

some health care policy-makers may conclude from it that optimal care will require the patient to access large, centralized treatment facilities. Such a conclusion may harm groups of patients and, in the long term, jeopardize the survival of institutions that are currently delivering good patient-centred care, but not exactly the way some clinical practice guidelines suggest.

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Reference

1. Hébert-Croteau N, Brisson J, Latreille J, Blanchette C, Deschênes L. Variations in the treatment of early-stage breast cancer in Quebec between 1988 and 1994. *CMAJ* 1999;161(8):951-5.

[Four of the authors respond:]

Jan Sundin reminds us of the importance of patient-related factors in the therapeutic decision-making process. Socioeconomic and living conditions, as well as patients' opinions and preferences, exert a key influence on the choice of treatment and should be taken into account in the assessment of the quality of care for breast cancer and other health conditions. Similarly, accessibility is becoming a limiting factor, not only in rural locations distant from major treatment centres, as is the case for Sundin's practice, but also in some urban areas, as a result of recent reforms in the organization of health services. Because of these considerations, we were very careful to distinguish

compliance with practice guidelines from quality of care for breast cancer. Practice guidelines are to a large extent based on clinical trials, and although they provide standards against which treatment variations can be assessed they are one among several determinants of optimal care for any individual patient.

Hospital caseload has been shown to be a common determinant of care, not only in our study but in many others (N. Hébert-Croteau, J. Brisson, R. Pineault, unpublished data). In the Quebec areas studied, surgical treatment was related to caseload. Accessibility to radiotherapy facilities is an unlikely explanation for this association, because selected patients resided in or close to major cities where such facilities are available. Although variations in the locoregional management of breast cancer may be related to quality of life, they have little impact on overall survival.¹ The likelihood of receiving systematic therapy consistent with consensus recommendations showed a more complicated association with caseload. In hospitals active in clinical research, patterns of systemic therapy varied only slightly with the volume of patients. However, in centres not involved in collaborative trials, use of systemic therapy decreased substantially with caseload. Thus, in our study, both concentration of patients and participation in multicentre clinical trials seemed to influence the care received. In our view, the importance of tumor boards and consultations in oncology should be emphasized,

whatever the size of the primary care centre. We feel that these measures can improve care irrespective of caseload.

In the current context of reform and mergers of health resources, it is important to identify which aspects of the organization of services significantly influence the process and outcomes of treatment for health conditions, such as breast cancer, that afflict a non-negligible segment of the population. Because various characteristics of the source of care are often closely related, only a critical assessment of their independent contributions can give us clues as to how to ensure high-quality care most efficiently.

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Reference

1. Early Breast Cancer Trialists' Collaborative Group. Effects of radiotherapy and surgery in early breast cancer. *N Engl J Med* 1995; 333:1444-55.

Correction

In a recent editorial by David Sackett,¹ 3 of the reference citations in the concluding paragraphs were numbered incorrectly owing to a copy-editing error. In the 4th last paragraph, reference footnote 10 should have been 12 and reference footnote 11 should have been 13. In the final paragraph, reference footnote 12 should have been 14.

Reference

1. Sackett DL. Time to put the Canadian Institutes of Health Research on trial [editorial]. *CMAJ*

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