Canadian Journal of Surgery | Journal canadien de chirurgie

Wait times: the appropriateness of the methodology and how they affect patients

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This issue of the *Canadian Journal of Surgery* (*CJS*) includes 2 articles on a common theme: waiting for surgery.[1,2] They complement others recently published in *CJS*, including an article on prioritizing patients waiting for hip and knee arthroplasty.[3]

Written by Shortt and colleagues,[1] the first of these 3 articles would imply that waiting periods are a standard feature of surgical care in Canada today and can be reasonably assessed by use of an administrative database. I have to here declare my interest, as I was one of the thesis supervisors for coauthor David Elliott when he first examined this possibility using the databases available to him in Nova Scotia. This gave me intimate knowledge of the problems involved in his study and its subsequent application.

Its fundamental flaw is that his study was based on historical data. Subsequent events have rendered its principal tenet, that the patient is most likely to be booked for surgery on his or her last visit, inoperative. If the other factors affecting patient consultations remained constant, his results might still apply. However, often patients deteriorate while they wait, and return for reassessments and alternative treatments such as injections.

The possibility of simple solutions to complex problems has been discussed with respect to wait lists in other areas. Two papers discussing wait lists for cardiac surgery are each worth reading. Hill[4] proposed a simple mathematical analysis, irrespective of case urgency, incorporating applicable death rates while waiting. The argument proposed was that an increase in death rates in any group would result in a higher priority for those individuals. Naylor and associates' critique[5] of Hill's paper made it plain that a simplistic mathematical model cannot work for cardiac care.

Our experience as surgeons would suggest that there are no constants in these equations and that only data collected prospectively can clearly demonstrate actual wait times and their effects on the treatment of patients. A recent assessment of waiting time for lower-limb joint arthroplasty and arthroscopy by Dunbar and colleagues[6] used prospectively gathered data. This pilot project revealed that a reduction in resources (beds and operating room time) directly affected the wait list: for every 1 person taken off the list, 2 were added.

The second paper in this issue of *CJS*, by Miller,[2] looks at the wait for surgery from the point of view of parents, in a relatively select population of families of pediatric patients

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booked for elective, non-urgent surgery. It is obvious that after a while waiting becomes a burden to the child and the family, although no data were presented demonstrating poorer outcomes because of the wait.

Both papers beggar such questions as why we have wait lists, the degree to which they are useful, whether they should continue and how we should manage them.

The essential trouble with wait lists is that they are convenient — to the surgeon who demonstrates prowess by attracting so many patients, to hospitals that can argue for more resources, and to provincial governments who can argue for more resources to be transferred from the federal government. What is not happening is a more in-depth examination of the utility and effectiveness of current resources and funding in dealing with the current patient population load. A lot of this is secondary to the global budgeting taking place at most hospitals, leaving the allocation of resources as an institutional responsibility and not a provincial one. Choices must be made, and sometimes they are difficult to explain to our patients. How does one justify supporting a chemotherapy budget of $1.5-million for a single drug when only 25% of treated patients will benefit by living 3 extra months? At the same institution patients are denied an operation that costs $8000, the beneficial effects of which are likely to last for 10 years or more.

The debate over the allocation of scarce resources has to come out of the closed meeting room and be put into the public forum. It is patently obvious that available monies will never be enough to meet all demands for health care, and that rationalization of resource allocation is necessary to obtain the best outcomes possible with that money. This debate has to take place at the national professional level. We must first put our own surgical houses in order.

An independent examination of how operating-room resources are allocated may not leave the profession looking any handsomer than the institutions. Traditionally we have divided scarce resources according to the needs of individual surgeons rather than those of patients. In my hospital patients can obtain privately paid-for plastic surgery while cancer treatments in another surgical specialty are cancelled for lack of resources. This is inappropriate professional surgical behaviour, and as such we are our own worst enemies.

The pressure to perform more procedures is not led nowadays by underemployed surgeons, but by aging baby-boomers. We, the custodians of patients' surgical expectations, must recognize our professional obligations to improve access to surgical services in a timely fashion. How do we do that?

Our first requirement is to make environments far more effective with respect to outcomes and efficiencies. A paper by Kehlet and Wilmore[7] is well worth reading by all those in managerial and leadership positions. It lays out how we can improve outcomes through a comprehensive review and implementation of the best practices available today. It clearly supports the need for buy-in from the colleagues and coworkers that control all aspects of surgical care.[8]

At a national level, our professional organizations must instigate methodologies to collect all pertinent data on patient outcomes, whether on a waiting list or after surgical treatment. This may appear to be a Herculean task, but there are now examples enough to demonstrate not only the utility of the data in asking for and obtaining more resources but also the outcome improvement that comes when participating surgeons know that they will be able to compare outcomes from their work to a national standard.[9] National registries that obtain real-time information in given areas are increasing in number. They are relatively expensive, but less so than clinical trials, the object of which is to focus on one question that the proponents feel is most likely to change clinical practice. As clinical practice is multifocal in its entirety, a national registry may better reflect the changes that occur over time and provide positive feedback for those that provide the data.

We also need to involve the public, both to educate them about the relative need for, prioritization of and effects of wait lists and to find out their main concerns. Data on the effect of waiting periods on the health of children wait-listed for surgery in the paper by Miller[2] are soft, but he did find that 37% of the children were unable to participate in their normal activities because of the underlying condition. Wright and coauthors[10] have shown that common procedures do not necessarily result in notable improvement of the patient's condition; indeed, when patient-oriented outcome evaluations before and after surgery were used, some patients were found to be worse off. A resources-oriented system would look closely at continued support of those surgical procedures; it may be that operative procedures showing effectiveness according to standardized outcome measures would receive more resources than those that do not.

One might assume that patient expectations are capable of change with respect to wait lists, but pain is one of the more powerful driving forces that influences patients to request surgical treatment; keeping patients who are in pain waiting for many months should be perceived and acknowledged to be cruel treatment.[11]

The last requirement is addressed to government. The issue of equality in access as a pillar of the Canadian health care system has diverted us away from examining whether that system is worth waiting for. In reality that the government has no routine measure of the effectiveness of the current monopolistic hospital system, and so has no yardstick for comparing other methodologies.

It is an absolute that health care is a political issue; it is not an absolute

that political bodies should have overwhelming control of the delivery of health care. We need to educate the public that the health care dollar may be better spent away from the large institutions that currently provide the only service in town. In the United Kingdom the inability of large hospitals to respond to increasing demands for common procedures (such as joint arthroplasty) is now being recognized, and so small specialized centres are being set up to reduce wait lists.

Wait lists are becoming an indictment of the current administration of our health care. We as surgeons should lead the way in organizing and presenting validated data to document waiting lists and the effects that they have on patients' health. We have to regain the public's trust in our abilities to deliver the health care that they need.

Competing interests: None declared.

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