The art of medicine

Medicine: before COVID-19, and after

Published Online
March 31, 2020
https://doi.org/10.1016/
S0140-6736(20)30756-X

It was a simmering that has caught fire. When, earlier this year, it became obvious that coronavirus disease 2019 (COVID-19) was a virus capable of pandemic damage and global reach, I wondered whether we were looking into the abyss. But my work in general practice was busy with so many seemingly more important things, and I looked away.

General practitioners deal in uncertainty: it is our stock in trade. We rate possibilities and reckon with potentials; we consider chances and debate differentials. We are Bayesians, constantly swinging between one action versus another. Little things—the tone of a patient's voice or the raising of eyebrows—pitch us one way or another. I was taught, at medical school in the north of Scotland, that when we hear footsteps, it is more likely to be a horse than a zebra—in other words, common things are common. But every week, rare things happen. We say that the estimated incidence of a blood clot with the combined oral contraceptive pill is about five per 10 000 women per year: tiny. But it also means that, with 3 million women in the UK or so prescribed the pill each year, we expect more than 300 women to have an iatrogenic harm, a pulmonary embolus. Terrible things happen every day—quiet deaths linked with poverty and pollution, only identified by painstaking data collection. But some things are obvious, perhaps only in retrospect and if we listen to the right people. A one-in-a-century global pandemic was predicted and expected, and is happening: yet it also seems surprising, even shocking.

6 months ago, I was getting on with things, lots of things. Fancy food on demand in restaurants that were intent on also giving customers "an experience". Trips at the weekend to nice hotels and outings to dinner parties, opera, and theatre were easy. Beautiful lives, edited into Instagram, gave some people fame and some people insecurities. At work, I was irritated but compliant with pointless paperwork and tedious referral processes, which were sometimes rejected by hospital departments, themselves under pressure to meet targets. And then the world turned.

COVID-19 leads the news, smears across our social media, agitates at the seams of society. Quarantine, such an old-fashioned word, is here. The schools have closed and we do not know when they will re-open. Exams have been cancelled and leaving parties held online. At the end of 2019, before this pandemic, I had updated my will and power of attorney, smugly thinking how far in advance of the inevitable I was. Indeed, the world turned.

The public response to this pandemic varies. Anxiety, here, is normal. A small dose of anxiety could even be useful. It would make us take the advice to self-isolate or social distance seriously. It would make us ensure that we have planned to be comfortable for a few weeks on our own. This is all very well if you have regular money coming in, the ability to use the internet, and transport, if needed, to get the shopping home. But there has also been some social panic, as contagious and dangerous as COVID-19. It can make humans, as a group, irrational or selfish.

I am anxious too, primarily about the people I love and the patients who I know are likely to die if they contract COVID-19. We may have people in our lives—older, or medically vulnerable—whose health is reasonable, but who we also know would not, realistically, be ventilated. We may have people in our lives whose work means they have a vastly increased chance of receiving a large dose of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

There has been much criticism aimed at the UK Government about poor preparation and lack of testing for COVID-19, inadequate personal protective equipment (PPE) in many National Health Service (NHS) settings, and an initially unclear message to the public about social distancing and self-isolation. This is still an age of incompetent politics. Nursing, medical, social care, and support staff are at risk. Many are fearful that they are not being protected with the equipment best able to defend them. But even if best practice is going to be possible—and with the numbers of patients predicted and the space and staff shortages in the NHS, it's hard to see how it will be—health-care workers will become sick. At the time of writing, three UK doctors have died of COVID-19.

Julian Finney/Getty Images

The reports of health-care professionals dying in other countries are stark.

Global pandemics reach us all. As a species, it seems that we are slightly stunned by our lack of autonomy over this pandemic. Celebrities and billionaires are not immune, despite reports of their escape to yachts, private islands, private testing, and an endless supply of hazmat suits. But, of course, the poor always come off worst, and there is no reason to think this will be an exception.

There is another side, of course. People are organising, street by street, to make sure that self-isolators are safe and fed. Medical students are offering to look after children to let their health-care worker parents get to work. Maybe "Big Society" is really little society, doorstep to windowsill. Red tape has been evaporated in some places as homeless people have been offered free accommodation. Some supermarkets are opening earlier to let vulnerable people or health-care staff get necessary food. People have applauded their health-care workers.

And perhaps people are becoming more aware of the environmental risks of human behaviour. The absence of people doing non-essential manufacturing and travel has resulted in a sharp drop in pollution. The possible expected reduction of pollution-related disease might make us question what life should look like once we are over the worst. We are guests on this planet. If only we took climate change as seriously and acted as swiftly. Could we imagine lockdowns to protect the planet? But slow deaths do not make headlines like frighteningly fast, pandemic ones.

Now many people in the UK are looking admiringly to the NHS, respectfully asking experts for advice, and paying homage to professionalism. Will these attitudes last once ventilators become scarce? Will there be civil unrest if people refuse to self-isolate? The NHS is threadbare of resources and cut to the quick of beds. The scars left after all the NHS contract negotiations are still visible, if healed at all. Yet the professional contract is not, at heart, with government, but with patients. This explains much professional discontent, when clinicians feel that the work stipulated serves a political agenda, not a clinical one. It also means that in times of crisis, liberated from the shackles of other peoples' priorities, we can get back to the core meaning of being a health-care professional.

Change in the NHS usually happens slowly, with many committees, consultations, and disagreements. Yet with little discussion, and rapid acceptance, my work in general practice has changed, utterly. In my practice we do not allow free booking of appointments: we phone everyone who wants contact with a doctor, and then work out what to do. We had been promised telemedicine equipment months or years ago and it suddenly happened. Technicians, working around the clock, had video consultation equipment up and running in a week. The delivery of PPE has taken far longer, with much confusion and angst, and justified criticism of government in being slow to realise the threat and need for urgent action. Still, my practice team have blossomed despite the daily changes, reorganisations, and increasing stresses. I have noted how many patients, at the end of consultations, ask us to stay safe. Last week, after an overwhelmingly busy day, making multiple, pressured decisions with far less information than I would have liked, this consideration almost made me cry.

It feels like a watershed, before COVID-19, and after. Despite the promises made by the UK Government of sending COVID-19 packing in "just" 12 weeks, the social disruption, isolation, and restrictions seem like the new normal. There is also a new running of the NHS to make space for the response to COVID-19. I've been notified that my annual appraisal has been made voluntary. Screening programmes locally have been suspended. Many health boards have made health checks disappear. Chronic disease reviews have been reduced to telephone checks.

There is perhaps an opportunity for us to capture, now. It might be one route to banish systemic tendencies to create overtreatment. The new normal could be never again allowing ourselves to agree to do work of more political than clinical importance. Divisions between departments seem to have been subsumed with common purpose, good will, and urgency. We have also been talking more with colleagues. Freed from routine work that atomises my colleagues to separate screens behind closed doors, we have been talking, debating, and discussing more often and in one place. Staff have been willing to work extra shifts. The trick will be to realise this and make sure we respect the meaning of it, and keep it. A resurgence in trust in professionalism seems to have given us permission to finally disregard low-value bureaucratic work. Instead, the priority is organising to give the best care we can to the people who need it most. The NHS has told people for years that it "puts patients at the hearts of all we do". I suspect most doctors, frustrated at bureaucracy and barriers, would disagree. That it has taken a global crisis, which is killing patients and health-care staff, and which will have profound psychological sequelae, to make this happen, is catastrophic, and an unpayable price. This is likely to be a divide in the global history of medicine. I can only hope that professional collegiality and solidarity will get us through.

Margaret McCartney
@mgtmccartney

Margaret McCartney is the author of *The State of Medicine: Keeping the Promise of the NHS* (Pinter & Martin, 2016).