VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Covid-19 has made news out of old news

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The coronavirus pandemic has brought many health and social care issues to the fore. It's really struck me that many issues that were already clear to health professionals before the pandemic have now become news, when previously they struggled for attention outside specialist healthcare publications. Things that were already essentially good and often mainstream practice before the pandemic are now presented as bad.

Already, it was a good idea to discuss resuscitation with patients and families and to have more structured, person centred plans, goals, and limitations of treatment, using processes such as ReSPECT¹ or advance care plans^{2,3} for people with long term conditions or frailty, including care home residents. The main push was to do more of this, for more people, more of the time—and hence to improve end of life care and avoid overmedicalisation of natural dying.

Already, it was good practice to avoid sending people from care homes into the bewildering environment of acute hospital beds, unless there was a very clear indication, and to try to provide healthcare treatment (including palliative care) in that familiar environment.^{4,5}

Already, we had to make daily decisions about admission to intensive care units (ICUs) based not on crude chronological age, disability, or quality of life judgments but on the patient's ability to benefit versus the risk of harm and the competing needs of other potential patients.^{6,7} And we already used evidence based scoring systems and large, rolling datasets to help guide decision making.^{8,9}

Already, we held it to be good practice to avoid hospital admission of people who didn't need the full facilities of a general hospital and to try to support them at home. And we already knew that hospitals running while rammed full—with overcrowding and long waits in the emergency department and stranded patients waiting weeks for community services—were bad for safety, quality, the patient experience, and the flow through beds.¹⁰⁻¹²

Established good practice

During the pandemic, however, there's been a constant narrative in mainstream and social media that it's somehow bad—even scandalous—to discuss treatment limits, avoid admissions from

care homes, provide palliative care for dying patients, consider carefully which patients may benefit from ICU admission, or run hospitals at lower bed occupancy.

Established practice is being portrayed as bad news. We've also seen the counter-phenomenon of problems that were plainly visible, but were largely ignored in mainstream media, suddenly becoming an issue.

The lack of pandemic preparedness after the 2017 flu pandemic report on Exercise Cygnus, like the lack of acute and ICU beds in relation to other countries, was there in plain sight.^{13,14} There were also endemic problems in the capacity, funding, and staffing of social care—notably, care homes and their relative lack of consistent support from properly integrated local NHS services.¹⁵⁻¹⁷

Likewise, the, health policy think tanks and public health experts had repeatedly highlighted cuts to public health funding.^{18,19} These cuts have in turn impaired our ability to respond to this pandemic. Those same think tanks and nursing organisations had also repeatedly highlighted the decimation of the community nursing and health visiting workforce.

News values are what they are. But we need to stop reporting good practice as a bad thing—even in contentious areas such as care for the sickest or dying patients. And we should stop neglecting to report on issues affecting frail older people in community settings, which leaves them out of sight and out of mind.

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