

Dear Residents and Staff Colleagues,

Please find enclosed the Anesthesia Residency Program Policy regarding resident involvement in the treatment of Covid-19 patients (suspect and confirmed):

Our goal is to strike a balance between clinical care, resident safety, and education. The suggestions below are informed by the evidence base arising from the SARS crisis. We are indebted to our colleagues in Toronto for their important work during that outbreak. The following guidelines attempt to cover a number of clinical scenarios. It will be impossible to account for every eventuality. Communication for the purpose of airway management of a Covid-19 patient must be attending to attending in the ICU or ward scenario.

As discussed with Dr. Chris Christodoulou (Chairman, Department of Anesthesia), Dr. Rob Brown (Associate Head Education, Department of Anesthesia), Dr. Craig Haberman (Medical Director, HSC Anesthesia), Dr. Faisal Siddiqui (Medical Director, SICU) and Dr. Marcus Blouw (Program Director, Critical Care), the agreed policy is as follows:

- 1.) All residents must confirm and document that they are fit tested for N-95 masks and practice donning and doffing procedures with PPE to minimize the risk of exposure and transmission of the coronavirus. A final confirmation of appropriate donning and doffing procedures will be released shortly. Training for Donning and Doffing is ongoing. Residents should familiarize themselves with the protocol for intubating Covid-19 patients. Strict adherence to PPE guidelines must be employed during management of these cases.
- 2.) As per PGME and the Dean of Medicine: all anesthesia residents that are either:  
(a) immunocompromised, (b) have coexisting disease that might worsen the morbidity of a novel coronavirus infection, or (c) are pregnant, will be excused from all clinical work effective immediately. Non-clinical rotations will be employed in lieu of clinical contact with patients.
- 3.) In known or suspected cases of Covid-19 for patients in the operating room, the attending anesthesiologist will determine whether it is safe and reasonable to allow the resident to be the primary intubator. If there is any concern, then the attending will be the primary intubator. The resident (PGY1-PGY5) can assist the staff anesthesiologist by giving medications, assisting with equipment preparation and preoxygenation. In the event of a difficult intubation requiring combined FOB/VL, the resident would perform the VL.
- 4.) When clinical circumstances allow (ie: there are no operations going on), residents may assist staff anesthesiologists during airway management on the wards or ICUs, but the staff anesthesiologist should still manage the airway. In these circumstances, the resident would perform the same functions as in the OR.
- 5.) In situations where the staff anesthetist is called to intubate a Covid-19 patient (outside of the OR), the staff anesthetist can delegate the care of a stable operative patient to a resident

where that care is within the capability of a resident for their level of training. Note that recent experience has suggested that the intubation of a Covid-19 patient may take 45 minutes with equipment preparation, donning and doffing. The staff anesthetist may also elect to call the back-up on-call anesthesiologist or an ACA in this circumstance.

6.) In a situation where the staff anesthesiologist cannot leave an unstable patient in the operating room (eg: massive transfusion, other compelling reason), then a senior resident (PGY 3-5) may be delegated to be the primary intubator to manage the airway of a Covid-19 patient assuming that external predictors on physical exam suggest the airway will not be difficult. In this hopefully rare circumstance, the staff anesthetist should call for back-up from a 2<sup>nd</sup> anesthesiologist and or an ACA as well.

7.) In the setting of a known difficult airway in a patient with Covid-19 and respiratory failure requiring intubation, planning should ideally be done well in advance by the consulting service to advise the anesthesiologist of the difficult airway. In this situation, the airway should be managed by the staff anesthesiologist and the most experienced assistant available, [i.e. 2<sup>nd</sup> on-call anesthesiologist, ACA or senior resident (PGY3-5)].

8.) When on an Intensive Care rotation as an anesthesia resident (SICU, MICU, MSICU, ICCS), a senior anesthesia resident (PGY3-5) may intubate Covid-19 patients in the following circumstance. There may be situations where the ICU attending cannot present in a timely fashion if a patient rapidly deteriorates. In these circumstances, the resident should use their discretion if the airway is favourable. If the resident has any doubt about the difficulty of the patient's airway, then they should call the on-call anesthesiologist to assist if available. Residents should not breach Covid-19 intubation protocols for any reason as it relates to Donning and Doffing PPE even when the patient's condition is dire. Every reasonable attempt should be made by the ICU attending to anticipate such events and attend personally, however this may not be possible.

Severe respiratory failure requiring intubation in children appears to be very rare in relation to Covid-19. Airway management in children should be performed exclusively by Pediatric Anesthesiologists in these very rare cases. Residents should not perform the airway management of children (neonates to age 16), but may assist as above at the discretion of the attending Pediatric Anesthesiologist. This policy will apply to the OR, PICU and the NICU.

9.) During the SARS crisis, intubation by an inexperienced provider was a risk factor for transmission of the virus. Dr. Funk discussed this data during his Grand Rounds last week. Under no circumstances should a PGY1 or PGY2 anesthesia resident be expected to intubate a patient with Covid-19 (confirmed or suspected). This policy applies to all operating rooms, wards, emergency rooms and Intensive Care Units in Winnipeg and in Brandon effective immediately and without exception.

10.) Whether on anesthesia or ICU, residents must immediately communicate to their staff attending that they have been consulted to provide airway management to a Covid-19 patient

(suspected or confirmed) to make a plan for the most appropriate resource distribution. Communication about these cases should be attending to attending.

11.) Residents on off-service rotations (emergency medicine, Gold surgery, internal medicine etc.) should continue to report to work and take full precautions with PPE where appropriate. Elective rotations are deferred until further notice. If the crisis worsens as we fear it might, anesthesia residents on off-service rotations may need to be repatriated to anesthesia if clinical circumstances warrant and to staff the operating rooms.

12.) A clinical rotation schedule has been devised for residents to follow at HSC, SBGH, the Grace and Pediatric Anesthesia during the Coronavirus outbreak. We will continue to follow this schedule in the interim. This is an evolving crisis and our schedules will have to be flexible. When residents are not engaged in direct clinical care, or there is expected to be minimal actual work or learning to do, residents should endeavour to leave hospital and go home. Further, and as previously stated, all educational activities will be held remotely via Zoom until further notice. Group activities such as talk rounds, grand rounds, journal club will remain deferred until further notice while we explore remote options. Our PGY 5 residents have seen their examination deferred to a later date due to the Covid-19 pandemic. I wish to express our commitment to support them and all our residents in any way we can in the months to come.

Please accept my best wishes to you and your families during this very difficult time. It is a privilege to work with such an outstanding group of people.

Sincerely and Respectfully,

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