

## Waiting lists for surgery

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Surgical waiting lists are seen by many as epitomizing the shortcomings of our public health care system. Yet, they can also be interpreted as being the result of a societal compromise between the founders' promise of universal access to care and the reality of currently committed resources. Regardless of one's perception, the debate about the "appropriate length" of a surgical waiting list has, arguably, become a fixture of everyday Canadian life.

The goal of the report by Taylor and colleagues in this issue<sup>1</sup> is to describe the building of a score to manage general surgery waiting lists. The difficulty in devising such a tool lies in the complex analysis of clinical surgical judgement, the subjective evaluation of patient suffering and the need for multidisciplinary politically astute consensus. The Western Canada Waiting List Project (applied here to general surgery) was devised with just these issues in mind.

Many previous efforts at describing surgical waiting list management have been based on physician surveys or consensus, and usually have aimed to determine "acceptable" (and "unacceptable") waiting times according to theoretical disease states. More recently, however, efforts have been made to more accurately document actual waiting times quantitatively.<sup>2</sup> In a survey of 62 surgeons, Simunovic and colleagues<sup>3</sup> described

median waiting times from diagnosis to operation for 1456 Canadian cancer patients, concluding that many were experiencing "significant delays to treatment." Another report related that 3-month delays in cardiac surgery were associated with subsequent decreased patient survival and quality of life.<sup>4</sup>

The aim of the study by Taylor and colleagues differs from such previous articles: it does not attempt to quantify waiting times; instead, it uses state-of-the-art research-based methodology and a concerted multidisciplinary clinical approach to propose an objective hierarchical management tool. The goal is thus not to determine an idyllic hierarchy of waiting times but rather to stratify or score patients on existing lists in a way that makes clinically reproducible sense by using objective criteria that are widely acceptable. Casting aside the date of listing by the proposed scheme may appear unorthodox but is in keeping with other contemporaneous efforts such as the Model End-Stage Liver Disease (MELD) score, which is currently being used by the American United Network for Organ Sharing to prioritize liver transplantation in the United States.<sup>5,6</sup>

The report describes a regression model to explicitly relate surgical judgement to individual patient and disease criteria. The authors convinc-

ingly demonstrate many aspects of the reliability and validity of their scoring system.

The process and the science thus appear optimal, but an important question remains unanswered: Can the scoring tool be used effectively in everyday life? The application of a scoring approach to clinical practice in itself is not new. There are already several similar grading systems that are widely used and well known to clinicians, such as the APACHE score in intensive care unit patients or the Child-Turcotte-Pugh classification in cirrhotic patients.<sup>6</sup> The current example, however, exhibits one major difference: the outcome against which the Western Canada Wait List Project tool is measured is not a clinical end point such as mortality or the need for hospital admission, but rather the clinical judgement of the surgeons themselves. It will therefore be crucial to further validate the tool against "firm" health outcomes before it can be widely accepted in clinical practice. Which brings up another point: the acceptability of the priority questionnaire by surgeons and, perhaps more importantly, by patients. Most surgeons would probably welcome the use of an objective tool to stratify the urgency of patient access to the operating room. However, one can only wonder how often a "surgeon override" clause might be used in daily practice when the imploring patient

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and the family are sitting across the busy surgeon's desk. Also, patients, many of whom already feel disenfranchised from much health care decision-making, might believe that this allocation scheme removes yet another piece of what limited humanity remains in the health care system.

In spite of such operational issues, there is a real need for a prioritization tool such as the one described by Taylor and colleagues. In fact, the legal need for such a tool is about to be appraised in Quebec where a patient waiting for cardiac surgery died after his original operation had been

allegedly postponed because of an illegal nursing strike.

#### References

1. Taylor, MC, Hadorn DC, and the Steering Committee of the Western Canada Waiting List Project. Developing priority criteria for general surgery: results from the Western Canada Waiting List Project. *Can J Surg* 2002;45(5):351-7.
2. Olson D, De Gara C. How long do patients wait for elective general surgery? *Can J Surg* 2002;45(1):31-3.
3. Simunovic M, Gagliardi A, McCready D, Coates A, Levine M, DePetrillo D. A snapshot of waiting times for cancer surgery provided by surgeons affiliated with regional cancer centres in Ontario. *CMAJ* 2001;165(4):421-5.
4. Sampalis J, Boukas S, Liberman M, Reid T, Dupuis G. Impact of waiting time on the quality of life of patients awaiting coronary artery bypass grafting. *CMAJ* 2001;165:429-33.
5. Cheng SJ, Freeman RB Jr, Wong JB. Predicting the probability of progression-free survival in patients with small hepatocellular carcinoma. *Liver Transpl* 2002;8(4):323-8.
6. Salerno F, Merli M, Cazzaniga M, Valeriano V, Rossi P, Lovaria A, et al. MELD score is better than Child-Pugh score in predicting 3-month survival of patients undergoing transjugular intrahepatic portosystemic shunt. *J Hepatol* 2002;36(4):494-500.

## Calendar Calendrier

### Interactive surgery symposium

The Mayo Clinic Interactive Surgery Symposium will be held from Feb. 2 to 5, 2003, at the Marriott's Camelback Inn Resort, Golf Club & Spa, 5402 East Lincoln Dr., Scottsdale AZ 85253. Sponsored by the Mayo Clinic, this update for surgeons will be directed by Drs. James Swain and John Donohue. Credits: 18 Category 1. For further information contact Courtney J. Clement, Mayo School of CME, Mayo Clinic, 13400 East Shea Blvd., Scottsdale AZ 85259; tel 480 301-4580; fax 480 301-8323

### Gastroenterology meeting

From Feb. 24 to 28, 2003, the Mayo Clinic will hold its winter gastroenterology meeting at the Scottsdale Marriott at McDowell Mountains, 16770 North Perimeter Dr., Scottsdale AZ 85260. The course director will be Dr. David E. Fleischer. Some of the areas to be covered include new therapies for gastrointestinal reflux disease; inflammatory

bowel disease; irritable bowel syndrome; hepatitis; cardiac causes of chest pain; cancer genetics for practising physicians; novel colon cancer screening; video capsule endoscopy; obesity; and cholestatic liver disease. For further information contact Courtney J. Clement, Mayo School of CME, Mayo Clinic, 13400 East Shea Blvd., Scottsdale AZ 85259; tel 480 301-4580; fax 480 301-8323

### Liver diseases and transplantation

The Mayo Clinic will sponsor a course entitled "Update in Liver Diseases and Transplantation" on Mar. 28 and 29, 2003 at the Embassy Suites Hotel, 4415 East Paradise Valley Pkwy S, Paradise Valley AZ. The course director will be Dr. David D. Douglas. The course will focus in depth on topics concerning hepatology and liver transplantation for the general practitioner, gastroenterologist and physicians with a special interest in liver disease and transplantation. For further information contact

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### Upper extremity update

The 19th annual upper extremity update symposium will be held on Friday, Apr. 4, 2003, at Mount Sinai Hospital, 600 University Ave., Toronto, Ont. The symposium is directed to practising orthopedic surgeons, plastic surgeons, general surgeons, physical therapists, occupational therapists and nurses with an interest in musculoskeletal disorders, and trainees in these fields. Credit: Maintenance of Certification Program, RCPSC, and Category 1, AMA Physician's Recognition Award. Contact: Continuing Education, Faculty of Medicine, University of Toronto, Ste. 650, 500 University Ave., Toronto ON M5G 1V7; tel. 416 978-2719/1 888 512-8173; fax 416 971-2200; email ce.med@utoronto.ca; Web site www.cme.utoronto.ca ■