



Ensuring Access to Care: Yesterday, Today, and Tomorrow

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ENSURING ACCESS TO CARE: YESTERDAY, TODAY, AND TOMORROW



It has been almost nine years ago to the day that I was privileged to join a distinguished group of community cancer care providers who gathered in a Chicago hotel room to address the need to extend participation in clinical trials to patients in their own communities. Under the skillful leadership of the late, past ACCC President, Edward Moorhead, M.D., the group was convened at the request of then NCI Director, Vincent DeVita, M.D., to elicit input from community providers regarding the best mechanisms to provide cancer patients with ready access to state-of-the-art cancer care, via clinical trials, in their own home towns.

The successful efforts of the NCI and the universities in training large numbers of medical, surgical, and radiation oncologists had paved the way for patients to be cared for in their local communities, and had obviated the need for them to travel to university-based centers for treatment. However, NCI clinical trials remained in the university setting, resulting in an ever-decreasing pool of patients to recruit for participation in studies that were critical to treatment questions of the time, such as the role of adjuvant therapy in post-menopausal women with stage II breast cancer or node negative breast cancer, and adjuvant therapy for colon cancer.

Prior attempts to extend clinical trials to community patients through their local physicians had been only minimally successful. Such efforts had exacerbated the old "town/gown" controversy. Meanwhile, the lack of answers to critical treatment questions was potentially costing lives.

Thus, this distinguished group, (all of whom were younger, less tired, and perhaps more optimistic than they are today) debated, and discussed, and sometimes outright argued about the best mechanisms to extend cancer patients' access to clinical trials in their own communities.

We succeeded and produced the ACCC Consensus Statement on Clinical Research in the Community. One has only to compare this document with the original Community Clinical Oncology Program's (CCOP's) Request for Proposal, issued by NCI in 1982, to verify the impact of the ACCC on the design of this now institutionalized NCI program.

Our goal, at that time, was to assist cancer patients in achieving access to state-of-the-art cancer care, at the time of diagnosis, without having to incur the physical and financial hardship of obtaining treatment at a significant distance from home. Altruistically, we also wanted to contribute data that would answer critical treatment questions that might help eradicate this malady or at least improve the treatment of future patients.

The experience in Chicago came to mind as I reviewed the contents of this issue of the journal. The article by Cathy Harvey and Jim Walker is an example of how access to current therapy can be extended to a rural community setting. Dr. O'Leary examines the concept of Continuous Quality Improvement. (The JCAHO's Oncology Clinical Indicators were devised under the leadership of another past president of ACCC, John Yarbrow, M.D., Ph.D. Two other ACCC past presidents were also on the JCAHO committee—Drs. Irvin Fleming and Robert Enck.)

While we have solved the problems of access hindered by bureaucracies and a town/gown mentality, and initiated mechanisms to ensure quality cancer care, economic constraints are threatening the progress we have made. Other articles in this issue discuss some of those threats. Personally, I see patients travel to one area of town for their lab work, another for X

rays, another to see their physician, and yet another location to receive their treatment. I worry about the ability to collate all of the clinical data in a manner conducive to high-quality clinical decision-making by physicians, oncology nurses, and other allied health personnel. As more time is spent figuring out where data is, how to obtain it, and how to respond to the mandates of third-party payors, less time is available to analyze the data, to review the medical literature, and to make clinical decisions. Meanwhile, patients are still incurring physical and financial hardships to achieve access to state-of-the-art therapies; they just don't have to leave town.

ACCC's mission remains the same: to ensure high-quality, state-of-the-art cancer care for patients. The ACCC Collaborative Research Group is a mechanism by which we can assist our members in gaining access to new diagnostic and therapeutic interventions, especially biologicals, such as the colony stimulating factor and the interleukins, at a time when the rate of development of new agents and devices has overburdened extant mechanisms' ability to determine their definitive value in oncologic care. Other Association initiatives, such as the formation of local chapters and ongoing lobbying efforts at the federal level, provide effective input to ensure that there is adequate reimbursement for quality cancer care.

I am confident that, just as the gathering in Chicago nine years ago helped us learn how to better manage stage I and stage II breast cancer and to extend the survival of Duke's C colon cancer patients, current ACCC initiatives can impact today's access problems.

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President**