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Robert W. Frelick

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IN MY VIEW

We Need Stronger Cancer Committees

By Robert W. Frelick

At a meeting of the Medical Director Special Interest Group (SIG) meeting at the ACCC Annual Meeting, I was discouraged to note that most of those present considered Cancer Committees to be useless as agents of change to improve hospital cancer programs. This is unfortunate, since most Cancer Committees are constituted by their hospitals' bylaws as multidisciplinary groups with responsibility for reviewing hospital cancer activities, overseeing the cancer registry, establishing and operating cancer conferences, choosing and participating in two Patient Care Evaluation (PCE) studies per year, evaluating the care of cancer patients, ensuring that consultative services from all major disciplines are available to all patients, ensuring that rehabilitation services are available and used, and encouraging a supportive care system for all cancer patients.

As a Surveyor for the American College of Surgeons' (ACoS) Commission on Cancer, I know that Cancer Committees are expected to promote quality-controlled cancer staging and to recommend activities and programs based on their own databases, including the PCEs. Cancer Committees are also expected to be responsive to new ideas for improved cancer control.

As a surveyor, I am also aware that many Cancer Committees do not fully realize all of their responsibilities or potential. Frequently, a Committee lets a strong chairman carry most of the burden. The tumor registrar is often expected to help organize the total program and then keep track of it. Many registrars do not have enough professional consultation or help. Hospital administrators often offer more support for comprehensive cancer programs than for their professional staffs.

What can be done to improve the Cancer Committee's function and credibility? All too often the pressure to establish a "marketable" hospital cancer program tends to ignore or over-ride the Cancer Committee. Special commissions and task forces are established for objectives already assigned to the Cancer Committee. I find that very few Cancer Committees take a critical look at the quality of their institution's cancer care, set goals and objectives for the cancer program, or assess their own activities.

The best and fastest way to advance cancer control is to mandate improvement in performance by organizations already in place, rather than invent new organizational patterns. When a medical or surgical department needs a boost, a new department of medicine is not formed, although a new chief may be chosen. By the same standard, physicians, nurses, and other staff interested in improving the lot of cancer patients should put their Cancer Committees on the spot by asking critical questions. Get the Committee to set goals and develop management guidelines. No one should be satisfied with status quo cancer control when adult cancer mortality rates, with few exceptions, have not shown much change over the years. No physician should be satisfied with cancer control in a community until there is at least a 90 percent or higher relative five-year survival rate for all major cancer sites. If patients had the benefit of state-of-the-art cancer control (prevention, screening, and treatment) then the mortality rate could probably be reduced by 20 to 30 percent.

I am urging the ACoS to consider awarding special recognition to exceptional cancer programs. These awards could be in each cancer program category, from prevention through early detection, diagnosis, treatment, rehabilitation, and support services. They could be evaluated on the basis of their multidisciplinary nature. Hopefully, such awards would stimulate multidisciplinary Cancer Committees to plan and develop one or more cancer control interventions. For example, a hospital might aim to increase the proportion of stage I breast cancers in their community to 60 percent of all breast cancers.

It might also help if the ACCC would stimulate hospital cancer programs by recognizing commendable annual reports from community hospitals, with separate awards for 1) a teaching hospital, 2) a community hospital's comprehensive cancer program, and 3) a small community hospital's cancer program. Each report should be judged by how well it portrays the multiple facets of a program. They should also include recommendations from the Cancer Committee, which would be expected to comment on their program's weaknesses and strengths in order to recommend interventions for improvement. No matter how frustrating government and third-party red tape becomes, we must concentrate on helping people to prevent cancer, or at least to minimize it, through early detection and state-of-the-art treatment. If we overlook the primary target of assisting cancer patients, we will lose our credibility to reduce governmental and insurance barriers to cancer care. One of the best ways to reduce cancer morbidity and mortality is to encourage multidisciplinary hospital Cancer Committees to take seriously the standards established by the Commission on Cancer of the ACoS. ■

Robert W. Frelick, M.D. *is Medical Director for Chronic Diseases, Delaware Division of Public Health, Wilmington, DE, and an ACCC Past President.*

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