

Armen G. Aprikian,
MD, FRCSC

CUA Vice-President

Cite as: Aprikian AG. “When will I have my surgery?” *Can Urol Assoc J* 2020;14(12):371.
<http://dx.doi.org/10.5489/cuaj.7031>

My mother called me the other day, somewhat frustrated, asking when her knee surgery will get done. She had been listening to our Minister of Health, who was reassuring the population that those who need surgery will be able to have it. Needless to say, she was put on hold in the spring due to the pandemic. After explaining to her, with a crackling voice, all that has gone on in our hospital, and without being able to answer her question to her satisfaction, she asked, “How do we decide who gets to have surgery and who is asked to keep waiting?”

During the intense period of the pandemic this spring, elective surgery was pretty much non-existent. The acute phase of the pandemic forced a dramatic limitation to OR access, requiring a much more careful distribution of the very limited time available. Indeed, a complete overhaul of how OR time was distributed was immediately conducted, with great support and acceptance by all surgeons across all disciplines. OR time was distributed based on patient need and no longer by service/discipline or surgeon. This resulted in an extreme prioritization exercise within surgical departments, reviewing in advance which patients with semi-urgent surgical needs would be lucky enough to access the OR the following week. Surgical groups, including urology, quickly mobilized and created prioritization algorithms and guidelines to help departments be more objective in selecting patients for surgery. The historical and often times opaque and non-data-driven method of OR time distribution was justifiably discarded and a more transparent, yet ethically heart-wrenching process was initiated. Surgeon-equity became less important and patient need became paramount. Of course, most non-cancer or semi-urgent elective surgeries would not get done. Patients understood the reasoning behind this extreme reaction to the pandemic and the pressure was manageable during the first wave.

The second wave of COVID-19 is now progressing throughout the country. However, one major difference between the first and second waves is that the population is no longer sitting idle avoiding medical consultations. The pressure for medical attention from non-COVID illnesses is much greater, making it more difficult to ration the limited healthcare resources. During the spring, there was rallying support to prioritize access to healthcare, particularly in surgery, for those who needed it most, while patients who had to wait understood and complied for the greater good. This time around, this is not so straightforward, and we cannot expect the population to be as patient (no pun intended, just ask my mother!).

The traditional allocation of healthcare resources, including access to surgery, pre-pandemic was not very objective or transparent. OR time was distributed by surgical departments to services and services distributed to individual surgeons. In order to be fair, OR time was distributed with surgeons in mind, not necessarily patients. A fair process was seen to be in place if surgeon complaints were low. Although many of these issues existed for several years prior to the pandemic, the will to address them was not so great due to the many competing stakeholders involved. However, many of the processes put in place due to the pandemic are worthy of maintaining, even if it creates some surgeon inequity. The pandemic sparked the establishment of prioritization recommendations with surgeon buy-in. Once the pandemic passes, there is no reason not to keep following many of these recommendations. Since our public healthcare is already resource-constrained, we should not automatically revert to the pre-pandemic ways of allocating such resources and maintain the increased transparency created and the gains realized in patient-based prioritization.