Lessons from Victoria's second wave

As a regional surgeon and director of surgery in the middle of Victoria's second wave of coronavirus, I am learning new things about this pandemic on an almost daily basis, but I am also aware that surgical colleagues around the country are looking on from outside, with only a partial understanding of where we are.

Australia's 'first wave' of COVID-19 was met with a united front. Rapid wind-back of elective surgery was followed by the transfer of public elective surgery into private hospitals under national agreements. Plans were made for the large-scale expansion of intensive care unit (ICU) capacity and staff were redeployed to deal with an overwhelming surge of COVID-19 patients. Yet our first wave wasn't really a 'wave' at all if we consider the global picture. It was a relatively well-confined outbreak, mainly limited to returned overseas travellers and dealt with by quarantine and border restriction.

History and science together are formidable predictors of the future. What might we have learnt from them this time? Perhaps that a pandemic virus such as this will have many waves or that, however optimistic we are, a vaccine takes some time to develop, or that our hospital and healthcare infrastructure is poorly designed to resist an airborne viral attack.

As the first wave faded, rather than learn from history and science, we let out a sigh of relief and planned a return to normal. The talk was of a 'surgical blitz' to catch up: hospitals, especially in the private sector, quickly ramped back up to full capacity. We let our guard down.

My advice? Use time wisely. Many healthcare facilities are old and unsuited to care for infectious patients. Patients who truly require urgent or emergency surgery will suffer if it is delayed, and yet there was no detailed or staged plan for how this work might continue.

In Victoria, our model of surgical care has surgeons working at many different hospitals – sometimes covering large areas of the state – and that brings its own complexities during a pandemic.

Some of the questions that have arisen include preoperative COVID-19 testing of surgical patients, appropriate personal protective equipment (PPE) for a range of surgical scenarios, the risks posed by a mobile health workforce, and the role of fit-testing, which varies in its uptake nationally.

In the midst of a major outbreak, it is clear that none of these systemwide problems have easy fixes. My recommendation is to make the most of the gaps between the waves. Use that time to redesign the services and facilities to cope better and more safely with a subsequent wave of COVID-19, rather than constantly trying to catch up mid-wave.

If this requires a reduction in bed numbers, better ventilation, new employment models or operating lists that look very different, that may be a cost worth paying. If this requires financial investment upfront, the current position in Victoria suggests this would be money well spent.

> My strongest conviction, however, is that, as surgeons, we need to be front and centre of decision-making that affects surgery.

While our colleagues in infectious diseases and public health medicine rightly stand at the forefront of the current pandemic, their expertise is not in the surgical field. We need to open the lines of communication and make recommendations early on from the surgical specialties to government. The recommendations should be based on the best evidence available. We should also be prepared to shut down quickly and early if there are outbreaks – and then be ready to recommence surgery as soon as it is safe to do so. Above all, prepare now – it will be time well spent. ■

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