

# Why we created this new journal

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**W**hy did we think that there was a need for a new journal that focused on community oncology? To understand our motivation, it's useful to review the history of the "War on Cancer," initiated with the National Cancer Act of 1971. This legislation has had profound ramifications on the conduct of basic research, clinical research, and clinical care in oncology. But one important consequence of the "War on Cancer" has not received much attention—the development of community oncology as a major success story in providing cancer treatment.

How did it happen? At the time of the National Cancer Act, there were only a few academic centers focused on the very young discipline of medical oncology. In time, a robust training program developed, leading to hundreds of oncologists now trained each year. Some of those oncologists stayed in academia, some stayed in research, but most went back out into their communities to take care of patients with cancer. At the same time, advances in technology and better therapeutic agents allowed cancer care to move out of the hospital and into the outpatient setting. This shift depended to a great extent upon the concurrent development of oncology nursing providing dedicated professionals who could deliver expert care without hospital support.

## Landscape of cancer care has shifted

What community oncology has accomplished is the design of an office infrastructure that encompasses physician-patient encounters in examination suites, on-site laboratory services, procedure capabilities, and integrated infusion centers employing an array of expert staff, including dedicated chemotherapy nurses and oncology pharmacists. In supervising those infusion centers, we are able to deliver a comprehensive program of care that includes cancer screening, diagnosis, and treatment recommendations. Our primary focus is on providing chemotherapy efficiently and safely. We follow patients long term, take care of the side effects, provide social and emotional support—the whole gamut of what cancer patients need.

Cancer care has therefore moved on from being conducted largely in highly specialized and centralized academic centers to the community, where a patient can find an oncologist virtually anywhere. The rise of satellite offices allows even the smallest communities in sparsely populated places like Montana to have access to local cancer care provided, for example, by my dedicated colleagues who fly to their patients once a week. This is a huge benefit because patients don't have to leave their communities, families, friends, and neighborhoods to get state-of-the-art cancer care. Cancer is a devastating enough disease without forced abandonment of an individual's critically important support system. Americans demand and deserve state-of-the-art care, with new advances made available as soon as they are developed. It is not an exaggeration to say that community oncology in America has played a large role in building the world's finest cancer treatment system.

## Community oncologists now care for four out of five cancer patients

So where do we stand? Currently there are over 5,000 community oncologists practicing in this country, along with more than 25,000 affiliated healthcare providers, such as oncology nurses, nurse practitioners, physician assistants, oncology pharmacists, and oncology social workers. The net effect is that community oncology now takes care of more than 80% of cancer patients in this

country. Furthermore, more than 60% of patients who are on clinical trials now come from the community, a rapidly growing percentage.

Community oncology has a very strong work ethic. Almost every medical oncologist I know keeps his or her office open 12 hours a day. Many are open on weekends. There is little bureaucracy with small businesses, so we don't have the multiple



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layers of decision making which sometimes paralyze bigger institutions. We have been very successful in developing an elaborate local communications system, including strong relationships with referring physicians—the surgeons and internists who first diagnose cancer. We make sure that clinical information gets back to the referring physicians in a timely fashion, a critical component in maintaining the continuity of care. In addition, we provide abundant support programs for patients and their families, often underwritten by the practice and provided free of charge. In fact, if I have learned anything over the 17 years I have been practicing, it is how important it is to treat not only the disease but the patient as a whole person in the context of his or her family.

It is a certainty that the world of oncology is changing. Part of that is external and has to do with reimbursement issues, which are having a profound effect on the way that community oncology is practiced. We need to accept that change has come, rise to the challenge, and help fashion an equitable reimbursement system that preserves access to cancer care. In addition, we are in an era of unprecedented drug development and biology discovery. We have learned more about the mechanisms underlying cancer in the past decade than we have learned in the 50 years preceding. This knowledge has not yet fully translated into new treatments, but they are coming. The pharmaceutical industry now has more than 300 cancer drugs in development. All of them have to be tested in people with cancer. More patients must be enrolled in clinical trials. Technology is evolving very rapidly, and the ability to integrate clinical data, treatment regimens, and outcomes through electronic medical records is a challenge and opportunity we must face head on.

### **A journal focused specifically on the way we practice**

The strength of community oncology is also our greatest weakness. The diversity of solutions to providing care has been arrived at largely in a vacuum. In the past, we really haven't communicated with one another. We talk informally at meetings and on hospital rounds in passing, but to some extent

we are on individual islands. And that is one of the major reasons that I am so enthusiastic about this journal. I believe there is a clear-cut need for a journal focused specifically on the way we practice—a journal of the community, by the community, and for the community oncologist.

This journal will focus on all aspects of community-based oncology. We propose to have *Community Oncology* concentrate particularly on original research, rare cancers in the community setting, quality of care in community oncology, end-of-life care, community practice guidelines, practice management and reimbursement issues, and news from Washington and the US Food and Drug Administration.

### **Clinical trials conducted by community oncologists**

The original clinical research section will feature phase II, III, and IV treatment and supportive care clinical trials conducted by community oncologists. A large number of investigator-initiated trials are exploring through the sponsors new schedules, combinations, and different disease settings for approved drugs. Many of these studies are conducted by community oncologists and often are unpublished due to lack of a suitable venue. We will encourage the conduct of such trials and plan to publish high-quality clinical research with immediate relevance to clinical practice.

An underserved area in the medical literature are case reporting and literature reviews for rare cancers. Those of us who practice in the community see rare cancers every week or month, but there is a paucity of information available about treatment and outcomes. We have an opportunity through *Community Oncology* to network with experts to obtain resources that will help plan treatment decisions.

Quality of cancer care in the community setting is an unexplored area, a field in its infancy. I believe that outcome data proving quality are going to be very necessary in the future as reimbursement and funding become more stringent. The conduct of multidisciplinary care in the community is very different from the staff model hospital, where medical oncologists, radiation oncologists, surgical oncol-

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gists, and oncology social workers all function under one roof. We have been able to integrate disparate practitioners in the community, but little has been published on how we accomplish this. There has been little discussion on how we can work together to improve care. Encouraging dialogues with other cancer providers and highlighting community-based solutions to enhancing quality care are tremendous opportunities for *Community Oncology*.

Part of improving quality derives from usable, realistic, and specific community oncology-based practice guidelines. *Community Oncology* can serve as a forum to develop and validate “best practice” approaches to care. From visiting practices across the country, I know there is much that we can learn from each other.

Medical oncologists in the community are, of course, responsible for providing end-of-life care, perhaps even more than in the tertiary centers because patients typically don't want to and are unable to travel when they are very ill. So the proportion of patients served is probably even higher than 80% for those patients who unfortunately have to deal with hospice and end-of-life care. There are few published data on the way palliative care is actually accomplished in the community. The journal will solicit papers regarding real-life challenges and solutions to end-of-life coordinated care.

### **Economics of providing quality care**

Another important area for this journal to cover is practice management and reimbursement. This is essential because, as community oncologists, we do more than provide quality patient care. We are directly responsible for running a small business in

such a way that it remains financially viable, thus allowing us to continue to serve our patients. We need to know more about the economics of care in the community. There is a paucity of data on practice analysis, how we should integrate technology, what our infrastructure needs will be as the landscape shifts, and how to address the reimbursement changes. What tactics should we take? How do we take care of patients now? Especially, how are the concerns of cancer patients and their community oncology care providers being represented in Washington?

One of the events that solidified my belief in the need for this journal was the formation of the Community Oncology Alliance (COA) in December 2002. The rapid and unprecedented participation of thousands of community oncologists revealed a pent-up desire for an organizational structure that spoke to their needs. COA is the voice of community-based medical professionals, staff, and patients, with one goal: To preserve the best cancer-care delivery system in the world. *Community Oncology* will feature a legislative news report in each issue to help disseminate and interpret the complex world of federal funding, drug reimbursement, and service provision.

Most importantly, *Community Oncology* is your journal. We encourage submissions from any and all cancer care providers with an interest in any of the above topics, or novel topics. Our vision is a journal that is a “must read” for community-based practitioners because it offers vital, useful, clinically relevant, and timely information for a rapidly changing and complex environment. Thank you for joining us on this exciting journey.



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