

## Correspondance

Prioritization  
for cataract surgery

Lorne Bellan and Mathen Mathen have presented data on the first attempt to institute standard prioritization criteria in a Canadian context for cataract surgery.<sup>1</sup> Although this is a worthwhile effort to manage waiting lists, we have a few concerns regarding the scoring system used for prioritization.

The 14-item Visual Functioning Index (VF-14 questionnaire) is already heavily biased toward working and driving. The program developers' addition of 60 extra points for work and driving impairment alters the point scoring system significantly and has not been validated in outcome studies. The fact that a correlation developed between VF-14 scores and difficulty with work or driving following institution of the system proves that surgeons used the system to prioritize their patients. However, unless objective patient-derived outcome measures are used to show that patients with high-priority scores also have better visual function outcomes or less morbidity while waiting for surgery, it does not prove that patients have been prioritized correctly for surgery. The reason for prioritizing waiting lists (rather than simply using a first-come, first-served system) is to reduce morbidity and mortality of patients waiting for surgery. Until this is achieved, the Manitoba Cataract Waiting List Program is just a consensus model to which this group of surgeons has agreed.

The use of an open-ended priority score with points given for waiting also defeats the objective of equitable treatment and encourages surgeons to manipulate the system. In many parts of Canada where 12- to 18-month waits for surgery are common, the mere act of waiting for 18 months would give a patient a higher priority score than someone who had much more severe visual morbidity who had not been

waiting as long. The act of waiting should only increase priority if the patient's clinical condition worsens or the wait produces clearly proven morbidity. Otherwise, if a patient waits for surgery without deterioration of his or her condition, it is a success of medical therapy rather than a failure of surgical therapy.

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## Reference

1. Bellan L, Mathen M. The Manitoba Cataract Waiting List Program. *CMAJ* 2001;164(8):1177-80.

## [The authors respond:]

The Manitoba Cataract Waiting List Program prioritizes patients for cataract surgery on the basis of functional impairment (VF-14), potential loss of work, potential loss of a driver's licence and time spent waiting.<sup>1</sup> We would argue that a prioritization system comprised of multiple independent components, some medical and some social, cannot be validated by a single "objective patient-derived outcome measure." We would also argue that as long as each component is reasonable and has been objectively validated where possible, the overall result is reasonable.

We chose the VF-14 as our ranking tool for functional impairment in Manitoba precisely because it has been objectively shown to be a highly consistent, valid measure of functional impairment caused by cataracts<sup>2</sup> and has been shown in outcome studies to be a robust predictor of change in patients' satisfaction with their vision.<sup>3</sup> International studies have demonstrated it to be reliable and responsive to change in visual function.<sup>4-7</sup> Two of the 14 questions in the VF-14 relate to driving; we do not believe this is a heavy bias. If

anything, the VF-14 is biased against visual impairment in the workplace because the questions were specifically selected to review a broad spectrum of vision-dependent activities in everyday life.<sup>2</sup>

We do not believe it is necessary to subject the additional points we awarded for potential loss of work to an outcome study. The ophthalmologists in our community made a value judgement that they wished to continue giving priority to patients who risked losing their jobs because of visual impairment. Similarly, most ophthalmologists tended to give priority to patients at risk of losing their driver's licence and wished to maintain this pattern of practice. (This has been subjected to outcome analysis: most studies looking at Snellen acuity after cataract surgery have shown a >90% rate of attainment of 20/40 acuity, the threshold for a driver's licence.<sup>8</sup>)

Giving points for time spent on the waiting list might encourage surgeons to manipulate the system if all patients were pooled together. However, in the Manitoba Cataract Waiting List Program each surgeon's waiting list is kept separate; all patients are assessed by the same criteria, but data are pooled only for statistical analysis. This separation of the waiting lists eliminates any reason to manipulate the system given that all members of the department share operating room time equally.

Sanmugasunderam and Romanchuk also argue that the length of time spent waiting for surgery should not affect a patient's prioritization if his or her functional impairment remains unchanged, unless the wait produces clearly proven morbidity. Surgery is booked when the cataract reduces visual function to a level that interferes with everyday activities.<sup>8</sup> This has been shown to have negative implications for general health<sup>9</sup> and has led some jurisdictions to set maximum reasonable waiting times for different levels of functional impairment.<sup>10,11</sup>

Sanmugasunderam and Romanchuk state that our program is "just a consensus model." We would argue that the consensus component of the model is an integral reason for its success. It was through consensus that we agreed upon the criteria to measure. We then selected the most objectively validated tools and agreed upon a relative scoring system. Another jurisdiction might go through the same process and come up with different criteria or a different scoring system. We feel that surgeons are more likely to accept the process if they have been involved in creating it.

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## Burgeoning career opportunities in radiation oncology

Four years ago *CMAJ* reported that residents training in radiation oncology were experiencing difficulty securing career staff positions in Canada and were seeking employment elsewhere, while others were leaving the specialty before completing training.<sup>1</sup> Currently, approximately 60 funded staff positions in radiation oncology are vacant and specialists are being recruited actively outside Canada by a number of provinces.<sup>2</sup> The Royal College of Physicians and Surgeons of Canada has recently revised its regulations to once again allow physicians in this specialty to have postgraduate training obtained outside North America assessed to determine their eligibility to sit Royal College examinations and ultimately obtain Canadian certification.

There are approximately 275 funded radiation oncology staff positions at 33 cancer treatment centres across Canada. This represents an increase of more than 60 positions in the last 4 years, including 35 in Quebec alone.<sup>3</sup> Attrition from the specialty is between 3% and 4% per year. Trends for the past 15 years show that the number of patients being treated by radiotherapy has increased by approximately 4% per year.<sup>4</sup> This rate is unlikely to change in the next 10 years.

Once the shortfall of 60 radiation oncologists is eliminated, Canada will need approximately 25 of these specialists per year to account for attrition and increasing need. However, for the next 4 years an average of only 14 residents will complete training each year. It is unlikely that this shortfall can be made up simply by offshore recruiting because other countries are experiencing similar problems. It is quite clear that for the foreseeable future, Canadian trainees in radiation oncology will have employment opportunities across the country.

This letter is to affirm to medical school graduates that the specialty will

provide good career opportunities for trainees for many years to come.

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## National stroke surveillance program needed in Canada

The Canadian Stroke Systems Coalition is to be congratulated on developing recommendations for creating a systems approach to stroke care in Canada.<sup>1</sup> Implementation of the recommendations should considerably reduce Canada's stroke burden.

To better understand the national stroke demographics and to monitor the actual impact of programs and research will require emphasis not only on monitoring of stroke risk factors as proposed by the Canadian Stroke Systems Coalition, but also on surveillance of stroke care, stroke incidence and stroke mortality. National stroke surveillance would allow us to develop an overall picture of stroke in the Canadian population, do time trend analyses, better ex-