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CORRESPONDENCE

The difficult clearance of the elective surgical backlog caused by the cancellation of cases due to the COVID-19 pandemic

Benoit Samson, MD

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To the Editor,

In June 2020, the CovidSurg Collaborative (CSC) estimated that 28,404,603 elective surgery cases would be cancelled or postponed worldwide during the peak of 12 weeks of disruption due to COVID-19 (2,367,050 operations per week). Furthermore, the CSC estimated that it would take a median of 45 weeks to clear the backlog by increasing the usual surgical volume by 20%.[1]

The province of Ontario, Canada has a population of 14.7 million.[2] A study by Wang *et al.* has shown an even worse situation in that province than the one reported by the CSC. By the end of June 2020, a backlog of 148,364 cases with an average weekly increase of 11,413 surgical cases was expected in Ontario. That study estimated it would take 14 weeks to clear the time-sensitive surgeries from the list and 84 weeks to eliminate the backlog if 719 additional operating room/hours per week were used in the currently non-utilized operating rooms throughout the province.[3]

The backlog and the estimated time needed to eliminate it must have worsened since the end of June 2020. The number of patients on the waiting lists will have increased since these studies did not account for potential future waves or surgical delays caused by shortages of personal protective equipment, ventilators, and drugs.[4,5] The reassignment of operating room staff to other areas of the hospitals also delayed the surgical management of the patients on the waiting lists.[6]

Eliminating the huge backlog of elective surgical cases creates unprecedented challenges for our healthcare system. The usual approach to managing peaks of this nature during a short-term crisis by increasing the regular surgical volume by 20% or more as suggested by the CSC may not be feasible or sufficient to solve the current problem, which may very well endure for many more months or even years. As previously reported, the imposition of overtime on the nursing, surgery, and anesthesia personnel for a prolonged period of time is poised to cause physical and psychological harm to these individuals, emphasizing the crucial need for proactive measures to prevent burnout and mitigate occupational stress.[6]

I would submit that out-of-the-box solutions have to be evaluated to eliminate such a huge backlog while maintaining the regular throughput of surgical cases to avoid further prolongation of the wait lists. It is doubtful that there are enough unutilized operating rooms in many jurisdictions to allow for parallel processing and simultaneous running of slates for backlog and regular cases. An intuitive approach would be to add extra shifts to the daily schedule to help offset the lack of supplementary operating rooms. However, additional nursing, surgery, and anesthesia staff would then be required to handle these extra volumes. Thus, as one part of a possible solution, a survey of available retired medical professionals may identify enough staff to allow additional eight-hour operating room shifts in the evenings or on weekends. These retirees could be employed as full-time staff or assistants. Interested nurses and physicians may also be trained to assist regular personnel.

Even if the above proves successful, other barriers to eliminating this unprecedented surgical backlog will need to be overcome, including intensive care unit bed availability bottlenecks, concerns relating to recovery

B. Samson, MD (✉) ·
Faculty of Medicine, University of Ottawa, Ottawa, ON, Canada
e-mail: bensam64@hotmail.com

scenario costs, and potential objections from professional unions, to name but a few.

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