

The Australian Orthopaedic Association 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 especially “choose wisely”, until such time a “business as usual” is reinstated.

The surgical management of patients is not an isolated event 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 an off-shore basis).

Therefore we support 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.

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 efficiencies should be made to use the theatre resource wisely and in a time efficient manner.

The 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.”

Within category three there are 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. Added to that is included the relative risk of surgery, sometimes guided by the ASA, the requirements of ICU bed and individual risks of operative surgery (such as obesity) that make a simple list of very limited utility.

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

There are natures of surgery of lower value to the wider health system, or likely to require longer periods of recovery or risk.

These would include spinal fusion surgery for isolated back pain, especially if over more than one segment; arthroscopic surgery for degenerative meniscal pathology in the over 50 year old; hip arthroscopic surgery; arthroplasty in patients with higher comorbidity or vulnerable patients (ASA 3 or above, frail elderly); surgery for "cosmetic" reasons including the removal of benign uncomplicated exostosis; surgery for deformity correction or limb lengthening in adults.

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