Oncology Issues

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ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

An Open Letter to ACCC Members

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To cite this article: Leslie G. Ford (1997) An Open Letter to ACCC Members, Oncology Issues, 12:3, 22-22, DOI: 10.1080/10463356.1997.11904684

To link to this article: https://doi.org/10.1080/10463356.1997.11904684

rather than any lack on the staff's part.

CREDIT can record and track information about protocols and patients and provides a variety of reports based on that information. Features of the CREDIT system include the capability to 1) enter visit, treatment, and laboratory schedules for each protocol with automatic calculation of an individualized patient schedule; 2) track all protocols and subsequent addenda and revisions with respect to IRB review dates; and 3) generate a myriad of reports, including those necessary for NCI progress reports and reapplication. In this era of cost containment, the CREDIT system was developed with the intention that it would streamline the workflow of the CCOP, freeing staff for case finding, keeping full-time employee needs to a minimum, and strengthening quality assurance efforts. To date, it has far surpassed expectations in all aspects.

We are pleased with our accomplishments. However, the program is still in its infancy and must rigorously strive for improvement in all quality control activities, in community education, in minority recruitment, and in overall patient accrual to clinical trials.

An Open Letter to ACCC Members

by Leslie G. Ford, M.D.

The Community Clinical Oncology Program is fourteen years old this year. As with any parent, I look back with great pride on how the program has developed and matured. Our original aspirations for the CCOP have been realized, and we are approaching adulthood with a renewed sense of accomplishment and anticipation.

In 1982 NCI-sponsored cancer treatment clinical trials were performed exclusively in universities and cancer centers. Cancer patients wanting access to state-of-the art care were referred by their community oncologist to one of these, often distant, locations. The introduction of the CCOP began to change the situation and provide more convenient access.

Today the early struggles of the pioneering community oncologists for acceptance as equal partners into the ranks of the cooperative groups are a distant memory. There has been a paradigm shift of the groups to integrate the community physician into the research process. This shift has subsequently reoriented how the groups define cancer research. The focus has been broadened to include interventions not only for the cancer patient, but also for family members and other individuals at risk. The spectrum has widened to include cancer prevention and early detection research as well as treatment, symptom management, and continuing care.

CCOP physicians hold key research positions on many cooperative group committees, and their contributions to treatment accrual remain strong. One-third of all patients in NCI-sponsored Phase III cancer treatment trials come from the CCOPs. From its earliest conception, the CCOP was envisioned as providing the network necessary to implement large-scale prevention clinical trials. When faced with the challenge, CCOPs responded in an extraordinary fashion. When the new concept of breast and prostate cancer chemoprevention trials in populations without cancer was introduced in 1991, the CCOPs randomized a large proportion of the current total of nearly 35,000 participants. When the results of these landmark prevention trials are in, the CCOPs will be duly recognized for their role in "making it happen." The CCOPs have already made major contributions to the literature in supportive care, quality of life, and pain management. The CCOP budget has grown from its first annual budget of approximately $8 million to the current one of almost $38 million. One feature inherent in the growth of the CCOPs is the increasing inclusion of multispecialty clinicians. CCOPs are no longer organizations of medical oncologists; they also include those specialists in dental, gastroenterology, infectious disease, gynecology, and urology necessary to accrue to the diversity of available clinical trials.

Today's clinical trials face struggles different from those early years. Concerns of reimbursement, managed care, complex informed consent, cancer prevention, and genetic testing have replaced early worries of whether community oncologists could measure up to the standards of the cooperative groups. Again, the CCOPs are uniquely positioned to respond to these challenges and turn them into opportunities. They have the understanding of the current health care delivery environment, the expertise to implement clinical trials, and the access to cancer patients, family members, and individuals at risk to make new research concepts a reality.

The CCOP is entering its adult years at the same time the scientific community embarks on an unparalleled period of research discovery in such areas as genetics, molecular targets for detection and intervention, and vaccines for prevention. The CCOPs provide the vehicle to bring this new technology to the community, as well as to help define it and make sure that issues raised within the community are addressed. The effective partnership between community and academic cancer centers is essential to translate the benefits of clinical research beyond the bench and bedside to the entire population affected by cancer.

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