Editorial

Ensuring adequate healthcare in COVID and non-COVID areas: An unprecedented challenge

Healthcare facilities are facing an ongoing challenge due to COVID-19 pandemic. The infrastructure of every hospital had to be altered to treat COVID patients. This entailed space allocation for COVID care within the crowded limits of the hospitals, and setting up of complex areas such as HDUs and ICUs in a short period of time. With no extra funds or time to procure new equipment, the existing monitors, ventilators, etc., have been redistributed.

With the government-directed lockdown in place, work in OPDs, elective OTs, laboratories, and other routine areas came to a halt. This helped in re-allocation of personnel from these areas to COVID and emergency areas, though some non-emergent services such as obstetrics and oncology care had to be continuously staffed. The number of emergency cases reaching the hospitals, specially those related to vehicular accidents, were fewer during the period of lockdown. Such a decrease has been reported during the initial part of the outbreak from other parts of the world also.[1,2]

As the lockdown is lifted in a phased manner, we will need to gradually restart most of the routine services while continuing to manage COVID patients as well as the emergencies. Reduced access to medical care cannot continue indefinitely. Mild problems can escalate in severity due to lack of medical attention. Patients with pre-existing conditions are particularly vulnerable and may have increased morbidity and mortality. For example, a sharp increase in all-cause mortality was reported from an Italian city during the peak of pandemic in that region, with COVID-19 accounting only for about half of the deaths.[3] The waiting list for elective surgical procedures is continuing to grow with routine surgeries at a near-standstill. Essential immunization has come to a halt, leaving children susceptible to serious preventable diseases.

If setting up COVID facilities quickly and managing COVID patients had been difficult, what awaits us now is even more problematic. The number of COVID patients is likely to increase for at least some more months before declining. There may even be a new surge in cases. The resumption of routine work in the hospitals will cause a substantial increase in workload. However, there is no guidance regarding the extent of routine work to be allowed and the distribution of staff between COVID and non-COVID areas.

COVID areas require a larger share of personnel than the usual wards and ICUs of the same size. Some of the reasons are shorter duty hours, quarantine of exposed staff, and infection of some personnel. In addition, a large number of ancillary staff is required for ensuring and monitoring strict infection control measures, and training of staff. Screening and triage, isolated from other emergency areas, need to be staffed round the clock. Isolation rooms, OTs and recovery areas, separately for confirmed and suspected COVID patients, are required. All this entails a large additional administrative staff.

There is no ready-made solution for these problems which have to be managed on an institution-to-institution basis, taking into account the personnel and facilities available, the increased turn-around times expected in the OTs due to aerosol-mitigation procedures and the case load. Some common sense measures do help. Pooling the manpower of the hospital from across the specialties and posting them judiciously based on actual requirement, has been used in COVID areas of PGIMER, Chandigarh. This distributed the extra burden of COVID patients across various departments. Another measure is to take care of the wellbeing of the staff—both physically (limit working hours, adequate rest/off following duty, ensure appropriate PPE and other infection control practices) and psychologically. We may need to consider ensuring that personnel do not exclusively work in COVID areas for long periods. Screening measures should be put in place to identify at-risk healthcare providers who should work only in non-COVID areas. These measures are likely to preserve the health as well as morale of our manpower. One Singapore hospital utilized reorganisation of medical staff into modular teams to prevent cross-exposure and thus lessen the risk of hospital transmission of COVID-19.[4]

Finally, hospitals and administrators should remain flexible and respond immediately and purposefully to changes in patient load, and requirements of personnel and equipment. A rotational pool of reserve personnel can be useful whenever any urgent deployment is needed.

COVID-19 pandemic is a once-in-a-lifetime crisis for all of us, doctors of all grades, nurses, technicians, other healthcare workers, ancillary personnel and administrators. We need to draw upon our professional training and determination, and rise to meet this challenge.

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