EDITORIAL

Surgical wait times in urologic oncology-what took so long?

In this supplement of the Canadian Journal of Urology, readers will find a series of papers emanating from a consensus conference for surgical wait times (SWAT) in urology. The conference took place over 2 days in December 2005, at the Kingsbridge Centre in King City, north of Toronto.

As surgeons practicing in a single-payer and resource-restricted environment, we are constantly reminded of the long waits that our patients often experience for medical procedures and definitive surgery. In my opinion, this problem is most acute in the practice of urological oncology.

Three years ago, my practice was exploding with a large series of complex urological oncology cases. The stress associated with this phenomenon coupled with the increasing media chatter about the topic lead me to work with others to try to develop a Canadian consensus about this problem. Urological cancers are complex and the biology is quite variable. Our task was quite simple: we wanted to develop evidence-based guidelines that best reflected the biological variation of urological cancers. To do this, we first assembled a working group consisting of David Bell from Halifax, Antonio Finelli and John Tshilias from Toronto, and Martin Gleave from Vancouver. This planning committee quickly developed a meeting agenda and made a decision to work with George Dranitsaris, a health-service researcher from the Toronto area. George brought the required expertise, energy and effort to the project that was vital for its completion. The planning committee also chose a group of urologists needed to get the task done. This group consisted of a host of urological oncologists who practiced in a variety of settings (academic and community) across the country. We also decided to conduct a survey on SWAT at the last Canadian Urological Association meeting in Ottawa and via mail.

Prior to the meeting, cancer-site group leaders representing urologists specializing in renal, bladder, prostate, and testicular cancers worked with their groups and with George Dranitsaris to develop the best possible evidence-based guidelines. Where guidelines were not based on evidence, expert opinion using knowledge about disease biology was employed. These rough guidelines were then hammered out into their final form on Day 2 at the meeting. In addition, excellent talks about wait times in general were delivered at the meeting by leaders in the field including Alan Hudson (wait-time strategy leader for Ontario), Jonathan Irish (head of surgical oncology at Princess Margaret) and Jonathan Lisus (counsel, McCarthy Tétrault).

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The intent of these guidelines is not to be overly prescriptive. Instead it is hoped that they can be used by urologists, administrators, and even politicians to help allocate and prioritize workplace resources. It is also envisioned that patients may be able to use them to help them better understand their medical conditions. These guidelines are also not meant to eliminate the urgency needed to treat non-malignant urological disease. Nor are they meant to address all the many other components of the wait time experience such as timely access to vital imaging, pathology, and referrals that are crucial in the management of these patients.

The SWAT in Urological Oncology Initiative would not have been possible without the assistance of key players who facilitated its success. First, I would like to thank Michael Jewett and the financial support of the Canadian Urological Association. Second, I would like to acknowledge the financial support of Martin Gleave and the Canadian Uro-Oncology Group. Third, I would like to thank George Dranitsaris for his hard work and thoughtfulness. Finally, I must also graciously thank AstraZeneca Canada and George Watkinson for financial and logistical support.

It is somehow strange that this effort took so long given the pressures we have practiced with for so many years. Nonetheless, there is never a better time to start than now.

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