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EDITORIAL

Collateral damage for failing to do in the times of COVID-19

Daños colaterales por dejar de hacer en los tiempos de la COVID-19

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The new coronavirus (SARS-CoV-2) is responsible for health, economic and social crisis of hitherto unknown magnitude and significance. In addition to the number of deaths, and the uncertainty about the care patients with post-acute sequelae of SARS-CoV-2 infection (PASC) will require,¹ there are also unintended consequences (collateral damage) for other patients. Their quantification has just begun and, although their effect is still unknown, their impact on many pathologies will begin to be observed in the coming months.^{2–4}

Although underuse⁵ (not providing the care that is needed, or advisable, for a patient) has been considered a health problem in all health systems, the analysis of its impact on health has not been given the same consideration as that of overuse. COVID-19 outbreak has radically changed this perspective. Underuse has come to the forefront because, during the most critical waves of the pandemic, in Spain as in the rest of the world, many of the programmed healthcare activities have been interrupted and the traditional way of accessing healthcare resources has been altered.

Cancelations, postponements, or delays

Patients suffering from a non-communicable disease, including the most vulnerable ones, such as the elderly, oncology, complex chronic or palliative care patients, in the best case have seen their care disrupted and at other times, their care interrupted. Cancelations, postponements, or increased waiting lists have been widespread around the world.^{6,7}

As the incidence of new cases of COVID-19 increased and hospital resources was redirected to them, scheduled surgery has been suspended. In the first 12 weeks of the pandemic, it has been estimated that more than 28 million surgeries were canceled worldwide.⁸ These cancelations have also affected oncological surgeries (estimated 37% of cancelations). The same estimation suggests that increasing a 20% increase in surgical activity before the outbreak, it would take about 11 months to perform the surgeries suspended by COVID-19. The outpatient activity has also decreased with an 87% reduction in Europe, affecting just over 2 million patients.⁹

In the US, the Kaiser Foundation, until April 2020, informed a 69% reduction in hospital admissions for non-COVID-19 patients.¹⁰ In the UK, between January–September 2020 and 2019, there were 4 million fewer referrals and 60% fewer referrals from primary care for suspected cancer.¹ Ninety-one percent of a total

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of 202 trauma and orthopedic surgeons surveyed last year said that all scheduled non-urgent surgery had been suspended due to COVID-19.¹¹ Transferring some patients to other centers has been the most common way of dealing with this situation. In the case of hip and knee surgery in Europe, 26% of the interviewed surgeons said that all surgical activity were annulled due to the pandemic and 68% referred that all non-urgent activity was canceled. In most centers (76%) re-interventions for acute infection were maintained.¹² In France, 91% of midwives radically changed their practice and the way they interacted with women. Most stopped all non-essential activity (84% postpartum pelvic floor rehabilitation, 78% birth preparation, and 64% follow-up consultations during pregnancy).¹³ In the case of headache consultations in Spain, 92% of centers replaced face-to-face consultations with telephone consultations, 60% maintained preferential face-to-face consultations and only 46% continued to carry out procedures considered urgent.¹⁴ The increase in waiting lists is the immediate and easily measurable consequence. The Information System on Waiting Lists in the National Health System (SISLE-SNS) on June 30, 2020 showed an average waiting time of 170 days, which represented an increase of 55 days over the previous year.¹⁵ The clinical consequences (torpid evolution, comorbidities, and the uncertain prognosis of these patients) are more undetermined. Although we do not have sufficient data, some sources suggest that patients have understood the reasons for this interruption, and satisfaction with health systems seems according to some data not to have decreased.¹⁶ No figures on what has happened so far in Spain at both levels of care are available, although it is expected that, in the territories and at the times of higher COVID-19 incidence results will be similar to the rest of the countries in our environment (for example the data provide by SUMMA at the Spanish Society Quality Assurance Conference, 2021¹⁷).

Reorientation of other resources

Healthcare resources in territories and periods with a high incidence of COVID-19 have been addressed to meet the needs of these patients, making the impossible possible to safeguard the non-delayable demands of the rest of the patients. However, the collateral damage caused by the rules to prevent the infection from progressing should be taken into account. Although the figures are still scarce, some of them suggest that these other decisions have also put non-COVID-19 patients at risk, for example, with fewer means available for patient transfers.¹⁸

Self-policing out of fear

In addition to the restrictions that the system has imposed, fear of infection has caused avoidance behaviors among patients. In France, in 2020, there was a 26% decrease in hospital emergency department visits, which, compared to the previous year's data, represented a 34% decrease in patients with heart attacks, 32% with strokes, and 42% fewer appendicitis.¹⁸

Less face-to-face consultations, more telephone, and telemedicine

Traditional face-to-face consultations have given way to telephone consultations and a boom in telemedicine.^{11,14} Patients have seen an abrupt change in the channels of interaction with professionals. Neither were prepared for such an abrupt change and its impact in terms of under-diagnosis and over-treatment has not yet been assessed. There is some evidence to suggest that the delays and the shift to telephone consultation of breast cancer patients have not altered their emotional balance.¹⁹ Further studies on the experience of non-COVID-19 patients during this period are sure to emerge in the coming months.

Training put on hold and focus on COVID-19

The reorientation and cancelations of healthcare activity have also affected those who have chosen the health professions as a career path and who have seen their training truncated, their teaching methodology changed, or their rotations disrupted.^{20,21} Most of the residents have focused their work on COVID-19. The consequences for the future of these interruptions are currently the only speculation.

Ethical conflicts during the pandemic with non-COVID-19 patients

Across the world, forced by the incidence of COVID-19, the measures have been similar.²²⁻²⁵ The urgency of the loss of life as a result of the new coronavirus justifies the decisions.

Scientific and professional societies, in many different latitudes, have drawn attention to ethical aspects that should not be overlooked and developed recommendations for action during the outbreak, including warnings about the risk of successive waves and the need to prepare for this eventuality by thinking of COVID-19 patients, but also of others. Measures to mitigate its effects, however, are awaiting better times,²⁶ although many patients cannot wait.

Unavoidable commitment

The current situation makes it advisable to establish, by consensus between scientific societies and health administrations, the criteria, resources, and timetable to correct the impact of the underuse of resources with non-COVID-19 patients due to the pandemic, as is already beginning to be done in our immediate environment.²⁷

Addressing this impact is a pressing need. The impact concerns the quantity and the quality of life of a very large number of people. It must be taken into account for the debate of the Health System recovery after the pandemic. This must be a commitment of the scientific societies, including the Spanish Society for Quality of Care (Sociedad Española de Calidad Asistencial, SECA).²⁸ Initiating this task is the direct responsibility of the health authorities responsible for the recovery plans of the health services, once this acute phase of the current health crisis has been overcome.

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