From the Editor's Desk

Therese M. Mulvey, MD

Make the Commitment to Quality Care

Quality is what makes a good physician great. Quality is the elusive—almost gossamer—aura that surrounds those who possess it. It is hard to define, and harder to replicate. We have all known that physician who exudes confidence without arrogance in a difficult situation, who knows the facts but can construct an explanation without condescension for those who possess fewer skills, and who can put the most frightened patient at ease with nothing more than his or her mere presence. The willingness to learn didactically and from experience, and to listen to patients and colleagues, has always been the hallmark of a good physician. But somehow, somewhere, we have lost our way. We now equate quality with an institutional brand name, a program promising all-inclusive care, or the pay-for-paper or pay-for-performance substitute. When did quality become the sole purview of the payer, institution, or multidisciplinary program?

One could argue that when oncology became a lucrative specialty, with large margins on drugs and imaging, quality was lost. Some argue that it was greed that led oncology to its current state of revenue-enhancing programs and service lines to augment paltry reimbursement for evaluation and management services. Perhaps quality was lost when margins were cut abruptly to practices and hospitals, so that to make ends meet the volume of patients seen was increased per full-time equivalent (FTE). Perhaps it was when we started considering ourselves or our partners FTEs.

Medicine in general—particularly oncology—is a difficult way to make a living. This statement is heard daily in physicians' lounges across the country. But medicine, when we ask ourselves honestly, is not just making a living. It is really a way of life—one we each chose many years back. More often than not, we chose science over philosophy, math over poetry, and studying over entertainment. Our choice occurred early in life, and our ultimate place today is the result of a long and often arduous road filled with sacrifice and, simultaneously, great joy. Yet every day, my e-mail inbox is filled with messages about increasing billing, getting the most out of each FTE, and measuring quality for payment benefits.

In the near future, quality may become part of legislation. Communicating with patients and documenting these encounters may result in tangible benefits. This may be the beginning of a return to physicians and patients determining what quality really is—the dialog between a trained professional and a patient with needs. Add to this the scientific knowledge, didactic learning, empathy, and talent of a skilled listener, and no payer, institution, or program could compete. We bring the quality. This is the singular gift that the oncologist brings to the cancer patient, and the glue that holds it all together. It is a responsibility that all of us must share. Without a singular commitment from each of us to listen and communicate clearly with our patients, we will all become buried in paper or bytes, decrying declining revenues and FTE productivity.

The written patient treatment plan asks that each of us take the time and make the effort to communicate in writing and in person with our patients what it is that we hope to offer for their individual disease states, and what they will experience. Once the plan has been executed, the written patient treatment summary will review what happened and why. This will start the patient on the journey from victim to survivor. Survivorship plans will begin to address the needs of the nearly 10 million people living after a cancer diagnosis. These small steps are soon to be part of proposed legislation, and much debate will begin about cost, time, and appropriate reimbursement. This debate is valid, and the process will require careful attention and vetting. However, in this process, we must continue to make the commitment to quality care, not only on paper but also in every patient encounter.

DOI: 10.1200/JOP.0860501