The Current State of Cataract Anesthesia in Ontario

A Joint Statement from the OMA Sections on Anesthesiology and Ophthalmology
(Accompanies the Joint Statement on Sedation Standards for Uncomplicated Cataract Surgery Under Topical Anesthesia)

This statement refers to cataracts performed under topical anesthesia only. Anesthesia for more complex cases with ocular comorbidities, cases done under eye blocks or combined surgical cases are outside the scope of this paper.

The Anesthesia and Ophthalmology Sections of the OMA are committed to the delivery of quality healthcare in Ontario. Quality care, timely access, patient safety, and high levels of productivity are all essential attributes of a sustainable health care system. Part of our Sections’ commitment to quality is our commitment to continuous improvement in the productivity of the services we provide.

We support the government’s effort to improve the productivity of the health care system. However, we are concerned that the rushed implementation of new fee arrangements relating to cataracts performed under topical anesthesia could lead to a loss of access to local services in northern and rural communities as well as lower volume centres in general.

Many models exist for providing sedation during cataract surgery. Presently, the most common practice in Ontario is for sedation to be provided by a dedicated Anesthesiologist. Other models in more limited use across the province and in other jurisdictions include nurse-administered sedation supervised by the ophthalmologist and cataract surgery with anxiolysis (a single, oral sedative or analgesic medication administered in doses appropriate for the unsupervised treatment of insomnia, anxiety, or pain) or with no sedation at all.

Over the past six years, the Section on Anesthesiology has worked with the Government of Ontario to introduce novel cost effective ways to deliver anesthesia services. The Anesthesia Care Team (ACT) is one example of how we have partnered with the MOHLTC to capitalize on productivity gains by delivering care in a more cost effective fashion while adhering to the principles of quality care, timely access and patient safety. ACTs have contributed to lower cataract case costs by enabling the safe and efficient functioning of high volume cataract centres such as the Kensington Eye Institute and others across the province. They are also very efficient in their use of the anesthesiology human resources. These teams are most effective in settings where there are:

- a sufficiently high volume of patients
• appropriate facilities where a supervising anesthesiologist can safely oversee multiple procedures at one time
• trained anesthesia assistant team members

It is important to note that the impact of an ACT is only attainable where all of these circumstances can be met. In localities where there is insufficient infrastructure, or an insufficient volume of cases, it is not possible to achieve these economies of scale.

The Government of Ontario recently imposed changes to the fee schedule in relation to anesthesia services for cataracts as well as surgical billing codes for the ophthalmologist.

While the reduced flat fee may be appropriate as a supervisory fee in settings where ACTs can be deployed, the new fee structure is inadequate as a means of funding the traditional single anesthesiologist model. While other cost-saving methods of delivering anesthesia could be developed they would take time to develop and implement. The ACT model is an example of a cost-saving model that is well suited to large centers with multiple eye rooms but not feasible in lower volume centres. The attached paper suggests some possibilities that might apply to lower volume centres but these options require investigation and planning to implement. If the government persists with the recently implemented changes uniformly across the province, it will have the unintended result of curtailing ‘close to home’ patient access to cataract surgery in rural and northern communities, as eventually anesthesia services will likely be withdrawn. Urban hospitals with relatively low volume programs could see themselves similarly affected. Furthermore, patients who require dedicated anesthesiology care would be left without access.

If this reduced access is a problem that the MOHLTC would seek to avoid, we believe that a potential solution to this problem would be a temporary delay of the current changes to allow for the phase in of new models in localities where alternatives like ACTs are not yet possible. This would allow time for transitioning to a sustainable anesthesiologist led model that might involve unique funding agreements for individual centres such as a per diem system or funding for anesthesia assistants. Any non-anesthesia led sedation model will also require a certified and funded sedation assistant as per guidelines of practice. Ophthalmologist-led sedation may represent a change in scope of practice for surgeons which will likely encounter significant resistance from both physicians and patients.

Both Sections urge the MOHLTC to return to the negotiating table with the OMA and that both parties engage the Sections so that solutions can be found and that agreement on the future direction of cataract anesthesia in Ontario can be reached.
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