# Who decides whether surgery is necessary in a pandemic?

By Philip Matley

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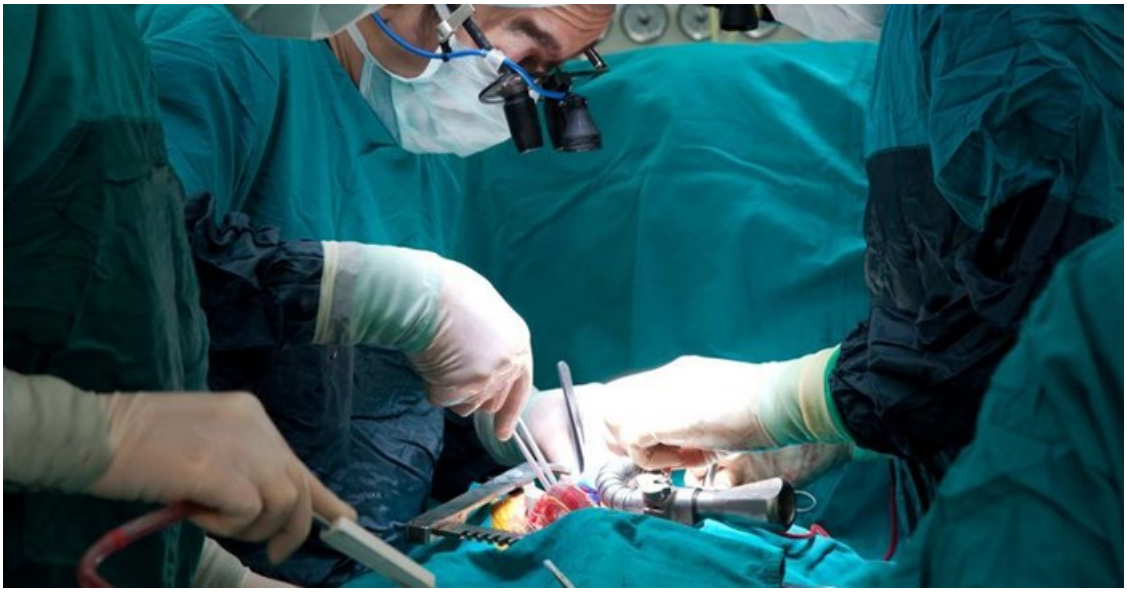

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Medical funders and managed health organisations have responsibilities to their members, clients and trustees to ensure that patient well-being is paramount and that the particular fund is protected from wasteful, irrational or fraudulent expenditure. However, the ultimate responsibility for surgical decisions lies with the surgeon who remains accountable to his patient, his professional societies, his peers and the law. Only in the most exceptional of circumstances would one expect a funder to interfere in a decision arrived at jointly between a surgeon and his or her adequately informed patient. This has always been the case. The current complexities of the Covid-19 pandemic are certainly not a reason to deviate from this principle.

## Virtually any medical service can be rendered

A national understanding of the need for on-going surgical services is developing for 2020. Initial calls by the surgical societies themselves to halt scheduled surgery well ahead of the promulgation of any disaster regulations were based on the predictions that the pandemic would peak in April 2020, following which there would be at least some sort of return to normality. It is clear that the crisis will continue well into 2021 and will in fact deteriorate considerably in the coming months, therefore patients requiring necessary surgery must be offered this now.

In terms of regulation 16(2)(a) of the Disaster Management Act of 2020, essential medical services are permissible and a recent senior legal opinion has stated that ‘virtually any “medical service” can be rendered, provided that the legal compliance criteria in regulation 16(6), Annexure E and the Occupational Health and Safety Act can be adhered to’. There is no legal impediment to scheduled surgical procedures being undertaken.

Timing in surgery is everything with a price to be paid when necessary surgery is delayed. The fact that a procedure can be scheduled in no way indicates that it is unnecessary or can be postponed indefinitely. Surgery for cancer as well as conditions associated with intractable pain or severe loss of quality of life simply cannot be delayed by months and months. Many conditions will almost certainly require emergency treatment later, if not managed correctly now. The list is innumerable and these preventable emergency procedures tend to be associated with high medical risk as well as considerable cost.

The risk of patients or healthcare workers contracting Covid-19 in hospital cannot be under-estimated, even if reduced by adherence to guidelines including effective use of PPE. Routine testing of in-patients or patients scheduled for surgery will certainly be helpful (in spite of the risk of false negatives) and all major hospital groups are requiring this as a routine. It is clear that this increased risk will continue beyond 2020. Patients need to be carefully informed of the risks and both surgeons and patients must balance this risk against the risk of denying surgical treatment. This they must do together and should reflect the decision in a specific Covid-19 consent form.

## Window of opportunity

Measures to “flatten the curve” have almost certainly created a window of opportunity to provide necessary surgical treatment. As the anticipated surge arrives it is likely that for a period, hospitals will only be able to provide resources for surgery that is immediately necessary to save life or limb, but this is simply not the case at present and accumulating large backlogs will not help anyone. This situation is quite unlike that experienced in the USA or Europe and therefore a requirement that there be a sustained fall in new Covid-19 cases before continuing with necessary surgery cannot be supported.

The ability of a hospital to provide such necessary surgical services will, in the context of the current pandemic, vary from location to location depending on Covid-19 case load, available resources, and the possibility of sub-dividing the hospital into Covid-19 and non-Covid-19 areas. Private hospitals may be in a better position to achieve this than state institutions and therefore the services offered by the two should not be compared. As the anticipated surge arrives it is likely that for a period, hospitals will only be able to provide resources for surgery that is immediately necessary to save life or limb, but this is simply not the case at present.

Priority at this time should be given to day-case procedures, particularly those that do not require general anaesthesia or intensive care and patients who because of low age and lack of co-morbidities are relatively low risk for serious Covid-19 infections. Several scoring systems have been proposed to aid decision making. Day clinics in particular do not have overnight facilities and therefore will not be treating or admitting Covid-19 patients, enabling procedures to go ahead there according to the relevant specialist group guidelines.

## Prioritisng patients

Many interventions can and will be postponed beyond 2020 but those that cannot, should not. Lists of procedures are completely unhelpful as it is not the procedure code that is key but the clinical indication for doing the procedure. It is the

surgeon and the patient who should be making this call as long as practice conforms to available specialty-specific guidelines. South African surgeons should be working, prioritising patients appropriately, and consulting closely with local hospital management, anaesthesiologists and nurses to ensure that local resources are adequate and properly managed, and that all safety guidelines are rigidly adhered to. This approach has been endorsed by the Federation of South African Surgical Societies (FOSAS) representing 19 surgical societies and associations in this country.

Funders at this time should be assisting surgeons wherever possible given the unique difficulties that the pandemic presents. Many surgeons continue to operate with their support staff working from home. Laborious pre-authorisation and requests for letters of motivation should be suspended during the crisis. In the majority of instances, the need for the procedure should be evident simply by noting the ICD10 code, most of which will reflect a PMB condition. Surgeons are simply not going to be performing unnecessary procedures whilst exposing both their patients and themselves to risk and to suggest that such practices are widespread at this time is to fundamentally misunderstand the nature of the doctor-patient relationship and the commitment of surgeons to firstly, do no harm.

## ABOUT THE AUTHOR

Philip Matley is the chairman of Surgicom and board member: South African Private Practitioners Forum