‘How the Covid-19 Pandemic has taught me to be a better doctor/psychiatrist’

In psychiatry we place emphasis on the widespread use of George Engel’s biopsychosocial model. In his original paper, Engel wrote of the prevailing attitude in psychiatry at the time that sought a return to the ‘neat and tidy’ biomedical model of other medical specialities driven by technological advance and elucidation of the mechanisms of disease.[1] In calling for a rejection of the primacy of the medical model, Engel contended that it was all medical specialities that were in crisis, and implored all doctors to think of all health as inseparable from the social factors in our lives and our psychology.[1]

The covid-19 crisis has necessitated a reassessment of how we practice psychiatry, and provided us with opportunity for growth and development as doctors. Whilst our fundamental biology and our medicines remain unchanged, covid-19 has caused a great deal of change to our social factors and environment. To prevent rising covid-19 transmission, our patients and the wider society have been required to stay at home, practice social distancing measures, and wear facemasks in public. These social changes have more greatly affected those in more deprived socioeconomic groups who, for example, have had to shield or self-isolate in more confined spaces, are less likely to have financial reserves to utilise, and are more likely to have suffered job or educational loss.[2] In short, the pandemic has highlighted the importance of social relations and treatments for our patients, and laid bare the devastating effects of economic inequality on health outcomes.

The need to socially distance provided the impetus for a rapid shift toward video consultations as standard practice in psychiatry; it is doubtful that this shift would have occurred at the rate it has without covid-19. While the longevity of the shift remains to be determined, it appears certain that some forms of video consultation are here to stay.[3] In my practice as a core trainee, during the past two rotations there have been a number of situations where video consultations have augmented practice, providing new channels

of communication into previously inaccessible places. On my acute psychiatric ward in East London we were able to set up a meeting in which three family members in Birmingham, London and Amsterdam communicated with their brother and son in a ward round. After establishing that this was viable, we were able to suggest video consultations to other disparately located relatives.

I have also been able to start my short-case psychotherapy training over Zoom with a patient who, covid-19 aside, is struggling to make or attend any appointments due to anxiety.

In summary, video consultation provides benefits in, for example, situations where there is a significant geographical distance between patient and psychiatrist, where staffing levels are light, and for certain forms of consultation where purer forms of verbal communication are key.[3]

In the summer I rotated from the acute wards to working with older adults in liaison psychiatry. On the wards in acute hospitals, infection-control measures require consultations to be conducted wearing surgical masks, aprons, gloves, and often visors. Communication with frail older adults on noisy wards has always been challenging, and requires resourcefulness. Sensory impairments are common and the value of checking for working glasses and hearing aids, locating the good ear and sitting on that side, and having a glass of water on hand for a raw throat, are tried and tested techniques for enabling otherwise complicated communication. Masks and visors designed with prevention of infection transmission in mind have the side effects of preventing the transmission of friendly smiles and impeding sounds, leaving older adults more isolated than ever. Certain actions have provided ways around the impediments to communication that covid-19 has generated. For example, with patients who have good vision but struggle with hearing, spending a bit more time using whiteboards and pads to write down messages has proven useful.

Friends and relatives remain, for the most part, unable to visit their loved ones on the wards. Older adults are less likely to possess a phone whilst an in-patient in hospital. The telephone and tablet resources on acute wards are technically unpredictable, adding to already established obstacles of delirium and acute confusion. This has brought new significance to the collateral history which increasingly doubles as a means to send messages to hard-to-reach patients, and to provide guidance on where and when to drop off essential items. In the future, increasing use of video calls would be one answer to relatives' inability to visit.

Alongside covid-19 infections we saw a 'social pandemic' relating to the effects of economic and social inequality on the health outcomes of different groups. The effects of social inequality on our health have been known for some time. In the 1970s the epidemiologist and public health doctor Sir Michael Marmot investigated cardiovascular disease experienced by civil servants in Whitehall.[4] He found that cardiovascular mortality and morbidity rates decreased in a stepwise gradient with increasing grade of civil servant.[3] The effects on life expectancy and disability-free life years remained when the groups were controlled for all the usual risk factors such as hypertension, smoking and family history of heart disease.[4] Marmot had found that socioeconomic status itself was a risk factor for cardiovascular disease.[5]

In psychiatry, a large sector of our patients are of lower socioeconomic status. The covid-19 pandemic has highlighted the disparities in living standards and challenges faced by this group. Patients living in smaller spaces with higher density of people and less material resources to draw upon have been worse off under the conditions of the lockdown.[2] In 2010, the UK government commissioned the 'Fairer Society, Health Lives' report, led by Michael Marmot. Marmot's report proposed a framework for action to close the gap in health outcomes linked to inequality with six policy objectives that sought to maximise individual and community potential through health, social justice and

sustainability[6]. The report called for investment in evidence-based measures designed to tackle inequality and therefore prevent disease and bring about a long-term benefit on disease burden, including mental health. The release of Marmot's report coincided with the 2nd anniversary of the 2008 financial crisis, and the government's subsequent focus on austerity lessened any real hopes of the investment required to action these policy objectives.

What we have seen from early on in the covid-19 pandemic are the results of this lack of investment. Covid-19 has been shown to cause more deaths in areas with more deprivation[7,] and has also discriminated against certain ethnic groups more than others. In a Channel 4 documentary 'Is Covid Racist?', Dr Ronx, an A&E doctor in East London, highlighted that two thirds of all healthcare workers who died were from BAME backgrounds, and spoke to the friends and families of some of those who tragically passed away. Dr Ronx captures their feelings of turning up to work: 'Am I going to go to work, am I going to get unwell and am I going to die?'[8] Although this sentiment was by no means exclusive to BAME frontline staff, there was certainly good reason for BAME staff to feel her words more acutely.

At my workplace in North East London we have a diverse workforce, typical of the population we serve. We have had many discussions about the virus, the vaccine, and how the pandemic has affected our friends and families. Covid-19 has made me more aware than ever about the importance of listening to and respecting the views of my colleagues. The events have provided an impetus to air and share our understanding of the events.

The covid-19 pandemic has brought about the most profound changes to our lives in recent times. The radical need for change in the way I practice has enabled me to improve as a doctor in how I communicate with my patients by the bedside, in facilitating remote communication and sharpening my awareness of the social factors that

influence and often restrict my patients lives. As a recent editorial in the BJPsych Bulletin by Peter Byrne and Adrian James implored, 'Placing poverty-inequality at the centre of psychiatry' is a worthy goal for those of us working in psychiatry.[9]

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If I were to be successful in this competition, I would like to spend the £250 on a tablet for the Dementia and Delirium Team nurses at Whipps Cross hospital so that they can help patients communicate with relatives at home through video calls with greater ease.

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