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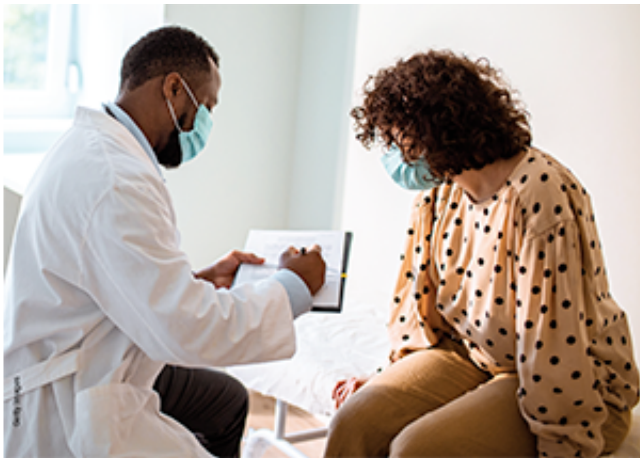
Returning to a new normal

Written by Louise Leger on August 28, 2020 for The Medical Post



After hundreds of thousands surgeries were postponed across Canada to free up hospital space and resources amid the pandemic, many specialists are now trying to catch up with a backlog of visits, procedures and other services. They (and physicians fortunate enough not to have a backlog) are also adjusting to a new normal of virtual visits and infection control.

Specialists tell the *Medical Post* that the process of reopening after the COVID-19 lockdown is a complex and unprecedented juggling act between pent-up patient demand and system limitations. The possibility of a second wave resulting in further shutdowns this fall or winter has only added to the complexity.

While some specialties—such as psychiatry—have had less difficulty maintaining continuity of care (with the not-insignificant adjustment to virtual practice), other specialties, such as orthopedics, have been especially hard hit and are struggling to catch up.

The Ontario Medical Association offers these sobering stats: Compared to March through June 2019, there were 11.5 million missed patient visits in Ontario. There were also 1.2 million fewer procedures and surgeries and 3.7 million fewer services provided by family doctors. Specialists provided 7.7 million fewer services and 5.5 million fewer diagnostic tests.

“Ontario’s doctors have been speaking publicly about the current backlog of deferred services during this pandemic for some time,” Dr. Samantha Hill, OMA president and a cardiac surgeon in Toronto, told the Medical Post over email. “Though our members have diverse needs based on their area of practice, some parallels can be drawn.”

Through the pandemic, doctors shifted the way they provided care almost overnight, said Dr. Hill, “sometimes at great financial cost to their practice and their staff.”

Across Ontario, for example, doctors were seeing an average of 350,000 patients per day before the pandemic.

“Now, they are seeing fewer patients since they need to extensively clean and sterilize examination rooms and equipment between visits,” she said. “There are also strict limits to the number of patients allowed in the waiting room at one time.”

Orthopedics: ‘Two to three years’

Dr. Jeremy Hall is an orthopedic surgeon and trauma team leader at Toronto’s St. Michael’s Hospital. “While a few scattered hospitals across Ontario have facilitated increased OR resources to address the orthopedic patient backlog, the majority of hospitals have yet to restore OR resources to that of pre-COVID levels,” he said in an email to the Medical Post. “Many are stuck in early phases of the ‘ramp-up,’ with goals for further increases over the fall barring restrictions in the event of a second wave.”
With the current level of care and proposed gradual increases, Dr. Hall said, “It will take at least two to three years to catch up on the operations cancelled/delayed as a result of COVID-19 restrictions and efficiency challenges.”

COVID-related delays in the operating room have led to diminished productivity, Dr. Hall added, and he predicted that as new patient assessments begin to catch up. This combination will lead to even greater wait times for orthopedic surgery. He also said he believes the delays will result in a worsening burden of disease. “In the end, I anticipate longer, less complete recovery for these patients.”

As daytime hours of operative resources in hospitals were running at full capacity pre-COVID, the only available increase would seem to need to occur after-hours and on weekends. But, according to Dr. Hall, this is “unlikely to provide the resources necessary to manage the backlog of orthopedic patients, as it will likely come at the cost of fracture care or the care of other subspecialty surgical patients. Furthermore, operating during off hours will inevitably lead to physician burnout.”
So what’s the solution?

“There are alternative solutions to increase daytime operating resources outlined in the province’s ramp-up strategy, such as optimizing the use of private facilities to deliver this care,” said Dr. Hall. “But this has yet to be realized.”

Psychiatry: Missing cues

“Due to pandemic and physical distancing, patients can wait longer until they call us or go into ER, and so are more acutely ill when seen,” said Dr. Mamta Gautam, a psychiatrist at the Ottawa Hospital and a member of a journal club of 12 psychiatrists.
Now cases and wait times are on the rise, due to the addition of COVID-related mental health issues and the exacerbation of existing issues.

Dr. Gautam said that during the height of the pandemic, she and most of her colleagues continued to connect with about the same number of patients. The biggest change is that most appointments are now virtual, and if they are in-person, personal protective equipment and other infection control measures can get in the way of the therapeutic relationship.

“For the first three months, (my workload) was mostly the same as before the pandemic, as my patients are referred to me at the cancer centre,” Dr. Gautam said. “Most of my colleagues had their usual waiting list too. In psychiatry, this can be lengthy (several months) as our work with patients is long-term, unless one has a primarily consulting psychiatric practice.

“However, since early June, we are seeing more mental health problems as the longer-term impact of the pandemic is being felt, and there is reopening and more patients being assessed for non-COVID-related, chronic issues.”

During the pandemic, she said, in-patient psychiatrists went into the hospital daily, taking needed precautions. “Initially, the wards and ERs were quiet, but they are extra-busy (now) as patients whose care was deferred are now more urgent.”

Meanwhile, psychiatrists who work in out-patient settings or private offices are mostly working virtually, something Dr. Gautam anticipates will continue for the foreseeable future. “Some psychiatrists with community

practices tell me that they will ask patients who are not stabilized to come into the office every few sessions for an in-person assessment, or will agree to see a patient in crisis in-person as an exception."

As with any "new-normal" office visit, in-person visits require a lot of special care.

Procedures now go something like this: The patient waits in their car until they are texted to come in. The office furniture is rearranged so that the patient sits by the door and the physician is at least two metres away. Both wear masks. There is regular use of hand sanitizer. The office is cleaned and sterilized between patients.

With virtual visits, "Many of us feel that we are more limited in our ability to create or maintain a therapeutic relationship without the non-verbal communication, and limited in our ability to do complete assessments," said Dr. Gautam. "It's much harder when assessing a new patient previously unknown to us. We were all initially straining to get cues over the phone/video, and exhausted by the end of the day. As we realized that we are still able to provide help and value to patients, we were able to relax and enjoy the experience."

Palliative care: Breaking the rules

Dr. Mino Mitri, a general internist and palliative medicine specialist in Vancouver, picked up more work than ever at the beginning of the pandemic, covering for colleagues who became ill or were at elevated risk of COVID-19. But once at work, in palliative care wards, the workload was very light.

"The hospitals were nearly empty," he said. "But my colleagues working in the community in palliative have another story: they were swamped. Patients have been refusing to go to hospitals for fear of the pandemic, so stayed home instead when they really needed to seek a higher level of care. It has been very challenging for the community teams to keep up with demand."

Dr. Mitri said that at one of his clinics, he had a backlog of one to two months, but has since caught up.

"I can speak on the behalf of several of my colleagues on two key areas that have impacted patient care. First, communication with patients. Excellence in communication is a cornerstone of palliative care practice, not only to better understand our patients, but also to provide therapeutic interventions. The masks, gloves, gowns, and inability to hold hands, hug or simply place our hands in their hands have barred our ability to more deeply connect with patients and their families. We know that 50% of communication is body language, and much of that communication is lost. I still admittedly 'broke the rules' when in one instance the daughter of a newly admitted patient was informed that her mother would likely not survive a bowel obstruction, and she tearfully asked for a hug. I couldn't say no."

The second key area, said Dr. Mitri, are the restrictions on visitors, which can result in some very unpleasant interactions.

"Hospices and palliative care units have been very strict with the number of visitors, but allow a few more visitors when a patient is actively dying. Physicians, nurses and other allied health members have been emotionally exhausted policing these rules. It goes completely against our usual standard of care," he said.

"We've been faced with angry family members, some criticizing the imposed rules and regulations, which none of us at the frontlines have asked for or created. We understand the grief they're going through, the loneliness of our patients, and the need for family support, particularly at these vulnerable stages in their lives. We've been conflicted, negotiating the rules with families, despite some escalating complaints to upper management who then bend the rules they've created. There is variability between institutions on these policies. There is a lot of frustration that we can't do palliative care properly . . . we're wrinkling more around the eyes so people know we're smiling."

Plastic surgery: Non-essential?

In Alberta, all elective surgery was cancelled from March 17 to May 4, which meant most plastic surgeons weren't working at all. Dr. Christine Nicholas is a plastic surgery fellow in Calgary who plans to open her practice in December.

"During this time, one of the other surgeons I work with told me his practice was reduced by 90%," she said. "We were able to do virtual consults, but it's very hard to do that with these types of patients. Also, if you

aren't operating, followups tend to diminish. Since May 4, things have steadily opened back up again. I would say by the end of June, we were almost operating again at full capacity."

Dr. Nicholas said there is "definitely" a backlog of reconstructive breast patients. "For revision breast surgery, that was delayed by two months. We are also seeing more melanomas that weren't presenting during the shutdown."

As with orthopedic surgery, the pandemic has made it difficult for surgeons to offer what are considered quality-of-life operations, which were deemed non-essential. "Because the consultant I work with does melanoma, we still were allowed to operate on those," Dr. Nicholas said. "However, those who have an elective hand practice, for example, were reduced to only call work."

Dr. Nicholas admitted she is worried about the financial impact should surgeries be cancelled when she starts her practice in December. "I will have a lot of initial capital costs," she said.

Cardiology: Catching up
Dr. Andrew Krahn is a cardiologist and president of the Canadian Cardiovascular Society. He estimates that for planned procedures, there is a backlog that will take six to 24 months to clear, depending on the sub-specialty. For his practice, where he largely implants cardioverter-defibrillators and pacemakers, he is working extra Saturdays, and expects it will take until the end of the year or early 2021 to catch up if there is no subsequent slowdown.

"Other areas, for instance, ablation or cardiac valves, will take longer to catch up because they had a more extensive wait list," he said. "They had a complete shutdown for those three months of the crisis period."

Meanwhile, outside the OR, 90% of Dr. Krahn's clinic assessments are done virtually, while many of his colleagues, he said, are at about 50% depending on the subspecialty.

Dr. Krahn noted that patient hospitalizations are back to pre-COVID numbers, a good sign that cardiac patients are no longer avoiding the ER. "So now, the challenge is the provision of care and the precautions that are taken to try to minimize transmission or outbreaks, either involving other healthcare workers or patients."

Virtual care:A game-changer
For most specialists, the consensus appears to be that virtual care is here to stay and that it is time-saving and efficient in many situations, but of limited value in others.

"Both doctors and patients have welcomed the increased options offered by virtual care," said Dr. Hill of the OMA. "Whether a patient is in a rural community or in a big city, this type of care has been an absolute game-changer. The COVID-19 pandemic has shown that it doesn't matter how close or far you are from your doctor when an in-person visit just isn't possible. The explosion of virtual care demonstrates the tremendous value of investing in digital healthcare solutions," she added.

Dr. Hall is wary of virtual visits. "Some surgeons continue with virtual assessments but unfortunately such interactions provide limited clinical information with respect to the physical exam, which is often essential in determining disease severity."

Virtual visits are not just about avoiding disease transmission, but other practicalities. "Vancouver General has an ambulatory building that's 11 storeys high, has four elevators, and has thousands of patients going through every day," said Dr. Krahn.

"Now, the fact you can't put the usual 10 or 15 people into an elevator has driven doctors to continue to do at least 50% of what they're doing virtually so they can still deliver the care that's necessary."

Optimistic about the future
Health associations and governments continue to work to ensure the provinces are well-positioned to withstand a second wave, said Dr. Hill. The OMA, for example, recently advocated caution reopening indoor bars and other measures to keep patients safe.

While Dr. Krahn worries about the financial hardship colleagues have endured—and could continue to endure in the event of another lockdown—he feels that Canada is reasonably well-positioned to address a potential spike in cases.

"First of all, we were, for the most part, extremely cautious at preparing for a surge in cases that would impose on our ICU critical care capacity," he said. "We learned how to do that. We know what it takes to convert a place into more of an ICU."

Dr. Gautam agrees there is reason to be optimistic. "We anticipate a second wave for sure. It is likely that nothing will change in how (psychiatrists) are practising, and we will continue to provide virtual care," she said. "The good thing is that both physicians and our patients have gone through the steep learning curve for new technology, and are now more comfortable with the use of, and value of, virtual care."

Should there be another lockdown, Dr. Krahn hopes that the needs of those patients missing their life-altering surgeries will be taken into consideration. "We had a good, quite effective dry run at locking down. We basically showed over a week we could go from business-as-usual to COVID-ready. . . . This has to be balanced with the expectations of the population. Because people are suffering out there and they need their care. The good news is I think we can adapt quickly."