

Statement on Wait Times in Obstetrics and Gynaecology

This Policy Statement was prepared by the SOGC ad hoc Committee on Wait Times and was reviewed, amended, and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

COMMITTEE ON WAIT TIMES

Scott Farrell, MD, FRCSC (Co-Chair), Halifax NS
 Charmaine Roye, MD, FRCSC (Co-Chair), Brantford ON
 Joan Crane, MD, FRCSC, St John's NF
 Don Davis, MD, FRCSC, Medicine Hat AB
 Mark Heywood, MD, FRCSC, Vancouver BC
 André Lalonde, MD, FRCSC, Ottawa ON
 Guylaine Gisèle Lefebvre, MD – Toronto
 Nicolas Leyland, MD, FRCSC, Toronto ON
 Vyta Senikas, MD, FRCSC, Ottawa ON

Project Manager

Christiane Menard, SOGC

INTRODUCTION

For many years, timely access to health care services care has been a high priority for patients, health care providers, health organizations, governments, and the general public. Wait-time benchmarks were recognized as a government priority in the 2004 “A 10-year plan to strengthen health care,”¹ and provincial, territorial, and federal governments have adopted a range of policies and strategies to address lengthy waits for care. In 2004, the Wait Time Alliance for Timely Access to Health Care was established and the federal, provincial, and territorial governments agreed to develop benchmarks for wait times in five priority areas (cancer, cardiac surgery, diagnostic imaging, joint replacements, and sight restoration). In April 2007, the WTA was expanded to include emergency care, psychiatry, gastroenterology, anaesthesiology, and plastic surgery.

There are currently no initiatives to manage and monitor wait times in the field of obstetrics and gynaecology, and benchmarks for appropriate wait times are lacking. The objective of this policy statement is to bring forward expertise-based recommendations for medically appropriate maximal wait times for consultation and procedures in obstetrics and gynaecology.

With respect to obstetrics, wait times have been mostly ignored in all provincial jurisdictions. Clearly, as soon as a woman conceives, the clock is ticking, and health care providers must respect standards of care that dictate the timing and number of antenatal visits and the timing and requirements for prenatal testing.

Failing to comply with these 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 a medico-legal claim. Timely access to consultation, antenatal testing,

Abstract

Objective: To develop benchmarks for wait times for obstetrics and gynaecology.

Methods: An expert panel reviewed the literature published from 1995 to September 30, 2007, and provided recommendations.

Evidence: The benchmarks in this document were recommended by the SOGC ad hoc Committee on Wait Times, which includes members with expertise in obstetrics, gynaecology, urogynaecology, and gynaecologic oncology. A literature review was conducted on wait times and access to care, and existing clinical practice guidelines and standards of care documents were reviewed.

This policy, developed by the SOGC ad hoc Committee on Wait Times, was adopted by the SOGC Council at its meeting on November 10, 2007. The SOGC Council includes representatives from all regions of Canada, experts from all areas of practice in obstetrics and gynaecology, family physicians, nurses, midwives, program directors, and residents, as well as a public representative.

Outcomes: Development through consensus of recommended wait times in obstetrics and gynaecology.

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Key Words: Wait times, benchmarks, obstetrics, gynaecology

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and delivery of health services is essential to ensure a safe pregnancy and delivery for the woman and her baby.

A clearly defined wait time strategy in obstetrics and gynaecology is essential to avoid the potentially negative effect that overly long wait times can have on patient care. Inappropriately long waits may adversely affect health outcomes and, in some cases, result in mortality. Clearly, lengthy wait times have existed for a number of years, and it will take some time to achieve acceptable solutions.

In 2006, a Fraser Institute report² indicated that total wait time between referral from a general practitioner and treatment, averaged across all 12 specialties and 10 provinces surveyed, was 17.7 weeks in 2005 and 17.8 weeks in 2006. Canada-wide wait time increased slightly from 2005 to 2006 and this level is reported as high, both historically and internationally. According to the report, wait time was 91% longer in 2006 than in 1993.²

In a report entitled “Wait Times—A Medical Liability Perspective,”³ the CMPA states that the accountability and liability issues facing physicians as a result of health care wait times flow from physicians’ duty of care to their patients. In law, physicians owe a duty of care to their patients and they may be held accountable and liable for damages suffered by their patients as a result of a failure to fulfill their duty of care. This duty requires the physician to exercise care in all that is done to and for the patient, including attendance, diagnosis, referral, treatment, and instructions. The CMPA recommends that specialty societies play a supportive role in the evaluation and determination of medically appropriate wait times and advocate for the processes necessary to manage wait times and the resulting improvements to patient care.³

ABBREVIATIONS

| | |
|-------|---|
| AGC | atypical glandular cells |
| ASC-H | atypical squamous cells |
| CIHI | Canadian Institute of Health Information |
| CMPA | Canadian Medical Protective Association |
| HSIL | high-grade squamous intraepithelial lesion |
| ICES | Institute for Clinical Evaluative Sciences |
| LSIL | low-grade squamous intraepithelial lesion |
| NICE | National Institute for Health and Clinical Excellence |
| WTA | Wait Time Alliance for Timely Access to Health Care |
| WTS | wait time strategy |

The Society of Obstetricians and Gynaecologists of Canada

The Society of Obstetricians and Gynaecologists of Canada, a non-profit professional organization, is one of North America’s oldest organizations devoted to the specialty of obstetrics and gynaecology. Its membership includes over 3000 obstetricians and gynaecologists as well as general practitioners, researchers, nurses, midwives, and others providing health care for women.

Since its creation in 1944, the Society has undergone significant evolution and now encompasses more than 30 committees, including clinical committees such as Aboriginal Women’s Health, Public Education, Clinical Practice—Obstetrics (focus on normal pregnancy), Maternal Fetal Medicine (focus on high risk pregnancy), Breast Disease, International Women’s Health, and professional development committees on ethics, human resources, and economics.

The SOGC’s mission is to promote excellence in the practice of obstetrics and gynaecology and to advance the health of women through leadership, advocacy, collaboration, outreach, and education. The Society embraces values and beliefs that lead to improved patient care and advocates for change in the health care system at the provincial, territorial, and national levels.

The SOGC is concerned that Canadian women do not have timely access to gynaecological and obstetrical health care. Most importantly, the SOGC is concerned that longer waits for consultation, investigation, and surgery can adversely affect the health and quality of life of Canadian women.

The SOGC believes that the specialty of obstetrics and gynaecology must be included in the WTA and that benchmarks for this specialty should be adopted by all provincial and territorial jurisdictions in the near future.

Process and Special Considerations

The SOGC acknowledges that the work of the WTA has led to improvements in wait times across the country. However, as there are no national benchmarks for wait times in obstetrics and gynaecology, the SOGC believes it is important to put forward benchmarks for consideration by the WTA.

The SOGC supports the WTA definition of wait-time benchmarks “health system performance goals that reflect a broad consensus on medically reasonable wait times for health services delivered to patients.”⁴ Like other specialty groups, the SOGC arrived at its recommendations for acceptable wait times through consensus among practitioners. Given the paucity of research evidence and the importance of clinical judgement, the SOGC followed the example of other medical groups and put forward benchmarks

that are “evidence based, but not evidence bound.” The proposed benchmarks are “performance goals that reflect a broad consensus on medically reasonable wait times for health services delivered to patients.”⁴

In the development of this policy, the SOGC endorsed the 10 principles proposed by the WTA for the development of wait-time benchmarks:

1. Canadians have a right to timely and high quality care and the achievement of wait time benchmarks should in no way compromise the quality of care provided to patients.
2. Wait-time benchmarks must be developed from the patient’s perspective.
3. Setting of wait-time benchmarks should be based on a pan-Canadian approach to ensure comparable access to necessary care, avoid duplication of effort and maximize economies of scale.
4. Wait-time benchmarks should be based on the best available evidence along with clinical consensus.
5. Wait-time benchmarks are dynamic and should be derived in an ongoing and transparent process that involves evaluation, timely updating and a refinement of benchmarks when necessary.
6. Successful development, improvement and implementation of wait-time benchmarks require the early, ongoing and meaningful input of the front-line health care workers.
7. Public accountability, through the monitoring and reporting of wait-times, is exceedingly important to maintain patients’ confidence in the health care system.
8. Wait-time benchmarks and any associated provincial targets to reduce wait times must be sustainable.
9. The development of wait-time benchmarks must not be achieved at the expense of reduced access to other health care services.
10. Wait-time benchmarks must be implemented with the use of appropriate guidelines and prioritization tools that are fair, equitable and transparent to the patient.⁴

Wait Times for Areas of Practice in Obstetrics and Gynaecology

The SOGC recommends the establishment of national benchmarks for obstetrical and gynaecological health services for consultation, investigation and surgery in the following areas of practice.

Obstetrics

- Consultation between a primary health care provider and an obstetrician for the first antenatal visit.

- Consultation between a health care provider and an expert in maternal fetal medicine for women presenting with risk factors for adverse perinatal outcomes.
- Investigation: maternal testing, fetal testing, including ultrasound.
- Delivery of post-term or post-date pregnancy.
- Surgery: Caesarean section.

Gynaecology

General gynaecology

- Consultation between primary health care provider and a gynaecologist.
- Diagnostic and therapeutic procedures for non-malignant disorders of the uterus or adnexa.
- Surgical treatment of non-malignant disorders of the uterus or adnexa.
- Surgical treatment for prolapse.

Gynaecological cancers

- Consultation between a primary health care provider and a gynaecologist.
- Consultation between a health care provider and a gynaecologic oncologist.
- Investigation: colposcopy.
- Surgery for gynaecological cancers.

Urogynaecology

- Consultation between a primary health care provider and a gynaecologist.
- Consultation between a health care provider and a urogynaecologist.
- Surgery for stress incontinence.

Obstetrics

Consultation between a primary health care provider and an obstetrician for a first antenatal visit

A woman who is pregnant requires antenatal care and investigation within the time specified by national standards of care. The timing of that care and determination of the appropriate health care professional will depend upon the patient characteristics. A schedule of antenatal appointments should be determined by the parity and the presence of medical complications. For a woman who is nulliparous with an uncomplicated pregnancy, a schedule of ten appointments is adequate. For a woman who is parous with an uncomplicated pregnancy, a schedule of seven appointments is adequate. Antenatal care may also be offered to women with an uncomplicated pregnancy by a midwife or general practitioner. Obstetricians should be involved when complications arise and in high-risk pregnancies.⁵

Midwives and general practitioners are also involved in antenatal care. Of interest is the fact that midwives are

limited in the number of pregnant women they can care for in one year: in most jurisdictions midwives can provide care to a maximum of 40 women per year. In addition, there are a limited number of family physicians providing obstetrical care in Canada. As there are no restrictions on obstetricians, they must respond to the increasing demand for maternity care. As the workload is shifted to obstetricians, wait times are inevitably extended as patient volumes in specialist offices increase. Establishing maximum acceptable wait times to consult an obstetrician is therefore essential.

Consultation with an expert in maternal fetal medicine for pregnant women with risk factors for adverse perinatal outcome

A pregnant woman receiving antenatal care may present with signs and symptoms and/or predisposing factors for adverse perinatal outcomes. It is essential for these pregnant women to have timely access to assessment and adequate antenatal testing and help in planning a healthy delivery, thereby preventing complications.

Antenatal testing

Antenatal care includes examinations, evaluations, and interventions that have been shown to reduce both morbidity and mortality rates. The effectiveness of antenatal testing strategies depends on timely application and interpretation of tests, leading to the recognition of a potential problem and effective clinical action.

Maternal screening

- Integrated screening at 11 to 13 weeks
- Maternal serum screening at 15 to 16 weeks
- Glucose screening at 28 to 30 weeks

Fetal screening

- Ultrasound for nuchal translucency at 11 to 14 weeks.
- Ultrasound for full screening at 16 to 20 weeks.
- Future ultrasound as needed for women who present with risk factors for adverse perinatal outcome.

Surveillance

- As appropriate, biophysical profiles and non-stress tests.

Post-term (Post-Date) Delivery

One of the most common indications for induction of labour is post-term pregnancy with a gestational age of at least 41 completed weeks. Induction of labour has been shown to reduce the likelihood of perinatal death.⁶ Other indications for induction include premature rupture of membranes, potential fetal compromise (significant fetal growth restriction, non-reassuring fetal surveillance), maternal medical conditions (type I diabetes, renal disease, significant pulmonary disease, gestational hypertension, chronic hypertension), antiphospholipid syndrome,

suspected or proven chorioamnionitis, abruption, and fetal death. This list is not meant to be all inclusive.⁷ The SOGC suggests that labour may be induced for logistic reasons, including risk of rapid labour and distance from hospital, and for psychosocial reasons.⁷

Caesarean Section

According to the SOGC guidelines for obstetrical care⁸

Emergency Caesarean section must be considered and implemented whenever acute fetal compromise is suspected and vaginal delivery is not imminent.

Urgent Caesarean section must be considered and implemented whenever acute fetal and or maternal compromise is not yet evident but the patient's clinical situation or progress of labour is such that a Caesarean section is indicated.

Caesarean section must be performed without delay for a failed trial of vaginal delivery of breech, multiple gestations, and mid-forceps.

Scheduled Caesarean section should be considered for women who require a repeat Caesarean section or who present with conditions that compromise the safety of the mother and/or of the baby.

Gynaecology

General gynaecology

Consultation between a primary health care provider and a gynaecologist for non-malignant disorders of the uterus or adnexa

Women with non-malignant disorders of the uterus or adnexa resulting in abnormal uterine bleeding may require a referral to a gynaecologist. Such bleeding is most commonly caused by uterine fibroids, endometrial polyps and dysfunctional hormonal cycles. Abnormal bleeding ranges in severity from prolonged heavier period flow through to life threatening hemorrhage requiring emergency intervention.

Surgical treatment of non-malignant disorders of the uterus or adnexa

When medical management fails or is inappropriate, the surgical options available to treat non-malignant disorders of the uterus or adnexa include hysteroscopy for diagnosis and/or resection of polyps and fibroids, endometrial ablation, and/or hysterectomy. Hysterectomy is a permanent solution for the treatment of menorrhagia and abnormal uterine bleeding.⁹ For the woman who has completed her family and has unsuccessfully tried medical therapy to control and reduce the bleeding, endometrial ablation or hysterectomy are often the only choices.¹⁰

Consultation for pelvic prolapse

A referral to a gynaecologist is required for women who need an evaluation and treatment of uterine, bladder, or

vaginal prolapse. Symptoms attributable to prolapse include a sensation of protrusion, pelvic pressure, urinary incontinence, rectal discomfort, and discomfort related to the irritation of externalized mucosal tissues.¹⁰ It is estimated that only 30% of women with incontinence seek treatment; others do not seek treatment because of embarrassment or because they believe that there is nothing that can be done and that 11% of women will undergo surgery for pelvic prolapse and/or incontinence during their lifetimes.¹¹

Surgical treatment for prolapse

The primary objectives of surgical treatment for symptomatic genital prolapse are the relief of symptoms, the reconstruction of pelvic supports, and the restoration of normal anatomy. Removing the uterus is only part of any surgical procedure for pelvic relaxation. Concomitant correction of any cystocele or rectocele must be undertaken to restore support of the vagina. Attention to support of the vagina and obliteration of a potential enterocele will minimize the risks of post-hysterectomy vault prolapse. There are no successful surgical alternatives to advanced uterine prolapse, other than hysterectomy and pelvic floor repair.¹⁰

Gynaecological Cancers

Consultation for pre-invasive disease of the genital tract

A woman can be referred to a gynaecologist or a gynaecologic oncologist who has training in the diagnosis and treatment of pre-invasive disease of the cervix, vagina, and vulva. This is a cancer prevention model, in which pre-cancerous lesions are treated before they progress to invasive cancer.

Consultation for invasive disease (cancer)

A gynaecologist or a primary health care provider may refer a woman to a gynaecologic oncologist for further investigation of suspected gynaecological cancer and treatment of gynaecological cancer.

Investigation: colposcopy

Colposcopy is commonly recommended as a follow-up to an abnormal Pap smear screening test. This investigation enables most women with an abnormal Pap smear, a potential manifestation of pre-cancerous changes, to have proper histologic diagnosis and directed destruction or excision of the transformation zone to prevent cancer from developing. A study conducted in seven gynaecological clinics in New South Wales, Australia, showed that women scheduled for colposcopy experienced increased situational anxiety, tension, impaired concentration, and somatic features of depression.¹²

Cytology results suggesting abnormal cells should mandate a patient appointment in a colposcopy clinic within 3 weeks for HSIL, 6 to 8 weeks for ASC-H, 6 to 8 weeks for LSIL,

and 6 weeks for persistent LSIL, and within 6 weeks for AGC.¹³

Treatment of gynaecological cancers

Gynaecological cancers include cancer of the cervix, endometrium, fallopian tube, ovary, vulva, and vagina, as well as gestational trophoblastic neoplasia. Endometrial cancer is the most common gynaecologic malignancy in Canada. Endometrial cancers are best investigated and managed in a multidisciplinary cancer clinic where the patient has full access to medical, radiation, and surgical oncology expertise and expert evaluation of pathology. Most of these patients will require surgery involving a hysterectomy, bilateral salpingo-oophorectomy, and retroperitoneal nodal evaluations. In patients with serous or clear cell endometrial cancers, extended staging or aggressive debulking will be indicated at the time of surgical evaluation.

A woman with a pelvic mass suspicious for ovarian cancer should be referred to a gynaecologic oncologist for evaluation. Management of apparent early stage ovarian cancer includes surgery to remove the primary tumour and surgical staging, including evaluation of all peritoneal surfaces as well as the dissection of pelvic and para-aortic lymph nodes. For metastatic disease, in addition to removal of the primary ovarian lesion, radical tumour debulking might be necessary, requiring bowel resection, diaphragm stripping, and other complex surgical procedures to minimize residual disease and improve the patient's survival. Recently, intraperitoneal chemotherapy has been proven to improve prognosis in ovarian cancer patients who are optimally debulked,¹⁴ emphasizing the importance of aggressive surgery in patients with advanced ovarian cancer. Neo adjuvant chemotherapy with delayed planned surgical debulking might also be a treatment option, depending on clinical presentations. Determining the best care in each case requires the expertise of a gynaecologic oncologist as well as the expertise of other health care professionals in a multidisciplinary cancer centre. It has also been well established that surgery for ovarian cancer provides excellent relief of related symptoms. As ovarian cancer tends to metastasize quickly, it should be treated relatively urgently.

Cervical cancer also needs to be assessed and treated relatively urgently. Small stage 1 cancers can often be treated and cured with surgery. If the cancer grows during the wait for treatment, both cure rates and surgical options will be affected; for example, fertility sparing surgical procedures for women who have not yet completed their families may no longer be possible.

Vulvar carcinoma must also be considered as it is a cancer that is disfiguring, and, in some situations, it may grow rapidly. This could compromise surgical options and success.

For tumours growing close to the rectum, for example, growth of the cancer may necessitate radiation treatment or major radical surgery requiring a colostomy.

For all gynaecologic cancers, individual patient symptoms must also be considered. For example, a patient with vaginal bleeding may need emergency surgery because of a significant decrease in hemoglobin requiring blood transfusions. Patients who are in pain or who are unable to eat satisfactorily because of severe abdominal distension or bowel obstruction require surgery urgently.

Gestational trophoblastic neoplasia is almost always curable when managed correctly and quickly. It is one of the conditions that must be considered as urgent.

Urogynaecology

Urinary incontinence is the accidental or unwanted leakage of urine. It is estimated that one in three women suffer from urinary incontinence. Urinary incontinence can develop at any age, but is commonly associated with childbirth. Studies show that only about 30% of women with incontinence seek treatment; others do not seek treatment because of embarrassment or because they believe that there is nothing that can be done. In most cases, urinary incontinence can be improved or cured.¹⁵

Consultation between a primary health care provider and a gynaecologist or urogynaecologist

A woman will be referred to a gynaecologist or urogynaecologist for the clinical assessment of lower urinary tract dysfunction and prolapse and associated problems, including incontinence. The specialist in urogynaecology has expertise in the management of general urinary and prolapse problems, including expertise in complex surgical procedures for the management of these problems.

Surgery for the treatment of incontinence

When conservative therapy has failed, the procedures most commonly used for surgical correction of stress incontinence include minimally invasive sub-urethral sling procedures, retropubic suspensions (open or laparoscopic), and periurethral injections.¹⁶

REVIEW OF THE LITERATURE ON WAIT TIMES IN OBSTETRICS AND GYNAECOLOGY

A Medline literature search found no publication on wait times for obstetrics and gynaecology in the areas of practice outlined above. There is, therefore, no publication on the effect of prolonged wait times for these procedures on clinical outcomes. In addition, there is no information in the current literature that can provide the basis for benchmarking wait times.

A number of reports addressing wait times were found in the review of grey literature. These are described in the following section.

REVIEW OF REPORTS ON WAIT TIMES

The Canadian Institute of Health Information

In 2005, CIHI published a report entitled "Understanding Emergency Department Wait Times," which focuses on who is using emergency departments and when, and how long patients wait to see a physician and how long their visits take.¹⁷ Data in this report are not useful in establishing wait time benchmarks for obstetrics and gynaecology cases.

Another CIHI report entitled "Waiting for Health care in Canada: What we know and What We Don't Know,"¹⁸ helps to define and measure wait times. However, the information focuses on wait times in the five priority areas (cancer, cardiac surgery, diagnostic imaging, joint replacements, and sight restoration); the report does not provide information about the areas of practice outlined earlier in this document.

The Fraser Institute

The Fraser Institute's "Waiting Your Turn—Hospital Waiting Lists in Canada," is a comprehensive study of wait times across provinces and medical specialties and documents the extent to which waiting lists for visits to specialists and for diagnostic and surgical procedures are being used to control health care expenses. The sixteenth edition provides updated wait list estimates for all provinces.²

The report outlines the results of a survey to practitioners of 12 medical specialties conducted in all 10 provinces. The survey data were corroborated by data from institutions and provincial governments or agencies when available. Although gynaecologists were included in the survey, no distinction was made between obstetricians, gynaecologists, urogynaecologists, gynaecologic oncologists, etc. The results therefore are not representative of the reality, as wait times depend on the sub-specialty. In addition, determination of acceptable wait times for hysterectomy, for example, should be made on the basis of the medical conditions that necessitate this common surgical procedure rather than the surgical procedure itself. The report also includes wait times for radiation therapy for cancer of the cervix, but not for surgical procedures for cancer (hysterectomy) or diagnostic procedures such as colposcopy. The report is therefore not useful to the SOGC in establishing a policy statement on wait times for the areas of practice outlined above.

Statistics Canada

Since 2001, Statistics Canada has been reporting on patients' experiences using health care services and

providing national and provincial governments estimates of wait times for specialized services.

In a report entitled “Access to Health Care Services in Canada—January to December 2005,” Statistics Canada reports that median waiting times for all specialized services remained relatively stable between 2003 and 2005 at 3 to 4 weeks, depending on the kind of care. The study also reports that most say that they received care within 3 months.¹⁹

According to this report, 11% of Canadians aged 15 years or over (2.8 million Canadians) visited a medical specialist in 2005; 19% of these people reported difficulties accessing care. Waiting too long for care was cited as the number one barrier among those who experienced difficulties. There is no information provided specific to the practice area in obstetrics, gynaecology, gynaecologic oncology or urogynaecology.

A review of birth rates shows that Canada recorded its highest number of births in seven years in 2005, up 1.5% from the previous years, indicating an increased need for specialized obstetrical care. Statistics Canada also reports that women in their thirties accounted for the highest proportion of births (31.4% of total births) in 2005.²⁰

The Institute for Clinical Evaluative Sciences

ICES is an independent, non-profit organization that conducts research on a broad range of topical issues to make health care more effective for Ontarians. In a May 2007 report, ICES evaluated the effect of Ontario Wait Time Strategy on the surgical procedures that were not priorities. Of 27 non-WTS procedures included in the study, only two were obstetric or gynaecologic: tubal ligation and Caesarean section. The wait times for these surgeries were not shown to have increased since the implementation of Ontario's WTS.²¹

The information in this report did not provide any guidance for establishing benchmarks in the clinical areas outlined above for obstetrics and gynaecology.

National Institute for Health and Clinical Excellence

NICE has published clinical guidelines on antenatal care for the National Health Service in England and Wales. While there are no specific wait time recommendations, there are recommendations with respect to the frequency of antenatal appointments: a schedule of 10 appointments for a woman who is nulliparous with an uncomplicated pregnancy, and a schedule of 7 appointments for a woman who is parous with an uncomplicated pregnancy. In addition, NICE recommends that women should have an ultrasound scan to determine gestational age between 10 and 13 weeks

and another between 18 and 20 weeks' gestation to screen for structural anomalies.⁵

REVIEW OF PROVINCIAL AND FEDERAL WAIT TIME BENCHMARKS

All provinces provide some wait times data on their web sites or in reports, but the scope and depth of reporting varies considerably. The level of detail also differs from one province to another. It is important to note that territorial governments do not maintain wait times for major surgery because residents often have to travel south for complex care.

Appendix A delineates the provincial wait time strategies as it relates to the obstetrical and gynaecological areas of practice outlined above. It is important to note that there are no wait time benchmarks for obstetrical care. Only Ontario and Nova Scotia provide benchmarks for gynaecological cancer surgery. Some provinces provide data on wait times for hysterectomies and/or gynaecological surgeries (BC, AB, SK, NB, NS) but the data are provided for groups of procedures and not specific to a particular health issue.

As for the federal government, in November 2006 the minister of health announced the establishment of patient wait times guarantees for prenatal care in First Nations communities. More specifically, the initial prenatal appointment is to be scheduled within 2 weeks of a positive pregnancy test, appointments scheduled with a health care provider every 4 weeks after the initial visit, and confirmation of a future appointment for a specialist and diagnostic services made within 2 weeks of a decision to refer a woman with an at-risk pregnancy.²²

SOGC RECOMMENDATIONS FOR WAIT TIMES BENCHMARKS IN OBSTETRICS AND GYNAECOLOGY

As there is insufficient published information to allow the establishment of evidence-based benchmarks, the SOGC endorses expertise-based recommendations for medically appropriate wait times for consultation, investigation, and surgical procedures in obstetrics, general gynaecology, urogynaecology, and gynaecologic oncology as outlined in this document.

Definition of Wait Time Benchmarks

The WTA defines medically acceptable wait time benchmarks as

the threshold wait time for a given health service and level of severity beyond which the best available evidence and clinical consensus indicates that the patient's health is likely to be adversely affected. The WTA specifically defines the term “wait-time benchmark” as “health system performance goals that

reflect a broad consensus on medically reasonable wait-time for health services delivered to patients.”²³

To ensure quality of care, the SOGC recommends that 90% of these services and procedures be available to women within the time recommended.

For the purposes of this policy statement, wait times are defined as follows:

Consultation: wait time between referral by a health care provider and a visit with a specialist.

Investigation: wait time between specialist visit and investigative procedure.

Surgery: wait time between the specialist decision and patient approval that surgery is required and performance of procedure.

Triage Process and Wait Times

It is important to note that there is evidence that risk indicators affect health outcomes and therefore affect the wait times proposed. The SOGC recommends the establishment and support of an appropriate triage process within the framework of a wait list benchmarking process. The triage process is a useful tool to identify and assign appropriate wait time benchmarks for obstetrical and gynaecological conditions. The triage process will also serve as an opportunity to collect data that accurately show how well this process is working.

Classification of Benchmarks

The SOGC has classified its proposed benchmarks according to the following categories.

PROPOSED WAIT TIME BENCHMARKS

| Obstetrics | Gynaecology |
|------------------------------------|-------------------|
| • Within 30 minutes | • Within 2 weeks |
| • Between 30 and 60 minutes | • Within 3 weeks |
| • Between 1 and 2 hours | • Within 4 weeks |
| • Within 1 week | • Within 6 weeks |
| • Within 4 weeks | • Within 8 weeks |
| • As required by standards of care | • Within 12 weeks |
| | • Within 26 weeks |

Obstetrics

Obstetrical consultation

In order to organize appropriate tests and arrange appropriately timed prenatal screening, a woman seeking prenatal care should be offered an initial appointment **within 4 weeks** of positive pregnancy test.

Obstetrical consultation for pregnant women with risk factors for adverse perinatal outcomes

A woman who has been identified as having risk factors for adverse perinatal outcomes should be seen by an obstetrician **within 1 week** of referral from primary health care provider.

Investigation: maternal testing

- Integrated screening at 11 to 13 weeks
- Maternal serum screening at 15 to 16 weeks
- Glucose screening at 28 to 30 weeks

Wait times may vary according to the number of weeks of pregnancy at the time of appointment.

Investigation: fetal testing

- Ultrasound for nuchal translucency at 11 to 14 weeks' gestation.
- Ultrasound for full screening at 16 to 20 weeks' gestation.
- Future ultrasound for women with risk factors for adverse perinatal outcome as needed.

Post-term delivery

A woman at 41 completed weeks of gestation and/or presenting indications outlined previously should have access to induction labour procedures **within 1 week**.

Surgery: Caesarean section

- Emergency Caesarean sections should be performed **within approximately 30 minutes**.
- Urgent Caesarean section should be performed **within 1 to 2 hours**.
- Caesarean section for a failed trial of forceps or for twin or breech pregnancy should be performed **within approximately 30 minutes**.
- Scheduled Caesarean sections should be performed at **39 weeks' gestation**.

GYNAECOLOGY

General Gynaecology

Consultation

A woman who suffers from abnormal uterine bleeding or prolapse and who is referred to a gynaecologist by a primary health care provider should be seen **within 12 weeks**.

Surgery for non-malignant disorders of the uterus or adnexa

A woman who has tried conservative therapy without acceptable results should have a hysterectomy **within 12 weeks** of the decision to perform the procedure.

Surgery for prolapse

A woman who presents with advanced uterine prolapse and who has tried conservative therapy without acceptable

results should have a hysterectomy and pelvic floor repair **within 12 to 24 weeks** of the decision to perform the procedures.

Gynaecological Cancers

Consultation: pre-invasive disease of the genital tract

A woman who is referred by a primary health care provider to a gynaecologist for investigation and treatment of pre-invasive disease of the cervix (abnormal Pap smear), vulva, or vagina should first be triaged based on their referring diagnosis and should be seen **within 2 to 4 weeks**.

Consultation: invasive disease

A woman who is referred to a gynaecologist or a gynaecologic oncologist for invasive cancer should be seen **within 2 weeks**.

Investigation: colposcopy

Referral for colposcopy is indicated for a woman with significant cytologic abnormalities on Pap testing, such as HSIL, ASC-H malignant cells or persistent LSIL, and AGC.¹³

The following wait time benchmarks are recommended for access to colposcopy.

- HSIL within 3 weeks
- ASC-H within 6 to 8 weeks
- LSIL within 6 to 8 weeks
- Persistent LSIL within 6 weeks
- AGC within 6 weeks

Treatment of gynaecological cancers

Although cancer surgery is included in the national WTA strategy, there are no pan-Canadian benchmarks. Working in close collaboration with Cancer Care Ontario, the Ontario government has established a system to track, measure, and publicly report wait times in near real-time. It is important to note that only hospitals that get funding for extra cases have to report wait times. Cancer Care Ontario does not provide benchmarks but rather recommends a patient priority rating tool and wait time targets for cancer surgery. The following scale—measuring the time from the decision to operate to the operation—reflects four priority ratings (maximum target time frames):

- **Priority 0: Immediate**
Oncologic emergency (e.g. bleeding, airway obstruction, etc.).
- **Priority I: 2 weeks**
Patients who have very aggressive tumours.
- **Priority II: 4 weeks**
All patients with known or suspected invasive cancer that does not meet the criteria of urgency category I or III.

- **Priority III: 12 weeks**

Patients who have indolent tumours.²⁴
The SOGC recommends adopting the priority ratings suggested by Cancer Care Ontario.

Urogynaecology

Consultation for incontinence

Women referred by a primary health care provider to a gynaecologist or urogynaecologist for the clinical assessment of lower urinary tract dysfunction and/or prolapse and associated problems, including incontinence, should be seen **within 12 to 24 weeks**.

Surgery

A woman who is diagnosed as having incontinence and who has tried conservative therapy without acceptable results should receive surgical correction of stress incontinence **within 12 weeks** of the decision that surgery is required.

SUMMARY

Wait times for consultation, investigation, and surgery are a significant health policy concern in Canada and in several other countries. According to the OECD, among the group of countries with wait times, it is the availability of doctors that has the most significant negative effect on wait times for surgeries.²⁴

There are, however, other factors that affect elective surgery, such as surgical capacity, the availability of proper equipment and instrumentation for gynaecological procedures, and the number of available beds within a health care organization. In addition, there are differences in wait times and access to care for patients living in urban areas affiliated with medical schools, in urban areas not affiliated with medical schools, and in rural areas. 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.

As there are no studies directly evaluating medical outcomes as a function of wait times for the areas of practice outlined in this document, a consensus approach has been used to create recommendations for medically appropriate wait times for specific areas of practice in obstetrics and gynaecology.

With respect to obstetrical care, the effect of delayed medical care for pregnant women can be life-threatening issue for both the mother and her baby. Clearly, introducing wait time benchmarks in obstetrical care is essential, and the needs of the patient must be met, regardless of resource availability.

With respect to gynaecology, extended wait times cause significant distress for women with an abnormal Pap tests and women who are diagnosed as having precancerous lesions or invasive cancer. With early diagnosis and treatment of gynaecological cancers, 100% cure is possible. The gynaecological conditions outlined in this report can cause situational anxiety, tension, impaired concentration, and somatic features of depression. The effect of the symptom on patient quality of life and the beneficial effect of physician intervention in improving symptoms, decreasing use of health care resources and allaying patient fears of serious disease need to be considered.

Consequently, the SOGC recommends that obstetrics and gynaecology be included in the Wait Time Strategy. The SOGC further recommends support for the establishment of an appropriate triage process within the framework of a wait list benchmarking process. Access to obstetrical care, in particular, is in crisis in Canada, and delayed obstetrical care is a life and death issue for the mother and for her baby.

The federal government is clearly committed to establishing a Patient Wait Times Guarantee, and in its March 2007 federal budget, it allocated substantial funding (\$612 million) to be used to help accelerate the implementation of patient wait time guarantees. The SOGC advocates for funding to establish wait time guarantees in obstetrics and gynaecology as outlined in this document. By bringing forward this policy statement, the SOGC anticipates that the establishment of wait time benchmarks in these specialty areas will be given the priority it deserves.

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