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As I was looking back on some of our *CUAJ* highlights from 2018, I was struck by the attention and thoughtfulness towards the quality of our care delivery explored in so many research articles, as well as the editorial commentaries, from authors around the globe, but particularly from those based in Canada. These ideas, laser-focused on barriers and potential solutions, spanned urological care delivered in disparate countries/regions; between teaching- and community-based hospitals; from quaternary care in centres of excellence to more commonplace (but nonetheless essential) urological care in our communities. Authors surveyed our collective adherence to guideline recommendations, the disparity of access and public funding across provinces, and the efficacy of multidisciplinary tumour boards, as well as patient experiences and satisfaction around complex cancer decisions, transitions of care, and other controversial topics, including mesh repairs for pelvic organ prolapse. This issue of the *CUAJ* is no exception, with a thoughtful article by Duplisea et al¹ and the companion commentary by Rafael and Booth² exploring shortfalls in the management of bladder cancer on both sides of the border. These articles offer real insight into an apparent efficacy-effectiveness gap within the urological community in its uptake of evidence-based recommendations such as neoadjuvant chemotherapy. Their call for enhancing infrastructure in order to determine and measure appropriate benchmarks for complex urological care seems well-justified.

A recent commentary in the December edition had some similarly novel musings on the collection and presentation of quality metrics, especially those that are patient-forward and enabled by social media platforms.³ Among the concepts explored in the article, Dr. Casey also reflects on the ongoing changes in urological practice in Canada, particularly the organic subspecialization and subsequent movement or “centralization” within our profession. As a quality initiative, this consolidation of complex surgical care to certain providers and hospitals has become predominant in the global conversation to improve outcomes. The rationale seems well-founded, given fairly consistent evidence in surgical oncology. Over the last two decades, multiple studies have reported that high-volume providers have better outcomes across multiple cancer sites, including lung, bladder, and hepatobiliary. Recently, three leading U.S.-based hospital systems publicly announced a “Take the Volume Pledge” to support restraint for surgical procedures being done by lower-volume providers and set minimum volume standards for a number of elective surgical procedures.⁴ There are only a few examples of mandated or “active” centralization of urological care. The Martini Clinic has centralized radical prostatectomy, performing more than 2000 cases per year with some documentation of superior oncologic and functional outcomes. Similarly, the U.K. experience of creating a single large pelvic cancer centre provides evidence that the creation of a centralized high-volume centre, alongside a quality program, can lead to improvements in outcome within a short period of time.⁵

Although there are some parallel experiences in North America, such as certain high-risk, high-resource intensive cancer surgical procedures in Ontario (i.e., lung, hepatobiliary), true regionalization of urological care is uncommon. Regionalization is a loosely defined term used in the broader health systems conversation to describe transferring the planning and delivery of care to specific regions, and usually includes aspects of coordination, de-centralization, and rationalizing of resources. The goal is to provide the highest healthcare value as defined by outcomes achieved per dollar spent, although the literature supporting definitive successes in Canada are limited. Increased provider volume of certain procedural cases alone does not truly reflect regionalization of care without the coincident implementation of a quality initiative with a keen eye on optimizing outcomes. We have, however, all witnessed some degree of “passive” centralization, alternatively described as consolidation or designation. Obvious reasons for this include the natural assembly of subspecialists for uncommon and

complex procedures, such those in pediatrics, as well as spontaneous transferring of more technically complex but lower-risk procedures (i.e., robotic-assisted laparoscopic prostatectomy, percutaneous nephrolithotomy) due to technology availability. There have likely also been other examples of passive centralization of more complex care in recent years due to rising awareness of the volume-outcomes phenomenon, both within the urological community, as well as our patients.

Although based on fairly consistent volumes-outcomes literature, the reactions to campaigns of more formal regionalization or “active” centralization have not been overwhelmingly positive, with concerns around the evidence base supporting this volume effect, including its retrospective nature; lack of case mix leading to a selection bias for higher-volume providers; lack of detailed patient characteristics to adjust for confounding; and inability to identify key processes of care that explain any effect of specific surgeons or hospitals. Further, there are often passionate concerns around issues of patient/surgeon autonomy and choice, as well as the practicalities of moving certain procedures and human resources to different hospitals. Others worry centralization may create access problems for a substantial proportion of patients and worsen existing disparities between those in rural communities or those treated at lower-volume centres, especially in our geographically unique country. Indeed, the relationship between these consolidation endeavors and access is complicated.⁶ In any event, I would submit that more immediate optimization of our outcomes is best served by understanding, measuring, and adopting the optimal processes-of-care associated with our “best-performing” centres and surgeons, coordinated with (or even instead of) further centralization. Perhaps the time is right to consider developing such a national quality strategy for our specialty across Canada.

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