Can New Zealand do better in colorectal cancer?

Ian P Bissett

How does New Zealand (NZ) fare in managing bowel cancer? The incidence of the disease is one of the highest in the World but the outcomes of treatment in terms of overall survival fall short of some of our OECD neighbours.\(^1\) Even within NZ the results for patients with colorectal cancer are worse for Māori both in terms of cancer related survival and post-operative mortality. While some of this is explained by higher comorbidity in Māori there is also evidence that access to and quality of care is poorer for this group.\(^2\) Identifying the problem is one thing but implementing changes that will result in improving outcomes is quite another.

This issue of the *Journal* includes a summary of the guidance for the management of Early Bowel Cancer produced and published by the NZ Guidelines Group.\(^3\) This guideline provides recommendations for those responsible for the management of bowel cancer once the disease has been diagnosed. Rather than starting from scratch this is based on a document produced by the National Health and Medical Research Council in Australia in 2005. In a pragmatic approach, using advice from a group of experts who were nominated for their knowledge of colorectal cancer in NZ, sections of the guideline that were considered out of date, inadequately supported by evidence, or inappropriate to the NZ context were identified.

Further literature searches were performed to answer clinical questions developed to address these areas using evidence dating from 2004 onwards. The draft guideline was then widely circulated within NZ to groups with a strong involvement in colorectal cancer management. The feedback received was also incorporated into the final document as appropriate.

This summary contains a list of 85 recommendations for the management of the patient journey from preoperative assessment to long term follow-up and includes cultural, communication, and reporting issues. Twenty-seven of these are ‘good practice points’ based not on published evidence but on the experience or opinion of leaders in the field. Many of these are ‘common sense’ such as “supportive and rehabilitative care should be available to all people with colorectal cancer.” The inclusion of these ‘good practice points’ serves to highlight the importance of many of the less easily measured components of the care of bowel cancer patients. These may nevertheless have a powerful impact on the patient and their experience of treatment. The other 58 recommendations have at least some published evidence to support them even if this merely shows that there is no clear advantage to a particular intervention.

Can this guideline make a difference for individuals with bowel cancer and for the provision of bowel cancer services nationally? I would suggest that there are at least four ways in which this may occur. The guideline provides a tool to help demonstrate evidence, calibrate performance, advocate for patients, and legislate for change.

The greatest limitation of a guideline is that it may be wrong and this may come about for several reasons, such as lack of supporting data, strongly held opinions of
influential players or conflicting priorities among the stakeholders. This guideline, however, gathers together the evidence relating to essential steps in the patient’s management and presents it in a way that clearly outlines the strength of that evidence. For busy clinicians it provides a resource of well researched answers to common questions. Where widely held beliefs are refuted by good evidence (such as the need for oral bowel preparation in colonic surgery) this is clearly demonstrated. The guideline has also incorporated contributions from the professional groups who manage colorectal cancer in NZ and therefore offers the clinician some further confidence that there is strong peer support for the recommendations stated.

The second possible advantage of the guideline is illustrated by a slight variation of an accepted management adage, ‘You cannot improve what you do not measure’. The guideline offers an accepted standard against which bowel cancer management can be assessed. Where there is good evidence for a particular treatment regimen there is also the ability to calibrate individual and group performance against that standard. This measurement itself tends to be a strong driver for improving compliance. Consider, for instance, the recommendation that postoperative chemotherapy should be offered to all Stage III colorectal cancer patients unless there is a particular contraindication. A requirement to document whether this has occurred is likely to increase the rate of delivery of adjuvant chemotherapy to this group, of whom only 69% were offered chemotherapy in a recent study. Detractors of guidelines consider them to be too rigid and likely to encourage doctors to practise ‘cookbook’ medicine with little thought of how they apply to individuals. This guideline includes five recommendations in relation to multidisciplinary teams, particularly that all patients with colon or rectal cancer should be discussed at a Tumour Board or Multidisciplinary meeting. This is the venue for clinicians to ensure that all patients have their management individually tailored to their specific situation. It is at the Tumour Board meeting that those who know the patient best can advocate for them. The treatment of many patients may appear straightforward but consideration, for instance, of the likelihood of a familial syndrome or the need for more extensive surgery may easily be overlooked by a busy clinician practising in isolation. In my experience the inconvenience of fitting a meeting into my schedule is greatly outweighed by the benefits of intellectual input from colleagues and improved decision making and outcomes for the patients.

Finally, implementation of these recommendations may be seen as impractical on a national scale. How can multidisciplinary teams, for instance, cater for patients from all over NZ? The guideline itself can be a powerful force to improve services. If it is accepted as the appropriate standard of care for patients, it gives surgeons, oncologists, and hospital boards the mandate to require change. At present there are multidisciplinary meetings advising the optimal management of patients with bowel cancer at most of the large centres, where oncology, pathology, and radiology specialists are available. It would not require a great capital investment to make these available by video-conference to all those who at present are functioning without them. The guideline itself has the potential to be used as a tool to put pressure on those who control budgets and ensure that its recommendations can be met at each institution. Rather than a threat to clinicians functioning in a smaller centre, it should be seen as a way to assist them to get what they and their patients need.
The success of this guideline in improving outcomes nationally is in our hands. It will depend on clinicians taking it seriously and bringing its recommendations to the attention of colleagues, managers, planners, and patients.

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**Author information:** Ian P Bissett, Associate Professor and Head of Colorectal Surgical Unit

1. Department of General Surgery, Auckland City Hospital, Auckland
2. Department of Surgery, School of Medicine, Faculty of Medical and Health Sciences, University of Auckland

**Correspondence:** Ian P Bissett, Department of Surgery, School of Medicine, Faculty of Medical and Health Sciences, University of Auckland, Park Road, Grafton, Auckland 1001, New Zealand. Fax: +64 (0)9 3779656; email: i.bissett@auckland.ac.nz

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