12 King's Bench Walk, London

daniel.sokol@talk21.com Follow Daniel on Twitter @DanielSokol9

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ETHICS MAN

The NHS is not at risk of being overwhelmed—it already is

For patients whose condition worsens as they wait in line, the NHS has already been overwhelmed

Daniel Sokol *medical ethicist and barrister*

Cases of covid-19 are surging and doctors warn of the NHS being overwhelmed. On 2 January 2021, there were 57 725 daily cases of covid-19 in the UK, a new record. Hospital admissions have also risen and many hospitals are struggling to meet the high demand. The government is petrified at the prospect of the NHS being overwhelmed. Yet, it already is.

Elective operations have all but stopped in many hospitals and resources reallocated towards the covid-19 effort. What this means is that patients with, say, a brain tumour might have their operation delayed. The patient will continue to suffer from symptoms until the rescheduled operation and, by the time of surgery, the tumour may be inoperable. The delay, therefore, could lead to a premature death or life changing symptoms that could have been avoided with timely intervention. In the US, about 10 000 excess deaths from colorectal and breast cancer are predicted within the next 10 years because of delays in diagnosis. In the UK, a study in *Lancet Oncology* has predicted over 3000 excess deaths from breast, lung, oesophageal, and colorectal cancer within five years.

The government will be aware of the collateral damage that pooling resources for the covid-19 effort will have on non-covid-19 patients. The reality is that the government, and probably the public, are more willing to tolerate a slow death from an underlying condition or a prolonged period of suffering, outside the glare of the media, than a quick death arising from a lack of intensive care facilities. The cancer patient's life is not worth any less than that of the patient with covid-19, but a patient who dies over a period of months or years because of tumour spread is less likely to cause a fuss or generate public outrage than the dramatic death of a patient with covid-19 in need of intensive care. The manner of death plays an important part in its perceived moral acceptability.

Moreover, the death of the patient with covid-19 is arguably more distressing for healthcare staff than the slow passing of the cancer patient. Clinicians may feel a greater sense of distress and helplessness at the sight of a patient dying rapidly from a condition that in normal times would be treatable. The morale of healthcare staff and the risk of burnout are all the more important when human resources are low.

When the government talks of an overwhelmed NHS, it refers to a situation where patients with covid-19 are deprived of potentially life saving intensive care treatment. It wants to avoid this scenario at all costs because it would attract opprobrium and, at worst, may lead to complaints and aggression towards clinicians, litigation, civil unrest, and staff absences.

In April 2020, frustrated by the lack of practical guidance for clinicians, I created a triage protocol to help hospitals with their decision making in the event of a covid-19 emergency. Despite calls to do so, the government has refused to release similar guidance. No doubt politicians worry that disclosing such a document would lead to public panic, criticism, and legal challenge.

Prioritising patients with covid-19 over others may be justifiable but it is important for all to appreciate that the costs of this, although less visible, are nonetheless very real for thousands of patients whose suffering goes unrelieved or whose conditions worsen as they wait in line. For those patients, who are paying the heaviest price, the NHS has already been overwhelmed.

Daniel Sokol is a medical ethicist and barrister specialising in clinical negligence. He is the author of *Tough Choices: Stories from the Front Line of Medical Ethics* (Book Guild, 2018)

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