# PARTNERSHIP + MOMENTUM = PROGRESS

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## New case-report process leads to better practice

### Surgeons, pathologists adapt safety checklist from airlines

It's not every day that an innovation in cancer control is a win-win-win for patients, physicians, and researchers – with cost savings to the system as well.

One such innovation is as easy as providing cancer surgeons and pathologists with a structured checklist when they are writing case reports, as an alternative to the traditional dictated narrative case report.[1,2]

A procedural checklist in the cockpit is standard in the airline industry, to which health policy experts have long pointed as the benchmark in engineering systems for safety. Many Canadian pathologists and surgeons across the country are taking that example to heart. They are introducing structured checklists as report templates in the operating room and laboratory.

> 'By improving surgical practice, the impact of using the report template could equal that of chemotherapy'
>
> – Dr. Walley Temple, Alberta Cancer Board

Two parallel projects, one each in surgery and pathology, are supported by the Canadian Partnership Against Cancer. They are geared to developing a national consensus on standards and content for structured checklist reports.

### Easier to understand

"In the past 20 years cancer pathology reports have become much more complex," says Dr. John Srigley, head of the Pathology and Laboratory Medicine Program at Cancer Care Ontario, and a professor at McMaster University's Faculty of Health Sciences.

Pathology reports now should include the type, size, and stage of tumour, plus the status of lymph nodes and descriptors of the cancer, affording new parameters for prognosis and for recommending adjuvant therapies, he says. "With so many fields to cover in a pathology report, the structured checklist is much easier to complete, and it's easier for the clinician to understand," he adds.

Dr. John Srigley, Cancer Care Ontario

He is working closely with the Partnership and the Canadian Association of Pathologists to adopt report templates from the College of American Pathologists as content standards for Canadian pathology.

*Continued ... 2*

## Dr. Simon Sutcliffe's next horizon

### The Partnership interviews the vice chair of its Board.

***Q. Following eight years as president of BC Cancer Agency you are winding up there. What are your plans?***

A. After 39 years in public health care, and heading up two major cancer organizations, increasingly I am interested in cancer control at a population level – specifically, in the interaction between developed and developing countries.

*Continued ... 2*


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# Entering his fifth career, Dr. Simon Sutcliffe eyes new horizons in the developing world

## Vice chair played key role in creation of Partnership

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I came into the cancer world as a radiation and medical oncologist, so most of my professional life has been about cancer treatment. Over the past 10-plus years there has been an increasing realization that by focusing on cancer treatment we are focusing on populations that have cancer and also have *access* to treatment. We tend not to focus on the time before or after they have cancer, or on the populations that cannot access treatment equitably – yet this is the situation in the developing world.

My move now is to explore how cancer control can be understood in the context of different cultures and economies. I will look at alliances of countries, for instance within the World Health Organization and the Latin America-Caribbean Alliance for Cancer Control.

So, this will be my fifth career. I have gone from cancer treatment (medical and radiation oncology), to cancer care in an institution, to cancer control in populations, and now to global cancer control.

***Q. Having worked in the US and South Africa before coming from England, you have always had an international perspective. You chaired the Steering Committee for the International Cancer Control Congress in Vancouver and in Brazil. Have international congresses stimulated your international interests?***

A. A bit of history is that the 1st International Cancer Congress in Vancouver in 2005 was a direct consequence of the Canadian Strategy for Cancer Control [i.e. the planning for the Partnership]. We wanted a forum to bring together people to share and learn how to do cancer control at a national population level.

We found that there are a few countries moving down that road, such as Australia, New Zealand, the Scandinavian countries, France, Great Britain, some American states, and Canada – in other words, part of North America, Western Europe, and Australasia, but not Eastern Europe, or most of the world.

We had a handful of highly westernized countries – and a vast majority for whom this activity has not received priority. Our question became how to highlight and raise awareness of cancer control in countries that do not have all the resources.

What came across very strongly is that these conferences are all very well, but if you want to make it mean something in most of the world, you must focus on the contextual realities of these global populations.

***Q. Could the Partnership have a leadership role among cancer control organizations internationally?***

A. Yes, I believe that there is an advantage to the Partnership model for the international view. Like most of the world, we do not have infinite resources for cancer control – rather, we are finding ways to make the whole greater than the sum of the parts.

The added value the Partnership model brings is in demonstrating that we can do a great deal through partnership and use of existing resources. If we in Canada cannot demonstrate how strategic collaboration and cross-sectoral partnerships can enhance the health and well-being of our population,

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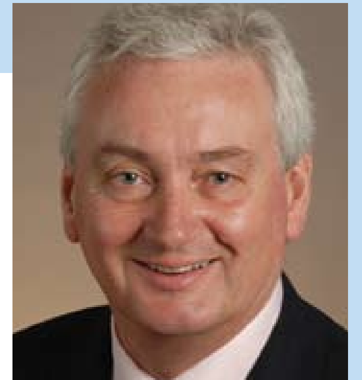
### Simon Sutcliffe, MD, FRCP, FRCPC, FRCR

Simon Sutcliffe is vice chair of the Board of Directors at Canadian Partnership Against Cancer. A radiation and medical oncologist, his clinical practice and research have been in the areas of lymphoma, leukemia, and endocrine malignancies, reproductive function in cancer patients, and immunodeficiency in cancer patients. After eight years as president of BC Cancer Agency he is leaving that position in December 2008. Previously he was president of Ontario Cancer Institute/Princess Margaret Hospital in Toronto.

Dr. Sutcliffe grew up near London, England, and studied or worked in the UK, US, and South Africa before moving to Toronto in 1979. Dr. Sutcliffe chairs the International Cancer Control Congress. He participated in the creation of the Canadian Strategy for Cancer Control, 1998-2002, and chaired the Governing Council from 2002-2006.



> We tend not to focus on the populations that do not have *access* to treatment
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> – Dr. Simon Sutcliffe

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## *Structured report projects in five provinces*

### 'National consensus on synoptic reporting is needed,' says Lee Fairclough

Development of a national consensus on the standards and content for structured checklists, or synoptic reports, is a priority project for the Partnership, says Lee Fairclough, VP of Knowledge Management.

PATHOLOGY PROJECT:

- Goal is to capture data that are required for optimal cancer staging information
- Includes working with Canadian Association of Pathologists to support:
  1. Adoption of templates from College of American Pathologists as national content standards
  2. Working with the provinces to expand use of templates

SURGERY PROJECT:

- Is based on cancer surgery templates developed by Alberta Cancer Board
- Includes report templates on cancer surgeries of the colon, rectum, breast, ovary, and head and neck
- Implements templates using WebSMR in Nova Scotia, Quebec, Ontario, Manitoba

OTHER PROJECT GOALS INCLUDE EVALUATING:

- Feasibility of a synoptic system
- Working collaboratively with Canada Health Infoway and Canadian Institute for Health Information
- Acceptability to users
- Feasibility and opportunities regarding data-sharing

*Continued from 1*

### Comprehensive, precise

"Studies in cancer surgery already show that using optimal cancer surgery improves five-year patient survival rates by 10%-15%, which is equal in some cases to the benefits of chemotherapy or adjuvant therapy," says Dr. Walley Temple, chief of the Division of Surgical Oncology at Calgary's Tom Baker Cancer Centre of Alberta Cancer Board.

"The checklist incorporates the elements of best practices, giving the surgeon or pathologist an immediate way of ensuring that he or she is actually applying them," he adds.

A structured checklist is both more comprehensive and precise than narrative reports, capturing key elements such as tumour size, depth of margin, and stage of cancer, says Dr. Temple.

He points with pride to the Alberta Cancer Board team whose report templates have met with enthusiastic acceptance by Alberta surgeons.

"Surgeons really like the fact that they can compare their own practice pattern to that of their counterparts across the province on a daily basis," he says. Surgeons post their reports on a provincial web site within 24 hours, compared to up to 90 days with traditional reports.

The Alberta electronic report templates – for surgeries of the head and neck, ovary, breast, colon, and rectum – are the models for the surgical reporting initiative in Manitoba, Ontario, Quebec, and Nova Scotia that is supported by Canadian Partnership Against Cancer.

"Sometimes we can make big gains by fine-tuning existing systems," says Lee Fairclough, VP of Knowledge Management at the Partnership. "With Dr. Srigley and Dr. Temple, we are working on a system change that embeds 'best practices' right at the point of care, which is where it counts the most." These initiatives exemplify the Partnership's mandate to accelerate cancer control in a way that is national, achievable, and measurable, she adds.

As an additional benefit, structured, digitized reports have high integrity as a research tool, she says. ■

1. The computer synoptic operative report – a leap forward in the science of surgery. Edhemovic I, de Gara CJ, Temple WJ, Stuart GC, Ann Surg Oncol 2004 Oct; 11(10): 941-947

2. Key issues in handling and reporting radical prostatectomy specimens. Srigley JR, Arch Pathol Lab Med 2006 Mar; 130(3) 303-317

# Simon Sutcliffe

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the challenges will be a daunting prospect for the rest of the world as it engages the evolving burden of cancer.

***Q. As you played a key role in creating the cancer control strategy that forms the Partnership's blueprint for action, and you are vice chair of the Board at the Partnership, you can take the long view.***

A. The Canadian Strategy for Cancer Control came from a national workshop in 1996, when a number of people asked, "Shouldn't Canada have a national cancer control plan?" Collaboration to create a Canadian, population-based cancer plan was essential.

The actual plan for a national cancer control strategy came out of the many multi-stakeholder working groups over several years, in a process that was managed by Health Canada, Canadian Cancer Society, and Canadian Association of Provincial Cancer Agencies.

Out of 158 recommendations, there emerged several priorities and I was appointed the first chair of the Governing Council. This was entirely a voluntary body, and it probably would have disbanded due to exhaustion of the volunteers if secure, ongoing, and appropriate federal funding had not been established in 2006. (As well, it had no authority or levers for change.) Thanks to that funding, we are now implementing and deepening this plan for cancer control through the Partnership. ■

## Our model resonates in world context

**Compared to many others, the Partnership model is flexible in creating change that is based on evidence.**

The Partnership applies a systems approach to:

- Help prevent cancer
- Enhance the quality of life of those affected by cancer
- Lessen the likelihood of dying from cancer
- Increase the efficiency of cancer control in Canada

To achieve these goals, the Partnership focuses on initiatives that are achievable, measurable, evidence-driven, and pan-Canadian in scope.

At the World Cancer Congress in Geneva in August, attendees were impressed that the Partnership got off the ground so quickly and has such a comprehensive strategy already in place, says Jessica Hill, CEO of the Partnership. "That is due to the dedicated work done by all those who volunteered their time and leadership in the Canadian Strategy for Cancer Control, creating the framework that we have now.

"Other countries are saying that our model is valuable precisely because it's about doing more with what you have, rather than building a costly new system," she says.

In just 18 months some Partnership initiatives are already making a mark internationally, says John Potter, MD, past director of prevention at Fred Hutchinson Medical Center in Seattle, Washington and chair of the Canadian Partnership for Tomorrow Project cohort study governance committee. "The Partnership is making a very important contribution to the world scene. The fact that it has the vision to support the cohort study – which is something we have really needed – speaks very highly for it."

The Partnership is 'an important contribution to the world scene'

– Dr. John Potter,
Fred Hutchinson Medical Center,
Seattle


### Canadian Partnership Against Cancer

This newsletter is intended as a twice-yearly update on the Partnership for all individuals and organizations in the cancer arena in Canada.



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