SWiM
Supporting Women in Medicine

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SHEFFIELD WOMEN IN MEDICINE

A newsletter amplifying the voices of women during the COVID-19 pandemic & beyond

Welcome to SWiM's Newsletter

In this issue:

WE ARE LOOKING FOR NEW VOICES

Email us with ideas or submissions for the next issue:
swim@sheffield.ac.uk

Introduction

By Dr Liz Dunningham

I've been grinning with pride reading through the articles for this edition. It is truly great stuff!

We are so happy to hear from behind the laboratory doors with an article from Consultant Virologist and all round hero Cariad Evans. Did you know that, when the government announced Public Health England had tested 5000 people, Sheffield Teaching Hospitals Virology had tested 2000, not included in the PHE figures?

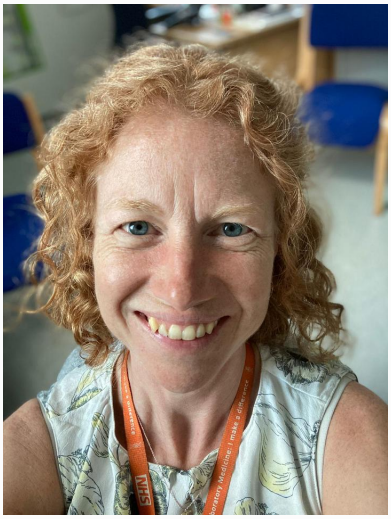
Orthopaedic surgeon Ms Antonia Isaacson reports from a very different Covid frontline after her department considered how, with elective surgery cancelled, their skills could best be put to use, and ended up providing a great service for patients attending with fractures and other injuries.

Who hasn't got emotional in the past few months, especially when the issue of race again came to the fore? This time like no other in my lifetime, despite many many previous examples of police brutality, has caused us to stop and examine our own privilege and even racism, yes, whether in mind, deed or thoughtless comments. Those involved in SWiM have long been thinking about how to address the issue of race. Before Covid, we thought we could make it the theme for one of our events. Now, the conversation has become more urgent so we are very pleased to have Marcia Hylton start that conversation for SWiM. Marcia is a Physician Associate in gastroenterology, and that's just one of the many strings to her bow. She's an inspirational woman and we are very grateful she has opened up on this raw time. I feel Marcia may be a TED speaker herself one day - remember you saw it here first.

Finally, I wanted to include this stunning piece of writing from my good friend Katherine Bonner. Mainly, because it is such an original perspective on the patient journey, written with wit, intelligence and insight. Reading it, we glimpse examples of good care and bad. There are even a couple of references to good art, something most of us do not get enough of!

I hope you enjoy these articles as much as I did.

Virology: Behind the Scenes



We asked Dr Cariad Evans, Consultant Virologist, about the extraordinary challenge faced by her specialty and laboratory colleagues during this time, and particularly about the achievements here in Sheffield.

'COVID-19 has shone light on some parts of the organisation which are usually hidden....'

These kind words were passed on to virology and they meant the world to us. Lab Medicine is often in the shadows but this has been our opportunity to shine. I have never worked with such an outstanding team in my life and I wish to take this opportunity to introduce them to you.

Sheffield was at least twice labelled as a 'covid hotspot', is this true?

There have been a few times when the media has labelled Sheffield as a hotspot, particularly early on in the pandemic, which was primarily due to the fact we were doing more testing. At one point Sheffield accounted for around 10% of the entire country's testing figures. If you are delivering on this scale then inevitably you will detect more cases and appear as a hotspot. We knew this to be the best strategy to prevent onward transmission.

Can you tell us about Sheffield's work in sequencing the COVID-19 virus?

Sequencing is a technology we established locally at the start of the pandemic, with the help of our colleagues in the University of Sheffield, and we are part of the COG-UK consortium. This is the first time real time sequencing has been performed in a pandemic response, with the aim of creating intelligence to share with public health agencies, hospitals, regional NHS centres and the government.

By looking at the diversity in the genome of the virus, you can wind the clock back and look for mutations, to understand when they occurred, where the strain emerged and other important viral characteristics. By early May we had sequenced over a thousand genomes from confirmed Sheffield cases and this data has contributed to understanding how the virus was originally introduced into the UK, how 1 mutation has potentially influenced its transmissibility and it is helping us investigate outbreaks.

Is there a 'typical' day in virology?

8am I am on a clinical expert group call including our Director of Infection Prevention and Control and High Consequence Infectious Diseases Consultant Lead. It's early days of the pandemic and we are all trying to assimilate fast moving science and guidance, to ensure staff and patient safety whilst delivering high quality care. I walk in to Lab Med to a hive of activity; our Lab Manager Leeanne appears to have been in since day break and is coordinating staff in response to the mounting numbers of samples which need SARS-CoV-2 PCR testing. Safe handling, sample booking in, coding up of test requests are all aspects of the service which often go unrecognised.

I sit down with my consultant colleagues to review our in-house SARS-CoV-2 PCR data. Dr Mehmet Yavuz, our Development Scientist, designed our PCR from an early Eurosurveillance paper facilitating laboratories in early set up of diagnostics, which has proved to be a highly sensitive and specific assay. His work enabled STH to start testing ahead of other NHS labs and while PHE was the only provider of the majority of the UK's testing. Today he presents an extraction-less PCR, this is necessary as we have just been told we will not be receiving any more consumable items for this initial PCR step, due to global shortages.

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Our biomedical scientists (BMS) work tirelessly to come up with solutions, expand testing, introduce and validate new platforms, handle urgent requests, and all on a regional scale. The wonderful Lisa (who is running Lab stores and dispatching swab packs all over the Trust) has walked in to provide tea and biscuits because she is worried we don't seem to have time to eat and drink these days....

I pop into the juniors office. Hayley and Mike have just written another collection of Trust algorithms, whilst fielding hundreds of calls and Alex is overseeing the National COG-UK sequencing samples to be expedited to the University. This is one example of many University of Sheffield collaborations. Amy is training to be a clinical scientist and is formidably bridging the gap between the BMS staff and the medics, which is essential for translating clinical demand into operational lab activities. My phone is ringing, there's a queue of people to chat to, and Alison my Consultant colleague is as calm as ever whilst overseeing training of a new team of COVID-19 helpers- the histopathology trainees whose contribution was invaluable. Raza our Clinical Lead is co-ordinating one of the largest staff testing initiatives in the UK and Kelvin our senior BMS is overseeing production of thousands of swabbing packs up in 'COVID corner'.

We surpass national testing targets and forget to count as everyone is working so hard. All disciplines within Lab Med are contributing; our microbiology colleagues let us know how each of them will support our ever expanding roles and responsibilities. Our Clinical Director offers strategic support. No one can check an email as our inboxes have spiralled out of control and our secretary competently helps field the demands of the COVID-19 Command Centre. Our fully qualified virology trainee steps up to the challenge, in her first consultant role, what timing! A retired colleague returns, after starting her career in the HIV pandemic she will now retire after the COVID-19 crisis is over. Her expertise is so valuable.

Next I attend a NERVTAG call (The New and Emerging Respiratory Virus Threats Advisory Group), my colleagues who encouraged me to apply for this position before a pandemic was declared, cover for me now. Meanwhile our F2s are gathering data with our Registrars, to write a publication on our experience of staff testing, which we believe will help NHS Hospitals continue to function safely.

It's nearing the end of the day but there is a National Virology Cell call, Raza, Ali and I stay in the office to take, we start to feel tired and realise we are pretty hungry. The domestics are waiting to come in to clean our room; their role in this response should never be underestimated. We bid farewell to the BMS staff on late, the PCR machines are whirring away and churning out hundreds of results. Staff who were swabbed today are getting same day results via text message. Every negative is just as important as the positives. I drive us all home in my Fiat 500, which now seems like a reckless IPC suggestion, but at the time it seemed logical as they are my work family.

A Different Frontline

Ms Antonia Isaacson shares her experience as an orthopaedic doctor working in minor injuries during the COVID-19 pandemic.

In a very short time, seemingly overnight, the COVID-19 virus changed normal NHS activity. Everything but emergency consultations and surgeries were cancelled as the NHS mobilised against an anticipated large volume of COVID-19 related patient admissions to our medical wards and Intensive care units. The effort of all the staff within these departments was nothing short of miraculous and we owe them a huge thanks for their effort and sacrifice. But I am an orthopaedically trained spinal fellow- a far cry from a medical or ITU specialist. This initially left me feeling that I wanted to contribute and help our patients and the NHS in general but couldn't really see where I fitted in. Others are far better qualified to treat unwell COVID patients, however, throughout this period people continued to become sick, injure themselves or each other by means other than COVID-19. Newly developed interests in running and cooking certainly seemed responsible for a considerable number of accidents. As a post CCT fellow in orthopaedics, I would like to share my experience of orthopaedic care for these patients during the COVID–19 pandemic.

Under normal circumstances, patients with fractured or suspected fractured bones would be examined and X-rayed in the minor injury unit of the emergency department. The affected bone or limb would be immobilised, and the patient would return to a triage fracture clinic within a few days for an orthopaedic review and further management, after which a patient may be discharged or may require further visits. It is seldom recognised that orthopaedics is a useful admission prevention speciality, but we have become adept at the management of orthopaedic conditions in an outpatient environment. At no time was this more essential than in the current pandemic.

During the pandemic, I, along with my colleagues, assisted in the minor injury unit, working with the emergency nurse practitioners to review, triage and treat patients with a variety of injuries. The aim of having an experienced orthopaedic opinion in minor injuries was to triage patients immediately; the patient could then be admitted, discharged or definitive management started immediately, reducing the number of attendances each patient required. We were also able to discuss each patient's treatment opinions relative to their risk of an adverse outcome from COVID-19 in a face-to-face consultation rather than over the phone, providing a more reassuring experience. For example, patients with minimally displaced wrist fractures, we were able to treat with a cast that could be removed by the patient or family member at six weeks after injury and prevent another hospital attendance and hence reduce further exposure risk.

This experience taught me a lot; not least it gave me a better understanding of the wide range of presentations our emergency nurse practitioner colleagues review and the pressure the emergency department is under to meet targets. As I have become more senior, I have become more specialised, and working in minor injuries helped me to recalibrate - for example understanding ankle sprains are far more common than ankle fractures. I was also able to treat a large number of wounds and removed numerous foreign bodies, performing minor surgical interventions that would prevent the need for further attendance. Working together with my emergency department colleagues benefitted all parties involved, improving our interdepartmental relationships. I would anticipate that with closer working between our departments in the future it would be possible to reduce the number of hospital visits each patient requires while not compromising patient care.

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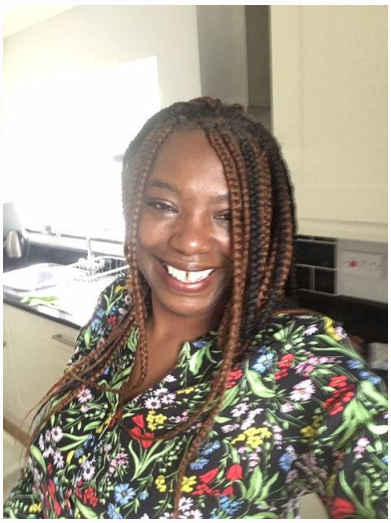
I felt that I was able to positively contribute to the department, lending my experience in orthopaedics to the treatment of fractures / minor injuries. It was fantastic, if tiring, to dust off old skills and know that I was helping to protect patients from further exposure risk. More significantly, even though I wasn't specifically actively treating COVID patients I felt I was part of a team, dealing with the pandemic, reducing the workload on medical specialities and the emergency department and protecting our patients.

As with any time of crisis, opportunities have emerged. With our increased focus on collaboration, and our improved understanding of our mutual department's strengths and challenges, we are better placed to improve our patient's experience and treatment. This experience will certainly shape my practice in the future, and hopefully, as this is replicated throughout the country it will lead to new and innovative ways of caring for patients and improving our NHS.

Normalising Courageous Conversations

By Marcia Hylton



The world has changed! We are living in extraordinary times. Who could have predicted at the beginning of the year that we would be in the middle of a pandemic? And who would have thought there would be a major paradigm shift in global consciousness caused by COVID-19, which disproportionately impacts the BAME population of which I am a part? Having family members contracting COVID-19 and the death of a family member abroad due to this terrible illness, not to mention the murder of George Floyd by the hands of those meant to protect and serve; these events have shone the spotlight, like never before, on systemic racism.

Racism is deeply ingrained in our society and therefore in our workplaces too.

Organisations across the UK are discussing how to tackle and uproot racism including Sheffield Teaching Hospitals where I work. But where do we start? I recall it all becoming overwhelming and too painful to talk about. A lot of tears and heartache. One day I hid in my office and broke down- I felt the collective trauma. It's fair to say my mental health has taken a battering these past few months and I needed, or should I say was forced by my mental state, to take time out to process all that was happening. I felt drained, heartbroken and was finding it difficult to focus.

The Hepatology department where I am a Physician Associate has been very supportive and has done all it can to help. However, I have found it difficult to talk to many colleagues. It is really hard and messy, I get that. Yet I know that these conversations need to be had, in order to effect change. We need to be normalising courageous conversations, together. And to truly listen. It's my belief that most people want to support racial equality and equity, It's just that they don't always know how to practically.

Brené Brown (US professor and TED speaker on vulnerability) says, "In order to empathise with someone's experience, you must be willing to believe them as they see it and not as you imagine their experience to be." This, to me, is what leadership is about. Listening and having empathy leads to the empowerment of others, it is inspirational and cultivates a shared vision which in turn leads to change. We must be willing to have those difficult conversations which will help towards building organisations that are more inclusive and diverse. We need to keep the conversations going and to not let them slip away as protests and media coverage die down - this problem has not gone away. This is a real pivotal moment in our global history and if organisations can keep the conversations going at an internal leadership level it filters through eventually to all-employee level.

Embrace the Learning Experience

When we are overwhelmed by upheaval, it is easy to fall into a cycle of, 'should have said', silence and self-blame. We can avoid this by instead asking ourselves two things: "What can we learn from this? What is the silver lining in all this?" One thing for sure, is that, in these bewildering times, we are not the same people we were only a few months ago - at least I'm not.Now, I'm feeling optimistic that the world can change for the better. That each and every one of us have some aspect of leadership within us- we are all leaders whether within our homes as mums, wives, sisters, or at work. We can influence change-that is what change is to me, influence. And when we do that with integrity, transparency and open minds and hearts, then we change our environment, we change the world.

Facing the Unknown

By Katherine Bonner

What's the worst that could happen?

I could die. This is the first thought that explodes in your brain when you get a cancer diagnosis. It's the drum beat to every following conversation you have whether it's with your husband, your surgeon or the checkout operator.

The next sensation is that of going into a mental free-fall as your future just disappears. Your life becomes a Road Runner cartoon where you don't take the corner well on the mountain pass and you're still moving your legs and arms but there's no ground beneath you and you have no idea what is going to happen next. Staring into the abyss. Plans just dissolve. You see a movie and you don't know when you will see another one (A Ghost Story dir: David Lowery starring Casey Affleck was, however, the perfect "last movie"), a friend calls from far away but the idea of visiting them becomes a laughable fantasy.

And now suddenly, three years later, the world has gone into lockdown. There is a killer virus creeping and leaping and catching a plane or a cruise ship to every country on the planet and I'm having flashbacks. I've been here before watching uncertainty and fear compete for my attention, their white noise blocking all rational thought.

So this is what I did then. And this is what I am doing now.

The first thing a cancer patient learns is cancer patience. So much waiting around and not just in waiting rooms. Every appointment with my surgeon is at least an hour and a half late. You fear time is running out but you spend hours doing nothing while you wait. You worry about parking tickets because it is easier than worrying about everything else. You wait for test results and for phone calls to understand the test results. And wait some more. You are sent for more tests and wait for more results.

So now I am much better at waiting. As a child my brother once paid me 50 cents to sit still. Just for a bit. I don't remember if I did and got the money but I remember being surprised that I was so annoyingly wriggly that he would pay me to stop. I think I have finally learned to be calmer. And wait. And see what happens.

During my treatment, I also tried to stop myself imagining every possible awful thing that might occur. You banish the big picture and focus on just dealing with each new development as it happens. That procedure on that day, this bigger-than-first required surgery on another day. You trust experts and you are drawn to hard facts backed up by evidence.

You learn a whole new vocabulary with complicated scientific words that will determine your future. The gallows humour that was once your edgy trademark now has more than a hint of desperation about it. People's laughs are hollow while yours becomes shrill. After one too many jokes, my surgeon recommends a psychologist. Turns out 'you've gotta laugh" is a flawed coping strategy. Sometimes you really do have to let yourself cry.
I frantically prepared for the short term and cut off my long hair, cooked a lot of meals for the freezer, leaned heavily on those closest to me, accepted help from my friends and was utterly humbled by the sheer compassion people showed me. Day by day, I got by. Day by day.

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'Turns out 'you've gotta laugh' is a flawed coping strategy. Sometimes you really do have to let yourself cry."

Dealing with other people's reactions to my predicament was tricky. Dealing with the entire world's reaction to this overwhelming situation is impossible. There is no right or wrong way to react just like there is no right or wrong way to grieve. The slow-motion tsunami of horror that is playing out on every screen and into every living room envelops each of us differently. Uncertainty and fear turn up the volume and shout inside your head, "the centre cannot hold." (I'm not sure if it is better or worse if you know the whole poem?!) *

I tell people that cancer is like a car crash. All cancers are different with different outcomes (that means how long you are going to live, for the uninitiated) in the same way all car crashes are different. And this is one big car crash that we are all in and it's just happened and we don't yet know who is going to go through the windscreen and who will escape unscathed. But all you can do is buckle up your seat belts and hope for the best.

Many months after my surgery and lengthy recovery and it had turned out my prognosis was pretty favourable, a friend I hadn't caught up with for ages said, great to see you, and he paused, so alive.

And he was right! Every day we are alive is a marvellous, marvellous day and, sometimes, it really is that simple.

* The Second Coming by W.B Yeats

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An enormous thank you is owed to the contributors of this issue for giving up their limited time to write and reflect and for allowing us to share their experiences.

Thank you!

Edited by Yasmin Ghafor
& Dr Liz Dunningham

With assistance from the
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