Position Statement

ASA Position Statement of the anaesthetic service provision during the SARS-CoV-2 pandemic *(updated February 14, 2022)*

It was found that "*Health care worker involvement with tracheal intubation conferred a 13-fold higher relative risk ratio for acquiring SARS infection when compared to healthcare workers not participating in tracheal intubation*."[1]

Personal Protective Equipment (PPE)

Please refer to the ASA Position Statement on the provision of PPE and training by health facilities during COVID-19 pandemic (currently not available).

We acknowledge that the safety of health care workers should be paramount during this pandemic. Anaesthetists and theatre teams should not be put in positions where their own health and safety is at risk. If there are concerns about PPE availability, these need to be considered and potential responses worked out prior to surgery. We reinforce that the anaesthetic team is not to undertake or be required to undertake tasks requiring PPE if the PPE is not available for use. Any such tasks are not to proceed until required PPE is available.

Encourage

- All health services to complete scenario planning for one, a few and many COVID-19 patients and for anaesthetists to be made aware of their role in each of these scenarios;
- Coordination between public and private, large and small hospitals and retrieval services and the role of anaesthetists to be clarified; and
- As anaesthetists are frequently called upon in the event of deterioration or resuscitation of patients, we recommend that all patients have goals of care (including end-of-life decisions) clarified at the time of admission, regardless of the nature of their admission. This is good practice and to aid in the conserving of resources should they deteriorate. Chest compression was significantly associated with high risk of infection during SARS. [2]

Staffing

This pandemic will affect multiple departments and resources in a hospital and coordination and communication of efforts is paramount. We recommend that there is anaesthesia representation in clinical service provision of which anaesthesia is a component and that anaesthetists must have leadership roles particularly in the organisation anaesthesia rosters.

Where procedures at high risk of generating aerosols (AGP's) are performed, we recommend an additional staff member be allocated whose sole role is to observe for PPE breaches (PPE spotter, buddy or guardian). This includes overseeing donning and doffing of PPE.

Where resources allow:

- Where anaesthetic input is required, that suspect/known COVID-19 patients are managed by specialist anaesthetists (and not trainees). This may require a specialist anaesthetist on-site in hospitals overnight; and
- If anaesthetists are working at a hospital which is predominantly caring for COVID-19 patients, they consider limiting themselves to one site or health service, if this is practical. This is to reduce cross

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infection and maintain a high level of compliance with the PPE policies of a single hospital. [3] This may be more relevant once there is high prevalence of COVID-19 in the community or once ICUs are nearing 50% capacity.

Employment Contracts

Under the Fair Work Act 2009, the ASA is unable to collectively negotiate agreements between anaesthetists and employers. The ASA is able to advise in relation to contract negotiation and aspects of appropriate contracts (see below).

We encourage hospitals and health services to expedite negotiations with anaesthetists and, if necessary, provide rapid credentialing and provision for scope of practice into ICU. We encourage anaesthetists to seek independent legal advice or discuss with their medical defence organisation (MDO) before signing or entering into any new agreement.

In some cases, a short-term contract which offers sessional rates of pay for in-hours anaesthesia services, on-call and second-on-call may be more amenable and easier to implement. In such a contract, we encourage that medical indemnity, Workers' Compensation and sick leave are included, especially if it is anticipated that the majority of patients will be known or suspected COVID-19. We also encourage that clarification of the termination of contract including any restrictive clauses to be determined at the outset. This may be time based or be able to be initiated by either party. It is anticipated that there will be a build-up of patients requiring surgery and interventional procedures that will need to be undertaken during the recovery phase of the pandemic and clarification as to whether this falls within the terms of a short-term contract should also be sought at the outset.

In some cases, anaesthetists may elect to continue with the fee for service model. In so doing, anaesthetists should consider the impact of COVID on theatre turnover. It is hoped that surgical services will continue during the pandemic for emergency and urgent indications.

Elective Surgery

At this time, we do not encourage elective surgery to be performed unless:

1. Scenario planning for the hospital/health service in the management of one, a few and many COVID patients has been completed and all staff are aware of their duties;
2. All staff caring for suspect/confirmed COVID-19 patients are proficient in the use of PPE; and
3. That there is enough PPE for now and for surge capacity and this has been communicated to staff.

Ultimately, the goal of PPE and policies are to prevent the infection of health care workers. Once the above three points have been addressed, elective surgery that cannot be safely deferred until the pandemic is over could proceed. For these patients, we suggest a clear policy and process for coronavirus stratification which may include:

1. *Delaying non-urgent major surgery for patients recovering from COVID-19 by a minimum of 8 weeks and delaying non-urgent elective minor surgery by 4 weeks*
2. Defined pathways and measures within hospital to minimise unnecessary patient exposure to potential sources of infection;
3. Clear and consistent PPE guidelines;
4. Level of precautions for patients undergoing surgeries where airway mucosa may be breached (for example, ENT, OMFS, dental, thoracic, bronchoscopy); and
5. Guidelines for perioperative testing.

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Once widespread community transmission has been established, we recommend airborne precautions for all aerosol generating procedures (AGPs).

Emergency Surgery

While we support emergency surgery be undertaken in a timely manner, we maintain that the safety of health care workers is paramount. We support the use of point-of-care testing to exclude Coronavirus infection prior to surgery being undertaken once this becomes readily available and reliable, noting that it will not be 100% reliable and reasonable measures to protect anaesthesia teams may still need to be taken.

References

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2. Liu W., Tang F., Fang L. Q., de Vlas S. J., Ma H. J., Zhou J. P., Looman C. W. N., Richardus J. H., Cao W.-C. (2009) 'Risk factors for SARS infection among hospital healthcare workers in Beijing: a case control study' *Tropical Medicine and International Health* 14(1): 52–59, doi:10.1111/j.1365-3156.2009.02255.x
3. T. K. TAN ., Special Report: How Severe Acute Respiratory Syndrome (SARS) Affected the Department of Anaesthesia at Singapore General Hospital * Department of Anaesthesia, Singapore General Hospital, Singapore
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