UNITED KINGDOM

# Transcript: 'All our ICU patients are in their 50s or younger' - frontline Welsh doctor recovered from virus, 3 April 2020

Dr. David Hepburn on Channel 4 News (a British broadcast service)

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'All our ICU patients are in their 50s or younger' - frontline Welsh doctor recovered from virus

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*A critical care consultant in the Royal Gwent Hospital in Newport is urging the public to keep listening to government advice. (Subscribe: https://bit.ly/C4_News_Subscribe) Earlier this week, Dr David Hepburn warned the hospital had run out of space in intensive care and had moved into operating theatres. This - in an area which has seen the highest levels of confirmed Covid-19 cases in Wales.*

## Introduction: Many cases, full ICUs

**Q:** There's been a lot of discussion about the Gwent area having a very high number of coronavirus cases. What does that *look* like from your perspective as an intensive care consultant? What's, what's it like in there right now?

**A:** We are definitely seeing a large number of cases. I've spoken to colleagues up and down the M4 [motorway] and I think we are definitely ahead by a week or two in terms of the rest of the M4 corridor in cases that we're seeing.

We've actually filled our intensive care unit now, above our normal capacity. Usually we have 13 ventilated patients—what they call level 3 patients, who need maximal organ support—and that's our maximum number we can take. We've got 16 ventilated patients in ICU at the minute, which has led us to completely run out of space. So we've taken over theatre recovery, we've got a further eight there. By the end of today we will fill recovery, which will bring us up to 25 patients. Then we have another area prepared, the old high-dependency unit and coronary care, that we've taken over as well. We can fit a further 22 patients in that area.

The way things are going at the moment—the rate of growth and the admissions we're seeing—I would say we will fill that by the end of the week, probably. So by the end of the week we will probably have quadrupled our capacity.

**Q:** Then what happens?

**A:** We'll have to find somewhere else. At the moment we're trying to identify other areas that we can put patients.

## Inside the ICU

**Q:** Can you paint a picture of what it's like inside your critical care unit? If I was to walk in, what would I see? What would I hear?

**A:** It's controlled chaos. Space is at a premium. Normally our patient population is made up of people who are acutely unwell, who are on ventilators, kidney machines, strong drugs to support blood pressure. There will always be a few of them. There'll be a few people who are recovering, getting ready to leave ICU, and then a few who just need a bit of supportive care who maybe aren't as sick as the others. The difference at the moment is everybody is desperately unwell. Everybody is on a ventilator. So the acuity, the severity of illness, is very high.

The staff are all wearing full PPE, so…what I'm wearing now but with the gown the other way round, plus goggles, plus respirator masks, or FFP3 masks, and two pairs of gloves. It's very hard to identify which staff member is which, so we've taken to writing our names and roles onto the front of the gown so that we can easily identify people.

## Young-than-expected patients

**Q:** How would you describe the atmosphere?

**A:** We're doing what we're best at doing. So morale is high. There's a great deal of camaraderie. Everybody is aware of the severity of the situation and I think everybody is focused at the minute on delivering the best care we possibly can to these patients.

The patient population, there are a lot of people who are in work. There are a lot of people who are younger. The pattern of illness in Gwent—I can't speak for anywhere

else—is much younger patients than we were expecting. When the reports started coming out of Wuhan, we were led to believe this was particularly dangerous for older patients. But I would say all of the patients we’ve got in intensive care are in their 50s or younger, at the moment.

**Q:** Really? I think that would surprise quite at lot of people.

**A:** And it surprised us. Our youngest patient is in their early 20s. There are patients who are very well—a chap who’s a fitness professional—there are a lot of patients who are, do not have any pre-existing medical conditions, they’re not diabetic or anything like that.

## Ventilators as Barriers to Patient Communication

**Q:** If it’s difficult sometimes to identify your colleagues in the unit, presumably, there is a real challenge in communicating with patients as well.

**A:** Yes, and that’s probably the biggest challenge we’ve found so far. The patients themselves, on the whole, are unconscious. We anesthetize most people on ventilators, just because it’s very unpleasant having a foot-long plastic tube through your mouth, down the back of your tongue, and into your upper airway. Most people will need some degree of sedation to tolerate that. It also means that they will synchronize better with the ventilators. They’re not fighting the ventilators; they’ll allow the ventilators to do their job. So the vast majority of patients are fast asleep at the moment—mainly for their comfort and also to facilitate their care.

## Ban on Vistors

**Q:** Can you have any visitors in the unit at the moment?

**A:** No. No, not at the moment. Logistically it just isn’t possible, at the moment, and

that's partly for public safety.

**Q:** And how difficult is that for everyone involved, given that some of these patients will be perhaps close to their last days?

**A:** It's incredibly difficult. We are updating people as much as we can. We've got dedicated people who are phoning and updating relatives every day. We're also using email. We're able to use video calling. But it's a poor facsimile of actually sitting down in a room with proper human contact, to be able to give someone a hug, or offer them a hand if they're upset.

**Q:** Can I ask you: if you have a patient in an end-of-life situation, can the family come into the unit?

**A:** Thankfully, we haven't been in that situation much yet. We are looking at potentially finding a way to allow family members to come in, accepting the risk and wearing full PPE. I mean, it's the last thing we want is to deny anyone time with a family member if they're going to die. But the practicalities, that we haven't ironed out yet. The danger is that then, particularly if you've got more elderly patients who have succumbed to the disease, if their relatives are often of similar age, which they've often are — wives, spouses, etc.— there's a real and tangible risk, that if the disease is transmitted to them, that they could end up in the same situation.

## Characterizing the Illness

**Q:** Have you had patients dying in the unit from coronavirus?

**A:** Yes.

**Q:** Can you explain to me why someone can die after having contracted coronavirus?

**A:** What we know is that, primarily, coronavirus causes respiratory failure. When it

spreads to the lungs it causes what we call a pneumonitis, where the lungs become very wet and waterlogged inside. So the normal mechanisms that keep fluid in the blood break down, the membranes and tissues in the lungs become porous, and allow fluid to leak into the lungs. It's almost like drowning. One of the things we can provide with the ventilators is we can provide pressure which pushes some of that fluid out and helps to keep the lungs open. So one of the mechanisms that people become exhausted is because the work of breathing is so great that they basically become exhausted and die.

If you imagine your lungs as normally like a nice light sponge, light and easy to move. If you've ever pulled a sponge out of a bucket of water, you know how heavy and wet a sponge can become. Exactly the same thing. If your lungs are absolutely sodden, then it's very, very difficult to breathe. And what happens over time is people's oxygen levels fall, the levels of carbon dioxide — which is a gas you normally breathe out — rise in the blood, that makes you even more drowsy; it has a narcotic effect. And then people will slowly develop worsening respiratory failure, and eventually they'll become unconscious, and their breathing will get more shallow, and they will die. So that's what would happen if you were left alone. Thankfully, we can intervene with a ventilator and prevent that from happening. But the deaths vary from multi-organ failure, which is basically a progressive shutdown of all the different organs including your kidneys, your circulation, failure of your liver, as well as your lungs. So we've see that. But we also see patients who develop a thing called myocarditis. Lately, often when they're starting to recover, the heart can become very adversely affected by the virus and they develop heart failure. That's been probably the leading cause of death in the COVID patients that we've seen.

## Personal Experience with Coronavirus Illness

**Q:** You've had coronavirus. What was that experience like?

**A:** Not one I'd like to repeat. It started off quite innocuously. I had a bit of a *burning* sensation in my nose. I lost the ability to smell, even though my nose was clear; it wasn't buggered up. I didn't feel too bad for the first three days, and I thought, "Well, i this is as bad as it gonna be, then okay, I should be okay." But actually as the week went on I felt worse and worse and worse. I developed *terrible* muscle pains, joint pains. I was *exhausted* just on minimal exertion. Even walking up the stairs, I was getting short of breath and having lie down afterwards.

## Impact of ban on vistors

**Q:** Just on the subject that we were talking [about] earlier: I spoke to one consultant in Swansea yesterday who said the worst thing is for patients in the later phases of their illness, where they can't have visitors around the bedside. And that's heartbreaking for staff and for families. He said when these patients are on their own during the last hours of their lives.

**A:** Mmmm. It's awful. And it flies, completely flies in the face of everything we've ever done. You know, a lot of patients will not survive intensive care even, you know, not in the middle of an epidemic. We are very used to providing a good environment for people to have a comfortable and peaceful death with their families around them. And we have psychologists, we have *excellent* nurses who are specialists in end-of-life care. Although it's a high-tech environment, we can provide a peaceful and compassionate end, and we really pride ourselves on that.

This situation is completely disrupting our ability to deliver that. No amount of video calling or phone calling can make up for that. That's something I am very worried about. We're very lucky that we haven't had many deaths at all yet. Our intensive care strategy is working, but in coming weeks this is going to be a huge, huge problem, and I have to be honest, it's not one that we've cracked yet.

The *sensible* thing to do is to keep people away —

**Q:** First, for you personally, how are you feeling about that?

**A:** [Pause/deep breath] There are a huge number of things that are not normal about this situation and that's one of them. And I will do my level best. The one thing we *can* do, and that we are able to do and that I will do, is we can, even if the patient's family can't come in, is we can be there. A doctor will be there. A nurse will be there. Our team of very caring and I — if necessary we will sit with those patients and hold their hands. And I, no one should die alone. No one should die without someone holding their hand and talking to them. talk to them. Ideally it would be the family, but at the minute we haven't got to the stage where we can facilitate that.

## Anticipated Rationing

**Q:** Are you envisaging a moment where you might have to ration healthcare in a worst-case scenario?

**A:** At the moment we've got sufficient capacity to deal with the demand, but as the weeks go on, if we don't see a slowing down in the infection rate, and don't flatten the curve, then then we will are gonna start running out of space. That's when very difficult decisions will have to be made. I hope to God I don't have to do that, but it may happen. We've seen it happen in Italy as well.

**Q:** Access to ventilators, for instance?

**A:** For instance, yeah. But it's more than just ventilators. It's staff as well. There will be enough ventilators of one shape or form, but you need a whole gamut of staff —at least five staff—to safely look after someone on a ventilator. And that's the big problem.

**Q:** And if you don't have that resource, in terms of staff available?

**A:** If you don't have enough staff, what happens is your outcomes start to get worse.

## Messages to the public

**Q:** Can I ask you, what will your message to the public would be now, from your perspective inside this unit?

**A:** My two messages to the public of the minute would be: one, keep doing what you're doing. Please support the NHS—we really, really appreciate it, and it's all the thanks we need. But the other thing that's *massively* important is please, please listen to government advice on staying in. Don't go out unnecessarily. Don't pop to the corner shop just to buy some milk. *Please, please* adhere to the advice.

Because at the minute we've got things just about under control. In two weeks, if infection rates rise even further, this is going to be a very, very different situation and it's going to be very frightening. People *really* need to heed that advice. And be aware that you can get this at *any* age and in any degree of health. Don't think you're so young and healthy that you won't get it, because we've seen people again and again developing this illness when they've had no medical problems before at all.

## Potential impact on NHS

**Q:** You've been working in the NHS for how long?

**A:** Twenty years.

**Q:** Do you think this experience will change you?

**A:** Yeah. I don't know how yet—because you never know in the midst of it, do you? But I think it will change — I think it's going to change the whole world. But I think that it will change the NHS massively in terms of the way we do certain things. I think the NHS will become more efficient in some respects.

**Q:** And what about your view of the profession you joined?

**A:** That hasn't changed. I joined intensive care to save people's lives, and that's we're gonna continue to try and do.

## Message to families of patients

**Q:** I just wonder if you have a message to the families of those in this unit and who perhaps can't be with their loved ones?

**A:** Yeah. And I can't imagine how awful it must be not to sit with your family members when they're this unwell. Please, please believe us when we say we will do *absolutely* everything we can to get them through this. We understand, we understand how difficult this is. Please bear with us.

But the one thing I can absolutely promise is, irrespective of what happens to your family member, we will always be there. We will always do our best to make sure they're comfortable and that they're not on their own. We are there and this is reason that we chose this job—to give comfort to people who are critically unwell, and we'll continue to do that.

## Coping/Decision-Making

**Q:** I mean, you're immersed in this, in the midst of this outbreak at the moment. How are you feeling at the moment — emotions you're feeling at the moment?

**A:** I guess it goes with the territory. You become good at putting these things in a box. They all go in a box somewhere, and one day they'll come out of the box. But now's not the time. So we'll address that when we come to it. But at the minute it's just focus on the tasks that we've got at hand, which is an absolutely Herculean task.

**Q:** What are you finding currently are the most difficult decisions you're having to make in the unit.

**A:** As I say, so far, because we were very aggressive very early in the outbreak, that we have still got capacity to take patients who will benefit from intensive care. We haven't had to make decisions based on availability of equipment, and I am dreading if we ever get to that stage.

## Lack of contact with patient families

**Q:** What do you find the most striking difference about treating patients with this virus then you would normally be in an intensive care unit role?

**A:** The biggest thing is the lack of contact with people's families. that's the one thing that is really playing on my mind, and it's the one thing I know that my colleagues are very worried about as well, is that we don't just treat patients; we treat patients and their relatives and their families, and we provide support, and it's very hard to do that remotely. I think that's got to be out biggest worry. I mean all they can do, relatives of patients that we've got is they have to trust us that we will do everything possible. Don't listen to adverse media reports about rationing or lotteries or people making the cut to come into intensive care. If your relative will benefit from intensive care, we will bring them in. But that's not to say that we will bring everybody in, because some people will not benefit, and that would be the same if we didn't have a pandemic.

## Predictions

**Q:** Do you think you're going to weather the storm here?

**A:** I hope so. I hope so. It really depends on the next few weeks. If you look at the — I've seen some of the public health projections, and there are two sets. There's a set if

we flatten the curve, I think we will deal with what comes in, as long as we can keep patients flowing through the hospital and get them out when they start to get better, I think we will weather the storm. If, particularly if the public ignore distancing advice, and people… you know, this is going on for awhile, there *may* come a point where people think, "You know what? I've had two weeks at home, I'll go out again." If that happens, then rate of infections will rise again and we cannot take another spike in infections.

If we can flatten the curve we've got that young for you here. Well that would mean that we would run out of space, we would run out of staff, we would run out of equipment, and we will have to, you know, the rationing that you spoke about will have to happen. And that's the one thing we don't want to happen.

If people get bored and they leave the house and then the infection rates start to spread, if we, it will be like a wave and it will wash the hospital away. And, you know, the fallout from that will be absolutely catastrophic and I can't emphasize that enough

### NHS workers dying (including fit and healthy)

**Q:** It must be particularly difficult for you and your colleagues seeing that quite a few NHS workers have, have died from this now.

**A:** Yeah. Yes, absolutely terrifying. And again it's a reminder that, you know, that the NHS staff, you know, there is a reason why we all do this, and there's a reason why people are willing to, willing to risk their lives to look after patients with coronavirus. And it's because that's what we all signed up for.

But it's the last thing anyone wants to see as healthcare workers losing their lives. But it, again, it's a reminder that the virus does not discriminate on your status, on your age, on your job title. And actually it doesn't care that much whether you've got pre-existing medical conditions. You know, these, some of these healthcare workers are fit

healthy people and that's absolutely, you know, that's terrifying.

I think that everybody who's working here would try not to think about that too much but everybody's aware of it. Which is why we're doing so obsessional about making sure that we, you know, check our PPE, check each other, and keep each other as safe as we can. But I'm afraid that won't be the last of it. We will see more healthcare workers dying with this.

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