



THE CANADIAN
MEDICAL
PROTECTIVE
ASSOCIATION

L'ASSOCIATION
CANADIENNE
DE PROTECTION
MÉDICALE

WAIT TIMES

A MEDICAL LIABILITY PERSPECTIVE

INTRODUCTION

The state of the nation's health care system is an issue of great importance to Canadians. While Canadians appear to be generally satisfied with the quality of care provided, they are increasingly expressing concerns about the timely access to care. Access to care has many facets but the most commonly heard concerns relate to the time that a patient is required to wait before receiving medically necessary treatment.

The wait-times situation has come to be one of the most dominant elements of health-care discussions. In the opinion of some, this has occurred to the detriment of other equally important issues facing the health-care system. Given the public policy attention devoted to the subject, any and all steps taken to address wait times are likely to attract scrutiny. The inherent complexities associated with addressing access to care can be too easily lost in the public debate. Given the increasing politicization of the discussion, there may also be a tendency to address only the symptoms of the wait-times issue without necessarily addressing the more complex root causes. As many elements are required in any solution to reduce health-care wait times (health human resources, access to technologies, improved infrastructure, greater funding, etc), it is not surprising that unidimensional approaches are unlikely to succeed.

While there has been an encouraging effort to reduce the length of time a patient has to wait for care, there has been less focus on addressing the real and potential concerns associated with the accountability and liability issues associated with managing wait times. The current lack of clarity as to “who is responsible for what” creates potential risk for governments, health-care institutions, physicians, other health-care professionals and, most importantly, for patients. A situation in which everyone is accountable often means, in reality, no one is. The Canadian Medical Protective Association (CMPA) believes an environment in which health-care accountabilities and liabilities are poorly defined is not in the best interest of Canadians. The Association maintains that, while Canadians benefit from wait-time initiatives that hold the potential to provide greater access to care, governments, institutions, health-care professionals and others have a collective responsibility to work together to address these accountability and liability issues. This is and should be an important element of any wait-times solution.

CMPA OBJECTIVES

This paper provides an accountability and medical liability perspective on wait times associated with health care. It identifies the most salient medico-legal considerations associated with the wait-times issue and offers recommendations for policy makers, health-care authorities and institutions, and physicians. While the paper highlights accountability and liability concerns that should be addressed, its goal is to contribute to the generation of appropriate solutions.

In offering its recommendations, the CMPA acknowledges that accountability and liability considerations form only one element of what should be a comprehensive wait-times plan of action. Nevertheless, these accountability and liability issues, if left unresolved, may well hinder the effectiveness of such a plan of action and, in so doing, undermine the effectiveness of health-care delivery in Canada. The CMPA is committed to working collaboratively with all interested parties to support a sustainable and effective solution to wait-time concerns.



BACKGROUND

As a starting point, it is perhaps instructive that the very definition of wait times is the subject of some debate. Most discussions regarding wait times for health care use as the basis of measurement the time between attendance at a consulting specialist and the completion of investigations or treatment. Some important participants in the discussion, in particular the College of Family Physicians of Canada, have expressed the view that the determination of wait times should also take into account the time between the patient's first visit with his or her family physician and when required, subsequent visits with consultants, as well as the time it takes for a patient who does not have a family physician to find one.⁴ Regardless of the definition chosen, the CMPA is of the view that a common, clearly communicated definition is required and such a definition should form the basis for all measurement activities.

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It is also important to acknowledge the requirement to wait for access to health care is neither new, nor is it a situation that is restricted to Canada. Timely access to health care is part of a broader issue of limited health-care resources that will likely, to some extent, always be present. It is safe to predict there will always be a gap between the demand for health-care services and the resources available to provide them. Given the demand is not constant, completely eliminating the gap would likely result in excess capacity. This would result in poor management of valuable health-care resources.

Accordingly, the reality is waiting times will never be zero. While disconcerting for those involved, manageable queues of patients awaiting non-urgent and elective procedures result in the best use of health-care capacity. If one accepts that the effective management of health-care wait times will be a permanent requirement, then the need to address accountability and liability issues takes on a strong degree of urgency.

In many Canadian jurisdictions, and for many clinical conditions, wait times are so lengthy they can be challenging to manage. Therefore, the issue facing the Canadian health-care system is how to reduce wait times and how to manage patients who must wait for an overly long period of time before receiving care. Wait times have become the focus of considerable public attention and are, for better or worse, the measure many people now use to grade effectiveness of the health-care system. In view of the multi-faceted nature of any solution to reducing wait times, quick progress on this issue is, while highly desirable, unlikely. Limiting investment in health care, either in the training of physicians, nurses and other health-care professionals or in the construction and maintenance of infrastructure, has long-term consequences. As an example, as Canada and many other nations have learned from experience, resolving a shortage of health-care professionals is not a task that can be accomplished in the short term. Reversing these effects requires both immediate action and a long-term commitment.

⁴ *When the Clock Starts Ticking – Wait Times in Primary Care.* www.cfpc.ca

Many Canadians, including physicians, have seen first hand that progress in addressing overly long wait times for medical treatment has been inconsistent across both different treatment procedures and different jurisdictions. One of the most concerning issues for Canadians is the disparity of access to care across the country. As an example, whether or not a cancer patient will receive radiation therapy within an established benchmark depends on the type of cancer involved, the province/territory within which a patient resides, and the hospital where the patient will receive treatment. The inconsistencies in both wait times and the approaches being pursued to reduce these times undermine confidence in the health care system.

The 2004 First Ministers *10-Year Plan to Strengthen Health Care* identified five priority procedures as the first phase of a multi-phased effort to address wait times for access to health care. These priority procedures are cancer care, cardiac care, diagnostic imaging, joint replacement and sight restoration. While the need to address high-priority procedures as a starting point is widely acknowledged as being a sound approach, it has inevitably led to concerns about resource allocations. As resources are increasingly focused on the five priority procedures, there is an increasing perception that other clinical areas are being “cannibalized” to divert resources to the “Big Five.”

A 2006 Canadian Medical Association on-line consultation with Canadian physicians revealed that 55 per cent of physicians cited the emergence of “have” and “have not” specialties as a result of resources being dedicated to the five priority areas. The media has been replete with stories that describe the “ballooning” effect that results from prioritizing certain procedures in a health-care system that is resource constrained and already operating at full capacity. This approach places some patients whose treatment requirements fall outside one of the five priority clinical areas in a difficult position as they see their wait time remain overly long and potentially being extended. Some physicians who treat such patients are also being placed in an untenable position as they struggle to find operating room time or access to care for their patients.

As noted above, wait-times management is not just a Canadian problem and our challenges are certainly not unique. Almost every country with a publicly funded health care system appears to have some problems with wait times, and wait times tend to increase in countries that have public health insurance and suffer from constraints on capacity (e.g. Portugal, the United Kingdom, and Italy). While lengthy waits are negligible in the United States², the American system is beset by other access-to-care issues that make simplistic comparisons with Canada problematic. The challenge facing Canada and many other countries is one of balancing the demand with the finite amount of available resources.

² *Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries* is available at www.oecd.org

MANAGING WAIT TIMES — PROGRESS TO DATE

A number of health care organizations and blue ribbon groups have considered the current wait-times situation and many have offered recommendations for reducing wait times. When viewed individually, the majority of these recommendations are generally very sound and, if implemented, would make a useful contribution to reducing wait times. However, when viewed in toto, they highlight the enormity of the challenge facing the health-care system.

In his final report³ released in June 2006, Dr. Brian Postl, the federal government's Wait Time Advisor, notes the wait-time initiative should be viewed as a long-term effort. His report urges immediate action in the following areas:

- Ongoing research to support benchmarking and operational improvements;
- Adoption of management practices and innovations in health systems;
- Accelerated implementation of information technology solutions;
- Cultural change amongst health professions;
- Development of regional surge capacity; and
- Public education to support system transformation.

The British Columbia Medical Association's Council on Health Economics and Policy report on wait times⁴ makes 29 recommendations based on existing evidence and research, under five categories:

- Building capacity;
- Establishing wait time benchmarks for all diagnostic, therapeutic and surgical services;
- Developing and implementing wait list management tools;
- Improving accountability; and
- Funding.

For its part, the College of Family Physicians of Canada has also released a report⁵ highlighting the significance of the shortage of family physicians as a factor in restricting timely access to care.

³ *Final Report of the Federal Advisor on Wait Times* is available at www.hc-sc.gc.ca

⁴ *Waiting Too Long: Reducing and Better Managing Wait Times in BC* is available at www.bcma.org

⁵ *When the Clock Starts Ticking* is available at www.cfpc.ca

ACCOUNTABILITY AND LIABILITY

The concepts of accountability and liability are fundamental both to reducing wait times and to addressing issues that result from an inability to achieve benchmarks and/or care guarantees. Governments, health-care authorities, hospitals and health-care providers all have some accountability for providing health-care services, but this accountability needs to be defined in a way that is practical for all involved.

Physician's duty of care

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. This duty of care is guided by the following considerations:

- A duty of care arises if there is a doctor-patient relationship.
- A doctor-patient relationship may be created when the patient is assigned to a physician for treatment, where the physician is contacted or consulted about a patient, or possibly when a patient is placed on a physician's waiting list.
- The scope of the duty of care is unique to each circumstance and depends on the extent of the physician's contact with the patient.

Physician accountability

Within their particular scope of practice, physicians have a responsibility to direct their patients' care. It is generally the

physician who determines which investigations are to be recommended, which prescriptions should be provided and which medical and surgical interventions are proposed. Notwithstanding this important role in care delivery, physicians do not ultimately make many of the decisions that impact on service accessibility. Such decisions are often made by health-care authorities and institutions who manage physicians', and consequently patients', access to resources.

Effective accountability requires those being held accountable to have the necessary powers to effectively carry out their duties. Individuals should therefore be held accountable if they have not followed procedures prescribed to govern their profession or to access the resources necessary to enable them to deliver upon their accountabilities.

For this approach to be viable, such procedures must be in place and be understood and accepted by all involved. The CMPA is concerned that, in many instances, workable procedures do not exist. In such a circumstance, physicians risk being faced with the need to deliver care to patients without having timely access to the resources necessary to meet their treatment obligations.

In a world in which timely access to care is not a problem, managing the queue of patients waiting for care would be a straightforward issue. This is often not the case. Regardless of the length of the queue, physicians remain responsible to place patients in the queue and to adjust queue positioning based on changing clinical priorities. The need to ensure queue management remains adaptable to changing clinical needs can not be overstated. This requires an ongoing monitoring of patients to ensure their clinical needs remain paramount.

Individual and collective responsibilities

One of the principal wait-times challenges facing physicians is the potential conflict between a physician's responsibility to an individual patient and his/her responsibility to other patients on the waiting list. Physicians are trained, oriented and, within a legal context, liable to provide a clearly delineated standard of care to individual patients. This individual responsibility to one's patient is a foundation of medical practice and it is clearly spelled out and well understood by physicians and, within their own scopes of practice, by other health-care professionals.

For most patients, the primary contact with the health-care system is their doctor. Patients expect their physicians, not the "system," to provide access to care and, when required, to serve as their advocate to gain such access. This expectation is unlikely to change based on government or institution-mandated accountabilities.

Furthermore, medical professional regulations and guidelines are almost exclusively based on individual patient care. Physicians and other health care providers are familiar with these regulations and how they impact care delivery. Issues relating to a physician's obligations in relation to the overall management of the waiting list are relatively new territory.

The role of benchmarks

Over the past few years, considerable emphasis has been placed on developing benchmarks for wait times, particularly but not exclusively for the five priority procedures. As government focus has rapidly shifted from benchmarks to targets to care guarantees, the identification of wait times has taken on a new urgency. The Wait Time Alliance (a coalition of several stakeholder groups facilitated by the Canadian Medical

Association) defines benchmarks as "health system performance goals that reflect a broad consensus on medically reasonable wait times for health services delivered to patients."⁶

If Canadians are to trust health-care delivery, they need to trust the indicators used to measure the performance of the health-care delivery system. Notwithstanding efforts to develop that trust, there is much work that needs to be done in the domain of benchmarks.

Conflicting measurement methodologies within and among provinces/territories are confusing and result in Canadians trying to compare apples to oranges. Given the trend to cross-jurisdictional comparisons, these methodological inconsistencies are coming under increasing attention. As an example, the Auditor General for Ontario has recently questioned why provincial wait times calculated for some of the five priority areas combine in-patient and out-patient wait times. Given that in-patients generally receive their appointments within a day, this measurement technique reduces the aggregate average and, in so doing, provides a faulty predictor of the wait time for treatment likely to be experienced by an out-patient. Similar examples of measurement inconsistencies exist in other jurisdictions. The lack of systematic consistency leaves the process open to criticism.

Reported wait times generally factor in neither waits for consultation nor the time taken to access family physicians. For example, there are indications in Ontario that, although the time a patient waits for surgery after being put on a waiting list may actually be getting shorter, the total waiting time may not be getting any better due to increased waits to see specialists following referral by a family doctor. A shortage of certain specialties contributes to longer wait times. It appears that a similar situation exists across the country.

⁶ *It's about time!* is available at: www.waittimealliance.ca

Notwithstanding the challenges associated with the establishment and reporting of benchmarks, their adoption has served to provide a measure of system performance. While the benefits of “medically reasonable” benchmarks are evident, there are certain risks associated with them. These risks largely involve the evolution of performance benchmarks to care guarantees and ultimately standards analogous to standards of care.

Over time, clinical prioritization has become less discretionary and it is now strongly influenced by established standards or guidelines. In establishing the appropriate standard of care, courts may well place a great deal of weight on clinical practice guidelines that are published by medical organizations. To date, the courts have not yet fully addressed the extent to which physicians, regional health authorities and governments may be held liable for injuries suffered by a patient who does not receive treatment within the wait-time benchmark. Assuming an ongoing supply and demand gap, a conflict between guidelines for “medically acceptable” wait times and clinical prioritization may well result.

Specialty medical societies and others must be cautious in contributing to the establishment of wait-times benchmarks that could be construed by the courts as a rigid standard. The danger of applying the same weight to wait-time guidelines as is accorded to clinical standards is real and it could potentially result in a number of unintended legal consequences.

Medical liability

Subsequent to the commitment on the part of Canada’s first ministers to develop benchmarks for “medically acceptable” wait times in five clinical areas, the Wait Time Alliance (WTA) responded to the challenge of developing medically acceptable wait

times. The final report of the WTA in August 2005⁷ emphasized that wait-time benchmarks were to be considered “health system performance goals” and included the following statement:

They are not intended to be standards nor should they be interpreted as a line beyond which a health care provider or funder has acted without due diligence.

Despite this distinction, such goals do, for the first time in Canada, provide a benchmark against which performance may be assessed. In addition to forming the basis of wait-time guarantees, these may be also significant from a medico-legal standpoint. The recent and rapid evolution from benchmarks to guarantees heightens this potential significance.

It remains to be determined how the courts might respond should civil litigation be launched if an actual wait time exceeds the wait-time benchmark or guarantee. Given this represents largely new legal territory, it is possible any such legal action would include all players in the health-care delivery system, including governments, health-care authorities, the relevant institutions and any health-care providers involved in the decision-making process. In terms of implications for physicians, from past experience, it can be expected that the courts will likely, based on the individual facts of the case, examine what a physician did, what alternatives were considered, and what efforts were made to obtain the necessary care for his or her own individual patient. In other words, the physician could be judged on his/her actions not only as they relate to providing care directly but also on his/her actions in gaining access to such care.

Any legal action would be further complicated if a patient’s condition deteriorated when a wait time exceeded the performance goal. In many ways, this is the

⁷ *It’s about time!* is available at: www.waittimealliance.ca

worst possible situation in which a number of complicating, and possibly extenuating, circumstances converge to disadvantage the patient.

Given the physician's responsibility to individual patients, there remains considerable potential for conflict with his/her as-yet-undefined responsibilities to other persons on the waiting list for care. For example, patients rightfully expect their physician will act on their behalf to gain timely access to the care needed. This gives rise to a potential situation in which a physician might be held accountable for not advocating strongly enough for a patient faced with overly long wait times. Conversely, it might easily give rise to a difficult situation in which a physician is open to accusations that he/she advocated too strongly for an individual patient at the expense of others with a higher clinical prioritization.

Government accountability

Many stakeholders have advocated two measures to incorporate government accountability for wait times – the establishment of wait-times guarantees and the withholding of funds when such guarantees are not met. Wait-times guarantees involve a commitment, on the part of governments, to deliver treatment within a publicly declared wait-time period. Should such treatment not be available within the province/territory, then provinces/territories are expected to pay for the treatment costs for patients who must travel to other jurisdictions to receive services within the wait-time period.

Over the past few years, a number of provincial/territorial governments have established wait-times guarantees, either on their own volition or, as an outflow from the 2007 federal budget, in conjunction with the federal government. While generally restricted to a few selective procedures, these guarantees represent a rapid evolution from benchmarks to what are expected to be

enforceable standards. For their part, provincial/territorial governments can hold regional and local health authorities accountable through performance agreements that include specific wait list reduction targets. In turn, it is not surprising regional and local health authorities and institutions appear to be attempting to use access to facilities as a means through which to hold physicians accountable for ensuring that collective targets are met.

Patient safety considerations

Any discussion concerning the effective management of treatment wait times must include consideration of patient safety. It is foreseeable that efforts to reduce treatment wait times and to create the most efficient system possible will generate concerns about patient safety. There are likely to be both positive and negative patient safety implications from efforts to reduce wait times. On one hand, improved access should lead to better results as patients receive care in a more timely manner. On the other hand, the rationing of time and resources to individual patients in order to enhance access for others may lead to negative outcomes. This creates a real dilemma for physicians.

Physicians should be cautious not to sacrifice quality medicine in order to achieve high process rates. This may well add to frictions between those responsible for managing the system and doctors trying to care for their patients. An increased emphasis on system performance and measurement is likely to exacerbate any such frictions. Courts, regulatory colleges and patients can be expected to hold physicians accountable for how they treated individuals – regardless of the pressures to “treat” waiting lists. This reality is unlikely to go away regardless of wait-time benchmarks.

RECOMMENDATIONS

A number of stakeholders have important roles to play in putting in place mechanisms to address the accountability and medical liability issues associated with health-care wait times. This section identifies key steps that can and should be taken to mitigate these issues. Success will not however be based on the actions of one or two of these groups but rather on each taking the necessary actions, both within their own domains and collectively with others. If true progress is to be made in reducing medico-legal risk, a broad range of actions is required.

What should policy makers do?

Governments and other policy-making bodies, particularly at the provincial/territorial level, are key players in addressing many of the accountability and liability issues described in this paper. The following eight proposed actions are all deemed to be readily achievable by governments, regulatory authorities and other policy makers, and each of these is likely to have a tangible and positive impact:

- Establish high-level accountabilities that set common parameters for regional authorities and institutions.
- Set medically reasonable wait times that do not create unreasonable expectations. In this respect, it is crucial to recognize the wait-times issue is driven as much by expectations (realistic or otherwise) as it is by other factors.
- Standardize wait-time calculation methodologies and reporting procedures.
- Respect the physician's ethical dilemma of serving the individual patient as well as the "wait list."
- Avoid the cannibalization effect wherein wait-time targets for one clinical procedure jeopardize access to others.
- Monitor the impact of wait times on patient safety and be prepared to adjust accordingly.
- Recognize the requirement for system flexibility to meet the needs of patients requiring more urgent care.
- Depict wait times as benchmarks or targets, not as guarantees.

What should health care authorities and institutions do?

The CMPA believes that regional and local health-care authorities and institutions, such as hospitals and clinics, should undertake the following actions to address wait times related to accountability and liability issues:

- Establish clear accountabilities that encompass all elements of the health-care delivery system, including institutions, physicians and other health care professionals.
- Communicate these accountabilities to all involved, including patients.
- Implement effective procedures to manage wait times including:
 - guidelines and tools for effectively prioritizing patients, and
 - methodologies to monitor patients and re-prioritize queue placements as required.
- Assist physicians in assigning patients to the queue and in ensuring flexibility to adapt the queue to changing clinical conditions.
- Actively share best wait times management practices. Greater emphasis on sharing practical lessons and best practices should have positive results.

- Implement reliable wait-time reporting. The emphasis here is on the words “reliable reporting” that engenders trust in the health-care system.
- Monitor and respond as necessary to instances of “cannibalization” of services.

What should the medical profession do?

The medical profession (specialty societies, national and provincial/territorial associations and others) can contribute to improved accountability and liability through the following realizable actions:

- Play a supportive role in the evaluation and determination of medically appropriate wait times. Since the likelihood of targets being interpreted by the courts and others as de facto standards is real, the importance of setting realistic targets cannot be over-emphasized. Within a legal environment that is yet to be fully charted, specialty societies and others should exercise prudence when contributing to establishing benchmarks. For example, particular care should be taken to ensure targets are realistic and in stating that wait-time benchmarks should not be interpreted as de facto standards.
- Advocate for the procedures necessary to ensure the management of wait times leads to better patient care. The medical profession should seek to leverage the patient safety benefits inherent in any wait-times reduction initiative, while actively working to minimize the potential negative implications.
- Require institutions in which physicians work, whether they are hospitals or clinics, to have clearly-established accountabilities and procedures for managing treatment wait times.

What should referring/consulting physicians do?

For physicians whose wait times may be exceeding the recommended benchmarks, it is important to recognize the courts, in consideration of the specific facts of the case, may determine the physician owes a duty of care from the moment his/her office accepts a referral, irrespective of whether the patient has been seen by the physician. Again depending on the facts of the case, it may be argued that the referring physician continues to have a duty of care beyond the simple act of referral which may include continued follow-up, monitoring, and advocacy for the patient.

The following recommendations for physicians address medical liability considerations related to treatment wait times:

For the referring physician:

- Be aware of the date of the scheduled appointment provided by the consultant and determine if the timing is a cause for significant clinical concern.
- Consider appropriate ongoing care for the patient during the period while he/she is waiting for the appointment.
- Inform the patient about the signs or symptoms for which he/she should seek additional medical care during the wait time.
- Communicate to the consulting physician any significant changes in the clinical condition of the patient.
- Should the clinical condition of your patient necessitate an earlier appointment or should the scheduled appointment exceed the wait-time benchmark, attempt to negotiate an earlier appointment. If this is not possible consider referring the patient elsewhere.

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- Document the clinical assessment and any attempts to arrange an earlier appointment.
 - Monitor patients and re-prioritize queued patients as an ongoing responsibility.
 - Communicate patients' needs to the care-providing institutions, consulting physicians and others as required.

For the consulting physician:

- Notify the referring physician of the scheduled appointment dates.
 - If, at the time of the referral, the wait time exceeds the benchmarks, consider:
 - Declining the new consultation and recommending referral elsewhere, and
 - Notifying the appropriate institution that the wait times are beyond the stated performance goals and that it is necessary to refer patients elsewhere.
 - Should the wait time begin to exceed the recommended benchmark for patients already assessed and on the physician's list, consider:
 - Informing the patients and discussing the potential adverse consequences of waiting, if any;
 - Discussing alternative treatment options if available, and
 - Offering possible referral elsewhere.
- Be aware of any legislation and/or institutional requirements with respect to the management of wait times.
 - Monitor patients and re-prioritize queued patients as an ongoing responsibility.
 - Communicate patients' needs to the care-providing institutions, primary care providers and others as required.
 - Document all actions taken in each of the above circumstances.



CONCLUSIONS

All Canadians recognize the potentially negative impact that overly long wait times can have on patient care. Inappropriately long waits may adversely affect patient outcomes, threaten patient safety, and frustrate patients and their providers. Moreover, medically unreasonable wait times are a serious threat to the confidence Canadians have in their health care system. While representing only the first step in what must be a concerted and sustained campaign, recent efforts to reduce wait times are encouraging and should be fully supported.

Since the root causes of lengthy wait times have existed for a number of years, even with immediate action, it will take some time to achieve acceptable solutions. In the interim, governments, regulatory authorities, regional and local health-care authorities, and health providers, including physicians, must work collectively to resolve the accountability and liability issues associated with wait-times management. It will take a coordinated effort from all parties involved if the fundamental questions are to be

addressed. However, until these questions are adequately addressed, the CMPA remains concerned physicians and their patients are at risk.

Accordingly, the CMPA is committed to working with all parties to put in place workable solutions to the accountability and liability issues. The Association believes implementation of the recommendations outlined above would result in the tangible reduction in the risk to which its members and their patients are currently exposed. The reduction of such risk should be an important element of any wait-times approach. In this regard, the CMPA recognizes compromises may well be required if the competing dynamics of system efficiency, patient safety, professional accountability, individual liability and patient expectations are to be met. The primary goal should be to ensure every Canadian has timely access to high-quality health care.



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