

During the COVID-19 pandemic I volunteered to be redeployed as a medical SHO on a COVID-19 ward. I did this with some trepidation as I have not practiced patient facing clinical medicine for some time. Fortunately the ward was very well staffed with experienced and supportive doctors redeployed from academia and a variety of clinical specialities. It was an interesting experience. We saw the clinical manifestations of a novel pathological entity emerging in realtime. The sense of camaraderie and team spirit was enjoyable and our efforts were greatly appreciated. Completing clinical tasks and getting a patient better and home was rewarding but I very quickly began to miss my microscope and books, neutrophils and mitoses and the cut up lab.

A number of the patients under our care had specimens sent to the histopathology laboratory either during their stay on our ward or shortly thereafter. One of these was from a particularly unfortunate patient who survived an ITU admission with COVID-19 and was subsequently found to have a lung mass. I received slides from the diagnostic lung biopsy when I had returned to histopathology post-redeployment. The histology showed an adenocarcinoma. Normally as histopathologists our patients are a name, date of birth, number and their pathology; their personality and life story are unknown to us. Knowing the person behind the biopsy made this diagnosis particularly weighted. Perhaps we are fortunate that in the most part we are emotionally disconnected from our patients but this experience reminded me that we must not forget the patient behind the slide.

I hope that in my future career circumstances will not necessitate an unscheduled return to patient facing clinical duties again. However, if they do at least I now have first-hand experience that pathologists can rejoin the ward round! Whether our preferred tools are a microscope, an ultrasound machine or a tendon hammer, we are all, after all, doctors.

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