



COVID-19, Here to Stay! What Do Orthopaedic Surgeons and Their Patients Do Now?

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The COVID-19 pandemic struck orthopaedic surgeons and their patients, among others, almost two years ago. We have previously explored the possible effect of a prolonged lay-off from elective surgical procedures on the technical skills of orthopaedic surgeons and team members during the 2020 shutdown.¹ The pandemic has seemingly caused permanent changes in physician-patient interactions, with mask wearing on both sides, lack of handshakes and hugs, and video visits without manual examination.² The authors enthusiastically embraced early hospital-based vaccination in December 2020, January 2021, and “boosters” in September 2021. We strongly encouraged vaccination for our patients, co-workers and colleagues, especially those who desired to attend in-person orthopaedic educational meetings and courses.³ At the same time, we were the first, to our knowledge, to call on the AAOS to require proof of vaccination to attend the annual meeting in August 2021, and the same for the specialty societies in the autumn months of 2021.³

Where are we now? Vaccination of the entire population is incomplete. Vaccination does not seem to completely prevent illness or the unrelenting spread of the virus. We have been asked to return to routine use of N-95 masks, rather than other paper or cloth varieties. One of us believes that this pandemic has introduced permanent changes to orthopaedic practice and patient interactions. The other believes that “things” will return to normal, and we will be better prepared for the next pandemic. Surgeons seem to have returned to in-person educational meetings, but with lower numbers of attendees. Virtual grand rounds seem here to stay.

COVID-19, like arthritis, fractures, and soft tissue injuries, is now a routine part of our professional and personal lives. Other viral infections, like influenza, hepatitis, and HIV may require hospitalization but now rarely cause death. It is believed that our country has come a long way with vaccines and therapeutic medication. The physical and emotional trauma inflicted by COVID-19 – including lockdowns, quarantines, isolation, masking and testing anxiety – is a nearly two-year horror show for which the world was not prepared.

Poliomyelitis was an incredibly scary viral disease from 1916 through the 1950s. One of us recalls the iron lung machine and children in braces! A relative developed hemiparesis from the disease. “My mother was afraid to let my sister and me go to school fearing we would contract the poliovirus.” Polio affected both young children and adults, with a case fatality rate of 2–5% in children, and 15–30% in adults.⁴ However, the use of three scheduled doses of the Salk inactivated polio vaccine was 99–100% effective, even more effective than the measles vaccine. The poliomyelitis virus was “conquered” with mass vaccination.

COVID-19 is not poliomyelitis. It does not cause paralysis. COVID-19 can cause serious cardio-pulmonary problems and death in the elderly, and those with significant comorbidities, like diabetes, morbid obesity, and immunosuppressive conditions. Most healthy individuals and the vaccinated are seemingly, but not always, protected from severe disease. Because of viral mutation, there are breakthrough infections despite immunization. The Omicron variant appears more infectious but less virulent than the Delta variant, perhaps giving hope that this virus is weakening. American society is hoping for herd immunity. Perhaps Sars-CoV-2 will become no greater a threat than the other four endemic Sars viruses with which we co-exist?

Education is clearly the key to living with COVID-19 and its presently endemic variant. Testing our patients and team members remains important. Orthopaedic surgeons, physician assistants, nurses, and their patients are likely going to wear surgical masks in the office and hospital for the foreseeable future. We are likely to continue elbow or fist bumping, rather than the old handshake. However, the clinics and operating room schedules should not be shut down again in vain attempt to “lock down” this virus. Patients need to be seen and treated despite COVID-19 infections. However, staffing shortages may instead limit the number of patients seen and operative cases performed in both the hospital and ambulatory surgery centers. Oral antiviral medication should be widely available for both staff and patients. Natural immunity will hopefully develop over time, and COVID-19 may someday be considered in the same category as the common cold – annoying but treatable. For now, however, this virus is here to stay. Lockdowns to achieve zero infection will never be effective or acceptable in our modern society. Americans are hearty and resilient, and hopefully the present apparent hysteria in the media will subside.

In recent weeks, mask mandates are changing and restricted access varies by region – often based on risk, but sometimes on politics. However, masks do reduce transmission of viruses, and it is important to respect those who wish to have added protection. The emotional and social damage of the disease and isolation is real and, for some, may be unrecoverable. Limiting commerce and medical care disrupts “elective” medical and surgical procedures often with long-term untoward consequences, impacts the economy negatively, limits care to those with other diseases and may affect the overall immediate and late physical and mental health of many. Dying *with* COVID-19 is quite different than dying *because of* COVID-19. Real numbers and perspective are crucial. Orthopaedic surgeons should seek accurate data and properly interpret it for our patients and community. Health care policy must be data and science driven!

References

1. Schultz RA, Lachiewicz PF. What's important: Is spring training necessary for surgeons after a long COVID-19 off season? *J Bone Joint Surg* 2020;102:1291.
2. Schultz RA, Lachiewicz PF. What will never be the same for surgeons after the COVID-19 pandemic? *AAOS NOW*. May 12, 2020.
3. Schultz RA, Lachiewicz PF. What's important: COVID-19 vaccination at last. *J Bone Joint Surg* 2021;103:461.
4. Hamborsky J, Kroger A, eds. Poliomyelitis. *Epidemiology and Prevention of Vaccine-Preventable Diseases (The Pink Book)* (13th ed.). Washington, DC; Public Health Foundation, 2015. Archived from the original on Dec 2016.
5. Jonas H, Jonung L, Hanke SH. A Literature Review and Meta-analysis of the Effects of Lockdowns on Covid-19 Mortality, *Studies in Applied Economics*, No. 200. Johns Hopkins; Baltimore, MD: 2022. Available at <https://sites.krieger.jhu.edu/iae/files/2022/01/A-Literature-Review-and-Meta-Analysis-of-the-Effects-of-Lockdowns-on-COVID-19-Mortality.pdf>. Last accessed on March 22, 2022.