Panel Summary

Taking a Step Towards Achieving Worry-free Surgery in Ontario

29 September 2017

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EVIDENCE >> INSIGHT >> ACTION

McMaster Health Forum

The McMaster Health Forum's goal is to generate action on the pressing health-system issues of our time, based on the best available research evidence and systematically elicited citizen values and stakeholder insights. We aim to strengthen health systems – locally, nationally, and internationally – and get the right programs, services and drugs to the people who need them.

About citizen panels

A citizen panel is an innovative way to seek public input on high-priority issues. Each panel brings together 14-16 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 29 September 2017, the McMaster Health Forum convened a citizen panel on how to achieve worry-free surgery in Ontario. This summary highlights the views and experiences of panellists about:

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

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

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Summary of the panel

Panellists began by reviewing the findings from the pre-circulated citizen brief, which highlighted what is known about the underlying problem – shortfalls in peri-operative risk assessment and management in Ontario – and its causes. They individually and collectively focused on six sets of challenges in particular: 1) 'worry-free surgery' can mean different things to patients, families and other stakeholders; 2) more surgeries are being performed, which creates challenges for society as a whole; 3) surgery-related complications have serious consequences for everyone; 4) how we assess and manage risk with surgery patients is not always optimal; 5) peri-operative risk assessment and management is not always delivered based on the best available data, evidence and guidelines; and 6) health-system-level factors make it difficult to support the widespread uptake of optimal peri-operative risk assessment and management.

After discussing the challenges, panellists were invited to reflect on three elements of a potentially comprehensive approach for achieving worry-free surgery in Ontario. When deliberating about strategies that could help to change the behaviours of health professionals and patients in order to support the use of clinical-practice guidelines (element 1), safety and excellent patient experiences emerged as two of the most prominent values. The deliberations then turned to the use of financial levers to improve risk assessment and management for surgery patients (element 2). Efficiency (value for money) emerged as the most prominent value during these deliberations, with panellists expressing mixed views about the efficiency of providing financial rewards to professionals and organizations for adhering to clinical-practice guidelines, and to patients for adhering to pre- and post-surgical instructions. Panellists then deliberated about broader system changes that they viewed as needed to improve risk assessment and management for surgery patients (element 3). In emphasizing the values of continuously improving and equity, panellists discussed the need to support current quality-improvement initiatives across the province and to ensure that broader system changes did not compromise equity.

When turning to potential barriers and facilitators to moving forward, panellists focused on the need to create a burning platform (or strong 'business case') for promoting worry-free surgery. This burning platform should rest on three key pillars: research evidence, professional experiences, and patient and family experiences.

"I don't want another dramatic thing to happen, and I also don't want other people to experience what I went through."

Discussing the problem:

Why is it challenging to achieve worry-free surgery?

Panellists began by reviewing the findings from the pre-circulated citizen brief, which highlighted what is known about the underlying problem – shortfalls in peri-operative risk assessment and management in Ontario – and its causes. Drawing from the research evidence provided in the citizen brief along with their personal experiences (as surgery patients and as caregivers), panellists were invited to reflect on their greatest source of worry about surgery-related risks before, during and after surgery (while in hospital and back at home), as well as problems that could have been avoided.

Panellists shared both positive and negative experiences with different types of surgeries, ranging from elective surgeries to urgent surgeries, and from day surgeries to surgeries requiring a hospital stay. Panellists were keen to share their different types of worries in order to improve policies and practices. As one panellist noted: "I don't want another dramatic thing to happen, and I also don't want other people to experience what I went through."

Panellists individually and collectively focused on six challenges in particular:

- worry-free surgery can mean different things to patients, families and other stakeholders;
- more surgeries are being performed, which creates challenges for society as a whole;
- surgery-related complications have serious consequences for everyone;
- how we assess and manage risk with surgery patients is not always optimal;
- peri-operative risk assessment and management is not always delivered based on the best available data, evidence and guidelines; and
- health-system-level factors make it difficult to support the widespread uptake of optimal peri-operative risk assessment and management.

We review each of these challenges in turn below.

Box 1: Key features of the citizen panel

The citizen panel about taking a step towards achieving worry-free surgery in Ontario had the following 11 features:

1. it addressed a high-priority issue in Ontario;
2. it provided an opportunity to discuss different features of the problem;
3. it provided an opportunity to discuss three elements of a potentially comprehensive approach to address 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 panellists; and
11. it aimed to find both common ground and differences of opinions.

'Worry-free surgery' can mean different things to patients, families and other stakeholders

The deliberations initially focused on the concept of 'worry-free surgery,' which was defined in the citizen brief as "[a] surgery that encompasses at least three characteristics: engaging the patient and the care team in the decision-making process in order to respond to the patient's needs and conditions; using care pathways that are informed by the best available clinical-practice guidelines; and minimizing risk for surgery-related complications by proactively identifying and addressing risk factors."

The deliberations revealed the need to re-examine the proposed concept of 'worry-free surgery' in light of several important considerations, including that:

- worries evolve throughout the surgical journey (some worries may come and go at any given time);
- many different people worry about surgery-related complications, not just patients and caregivers (e.g., citizens in their capacity as taxpayers, health professionals, managers and policymakers);
- the lack of information and communication throughout the surgical journey is often the greatest source of worry as it exacerbates a feeling of uncertainty about the surgical procedure and its associated risks; and
- some factors that are critical to achieving worry-free surgery are not made as explicit as they need to be in the proposed definition, including:
    - information sharing and clear communication between patients and their care team (e.g., information about the health condition, the benefits and risks associated with each treatment option, and what to expect before, during and after surgery),
    - personalization (e.g., patients and caregivers have different personalities, skills, competencies and worries that must be considered),
    - information sharing across the system (e.g., having a comprehensive system in place to systematically collect and share patient information across professionals and settings),
    - continuity of care throughout the surgical journey; and
    - co-creation of the care team and support systems needed by patients and caregivers.

We turn now to what panellists considered to be the two most salient factors to be added to the definition, namely information (too little, too much or too jargon-filled) and personalization.

The lack of information and communication throughout the surgical journey was among the most predominant themes during the deliberations. Panellists emphasized the need to get clear information about their health condition, the benefits and risks associated with each treatment option, and what to expect before, during and after surgery. Some panellists expressed that the care team often focuses on the risks, while neglecting to inform patients and caregivers about what the changes would be to their "day-to-day life." Several panellists who underwent day surgeries highlighted that these types of surgeries are often presented as simple and risk-free. This may give the impression to some patients and caregivers that they do not need a lot of information, and perhaps gives the impression to professionals that they do need to spend much time providing information about day surgeries. As one panellist noted: "I think the lack of information is a lot more prevalent with day surgeries than [surgeries] that require a night stay because it feels more like an assembly line." Several panellists acknowledged that having to endure pain was a source of worry, and many pointed out that what was more worrisome was their incapacity to distinguish between normal pain due to the surgical procedures and pain due to an adverse event (such as a leak after gastric-bypass surgery).

While the need for better information sharing (and especially for more information) emerged, a few panellists expressed that they were sometimes overwhelmed with the information provided by health professionals. As one panellist noted: "The doctor overwhelmed me with information and so I didn't ask too many questions. I came out really concerned." Some panellists shared that feeling overwhelmed by information was often exacerbated by the language used by professionals, with one panellist saying "the care team made it sound really serious and I was thinking about a messy death." This led some patients and caregivers to seek out information on their own, most notably on the internet. Yet, they experienced difficulty finding trustworthy information sources on the internet.

Another key theme that emerged was the perceived lack of personalization in communications about peri-operative risk assessment and management. Returning to the assembly-line metaphor, one panellist pointed out that surgical procedures are not like building cars: "Each of us are different and we have different needs." This resonated with a second panellist who emphasized that "patients have different personalities" and the communication process must be adapted accordingly. Yet, many panellists felt that some professionals lacked the necessary communication and 'bedside manner' to personalize communication in this way. This led several panellists to suggest the need to train professionals to be able to adapt the conversation to the patient and family in front of them, and to be empathetic in the encounter. For example, one panellist stated: "No matter

what profession you are in, communication skills are really important. Two people may give the same information, but how you deliver a fact can be perceived very differently." In addition, some panellists indicated that they expected personalized information, as opposed to generic information about the surgical procedures, with one panellist stating that "you want to know what is going to be particular to your situation."

More surgeries are being performed, which creates challenges for society as a whole

Some panellists suggested that the growing volume of surgeries being performed in the province may also be driven by patients actively seeking medical care for various problems (e.g., clouded vision, joint pain and obesity), which ultimately leads to more medically necessary surgical procedures (e.g., cataract surgeries, hip and knee replacement surgeries, and bariatric surgeries). Panellists suggested that empowered patients should be added as a contributing factor to the growing volume of surgeries, along with the factors presented in the citizen brief. But they recognized that this growing volume creates challenges for society to fund the health system.

Surgery-related complications have serious consequences for everyone

Panellists generally agreed on the serious ripple effects created by surgery-related complications, and discussed three types of consequences: for health professionals, for both caregivers and professionals, and for the general public. First, several panellists expressed empathy towards health professionals who have to worry about legal threats arising from the courts and disciplinary threats from their professional colleges that can arise from surgery-related complications, on top of their growing workloads and competing priorities. Second, some expressed concern about the effects that surgery-related complications have on caregivers and professionals. In particular, they emphasized their concern that the health system is not equipped to care for caregivers and professionals, which is a situation made more difficult when unexpected complications arise. Lastly, panellists pointed out that surgery-related complications (particularly significant harms and even deaths that could have been prevented) can have a larger ripple effect and contribute to public distrust in the health system. With the increasing popularity of social media, patients and caregivers

increasingly share stories of adverse events, including harms experienced in hospital. While these adverse events may be isolated cases, they may have a serious negative impact on the public. As one panellist said: "One bad apple ruins the whole bunch."

How we assess and manage risk with surgery patients is not always optimal

Panellists, several of whom had experienced multiple surgeries in different settings, reported experiences that varied greatly in how surgery-related risks were assessed and managed. The majority of panellists reported negative experiences due to the following factors:

- a lack of information and communication with the care team;
- a lack of continuity of care (particularly after being discharged from hospital);
- the absence of a clear contact person who was easily accessible and could answer their questions at any given time (either a health professional or peer); and
- problems navigating the system before the surgery and after being discharged.

Panellists generally acknowledged the desire to be more meaningfully engaged in peri-operative risk assessment and

Box 2: Profile of panellists

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 panellists.

- How many panellists?
  11
- Where were they from?
  Greater Toronto and Hamilton area (10), as well as southwestern Ontario (1)
- How many have experienced surgery?
  As patients only (10)
  As patients and caregivers (1)
- What types of surgeries?
  Elective surgeries only (7), emergency/urgent and elective surgeries (2), emergency/urgent and cancer surgeries (1), and cancer surgeries only (1)
- How old were they?
  18-24 (1), 25-44 (4), 45-64 (4), 65 and older (2)
- Were they men, or women?
  Men (5) and women (6)
- What was the educational level of panellists?
  9% completed high school, 27% completed community college, 45% completed a bachelor's degree, and 18% completed post-graduate training or a professional degree
- What was the work status of panellists?
  27% retired, 18% working full time, 18% working part-time, 18% self-employed, 9% unemployed, and 9% disabled
- What was the income level of panellists?
  18% earned less than $20,000, 18% earned between $20,000 and $40,000, 9% earned between $40,000 and $60,000, 9% earned between $60,000 and $80,000, 18% earned more than $80,000, and 27% preferred not to answer
  (Note: percentages may not add up to 100%, as they are rounded to the nearest percent)
- How were they recruited?
  Selected based on explicit criteria from the AskingCanadians™ panel

management (as patients and caregivers). They identified three key factors that can impede such engagement:

- patients and caregivers feeling vulnerable during the surgical journey;
- patients and caregivers adopting a deferential attitude towards health professionals; and
- the surgery itself often appears like a 'black box' to patients and caregivers (i.e., little is known about what happened during the surgery, particularly in the case of patients who underwent general anesthesia).

One panellist who had cancer surgery reported a positive experience with regards to being engaged in peri-operative risk assessment and management. This panellist pointed out the importance of having access to a case manager to coordinate their care. In addition, the same panellist indicated that group information sessions with peers who experienced the same surgeries helped to mitigate potential sources of worry, and empowered them to play an active role as a full member of their care team.

Peri-operative risk assessment and management is not always delivered based on the best available data, evidence and guidelines

There was a general lack of awareness among panellists about the existence of clinical-practice guidelines that could support optimal risk assessment and management. While panellists acknowledged the importance of having surgical care based on the best-available research evidence (including clinical-practice guidelines), they also emphasized that such evidence should include the lived experiences of previous surgery patients, who could make a significant contribution to:

- informing other patients, empowering them, and mitigating their potential worries; and
- informing health professionals, managers and policymakers about what is needed for optimal surgical care.

Health system-level factors make it difficult to support the widespread uptake of optimal peri-operative risk assessment and management

Discussions about health-system-level factors focused on four key challenges. First, the fragmentation of care was perceived as one of the biggest challenges to supporting the widespread uptake of optimal models of surgical care. In particular, panellists emphasized the lack of coordination between professionals delivering specialized care, and those delivering home and community care.

Second, the significant shift towards more surgeries being done without the patient being hospitalized was seen as contributing to: 1) the misperception that such surgeries are not risky; 2) the uptake of models of care similar to 'assembly lines,' with limited opportunities for information and communication; and 3) patients and caregivers not being properly equipped to engage in risk assessment and management.

Third, panellists expressed serious concerns about how current physician-remuneration arrangements impede the adoption of optimal models of care (notably, the concern that the existing billing and funding system does not allow surgeons and hospitals to be paid for monitoring and supporting patients remotely after being discharged). They also worried that current financial arrangements (and the billing system) may encourage unnecessary pre-operative testing.

Lastly, the absence of a comprehensive system to collect and report surgical data, including the number of surgeries being done and rates of complications and outcomes, was identified as a serious factor limiting any quality-improvement efforts.

"Patients have idiosyncratic needs."

Discussing the elements:

How can we address the problem?

After discussing the challenges that together contribute to or constitute the problem, panellists were invited to reflect on following three elements of a potentially comprehensive approach to taking a step towards achieving worry-free surgery in Ontario:

1) strategies to support the implementation of optimal peri-operative risk assessment and management;
2) financial arrangements that support the implementation of optimal peri-operative risk assessment and management; and
3) broader system arrangements that support the implementation of optimal peri-operative risk assessment and management.

The three elements can be pursued together or in sequence. A description of these elements, along with a summary of the research evidence about them, was provided to panellists in the citizen brief that was circulated before the event.

Element 1 – Strategies to support the implementation of optimal peri-operative risk assessment and management

The discussion about the first element focused on strategies that could help to change the behaviours of health professionals and patients in order to support the use of clinical-practice guidelines. As outlined in the citizen brief, this could include strategies targeting health professionals, such as:

- providing information and education to professionals (for example, educational materials and meetings);
- integrating guidelines into technologies most frequently used by professionals (for example, smartphone apps); and
- adopting mechanisms to evaluate the performance of professionals and providing feedback to them (a strategy known as 'audit and feedback').

This could also include strategies targeting patients and the general public, such as:

- engaging patients and the public to raise awareness about the existence of guidelines and to encourage their use;
- improving communication and shared decision-making between professionals and patients based on the best available guidelines;
- educating patients about what peri-operative care they need (for example, with tools to help patients become engaged in making treatment and recovery-related decisions); and
- developing mass-media campaigns to raise awareness about the need to address overuse of unnecessary routine testing before surgeries.

Nine values-related themes emerged during the deliberations about element 1. Safety and excellent patient experiences were the two most prominent values that emerged during the discussions. These two values were related to expected outcomes that should guide the implementation of optimal peri-operative risk assessment and management.

Most panellists emphasized the need to empower surgery patients and their caregivers. Greater empowerment would allow patients and caregivers to engage in high-level conversations about surgical procedures (in part by using tools for those with limited literacy skills and those for whom English is a second language). To achieve this, panellists indicated there was a need to: 1) raise public awareness about clinical-practice guidelines

(using different educational materials such as websites, online videos, DVDs and pamphlets); 2) build capacity among patients and caregivers to find and use information about peri-operative risk assessment and management; and 3) provide peer support so that people with lived experiences can help their fellow patients (such as peer support groups). Some panellists highlighted the fundamental role of professionals in supporting such empowerment, with one panellist pointing out that "physicians and surgeons need to instill a responsibility in the patient to learn and to engage in the surgery."

Box 3: Key messages about strategies to support the implementation of optimal peri-operative risk assessment and management (element 1)

Nine values-related themes emerged during the discussion about element 1:

- Safety
- Excellent patient experiences
- Empowerment
- Trust
- Credibility
- Competence/expertise
- Accountability
- Collaboration
- Adaptability

Three additional values-related themes emerged during discussions about empowerment: trust, credibility and competence/expertise. A minority of panellists expressed dissenting voices regarding the need to focus efforts on empowering patients and caregivers. For them, calls for greater empowerment reflected a lack of trust in the credibility and competence of health professionals and organizations. They emphasized the need to ensure that professionals and organizations producing and supporting the uptake of clinical-practice guidelines are perceived as trustworthy, credible and competent. Similarly, patients and caregivers should be able to trust that those delivering peri-operative care are trustworthy, credible and competent. As one panellist noted: "I'm a little skeptical of second guessing the medical professionals by going online. I think we are in an era where everyone thinks that more information is better, but at the end of the day, if you trust the person who does this for a living, I don't see the necessity to go down the rabbit hole. Trust the doctor and the team around you."

The three remaining values-related themes that emerged during discussions about element 1 were accountability, collaboration and adaptability. Panellists indicated that greater emphasis should be put on accountability to facilitate or trigger the use of clinical-practice guidelines. Panellists suggested that hospitals and professional regulatory bodies should be held accountable to enforce the uptake of clinical-practice guidelines as standards of practice (using carrots to incentivize professionals/organizations and sticks when they deviate from

the standards). In the same vein, panellists indicated that professional regulatory bodies should consider credentialing as a strategy to ensure that health professionals use clinical-practice guidelines. However, there were mixed views among panellists about the capacity of professional regulatory bodies for "self-policing."

Collaboration among patients, caregivers, professionals and organizations also emerged as a key value for how to proceed. Several panellists highlighted that strategies proposed in the brief were perceived as targeting individual health professionals. They indicated that strategies may be more promising if they target entire care teams (which should include patients and caregivers) in order to support optimal peri-operative risk assessment and management. Given this, panellists viewed clinical-practice guidelines as more promising if they are developed for multidisciplinary care teams, as opposed to being developed for each type of professional.

Lastly, panellists indicated that adaptability should be a key feature of clinical-practice guidelines. While panellists recognized that clinical-practice guidelines should be promoted as 'standard practices,' they indicated that guidelines should not be a substitute for professional judgment and may require adaptations to meet specific patients' needs, values and preferences. As one panellist pointed out, promoting the use of clinical-practice guidelines should not lead to an assembly-line culture. Specifically, this panellist indicated that "health care is not like Toyota. The product is not the same in every encounter, so it is hard to come up with a set of guidelines that deal with this. You need some amount of flexibility that allows you to adapt the guideline for a person." Similarly, panellists indicated that the information or educational material provided should be adapted to the "idiosyncratic needs" of patients.

Element 2 – Financial arrangements that support the implementation of optimal peri-operative risk assessment and management

The discussion about the second element focused on the use of financial levers to improve peri-operative risk assessment and management for surgery patients. As outlined in the citizen brief, financial levers could include:

- financial rewards to patients to improve their adherence to pre-operative and post-operative instructions;
- financial rewards to professionals and/or hospitals (for example, link doctors' remuneration with the use of clinical-practice guidelines, or link the quality of care with hospital funding);
- financial penalties to professionals and/or hospitals (for example, no payment for additional costs associated with preventable errors); and
- modifying the funding for peri-operative care to reflect new models of care as identified by the best available clinical guidelines (for example, changing billing systems to support discharge planning and remote monitoring).

The deliberations about element 2 initially examined whether professionals and organizations should be financially rewarded if they adhere to clinical-practice guidelines. During these deliberations, efficiency (value for money), as well as being based on data and evidence, emerged as the most prominent values-related themes.

Box 4: Key messages about financial arrangements that support the implementation of optimal peri-operative risk assessment and management (element 2)

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

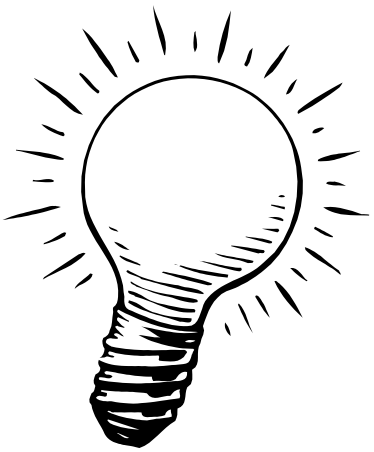
- Efficiency (value for money)
- Based on data and evidence
- Trust
- Accountability

Panellists expressed mixed views about the efficiency of providing financial rewards to professionals and organizations to support their adherence to clinical-practice guidelines. Panellists made the case that if health-system leaders and stakeholders agree that clinical-practice guidelines are the right thing to do (since they are based on the best-available research evidence), then no financial rewards should be provided for this.

The same two values-related themes emerged when panellists discussed financially rewarding patients for adhering to pre- and post-surgical instructions: efficiency (value for money) and trust. Panellists again expressed mixed views about the efficiency of such measures. On the one hand, some panellists believed that financially rewarding patients could be a potentially cost-effective strategy that could lead to better health outcomes in the short term, while limiting system costs (e.g., surgeries not being delayed or cancelled because patients are adhering to pre-surgical instructions; re-admissions not happening because patients are adhering to post-surgical instructions). However, one panellist expressed hesitation with this approach and stated that "I could go along with it if there was a one-to-one show that we save a dollar." Others were opposed to rewarding patients for doing what was already good for them ("why would we reward someone for stopping at a red light").

Some panellists also expressed a lack of trust – a third values-related theme – in some patients who may lie to get such rewards (even if they do not fully adhere to pre- and post-surgical instructions).

Lastly, accountability emerged as a key values-related theme during discussions about the use of financial penalties for professionals and organizations. As noted above, panellists were generally opposed to financially penalizing professionals if they do not adhere to clinical-practice guidelines. On the other hand, panellists suggested that professionals should be held accountable by their organizations and professional regulatory bodies (e.g., through reprimands and credentials being removed). Panellists were more inclined to use financial penalties with health organizations if clinical-practice guidelines were not routinely used. Similarly, panellists generally agreed that health organizations should play a more proactive role in reporting to professional regulatory bodies (via a track record system) whenever professionals are not adhering to clinical-practice guidelines.



Element 3 – Broader system arrangements that support the implementation of optimal peri-operative risk assessment and management

The discussion focused to a lesser extent on the third element, which examined broader changes that must be made to improve risk assessment and management for surgery patients. As outlined in the citizen brief, this could include strategies to improve how the system is governed and how care is delivered, as well as systems to monitor the quality and safety of peri-operative care.

Two values-related themes emerged during the discussion about element 3: continuously improving and equity. Continuously improving peri-operative risk assessment and management was the most prominent value that emerged when asked about what kinds of broader health-system changes are required to take a step towards achieving worry-free surgery in Ontario. Panellists emphasized the need to support current quality-improvement initiatives across the province. Specifically, panellists were inclined to have the focus be on improving teamwork and communication, and providing routine safety procedures (for example, surgical-safety checklists and surgery-room "black boxes"). These were perceived as 'low-hanging fruit' on a path towards instilling culture change. Panellists also reinforced the need to put a comprehensive system in place to collect data about surgical outcomes, as well as a system allowing health organizations to document problems and notify professional regulatory bodies whenever professionals were not adhering to clinical-practice guidelines. They expressed frustration that such a comprehensive system was not already in place, and argued that it was a fundamental element to any quality-improvement initiative, with one panellist saying that all surgeries should be "tallied up."

Box 5: Key messages about broader system arrangements that support the implementation of optimal peri-operative risk assessment and management (element 3)

Two values-related themes emerged during the discussion about element 3:

- Continuously improving
- Equity

Equity emerged as a value related to criteria about whether to proceed with some mechanisms such as public reporting of performance data. A few panellists worried that

such mechanisms could compromise equity since it could create perverse incentives for certain professionals and organizations to "cherry pick" patients that may help them score well, or avoid those who may cause them to score poorly in their performance reports.

"(The) focus on the evidence-based business case is a selling point for everything discussed."

Discussing implementation considerations: What are the potential barriers and facilitators to implement these elements?

After discussing the three elements of an approach to taking a step towards achieving worry-free surgery in Ontario, panellists examined potential barriers and facilitators for moving forward. Deliberations about potential barriers generally focused on the challenges of "improving the system within the system." Moreover, some panellists emphasized that health-system leaders must be cognizant that Ontario citizens do not want to pay more taxes, and that they want to do more with less.

When turning to potential facilitators for implementation, panellists suggested the need to create a burning platform (or strong 'business case') about worry-free surgery. It was suggested that this burning platform should rest on three key pillars: research evidence, professional experiences, and patient and caregiver experiences. In particular, panellists emphasized the need to put the "focus on the evidence-based business case" as a selling point. Moreover, they called for greater engagement with professionals in order to better understand what they are experiencing in terms of peri-operative risk assessment and management. In addition, the importance of sharing personal stories of peri-operative risk assessment and management was highlighted, given that such stories could raise public awareness about the problem and "personalize" the statistics. This in turn could ultimately trigger patient and caregiver advocacy initiatives.

Acknowledgments

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Conflict of interest

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