

Turn up the volume

→ Anna Wagstaff

If you had cancer, you'd want to be treated by experienced specialists working within a specialised multidisciplinary team. So why are so many of Europe's cancer patients still being treated in hospitals whose case-loads are clearly too low to provide this level of care?

Periodically articles appear in cancer journals revisiting the growing evidence on the link between volume and outcomes, and contemplating what action, if any, should be taken in response.

Judging by the weight alone, the evidence that patients have worse outcomes if they are treated by physicians or at hospitals with a lower case-load of similar patients is pretty conclusive.

An overview published in 2002 of a total of 135 studies (*Ann Intern Med* 137:511–520) revealed that 71% of studies of hospital volume and 69% of studies of physician volume reported statistically significant associations between higher volumes and better outcomes. This included 10 out of 12 studies on pancreatic cancer surgery (showing a median difference of 13 deaths per 100 cases), three out of three for oesophageal cancer surgery

(12 deaths per 100), two out of two on breast cancer surgery, eight out of 15 on colorectal cancer surgery, two out of five in lung cancer and three out of five in gastric cancer (see Table).

In studies that found no significant difference in outcome, the results indicated either a relationship that fell short of significance or no relationship at all. There is almost no evidence of any inverse relationship between volume and outcome.

This is all quite compelling stuff. So why is it that thousands of cancer doctors treating small numbers of patients in small hospitals all over Europe do not feel compelled to stop?

There is now a general acceptance that when it comes to “tricky procedures”, such as pancreatic and oesophageal surgeries, it is the skill of the surgeon, and indeed the intensive care unit, that counts most, and this is likely to be lower in surgeons/ITU

departments that handle few cases a year.

However, variations in outcomes for other cancers may not be so tightly related to volume – indeed the review of the studies showed that they are not. For every study that shows a volume–outcome relationship for gastric cancer, or ovarian or breast cancer, there are two that indicate that the main cause of variations can be explained by factors other than volume. Some point to failings in the pathology, mistakes in the diagnostic work-up, or incorrect staging leading to over- or undertreatment. Others point to the absence of a multidisciplinary discussion, poor selection of treatment modality, usually an under-referral to chemo- hormonal or radiotherapy. Lack of specialist training and/or failure to follow guidelines are also frequently mentioned factors.

OVERVIEW OF THE LINK BETWEEN HOSPITAL / **PHYSICIAN** VOLUME AND OUTCOME

Type of cancer surgery	Studies included	Studies with a significant volume–outcome association	Median cases a year defining low volume (range)	Median cases a year defining high volume (range)	Median average mortality rate (range)	Median absolute difference in mortality rate for high vs low volume
Pancreatic	10	9	5 (1–22)	20 (3–200)	9.7 (5.8–12.9)	13.0 (3.0–17.9)
	2	1	1 and 9	10 and 42	8.0 and 12.9	7.0 and 10.2
Oesophageal	3	3	5 (5–10)	30 (11–200)	13.9 (8.9–14.0)	12.0 (11.0–13.9)
Breast	1	1	10	151	N/A	a
	1	1	10	50	N/A	N/A ^b
Colorectal	10	4	18 (10–84)	115 (18–253)	6.0 (3.5–12.3)	1.9 (-1.2–9.7)
	5	4	12 (5–21)	22 (9–40)	3.0 (2.0–6.0)	1.0 (1.4–1.9)
Lung cancer	4	2	7 (5–37)	19 (11–170)	5.5. (1.9–12.9)	1.9 (1.6–3.9)
	1	0	22	132	1.9	1.1 ^c
Gastric	3	1	10 (5–15)	63 (15–201)	10.9 (6.2–12.2)	6.5 (4.0–7.1)
	2	2	1 and 2	2 and 12	6.2 and 12.2	4.0 and 5.7

a Outcome data were for 5-year survival, not short-term mortality. Patients receiving care at the lowest-volume hospitals had a 60% higher risk for death within 5 years than those undergoing surgery at high-volume hospitals.

b Patients with high-volume surgeons had better 5-year survival (odds ratio: 0.85)

c Difference in mortality rates between high- and low-volume surgeons was of borderline statistical significance (P=0.08)

Source: *Ann Intern Med* 137:511-520

There are three reasons to question over-reliance on the volume=quality assumption. Firstly, the correlation between volume and outcome, though real, is an inconsistent and unreliable reflexion of the multiple underlying factors that really make the difference. It would therefore seem sensible for strategies for improving outcomes to concentrate on these underlying factors rather than on volume.

Secondly, concentrating on volume can have undesired side-effects – pressure to keep up personal volumes could, for instance, influence a surgeon's decision on what treatment to recommend for lower-risk prostate cancer patients.

Thirdly, adopting volume as a quality criterion would force many doctors, departments and hospitals to stop carrying out certain cancer procedures. This will mean some cancer patients will have to travel further for

their treatment. For some patients, and some one-off procedures, this may not be a problem. For patients who are frail, very unwell, or find it difficult to travel, it can turn an already bad experience into a nightmare. Why do this to patients if the outcome benefit seen in larger hospitals can be replicated in smaller centres by replicating the multidisciplinary structures, the diagnostic procedures, the level of specialisation, the protocols or whatever is responsible for the better outcomes?

There is another reason why many cancer patients are still treated in centres that don't see a large number of similar patients in a year – straightforward self-interest on behalf of the doctor and/or the centre. Many doctors in Europe are paid per patient or per procedure, and removing their right to treat cancer patients who come their way would hit their

income. There is also a certain status involved in treating cancer, and doctors may resent the blow to their prestige, or worry that giving up cancer cases will affect their career prospects. For many the main deterrent to giving up treating cancer patients is simply job satisfaction.

Similar mechanisms work at an institutional level. Hospitals are less likely to refer patients to a specialist centre if they lose money as a result. There is also a fear within some local general hospitals that if they concede the principle with respect to one type of cancer or indication, then bit by bit they will lose more patients to specialist centres and ultimately become unviable, and the hospital will be closed.

Pressure from self-interest can, however, also work in the opposite direction, where large hospitals and specialist centres may be looking to expand in size and prestige.

“Taken together, the evidence paints a consistent picture that must be taken into account”

MOUNTING PRESSURE

In May 2003 an editorial appeared in the *Journal of the National Cancer Institute*, entitled *Taking action on the volume–quality relationship: How long can we hide our heads in the colostomy bag?* The title referred to the latest addition to the evidence on volume–outcome, published in the same issue. It showed that out of every hundred patients treated for colorectal cancer, seven more deaths would be expected if the patient was treated at a hospital dealing with less than seven cases a year than if they were treated at a hospital dealing with more than 20. Patients would also be 7% more likely to undergo a full colostomy at the smaller centres.

While accepting the need to dig deeper into the factors behind the discrepant outcomes, and agreeing that “the better long-term solution would be to disseminate the components of practice that lead to better outcomes,” the editorial injected a sense of urgency into the debate, suggesting the time had come to talk in terms of minimum volumes, where a hospital whose admission rate was below the minimum would have to refer patients to a larger centre. The authors pointed a finger at vested interests in the medical profession. “Colostomy rates or mortality rates that are unexplainably high for similar patients are simply not acceptable. If these decisions did not involve livelihood, prestige and power, we would have demanded action long ago.”

Three years later, however, the

same journal seemed to put the brakes on again. An editorial titled *Transcending the volume–outcome relationship in cancer care*, which accompanied newly published findings on the volume–outcome relationship in ovarian cancer, warned against reading too much into published relationships between volume and outcome.

Reporting on the studies, it said: “higher hospital volume was associated with lower two-year mortality, with or without case-mix adjustment – but the relationship lost statistical significance (by conventional standards) once surgeon volume was entered into the equation” and “a modest positive association between hospital volume and overall survival remained after case-mix adjustment, but the association was no longer statistically significant once surgeon volume was included and weakened even more after accounting for whether the patient had postoperative chemotherapy.” It then went on to make a case for something that the study in question had not been designed to explore and was therefore unable to draw conclusions about: “key elements of ovarian cancer treatment generally considered to be quality enhancing and that may be associated with better survival... generally delivered superior care.” The take home message was: more research looking at more cancers in more detail is needed before we take any action.

The principle behind trying to identify the specific mix of structures, processes and volumes that can account for statistical differences

in various outcome measures is surely a good one. But there is a danger of being sucked into a level of detail where it is hard to draw any meaningful conclusions. Worse still, it becomes very easy for anyone with their own agenda to pick and choose the evidence to suit their argument, which risks bringing the integrity of the whole debate into question. The resulting confusion and scepticism serve only to reinforce inertia to making changes to a status quo that is known to be letting many patients down.

COMMON SENSE

Bob Haward, recently retired professor of cancer studies at St James University Hospital in Leeds, UK, got to know this area of literature very well when, at the end of the 1990s, he was given the task of helping improve the UK’s poor survival rates through drawing up guidance for treatment of the major cancers. He advocates the use of common sense.

He points out that whether the conclusion regarding management of a particular cancer is that what matters most is volume (be it surgeon or hospital), or a correct choice of treatment modality (implying a multidisciplinary approach), or level of specialisation, or correct diagnostic procedures, the practical implications all point in the same direction. Against very low case loads.

“There is a simple logistics thing. If you are setting up a sarcoma team with people who are knowledgeable and experienced, you can’t do this for



JON NICHOLSON / CORBIS

Looking ahead. The evidence and common sense indicate that patients' chances of surviving with a good quality of life are likely to be higher if they are treated by teams who specialise in that sort of work

a population of 100,000, because the team would be meeting about once or twice a year. A breast team can function with a population of 100,000. A sarcoma team can't."

A similar argument applies with specialisation. "If you go back to the original work done in the West of Scotland, for instance, they found that the specialist gynaecologist got better results than the general gynaecologist, who got better results than the general surgeon operating on ovarian cancer. That gradation from generalist to specialist is a reasonably consistent theme in a modest number of papers in the literature. So that suggests there may be something going on. But of course if you are a specialist in something you are likely to be doing a lot more of it, so that overlaps substantially with this whole question about volume and outcome."

As for the evidence that volume has an independent effect on outcome, Haward believes it is robust, and applies far more widely than pancreatectomy and oesophagectomy – in particular when you go beyond the usual outcome measures of post-

operative complications or survival, to look at the quality of life these patients are left with.

The evidence cited in the JNCI editorial that colorectal patients are 7% more likely to be given a full colostomy if they are treated in a smaller hospital is echoed by figures for full mastectomy in breast cancer. Experience counts when it comes to getting accurate results from a sentinel node biopsy, avoiding damage to the axillary nerve, and even minimising the cosmetic damage where full mastectomies are warranted. For patients, this translates into lowering the risk of lymphoedema, preserving good arm and hand function and better body image. The story is similar for gynaecological and prostate cancers, in terms of protecting patients' sexual function, continence and fertility.

Volume can also be important when it comes to certain diagnostic procedures: in addition to the sentinel node biopsy, the quality of mammography, and endoscopic colopancreatography have been shown to improve with frequent practice.

Finally, practice and experience can also breed confidence. There is

now evidence from a range of cancers – testicular, gastric, and germ cell – to indicate that patients do better with doctors who do a lot of that particular type of treatment, because when complications arise, they are less likely to be blown off course and deviate from the protocol.

Haward freely admits that none of the evidence, taken alone, is of the quality physicians expect when drawing up guidelines. But taken together, he argues, it paints a consistent picture that must be taken into account when considering how to structure the delivery of cancer services – even if some doctors or hospitals lose out as a result.

"People feel there is a rough justice in using this [minimum volumes] to determine policy. There is a feeling that if only you could work hard enough and disentangle what it is about high volume that gives the good outcomes, we could all do it in our low-volume centres and get as good outcomes as they do. I don't think this washes.

"I agree there is a rough justice aspect to it, and there probably are some clinicians in small centres who

TOO FEW

- Good quality cancer care requires specialist pathologists and radiologists to give a detailed and accurate diagnosis, a specialised multidisciplinary team to decide on the best treatment plan for each patient, and specialists, with strong back-up, to carry out complex or tricky parts of the treatment.
- Smaller hospitals are unlikely to have enough patients to merit employing specialists in every cancer, or to merit regular multidisciplinary team meetings. Doctors treating low numbers of patients can not develop the skills and expertise of their colleagues treating high numbers of patients every day in specialist centres.
- Patients pay the price with a lower chance of survival and a higher chance of having their lives blighted unnecessarily by loss of bowel function, loss of a breast, loss of their sex life or their fertility.

get as good results as their colleagues in the bigger centres, and there are some poor services in bigger centres. But in general I think we ought to be taking this literature seriously, and try to organise services in such a way that we provide the configuration of service that is most likely to lead to the best outcomes. Certainly we should be eliminating the thing that most people would agree is unsatisfactory, which is very low volume complex-procedure work.”

And that is exactly what happened as the UK was divided into 34 cancer networks, where each was asked to ensure that all patients were treated by multidisciplinary teams with expertise in the relevant cancer and with a minimum expected case load, according to the population it served. For colorectal cancers this was specified as a minimum population of 200,000, for oesophago-gastric cancer teams and rare head and neck cancers, such as thyroid cancer, as a minimum population of one million, and for pancreatic cancer teams, two to four million.

Inevitably, the policy created resentment among some of those who lost their right to treat cancer patients.

That’s life, says Haward. “No doctor has the divine right to practice medicine any way he or she sees fit.” The health service, he says, isn’t there to look after doctors’ needs, they are in the health service to look after patients.

He does feel, however, that posing the issue of minimum volumes as a stark choice between whether or not to centralise specific cancer services may have been unhelpful and could have contributed towards polarising the debate.

STRIKING A BALANCE

Haward points out that even where an element of care needs to be centralised, that does not mean that the totality of care needs to be centralised. He says that one of the most satisfying aspects of the UK policy development was the widespread recognition that cancer care is multidisciplinary at the level of deciding clinical management and organising who does what, and how. “We’ve tried to strike a balance between different institutions and the personnel in the community and local hospitals as well as more specialist hospitals. We have tried to encourage the idea that good cancer care is a partnership between community and

local hospitals and more specialist and more remote services. It is not all or nothing.”

In practice, he says, the system has shown it can take advantage of opportunities to keep treatments local. One such opportunity arose when the number of non-surgical oncologists in district general hospitals more than doubled as part of the cancer plan. “In ovarian cancer you probably do need to centralise the decision about what is the most appropriate form of chemotherapy, but very often you don’t have to centralise its delivery. And networks have taken the spirit of Calman-Hine [the report behind the UK reorganisation], namely that the specialist team needs to think about what management the patient should get, but many are now quite satisfied that platinum-based chemo can be safely delivered by many of the district general hospitals, so there is no need for patients to come all the way to the larger hospitals to get it.” Efforts are also made to keep palliative care as close to home as possible while still offering a specialist multidisciplinary service.

One way this local care delivery has been achieved is through video-conferencing, which allows, for example, palliative care specialists or medical oncologists delivering chemo at district hospitals to take part in multidisciplinary meetings involving regionally based specialist teams.

If cancer continues to become more like other chronic diseases over the next 10–20 years, Haward says that the current network structure could easily adapt further to include, for instance, community-based cancer clinics run along the same lines as diabetes clinics, and a far greater level of patient self-management.

Some voices still urge caution

until further research has been conducted, but there are indications that they may be running out of time. In the US, the Leapfrog Group, a coalition of around 140 public and private purchasers of health care, has adopted minimum volume quality criteria for pancreatic resections (11 or more per year) and oesophagectomies (13 or more), and is keeping other cancer treatments under review. Many European health insurers are beginning to look at following suit – surgical complications, tumour recurrence and metastatic disease all cost extra to treat, so the payer shares the interest of the patient in getting it right first time.

In Switzerland, where the 26 cantons have for centuries guarded their independence fiercely, attempts are being made to rationalise cancer service delivery across the country. Defining minimum volumes where appropriate is one principle. “The federal office of public health has given a mandate to different people to define [minimum volumes] and to try to get the figures incorporated into the insurance process,” says Reto Obrist, a medical oncologist from the Vallais canton, and a key player in the development of the Swiss national programme against cancer. “One could imagine that in a couple of years, insurers will only pay if such and such intervention is done in a hospital with a minimum volume.”

Insurance companies are already flexing their muscles, insisting, for instance, that patients participating in trials using peripheral stem cell transplantation for lung cancer would be reimbursed only if they were treated at a particular centre in Lausanne. Obrist expects similar restrictions to be placed on pancreatic resections and, possibly, oesophagectomies. But he is painfully aware that the problem

goes deeper than that. Despite recent progress towards concentrating gynaecological cancer services in specialist hospitals, for instance, Obrist admits that in his own canton, on average every gynaecological surgeon operates around three ovarian cancer patients a year, “which is awful, but I have no means to change that”.

He says that there is a certain envy of the French, “because they can implement things in a top-down manner. We are not in that situation, so we have to work from the periphery up.”

There are hospitals that are deciding of their own accord to stop doing procedures they feel they have insufficient expertise in, and in Switzerland this trend may speed up considerably if insurers decide not to pay separately for the costs of treating any complications that may arise. Others are calling in experts from regional specialist centres to take on tricky operations. Some are even paying surgeons with low volumes not to operate.

Patients are also increasingly taking matters into their own hands by choosing to travel sometimes long distances to be treated in hospitals that can show they have a high case load and good results. It is an option that

may work well for them, but there will be many more patients who are less assertive or less able to travel who remain behind in hospitals with ever-dwindling case-loads.

Pressure to stop doctors treating low volumes of cancer patients is now building from some of the professional bodies. In 2000 the European Society of Mastology became the first Europe-wide professional oncology body to issue guidelines over minimum case loads. Their recommendations for specialist breast units included a mandatory requirement that the unit as a whole “must be of sufficient size to have more than 150 newly diagnosed cases of primary breast cancer,” and that individual breast surgeons “must personally carry out the primary surgery on at least 50 newly diagnosed cancers per annum.”

The guidelines have been welcomed by many breast cancer patient groups, including Europa Donna, and have been referred to in a European Parliament resolution. The response from Europe’s medical community, however, has been more muted. In Switzerland, says Obrist, the guidelines have not gone down very well in the profession. Karin

TOO FAR

- Concentrating certain cancer services in specialist centres that treat a minimum number of patients or cover a minimum catchment population means some patients will have to travel further.
- For patients who are less used to being far from home, have poor access to transport, have no friends or family to help them, and have an arduous route to travel – possibly daily for weeks at a time – travelling to a specialist centre can be an ordeal, particularly if they are already feeling very unwell.
- Ideally cancer services should be organised to allow patients to receive each element of their care package as close to home as possible without compromising quality. Transport facilities and ease of access have to be considered when choosing which hospitals to designate as specialist centres.

“Specialists in colorectal or ovarian cancers travel to assist with operations in the smaller hospitals”

Jöns, a breast cancer survivor and MEP, has complained that in Germany hospitals are banding together to give the appearance of fulfilling the criteria without actually changing the way they work.

In the Netherlands, however, the national scientific committee on breast cancer is proposing that EUSOMA's criteria be adopted as national guidelines. Furthermore, the country's larger cancer centres are arguing for all cancer work to be concentrated in no more than 20 hospitals across the country. This would be a major change, for instance, for the breast cancer patients living in the area covered by the North Netherlands Comprehensive Cancer Care Network – one of nine such networks – who currently have 16 hospitals to choose from in their region alone.

Renée Otter, director of the North Netherlands network, fully accepts the need to refer patients needing tricky procedures, particularly for less common cancers, to specialist centres. However, she is convinced that the proposed level of centralisation for breast cancer surgery cannot be justified, and that the net effect would be to deliver a worse service for patients because they would be forced to travel so far from home, for little benefit.

She and her colleagues decided to examine the evidence from their own region, where hospitals have for years been recording detailed data on case management. They wanted to find out whether differences in outcome could be attributed principally to the surgeon or to the 'oncology manage-

ment and policy' at the hospital, and what influence volume had on either. The outcome measure they used was the proportion of early breast cancer patients treated with breast conserving therapy (controlling for case mix).

Instead of the usual regression analysis, this study, accepted for publication in *Breast Cancer Research and Treatment*, used a method adapted from industry to look at the relative importance of differences at the level of the patient, the surgeon and the hospital. Differences between surgeons accounted for just over 5% of differences in outcome, but exactly what made one surgeon better than another was not clear. Membership of the regional tumour working group had the strongest effect; volume, defined as greater or less than 30 patients a year, did not seem to play a significant role. At the level of the hospital, which accounted for almost 3.5% of outcome differences, volume (using a threshold of 100 patients) did play a role, but the effect did not reach statistical significance. What did stand out was the importance of multidisciplinary care – especially the cancer conference and the composition of the multidisciplinary team.

Otter argues that EUSOMA itself is “more focused on the cooperative specialist multidisciplinary team – on processes and structure – than on volume alone,” and feels that the North Netherlands study shows a slightly lower level of centralisation may be safe, so long as these other criteria can be fulfilled. But like Haward, she recognises that the two

issues are inextricably linked, and the study concludes that “hospital volume is not the final factor, but a minimum volume is a prerequisite for well-organised care, e.g. multidisciplinary teams and conferences.”

She believes that if insurance companies are going to set quality indicators, in the case of breast cancer the requirement should focus on treatment via a specialist multidisciplinary team that meets for some hours at least once a week. “If you are not able to arrange this, because it will take too much time from other work, this means that you do not have enough patients and you should stop treating this kind of patient.”

The North Netherlands network has started looking at how groups of smaller hospitals can collaborate to provide specialised multidisciplinary cancer services for patients drawn from a combined catchment population. Surgeons specialising in colorectal or ovarian cancers travel to assist with operations in the smaller hospitals. Heavy use is made of videoconferencing to ensure the participation of specialist pathologists, radiotherapists and all other members of the team in multidisciplinary conferences.

The aim, says Otter, is to ensure that around 70% of cancer patients can be treated locally, with the remaining 30% of rare or difficult cancers being referred to specialist centres. Time will tell whether the hospitals will be able to achieve the required level of collaboration. “If they are not willing to start with such communication techniques, I will

not push them any more, and all patients should be referred.”

Otter believes that local treatment is worth fighting for. She talks of the time breast cancer screening was rolled out across the Netherlands. “In some areas, where it is agricultural, the women came very late to the doctor and they all had T4 breast cancer. It was ulcerating. These kinds of people have to work hard for their income, and they go on till they fall down. If they come to the hospital usually it is too late. But even when they come, if they are told they have to go 200 km from their home, I wonder whether they will do it. Not all of them will.”

Such research as has been done among patients in the North Netherlands region has shown a range of attitudes. “If I remember rightly a quarter of them said it doesn’t matter how far, but I’ll go. Others said, it depends for which kind of things I have to go elsewhere, and why I couldn’t get it here.”

Haward believes that doctors sometimes overemphasise the importance patients attach to local treatment to suit their own purposes. But he agrees that if you are going to stop smaller hospitals carrying out certain procedures, it is important to explain why.

He tells the story of what happened when, shortly after the publication of the Calman-Hine report into the reorganisation of the cancer services, a proposal was made to close some of the gynaecological cancer services in a hospital in a town on the south coast. “The local people wanted to keep the service, but the supporters of Calman-Hine were arguing that certain patients should be sent to a specialist centre further away.” The health authority put the question to the public. It organised a ‘citizens jury’ made up of a represen-

TURNING UP THE VOLUME

Countries with highly centralised health systems can impose a structure on their cancer services from above. Where no such powers exist, there are a variety of ways to move towards greater referral of patients to specialist centres.

- Insurance companies can refuse to pay for patients to be treated at hospitals that don’t meet certain quality criteria – including minimum volumes.
- Professional bodies, like EUSOMA, can define minimum criteria.
- Patients can boycott hospitals that don’t fulfil minimum criteria.
- Hospitals can choose to refer patients to the nearest major centre, or call in surgeons from more specialist centres.
- Hospitals within a given region can club together and decide which will specialise in what; they can refer patients between themselves.

tative group of local people, including patients, and invited them to listen to the evidence, and hear witnesses from both sides. “What was interesting was that when the citizens jury actually had the arguments laid out, they had no problem with certain types of patient needing to travel the extra distance.”

Not all patients have the same priorities. And what may be acceptable to fitter, younger patients may be traumatic for elderly or very sick patients. Cultural factors also play a role. Otter accepts that she might think differently if she were in the States, but patients in the Netherlands, she says, are used to having good care close to home.

Haward has noted a ‘paradox’ at international meetings. “The countries that were most concerned about the whole business of local versus more centralised services were the smaller countries where even centralised services weren’t very far away for patients. It was Israel, Holland and the UK that were really bothered. Countries like Canada, Sweden and Australia weren’t in the least bit bothered.”

It is an interesting observation, and

points to the potential for attitudes to change, but it also points to the need for health systems to find ways to take account of the priorities of the patients they serve. Otter says that in the Netherlands, pressure from patients associations has “opened the eyes of the professionals to discuss better what they can and what they can’t deliver locally.”

Asking patients about their preferences and priorities regarding the way their cancer services are delivered is important. But in many countries, the whole issue of how best to organise quality cancer services is not being systematically addressed by anyone, be they patient, professional or policy maker. There is therefore a simpler question that health service managers, administrators and policy makers needs to ask, and it this: *Would you like us to look into the options and discuss them with you?*

There would be no need for a citizens’ jury to find the answer to that question. And to echo the editorial that appeared in the JNCI more than three years ago: If this question did not involve livelihoods, prestige and power, policy makers all over Europe would have asked it years ago.