

REFLECTIONS

"Fever clinic duty" during Covid-19: through the eyes of a preclinical doctor–teacher

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Abstract

In this narrative, a teacher of physiology writes about her shifts at an out-patient fever clinic during the Covid-19 pandemic. Apart from describing the author's own struggle during her return to a clinician's role, the narrative reveals the anxieties, fears, challenges and stigma faced by patients and the pressures on the healthcare team in a pandemic situation.

Key words: Covid-19, pandemic, patients, challenges, stigma

Fifteen years after taking the Hippocratic Oath, I was going to enter the clinical arena once again.

Doctor-teacher is a name I have chosen for my job description when people ask if I am a doctor or a teacher. If I am a doctor, how is that I only teach, and whom do I teach?

After successfully completing the MBBS degree, destiny or choice pushed me to take up post-graduation in a preclinical subject, physiology and after graduation I started teaching physiology to first year medical and paramedical students. I was happy, as teaching had always been my passion, and didn't realize how fifteen years had passed.

Then came Covid-19. The year 2020 will be remembered for "The pandemic" for decades to come, and has been traumatic worldwide. Every aspect of human life has been affected. The virus is yet to reveal its course in the days to come and there is no way of knowing when the sharp rise in cases will reach a plateau, and we can expect more waves to hit us.

Today, the hospitals are flooded with patients, in Covid wards and Covid ICUs, and many are unable to fight it out. Despite the utmost care and precautions, doctors, nurses, helpers, ICU staff, even administration and security, everyone in the hospital is turning symptomatic. With a dearth of healthcare workers due to the exhausting work pressure and the

increased workload, infected health workers have been called in for respite measures soon after recovery.

As offline classes were suspended, my colleagues and I, and our students, adapted to online classes with lectures, assignments, tutorials, and even a practical exam. Humans have great adaptability in times of crisis!

Then came the "opportunity", I would say, to remind myself of Hippocrates' Oath that I had taken 15 years earlier. There was a dire need for all doctors in the institution to pitch in at one of the out-patient departments. This is where patients with any symptoms related to Covid-19 infection would be seen, their vitals recorded, and advice given on tests to rule out Covid-19. If the person tested positive, the doctor had to decide whether s/he needed home isolation or admission in the hospital. If the test was Covid negative, other treatment was advised, or transfer to the correct department. This was "fever clinic duty".

Fever clinic duties were rotated among departments. It took some days for me to internalise the fact that I would be interacting with patients in the hospital setting after a decade and a half. The faculty of the department in-charge of the fever clinic and clinicians did all that they could to refresh our knowledge and skills by retraining us.

I started the day at the clinic with mixed feelings, of excitement and apprehension.

The first challenge of the day was to "don" my personal protective equipment (PPE). Following the prescribed routine, I put on each item – the PPE suit, shoe covers, mask, shower cap, face shield and double gloves. And a cover for my mobile phone. I felt I was choking, and started getting a slight headache. I could feel the sweat roll down my face but could not wipe it. I knew that I would not be able to get out of the suit for the next six hours, which meant no drinking, eating, or using the restroom until my shift was over.

I entered the OPD, sat down, and took several deep breaths, remembering my pranayama techniques, to relax before the first patient arrived.

The clinic was well-organised. There were registration counters, a swab collection section at the entrance, a nursing station on one side to record the patient's vitals, and a data entry section on the other. There were three consultation

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counters for doctors. Forms to be filled during patient encounters, prescription pads and hand sanitisers were arranged on the counter. I sat down at one of them, waiting for my first patient, who may or may not be suffering from Covid-19.

My bigger worry was that it had been a long time since I had seen patients in a clinical setting.

Then I saw my first patient.

I tried not to let my apprehensions be obvious. Luckily he could not see my expression, thanks to the PPE, the face shield, and the distance between us in the OPD.

The hours passed by and I settled into my role as clinician. As each patient approached me, I listened to them reporting their symptoms, and decided on the line of management. My headache disappeared. Slowly, I got a grip of the art of counselling patients and making decisions – I had been teaching this to my students in a classroom setting but for many years had not applied it myself in a clinical scenario. There were many decision-making dilemmas, as every patient is unique in his / her own way.

Of course, I could do all this because of the clinical staff, coordinating faculty and my department colleagues who readily responded to our calls, despite their own busy schedules. I kept aside my ego and called when I had even the slightest of doubts. As I was taught in my student life, and as I teach my students now, "Patient care is of utmost priority!"

There was a long queue of patients, and we had to minimise their waiting time, while doing justice to each patient.

It was only when the doctor on duty for the next slot said "Doctor, thank you, I will take it forward from here," that I realised six hours had passed.

On leaving the OPD, the next task was of removing, or "doffing" the PPE. This must be done with great care, and I was worried when doing for the first time, even though I had watched the video of the procedure. Finally, having removed the PPE, washed my hands again and again, and sanitised my mobile, I exited the fever clinic.

The thought lingered: "Did I do everything right?" My logical mind told me that the pain in my throat was due to the hours of talking loudly so that my patients could hear me through my mask, face shield and the distance between us. Still, I woke up often in the middle of the nights that followed, thinking: "Is it voice strain or have I got infected?"

It took some days for the physical and mental exhaustion to subside. Then I slipped into the routine – donning, listening to dozens of anxious patients as their first point-of-care physician, doffing, sanitising...

Patients entering the fever clinic had one thing in common: fear. Many were in denial. Some would say: "I only have a fever, cold, cough, this is common for me, it happens with the

change in seasons. I came to get tested just so that I can be relieved that I don't have corona." Some would come to get clearance for international travel and say: "Doctor, I have no symptoms, I need to get the RTPCR test for air travel. But tell me, what are the chances of my getting Covid just by visiting this fever clinic?!" Some came to get tested as their family members had tested positive. Many had no symptoms but wanted to get tested, because they were under the misconception that a negative test meant they would never test positive ever!

One of the biggest doubts in people's minds concerned the indications for the tests and the costs involved. Many were misled by misinformation in the media, and a few had bad experiences elsewhere and were sceptical of doctors and the healthcare system.

I soon realised that my first responsibility as a doctor at the fever clinic was to allay their anxiety and fears. I had to educate and counsel patients, dispel the myths related to Covid, and give them the facts.

Patients who tested positive would break down: "This can't be my report. I have not gone out of the house for days. I always wear a mask. Doctor, please check again."

Most patients feared the stigma associated with the disease. "How will I tell this to my family, my neighbors? What will I do now?" My job was first to help them accept the diagnosis.

Many were anxious about the reports that the disease was unpredictable. "Doctor, I have heard most are okay in the beginning but I have heard that some collapse suddenly. One of my neighbors took a turn for the worse during home isolation, went to the hospital and never came back. I am very scared." Patients with mild symptoms preferred hospitalisation to home isolation due to such fears. A few brave people would say: "Okay, I have corona, now what? Should I get admitted or will you prescribe medicines and let me stay at home?" Some parents worried about their children, others worried about their elderly parents. I patiently listened to them and answered their queries, helping them come to terms with the situation.

At the same time I was thinking of decisions such as whether the patient could isolate at home or needed to be admitted to the ward. If they could be treated with home isolation, a list of instructions followed, medication, precautions, personal hygiene, and monitoring and warning signs for which they should come to the hospital. As I did all this, I would keep an eye on the queue of patients behind. Some would have moderate to severe symptoms, many were brought with breathing difficulties. A few were sitting on wheel chairs. Patients with such symptoms had to be assessed and an immediate decision taken on whether they should be sent to the casualty ward or admitted. These had to be communicated to the patients and their care givers.

I also had to remind myself that not all patients in the fever clinic would have Covid-19. Many people just had the flu, but there were patients with dengue, chikungunya, upper respiratory tract infections.

Then there were patients who were sent from other departments, for preoperative evaluation, or before invasive investigation procedures, to test for Covid. Some of them would test positive. There were patients who were well informed about the disease but highly apprehensive. There were patients who had to get tested in order to take an exam, or attend an interview. Some of them were more disturbed about missing their appointment than the disease itself.

One made me overcome my own fears: "Doctor, I am a transplant patient, and have come for follow-up. I have fever, joint pains so I wanted to rule out Covid, dengue and chikungunya." He was calm, composed and had a very different approach to illness, accepting it as a part of life.

As the days went by, I realised that many people were afraid

not so much of the disease as the economic burden associated with the illness and isolation, the medical expenses, and loss of wages.

Less evident to the patients was the pressure on all the healthcare staff and institutions providing care. Day after day, month after month, doing their duty, keeping each other's morale up, praying for the end of the pandemic. I am humbled by the doctors and the paramedical teams in Covid wards and ICUs everywhere.

Fever clinic duty took me back to clinical practice under unusual circumstances. While initially I struggled to return to the role of a clinician, it was also an opportunity for me to look at the pandemic from the eyes of patients, relate to their anxieties about the stigma of the disease, the economic burden they would face, and their apprehensions about the uncertainty of the progress of the disease.

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6-6-2020: A date that went viral among ophthalmologists

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Abstract

6-6-2020 was a landmark date for the ophthalmology community, not only because of the normal visual acuity connotation of 6/6 and 20/20, but because it genuinely reflects every ophthalmologist's dream to bring back perfect vision for every patient. The Covid-19 pandemic had forced ophthalmologists to "refuse to operate" albeit for a short period. This narrative describes how, during a telemedicine call, a surgeon experienced the distress of refusing to operate on a mature cataract. It reveals the trauma caused by the disordered goals of eye care during the pandemic, when elective procedures were abandoned and only emergency services were provided.

Key words: Ophthalmology, Covid-19, cataract surgery, perfect vision, blindness

The magnitude of cataract blindness is high and there are many challenges to achieving the target of universal eye care despite the vigorous government push and the active efforts of non-governmental organisations (1). "Perfect vision" is what any ophthalmologist worth her salt, genuinely dreams of for her patients. The ophthalmologist's cup of joy overflows after a successful cataract surgery when the postgraduate student smilingly reports "Patient's vision is 6/6". To an eye surgeon, this number has great significance.

On June 6, 2020 – (6-6-2020), the usually bubbly ophthalmology community very quietly observed this unique day – as it went viral on the social media, partly because the date matched 6/6 or 20/20 — the connotation for normal visual acuity, and also because it symbolised the goal of every ophthalmologist: "6/6 or 20/20 in every eye, in every patient." However, on this day, the numbers 6/6 had taken on a new meaning — the minimum "safe distance" when the early pandemic control policies allowed only emergency and not elective surgeries. So, not surprisingly, on this date – 6/6/2020 – a telemedicine call numbed me and my goal, like a frozen globe.

I responded, and the patient said "Doctor, I am Krishnappa speaking" (*all names changed*). He narrated his story "Six months back, I had visited your hospital for my wife

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