

WAIT TIME ALLIANCE

**Canadian
Anesthesiologists'
Society**

**Canadian Association of
Emergency Physicians**

**Canadian Association of
Gastroenterology**

**Canadian Association of
Nuclear Medicine**

**Canadian Association of
Radiation Oncology**

**Canadian Association of
Radiologists**

**Canadian Cardiovascular
Society**

**Canadian Medical
Association**

**Canadian
Ophthalmological
Society**

**Canadian Orthopaedic
Association**

**Canadian Psychiatric
Association**

**Canadian Society of
Plastic Surgeons**

**Society of Obstetricians
and Gynaecologists of
Canada**

WAIT TIME ALLIANCE MEMBER ASSESSMENTS OF 10-YEAR PLAN TO STRENGTHEN HEALTH CARE

May 2008

CANADIAN ANESTHESIOLOGISTS' SOCIETY (CAS)

As part of the Wait Time Alliance, the Canadian Anesthesiologists' Society (CAS) recently published benchmarks for patients with Chronic pain. In April 2008, the CAS Section on Chronic Pain Management surveyed the Section members on their perception of wait times across Canada.

1. Assessment of wait time for patients with chronic pain

33% of respondents say wait times for a routine assessment is more than one year.

Most respondents prioritize patients with Complex Regional Pain Syndrome. Other priorities include Acute Lumbar Radiiculopathy for Epidural Steroid Injection and Palliative Care Patients. 30% of respondents reported that the longest wait time for prioritized patients is 30-60 days.

63% of respondents say the maximum wait time for a palliative care consult is 0-14 days, 37% say the maximum wait time for acute complex pain syndrome and acute lumbar radiculopathy for epidural steroid injection is 14-30 days.

2. Key Barriers to improving/sustaining access

51% of respondents say lack of support staff is a significant barrier to assessment and management of chronic pain patients. 44% of respondents also said lack of access to rehabilitation programs and lack of access to psychosocial programs poses a significant barrier. 34% of respondents believe that their provincial government is not supportive of the management of chronic pain.

3. Recommendations (including establishing benchmarks)

The Society recommends that patients wait no longer than six months from the time of referral by their primary physician to their first assessment by a subspecialist in chronic pain management, with the proviso that shorter wait times should be targeted for certain conditions for which early intervention may be particularly beneficial (see Table).

Recommended Benchmarks	
Condition	Wait time for first assessment by pain subspecialist after referral by primary physician ^a
Acute neuropathic pain of less than 6 months' duration	30 days
Acute lumbar disc protrusion	3 months
Cancer pain ^b	14 days
Subacute chronic pain in an adult of working age where intervention may improve function	3 months
Other types of chronic pain	6 months
^a These wait times do not include subsequent waits for rehabilitation programs, psychology-based programs, or interventional procedures that may be deemed appropriate after the initial consultation with a pain subspecialist.	
^b Service within 14 days is recommended for patients who do not have access to a palliative service or in cases in which a palliative care team has asked for a specific procedure.	

CANADIAN ASSOCIATION OF EMERGENCY PHYSICIANS (CAEP)

CAEP, The Canadian Association of Emergency Physicians is a national advocacy and professional development organization

CAEP's Mission: "to provide leadership in emergency health care with a goal to enhance the health and safety of Canadians "

Emergency Departments (EDs) are a major access point to the healthcare system and therefore a highly visible indicator of the state of Canadian health care generally. 14 million visits are made to Canadian EDs every year means Canadians' opinions about wait times are determined very substantially by their ED experiences.

- On average, 60% of all patients hospitalized in Canada are admitted through the ED.
- Overall, 1 in 25 patients waited in the ED longer than 24 hrs for admission to an inpatient unit once the decision to admit was made.
- In large community and teaching hospitals, that went to 1 in 20.

CIHI 2007

- **ED overcrowding is caused by hospital overcrowding**, which is caused by several factors: shortage of acute care beds, staffing shortages, bed closures, limited community care resources and a lack of integration of systems.
 - 30% reduction of acute care beds between 1991-1997 with no increase in ED overcrowding
 - Further 14% reduction from 1998-2000 led to "substantial" worsening of ED overcrowding
 - Acute care bed occupancy rates during restructuring period >90%
 - Human resource shortages; ED doctors and nurses
- Shortage of hospital beds, aging and increasingly complex patient population mean that hospitals have more sick patients than there are beds. Overflow patients are "warehoused" in EDs and this creates access block. One patient "warehoused" in an ED denies access to four patients per hour; admitted hospital patients in the ED use disproportionate share of resources and require 2.5 times more service from emergency physicians and nurses compared to the average ED patient.
- ED stretchers and nurses are diverted to care of admitted hospital patients and therefore emergency patients cannot be placed in (already full) treatment areas, paramedics cannot unload and patients are left in the waiting room or to wait in hallways.

Increasing ED visit rates for those >55 and particularly for those >75

Physician response			
CTAS level	Level of illness	time/min	Sentinel diagnosis
1	Resuscitation	Immediate	Cardiac arrest
2	Emergent	<15	Chest pain
3	Urgent	<30	Moderate asthma
4	Less urgent	<60	Minor trauma
5	Non urgent	<120	Sprains

- ED length of stay: time of patient first encounter (the earlier of triage nurse assessment or patient registration) UNTIL the time of patient departure from the ED
- “Low-complexity ED patients are associated with a negligible increase in ED length of stay and time to first physician contact for other ED patients.”

Schull, Kiss and Szalai

- Solutions for this significant problem include increasing bed capacity, implementing overcapacity protocols, length of stay benchmarks, address hospital occupancy rates as well as planning for Human Health Care Resources and the aging population.

Triage levels and wait-time benchmarks for emergency department care

(Canadian Triage and Acuity Scale)

CTAS Level	Length of stay in the ED
1, 2, and 3	Not to exceed 6 h in 95% of cases
4 and 5	Not to exceed 4 h in 95% of cases
All admitted patients	Transferred out of the ED to an inpatient area within 2 h of decision to admit

CANADIAN ASSOCIATION OF GASTROENTEROLOGY (CAG)

A Multi-Faceted Approach is Needed to avert the forthcoming crisis in digestive health care the Canadian Association of Gastroenterology (CAG) has estimated that at least a two-fold increase in gastroenterologists (GI's) is required. This does not take into account the anticipated increased demand for colon cancer screening. One straightforward means to begin to address the problem is to increase the number of residency positions in gastroenterology. The CAG strongly advises that this be implemented immediately as one part of a multi-faceted approach.

GI Target Wait Times in Canada have been established with 24 recommendations for the maximal waiting time. Patients support these recommendations as shown by a survey conducted by consensus physicians.

GI Wait Times in Canada in a recently published Canada-wide audit reveals that the digestive health care needs of Canadians are not being met in a timely fashion.

For example:

- The median wait time from referral from a family doctor to full assessment by a GI is 16 weeks.
- 20% of patients with so-called alarm symptoms, who may have serious underlying disease such as cancer, wait at least 5 months to be assessed by a GI, despite the target wait time being < 2 months.
- The wait time target for an individual referred because of a high likelihood of cancer (based on physical exam or X-Rays) is < 2 weeks. Despite this, 30% of Canadians in this situation wait 8 weeks or longer.
- 30% of patients with a positive fecal occult blood test (an alarm sign for colon cancer and the current screening test being implemented across Ontario) are waiting 20 weeks or more to have colonoscopy, even though their wait time target is < 8 weeks. Imagine the anxiety these patients suffer knowing that they have tested positive on a screening test for colon cancer, yet have to wait months to have a definitive test.

The Number of GI Physicians in a recent census is revealed to be 1.83 GI's per 100,000 population in Canada, one of the lowest GI to population ratios in the western world (compare to USA at 3.9 per 100,000 and France at 3.5 per 100,000).

- One-third of currently practicing GI's are > 55 years old. Based on expected retirements and the number of young doctors currently entering training programs, it is estimated that by 2015 we will have 10% fewer GI's, unless training programs are expanded immediately.
- The digestive health care needs of Canadians are not being met at present, yet the demand is increasingly dramatically as colon cancer screening programs are initiated across Canada. Something must be done to enhance human resource capacity soon, otherwise access to digestive health care will continue to deteriorate.

CANADIAN ASSOCIATION OF RADIATION ONCOLOGY (CARO)

BACKGROUND

CARO has had a policy in place since 1994 ('CARO standard', re-ratified in 2002) that:

- 1) Consultation with a Radiation Oncologist should take place no more than 2 weeks (10 working days) after referral, and
- 2) Treatment should commence within 2 weeks (10 working days) after the patient "is ready to treat" (the latter term takes into account planned delays while the patient is recovering from the effects of surgery, chemotherapy etc).

1. Assessment of Government Action to Date

- The CARO standard was recommended to the Government's wait time advisor in 2005 as the maximum acceptable waiting period for Radiation Oncology. The then Federal wait time advisor, Brian Postl, chose not to adopt the CARO standard with two significant deviations.
 1. No wait time benchmark was established for time from referral to consultation, and
 2. The benchmark adopted for time to treatment (from decision to treat) was set at 4 weeks – exactly double that recommended by the experts.
- CARO questioned Dr Postl in March 2006 but the response from his successor (deputy minister Nora Kelly) did not answer the questions posed, and CARO does not know if the adopted definition was a misinterpretation of the CARO standard (and thus the submitted evidence), or was a purposeful "watering down" of the recommended standard. Either way, it is not evidence-based and is contrary to the standards that exist in several other countries (e.g. the UK and others).

Benchmarks & Wait time guarantees

- When the benchmarks were approved in March 2007 by all Provinces, 6 chose cancer as the benchmark and shared in the \$500m of Federal funds to be used for waiting times reduction. However, with the exception of Manitoba, the benchmarks adopted (8 weeks) were double the wait time standard of 4 weeks, which itself is double the CARO standard of 2 weeks. Additionally the implementation date for the benchmark guarantee was 3 years out (2010), and in all cases (with the possible exception of Nfld) was already being achieved. For patients with cancer, a waiting period of 8 weeks is unacceptable for all but the slowest growing cancers, and even for these has not been shown to be safe or acceptable.

Progress

- CARO is pleased that a national wait time benchmark has been set, and that guarantees have been announced. We are disappointed that these differ so greatly from the evidence-based recommendations, but accept that this is progress in the right direction.
- Significant improvements in wait times have been observed. Because of the lead time in building new infrastructure and training HHR it is likely that much of this improvement was in progress already, but we are hopeful that the money promised will lead to further improvements in the future.

- While there have been important improvements in radiation treatment wait times on average as a result of better reporting, improved efficiency and new resources, there continue to be inequities across provinces, from centre to centre within provinces, and across tumour sites. Therefore, individual patients may still have long waits to start RT despite the improvements that have occurred overall.
- In addition, patients in many regions may not have timely access to specialized RT techniques that have been shown to enhance survival and reduce side effects (e.g. IMRT and stereotactic radiotherapy).

2. Key Barriers to improving/sustaining access

- National wait times data remains spotty, with differing definitions and availability of wait times by Province.
- Cancer incidence is set to double over then next 20 years due to the ageing of the population.
- Replacement and expansion programs for modern linear accelerators (which have a life-span of approximately 8 years) have to be anticipated and then funded.
- National shortages of Medical physicists, radiation therapy technologists, and other staff will continue to delay or prevent clinic expansion to meet anticipated demand.

3. Recommendations

- A consultation wait time standard of no more than 2 weeks should be established
- The government benchmark of 4 weeks from 'decision to treat' should be reduced to 2 weeks
- The wait time guarantee level should be reduced from 8 to 4 weeks.
- There needs to be increased emphasis on reducing variability across the country so that all Canadians regardless of location or type of cancer have access to the highest quality treatment, which is the ultimate objective of CARO and national and provincial health agencies. This may necessitate expanding the metrics to better track this variability.
- CIHI should continue to publish national wait time reports.

In summary

Delay in provision of cancer services has a direct effect on the chance of successful cancer cure. Progress has been made, but the benchmarks that are in place are unacceptably long, and do not reflect the recommendations of experts in the field. Wait times for initial consultation have not been addressed, which is perceived as a serious omission. As the Canadian population ages it is likely that cancer waiting times will significantly worsen and CARO believes that national bodies (such as CPAC) must address HHR issues as well as ensuring that sufficient funding from FPT governments be made available for cancer interventions that have been shown to be effective and cost-effective, such as radiation therapy.

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CANADIAN CARDIOVASCULAR SOCIETY (CCS)

Government action in addressing wait times for access to care

1. It's about the patient – not the procedure.

Governments still need to do more and focus on the patient journey to access care. By continuing to focus on just one procedure such as cardiac bypass surgery (CABG) for which access was already an "A", wait times are NOT being meaningfully addressed.

Wait times for access to care must focus on the patient and their journey through the continuum of cardiovascular care -- from the onset of symptoms through to rehabilitation. Addressing only one procedural component of this care continuum (such as cardiac bypass surgery) does not have a meaningful impact on the patient's total wait time for access to care.

Approx. 1 in 3 respondents to a 2007 CCS national survey of cardiac care centres are "not very satisfied" or "not satisfied at all" with government action over the past 2 years to address wait times. The highest level of dissatisfaction (38%) is with the Federal Government's actions.

Despite monitoring wait times for more than five years, **less than one-half** of cardiac centres rate access as "excellent" or "very good".

2. The CCS Benchmarks for Access to Cardiovascular Care need to be adopted by Governments and Cardiac Care Centres across the country.

Almost all respondents to a 2007 CCS National Survey believe that adoption of the CCS benchmarks is feasible within the next 2 years. The CCS benchmarks were also seen by most as been "highly" or "very" credible.

"Very important": Almost all CCS national survey respondents also believe that access targets need to be adopted along the broad continuum of cardiac care. This is also known as the "Patient Journey" to access care.

3. The CCS wants to work with Governments to address barriers to improving access to cardiovascular care.

Respondents to the 2007 CCS National Survey indicated that the following are (in order of severity) the top barriers to patients' ability to access cardiovascular care:

- Human resources,
- Physical resources,
- Funding, and
- Data collection and availability.

CANADIAN OPHTHALMOLOGICAL SOCIETY (COS)

Assessment of Government Action to Date

Overall there has been significant progress in the provision of cataract surgery in Canada since the 2004 First Ministers' Accord. Prior to the Accord we would have ranked wait times for cataract surgery at somewhere between a D and a C nationally; in the most recent report card nationally the score has increased to a B. It is also encouraging that three provinces now rank at the A level (AB, BC and ON) and that four provinces continue to show steady improvement in their wait times (NB, ON, MB, AB). It is a little disconcerting that wait times in two provinces (NL and PEI) are deteriorating, although that may simply be due to better reporting systems more accurately documenting what is really happening.

The fact that the provinces use different statistical reporting methods to share their data continues to be a significant problem. It is frustrating to have to make inferences from the limited information presented to try to make valid interprovincial comparisons. This commitment in the original Accord has never been accomplished.

The Accord allocated money to reduce wait times for sight restoration. Manitoba is to be commended for assessing where problems existed in the delivery of eye care and distributing the new money to the projects where they would do the most good. Other provinces limited themselves to only allocating resources to cataract surgery. This has meant that chronic wait issues for the delivery of care in areas such as diabetic retinopathy or macular degeneration didn't improve at all in these other provinces. The COS continues to feel that there are significant wait time issues in many areas of eye care beyond cataract surgery that need urgent attention.

Key Barriers to improving/sustaining access

Infrastructure needs are not uniform across the country. Some provinces, most notably Ontario, have added significant new infrastructure to meet demand. It is important that all provinces provide funding to update the capital equipment involved in ophthalmic surgery on a periodic basis: technology continues to evolve at a rapid rate and it is critical to regularly update equipment to take advantage of this. Improvements in patient flow are extremely variable across the country. Changeover times between cases varies as much as fourfold between institutions. These types of inefficiencies must be addressed to maximally utilize the infrastructure we currently have.

In the long run, health human resources are going to be the greatest obstacle to overcome in allowing us to provide appropriate care in a timely fashion to our patients. Despite recent increases in residency training positions in Canada, the projections are that the ratio of ophthalmologists to population will continue to decline over the next 15 years. The ratio will deteriorate even faster for the population over 65, our principal demographic target, because of the aging of the baby boomers.

Recommendations

We would like to see the wait times data collection expanded. We would like to see monitoring of the time it takes for a patient to wait to see an ophthalmologist measured as well as measuring other surgical waits beyond cataract surgery. We also would like to strongly encourage governments to extend this process of establishing benchmarks and then measuring results to areas beyond the initial five specialty areas. We believe that this is a good process that would be appropriate for all areas of medicine that experience significant wait lists. We would like to see governments agree on common reporting methodologies to allow interprovincial comparisons. We would also like to see organized Health Human Resource planning on a national basis so that we train the right mix of specialists to meet our needs.

CANADIAN ORTHOPAEDIC ASSOCIATION (COA)

Assessment of government action to date

- According to the Health Council of Canada's latest report, T2 wait times for hip and knee arthroplasties are generally approaching the recommended six-month benchmark, which correlates with anecdotal evidence from COA members.
- While hip and knee arthroplasty wait times may be reduced, the demand for service is as great as ever because of demographics and a critical shortage in HHR.
- There is considerable anecdotal evidence from COA sub-specialty members (shoulder, spine, foot and ankle) that T1 and T2 wait times are excessively long: up to three years for T1 and up to two years for T2.
- Many of these sub-specialists can no longer take new patients as a result.

Key barriers to improving/sustaining access

- The COA has calculated that 400 more orthopaedic surgeons are needed now to approach the surgeon/population ratios in most other G7 countries.
- Throughout this decade, Canada has lost up to half of its graduating orthopaedic surgeons to other jurisdictions (mainly the US).
- The main reason was their inability to find work in Canada, despite the huge demand for orthopaedic services.
- A major barrier to employment is the lack of adequate hospital-based resources (OR staff, OR time, prosthetics budget) needed to support expanded orthopaedic services.

Recommendations

- Medical faculties need to increase the number of openings for specialty training in orthopaedics.
- Regional Health Authorities need to develop programs that help hospitals marshal the necessary resources (anesthetists, nurses, OR time, prostheses) to meet demand and retain the orthopaedic surgeons Canada is training.
- Musculoskeletal care models that offer treatment via multidisciplinary teams — which might comprise primary-care physicians, nurses, advanced practice physiotherapists or physician assistants and centralized intake and assessment centres — have been shown to significantly reduce T1 and T2 wait times for all orthopaedic services by increasing efficiencies throughout the continuum of care.

CANADIAN PSYCHIATRIC ASSOCIATION (CPA)

Assessment of wait times in Psychiatry:

Access to specialist services for patients with psychiatric illnesses is a significant problem throughout the country. Not only are wait times for these services lengthy, but in many areas family practitioners have difficulty getting service at all. The rural service gap is especially significant. Yet, for patients who need care and are hesitant to request it because of stigma or feelings of shame, ease of appropriate access is essential.

Key Barriers to Improving/sustaining access:

Consistently achieving systemic benchmarks of care across the country will be a challenge. There are rural and remote areas where resources simply don't exist in the locality. Inventive ways of service delivery (telepsychiatry and others) will have to be developed to deal with this geographic inequity of resources. Any monitoring system will, therefore have to identify not only those patients referred for physician care and their wait times, but also those not referred because there is no specialist available to whom they can be referred. Getting this information may be a challenge for the system; yet it is vital for the patient concerned. If healthcare is denied, then healthcare unavailable is a disgrace.

For many illnesses, onset may be gradual. As with the rest of the medical community, we believe that wait times must be based on discrete measurable events. Assuming easy access to a family practitioner, the wait time count will start when the patient and the physician both decide that such a referral is needed.

The problem should not be seen as one of a single wait time. Far too often, referral to a psychiatrist for serious and disabling illnesses is followed by a subsequent delay in access to inpatient or out-patient programs of care rehabilitation, psychotherapy or behavioural therapy to address the predisposing factors that contributed to the development of the illness, or which contributed to lingering difficulties.

Indication	Emergent	Urgent	Scheduled
Access to family practitioner Acute or urgent mental health concerns	As deemed appropriate after triage	Within 24 hrs.	Within 1 week
Access to psychiatrist after referral by family physician First Episode Psychosis	Within 24 hours	Within 1 week	Within 2 weeks
Mania	Within 24 hours	Within 1 week	Not generally applicable
Hypomania, with previous diagnosis of mania	Not generally applicable	Within 2 weeks	Within 4 weeks
Post-partum severe mood disorder or psychosis	Within 24 hours	Within 1 week	Within 4 weeks
Major Depression	Within 24 hours	Within 2 weeks	Within 4 weeks
Diagnostic and management consultation (including consultations for child and geriatric conditions not otherwise noted above)	Within 24 hours	Within 2 weeks	Within 4 weeks

CANADIAN SOCIETY OF PLASTIC SURGEONS (CSPS)

The specialty of plastic surgery encompasses a wide range of surgical expertise. Subspecialty areas include craniofacial surgery, hand surgery, reconstructive microsurgery, burns and peripheral nerve surgery. More than 90% of procedures performed in Canada are reconstructive or traumatic in nature.

A recent publication has shown that training positions in reconstructive plastic surgery have not kept pace with increasing demand¹. An aging population has resulted in overwhelming demand for procedures such as breast cancer reconstruction, skin cancer treatment and arthritic hand surgery. Wait times for elective surgery have increased markedly as the diminishing pool of surgeons necessarily shift their practices to address the more acute conditions.

A particular problem in plastic surgery is wait times between GP referral and specialist consultation. The 2007 Fraser Institute report highlighted this area of concern with plastic surgery wait times being the second highest of all specialties in Canada². Most provincial wait time collection strategies have failed to collect data on this important wait time segment and it is therefore not being adequately addressed.

There is a need to create additional training positions in plastic surgery as well as increase the efficiency of the current cohort of surgeons through innovative approaches such as centralized wait lists, multi-disciplinary teams employing Physician Assistants (PA's), and dual operating room bookings.

An effort must be made to improve and harmonize wait time data collection methodologies both within and across provinces as sound decisions depend on credible inputs.

The Canadian Society of Plastic Surgeons has recently developed wait time benchmarks for over 90 different plastic surgery procedures. The benchmarks represent a consensus of Canadian plastic surgeons, with 66% of them participating in the process. The next step is to accurately collect wait time data on these areas so that resources can be responsibly re-allocated and new delivery approaches developed.

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¹ Macadam, S. A., Kennedy, S., Lalonde, D., et al. The Canadian plastic surgery workforce survey: interpretation and implications. *Plast Reconstr Surg* 119: 2299-2306, 2007.

² Waiting Your Turn: Hospital Waiting Lists in Canada. Fraser Institute, 2007. Accessed May 1, 2008. <http://www.fraserinstitute.org/Commerce.web/newsrelease.aspx?nid=4967>

THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA (SOGC)

Statement on Wait Times in Obstetrics and Gynaecology

The Society of Obstetricians and Gynaecologists of Canada (SOGC) is concerned that Canadian women do not have timely access to gynaecological and obstetrical care. The long wait times for consultation, investigation, and gynaecological surgery can adversely affect the quality of health and life of Canadian women. The effect of delayed medical care for pregnant women can be a life threatening issue for both the mother and her baby.

One of the key issues for the SOGC at this time is that **there are no national benchmarks for wait times in obstetrics and gynaecology (OBS/GYN) in Canada**. The result has been continuous reductions in access to care in Canada and a significant downgrading of Canada's international ranking among OECD countries with respect to maternal, perinatal, and infant mortality rates. For example, Canada had the second lowest maternal mortality rates back in 1990. Canada is now ranked 11th or 12th among the 30 OECD countries. Such a decline cannot be taken lightly.

In March 2008, the SOGC arrived at its recommendations through consensus among practitioners and has presented them in a *Statement on Wait Times in Obstetrics and Gynaecology* published earlier this year. The SOGC believes that having wait time benchmarks is important, as it will lead to an examination of the factors that affect timely access to maternity care and gynaecological services in Canada.

Recommendations:

- *The SOGC recommends that the specialty of obstetrics and gynaecology be included in the WTA and that benchmarks for this specialty should be adopted by all provincial and territorial jurisdictions in the near future.*
- *The SOGC recommends the establishment and support of an appropriate triage process within the framework of a wait list benchmarking process.*

Another key issue for the SOGC is the fact that **there are currently no initiatives to manage and monitor wait times in the field of obstetrics and gynaecology**. In fact, wait times have been mostly ignored in all provincial jurisdictions.

As soon as a woman conceives, health care providers must respect standards of care that dictate the timing and frequency of obstetrical and/or gynaecological care. Failing to comply with standards can be detrimental to the health of the mother and the life of her baby. There are also consequences for the obstetrician, who may face reprimand from the regulatory college and/or medico-legal claim. **The accountability and liability issues facing physicians as a result of health care wait times flow from physicians' duty of care to their patients**. This issue is amplified in the area of obstetrics and gynaecology because the woman is carrying a baby.

Antenatal care and investigation must be conducted within timelines specified by national standards of care. Depending upon a patient's characteristics (with or without complications), this care can be effectively provided by different health care professionals (obstetricians, family physicians, midwives, nurses, etc.). SOGC research indicates that **obstetricians are faced with ever increasing workloads** because they are providing primary maternity care when often GPs, midwives and nurses are equally well qualified to provide that care. The result is an increase in the volume of patients specialists must treat, and in the wait times to receive the care.

Recommendation:

- *The SOGC believes that a multi-disciplinary collaborative care model for maternity care should be adopted and we urge the federal government to support the implementation of the National Birthing Initiative.*

Conclusion

Wait times for consultation, investigation, and surgery are a significant health policy concern in Canada. The effect of delayed medical care for pregnant women can be a life threatening issue for both the mother and her baby. The SOGC favours prevention rather than treatment. Benchmarks would not only improve access to required healthcare services, it would also decrease the human and financial burden on OB/GYNs and the healthcare system in general.



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