

Patients waiting for elective general surgery: a culture of waiting?

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Health care has long been a source of Canadian national pride, but decades of budget cuts and attempts at system reengineering have led to a perceived deterioration in access to care. Part of this perception centres around a “culture of waiting”: waiting to see one’s general practitioner, waiting to see a specialist, waiting for diagnostic tests and waiting for appropriate treatment. Of course, waiting is unpopular in this age of real-time access to the universe, and increasing expectations. Nevertheless, there is mounting evidence that waiting times for surgery are indeed lengthening.^{1,2} Although it is difficult to consistently relate this finding to a negative outcome, it has been suggested that shorter waits might be associated with improved patient outcomes and health care savings.³⁻⁵

Olson and de Gara (page 31) have attempted to describe waiting as it relates to the various steps leading to 3 types of general surgery operations. The strength of their report lies in the measurement of waiting times of actual events rather than through survey-based hypothetical responses. Their report is a descriptive snapshot of events that occurred over a short period in what is implied to be a “typical” Canadian health care insti-

tution. From prospectively acquired data on 74 patients, the authors describe a hierarchy of waiting times whereby common cancer operations are associated with a shorter waiting period than cholecystectomy. This is true for patients who did not undergo additional testing after referral to the general surgeon (13.1 days for breast resection, 15.0 days for colon resection and 55.2 days for cholecystectomy), and the authors state it would also have been true for patients undergoing additional testing if the sample size had been greater.

What message should we then take home? Should we berate the system for not giving equal timing of access to all patients irrespective of diagnosis? Should we congratulate surgeons on prioritizing their practices according to clinical and common sense?

Unfortunately these results can’t help us decide whether we are dealing with an acceptable waiting time or an unacceptable delay in getting appropriate care. It is hard to draw conclusions because of the very small sample size and because the presented information is incomplete. For example, given that a delay to surgery indeed exists, what are the processes at play, which *de facto* led to the described data? These depend

on physician, patient and other factors.^{2,6,7} Initially, it might appear that malignancy was the only key factor, but the authors do not provide any information about other patient factors such as employment status, family status or the acuity of patient symptoms, all of which have been shown to affect waiting times.^{2,6,8} It is certainly not uncommon to see a patient with a nonmalignant disease, who is anxious about needing an operation, generously offer to give up a spot on a waiting list. Because of this lack of information, we cannot get a real sense of how representative the described sample is and cannot extrapolate the promised “usable quantitative benchmark of waiting time.”

The authors report that 12 of 86 electively scheduled patients required urgent operation. What does this 14% figure (95% CI 7.4%–23.1%) represent? Once again, we cannot draw any conclusion without knowing how the number of patients in this group was drawn from each surgical practice. We don’t have any information regarding the practice characteristics of the participating surgeons or the referral patterns from the corresponding general practitioners. Depending on how many patients were seen in the surgeons’ offices at the same time as the stated

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12, this number may indicate a lack of operative time, a poor distribution of existing operative time, a poor strategy of operative prioritization or imprecise clinical acumen. Regardless, the expressed denominator (the number of patients booked for elective surgery over the duration of the study) is not really informative.

Thus, we are left with little more information regarding “an objective measure of waiting time for selected procedures.”

As we wait for other fact-finding efforts, such as the Western Canada Waiting List project, we stand by our patients and are left with them to share this “culture of waiting.”

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SESAP Questions Questions SESAP

Category 3, Items 41–45

- (A) Adenocarcinoma of the appendix
- (B) Carcinoid of the appendix
- (C) Both
- (D) Neither

Item 41. Microscopic invasion of the mesoappendix common

Item 42. Synchronous metastases present in over 30% of patients

Item 43. Appendectomy curative in 90% of patients

Item 44. Commonly recognized at time of operation

Item 45. Five-year survival rate significantly reduced in patients presenting with perforation

For the 5 items above select the one lettered phrase that is most closely associated with each one. For the critique of Items 41 to 45, see page 46.

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