From the Editor's Desk

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I recently had occasion to review the charges associated with treatment for one of my patients. We are planning for one year of a biologic therapy in addition to chemotherapy because new data have changed the standard of care for early-stage breast cancer. At the University of Michigan (Ann Arbor, Michigan) the charge for this treatment would be more than \$100,000—an astounding amount. Although this patient has third-party coverage, the day is likely to come when both public and private third-party payers will say that a cost of this magnitude is not supportable. Yet the evidence supporting use of this drug is clear in her case. Our current health care financing system cannot support sums of this size. Something will give.

As oncologists, much of the value we provide to our patients is in our role as “expert solution provider.” Our patients seek our solutions to their cancer problems. Initially, most interpret the cancer diagnosis as a death sentence. Often they are incorrect—they are not going to die because of their cancer—and we help them navigate the treatment and survivorship phases of their illness. Sometimes they are correct, and we provide solutions and palliative care until death. Whether in private offices or hospital-based centers, we lead a team of highly skilled individuals who provide these solutions. We are undercompensated for the value of our solutions. Again, to use the University of Michigan as an example, we lose between \$55 and \$300—depending on the oncology diagnosis—each time we provide an evaluation and management service as part of the solution.

Before the implementation of the Medicare Modernization Act (MMA), the compensation for chemotherapy drugs subsidized our expert solution services. We are moving to a more competitive model for our expert solutions—one likely to involve more cost to the “first party.” Other professionals—think laser vision correction, cosmetic surgery, and dentistry—have successfully found their way to provide value to first-party payers. I hope that eventually the value we provide will include measurable quality. The *Journal of Oncology Practice* will continue to provide examples of successful implementations of quality and provision of value to our patients.

Several articles in this issue of *JOP* suggest quality, efficiency, and safety contributions to the expert solution of patients’ cancer problems. We continue on the quality theme with a Member Perspective by Joseph Bailes on ASCO’s National Initiative on Cancer Care Quality (NICCQ). This study is landmark; HIPAA (Health Insurance Portability and Accountability Act) strictures may prevent its repetition on so comprehensive a scale any time soon.

In our cover story on survivorship, we introduce the “survivor phase” of cancer treatment. Two ASCO members who have emerged as leaders in this field, Ellen Stovall and Patricia Ganz, were involved with formulation of *From Cancer Patient to Cancer Survivor: Lost in Transition*, the Institute of Medicine’s report on survivorship. The report, released in November, 2005, calls for three innovations: (1) to introduce survivorship as a distinct phase of care; (2) to develop a survivorship care plan; and (3) to establish and use evidence based-guidelines to manage late effects of cancer and its treatment. Look for further information on the cancer survivorship plan as ASCO develops its recommendations for creation and implementation of this potentially valuable tool.

We examine two aspects of the electronic health record (EHR), in our feature story and our Original Research reports, as implementation of this technology unfolds. (Recall that in our July 2005 issue, we discussed the history of the EHR [“Electronic Health Records,” pages 57-63]). Our feature story examines experiences with the growing number of practices that have implemented an EHR. An Original Research contribution by DuBeshter et al looks at their experience with a chemotherapy-ordering system in a gynecologic oncology practice. The positive experience (time saved and error reduction in drug dose and timing) should be put in the context of a practice limited in size and scope. However, the existence of a physician-champion—which is one requirement for a successful implementation of computerized physician-order entry system—should be obvious from DuBeshter et al’s report.

So where does that leave my patient and her payments and copayments for expensive new therapies? Stay tuned; the price and value calculation may change again, as a Scandinavian group (Joensuu et al) recently showed at the 28th Annual San Antonio Breast Cancer Symposium (San Antonio, Texas, December 8-11, 2005) with their excellent results using shorter biologic therapy duration for patients such as mine.

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