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# An Interview with ACCC President Carl G. Kardinal, M.D.

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AN INTERVIEW WITH

# ACCC President Carl G. Kardinal, M.D.

**What are the major issues affecting cancer care?**
There are so many issues facing us today that it is hard to remain focused. Among the most important questions to be answered are:

- What form will health care reform take?
- Is quality care compatible with health care legislation?
- Can costs be reduced without compromising care?
- Can organized medicine, including oncology, regulate itself to eliminate waste and abuse?
- Can effective liaisons be established between medicine and the government, the insurance industry, the pharmaceutical/biotech industry, and responsible advocacy groups?
- Will the hands of the pharmaceutical/biotech industry be so tied and revenues so controlled that there will be inadequate funding for support of basic clinical research?
- How will the National Cancer Institute and the National Institutes of Health fund clinical trials?

**Any answers to these pressing problems?**
To a large extent, medicine has not been good about regulating clinical practice. Regulation is now coming from outside—from either the government or from third-party payors. Oncologists and cancer program administrators, as well as medicine in general, need to take a long hard look at themselves to assess what is really necessary for quality patient care and what is excessive and does not really contribute to the comfort, welfare, and curability of individuals with malignant disease. Quality care and health care reform are compatible; however, clinical practices must not be overly restricted and funding must be sufficient.

**What is the future of clinical research?**
Although the Administration has voiced its commitment to clinical research, the future of clinical trials is far from assured. Because the funding mechanisms for clinical trials have not yet been resolved and given the decreased level of trust between government officials and the public with reference to clinical trials, increased funding may not be forthcoming. In addition, probabilities are that third parties will elect *not* to reimburse for clinical trials, especially if costs exceed those required for standard patient care.

A recent ACCC survey of oncologists indicated that more than 3,000 patients were denied participation in clinical trials by their insurance companies last year.

Presently, many good clinical trials are being funded by the pharmaceutical/biotechnology industry. If, however, the pharmaceutical/biotech industry is so regulated that it does not have the funds available for research and development, we will see a major step backward in clinical trial development and cancer research.

**What can ACCC do to promote further development of research activities at the community level?**
Since ACCC's inception, the Association has recognized the value of clinical research and worked consistently to promote research at the community level. In 1982 ACCC was a strong advocate for the Community Clinical Oncology Program (CCOP) and was instrumental in its creation. Throughout the last 10 years,

ACCC has functioned as a forum for CCOP leaders and as an advocate for increased CCOP funding by Congress and the NCI. We will continue this advocacy role.

The Collaborative Research Group (CRG) is an important mechanism by which ACCC is providing additional clinical research opportunities for our members. The CRG is made up of 50 ACCC institutions that participate in clinical trials funded by pharmaceutical and biotechnology companies. Clinical research is the only mechanism by which we will ultimately develop better treatments for cancer patients.

**What should ACCC focus on this year?**

I would like ACCC to concentrate this next year on two major issues: 1) the funding of patient care costs of clinical trials and its corollary—the funding of laboratory correlative studies; and 2) the development of meaningful follow-up guidelines for the common tumor types, such as breast, colorectal, and prostate cancers.

**Why should the Association develop follow-up guidelines?**

At the present we have no follow-up standards that have been well tested in terms of their utility and/or value for increasing curability of the cancer patient. Third-party payors have already tried to initiate guidelines for oncology follow-up care. Blue Cross of Illinois, for example, issued guidelines that specified the frequency of follow-up for patients with treated breast, colon, lung, and vaginal cancer. They set the limits on the number and type of lab tests and X-rays that could be done. Physicians who failed to comply with the guidelines would be dropped from the insurer's plan. The Illinois Medical Oncology Society (IMOS) successfully challenged the guidelines, showing, among other things, that the insurers follow-up would be less frequent and less focused on the natural history of the disease than the community standards defined by clinical trials.

Clinical practice guidelines must be established by the oncology community rather than by external parties or third-party payors. Professional societies, such as the ACCC, must proactively establish practice guidelines before they are forced upon us. I would like to see the Association pilot clinical practice guidelines for follow-up care in the common malignant diseases, such as breast, colon, and ovarian cancers. Follow-up recommendations for NCI-established clinical trials are at least a starting point for evaluation of clinical practice guidelines.

Our first step in developing guidelines will be to conduct a large survey of oncologists within the United States to determine what actually impacts on clinical practice. We need to determine the number of curative recurrences, the number of noncurative recurrences, and the effects on patients in terms of finding recurrences early, particularly those patients with potentially curative disease.

**How has your experience prepared you to take over leadership of the Association?**

After leaving my position as head of the Department of Medicine at Ellis Fischel State Cancer Hospital in Columbia, Mo., I moved to the Ochsner Cancer Institute in New Orleans, La. That was in July 1980. Today I am associate director of the Ochsner Cancer Institute, a position that has allowed me to understand the challenges of coordinating multidisciplinary cancer care, clinical research, cancer education programs, and cancer control efforts.

My first association with ACCC began in 1982, when the Association was working with NCI to develop the concept of community involvement in clinical research. In 1983 when the CCOP program was first becoming a reality, I became a CCOP principal investigator and have had continuous funding for Ochsner's CCOP program. Over the years, I have served on the Executive Committee of the National Surgical Adjuvant Breast and Bowel Project, the Executive Committee of the North Central Cancer Treatment Group, and the Steering Committee of the Breast Cancer Prevention Trial. This long experience as a clinical investigator accounts for my strong commitment to ensuring adequate funding for clinical trials. I am equally committed to the Association's continued support of and service to its multiple constituents, who include physicians, medical directors, administrators, nurses, and others involved in cancer program development.

**How should ACCC work with other professional cancer organizations?**

ACCC has already formed close liaisons with other professional organizations, particularly the National Cancer Institute, the American Cancer Society, the Oncology Nursing Society, the American Society of Clinical Oncology, and the American Society of Hematology. In addition, we have begun and will continue to share strategies with national advocacy groups for the AIDS community, with whom we share many common causes. The ACCC's annual Presidents' Retreat allows representatives from these organizations, as well as other national and state oncology societies, to discuss issues and define cooperative initiatives. The stronger the liaison with other organizations, the stronger the voice of oncology will be nationwide. ■