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How can we manage covid fatigue?

Fiona Godlee *editor in chief*

What's the long term outlook after covid? And what's the prognosis for health systems and staff struggling with covid pressures, waiting lists, and stretched resources?

Most people make a good recovery, but the wide range of covid related illness and organ damage weave a complex prognostic picture. Of patients discharged from hospital, more than one in 10 will die within six months, writes Emily Fraser (doi:10.1136/bmj.n1565).¹ Some patients with lung damage will have persisting respiratory symptoms, but for those who were previously fit and without other complications the outlook is good, with functional recovery better than expected from the radiological evidence.

Up to 376 000 people in the UK have reported ongoing symptoms more than 12 months after contracting the virus, with persistent mental and physical fatigue a troubling reality for many (doi:10.1136/bmj.n1559).² This presents clinicians with a range of challenges. Should patients with fatigue follow the dominant advice of the CFS/ME communities: that pacing rather than graded exercise therapy is the safest route, as is now also recommended in controversial draft guidance from the UK National Institute for Health and Care Excellence? Or does this risk sentencing patients to a lifetime of symptom monitoring and long term disability? What of the researchers braving this often toxic academic terrain?

Promisingly, away from the "fire and fury" of debate, doctors and others are quietly working out how best to treat each patient without causing harm (doi:10.1136/bmj.n1559).² Careful screening for post-exertional malaise and individualised treatment plans seem to be the way forward. But it's also crucial to tackle endemic power imbalances between patients and professionals and to co-produce knowledge and services (<https://blogs.bmj.com/bmj/2021/06/23/how-power-imbalances-in-the-narratives-research-and-publications-around-long-covid-can-harm-patients>).³

The needs of patients with long covid are just one of many calls on stretched healthcare resources. We also need a primary care led vaccine infrastructure (doi:10.1136/bmj.n1578) and a full recovery plan for the NHS

(<https://blogs.bmj.com/bmj/2021/06/18/chris-ham-the-governments-response-to-the-nhs-backlog-has-fallen-short>).^{4 5} We can't recoup the vast sums squandered on test and trace, but perhaps a rethink will soon be in order after the US Food and Drug Administration's warning against using the Innova rapid test (doi:10.1136/bmj.n1582).⁶ This comes on top of continuing grave concerns about the test's reliability and evaluation (doi:10.1136/bmj.n1058) and now a call for trials in schools to be suspended (<https://blogs.bmj.com/bmj/2021/06/17/daily-contact-testing-trials-in-schools-are-unethical-and-ex>

[tending-them-to-include-the-delta-variant-puts-everyone-at-risk](https://blogs.bmj.com/bmj/2021/06/15/sheila-bird-diagnostic-tests-must-be-more-rigorously-regulated)).^{7 8} Despite all this, the UK regulator has extended authorisation for two more months (doi:10.1136/bmj.n1582),⁶ so it will be worth brushing up your understanding of how to interpret lateral flow tests (doi:10.1136/bmj.n1411).⁹ In case you need reminding, context and pre-test probability are everything (<https://blogs.bmj.com/bmj/2021/06/15/sheila-bird-diagnostic-tests-must-be-more-rigorously-regulated>).¹⁰

Sadly, the pressure on healthcare systems and staff is causing moral distress and injury (doi:10.1136/bmj.n1543),¹¹ which won't be helped by doctors in the UK retiring in greater numbers and at a younger age (doi:10.1136/bmj.n1594).¹² Tax rules on pensions are a major factor (doi:10.1136/bmj.n1517).¹³ The government has changed the rules for judges and must do the same for doctors if this haemorrhaging of vital talent and experience is to be stemmed.

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