Women can only have expectations regarding their breast care management if they have been allowed access to education in this. Education breaks the silences, changes the perceptions and this is where advocacy plays a crucial role-in providing information, education, in changing expectations, in allowing women to have a voice in advocating for better breast care.

Breast cancer advocacy spreads different messages to women, and men, in the different countries, lobbying for different goals and objectives, but with one ultimate vision-to raise expectations of each woman, of each citizen in Europe, in order to ask and obtain optimal breast cancer management, to strive for best health care, respecting the woman's needs.

The purpose of this presentation will be to propose how the breast cancer advocacy movement can act as the catalyst, through education and information, to bring about this transformation in the expectations of European women in breast health management issues.

446 Invited

Breast units in Europe – where do we stand?

L. Cataliotti. *University of Florence, Surgery Department, Firenze, Italy*

In October 1998 in Florence the First European Breast Cancer Conference took place. Delegates agreed a consensus on research, genetic predisposition, psycho-social status, treatment and notably quality of care: "The Florence Statement" demanding that all women have access to multidisciplinary breast clinics based on populations of around 250,000; also calling for mandatory quality assurance programmes for breast services.

In this regard Eusoma and EORTC established a working party, which developed the guidelines "The Requirements of a specialist Breast Unit' setting the standards for forming high quality Breast Units across Europe.

These Guidelines have been influential in the introduction of the multidisciplinary working in several countries. The Brussels Statement, following EBCC2 drew attention to these guidelines and demanded that processes of accreditation of breast units be implemented. The importance of the establishment of multidisciplinary breast units was again stressed in the Hamburg Statement which followed EBCC4. Attention was drawn to the approval given to this in the European Parliament (Resolution Number A5–0159/2003).

With the aim of assuring the provision of high quality specialist breast units across Europe, Eusoma has developed in collaboration with Euref and Europadonna a voluntary process of accreditation.

Initial accreditation will be on the potential of the Unit to meet the recommendations set in the guidelines i.e. their buildings, hardware, specialist team, protocols, aims for service provision.

The results of audit cannot be used as a basis for Initial Accreditation since no outcomes will be available. Therefore Units satisfying the criteria will be accorded "Initial Accreditation.

Re-Accreditation will be based on the outcome measures for case management stipulated in the various EUSOMA Guidelines, recorded contemporaneously onto the data base designed for the EUSOMA Network.

The first Re-Accreditation will give the Unit 'Full' Accreditation.

A report based on raw anonymous data will be sent each year to Units which have received Initial Accreditation. This is designed to inform them on how well they are complying to the outcome measures which will be assessed for Full Accreditation at five years.

Full Accreditation may be applied for when a Unit has 5 years of Audit Data, which may include cases treated in years prior to the Initial Accreditation.

447 Invited

Hospital volume specialization, guidelines and outcomes in cancer treatment: importance in quality of cancer care

I. Ray-Coquard. *Centre Regional Léon Bernard, Lyon, France*

An extensive, consistent literature that supported a volume-outcome relationship was found for cancers treated with technologically complex surgical procedures, eg, most intra-abdominal and lung cancers. An association with hospital and surgeon volume in colon cancer varied with the volume threshold. For breast cancer, British studies found that physician specialty and volume were associated with improved long-term outcomes, and an American report showed an association between hospital volume of initial surgery and better 5-year survival. Studies of non surgical cancers, principally lymphomas and testicular cancer, were few but consistently showed better long-term outcomes associated with larger hospital volume or specialty focus. Studies in recurrent or metastatic cancer were absent. Across studies, the absolute benefit from care at high-volume centers exceeds the benefit from break-through treatments. Although these reports are all retrospective, rely on registries with dated data, rarely have predefined hypotheses, and may have publication and self-interest biases, most support a positive volume-outcome relationship in initial cancer treatment.

Another aspect of the quality of cancer care is the conformity with guidelines. Although cancer treatments have been subject to RCTs, not all aspects of the quality of caring for cancer patients have been evaluated in trials. Accordingly, it is also desirable to include measures that are based on guidelines, other consensus statements, and expert opinion about optimal care. Developing measures of overuse of care will require convening panels of clinicians and other experts. Recently, it was demonstrated that conformity with guidelines was significantly correlated to overall survival of patients managed for localized breast cancer.

Improvements have been demonstrated in compliance with evidence-based guidelines or evidence-based medicine, and in short-term length of stay, complication rates, and financial outcomes. However, some attempts to improve practice have been moderately successful in achievement of reduced health care costs, reduced hospital length of stay, and possibly improved outcomes. Other methods that are still in use have been demonstrated to have little effect. Programs that have not succeeded have relied on voluntary change in practice behaviour without incentives to change or have had no accountability component. Further research is needed to assess how guidelines are enacted in organizations other than those demonstrably committed to improvement, ways to improve compliance of health care providers who are not committed to change, and thods to improve accountability.

Also scientific literature supported a real impact of hospital or physician's volume specialisation on cancer patient's outcomes; successful implementation of validated guidelines could be an opportunity to increase quality cancer management whatever is the volume of managed patients. Given the public fear of cancer, its well-defined first identification, and the tumor-node-metastasis taxonomy, actual cancer care should and can be prospectively measured, assessed, and benchmarked. The literature suggests that, for all forms of cancer, efforts to concentrate its initial care would be appropriate.