Victimized Again?

John V. Cox, DO, MBA, FACP

As I write this, President Obama is signing a health care act that will initiate a journey of reform for the American health care system.¹ There is a visceral uneasiness among many about the way the act became law. The shrill, accusatory language on both sides of the health care debate and the passage of such a large bill without bipartisan support feed distrust of government. Yet over the last few years, many experts—both conservative and liberal—have detailed the shortcomings of our current health care system. With concordant voices, analysts have pointed to a system of remarkable technology and diversity—yet one that suffers from striking variations in cost and quality of care, lackluster global health care measures when compared with other industrialized countries, and an extraordinary price tag to pay for such results. Ladled onto these systemic issues are the voices of citizens who arrive in our offices equally fearing life-threatening diseases and the economic consequences of treatment. Can we do better?

A colleague mentioned to me that in traveling the country, she had found oncologists often voiced feelings of being victimized by the system. They were tired, overburdened by the moment, and struggling with market forces in their locales, whether insurance contracting, hospital/institutional relationships, or interpersonal conflicts in practice. The language used is that of victims. A cancer survivor, on hearing this discussion, questioned, “Don’t you see? You folks are in the perfect place! You have influence over the patients in your care. You can change the system.” She saw the opportunity in change. Are oncologists so focused on the moment, grieving for what is lost and what has “been done to them,” that they do not see the opportunity that health care change can provide?

This is not to underestimate the challenge. Our future lies not in models of care built around buy-and-bill chemotherapy services, nor does it lie in elaborate, freestanding centers with integrated technology designed to diversify revenue. The future is ours to define, and it will be patient centric. My bet is that it will focus on team play, on cooperation rather than competition, and on integrating disciplines rather than simply diversifying income streams. Such patient-centered approaches are featured in the “Blueprint for a Better Cancer Care System” created by the Cancer Quality Alliance.² A better system will be generated by our innovation, spurred on by the stressful opportunity of change.

To this end, this issue of *Journal of Oncology Practice* contains an article by two attorneys, Barkley and Blau, describing the complexities of bringing about structural business change in a market context. How do you partner with your competition or your hospital neighbor? The article is based on a presentation at the Third Annual Cancer Business Summit held last year in Dallas, Texas.³ The detail and depth of this piece will provide readers with an understanding of the complexities with which change will force us to grapple. Yet I believe the opportunities of working together to provide better care will likely drive many of these discussions.

Also presented is a new installment in an ongoing series of articles revealing how oncology is practiced in other parts of the world. Adams and Marx present the day-to-day life of an oncologist in Australia.

Our feature article by Baer et al outlines data from a survey created to look at factors limiting site participation in National Cancer Institute cooperative group trials. Unsurprising to anyone active in research, participation costs practices and institutions a lot of money. The current level of reimbursement for these trials does not come close to covering costs. The authors, along with an accompanying commentary by Zon, underline the challenges of maintaining a viable research program featuring National Cancer Institute trials.

Electronic medical records (EMRs) are part of our future. Corrao et al discuss the necessity of adequate usability testing when choosing and implementing an EMR system. This is a term of art unfamiliar to most oncologists. If you are in the process of considering an EMR system for your practice setting, read this piece and the accompanying commentary by Schumacher, a leading expert in the field.

Genetic testing for cancer predispositions is an evolving and complicated domain. As this area has grown, practicing oncologists have recognized the many issues involved with having appropriate discussions with patients, ordering the right tests, and counseling patients regarding results. There are growing commercial interests now marketing tests directly to consumers and ballyhooing the efficacy of their products. Oncologists should read the recent ASCO update to the genetic testing policy in *Journal of Clinical Oncology*⁴ as well as the commentary by Mulvey in this issue of *JOP*. No doubt you will see or have seen a patient who brings in the results of one of these genetic assays. These articles will prepare you to provide information to your patients.

Many other articles await you in this issue. As always, we appreciate reader feedback at jopeditorsdesk@asco.org. Good reading.

DOI: 10.1200/JOP.092003

References

1. Patient Protection and Affordable Care Act, Pub L No. 111-148. <http://www.kff.org/healthreform/upload/finalhcr.pdf>
2. Rose C, Stovall E, Ganz P, et al: Cancer Quality Alliance: Blueprint for a better cancer care system. *CA Cancer J Clin* 58:266-292, 2008
3. Anatomy of a Cancer Center Transaction. Presented at the 2009 Cancer Center Business Summit, Dallas, TX, October 8-9, 2009
4. Robson ME, Storm CD, Weitzel J, et al: American Society for Clinical Oncology policy statement update: Genetic and genomic testing for cancer susceptibility. *J Clin Oncol* 28:893-901, 2010