Redeployment during the COVID-19 pandemic: personal accounts from four ophthalmology trainees

BY NADA BURGESS, MARY HENRY, MARIA TADROS, YU JEAT CHONG

We once believed that the coronavirus would not penetrate the safe confines of the United Kingdom, like so many outbreaks before this. Once the news came that this pandemic descended into our hospitals, the anxieties about redeployment began.

Many of us thought the days of working the general medical wards were long behind us. We were safe within our lovely comfortable subspecialty of ophthalmology. The closest we had come to 'those days' was inserting the cannulas for IV Diamox or IV methylprednisolone, and often we would bribe the nursing staff with smiles to do this for us, so we could continue our slog in the busy eye casualties. How to prescribe magnesium infusions and IV immunoglobulin was long forgotten, to name just a small aspect of the prescribing we were about to encounter. We were brushing up on pneumonia management, electrolyte disturbances and advanced life support (ALS) over online e-learning, in the hope that this would do something to prepare us for what was to come. We rummaged through our loft boxes in search of our dust covered copies of the *Oxford Handbook of Clinical Medicine* and clutched them like comfort blankets. But the reality of managing a ward full of COVID-19 positive patients with additional complex medical needs was more than we expected.

Our concerns had been of adequate PPE, the risk to our health and subsequent risk to the loved ones we lived with. What would we encounter and what would we bring home?

Our redeployment began like a message through the grapevine. For three of us, there was a message from one of our ophthalmology consultants, relayed via a secretary, to contact one of the medical consultants. A quick phone call later and we were enrolled to start our first medical shift with two days' notice. For the fourth, an incorporation into the 9-5 junior doctor rota was verbally agreed. For three of us, a verbal rota was conveyed of a 12.5-hour shift pattern of four days on, four days off, four nights on, four nights off, repeated.

We were told the number of the ward we would each cover that day at morning handover, took one last look at each other, and wished each other luck.

Maria Tadros, ST1

I was asked to present to the acute medical unit (AMU) at 9am on Monday morning. By 10am, I had been allocated to the COVID-19 high-dependency ward.

As the days and weeks went on, I grew more comfortable with the environment and the anxiety eased. The respiratory team were one of the most supportive and uplifting groups of medics I have ever had the pleasure of working with. In the midst of the stress and unknown, this team found time to take me under their collective wing and allowed me to flourish in this new role in ways I never would have expected.

I saw humanity and compassion beyond anything I've ever seen before. Where the reality of life and death was unimaginably cold and harsh; I've seen kindness, warmth, and care. Juniors, consultants, ward sisters, frequently took the time to make you pause during the whirlwind of the day, simply to mentally check-in: "Yesterday was tough, are you ok?" At the worst of times, people became their best.

I saw as many deaths and spoke to as many grieving relatives in those six weeks as I have in the last four years of my career as a doctor. I fought for my patients until their last moments and held their hands minutes before they passed. After each loss, I learned to dig deep for the strength to start all over again for my next patient. And I truly believe this experience has taught me the value of kindness, empathy and of preserving those vital human moments in every moment, in every task.

At the end of my redeployment, I was unlucky enough to catch the virus myself. This gave me a new level of understanding that I had hoped to avoid, particularly after witnessing first-hand how devastating this illness can be. Thankfully, I fully recovered, but the experience gave me new perspective and appreciation for both the personal risk the medical team continues to take every day, and for the fear and vulnerability of the patients they care for.

As healthcare professionals, I believe we have cultivated an ability to brace against the storm and push through for our patients. And I have been incredibly proud to watch my colleagues adapt to the harshest environment and do exactly that, while taking care of one another.

Having now returned to ophthalmology, I will reflect on this experience for a long time. Initially, I was concerned that the trauma of this redeployment would be overwhelming, but I now see this as a resource – as something productive I will carry into my future. I have no doubt that this experience has shaped me – as a doctor and a human. It has taught me what kind of surgeon I want to be, and for that I am grateful.

"We rummaged through our loft boxes in search of our dust covered copies of the *Oxford Handbook of Clinical Medicine* and clutched them like comfort blankets"

Mary Henry, ST2

I was one of the luckier ones. ST2, fresh-faced and not long out of the foundation programme, so in theory this should have been easy.

I knew I had no choice. I knew this was an unexpected but real consequence of becoming a doctor and my duty after making that solemn oath on qualifying. I knew that we are doctors before ophthalmologists and I was happy to support however I could; but I couldn't help feeling disappointed. We'd worked so hard on getting a place in the specialty of our choosing and now that was taken away in a day. I was sent to a COVID-suspect ward where full PPE seemed most readily available for confirmed cases and I would later face the uncertainty of whether I was going to fall ill because another one of my patients had been confirmed positive. But I thankfully remained well throughout.

I was on the geriatric ward with one other junior who was always approachable and our assigned consultant was in fact a geriatrician. He was keen on teaching and always contactable for escalation, which gave me a sense of calm and reassurance. The first ward round was stressful, but it didn't take long to become accustomed to the basic maintenance of a medical ward again; and routine medical examination had become so limited due to the risk of infection that things felt manageable. Still, I feared the inevitable. Patients crashing, with me being the only doctor around, having to perform acute medical assessments that I was no longer confident in doing. It was only a matter of time until those cases came. Patients were suddenly crashing, appearing no more unwell than before but their oxygen demands shooting up. With most patients on my ward not being for escalation to higher level care; there was little more we could do. But for some patients it felt like we should have been able to do something.

There was something about looking someone in the eye and telling them they were dying that I struggled with. I had done it before but this was different. This was quick. And the frequency of patients becoming end-of-life was higher than I was used to on my geriatric foundation placement. The limited visitation added to the emotional toll of relaying this information to relatives over the phone. It became taxing. Sitting on the other end of the phone hearing them respond with gratitude for all that we were doing and had done, I would cry. How could I not?

Nada Burgess, ST3

Our experiences were different, but one thing was unanimous; we were thrown into the deep-end. No one understood how daunting it was for an ophthalmology registrar to suddenly manage a whole ward round. Yes, we had done it before in our foundation training, but that was a distant and vague memory at this stage. The wards comprised of up to 34 patients and we divided the ward into two: males and females. On my first day on the COVID positive ward, I was due to run a ward round of 17 patients and given the help of an obstetrics and gynaecology consultant; equally out of her comfort zone and also on her first day on the medical wards. We introduced ourselves to each other and then initially laughed at how far from medicine we both were. As reality dawned, our laugh-filled faces quickly transformed into astonishment and shock. We laboured on, constantly asking for help from a medical registrar who was covering the other half of the ward. It was slow. The nurses stopped to ask us questions as the day went on but were often met by our blank and clueless faces.

We were surrounded by COVID-19-positive patients, delirious from sepsis, unknowingly coughing in our faces. It was the peak of the pandemic. Everyone was afraid to get coronavirus. Those patients in the community with non-COVID-19 related illnesses were too afraid to come into hospital until they plainly had no other option. By which time they were very unwell. Everyone was very sick. Every case was complex. And everyone on this ward had COVID-19 to top it all off.

Many of the patients were end-of-life. The rest were teetering on the edge of it. It seemed if coronavirus did not kill them, it was the secondary pneumonia, the COVID-19 related thrombosis, the haemorrhage from the treatment, the acute kidney injury from severe dehydration, the pulmonary oedema from fluid rehydration, the subsequent electrolyte imbalance; the list was endless. Every day I went home and did not know which patients would still be there in the morning. I certified death more in a few weeks than I have in all my career. Every day there was a list of relatives to speak to about grave deterioration and to break bad news. It was heartbreaking. I had never had situations like this, being so detached from our loved ones in hospital. So many of them coming into hospital to do what I feared the most; to die alone. Numerous times I would be crying silently on the other end of the phone as I promised that I would pass on words of love to my patients for their relatives. We had forgotten how protected from death we were in our subspecialty of ophthalmology. This was a harsh reminder. The Thursday evening claps seemed so detached, as little did our neighbours know what sorrows we were facing.

Yu Jeat Chong, ST5

I have always wanted to be an ophthalmologist since medical school. In that sense, the two years of foundation training programme prior to entry into specialist training was more of a rite of passage rather than something I felt necessary.

As a senior registrar in ophthalmology, I never thought the day would come where I would have to be 'redeployed' to acute medicine. It was with a sense of trepidation that we began our journey on the medical wards. There was the fear of contracting COVID-19, passing it on to our loved ones. There was the fear of failing the principle of non-maleficence, and harming patients because we have been out of practice with medicine for so long.

Infectious diseases felt like something that you learned in medical school for exams, but never really had to face with a sense of urgency. After all, isn't the epidemiological transition from infectious epidemics to non-communicable chronic diseases the hallmark of a developed country? Everything changed with COVID-19. People and doctors I knew were falling sick. We knew some of the doctors who passed away personally. A parent of my close friend almost ended up on ITU despite being fit and well. A family member of mine passed away in the community from the virus. The virus was very much real.

And here we were as ophthalmologists, doing cannulations, arterial blood gases, prescribing fluids, breaking bad news and completing discharge summaries. There were numerous flashbacks to my time in the foundation programme. I would never forget the look of 'impending death'. There were many such patients on the medical ward during our time. I know that this is part of the job in medicine. However, this was not normal. People were scared, and visiting times were restricted. There were circumstances when the only person holding a dying patient's hand was a caring nurse rather than family.

I was fortunate enough to stay in touch with my colleagues from my formative pre-ophthalmology days. We have come a long way since, taking up the helm as registrars in fields such as ENT, infectious disease, obstetrics and gynaecology, endocrinology, cardiology. Our lives and specialties have been turned upside-down in 2020. There was

a time when I related to the article 'Les Miserables' about exams by Gwyn Samuel Williams; the worst fear for an ophthalmology trainee was to fail the FRCOphth and see others pass and leave study groups. There is now a more literal meaning for the medical profession to the lyrics: 'There's a grief that can't be spoken. There's a pain goes on and on. Empty chairs at empty tables. Now my friends are dead and gone...'

The fight against COVID-19 is far from over. While there is a fear amongst many doctors who are out of medicine to be redeployed into areas out of their comfort zone, I believe that we have to provide assistance to our medical colleagues who are so valiantly defending the frontlines. After all, this was what we trained ourselves to be, doctors.

WEBSITE RECOMMENDATIONS:

1. Mind, mental health charity: www.mind.org.uk
2. Every Mind Matters: www.nhs.uk/oneyou/every-mind-matters
3. Samaritans, mental health charity: www.samaritans.org

AUTHORS

Nada Burgess,

ST3 Ophthalmology, West Midlands Deanery, UK.

Mary Henry,

ST2 Ophthalmology, West Midlands Deanery, UK.

Maria Tadros

ST1 Ophthalmology, West Midlands Deanery, UK.

Yu Jeat Chong,

ST5 Ophthalmology, West Midlands Deanery, UK.