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Planned Pathways in the Management of Cancer

In the last three decades the incidence of cancer in Denmark has been among the highest in the OECD countries. At the same time the outcomes of cancer treatment rank among the poorest. Since the turn of the century, this picture has changed completely as a result of the national Cancer Plan I and Cancer Plan II, adopted in 2001 and 2006 respectively. One important tool in this process is the universal use of planned patient pathways, in which the necessary diagnostic and surgical capacities are pre-booked and the services delivered according to national guidelines.

Mr. Gaub stressed that packaged pathways can be extremely helpful for cancer care but that they are also challenging for both management and clinicians. Indeed, packaged pathways will be neither implemented nor a success unless managers play an active role.

High cancer incidence in Denmark is often related to lifestyle choices but outcomes are always determined by the healthcare system. The system in Denmark is often marred with delays; long waiting lists and delays cost lives. There are waiting lists for each step in the care process, from diagnosis to treatment. At Sygehus Lillebaelt they found a solution to this problem: compressing waiting times into packages (packaged pathways). For example, there is a lung package, with a lung team. The diagnostic work-up for suspected lung cancer is then done within 10 days.

Gaub defines a packaged pathway as a standardised part of clinical pathway, diagnostic or therapeutic, consisting of prereserved elements, in predetermined sequences and according to national consensus guidelines.

To facilitate packaged pathways there should be electronic communications everywhere with universal access to lab-data and imaging and easy access to initial examination, e.g. thoracic xray. There must also be teams of specialists, a contact physician and contact nurse and a team boss. Jobs must be easily swapped if it allows smoother operation and a weekly team conference is the essential cornerstone.

The advantages of packaged pathways include that results from diagnostic tests are always available at an agreed time, since capacity is pre-reserved and there is also a high rate of productivity and high training efficiency. Unused pre-reserved slots are rarely wasted, if released 72 hours before occurrence and any team member can answer questions from the patient. Losing patients between departments is rare thanks to contact nurse and physical handing-over procedures.
But if packaged pathways are such a good idea, why didn't everybody do it a long time ago? Gaub explained that success depends on rigid planning to make it work 52 weeks per year and that consultants must accept to be booked by their colleagues. Other factors producing resistance to packaged pathways include misconceptions about the need for excess capacity, misconceptions about "industrialised" pathways, the tendency to view a long waiting list as an asset (a well padded order book) and surprisingly the failure to realise that delayed diagnosis costs lives.

Packaged pathways are not always the best choice, they will not work if the weekly volume is below two to four patients as pre- reservation becomes mean ing less. This is also true if bottlenecks are not removed immediately and if failure to deliver results occurs frequently, and there is a lack of cooperation and commitment.

To conclude, Mr. Gaub stressed that the role of the management is key. They must provide the hardware, break down old habits and keep an eye on the results - all the time.

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