Editorial: COVID-19 Impact on Australian Orthoptic Clinical Practice

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Many would agree that compared to other countries, Australia has been labelled a pandemic success story. Our nation of 26 million has largely been willing to follow public health directions and our governments in general have allowed science to guide policy. By November 2020 and for the first time in almost 300 days, Victoria recorded zero active COVID-19 cases after its deadly second wave.[1] Since then, Australia continues to experience small outbreaks that have been managed effectively with public health measures, snap lockdowns and border closures.

When the World Health Organization declared the COVID-19 outbreak a pandemic in March 2020,[2] it was a very different story. Australia watched the rest of the world as several countries struggled to deal with the overwhelming number of cases. As cases increased in Australia, uncertainty fuelled anxiety amongst health care workers (HCWs). It was an unsettling time as reports of the growing number of infections in Europe flooded the news and early reports emerged in the ophthalmology space of evidence of SARS-CoV-2 on the ocular surface.[3,4]

The Australian Government responded rapidly to stay on top of the pandemic. By mid-March, the National Cabinet introduced widespread measures to protect the public including restrictions on social gatherings, physical distancing and contact tracing. In further steps, states and territories announced border closures and mandatory 14-day quarantine for travellers entering their jurisdictions.[5] Border closures impacted eye care service delivery in our cross-border towns, as well as the vital care needed for our regional and remote patients.[6]

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On March 25th, the National Cabinet acted on the advice of the Australian Health Protection Principal Committee to temporarily suspend all non-urgent elective surgery.[7,8] By cancelling surgeries, the National Cabinet acted to preserve vital reserves of medicines and important hospital resources, including personal protective equipment (PPE), to help prepare public and private health services for their role in the COVID-19 outbreak. There was common belief amongst governments and key peak bodies that a consistent national approach, which prioritised the health, safety and wellbeing of all patients and healthcare workers was necessary.

Cancellation of elective surgeries created a significant flow-on effect for orthoptists in clinical practice. Cataract is the second highest cause of vision impairment for both indigenous and non-indigenous older Australians and cataract surgery is the most common surgery performed by ophthalmologists.[9] In 2019 alone, Medicare reported that over 160,000 cataract surgeries were performed.[10] In general practice, much of our daily orthoptic clinical practice involves the assessment, diagnosis and care of pre- and post-operative cataract patients. Suddenly private ophthalmology and outpatient clinics were unusually quiet with exception of phones ringing and frequent exchanges regarding surgery cancellations and appointment rescheduling.

Whilst some public hospitals were slow to implement changes in ophthalmology outpatient settings, many private ophthalmology practices swiftly installed perspex screens at reception, sourced breath shields for diagnostic testing equipment and began the process of procuring rapidly dwindling sources of PPE and disinfecting products. The overwhelming volume of information from numerous sources highlighted the need to establish a 'single source of truth' for orthoptists to avoid confusion and misinformation. Orthoptists employed in the public health system adhered to state health department and hospital directives, but many in private ophthalmology practices relied on trickled down information from employers, practice managers or the Royal Australian and New Zealand College of Ophthalmologists (RANZCO).

Initially inconsistencies were seen in PPE guidelines across federal and state health departments as the debate about

the mode of transmission for COVID-19 continued and data was less clear around eye protection.[11] At the time there were also no nationally approved infection prevention and control (IPC) guidelines for allied health practice, and these were later developed by Allied Health Professions Australia in consultation with Orthoptics Australia for the Department of Health.[12] To seek clarification on specific IPC matters, Orthoptics Australia (OA) and Optometry Australia sought external advice from an infection control expert as there were still many unanswered questions and ambiguities about best practice for disinfection of some semi-critical devices such as applanation tonometer tips and how to safely perform visual fields in small rooms without adequate ventilation.

The disruptions to clinical practice continued on March 30th, when RANZCO introduced triaging guidelines for Fellows and other health professionals.[13] The guidelines intended to help preserve limited PPE, reduce movement of people and to help protect staff, patients and the wider community. However, the guidelines were prescriptive and left little to ophthalmologist or orthoptist discretion, often raised more questions, failed to address individual patient preferences and did not cater for our patients with low vision and blindness. The challenges were numerous as many orthoptists were tasked with triaging patient bookings and referrals. Many were tasked with triaging many hundreds of appointments.

There were added complexities with inconsistencies amongst ophthalmologists around criteria determining which patients fell into medium urgency categories and assumptions about who could manage telehealth consultations. It also did not take into consideration subjective levels of risk appetite across institutions, practices, ophthalmologists, orthoptists, staff and patients.

In order to continue vital care to many patients, the Federal Health Minister, Greg Hunt, announced the telehealth expansion to fight COVID-19.[14] As of March 30th, patients were able to access allied health practitioners via telehealth for bulk-billed services under existing Medicare items. However, Professor Michael Kidd, Principal Medical Advisor to the Department of Health, later announced that additional telehealth services applied to existing MBS item numbers only and there would be no expansion, despite the Prime Minister using wording such as 'universal access'.

Telehealth was widely promoted, however funding for allied health telehealth services including the provision of orthoptic services via telehealth was not adequately addressed. Orthoptics Australia, like many other allied health peak bodies at the time, sought assistance from organisations like Allied Health Professions Australia and Private Healthcare Australia to lobby private insurers, NDIS and DVA to ensure patients had access to orthoptic services via telehealth.

Much of the existing digital infrastructure systems at the time were not set up adequately for telehealth consultations and many of the platforms used were not optimised for virtual consultations. There were very few established guidelines on telehealth apart from in areas such as rural health for GPs and Orthoptics Australia along with other organisations needed to develop guidelines and gather resources to assist members.[15,16] Several allied health professions including orthoptists struggled with how to accurately or adequately assess patients via telehealth. In early 2020, very few Apps for testing visual acuity had been rigorously tested for use in telehealth and not many were practical or accurate in paediatric patients and for those with low vision and blindness.

By May 15th, minor easing of restrictions occurred, but the impact of the pandemic on orthoptists became a focus for OA. Some public hospital-employed orthoptists had been re-deployed into other non-clinical roles within the department or to roles within the other hospital departments. Quieter private clinics meant sessional or locum orthoptists had work hours reduced and sessions cancelled. Others were isolated from colleagues and friends working from home. OA together with the UTS Discipline of Orthoptics and in collaboration with the University of Liverpool undertook a survey to investigate the ongoing impact of the COVID-19 pandemic on orthoptic work and practice. There was a drive to capture timely information and the potential to share emerging innovative practice, not only within the orthoptic profession, but with other professions and health settings also. There was also a shared desire to consider the pressures on eye health care professionals and coping mechanisms under trying conditions.

Breaches in Victorian hotel quarantine in late May set off Victoria's deadly second wave and by August 2nd, the Premier had declared a state of disaster. More than 3,500 healthcare workers were infected during the second wave and many public hospitals in Victoria were severely impacted with HCWs off work, either sick or furloughed.[17] Orthoptists continued to be at risk of infection due to the nature of eye examinations and the proximity to the patient's face and the demographics of the patients in practice.

In 2020, the pandemic significantly altered orthoptic clinical practice. Today many COVID-19 protocols remain embedded in routine clinical practice. Infection prevention and control practices under pandemic conditions are better understood and innovations in telehealth and other digital technologies have accelerated changes in eye health care. Until the COVID-19 vaccine rollout is completed in Australia, many of the changes we see today will remain in place well into 2021.

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