Quality of care in clinical oncology: from the dreamworld to the real world of outcome assessment

We read with great interest the recent article by Vardy and Tannock [1] and the letter by Gorodokin and Novik [2] about
the definition of the quality of care in oncology. Both of them deal with a controversial aspect of clinical practice, still undefined from either a methodological or a practical point of view. Three distinct issues are handled by Vardy and Tannock in their review:

(i) Is the right treatment being given?
(ii) Is cancer treatment being done well?
(iii) In addition to the disease, is the patient also being treated?

The letter by Gorodokin and Novik integrates this approach, and identifies the two main outcomes of a high-quality oncologic care in overall survival and quality of life.

The two papers define the bases of quality of care in oncology and all oncologists should review either their own work or the work in their departments on the basis of the recommendations of Vardy and Gorodokin. However, some questions merit being discussed in detail.

Survival and quality of life are nearly unanimously considered the main patient outcomes, and every effort should be made to increase the quality of both clinical research and clinical practice, in order to improve them as much as possible [3]. Nevertheless, it is often hard to define and assess quality of care on the basis of these main outcomes, and frequently we have to use surrogate end points to assess the quality of our work in daily clinical practice [4, 5]. It follows that on one hand the quality assessment based on the main patient outcomes is obvious from a speculative point of view, but on the other hand it remains an unsolved problem in daily clinical practice. Indeed, neither the results of clinical trials, nor the levels of evidence used to draw up clinical guidelines can often overcome the need to use surrogate end points of efficacy to support both definition and assessment of quality of care. An interesting review tried to assess the impact of clinical practice guidelines on the quality of cancer care. Unfortunately, the conclusions, although promising, remained inconclusive, as the use of surrogate outcomes of effectiveness to assess quality of care could not be avoided, and surrogate end points could not be related to the main clinical outcomes [6]. Likewise, in recent years a number of clinical trials have tried to conjugate the main patient outcomes with some different surrogate outcomes of efficacy, but the results remain controversial and inconclusive when they are transferred from clinical research to clinical practice [7, 8].

At this point, a question seems to remain unanswered: can we really consider quality of care assessment a topic of clinical practice in oncology, or conversely should it be considered a sort of tale, lacking in any relationship with the real dimension of clinical practice?

Although no definitive data can be obtained from literature, it is mandatory to overcome the constitutional limits of the evidence-based medicine and the fragmentariness of the different experiences in daily clinical practice, in order to reach a comprehensive dimension of outcome research. Such a challenge can represent an intriguing field of investigation for clinical research and clinical practice, and if clinical and outcome research will represent the main tools of intervention, a new era might commence for quality of care definition and assessment in clinical research and clinical practice [9].


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