

“At the beginning of the pandemic we were not allowed to use masks”

## NHS maternity doctor in London, UK speaks to Global Workers’ Inquest into the COVID-19 Pandemic

**Margot Miller**  
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A doctor who works in a busy maternity unit in a National Health Service (NHS) hospital on the outskirts of London has provided a submission to the Global Workers’ Inquest into the COVID-19 Pandemic. He is an obstetrician and gynaecologist who has worked throughout the pandemic.

More than 200,000 people have died from COVID in the UK, including 2,100 health and social care workers, with hundreds of people still dying each week.

With public health restrictions on COVID-19 ended months ago, scientists are predicting a winter surge of the disease. Already, COVID hospitalizations are on the rise. On September 28, 7,024 people with COVID were in hospital, an increase of 37 percent from the previous week.

“It is a challenging period as COVID has had a major impact on normal services,” the doctor told the Inquest.

“There was a huge increase in COVID patients”, he explained. “A fair amount of space, resources and manpower is required to care for these patients. This impacted other patients who needed care in the maternity unit.”

Since the pandemic started two and a half years ago, “COVID patients in the maternity unit had to isolate in rooms for days and days. Also, if they were in bays, we had to restrict the numbers who could stay. It was a huge challenge in view of logistics and space. The ultimate result was that people who were waiting for normal services and care were delayed. Frustration among the patients and colleagues is high. Many bear it because they consider that it is the norm.”

With COVID patients being hospitalised in large numbers, “Other services were cut or changed onto different pathways. Most of the general clinics were cancelled or shifted to phone-based consultation. Treatment and screening for cancer got delayed. Over-the-phone consultation was an alternative even though it is not the optimum.”

Already-long waiting lists have ballooned dangerously, “Along with COVID, there was a huge, direct impact on theatre cases. Theatre [operations] was cancelled unless considered an emergency. But ‘not an emergency’ doesn’t mean that it is not required. These are people who still have a problem and are waiting for surgery, for a hip replacement, knee replacement, or treatment for heavy menstrual bleeding.”

During the peak of each wave, “Wards were turned into COVID-only wards. Therefore, there is no place to admit other patients. Theatres were changed into ITUs [Intensive Therapy Units].

“Even though the number of patients increased, there was no physical increase in beds or staff. This meant a considerable portion of patients had to be looked after in the community. If there was no COVID, the same kind of symptomatic patient would definitely have care in a hospital set up. Also, these patients were not attended by an expert, but for example by paramedics. There was a knock-on effect at every level.

“Lack of staff is another challenge,” the doctor continued, “with staff ending up sick due to COVID. NHS staff are directly in contact with patients in numerous ways. This makes them more vulnerable to infection and increased exposure to COVID. This was real challenge during the period.”

### Staff catching COVID

“One my friends who works in hospital as a health care provider, both her husband and son ended up with COVID. They contracted it from her, from the hospital. She managed to find a bed for her husband as his condition was deteriorating. But the sad part was her son, with a similar condition, had to be monitored at home with oxygen. Imagine, as a health care worker knowing what is going on and having to look after her own child with worsening symptoms. The worst experience of her life. She told me that she was almost dying on a few days. Luckily, they both survived.”

Asked how patients and staff are protected from catching and spreading COVID-19, the doctor replied, “Barrier nursing was subject to cuts throughout the pandemic, with one circular after another [from management].

“At the beginning of the pandemic we were not allowed to use masks at all in the clinics. People had to argue management. If they wore a mask, they were considered as persons who are against the trust’s policies. Also, gradually they were issuing protocols to cut down barrier nursing layers.

“I can remember when we had to do instrumental deliveries [assisted births, using forceps or ventouse suction cup] with only a plastic apron, visor, gloves and a surgical mask in COVID patients. FF3 masks were allowed during theatre procedures mainly. In an instrumental delivery you are so close to a patient that you are subjected to exposure from all sorts of body fluids and even from breathing. You can’t do instrumental delivery by standing miles away from a patient.

“Health care workers should have the freedom to decide what PPE [personal protective equipment] to use, health service or care is so broad it can change from person to person. Here what we experience are rules made in view of the financial side rather than the cost of human life.”

## Risk to pregnant women and babies

The doctor explained the dangers pregnant women and newborn babies face from COVID.

“This is a very broad topic and the area that comes under the topic is vast,” he said. “Firstly, the management of pregnant women with COVID is the same as for the general public. That means, if someone pregnant is admitted with COVID and she needs x-ray, antibiotics, ICU, the advice is the same as for the general public.

“But we knew pregnant women are the most vulnerable group as their immunity is already hampered. So, they are in the risk group. On top of that, the BAME group, black, Asian and members of other minor ethnicity groups were also a vulnerable group due to various compounding factors. Most of the pregnant mothers who died during the pandemic belonged to this group.

“Caring for pregnant women during the pandemic was challenging, a huge task due to:

“1. Lack of adequate space: most of the pregnant mothers were cared for in a bay area and that means open wards. So, if someone was found to have COVID all the bay had to isolate and the number of spaces available for other patients became limited.

“Also, maternity patients usually stay around two to three days once they are admitted for labour or for LSCS [C-section] and their risk of catching the virus in the hospital also increases.

“2. Lack of tests: at the beginning of the pandemic there was a huge shortage of test kits. Who should get the test for COVID was decided by management not the clinicians. There were times when we knew 100 percent that a patient had COVID but we were not allowed to carry out the test. It was risking others’ lives also. Later they managed to increase the number of tests, but it took a while.

“3. Cutting down of clinic services: pregnancy is a nine-month long process. Clinic visits are very important, as well as scan appointments. These we had to reschedule and most of them were carried out as phone consultations. Also scan appointments were rescheduled and the risk group who get scans was redesigned to reduce the turnover.

“On top of that, finding staff to cater for mothers was a real challenge as they also ended up with COVID. If someone ended up caring for a COVID patient during labour, there was a possibility they might end up in same situation, as they were having close contact for hours in the same room over and over.

“4. Ventilation: this was real challenge as none of the wards or rooms were built with considering ventilation. Some theatres had to be abandoned due to poor ventilation and air circulation. High patient turnover, lack of staff, poor ventilation, not enough space – all of these went hand in hand, putting people at greater risk.

“Mothers were not allowed to be accompanied by their birth partners during labour as in the past. One birth partner was allowed only. That person couldn’t be changed. Some women had to give birth alone as their family members were also ill.

“In our unit we didn’t have a huge number of patients coming in with severe COVID who required ITU [intensive care unit] admission. But we had quite a lot of people with mild to moderate symptoms. Most of them were managed over the phone and medicines distributed to their home.”

The pandemic was traumatic for maternity staff and patients, with the

doctor recalling, “One day I went to see a patient in A&E [Accident and Emergency] who came with respiratory difficulty and serious COVID, and the first question my patient asked was, ‘Doctor am I going to die?’ That was the impression the general population had about pregnancy and COVID.”

## National Health Service was unprepared

When the pandemic hit in February-March 2020, the NHS was completely unprepared, and the Johnson government downplayed the risks to justify its own criminal inaction.

“We have noticed that irrespective of the nature of the country, poor, rich, developed, developing, every country had very poor preparation for the pandemic. Wards were not designed to handle the situation. There was inadequate bed capacity, not enough ITUs or ICU [intensive care unit] facilities. Ventilators were not enough to cater for the situation at all.

“It is time to redesign or rethink facilities, so we are able to cater for future problems like this.”

For more than a decade, the British government was repeatedly warned about its poor preparation for a pandemic. Simulated exercises conducted by Public Health England in 2016 showed the NHS could not cope, resulting in mass casualties.

As the pandemic continues, the impact on NHS staff has been catastrophic. On June 22, *Nursing Notes* reported a survey of 2,000 health workers that found “understaffing stress and burnout, compounded by low wages” were prompting nearly four out of five staff to consider leaving the profession.

“There is immense pressure on NHS staff,” the doctor told the Global Workers Inquest, “Staff are getting sick day by day. The number of absentees is starting to increase and on top of that the pressure starts to mount on people who care, to come to work. But they have to consider the safety of family members. Some people are the sole bread winner of the family and even if they have co-morbidities or are more vulnerable to COVID, they have to work.

“NHS staff bear the pressures from work, family, income and pressure from dying patients and their families. At the same time, they have witnessed their colleagues dying, intubated in the same hospital, in the same department, and the mental pressure is huge.

“Imagine living in fear, always thinking that you could be the next like your intubated colleague!

“I have come across a few of my colleagues who ended up with Long COVID. One colleague had to come back to work in a wheelchair and another ended up with continuous tremor in her hands. A few had to have weeks and weeks off due to symptoms including shortness of breath, or fatigue. They were all very fit persons before the disease, but they became totally different, less able, following COVID.”

Health workers are disproportionately affected by Long COVID. They are among the 1.2 million people with symptoms for more than 12 weeks after initial infection. A *Guardian* article dated July 6, 2022, reported “at least 199,000 NHS workers are currently living with long Covid.”

The doctor also reported problems with administering the mass COVID vaccination programme, which involved many non-clinicians, “People didn’t have adequate training. Standard practice should be to aspirate the needle, especially when there is a possible risk of injecting a blood vessel with a serum that could cause complications. This is not always done.”

He said the Johnson government’s decision to abandon all public health controls to curb the spread of COVID was “driven by greediness and power hunger. If we had followed infectious disease control measures, many more people would still be living.

“Governments always prioritise the economy before lives. That is why they had patch-like mitigation measures throughout. They were too late to close the borders and too early to open the borders. They removed social distancing, mask rules, gathering and partying rules purposefully, to spread the virus in order to fulfil the dangerous herd immunity concept.”

The doctor agreed that schools, colleges and universities are not safe places. “Students don’t know how to keep socially distanced; it is not practical at all. If you visit any school, you have enough examples to say that kids can’t maintain their social distance.

“The government uses the terms ‘herd immunity’ and ‘endemic’ to cover their inability and unwillingness to control the pandemic. They lied to people and society by using these words. They try to hide their actual management plan, which was mitigation, to prevent the collapse of their financial gains.

“Herd immunity is not achievable. People are being infected with the virus over and over again and new variants are emerging with every peak of infection.”



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