Waiting times for knee arthroplasty

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The paper on waiting times by Kelly and associates (*Can J Surg* 2002;45[4]:269-76) deserves close attention from all surgeons who face challenges with waiting lists. Government-imposed financial restrictions curtailing access to medical services have resulted in the haphazard evolution of waiting lists and attendant work that supports them. It is therefore logical to suggest that governments should play a greater role in managing these waiting lists. Kelly and associates demonstrate that this has not happened but that individual orthopedic surgeons have done remarkably well in running waitlists for joint arthroplasty and ensuring that equitable access is guaranteed.

When one examines the variation among clinical practice that is inevitable in the surgical sciences, there is remarkable concordance in the data presented by Kelly and associates among many of the factors that they use to assess equity. Other papers publishing outcomes of joint arthroplasty have suggested that there are variations in outcome that depend on the volume of procedures performed by individual surgeons. This paper also supports the idea that access for surgery varies according to surgical volume, with patients being managed by surgeons who perform a low volume of knee arthroplasty having a shorter waiting time than those managed by surgeons performing a high volume of knee arthroplasty. This discrepancy between low-volume surgeons and higher volume surgeons requires further analysis. Are the waiting times lower because those surgeons have other special interests in orthopedic surgery or is it because they have limited the number of patients that they see to better manage their waiting lists? Patient access to surgeons for assessment and placement on a waiting list is another factor that can deny the patient equitable access to needed surgery. I understand that some surgeons have closed their practices to new patients when their waiting list gets to a critical point. There is then a waiting list for a consultation with an orthopedic surgeon, and that also needs to be studied.

A strong message from this paper is that equity involves an assessment of and allowance for pain as a primary factor. This message should be acted on nationally in all surgical clinics where waiting lists apply. The use of the Medication Quantification Score to measure outcome will allow for an improved assessment in this area, but a clinical pain assessment score is also a requirement.

Determining what are appropriate waiting times for different groups is not easily done. I believe that one way the surgical profession could demonstrate leadership is to work with patient advocacy groups to determine what the patients think. This could provide a more persuasive argument for asking politicians to support adequate funding for surgical treatments. Decisions regarding resource allocation are being made without any regard to the impact of waiting on the individual patient. We can, as a profession, initiate the process that allows patients to have a say in what an appropriate waiting time should be for a specific procedure. This could help to restore a trust in the profession that is ebbing as we deliver the realities of the current health service to individual patients and demonstrate our impotence in changing these realities. One example of this process is the advocacy of the Arthritis Society, working with the Canadian Orthopaedic Association in determining priorities for the treatment of patients with arthritis. It is time for major initiatives from our professional organizations.■

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