A FIRSTHAND LOOK AT AUSTRALIAN ICUs IN THE TIME OF CORONA

An Interview of Dr Ken Hillman

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These days, our media, our emails, and our thoughts are saturated with news of the COVID-19 pandemic. A lot of this news is filtered down from one source, to the next. As medical students, while we understand more about it than the general population, we still find ourselves on the outskirts of this pandemic.

Dr Ken Hillman is an ICU specialist at Liverpool Hospital NSW and a Professor of Intensive Care at UNSW. In this capacity, he has helped manage many severe cases of COVID-19 in Southwest Sydney. We were fortunate enough to interview him in April about his firsthand experiences and insight on the pandemic.

Based on your personal experiences, how are you and other ‘frontliners’ coping with the emotional stressors of dealing with this pandemic?

Relative to other seriously ill patients, the COVID-19 patients are no different in terms of the level of their illness and support required. The major difference has been the anxiety of staff and the fear that they themselves may contract the illness and pass it onto their families. The workload is also increased, related to the number of seriously ill patients and the lengthy procedures that have to be undertaken with PPE. Having said that, I stand back in awe at how committed the ‘frontliners’ are; the way they organize themselves with all sorts of innovations and how team work becomes genuine interaction around a common challenge. Memorable.

How do you feel about how Australia (as a whole) is handling the COVID crisis? What was handled well and what could be improved on?
We have done well in Australia with early and appropriate interventions. However, with this question I can’t help but reflect on the serious situation in the USA. According to WHO, it is the 36th worst health system in the world. It is a system based on individuals and their ability to pay. In other words, there may be some centres of excellence, but the public health system is poor, and serious inequalities still persist across the country. The number of people infected may not even be a reflection of the real number as people may not have testing available or the ability to pay for it. Twenty percent of Americans become bankrupt as a result of management in ICUs. I’m not too sure who is paying for those costs in the current pandemic. For the advocates of a private health system, the way America is handling the situation will cause some reflection.

How is our health system coping, given the added burden by COVID-19? Are we equipped with the resources necessary to cope with potentially increasing demands?

Intensive care is an international specialty that believes in communication. Intensivists have been in contact with each other since the pandemic first started; firstly with our Chinese colleagues, then from Italy, Spain, the UK, and the USA. We were able to quickly figure out that the strategies we have been using for many years work in COVID-19 patients and that the key to managing the pandemic was control in the community. If those measures were late in coming, the number of detected cases would rise and of those, a certain percentage would deteriorate and require ICU.

Modelling and projections would give us some idea of the resources required in ICU. Some countries such as the UK have had shortages of personal protective equipment (PPE) and others with ventilators and ICU and hospital beds. The Australian health system has been well organized and well prepared to cope with the pandemic. So far, there have been no shortages of supplies for the seriously ill. The death rate has been low compared to many countries. I suspect this is related to the early and strict community measures.

We keep hearing about interventions that supposedly work against COVID-19 (e.g. hydroxychloroquine). What actually works in the management of moderate to severe cases of COVID-19?

Although I work in an intensive care unit (ICU), surrounded by technology and a complex mix of drugs, I’m more a believer that the secret of good care in ICU is doing the simple things well. We have a history in ICU of searching for the magic bullet and despite millions of dollars from international pharmaceutical companies, it has yet to be found.

We use drugs such as morphine to relieve pain (when did you last see the morphine drug representative trying to sell their product?); intravenous fluids and noradrenaline to maintain blood pressure (when did you last see the noradrenaline drug representative?); and antibiotics to treat infections. There are several trials currently being undertaken both in the community and in intensive care. So far, no magic bullet.

The key to caring for severe cases of COVID-19 being managed in ICU is early intervention, teamwork, and using interventions such as tried and true ventilator strategies that we have been using for many years. Early intervention is particularly important for the common presentations that we manage in ICUs, such as severe trauma and septicaemia. Australian intensive care clinicians are responsible for a hospital wide system for the early detection of deteriorating patients in the general wards of hospitals: doing simple things early and well.

Do you feel that Australian medical students, pre-clinical and clinical, have a role in this crisis? If so, what might those role/s be?

When I was working at St. Bartholomew’s hospital in London, I used listen to the stories from the senior consultants about how they were conscripted into an allied army that was sweeping across Europe towards the end of the Second World War. They were at the end of their fourth year of training and said that, under the supervision of more senior physicians, they felt they could cope and that in the bigger picture they were better doctors as a result. In other words, I think it is great idea. As we have little idea of where this crisis will take us, their role shouldn’t have too many boundaries. At the same time, they need to be genuinely supported at all times.

How do you think COVID-19 will change the global picture of health in the long term?

There will be more emphasis on not just
measuring public health problems from centralized academic departments and offices in major Australian cities, but a move to more interventions that work—developing, implementing, and evaluating them at the coalface. For example, it remains a disgrace that Aboriginal Australians have the same health outcomes as developing countries. But, how often do we hear those statistics from well-meaning public health people and other advocates. Change is necessary. The COVID-19 crisis has demonstrated that health care can address and solve health issues at the coalface. The funding models need to change; emphasizing the need to get one’s hands dirty, getting out there, and doing something that genuinely changes the appalling figures.

Is there anything else you want our readers to know as a healthcare professional seeing this crisis firsthand?

Most of the deaths that occurred because of the pandemic were in the elderly and frail. As one ages, you become more vulnerable to incidents such as falls and infections. The pandemic has focused our attention on the need to revise the way we teach medicine. Currently, we teach a single disease model with single disease specialists diagnosing and treating that single disease. There is still a need for that.

However, the population of patients needing health care is changing as the population ages. Increasingly, patients will have multiple comorbidities as they age which may be modified but rarely cured. Ageing and frailty are inevitable, progressive, and largely irreversible. This is occurring in an age and death denying society. Our health system is not being honest with what we can do and, equally important, what we can’t do.

I would like to see a universal system where we could determine the attitudes and beliefs of people and how that can be translated into their genuine wishes and choices around health care. In other words, who this person is. Then, this would be available to the health system every time someone encounters it. Over 70% of Australians want to die at home; over 70% die in acute hospitals. While appreciating the efforts of well-meaning health professionals, most older frail people do not want to be in hospitals. Empowering people to make genuine choices based on who they are and what their priorities in life are will happen in the lifetime of current medical students. A bit like how birthing was reclaimed by society in the 1960's, dying and death will become de-medicalised.

Author’s Note
For more firsthand reflections on intensive care, Dr Hillman’s book ‘Vital Signs’ sheds light on the experiences of patients, families, and staff in the ICU. To explore regarding the de-medicalisation of dying and death, his other work ‘A Good Life to the End’ is another good resource.

If you want to learn more about COVID-19 from a firsthand Australian perspective, tune into the episode of our podcast The Global Health Chat entitled ‘Things May Never Be the Same Again: COVID-19 and the Australian Frontline’ where we discuss the pandemic with respiratory physician, Dr Jonathan Williamson.

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