Postponement and Cancellations: Orthopaedic Surgeons on the IMPACT

During the circuit breaker period in April 2020, the Ministry of Health (MOH) issued a directive that categorised medical services into "essential" and "non-essential" services. This encouraged the deferment of non-urgent surgeries, among them selected orthopaedics services. *SMA News* invites Dr Kumaran Rasappan (KR) and Dr James Wee (JW), both orthopaedic surgeons, to share on the effects this had on their respective subspecialties. Dr Kumaran also shares his thoughts on the term "non-essential" and how it can be detrimental to medical services.

Dr Kumaran is an associate consultant with the orthopaedic surgery department in the National University Hospital. He specialises in orthopaedic trauma and musculoskeletal oncology. Other than spending most of his time operating at work, outside of work he enjoys high-altitude climbing, hiking and running.

Dr Wee is a dual subspecialty orthopaedic surgeon who is accredited by the Ministry of Health in Singapore. He is double fellowship-trained in the subspecialites of hip and knee surgery at Oxford University Hospitals, and foot and ankle surgery at the Royal National Orthopaedic Hospital in the UK.

In my opinion, it was unfortunate that the term "non-essential" was used to describe certain subspecialties because there is no such thing as a "non-essential" surgery. "Non-essential" belittles the work done when in fact, each specialty in medicine is equally important and complements each other in complex ways.

I personally did not have any of my cases cancelled, but my colleagues in orthopaedic reconstructive surgery had their elective surgeries cancelled or postponed. One thing is constant in their view – when a patient with knee pain gets denied an elective total knee replacement surgery, for instance, their morbidity increases. Their muscles defunction, their pain increases and the chances of them walking as per their premorbid condition, even with a surgery in the future, are reduced.

These delays lead to an enormous backlog of patients waiting for their much-needed surgery, which may be prioritised instead when systems again run as per pre-pandemic settings. These chronic neglected cases may then, in the future, become the new "essential" services. Thus, there should not be such labels for medical services."

– Dr Kumaran Rasappan

The initial impact

What was the initial impact COVID-19 had on your surgical load and patients? What were some of the major changes and issues you faced during this period?

KR

As I subspecialise in orthopaedic trauma and musculoskeletal oncology, many of my patients were emergency or semi-emergency cases who needed to be operated on within a few days (trauma) or a few weeks (oncology). Thus, there were not many cancellations of my cases other than benign limb tumours. However, I know that some of my other colleagues doing primarily elective procedures had to cancel many of their cases. Based on my understanding, the biggest challenge for them was prioritising which cases get postponed, before rescheduling the affected cases at a later allowable timing while managing the uncertainty that the rescheduled date also had a high chance of getting postponed again. Another aspect of this challenge was how to break the news of the postponement to their patients, some of whom already had their surgeries postponed multiple times.

JW

I made the transition from working in a restructured hospital (RH) to private practice in May 2021. When COVID-19 first reached our shores in 2020, I was mobilised to help staff the screening centre at the National Centre for Infectious Diseases (NCID). Surgeons like me worked ten-day shifts at NCID, and the challenge laid in juggling our clinical duties at the main campus of the RH to accommodate the NCID shifts. In addition, the surgical load plummeted by around 70% to 80% (by my rough estimate) because many non-urgent surgeries were cancelled to free up resources for COVID-19 patients, and also because some patients who were apprehensive about coming to the hospital postponed their surgeries.

When I first started private practice in mid-2021, the patient load in the first few months was predictably low, due largely to the effect of border closures causing a marked reduction in foreign patients to near zero. Speaking to other doctors who had already been established in private practice for several years, my understanding was that the drop in patient load had significantly affected them as well, and not just the newcomers. Things improved with the partial re-opening of our borders in end-2021, but the situation has been in flux with the emergence of the Omicron variant worldwide.

Ongoing patient management

How did you cope with the continued care and treatment of your patients during this time?

KR

The constant cancellation and reshuffling of operating theatres (OTs) was one of the key ongoing challenges. There were two reasons for this. One was due to the workflow mandating that we cancel elective cases. The other was that there were numerous times when OT staff were down with COVID-19 and OTs had to be closed. Thus, we had difficulties even with urgent surgeries due to the shutting down of OTs. We would have to look out for available OT slots on a daily basis to figure out how we could reshuffle and slot surgeries into the available lists. As for my elective colleagues, they faced the more difficult challenge of repeatedly informing their patients that their surgeries had to be cancelled or postponed. They constantly needed to call and reassure patients that the hospital was looking into the next available slot for their surgeries. They also had to reschedule clinic visits because consent for surgery had expired and for some, the patient's conditions had worsened. Allied health services such as physiotherapy were key in the rendering of conservative management for these patients to try to keep their symptoms at bay.

JW

In the RHs, there was a system of prioritising our surgical patients according to medical urgency and symptom severity, and the decisions on how to apportion our limited surgical resources had to be made on a case-by-case basis. The postponement of non-urgent surgeries, sometimes more than once, resulted in severe lengthening of already long waiting times for my patients. Thankfully, when my team and I called up our patients to reschedule their operations, the vast majority were understanding of the situation. In fact, many even expressed concern for my well-being and wished me well. Such encounters provided much-needed oases of support and encouragement.

How did the frequent changing of rules impact your patients' course of treatment?

KR

The anticipation and uncertainty was palpable, not only among the patients but also among the surgical staff. We could not give patients 100% assurance that their surgery would be done on a specific date. Through our experience, we learnt that the rules were constantly changing, and what we said to them this week might change as quickly in the week after. Thus, we had to speak with them about rescheduling dates with caution. Patients were understandably upset about the uncertainty and anxious about whether their newly scheduled surgery date would also get cancelled.

Some patients could not wait for the rescheduled dates due to increasing symptoms, and went to other hospitals to have their surgeries done sooner. Others who waited had a slow but constant deterioration of symptoms. Some of my colleagues in arthroplasty mentioned that patients with osteoarthritis of the knees started getting fixed flexion deformities due to the lack of movement and ambulation because of pain, which could warrant a more extensive procedure in the future. There were also instances where patients' surgeries had been delayed for almost a year since the COVID-19 cases spiked in June 2021.

JW

As the virus mutated and the case numbers waxed and waned, the Government had to adapt to the rapidly changing situation, and the frequent rule changes led to a lot of uncertainty for both my patients and me. As postponements in RHs had become the norm rather than the exception, surgery bookings were little more than best-case scenario projections, and patients were told to expect last-minute changes, sometimes only on the day before surgery. Many of my patients had to wait six months or longer for their elective surgeries, such as hip and knee replacements, knee and ankle ligament reconstructions, and the relatively small surgeries like bunion corrections. This sometimes resulted in their conditions becoming more severe as a result of the extended delay to treatment. Fortuitously, they did well after their eventual surgeries and did not suffer lasting consequences. However, this may not have been the case across all surgical specialties. Another challenge was in post-operative follow-up, as reduced clinic appointment availability resulted in less frequent outpatient reviews. I mitigated this by corresponding with my patients more regularly through email or over the phone.

In private practice, the delays were significantly shorter in duration, typically resulting in delays measured in weeks rather than the multi-month postponements seen in the RHs. I was also able to maintain close follow-ups of my patients post-surgery. As such, the impact for my patients in private practice was considerably more muted.

Two years in

How has the situation changed since? Has it improved after the recent shift to allow more elective medical services?

KR

The Ministry of Health is well aware of the long-term implications of disallowing surgical services deemed "non-essential" from continuing. The backlog of mounting postponed cases and increasing morbidity from the paucity of treatment may come as a tidal wave when the pandemic ends. Thus, surgeons like me are appreciative that the rules are always trying to allow for these services to continue. With the unpredictability of case transmission in the community and hospitals, there have often been sudden brakes to these plans and rules without much pre-empting. In the last month however, more OTs have started opening up for elective surgeries, albeit with some hiccups, which came as a breath of fresh air for most elective surgeons.

In the National University Hospital (NUH), we switched to the Next Generation Electronic Medical Record (NGEMR) platform on 26 February 2022. There were a lot of system changes that our institution had to get used to and we are still learning every day. Even though the national COVID-19 rules started allowing elective cases to proceed, the hospital has limited the elective case listings for March so that we can learn to cope with the NGEMR switch. Many of us in NUH are looking forward to April where all restrictions would hopefully be lifted (*fingers crossed*) and we can continue freely listing elective cases.

JW

With the recent shift to allow more services that were previously termed "non-essential", the situation has improved. Although my colleagues in the RHs have had to, once again, postpone cases due to the surge in Omicron-variant cases, I understand that the previous backlog of cases has largely been cleared.

In private practice, there is once again a need to delay surgeries by one to two weeks in view of bed-shortages as the country grapples with the high infection numbers, but this relatively minor delay has not proven to be detrimental to my patients thus far.

What are some lessons these events have taught you?

KR

There are three lessons the pandemic has taught me.

Working together

One subspecialty cannot keep pushing for their cases so that they get done first before other non-urgent surgeries. For a patient, even the least urgent surgery, regardless of specialty, is the most important surgery for him/her. Everyone should understand this and play ball. We have to give and take, and be able to appreciate that we have to postpone certain cases at times for the greater good. Essentially, we are all working to fight the pandemic together. Regardless of our vocation, we are all doing our part. We should work together and help each other to overcome these trying times.

Psychological impact on staff

These last two years have left a deep and perhaps unrecognised psychological impact on all hospital staff. We may be burnt out without even realising that we are nearing the end of our matchsticks. Collectively, we need to recognise this and help our colleagues when the situation gets tough. Simple gestures like being there to talk about difficult experiences, expressing care and concern for their well-being, or simply just enquiring about their day all go towards making a small but significant difference in the mental well-being of colleagues.

Taking things in good stride

As many of us may have learnt over the last two years, there are many things that are not within our control. We may plan for something with intricate meticulousness, just to have everything changed on the very day of implementation. I have learnt not to get irritated or frustrated with these multiple changes of systems, workflows and rules. I have also realised that the higher management has worked really hard and are at times equally as frustrated with things that do not go according to their plans. Everyone is on the same boat and trying their best. Last but not least, I have learnt to look on the positive side and take things that happen around me at work in good stride. That way, I feel less irritable and much happier.

JW

It has reinforced the lesson that good communication between doctors and their patients is paramount in cementing trust in the doctor-patient relationship. This is especially crucial in times of unpredictability and limited resources. As doctors, we can better understand the needs and problems of our patients, and prioritise their care accordingly; for patients, they can better understand the shifting challenges placed on the healthcare system by the fast-changing COVID-19 situation, and adjust both their expectations and schedules to cope. ◆