COVID-19 brought out the best and worst of us

There is no doubt that the COVID-19 pandemic response in South Africa demonstrated both the highs and lows of our healthcare system. The hard lockdown in 2020 was implemented to allow the healthcare system to prepare for the burden of patients expected in the first wave.[1] The second and third waves created even greater burdens on healthcare systems and providers. Hospitals were understaffed and overburdened with the sheer number of patients contracting SARS-CoV-2 infection and a significant number needed admission and supplemental oxygen. How we coped and adapted our systems, has been the topic of many coffee- or wine-occasions and a substantial number of publications, each providing some insight into what happened, but also giving us cause to stop and think about how we can do things in future.[2]

Authors from the Universitas Academic Hospital in Bloemfontein, report their experience of 'redeployment' of staff to fill a need within their COVID-19 response, to great success.[3] The respiratory technologists who were primarily responsible for lung function testing during 'normal' times, were not performing tests due to the COVID-19 restrictions. Their primary skill set, being that of respiratory physiology testing and understanding of oxygenation and respiratory support, they had no practical experience of managing critically ill patients. The authors do not indicate who came up with the idea, but after a short 'ICU immersion course', they were deployed to assist with managing the oxygenation support of patients with severe COVID-19 infection in the makeshift COVID-19 wards. The six technologists managed the respiratory oxygen support in over 100 patients over the 1-year study period.

What is clear, is that these individuals formed a critical part of a team, managing very sick patients. The overall mortality of 41.5% is in keeping with the expected outcomes in our context.[4,5] Over the one-year period, over 40 patients would have died in their care, something they would not have been trained for. They were however, provided with support and counselling to ensure that they were coping with the new job challenges. It is also clear from the way the authors have expressed the value of the respiratory technologists to the team of '*inexperienced clinicians and nurses*', that they were indispensable. Like in many hospitals, most clinicians were out of their depth during COVID-19 wave peaks, if not clinically then at least, operationally. Each team member in the front-line team would have brought what they had to offer, no matter how inexperienced in COVID-19 respiratory failure management they were. Each of the nurses, doctors, housekeepers, porters, cleaner, clerks, catering staff have contributed in some way. That is the only way we survive in a crisis.

This study highlights the importance of thinking out-of-the-box during a crisis, but also asks the question of '*given the narrowly-defined job descriptions, could we be doing more in our workplaces? Could we find new ways to support services within our hospitals, by bringing our skill sets to the table and looking for opportunities to serve?*' It really is testament to the character of these individuals who stepped up and worked on the frontline beyond their normal duties and comfort zones. How many more patients would have died if they had thrown up their hands and said '*outside of my job description*!'

Bring what you can, together we are so much more capable.

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1. Naidoo R, Naidoo K. Prioritising 'already-scarce' intensive care unit resources in the midst of COVID-19: a call for regional triage committees in South Africa. BMC Med Ethics 2021;22(1):28. https://doi.org/10.1186/s12910-021-00596-5
2. Michell W, Joubert I, Peters S, et al. The organisational response of a hospital critical care service to the COVID-19 pandemic: The Groote Schuur Hospital experience. South African J Crit Care 2021;37(2);63-69. https://doi.org/10.7196/SAJCC.2021.v37i2.503
3. Maasdorp SD, Pretorius M, Pienaar P, et al. Afr J Thoracic Crit Care 2022;28(2):66-69. https://doi.org/10.7196/AJTCCM.v28i2.210
4. African COVID-19 Critical Care Outcomes Study (ACCCOS) Investigators. Patient care and clinical outcomes for patients with COVID-19 infection admitted to African high-care or intensive care units (ACCCOS): a multicentre, prospective, observational cohort study [published correction appears in Lancet 2021;397(10293):2466]. Lancet 2021;397(10288):1885-1894. https://doi.org/10.1016/S0140-6736(21)00441-4
5. Calligaro GL, Lalla U, Audley G, et al. The utility of high-flow nasal oxygen for severe COVID-19 pneumonia in a resource-constrained setting: a multi-centre prospective observational study. E Clin Med 2020;28:100570. https://doi.org/10.1016/j.eclinm.2020.100570

Afr J Thoracic Crit Care Med 2022;28(2):53. https://doi.org/10.7196/AJTCCM.2022.v28i2.260