GUIDELINES FOR ESSENTIAL SURGICAL CONSULTATIONS

INTRODUCTION

Since the announcement of the COVID-19 pandemic and the subsequent state of lockdown in South Africa, most surgeons in private practice will have limited their practice to emergencies only[1]. Because of the perceived increased risk of infection while currently in hospital, and the alarmingly high rate of mortality reported from Wuhan in a group of elective patients undergoing routine surgical procedures who were then complicated by COVID-19 infection[2], almost all institutions have adopted a policy of not performing any elective surgery and, where possible, to delay all elective and semi-elective procedures until greater patient safety for inpatient treatment can be assured.

At present there exists uncertainty of the prevalence of **asymptomatic** COVID-19 patients in the general community. Such asymptomatic patients constitute a serious risk of infecting anyone who comes into contact with them in a closed environment. To illustrate and emphasize this risk, recent testing at a Johannesburg private clinic was reported to have demonstrated a substantial number of totally asymptomatic medical and associated staff who tested positive for COVID-19. Until reliable data from PCR testing in the general population becomes available, it is currently not possible to estimate what proportion of the asymptomatic general urban patient population is infected with COVID-19 virus.

Any face to face consultation requires additional travel, and since most specialists practice in large hospitals, will increase traffic through that clinical facility. Routine conventional face to face consultations in the normal clinical setting places the patient, the doctor and the doctor's office staff at increased risk of accidentally becoming the focus of a COVID-19 infection nidus. Although this risk is assumed at this time to be small, it would nevertheless seem questionable to consult in a routine manner with patients whose condition and diagnosis does **not** merit urgent attention. Elective and non-urgent patients can be safely deferred for many months until such time as either the epidemic is under control, or the risk quantified, and effective mitigation strategies effected.

On the other hand, there is an important category of patient who have pathology of a progressive nature with an aggressive natural history. Although not an emergency warranting admission, this category of patient, if left unattended, may ultimately result in significantly worse outcomes, or in some cases future presentation as a life-threatening emergency, or even future death of the patient. A substantial proportion of these cases will already have been identified and would normally have been carefully monitored at regular intervals; examples are an aortic aneurysm that is approaching a size which demands intervention, or a follow up after intervention for malignancy. Many of these patient's follow up visits have been put on hold pending the anticipation of large volumes of very ill COVID-19 patients occupying facilities. Included in this category of semi-urgent patients are new patients with a clinical presentation that would normally be considered for consultation as soon as possible e.g. recent onset GIT bleeding, haematuria or presentation with recent onset angina or a TIA.

It is this category of patient that should be considered semi-urgent or essential and these patients should receive attention as soon as possible. These are NOT elective patients, but rather at substantially increased risk of harm if consultations and investigation are unduly delayed, therefore justifying any small but increased risk that may result from scheduling for early face to face consultation.

The purpose of this document is therefore to provide the practitioner with some guidelines to be followed over the next weeks and months when scheduling and planning such essential patients for non-emergency consultations.

ETHICAL CONSIDERATIONS

Attention is drawn to the ethical rules of practice which require the practitioner to attend to his or her own self as a matter of priority.

The practitioner shall:

8.2.4 Refrain from engaging in activities that may affect their (own) health and lead to impairment.

On the other hand, ethical rules stipulate that the practitioner should:

5.1.7 Not refuse or delay treatment …… because they – the health care practitioners - may be putting their own health at risk.

JUSTIFICATION

Attendance as an outpatient for prolonged face to face consultations is not without intrinsic risk for the patient, particularly in institutions where COVID-19 patients are being triaged and treated. Although the risk to the patient is relatively small, such risk must be justified. It is therefore important that only patients suspected to have disease with an aggressive and potentially life-threatening natural history be identified as falling into this category of semi-urgent or essential and being fast tracked for face to face consultation.

On the other hand, face to face consultations can place the practitioner at increased risk of inadvertently exposing himself or herself to an asymptomatic COVID-19 source. Until better information is available, it seems reasonable that, in the absence of testing every patient, the practitioner adopts every reasonable precaution to protect themselves. Especially those practitioners over sixty years of age and those with co-morbidities, should endeavor to implement as many of these recommendations as reasonably possible prior to commencing face to face consultations. Alternatively, such high-risk practitioner should elect **not to consult at all** until the situation has stabilised, in which case the practitioner is obliged to arrange a reasonable alternative for these semi-urgent patients.

GUIDELINES FOR IMPLEMENTATION

All patients should provide **informed consent** to confirm that they understand that they expose themselves to a slightly increased risk of viral infection by attending the proposed consultation. Patients should also be informed that appropriate screening will be applied prior to entry into the facility. Consent should include the protection measures that will be put in place to protect both the patient and the practitioner.

The scheduling of patient bookings should take into account the length of the consultation, any time required for investigative procedures and should additionally take into account the time required to sanitize and sterilize the examination area prior to entry of the next patient For example, a consultation and procedure (such as ultrasound) that would normally take 35 minutes ,should be scheduled at hourly intervals in order to accommodate the additional sterilization precautions required. Ideally, only a single patient should be seen at a time, and all attempts should be focused on avoiding people congregating in the waiting area.

Any administrative documentation or other required paperwork should be completed (if possible, in electronic format) prior to the consultation to minimize interaction between the patient and the administrative staff.

Doctor's consulting room's administrative staff should provide the facility screening team with a list of the names of the individual patients expected on a particular day to facilitate entry control.

Patients should not normally be accompanied by anyone else unless special circumstances dictate otherwise. Unless the patient is infirm and unable to walk without assistance, the patient should be **unaccompanied** from the time of arrival at the facility to the time of departure from the facility. For infirm patients, only a single accompanying person should normally be permitted.

All patients should be screened according to the local institutional policy prior to entering the building.

On arrival at the facility the patients should undergo a screening procedure for COVID-19 infection, such screening to be determined by the management of the facility in which the consulting rooms exist. Only persons who have passed the screening tests should be permitted into the facility. No patients with symptoms of an upper respiratory tract infection i.e. cough, runny nose, pyrexia or history of recent exposure to a COVID-19 positive patient will be permitted to enter the facility. Such patients should immediately be referred for COVID-19 PCR testing and rebooked for consultation several weeks in the future.

All patients should wear a face mask while in the hospital and in the doctor's rooms. Should the patient be required to remove his face mask for an oral examination or procedure, all nearby horizontal surfaces should be regarded as contaminated and sanitized after the patient's departure.

Scheduling should give consideration to ensuring that the patients **do not wait** in the normal waiting room, but rather are immediately directed to the examination room or procedure room in which the consultation or investigation will take place.

On arrival in the doctor's consulting rooms, the patient should immediately be escorted to the room in which he or she will be examined. The person escorting the patient to the examination room should endeavor to minimize any surface contact between the patient and the surrounding surfaces.

All linen and contact surfaces with which the patient may come into contact, should be sanitized or renewed prior to the patient entering the room. This includes the examination couch, blood pressure cuff, stethoscope, and all ultrasound probes which may come into contact with the patient. A 70% alcohol-based sanitizing solution is preferred, but prolonged washing with an antiseptic soap is an alternative.

The medical personnel (the doctor, nursing stuff or technician) should wear PPE appropriate to the situation. The age and any co-morbidity of the medical personnel

present should dictate the extent of the PPE used during the consultation. For high risk personnel who elect to continue with face to face consultations, it is suggested that full PPE be considered for the duration of the consultation session, discarding gloves and apron between each patient. Obviously full hand washing with detergent should be completed prior to the examination and after completion of the consultation.

Any surface coming into contact with the patient should be regarded as potentially contaminated and therefore sanitized. All linen should be renewed, and gloves and apron discarded once the consultation has been completed.

After completion of the consultation/ultrasound/procedure the patient should be encouraged to exit the consulting rooms as soon as possible after all post consultation administrative details have been completed (such as booking any follow up appointment or receiving a script).

The patient should, on departure, be instructed to notify the rooms if they develop any suggestive symptoms such as a pyrexial illness, sore throat or persistent cough within seven days of the consultation.

In respect of case files, clinical notes, laboratory and X-ray reports etc., care should be taken not to contaminate these documents. A workflow should be structured to peruse the file, reports etc. prior to donning gloves and apron. After completion of the consultation, removal of gloves and apron together with full handwashing should be performed prior to making or dictating any notes, writing any scripts and performing any other administrative task required.

Avoid accepting telephone calls or handling cellphones while using any form of PPE. Disinfect cellphone regularly as these are extremely high touch items.

After the patient has left the consulting rooms, all possible contact surfaces, including door handles and other high touch surfaces, stethoscopes and ultrasound probes should be sanitized and cleaned prior to the arrival of the following patient. If the patient has required removal of their mask, all horizontal surfaces within three meters of the patient should be sanitized.

Any protective equipment that was in contact with the patient such as gloves and apron should be discarded. In the event that full PPE is used to protect the high-risk practitioner, it is suggested that these be discarded only at the end of the consulting session.

Any linen or toweling to which the patient has been exposed, should be regarded as contaminated and appropriately handled. Washing should be performed with detergent at temperatures between 60 and 90 degrees Celsius (WHO recommendation).

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1. ***American College of Surgeons: Local resumption of Elective Surgery Guidance (17 April 2020):*** *https://www.facs.org/-/media/files/covid19/local_resumption_of_elective_surgery_guidance.ashx*

2. ***Lei S et al. Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection. EClinicalMedicine. 2020 Apr 5:100331. doi: 10.1016/j.eclinm.2020.100331.*** *https://www.thelancet.com/pdfs/journals/eclinm/PIIS2589-5370(20)30075- 4.pdf*