UK Covid-19 Public Inquiry

Witness Name: Gillian Tierney
Designation: President of the Association of Surgeons of Great Britain and Ireland (ASGBI), 1st January 2023 – 31st December 2024.
Relevant Period: 1st March 2020 and 28th June 2022
Statement No. V4
Dated: 16th August 2023

WITNESS STATEMENT OF PROFESSOR GILLIAN TIERNEY

Personal Details

1. My name is Gillian Tierney. I was appointed as President of the Association of Surgeons of Great Britain and Ireland (ASGBI) by election of the Council of the Association for the term commencing 1st January 2023 to 31st December 2024. I was previously Vice-President of the ASGBI from 1st January 2021 to 31st December 2022. Previous to this, I was Director of Emergency General Surgery of the ASGBI from 2018 to 2020. I am a full-time Consultant Surgeon employed by the University Hospital of Derby and Burton (UHDB) NHS Foundation Trust and Honorary Professor at the University of Nottingham.

2. This witness statement relates to the matters addressed by the Inquiry's Module 3, which is examining the response of the health and care sector across the UK and the impact of the way the healthcare systems functioned in the United Kingdom during the Covid-19 pandemic within the relevant period.

3. I have prepared this witness statement myself, with the support of the Secretariat of the ASGBI, previous Presidents and Executive Directors using information in the Covid resources section of the ASGBI website.

The Association of Surgeons of Great Britain and Ireland's role, function and aims.

4. The Association of Surgeons of Great Britain and Ireland (ASGBI) is a voluntary membership organisation representing general surgeons in the UK and Ireland. It has no government funding and is funded by membership fees. The organisation was established in 1920 and has approximately 1500 members which comprise of consultant surgeons, specialty doctors, trainees, and medical students. It is the umbrella organisation in general and emergency surgery in the United Kingdom and Ireland. It has a network of regional representatives who are Consultant Surgeons in England, Scotland, Northern Ireland, and Ireland. It has a trainee organisation, The Moynihan Academy. It provides leadership, education, and support to members, and represents the views of its members to the Presidents of the four Royal Colleges of Surgery (RCS) of England, Edinburgh, Glasgow and Ireland, and other speciality associations within medicine, anaesthesia, and allied groups. Regional representatives in England provide a speciality professional advisor role for the RCS England in the process of new consultant job approval and appointments. The ASGBI is a membership company (A Company limited by guarantee registered in England, registration number 06783090) and the Executive Directors chair committees and have portfolios within General Surgery including Emergency General Surgery (EGS), Trauma, Research, Education and Training and Equality Diversity and Inclusivity (EDI).

Communication During the Relevant Period.

5. Internal communication took place in our fortnightly Executive online meetings attended by the President, Vice-President and Directors, and our monthly online Regional Representative meetings, attended by the President, Vice-President, and Regional Representatives. External communication to members during the relevant period was in three ways, in regular email updates to the membership database, with publication on our website and posts via our Twitter account. It is my understanding that there were, in the relevant period, regular meetings and conversations between the Presidents of the four Royal Colleges of Surgery and the ASGBI President and President-Elect, along with presidents of other speciality surgical societies (The Federation of Specialist Surgical Societies, FSSA), Presidents of the Association of Coloproctology of Great Britain and Ireland (ACPGBI), the Association of Upper Gastrointestinal Surgeons (AUGIS) and anaesthetic societies. A single statement was designed exclusively by the ASGBI at the start of the relevant period (GT/1 **INQ000226447)**, but thereafter the association contributed to statements from the Royal Colleges of Surgery and the Federation of Speciality Surgical Associations (FSSA), and these were shared with members.

ASGBI Statement on Delivering the Emergency General Surgery Service in the UK during the coronavirus Covid-19 pandemic 20th March 2020

6. This, the ASGBI Statement on Delivering the Emergency General Surgery Service in the UK during the coronavirus Covid-19 pandemic, (**GT/1 INQ000226447**) was the first statement to members of the ASGBI. The surgeon who was President during the relevant period has told me that this was in response to multiple queries received from the membership about the emerging pandemic and its effect on surgical practice, I have no further knowledge of the nature of the queries. It is the only statement released by the ASGBI independently before regular collaborative statements were issued. The statement was designed by members of the ASGBI Executive Board at that time. The aim of the advice to members was to enable them to provide safe, efficient care for continuing emergency general surgery in their hospitals. Members were advised to increase ambulatory services and minimise hospital attendance / bed occupancy. It was recommended to reduce outpatient attendance by using video or teleconferencing where possible. Members were advised to make active decisions on urgent elective surgical cases in light of

potential national guidance relating to the suspected increased risks of inpatient surgery. Surgeons were advised to work collegiately and to be prepared to help with other roles, whether as leaders or followers. They were advised to look after their personal safety and well-being, and that of their colleagues. They were recommended to attend training sessions and follow national guidance on PPE and to support younger colleagues. A quote from this statement reflects the state of uncertainty at that time "Many of us have seen enormous changes this week with COVID-19 and this advice is offered to assist teams and support patients requiring Emergency General Surgery. Requirements will vary depending on how compromised your service becomes and as matters progress, aspects of this advice will become out of date. It is important that teams refer to the national websites and follow NHS guidance on handwashing, self-protection, self-isolation, and medical practice."

The Intercollegiate General Surgery Guidance on Covid-19 Update released 27th March 2020.

7. The next statement issued by ASGBI a week later was "The Intercollegiate General Surgery Guidance on Covid-19 Update released 27th March 2020". (**GT/2 INQ000226454**). This statement was released jointly on behalf of all four Royal Colleges of Surgery, the ASGBI, the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and the Association of Upper Gastrointestinal Surgeons (AUGIS). It was published on the websites of all those organisations and sent to all members by email.

8. For emergency patients, this guidance advised that all emergency patients should be considered as possible covid cases and so a CT scan of the chest should be considered in all emergency admissions (the main diagnostic test at that time), especially in those patients already having a CT scan of the abdomen. Advice was given to avoid all unnecessary surgery and to treat patients with medical options, such as antibiotics, when possible. If a patient required theatre, there were to be minimum staffing levels, anaesthetic intubation and extubation in the operating theatre (rather than the anaesthetic room), smoke extraction suction devices were to be used and all staff should be in PPE including visors.

9. In elective cases it was advised to consider the increased and (at that time)

unknown risks of having elective surgery in the pandemic and to postpone surgery or use non-operative treatments when possible. It was recommended that the risks of contracting Covid while in the hospital and the subsequent increase in risk of death be specifically detailed in the consent form. Risk-reducing surgical options such as the formation of a stoma, or "bag", rather than an anastomosis or "join" were advised in order to prevent the risk of a leak from a join and a longer hospital stay with the possible requirement for intensive care.

10. Personal protective equipment (PPE) was recommended for all major abdominal surgery (laparotomy). Eye protection was recommended as was the ability to practice "donning and doffing" i.e. the safe application and removal of surgical gowns. The statement regarding PPE also said to "follow national/local guidelines".

11. Laparoscopy or "keyhole" surgery was thought to be a risk for aerosol generation and so its use advised against. It was advised that routine laparoscopic cases such as the removal of an appendix or gallbladder be performed in the previously traditional open surgery method if surgery was unavoidable. If laparoscopic surgery was to be performed it was recommended that specific filters be used with the equipment to decrease the risk of virus aerosol generation.

12. It was advised that all endoscopy be avoided unless an emergency. This was due to concerns about the generation of aerosols. It was recommended that full PPE be worn for any necessary endoscopic procedure and that the guidance of the British Society of Gastroenterology (BSG) be followed.

Updated General Surgery Guidance on COVID-19" (GT/3 INQ000226455) released 6th April 2020 from the Royal Colleges of Surgery

13. This guideline references the UK government updated guidance on PPE released on 2nd April (I cannot share that guidance in this report as it has been deleted from the UKGov website and the site reads "this publication was withdrawn 27th May 2022"). This guidance specifically recommended the use of PPE in common general surgical settings including the ward, admission area, endoscopy, and operating theatre. This updated guidance recommended professionals to:

"Consider the possibility of COVID-19 infection in every patient, follow national guidelines, and apply common sense to at-risk clinical environments. Unfortunately,

many patients will be disadvantaged by the current pandemic and increased risks apply to all patients. Teams may have to apply judgement based on local circumstances, resources and for some exceptional patients. This guidance is intended to aid development of consensus regarding regional and local approaches to treatment. There will remain a great deal of uncertainty regarding the pandemic, and you should update yourself from government and hospital resources also. The Colleges and other bodies have excellent resources online." This extract from the guideline demonstrates the uncertainty that existed at that time and lack of didactic recommendation.

14. The recommendations for emergency surgery remained that evidence for Covid infection should be sought in any patient referred acutely or needing emergency surgery. It was recommended that a patient history, Covid testing, and CXR should be used. It remained advice that any patient undergoing an abdominal CT scan for acute pain as an emergency presentation should have a CT chest at the same time, unless CT chest had previously been performed within 24 hours. It was noted at that time that tests for Covid, including CXR and chest CT, might be false negative. The message was to suspect and try to exclude Covid infection in all patients presenting as an emergency.

15. A new recommendation regarding elective surgery was that any patient prioritised to undergo urgent planned surgery must have self-isolated and be assessed for Covid as above. The greater risks of adverse outcomes from possible Covid infection after surgery should remain factored into planning and consent. Stoma formation ("bag") rather than anastomosis ("join") to reduce the need for unplanned post-operative critical care for complications remained a recommendation.

16. A new recommendation was that general anaesthesia was recognised as an aerosol generating procedure (AGP). Operating theatres where AGPs were regularly performed were considered a higher risk clinical area and full PPE was advised where Covid was possible or confirmed. At that time "In line with Public Health England (PHE) guidance, full PPE consists of disposable gloves and a fluid repellent gown, eye/face protection and FFP2/3 mask". It was stated imperative to practise sterile donning and doffing of PPE in advance. It was noted that procedural tasks were slower and more difficult when wearing full PPE.

17. The initial recommendation to avoid laparoscopy was modified to recognise the risk that laparoscopy was a potential AGP, and caution was advised. The level of risk

had not been clearly defined and the level of PPE deployed was described as "important". Advocated safety mechanisms (filters, traps, careful deflating of the abdomen) were recognised as difficult to implement. The smoke plume at laparotomy (open surgery) from coagulating instruments was also noted as not without some risk. Given the requirement to protect staff and other patients, a safety-first approach was needed and so a recommendation to consider laparoscopy only in selected individual cases where clinical benefit to the patient substantially exceeded the risk of potential viral transmission to surgical and theatre teams was made. The recommendation for non-operative management whenever possible continued. Appropriate non-operative treatment of appendicitis and open appendicectomy (as opposed to laparoscopic) was recommended. It was noted that some gall bladder operations could be reasonably deferred for several weeks if clinically safe.

18. In theatre practice the recommendation remained for minimum numbers of staff in theatre with "appropriate" PPE. There was a firm recommendation for smoke extraction to be used with diathermy (coagulation) and other energy sources. There was a recommendation for team changes for prolonged procedures in full PPE due to staff exhaustion.

19. It remained the case that only emergency endoscopic procedures were recommended. Routine diagnostic work was advised to be postponed due to the risk of AGPs, and BSG guidance was recommended for urgent cases. Upper gastrointestinal procedures were noted as high risk AGPs and full PPE was recommended.

20. A new recommendation was to consider the diagnosis and risk of Covid in other situations in the Emergency General Surgery setting and to use PPE accordingly. Presentations of Covid infection with intestinal symptoms had been recognised and Covid had also presented initially as an apparent post-operative complication in inpatients. Naso-gastric tube placement was a potential aerosol generating procedure (AGP) and caution was advised. Also, although chest compressions with CPR were not normally considered aerosol generating, compression patients often splutter and cough so full PPE in these instances was also recommended.

Personal Protective Equipment.

21. Members, Regional Representatives and Executive Directors expressed variation around the availability and appropriateness of PPE in their Trusts. It is impossible to

detail exactly the numbers of Members, Regional Representatives and Executive Directors, however, at every meeting at least one individual raised the issue. Surgeons described some trusts using the term PPE to describe a plastic apron and standard theatre paper face mask, whilst others offered full sterile fluid-resistant gowns and N95 face masks. Some members reported being advised to use a single facemask and apron for an entire ward-round of many patients, due to a lack of supplies. Members reported purchasing their own PPE online from industrial supplies companies. Due to shortages in my own Trust, I purchased industrial PPE facial protectors, a colleague purchased safety glasses and we shared these with colleagues delivering emergency care. Retired nursing staff from my own Trust, donated handmade cloth face masks for staff. Other ASGBI colleagues shared similar stories during Executive and Regional Representative Meetings. It was apparent from the published accounts of colleagues in China 'The novel corona virus outbreak in Wuhan, China.' Zhu et al. Global Health Research and Policy (2020) 5:6 **(GT/4 INQ000226456)** that risk to healthcare providers was significant and that access to proper PPE was essential to protect those workers. Publications from Italy (Spinelli, A. and Pellino, G. (2020), 'COVID-19 pandemic: perspectives on an unfolding crisis'. Br J Surg, 107: 785-787. **(GT/5 INQ000226457)**)
stressed the significant mortality among doctors and nurses. Despite recommendations that all patients should be treated as if positive for Covid, and that full PPE should be used in all operative settings, including endoscopy and some ward procedures (insertion of nasogastric tubes), it became apparent in conversations with members and meetings of regional representatives that NHS supplies of PPE were not always available.

Black and Minority Ethnic Colleagues.

22. The ASGBI has many members from BAME backgrounds and was concerned that the majority of healthcare professionals who died from COVID-19 were from Black Asian and Minority Ethnic (BAME) backgrounds. This impression was from reports of the deaths of colleagues in ENT and Emergency medicine who were from BAME backgrounds. It was evident that people from BAME groups generally were disproportionately represented among those suffering critical illness or death from COVID-19. The Royal College of Psychiatrists published a report on this issue in May 2020 (Impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) staff in mental healthcare settings | assessment and management of risk. 13 May 2020. **(GT/6 INQ000226458)**). Workplace safety for surgeons was a prime concern for

ASGBI. The ASGBI advocated this strongly via their President at the time through the Colleges to Public Health England during the crisis. Older members and / or those with comorbidities were also believed to be at higher than average risk. The ASGBI recommended in a statement 'ASGBI support for Members of Black Asian and Minority Ethnic Groups during COVID-19' **(GT/7 INQ000226459)** on their website and sent to members that everyone, and particularly those from higher risk groups should, have adequate access to appropriate PPE, including fit-testing of FFP3 masks. Members were advised to notify their clinical director / manager and Occupational Health of all health issues. Members were urged not to feel pressurised into exposing themselves to personal risk. It was noted that many colleagues had been redeployed or moved to other units. A strong recommendation was made for appropriate training and orientation in these circumstances. Members were advised to contact the ASGBI if in need of support. I am not aware of any resulting specific contacts.

Staffing.

23. Staffing levels were generally lower than usual partly due to evolving Trust policies regarding isolation after testing positive. The ability of members to deliver emergency care was impacted by their own health issues. Those assessed by Trust occupational Health services as at high risk due to medical conditions were unable to work in high-risk environments. The operating theatre was regarded as a high-risk environment as was out-of–hours emergency cover. Some members voiced concern that Trust Occupational Health departments were delayed in their ability to perform individual risk assessments. This was a particular issue for our BAME colleagues. Some Muslim colleagues found it challenging to source appropriate PPE due to facial hair. It was difficult to achieve an adequate seal on facemasks and the more advanced "hood" types of PPE were not initially widely available. This information was reported to the ASGBI by the regional representative network and was also shared on social media platforms. The ASGBI statement in support of BAME colleagues **(GT/7 INQ000226459)** was issued to support members on 7th May 2020. There was deterioration in mental well-being among staff who were aware of the deaths of colleagues. This was widely acknowledged in the profession though no specific metric was recorded. It may be that subsequent NHS Trust appraisal processes in which there is a new question about mental well-being could evidence this.

Surgical Prioritisation.

24. The four Royal Colleges of Surgery via the FSSA issued a priority list for surgical procedures and conditions "Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic" **(GT / 8 INQ000226460)** to aid Trusts to list patients for operations appropriately with the resource constraints in the relevant period. This guide was produced by the FSSA at the request of NHS England at the start of the pandemic. It was written by specialists in the procedures listed and was updated at least every month. The main themes were the prioritisation of immediately life-threatening emergency cases over elective cases and the prioritisation of malignant (cancer) cases over benign (non-cancer) cases in all branches of surgery. There was no significant change between editions, and I attach editions 24th August 2020 **(GT/9 INQ000226461),** 25th September 2020 **(GT/10 INQ000226448),** 30th October 2020 **(GT/11 INQ000226449)** and 27th November 2020 **(GT/12 INQ000226450)** as references . Some members found this frustrating, as there was debate about the categorisation within patients. The regional representatives expressed the members' frustration at the prioritization list. The ASGBI is unaware of any subsequent evidence that a particular patient group was disadvantaged. ASGBI members do not deliver care to patients with ischaemic heart disease or hip replacement surgery. Some surgeons reported issues with the provision of care to patients with colorectal cancer the Association of Coloproctology of Great Britain and Ireland (ACPGBI) would be appropriate to comment on this issue.

Healthcare Provision and Treatment.

25. ASGBI members did not raise concerns about their ability to provide safe and appropriate care to patients with non-covid conditions within healthcare settings during the relevant period. Members generally accepted the need to practice in a different way in an effort to maintain staff and patient safety when so much was unknown. However, there was much discussion within the surgical community about the recommended changes set out earlier in this document. Surgeons with a major interest in laparoscopic surgery felt that despite the risks of AGP, the benefits of laparoscopic surgery to the patient outweighed the disadvantages of open surgery in some cases. Surgeons with a major interest in endoscopy e.g. those involved in bowel cancer screening were concerned about cessation of that activity due to the risk of AGPs. ASGBI members are not involved in the management of ischaemic (coronary) heart disease, colorectal cancer, or hip replacement surgery. These topics

from a surgical perspective could be addressed by the Society of Cardiothoracic Surgeons (SCTS), the British Orthopaedic Association (BOA) and the Association of Coloproctology of Great Britain and Ireland (ACPGBI).

Issues due to the cancellation delay or de-escalation of surgery.

26. ASGBI members are mainly involved in the provision of emergency general surgery services. Major emergency general surgery procedures were categorised as 1A procedures in the surgical prioritization list and so were not exposed to cancellations or delays. When surgery was not performed in the more minor emergency setting e.g. acute appendicitis, alternative treatments, such as antibiotics were used. Emergency cases are not usually placed on a waiting list in the acute setting. ASGBI members are not involved in the management of ischaemic (coronary) heart disease, colorectal cancer, or hip replacement surgery. These topics from a surgical perspective could be addressed by the Society of Cardiothoracic Surgeons (SCTS), the British Orthopaedic Association (BOA) and the Association of Coloproctology of Great Britain and Ireland (ACPGBI).

Private Healthcare Providers

27. It is my understanding that private healthcare providers were not involved in the provision of any emergency general surgery or trauma care during the relevant period. The use of private providers for elective cases was patchy in its uptake. There was no ASGBI member reporting significant use of the private sector in the relevant period. This might reflect the fact that other surgical specialties had greater experience.

Healthcare Inequalities

28. ASGBI is unaware of any inequalities in treatment or follow-up care for patients undergoing surgery during the relevant period.

Surgical Research

29. The impact of the pandemic on scientific research was positive and negative. Surgical research projects were put on hold and researchers were redeployed to the clinical environment. Many PhD students researching as part of surgical training

required an extension to their research period and clearly any work involving patients or human volunteer subjects ceased completely during the relevant period. There was the opportunity to deliver observational studies on the impact of the pandemic in many areas of healthcare delivery. For example, the ASGBI was strongly linked to the Covid-Harem study on the conservative management of acute appendicitis during the relevant period and this has resulted in a number of peer-reviewed publications "The HAREM (Had Appendicitis and Resolved/Recurred Emergency Morbidity/Mortality) Study" **(GT/15 INQ000226453)**. It has been proven that non-operative management of this condition is safe and acceptable to patients and is now evidence-based, this offers patients a new conservative management option when discussing consent as part of shared decision making. Other groups in surgery worldwide have published on the effect of the pandemic in their particular area of practice, the ASGBI has no research links in ischaemic heart disease, hip replacement or colorectal cancer. These topics could be addressed by the Society of Cardiothoracic Surgeons (SCTS), the British Orthopaedic Association (BOA) and the Association of Coloproctology of Great Britain and Ireland (ACPGBI).

Impact on Surgical Training

30. Trainees were enormously affected in surgery. We had communication from our trainee organisation The Moynihan Academy which represents trainees in England, Scotland, Ireland, and Wales with an interest in emergency surgery and trauma. They report that trainees have not had adequate exposure to training in order to achieve their curricular objectives and to qualify as consultants for independent practice. Many procedures described as "high volume, low complexity", in general surgery, hernias and gallbladders, were not done during the relevant period. These cases form the backbone of general surgery training. In addition to this, some more specialised procedures did not take place at all. As a result of this many trainees require an extension of their training time. Post-pandemic many of these cases are being outsourced to private providers in settings providing no training. A high level of anxiety persists among all surgical trainees about their future and the ability to receive appropriate training. ASGBI has tried to mitigate this anxiety by providing a series of online educational webinars supported by industry during the relevant period. The topics covered were those encountered commonly in the field of emergency general surgery and trauma. We have also delivered simulation training at our national conference to allow trainees hands-on training. In addition to this, all trainees at the height of the pandemic were redeployed to other clinical areas, mainly

ITU. They were asked to rapidly acquire skills not within their portfolio and to work in unfamiliar clinical settings. Not least, they experienced death at a far greater scale than they had previously, not only of patients, but also sometimes of colleagues. The effect of this on mental health and well-being persists. The ASGBI trainee organisation has instituted the online phenomenon of "Well-being Wednesdays" with simple tips on their twitter account for good mental hygiene and well-being.

Future Recommendations

31. The ASGBI would recommend regular clear honest communication to all professionals in healthcare in the event of a future pandemic. This should take place daily in a virtual space with the opportunity for interaction. Particular focus on honest messaging with no political or economic considerations for both patients and professionals would be essential. We would suggest that this communication be delivered to subspecialty groups within the profession, as the concerns of surgeons would be different to those of e.g. rheumatologists. The communication should be delivered by recognised leaders in surgery, perhaps the presidents of the Royal Colleges in rotation. There should be the opportunity to question and evidence recommended changes in policy and the event should be two-way, rather than simply announcing policy, there should be dialogue and learning from those delivering care.

32. In addition to this, a medicolegal focus to protect professionals, operating by necessity with unconventional protocols and uncertainty, would help with uncertainty and morale in the profession. Professionals would wish to be able to explain clearly to patients why a recommended practice might differ from their usual evidence-based practice in method, surgical approach or timing e.g. if it is recommended not to perform a procedure in a laparoscopic manner, but to use open surgery, and that patient subsequently develops a hernia (more likely in open than laparoscopic surgery) and then a small bowel obstruction (complication of a hernia) and then not survive. The surgeon involved in that open procedure should be exempt from litigation, as they were acting in line with recommendations at the time of the original operation which differed from the practice they knew would usually be in the patients best interests. Professionals would wish a clearly documented medico-legal indemnity if in the future it became apparent that the deviation from standard practice either was not required or inadvertently caused the patient harm. It might also be useful to have a series of updated communications for professionals to share with

patients in consultations and the opportunity to share NHSE answers to their questions and to explain the reasons for changes in protocols in an open "live" clinical setting. A focus on equality diversity and inclusivity for both patients and staff is essential.

33. We have learned the absolute importance of clarity and honesty in communication at all levels. We cannot stress the psychological damage suffered by a generation of medical students, doctors and nurses and the effect this will have on the career choices of the next generation. If there is a future pandemic it is essential that consideration is given to the effect on the younger members of the profession and those still in training. The system needs to have consideration paid to resilience at every level.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 16th August 2023