Improving clinical practice in ENT: lessons learnt from the COVID-19 pandemic

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While currently in the midst of another wave of COVID-19 infections, putting untold strain on both healthcare systems and healthcare workers around the globe, it is important to reflect on the changes that we have all had to make. All ENT departments, within a very short timeframe, restructured clinical services to prioritise the delivery of patient care to those with the greatest clinical need, while increasing services such as tracheostomy for the high number of patients with COVID-19 in intensive care. We also changed the methods that we use to teach our trainees and share knowledge with colleagues. Many of these changes have been successful and should now be maintained in the future.

It has been fascinating to see the how the research community built new research networks and redirected focus to projects related to understanding SARS-CoV-2 infection; surveillance and public health measures, optimising patient management of the disease and understanding the impact of COVID-19 on different healthcare systems. This resulted in over 89,000 peer reviewed publications relating to COVID-19 in 2020 and the development of new research structures such as *CovidSurg* , a global collaborative platform of studies aiming to explore the impact of COVID-19 on surgical patients.[1]

Two papers in this issue demonstrate how clinical practice in ENT adapted to COVID-19. The first explores the publication of guidance relevant to ENT.[2] Both national bodies and specialist societies across the globe published guidance on how services should be reconfigured, patients prioritised, and ENT surgeons protected, particularly with respect to aerosol generating procedures given the potential high risk of infection. It is the speed of publication that was particularly impressive. Of the 175 online publications of COVID guidance related to ENT, 41% were published between the third and fourth week of March 2020.

The second study explores the impact of this guidance on clinical care through a prospective audit of the management of tonsillitis and peritonsillar abscess in 86 hospitals across the UK following the publication of guidelines by ENT UK, the professional body representing ENT surgeons in the UK. This provided a pathway that aimed to prevent hospital admission when safe to do so.[3] Increased use of single doses of intravenous dexamethasone and antibiotics resulted in return to swallowing in many patients, allowing patients to be discharged safely, without later increases in re-presentation or admission.

These studies show the strong clinical leadership has been demonstrated within the ENT community, removing traditional barriers to change. Clinicians have taken the initiative to develop new pathways and new ways of working. An almost overnight change from face-to-face appointments to remote appointments took place in many hospitals, showing how we can adapt when needed. Remote appointments, either by

telephone[4] or video calls,[5] are suitable for many ENT patients, preferred by many and are certainly here to stay.

There has been rapid scaling of technology such as digital consultation platforms to enable this remote service delivery. Video conferencing facilitates multidisciplinary team meetings, bringing together clinicians at distant locations to discuss patient management in an efficient manner without the need to spend hours travelling to meet in the same location. Virtual patient consultations can allow sharing of digital information such as imaging without the patient needing to leave their home, reduced footfall in previously over-crowded outpatient departments.

New teaching and training opportunities have arisen through the use of digital conferencing platforms, replacing traditional teaching programmes and allowing us to reach larger audiences.[6]Entire conferences have successfully moved to virtual participation. These opportunities have the potential to significantly enrich training and teaching in the future.

We have seen many examples of enhanced local system working. ENT and intensive care teams have needed to work more closely together to manage patients with COVID-19 requiring a tracheostomy.[7] It is important that these closer relationships are maintained in the future for patient benefit.

The ENT community has demonstrated strong clinical leadership, adaptability to rapid change, enhanced clinical pathways and local networks, widespread use of digital technology for consultation and teaching and redirection of research programmes. These have permanently changed the way we work and, when the current global pandemic improves as COVID-19 infections drop and vaccination programmes are rolled out, we should ensure that the positive changes that have been made are embedded in clinical practice to improve patient care.

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