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GUEST EDITORIAL

The challenges of delivering gynaecological oncology care during a pandemic – personal experiences from South Africa

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Introduction

The past 12 months have been an unprecedented time for all of us, not least the challenges of doing our day-to-day jobs when services were closed around us and patients distanced from much needed oncological care. Gynaecological oncology surgical and radiation specialists from across the state sector in South Africa were asked to reflect on this time and how it impacted themselves and their patients. Below is a collection of these personal experiences and thoughts. The authors names and reflections are not linked.

I had a full-on exposure to a coughing patient just before lockdown 5 and went into isolation. Fourteen days went past without incident and I survived, but many of the women we serve did not. The radiation department on our circuit stopped seeing patients and delayed radiation for the poor women of our community who had already waited weeks for treatment. We were stopped from having MDTs because the department would not engage even having a ZOOM meeting. Things became chaotic and we got angry with each other. People were afraid and confused. Patients where denied access to the hospital and treatment. I have no doubt we will continue to see the fall-out for months and maybe years to come.

There were good things that came from this experience. It made me as an individual evaluate my material needs. I realised how hard my housekeeper worked and I thank her every day. I spent time with my adolescent children and we engaged as a family and grew closer together. We planted a vegetable garden and went off the grid as far as electricity is concerned.

I am privileged to be able to have isolated with space, running water, hand sanitiser and immediate access to health care. I acknowledge that many have lost their jobs, their homes and have been subjected to domestic violence and hardship. I will never know.

We aimed to provide holistic care for gynaecological cancer patients, despite re-allocation of staff to the COVID service, and theatre-time shortages.

Risks of not treating cancers were balanced against risks of SARS-COV-2 to patients and staff. Only patients with severe symptoms, or with curable cancers who were young and well enough to survive perioperative COVID, had surgery and/or chemotherapy. We continued treating women with HSIL paps, but triage and telemedicine played a new, important role for gynae follow-up patients.

Obstetrics cannot de-escalate, and needed extra staff for separate COVID and non-COVID components. Little assistance with managing pregnant COVID patients was given by other disciplines, though we had to help in non-O&G COVID wards or Casualty, in addition to our usual work.

I did shifts in Casualty, admitting acutely short of breath COVID patients, trying to not introduce myself as a gynaecologist to the male patients!

Most had similar symptoms and signs, and required oxygen, steroids, and clexane.

Contact with patients was curtailed, so some of the humanity of the practice of medicine was lost.

How fortunate to have a job and be able to contribute, and to not have to stay home doing home-schooling! There was lots of lovely family time: cooking and baking, playing games, and exercising in the garden, so lucky that our greatest hardship was not being able to walk the dog.

And now?

There are loooong waiting lists, and resultant suffering.

The COVID crisis caused rapid changes in the way we organise ourselves in clinical teams. In addition to all the organisational changes, many health workers became ill which caused a significant shortage of staff at times. This caused anxiety and uncertainty which led to problematic team dynamics. One example was "othering".

"Hell is other people", the French philosopher Sartre once stated. 'The Other' is defined as "those outside of, and implicitly subordinate to, the dominant group". 'Others' may be less powerful groups within a particular society or identified as outsiders and 'foreigners'.

Distressing news was available since January from China; high death rates, permanent disability from the disease, people dying in their homes or in front of full hospitals. The perception of the virus as a threat came late to us in South Africa. Even in early March, mainstream media and politicians did not see an urgent need to act. The perception was of China (and later Europe) as the 'other'. On a more local level in the hospital, othering manifested

as turf wars. Who is giving the most staff to the COVID effort? Which wards need to be evacuated, which lists to be cancelled? "The Urologists go home early every day", "the Orthopaedic surgeons only work every second week", "The medics get all the attention" (and donated food and claim all the manpower). As the stress and anxiety increased the focus on "the other" increased.

During this time there were clear examples of leadership for wellbeing vs leadership for confusion. Leaders with a consistent message and who modelled positive behaviours and attitudes had a calming effect. One such example of solid leadership was President Cyril Ramaphosa. Leadership for confusion used this crisis for political gain and a strategy to increase fear of foreigners by referring to COVID as the "Wuhan virus" and "Kung Flu".

At the same time the pandemic also brought out the best in clinical teams. There was a lot of confidence, bravery and kindness towards colleagues and patients in the face of the pandemic.

Swarm intelligence occurs when all the members of a group come together to create a synergy that magnifies their individual capabilities. It is unselfish behaviour that one sees when people know that they depend on one another. It is more instinctual than cooperative, in which people work deliberately together to achieve a common goal; it's an emotional and reactive behaviour, not a plan that can be written out on a flowchart. There was a unity of purpose: all knew that their goal was to protect lives, with all other goals subservient to that. It needs a spirit of generosity, in which individuals seeks to help others succeed.

I am still sure of my decision to become a doctor.

When COVID lockdown hit, we were already in trouble because of our pre-COVID three-month waiting period for surgery. Our hospital had committed to continue providing care for oncology patients. However, lockdown meant that patients with gynae malignancies were turned away from clinics and peripheral hospitals, and could not get hospital transport to come to our hospital. While promises to continue surgical services were made by the hospital, it was never going to happen. All theatres were depleted of reusables such as airway circuits (which could not be reused), and Human Resources (nurses and doctors contracting COVID). Cancer had to compete with alcohol-related trauma as people had their own secret stashes. Our patients would starve for days waiting to go to theatre. We had to resort to operating off site for cases we could, and open "minor theatres" in the wards under sedation and local anaesthesia administered by the surgeons. Despite this it was clear that there would be more cancer deaths than COVID deaths.

Symptomatic patients with gynae cancers would refuse to return home without being seen by doctors despite the hospital refusing to issue PPE to outpatient departments. This further subjected us to COVID exposure.

We are not out of the woods yet. Many patients are now inoperable due to advanced disease and too ill/frail to undergo surgery. We are consuming more blood products than before as many patients have ongoing bleeding. We have to focus on the strongest to maximise outcome. Our waiting period for surgery is now one month because we have lost track of many patients that were on the waiting list. We continue to operate at the peripheral hospitals and do minor cases under sedation in the wards. We are still bracing ourselves for the second wave of COVID.

This time last year it was just a tiny news item, little did we know that in 12 months we would have a whole new vocabulary – "COVID"; "pre-COVID"; "post-COVID"; "first wave" and "PPE". I'm not sure where we are now, "in-between COVID", "pre-second wave COVID"? I was all ready for it, I watched the news in Europe then rushed to order new scrubs and a stethoscope and re-wrote my will, I was ready for the frontline!

I then read every article or letter that spoke about managing oncology services in the middle of the COVID-chaos. Every day I chatted with my colleagues about what we would 'de-escalate", what protocols we would change to continue radiotherapy and chemotherapy services and who we could delay. We spent a lot of time trying to guess what the right thing was to do, we panicked, we calmed down, we were angry, we calmed down, and then repeated the cycle again every day for six months. Teams were established in the department so that we had a chance of still managing if one went down and others had to self-isolate. We all became suspicious of every cough.

By some miracle we stayed open, all patients who managed to make it through the primary and secondary level hurdles into our centre were treated. Threats of reducing surgical lists caused a lot of upset and protesting but many patients were still able to get on a slate, and in oncology all other primary tumours were treated with a home-grown mix of reduced treatment time and a bit of chemo. We ploughed on with our in-person MDT – one of the last MDTs to resist the scourge of the ZOOM/TEAMS platform.

The doctors in the UK are seeking protection from prosecution if they have to ration services and decide who will get an ICU bed. In South Africa that is second nature to us, we constantly have to decide what we can do for the patient in front of us with what we have available. It was clear to me from the start that as South Africans, COVID wasn't going to scare us, particularly in oncology – death is an everyday part of life – to me it was a shame that there was not better use of our skills out on the COVID wards.

Turns out the scrubs and stethoscope were barely needed except for a few shifts poking peoples' noses in the testing tent – it was a unique use of a vaginal swab and my first foray into the hidden anatomy behind the nasal passage – not an ideal use of gynaecological skills. In the meantime the scrubs are in the cupboard just in case I'm needed for the second wave.

Now in the 'in-between COVID' slot we see neglected malignancies the size of which we can never unsee. Patients had been told we were closed, or the hospital was too dangerous to visit, or the doctors were at home.

The tragedy was we were just here waiting for them.