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Health Crisis Management in the Season of Covid-19 in an Acute Care Hospital Paris, France

PAPON Benoit Jerry*

Assistant Professor of Emergency Medicine, MD., FACEP Weil Cornell Medical College, Former Head of the Emergency Dept, American Hospital of Paris, France

***Corresponding author:** PAPON Benoit Jerry, Assistant Professor of Emergency Medicine, MD, FACEP Weil Cornell Medical College, Former Head of the Emergency Dept, American Hospital of Paris, France

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ABSTRACT

Abbreviations: NTSB: National Transportation Safety Board; HCW: Health Care Workers; PPE: Personal Protective Equipment; SMUR: Service Mobile d'Urgence et de Réanimation; SAMU: Service d'Aide Médicale Urgente

Foreword

To fully understand the medical landscape in France, it is important to appreciate how the French Healthcare System functions and how the American Hospital of Paris is an integral part of this network. Following are key points which will clarify that understanding.

Emergency Call Management

First, when an emergency occurs, French citizens must choose between three different telephone numbers depending on what type of emergency they are experiencing. Rather than a single 911 number for any type of emergency as in the United States, a person in France must dial 17 to reach the Police, 18 to reach the Fire Department, and 15 for medical assistance. SAMU-Center 15 is only dedicated to medical emergencies. Located in each « Départements» (we would say "county" in the U.S.), the "SAMU-Centre 15" (Service d'Aide Médicale Urgente) receives and dispatches incoming calls and provides rapid and appropriate answers to each caller. In cases where the caller does not have a life threatening emergency, the SAMU-Centre 15 responses might include offering pertinent medical advice; sending a primary care physician to the home to consult with the patient, (this could be a physician on duty or an emergency physician from «SOS Médecins," a sort of "doctor on wheels"); or sending adequate first aid assistance, such as a Fire Department Team or a basic ambulance like the French Red Cross, Civil Defense volunteers, or a private ambulance. In non-life-threatening situations, the call can be handled from the team in the SAMU-Centre 15.

However, should the caller require urgent, life-saving actions, the dispatcher would transfer the call to an emergency physician (regulateur) who would coordinate response efforts. This Coordinator would send a Mobile Resuscitation Unit (Service Mobile d'Urgence et de Réanimation or SMUR). This could be a Red ACLS ambulance from the Fire Department or a White ACLS ambulance from the public hospital. Either comes equipped with paramedics and an emergency physician or an anesthesiologist onboard. In other words, "the Hospital comes to you" and is able to initiate CPR, C-Pap or TPA on site. Once stabilized, the patient would be transported directly to ICU/CCU or Cath lab/OR, bypassing the

ER. A very important thing to note is that the Fire Department and SAMU SMUR are free of charge for the patient.

Public vs. Private, and Costs

Second, the French Healthcare System is a dual system made up of both public and private hospitals. Public Hospitals may be teaching or non-teaching hospitals. Physicians are paid monthly depending on their grade (from medical student to the head of the unit). On paper, these physicians work 35 hours a week. However, their work week is actually more like 50-60 hours for that same monthly salary. Private Hospitals are either for profit or non-profit. Physicians are usually paid based on fees for services rendered. "Les Cliniques» are not comprehensive care centers. They are specialized in General Surgery, Orthopedic and Obstetric services, but usually do not admit emergency medical cases. During the first wave of Covid-19, the French Health Agencies used only the public beds in hospitals. Cliniques were almost always empty and though prepared and ready to help, were not considered or involved in the initial response.

Socialized Medicine: Vicious Cycle of Costs and Resources

Third, both public and private hospital care is 70% reimbursed by the basic Social Security System. As 99% of people are covered with a complimentary insurance even the remaining 30% of hospital fees are refunded to the individual. So, though hospital emergency services are effectively free of charge to each French citizen, the French budget suffers simultaneously. All these matters are important because the French Healthcare System was ranked number 1 in the world by the WHO in 2000 (AFP, WHO, GENEVE, 21 juin 2000). Over the past 20 years, the French Government has made desperate efforts to decrease the medical expenses of the healthcare system (close to 14% of the Gross National Product). To have better control, they have exponentially increased the administrative management and administrative onus. For instance, every single action with a patient must be tracked through multiple software programs (which were not designed for use by the caregiver) as well as requiring the creation and maintenance of electronic health records. Health managers promise to deliver resources at low costs. Unfortunately, it is not quite possible under these conditions. In developed countries around the world, we are witnessing a depletion of resources with patients unable to access services. The French Healthcare System has slipped to a ranking of 18th in the world today.

The duplication of processes, heavy workload, and the government regulations implemented to try to minimize costs have lead to the exhaustion of nurses and physicians. Without attractive work conditions, the public hospital is sick, and the private system is not much better. Strikes and protests in the streets were common when the Covid crisis struck. We were supposed to be prepared to face this kind of crisis. Many studies and numerous reports for preparedness were published by distinguished professors in Healthcare Management, Public Health, and Emergency & Disaster Medicine. However, their messages were shelved rather than heeded. At the beginning of this crisis, primary care physicians and private nurses gave care at great personal risk, without Personal Protective Equipment (PPE), surgical masks or N95 masks. The lack of ICU beds in the city caused the decision to evacuate patients through TGV (high-speed train) to hospitals in the southwest of France. In Alsace (east of France), ICU patients were evacuated through choppers to Germany (Germany has twice the French ICU bed capacity). Even in leading teaching hospitals, the workforce quickly became exhausted or sick. It became necessary to recruit nursing and medical students to lend a hand in Covid units.

Covid Crisis Management at AHP

The American Hospital of Paris is a very special member of the French hospital network. AHP is a non-profit hospital, but it charges the real cost of care. This means that patients who receive benefits from the French Social Security Program are not refunded 100% and the remaining bill could be substantial. For years, AHP has been the hospital of choice, preferred for visiting or native executives of international or French companies or VIP's from the film industry. For the American Hospital of Paris, the Covid-19 Crisis entered on February 28, 2020. A Covid-19 affected patient was admitted through the ED. Immediately, the hospital administration and the President of the Medical Board set a Taskforce to organize the way patients would be admitted and how Covid units would be organized. During each daily meeting, the focus was on management and demand forecasts of intensive care capacity, hospitalizations in medicines, operation rooms and emergency department resources. Due to lack of intensive care beds, the hospitals functioned beyond capacity and were required to transfer stable patients as soon as possible to normal units in order to face the demand. We turned recovery beds into ICU beds by equipping them with appropriate ventilators. Two different pathways were set for possible Covid patients and for non-Covid patients in the ED. Nurses and ER Doctors received PPE and informed ancillary services as well as transport services or CT Scan technicians and radiologists about suspicions of Covid to be sure they wear the PPE. Working with PPE is not the usual way to take care of patient. The use of new protocols and the extra time needed to update staff and families was exhausting.

Infectious disease specialists, pneumologists and internists defined new units dedicated to both unconfirmed and confirmed Covid patients. And of course, like all other hospitals, we postponed all elective, non-urgent services to allow these new designations. The AHP was lucky. We experienced patients with long hospitalizations, especially in intensive care with unexpected drug use, as did many other hospitals. However, AHP was not concerned with shortages in sedative or curare drugs. We secured enough PPE and staffing to

maintain our standard of care. For the first time in decades, doctors once again became key people in the organization of care in the hospital. Physicians specialized in infectious diseases or internists gave "teleconsultations" on Facetime and assured follow up of discharged patients. To prevent Covid's transmission, the hospital limited the visitation of relatives, even for patients in critical condition. As a result, Secretaries, Nurses and Physicians spent a lot of time on the phone to keep family and relatives informed about their loved ones.

At the first wave and due to the lockdown, we experienced a marked reduction in all usual chief complaints in the ED. No more ankle sprains or kidney stones, and even abdominal pains remained at home. One thing that puzzled us: "What about chest pain or strokes?" No one knows. As Covid disease was a new disease, it was very labor intensive to read all the abstracts published every day around the world. Fortunately, newsletters with summaries allowed us to remain updated, (special thanks to Prof. Anne-Claude Crémieux & Prof. Frederic Adnet). We cannot overlook the crucial role of the social network (WhatsApp group to keep us informed about new drugs or new ventilation patterns). Physicians never shared experiences so quickly and instantly around the world.

Summary

1. This unprecedented situation is very challenging for the safety of the Healthcare Worker (HCW). HCW's were faced with the uncertainty of contracting infections while performing procedures on patients with a confirmed or suspected diagnosis of COVID-19. The COVID-19 Pandemic has put enormous pressure on the healthcare system. Though exhausted and anxious at the idea of transmitting this disease to their loved ones, HCW's went to great lengths to be present to the sick and dying. Without the full involvement of these caregivers who demonstrated a selfless dedication to a flawless vocation, the healthcare system would not have been able to hold up.

2. Solidarity between caregivers and support of the public (8 p.m. applause at the windows, gift of takeaway food, fruit baskets, chocolates, flowers, cakes, etc.) were decisive in this period. However, it was a period of great frustration for us. We were fighting against a disease for which no treatment was active and where we were losing too many patients. HCW's need burnout prevention, and this starts with an appropriate staffing plan.

3. An emergency management system in healthcare should prevent and react to emergencies effectively, as well as avoid unpreparedness and communication mistakes. Political and public leaders need to listen and read recommendations provided by professionals dedicated to hazard & crisis management. As we use a National Transportation Safety Board (NTSB) to investigate plane crashes and provide appropriate changes and adaptations to prevent them, the healthcare system needs a similar agency with equivalent power.

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