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The Evolution to Community Oncology

Many of the current regulatory and financial constraints being placed on comprehensive oncology care are jeopardizing the innumerable gains made in the past thirty years. Consider their impact in light of this oncology timeline:

During the 1960s, the practice of oncology was essentially limited to university medical centers concentrated in large metropolitan areas of the country. Leaders in cancer treatment were primarily comprised of surgeons interested in treating cancer using extensive surgical techniques. Hospital administration did not yet view oncology as a focused program, but was primarily concerned with sufficient operating room time and an adequate radiology budget to allow for the purchase of the new therapeutic radiology equipment (cobalt teletherapy and low energy accelerators). Therapeutic radiology was usually performed by general radiologists as requested by surgeons. Chemotherapeutic agents were generally administered to patients by surgeons for palliation and as a last-hope treatment. Within the department of medicine, hematologists were recognized as the only credible practitioners.

Patients with cancer could choose between "curative" radical surgery, or when surgery was not possible or was refused, "palliative" chemotherapy and radiation therapy. The patients were sent by their local physicians to metropolitan university centers, usually never to return to community care.

In the early 1970s, the newly created National Cancer Institute recognized the comprehensive cancer center as the best location for treatment. However, the few community oncology programs were poorly organized, lacking in leadership, poorly funded, and absent of vision.

By the mid-1970s several community cancer programs emerged as major forces and began to change the shape of oncology. New and effective chemotherapeutic agents were developed. New equipment was engineered in radiation therapy. At the same time, clinical research programs developed and funded by the National Cancer Institute helped to firmly establish the role of chemo-radiation as curative alternatives or supplements to surgery. As the combinations of surgery, chemotherapy, and radiation therapy were explored, the leadership of oncology evolved into multidisciplinary teams.

With the financial backing of federal and private insurance programs around the nation, community oncology programs developed and grew. By the late 1970s, 80 percent of cancer care in the United States was diagnosed and treated in non-university settings. As a result of these changes, most clinical research began to be carried out in focused multidisciplinary oncology programs.

The evolutionary changes were of major benefit to the individual cancer patient, who could now receive multidisciplinary, state-of-the-art treatments in the local community setting. Support and educational programs were developed by community oncology programs to minimize the fear associated with the diagnosis of cancer and to promote early detection of many types of cancer. Treatment procedures became less radical from a surgical perspective, and more of the community took part in the support of patients with cancer. By the late 1980s, most communities either had developed or were developing state-of-the-art multidisciplinary programs. Clinical research in oncology continued through the National Cancer Institute's Community Clinical Oncology Program (CCOP). Hospital administration now recognized that the cancer program could be a leader in revenue generation and in overall importance to the institution.

The sum result of this national evolution to community oncology programs has been a dramatic improvement in the cancer cure rate, from one out of every five patients to one out of every two patients cured.

As the 1990s have progressed, however, concerns for the future of community oncology programs are growing. As the national political attention turned to runaway medical costs, new systems were developed to control the use of medical resources and to save costs. Yet major cuts in the Medicare program as well as the development of national and local health maintenance organizations have fragmented service and in many communities have led to the unraveling of coordinated patient care. Most community oncology programs are threatened with cutbacks in personnel and services.

Nevertheless, opportunities still exist as the evolutionary process proceeds. Value of service becomes a new goal, and efficiency in the use of medical resources is a necessity. The leadership of the oncology community has an opportunity to partner with the patient community and the businesses that control the health payment organizations. Education of patients and businesses, coupled with legislation requiring adequate reimbursement, will allow the progress we have made in community oncology programs to continue into the 21st century. Communication, cooperation, and leadership are the building blocks of community oncology for the future.

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