



Short Communication

Challenges in private practice during novel coronavirus disease 2019 (COVID-19) pandemic

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ABSTRACT

An outbreak of respiratory illnesses of unknown etiology which was later identified as novel coronavirus (nCoV) contagion with its axis in Wuhan, People's Republic of China rapidly emerged as a public health emergency of global concern. This started as a cluster of cases in December 2019 and there have been large numbers of confirmed cases of novel coronavirus disease (COVID-19) ever-since worldwide including India. Because of its encyclopaedic quandary, COVID-19 was labelled as a pandemic by World Health Organisation (WHO). Thus, it became important to strengthen the health care delivery system at the public as well as private sector. Here we describe the challenges faced in private practice by a clinician in patient management during this pandemic in India and measures taken to overcome them with the help of WHO and national guidelines, clinician's professional expertise and optimum infection prevention and control practices.

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1. Introduction

In December 2019, a clutch of cases of respiratory disease with pneumonia as the main feature was reported in Wuhan city, Hubei Province of People's Republic of China. This was later found to be caused by a novel coronavirus (CoV) [severe acute respiratory syndrome Co-V-2 (SARS-CoV-2)] and the disease caused by it as COVID-19.¹ CoVs belong to a family of viruses which have been involved in many global outbreaks of severe respiratory illnesses such as the Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS).¹ SARS-CoV-2 has been defined by World Health Organisation (WHO) as 'a new strain of coronavirus that has not been previously identified in humans'.² In response to this, countries universally launched various measures to strengthen their health care facilities in both public and private zone. In this article, we wish to highlight the challenges among uncertainties faced by a clinician in managing patients during COVID-19 pandemic and measures taken to overcome them with

the help of WHO and national guidelines, clinician's professional skills and genuine infection prevention and control practices.

2. Challenges and their Resolution

The clinic where the clinician consults patients on Out Patient Department (OPD) basis has an area of approximately 400 square feet located on ground floor of the building. It is segregated into two parts, the reception (patient waiting) area where the basic details of patient are recorded and consulting area. Staff consists of the clinician, a nurse, a receptionist and a helper. COVID-19 had already touched the shores of India with its first case reported in Kerala on 30th January 2020.³ Given the peripatetic Indian nature, it was advisable to start getting prepared to face such cases soon. Since COVID-19 is a novel disease there were continuously new updates regarding symptoms, diagnosis and guidelines for various aspects of the disease. The constantly evolving guidelines posed various challenges. These included educating the staff and upgrading their knowledge about various aspects of the disease and

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importance of recording patients details properly especially travel details, training of staff in standard and transmission-based precautions, staff protection measures, changes in infrastructure regarding ventilation and regulated traffic flow of patients, restriction of patients appointment to avoid overcrowding and maintain social distancing among patients, laboratory testing policy, environmental cleaning and surface disinfection and proper biomedical waste disposal. Hence, a medical microbiologist was also involved. To begin with, a multi-disciplinary approach was mounted. This included basic education regarding the disease and its various aspects especially mode of transmission and importance of accurate recording of travel history. Training on proper hand hygiene, respiratory hygiene and cough etiquette was provided to the staff.² Alcohol-based hand sanitiser was made available at the entry of reception area, reception desk and consulting room which also had basin with liquid soap for hand washing and disposable paper towels.² Printed posters of methods of hand hygiene were posted near all hand hygiene units. Personal Protective Equipment (PPE) including gloves and medical mask was made available to all staff members.² The windows of reception and consulting area were kept open and the air condition was switched off keeping in mind the respiratory mode of transmission of the virus as airborne contaminants in the room get diluted when clean air is added to the room and chances of inhalation of infectious droplets are reduced.² Patients entered from the main door and exited from the back door to maintain uni-directional flow. Patients were seen in batches and by appointment. Their seating chairs in reception area were kept at a distance of three feet to maintain social distancing.² Patients were requested to wear face mask. Surface cleaning was done with 1% freshly prepared sodium hypochlorite at the beginning and end of the day. Disinfection of equipments like stethoscope, BP apparatus cuff was done with 70% alcohol in between patients.² Gloves and mask were discarded as per revised Biomedical Waste Management plan. Maharashtra saw its first case in March.⁴ This meant that all the above-mentioned measures had to be intensified and new measures to be added as per refurbished guidelines. In addition to above practices, reinforcement was done among staff about contact and aerosol-based precautions. Patients with fever and or respiratory ailments and those with non-communicable diseases were segregated and allotted separate consultation timings. Doctor and nurse started using N95 mask, goggles, face shield and full body cover as they had started screening patients while other staff continued using surgical mask.⁵ Gloves and Plastic Cover All were discarded in a bin with double layered red bag duly labelled. Mask, goggles and face shield in double layer yellow bag duly labelled, kept separately before handing it over for treatment.⁶ Gradually, cases started rising April onwards and soon Mumbai became

hotspot of COVID-19 with new cases being reported daily which led to enforcement of lock-down in Mumbai. Now, community transmission had come into play and hence there was need to evaluate patients more cautiously. Amidst the worsening scenario, demands also increased. Staff travel to work place became difficult due to lockdown so emergency care provider's card was issued to them and they used mask while travelling also. Availability of masks and respirators were worsening and hence the staff started re-using N95 mask as per guidelines.⁷ Initially, testing was restricted to government-run hospitals but with gradual increase in cases private laboratories were also roped in.³ Laboratory testing criteria for COVID-19 was revised to add patients on dialysis and chemotherapy to the testing list and re-revised to relax the testing criteria to include testing of all symptomatic patients and all high risk patients.⁸ This led to increase in demand for testing and rise in case detection with the precarious category of asymptomatic cases being detected. But all private laboratories offering test for detection had a waiting period of 24-48 hours before sample collection. Till the test reports were available, all precautionary measures were strictly adhered to and suspected cases were advised isolation at home or hospital depending on symptoms.⁹ With the advent of antigen testing by mid-June immediate screening of patients was an available option.¹⁰ Patients with fever and or respiratory symptoms and non-respiratory symptoms continued to be segregated at time of giving appointment. In the clinic, the triage criteria also shifted as surveillance case definitions for nCoV was refreshed.⁹ It stated that person with respiratory symptoms with unexplainable etiology or atypical presentation in immunocompromised should also be screened for COVID-19.⁹ This indicated that this pandemic was unfolding at a fast pace with variability about its development and impact. Surface disinfection was strengthened and additionally, disinfection of surfaces like examination table, patients chair and other frequently touched surfaces was done after every patient with special insistence on cleaning of door handles and knobs. Scrubbing of floor with detergent and water was done at the end of the day. Current guidelines mention addition of new symptoms in COVID-19 management which includes headache, muscle pain, chills and loss of smell and presentation of COVID-19 in unusual forms.¹¹ Currently, the latest policy of patient management is followed by the clinician and staff members of the clinic along with above mentioned contact and aerosol-based precautions, use of PPE and thorough surface cleaning and environmental disinfection.

3. Conclusion

Microorganisms have predated human beings. Hence it is essential to strengthen health care delivery system and invest in preparedness of such pandemics to save millions of lives. A more resilient and responsive health care system

consisting of a conversant health care professional with a robust infection control policy as its back bone is the need of the hour.

4. Source of Funding

None.

5. Conflict of Interest

None.

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