

LETTERS TO THE EDITOR

OVERVIEW

Please submit letters for the editor's consideration within 3 weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

Ethical considerations

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Editor – Thank you for publishing the article 'Evaluating the national PPE guidance for NHS healthcare workers during the COVID-19 pandemic' which gives an evidence-based summary of current PPE guidelines.¹

The authors' discussion of ethical considerations mentions avoiding harm to the public, the moral duty of government leaders to be open and honest if there is insufficient quality or quantity of personal protective equipment (PPE) and that healthcare workers (HCWs) should be duly informed of their own personal risks when caring for COVID-19 patients. It does not mention two further issues that I wish to highlight here: autonomy of HCWs to ensure their own safety and indemnity.

The first step in assessing unwell patients is always to ensure that it is safe to approach. Given that some HCWs working in high-risk COVID settings are still unable to access PPE and the rising death toll among HCWs, the importance of this cannot be overstated. HCWs can be tempted to accept poor quality or availability of PPE out of a duty of care and fear of indemnity while putting themselves at risk. They are not encouraged to exercise autonomy in the event that they deem the risk to themselves greater than potential benefit to the patient.

As of April 2020, the Medical Protection Society has stated its position that 'If a doctor decides they cannot safely see a COVID-19 patient because they do not have adequate PPE and a patient subsequently comes to harm, they should not be held personally accountable by their employer or the regulator.'² It is calling for 'urgent reassurance' from the general medical council and employers on this issue. Government MPs are also asking for emergency laws to protect doctors forced to make difficult decisions during the pandemic.

In view of this, I would suggest that HCWs should not only be 'informed' of their own personal risks but be encouraged and empowered to make valid autonomous decisions considering their own safety without fear of indemnity. To make this a reality, we need employers and regulating bodies to make changes in policy that reflect how much we as a society value the lives and diligence of HCWs in these difficult times. ■

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Safe surfaces

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Editor – Embarrassing stories are ubiquitous when it comes to early experiences in theatre. As a fairly fledgling surgeon myself, I still remember scrubbing for the first time. Watching carefully, I copied the consultant's every move, entered theatre, let out a sigh of relief and stabilised the stool as I sat. An experienced scrub nurse saw me touch the non-sterile surface and informed me immediately of my faux pas.

A similarly authoritative figure recently served me in the supermarket. Well meaning, I'm sure, he scalded me for standing too close as I packed my bags. Bizarrely, he seemed unperturbed by handling every item as it passed through the scanner. My basket was then immediately picked up by the next customer as I left the store. Surfaces were not of concern, only the '2-metre rule'.

To the nation's credit, behaviour in such public places is almost unrecognisable. Most are receptive to social distancing advice and even seem to have overcome their instinctive reaction to hoard toilet rolls. However, many seem oblivious to the potential risks of handling every packet in search of the best sell-by-date. Surface hygiene is undoing otherwise good precautionary behaviours.

The environmental spread of COVID-19 is undoubtedly multi-modal. Avoiding airborne droplet transmission is merely one weapon in our arsenal. SARS-CoV-2's ability to survive on dry surfaces extends into hours. Its half-life on plastic, such as the handle of a supermarket basket, is >6 hours, compared with 1.2 hours in aerosol form.¹ While observed viral decay is exponential, this is unlikely to negate the risk posed by regularly handled surfaces.¹

It unfortunately matters little how frequently people are washing their hands if they are rapidly 'recontaminated'. While employers are instructed to disinfect high-touch surfaces within public spaces, to do so between each person is impossible.² As such, behavioural changes to limit contact are imperative to mitigate the inevitable associated risk. The same absent-minded contact that led me to reposition a theatre stool is driving people to pick the basket at the top of the pile.

Public perception over how to stay safe from COVID-19 seems dramatically skewed towards avoidance of airborne droplets.

The motivation to stay safe is undoubtedly present but, without understanding, it can be so easily misguided. We have recently read Greenhalgh and colleagues' 'call to arms' for the public to wear face masks as a precautionary principle.³ Do we not also need to better address the other main means of transmission? We need safer surfaces. ■

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Prime time for handheld echocardiography in COVID-19 pandemic

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Editor – We are in unprecedented times as the world tries to combat the 2019 novel coronavirus (COVID-19). It is imperative that innovative technologies limiting the spread of COVID-19 within healthcare settings are introduced as initial reports estimate that 3.5% of healthcare workers are becoming infected.

There is much evidence supporting the use of handheld echocardiography (HHE) techniques to augment physical findings during the cardiovascular examination. Now, is the prime time for clinical translation of HHE, mainly to reduce the number of transthoracic echocardiography (TTE) procedures. TTE remains the first-line imaging test for the assessment of cardiovascular disease. TTE systems tend to be bulky, wired for electrical supply and have huge non-sterile exposed areas (keyboard, screens, base-unit) where SARS-CoV-2 could survive for days. Alternatively, HHE devices are small, cheaper, lightweight and only require a single clinician at the bedside as images can be sent wirelessly. Disposable ultrasound probe covers can almost seal these devices limiting any cross-infection. Furthermore, HHE devices have evolved to not only provide B-mode but also include colour Doppler for valvular assessment. Paradoxically, the clinical need for HHE is even more relevant in the current pandemic, as COVID-19 has several cardiovascular clinical presentations. In suspected ST-elevation myocardial infarction, HHE can differentiate left ventricular regional wall motion abnormality versus global dysfunction, the latter favouring a diagnosis of COVID-19 myocarditis. These applications make HHE a far more appropriate option while echocardiography procedures are being rationalised due to high-risk of transmission.^{1–3}

Operability of HHE by medical students and inexperienced clinicians can be obtained rapidly and provide more accurate diagnostic results compared with clinical examination.^{4,5} Thus, there is an urgent need to address these training requirements through the British Society of Echocardiography.

We conclude that HHE can reduce the scanning time, possibly the risk of transmission and minimise costs, while providing reasonable diagnostic information. This will help achieve the goal of protecting patients and healthcare workers. Ultimately, this may lead to a change in standard practice following COVID-19 as the benefits of bedside HHE are realised. ■

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COVID-19, hydroxychloroquine and the eighth alternative

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Editor – The duty of a physician has been proposed as 'cure occasionally, relieve often, comfort always.'

'Comfort always' relates to the art of medicine. The scientific underpinnings of medicine evolved over centuries and is currently founded upon evidence-based medicine (EBM). EBM is data driven; stratified into a hierarchy with meta-analysis of randomised controlled trials at the top.¹ Seven 'alternatives' to EBM in the absence of evidence are eminence, vehemence, eloquence, providence, diffidence, nervousness and confidence-based medicine.² The eighth and the latest entrant to this august group is 'propaganda-based medicine' (PBM). The rise of PBM has been driven by the ubiquitous presence of social media platforms which influence popular opinion and the main vehicle for the dissemination of information in today's world. Healthcare and beliefs are very much an integral part of this social media driven information society. These platforms have far reaching influence, significantly more than the conventional peer-reviewed scientific publications and websites in shaping public opinion. Claims of efficacy of drugs