

SURGICAL ONCOLOGY NETWORK

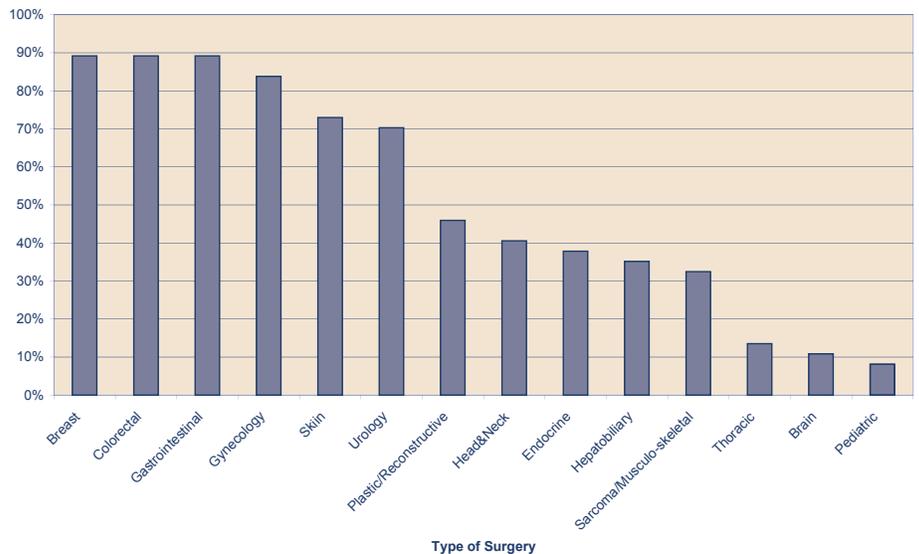
Infrastructure Survey - Highlights to Date

In the fall of 2004, the BC Surgical Oncology Network (SON) sent out a survey to all hospitals in BC to assess what infrastructure is in place at their facility (i.e. equipment, resources, staffing). It was hoped that this information would prove useful when developing clinical practice guidelines that include specific requirements for equipment or resources. For example, this will allow the identification of which facilities can and cannot perform certain procedures (according to best evidence) and could provide support to surgeons when requesting resources.

As of May 2005, the SON has received surveys from 85% of hospitals/health care facilities in the province. The following is a brief summary of the survey responses.

Of the organizations that responded to the survey, 69% perform surgery. Of these, all do day surgery (100%), 87% do inpatient surgery and **82% do some form of cancer surgery**. The most common cancer surgeries performed, based on self-reporting, are shown here (all figures shown on the following graphs are based only on those hospitals performing cancer surgery).

Frequency of Cancer Surgery Performed



... continued on pg 7

In This Issue...

- 1 Infrastructure Survey
- 4 Health Quality Initiatives in Canada and Beyond
- 5 National Surgical Quality Improvement Program (NSQIP)
- 6 Interview with Dr. Peter Doris

Mark Your Calendars!

Surgical Problems in Proximal GI Cancer Management

Saturday, December 3, 2005
Vancouver

The BC Surgical Oncology Network and the BC Surgical Society are pleased to present another exciting fall conference. This year's conference will be focused on proximal GI cancers.

Highlights include:

New Developments in Upper GI Endoscopy
Gastric Cancer (Guest Speaker: Carol Swallow), Cardia Tumours
Genetic Markers in GI Cancer, Adjuvant Treatment in Gastric and Pancreatic Cancer
Weird and Wonderfuls (GIST, gastric lymphoma and carcinoid)

See <http://www.bccancer.bc.ca/SON/> for more information. A brochure will be mailed shortly

Network News

CME

The Head & Neck Travelling Road Show stopped in Surrey on April 29, 2005. Thanks to Drs. Sam Bugis, Rob Irvine and Frances Wong for participating as speakers. Unfortunately the Victoria date was cancelled due to speaker illness, however, it will be rescheduled as soon as possible. The Prince George lecture will feature Rona Cheifetz and Nadine Caron and will be held this fall.

We are also pleased to advise that the SON will once again be co-hosting a fall surgical oncology conference in conjunction with the BC Surgical Society. This year's conference, *Surgical Problems in Proximal GI Cancer Management*, will be held on December 3rd, 2005.

Clinical Practice

Initial results of the infrastructure survey are included in this newsletter. Dr. Noelle Davis and the BC Surgical Oncology Network have also had an abstract accepted for poster presentation at the Canadian Surgery Forum. This poster compares how well hospitals in BC meet the facility requirements of a leading breast cancer guideline.

Research & Outcomes Evaluation

The SON is pleased to announce that Colleen McGahan has been hired as the Surgical Oncology Program's biostatistician. She will be updating our surgical atlas and working with the network to post this information online.

The SON will also be preparing regional reports based on the surgical atlas. These will be provided to participants of our fall annual meeting. Examples of the data these reports will contain include:

- Surgery volumes by health authority and hospital as well as comparison to provincial data
- Surgery volumes by residence of patients (where do residents have surgery done)
- Cancer incidence by region
- Regional infrastructure availability and comparison to province

Outcome Collection

The SON has entered into an agreement with HDC Health Data Consortium to conduct a 6-month pilot project to electronically collect outcomes data. This project has two components – one is to track breast cancer outcomes data and the other is to create an electronic version of the SON's current rectal cancer monitoring project form. Both components will have a web-based and a PDA-based (personal digital assistant – in this case a PocketPC) means to collect data.

The breast cancer component is designed to support the SON's breast cancer guidelines, in particular, it will allow surgeons to instantly ascertain their False Negative Rate (FNR) for Sentinel Lymph Node Biopsy. The rectal cancer form will provide surgeons with an alternate means of submitting information on their low rectal cancer surgeries to the Rectal Cancer Monitoring Project. They will then be able to compare their outcomes with provincial rates any time they wish.

Surgical Tumour Groups

Breast

A guideline on stand-alone Sentinel Lymph Node Biopsy is currently being finalized. This guideline will recommend circumstances in which it is safe to perform a stand-alone Sentinel Lymph Node Biopsy without an axillary node dissection.

Rectal

The Rectal Cancer Monitoring Project has been hard at work to complete the data set for the first year of the project (Oct 1, 2003 to September 30, 2004). Under the auspices of the BC Cancer Registry, the SON is collecting information directly from hospitals on all rectal cancer cases during this period. This will allow the SON to assess the quality of surgery being performed in the province and hopefully, demonstrate an improvement from Dr. Phang's 1996 study. In addition, it will provide information on the success of the voluntary data submission process.

Information obtained for the project is kept strictly confidential however, individual surgeon data will be sent to each surgeon as part of the year 1 analysis. It is hoped that this will be useful for each surgeon's individual quality assurance endeavours.

Did You Know That ...

Talk of networks is buzzing in health services. The Spring 2005 issue of the Canadian Health Services Research Foundation (CHSRF) newsletter, *Links*, was focused on networks (www.chsrf.ca). The authors note that "the value of networks...[is in] the access they give to exchanges of informal knowledge. The focus of these networks is people, not organizations. Interaction is based on personal interest and ideas, not organizational interest and accountabilities". Tina Strack, Barbara Poole, Simon Sutcliffe and Frances Lasser have just had an article accepted for publication, *Networks as a Means of Cancer Control*, that explores these very concepts as they relate to knowledge translation in cancer care.

Upcoming Oncology Related Conferences

World Congress on Melanoma September 6-10, 2005 Vancouver

The Canadian Melanoma Foundation, The University of British Columbia and the BC Cancer Agency combine to support the forthcoming 6th World Congress on Melanoma. The Congress will bring together the world's experts on the prevention, treatment, management and research on one of the most prevalent cancers of modern times.

Program highlights:

The argument against sentinel node biopsy in melanoma

Meirion Thomas

Prediction of melanoma in the non-sentinel nodes

Alistair Cochran

Surgical margins: what does the latest information show?

Chairs: Natale Cascinelli; Mario Santinami

Concurrent Symposia:

Difficult sites and difficult cases

Chairs: Mario Santinami, Charles Balch

Management of congenital nevi, dysplastic and atypical nevi

Chairs: Allan Halpern, David McLean

Sentinel lymph node biopsy: does it prolong survival?

Chairs: Merrick Ross, Bill McCarthy

Visit <http://www.worldmelanoma.com/> for more information.

Canadian Surgery Forum September 8-11, 2005 Montreal

Program highlights:

Thursday, September 8, 2005

CAGS Postgraduate Course: Colorectal and Breast Cancer: Identifying the High-Risk Patient and Treatment Considerations

Description: This half-day course will provide an approach to obtaining an adequate family history of a patient with colorectal or breast carcinoma, identifying 'high-risk' families/individuals, making

screening/surveillance recommendations and understanding the role of prophylactic surgery.

Sunday, September 11, 2005

CATS/WCOG Postgraduate Course: Management of Cancers of the Esophagus and Esophagogastric Junction (sponsored by the Canadian Association of Thoracic Surgeons)

Description: This one-day course will provide insight and up-to-date information on the staging and management of early and advanced esophageal cancer. The course will feature lectures, debate and panel discussions during which participants will be asked to interact with experts in the field such as Dr. John Wong from the University of Hong Kong.

See <http://www.cags-accg.ca/> for more information.

Annual Cancer Conference November 3-5, 2005 Vancouver

The BC Cancer Agency's annual conference provides an opportunity for cancer care professionals and researchers to share knowledge, innovation, and steps forward in clinical care and translational science. This year's theme is "Cancer and Families", encompassing topics from hereditary cancers to psychosocial supports. For registration information, please visit the Agency's website: www.bccancer.bc.ca

American College of Surgeons Clinical Congress October 16-20, 2005 San Francisco

The theme for this year's Clinical Congress is "Education for the Spectrum of Surgical Practice".

Program highlights:

General Sessions:

Management of Colorectal Hepatic Metastases

Specialty Sessions

Novel Staging Modalities for Lung Cancer

Skills-Oriented Postgraduate Courses

Laparoscopic and Hand-Assisted

Laparoscopic Colon Resection
Stereotactic Breast Biopsy

See <http://www.facs.org/clincon2005/index.html> for more information.

1st International Cancer Control Congress October 23-26, 2005 Vancouver

The Canadian Strategy for Cancer Control and the Public Health Agency of Canada are proud to bring together a broad constituency to share strategies, experiences, tactics and best practices to address the implementation of population-based cancer control—with principal foci on the science underlying cancer control, what population-based programs are effective, key elements for maximum impact at the population level, collaborative multi-sectoral partnerships needed—culminating in exploring how to build an international community of practice.

See <http://www.cancercontrol2005.com> for more information.

North Pacific Surgical Association Annual Scientific Meeting November 11-12, Vancouver

Abstracts accepted until June 30, 2005.

The Vancouver caucus of the North Pacific Surgical Association is looking forward to hosting the 92nd annual scientific meeting. The Founders' Lecturer will be Professor Myrrdin Rees of The Hampshire Clinic, Basingstoke, England. Jack Poole, CEO of the 2010 Olympic Games organizing committee will be the guest speaker. There will also be an opportunity to hear NASA astronaut and Canadian surgeon, Dr. David Williams.

See <http://www.nopacsurg.org/2005-meeting.htm> for more information.

Health Quality Initiatives in Canada and Beyond

Oncology Indicators Ontario – Cancer System Quality Index

The Cancer System Quality Index was developed by the Cancer Quality Council of Ontario in partnership with Cancer Care Ontario to provide a broad view of the quality of cancer services in Ontario and its regions. Made up of 25 indicators, the Cancer System Quality Index tracks Ontario's progress against cancer and points out where cancer service providers and managers can make improvements, so that all Ontarians have timely access to the highest quality of care no matter where they reside.

By using a single system-wide index to measure and track the quality and consistency of cancer services, service providers and managers will have an understanding of where improvements can have the greatest impact. Regular updates will chart progress against these 25 indicators and point to areas where further improvements can be made.

Each indicator is a measure of progress against one of five goals that have been established to focus efforts on improving quality of care in the cancer system:

- Improved access to services
- Better outcomes
- Use of evidence when treating cancer
- Greater efficiency
- Improved measurement

See <http://www.cancercare.on.ca/qualityindex/>.

Patient Safety Initiatives Canada - Canadian Patient Safety Institute (CPSI)

In September 2001, the Royal College of Physicians and Surgeons of Canada held a one-day forum on patient safety as part of its Annual Conference. Consensus was reached on the need to develop a coordinated strategy for improving patient safety within Canada. The National Steering Committee on Patient Safety, (NSCPS), chaired by Dr. John Wade, was created as a result of this one-day conference. The committee was supported by five working groups with responsibility to address the following aspects of patient safety:

- System Issues
- Legal/Regulatory Issues
- Measurement/Evaluation
- Education/Professional Development
- Information/Communication

In September 2002, the NSCPS released the report *Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care* <http://rcpsc.medical.org/publicpolicy/index.php>. The report provided various recommendations including the establishment of a Canadian Patient Safety Institute (CPSI) to promote innovative ways of improving patient safety, such as professional development programs, and research and analysis of patient safety issues.

Activities of the CPSI

In seeking to fulfill its purpose, the CPSI will collaborate with territorial, provincial, federal governments and health system stakeholders to achieve the following objectives:

- provide advice to governments, stakeholders and the public on effective strategies to improve patient safety;

- perform a coordinating role across sectors and systems;
- promote best practices related to patient safety; and
- raise awareness of patient safety issues with patients and the general public through public education and reporting.

See <http://www.cpsi-icsp.ca/> for more information.

Quality Improvement Initiative USA - The Leapfrog Group

A 1999 report by the Institute of Medicine gave the Leapfrog founders an initial focus – reducing preventable medical mistakes. The report found that up to 98,000 patients in the US die every year from preventable medical errors made in hospitals alone.

The Leapfrog Group identified and has since refined four hospital quality and safety practices that are the focus of its health care provider performance comparisons and hospital recognition and reward. Based on independent scientific evidence, the quality practices are:

- computer physician order entry
- evidence-based hospital referral
- intensive care unit (ICU) staffing by physicians experienced in critical care medicine
- The Leapfrog Safe Practices Score

Computer Physician Order Entry (CPOE): With CPOE systems, hospital staff enter medication orders via computer linked to prescribing error prevention software. CPOE has been shown to reduce serious prescribing errors in hospitals by more than 50%.

Evidence-Based Hospital Referral (EHR): Referring patients needing certain complex medical procedures to hospitals offering the best survival odds based on scientifically valid criteria — such as the number of times a hospital performs these procedures each year or other process or outcomes data — research indicates that a patient's risk of dying could be reduced by 40%.

ICU Physician Staffing (IPS): Staffing ICUs with doctors who have special training in critical care medicine, called 'intensivists', has been shown to reduce the risk of patients dying in the ICU by 40%.

The Leapfrog Safe Practices Score: The National Quality Forum's 27 Safe Practices: The National Quality Forum-endorsed 30 Safe Practices cover a range of practices that, if utilized, would reduce the risk of harm in certain processes, systems or environments of care.

This list is based on criteria such as:

- (1) There is overwhelming scientific evidence that these quality and safety leaps will significantly reduce preventable medical mistakes.
- (2) Their implementation by the health industry is feasible in the near term.
- (3) Consumers can readily appreciate their value.

Current Progress

The Leapfrog Group began collecting data in June 2001 by querying urban and suburban hospitals in six regions and has recently expanded from 23 to 28 regions. In 2004, Leapfrog's 23 regions accounted for almost half of the U.S. population and encompassed 1,664 urban, suburban and rural hospitals. At the end of 2004, 55 percent (692) of targeted hospitals had responded. In addition, more than 240 hospitals outside of the 23 regions had responded to the survey on their own initiative, without a formal request from Leapfrog.

See <http://www.leapfroggroup.org/> for more information.

National Surgical Quality Improvement Program

Summary:

Eleven years ago the Veterans Health Administration (VHA) created the NSQIP to measure operative morbidity and mortality in VA Hospitals. After implementing the program in 128 hospitals, surgical mortality decreased 27% and morbidity decreased 45%. In 2001, a collaboration of the VA and the American College of Surgeons (ACS) resulted in a grant from the Agency for Healthcare Research and Quality (AHRQ) to implement the NSQIP in private sector hospitals. After 21/2 years of study data, nearly 100,000 surgical cases have been collected from 18 private hospitals.

The study results show the program has been successfully implemented in these hospitals and the NSQIP methodology works well in the private sector. As a result of the program's success in the VA and the private sector initiative, the ACS developed a business plan to offer this program, beginning with General and Vascular Surgery, to all interested and qualified hospitals. The ACS NSQIP is now being made available to all private sector hospitals that meet the minimum participation requirements, complete a hospital agreement, and pay an annual fee.

The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) is a national, validated, outcomes-based, risk-adjusted program for the measurement and enhancement of surgical care. During the mid-to-late 1980s, the Department of Veterans Affairs (VA) came under a great deal of public scrutiny over the quality of surgical care in their 133 VA hospitals. At issue were the operative mortality rates in the VA hospitals and the perception that these rates were significantly above the national (private sector) norm. To address the gap, it was mandated that the VA report its surgical outcomes annually:

On a risk-adjusted basis to factor in a patient's severity of illness, and
Compare them to national averages.

The only problem was that these "national averages" did not exist.

As a result, the VA embarked upon the National VA Surgical Risk Study (NVASRS) in 44 VA medical centers. The foundation for their work was Lezzoni's "algebra of effectiveness", which states that outcomes of health care can be described by this equation:

Patient Factors + Effectiveness of Care + Random Variation = Outcome

For this equation to move from theory to practical application, the VA recognized that they needed to build a statistically reliable database of patients' pre-operative risk factors and post-operative outcomes. They also had to create methods for accurate risk adjustment and to account for random events. During this period, information was collected on pre-operative, intra-operative and 30-day outcome variables on a total of over 117,000 major operations.

Using this data, the NVASRS was able to develop risk models for 30-day mortality and morbidity in nine surgical specialties. Additionally, they found that the risk-adjusted outcomes produced by the models matched the quality of systems and processes in the 44 hospitals. Their work allowed, for the first time, a comparative measurement of the quality of surgical care in the nine specialties.

NSQIP Results 1991 – 2001

27% decline in post-operative mortality

45% drop in post-operative morbidity

Median post-operative length of stay fell from 9 to 4 days

Patient satisfaction improved

The success of the NVASRS study encouraged the VA to establish an ongoing program for monitoring and improving the quality of surgical care across all VA medical centers, and the National Surgical Quality Improvement Program (NSQIP) was born. Each year over 110,000 major surgical cases have been added to the database, creating the over 1.3 million cases presently in the VA system.

In 2001, the American College of Surgeons (ACS) began to take an active interest in the NSQIP and its results in reducing surgical mortality and morbidity rates. The ACS applied for a grant to expand the program further into the private sector. Three years of private sector experience has demonstrated the effectiveness of the NSQIP as a quality improvement tool and as a source of new clinical knowledge for hospitals outside the VA system. As a result of the program's success in the VA and the private sector, the ACS developed a business plan to offer this program, beginning with General and Vascular Surgery, to all interested hospitals.

In October of 2004, the College began enrolling new private sector hospitals into the ACS NSQIP. The ACS NSQIP is available to all private sector hospitals that meet the minimum participation requirements, complete a hospital agreement, and pay an annual fee of \$35,000. Hospitals can benefit from participating in the ACS NSQIP for many reasons; most importantly the program can contribute to the reduction of surgical mortality and morbidity. The VA program will continue its parallel system (the VA NSQIP) and will compare its results against the ACS NSQIP private sector data.

See www.acsnsqip.org for more information.

Interview with Dr. Peter Doris



“we have well trained surgeons who do a good job, but they also want to do their jobs better”

**Dr. Peter Doris MD, MSc, F.R.C.S.(C), F.A.C.S
Chief of Surgery, Surrey Memorial Hospital**

Tell us about your background.

I am a native of Ontario and went to Medical School at Queens University and was the last of a generation of surgical trainees that trained in multiple sites. I ended up training in Kingston, Winnipeg and Sheffield, England. My research at the time was in Gastro-Intestinal physiology and the clinical activity was predominantly Gastro-Intestinal Surgery including Gastro-Intestinal cancer. I then went back to Kingston and was on staff there for 13 years. During that time, I progressively increased my research and clinical interest in breast disease and Breast Cancer. I came to BC in 1987 and started in general surgical practice with an increasing interest in oncology. I was involved in the academic side of surgery while in Kingston and England, and on the administrative side in BC where I have been Chief of Surgery for more than 10 years.

Why did you get into Surgical Oncology?

Well number one because I am a surgeon and surgeons like to do things and see the feedback of their activities very quickly. As a general surgeon, a large part of what we do is related to oncology. It is the ability to intervene in the natural history of the disease and see the effects of your intervention in a short time line.

You are the chair of the SON's Research and Outcomes Evaluation Committee (ROE). How can and how should the Surgical Oncology Network play a role in Surgical Outcomes Evaluation in BC?

In Canada and in BC we have well trained surgeons who do a good job, but they also want to do their jobs better. In order to identify areas where people can get better, they need to have information about how they are doing and that has been one of our difficulties. We have information about short term outcomes, which is how we've been traditionally organized, and this is roughly M & M Rounds. However to determine your effectiveness for cancer you need to have feedback at the individual level.

Case in point; the report that Dr. Terry Phang brought in on outcomes for treatment of rectal cancer in BC. That report indicated that, in general, the results in BC were not at an acceptable level. The response was that training programs were developed and these were attended by the majority of surgeons who do this surgery. There was a coordinated effort at data collection and eventually we will be giving feedback to the surgeons in terms of their effectiveness. I would submit that the initial reporting of outcomes by Dr. Phang set the stage for this kind of initiative. I believe that in all of the surgical disciplines, but more specifically oncology, if you gave surgeons

feedback on how they are doing and if they were not doing as well as one would hope, they would create a change and make it happen.

What do you think the NSQIP can do in BC?

There are two requirements that surgeons have to identify to the public. 1) Effectiveness of treatment. As surgeons we should know how effective our treatment is and we should be able to transmit that to the patient. 2) Patient safety. If an individual is coming in to have a surgical procedure we should be able to identify safety considerations looking at traditional outcomes activities. If you are only using a short time line there can be difficulties when you deal with relatively low frequency events. If you are a surgeon or a hospital that has a relatively low number of procedures a year you may not be able to identify how you are doing.

What the NSQIP has been able to do is identify systems that are outcomes based but it is risk adjusted so you can compare patients in different locals with different co-morbidities. The tool has been scientifically validated so you put the information that you get from NSQIP into a realistic algorithm of care. What the Veterans Administration in the US has been able to do is decrease morbidity and mortality as well as increase clinical effectiveness and they have done this in a very public forum. We should transport a similar type of system to establish the patient safety side and through the Surgical Oncology Network look at outcomes to deal with the effectiveness side.

Do you think there would be any resistance from surgeons to Outcomes Evaluations?

No, surgeons have always been outcomes oriented. If you ask a surgeon why he does a certain procedure or why he does it a certain way, the answer will always be couched in outcomes. What we are proposing to surgeons is that the outcomes information be cleaner data so that the surgeons will be able to make those kinds of decisions based on real-time data. I am absolutely convinced that surgeons are doing a good job and they'd like to do as good a job as they can. If they are given the correct tools they will respond as they did with the Rectal Cancer project. There hasn't been any acrimony or difficulty related to this. When we give surgeons back outcomes data, we will find many areas where we are doing better than International norms and it would be nice to be able to objectively demonstrate that.

Is there anything else you would like to say?

Outcomes based analysis has to be done so we know what our actual data is rather than reporting a scene from some other place and some other time that may or may not be applicable to our staff and our system. We must move forward into a system where we are constantly improving, but we are doing it in a way that we can understand and measure for ourselves. We also have to be aware of the Best Practices and other activities that are happening internationally. For example if someone came forward and said the outcomes are better if you manage a certain type of cancer in a certain way, we should be able to go to our data and say here's our outcomes right now with our current method of management. Then we can ask is this applicable for trial in BC? In the absence of information about local data, the decision making process is entirely different.

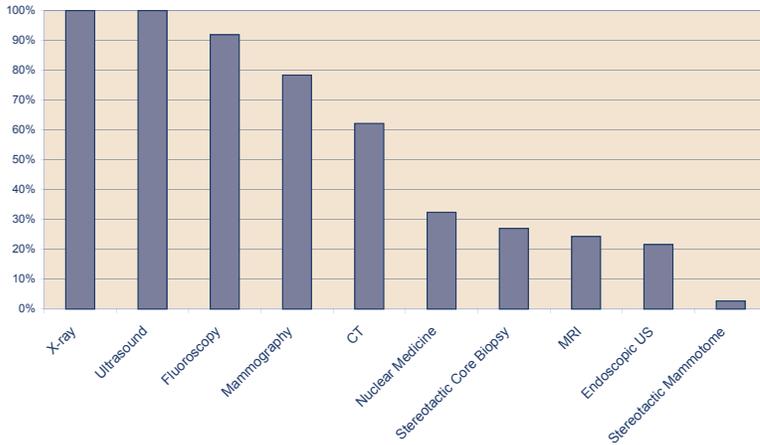
The Surgical Oncology Network would like to thank Dr. Doris for his time and input.

Infrastructure Survey - Highlights to Date

cont. from Pg. 1

The survey was particularly interested in determining what equipment is available in hospitals throughout BC. The chart below shows that ultrasound and x-ray are by far the most readily available medical imaging equipment. Hospitals were also asked if they had offsite access to equipment. Interestingly, of those that did not have a particular resource onsite, several reported that they did not have offsite access to it either. It should be noted that ‘offsite’ was not defined however.

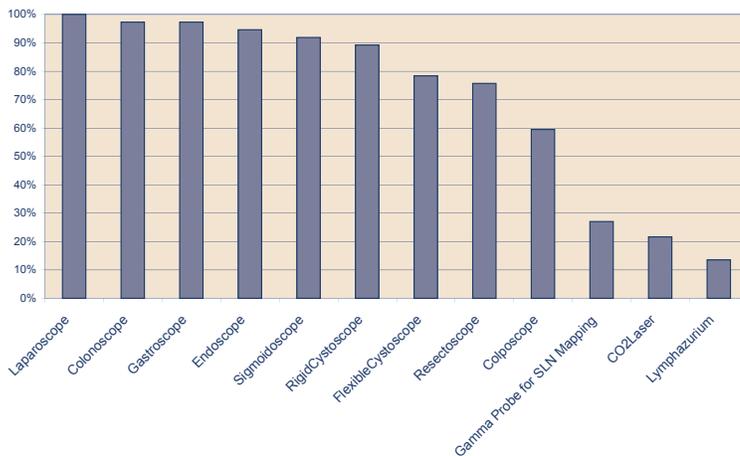
Medical Imaging Services Available Onsite



Equipment	% Reporting No Offsite Access
Stereotactic Core Biopsy	96%
Endoscopic Ultrasound	72%
Nuclear Medicine	60%
Mammotome	47%
MRI	43%
Mammography	38%
CT	36%

The following OR equipment and hospital services are available at BC hospitals that perform cancer surgery.

Onsite OR Equipment



Service	% Available Onsite
Onsite Pathology	60%
Anesthetist or GP with training in Anesthesiology	100%
Ability to perform Intra-Abdominal Surgery	95%
Radiologist	86%
Endoscopy suite	84%
Access to online BCCA Cancer management Guidelines	70%
Colposcopy suite	49%
Respirologist	46%
Cardiologist	41%

The goal of the infrastructure survey is to provide a snapshot of the equipment, resources and services available at BC hospitals. This data will be particularly useful in looking at clinical practice guidelines. For example, survey results show that only 10 hospitals meet the requirements of an international breast cancer guideline. Results indicate that most hospitals in BC lack the infrastructure that has been demonstrated to produce the best outcomes in breast cancer treatment. Provincial strategies to promote the use of practice guidelines and referral protocols will be crucial in overcoming these deficiencies in infrastructure. Hopefully this infrastructure survey will be one tool to help improve patient care.

Colon Cancer Clinical Trial Open

Two new adjuvant therapy trials for colon cancer are underway at the BC Cancer Agency. These trials are for Stage II and Stage III patients and require that patients are enrolled and start treatment within 8 WEEKS of surgery. Patients can be referred to Hagen Kennecke (VCC), Jiti Gill (FVCC), Catherine Fitzgerald (VICC) and Marianne Taylor (CCSI).

Chairs:

Dr. Noelle Davis
604 877-6000 ext. 2391
noelle.davis@bccancer.bc.ca
Dr. Con Rusnak
250 592-5959
crusnak@caphealth.org

Committee Chairs:*Clinical Practice*

Dr. Noelle Davis
604 877-6000 ext. 2391
noelle.davis@bccancer.bc.ca

Continuing Medical Education

Dr. Rona Cheifetz
604 875-5880
cheifetz@interchange.ubc.ca

Communications

Dr. Blair Rudston-Brown
250 753-5319
blair@rudston-brown.shawbiz.ca

Research & Outcomes Evaluation

Dr. Peter Doris
604 583-1668
peterdoris@telus.net

Return Undeliverable Canadian
Addresses to:

Surgical Oncology Network
BC Cancer Agency
600 West 10th Avenue
Vancouver, BC V5Z 4E6
Tel: 604 707-5900 ext. 3269
Fax: 604 708-2108
Email: son@bccancer.bc.ca

Cancer research in BC gets a new home

(Reprinted from March 15th *Pulse* (PHSA's monthly bulletin) - www.phsa.ca/news/pulse)

Hundreds of people were on hand March 1 as the new BC Cancer Research Centre officially opened its doors. The \$95 million building, one of Canada's largest free standing cancer research centres, is the new home for eight of the BC Cancer Agency's research departments. The new building provides a unique opportunity to increase the number of clinical and basic research teams brought together to address key issues in cancer control. Capacity will increase from 318 researchers in the former research centre, housed for the past 26 years in an outdated former bakery across from the BC Cancer Agency's Vancouver Centre on West 10th Ave, to up to 600 scientific and medical personnel.

"This new building will not only improve the research capacity of our existing research team, but will help the BC Cancer Agency attract leading cancer researchers from around the world to our facility," said Dr. Simon Sutcliffe, president, BC Cancer Agency. "We have created an environment that will allow some of the world's best clinicians and scientists to work collaboratively to discover the causes of and cures for cancer."

The building was funded by donations to the BC Cancer Foundation and contributions from the federal and provincial governments. The federal contribution came in the form of \$27.8 million through the Canada Foundation for Innovation. The provincial Knowledge Development Fund of B.C. also contributed \$27.8 million. A planned connecting bridge between the research centre and BC Cancer Agency Vancouver Centre across the street will encourage collaboration between the clinicians and scientists, an important component of the BC Cancer Agency's focus on translating research quickly from the researcher's bench to the patient's bedside.

"The new BC Cancer Research Centre is a concrete example that if we all work together – scientists, physicians, community, universities and governments – we can achieve far beyond what we could imagine," said Dr. Victor Ling, vice president of research at the BC Cancer Agency, who will head up the new centre. "The challenge before us is to sustain this momentum for the benefit of all cancer patients and their families. Many, many thanks to all of you who have contributed your money, expertise, goodwill, blood, sweat and tears to making this new research facility a reality. We won't let you down."

For more information**Newsletter Editors:**

Dr. Blair Rudston-Brown
Dr. Rona Cheifetz

This newsletter is published three times a year.
To submit story ideas or for any other information please contact: Denise DesLauriers, Program Assistant
T: 604 707-5900 x 3269
E: ddeslauriers@bccancer.bc.ca
Visit the SON Website:
www.bccancer.bc.ca/SON or email us:
son@bccancer.bc.ca

The Council & Network

The BC Provincial Surgical Oncology Council exists to promote and advance quality cancer surgery throughout the province by establishing an effective Network of all surgical oncology care providers and implementing specific recommendations. The Network will enable quality surgical oncology services to be integrated with the formal cancer care system. Communications to enhance decision-making, evidence-based guidelines, a high quality continuing education program, and regionally based research and outcome analyses are the initial priorities.