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15 December 2023

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Covid enquiry submission

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I think that as Victoria had the longest lockdowns of all the states we are in a unique position to detail aspects of eye care that went well during the pandemic and areas that did not and could be improved when the next pandemic occurs.

As we went into lockdown I communicated with colleagues at Moorfield's Eye Hospital in London for guidance, who at that stage were weeks ahead of us into the pandemic. Our unit members also sought guidance from the American Society of Retinal Specialists and the American Academy of Ophthalmology, both of whom were publishing guidelines for care of eye patients during a viral pandemic. We used this advice to plan our own approach.

Following the advice from the United Kingdom and the USA, we split our team and had an increased number of rotations through operating lists. The consensus was that the highest risk for infection for health care workers from patients was in the outpatient clinic.
A split team meant the entire unit would not need to isolate if one team was exposed. By increasing rotation through theatre lists, one member of the team was always in theatre during clinic, hence also sparing that person to continue working should a clinic exposure cause all of the clinic team to isolate. **For the future this is a straight forward rostering change that can implemented quickly.**

As per DH guidelines only Category One patients were planned for theatre. Guidelines for this categorization were utilised however our unit maintained dicretion over which cases fulfilled those criteria. **I think that it is very important for clinicians to prioritize surgical conditions to reduce blinding outcomes** – this was not the case in the UK. I am aware that conditions that we classified as category one in Australia did not receive surgery in the UK, resulting in poor outcomes and ongoing issues for those patients in the UK.

As we commenced lockdown it became apparent that the hospital did not have enough PPE, in particular N95 masks. Our hospital engineers rapidly installed slit lamp shields, as previously we did not have protective shields on slit lamps nor did we wear masks when examining patients in the outpatient clinic. [redacted] is a unique specialty as we are not only front line doctors but due to the nature of the slit lamp microscopic examination, we needed to be in very close facial proximity (often cms away) to patients for often prolonged periods of time which increased our airborne transmission risk.

For the future, the provision of adequate PPE is vital and I think this needs to be manufactured in Australia to ensure supply. Every health care worker should be fit tested and hence know their appropriate mask. I was not able to be fit tested until after the second wave in Victoria due to the limited availability of fit-testing spots.

During the numerous lockdowns in Victoria we reinstituted the measures detailed above and continued with urgent surgery. I think it is important to acknowledge that with the measures introduced by DH / the RVEEH eg. screening questions, RAT and PCR testing surgery could continue, particularly as we did not have inpatients with Covid.
Most of our eye surgery is day case surgery performed under local anaesthetic and this is lower risk for the anaesthetic / theatre staff than patients undergoing general anaesthetic. **Deferring semi-urgent and elective cases has resulted in compromised patient outcomes and has created an ongoing service delivery challenge that will impact the Health Service for the forseeable future.** Continuing with as much semi elective and elective surgery as possible reduces the burden of overdue elective surgery that we are now facing. This could have been scaled up once vaccination for health care workers was available. In particular this could continue in hospitals / day surgery units that do not have inpatients with Covid or a future viral disease.

Vitrectomy surgery had been identified as a potential aerosol generating procedure so we conducted a study which refuted, this both in the lab and in theatre.[1]

Telehealth was encouraged during the pandemic however we found this is not helpful for patients with eye disease. We instituted week one phone reviews post surgery however we have now ceased this as post operative problems were missed and we were not providing the standard of care that we believe should be provided.

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[1] Okada M, Sousa DC, Fabinyi DCA, Hadoux X, Edwards TL, Brown KD, Chiu D, Dawkins RCH, Allen PJ, Yeoh J, van Wijngaarden P. Vitrectomy as an Aerosol-Generating Procedure in the Time of COVID-19: The VAPOR Study. Ophthalmol Retina. 2021 Jan;5(1):97-99. doi: 10.1016/j.oret.2020.07.023. Epub 2020 Jul 30. PMID: 32739608; PMCID: PMC7391065.

Our greatest failure was in the monitoring and screening of diabetic patients, in particular insulin dependent diabetics. In our haste to protect them from being infected with Covid, knowing that diabetes was a risk factor for severe disease, we did not institute better care and many were neglected for 3 years. We are now facing exponential numbers of patients with end stage diabetic eye disease and blindness. This is a very depressing situation, particularly as there are many treatment options for diabetic retinopathy when it is detected early but is now too late.

I believe that the causes are multifactorial.

1) Telehealth management of general diabetic care is not optimal.
2) Some diabetics didn't even receive telehealth calls.
3) Screening for diabetic eye disease conducted by optometrists ceased due to closure of optometry practices.
4) Diabetic eye disease progresses silently until it is advanced and so patients are not aware until visual loss has occurred.
5) Most people exercised less during the lockdowns and very many people report weight gain due to this.
6) Stress often leads to "comfort eating".

There have been articles in the press about diabetic renal disease and peripheral vascular disease which have also increased so this is not only an eye problem but a diabetic complications problem.

For the future we need to prioritize care and screening of diabetic patients in a fashion that can make them confident to be seen safely face to face and communicate to all our patients with diabetes the importance of ongoing care to prevent complications. Screening with comprehensive imaging could be very useful in this setting and could minimise face to face examination.

I would like to conclude by emphasising that with appropriate PPE, good infection control habits and Covid screening ophthalmologists can continue to work face to face providing eye care and treating blinding diseases. If I knew at the start of 2020 what I now know, I believe that we could have provided better care for the people of Victoria.

Your sincerely