Oregon Chapter
American College of
Emergency Physicians

Statement for the Record
House Health Care Committee
May 20, 2020
COVID-19 impacts on Emergency Physicians

Chair Salinas and members of the committee, my name is Dr. Chris Strear and I'm the President-elect of the Oregon Chapter of the American College of Emergency Physicians. Thank you for inviting me to talk about the impact of COVID-19 on emergency physicians. The single most critical issue for our members during the pandemic is the shortage of personal protective equipment, or PPE. We are deeply worried about the safety of our patients, our families, and ourselves as we have had to reuse PPE in a manner for which it was never intended, during a pandemic that has hit us like nothing before in our careers.

The CDC outlines surge capacity strategy for PPE use under conventional capacity, contingency capacity, and crisis capacity. Conventional capacity refers to PPE use under "business as usual" conditions, our old PPE practice. Contingency capacity refers to use under conditions that may be different from usual, but do not put health or safety at significant risk. This is the condition under which we should be operating when hospitals resume elective cases. Crisis capacity refers to use that is known to not meet usual standards of care, but must be used because there are no other options and the need is dire. We have been operating under PPE crisis capacity strategies since the beginning of the pandemic. And you should know that there was never even a consistent standard for what "crisis capacity" meant for hospitals across the state, meaning that different providers have had dramatically different access to PPE, often not even meeting basic CDC guidelines for crisis use, depending on the hospital in which they work.

In order for counties to begin phased reopening throughout Oregon, and for hospitals to resume elective procedures, the hospitals and counties must attest that they meet certain key prerequisites, including 14- or 30-day supplies of PPE, depending on the type and location of the facility. As of May 15, 31 counties were approved to begin opening, meaning that hospitals attested that they had sufficient – meaning contingency capacity, NOT crisis capacity – supplies of PPE. However, doctors, nurses and techs in EDs have continued to work under suboptimal, crisis PPE standards. Some providers have to reuse masks for up to a week at a time, and we have even heard of physicians sterilizing their N95s in a crock pot. These standards are not safe, often fall short of even the CDC's crisis capacity requirements, and seems in direct conflict with some hospitals' attestations that they have sufficient PPE supply.

OR-ACEP surveyed members about the PPE situation in their ERs, and as elective surgeries begin and reopening is anticipated, here's what we heard back:

Only 23.6 percent feel they are as safe as they reasonably can be during their shift
Only 18.9 percent said they feel safe returning home after a shift if they live with others
Only 15.8 percent are able to wear PPE they supply themselves, despite this strategy being Oregon's Plan A for PPE supplies, and a recommendation of the CDC

And in our members' own words, we heard stories such as the following:

"I have taken roughly a 50 percent pay cuts and I'm working more to try to accommodate the lost income. I have not received a single new mask from the hospital and we have no clear trajectory when PPE will be available. I'm re-using several masks that my family sent me and have now used them each at least 5-times, using one per shift and then re-using for several days. I feel like I can't speak up about this for fear of retribution by the hospital."

"I am told NOT to use N95s while seeing COVID positive or suspected patients unless there is an aerosolizing procedure. I am NOT allowed to bring in personal PPE. We were still following "crisis guidelines" (for PPE) that are not actually best practices."

And on a personal note, I haven't seen my children since March to avoid infecting them. Some of my colleagues are living away from home to keep their families safe. When I speak today about the severe rationing that frontline providers in the ED are experiencing, I am speaking for over 500 emergency physicians as well as countless ICU providers, hospitalists, nurses, and techs who make up the frontline.

For a patient to undergo an elective procedure, that patient has almost certainly tested negative for Covid. However, in the emergency departments, we have to assume every patient we see is Covid positive. Yet our PPE continues to be restricted and use is applied inconsistently throughout the state. Additionally, organizations must have capacity to manage a new surge in Covid cases before resuming elective cases. We are hearing from members across the state, however, that admitted patients are boarding for hours in the EDs despite resumption of elective cases. These dynamics create an apparent disparity in standards within a hospital that further underlines the potential mismatch between attestation of capacity and the capacity we are seeing on the frontline, in real time.

Our board has been working with the Oregon Health Authority and the hospital association to address our concerns surrounding transparency in data for each hospital's PPE stores, days of PPE on hand, and burn rates, but so far the data has been inconsistent and incomplete, and not useful for guiding policy standards. We want to work proactively and collaboratively with our healthcare partners moving forward to establish a truly meaningful standard that can be measured and enforced. To that end, we recommend convening a task force with representation of front-line healthcare providers, as well as hospital administration, to devise a measure for PPE that accomplishes the following four objectives:

Consistency in standards from one hospital to another. We are advocating for coordination of PPE amongst hospitals throughout the state – shared resources so all frontline providers have an equal opportunity to better protect themselves, their families, and their patients. One person should not be in a better safety position because they work at one hospital system or another.
A rational formula applied to all hospitals to determine in a standardized and meaningful way where they stand in terms of PPE supply.
Transparent reporting of this information.
A mechanism for accountability to and enforcement of these standards.

And there needs to be a sense of urgency in this: the more our society starts to reopen, the greater the risk of a new surge – one potentially worse than what we have already seen – and every day we delay amplifies that risk.

It is never too late to do the right thing. We appreciate the opportunity to voice our concerns about front line healthcare worker safety, along with our suggestion for a way to move forward that is fair, equitable and representative of the people impacted most by having access to appropriate PPE.

Thank you so much for your time and consideration.