Statement on Managing Senior Medical workforce in Intensive Care during the Covid-19 Pandemic.

The Covid-19 pandemic has overwhelmed health services in many countries across the world. Australia and New Zealand have benefitted from some 'early warning'. Nevertheless, modelling has suggested that standing Intensive Care resources will not be sufficient to manage demand even using conservative estimates with considerable anticipated epidemiological curve flattening.

If the system is overwhelmed, strategies will need to be put in place to manage both the Covid-19 cohort and all the other patients requiring Intensive Care. The precise configuration of such strategies will vary with local patterns of practice, resources and available personnel. There may need to be a staged approach as the demand increasingly overwhelms resources.

Appropriately, considerable planning has been undertaken to increase the Intensive Care bed capacity in both countries. But beds alone will not be effective without staff. This statement is designed to address one aspect of staffing – senior or specialist doctors. Factors that impact on senior staff requirements will include:

- The increase in clinical demand as detailed above
- The finite number of trained and credentialled Intensive Care Specialists
- Loss of staff to illness including Covid-19. Note that more than 10% of infected patients in some countries have been health care workers.
- Loss of staff due to quarantine and isolation requirements following high-risk exposure
- Disruption of patient transfer from rural and regional centres due to excessive case load. This may require the management of severely ill patients on site that would be transferred to major centres under normal circumstances.
- The possibility of Covid-hot spots making demand less homogeneous. This might apply at hospital or jurisdictional level and could be especially devastating if it occurred in rural or regional centres with very limited local Intensive Care resources. There is particular concern where social factors including housing and population density make social distancing and home quarantine essentially impossible.

In response to this potential crisis, we make the following recommendations. Note that these apply only to senior medical staffing. We acknowledge that many other factors will be essential to deal with the anticipated demand for Intensive Care management.

- Existing referral and clinical networks should be formally developed into 'hub and spoke' arrangements. This especially applies to smaller rural hospitals but also to lower level metropolitan Intensive Care Units.
    - Each rural and remote ICU should establish a clear liaison with a single larger ICU to provide consultant level support and advice on patient management, potential patient transfer and appropriate triage.
    - This will entail establishing secure video/web links between smaller and larger centres

The Presidents of:
College of Intensive Care Medicine of Australia and New Zealand
Australian and New Zealand Intensive Care Society
Australian and New Zealand College of Anaesthetists
Australian Society of Anaesthetists
New Zealand Society of Anaesthetists
Australasian College for Emergency Medicine

fivec@cicm.org.au

  - Special provisions may need to be invoked at a jurisdictional level to provide material support for rural and remote centres in the event of a crisis. This might include relocation of resources including specialists or facilitated patient transfer.

- Temporary scope of practice for non-Intensivist doctors should be clarified and documented within the relevant Health Service

- Specialists or other doctors working outside their usual scope of practice are entitled to appropriate indemnity insurance and this should be clarified in discussion with Hospital administration and with MDOs.

- Senior doctors working outside their usual scope of practice should ideally be offered up-skilling education.

- Consideration should be given to changes in models of care, especially in relation to the management of less acutely ill patients ('HDU') and Rapid Response or MET services.
  - Responsibility could be transferred to other medical teams to free-up ICU specialists

- A stepwise escalation plan that preserves Intensive Care Specialist oversight of patient care for as long as possible should be developed.
  - Access to specialist oversight and advice for non-intensive care specialists working outside their usual scope of practice should be facilitated, as far as local circumstances can reasonably allow.

- Welfare and peer support resources should be given a high priority

- Specialists should have a choice in the decision to work outside their usual scope of practice.
  - All specialists should be supported in the decision they make for themselves with no recrimination or discrimination.

The Presidents of:
College of Intensive Care Medicine of Australia and New Zealand
Australian and New Zealand Intensive Care Society
Australian and New Zealand College of Anaesthetists
Australian Society of Anaesthetists
New Zealand Society of Anaesthetists
Australasian College for Emergency Medicine

fivec@cicm.org.au