From the Desk of the Editor

The *Journal of Oncology Practice* (JOP) will address the practical needs of our fellow clinicians. The JOP has a different focus from its sister ASCO publications; we will feature a broad range of topics of interest to your day-to-day practice. We will explore issues that are necessary to sustain an oncology practice in the 21st century. In this inaugural issue, we start with a focus on recent changes in the Medicare program.

Created by Congress in 1965, the Medicare program was intended as a health insurance program for the elderly. Because most of us were not practicing medicine before Medicare, most of us consider the program an immutable fact of our professional and personal lives. Let me use my own family and career as an illustration.

On August 27, 1963, after a diagnostic paracentesis that started a 6-day hospitalization, my grandmother Laura died of pancreatic cancer at age 76. She was a widow living on a central California farm. My aunt recalls that she received two doses of morphine before she slipped into hyperglycemic coma. No chemotherapy, computed tomography, or hospice program for her. Her estate paid the \$294.65 hospital bill and the \$27.50 to her general practitioner.

A generation later, in 1991, the story was quite different when my mother died at home of pancreatic cancer at age 69. She initially had a Whipple procedure, a 5-day hospital stay, and convalesced in our home for a month with a visiting nurse's help before returning to her own home in Fresno. Two months later, she had a myocardial infarction and a heart catheterization. My mother survived approximately 4 months longer than her mother-in-law, saw two granddaughters born during the course of her illness, and benefited from the skills of the physicians and nurses who cared for her. However, seeing the hospital bill for over \$21,000—of which the Medicare allowable charge was approximately \$2,600—was my introduction to hospital finance under Medicare.

When I entered medical school in 1973, I joined the fifth class of one of the three newly created California medical schools. California policy makers had responded to the enlarging demand for physicians (created in large part by the Medicare program's ability to pay them) by creating three new medical schools. My campus in San Diego, and the Davis and Irvine campuses, augmented the two existing state-sponsored schools in San Francisco and Los Angeles. The availability of Medicare funds for training, and for payment of hospital care for the elderly ill, enabled a progressive state government to create the three new schools.

All of us have similar tales. For the current generation of physicians, the Medicare program reimburses for the care of patients we serve, and it has subsidized our education and training. Medicare also indirectly provides financial incentives for development and deployment of the therapies we use. Because the program currently consumes 2.6% of gross domestic product and is growing at a rate many consider unsustainable, changes in its benefits and structure are inevitable. The Medicare Modernization Act (MMA) of 2003 is likely to be the first of many changes with which we will

have to deal. Some of the changes, as they affect oncology, will be painful.

In this inaugural issue we include articles on several aspects of recent Medicare changes. Our cover story features three of our colleagues—from Kansas City, Albuquerque, and Paducah—providing their early experiences with implementing MMA. We also explore Medicare's experiment with coupling reimbursement for colon cancer chemotherapy to clinical trial participation; the changes coming for hospital-based practitioners; and we report from ASCO's clinical trials workshop. We begin a series of regular contributions from ASCO's reimbursement specialists, legal counsel, and from volunteer leaders of ASCO's Clinical Practice Committee and state affiliates. There are additional insights from contributors who are patient advocates, award winners, newsmakers, and fellows in training.

Our first peer-reviewed, original research article is contributed by Monika Krzyzanowska, MD, MPH, and her colleagues from Peabody, Massachusetts. They have tracked chemotherapy-related admissions to hospital, identified preventable causes of admission, and propose some interventions to reduce future chemotherapy-related admissions. We will consider for publication submissions of investigators' original research at the intersection of quality of care, therapeutic intervention, and efficiency maximization.

We welcome submission of original material for peer review and publication: business case studies, trials of new interventions that may have workflow change, process improvement or economic end points, pharmacoeconomic study results, and other contributions of interest to oncologists and their teams. Most of these studies will come to us from practicing clinicians, clinical scientists, and from outcomes, operations, and health-services researchers. We look forward to reading and reviewing your contributions.

Future issues will continue to feature material on oncologic best practice methods originated by our colleagues, who may care for patients in office, hospital out-patient, academic, or home-care settings. These pieces may be first-authored, multiauthored, or may result from interviews by our staff.

Finally, credit and thanks for this inaugural issue and the concept of the JOP itself is due to ASCO's volunteer leadership, including our current President, Dr. David Johnson, and the Chair of the Clinical Practice Committee, Dr. Dean H. Gesme. Dean was helped by Drs. Jack Keech, Edward Ambinder, Ed Balaban, John Cox, Jeff Gordon, and Sam Silver. Dr. Joseph Bailes, a longtime ASCO volunteer and former President also deserves special thanks. Finally, thanks to the ASCO staff, particularly to Dr. Deborah Kamin and to Deborah Whippen, who have tirelessly worked on our members' behalf, and to all of the members who have volunteered their services in anticipation of a successful service to our patients and colleagues.

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