EFFICIENT HEALTH SERVICE CORRIDORS FOR THE DIAGNOSIS AND TREATMENT OF WOMEN WITH BREAST CANCER

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Key Implications for Decision Makers

Women with breast cancer are currently diagnosed through the *Programme québécois de dépistage du cancer du sein* (“PQDCS” corridor), an organized screening program, or through the usual clinical services (“clinical” corridor). The key implications emerging from this research involve these two service corridors.

- Physicians are important actors in the initial referral to the two service corridors. They appear to favour women’s participation in the PQDCS. The medical indication for referral influences the waiting time for the first breast procedure. Therefore, physicians must be clear as to the reasons for their referral, both with patients and healthcare professionals.

- Women perceive their physician as an actor who facilitates referrals throughout the continuum of services.

- The “PQDCS” designation of screening centres and referral centres for investigations has formalized the service network for breast cancer screening and diagnosis. PQDCS services are used extensively by women in the clinical corridor. This constitutes a success in terms of the objectives of the *Programme québécois de lutte contre le cancer*, a cancer control program.

- The PQDCS corridor is not associated with shorter waiting times for diagnosis of breast cancer than the clinical corridor. The presence of symptoms or clinical signs appears to be an important determinant associated with the shortest waiting times.

- The waiting times observed for women diagnosed with breast cancer do not meet the recommended Canadian standards, neither for women in the PQDCS corridor nor for those in the clinical corridor. Better functional integration of services, designed in part to reduce the number of appointments for investigations, might be the next step to consider for reducing waiting times.
Executive Summary

The scientific literature suggests that excessive waiting times for the diagnosis and treatment of women with breast cancer can influence their prognosis. Consequently, practice guides are increasingly defining and recommending the optimal times at various stages of the continuum of care of patients with breast cancer. The *Programme québécois de lutte contre le cancer* (PQLC), a cancer control program, and the *Programme québécois de dépistage du cancer du sein* (PQDCS), an organized screening program, both strive to ensure that cancer patients obtain better continuity of healthcare services.

In this study, we addressed the issue of continuity of healthcare services by using as indicators the continuity of various waiting times in the continuum of services available to women with breast cancer.
Six service corridors used by 696 women with breast cancer were identified and examined in terms of waiting times. These service corridors were determined based on two criteria. Breast cancer detection through PQDCS or through the usual clinical system was used to define the PQDCS corridor and clinical corridor respectively. Each of these corridors was then subdivided into three corridors based on the indication for referral for breast examination (screening, symptomatology, or follow-up for a breast abnormality). In our study population, cancer detection through the PQDCS or the usual clinical system was not associated with waiting times for diagnosis and initial treatment. In contrast, the reason for referral was associated with waiting times. Women presenting symptoms, whether in the PQDCS or not, had the shortest waiting times for diagnosis of breast cancer and onset of surgical treatment. Sixty-three to 89 percent of women presenting symptoms met the recommended Canadian standards for time between first breast procedure and cancer diagnosis, while these percentages ranged from 43 to 50 for women with follow-up for a breast abnormality and between 32 and 46 percent for women diagnosed through screening. Following diagnosis, surgical treatment was performed
within two weeks for 52 and 57 percent of women with symptoms, for 32 percent of women with follow-up, and for 36 and 37 percent of screened women.

The PQDCS helped formalize services for breast cancer screening and diagnosis by designating screening centres and referral centres for investigations. These services are used both by women diagnosed through the PQDCS and those diagnosed through the usual clinical system. In fact, 85 and 74 percent of women in the clinical corridor use PQDCS services for their initial breast procedure and their diagnostic procedure, respectively. Despite structures intended for detection and investigation of breast cancer, the number of days required to complete investigations remains high, especially for women who have been screened, probably because the tumours to be investigated are smaller. The next step to consider for improving the continuum of services available to women with breast cancer would be better functional integration of services so as to reduce waiting times for women. Other findings emerging from this research are presented in the key implications section.