Impacts of elective surgery restrictions on training, service to the community and public

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Impacts of elective surgery restrictions, as a COVID-19 response, on the Australian plastic surgery training program

Initial responses

The arrival of the COVID-19 pandemic in the Australian community in the first quarter of 2020 resulted in deleterious impacts on the training of Australian plastic surgeons, almost immediately. The range of effects is broad and started with the cancellation of the annual registrars’ conference and all other face-to-face education activities in March 2020. While activities related to formal teaching were able to pivot quickly to online delivery, the impact of decisions to limit surgical procedures, and specifically elective surgery, have been more profound and were harder to mitigate. These will be discussed with consideration to education, caseloads, employment and assessment.

Plastic surgery education in Australia is overseen by a single provider, the Royal Australasian College of Surgeons (RACS) but delivered, in the main, by volunteer surgical trainers and supervisors organised by the Australian Society of Plastic Surgeons (ASPS). An immediate effort between RACS, ASPS and other speciality training boards sought to develop a set of ‘no-disadvantage’ principles to apply to all educational activities. Thus, when COVID-19 forced impacts on the delivery of surgical education, the trainees were allowed more time, relief from training requirements, and other flexible measures as needed, to ensure as great a degree of protection from disadvantage as possible. However, events at a hospital level could not protect our trainees from the fallout of COVID-19 as successfully as we had hoped.
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Impacts on education
Most surgical education occurs in operating theatres and clinics, much as it has done for centuries, albeit supplemented with formal teaching, courses, private study, conferences and exams. The direct impact of COVID-19 on both theatres and clinics has been profound and, interestingly, geographically patchy. COVID-19 responses varied markedly from state-to-state and even from hospital to hospital. Common among these responses were reductions in elective surgery operations and clinic attendances. Some jurisdictions saw the relocation of elective surgery from public hospitals to contracted spaces within private hospitals. This had the effect of reducing trainee exposure to many of the routine teaching cases.

Impacts on case loads
Trainee plastic surgery registrars are required to log all cases they are involved in and are expected to log, as a minimum, 200 cases per six month training period. While the experience of the majority of trainees was that they were able to meet this minimum, it was more commonly a deleterious change on the mix of work undertaken that was noted. For example, centres with a focus on trauma may have seen little change in day-to-day operations while centres with a focus on breast cancer reconstruction were hard hit with requirements favouring basic reconstructions over microsurgery being imposed. A small number of trainees felt that their case loads were inadequate to provide meaningful training and have requested an extra six months of training time. This represents a significant impact on them personally, professionally and financially.

Impacts on employment
A number of plastic surgery roles involve extensive cosmetic surgery exposure and this work disappeared for many months due to state government restrictions. This saw the complete collapse of one training position, with no source of income for the trainee. The Australian Board of Plastic and Reconstructive Surgery aims to avoid this ever happening again by ensuring that payment for trainees is never dependent on week-to-week activity. Other training roles with extensive cosmetic surgery exposure (Australian trainees log approximately 6000 major cosmetic cases per annum) were able to pivot more successfully to focus on trauma and permitted, urgent elective surgery. Nevertheless, the loss of trainee exposure to cosmetic surgery remains a detriment to each affected trainee.

Impacts on assessment
The reduction in elective surgery made some training positions hard to assess because the volume of surgical activity was so significantly affected. Plastic surgery trainees are assessed every six months against a set of criteria that includes both technical and professional skills. The pandemic provided opportunities for trainees to respond to unusual, non-technical challenges in areas including reorganising teams, advocating for patients and complex multi-disciplinary care. The impacts of reduced elective surgery activity did make assessing technical skills more difficult for supervisors and trainers. Occasions existed where supervisors felt unable to make a proper assessment of technical skills for trainees in markedly impacted roles. On these occasions, which were felt to be no fault of the trainee, applying the agreed ‘no-disadvantage’ test ensured they continued training with an overall satisfactory performance rating.

Conclusion
The decisions of state governments to include, within their COVID-19 pandemic responses, a reduction in elective surgery has had impacts on surgical training which varied from mild to severe. Decision-makers should consider all stakeholders, patients, communities and surgical workforces, as well as the efficacy of their interventions, when considering such measures in the future.

Impact on service to the community and public
The COVID-19 pandemic has had profound effects on the Australian community for the last two years or more, with many of those effects being related to the provision of healthcare.

Initially, there were fears of a devastating wave of infections that would put many lives at risk and overwhelm our health services. The initial nationwide lockdowns and shutting of international borders were a coordinated effort by state and Commonwealth governments to protect the community and allow the health system time to prepare. This included procuring personal protective equipment (PPE), a stockpile of ventilators and a reorganisation of hospitals and health services to ‘clear the decks’ in preparation.
Cancelling all but emergency and urgent surgery was an important part of this preparation to free up hospital beds and staff.

Sadly, Victoria’s second wave highlighted the risks of uncontrolled infections in an unvaccinated population and a prolonged and arduous lockdown was required to bring the case numbers back under control. Once again, elective surgery was restricted in the public and private sectors to both free up hospital capacity, but also in an effort to minimise community movement and interaction. Similar restriction on other non-essential non-medical services had devastating personal, psychological and financial consequences for many. Widespread school closures led to prolonged periods of remote learning. We are only now beginning to understand the subsequent costs to educational progression, social development and mental health of students.

As time progressed, we began to see differing approaches across the states to managing the risks of infection. Outbreaks in Victoria and New South Wales prompted the other states to close their borders in order to protect their own communities, businesses and health systems. For many people living in these states, life could continue with only limited interference from various restrictions that were mostly aimed at limiting interaction and ‘super spreader’ events. The exception to this were the sometimes devastating personal costs of being unable to cross state boundaries.

Thankfully, with the development of effective vaccines, and an enthusiasm among the populace to receive them, the health effects of subsequent outbreaks have been minimised. Nonetheless, the response to each outbreak has involved restrictions on elective surgery activity without any sense of nuance or differentiation based on relative risk to the community, the health service or the setting.

Frustratingly, as surgeons who specialise in a field with limited surgical emergencies, we have often felt the brunt of these restrictions. In Victoria, in particular, in addition to the prolonged restrictions on elective activity with each subsequent outbreak and lockdown, cosmetic surgical procedures were singled out as unnecessary and were specifically banned from taking place for many months at a time. While acknowledging that hospitals involved in the COVID-19 response were at times under significant strain, there appeared to have been an inability to recognise that many of the other health services were, in fact, being underutilised. In particular, many day surgery facilities, private hospitals and health services in regional centres were often sitting largely idle while the major metropolitan hospitals were nearly overwhelmed. Distinguishing the different stresses on different parts of the system was only belatedly recognised in Victoria in late 2021 when initially regional hospitals, and then private hospitals, were allowed to recommence activity at an earlier time than the metropolitan public hospitals.

The consequence of this blanket restriction on elective surgery activity has now become obvious, with significant increases in public hospital waiting lists and the presentation of more advanced stages of illness and disease. These outcomes were entirely predictable and underpinned the advocacy that the specialty surgical societies (including ASPS), RACS and the AMA were undertaking in an attempt to allow elective surgery to recommence at an earlier time, and with more autonomy, by the various health services.

The lack of elective surgical activity over the last two years has had significant immediate effects on the experience gained for our trainees and young consultants and, in some instances, has led to the premature retirement of our experienced colleagues. The backlog of cases will take many years to clear and will need a concerted effort from all involved to achieve. Creative solutions will be required, not just a promise of more funding from governments. Critically, the major issue will most likely be a shortage of staff, especially experienced nurses, who have left the health system and can’t simply be easily replaced.

Hopefully, these experiences will prompt a rethinking of the importance of elective surgery within the community and the need to give it more priority to avoid the consequences of prolonged pain and disability, as well as the ramifications of more advanced diagnoses and subsequent treatment. It has also been a reminder that elective surgery is actually necessary surgery, and a vital part of the healthcare system.
References