HealthManagement.org
The Journal
LEADERSHIP • CROSS-COLLABORATION • WINNING PRACTICES
VOLUME 20 • ISSUE 4 • 2020 • € 22
ISSN = 1377-7629

COVID-19 Management

290 **Prof. Henrique Martins:** Digital Healthcare System - Now More than Ever

302 **Prof. Arch. Simona Agger Ganassi:** Towards Post-COVID-19: Lessons and Challenges for Hospitals and Healthcare Infrastructures

310 **Prof. Laura Oleaga:** How is the Pandemic Affecting Radiology Practice?

324 **Juhan Lepassaar:** Healthcare Cybersecurity in the Time of COVID-19

326 **Prof. Geraldine McGinty:** U.S. Radiology Responds to the Pandemic and Looks Ahead

328 **Alanna Shaikh:** Healthcare Has No Excuse for Another Pandemic Like COVID-19

COVID-19 in Private Practice: How to Cope With It?

A radiologist in France's private healthcare sector describes the experience of his clinic and comments on limitations of the system revealed when COVID-19 hit hard.

Our imaging centre is located in Sarcelles-Lochères, a suburban area 15 km North of Paris. We are a 250-bed private clinic with an active emergency department, an oncology centre and many outpatient facilities including a comprehensive imaging department, from Breast Imaging to Interventional Radiology in addition to a large Nuclear Medicine Centre (PET CT and NM).

Our current activity is mainly cancer in all fields, neurology and MSK serving a large area, local and nonlocal, in "la Région Ile de France."

The centre encountered COVID-19/SARS Cov 2 quite early because the first French cluster was identified in nearby Creil. We received patients in early March. Also, one of our medical assistants was struck and needed a, happily, short stay, in ICU.

In the meantime, multiple cases were declared in some parts of the country and multiple French administrations tried to find out how to cope with the epidemic while politicians were discussing the matter under different influences and not without controversy.

One cannot assess our situation without considering our organisation as kind of a general hospital-based practice comprising hospital departments and the Oncology clinic as well as outpatients multi-purpose facilities (Paediatrics, Gyn/Obs, Renal dialysis, etc).

At first, we got orders to freeze all activities and close our departments, except the vital ones, and to postpone all non-urgent procedures and screenings. But, soon the nearby general hospital, a 950-bed hospital, was inundated and our clinic was asked to receive COVID patients in ICU and/or for hospitalisation and all physicians were asked to take on the night shift.

At the same time, the flow of patients soon became tsunami-like.

Action Plan

We had to simultaneously address diverse acute problems as well as future problems. These were:

1. Multiple administrative orders: It is well known that France is a highly administrated country and there is, at present, a large debate about its multiple, parallel, layers.

We received floods of emails from various sources, eventually contradictory if not very imprecise. The Île de France Regional Agency (ARSIF) did the job and one has to consider that it is overseeing a very large region (13 million inhabitants) with multiple hospitals of all types, public and private. In some other regions, the traditional rivalry and, in some cases, discrimination between public and private hospitals contaminated the background situation. However, it should be mentioned that ARSIF is not willing to pay, at present, for the night shifts in private hospitals reflecting the administration's position.

2. Lack of personal protection equipment (PPE): Lack of PPE soon appeared leading to unnecessary contamination between people and healthcare workers and to a highly criticised decision to restrict access initially to some identified professionals, excluding at first, town practitioners, GPs and specialists. Pharmacists were unable to deliver any masks either to the population or the practitioners.

Once more, the resourcefulness "Système D" made miracles into a complete nightmare while prices rose at once. At present, resources are a little more stable but still precarious and lots allotted to town physicians are not sufficient.

3. Knowledge about the disease: Another flood took place, beneficial this time. We got early information and description through international publications, mainly from Chinese authors, and soon, the French Society of Radiology, and the French Thoracic Imaging Society, published some cases, with commentaries, and some recommendations. Many companies participated in knowledge information through webinars and software promotion, ie, structured report and/or Artificial Intelligence. Regular updates were made available through various networks, including the French network of private radiology clinics, VIDI, about unusual abdominal or neurological cases, and associated pulmonary emboli variants.

4. Personnel management: One of the biggest challenges has been, and still is, medical and nonmedical personnel scheduling (various techs, including cleaning). Even though normal activity has been cut by roughly 85% overnight, we had to cope with multiple situations: confinement, closed schools and working parents, real or opportunistic sick

leave, depression and fears. Happily, most of our personnel accepted the challenge, floods of potentially infected patients, new rules, protection and patient handling. All radiologists were present and are still postponing holidays and personal matters.

5. Healthcare changes: We used to take care of multiple types of patients through our different specialties and we had a to switch to nearly a single disease within a few days at very short notice. At the beginning, we were able to manage a dedicated COVID circuit, one of our CTs being allocated to COVID patients and dedicated waiting rooms before dispatching either to the emergency department. We also divided patients into COVID/non-COVID cases, or referred to physicians. We had to deploy medical and nonmedical personnel from other departments to the CT department to handle increasing numbers of patients. At the peak, we had to perform up to 70 to 80 thoracic studies a day, often extended to the abdomen and the pelvis, according to clinical presentation. Patients came from the nearby regional hospital, our own emergency department, GPs and self-referral. Self-referral appeared quite early also as people learnt quite soon that CT was a very important tool in COVID's case handling.

One reason is that our area of catchment is located in a impoverished multi-ethnic suburb with sub-standard housing and where cultural habits may have helped virus dissemination. It proved impossible to filter the cases for various reasons, including a language barrier, and we took the decision to image all patients. It was the right decision as we saw a lot of positive cases with many clinical discrepancies, some of them very severe, even in rather young people.

Every patient was met by the radiologist(s) in charge and informed before discharge or dispatching to the emergency department for case management.

In the meantime, we kept MRI, ultrasound and interventional departments on standby mode for "non CT" emergency cases.

At the same time, non-COVID emergency cases tended to be more severe because of delays, whatever the cause, saturating emergency services.

6. Specific organisation: Dedicated pathways were soon mandatory but our main problem was, as anyone would expect, disinfection processes and patient/personal protection. Staff and doctors found out quite quickly the proper and efficient handling procedures needing more than a doubling of onsite personnel. Protection procedures, protection handling and cleaning were quickly learnt and integrated, successfully.

To date, only one team leader radiology technician got infected quite severely but is now out of danger. We decided not to test all personnel systematically but only if they displayed clinical symptoms.

We also introduced a self-structured reporting system with database construction thanks to an agreement between the VIDI group and a French software company. This promoted structured reporting software dedicated to COVID-19 according to French Society of Radiology (SFR) recommendations.

7. Financial problems: As a private imaging centre, we still have to find solutions to cope with an 85% reduction in turnover for an undefined period.

8. What is next? Progressive resumption of activity has been announced and we shall have to face undiagnosed cases, aggravated chronic diseases and co-existence with a persistent virus. This will all need costly and lengthy procedures. It is possible that the second wave is ahead.

We have learnt many things during this crisis and, above all, the human value of our teams

The Future

No doubt, the story is not fully written yet. There will be a before and after questioning many aspects of French society that applauds healthcare professionals every evening but is not really willing to change. As we all know, "what doesn't kill you makes you stronger." We have learnt many things during this crisis, above all, the human value of our teams. ■

Author: **Robert Lavayssière**
Staff Radiologist & CEO of Centre d'Imagerie Paris-Nord | Sarcelles, **France**
Honorary member of the French Society of Radiology and member of the Board
robert.lavayssiere@groupe-vidi.fr | sfrnet.org/sfr/ | ipn-sarcelles.fr/fr/ | @SFRadiologie

Key Points

- France's administrative processes caused frustration in dealing with the COVID-19 crisis.
- Overnight, personnel became unavailable because obligations to childcare, sick leave and mental health concerns had to be addressed.
- Non-COVID cases suffered because of the pressure on virus patients.
- The value of a strong team proved itself during the crisis.