A REPORT TO THE AMERICAN COLLEGE OF SURGEONS BOARD OF REGENTS:
THE EFFECT OF THE COVID-19 CRISIS ON RURAL SURGEONS AND RURAL
HOSPITALS AND SUGGESTIONS ON HOW THE COLLEGE CAN HELP

Michael D. Sarap MD, FACS
Chair, ACS Advisory Council for Rural Surgery

This report is the result of a request by ACS Regent James Elsey to form a taskforce of rural surgeons to identify the unique negative consequences of the COVID-19 crisis on the rural surgical workforce and to define areas where the American College of Surgeons might be able to intervene. As Chair of the Advisory Council on Rural Surgery, I was immediately able to identify and contact a core group of rural surgeons across the US with varied geographic and practice situations. I asked them to reflect on the effects of the current crisis on rural surgeons and what their perceptions were of the ability of the College to help their practices and communities. I also sent out a message on the ACS Rural and General Surgery Communities and the ACS Rural Listserv asking for reports and comments about how their lives and practices have been altered over the last three weeks. I included my personal email and phone number in the note to encourage personal responses from surgeons hesitant to make public comments via the digital sites. Over the last 5 days I have exchanged innumerable personal notes and had long conversations with surgeons from across the nation. There has also been a very robust response to my inquiry via the ACS Communities and the Rural Surgery Listserv.

Several common themes emerged from all the information and comments that have been collected. Most of these have described truly heroic efforts by local surgeon-leaders to prepare their small understaffed and undersupplied facilities for the coming COVID-19 storm. Nearly everyone applauded the early and frequent information updates from the College of Surgeons as the main stimulus for halting elective procedures and moving their facilities into disaster mode. Most of us have forwarded every ACS memo to our fellow medical staff members and administrators. The majority of the surgeon accounts however were tempered by the prediction of economic ruin to their practices and their facilities from this crisis and a palpable personal fear of contracting the disease while treating their communities. Many had already separated themselves physically from their families so that they could continue to work without the added fear of spreading the virus to their families. Demographic studies show that the rural surgical workforce is composed of a significant proportion of males over age 60, who are at a very high risk for major complications from contracting COVID-19.

Observations, comments and commonalities of responses from rural surgeons:

Common to all hospitals, the lack of adequate PPE supplies and test kits was mentioned by everyone. Unfortunately, rural facilities will be the last ones who will get additional supplies. There were accounts of small facilities that were actually forced to send their already insufficient numbers of masks, gowns and face shields
to larger facilities within their system to help with urban surges of COVID-19 patients. Additionally, as the national blood supply dwindles, due to collection delays, rural facilities will feel that shortage the most.

Rural hospitals that have strong physician input are clearly ahead of the curve in preparation compared to facilities where administrators monopolize the planning strategies and actions. Fellows of the American College of Surgeons have taken the lead in rural America in terms of preparing for the COVID-19 crisis. The flow of information from the College very early in this process facilitated the ability of surgeons to take the lead, even at the expense of limiting their own elective surgical procedures and office visits.

Transfer of patients to larger medical facilities may become very difficult. Rural hospitals will then become “islands” where COVID-19 as well as trauma and complex surgical cases will need to be cared for with very limited resources. Difficult ethical decisions will need to be made in those facilities to determine which patients receive the already limited resources.

Transition to telemedicine for office and clinic visits has been much easier in urban centers than in rural locations with limited access to broadband Internet and elderly populations with little digital experience.

Preparing for a large surge of COVID-19 patients, while still having to care for other acute medical issues, is a real problem in small community facilities. Many CAH have only one or two ventilators or the only ones might be the ones used in the operating room. Critical care beds and experienced nursing and respiratory technicians to staff them are in very short supply in rural areas and would not be able to cover very ill patients on a 24/7 basis, especially if these key team members become ill with the virus. Conceivably, one physician could be the sole provider for a facility with a full census leaving the entire facility at risk if that physician becomes ill.

The economic impact of this crisis is already becoming a reality. Physician practices and rural hospitals survive on very thin margins because of several factors that have been previously discussed at length by the Advisory Council for Rural Surgery. Recent rural hospital closures continue to occur almost weekly. Elective surgical procedures and outpatient elective testing are the lifeblood of rural hospitals and, without this income, many private surgical practices and rural hospitals will cease to exist due to the additional burden imposed by the COVID-19 crisis. Several surgeons mentioned that their hospitals currently have much less than 30 days cash on hand.

How Can the American College of Surgeons Help Rural Surgeons and Rural Hospitals:

An ACS statement that a local hospital COVID-19 task force should be physician led with role of administration as supportive rather than directive.
Pandemic tort reform - The standard of care for this novel virus is unknown, the healthcare system is overwhelmed and people will die as a result. Rural physicians with limited resources should not be held accountable to the same standards as their urban counterparts during a crisis, especially when transfer is not an alternative.

Develop directives for ethical resource allocation (i.e. Who will not benefit from mechanical ventilation?). Code status directives for COVID-19 patients. Help develop COVID-19 palliative care plans and order sets.

Publicize immediate ideas for reprocessing and repurposing supplies. Recipes for disinfecting solutions for surfaces and equipment since the disinfectant wipes are running out. Recipes for hand sanitizer.

Develop statements regarding transfers for STEMs, trauma, CVAs and other complex medical conditions usually transferred out after stabilization.

Applaud journals that have removed the pay wall and encourage all others to participate in this sharing of information.

Advocacy for real financial relief for those surgeons on the front line risking their lives and, at the same time, forfeiting their ability to pay their practice expenses by halting elective procedures. If corporations will be getting financial bailouts that they will never have to repay, the same government support should be available to rural physicians and rural hospitals.

Relaxation of state licensing and credentialing requirements to facilitate use of telemedicine support from critical care and pulmonary specialists for local physicians caring for critically ill patients on ventilators. This could also facilitate teams of critical care physicians and nurses to travel to overwhelmed rural facilities to help with patient care (Rapid Rural Relief Teams).

Consideration of an EMTALA waiver to prevent Emergency Departments and small hospitals from being burdened by noncritical patients, while dealing with a COVID-19 surge.

Help rural surgeons with simple instructions regarding setting up low cost telemedicine capabilities in their offices and clinics.

Develop checklists or inventory audits for small hospitals to help them determine how may patients they can handle in a surge or crisis event. This would include the necessary equipment, disposables, drugs, nursing and ancillary staff and anything else required to care for a specific number of patients without outside resources. Development of plans to facilitate an increase in surge capacity.
Insure the availability of the most updated data and information pertaining to therapeutic options for COVID-19.

**Conclusion:**
The American College of Surgeons has been a national leader in disseminating information about COVID-19, including best practices for disaster preparation, diagnosis and treatment of this pandemic. The early recommendation to eliminate elective surgery to conserve limited local and national supplies of resources undoubtedly is already responsible for saving many lives. The COVID-19 Newsletters continue to be an outstanding and life-saving resource for all physicians and hospitals. The Advisory Council for Rural Surgery truly appreciates the support of the Regents and ACS leadership during this crisis. There are many reasons, despite the current pessimism, that most rural communities can weather this storm. The isolation inherent in “being rural” may be an advantage in hopefully limiting the amount of COVID-19 disease in rural communities. Rural communities and surgeons are used to “doing without”; they are tough, resilient and have grit. Rural communities are always very resourceful and very supportive of each other. With the rural community’s own “natural resources” and, with the continued help and support from the American College of Surgeons, rural surgeons will continue to do their utmost to care for their friends, neighbors, families and colleagues in their local communities as they have for generations.

**Rural Surgery Taskforce Members Contributing Material for this report:**

Mark Puls – Alpena, Michigan  
Julie Conyers – Ketchikan, Alaska  
Sue Long – Buckhannon, West Virginia  
Matt Rossi – Hopedale, Illinois  
David Welsh – Batesville, Indiana  
Glenn Levine – Coquille, Oregon  
Caleb Schroeder – Hastings, Nebraska  
Mark Diluciano – Cambridge, Ohio  
Michael D. Sarap – Cambridge, Ohio

I would like to thank the dozens of Fellows of the American College of Surgeons who have contributed by phone calls, emails and postings on the ACS Communities and ACS Rural Listserve over the last several days.