DEF034 - DR. JAMES INTERVIEW TRANSCRIPTION

CORONAVIRUS: INSIDE A LONDON ICU

→ Listen to the interview
→ Defiance Website

- -

Peter McCormack 02:39:
Good evening, Dr. James. How are you?

Dr. James 02:42:
Yeah. Not bad Pete.

Peter McCormack 02:44:
I've got to talk to you, I've obviously known you for quite a long time, probably 25, maybe 25 years, maybe a bit longer. And obviously I know you're a doctor and thank you for giving up your time because obviously you're very busy right now, but I think it's going to be very useful to talk to you about what's happening and get some of this information out there. So just as a starting point, can you just explain to people what is your day to day job and role before we get into this?

Dr. James 03:10:
Yeah, sure. So I'm a NHS consultant in anaesthetics and intensive care. So I split my time usually between running an intensive care unit, a big busy NHS

hospital, and also putting patients to sleep for various types of operations. Of late, given what's been happening with COVID, all of my time has been dedicated to intensive care for the last two to three weeks. Essentially it's been a extremely busy and challenging time for us.

Peter McCormack 03:44:
Okay, so you're right in the heart of what's happening right now. Before we get into that, can you just talk me through what a standard day would have been like two months ago, just a very quick overview of a standard day for you.

Dr. James 03:57:
Yeah, so from an intensive care perspective, I would probably turn up to work at about 8:00 AM, I Touch base with the junior doctors that I work with and then run a ward rounds of about 10 to 11 patients that we have on intensive care. There would be a me running the team. I probably have four to five junior doctors helping me look after those 10 or 11 patients who are critically unwell, some of the most unwell patients within the hospital, and they'd often be on various life support machines, ventilators, kidney dialysis machines. They'd often be in medically induced comas. So sick patients who need lots and lots of staff around to look after them.

Dr. James 04:42:
So as well as the doctors that these patients would often have at least one nurse per patient looking after them around the clock. So that's what we do. We do a ward round in the morning, we'd review all of the patients in the afternoon. We'd do various jobs that need to be done for the patients. So scans, procedures, reviews by other teams. And then we'd go around and see those patients again in the evening just to make sure that they're stable. And essentially, we're taking them through a process of critical illness. We have all comers come to us.

Dr. James 05:21:
So patients who've had major operations and needs a period of critical care after their operations to get them better and get them well enough to rehab and then leave the hospital, or it could be patients who have come in with severe infections, with sepsis and need life support to get them through critical infection, or it could be patients with kidney failure who need temporary dialysis. So we see a whole variety of patients, and it's a very labor intensive job with probably the most labor intensive part of the hospital, and that's because we're dealing with generally the sickest patients around. So our job is to get them through their critical illness, get them out of intensive care to either a medical or surgical ward bed, and then for them to get out of hospital eventually.

Peter McCormack 06:16:
And in that scenario, when does it get stressful? Do you have to plan for certain scenarios? Surge planning is something you've mentioned to me before. What is a normal abnormal situation, if you understand the question?

Dr. James 06:32:
Yeah, so we're a big busy place, and one of the most stressful things is bed occupancy. So we like to run at about an 80% bed occupancy. So if you've got 10 beds, it's always good to have no more than eight of those filled so that at any one time if there's a disaster in A&E or a disaster in the operating theaters or on the wards, you've got the ability to bring patients in quickly. Unfortunately, given the circumstances we work under, our occupancy in normal conditions tends to be 90% or 100%, or even more than that, where sometimes we have patients on the wards waiting to come in.

Dr. James 07:16:
A lot of that is to do with the way that critical care bed provision has historically been set up in the UK. There's been data flying around in the mainstream media showing that compared to other European countries and other other international countries, we have a far lower intensive care bed provision per capita population than many other EU countries. So we're constantly under strain and that's one of the most stressful parts of my job is trying to trying to have beds available so that I can get patients in quickly should they need.

Peter McCormack 07:55:
Should there be an emergency incident and you are running an 80, 90, 100% occupancy and suddenly you need five more beds. What suddenly happens in a scenario like that, do you have to make beds available, or are you distributing people through different hospitals in London?

Dr. James 08:10:
So ordinarily we will have one or two patients who are ready to go to the ward, but because hospitals are so full, those ward beds might not become available to us. So in situations of strain, our bed managers can create those beds so that we can get patients who are ready to leave out and get new patients in. In the event that we've got an intensive care unit full of patients that actually need to be in there, then we can call around to local hospitals and get patients transferred out to other hospitals to make capacity if required, or we've got alternatives, there's creating a intensive care unit potentially in the operating theaters, getting patients onto ventilators there whilst we create the bed on intensive care. So that's a temporary thing that we might look to do for no longer than six to 12 hours really with a view to getting your patient into intensive care at the earliest opportunity.

Peter McCormack 09:17:
Okay. All right. So now a bit of a switch. Tell me what today was like.

Dr. James 09:24:
Okay, so today I've turned up to work at eight o'clock and we had a handover meeting that consisted of... Who did we have in the room? We had three intensive care consultants coming off the night shift. We had three intensive care consultants coming onto the day shift. They were supported by two further anaesthetic consultants on the day sift, and a whole host of junior doctors, probably about 20 junior doctors who are supporting us. A very big handover. And the reason for the increase in staffing numbers is because we've got huge numbers of patients being ventilated all over the hospital because of COVID-19.

Dr. James 10:14:
So we have approximately doubled the amounts of ventilated patients we would ever have under normal circumstances in our hospital. So not only do we have patients ventilated in our intensive care units, we've got them ventilated in the operating theaters, we've got them ventilated in the recovery areas, we've moved out into ward areas and we're ventilating patients there. So you need an incredible amount of manpower to manage all of these patients.

Dr. James 10:56:
So after our morning handover, we'd split off into about four different teams and we are looking after groups of patients in various areas of the hospital. And my job today was also to be what we call the outreach consulting. So not only was I looking after 12 intensive care patients, I was also manning a team of doctors who were being called to sick patients in the emergency department and on the wards. And we had a huge amount of calls for patients on the wards in the emergency department who have got severe respiratory failure related to COVID-19 disease, who are at extreme risk, who ideally need an intensive care or high dependency level of care, but are on the wards, and are very vulnerable. So I spent most of my day going from ward to ward trying to figure out who needed to come into intensive care.

Dr. James 12:05:
Because we were absolutely full, we've also had to rely on some of our neighbouring hospitals to come and pick up our patients and take them away from us. They're slightly less busy than us. So we're relying on the network of our neighbouring hospitals to come and take patients away from us and just try and take some of the strain off us to decompress us, to try and create a bit more capacity in our place so that when the next patient comes through ED, we've got a bed to put them in. So it's been stressful and I've lost count of how

many patients I have had to see and how many beds I've had to try and create. Yeah, it's been, it's been hard work.

Peter McCormack 12:52:
Are you at the point now, I mean I'm guessing you are, but are you at the point now where people aren't getting the care they require because you haven't got enough beds, enough ventilators and enough staff?

Dr. James 13:05:
Yes. I think we're under no delusions that it's a different landscape that we're working in. So we know that these patients are not getting the type of care that we would have been giving four weeks ago. And that's mainstream knowledge. It's out there in the press, we know that our numbers are not going to be able to cope with the barrage of patients we've got. So I said earlier that usually one intensive care nurse would look after one of these patients. We are expecting our nurses now to look after six of these patients. So you have one trained nurse looking after six ventilated patients.

Dr. James 13:56:
As a consultant, I've been told that soon I'll be expected to look after anywhere between 30 and 40 patients, whereas ordinarily I would look after 10 to 12. So clearly these patients aren't getting the attention that they would have got previously, but quite simply there's nothing else we can do really. We just don't have the workforce to cope with this. So our standards are going to have to change and that's what we're seeing very much so at the moment.

Peter McCormack 14:36:
Yeah. And listen, I don't think there's going to be anyone listening to this or externally who's going to judge you on this, but I have got some tough questions as well. So for example look, I know you, so I can ask you these questions. Are you in the position now, or are you having to prepare and put in procedures in place where you're going to have to make decisions about who can have certain equipment, and are people... And this is a really tough question, but are you're going to have to leave people in a position where they're possibly going to have to die because a ventilator has to go to somebody else? Are we in that position yet? Is that coming? Because the reason I ask is that I spoke to an ICU doctor in Australia, they're behind us, but they're planning their triage at the moment for wartime triage. Is that something that's going to happen?

Dr. James 15:25:
So there's always been an element of this in intensive care and in the NHS in general. So there are an unrestricted number of transplants out there. So there's some sort of, you have to decide who's going to benefit the most from

what's out there. And we do this in intensive care usually. As I said, we have a limited resource and we have to pick the patients who are going to benefit the most from our resource.

Dr. James 16:00:
Right now, this has been multiplied tenfold, if not more. We're not officially at the stage where we are restricting access to ventilators based on parameters, things like age, that's a big topic. Should we be saying if you're over 80 for example, should you be getting a ventilator? We're not at that stage now, but I sense it will be coming. It will be coming soon. It's got to come from up high I think.

Dr. James 16:41:
So there are a number of national bodies that are looking at this, and I think the guidance will come soon to us where we'll be given criteria which will help us make decisions on who should be getting these ventilators and who won't be getting them. So it's a difficult conversation to have and I think society as a whole needs to have a look at this. It's not just us as medical practitioners who should be making these decisions, but I think there's a broader role for society to be involved in the discussion. But look, it's coming. There is no doubt about it.

Peter McCormack 17:17:
Well, what is the daily pace of change you are seeing, because we had a pre-call, we had a talk through this and you gave me some idea that you had a few people come through the door and then suddenly the hospital was overrun. What is the daily pace of change in your experience, and is it overwhelming? Talk me through that.

Dr. James 17:38:
Yes. So as I said to you earlier, so it's actually two weeks ago today that this really kicked off for us. And I was running our COVID ICU two weeks ago when we started getting calls from the emergency department and I went down there and it was just like a completely different planet really. We were getting streams of people coming in with respiratory failure and we had to put a lot of patients on ventilators within the first 24-48 hours. And just the emotion of it all was just completely overwhelming when I realised the scale of what was happening, and ever since two weeks ago, and I must say it's felt like two months to me the last two weeks. But it's just been a relentless just swell of patients coming in through our hospital who need to be put on ventilators and the numbers are getting worse.

Dr. James 18:37:
So look, I think we're in a hospital where we're putting 10 to 12 people on a

ventilator a day and that's not sustainable. I told you we normally have 20 or so beds in our ICU in usual conditions. And we would be filling that up in less than a couple of days at the rate that we're going. So it's just really-

Peter McCormack 19:04:
Sorry, how long do they need the ventilator usually for?

Dr. James 19:07:
Yeah. So this is a difficult question. We haven't come to a consensus internationally, what exactly that the disease in the lung is being caused. People are staying on ventilators for longer than we would anticipate them to do. So we're just not sure what we're dealing with. There's no international consensus really on what's going on. I think people are staying on ventilators. There's no clear cut answer, but easily upwards of seven days. And you could be looking at three, four weeks in some types of patients. So this is not a quick fix. Lots of people will go onto a ventilator and won't survive that process and lots will die on the end of the ventilator. And the whole process of death with COVID is a completely another discussion. It's not a nice death to have because many hospitals in the country are restricting who can come in to see their patients. And actually lots of places say you can't have any visitors.

Dr. James 20:26:
So just yesterday I had to phone one of our patients' wives, a lady that I'd never met before in my life, never spoken to, and I had to tell her that her husband was dying on the end of the ventilator and that we had to switch off the ventilator because we weren't going to be able to save his life. And I had to do that over a telephone call and she wasn't allowed to come and see him or be with him when he died. We're just dealing with a whole new paradigm here, just emotionally it's hard, hard work. So yeah you're on a ventilator, who knows how long you're going to be on the ventilator for, you might survive, there's a good chance that you won't survive.

Peter McCormack 21:17:
I'm going to make an assumption here. I've never asked you about your training as a doctor, but I'm going to make an assumption as part of your training that you deal with the psychological side of death and communicating that to families. And I'm assuming there's support there during the job, but I'm also going to ask, how is it now, how is it different, how are you coping, how are your colleagues coping with all of this? Talk to me about that.

Dr. James 21:43:
Yeah, so we've all cried. As I said, you have a moment when you realise the enormity of it and you can't help but cry. And that I think is actually a good thing. It's stressful, people are worried about their own health, particularly my

older colleagues. They're not immune to this disease. They're putting themselves at risk.And so that's one part of the psychological turmoil of this. The other part is obviously dealing with some casualties on a mass scale that we haven't seen before.
We're not used to having to make these very, very tough decisions about who can get onto a ventilator, how quickly can they get onto a ventilator? Are they going to survive on such a scale.

Dr. James 22:42:
And not being able to deliver the standard of care that we're so used to is difficult. Every aspect of this is just so, so difficult. We've got high levels of staff sickness. So the staff that are on site are just under huge amounts of pressure, and we've only been doing it for two weeks and we're all at breaking point already, but you've got no other option but to carry on and just get through it.

Peter McCormack 23:16:
Are you processing the reality of the impact on health workers globally, so I saw... Again, look, sorry mate, but I've got to ask you this. I saw a report yesterday that just doctors alone in Italy so far 51 have died. There is a reality that every day you go into work that you don't know personally if you're going to get sick or your colleagues are going to get sick and what's going to happen to them. You're doing a job now, which is like a wartime job where you actually risking your life, your colleagues are risking your life. Do you have time to process this, are people thinking about this, is it impacting on how people even can do their job, like how are you dealing with that side of things?

Dr. James 23:58:
Yeah, it's hard. I mean, if you stop and think about it for too long, you just wonder what the hell I'm I doing? I'm putting my own life at risk. None of us signed up to potentially die from doing this job. Yeah, and if you stop and think you just question yourself, is it worth it putting your life at risk, putting your family's emotional state at risk, but what can you do, we have no other option here but to do this. And that's the feeling on the ground is that no matter how hard this is, I'm surrounded by some amazing people when I walk into that hospital who, sorry, I'm breaking up a bit here. Can you just giving me a moment Pete?

Peter McCormack 24:59:
Yeah, of course. Take your time.

Dr. James 25:07:
Sorry mate. Yeah. I'm surrounded by amazing people who are doing the most amazing thing. It's just hard, but you can't do anything else.

Peter McCormack 25:27:
Listen, I don't want to push you too hard, but the reason I want you to do this is that one of the most important parts for me in my research as people fight over the models and the data and how real this is and how isn't it real, the just the flu crowd, the one benchmark high views since Wuhan now with Italy, Madrid and here in the UK is the reports from the doctors which have been universally the same. That is why James like this is why I messaged you this morning. I said I want to talk to you, so I'm sorry this is tough and I'm sorry I'm asking tough questions, but I have been fighting disinformation. I've got to ask some tough questions.

Peter McCormack 26:08:
And look, I also want to ask you because this is the stuff other people don't know. So I just want to ask you a bit about the patient. Talk to me about the range, very early on this was believed to be a condition that mainly affects the old people. And obviously it affects older people more, but can you talk to me about the range of people coming in, and one thing I'm going to drop in there as I've seen the reports today, another 59 died, of that I saw a report that today that 13 we're healthy adults. So can you talk to me about the range you've got coming in?

Dr. James 26:38:
Yep. We've got young people in. So the youngest is a late 20s, we've got lots on ventilators in their 40s who some have very mild diabetes, mild high blood pressure, but these aren't unwell people. They have jobs, they are active. So we've got people in their 20s, 30s, 40s on ventilators. We've got another group of patients in their 60s, 70s who are probably carry a few more health conditions with them, and they are also on ventilators, but this is not exclusively a disease of the elderly. Young people will die from this, absolutely.

Peter McCormack 27:35:
Now one thing I didn't know prior to this is that, or I didn't realize was the scale of the normal flu season, it just didn't cross my mind. I'm aware it happens. Some people have posted information at me saying, well, a bunch of people die from flu every year, children still died from flu every year. There is this just the flu crowd. How is this different?

Dr. James 27:57:
Yeah, we see seasonal flu every year, and it's a severe disease in its worst form. It looks a bit like COVID, but what we don't see with seasonal flu is 10 to 12 people needing to go on to ventilators a day for many days in a row, which overwhelms the health service. This is a disease where there's no immunity in the population and it's just striking people down as it works its way through the population. So the scale of what we are seeing now is far, far worse than the

worst flu seasons we've ever experienced. So the bad swine flu season, nothing like this, nothing like the scale of what we've got now. So yeah, flu is a bad disease and it kills a lot of people but this is a whole different ballgame.

Peter McCormack 29:04:
Okay. I'm conscious of the time and I want you to get home, so I'm going to keep it just to another couple of questions and just some important closing questions. What are the main myths that you are seeing disseminated or perpetuated right now with regards to this?

Dr. James 29:22:
The main myths?

Peter McCormack 29:24:
Yep.

Dr. James 29:25:
Well yep, a disease of the elderly which as I've explained, no, we're seeing young people get this. You have to have health problems to get this, no, no you don't. Not so much a myth, but one of the biggest frustrations to all of us in the NHS is just the lack of respect for social distancing and self isolating when necessary. I'm no public health expert, but there are people who are, and they are telling us these things for a reason. And the very reason is to reduce the amount of people getting severe disease and overwhelming us, which is what it feels like right now for me is that we're overwhelmed and we just need people not to get this disease. And the only way they're going to do that is by staying at home and not going to the pub or to restaurants, which obviously you can't do now. But people need to respect the rules that are in place. I think they are there for a reason and the reason is to keep people alive essentially.

Peter McCormack 30:41:
So I was aware we were going to record tonight and I tried to observe my standard day, and a couple of things that stood out to me today. I've got a couple of deliveries from Amazon, ironically face masks and gloves. And the delivery driver wasn't wearing gloves himself or a mask. And then I also went to Sainsbury's, And what was quite interesting is they were staggering the people who came in, but hardly anyone was wearing a mask, hardly anyone was wearing gloves. So anyone could be going into somewhere like supermarket and easily spreading. And I've also read the reports that it spreads easily inside. If the supermarket is the place that everyone has to keep using and that is a central focus of like congregation of people and people touching things and moving things on conveyor belts and such. Is there any advice you can give to people in that experience, in that day to day

experience, the things that you think people should absolutely be doing right now?

Dr. James 31:37:
That's a tough one. I think you got to be pragmatic as well. So people have got to live, people have got to get food and you've got to be sensible though, you should try and go as infrequently as possible. You've got to try and keep distance from people, but it's hard when you're out and about if you're doing essential tasks. Should you wear masks? I don't know. I'm not a public health expert and I don't want to advise on something that I don't have a sound enough knowledge on, but I think sensible pragmatism is what's needed. Just try and plan your life so that you can spend as much time as possible at home and not in the supermarket if at all possible. Where the supermarkets can up their online delivery capacity, I don't know, but that those types of things would make sense to me.

Peter McCormack 32:42:
Okay. Somebody forwarded me a video, it was a radio calling by another doctor, Dr. Jack, and he was very angry, he called into LBC. And one of the things he was very angry about was people not respecting social distance and not understanding. My assumption though there is a massive disconnect between what he is seeing day to day in the hospital and then the perception people have of how serious this is. Can you think of any way we can bridge that gap? Is this conversation we're having now, is this good enough to bridge that gap? Do you think we need reporting with inside the hospital so people understand the... Do you have an opinion on this?

Dr. James 33:21:
Yeah, I think human stories always help. And I've listened to that Dr. Jack interview. And just news from the front line I think helps. And I don't know if this is going to help or not, but this is our experience, we're being overwhelmed and it's not a pretty sight. So I hope that more people come forward and talk about their experience. I saw a YouTube clip of I think Sky News got into one of the hospitals in Lombardi, and it was powerful because actually that looks what our hospital looks like now. So if you've got a news team into our ICU and onto our wards, I'm sure that would be a pretty powerful message, that this isn't happening in China or Italy, this is happening right here right now in the UK. So yeah, I mean get the cameras in, and show the people what's happening.

Peter McCormack 34:29:
All right man. Listen dude, I love you man for everything you do. And I think you should know that everyone knows that... Not just you, all health workers are doing an amazing job that you put yourself in harm's way. I really

appreciate you giving me the time because I know your evenings are limited now with your family. Is there anything you want to close out on, any final things you want to say, anything I've not asked that you wish I'd asked?

Dr. James 34:54:
No, not really. Just that there are some really amazing people out there doing a really hard job, and they're absolute heroes. The nurses that are looking a these people, the cleaners, the porters, the canteen stuff, these guys are heroes, absolute heroes. When this is all over, I just hope that people will still keep them in their minds. And I just hope that NHS bosses can start to treat their staff with just a little bit more respect. I know Dr. Jack said this, but I'm going to reinforce what he says, NHS staff don't want the world, but what they would like is to not have to pay ludicrous amounts of money to park their car at work, not have to buy their own Christmas dinner, not have their coffee and tea taken away from their department's just to save a few hundred pounds. Just treat us with a bit of respect. We're willing to put ourselves out there. So I just hope that when it's all finished people remember what we've been through. Yes. That's all I've got to say with it really.

Peter McCormack 36:18:
All right ma. Listen look, take care, give the best to your wife and your family. Love what you're doing, really appreciate it from my family. Stay in touch, keep me updated on what's going on. I am not going to stop thinking about you through this process. When I do get a chance to buy you a beer afterwards I'd love to have a proper catch up with you, but take care buddy. I really do appreciate this man and keep keep fighting hard.

Dr. James 36:44:
Yeah. Thanks Pete. Cheers. Take care.