From the Editor's Desk

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Here's a radical thought prompted by my latest marathon medical record dictation session: Imagine the written records recorded in a format which is actually useful, saves time, and facilitates patient care. If we're honest, we'll admit that our current motivation for creating medical records has more to do with forestalling a postpayment payer audit or defending our actions in a medical-legal review than ensuring quality patient care or communicating with patients or other members of the patient care team. If handwritten, the records we currently use are either illegible or incomplete; if dictated and transcribed, they are time consuming and are not contemporaneous with the visit. After their creation, most records are filed away in the chart or mailed off to a referring physician, and are seldom read again.

I have in mind an automated record that helps to organize the physician-patient encounter. As I imagine it, the patient and I would look at the computer screen together, and the medical record program would present questions, laboratory test data, and summaries of previous encounters and treatments in an organized and logical fashion. Starting with an open-ended question such as "What's on your mind?" "What can I do for you today?" or a similar query, the encounter would be driven by logic that considers the patient's answers and my questions. My patient and I would review the prompts and respond to the system's queries with mouse clicks, brief spoken sentences, or by typing or writing by hand. A record of our encounter would be generated electronically.

After we've completed the free-form portion of the encounter, we can review and address important overlooked items on the basis of system-generated prompts. Truly dynamic or changing symptoms or signs (e.g., status of cancer-related pain, hospitalizations, physical findings) should produce prompts for continuing updates. The unchanging or static aspects of the patient's history (e.g., place of birth, date of original diagnosis, cancer deaths in the family) could be shown as a reminder, but would not be re-dictated or entered repeatedly. Other, semi-static events, such as relapse date, site and biopsy confirmation, and new familial cancer information, could be presented for review and updated in the record if needed. The system will automatically keep an audit of both when we reviewed the information and when changes, if any, were made—no more mindless repetition of the family history, review of systems, and other tedium.

The documentation could be formatted in several ways. For the referring physician, there could be a short summary that focuses on changes in the patient's condition, the factors involved in medical decision making, and the plan going forward. For the infusion nurse, pharmacist, or radiology-scheduling clerk, the pertinent diagnosis and ordered drugs or test could be extracted and presented as needed for their task. For a post-payment audit, all of the information, with the time-stamped audit trail, could be prepared and submitted.

There are many partial implementations of my ideal system. I think systems like these will save us the most precious resource we have—time—and should improve our patient interaction. Features, case studies, and Original Research in the *JOP* will describe implementations of these systems by our colleagues.

Meanwhile, this issue's cover story continues our theme on quality. We profile the recently formed Cancer Quality Alliance, and ASCO's role as a founding member. The Alliance draws on ASCO's landmark study on quality, the National Initiative on Cancer Care Quality (Malin JL, Schneider EC, Epstein AM, et al. *J Clin Oncol* 24:626-634, 2006) and the ongoing Quality Oncology Practice Initiative (Neuss MN, Desch CE, McNiff KK, et al. *J Clin Oncol* 23:6233-6239, 2005), and draws energy and expertise from the survivor and patient advocacy community, as well as our multidisciplinary partners in cancer care.

Our Original Research reports on efforts at a community hospital to enhance the safety of chemotherapy administration through a standardized order set. The study by Dumasia, Harris, and Drelichman measured a surrogate safety end point, correction of handwritten orders by a clinical pharmacist. As they point out, these standardized order sets are transitional to a computerized physician order-entry system. There are several of these computerized physician order-entry systems available, and the *Journal* will follow stories of implementations.

Our Profiles in Success interview features Peter Paul Yu, MD, from California's Silicon Valley. We explore the fit, the organization, and the operations of Dr. Yu's five-oncologist group within Sutter Health System, one of the largest multispecialty groups in California, if not in the nation. Their structure apparently allows them to retain the focus of a single-specialty oncology group while taking advantage of the economies of scale and capital structure of a large, multispecialty group. Finally, our Washington Consult records a conversation with Richard Pazdur, MD, director of the U.S. Food and Drug Administration's Office of Oncology Drug Products, and the efforts he is making to facilitate drug approval.

We'll see you in Atlanta, Georgia, at the Annual Meeting. Look for *JOP* at the main ASCO booth. Stop by and say hi, meet the staff, and share your ideas and opinions about the *Journal*.

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