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Improving waiting times for surgery

I would presume that everyone who provides surgical care in Canada is aware of the problems posed by restricted resources for surgical services. I have written previous editorials on the subject detailing the problems and outlining some of the solutions proposed to address the consequences of diminished surgical resources.

It was widely recognized by health ministries across the country that waiting times for certain surgical services such as cataract extraction, cancer surgery and hip- and knee-replacement surgeries were becoming unacceptably long, and concrete measures were undertaken in a number of provinces to specifically target waiting times for these procedures.

Hip- and knee-replacement surgeries are good models for this type of intervention. The procedures are purely elective; the costs for providing them are well known and the number of surgeons performing these procedures is substantial. Thus provinces or health regions are able to develop models that could increase surgical volumes with minimal disruption to care in other areas.

A variety of models have been developed that have been used with considerable effect, as evidenced by increasing volumes of hip- and knee-replacement surgeries in the jurisdictions that have adopted a different approach to care delivery.

These models have a number of common features that could be adopted for surgical care in areas other than hip and knee arthritis. The first is a central registry of patients waiting for the procedure in question. This avoids duplication of patients on different surgeons' waiting lists and allows tracking of patients from the original request for consultation to the consultation itself and finally to the surgical procedure. Setting guidelines for waiting times and tracking the time that lapses between the initial referral and the surgery has resulted in a significant improvement in these waiting times.

The second feature relates to the patient's in-hospital experience. Establishing uniform presurgical education for the patient and care pathways that provide uniformity in interventions such as physical therapy, drug therapy and performance goals, provides patients with a much better understanding of what to expect during and after the surgery. Involving patients and their families in discharge planning before they are admitted to hospital has also been crucial to decreasing the length of stay for patients in the acute care setting.

Finally, increased in-hospital efficiency of care delivery has been essential in increasing the volume of joint-replacement surgery. This has been achieved in a variety of ways, including additional operating room time for hip- and knee-replacement surgeries, improved change-over times in the operating room between patients and the performance of a minimum number of procedures in each 8-hour day.

Bringing all of these disparate initiatives together is no easy task and involves a cooperative effort among referring physicians, surgeons, anesthesiologists, nurses, physical therapists, x-ray technologists, hospital administrators, governments — the list is long and complex. However, a number of jurisdictions have established such coordinated programs, and the decreasing waiting times for surgery have demonstrated their success.

One of the major concerns expressed by individuals who do not work in joint-replacement surgery was the possibility that increasing the resources available for these procedures would substantially decrease those for other orthopedic procedures and that surgical volumes outside of hip- and knee-replacement surgery would decline. A review of the data in Ontario by the Ministry of Health and Long-Term Care has not demonstrated this phenomenon. Over the last 2 years, the volume of hip- and knee-replacement surgeries has increased by almost one-third; the waiting time for these procedures across the province decreased by half, yet the volume of non–joint-replacement orthopedic procedures increased by about 6% per year.

Although I am writing about hip- and knee-replacement surgeries because of my knowledge and interest in these procedures, particularly in the province of Ontario, I know other parts of the country have experienced similar success with this type of integrated program. It is time that surgeons examine this type of improved care delivery for all types of surgical intervention and work with their nonsurgical colleagues in their hospitals and health regions to try and develop similar programs to address excessive waiting times in their areas of specialization.

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L'amélioration des temps d'attente en chirurgie

Je suppose que tous les fournisseurs de soins chirurgicaux au Canada connaissent les problèmes posés par la restriction des ressources attribuées aux services chirurgicaux. J'ai déjà rédigé des éditoriaux sur la question où je décrivais en détail les problèmes et certaines des solutions proposées pour contrer les conséquences de ces compressions.

Partout au Canada, les ministères de la Santé ont reconnu que les temps d'attente pour certains services chirurgicaux comme la chirurgie de la cataracte, la chirurgie du cancer et l'arthroplastie de la hanche et du genou devenaient inacceptables, et de nombreuses provinces ont pris des mesures concrètes afin de s'attaquer spécifiquement aux temps d'attente pour ces interventions.

De telles mesures s'appliquent particulièrement bien à l'arthroplastie de la hanche et du genou. En effet, les interventions sont purement électives, les coûts sont bien connus et beaucoup de chirurgiens les pratiquent. Il est donc possible pour les provinces ou les régions de santé de créer des modèles pour accroître le volume des interventions chirurgicales en perturbant très peu les soins dans d'autres domaines.

On a ainsi proposé divers modèles qui ont eu un effet important, comme en témoignent les volumes à la hausse des arthroplasties de la hanche et du genou dans les administrations qui ont modifié leur stratégie de prestation des soins.

Les modèles en question ont de nombreux traits communs que l'on pourrait adapter aux soins chirurgicaux dans d'autres domaines. Il y a d'abord un registre central des patients en attente d'intervention, ce qui évite l'inscription en double de patients sur les listes d'attente de différents chirurgiens et permet de suivre les patients depuis la demande initiale de consultation jusqu'à la consultation et à l'intervention chirurgicale. L'établissement de lignes directrices sur les temps d'attente et le suivi du temps écoulé entre la référence initiale et l'intervention chirurgicale ont réduit considérablement ces temps d'attente.

La deuxième caractéristique a trait à l'expérience vécue par le patient à l'hôpital. L'uniformisation de l'information préchirurgicale pour les patients, du cheminement des soins (en physiothérapie et pharmacothérapie, par exemple) et des objectifs de rendement permet aux patients de comprendre beaucoup mieux à quoi ils doivent s'attendre pendant et après l'intervention chirurgicale. La participation des patients et de leurs familles à la planification du congé avant même leur admission a aussi joué un rôle crucial dans la réduction de la durée du séjour aux soins actifs.

Enfin, une meilleure efficacité de la prestation des soins à l'hôpital a joué un rôle essentiel dans l'augmentation du volume des arthroplasties. On a obtenu cette amélioration par divers moyens, y compris en augmentant le temps de salle d'opération consacré aux arthroplasties de la hanche et du genou, en réduisant le temps écoulé entre chaque patient en salle et en exécutant un nombre minimum d'interventions au cours de chaque journée de 8 heures.

Il n'est pas facile de faire converger toutes ces initiatives disparates et un effort de coopération entre médecins

