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Three waves in Bærum

EDITORIAL

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Knowledge about the outcomes among COVID-19 patients admitted to a local hospital in the Oslo area provides key information preparing us for the next wave of coronavirus infections.

In this issue of the Journal of the Norwegian Medical Association, Myrstad and colleagues present the course of illness and treatment for the 300 COVID-19 patients who were admitted to Bærum Hospital during the first three 'waves' of coronavirus infection in 2020 and 2021 (1).

Bærum Hospital is a relatively large local hospital that caters to nearly 200 000 inhabitants. For a department with approx. 90 beds, eight of which are reserved for patients in need of intensive monitoring and care, these patients are likely to have represented a considerable burden. Unsurprisingly, two-thirds of the admitted patients had respiratory failure, whereof 15 % (31 patients) were in need of invasive ventilation. The mortality rate among those 15 patients who were treated on a ventilator during the last wave was 27 % (four of them died), which is low (2, 3). During the two last waves, about four-fifths of the patients with respiratory failure were treated with steroids, as is recommended (4). Hospital mortality fell during the three waves, to less than 5 % in the last wave. As discussed by the authors, the reason could be that the average age of the patients at that time was lower than in the first wave, and that the first wave included many frail patients (5). The mortality rate in the first wave could also be associated with the fact that one-fifth of the patients did

not receive prophylaxis against venous thromboembolism. Signs of coagulation disorders have prognostic value in COVID-19, and thromboembolism prophylaxis is important and challenging (6, 7).

It is difficult to determine the appropriate level of treatment for a patient with severe COVID-19. For this, we need even better prognostic tools, not least if we were to face a real crisis situation where we would be unable to provide the best documented treatment to all patients. Based on the habitual and current clinical condition of patients, both the primary health services and the hospitals, need a well-documented basis for assessing prognoses and treatment levels, for example regarding which patients should receive invasive ventilation treatment (2, 3, 5).

At the time of writing (17 December 2021) we are in the middle of a new wave of coronavirus infection, and the number of hospitalised patients is higher than ever before. What will happen going forward with the highly contagious Omicron variant is uncertain. The big question is how pathogenic this variant will be in a population which is almost universally vaccinated. In this context, it should be noted that we are still at the assessment stage when it comes to intensive care capacity in Norway (8). In fact, our intensive care capacity is no larger today than it was two years ago. This is scandalous.

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One might well ask whether the authorities could have made more active use of the relatively calm phase that we experienced last year. The number of beds available for intensive care depends on physical space in our intensive care units, but also on the availability of healthcare personnel with the required skills. We know, for example, that many nurses with intensive care training do not work in intensive care units. What is needed for them to consider working in the function for which they were trained?

Thanks to this and previous reports from Bærum Hospital, we now know more about the outcomes among a large group of COVID-19 patients who were treated at this hospital. Combined with data from the Norwegian Pandemic Registry, this is important information, not least for other hospitals that now can compare these results with their own findings.

How have those hospitals that have admitted many patients been able to address such tasks as the organisation of personnel and use of space? What consequences have the handling of the pandemic entailed for other patient groups, and for the numerous healthcare workers who are left to cope with the situation? Both the workload and psychosocial burden have perhaps been greater than many have wanted to admit. We need more knowledge about these issues.

When we see the enormous sums that are spent on compensating for the national infection control measures, it is paradoxical that the health services have not been provided with additional funding to increase their staffing and build emergency preparedness. 'Everybody' wants better preparedness, but few are willing to pay for it. The additional allocation of NOK 700 million to the

specialist health service in the revised national budget is a large amount, but unfortunately not much in terms of building preparedness. Perhaps the Coronavirus Commission was too generous in its evaluation when it concluded that the national authorities have handled the pandemic well (9).

There are limits to how long the health services will be able to continue delivering quality care in a threatening state of emergency, as they are doing now.

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