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What's Important: Weathering the COVID-19 Crisis

Time for Leadership, Vigilance, and Unity

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On March 13, 2020, the President of the United States declared a national emergency in response to the coronavirus disease 2019 (COVID-19) caused by the novel SARS-CoV-2 virus[1]. This comes as the global community races to grapple with a pandemic that has so far claimed nearly 10,000 lives and continues to spread at alarming rates[2]. According to the World Health Organization (WHO), it took 3 months to reach the first 100,000 confirmed COVID-19 cases but only 12 days to reach the next 100,000 cases[2]. Within the United States, the Centers for Disease Control and Prevention (CDC) reported 10,442 confirmed or suspected COVID-19 cases spanning 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands as of March 19, 2020[3]. While multinational clinical trials are ongoing, there are currently no known medical treatments or vaccines available, and the focus has been on expediting diagnosis and slowing community transmission.

Given the differences in the impact of COVID-19 across our communities—with some deeply immersed in the catastrophic impact of the disease while others await their turn—it is no surprise that the pandemic has been met with variable responses by health-care systems, ranging from watchful waiting to more aggressive measures. In the midst of this unprecedented public health emergency, there is now, more than ever, a need to unify our approach. Our task is balancing the need to minimize community transmission, protect health-care personnel, and preserve resources while reaffirming a commitment to care for all patients.

Because of the severity of this health-care emergency, physicians of all specialties are urged to lead in the immediate initiation of emergency response plans, if those are not already in place. Although disruptive, such plans should include instituting a temporary suspension of all nonessential medical, dental, and surgical services. The goal is to preserve vital resources including staffing, personal protective equipment (PPE), ventilators, medications, and intensive care unit (ICU) beds. Hospitals, even those far away from the outbreak clusters or those not actively dealing with COVID-19 cases, are already running low on PPE as public anxiety and screening increase. There is also a concern about the ability of our health-care system to handle a potential spike in critically ill patients.

A temporary suspension of nonessential procedures is also critical to minimizing the risk of exposure for patients and health-care staff. Patients ≥65 years of age, and especially those with medical comorbidities such as immunodeficient states or pulmonary disorders, appear to be especially vulnerable to COVID-19-related complications and death. To aid in the determination of surgical necessity, the Centers for Medicare & Medicaid Services (CMS) has published a tiered approach based on the acuity of the condition and geographic prevalence of COVID-19[4]. Under this guidance, surgeons are encouraged to postpone all procedures with low or intermediate acuity and those performed at ambulatory surgery centers or hospital outpatient departments. High-acuity procedures should not be postponed regardless of the COVID-19 status.

In an effort to minimize the risk of community transmission of COVID-19 while continuing to provide uninterrupted care for patients, telehealth is stepping into the spotlight. Whenever possible, practices are encouraged to utilize patient portals, the telephone, digital platforms, and video conferencing as alternatives to face-to-face visits. Telehealth can be used as an adjunct to telephone calls in scenarios such as triaging new problems, monitoring postoperative patients, providing treatment recommendations, and

delivering routine care for patients with chronic diseases. This is especially useful for vulnerable patients or quarantined patients, who can be monitored remotely. Unfortunately, most practices are currently not equipped to deliver care this way and there are concerns regarding HIPAA (Health Insurance Portability and Accountability Act) violations. To facilitate those obstacles, the Office for Civil Rights at the U.S. Department of Health and Human Services announced on March 17, 2020, that it "will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency."[5] This allows physicians to use popular applications, such as FaceTime, Skype, and WhatsApp. However, physicians should refrain from using non-private streaming applications (e.g., Facebook Live) that are broadcast to the public. Physicians are also encouraged to discuss the potential privacy risks with patients before using third-party applications. It is likely that, when the COVID-19 crisis is over, telehealth will emerge as a sustainable tool as hospitals and providers learn to use it.

Not since the influenza pandemic of 1918 has the medical community been faced with a health challenge so great. This is an extraordinary event that requires physician leadership and a unified focus. Routine services must be temporarily suspended in all medical care settings. This approach is not based on fear but rather on resilience, and reflections on lessons being learned around the world. We must be prepared for the potential surge of patients with life-threatening respiratory infections and address expected shortages of medical personnel, PPE, medications, hospital beds, respirators, and other resources needed to care for the critically ill. We should also focus on supporting our medical colleagues who may require additional health-care personnel to fight the COVID-19 pandemic. The suspension of routine workflow is understandably disruptive and a financial sacrifice. Physicians in all parts of the United States are not just losing income but they are actively hemorrhaging money, particularly private practices that continue to pay their support staff at a time when many offices are effectively closed. These may be easy decisions in areas already impacted by the virus, but they are tough decisions in areas that are not yet affected.

We should be unified in our approach and work collaboratively with our peers to ensure the timely and responsible development and initiation of policies. The COVID-19 pandemic will undoubtedly change our ways of life for many years to come. Once this crisis passes, and it will, every human being will have endured the effects of this pandemic, either directly or indirectly. Let this be the time for leadership, resilience, vigilance, and common resolve.

References

1. Centers for Disease Control and Prevention. Interim guidance for healthcare facilities: preparing for community transmission of COVID-19 in the United States. Accessed 2020 Mar 24. https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html
2. World Health Organization. Coronavirus disease 2019 (COVID-19) situation report – 59. 2020 Mar 19. Accessed 2020 Mar 24. https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200319-sitrep-59-covid-19.pdf?sfvrsn=c3dcdef9_2
3. Centers for Disease Control and Prevention. Coronavirus disease 2019 (COVID-19): cases in U.S. Accessed 2020 Mar 19. https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html
4. Centers for Medicare & Medicaid Services. CMS adult elective surgery and procedures recommendations: limit all non-essential planned surgeries and procedures, including dental, until further notice. 2020 Mar 18. Accessed 2020 Mar 24. https://www.cms.gov/files/document/31820-cms-adult-elective-surgery-and-procedures-recommendations.pdf
5. U.S. Department of Health and Human Services. Notification of enforcement discretion for telehealth remote communications during the COVID-19 nationwide public health emergency. Accessed 2020 Mar 18. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html