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Quality Measures in Breast Cancer Surgery

M Barry, ADK Hill



The development of accurate quality performance measures in breast cancer surgery is extremely challenging as highlighted by Monica Morrow in a recent editorial¹. Traditional quality measures in surgical oncology have focused on 30-day morbidity and mortality which are not relevant to breast cancer surgery which is typically associated with low morbidity and mortality. Dr Morrow suggests that the recent study by McCahill et al which uses re-excision of margins following breast conserving surgery (BCS) as an indicator of surgical quality fails the lithmus test as a quality measure for a variety of reasons². Essentially, there are too many variables that may influence the decision to proceed with breast conserving surgery in the first place such as patients' age, surgeons' bias and appropriate preoperative imaging. Using re-excision of margins as a tool to measure quality would encourage breast surgeons to perform a wider excision than is oncologically necessary and compromise the aesthetic appearance of the breast. In addition the quality of pathological margin processing may also vary considerably between institutions. It is therefore essential that any proposed quality measure in breast cancer surgery is evidence based and compliments our understanding of modern breast cancer biology. It is equally important that any proposed quality indicator is reliable and appropriately validated and is cost-effective in terms of collecting the relevant data.

In Ireland, breast cancer care has been centralized into 8 dedicated centers that provide a multidisciplinary care plan for each patient. More importantly, this care pathway happens in accordance with 27 key performance indicators (KPIs) developed by the National Cancer Control Programme (NCCP) and the Health Information and Quality Authority (HIQA). These KPIs mandate that breast cancer care occurs in a timely fashion as clear time lines have been established for surgery, chemotherapy and radiation oncology. They also record the diagnostic process and ensure that the appropriate diagnostic tools are used such as ultrasound-guided core biopsies instead of fine needle aspiration cytology. In addition, these KPIs are audited for each unit on a monthly and yearly basis and both internal and external assessments are arranged on a frequent basis to ensure that the relevant governance structures are in place to provide appropriate care for all symptomatic breast patients. But do these KPIs reflect the quality of care?

It is possible that an individual breast unit may meet all the NCCP and HIQA timelines and targets and still provide a very poor quality of service. For example, a patient with inflammatory breast cancer may have surgery first rather than appropriate neo-adjuvant chemotherapy or patients may be advised to have a mastectomy when they are clearly a candidate for conservation surgery. Equally, patients undergoing mastectomy may not be offered the option of breast reconstruction or patients maybe undergoing unnecessary axillary lymph node dissections with its significant attendant morbidity. So if nationally enforced KPIs cannot guarantee appropriate evidence based care, why do we use them? Firstly, these KPIs were not designed to assess or measure quality they are designed to create a national standard of care to make sure that the right patient is clinically assessed in the right place within the right time limits. They provide a national framework to standardize care across all the 8 breast cancer centers. In short, KPIs reflect the patient process but do not reflect patient outcomes or quality of that process. So if KPIs don't measure quality in breast cancer surgery, what can we use to assess quality of care?

Patient related outcome measures (PROMs) have been used successfully within the NHS to measure quality of patient care³. PROMs examine what happens when patients interface with the healthcare system and the high response rates achieved indicate how much value patients put on their outcomes⁴. It also involves patients in their own care pathway and provides a forum for patients to initiate change within the health service. Another advantage of PROMs is that they are easy to complete and cost effective as demonstrated by Browne et al⁵. It is essential that PROMs are analyzed in conjunction with patient's clinical progress to provide a more complete quality measure. Ideally, PROMs could be completed online by patients and then the relevant clinical data and KPIs could be combined to generate a quality control and assurance tool. However, it is critical that patients are involved in the development and evaluation of these PROMs to provide a more meaningful appraisal of the health service. If "money is to follow the patient" in healthcare funding then these PROMs could also be used to identify institutions that provide a quality service to their patients and therefore justify further investment and development. The authors of this editorial believe that in the absence of validated quality control and assurance methods the combination of KPIs and PROMs would provide a more complete 360 degree assessment of breast cancer care in Ireland.

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