"Never before have there been so many deaths in such a short time"

An intensive care physician's report to the Global Workers' Inquest into the COVID-19 Pandemic

An intensive care physician in Germany
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An intensive care physician, who has worked continuously for many years in intensive care units at various hospitals, including large ones, sent us this report as a contribution to the Global Workers' Inquest into the COVID-19 Pandemic. We are honouring the physician's request for anonymity.

As an intensive care physician, I am familiar with all medical-technical support methods, whether it is dialysis, ECMO [Extracorporeal Membrane Oxygenation], ventilation and NO-[nitric oxide] ventilation. I have been responsible for up to 20 patients at a time. Yet, I have never experienced anything that compares in degree and magnitude to the current situation.

This disease is one of the most dangerous and malignant of all, both because of its high contagiousness and because it directly attacks and damages all organ systems, especially the lungs. People die an agonizing, long, miserable death.

As COVID-19 spreads, the pandemic encroaches on every area of life, destroying biographies and ending lives prematurely. I have seen dramatic individual fates: Patients who contracted the disease just before being discharged and then died miserably. A family reunion with young, COVID-positive family members leading to the severe illness of an older person with a pre-existing condition. The first to be infected had overcome it, but others died from it. The thought of having contributed to the death of a parent, grandparent, relative or friend is something you never get rid of.

All these cases could have been avoided!

When the pandemic began, we quickly had critically ill patients of various ages, from 50 to 80, almost all of whom, fortunately, survived. It was a time of finding one's way and improvisation. At that time, there was a complete lack of personal protective equipment. The bourgeois state had not prepared anything, although there would have been time to do so at the latest since the end of 2019.

For example, we worked with an FFP2 protective mask, which should have been replaced every 4-8 hours, for many weeks! The masks were sprayed off at the end of the shift and dried until the next day. The gloves we had were poor quality and cracked, so we put on several pairs on top of each other.

There were a lot of hospitals in this condition. In the meantime, we learned how to dress and change quickly in a routine: gowns, masks, hoods, goggles, gloves—everything had to fit.

By April 2020, there were numerous public initiatives, such as "clap for carers," which has since become a bad word among us. There was a kind of state support that can only be described as eyewash and phoniness. Funds were loosened for publicity; new beds were organized, and rooms and even container clinics were provided as expanded hospitals. But what good are more beds if there are not enough staff? The bottleneck has always been the number of trained nurses. The staff shortage, which already existed before, has become even worse. And nursing shortages always mean additional and unnecessary deaths.

For a while, we were supported by colleagues from the normal wards, who were very dedicated and extremely important to us. That fell away later. And yet, in the second wave last winter, many more patients came, and their illnesses were much worse.

From today's perspective and compared to what has developed since, the first phase presents a positive picture: hospitals developed a kind of cooperation, mobilized resources and helped each other. Technical tools that had been developed for other purposes were used for COVID-19 to evaluate and share experiences and make them useful to all. Most of this has since fallen away and been abandoned due to lack of time.

Dying has become commonplace

COVID-19 always runs a different course than conventional diseases. Unlike pneumonia, for example, it is in no way predictable. Patients who are in reasonably good condition must be intubated quite suddenly. Often, the sudden change occurs within a few hours. Patients die rapidly in large numbers, and it affects not only those with pre-existing conditions, such as obesity, but everyone, including younger people who are only around 40 years old. Immunosuppressed people are particularly at risk, but SARS-CoV-2 can be life-threatening for everyone. The disease has its own severity. Its severity is not due solely to pre-existing conditions.

Never before have there been so many deaths in ICUs in such a short time, before coronavirus. Far too many are dying. The severity of cases now is completely comparable to last winter's wave, when about 75 or 80 percent of ICU patients died. It is not the case that someone is admitted seriously ill and then dies, but for most of them it is a long course of events. It drags on for weeks. Many who are already considered stable deteriorate suddenly.

Dying has become an everyday occurrence. When someone survives, we are extremely happy about it. Every time, we fight with great effort, always make new attempts and give every possible nursing and medical support. But with COVID-19, new complications keep coming. It is a tough struggle for every day, every week of the patient's life.

We do everything we can to find more ways to ensure people get better. Until we give up because the sick person can't take any more—but a lot

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has happened by then. Every bed that becomes free when a patient dies is immediately filled. Since the autumn, beds have not been vacant.

A matter of life and death: The use of ECMO

With COVID-19, in addition to the well-known pneumonia, a form of acute respiratory failure, ARDS [Acute Respiratory Distress Syndrome], often occurs. ECMO, Extracorporeal Membrane Oxygenation, a type of artificial lung outside the patient's own body, is then used as a possible support. It helps the sick person to have more time but cannot heal destroyed lung tissue. If the lungs do not restore themselves, ECMO makes no sense either.

Working with ECMO is always a risk. Its use requires a lot of effort but works well when there is routine and safety. Before coronavirus, the use of ECMO was really the exception, the absolute peak of a treatment. Today, it is the order of the day.

In carrying out treatment, simple, mechanical activities are enormously time-consuming: Regularly turning patients over determines the daily routine. This keeps four to five doctors and nurses busy together for up to half an hour or three-quarters of an hour. They must do it together. The positioning is prepared, and then no tube can be allowed to slip when the patient is turned over. All connections, all vital supplies of medications, must be secured. If a mistake happens, patients can be seriously harmed.

What you can never rule out: Patients can suddenly collapse; their circulation can collapse. Nevertheless, the positions of several patients must be changed several times a day. Each time it is an exceptional situation with high stress for all involved. And, of course, nothing else unforeseen must happen during this time.

The transport of patients is also dangerous. Transfer to other hospitals, according to the "cloverleaf system" of the Bundeswehr (armed forces), is only an option for stable patients who, for example, do not need to be placed on their stomachs. In the case of more severe lung failure, it is not possible at all, and in any case, it is associated with high risks.

ECMO has been around for many decades, but only in the last 10 years or so, since the late 1990s and early 2010s, has it become increasingly widespread thanks to significantly improved technology. Today, the machine can independently pump blood through the body, and the larger membranes are much better at oxygenating the blood. The coating is better and safer, so it has a longer duration of use without the risk of clogging the tubes. Fortunately, ECMO is much less prone to breakdowns today.

Still, ECMO treatment is in an absolutely exceptional area. Nurses and physicians must give their all—it's always a matter of life and death.

The big problem is that you need enough people for ECMO patients. The original plan was for a nurse-to-patient ratio of 1:1, but even before coronavirus, there were far too few staff. In the pandemic, the ratio was quickly increased to 1:2 or even 1:3. People simply capitulated to the fact that there were too few staff.

Continuous long-term stress

Physical exhaustion is one thing. But there is also psychological exhaustion resulting from the terrible characteristics associated with coronavirus, as well as the fact that the nursing staff has been massively thinned out. Everyone is reaching their limits, and everyone can see that the pandemic is far from over. Some are quitting, some are becoming sick more often and for longer. These are all signs that the workload is too high. Many people lie awake at night, and I, too, regularly wake up at night. You're never well rested.

My shifts regularly last nine hours, often 10 or 11, without any decent breaks. Officially, when doctors work up to 11 hours, they are supposed to take at least a three-quarters of an hour break. In reality, this simply does not exist. Even a half-hour break would be a rare exception. The expression "going to lunch" provokes loud laughter on our side. This idea is completely absurd. We don't get away at all, we don't have any real rest during the shift, where we could switch off, for example. After all, we are responsible for all eventualities, must be constantly awake and ready, because immediate intervention is often required.

In addition, there is the constant risk of infecting ourselves. People become corona-positive on a regular basis. At first, we were shocked, but now it's part of the job. We also experience nurses being absent for a very long time or permanently as a result of Long COVID. Often, patients are infected, but it can also happen in the private sphere. We test ourselves regularly, several times a week, and it is also recommended that everyone gets vaccinated.

When [Health Minister] Jens Spahn announced, "The pandemic has been eliminated," this was received with bitter sarcasm in nursing, just like all the trivializations, the talking down, the lies that are spread in politics. Every one of us, including every medical worker, knows full well that this is not the case. Among medical staff, distrust in the bourgeois class and its state has grown strongly. Politicians obviously live in a different world. They are completely indifferent to the dying of so many people. Their policies can only be described as deliberate, planned neglect and a criminal denial of the duty to provide for the future.

The support of the WSWS

The ideological pressure was felt from the beginning. Vaccine deniers were on the ascent. That's when it was important to have the good support of the WSWS. It emphasized that this was not a purely technical or medical problem but a political one. It developed a deep understanding about the pandemic, which is not over yet.

I support the WSWS initiative for a Global Workers' Inquest because I want it to be understood what a deadly, devastating pandemic COVID-19 is and how it is ravaging human society. The working class is, after all, the overwhelming majority of the population. It must develop an awareness of the ferocity and danger of SARS-CoV-2.

One must stand firm against all those who spread lies out of ignorance, fear, weakness or even— and this is definitely a different camp—out of malice and criminal intent. The disease must be understood so that the right demands can be made and enforced, which amount to a coordinated elimination of COVID-19 worldwide. This is closely linked to class issues. The malicious, deliberate denials are done out of class interests in protecting profits.

But the working class wants to live! It is the foundation. It is in conflict with the profit-oriented society. It can speak the truth so that profit does not destroy life. It embodies the only perspective that has a future. Its point of view cannot be mixed with that of the bourgeois class. There is only either-or. Like the old medical saying about pregnancy: Just a little bit pregnant—that's not possible.

The grave abuses with "herd immunity"

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A good example are the grave abuses being perpetrated with the term herd immunity. This was originally a positive term. It defines, for certain diseases, what is needed to protect those who, for certain reasons, cannot develop immunity. An epidemic collapses when a certain percentage of society is immune, either through an infection suffered or through vaccination. The end of an epidemic is not reached when 100 percent are immune to it, but the concept of herd immunity defines the necessary percentage that must be reached to protect the rest who are not. Then the chain of infection is broken in the "herd" concerned.

This is a societal, social, not an individual concept. It allows us to determine how many people need to be vaccinated to end an epidemic. Examples of this are measles and even smallpox, which, after all, have been eradicated. It becomes clear that the original purpose of the concept of herd immunity was to protect people.

Today, however, it is not used to block the pandemic, but in the sense that the epidemic itself must generate herd immunity. This is done at the cost of hundreds of thousands and millions dying by then. That is nonsensical and inhumane. In the past, when the pathogens of the great epidemics and their transmission were understood, no one would have issued the slogan: Let the plague rage so we can achieve herd immunity.

Personally, I think that universal compulsory vaccination is the right thing to do, because it would strengthen individual and societal protection. Vaccinations are definitely important. Among our patients, we have a lot of people who were not vaccinated, but we also have people who were vaccinated twice. Vaccination is only one step of many. The issue of vaccination is now topical, and the government is betting a lot on compulsory vaccination, but this alone will not stop the pandemic.

To focus solely on vaccination and mandatory vaccination does not do justice to the dangerousness and ferocity of this disease. With Omicron, the virus is spreading rapidly right now. A mutation is a random thing, but the virus that mutates "seeks out" and "finds" the loopholes in the human body's defences with a previously unknown probability through the "random mutation." This is not a matter to be taken at face value. This is not an abstract matter.

A social task

At the moment, there is no real cure at all for COVID-19. We have nothing to fight the virus. Eliminating COVID-19 in this way will not succeed. What is needed are lockdowns and tracking-and-tracing to stop the pandemic. This needs to be addressed now.

It's a societal task—to eliminate and eradicate the virus, just like smallpox or measles. And you must eliminate it globally. This process must be organized politically, and the bourgeois class is not ready to do that. So, the fight against the pandemic becomes a question of power against the bourgeois class. It will not tolerate any delay.

The *World Socialist Web Site* is the only one to offer a clear and scientifically sound perspective. This has helped me personally very much to hope for the future and to resist resignation and capitulation to this terrible disease and the malignant ignorance in the ruling politics.

Why hasn't the fight against the pandemic been taken up seriously yet? It becomes very clear. Profit counts more than human life. The WSWS has taken a clear position on the pandemic from the very beginning, and this was and is of great importance.

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