Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Invited Commentary

An invited commentary on “The Surgeon and the COVID-19 pandemic”

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This perspective from experienced surgeons working in the USA and Italy will mirror conversations being held in theatres, healthcare offices and surgical management meetings across the world. Major incidents usually require a surgical response; Warfare, natural disasters, terrorist attacks and major transport incidents see us take on pivotal roles. This has not been the case during the current pandemic, we have largely been bystanders, playing a supporting role. COVID-19 has forced the focus to be on emergency and intensive care, with surgeons being essentially furloughed, re-deployed or limited to emergency care provision. The surgical challenges to this point have been relatively straightforward – cancelling almost all elective activity, telemedicine clinics, moth-balling endoscopy services, emergency surgical cases being open (rather than laparoscopic), consultant delivered and only when a conservative alternative does not exist [1,2].

Much of this perspective looks at the challenges of re-establishing elective surgical services. A recognition that surgical specialties differ is important and a blanket policy cannot apply. Some are suited to telemedicine initiatives and others are not. Support services vary - many use predominantly non-interventional investigations whilst others require more invasive modalities such as angiography and endoscopy. Some specialties practice predominantly open surgery whilst others are more suited to laparoscopic, radiological or robotic approaches. Surgical leaders nationally and locally will need to embrace these challenges, work closely with healthcare managers and give clear guidance, whilst still allowing for a degree of flexibility. This is a pandemic and countries, regions, and hospitals will continue to differ in their response. Re-establishing elective activity will correctly focus on cancer patients already on delayed pathways. There are many other patients without cancer who also require urgent or life-saving operations and these must also be factored in. The pandemic has driven much of the public to alter their healthcare seeking behaviour and many will potentially seek alternative access or present with more advanced diseases. Most countries have seen reduced emergency patient activity during the pandemic and a rebound surge in demand is likely as work, travel and sport resume. It may therefore be prudent to retain some additional short-term emergency care capacity alongside re-establishing the elective service [3].

The authors have highlighted additional challenges faced by surgical trainees across the world. Most will have had their training ‘on hold’ and struggled with poorly defined roles during this crisis. Procedures providing opportunities to learn and develop have either disappeared, been managed conservatively or resulted in exclusion where consultant operating is the rule. Clinics and endoscopy opportunities have also essentially ceased. The resumption of some elective activity does not assume a return to normality and for some surgeons, a period of extended training seems inevitable.

Thanks go to Roberto Verzaro and Seigo Nishida for this insightful perspective [4]. Articles on COVID-19 will undoubtedly fill surgical journals for some time. Surgeons and managers will plan carefully for surgical services to resume but need to factor in a significant degree of uncertainty. With time, the full effects of COVID-19, future possible spikes of the disease and vaccine development will become evident.

AUTHOR CONTRIBUTION

Ehsanul Choudhury and Simon Wakefield both wrote this commentary after discussion and review of Verzaro R, Nishida S. The Surgeon and the COVID-19 pandemic. Int J Surg 2020;78:160-161.

PROVENANCE AND PEER REVIEW

invited commentary, internally reviewed.

DECLARATION OF COMPETING INTEREST

No conflict of interest

REFERENCES

[1] Royal College of Surgeons of England, Updated intercollegiate general surgery guidance on COVID-19, Available at: https://www.rcseng.ac.uk/coronavirus/joint-guidance-for-surgeons-v2/April 2020, Accessed date: 9 May 2020.
[2] American College of Surgeons, Surgical care and Coronavirus disease 2019 (COVID-19)
19), https://www.facs.org/about-acr/covid-19/information-for-surgeons April 2020, Accessed date: 10 May 2020.

[3] Royal College of Surgeons in Edinburgh, Second phase of NHS response to COVID-19, https://www.rcsed.ac.uk/professional-support-development-resources/covid-19-resources April 2020, Accessed date: 10 May 2020.

[4] R. Verzaro, S. Nishida, The Surgeon and the COVID-19 pandemic, Int. J. Surg. 78 (2020) 160–161, https://doi.org/10.1016/j.ijsu.2020.05.001.

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