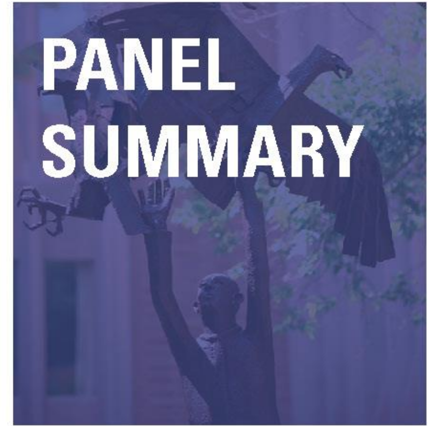
McMaster University

McMaster HEALTH FORUM



PANEL SUMMARY

IMPROVING THE DELIVERY OF COMPLEX CANCER SURGERIES IN CANADA

(EDMONTON PANEL)

4 OCTOBER 2014

EVIDENCE >> INSIGHT >> ACTION

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

About citizen panels

A citizen panel is an innovative way to seek public input on high-priority issues. Each panel brings together 10-14 citizens from all walks of life. Panel members share their ideas and experiences on an issue, and learn from research evidence and from the views of others. The discussions of a citizen panel can reveal new understandings about an issue and spark insights about how it should be addressed.

About this summary

On October 4, 2014, the McMaster Health Forum convened a citizen panel in Edmonton (Alberta) on how to improve the delivery of complex cancer surgeries in Canada. The purpose of the panel was to guide the efforts of policymakers, managers and professional leaders who make decisions about our health systems. This summary highlights the views and experiences of panel participants about:

- the underlying problem;
- three possible options to address the problem; and
- potential barriers and facilitators to implement these options.

The citizen panel did not aim for consensus. However, the summary describes areas of common ground and differences of opinions among participants and (where possible) identifies the values underlying different positions.

Table of Contents

Summary of the panel ... 1

Discussing the problem: What are the most important challenges to improving the delivery of complex cancer surgeries? ... 2

- Making decisions in the midst of a cancer diagnosis is difficult ... 3
- Lack of support for informal and family caregivers ... 5
- Inequities exist in access to optimal surgical care ... 6
- Inequities exist in access to palliative care ... 6
- Current financial arrangements limit our capacity to improve the delivery of complex cancer surgeries ... 6
- Regulations for surgeons and hospitals are lacking ... 7

Discussing the options: How can we address the problem? ... 8

- **Option 1** – Encourage the local adoption of quality-improvement initiatives to improve the delivery of complex cancer surgeries where they are now being provided ... 9
- **Option 2** – Implement province-wide quality-improvement initiatives to improve the delivery of complex cancer surgeries where they are now being provided ... 11
- **Option 3** – Regionalize complex cancer surgeries into designated surgical centres of excellence ... 13

Discussing the implementation considerations: What are the potential barriers and facilitators to implementing these options? ... 16

Discussing how to move forward ... 17

Acknowledgments ... 18

Summary of the panel

Panel participants discussed the shortfalls in the delivery of complex cancer surgeries in Canada and the causes of these shortfalls. In particular they focused on six challenges, which gave them the opportunity to begin to articulate the values underlying their positions on this topic: 1) making decisions in the midst of a cancer diagnosis is difficult; 2) informal and family caregivers lack support; 3) inequities exist in access to optimal surgical care; 4) inequities exist in access to palliative care; 5) current financial arrangements limit our capacity to improve the delivery of complex cancer surgeries; and 6) regulations for surgeons and hospitals are lacking.

Participants reflected on three options (among many) for improving the delivery of complex cancer surgeries in Canada: encourage the local adoption of quality-improvement initiatives to improve the delivery of complex cancer surgeries where they are now being provided (option 1); implement province-wide quality-improvement initiatives to improve the delivery of complex cancer surgeries where they are now being provided (option 2); and regionalize complex cancer surgeries into designated surgical centres of excellence (option 3). Participants generally agreed that option 3 was more likely to significantly improve the delivery of complex cancer surgeries by changing the structure of the system, rather than simply changing care processes. Several values-related themes emerged during the discussion about option 3, which include: continuously improving; excellent health outcomes; expertise; safety; cost-effectiveness; policies based on data and evidence; collaboration among providers; fairness; and excellent patient- and family-experience.

When turning to potential barriers and facilitators to moving forward, the discussion initially focused on existing, yet passive, efforts in the province to regionalize certain surgical procedures. Participants mostly emphasized the resistance to the three options that might be encountered from local providers and managers (e.g., to the imposition of province-wide quality-improvement initiatives), but also public resistance (if regionalization leads to a loss of local expertise or the regionalization model is based on only the two 'poles' of Calgary and Edmonton). Lastly, the long time required to assess the full impact of these three options could also be perceived as a barrier, and fuel resistance towards such quality-improvement efforts.

"It is a daunting journey. If I didn't have people helping me, I would say forget it [undergoing complex cancer surgery]."

Discussing the problem:

What are the most important challenges to improving the delivery of complex cancer surgeries?

Panel participants began by reviewing the findings from the pre-circulated citizen brief, which highlighted what is known about the underlying problem – shortfalls in the delivery of complex cancer surgeries in Canada – and its causes. In particular they focused on six challenges, which gave them the opportunity to begin to articulate the values underlying their positions on this topic:

- making decisions in the midst of a cancer diagnosis is difficult;
- informal and family caregivers lack support;
- inequities in access to optimal surgical care exist;
- inequities in access to palliative care exist;
- current financial arrangements limit our capacity to improve the delivery of complex cancer surgeries; and
- regulations for surgeons and hospitals are lacking.

We review each of these challenges in turn below.

Making decisions in the midst of a cancer diagnosis is difficult

Participants initially focused on the challenges of making an informed decision in the midst of a cancer diagnosis. They identified two sets of related challenges that may affect decisions faced by patients requiring complex cancer surgeries and their families: 1) the emotional nature of the cancer diagnosis; and 2) the lack of information and decision support.

Participants discussed at length the emotional nature of the cancer diagnosis. A few participants complained that they were informed about their diagnosis and the available treatment options in ways that did not fully consider their emotional needs. As one participant said: "The doctor looked at the scan and said 'yes, you have cancer.' It was very cold and he had no bedside manners. He didn't even say what type or stage." A second participant claimed that the pressures on the health system and healthcare providers have created a context where patients have become simple statistics: "The system has pushed healthcare workers so far that they are not in touch with your feelings. When a patient is in hospital they become a number sitting in the hospital. The patient is just a number. Their dignity is gone. When you take that last bit of dignity, what do they have left?" A third participant added that hospitals now seem to be run like businesses. "When you're in there you see a doctor, he can see you only

Box 1: Key features of the citizen panel

The citizen panel about improving the delivery of complex cancer surgeries in Canada had the following 11 features:

1. it addressed a high-priority issue in Canada;
2. it provided an opportunity to discuss different features of the problem;
3. it provided an opportunity to discuss three options for addressing the problem;
4. it provided an opportunity to discuss key implementation considerations (e.g., barriers);
5. it provided an opportunity to talk about who might do what differently;
6. it was informed by a pre-circulated, plain-language brief;
7. it involved a facilitator to assist with the discussions;
8. it brought together citizens affected by the problem or by future decisions related to the problem;
9. it aimed for fair representation among the diversity of citizens involved in or affected by the problem;
10. it aimed for open and frank discussions that will preserve the anonymity of participants; and
11. it aimed to find both common ground and differences of opinions.

for five minutes, then they are off to the next one. You are treated as a number and hospitals [are run] like department stores." Several participants emphasized that the system needs a makeover to regain what we lost – the contact and familiarity between healthcare providers and patients. This was perceived as essential to support patients and families who must face extremely emotional and potentially life-changing decisions.

Participants also pointed out the lack of information and decision support available. As one participant indicated, patients and families are in dire need of support to make informed decisions. "A person cannot go through it by themselves, we need the knowledge to make informed decisions." A second participant was shocked that doctors did not fully disclose all the information about the treatment options available to her husband, who was recently diagnosed with oesophagus cancer (including the option of not undergoing complex cancer surgery). This participant pointed out that the lack of information and decision support created an environment that fuelled decisional conflicts among family members, which are already fuelled by the emotional intensity of the cancer diagnosis. " I didn't want my husband to have the surgery. Nobody said he didn't have to do it. No option was given. No one talked to me about it. They totally ignored me as a caregiver." Reacting to this experience, another participant said: "I know that the system is overwhelmed, but it terrifies me because I want to know my options to make educated guesses."

Participants then discussed the different types of questions they believed were important to ask in order to make informed treatment decisions.

- What will be the impact on my family?
- What will be the costs associated with undergoing complex cancer surgery (e.g., out-of-pocket expenses associated with travel if the surgery is not delivered locally)?
- What is the expertise of the surgeon (e.g., specialty area and volume of surgery)?
- What are the risks associated with this type of surgery?
- What are the risks associated with travel to undergo complex cancer surgeries?
- Is there high-quality post-operative care available locally (if the surgery is not delivered locally)?
- What will be my quality of life after surgery?
- Is it worth undergoing complex cancer surgery at this stage in my life?

Several participants called for mechanisms to help patients obtain timely and trustworthy information to answer these questions. This information should be linguistically and culturally sensitive, as well as accessible to people with limited literacy skills. Some

participants emphasized the need to have an advocate with the knowledge and skills to interpret such information, and to guide patients and families through the decision-making process. A few participants also pointed out that this information should be accessible via a centralized system.

Lack of support for informal and family caregivers

Participants were critical of the lack of support offered to the informal and family caregivers of patients who undergo complex cancer surgeries. They emphasized the crucial role that caregivers play along the cancer journey. "It is a daunting journey. If I didn't have people helping me, I would say forget it [undergoing complex cancer surgery]." One participant said: "As Canadians, we deserve the right to have the proper support system in place when going through cancer." Yet, many informal and family caregivers faced many challenges in their roles, particularly those with lower incomes and those living in remote and northern communities who must travel to urban centres to accompany their loved ones undergoing complex cancer surgeries. Participants called for greater financial support to alleviate the burden on caregivers, who can face significant out-of-pocket expenses, as well as greater practical support, including accommodations like the Ronald McDonald Houses that provide a 'home away from home.'

Box 2: Profile of panel participants

The citizen panel aimed for fair representation among the diversity of citizens likely to be affected by the problem. We provide below a brief profile of panel participants.

- **How many participants?**
  13
- **Where were they from?**
  All participants were within two hours driving distance from Edmonton
- **How old were they?**
  All participants were at least 25 years of age – 25-44 (7%), 45-64 (54%), 65 and older (39%)
- **What perspective did they bring?**
  All participants had experience with cancer, complex cancer surgeries or other major surgeries, as patients or informal/family caregivers
- **Were they men, or women?**
  Men (38%) and women (62%)
- **What was the educational level of participants?**
  8% completed elementary school, 17% completed high school, 33% completed community college, and 42% completed a bachelor's degree/post-graduate training or professional degree
- **What was the work status of participants?**
  10% self-employed, 20% working full-time, 20% working part-time, 40% retired, and 10% disabled
- **What was the income level of participants?**
  17% earned less than $20,000, 25% between $20,000 and $40,000, 33% between $40,000 and $60,000, 8% earned more than $80,000, and 17% preferred not to answer
- **How were they recruited?**
  Selected based on explicit criteria from the AskingCanadians™ panel and from advertisements via cancer organizations and societies

Inequities exist in access to optimal surgical care

Participants were concerned about inequities in access to optimal surgical care across Alberta, but also across the country. A few participants claimed that certain patients are privileged because they live near a surgical centre of excellence. These participants were quite concerned about the barriers to accessing optimal surgical care for those living in rural and remote areas. Such patients and their families will likely face significant emotional and financial burdens when travelling to undergo complex cancer surgery delivered in another region. One participant was particularly worried about the health and safety of patients having to travel to obtain surgical care, which could create additional risks (e.g., stitches could rip). This participant also expressed concern that the overall health outcomes and recovery of patients could be affected by the lack of comfort and the additional stress generated by the travel. A few participants pointed out that these inequities have been an ongoing issue given the vast Canadian landscape and its low-density population, which require that many patients travel to obtain specialized care only available in urban centres. However, they emphasized that it was essential to collectively find ways to overcome all the barriers that may restrict access to optimal surgical care and to alleviate the burden on patients and families who must travel.

Inequities exist in access to palliative care

A few participants discussed the lack of access to palliative care. These participants emphasized that palliative care was essential to ensure the best possible quality-of-life for cancer patients and their families. They regretted that patients and families are often referred to palliative care very late in their cancer journey. One participant went further and claimed that access to high-quality palliative care is "sadly lacking" in rural areas.

Current financial arrangements limit our capacity to improve the delivery of complex cancer surgeries

Participants talked to a lesser extent about current financial arrangements and how they may limit our capacity to improve the delivery of complex cancer surgeries. A few participants expressed concern about the financial sustainability of the health system given that the costs associated with cancer surgeries are expected to rise over time. As one participant said: "I care what it costs. I'm always prepared to be told: '*we can't afford to pay that*'." A second participant, while acknowledging the difficult fiscal situation, said that this emphasis on the lack of funding sometimes makes patients feel like they are part of the burden. "The system is so burdened financially with hospital cut backs. We hear all about it. But sometimes,

patients in need will go in and start to feel like [they are] part of the burden. The last thing you want to see is for the patient to feel that they are a burden before they die."

Regulations for surgeons and hospitals are lacking

Participants also talked to a lesser extent about current regulations for surgeons and hospitals. A few participants expressed concern about the minimal regulation regarding which procedures surgeons can deliver within their specialty area, or how frequently they need to deliver these procedures to ensure their surgical skills remain up to date. They were similarly concerned about the lack of regulation about which surgical procedures hospitals can deliver or how frequently they need to deliver them to ensure that quality remains high. One participant indicated that there was a need to raise public awareness about this. "That scares me. It is very scary and Canadians need to pay attention to that." Other participants were also concerned that 'solo' surgeons could be allowed to perform these high-risk and resource-intensive cancer surgeries in low-volume hospitals. One participant indicated that it was critical that surgeons performing these very complex procedures be adequately supported by highly skilled personnel, including other surgeons who may be called upon to provide support and advice during the surgery (especially if an adverse event occurs). "I was fortunate that I had both the surgeon and his mentor work on me."

"[Regionalization is the most] cost-effective use of trained personnel."

Discussing the options:
How can we address the problem?

After discussing the challenges that together constitute the problem, participants were invited to reflect on three options (among many) for improving the delivery of complex cancer surgeries in Canada:

1) encourage the local adoption of quality-improvement initiatives to improve the delivery of complex cancer surgeries where they are now being provided;
2) implement province-wide quality-improvement initiatives to improve the delivery of complex cancer surgeries where they are now being provided; and
3) regionalize complex cancer surgeries into designated surgical centres of excellence.

Several values-related themes emerged with some consistency during the discussion about these options, including: stewardship; continuously improving both surgical and post-operative care; implementing policies based on data and evidence; excellent health outcomes; and fairness. We review the values-related themes for each option in more detail on page 9.

Option 1 – Encourage the local adoption of quality-improvement initiatives to improve the delivery of complex cancer surgeries where they are now being provided

The discussion about the first option focused on encouraging healthcare providers (e.g., surgeons, nurses and others) and managers to adopt quality-improvement initiatives in local hospitals in order to improve the delivery of complex cancer surgeries. Examples of such local quality-improvement initiatives may include: promoting audit and feedback; promoting the use of clinical decision support systems; promoting continuing medical education; and implementing enhanced recovery programs.

Four values-related themes emerged during the discussion, which highlighted the potential benefits of option 1. These values-related themes include:

- collaboration (option 1 relies on the collaboration of all local health-system stakeholders);
- continuously improving (option 1 may support local continuous-improvement efforts);
- ensuring an excellent patient and family experience (option 1 may be particularly attuned to the needs of local patients and families); and
- innovation (option 1 may encourage local innovations in the delivery of complex cancer surgeries).

Overall, this option was perceived as the easiest to implement. Participants generally agreed that one of the strengths of this option was that it relies on collaboration among all local health-system stakeholders (e.g., surgeons, nurses, managers, patients and families). This option could ensure that all stakeholders buy in to the collaborative efforts necessary to improve the delivery of complex cancer surgeries where they are now being provided.

Participants also indicated that this option supported continuous improvements to the delivery of care by providing direct feedback to healthcare providers and managers. A few participants suggested that this option also aimed to improve the care experience of patients and families wherever complex cancer surgeries are performed (in both low- and high-volume hospitals). In addition, a few participants emphasized that this option could be seen as encouraging local innovations in the delivery of complex cancer surgeries, instead of imposing a rigid delivery model for all surgeons and hospitals.

Despite the potential benefits of option 1, participants focused their discussion much more on the potential drawbacks of encouraging the local adoption of quality-improvement intiatives. They generally indicated that option 1 was too limited in its capacity to improve the delivery of complex cancer surgeries. A few participants even questioned whether this option was really new. As one participant said: "Isn't it what they are trying to do now?"

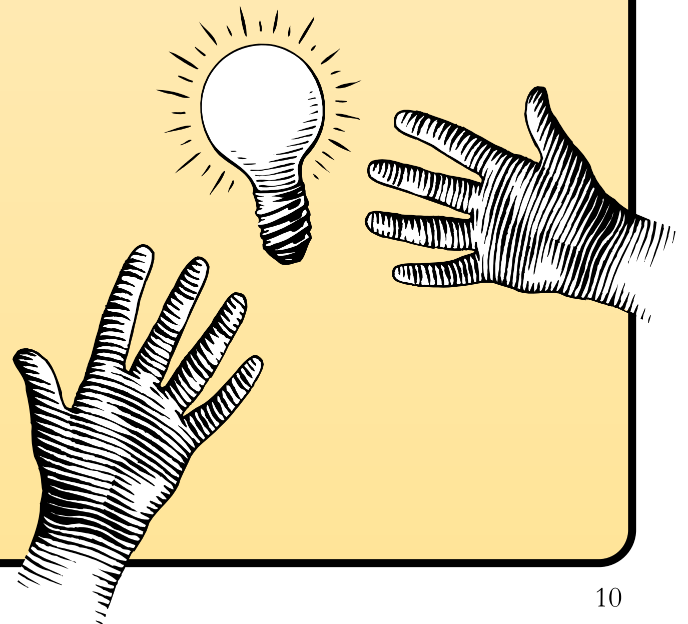
When discussing the limitations of option 1, three values-related themes emerged:

- stewardship (option 1 may lack coordination and management from a higher authority necessary to implement these local quality-improvement initiatives);
- policies based on data and evidence (option 1 may lead to policies that are not aligned with what is known about the relationship between surgical volumes and outcomes); and
- excellent health outcomes (option 1 may improve the local delivery of care, but not patient outcomes).

Participants argued that simply 'encouraging' local quality-improvement initiatives could be ineffective. They indicated that this approach lacked coordination and management from a higher authority. Without proper stewardship, these local quality-improvement initiatives will be, as one participant pointed out, "moving targets that could be easily side-tracked."

Box 3: Key messages about option 1

- Participants generally indicated that option 1 was too limited in its capacity to improve the delivery of complex cancer surgeries.
- When discussing the limitations of option 1, three values-related themes emerged:
  - stewardship (may lack coordination and management from a higher authority necessary to implement these local quality-improvement initiatives);
  - policies based on data and evidence (may lead to policies that are not aligned with what is known about the relationship between surgical volumes and outcomes); and
  - excellent health outcomes (may improve the local delivery of care, but not necessarily patient outcomes).



In addition, a few participants were concerned that change may be guided more by local politics than by data and evidence. These participants indicated that available evidence regarding post-surgical outcomes in low-volume versus high-volume hospitals is pointing in the direction of structural changes to the system, rather than simply changing care processes. So, while option 1 could improve the local delivery of care, participants did not think it was the most promising option to improve patient outcomes.

Option 2 – Implement province-wide quality-improvement initiatives to improve the delivery of complex cancer surgeries where they are now being provided

The discussion about the second option focused on implementing province-wide quality-improvement initiatives to improve the delivery of complex cancer surgeries where they are now being provided. Like option 1, this second option is not intended to change where and by whom these cancer surgeries are being provided. However, in contrast to option 1, this option proposes a top-down approach to quality improvement and assumes that healthcare providers and hospital managers can achieve significant improvements, but that they need appropriate support, incentives and directives to do this. Examples of province-wide quality improvement initiatives may include: developing provincial guidelines and standards for these cancer surgeries; implementing a pay-for-performance scheme for hospitals; developing or expanding supports for patients and families; and establishing requirements for reporting to the public about quality indicators and other performance measures.

Four values-related themes emerged during the discussion about option 2:

- continuously improving (option 2 may support province-wide continuous-improvement efforts, and facilitate the dissemination and uptake of successful local initiatives across the province);
- stewardship (option 2 actively involves the provincial government in developing guidelines and standards for complex cancer surgeries);
- accountability (option 2 may increase public accountability by establishing requirements for ongoing reporting about quality indicators and other performance measures); and
- fairness (option 2 could be extended to include the development of pan-Canadian guidelines and standards to ensure that all Canadians have access to optimal surgical care).

Overall, this option was perceived as more promising than option 1 to continuously improve the delivery of complex cancer surgeries where they are now being provided. However, a few participants viewed options 1 and 2 as complementary, rather than being mutually exclusive. These participants indicated that successful local quality-improvement initiatives (as described in option 1) should feed into province-wide quality-improvement initiatives (as described in option 2).

Participants generally agreed that one benefit of option 2 was the stewardship role played by the provincial government in developing guidelines and standards for these complex cancer surgeries. Participants emphasized that the government had access to more levers to bring about change than local health-system stakeholders alone. A few participants argued that option 2 should not be restricted to the level of the province. They suggested that what is needed is the development of pan-Canadian guidelines and standards to ensure that all Canadians have access to optimal surgical care.

Several participants also emphasized that this option could improve public accountability by establishing requirements for ongoing reporting about quality indicators and other performance measures. However, a few pointed out that there will likely be resistance among healthcare providers and hospitals to requirements established at the provincial level.

Box 4: Key messages about option 2

- Four values-related themes emerged during the discussion about the potential benefits of option 2:
    - continuously improving (may support province-wide continuous-improvement efforts, and facilitate the dissemination and uptake of successful local initiatives across the province);
    - stewardship (actively involves the provincial government in developing guidelines and standards for complex cancer surgeries);
    - accountability (may increase public accountability by establishing requirements for ongoing reporting about quality indicators and other performance measures); and
    - fairness (could be extended to include the development of pan-Canadian guidelines and standards to ensure that all Canadians have access to optimal surgical care).
- When discussing the limitations of option 2, two values-related themes emerged:
    - fairness (option 2 may have some unintended consequences to consider like 'cherry-picking' patients); and
    - excellent health outcomes (option 2 may not lead to the most optimal patient outcomes).

When discussing the limitations of option 2, two values-related themes emerged:

- fairness (option 2 may have some unintended consequences like 'cherry-picking' patients); and
- excellent health outcomes (option 2 may not lead to the most optimal patient outcomes).

Several participants expressed concerns about how public reporting, as well as pay-for-performance, may affect fairness in access to complex cancer surgeries. More specifically, these participants were concerned that such quality-improvement initiatives could actually lead providers and hospitals to 'cherry-pick' patients who may help them score well, or to avoid those who may cause them to score poorly, in order to make their statistics look better. As one participant said: "I have concerns that [they wouldn't] want to take people like me because the success rate is not there. My chances of my survival are not high."

In addition, participants generally agreed that, by not making structural changes (i.e., maintaining the delivery of complex cancer surgeries where they are now being provided), the impact of option 2 would most likely be limited in improving health outcomes.

Option 3 – Regionalize complex cancer surgeries into designated surgical centres of excellence

The discussion about the third option focused on regionalizing complex cancer surgeries into designated surgical centres of excellence. This option includes efforts to change the structure of the health system and to set province-wide standards to support the regionalization of complex cancer surgeries. This option assumes that changes to who performs the surgeries and where they are performed will be needed to improve the delivery of care. This option proposes a top-down, province-wide approach to designing and implementing changes to who does what and where across the province. As with option 2, this option can include developing or expanding supports for patients and families.

Nine values-related themes emerged during the discussion about option 3:

- continuously improving (option 3 is more likely to yield continuous improvements in the delivery of complex cancer surgeries since it focuses on changing the structure of the system);
- excellent health outcomes (option 3 is more likely to improve patient outcomes);
- expertise (option 3 aims to generate the concentration of expertise necessary to perform complex cancer surgeries);

- safety (option 3 may ensure safer surgical care with its concentration of expertise);
- cost-effectiveness (option 3 aims to make the most cost-effective use of trained personnel);
- policies based on data and evidence (option 3 may lead to policies that are aligned with what is known about the relationship between surgical volumes and outcomes);
- collaboration (option 3 may nurture greater collaboration among providers);
- fairness (option 3 should not create additional barriers restricting access to complex cancer surgeries); and
- excellent patient- and family-experience (option 3 should be attuned to the values, needs and preferences of patients and families).

Overall, participants generally agreed that option 3 was more likely to significantly improve the delivery of complex cancer surgeries since it was aiming to change the structure of the system, which ultimately was more likely to yield continuous improvements and improve patient outcomes. Referring to their personal experiences, as well as the volume-outcome literature, participants pointed out that this option offered the most "cost-effective use of trained personnel."

Participants also emphasized that having a concentration of expertise in regional surgical centres of excellence was the best way to ensure safer surgical care. As one participant indicated, regional centres "will have the tools to deal with complications in a better fashion" than solo surgeons working in low-volume hospitals.

Still referring to the concentration of expertise, participants indicated that option 3 was the one making the most cost-effective use of trained personnel, and the one most closely aligned with what is known about the relationship between surgical volumes and outcomes.

Several participants also indicated that this option would most likely create an environment that could nurture greater collaboration among providers (e.g., having several surgeons being able to support each other and provide mentoring opportunities for trainees).

Participants emphasized the need for fairness in access to optimal surgical care and that regionalization efforts should be attuned to the values, needs and preferences of patients and families. They called for supportive housing for patients and families who must travel, immediate financial support to reduce out-of-pocket expenses (e.g., gas vouchers and other types of allowances), supports for the use of communication technologies that allow patients to stay in touch with their families back home during their hospitalization, volunteer programs that could offer practical support (e.g., driving patients to appointments), and peer support programs so that patients and families could be coached by people who have experienced similar cancer journeys.

Box 5: Key messages about option 3

- Participants generally agreed that option 3 was more likely to significantly improve the delivery of complex cancer surgeries.

- Nine values-related themes emerged during the discussion about option 3:
    - continuously improving (focuses on changing the structure of the system);
    - excellent health outcomes (more likely to improve patient outcomes);
    - expertise (generates a concentration of expertise);
    - safety (ensures safer surgical care);
    - cost-effectiveness (most cost-effective use of trained personnel);
    - policies based on data and evidence (aligned with what is known about the relationship between surgical volumes and outcomes);
    - collaboration (among providers);
    - fairness (should not create additional barriers and should mitigate the negative consequences); and
    - excellent patient- and family-experience (should be attuned to the values, needs and preferences of patients and families).

"[Regionalization] needs to be looked at in a holistic way, with the family taken into consideration."

Discussing the implementation considerations:

What are the potential barriers and facilitators to implementing these options?

After discussing the three options (among many) for improving the delivery of complex cancer surgeries in Canada, participants examined potential facilitators for moving forward. The discussion initially focused on existing, yet passive, efforts in the province to regionalize certain surgical procedures. A few participants indicated that there was an opportunity to build on this foundation in moving forward with efforts to regionalize complex cancer surgeries.

When turning to potential barriers, participants identified different types of resistance that could be encountered with the three options. For instance, some participants pointed to the likely resistance of local providers and managers to adopting quality-improvement initiatives (option 1), and especially those imposed by the provincial government (option 2). Other participants emphasized the resistance of providers and managers to publicly reporting on

quality indicators and other performance measures (option 2). Others predicted public resistance to the loss of local expertise if complex cancer surgeries were regionalized, and to a regionalization model based on only the two 'poles' of Calgary and Edmonton (option 3). Lastly, a few participants indicated that the long time required to assess the full impact of these three options could also be perceived as a barrier, and fuel resistance towards such quality-improvement efforts.

Discussing how to move forward

As the citizen panel concluded, participants expressed a desire to move forward in four ways. First, most participants called for health-system leaders and stakeholders to proactively regionalize complex cancer surgeries into designated surgical centres of excellence. As one participant said: "We need to work on the regional model for centres of excellence and making use of facilities that are barely being used for other procedures." Some participants debated whether new investments were necessary to achieve this vision, with one participant claiming that "we don't need more money, we just need it to be spent better." Second, they emphasized the need for the delivery of complex cancer surgery to be characterized by compassion, as well as patient- and family-centredness. They called for packages of care that would address the social, practical and emotional needs of patients and families before, during and after the surgeries. As one participant pointed out, regionalization "needs to be looked at in a holistic way, with the family taken into consideration." They also indicated that it was particularly important to pay special attention to those who must travel to obtain surgical care. Third, participants called for national standards for complex cancer surgeries, with one of them promoting the development of a "National Council of Cancer Standards." Lastly, participants encouraged health-system leaders to invest in the training of a critical mass of surgeons with the expertise to perform such complex cancer surgeries, to create favourable hospital environments to provide optimal surgical care, and to implement provider-retention strategies.

Acknowledgments

Authors

François-Pierre Gauvin, PhD, Lead, Evidence Synthesis and Francophone Outreach, McMaster Health Forum
Julia Abelson, PhD, Faculty, McMaster Health Forum, and Professor, McMaster University
John N. Lavis, PhD, Director, McMaster Health Forum, and Professor, McMaster University
Rami Abu-Zeidan, Medical Student, University of Alberta

Funding

The citizen brief and the citizen panel it was prepared to inform were funded by the Canadian Partnership Against Cancer. The McMaster Health Forum receives both financial and in-kind support from McMaster University. The views expressed in the panel summary are the views of panel participants and should not be taken to represent the views of the Canadian Partnership Against Cancer, McMaster University, or the authors of the panel summary.

Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the panel summary. The funder reviewed a draft panel summary, but the authors had final decision-making authority about what appeared in the panel summary.

Acknowledgements

The authors wish to thank the entire McMaster Health Forum team for support with project coordination, as well as for the production of this panel summary. We are especially grateful to all the participants of the citizen panel for sharing their views and experiences on this pressing health system issue.

Citation

Gauvin FP, Abelson J, Lavis JN, Abu-Zeidan R. Panel Summary: Improving the Delivery of Complex Cancer Surgeries [Edmonton Panel]. Edmonton, Canada: McMaster Health Forum, 4 October 2014.

ISSN

2368-2116 (Print)
2368-2124 (Online)

McMaster
HEALTH FORUM

>> Contact us

1280 Main St. West, MML-417
McMaster University
Hamilton, ON Canada L8S 4L6
Tel: +1.905.525.9140 x 22121
Fax: +1.905.521.2721
Email: mhf@mcmaster.ca

>> Follow us

mcmasterhealthforum.org
healthsystemsevidence.org

tinyurl.com/mhf-iTunesU
tinyurl.com/mhf-YouTube
tinyurl.com/mhf-Facebook
tinyurl.com/mhf-Twitter

EVIDENCE >> INSIGHT >> ACTION