Position statement on the staged and safe approach to the return of orthopaedic surgery during COVID - 19

Australian Orthopaedic Association

24 April 2020

The Commonwealth announces a staged return to some elective surgery from 27th April 2020.

The Australian Orthopaedic Association (AOA) welcomes a staged and safe approach to the return of orthopaedic surgery. This would apply to treatment of conditions of bones and joints across the spectrum of orthopaedic surgical management, recognising that safety of patients and the health workforce is paramount. It is further recognised that this will occur in a system that is resource-constrained and surgeons and hospitals will need to "choose wisely", until such time a "business as usual" is reinstated.

The surgical management of patients is not an isolated activity but must be viewed in the context of overall health effect of the nation, the use and supply of PPE, the resources likely to be consumed and the stability and security of the logistic supply chain (which often has on off-shore basis).

Therefore, AOA supports the restriction of service at this time to be made on a fractionated or rationed system ("the allocation"), based on a percentage by time of previous operating time sessional use. This is best used as a moderator because it is equitable and even in its effect and can be based on readily available data. It is probably best applied at a hospital level, as some surgeries can be safely left for restoration of normal activity. An example of this is surgery carried out for cosmetic reasons or where a superior clinical benefit has not been demonstrated through surgical intervention.

It is expected that surgeons will work with hospitals to prioritise their patients' needs for surgery, accounting for risk factors and co-morbidities, while having regard also for the safety and availability of health care workers and hospital facilities.

Double theatres should be avoided, surgery should be consultant-performed as much as practicable and all efforts should be made to use the theatre resource wisely and, in a time-efficient manner.

AOA has advocated that the category system for elective (planned) surgery has not been ideal for orthopaedic surgery but accepts that Category 1 and 2 surgeries will continue, within surgical time-based restrictions, at this time. This should include most types of time critical orthopaedic surgery in most parts of the body. These are time dependant operations that would include many reconstructions and joint stabilisation procedures, and not just arthroplasty surgery.

"Category 3 – Needing treatment at some point in the next year. Their condition causes pain, dysfunction or disability. Unlikely to deteriorate quickly."

Category 3 encompasses many conditions of the musculoskeletal system, which can cause significant pain and disability and reduce quality of life. Further they can restrict function, impose significantly on activities of daily living, and reduce participation in the workforce and social functioning.

Orthopaedic surgeons of all disciplines are used to assessing, prioritising and planning surgical treatment for these patients. Their professional judgement can be relied upon to balance risk and to prioritise these patients within an ‘allocation” towards high value and low risk procedures.

The production of long lists of what could or should be performed at this time of limited resources is thought to be unhelpful. Many decisions are also contributed to by individual patient circumstances and functional loss, within the broader category of a particular operative treatment. Various scoring systems, adequacy of non-operative treatments, individual circumstance and pain reports all underpin the expert judgement of the surgeon in decision making at this time. Other factors assessed include the relative risk of surgery, guided by the ASA, the requirements of an ICU bed and individual risks of operative surgery (such as obesity). The treating orthopaedic surgeon should consider all these factors, as low risk and high value procedures should be the only ones booked at this time.

Therefore, the AOA supports the judgement of orthopaedic surgeons to prioritise their patients within “the allocation” of operative surgery, which each surgeon will receive.

Certain procedures that are of lower value to the wider health system or equivocal benefit to patients should be avoided at this time. These include those that could be safely and reasonably deferred, or those likely to require longer periods of recovery or greater risk, such as operations in patients with high co-morbidities (ASA 3 or above). Surgery for cosmetic conditions or deformity correction and conditions that remain well controlled with non-operative treatment should not be performed until “business as usual” is re-instated with respect to operating room resources.