

How we coped with covid-19 and the year's silver linings

Doctors and patients tell **Kathy Oxtoby** what has got them through the past 12 months, and the positives they have taken from 2020

Video meetings and audio books, camaraderie with colleagues and royal college work, running and long walks. These are just some of the ways doctors have been dealing with this difficult year.

To describe the year as challenging is, of course, a massive understatement. But along with the challenges presented by the pandemic have come positives, clinicians say, from a greater awareness of mental health and the importance of equality, to cleaner air and the benefits of the closeness of family.

APPRECIATION OF THE NHS BROUGHT ME TO TEARS

Lade Smith, consultant psychiatrist, visiting senior lecturer, and clinical director, forensic services, Maudsley Hospital, London, and clinical director, National Collaborating Centre, Royal College of Psychiatrists

What's saved me has been

audio books—after being at a computer reading all day I feel I can't pick up another book—and late evening walks.

I'm having more meetings with colleagues, where we pass on information but also check in with each other to ask how we're feeling.

It turned into superheroes, putting over 800 staff to remote access in five days. And colleagues are covering for others who are unable to come to work because they are shielding or in a potentially high risk group. I've been really impressed with how readily they've been doing this.

And it's been heartening that people, some of whom I haven't heard from for a long time, are remembering me, remembering I'm a health worker, and asking, "Are you ok, are you safe?"

The first time that people clapped for the NHS I was a bit cynical. By the third time, when things had got so overwhelming, hearing everyone clapping I found myself in tears to hear that ring of appreciation for the NHS.



I HAVE RE-EVALUATED WHAT'S IMPORTANT IN MY LIFE

Ian Higginson, consultant in emergency medicine, University Hospitals Plymouth NHS Trust, and vice president, Royal College of Emergency Medicine

Having the family together during lockdown was reassuring—it felt like we were "hunkering down" for whatever was to come. I also have a friendship network composed of people with a strong sense of community and a good sense of humour.

Being part of an incredible emergency department team has helped. We stayed positive, and it felt good to continue to provide care for patients during this time of great need. And my royal college work has enabled me to

feel I've made a contribution both to disseminating information relating to covid and emergency medicine's response to it.

The pandemic has prompted me to re-evaluate what's important in life and get my work-life balance sorted. I'm a drummer, and playing live is hard to do during a pandemic, but I've learnt more about mixing and music production.

Video conferencing has enabled those of us working in emergency medicine to connect with each other across national and international borders, sharing our concerns and successes. I hope we'll continue to share our incredible experiences across the world.



MY NHS FAMILY GAVE ME A SENSE OF PURPOSE

Farah Bhatti, consultant cardiothoracic surgeon and council member of Royal College of Surgeons of England

While so many people were furloughed, shielding, and feeling isolated, being able to continue working with my NHS family gave me a sense of purpose through the crisis.

It's also been great to share guidance and help to define best practice and with issues concerning healthcare staff such as PPE availability and testing.

I also have an extremely supportive husband, who is with me through thick and thin.

This year has shone a light on the terrible things happening in the world, such as the increased risk of covid in ethnic minority communities and the killing of George Floyd, renewing interest in Black Lives Matter. We mustn't stop trying to create a more equitable society.

I'm very involved in equality, diversity, and inclusion—it's what drives me. I feel honoured to have been invited onto an independent panel to look at diversity in the leadership of the Royal College of Surgeons of England. That's a good thing to come out of this difficult year.

We must not stop trying to create a more equitable society

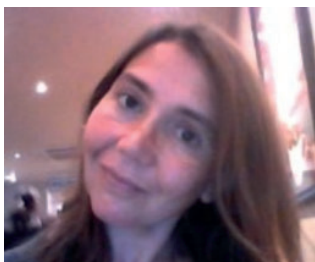
CLINICAL RESEARCHERS ARE MORE COLLABORATIVE

Sarah Markham, visiting researcher, Institute of Psychiatry, Psychology and Neuroscience, King's College London, and member of *The BMJ* patient panel

Ironically, what's helped me is that I'm a mental health patient. This has given me so many opportunities through life to build up resilience, to learn to take things in my stride, as well as experience of facing uncertainty, negative outcomes, and risk.

I've been detained under the Mental Health Act so have had previous experience of a kind of lockdown—so nothing that has been implemented has bothered me.

As I'm an academic researcher, covid has brought me lots of interesting work. I'm currently working on a systematic review of mental health research that's been initiated in response to the pandemic. Historically, clinical research teams can be competitive with each other, whereas now it's in everyone's best interest to collaborate to better understand the virus, which is a positive change.



PIZZA FRIDAYS HAVE KEPT ME GOING

Richard Fieldhouse, chair of National Association of Sessional GPs (NASGP) and locum GP in Chichester, West Sussex

At the beginning of the pandemic across the country most locum work was cancelled, so doing [fewer] sessions helped me focus on my work with the National Association of Sessional GPs (NASGP).

What's been getting me through is being able to make a difference to the lives of GP locums. My wife—also a locum—and I both help run NASGP, and we've been spending time making the organisation's locum IT software LocumDeck more powerful and much simpler to use.

We've also launched a network of GP locum chambers, which are managed local collectives of self-employed locums supporting local practices.

My pizza oven has kept me going. I bought a portable pizza oven a few years back, and I've been having pizza Fridays.

As much as I miss my sons visiting, I'm no longer exposed to their cats' allergens. So now I can go running for 10 miles without any puff of an inhaler for the first time in decades.

I'VE BEEN OUT EXPLORING IN THE FRESH AIR

David Turner, GP partner, Chorley Wood Health Centre, Hertfordshire

Our team really pulled together and knuckled down to convert the practice mostly to phone appointments, then later, to start ramping up face-to-face appointments.

As well as maintaining the surgery routine to keep things as normal as possible, I've been cycling, walking, and exploring local areas I didn't know existed.

There's been less traffic on the roads so it's been nice to be out in the fresh air, which is cleaner. With less traffic my journey to work has gone down from an hour and a half to 15 minutes, which has made a huge difference to my day.

During the first few weeks [of the pandemic] things were quieter, and I had time to catch up on routine stuff like updating records and QOF [Quality and Outcomes Framework]. And we were only dealing with patients with serious problems—so for a while there were no “worried well.”



ONLINE CONNECTIONS ARE LIKE HAVING AN EXTENDED FAMILY

Liz Bragg, associate specialist paediatrician, Cardiff and Vale University Health Board

Video meetings with colleagues stopped me quietly going mad with my own company. I worked from home for six weeks—I was shielded because of health problems—so seeing people by video made a massive difference.

Group chats on Facebook with like-minded people is like having an extended family. We take it in turns to support each other, share how awful things feel, and get group reassurance. I was impressed with the way our IT department organised laptops for staff to work from home. I've been asking for years if I can access emails from home—during the pandemic this happened within days.

It's good that lots of people are suddenly thinking about mental health. There's a greater awareness that everybody needs to watch everybody's backs to make sure they're coping.

I liked the lack of emissions—that we were letting the planet breathe again. And having connections with people will continue to get me through. Staying connected is what makes us human.



RUNNING IS A FORM OF MEDITATION AND RELAXATION

Ceinwen Giles, director of partnerships and evaluation, Shine Cancer Support, a cancer support charity for young people

Awful as things have been this year, what has got me through is the team I work with. A small team of five, we have all had a cancer diagnosis, are all in the same situation, and

stay in touch with each other personally as well as professionally.

Running has helped a lot. I have an immune deficiency, and in the darkest days of lockdown, when I was having to shield, I went running every day by myself. For me it's a form of meditation and

relaxation.

It's been nice to spend more time with my husband and daughter, even though there were times when we drove each other crazy.

We used to run three-day retreats on coping with a cancer diagnosis but have had to redesign these programmes to be



delivered online. Even if things go back to normal we'll keep some of our

online programmes because we can reach people in different parts of the country more easily.

There's been a lot of camaraderie within our online patient community, and it's helped to make sure people don't feel alone and isolated.

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A new year's resolution

Having faced the full force of the covid-19 storm, health workers must now set out a vision for the future

Few health workers will be sad to see the end of 2020. The prospect of a return to normality seems within reach, however, with several vaccines against SARS-CoV-2 coming on stream¹ and advances in treatment reducing deaths among those infected.² But what will that normality look like? The normality we departed from at the onset of the pandemic was unjust, unsustainable, and shaped the evolution of, and responses to, the pandemic with devastating consequences, particularly for the most deprived and vulnerable. The start of a new year offers an opportunity to ask how we can create a better future for everyone. Just as in wartime and in the global financial crisis,³ many have profited greatly from the pandemic, whether as providers of online services⁴ or by taking advantage of the rush to procure essential goods such as personal protective equipment.⁵

Compelling vision

But many were far less fortunate, and vulnerable to an infection that spread especially rapidly through communities where successive generations had been living ever more precarious lives. As the recovery begins, the powerful groups who benefited from the systems that created those conditions⁶ will, once again, seek to shape the world to their advantage. Health workers cannot remain silent. They must offer a compelling vision of how we should reconfigure the world so that it produces and sustains health for all, resilient in the face of future threats.

A country navigating the pandemic is like a ship navigating treacherous and unpredictable waters in a storm.

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We should reconfigure the world so that it sustains health for all, resilient in the face of future threats

If the ship, its crew, and its passengers are to come through the experience unscathed it needs three things. First, it needs an experienced captain who understands the ship and commands the trust of the crew. Unfortunately, in some of the countries worst affected, captains were either away from the bridge, denied there was a storm, or had lost the trust of those who depended on them.⁸

Second, it needs a crew that is adequate, well trained, and a team to achieve the same goal. Yet in too many countries, too few staff were working in health systems that were highly fragmented. It also needs passengers who are fit enough to withstand the storm. One of the sentinel challenges of covid-19 was finding large segments of the population weighted by a disproportionate burden of preventable disease that predisposed them to severe covid-19 once infected.¹⁰

Third, we need a ship that is securely constructed. Yet in many of the countries that have fared worst, we have been working in vessels that are full of holes.¹¹ Social safety nets have been ripped asunder, allowing too many people to fall through the gaps. We have made many demands on people—to stay at home, to face loss of income—and we have added greater uncertainty to what were already difficult situations,

particularly for some ethnically or economically marginalised groups. The disproportionate exposure to covid-19 of many in these groups—a consequence of precarious jobs and social circumstances that denied them the luxury of social distancing—drove, in large part, the high burden of covid-19 among minority and marginalised groups worldwide.

A covid secure future

As we look to the prospect of a covid secure future, with effective vaccines, new treatments, and continued countermeasures as necessary, we must ask how we can strengthen the foundations of our societies, coming together to repair the torn safety nets. We must never be afraid to challenge political leaders when they are going in the wrong direction, and we must insist that they really are guided by the science, and not just those bits that support their beliefs.

We must ensure that our fellow citizens are as healthy as possible and insist that our health systems are adequately staffed, with the tools needed to do the job, and teams that are pulling together in the same direction.¹² If we do all this, then we, and the populations we serve, can weather any future storms.

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Shepherding preprints in a pandemic

The medRxiv server has had to adapt at pace this year, as preprints have been adopted widely during the covid crisis, says **Theodora Bloom**

People tend to have opinions on preprints and whether they help or hinder progress in research. I'm an unabashed preprint advocate. Of course, some preprints are more important and interesting than others, and some plain wrong, just like journal articles. And I declare an interest: last year BMJ joined forces with Cold Spring Harbor Laboratory and Yale University to launch a preprint server for clinical medicine, medRxiv (pronounced "med-archive"), to enable quicker exchange of research ideas. In its first six months medRxiv handled a few hundred articles. In 2020 it has posted over 12 000, mostly on one topic: coronavirus.

Before the launch we decided what types of papers to post, how to screen them quickly while limiting risk to patients and populations, and what requirements to place on authors. The pandemic changed none of these criteria, but they were all tested repeatedly through

Founding and management of medRxiv

medRxiv's founders and management committee are John Inglis and Richard Sever (Cold Spring Harbor); Harlan Krumholz and Joseph Ross (Yale); and Claire Rawlinson and Theodora Bloom (BMJ).

Head of content (and screening) is Samantha Hindle, supported by Dinar Yunusov (both at Cold Spring Harbor), and the lead clinical and editorial consultant is John Fletcher (BMJ), who has been supported in the covid era by Ginny Barbour (Queensland University of Technology).

For more information see <https://www.medrxiv.org/about-biorxiv>.

discussion channels and video meetings.

For example, medRxiv aims to post only research articles (including systematic reviews) and protocols, not opinions or commentaries. But what counts as research? We decided that a preprint describing publicly available data should include research methods, contain more than just graphs and discussion, and discuss the research presented, rather than using a small amount of data to justify an extensive opinion.

Aiming to reduce health related public panic, in January and February we considered declining any extreme predictions of R0 or rising cases. But, as cases surged, this seemed naively optimistic. We also decided to post articles that might be out of date in a couple of months because the data were changing quickly.

Coping with volume

In March and April, as our teams in the northeastern US and the UK entered lockdown, we all worked long hours (from home), dealing with medRxiv submissions that increased 10-fold in three months. In April and May it became clear that we had to scale up to deal with the volume of submissions: first, training more screeners who establish that a submission is within scope and meets reporting requirements; next, recruiting more affiliates—clinical researchers who confirm that a submission describes clinical research and wouldn't be dangerous if posted; and securing help for the single clinical adviser who looked at every paper.

Studies with human

PREPRINT

Sharing research openly and at pace has risks but aren't the risks of opacity and delay even greater?

participants are posted on medRxiv only if they had ethical oversight. We thought this a straightforward requirement, but we heard from many clinicians who were certain that they didn't need oversight because they had "the answer" to treating the most seriously ill people, sometimes with treatments that were banned or reported to be dangerous. When we saw President Trump promoting unproven treatments and branding a (preprinted) study that countered his view an "enemy statement," this upped the ante on how we handled treatment claims, and we ensured that all had clinician input.

Preprint v press release

Another area of debate was studies of small numbers of people. Early on we saw reports of loss of taste and smell in handfuls of patients in Italy: was this important or just an interesting curiosity? Ensuring that patients aren't identifiable became a focus as we received increasing submissions from clinicians that read like a referral letter to a colleague—describing patients' home life, work, dates of illness, and comorbidities. Some governments also disregarded patient confidentiality in the drive to control viral spread.

And now, with a light at the end of the pandemic tunnel and our workloads and workforces stabilised, discussions focus on claims about treatments and vaccines. Should we post studies of ill defined herbal remedies, for

example, even within a registered clinical trial? Are there particular requirements for vaccine studies?

One example of when we had no doubt about posting a preprint as quickly as possible was the Recovery trial's preliminary result on dexamethasone. This was submitted a few days after the UK chief medical officer recommended the treatment and a few weeks before the peer reviewed article appeared in the New England Journal of Medicine. How many lives were saved by improved treatment in those weeks? And how much better was it that physicians could read the full preprint before prescribing, rather than a press release?

Such examples drive us to carry on preprint shepherding—despite occasional accusations of censorship and bias from authors whose preprints we decline, and despite the view of some eminent journal editors that, when we focus on speed, we devalue accuracy or reliability. Sharing research openly and at pace has risks, the worst of which medRxiv aims to mitigate, but aren't the risks of opacity and delay even greater? If posting preprints weren't an option, how much of this research would remain behind closed doors, and how much less informed would be global discussions of policy and treatment options?

We launched medRxiv as a service to the clinical research community, and we look forward to hearing your ideas and contributions as its development continues.

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