7.1.1 Waiting Times

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Learning Objectives

1. To identify the key ethical issues with regard to waiting lists
2. To articulate the physician’s ethical responsibility with regard to waiting lists.

Case

Dr. Simmons, a family physician, sees Mr. Lambert, a 42-year-old automobile worker, in his clinic for consultation regarding a sore shoulder. Mr. Lambert is a father of three who injured his shoulder playing recreational hockey and is having difficulty at work. He is worried that he might have to take time off work, and since the injury wasn’t in the workplace he may not be eligible for benefits. Dr. Simmons suspects that Mr. Lambert has injured his rotator cuff and initiates a referral to Dr. White, a local orthopedic surgeon. Dr. White's office contacts Dr. Simmons two weeks later to let him know that the earliest appointment to see Dr. White for a shoulder problem will be in nine months. Dr. Simmons contacts the other local orthopedic surgeon and learns that her waiting list is 13 months. Dr. Simmons asks if there is anything that can be done to expedite the process, and Dr. White's office informs him that, if the injury was work-related, the Worker's Compensation Board could get him an appointment in six weeks.

Mr. Lambert eventually has to stop working while he waits for his appointment with Dr. White. Nine months later Dr. White diagnoses rotator cuff pathology. He requests an MRI arthrogram to assess the rotator cuff and the glenoid labrum and tells Mr. Lambert that he will make a final decision about operating once he gets the results of the MRI. In the meantime, he recommends physiotherapy and analgesics. Mr. Lambert gets a call from the hospital a week later with an appointment for an MRI in five months. Mr. Lambert asks Dr. White if he knows of a private MRI facility so that he can get his operation faster and return to work sooner. He also asks Dr. Simmons whether he knows about any orthopedic surgeons who work privately so that he might be able to have surgery performed sooner.

Questions

1. What is Dr. Simmons' ethical obligation to Mr. Lambert at this point?
2. What is Dr. White's ethical obligation to Mr. Lambert at this point?
3. Is the system of rationing health care via waiting lists justifiable on an ethical basis?
4. Is there a point at which waiting lists become unethical?
5. Can a health care system be unethical?

Discussion

A survey of 12 bioethicists in Canada placed waiting lists second in a list of the top 10 ethical challenges facing Canadian patients in 2005. The bioethicists argued that inappropriately long waits can impede a patient's return to normal function and employment, and contribute to psychological distress. Waiting lists may also compound the problems of resource scarcity, as acute care hospital beds may be occupied inappropriately by patients awaiting surgery or waiting on a list for a nursing home bed.

The focus of ethical obligation for physicians has broadened in recent times from the Hippocratic tradition of focused dedication to the patient of the moment to include ensuring equitable allocation of scarce resources. The issue of dealing with waiting lists as a solution to the problems arising from scarcity of resources and limits to patient autonomy is challenging to physicians because it is a subject over which reasonable people can easily disagree. Dr. Simmons does have an obligation to his patient to seek out the best treatment and to be an advocate for him in the health care system. Both ethically and legally, he has a fiduciary responsibility to act in this way. Dr. White, the orthopedic surgeon, also has a responsibility to Mr. Lambert as he has seen him in consultation and is aware of his condition. If no alternative source for surgery or diagnosis was available, the issue would be straightforward, as both physicians would be left to advocate with the government and their
hospitals for increased resources to reduce the waiting lists. The issue arises because there are alternatives available within the health care system; however, access to these alternatives is restricted via a variety of mechanisms.

The entire concept of waiting lists is open to abuse and criticism because there are few generally accepted standards about who should be on lists, when they should be placed on lists and how they should be prioritized once they are on the lists. An attempt is made to address equity by trying to ensure that everyone waits an equal amount of time; however, if there is no mechanism to account for the acuity of the patient's problem, it could be argued that, while equitable, the process may not be just or fair. It has been argued that, until such standards are established and agreed upon, it is pointless to try and reduce waiting lists by allocating more resources. If hospitals and practitioners are provided with more resources to help reduce waiting lists, this produces an incentive to maintain the waiting list in order to receive even more resources. A counter-argument can be made that, in the case of surgical procedures such as joint replacement or cataract surgeries (which are dependent in part on the skill of the surgeon), those with long waiting lists may have earned the respect of their referral base through consistently high performance. In this case, a surgeon with a long waiting list may be the best target for new resources, and therefore, rather than examining the waiting lists for individual practitioners, regional or local waiting times should be established more globally. Numerous organizations and collaborations have worked to establish criteria for performing procedures and have worked to establish medically acceptable waiting times to try to alleviate these problems. The Western Canada Waiting List Project (WCWP) and the Ontario Cardiac Care Network are two frequently cited examples. The WCWP is seeking to establish medically acceptable waiting times for a range of procedures, and the Cardiac Care Network has established explicit clinical and diagnostic criteria that are used to prioritize patients waiting for cardiac surgery.

Waiting lists can also impact on choice of treatment and clinical practice, as has been shown in a study looking at radiation oncology practice in Queensland, Australia. Radiation oncologists reduced the amount of therapy to patients as waiting times increased, and this was most noticeable in palliative patients. As the clinicians felt the time pressure building, the number of fractions per patient decreased, which would then allow for more patients to be treated. A United Kingdom survey found that patients waiting for hip replacement surgery faced long waits for the initial appointment and for an operation date. At the time of surgery, those who had waited the longest had the highest levels of pain and disability, suggesting that patients had not been prioritized according to these criteria or that, once placed on a waiting list, their priority was not adjusted for worsening symptoms.

In the present case, Drs. White and Simmons have an ethical responsibility to seek expeditious care for their patient to give him the best chance of returning to normal function at home and at work. They should try and ensure that their patients do not have to wait an unreasonable amount of time to receive the care that they need. The challenge that patients, governments, physicians and the courts face is around the definition of what constitutes a reasonable time to wait for care. Since there are alternative pathways such as out-of-province referral or referral to a private facility that might be open to Mr. Lambert, it could be argued that a 14-month wait to decide whether he needs surgery is unreasonable when it keeps him out of the workforce and places stress on his family. It therefore could be argued that Drs. White and Simmons have an ethical obligation to disclose the availability of alternative treatment pathways and to facilitate a referral if this will provide the best care for the patient.

Some physicians would argue that referral to a private facility would constitute queue jumping, which is against the ethical principles of social justice and equitable access to care. Do these principles override physicians' fiduciary responsibility to their patients to seek the best care for them? If a physician believes in these principles, how should he or she manage a patient who is seeking a referral to a private facility? A similar question has been asked regarding physicians and the provision of abortion services, and both legally and ethically, a physician is required to ensure that the patient receives the care that he or she needs even if it runs counter to the physician's own personally held beliefs. If a physician does not feel that using private services to expedite care is acceptable, then he or she has an ethical obligation to transfer the patient's care to a physician who would be willing to provide such a referral. A case could also be made that, if he does not already have one, Dr. White needs to develop an appropriate waiting list policy of his own with a mechanism to prioritize the cases on his waiting list.

The conflict arises here because there are no accepted standards for waiting lists and no widely used systems for prioritizing patients. There are also well-established and government-sanctioned routes to bypass public waiting lists that raise questions about the ethics of the whole system. In Canada, the workers' compensation boards in some provinces contract for faster services in order to return employees to work faster and reduce the burden of their disability patients. The same patient sustaining the same injury in a non-employment-related environment does not have the same access. If the arguments used to justify the Workers' Compensation Board system are related to returning a patient to work faster for the patient's benefit, why would they not apply if the patient was
not injured on the job? If the purpose is to allow the Workers' Compensation Board and employers to reduce their disability costs, then why is it not acceptable for a patient to seek faster treatment in order to preserve income opportunities? The same argument applies to priority treatment of Royal Canadian Mounted Police (RCMP) officers and the Canadian military. If it is acceptable for these employers to bypass queues in order to return their employees to work as quickly as possible, why is it not equally acceptable for individuals to seek faster treatment in order to return to work as soon as possible? Some might argue that members of the military and the RCMP are serving society more broadly and that it is in the public interest to ensure that they can return to work as quickly as possible. As a counterpoint, for health care that is not provided anywhere besides within the public health care framework in Canada and where no one is receiving special consideration or priority treatment, the ethical basis of waiting lists can be much more easily supported.

The issue of ultimate responsibility for funding a patient's treatment is also open for argument. The government collects taxes to help fund the health care system and thereby spreads the costs of an individual's care over the entire population. The government has many other priorities, however, and an individual patient may not agree with how his or her tax dollars are being spent, especially when the patient or a family member may require care. If a government chooses to fund a system to the point that waiting lists are required to ration care, does a patient with the means to afford care have an obligation to stay in the waiting list? Governments that are responsible for health care systems with long waiting lists have started sending patients to other jurisdictions to obtain care more quickly. \(^{13}\) A centralized process for out-of-jurisdiction referrals is likely to be more efficient than individual physicians' attempting to carry out the same process for their patients, but is still subject to the variability of governmental budgetary pressures.

**Conclusion**

In summary, waiting lists and dealing with waiting lists is a complex ethical problem facing Canadian physicians, Canadian patients and the government. If there are well-established guidelines about the criteria for being placed on a list and on how to prioritize patients once they join a list, then waiting lists can be justified as ethically acceptable solutions to the problem of scarce resources. If a patient does face unreasonable waiting times, a physician has an obligation to inform the patient of other options for obtaining care, including possible referral to other providers.

**References**
