No doctor is an island: the 'social distancing' of guidelines during the COVID-19 pandemic

Editor

The COVID-19 pandemic has affected the lives of millions. As hospitals expanded their capacity to manage COVID-19 and 'social distancing' was adopted to minimise viral transmission, non-emergency surgical activity all but ceased. As infection rates appear now to have peaked however, there is debate regarding how to re-start elective surgery.

As elective work is once again encouraged, we must consider how guidelines can support this. In the operating theatre, fragmented guidance has done little to rationalise practice. For example, procedures requiring 'full' or 'aerosol generating' personal protective equipment (PPE) differs between contemporary guidelines issued by Surgical Royal Colleges[1], the Association and Royal College of Anaesthetists[2], and Public Health England[3]. This has resulted in different staff groups having misaligned expectations of the PPE required for the same procedure.

Whilst it is understandable in a fast-moving situation that stakeholders have access to different information, guidelines must be workable. In practice, surgeons, anaesthetists and operating theatre staff must work together if surgery is to be done. It is therefore imperative that guidelines are developed with an appreciation of how they must be used, and in collaboration with all of those who must use them.

The tendency in guidelines to avoid aerosol generation at all costs is problematic. Initial Intercollegiate guidance discouraged laparoscopic surgery[1], but whilst open surgery *may* generate less aerosols, the guidance failed to consider if aerosols generated from the abdominal cavity are as important as those from the respiratory tract[4]. Furthermore, the risk to staff is not balanced against the benefits that laparoscopy offers to the patient. This is complex clinical and ethical territory, but to reconcile these factors collaboration between surgeons, anaesthetists, virologists and infection control specialists is required as a minimum. Notably, the advice regarding laparoscopy has recently been reviewed, with the Association of Laparoscopic Surgeons of Great Britain and Ireland offering a reasoned argument for laparoscopy in the elective setting[5].

For elective surgery to resume in a safe and productive way, it must be acknowledged that in addition to protecting colleagues, jointly agreed systems should be implemented to test patients for SARS-CoV-2, protect them from the virus, and expedite recovery. Open surgery in a patient for whom laparoscopy is feasible may, for example, result in complications and a prolonged hospital stay with a risk of the nosocomial acquisition of COVID-19.

Good surgical care is good surgical care, pandemic or no pandemic. Though resource limitations and infection control should play their part in guidelines, they must be developed in collaboration with all of those who must use them. A fear of the unknown has hitherto resulted in disjointed guidance that at times has appeared hurried. The effect of the SARS-CoV-2 virus will be with us for many months to come and distancing and isolation will remain necessary. We hope however that in perioperative care, social distancing will extend only to the workplace, and that the distance between professional groups will not be so evident in future guidelines.

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