The hospital is fitted out with single-room, en-suite occupancy throughout, facilities that would be very helpful in limiting the spread of coronavirus.

Some priorities are broader than the health system. Protecting the NHS and its workers depends on minimizing coronavirus transmission not only in hospitals but also in the community. This relies on robust public health surveillance for COVID-19 and influenza, and efficient contacting tracing.

The recent roll-out of a mass testing pilot in Liverpool has had promising take up. More than 100,000 people have been tested and over 900 positive cases without symptoms identified. We hope that other cities will be able to learn from Liverpool's lead and refine mass testing to meet the needs of their communities.

Where next?

The current government policy for COVID-19 appears vague. The end goals are unclear. We understood "Protect the NHS," but now what? There is a damaging lack of direction or consensus at the highest levels, which erodes trust and seems to shift accountability to local authorities. This muddled approach could also contribute to the spread of dangerous misinformation.

Instead, we need a transparent, meaningful public debate between multiple sectors about the inevitable health, economic, and social trade-offs entailed in COVID-19 policy. A healthy dose of trust and, where the health system is concerned, forgiveness between healthcare workers and NHS leaders and government, will be required.

Thank you for your support

We have learned much over the last year. The pace of change has been breathless. But whether you are a healthcare worker, epidemiologist, or prime minister, there is still much more to learn. New government health policies have been introduced rapidly with variable communication. Considerations around the practicalities of implementing policy change have, on several occasions, been found wanting.

We are doing our best to stop the spread of COVID-19 in hospitals. However, we have seen that, when hospitals are pushed to capacity, infection prevention becomes difficult.

A single person acquiring this disease in hospital is one too many and someone we have let down. Breaking the news to the person affected is an awful conversation for a health worker to have. At present, due to visiting restrictions, that conversation is often had over the phone. We look forward to a time when hospitals receive visitors again and we can restart face-to-face discussions about care.

We appreciate the outpouring of support for the NHS from the UK public. We know the efforts everyone is making to reduce community transmission. We see the take-up of coronavirus tests, wearing of masks, and adherence to social distancing. These community actions are the best way to prevent hospital transmission of COVID-19.

Although tired, frontline NHS healthcare workers are striving to provide the best care possible during this second wave. We have seen with our own eyes that the care patients receive and the outcomes of people with COVID-19 have improved. It is a joyful feeling to see those affected walk out of hospital. Nearly eight decades after it opened, the NHS remains here for those who need it. Thankfully, that's one thing that COVID-19 won't change.

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Citation: 'We will not forget our colleagues who have died': two doctors on the frontline of the second wave (2020, December 2) retrieved 3 May 2024 from https://medicalxpress.com/news/2020-12-colleagues-died-doctors-frontline.html

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