Creating a COVID-resilient future for surgery

Editor

The coronavirus pandemic will change every surgical specialty. For now, our focus is on surviving the storm[1]. How do we keep surgeons and patients safe? Health services, surgical colleges and societies have produced guidance in a surge of evidence and opinion that threatens to overwhelm us[2]. While sorting the wheat from the chaff, we must address our most important challenge: how do we re-design surgery in the COVID-era[3]?

As well as reducing surgical activity[3], the pandemic will contract capacity. Necessary modifications to existing infrastructure are perhaps most visible: multi-occupancy wards will house fewer patients, waiting rooms will be obsolete, and occupancy levels will shrink in areas as diverse as recovery, radiology and discharge lounges. Less obvious is loss of capacity arising from changes in practice. Precautions for aerosol-generating procedures, like intubation and laryngoscopy, will reduce productivity as modified work practices designed in response to the pandemic remain in place for at least the medium term. In reconsidering patient flow, surgeons must refine care pathways to practice safely while minimizing waste and delay. This requires collaboration with colleagues in anaesthesia, nursing and other areas to adapt best practice guidance to the local context. If investment in additional infrastructure is not possible, options like extending or staggering the working day or week may be required to maintain necessary surgical activity levels and to retain the capacity of our health services to train future surgeons.

Rebuilding the confidence of society in the safety of surgical facilities is essential. Preoperative cocooning, testing and cohorting of elective surgical patients with the highest standards of infection prevention and control must become standard. We cannot guarantee COVID-free wards or hospitals but separation of scheduled surgical patients from unscreened patients admitted as an emergency is mandatory. Health systems that previously prioritized bed allocation based on emergency department waiting times must now pivot to ensure ring-fenced surgical beds, if scheduled care is to resume. The rapid adoption of remote consultation and care in the community that was a feature of recent months must become permanent so that only those who need the most complex care attend in person.

More patients than ever need our care[4]. Inevitably, over the coming months and years, hospital pressures due to COVID-19 will fluctuate. It is unsustainable that surgical services would repeatedly cease. Instead we must become agile, increasing and decreasing activity depending on local circumstances and coronavirus prevalence. Surgeons cannot leave the development of our future health system to others; society needs the rigour that surgeons bring to service redesign[5]. We must promote standard practice based on evidence, audit our outcomes and increase our skill in rapid-cycle testing and learning. Surgeons need reliable data, good communication and certainty that health service managers are ensuring access to the personal protective equipment that is essential for our continued practice. Patients need confidence that everything possible is being done to ensure their surgical journey is safe. Rebuilding trust depends on surgical leadership to navigate our new world.

D. A. McNamara
Co-Lead, Irish National Clinical Programme in Surgery; Consultant General and Colorectal Surgeon, Beaumont Hospital and Clinical Professor of Surgery, RCSI

National Clinical Programme in Surgery, Royal College of Surgeons in Ireland, Proud's Lane, Dublin 2, Ireland and Department of Colorectal Surgery, Beaumont Hospital, Dublin, 9, Ireland

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