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As the health-care landscape in Canada continues to evolve, efforts to measure, compare, monitor and improve the quality of patient care are becoming increasingly important. To this end, validated and clinically relevant quality indicators have huge potential to substantially improve the quality and efficiency of patient care across the country; this has become a foundation of a growing effort to improve the quality of health care.

This topic, triggered in part by a recent Cancer Care Ontario (CCO) report of positive margin rates in radical prostatectomies, was of profound interest at the January 2009 Issues & Controversies in Prostate Care (ICPC) conference, an annual educational program for Canadian physicians involved in the care of patients with prostate diseases. Similar to the successful quality-improvement initiatives by CCO in colorectal and ovarian cancer surgery, the hope was that by identifying any inconsistencies across health regions in the number and measurable outcomes of radical prostatectomies as compared against “accepted or reasonable standards,” the quality of surgeries and their oncologic and functional outcomes could be improved. In general, physicians practising in Ontario felt that this CCO report helped them better understand their practices, and while the report was focused on the Ontario landscape, those practising outside of the province also found the information to be valuable, insightful and a prelude of what was likely to come to their own community.

According to a 1999 report by the Institute of Medicine,<sup>1</sup> approximately 99 000 preventable deaths occur each year in the United States as a result of medical errors. This report triggered an avalanche of investigations and the development of standards of care to address the problems and inconsistencies of care across a host of health issues. Dr. Peter Carroll, a recognized leader in the field of prostate cancer research and treatment, discussed the wide variability and lack of standards in the quality of care received by men with early-stage prostate cancer in the United States. Even after the development of appropriate structure, process and outcome measures, wide variations remain with overall compliance only slightly surpassing 70%, and the quality of surgeries, particularly radical prostatectomies, varying greatly by centre.

While there may be many explanations for the variations in treatment (including patient risk and comorbidity, patient preferences and experience, anxiety [patient and physician], physician incentives and uncertainty/lack of consensus regarding the best approach), it is important that the focus always remain on getting the patient the best level of care. This is the spirit behind the development and application of quality indicators.

It is important to note that defining and quantifying meaningful quality indicators in prostate cancer is a difficult process, which often includes several measures relevant to the quality of cancer care. These measures may be related to structure (e.g., the number of patients treated), process (e.g., pretreatment disease severity assessment) and outcome (e.g., treatment failure).<sup>2</sup> Quality indicators must be based on medical evidence, developed through a process in which health-care providers are included, and reviewed and updated on a regular basis. Clinically irrelevant or immeasurable indicators only work to produce misleading results that are not indicative of the actual level of care received by patients. To this end, the development of appropriate quality indicators in prostate cancer will require the involvement of many resources. Support from national bodies, such as the Canadian Urological Association, is key to the implementation of this quality improvement initiative among the health-care community.

As we move forward, urology will be held accountable for the management of prostate cancer and other urologic malignancies; the government and public will demand transparency and individual outcomes will be documented in the public domain. Unfortunately, there are no national coordinated strategies for defining, collecting and combining data on uro-oncologic quality indicators, thereby making it

difficult to identify gaps in the quality and efficiency of care received by patients across Canada. Although CCO has begun the initiative, it is incumbent upon us, as specialists and experts in uro-oncology, to assume accountability for the well-being of our patients and the quality of care we deliver. By focusing on the implementation of local and national standards of quality assurance across all cancer-treatment strategies (whether it be surgical, medical or radiation) and observing it as a team effort, there is consensus that better quality care is certainly attainable. This is our call to action.

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## References

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