In search of 'truth' and standards for reporting cardiac procedure waiting times

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In this issue of the *The Canadian Journal of Cardiology*, Dr Munt and colleagues (pages 497-502) present an approach for deriving what they call 'true' waiting times for cardiac surgery for valvular aortic stenosis, and compare this to the waiting times that are usually reported for this procedure in British Columbia. This paper is notable because it rightly draws attention to the challenge of developing and using standardized definitions for reporting waiting times in a Canadian context. The authors provocatively suggest that currently reported waiting times are incorrect, and that the 'true' waiting time is approximately three times longer than those currently being reported. They conclude that the true waiting time for cardiovascular surgery should be redefined as "the time interval between the patient's first contact with a medical care provider with symptoms or signs which ultimately lead to cardiovascular surgery and the date of that surgery".

The methodological approach adopted by Munt et al for deriving the proposed 'true' wait time is sound; they use the combination of a state-of-the-art cardiac procedure registry (data from the British Columbia Cardiac Registries database) and data from the province's Medical Services Plan to accurately compile the timeline for patients' typical care trajectories. These data include initial contact with primary care physicians, followed by diagnostic testing and assessment by specialists, subsequent acceptance on the surgical waiting list, and eventually surgery. Despite sound methodology, this proposed and so-called 'true' waiting time is conceptually problematic for a variety of reasons.

First, the implication of referring to the entire time period in their proposed definition as a 'true' wait time is that patients are actually *waiting* all of that time. There are many instances where that assumption is simply not correct; for example, when a primary care physician and patient together decide to adopt watchful waiting and follow symptoms clinically before making subsequent decisions, or when a patient asks for time to think about things, have discussions with family and organize personal affairs before proceeding to the next steps in a proposed diagnostic/therapeutic pathway.

Second, even if one were to accept the premise that patients are indeed waiting for all or most of the proposed 'true' wait time, one has to recognize that it includes intervals in which the patient is interchangeably waiting for different things and for different people – specialist assessment, echocardiography, cardiac catheterization, surgical assessment, official

surgery waiting list registration and, eventually, surgery. Collapsing all of these intervals and different waiting intervals into a single (long) time period and referring to it as a 'true' waiting time provides no information as to how and why time passed, where it accumulated most notably, and what might be done about it.

Third, the proposed single 'true' waiting time measure overlooks how waiting time data could and should be used by decision-makers and health care system stakeholders to achieve system improvement. For the interval between initial assessment by a primary care physician and subsequent assessment by a specialist, the target audience includes primary care physicians (who may need to more promptly decide to initiate specialist referral) and specialists (who may need to work toward developing mechanisms for organized triage and prioritization of referrals for timely assessment, and also develop formal estimates of future person-power needs in specific specialist pools). The interval between physician assessment and subsequent diagnostic testing with echocardiography or cardiac catheterization, meanwhile, speaks to the supply side of those diagnostic testing resources. A significant bottleneck at that time interval would indicate a need for better queue management and/or a strategic investment of financial resources for corresponding human and equipment infrastructure in those areas. The latter time intervals between surgical assessment, waiting list registration and eventual surgery relate more directly to the efficiency of surgical planning, availability of adequate surgical infrastructure, and the swift and effective management of the perioperative period. Significant delays in those later periods would again indicate a need for better management, with tools such as scheduling systems and strategic investment and innovation in the surgical services provided preoperatively, perioperatively and postoperatively.

A fourth and serious concern with the waiting time definition proposed by Munt et al is that, if injudiciously reported, it has the potential to unjustifiably alarm the general public and health care system decision-makers. A headline reading that 'true' waiting times are really three times longer than previously reported could provoke fear, outrage and suspicion among many stakeholders, and ultimately undermine the credibility of all health care system report cards, when in fact, the originally reported waiting times are entirely accurate, although admittedly for only one of the waiting time intervals of potential interest.

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These concerns notwithstanding, Munt et al do us a service by drawing attention to the need for standards around the reporting of waiting times. In doing so, they echo the calls of Sanmartin and colleagues in the Western Canada Waiting List Project (1). Unlike Munt and colleagues, however, Sanmartin et al do not call for the lumping of all waiting intervals into a single overall waiting time. Rather, they propose the explicit consideration of each of the time intervals identified, the development of corresponding information systems to gather the data needed to report on each of the time intervals, and the dissemination of information to the interval-specific target audience that can then act on specific findings for a given interval in the care trajectory. The discussion of arguments for and against the reporting of health care system performance statistics such as waiting times to the general public (versus only to health care system decision-makers and providers) is beyond the scope of this editorial, although there are compelling arguments on both sides of this debate.

Accurately measured and defined waiting times are an important foundation for any efforts to improve health care system access and efficiency. The way forward involves explicit consideration of the entire care trajectory and the establishment of information systems to capture the data required to compile information on each of the time intervals that contribute to the overall time between initial health care system contact with symptoms and the definitive procedures that patients require.

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REFERENCE

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