Improving the quality of care of Canadians waiting for elective surgery: an important health care priority

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Summary

The backlog of cases on surgical wait lists is a substantial problem for surgical patients, their families, surgeons, health care systems and governments. There are several approaches governments can take to improve the health, well-being and surgical outcomes of waiting patients. First, provinces should consider patient-centred approaches to triaging that reflect pain, symptoms or functional gain, and approaches using multidisciplinary teams or centralized triage. Second, governments could provide prehabilitation and mental health supports aligned with patients' and families' preferences during unavoidable waits. Wait times are not going to shorten any time soon; provinces should not only find innovative approaches to reducing waits, but also organize services to improve the health and well-being of waiting patients. Such changes will allow for optimization of patients' surgical outcomes and reduce the complexity of managing the wait list for their surgeons.

Wait times are an important health care concern because delayed access to surgical care can lead to disease progression, increased symptoms of anxiety and depression, risk of mental health flare-ups and worsening of surgical and nonsurgical patient outcomes. Here, we articulate how the Canadian health care system is missing an important opportunity to improve the short- and long-term health and well-being of patients who are waiting for surgery.

Current practice and impact on surgeons, patients and the health care system

The principle of distributive justice governs wait list management and is applied by hospitals and surgeons. This principle means that for the same diagnosis, or its corresponding priority code,[1] the order in which the surgery is registered specifies its priority (also referred to as "first-in-first-out"). The complexity of wait list management occurs in part because surgeons are able to override the policy and make exceptions to this principle for a variety of reasons,[2] including differences in the type and severity of the condition being treated, surgical practice profile, volume, experience, availability of surgical resources, characteristics of the patient and all other patients awaiting treatment, and their underlying surgical indication(s). Prioritization is further complicated by changes in the health status or social readiness of waiting patients, regardless of whether the changes are related to their surgical indication.

To provide guidance to surgeons, provinces have introduced target wait times for different operations. These administrative targets are procedurally based thresholds, and are not individualized for the patients on the wait lists — there are no modifiers for patient pain, disability, symptom severity, or impact on quality of life to help inform their prioritization.

Canadian research has reported the pitfalls of provinces' approach to wait list management, namely that patients with severe pain or worsening symptoms and deteriorating health-related quality of life are not prioritized. There

is also evidence that patients whose health status deteriorates while waiting for an operation don't achieve the same benefit from surgery, are more likely to experience incomplete postoperative recovery, report poorer perceptions of shared decision making with their surgeon, and consume more hospital resources.

Surgeons, primary care physicians and others manage patients' health care needs while they are waiting for surgery. Surgeons have limited time to address ancillary conditions, or even problems that can be attributed to their patients' wait such as symptoms of anxiety or depression. At the intersection of primary care and surgery, there are few options available for waiting patients, especially resources that can help address their mental health concerns.

Optimizing surgical outcomes and supporting waiting patients

In addition to increasing capacity, there are evidence-based approaches to reducing surgical wait times,[3] including triage through multidisciplinary teams or centralized intake. These initiatives have not yet been introduced by most provinces, nor accepted by many surgeons, but should be carefully evaluated.

Prehabilitation refers to the process used to strengthen a patient's functional ability to recover from surgery and has been associated with better outcomes and lower postoperative complication rates.[4] Its components include physical activity, guidance on nutrition and reducing preoperative stress. Failure to offer prehabilitation programs is a missed opportunity, as such programs have been associated with improved operative outcomes. Such programs could be made available to patients at the surgeon, hospital, or provincial level.

For patients waiting for surgery, provinces could collect and monitor pain, functional disability, or symptom severity in a manner that can consistently and efficiently be fed back to their health care providers, such as through telephone-based or online surveys. Patients' symptoms and mental health status reflect the gender- and culture-related diversity in the prevalence of depression, anxiety and other somatic disorders, and could inform the surgical triage process.

Waiting patients should have access to mental health services, such as the publicly funded BounceBack program in Ontario, in which coach-based telephone interventions under the supervision of clinical psychologists could be used to monitor the status of waiting patients and direct those in need to additional resources.[5] These services would accommodate the perspectives and preferences of waiting patients and their families for accessing mental health services.

Waiting patients in most provinces are not provided with additional services, technologies or funding to help address the physical and/or mental health effects of their surgery's delay. Those who are economically disadvantaged bear the brunt of postponed access to surgery because they do not have the same ability to self-finance noninsured physical and mental health care services, including medications, medical devices and counselling. To address this inequity in access, waiting patients could be provided access at no cost or reduced cost to help manage symptoms during prolonged waits.

Conclusion

Waiting for elective surgery prolongs the need for patients to manage their own symptoms, is challenging for surgeons and health system managers alike, and is likely unavoidable for the foreseeable future until new initiatives that increase surgical capacity are developed. Provinces are stewards of public health care resources and make all the critical allocative decisions. They can change policies, implement evidence-based solutions for wait list management, fund prehabilitation support services, and work with surgeons and other health care providers to reduce complexity, improve quality and reduce disparities, ultimately benefiting the welfare of people in Canada.

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