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Cite this as: *BMJ* 2022;378:o1761

http://dx.doi.org/10.1136/bmj.o1761

Published: 20 July 2022

ACUTE PERSPECTIVE

David Oliver: My personal pandemic experience is just one of many

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I rarely write about my personal experiences, but practising medicine during the covid pandemic has finally given me the motivation. I'm just one of hundreds of thousands of clinical and care staff who have lived through it all, and my story is no more important than anyone else's. But I'd still like to tell it.

I came into the pandemic already tired from three decades as an NHS doctor working on big, busy hospital wards and the acute medical take, combining it all with many external national roles. Ideally, I wanted a break from medicine. I'd seen the reports from China, northern Italy, and the US about the impact of covid. By February 2020—when the chief executive of NHS England, the health secretary, and the chief medical officer were fielding stories from the press—I could see the writing on the wall, despite politicians' desire to play down the scale of the threat and to spread reassurance.

By early March I'd looked after my first patient to die from the virus, at a time when covid tests were still hard to obtain. Over the next four months I was a consultant for a designated acute "hot" covid ward, where all 28 patients were infected. I was also covering "hot" areas in escalation wards, the emergency department, and the acute medical unit when on call.

In those early days we had no vaccine, little evidence about effective treatments, and very variable personal protective equipment (PPE), with confusing and inconsistent advice about its specification. People I worked with were coming to work every day at personal risk and with varying levels of anxiety, not just for themselves but for their partners. I seemed almost blasé about personal risk at the time and enjoyed feeling more useful than at any time since I was a medical registrar—but my wife was worried every day, knowing that I'd be more interested in trying to speak to deaf or confused or anxious patients at close hand than worrying about personal protection.

Daily impact

I lost close NHS colleagues and friends to covid, watched many more become sick from it, and saw the daily impact of covid care on the nurses, healthcare assistants, allied health professionals, and young doctors I worked alongside. Some of their anxiety was about personal risk, but much of it was due to the relentless distress we were dealing with.

Covid medicine affected the training experiences of doctors starting their careers. In debriefings with them and other staff members, it became clear that the wider covid restrictions in society and concerns about infecting friends and family left them with few release valves to help their wellbeing.

Most inpatients with covid were not in intensive care but on general wards. With only flimsy PPE, we saw patients in their dozens with prolonged respiratory distress, high oxygen requirements, and other complications such as delirium or severe weakness. They were clinging to life or requiring palliative care. There are always some dying or deteriorating patients on general wards, but it's different when they're the majority.

Because of visiting and travel restrictions we had to spend hours on the phone having awful conversations with patients' distressed family members, breaking bad news or explaining that their loved one was sick enough to die. In usual times, such encounters would have been face to face. One Saturday five of my patients died within 90 minutes, and we had to speak to all of their families by phone.

During the second major wave from December 2020 to April 2021, the peak number of patients in hospital was twice as high as in the first wave, rising exponentially and rapidly that January. For the second time I was a consultant for a 28 bed "all covid" ward, for five months. This time we at least had vaccines, a range of evidence based treatments, and a much better understanding of how to manage patients.

But the same pressures and personal risks affected a staff team who were already tired. And isolation rules meant that patients were constantly being moved on and off the ward, depending on whether they'd just tested positive or gone 10 days beyond a positive test. It's hard to provide any continuity of care in those circumstances—and families were increasingly upset and sometimes hostile about the visiting restrictions.

Unsung heroes

In the spring 2022 wave I was once again the senior doctor on a designated covid ward. By this stage, anyone who tested positive was moved or admitted to my ward and then, if still an inpatient, moved off again within five days. This meant a frantic churn of patients.

Throughout the pandemic response operational and clinical managers have been unsung heroes, doing what they could to flex admission routes, bed bases, ward configurations, and staff roles. They did the best they could in uncertain circumstances, as decisions on patient moves and flow affected clinical staff coping with constant change. However, the repeated failings on PPE provision, staff testing, confused policies and communications for clinicians,

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and suppression of staff's concerns are things I find hard to forgive.

After two years of dodging the bullet I then caught covid myself in March, and, while not sick enough to be admitted, I haven't been right since. Some of my symptoms have doubtless been covid related, but others were due to burnout, anxiety, and depression—eventually leading to my being signed off work sick in mid-May, unsure when I can return to clinical work. Having been elected as president of the Royal College of Physicians in April, I reluctantly and with great sadness had to withdraw from the role last week, as I no longer felt able to do it justice. If this has happened to me—a veteran, stress tempered NHS doctor, 33 years in the job, with no long term conditions and previously fairly robust—then few of us are likely to be exempt from the strains of the past couple of years.

The NHS is now battling such a major backlog of cancelled elective procedures and relentless pressure on urgent care that this week every ambulance trust declared a major emergency. The service faces huge recruitment and retention issues, staffing gaps, social care pressures, and health inequalities, further adding to the strife. The timing—where so many staff find themselves tired, burnt out, demoralised, or unwell—could not be worse.

A George Cross won't compensate for this, and the mood music created by intransigence on terms and conditions won't help. Without sufficient clinical and care staff, in sufficiently good health, and with sufficient support, energy, and morale, there will soon be no viable NHS or social care system.

Competing interests: See www.bmj.com/about-bmj/freelance-contributors

Provenance and peer review: Commissioned; not externally peer reviewed.

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