

# Clearing elective surgery waiting lists after the COVID-19 pandemic cannot be allowed to compromise emergency surgery care

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Many patients with gallstone pancreatitis were not receiving timely, surgical care even before the pandemic



**E**lective surgery waiting lists have long been a sensitive political issue.<sup>1</sup> Reducing the increased backlog and waiting times caused by coronavirus disease 2019 (COVID-19) pandemic-related restrictions on elective surgery will be a major health priority during the next three to five years. Delaying emergency surgery is one approach used to prioritise elective surgery, but focusing on elective surgery rates may result in delayed theatre access for emergency operations,<sup>2,3</sup> compromising emergency surgery outcomes and prolonging hospital stays and consequently increasing costs.



In the past, emergency surgery was often delayed until after normal working hours, some patients undergoing surgery late in the evening, overnight, or even

the next day. The overnight surgeon was often an unsupervised trainee working excessive hours.<sup>3</sup> Without clear key performance indicators for emergency surgery, longer patient suffering, poorer clinical outcomes, and the impact on hospital staff and bed use could neither be measured nor managed.

This is no longer acceptable. The demand for emergency surgery is highly predictable.<sup>2</sup> Some fifteen years ago, general surgeons, including those in New South Wales, argued that emergency surgery needed separate and equal access to consultant-supervised daytime theatres, and that only limb, organ, or life-saving operations should be performed overnight.<sup>3</sup> Unfortunately, their advocacy has not been translated into practice.

In this issue of the Journal, Blundell and colleagues report time to surgery for patients admitted to NSW hospitals with mild gallstone pancreatitis during the ten years preceding the COVID-19 pandemic.<sup>4</sup> A wealth of high quality, evidence-based studies have led to the recommendation that cholecystectomy be undertaken during index admissions,<sup>5</sup> but only 38% of NSW patients underwent index admission surgery,<sup>4</sup> well short of both best practice and NSW guideline standards.<sup>2</sup> Delayed cholecystectomy was associated with more frequent open procedures and gallstone-related re-admissions.<sup>4</sup> As in similar studies,<sup>5</sup> delayed theatre access was a major contributor to poor performance.

This delay in emergency theatre access reflects a much broader problem. Hip fracture and emergency laparotomy are



two time-sensitive emergency operations, and post-surgery mortality is higher than for the equivalent elective surgery.<sup>6,7</sup> Mortality following hip fracture increases when surgery is delayed beyond 48 hours,<sup>8</sup> but in Australia only 80% of patients underwent surgery within this period.<sup>6</sup> The most frequent single reason for delay was lack of theatre access (28% of cases), with a sixty-fold variation in access between hospitals.<sup>9</sup>

The 2021 Australian and New Zealand Emergency Laparotomy Audit found that among seriously ill patients, only 59.7% with a surgical urgency of within 18 hours or 23.6% of those with surgical urgency of within two hours underwent surgery within these windows, and that inter-hospital variation was considerable.<sup>10</sup> In England and Wales, the figures were, in contrast, 80.9% and 68.4% respectively.<sup>11</sup>

Elective surgery was restricted during parts of the COVID-19 pandemic. In Australia, waiting times for patients requiring emergency surgery during these periods were shorter, and they were more likely to undergo daytime surgery with direct consultant involvement.<sup>12</sup>

Taken together, these findings strongly suggest that theatre access for emergency surgery already fails to meet evidence-based best practice standards in Australia. Emergency surgery care should not be further compromised as the health system clears the elective surgery backlog.

Delaying elective surgery is not ideal, but a short delay is rarely life-threatening, even for Category 1 patients. This is not the case for emergency surgery; for patients with abdominal sepsis, mortality rises by at least 6% with each hour of delay.<sup>13</sup> Deferment of only a few hours will increase post-surgical mortality and the risk of poor outcomes, and extend the length of hospital stay, the primary driver of surgery-related costs.

Emergency surgery must have the same political priority as elective surgery. This will require hospitals holding surgical emergencies to the same performance standards as elective

surgery. Key performance indicators should be publicly reported for each hospital with the same rigor as for elective surgery,<sup>2</sup> including time to surgery, out-of-hours operations, length of stay, inpatient bed-days attributable to delayed theatre access, consultant presence, and index admission cholecystectomy. Public reporting would be entirely in keeping with the federal 2020–2030 national strategy for clinical quality registries.<sup>14</sup>

Much of the required information is already available in routinely collected hospital administrative data. For emergency surgery, critical outcomes are dependent on timely treatment; it would be straightforward to extract outcomes data and to promptly generate statistical process control charts in order to monitor and publicly report emergency surgery performance measures for benchmarking against evidence-based standards. Prioritising the reduction of elective surgery waiting lists after the COVID-19 pandemic must not be at the expense of timely emergency surgery care.

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