100TH ANNIVERSARY COMMEMORATIVE BOOKLET

100 years

Commission on Cancer | 1922–2022

ACS AMERICAN COLLEGE OF SURGEONS

TABLE OF CONTENTS

100 years
Commission on Cancer | 1922–2022

FOREWORD

In 1922, the American College of Surgeons (ACS) established the Committee for the Treatment of Malignant Diseases and published standards for emerging "cancer clinics" to conduct high-quality cancer care. For nearly 100 years, the evolution of the Commission on Cancer (CoC) has been seen as a steady hand, guiding cancer care by reviewing and revising standards for cancer programs using an evidence-based approach. This history represents significant structural milestones in cancer programs, including establishing and empowering a Cancer Committee, defined leadership and authority, multidisciplinary representation, tumor boards to discuss increasingly complex cancer patients, and a robust data collection system to track the care and outcomes of the majority of cancer cases in the United States.

For the past decade, efforts were made to address the entirety of the patient's experience: prevention and screening, distress monitoring, understanding barriers to care, and survivorship and palliative care. Revisions of our standards and expectations for programs were renewed in 2019 and 2020. Changes in the National Cancer Database (NCDB) reporting structure to include a more timely, facile, and comprehensive data system, the Rapid Cancer Reporting System, was developed while the College expanded a unified infrastructure for all ACS Quality Programs.

While poised to move in this new direction, our world was upended by rapid spread of the SARS-CoV2-19 Coronavirus pandemic. The impact of COVID-19 patients interrupted the normal workflow of cancer patients, halting screening efforts and imposing significant delays in treatment and care for many months and ongoing today. The persistent impact of this looming force has continued to cause our programs to change course, lean on telemedicine for care, and has had costly effects on our institutions. In these times, I am constantly impressed by the strength, resilience, and compassion exhibited by the volunteer leaders and members of the Commission and our 1,500 cancer programs. The passion to care for cancer patients in the face of adversity and personal risk is powerful.

The Commission strives to develop inclusive programs that address care of any cancer patient by addressing specific barriers to overcome disparities that we must acknowledge, provide tools that will allow visibility of these differences, and encourage paths to overcome them.

The Commission continues to be the guiding force for improving the quality of cancer care in America. As we approach our centennial anniversary, as Chair of the CoC I must thank the leaders who have brought us here and those who are going to carry us forward. The incredible College staff are tireless in their support and guidance, working with the volunteer leaders and members, our member organizations, and other agencies that we work with for the benefit of our patients.

Timothy W. Mullett, MD, FACS
Chair, Commission on Cancer
Professor, Thoracic Surgery, University of Kentucky

100 years
Commission on Cancer | 1922–2022

The 1930s and 1940s

CLINICAL RESEARCH

ORGANIZATION OF SERVICE FOR THE DIAGNOSIS AND TREATMENT OF CANCER—A MINIMUM STANDARD

RECOMMENDED BY THE COMMITTEE ON THE TREATMENT OF MALIGNANT DISEASES[1], AMERICAN COLLEGE OF SURGEONS

WHILE recognizing that there are many unsolved problems with regard to cancer, the Board of Regents of the American College of Surgeons, on the advice of its Committee on the Treatment of Malignant Diseases, has announced[2] its policy of emphasizing the necessity of making the benefits of contemporaneous knowledge of cancer available to each and every cancer patient in the country. The College is convinced that, while awaiting future discovery of more efficient methods of treatment of the disease, it is possible effectively to reduce the suffering and mortality from cancer by an organized application of the knowledge that already is available.

The merits of cancer institutes and cancer laboratories are fully acknowledged, but it is felt that there is an urgent need for making our present knowledge more generally effective, and that this need can be met most efficiently through the formation of cancer clinics in approved general hospitals. Such already existing hospitals form the natural centers in which modern diagnostic and therapeutic procedures should be conducted, and constitute a means for an immediate widespread influence on the disease. Ordinarily these hospitals have the personnel and equipment for such service but a definite organization for this special service is necessary in order to obtain the maximum of efficiency in the campaign against cancer. The utilization of already existing hospitals for this purpose has the additional advantage of entailing the minimum of increased expenditure for the accomplishment of the purpose.

[1]The Committee on the Treatment of Malignant Diseases consists of Robert B. Greenough, Boston, chairman; Albert C. Broders, Rochester; Curtis F. Burnam, Baltimore; George W. Crile, Cleveland; Bowman C. Crowell, Chicago; William Duane, Boston; Edwin C. Ernst, St. Louis; John M. T. Finney, Baltimore; Burton J. Lee, New York; Frank Lynch, San Francisco; Robert T. Miller, Jr., Baltimore; Henry K. Pancoast, Philadelphia; H. Gideon Wells, Chicago; and Francis C. Wood, New York. Communications concerning the subject dealt with in this article may be addressed to Bowman C. Crowell, M.D., director of Clinical Research, American College of Surgeons, 40 East Erie Street, Chicago, Illinois.

[2]Surg., Gynec. & Obst., 1930, li, 570.

While the standard herewith presented applies especially to hospitals, other institutions that are shown to have the required personnel, organization and equipment for carrying on the work according to these standards may be included in the list of cancer clinics approved by the College.

In the publication to which reference has already been made the general recommendations of the College in regard to such clinics were outlined. There is presented below a more specific statement in the form of a minimum standard for cancer clinics and cancer services in general hospitals in which are formulated the requirements for an acceptable cancer clinic or cancer service. The Committee on the Treatment of Malignant Diseases takes the position that compliance with this standard forms one of the best methods of assuring to the patient the maximum benefits of our present knowledge of cancer. Explanatory comments on each of the clauses of this minimum standard are appended. These comments are followed by a repetition from the previous publication of the relation which the American College of Surgeons will bear to the cancer clinics.

MINIMUM STANDARD FOR CANCER CLINICS

1. *Organization.* There shall be a definite organization of the service, and it shall include an executive officer and representatives of all the departments of the hospital which are concerned in the diagnosis and treatment of cancer. The services of a secretary and of a social service worker shall be available.
2. *Conferences.* As an essential feature of the service there shall be regular conferences or consultations at which the diagnosis and treatment of the individual cases are discussed by all members of the clinic who are concerned with the case.
3. *Patients.* Reference to the cancer clinic of all patients in whom the diagnosis or treatment of cancer is to be considered shall be either volun-

tary or obligatory in accordance with the vote of the medical staff or of the governing board of the hospital.

4. *Equipment.* In addition to the diagnostic and therapeutic surgical equipment which is required in every approved general hospital there shall be available an apparatus for X-ray therapy of an effectiveness which is generally agreed upon as adequate, and an amount of radium sufficient to insure effective treatment.
5. *Records.* In addition to the records which are required in every approved general hospital, there shall be additional records of: (a) The details of the history and of the examination for cancer in different regions of the body, such as are indicated on the form records which are recommended by the Committee on the Treatment of Malignant Diseases, American College of Surgeons. (b) The details of the treatment by radium or X-ray as indicated on the form records which are recommended by the Committee on the Treatment of Malignant Diseases, American College of Surgeons. (c) Periodic examinations at intervals for a period of at least five years following treatment.
6. *Treatment.* The treatment of cancer patients shall be entrusted to the members of the staff of the cancer clinic except in cases in which adequate treatment in accordance with the collective recommendation of the staff of the cancer clinic can be procured otherwise.

DETAILED EXPLANATION OF THE MINIMUM REQUIREMENTS FOR CANCER CLINICS

CLAUSE I

Organization. There shall be a definite organization of the service, and it shall include an executive officer and representatives of all the departments of the hospital which are concerned in the diagnosis and treatment of cancer. The services of a secretary and of a social service worker shall be available.

The staff of a cancer clinic or cancer service should include primarily representatives selected from the departments of surgery, pathology, and radio-therapeutics who are qualified by a special knowledge of cancer in their respective fields.

The American College of Surgeons regards cancer as essentially a surgical disease, and as a rule a surgeon who is a Fellow of the American College of Surgeons should be selected as executive officer of the clinic. However, the accurate diagnosis and the effective treatment of cancer today must be regarded as a group problem which requires the co-operative efforts of representatives of these several departments who have been trained adequately to bring contemporaneous knowledge and experience to the consideration of the individual cancer case.

Within the surgical division of the clinic representatives of the surgical specialties, such as gynecology, urology, and surgery of the diseases of the eye, ear, nose, and throat, should be included, and representatives of the departments of internal medicine and dermatology and such other special departments of the hospital as may be concerned in the diagnosis and treatment of cancer cases should also be included.

The special services of a secretary are essential for recording accurate data in regard to the diagnosis and treatment, and for the maintenance of card catalogues with cross references of patients and diseases. The social service worker's assistance is of the utmost value in maintaining an effective follow-up system by which end-results of treatment may be determined, and she should work in close co-operation with the secretary of the clinic.

CLAUSE II

Conferences. As an essential feature of the service there shall be regular conferences or consultations at which the diagnosis and treatment of the individual cases are discussed by all members of the clinic who are concerned with the case.

The essential feature of a cancer clinic is the group method of study of cancer cases. This is accomplished by a conference of the staff which includes representatives of all of the departments concerned. Such a meeting may be held daily or at longer intervals. It may be formal or informal, but its purpose should be the discussion of the diagnosis of each individual case, the consideration of the details of information obtained from the pathological and radiological laboratories, and a discussion of the methods of treatment which may be expected to give the best results. In addition to the discussion of individual cases by members of the clinic staff, from time to time reports should be presented of the end-results of treatment of different forms of cancer, with a comparison of the results obtained in similar cases in other clinics.

In the development of these conferences of the members of the clinic, it is of great value to encourage the attendance of members of the medical profession who are not members of the clinic, and to present at intervals patients who have been the subject of previous treatment.

CLAUSE III

Patients. Reference to the cancer clinic of all patients in whom the diagnosis or treatment of cancer is to be considered shall be either voluntary or obligatory in accordance with the vote of the medical staff or of the governing board of the hospital.

As a matter of expediency, at the time of the first organization of a cancer clinic reference of patients to it may be made a purely voluntary matter on the part of the other members of the hospital staff. As the clinic becomes established in many hospitals it is found desirable that all cases of cancer or suspected cancer should be automatically referred to the cancer clinic for preliminary investigation. In any case, it should be obligatory that all cases of cancer on discharge from the hospital be referred to the cancer clinic for subsequent follow-up.

CLAUSE IV

Equipment. In addition to the diagnostic and therapeutic surgical equipment which is required in every approved general hospital there shall be available an apparatus for X-ray therapy of an effectiveness which is generally agreed upon as adequate, and an amount of radium sufficient to insure effective treatment.

Every approved general hospital at the present day has instruments and apparatus available for diagnosis where operative procedures, such as the examination of the bladder, bronchus, œsophagus, rectum, and sigmoid, are required, together with the instruments and appliances for general surgical work, including electro-surgical equipment. An approved hospital has also a complete X-ray apparatus for diagnostic purposes. However, for the effective treatment of cancer cases the department of radiotherapy should be supplied with equipment sufficient to insure high voltage X-ray therapy and an amount of radium sufficient to insure effective treatment. At the present time it is the opinion of the Committee that the X-ray therapy apparatus should have an effective strength of 200,000 volts, and that at least 200 milligrams of radium in the form of salt or an equivalent amount of emanation should be available.

The pathological department of the hospital must also be equipped to provide information in regard to tumors in the light of modern knowledge of this subject. Such reports should include not only the pathological diagnosis of cancer but also further details in regard to classification of the type and degree of malignancy, and, where possible, an estimate of the radio-sensitivity of the tumor.

Provision should also be made for the permanent preservation of microscopic slides and gross material, as well, and all of this material should be preserved, filed, and catalogued in such a way that a review of the material may be readily accomplished at some future time when special study of this subject may be required.

CLAUSE V

Records. In addition to the records which are required in every approved general hospital, there shall be additional records of: (a) The details of the history and of the examination for cancer in different regions of the body, such as are indicated on the form records which are recommended by the Committee on the Treatment of Malignant Diseases, American College of Surgeons. (b) The details of the treatment by radium or X-ray as indicated on the form records which are recommended by the Committee on the Treatment of Malignant Diseases, American College of Surgeons. (c) Periodic examinations at intervals for a period of at least five years following treatment.

The special records used in the cancer clinic consist chiefly of the complete record forms for history, examination, diagnosis, and treatment, which are recommended by the College with a view to making the records of different clinics uniform and comparable. Samples of these record forms may be obtained from the Department of Clinical Research of the College. To insure that all the necessary data are obtained the responsibility for filling out these forms should be placed definitely upon the examining physician. In addition, provision must be made by a card catalogue system to control the follow-up of patients after they have been discharged from the hospital, and to insure investigation of cases which fail to report to the clinic before so much time has elapsed as to make their investigation difficult.

CLAUSE VI

Treatment. The treatment of cancer patients shall be entrusted to the members of the staff of the cancer clinic except in cases in which adequate treatment in accordance with the collective recommendation of the staff of the cancer clinic can be procured otherwise.

In cases in which treatment by surgery or by radiation requires special knowledge or technique it is advisable that such treatment be given by members of the staff of the cancer clinic. However, in such cases as require treatment by surgery or by radiation which can be provided by others than members of the clinic staff, the special assignment of these cases to the staff of the cancer clinic is not essential. In general, it is to be recognized that members of the hospital staff who accept service in the cancer clinic thereby deprive themselves of certain professional experience in other lines, and it is not unreasonable to expect the other members of the staff of the hospital to recognize that fact by assenting to a reassignment of the clinical material of the hospital which will give to each member of the staff an equal opportunity for development of his special interests.

RELATION OF THE AMERICAN COLLEGE OF SURGEONS TO THE CANCER CLINIC

The American College of Surgeons through its Committee on the Treatment of Malignant Diseases, Department of Clinical Research, will co-operate with the cancer clinics in the following respects:

It will furnish to men and hospitals desiring to form such clinics information as to the methods to be adopted in the organization of the clinics.

It will put the stamp of approval of the College on such clinics as conform to the standards of the College for such clinics.

It will furnish to the clinics samples of uniform record blanks for the recording of their cases.

It will ask the clinics to co-operate in furnishing data on their cases for a scientific study of the results of treatment by various methods. This study will be a continuation of the studies that the Committee has been making during several years on data furnished by a limited number of selected clinics, the results of which have been published.

It will furnish the clinics with an opportunity of discussing their administrative problems in a series of round table conferences at each of the annual Clinical Congresses of the College and at the sectional meetings of the College which are held throughout the country each year.

It will publish and distribute to the clinics the results of its studies, based on the data collected, after analysis by the committee.

It will issue in the *Bulletin* of the College from time to time articles dealing with the administrative and scientific phases of the clinic work, and the proceedings of such round table conferences and symposiums as may be held.

It will co-operate with the clinics in such other ways as may be to their advantage.

THE OBLIGATION OF THE GENERAL HOSPITAL IN PROVIDING BETTER SERVICE FOR THE CANCER PATIENT*

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ORGANIZED effort in behalf of special groups of cases has come to be the modern vogue in medicine. One finds specialists in tuberculosis, cardiac disease, cardiac disease in children, specialists for postural defects in children, asthma specialists, rectal specialists, gastroenterologists, dermatologists, syphilologists, and those devoting themselves to neurology, while some specialize in psychiatry, and still others devote themselves to the peripheral nervous system. There are orthopedic surgeons, fracture specialists, nose and throat specialists, gynecologists, chest surgeons, cerebral surgeons, neurological surgeons and intra-oral surgeons, and one could add to this list still further.

But with all these various special activities, it is only recently that we are beginning to develop specialists in the cancer field. Until the last few years the unfortunate patient afflicted with cancer has been handled by all sorts of men, some poorly trained and some well trained in the diagnosis and treatment of these diseases. Today we are witnessing a remarkable awakening in behalf of the cancer patient. We have come to realize that it has been his lot to fall betwixt and between many types of professional activity and the service rendered to him has been inadequate, often ill-advised and ineffective. As one travels through the southwestern part of the United States huge sanataria are encountered everywhere, devoted to the care of those afflicted with tuberculosis. Vast sums of money are invested in this organized effort to care for the tuberculous patient and to cure him of his disease, but a similar organization in behalf of the cancer patient has, until recent years, been lacking. Large endowments have been given to aid laboratory research in the field of cancer and much valuable information has been collected through these activities. But well directed research should never be divorced from the clinical care of cancer patients for each activity is the complement of the other. At a meeting of the American College of Surgeons held in Chicago some years back, where a group of earnest women were preparing to organize an institute devoted solely to cancer research, the meeting came to a dramatic close when Dr. Maud Slye, who has spent many useful years in research in cancer, said, "Out of the isolation of many years in a research laboratory, I beg of you to include in your plan hospitalization for cancer patients."

The American College of Surgeons with the cooperation of the American Society for the Control of Cancer has been developing, in recent years, a well conceived plan to provide better service for cancer patients in this country and Canada. These two national organizations have cooperated fully, the American Society for the Control of Cancer surveying the country through its field representatives, and the American College of Surgeons organizing and standardizing special cancer clinics. The American College through its Malignancy Committee, which is headed by Dr. Bowman C. Crowell, Associate Director of the College, and Dr. Robert B. Greenough, Chairman of the Committee, has outlined a comprehensive plan of organization.

A considerable number of cancer institutes are already in existence in large centers, and many of them are doing important work in developing better methods of diagnosis and treatment for patients afflicted with cancer. Such institutions are well rounded, combining laboratory research and clinical care in a splendid way, and the service which they are rendering to the public as well as to the medical profession is incalculable. They are, in fact, educational centers, visited by members of the medical profession in increasing numbers, in their desire to educate themselves in the field of cancer. Some of these institutes may be enumerated: Huntington Hospital, Boston; Howard Kelly Hospital, Baltimore; Cancer Institute of the University of Minnesota; Steiner Clinic, Atlanta; New York State Institute, Buffalo; Mayo Clinic, Rochester; Institute de Radium, Montreal; The Cancer Institute of the City of New York; Memorial Hospital, New York. These institutions have become centers of training for young men who desire to prepare themselves as specialists in the field of cancer. At the Memorial Hospital, a generous donor established several years ago Clinical Research Fellowships. A course of three years spent in such a Fellowship provides training in the diagnosis of cancer, the pathology of neoplastic diseases, X-ray diagnosis, the fundamentals of the physics of radiation and cancer therapy, including the use of surgery, radium and the X-ray. Efforts such as this and similar ac-

*Presented at the Clinical Congress of the American College of Surgeons, Hospital Standardization Conference, St. Louis, October 17–21, 1932.

tivities in other institutes provide training for the development of the cancer specialist, for there is need today for this type of specially trained man.

In large centers, where it is impossible to obtain sufficient funds with which to establish a cancer institute, important hospitals are serving the cancer patients. The Stuyvesant Square Hospital of New York, the Barnard Free Hospital of St. Louis, and the State Hospital for Cancer at Pondville, Mass., are institutions of this type.

But these larger institutes and cancer hospitals can care for but a small proportion of the patients suffering with cancer. The vast numbers of cancer patients in the United States and Canada must inevitably seek aid from the general hospitals now existent, and the responsibility of these hospitals toward this enormous problem must be faced. An inspection of almost any large general hospital in the United States or Canada will disclose cancer patients indiscriminately scattered throughout the services of the hospitals, some under the care of the surgeon, others in a general medical ward, pediatric or orthopedic ward, and not a few under the care of the roentgenologist or radiologist. Patients afflicted with other diseases of major import are segregated to permit an effective focus on the problems surrounding them. Cancer is a major health problem and it must be intelligently met by the boards of managers and medical staffs of the large general hospitals in this country. No such hospital can today be considered fully efficient unless a well organized cancer service exists within its doors.

The first cancer clinic in a general hospital was established by Dr. Robert Greenough at the Massachusetts General Hospital in Boston, and many other large general hospitals have formed clinics for cancer patients where adequate diagnostic and therapeutic facilities are available and a selected staff, trained for this task, is carrying on effective work.

The personnel of the cancer clinic must be carefully chosen, for the success of such a clinic depends largely upon the leadership of the group controlling it and the technical training and intelligence of the men who compose the group. The head of the clinic should be chosen because of his qualities of leadership, interest and training, and he may be a surgeon, a pathologist, a radiologist, or an internist. The basic idea behind the cancer clinic is the wisdom of group judgment and the full appreciation that no one man should decide the fate of a cancer patient. One of the difficulties encountered in the development of these clinics has been the reluctance of many general surgeons to relinquish the care of cancer patients in their own service. The average general surgeon, wholly untrained in the radiological field, is incompetent to determine whether a given form of cancer in a particular patient should be treated by surgery alone, by radiological methods alone, or by a combination of surgery and irradiation. The cancer specialist should have a knowledge of the pathology of cancer and its reaction to various physical agents, since the advent of irradiation has developed many new criteria with respect to radiosensitivity. The cancer group should include a pathologist, an internist, a radiologist, surgeons, a gynecologist, a urologist and a dermatologist, a rhinolaryngologist and a neurologist, and these men together should focus intensively upon the problems surrounding the cancer patients. The cancer clinic is built around the weekly cancer conference, and this is one of the most important activities of such a clinic. Men in various branches of the profession meet here to study and diagnose the patients presented before them for examination, permitting a group judgment upon each case under discussion. A doctor may bring his own patient to such a conference and after due consideration receive the opinion of the group, departing with his patient to do as he may see fit. The clinic, therefore, interferes in no way with the private practice of doctors in any community.

Careful records should be kept of the patients entering the clinic and follow-up clinics must be established if the end results of treatment applied are to be fully appreciated. The American College of Surgeons is undertaking to standardize these clinics and insists upon adequate, carefully kept records in the cases carried on the clinic roster. End result forms have been prepared by the members of the Malignancy Committee and cancer clinics are expected to return these forms from time to time, reporting the end results to date of the cases registered in the clinic.

A cancer clinic in a general hospital should be provided with diagnostic X-ray equipment, a high voltage X-ray machine, and an adequate supply of radium; but what is still more essential, it must have competent men fully qualified to use these effective but dangerous agents. Radium, especially, should never be used unless the doctor has received adequate technical instruction in the science of radiology. Disaster will surely befall a clinic in which this rule is disregarded. If the cancer group contains no surgeon adequately trained to use radium, one or more surgeons should be sent to institutions where proper instruction may be obtained, or men with proper technical training brought in from the outside to do this highly important work.

Unless all of these requirements are properly met, the cancer clinics in general hospitals will not be given the stamp of approval of the American College of Surgeons.

Cancer diagnostic clinics are also being established by the College in small communities where adequate radiological therapeutic facilities are lacking. A similar group judgment is rendered in such a clinic, the major focus being upon diagnosis. The educational value of such a clinic is enormous, for the diagnostic acumen of those attending the clinic is necessarily improved. Modes of treatment are discussed for each individual patient, and those who require roentgen ray or radium therapy are referred to the nearest fully equipped cancer clinic in a larger hospital where correct therapy may be applied. The follow-up of a patient may be carried on later by the diagnostic clinic.

In the organization of these various clinics in behalf of cancer patients, approval by state, county, or provincial medical authorities should be sought. The College proposes to send its representatives at various intervals to visit these clinics determining the character of the work being done.

At last a well conceived plan is in operation to render service to the cancer patient. This hospital conference, under the auspices of the American College of Surgeons, is bringing men together from various parts of the United States and Canada representing many of the important hospitals of the country. What are these representatives to do with the challenge which they must meet concerning their obligations to the cancer patients in their community? Will the same old archaic methods of handling this disease continue, as in the past, or will hospitals, appreciating the dire need of the cancer afflicted, bring about the reorganization necessary within their own doors to provide effective service in the field of cancer?

THE RÔLE OF THE SOCIAL WORKER IN THE DIAGNOSIS AND TREATMENT OF CANCER*

ELEANOR COCKERILL, ST. LOUIS
Social Worker, Barnard Free Skin and Cancer Hospital

SINCE the inception of medical social work the rôle of the social worker in the diagnosis and the treatment of disease has become increasingly important and significant. She has been able, through her understanding of the social implications of disease, to aid in the restoration of sick individuals to a state of physical and social well being. The social worker's rôle is primarily the same regardless of the specific diagnosis involved but there are social implications inherent in certain diseases which make her rôle particularly strategic and useful. Cancer, a disease ranking second as a cause of death in the United States, offers a real challenge to her. The direct effect of this disease upon the community in the creation of dependents who must eventually be supported from public funds, and the threat to family solidarity which is implied in its attack upon wage earners and home-makers, make the cancer problem one of sufficient social importance and consequence to demand her best effort. The increased emphasis now being placed by the medical profession upon the early diagnosis and treatment of the disease and the development of research projects based upon careful observation of patients after treatment, have resulted in a realization of the valuable contribution which the social worker is prepared to make. The need for prompt and continuous cooperation from the patient and the obvious assistance to be gained through a utilization of community resources have shown the importance of a unifying force between surgeon, patient, and community which will be productive of an effective relationship. It has been found that the social worker, who is familiar with the plan of the surgeon, the problem of the particular patient, and the resources of the community, is the person best fitted to establish this relationship. The surgeon recognizes that his efforts must be directed toward the skilled and intricate treatment demanded by the disease. The nursing staff is concerned primarily with the bedside care of patients undergoing treatment. The laboratory personnel has a definite task within the hospital. The admitting officer, clinic manager, and historian have only a fleeting contact with each patient in the performance of their duties. Each of these staff members has a real function to perform, but the social worker is the only one who is in a position to view the problem of each patient in its entirety. From the surgeon she learns the details of his physical condition—the type and stage of the cancer, the therapy advised, and the possibility of arrest or cure. From

*Presented at the Clinical Congress of the American College of Surgeons, Hospital Standardization Conference, St. Louis, October 17–21, 1932.

CHANGE IN CANCER RECORD FORMS OF THE AMERICAN COLLEGE OF SURGEONS

EARLY in 1948, a group in the American College of Radiology approached the Cancer Committee of the American College of Surgeons with the suggestion that a revision was desirable in the x-ray treatment section of the Abstract Cancer Record Forms (reverse of Forms 20 to 43) which are so widely used in cancer clinics throughout the country.

It was pointed out that "hardness, or quality, is an index of the penetrating power of x-rays. This is officially expressed as the half-value layer, and is abbreviated 'hvl.' Hardness depends upon voltage and filter thickness. A record of hardness can, therefore, be substituted for voltage and filter."

The changes were approved successively by the Commission on Radiological Units, Standards, and Protection, and the Committee on Cancer, and Board of Chancellors of the American College of Radiology. The Cancer Committee of the American College of Surgeons thereupon agreed to make the appropriate changes as suggested and has so instructed the Physicians Record Company, of Chicago, who print and distribute these forms. We have been advised that the forms to be supplied by this Company in the future will be completely reprinted to include the changes here indicated. The new form suggested and approved is as follows:

Date Begun	Date Ended	Half-value Layer	Size Port	No. Ports	Total No. Treatments	Total Tissue Roentgens	
						Skin	Lesion

CHANGE OF NAME FOR COMMITTEE ON FRACTURES AND OTHER TRAUMAS AUTHORIZED BY BOARD OF REGENTS OF THE AMERICAN COLLEGE OF SURGEONS

AT a meeting in St. Louis on April 23, the Board of Regents unanimously voted acceptance of the recommendation of the Committee on Fractures and Other Traumas that the name of that Committee be changed to the Committee on Trauma.

In 1922, the American College of Surgeons formed a Committee on Fractures, since which time that Committee has been active in promoting the better care of fractures. In 1939 the Committee amalgamated with the Committee on Industrial Medicine and Traumatic Surgery under the name Committee on Fractures and Other Traumas. Recently, for the sake of brevity and convenience, and to interpret more accurately present trends and the increasing emphasis on the surgery of trauma, after many months of consideration it was decided that it now seemed advisable again to change the name of the Committee.

Originally a small group, the membership has been enlarged until at present it numbers 46, representing all parts of the United States and Canada. Many years ago, in a well considered effort to secure a more widespread effect of its work, the Committee organized Regional Fracture Committees. There are now 97 of these with a membership of nearly 2,000. To facilitate the work of these Committees and make more frequent meetings possible, the country has been divided into 13 sections consisting of four or five states or provinces, each headed by a Section Chief. Conferences between the Committee on Trauma and the Regional Fracture Committees are held during the annual Clinical Congress and the Sectional Meetings of the College.

The Committee on Trauma recognizes that local practice or circumstances may favor the temporary retention of the name "Regional Fracture Committee," but it is the opinion of the parent group that the need for educating the medical profession and the laity in the care of other traumatic lesions is equally great, and it is desired that the Regional Committees devote their efforts to other trauma[1] as much as to fractures.

[1]When "other trauma" is mentioned, it is interpreted to include the following: skin contusions, lacerations, avulsions, burns, and skin grafting; injuries to skull and face, brain and spinal cord, peripheral nerves, neck, larynx, thorax, abdomen (lacerations, puncture, and compression trauma), retroperitoneal tissues, genitourinary tract, hands and feet, tendons (immediate and delayed repair), gunshot and stab wounds of blood vessels, fractures, dislocations, amputations, shock, and rehabilitation.

100 years
Commission on Cancer | 1922–2022

The 1950s and 1960s

A Standardized Method for Reporting Cancer End Results

The data on which Dr. Ernest M. Daland, Boston, and Dr. Leon G. Michell, Lynn, base their paper entitled "Cancer of the Rectum. Results of Treatment of All Cases Admitted to the Pondville Hospital June, 1927 through December, 1946" published in the July issue of *Surgery, Gynecology and Obstetrics*, were reported according to the method approved by the Joint Committee on Reporting Cancer End Results. The forms used in collecting these data are illustrated in the following report, and rules are given.

Said forms and rules were first laid down by the American College of Surgeons' Committee on Cancer acting upon the recommendations of a duly appointed subcommittee. The latter consisted of Drs. Daland, Ian Macdonald, Los Angeles, Murray Copeland, Washington, Hayes Martin, New York and Harold Dorn, Washington. Their work was begun in 1948 after Dr. Daland put the problem to the Cancer Committee. The rules and forms subsequently developed by the Daland group were approved by the Regents in 1950.

Other national organizations interested in cancer then asked that a joint committee be set up to study the problem of reporting cancer end results. The explanatory preface to and minor changes in rules and forms resulted.

The report which follows is approved by all of the Joint Committee's member organizations. —*Editor*

THE LACK OF UNIFORMITY in reporting cancer end results is a source of worry to clinicians and research workers seeking to evaluate therapy from published reports. In order to overcome this difficulty, the Joint Committee on Reporting Cancer End Results was established in 1950 to recommend rules and forms aimed at eliminating the major causes of confusion.

Representatives on the Committee from the American College of Surgeons are Drs. Ernest M. Daland, Grantley W. Taylor, and Murray M. Copeland; from the College of American Pathologists, Drs. B. Earl Clarke, Maxwell J. Fein, and Theodore J. Curphey; from the American College of Radiology, Drs. Donald S. Childs, Harold W. Jacox, and Frederick W. O'Brien; and from the American Cancer Society, Drs. Alton Ochsner, E. B. Wilson, and E. Cuyler Hammond. Dr. Harold F. Dorn, of the U. S. Public Health Service, is a member at large. Dr. Childs is the chairman of this group, and Dr. Hammond the secretary. The following report has been adopted by the Committee.

The purpose of any statistical analysis is to obtain reliable answers to certain specific questions. Therefore, the analytic method of choice depends upon the nature of the questions as well as upon the data available, and it is frequently necessary to employ several different methods in order to answer various questions. For this reason, no one method of analyzing cancer end results can be recommended as a solution to all the problems which may arise. Nevertheless it is possible to outline certain basic principles and to suggest a simple standard type of analysis applicable to most sets of data on this subject. More detailed supplementary analyses would then depend upon the exact problem which the investigator seeks to elucidate.

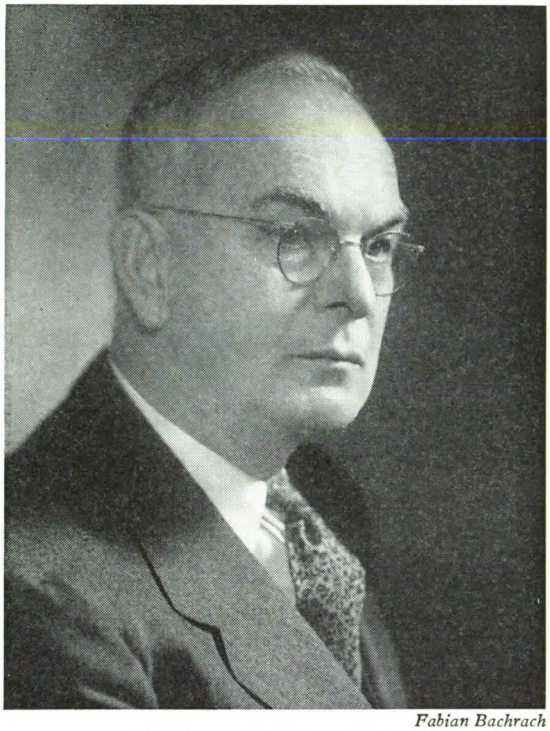
The following are among the most common of the numerous reasons for reporting cancer end results:

1. Comparison of the effectiveness of alternative methods of treatment (*a*) in achieving permanent cures, (*b*) in extending the life of the patient whether or not permanent cures are achieved, (*c*) in recurrent cases of cancer, (*d*) in the relief of suffering in incurable cases of cancer.

2. Analysis of the influence on the course of the disease of such factors as (*a*) histologic type, (*b*) size and extent of the lesion, (*c*) evidence of metastasis, (*d*) duration of symptoms, (*e*) age and condition of patient.

While there are various perfectly correct methods by which these comparisons may be made, it is obvious that two different series of cases can be compared only if the same method of analysis is used for both. For example, the effectiveness of a certain treatment used by one doctor can be compared with the effectiveness of an alternative method of treatment used by another doctor only if the end results are presented in exactly the same way. Thus a standard method of reporting is essential when the purpose of reporting is to make such comparison possible. This in no way limits the freedom of the investigator to make additional analyses by other or more detailed methods when desirable.

A great deal of confusion exists in the reporting



Fabian Bachrach

Dr. Ernest M. Daland, Boston

of cancer end results. Widely different cure rates are published for what appears to be the same type of cancer and it is frequently impossible to tell whether the differences are due to variations in the method of treatment or whether they are due to variations in the method of reporting the results. The principal reasons for this confusion seem to be:

1. *Selection of cases.* The result of therapy depends in no small measure upon the condition of the patient at the time treatment is initiated and there are great variations in the type of patients coming to the attention of different doctors. For example, some doctors see a preponderance of advanced or recurrent referred cases while other doctors see a preponderance of relatively early cases and refer their advanced cases for treatment elsewhere. Aside from this there is frequently a selection in the cases reported in the literature. Some authors present only "hopeful" cases; some present all cases treated, whether hopeful or not; and some present all cases seen, including those not treated.

2. *Proof of diagnosis.* Some authors present only cancer cases with microscopic confirmation of the diagnosis, some include cases without microscopic confirmation of the diagnosis, and still others simply make no mention of the method of diagnosis.

3. *Inadequate follow-up.* Comparatively few doctors or hospitals are able to obtain a five year follow-up on every diagnosed case of cancer. Survival rates are usually based only upon those cases which were followed, but frequently no mention is made of the number of cases which were lost to follow-up. This also can make a considerable difference in survival rates since it cannot be assumed that untraced cases had the same history as traced cases. From the Committee's observations, it appears that the proportion of cases followed for five years varies from 100 per cent down to a very low percentage indeed.

4. *Cure rates vs. survival rates.* "Five-year cancer cures" are distinguished from "five-year cancer survivors" by the fact that the former are cases which are alive and apparently free of cancer five years after diagnosis, while the latter are all cases alive five years after diagnosis including cases alive but with evidence of cancer. While both five-year cure rates and five-year survival rates are useful, though for somewhat different purposes, serious error results from mislabeling or failure to specify clearly which of the two is meant. Another difficulty which arises in this matter is the fact that in reporting five-year cure rates there has been no uniform method of handling cases which die of causes other than cancer before the end of the five-year period.

The rules and standard forms adopted by the Committee are given at the end of this report. They are designed for the presentation of minimum basic information in a uniform manner. It should be emphasized that the investigator is expected to give additional information in supplementary tables and in the text. This will give the reader the necessary data to make analyses most suitable for the purpose he has in mind. For example, the reader will be able to compute five-year cure rates or five-year survival rates as he sees fit. In some instances, an author may wish to supplement his report with information on yearly results up to and beyond the five-year period.

Certain problems in connection with the use of the standard form should be clarified. In reporting on a series of cases, a form should first be filled out including every case seen of the particular site or type under consideration. The series should be

precisely identified in terms of site, source of cases, and time period covered. Supplementary forms may then be filled out for selected subgroups classified according to such factors as stage, grade, histologic type or method of treatment.

The general summary section at the top of the form need only be filled out for the over-all series of cases. It is included to insure that all cases are reported without selective bias. The total experience is divided into four mutually exclusive categories: Section A, Section B, Other (a), and Other (b). Those cases classified as "other" appear only in the summary; whether or not these cases had been treated previously is immaterial and no follow-up information is required on them.

Rules for Reporting Five-year End Results of Persons with Malignant Neoplastic Diseases

1. Include *all* cases diagnosed as having a malignant neoplasm, whether treated or not. Whenever possible, all cancers should be classified according to the site of origin.

2. Cases reported should be divided into two sections, A and B, as defined below.

   Section A. *Cases not previously treated.* The duration of these cases is measured from the date of the original diagnosis of this cancer.

   Section B. *Cases previously treated.* The duration of these cases is measured from the beginning of subsequent treatment.

   The total number of cases in Section A and the total number of cases in Section B should always be reported. However, if the investigator so desires, he may report the full details for one of these two sections only. It is generally desirable to report every case from the date of original diagnosis until the end of the five-year period. If this is done, then all cases will fall in Section A. The detailed tabulation of Section B cases is designed primarily for those investigators who wish to report on the efficacy of treatment in recurrent cases of cancer.

3. Include only cases with an elapsed duration of at least five years. Report the status of each patient on the fifth anniversary. Each patient should be examined at least yearly.

4. The condition of patients classed as alive and free from cancer must be established through examination by a physician at the end of the five-year period or a later date.

5. The percentage of cases with a microscopically confirmed diagnosis is a measure of the accuracy of diagnosis. This percentage should be as high as possible; however, cases without microscopically confirmed diagnosis should be included but shown separately.

6. Whenever possible, an autopsy should be performed. A high degree of accuracy requires that autopsies be performed at least on all those patients who die before the end of the five-year period.

7. The percentage of cases untraced for the full five years should be as close to zero as possible. If it is greater than ten percent, the report will be of doubtful validity.

8. In reporting on cancer of a given primary site, patients will be classified according to the status of that disease. If a new primary histologically proven cancer develops, it should be considered as an intercurrent disease even though it may cause the death of the patient.

9. It is most important that the report should include all the basic data shown on the accompanying forms. This is considered to be the minimum amount of information needed for a useful report; many investigators will wish to give additional information in supplementary tables and in the text. It is left to the discretion of the investigator whether he wishes to compute five-year survivor rates or five-year cure rates or both.

10. The attached form is recommended for use in tabulating end results.

Form follows on pages 152 *and* 153

October 1951

A REPORT OF FIVE-YEAR END RESULTS—CANCER OF_____

This series consists of all patients with cancer of the_____, both early and advanced, applying to_____ during the period_____ to_____.

GENERAL SUMMARY		Number of Cases
TOTAL EXPERIENCE—All patients applying		
SECTION A	Cases not previously treated	
SECTION B	Cases previously treated	
OTHER	a. Applied after treatment elsewhere, no evidence of cancer on admission or thereafter	
	b. Consultation only, no treatment requested	

SECTION A. Cases not previously treated

RESULTS AT END OF FIVE YEARS		Number of Cases		
		With Microscopic Proof	Without Microscopic Proof	Total
GROUP I	c. Refused proffered treatment			
	d. Untraced for full five years without recurrence at last examination			
GROUP II	e. Dead within five years of other causes without recurrence of cancer			
GROUP III	f. Dead, cancer present or died of complications of treatment			
	g. Dead—presence of cancer unknown			
	h. Living with cancer present at 5 years			
	i. Living with condition unknown at 5 years			
	j. Untraced full five years with cancer at last examination			
	k. Untraced full five years, not classifiable in "d" or "j"			
GROUP IV	l. Living, continuously free of cancer, verified by medical examination at 5 years			
	m. Living, apparently free of cancer, not verified by medical examination at 5 years			
	n. Living, successfully treated for recurrence, free of cancer at 5 years			
TOTAL				

SECTION B. Cases previously treated

RESULTS AT END OF FIVE YEARS		Number of Cases		
		With Microscopic Proof	Without Microscopic Proof	Total
GROUP I	c. Refused proffered treatment			
	d. Untraced for full five years without recurrence at last examination			
GROUP II	e. Dead within five years of other causes without recurrence of cancer			
GROUP III	f. Dead, cancer present or died of complications of treatment			
	g. Dead—presence of cancer unknown			
	h. Living with cancer present at 5 years			
	i. Living with condition unknown at 5 years			
	j. Untraced full five years with cancer at last examination			
	k. Untraced full five years, not classifiable in "d" or "j"			
GROUP IV	l. Living, continuously free of cancer, verified by medical examination at 5 years			
	m. Living, apparently free of cancer, not verified by medical examination at 5 years			
	n. Living, successfully treated for recurrence, free of cancer at 5 years			
TOTAL				

Appointments to Cancer Committee

CHARLES S. CAMERON, M.D., F.A.C.S., New York, has been elected a member of the College's Committee on Cancer. Dr. Cameron, who came into the College in 1946, is the medical and scientific director of the American Cancer Society, and clinical assistant, Memorial Center for Treatment of Cancer and Allied Diseases.

The following organizations were invited by the committee to appoint representatives as advisory members, who are as follows: *American Cancer Society*, E. Cuyler Hammond, Sc.D., New York, director, Statistical Research Section, Medical and Scientific Department; *National Cancer Institute*, Raymond Kaiser, M.D., Washington, D.C., chief, Control Branch; *College of American Pathologists*, William O. Russell, M.D., pathologist, M.D. Anderson Hospital, Houston, Texas; and *American College of Radiology*, Theodore P. Eberhard, M.D., co-ordinator of oncologic teaching, Jefferson Medical College, Philadelphia.

The American College of Physicians has not yet appointed its representative.

With these additions the Committee on Cancer now numbers 27. Dr. Edwin P. Lehman, Charlottesville, Virginia, is the chairman, and Dr. Danely P. Slaughter, Chicago, the vice chairman.

Cancer Facilities Affected by Two New Requirements

CANCER CLINICS AND CANCER DIAGNOSTIC CLINICS will be affected by two requirements recently made by the College's Committee on Cancer, under whose jurisdiction comes approval of these facilities.

Number one makes it mandatory that hospitals conducting cancer clinics and diagnostic clinics have as part of their program a cancer registry. Such a registry may of course be the only cancer activity conducted by the hospital, but when the hospital has a cancer clinic or diagnostic clinic, it must also maintain a cancer registry. A registry contains the record of every cancer patient, both private and public, inpatient and outpatient, admitted to the hospital. It includes an abstract of each patient's clinical record, and annual follow-up notes. At an annual meeting of staff members who have treated one or more cancer cases within the year, the treatment as set forth in the registry will be discussed. The Cancer Committee is now preparing a brochure on this registry.

This accreditation requirement for cancer clinics and diagnostic clinics will become effective December 31, 1955.

The other new requirement for these facilities is that, if they are not operating in an approved hospital, they must, to be approved, be operating with the explicit approval of the county medical society. Since inception of the College's cancer control program, approval of a clinic which is an integral part of the hospital has been contingent upon whether said hospital meets with the College's approval. The medical society prerequisite will assure adequate medical guidance of any clinic functioning as a separate entity outside of a hospital, or in a nonapproved hospital.

These recommendations made by the Cancer Committee on September 21, 1952, were approved by the Regents at their December 5 and 6, 1952, meeting.

As responsibility for use of radium and radioactive isotopes is often the cause of controversy, the Cancer Committee also went on record as recommending that whenever possible said responsibility be jointly shared by the department of radiology and the surgical service concerned. This recommendation was accepted by the Regents, preliminary to further elaboration.

Termination of the cancer detection center program as of August 31, 1953, is another outcome of the above meetings. Inspection of this third type of cancer control facility has conclusively demonstrated the impossibility of standardizing detection procedures, or even making them sufficiently uniform for rating. The final list will be published in the September-October BULLETIN.

The Cancer Committee and the Regents, however, wish it clearly understood that this action does not in any wise imply disapproval of existing detection centers or the principle of cancer case finding. The College urges the American Cancer Society, which financed this activity, and other agencies interested in cancer control to continue the exploration and evaluation of case-finding methods. A pioneer in cancer control, the College's interest in this work continues unabated, as demonstrated by its constantly increasing activity with clinics and diagnostic clinics.

Modification of the make-up of the Cancer Committee itself is another result of its 1952 meeting. Hereafter it will consist of not more than 25 voting members, all Fellows. The American Cancer Society, National Cancer Institute, American College of Radiology, American College of Physicians, and College of American Pathologists are being invited to appoint annually one official representative to serve as a nonvoting advisory member. The assistant director in charge of the College's Department of Professional Services and Accreditation is an ex officio, nonvoting member and holds the office of secretary. This is the responsibility of Dr. Walter E. Batchelder.

Absence without sufficient excuse from three consecutive annual meetings will automatically bring about the dismissal of a voting member.

To act in the interval between annual meetings an executive committee is to be appointed by the chairman, Dr. Edwin P. Lehman, Charlottesville, Virginia. Ex officio voting members are the chairman and vice chairman, and, nonvoting, the secretary. Dr. Danely P. Slaughter, Chicago, has accepted the vice chairmanship.

New members of the committee are as follows: C. Theron Clagett, Rochester, Minnesota, Charles Eckert, St. Louis, Karl H. Martzloff, Portland, Oregon, H. Mason Morfit, Denver, Harry S. Morton, Montreal, Harry M. Nelson, Detroit, and Paul H. T. Thorlakson, Winnipeg. Resignations of Drs. Charles F. Branch, Lewiston, Maine,

(*Continued on page 91*)

Cancer Facilities

(*Continued from page* 81)

and Emile Holman, San Francisco, were regretfully accepted. Complete roster of this committee can be found in the January-February BULLETIN.

Functions of this group are, in brief, preparing programs on cancer at College meetings; approval of clinics and standards therefor; advising the Regents in appointment of Fellows to represent the College in other organizations concerned with cancer; and keeping the College properly active in this field with regard to the public and other societies.

The Committee on Cancer has found the suggestions received from Fellows enlightening and productive and hopes that more will be forthcoming.

Trauma Committees

(*Continued from page* 74)

trauma and nutrition. This is the third annual Symposium on Care and Nutrition of the Seriously Injured Individual, which is to take place this year on the afternoon and evening of May 21 at Ann Arbor. Dr. Clifford H. Keene, of Willow Run, is chairman of the joint committee arranging this event.

Seeking to bring the attention of interns and residents to the above project, the sponsors have invited members of resident staffs of hospitals in Toledo, Windsor, and Michigan (exclusive of the University of Michigan Hospitals), to submit for review titles of projected fifteen-minute essays of some aspect of trauma or nutrition. Each essayist must be sponsored by a Fellow of the American College of Surgeons. Subjects and speakers for the symposium are now being selected from these. A scroll known as the "Frederick A. Coller Award" will be presented for the outstanding essay.

London, 1954

THE AMERICAN COLLEGE OF SURGEONS will hold a Sectional Meeting in London, England, May 10 through 12, 1954. The Fellows in Britain are making great preparations both for scientific sessions and for clinic trips all over the British Isles.

In addition, visits to the principal clinics on the Continent are to be arranged to follow the London meeting.

Since hotel accommodations in England are reserved as long as one year in advance, it is necessary for the College to make reservations prior to May 1, 1953.

In view of the fact that the College is now in the process of securing hotel accommodations in London for the period of this meeting, *each Fellow who has some intention of attending the session there is urged to so inform the College at once* in order that an estimate of the number of rooms to reserve may be made. Firm individual reservations will subsequently be confirmed to these Fellows.

This is a great opportunity, particularly for Fellows who served in Europe during World War II.

Medical Staff Meetings

(*Continued from page* 35)

objective of a medical staff meeting—evaluation of the care given patients in a particular hospital.

4. ATTENDANCE AT MEETINGS. Adequate and effective participation in the evaluation of patient care requires regular, conscientious attendance at meetings of the active medical staff, departments or committees. It is expected that members of the active medical staff shall attend at least 75 per cent of these official meetings, unless excused by the executive committee of the medical staff for such exceptional conditions as sickness, absence from the community, or because of medical emergencies.
5. The Commission's standard on attendance at staff meetings pertains to the active medical staff members. It is the decision of the local hospital staff whether the attendance of associate staff members is required.
6. Departmental meetings and clinicopathologic conferences, although highly desirable and recommended, are not required by the Commission. These are requirements of the American Medical Association's Council on Medical Education and Hospitals for intern and resident training programs.

Remember, the Commission's requirements for medical staff meetings are the minimum for quality patient care. Many hospital staffs exceed these requirements and for this they should be commended.

Chapter Rounds

FROM THE ARKANSAS CHAPTER of the American College of Surgeons comes word that it will hold an evening meeting on Sunday, March 11, preceding the Sectional Meeting in Little Rock. Dr. Truman G. Blocker, Jr., of Galveston, Texas, and Dr. H. Prather Saunders, Chicago, of the A.C.S. staff, will be the guest speakers. Dr. Roy I. Millard, Russellville, is president of this group.

The fourth annual clinical pilgrimage of the NEW JERSEY CHAPTER was made December 2 through 4 when members of this group were in Washington, D.C. for an evening session at the Armed Forces Institute of Pathology and a day of clinical programs at George Washington University School of Medicine. President of the N.J. group is Dr. Philip J. Kunderman, New Brunswick. Dr. James H. Spencer, Newton, is chairman of the Program Committee.

On the second day of its November 11 and 12, 1955, meeting in Jackson, the MISSISSIPPI CHAPTER reports that it had the privilege of visiting at the University of Mississippi School of Medicine where faculty members presented operative clinics,

Cancer Registry Is A.C.S. Requirement

MEDICAL INSTITUTIONS AND HOSPITALS seeking the American College of Surgeons' approval of their cancer programs must have a cancer registry. This is a requirement made by the College, not by the Joint Commission on Accreditation of Hospitals. In other words, there is no connection between this stipulation made by the College and what the Joint Commission requires of hospitals before they may be accredited as hospitals. On the part of many hospitals and surgeons there seems to be widespread misunderstanding in this connection, and Fellows are urged to clarify the point when it comes up in institutions where they work.

A cancer registry is now, it is true, a prerequisite to approval of a hospital's *cancer program* by the American College of Surgeons. Working with the assistance of grants from the National Cancer Institute and the American Cancer Society, the College is the only group responsible for approval of cancer programs in hospitals.

To be accredited as a *hospital per se* by the Joint Commission on Accreditation of Hospitals, an institution need only comply with the *Standards for Hospital Accreditation.* This publication says nothing about a cancer registry.

While a member of the Joint Commission and a party to its activities, the A.C.S. continues to carry on, and be totally responsible for, its own long-established program in the field of cancer. This work is accomplished under the aegis of the Committee on Cancer, of which Dr. Danely P. Slaughter, Chicago, is chairman.

The recently revised *Manual for Cancer Registries and Cancer Clinical Activities* sets forth the College's stipulations for such projects. It is available upon request from the Department of Professional Services and Accreditation headed by Dr. James B. Mason.

Goal of the Cancer Control Program

R. Lee Clark, M.D., F.A.C.S., Houston, Texas, and
James B. Mason, M.D., F.A.C.S., Chicago, Illinois

Implicit in an occasional comment addressed to the Department of Professional Services is the judgment that the function of the College's cancer control program is solely administrative. This implication reveals a misunderstanding of the orientation of the program. Therefore, this statement has been prepared to clarify for hospital committees on cancer the relationship of cancer registries, the reporting of end results, and other facets of the program.

The goal of the cancer control program is to improve medical management of the cancer patient. Since the cornerstone of this management is the initial contact between patient and physician, the program is focused on care at the community level. Each facet of the program is designed not only to contribute to the accomplishment of this mission but, in fact, to be an integral part of the whole.

Motivating—indeed, permeating—the Committee on Cancer's dual mission of establishing a standard for cancer programs and extending professional education is the philosophy that he who does not profit from the past is destined to repeat it. The cancer registry is a tool for measuring end results, and end results are past experience.

The purpose of computing end results, therefore, is to enable the professional staff by reviewing and analyzing its past experience to improve the care given the cancer patient within its own institution, and to compare end results with those obtained by different hospitals. As the hospital or medical institution requests the College to survey its individual cancer program, it participates voluntarily in the College's program, which is essentially one of self-evaluation.

Whereas each hospital is concerned with the absolute value of the survival rate, the College is concerned with the completeness of reporting that rate. The *Manual for Cancer Programs* states: "The *adequacy** of follow-up and the *quality** of survival rates will be given great weight by the Committee on Cancer [of the College] in determining the approval or disapproval of a cancer program." In applying these criteria, the College is prepared to assist cancer registries in achieving such competency of organization and operation that the information based on survival studies is valid.

Toward this aim, the College conducts cancer program workshops, educational forums designed to guide physicians, secretaries and others connected with a registry in solving problems of administration and operation. Based on the experience gained at six pilot workshops conducted from 1959 through 1962, future programs (see box) will be sponsored by the College assisted by the American Cancer Society and the U.S. Public Health Service.

Availability of statistics from cancer registries also gives a new and necessary dimension to the College's program of professional education. At present, analyses of problems generated by patient care are presented in individual papers, panel discussions and symposia at chapter and sectional meetings and at the Clinical Congress and diagnostic and clinical aspects of cancer are presented in motion pictures such as the specially produced Ciné Clinics; but, unless each hospital can precisely measure its past and current status in the field of cancer, these individual presentations are, as it were, out of context. The element of comparison is missing.

To reiterate, the goal of the Committee on Cancer, action arm of the College in this undertaking, is the improved care of the cancer patient at the community level. Both in the committee's approval program and in its professional education program, the registry and computation of end results are a necessity enabling each institution to answer for itself the questions "Improved over what?" and "How much improved?"

*Authors' italics.

Cancer Program Workshops

at

Sectional Meetings, A.C.S.
Charlotte, North Carolina
Wednesday, February 13, 1963
Pittsburgh, Pennsylvania
Wednesday, March 13, 1963

Dr. R. Lee Clark *is chairman of the American College of Surgeons' Committee on Cancer, and* **Dr. James B. Mason,** *assistant director, A.C.S., is administrator of Department of Professional Services.*

The Heritage of the Cancer Program

THE CANCER CONTROL PROGRAM of the American College of Surgeons has attained eminence in good measure from the rich heritage bequeathed it from achievements of two committees which labored between 1912 and 1934. Within this time frame, which includes two years of the life of the Clinical Congress of Surgeons of North America* and the first two decades of the life of the College, it is pertinent to cite several historic contributions which are milestones in this program.

The date November 15, 1912 is significant. On this day of the third Clinical Congress of Surgeons of North America a "Cancer Campaign Committee," ancestor of the present Committee on Cancer, was appointed. Headed by Dr. Thomas S. Cullen, of Baltimore, this committee quickly became a prominent instrument of its parent. It also served the College as its cancer committee until 1922, when the Board of Regents established the Committee on the Treatment of Malignant Diseases with Radium and X-ray, with Dr. Robert B. Greenough, Boston, as chairman. In 1929 this committee was redesignated the Committee on the Treatment of Malignant Diseases, and in 1939 the name was changed to the Committee on Cancer. Thus has the line of descent been established.

The prime mission of the Cancer Campaign Committee was education not only of the medical profession but—an innovation of parts—of the public. During the third Clinical Congress, on November 12, 1912, the first scientific meeting for education of the public was conducted by Dr. Cullen and many prominent physicians and laymen at the Academy of Music in Brooklyn. The following year at Orchestra Hall in Chicago the committee sponsored the first cancer symposium in the United States for surgeons; and to this day such a symposium is an important event at each Congress. The committee also took part in the first international cancer conference, conducted in 1927 at Lake Mohonk, New York, by the American Cancer Society.

Another innovation, brought about by Dr. Cullen (page 87) and others, was publication for the first time in a magazine read by laymen of an article on cancer. It was entitled "What Can We Do About Cancer?," by Samuel Hopkins Adams, and was published in the May 1913 *Ladies' Home Journal.*

Another contribution to cancer control was initiated on May 22, 1913, just 17 days following the founding† of the American College of Surgeons, when Dr. Cullen and members of his committee conferred with representatives of the American Gynecological Society and ten other professional organizations at the Harvard Club in New York. From their deliberations emerged the American Cancer Society's forebear, the American Society for the Control of Cancer.

In 1921 another important professional milestone in cancer control was reached when the Board of Regents authorized establishment of the Registry of Bone Sarcoma,[1] with Dr. Ernest Amory Codman, Boston, as chairman of the committee in charge. Over the years this registry, which by 1939 contained the records of more than 2,200 cases, made noteworthy contributions to the knowledge of bone sarcoma, providing a unique source for research and teaching material.

The registry was in 1953 transferred to the Armed Forces Institute of Pathology in Washington.

Another milestone was reached in 1927 when the American Cancer Society appointed Dr. Greenough, and Drs. James Ewing and John C. A. Gerster, of New York, "to report on the best methods of improving the service to the cancer patient." On their findings, entitled "The Medical Service Available for Cancer Patients in the United States—Suggestions for Its Improvement,"[2] is based the College's present program for survey and approval of cancer facilities, for one of their recommendations was that cancer clinics be organized in general hospitals.

Accepting the American Cancer Society's invitation in 1929 to make "present-day knowledge of cancer immediately available to the patient in the

*Clinical Congress of Surgeons of North America was sponsored by *Surgery, Gynecology and Obstetrics* until 1917, when it became the Clinical Congress of the American College of Surgeons.

†May 5, 1913, in Washington, D.C.

Second in Series

IN COMMEMORATION of its 50th anniversary, a project of major importance initiated by the American College of Surgeons since it was founded in 1913 is being described in each BULLETIN; and the accompanying article on the cancer program is the second. It was written by Dr. James B. Mason, assistant director, A.C.S.

most effective way through the supervision of the organization and administration of cancer clinics in approved hospitals throughout the continent," the College in 1931 laid down the rules in its statement entitled "Organization of Service for the Diagnosis and Treatment of Cancer—A Minimum Standard."[3]

The success of the cancer program can be attributed in large measure to the late Bowman C. Crowell, the pathologist, who as director of clinical research and registrar of bone sarcoma directed the project from its inception until he retired in 1949.

Survey of programs began in 1931 and the first list of "cancer clinics approved" was published in 1933,[4] when they numbered 140. Today, 30 years later, 937 programs[5] are approved, and the requirements are higher and more stringent.

As the College progresses into its second 50 years and the thirty-second year of the cancer control program, it takes genuine pride in this continuing and growing contribution under the direction of the Committee on Cancer.

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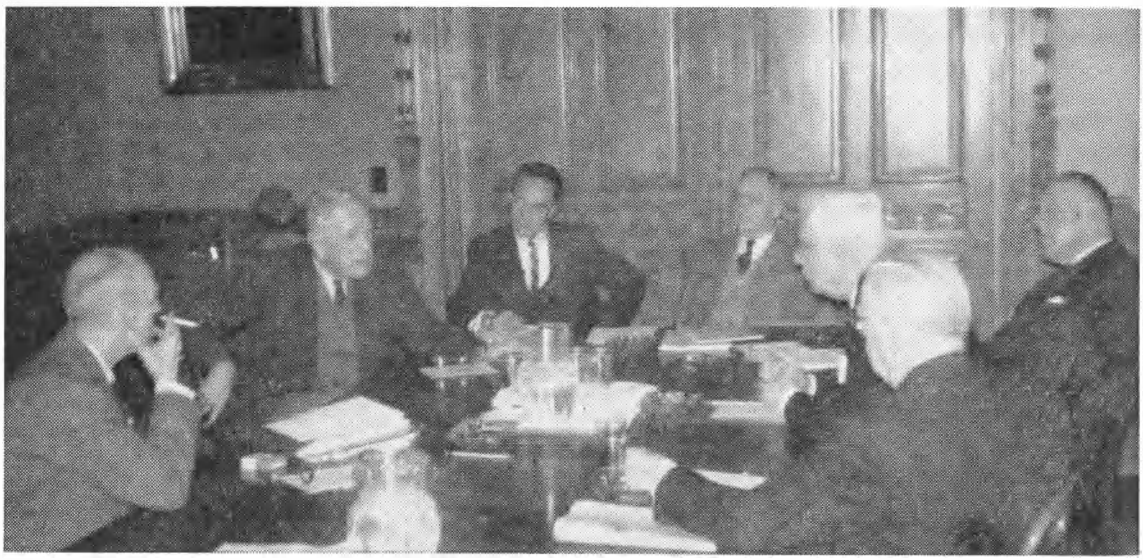
Director and Cancer Program Staff Members Confer



SURGICAL STAFF PROBLEMS encountered by the College's staff as its members survey cancer programs are the object of attention here from Director John Paul North (*second from left*) and staff members. They are (*left-right*) Dr. Carl Bachman, Rutherford, California; Mr. Willard W. Webber and Dr. James B. Mason, Chicago; Drs. Norris J. Kirk, Lancaster, Pennsylvania, Harold R. Hennessy, Park Ridge, Illinois, and (*back to Photographer Fred Bosselman*) James W. Nelson, Towson, Maryland. Dr. Mason administers the cancer program (page 85), assisted by Mr. Webber.

In 1962 Drs. Nelson, Hennessy, Kirk and Bachman made 635 surveys, which included certain hospitals assigned to the A.C.S. as a member of the Joint Commission on Accreditation of Hospitals.

A program which wishes to be approved requests a survey from the College. Approved facilities are re-surveyed every three years.

A cancer program is not a requirement for accreditation of a hospital by the Joint Commission, Dr. Mason points out.

100 years
Commission on Cancer | 1922–2022

The 1970s and 1980s

The Commission on Cancer

An historical review

by George W. Stephenson, MD, FACS, ACS Consultant, *Chicago*

The American Gynecological Society held a symposium on "Cancer of the Uterus" in Baltimore on May 30, 1912. One result of the meeting was the apointment of a committee to consider the best means of educating women to create an effective weapon against that disease.

In the summer of 1912, Dr. Thomas S. Cullen of Baltimore wrote to Dr. Franklin H. Martin, saying that he had analyzed his case records of patients with cancer of the cervix and found only 37 percent showed "five-year cures." He concluded that methods of treatment could not be bettered, but that widespread public education was the only hope for improvement. Dr. Martin invited him to present a paper at the 4th Clinical Congress of Surgeons of North America in November in New York City.

On the evening of November 14, 1912, at a session in Brooklyn attended by surgeons and the public, Dr. Cullen was a featured speaker on cancer of the uterus. Members of the Clinical Congress who attended the session voted to establish a "cancer campaign committee" with Dr. Cullen as chairman. The next day, the Congress ratified the action and charged the committee to consider methods of educating the public against cancer.

At that 1912 Clinical Congress, Dr. Martin proposed a plan for the "standardization of surgeons," which led directly to the formation of the American College of Surgeons in 1913. At the same 1912 meeting, Dr. Ernest A. Codman of Boston proposed "standardization of hospitals," a concept that developed into a functioning program in 1918. Thus, the College and two of its major accomplishments originated without prearrangement at the same meeting, a portentious week for medicine in this country and throughout the world.

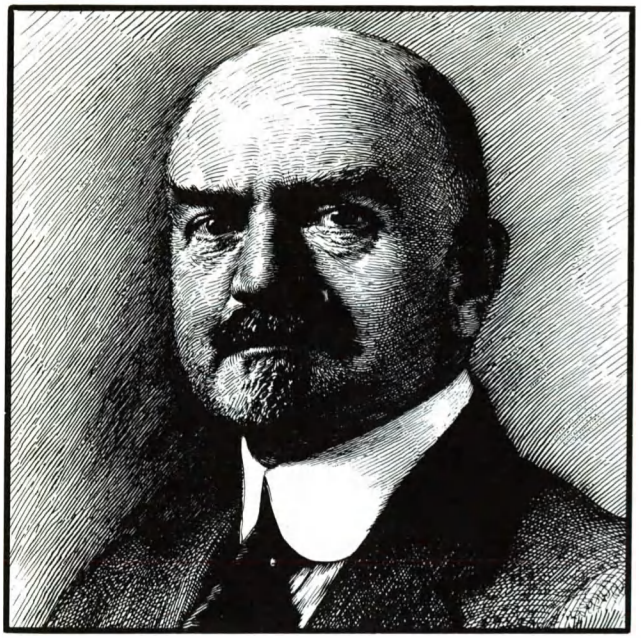
First articles

Dr. Cullen proposed that he himself write an article on cancer for the *Ladies Home Journal,* but the publisher and editor felt that a lay writer would be better and agreed upon Mr. Samuel Hopkins Adams who was "pumped full of the subject" by Cullen, Dr. Joseph C. Bloodgood, Dr. William H. Welch, Dr. John B. Murphy, the Mayo brothers, and others. Adams wrote "What Can We Do About Cancer?" which appeared in the magazine on May 22, 1913. Variations appeared in *Collier's Weekly* and *McClure's Magazine.*

Adams' thesis was that the origins of cancer were poorly understood except for the danger of persistent irritation of any body tissue, and that the most concerned and experienced members of the profession were convinced that early detection and surgical treatment were necessary to improve the chances of afflicted patients. The article emphasized that cancer is curable but that early detection is necessary. Over 11 million people read these first articles on cancer to appear in the public press.

On the same day that Adams' article appeared in the *Ladies Home Journal,* May 22, 1913, representatives of ten major medical societies met at the Harvard Club in New York, at the invitation of the American Gynecological Society.* The representatives

**The societies represented were: American Medical Association, American Surgical Association, Clinical Congress of Surgeons of North America, Western Surgical Association, Southern Surgical and Gynecological Society, and American Gynecological Society.*



Dr. Cullen

at that meeting organized the American Society for the Control of Cancer. From that first day, there has been close and effective collaboration between the College and what became the American Cancer Society in 1945.

In 1931 and again in 1945, the directors of the Society and the Regents of the College met to discuss mutual activities and future collaboration. They agreed that the Society would work to educate the public, while the College would work in the area of clinical care and professional education. That working relationship continues today.

No sooner had the Cancer Campaign Committee begun to function than the activities of the Clinical Congress and of the College were curtailed by World War I. In 1917, the College absorbed the Congress and coordinated its activities. At that time, the executive committee of the American Society for the Control of Cancer included College representatives who were members of Dr. Cullen's committee.

It is not possible in the space assigned, to do full justice to the campaign against cancer and the Fellows of the College who have accomplished so much. However, we shall summarize the major activities.

Bone Sarcoma Registry

In August, 1920, Dr. Ernest Codman sent a letter to every FACS, seeking information on living cases of bone sarcoma. This broadcast request was unique, and conceived because the disease was so uncommon that few physicians had ever seen it. The Board of Regents appointed Dr. Codman chairman of a committee to establish a Bone Sarcoma Registry in 1921. Dr. Joseph C. Bloodgood and Dr. James Ewing were members of that committee.

Two years later, the committee reported reasonably accurate diagnosis of osteogenic sarcoma in 90 patients, leading to a generously extrapolated conclusion that there were 500 cases of bone sarcoma in the United States. A major finding in the report was the irrational differences in nomenclature, and the committee proposed a joint effort by the American Society of Clinical Pathologists and the College to develop a classification and nomenclature to be used by all Fellows and approved hospitals.

The collection of case records with gross and microscopic tissue specimens continued for years. (It became a function of the College staff after 1925.) The material was available for teaching purposes in Chicago and elsewhere. Based on the collection, Dr. Anatole Kolodny of Iowa City produced the April 1927 issue of *Surgery, Gynecology and Obstetrics* under the title, "Bone Sarcoma: The Primary Malignant Tumors of Bone and the Giant-Cell Tumor."

Dormant during the years of World War II, the collection was refurbished and presented to the Armed Forces Institute of Pathology on permanent loan in 1953.

Dr. Codman

Early Committee on Cancer

Collateral to Dr. Cullen's committee, the Board of Regents appointed a committee on "The Treatment of Malignant Diseases with Radium and X-Ray," with Dr. Robert B. Greenough as chairman.* Its first effort was to accumulate case records of patients with cancer of the cervix of the uterus who could be considered "cured" three years after treatment. The cases were to be analyzed by type of treatment. The report, issued in 1924, concluded that for women treated in early stages of the disease, surgery and radiation therapy were equally effective, but when treated in advanced stages, palliation and duration of life were improved by radiation therapy.

The following year, Dr. Greenough reported that forms had been developed for similar studies of cancer of the breast and of the mouth and tongue. Soon after, forms relating to the colon and the thyroid gland were added.

In 1930, the name of Dr. Greenough's committee was shortened to "The Committee on the Treatment of Malignant Disease," then changed again in 1939 to the "Committee on Cancer."

The newly developed radio frequency cautery became available in 1930, and the Grigsby-Grunow Company placed 200 sets with Fellows of the College for clinical trial, particularly for cancer cases. At the Clinical Congress that year, during a Conference on Electro-Surgery, Dr. Bowman Crowell reported that 196 surgeons had used the sets in 913 operations, using local, spinal, and gaseous anesthetics. When they compared electrosurgery to the cold knife, they observed less postoperative pain and fewer wound abscesses, shorter operating time, and better hemostasis, but longer skin-healing time, muscle contraction, and an ever-present danger of fire or explosion. The manufacturer used the results in subsequent development of the apparatus.

Cancer clinic standards

Standards for cancer clinics entitled "Organization of Service for the Diagnosis and Treatment of Cancer" were developed in 1930 at the request of the American Society for the Control of Cancer. They were published in the *Bulletin,* and the first surveys were done in 1931 by Dr. Earl W. Williamson, a member of the College's field staff in the Hospital Standardization Program.

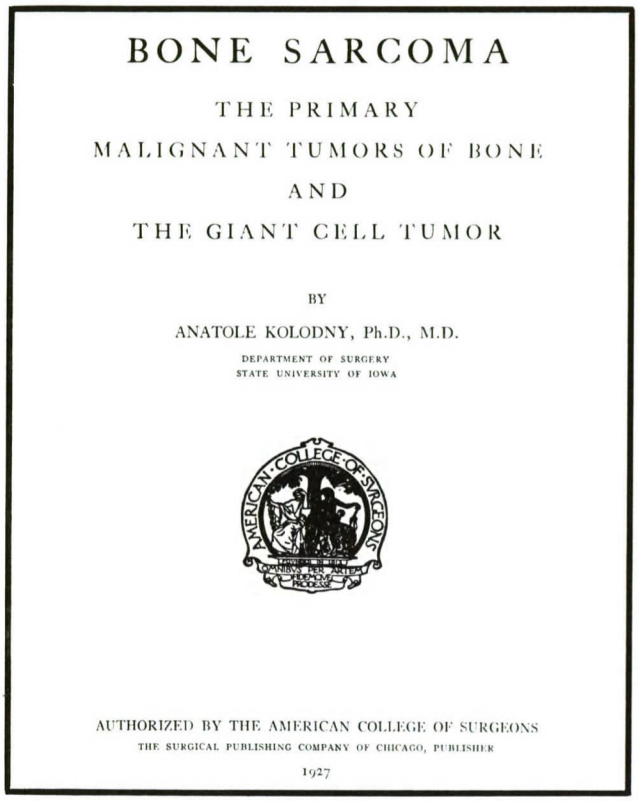
Dr. Crowell

The 1937 report of field activities showed 240 clinics approved; about half were "complete," while 15 percent were "diagnostic" only. About 78,000 patients were seen in approved clinics in 1939.

The first revision and expansion of the 1931 "Minimum Standards" appeared as a "Manual for Cancer Programs" in 1954, containing a section on a method for reporting end results. Two years later, a revision included the demand that each approved cancer program must have a registry and that the records in the registry should show the condition of each patient on admission, the diagnosis authenticated by tissue examination, the treatment given, and the end results.

Evaluation of the quality of care was first suggested as a requirement for approval in 1960, and went into effect in 1973 through a change in emphasis. A report in the April 1979 *Bulletin* lists 797 approved programs, evidence of the effective efforts of the staff and the Approvals Committee, which Dr. Robert J. McKenna now chairs.

**The other members were: Dr. Curtis Burnham, a specialist in radium therapy; Dr. George Crile; Dr. John M. T. Finney; William Duane, PhD; Dr. Henry Pancoast, a specialist in x-ray therapy; and Dr. C. Francis Wood, a pathologist.*


BONE SARCOMA

THE PRIMARY
MALIGNANT TUMORS OF BONE
AND
THE GIANT CELL TUMOR

BY

ANATOLE KOLODNY, Ph.D., M.D.

DEPARTMENT OF SURGERY
STATE UNIVERSITY OF IOWA

AUTHORIZED BY THE AMERICAN COLLEGE OF SURGEONS
THE SURGICAL PUBLISHING COMPANY OF CHICAGO, PUBLISHER
1927

From a collection of case records with gross and microscopic tissue specimens, ***Dr. Anatole Kolodney*** *wrote the entire April 1927 issue of Surgery, Gynecology and Obstetrics under the title above. The collection was available for teaching purposes in Chicago and elsewhere.*

Starting in 1947, on a grant from the American Cancer Society, efforts were made to develop standards for Cancer Detection Centers, which would be subject to inspection and approval. With additional staff, this project continued until 1953, when there was general agreement that valid evaluation and rating of such facilities were not feasible. The last listing of approved Cancer Detection Centers appeared in October of that year.

The report forms developed by Dr. Greenough's Committee on the Treatment of Malignant Disease related to cancer of the cervix at first, then were expanded to include informaiton on the breast, uterine fundus, ovary, thyroid, colon, rectum, lung, esophagus, larynx, mouth, prostate, kidney, bladder, testicle, and bone. They were designed to be reviewed by the committee and for possible use as part of a patient's hospital records.

The analysis of the submitted reports was done by Dr. Bowman Crowell, who annually reported the results at the Symposium on the Curability of Cancer at the Clinical Congress, for the first time in 1932. By 1936, he could report records on more than 24,000 cases of five-year "cures," and by 1948 the number had reached almost 44,000.

A brochure entitled "Cancer is Curable" containing the proceedings of the 1948 symposium, was published in 1950 and distributed widely. The Regents decided not to solicit any more reports, and the United States Public Health Service acquired the records. The conclusions were viewed as evidence of the effectiveness of educating the public and the profession about this disease.

End-results reporting

Active concern with end-results reporting in the treatment of cancer patients started in 1947, when a subcommittee was appointed with Dr. Ernest Daland as chairman. The subcommittee developed forms approved by the Regents, who also approved a joint committee to include representatives of the College of American Pathologists, the American College of Radiology, the American Cancer Society, and this College. The Committee's function was to insure agreement before collecting data.

As a product of the collaborative effort, an article appeared in the July-August 1953 *Bulletin* entitled "A Standardized Method for Reporting Cancer End Results." The article stressed that no standard criteria existed for reports on cancer because there had been no uniformity in the selection of cases for analysis, no proof of diagnosis, no adequate follow-up, and no distinction made between "cure" and "survival." Included in the article were forms designed to permit standardization of reports.

The following year, Dr. Murray Copeland was appointed by the Regents to represent the College as a member of the Committee on Clinical Stage Classification and Applied Statistics of the International Union against Cancer. One outgrowth of this collaboration was the organization of the American Joint Committee for Cancer Staging and End Results Reporting.*

Grass-roots activity

Believing that greater activity at the grass roots was desirable, Chairman Danely Slaughter proposed in 1947 that the country

*See article by Dr. Murray Copeland in this issue, page 22.

"Education of the profession as to the curability of cancer with early, prompt, and adequate treatment has been a major concern of the Commission on Cancer from its inception."

be divided into geographical areas, with a member of the committee responsible for each. That member was then to appoint a chairman for each state (or large locality) and the chairmen were to select members of their local committees to serve as official representatives of the Committee and to assist local cancer clinics with their programs.

This concept was implemented slowly because few FACS were able or willing to give the necessary time to make it effective. It was modified in 1960 by the appointment of at least one Liaison Fellow in each state and province who was to relate to all cancer control activities in his area. A Subcommittee on Regionalization, under Dr. Ashbel Williams, reported some 49 participants and an obvious need for the program.

Recognizing that cancer requires a multidisciplinary approach to both diagnosis and treatment, the Regents voted a change, effected in October 1965, by which other organizations joined the College as members of the Commission on Cancer. At present, the other organizations are: the American Academy of Family Physicans; the American Academy of Pediatrics; the American Association for Cancer Education, Inc.; the American Association of Cancer Institutes; the American College of Physicians; the American College of Obstetricians and Gynecologists; the American College of Radiology; the American Cancer Society; the American Medical Association; the Association of Community Cancer Centers; the College of American Pathologists; the Health Resources Administration; the National Cancer Institute; the National Tumor Registrars Association; the Society of Surgical Oncology; and the Veterans Administration.

Nineteen Liaison Members join 40 Active and 23 Senior Fellows to constitute the Commission.

There are four operational committees: Education; Patient Care and Research; Approvals; and Field Liaison.

In the ensuing years, the Commission held meetings and conferences for Liaison Fellows, and developed a Cancer Program Manual in 1966. In 1974, to be consonant with the American Cancer Society, the Commission divided the United States into four areas and appointed a Liaison Fellow as chairman for each area.

Liaison Associates, who represent other organizations that constitute the Commission, have been appointed along with Liaison Fellows in some communities. A concise explanation of the Field Liaison Program appeared in the April 1979 *Bulletin* (p. 22). It was written by Dr. Ronald C. Jones, the current chairman of the Committee on Field Liaison.

Educational efforts

Education of the profession as to the curability of cancer with early, prompt, and adequate treatment has been a major concern of the Committee (now Commission) on Cancer from its inception. It has always had responsibility for the Symposium on Cancer at each Clinical Congress and for programs at sectional and spring meetings. Since 1959, this facet has been a charge of the Committee on Education, which also has supervised postgraduate courses at the Clinical Congress, usually with standing room only.

The Committee on Education has participated in the preparation of Cancer Comission exhibits for the Clinical Congress and other medical meetings. It supervised preparation of two films, "The Hospital Cancer Program" and "The Cancer Registry, Its Organization and Operation," both used enthusiastically at the local level. Dr. Stuart H. Q. Quan is the current chairman.

Other publications by the Commission on Cancer that are in frequent demand are: the Cancer Program Manual; the Cancer Registry Manual; the Guidelines for Follow-up of the Patient with Cancer; Cancer Program Survey Report Forms; and material on Survival and End-Results Reporting. Over the years, members of the Commission and the staff have written articles for the *Bulletin* and other publications.

Guidelines for cancer care

A project that involved committee members and staff arose from legislation in 1965 (P.L. 89-239), which followed recommenda-

"Over the years, the College has been well served by the succession of members of the Commission (nee Committee) and notably by the chairmen."

tions of the President's Commission on Heart Disease, Cancer and Stroke. The law required the Surgeon General to establish and maintain "a list of facilities" equipped and staffed to provide the most advanced care of patients suffering from those three diseases (kidney disease was added later). The Regional Medical Programs Service negotiated a contract with the College to establish standards, and the Commission on Cancer recommended an ad hoc committee on Guidelines for Cancer Care. Dr. Warren H. Cole, former president of the College and of the American Cancer Society, was asked to be the project director.

After three years of multiple meetings with panels of experts and after site testing tentative criteria at an expense of $250,000, a 208-page volume was produced in 1970. However, governmental philosophy and responsibility had shifted, and acceptance was refused. The Regents then authorized a printing of 25,000 with major distribution to all accredited hospitals. It was not reissued.

The Joint Commission on Accreditation of Hospitals accepted a Regional Medical Programs Service contract to develop the list required by P.L. 89-239, and gave the College a subcontract for the cancer area. Questionnaires completed by most of the 7,300 accredited hospitals supplied material published in 1972 under the title "Hospital Services for Selected Chronic Disease Patients —Cancer," one of seven volumes covering the whole project. However, money was not available for the inspections and evaluations that would have made the lists valid, and the project was scrapped.

The National Cancer Act of 1971 provided funds to establish comprehensive cancer centers and community cancer centers designed to provide treatment within their capabilities and to make referrals along the line when appropriate. Liaison Fellows are potential assistants in expanding this plan.

Hospital categories

In 1972 an ad hoc committee of the Commission on Cancer recommended that approved cancer programs be categorized. All must meet two basic criteria: accrediation by the Joint Commission on Accrediation of Hospitals; and establishment of a multidisciplinary cancer committee responsible for a functioning cancer registry, educational cancer conferences, consultation services, and a system of quality-care evaluation. A hospital with an approved cancer program in Category I must also have full facilities and personnel within the institution, 300 or more cancer patients annually, residencies in related specialties, and ongoing research in cancer. Category II hospitals need not do research in cancer, may refer some types of cancer patients elsewhere, and may treat less than 300 cases per year. Category S contains hospitals for specific types of cancer or specfiic age groups of patients, and specialty hospitals (ENT, Orthopedic). The Cancer Commission finalized the categorization of approved hospitals in 1974. The system continues today.

The committee on Patient Care and Research, now chaired by Dr. Robert L. Schmitz, produced a manual in 1976 entitled "The Patient with Cancer: Guidelines for Follow-up." Its loose-leaf form allows for revisions as later information appears about the search for recurrence or a second cancer.

With the help of Liaison Fellows, the committee has collected and studied patient records to determine the relation between liver tumors and the use of contraceptives. A second study was on five-year end results among 20,000 patients with carcinoma of the colon. The committee has also completed similar research on cancer of the breast, and is studying other sites as well.

Volunteer effort

Over the years, the College has been well served by the succession of members of the Commission (nee Committee) and notably by the chairmen. Starting with Dr. Thomas S. Cullen, the chairmen have been: Dr. Robert B. Greenough, Dr. Burton S. Lee, Dr. Charles H. Dukes, Dr. Frank E. Adair, Dr. Grantley W. Taylor, Dr. Edwin P. Lehman, Dr. Danely P. Slaughter, Dr. R. Lee Clark, Dr. Murray M. Copeland, Dr. John W. Cline, Dr. Benjamin F. Byrd, Jr., and Dr. Harvey W. Baker.

It is not possible to list here even the chairmen of the state and local committees, let alone their hundreds of members. However, it is obvious that the success of the campaign against cancer depends, in large part, on the support of all the Fellowship through countless man-hours of volunteer effort.

"The success of the campaign against cancer depends, in large part, on the support of all the Fellowship through countless man-hours of volunteer effort."

Similarly, the staff members who have handled administrative details, and particularly those who have been visiting facilities in the field are noteworthy for their devotion and effectiveness. The Assistant Directors of the College who have served as secretaries to the Commission are: Dr. Bowman C. Crowell, Dr. Charles F. Branch, Dr. Walter Batchelder, Dr. Robert S. Myers, Dr. James B. Mason, Dr. Owen McDonald, Dr. Andrew Mayer, and Dr. Charles R. Smart.

Former members of the field staff, many of them Fellows of the College, are: Drs. Carl Bachman, Walter Batchelder, Thomas H. Bate, Harold M. F. Behneman, Marc W. Bodine, Jacob F. Heinrich, Harold R. Hennessy, Charles F. Hill, Hall G. Holder, Harold A. Kazmann, Norris J. Kirk, C. Stanley Larson, John Lawler, Eugene G. Miller, James W. Nelson, John H. Schaefer, Herbert H. Schoenfeld, Irwin Schulz, William H. Snyder, Joseph A. Weinberg, and G. Russell Wright.

The current field staff members are: Dr. Walter W. Fischer, Dr. Harry G. Hardt, Dr. Christopher Southwick, Dr. Donald E. Stewart, Mary P. Christie, Rosemarie E. Clive, Marjorie S. Krennerich, and Willard W. Webber.

Originally financed completely by the College, the cancer program received a financial boost in 1938 by a grant from the National Cancer Institute for $6,000. Governmental support has continued, and the American Cancer Society has been granting funds since 1947. The amounts of the grants have increased as the programs have grown and costs have increased. In 1978, the total budget for the Cancer Department was $584,-387 of which $179,930 was from the NCI and $160,867 from the American Cancer Society. In addition, the autonomous American Joint Committee received $81,127 from the NCI and $41,303 from the American Cancer Society.

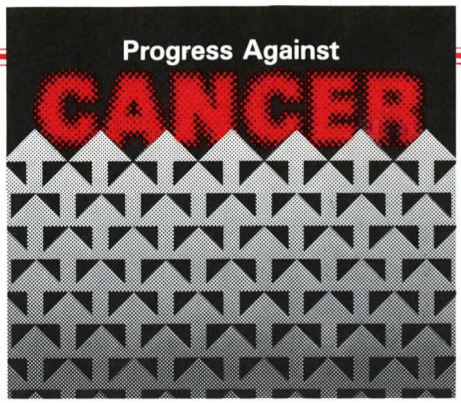
Accomplishments

When the campaign against cancer started, the disease was considered a dread disgrace, usually revealed only when advanced, and hopeless even when treated by surgery or an escharotic salve. The College and the American Cancer Society, with governmental support, have been largely responsible for changing the picture remarkably. Cancers of the breasts in the wives of two public figures have been fully reported in newspapers, magazines, and on television. Self-examination is taught on prime time. The profession is searching for almost microscopic tumors, employing mammography, thermography, and ultrasound, and making one-cell diagnoses.

"Bringing the best and latest knowledge of all aspects of the fight to the profession is the College's contribution."

Treatment is multidisciplinary, employing surgery, radiation, and chemotherapy. Research is active in the fields of genetics, virology, and immunology with respect to cancer.

Bringing the best and latest knowledge of all aspects of the fight to the profession is the College's contribution. It will be the major part of the activities of the Commission on Cancer until that day when the cause of cancer has been found and a really effective method of cure has been established.



The College's Commission on Cancer: Evolving to meet the needs of the times

by Walter Lawrence, Jr., MD, FACS, Richmond, VA
Chairman of the Commission on Cancer
of the American College of Surgeons

Any worthwhile program cannot remain static but must continually be modified to meet its established goals and needs. This is certainly true of the Cancer Program of the College's Commission on Cancer. For some surgeons involved in cancer care, the most important recent change in the program might be the influx of nonsurgical disciplines into the approvals process; while for others, the most significant change might be the refinement and expansion of the minimum guidelines for approved hospital cancer programs that are described in the recently revised *Cancer Program Manual*. The Commission on Cancer is evolving to meet the needs of the times, and all of us involved in the Commission are proud of the progress being made.

The expansion of the Cancer Program has been stimulated by a host of new ideas designed specifically to improve cancer patient care. The enthusiasm and increased activity of the Field Liaison representatives have been the prime reasons for the marked increase in both the number and the quality of cancer programs approved by the Commission. We are proud of the fact that more than 940 hospital cancer programs in the United States and Puerto Rico have been approved (Table 1). These programs treat more than 60 percent of all cancer patients in the nation (Table 2).

TABLE I

Cancer Programs Approved by the Commission on Cancer of the American College of Surgeons

Year	Total Surveyed	Initial Programs	3yr	Provisional	Non-Approved	Dis-continued	Total Approved	Net Gain (or Loss)
1973	338	19	200	108	30	28	771	(39)
1974	269	29	186	59	24	7	767	(2)
1975	316	37	194	86	36	9	752	(8)
1976	296	46	180	62	54	17	729	(25)
1977	313	78	223	57	33	15	745	30
1978	314	67	244	59	11	11	797	45
1979	312	73	251	43	18	8	840	49
1980	358	102	301	51	6	10	925	86
1981	144	29	111	29	4	4	943	21

Chairman of the Commission on Cancer of the American College of Surgeons, ***Dr. Lawrence*** *is professor of surgery in the division of surgical oncology and director of the cancer center at the Medical College of Virginia in Richmond.*

The specific responsibilities of the Commission's Committee on Education have expanded to allow more effective dissemination and analysis of the information gained through the Patient-Care Evaluation Studies conducted by the Committee on Patient Care and Research. Both the research and educational value of these studies have become quite apparent, as shown in the study on cancer of the prostate, reported in this issue by Drs. Murphy and Schmitz (see page 17). Refinement of the data collected on cancer patients and expanded use of our unique data base are being accomplished through innovative methods and computer programs, as described in this issue by Mrs. Rosemarie E. Clive and Dr. Brent James (page 14). Dr. Charles R. Smart's report on the progress against cancer from a review of 500,000 cancer patients is an excellent example of the productive use of data (page 5).

Rising Costs

While the Cancer Program has expanded, our financial status has not kept up with either our enthusiastic growth or increasing inflation. We continue to receive generous funding for this program from both the American Cancer Society and the National Cancer Institute, as well as the continued support of the College. Nevertheless, the costs of our enthusiasm have been racing ahead of our finances, and a critical assessment was needed.

The Executive Committee and the Committee On Approvals of the Commission on Cancer made a demanding assessment of the problem. From this appraisal of our entire program and procedures, we learned that:

- Our consultant staff activities often overlapped or duplicated the actions of other competent groups, such as some local divisions of the American Cancer Society or various central tumor registries.
- Deployment of consultants and surveyors from a central point on a national basis required long-range planning, and when cancellations by one or more hospitals occurred, time and money were wasted.
- Our form of staffing for consultant and surveyor visits often resulted in untimely delays in response to individual hospitals.
- Air fares and other travel costs increased considerably within the past year or two, and further increases in the near future are likely.
- Our funding needs for the entire program were certain to increase in the immediate future.

TABLE II

The Potential of Hospital Cancer Programs on Cancer Management in the U.S.

American Cancer Society *Facts and Figures* 1981 — estimates	815,000	new cases
New cases admitted to approved hospitals annually	492,920	(61%)
Total acute medical surgical hospital beds in U.S.	1,107,084	beds
Total number of beds in approved hospitals	359,543	(32%)
Total cases registered in approved cancer programs	5,748,397	cases
Known dead	3,715,679	(65%)
Known alive	1,856,447	(32%)
Lost to follow-up	176,241	(3%)

Solutions

We concluded that our goals could still be accomplished if we were willing to streamline operations and make some drastic changes in our procedures. This led to the concept of regionalization of the consultant and survey process.

"Our goals could still be accomplished if we were willing to streamline operations and make drastic changes in our procedures."

"Regionalization" simply means hiring motivated, qualified individuals who are acquainted with their area's needs relative to cancer programs. The Commission On Cancer of the American College of Surgeons can and will employ knowledgeable local consultants to develop cancer programs for their area. Many individuals throughout the country have adequate experience and proven ability in the management of cancer programs. They have strong backgrounds in both tumor-registry activities and the approval process, as well as the ability to instruct others in the various aspects of managing hospital cancer programs.

The survey process is being regionalized in a similar fashion with the use of physicians from all of the disciplines involved in cancer patient care who have had close association with the Commission On Cancer and have both the interest and the motivation to assist the Committee on Approvals in this important process. Fee-for-service contractual arrangements at the local level will lead to considerable reductions in costs for personnel and travel. We are convinced that this alteration in the consultant and survey process can be accomplished without loss of quality and will assist us in our critical need for cost containment. Careful planning will minimize the inevitable disruptions that these changes will cause.

This modification of the cancer program requires a sustained effort to maintain consistency in measuring the performance of the hospital cancer programs against the standards for approval. However, regionalization offers more service to hospitals, permits cross-fertilization of ideas, and involves interested and qualified professionals on a multidisciplinary level in the consultation and survey processes.

The Executive Committee has instituted other changes to improve efficacy, economy, and efficiency of the consultation and approval mechanisms, including: a decrease in the number of meetings of the Executive and Approvals committees to two each year, a corresponding decrease in travel expenses for these meetings, and a more rapid method of notifying hospitals of their approval status through automatic approval, if there are no reservations on the part of the reviewers from both the staff and the Committee on Approvals after survey.

Hospital fee

For more than 17 years, the Commission On Cancer has been able to provide these services to hospitals without cost to the institution. Although the Commission feels that it is necessary to continue to provide consultations, newsletters, comparative statistical reports, the processing of hospital data for national audits, and faculty and materials for workshops without cost, the Executive Committee thinks it appropriate to ask hospitals that benefit from this program to partially support it. Accordingly, hospitals have recently been assessed a fee for surveys conducted after July 1, 1981. The fee of $500 for each survey of a hospital cancer program or for a multiple or joint hospital program will provide further assistance to the Commission in its effort to maintain the standards of excellence developed over the past 17 years.

"The Executive Committee thinks it appropriate to ask hospitals that benefit from this program to partially support it."

I have attempted to describe our efforts at solving some of the recent housekeeping problems of the Commission on Cancer and our attempts to expand both the number and the quality of hospital cancer programs in our nation. I hope it will give you a better understanding of the reorganization that has taken place and the confidence that progress will continue to be made in cancer patient care in our nation's hospitals.

COLLEGE NEWS

What is the Commission on Cancer?

by Richard E. Wilson, MD, FACS, Boston

Chairman of the Commission on Cancer of the American College of Surgeons

The Commission on Cancer of the American College of Surgeons has as its primary objective improving the quality of care for patients with cancer. The Commission is organized into four subcommittees: the Committee on Approvals (chaired by Dr. Irving Fleming), the Committee on Education (chaired by Dr. Charles Balch), the Committee on Patient Care (chaired by Dr. William Donegan) and the Committee on Field Liaison (chaired by Dr. Ronald Jones). The Executive Committee of the Commission is chaired by Dr. Robert Schmitz and consists of the subcommittee chairmen, Dr. Charles Smart, and the Chairman of the Commission.

Each of these subcommittees has specific responsibilities, but the responsibilities are integrated to improve the efficiency of the program. The Commission on Cancer, which has broad representation not only from surgery but from all of the medical disciplines involved in the care of cancer patients, is a dynamic organization; each subcommittee is constantly evaluating its activities and seeking to modernize and streamline its functions.

The Committee on Approvals is responsible for reviewing and approving cancer programs in hospitals that request a survey on a voluntary basis. This committee now has representation from the fields of medical oncology, radiotherapy, and diagnostic radiology, and from community oncology programs, cancer centers, and the National Cancer Institute. Members of the committee have initiated a new system of survey and consultation that involves regional rather than central personnel. New surveyors in each area of the country have been trained at special workshops organized by the Commission. In the past year, 260 surveys were carried out by 49 surveyors, while there were 248 consult visits by 65 consultants. There are a total of 976 Commission-approved programs in hospitals that last year cared for 513,296 newly diagnosed cancer patients out of an estimated total of 805,000 new patients with cancer in the United States in 1981. Thus, more than 60 percent of cancer patients in this country are treated in hospitals with Commission-approved cancer programs. Because there is a charge for surveys, the program is now financially self-sufficient.

There has been a major shift in emphasis on what features constitute an approved hospital. The responsibility for the program in any given hospital lies with the cancer committee of that hospital. Organizing that committee is the major task of the surveyors. The committee is then responsible for the quality of patient care within the hospital, staff education, the cancer registry, and patient follow-up. Computerized data management and collaborative efforts among hospitals are encouraged to magnify the effectiveness of the cancer programs and to improve their efficiency.

Dr. Smart and his colleagues have pioneered the development of a computer software program named CanSur. Such software is the costliest portion of any computerized data-management system. The American College of Surgeons, through grants from the National Cancer Institute and the American Cancer Society, makes this CanSur software package available at no cost to hospital cancer programs. The software is compatible with large IBM computers, the Data General minicomputer, and several microcomputers. This program is now functioning in nine individual hospitals and in 39 centers serving over 100 hospitals throughout the United States. The advantages of a computerized data base are: ready availability of information for the hospital staff, the ability to collate data on a national scale, and rapid retrieval of information for individual patient follow-up.

The Commission's educational programs have had a significant impact on improving cancer care. These programs involve surgeons and other physicians, nurses and other paraprofessionals, hospital administrators, and patients. The responsibility for developing a postgraduate course on cancer at the Clinical Congress each year lies with the Education Committee; the annual cancer symposium at the Clinical Congress is the joint responsibility of the Patient Care Committee and the Education Committee.

(continued on next page)

COMMISSION, from pg. 15

The Patient Care Committee has sought to define standards for surgical treatment of cancers in specific sites. The committee has developed short-term and long-term audits, and the response from Commission-approved hospitals has been excellent. The data derived from these patterns-of-care studies serve as the basis for the cancer symposia at the Clinical Congress. This year's symposium will be based on a survey of treatment patterns for prostatic cancer; next year's will discuss an ongoing review of breast-cancer treatment patterns.

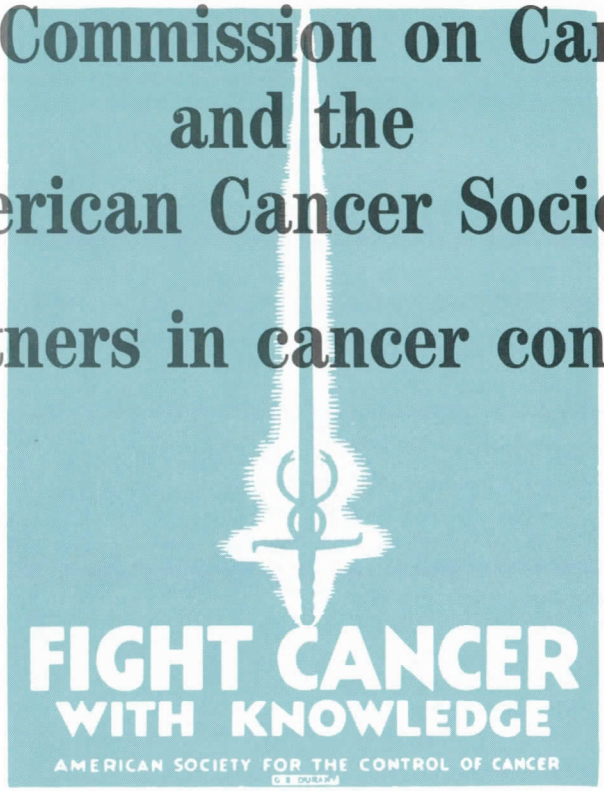
The Field Liaison Committee is concerned with the process of caring for cancer patients on a local and regional basis. In a highly organized manner, new therapeutic concepts, data-management techniques, and information from the cancer department of the American College of Surgeons are brought to every Commission-approved hospital by liaison fellows. A *Field Liaison Newsletter* is published frequently and a breakfast meeting for liaison fellows is held during the Clinical Congress each year.

As surgical oncology has reached greater prominence as an area of expertise in general surgery, the Commission on Cancer has established closer ties with the Society of Surgical Oncology to strengthen the role of the surgeon in cancer investigation and in the competitive drive for grant support and training programs. To improve the fund of oncologic knowledge among surgeons throughout the country who deal with cancer patients, the Commission is trying to develop cancer management courses, which will be conducted regionally through the field-liaison program. In addition, the Commission on Cancer is seeking to develop surgical expertise at the community hospital level to encourage clinical research activities through community cancer oncology programs and regional cooperative groups. The surgeon has always maintained a leadership role in the diagnosis and treatment of patients with cancer, and the Commission on Cancer seeks to strengthen that role with its broad range of activities.

100 years
Commission on Cancer | 1922–2022

The 1990s and 2000s

The Commission on Cancer and the American Cancer Society: Partners in cancer control



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The American Cancer Society and the American College of Surgeons have been partners in cancer control since the birth of both organizations in 1913. They have had shared goals, despite somewhat differing target audiences for their messages, and both their leadership and participants have been shared as well. A review of the history of both organizations may explain the reasons for their extremely effective partnership of these past 80 years. Having had the personal privilege of serving as Chairman of the Commission on Cancer of the College, and as president of the American Cancer Society, I feel a particular pride in describing the accomplishments in cancer control for both organizations.

by Walter Lawrence, Jr., MD, FACS, Richmond, VA

It was a very good year

In 1912 (according to George Stephenson, MD, FACS, College Archivist), Dr. Thomas S. Cullen expressed grave concerns regarding the management of cancer of the cervix at a meeting of the Clinical Congress of Surgeons of North America, the same meeting at which Dr. Franklin Martin proposed a plan for the formation of the American College of Surgeons. Dr. Cullen discussed the need for effective public and professional education about cancer, particularly cancer of the uterus. The initiatives resulting from his lecture were two; the first was the resolve at the Clinical Congress that a Cancer Campaign Committee be established as part of the new organization to be formed in 1913—the American College of Surgeons. The second initiative was a proposal that an article be published on cancer, for the education of the public. This article was subsequently published in 1913 in the *Ladies' Home Journal* (with variations appearing in some other popular magazines). This article, written by Samuel Adams after he was educated on the subject by Dr. Cullen and his colleagues, stressed cancer awareness and the vital importance of early diagnosis.

Interestingly enough, a meeting on the need for public cancer education, which included representatives of 10 major medical societies, took place in New York on the same day in 1913 that Dr. Adams' article was published. This meeting led to the formation of the American Society for the Control of Cancer (ASCC)—the forerunner of the American Cancer Society. Thus, Dr. Cullen's concern about cancer in 1912 led to the formation in 1913 of the predecessors of both the Commission on Cancer of the American College of Surgeons and the American Cancer Society. It is curious that in that same year another famous oncologist, Dr. James Ewing, became chief of pathology and president of the newly named Memorial Hospital for Cancer and Allied Disease. Also in 1913, Dr. Ewing spoke at the inauguration of another great cancer research hospital that was being opened at the Roswell Park Memorial Institute in Buffalo, NY.

Thomas S. Cullen, Chairman of Cancer Campaign Committee of the American College of Surgeons, 1913-1922.

Pioneers, plans, and partnerships

The subsequent activities of the ASCC and the Cancer Campaign Committee were relatively limited from the time of their origin in 1913 until after World War I. The focus of the Cancer Campaign Committee led by Dr. Cullen between 1913 and 1922 was uterine cancer and radium treatment, while the thrust of the ASCC was public education designed to combat the public's image of futility regarding uterine and other cancers. The ASCC was a relatively small organization at that time, was directed primarily by physicians, and received its modest funding from Mr. John D. Rockefeller and a few committed women of wealth. Cancer control activities by these two organizations were modest by today's standards, but both groups were coordinated and urged to action by the same leaders. This togetherness of spirit was demonstrated by Dr. Cullen, who was

Overleaf background: American Society for the Control of Cancer, 1913-1945 (forerunner of the American Cancer Society.

not only a cancer leader in the American College of Surgeons but was active in the ASCC as well. He later received one of the ASCC's highest awards, the annual National Division Award (now often called the St. George Medal).

The idea of cancer registries for improving cancer control began in 1921 with the American College of Surgeons' Dr. Ernest Codman. He, along with Dr. James Ewing and others, established a Bone Sarcoma Registry after their appointment to a committee for this purpose by the Board of Regents of the College. Dr. Codman was also the one who, in the early years of the American College of Surgeons, proposed standards for hospitals, a concept further developed by the College in later years. This plan actually was a forerunner of the Hospital Cancer Program of the Commission on Cancer.

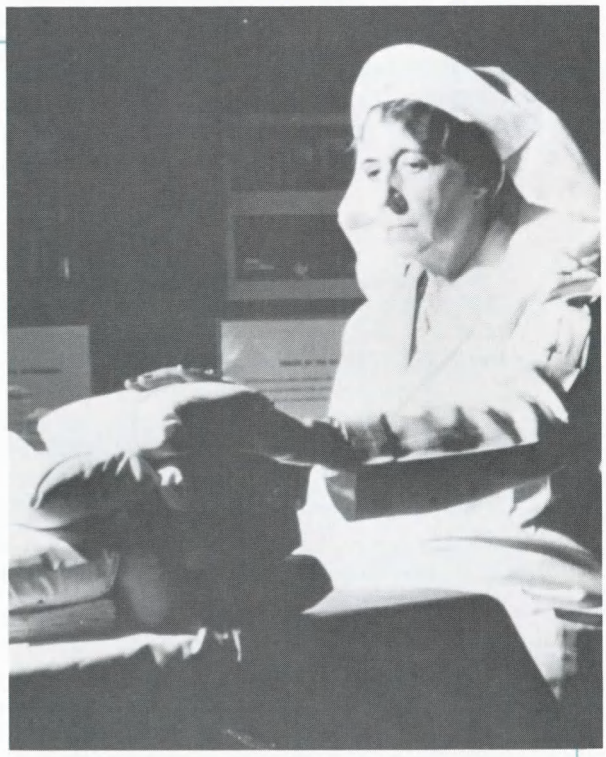
ASCC had little involvement with these initiatives of the College until a combined meeting of the boards of these two organizations in 1930 led to a cooperative venture concerned with standards for cancer clinics. The 1930 ASCC proposal to Dr. Robert Greenough's Committee on Treatment of Malignant Disease (the replacement committee for Dr. Cullen's Cancer Campaign Committee) was that standardization of cancer clinics be developed, published, and implemented. The small grant and the intellectual stimulus from the ASCC led to standards, a review process and, ultimately, the excellent Cancer Approvals Program we have today in the College's Commission on Cancer.

The partnership activity between the College and ASCC in the 1930s was the Committee on Treatment of Malignant Disease of the College and the ASCC, a public organization with a modest $50,000 annual budget committed primarily to patient service and public education. During this time, the ASCC established the Women's Field Army, which was a group of uniformed and committed women who prepared bandages and provided other services for cancer patients. The link between the ASCC and the College was well demonstrated by the fact that two of the four chairmen of the American College of Surgeons' Committee on Treatment of Malignant Diseases ultimately served also as president of the ASCC or the ACS (see Table 1, page 22).

In this story of partnership between organizations, a key surgeon stands out: Dr. Frank Adair. Under his leadership in 1940, the Committee on Treatment of Malignant Disease broadened its role with a change of name to the Committee on Cancer. Dr. Adair piloted this committee of the College from 1940 through 1946 and served as president of the ASCC from 1944 to 1946. These were the years in which radical changes took place in the ASCC (along with a name change from the American Society for the Control of Cancer to the American Cancer Society).

Growing up and out

In 1945, another ASCC change enabled it to become a much stronger and more active partner for the American College of Surgeons. Mrs. Mary Lasker, with the help of her husband Albert, stimulated the ASCC to focus on fund-raising for cancer research and cancer control. Her efforts led to the formation of a larger and better organized team of volunteers, the National Board of



Women's Field Army (initiated in 1936).

Directors, consisting of equal numbers of physicians and lay people. The annual budget from fund-raising activities jumped in 1945 from $50,000 to $1 million. One million dollars may not sound like much in light of today's American Cancer Society's total budget of over $350 million. However, the fact that the $1 million budget was twice that of the National Cancer Institute in 1945 may give some idea of the impact of the changes produced by this outstanding woman, the wife of an advertising leader for tobacco products!

Table 1
Committee on Treatment of Malignant Diseases 1930-1939

Chairmen: Robert Greenough*
Burton Lee
Charles Dukes
Frank Adair*

* President, American Cancer Society

Table 2
Committee on Cancer (Chairmen)

Frank Adair*	1940-46
Grantley Taylor	1947-51
Edwin Lehman*	1952-53
Danely Slaughter	1954-59
R. Lee Clark*	1960-63
Murray Copeland*	1964

All active American Cancer Society (*past president)

Table 3
Commission on Cancer (Chairmen)

John Cline*	1965-68
Benjamin Byrd*	1969-75
Harvey Baker	1976-79
Walter Lawrence, Jr.*	1980-82
Richard Wilson	1983-85
Robert Beart	1986-87
Sam Wells	1988-89
John Niederhuber	1990
Glenn Steele	1991-92

* President, American Cancer Society

With the transformation of the American Cancer Society, cancer control planning began in earnest between the boards of the Commission on Cancer and the American Cancer Society. The liaison program for the American College of Surgeons hospital cancer program was initiated in 1947 by Dr. Danely Slaughter, later Chairman of the Committee on Cancer and an active American Cancer Society volunteer. The American Cancer Society also provided a grant to the Committee on Cancer in 1947 for developing standards for cancer detection centers. Dr. Ashbell Williams, later a president of the American Cancer Society, expanded this liaison program of the College in 1960 and coordinated it with the society.

A list of chairmen of the Committee on Cancer of the American College of Surgeons, from its inception in 1940 to its transformation to a multidisciplinary Commission on Cancer in 1965, shows the close alignment of this cancer control team with the American Cancer Society (see Table 2, this page). These chairmen had a history of leadership in the society and the College, with four of the six actually serving as president of the American Cancer Society. One of these presidents, Dr. R. Lee Clark, was the initial leader of the M.D. Anderson Tumor Institute in Houston, TX. Dr. Murray Copeland, the last chairman before the committee became a commission, was not only president of the American Cancer Society in 1965, but was also the surgeon who was responsible for initiation of the American Joint Committee for Cancer Staging and End Results Reporting.

Although the multidisciplinary Commission on Cancer was not formally established until 1965, the multidisciplinary flavor of the commission began in 1953, when the first liaison representatives were appointed to the Committee on Cancer (later the Commission). The American Cancer Society representative was one of the first of what now totals 29 liaison representatives; the American Cancer Society has had two liaison

representatives since 1985. Of these, Dr. Arthur I. Holleb, chief medical officer of the American Cancer Society until his retirement in 1988, served 20 years in this role and may well have been the longest serving member of the Commission on Cancer. The current chief medical officer of the American Cancer Society, Dr. Gerald P. Murphy, has served in this capacity since 1988. His prior service to the Commission was as Chairman of the Patient Care and Research Committee in the mid-1970s, and he served as president of the American Cancer Society in 1984.

Dr. John Cline served as the Commission on Cancer's first Chairman (1965–1968). The continued sharing of partnership between the Commission on Cancer and the American Cancer Society is demonstrated by the almost uniform involvement of Commission chairmen and members in American Cancer Society programs and activities (see Table 3, page 22). A prime example is Dr. Benjamin Byrd, who was Commission Chairman from 1969 to 1975 and American Cancer Society president in 1976, and who continues to serve as a national volunteer. Also, Harvey Baker, Commission Chairman from 1976 to 1979, received the society's National Volunteer Leadership Award not long before his untimely death. Most of us involved with the commission have been active in the American Cancer Society as well.

Foundations for the future

One measure of partnership in endeavors like these might well be a financial commitment to the "cause." Prior to 1959 the grants made by the American Cancer Society to the Commission on Cancer were undoubtedly modest, but subsequent funding for the American Joint Committee on Cancer (AJCC) (beginning in 1959) and for the Commission itself (beginning in 1968) has been considerable. The former contributions to the AJCC total $1.68 million, and the grants to the commission itself total $5.64 million. The American Cancer Society grants to the commission were for the Approvals Program, the Liaison Program, Patient Care Evaluation, and, most recently, the National Cancer Data Base. The focus on quality of cancer patient care and the role of an effective cancer data base in this process has culminated in this partnership effort with the

Mary Lasker, the person primarily responsible for transforming the ASCC in 1945 into an effective fund-raising organization for research.

Arthur I. Holleb, MD, chief medical officer, American Cancer Society, and liaison representative to the Commission on Cancer from the American Cancer Society for 20 years (1968-1988).

Gerald P. Murphy, MD, Chairman, Patient Care and Research Committee of the Commission on Cancer (late 1970s).

National Cancer Data Base, a resource that is a great aid to many of the American Cancer Society and Commission on Cancer programs.

The staff of the Cancer Department of the American College of Surgeons, so critical to the success of the Commission on Cancer, deserves special mention. Through the years, these individuals and their leaders have been active supporters of the American Cancer Society and of the Commission, and this had led to continuous integration of cancer control efforts. In recent years, Drs. Andy Mayer, Oliver Beahrs, Charles Smart, and the current leader, David Winchester, have all been active in the American Cancer Society either before, during, or after their respective roles with the Commission and the College's Cancer Department. The tradition of partnership has been maintained by these highly committed staff leaders, as well as the part-time volunteers, for 80 years.

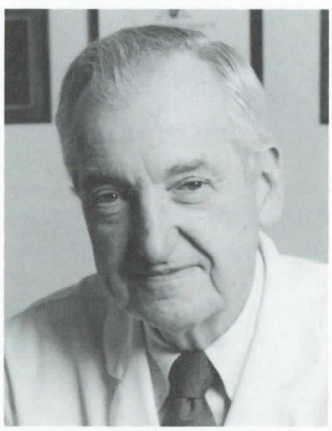
Through the years, most Fellows of the College who participate in hospital cancer programs as liaison Fellows or Commission members have been equally active in their own units and divisions of the American Cancer Society. The goals of these organizations are so similar, and the collaborations have been so active, that most of us have considered all of this as one unified cancer control program. After more than 30 years of personal involvement in both the American Cancer Society and the American College of Surgeons, I feel extremely proud of their mutual accomplishments. The American Cancer Society and the Commission on Cancer of the American College of Surgeons are truly "partners in cancer control." Ω

Acknowledgments

The author is indebted to Mrs. C. Blankenship (Administrator, ACS Cancer Department), Laura Meadows (American Cancer Society national office), Arthur I. Holleb, MD, FACS, and to George Stephenson, MD, FACS (from whose 1979 historical review I obtained much information that is contained herein).

This article is a condensation of the keynote address delivered at the annual meeting of the Commission on Cancer in New Orleans, LA, October 11, 1992.

***Dr. Lawrence** is professor of surgery at the Massey Cancer Center at the Medical College of Virginia, Richmond, VA. He is the immediate past president of the American Cancer Society and former Chairman of the Commission on Cancer.*



The COC:

Its roots and destiny

Eighty-one years ago, in 1912, at the Fourth Clinical Congress of Surgeons of North America, two plans were proposed: the first, for the "standardization of surgeons," led to the formation of the American College of Surgeons in 1913; the second plan, for the "standardization of hospitals," developed into a functioning program in 1918, and was the founding of the Joint Commission on Accreditation of Hospitals, known today as the Joint Commission on Accreditation of Healthcare Organizations.

Evolution

The Cancer Campaign Committee was appointed by the Board of Regents in 1913 to analyze case records of patients with cancer of the uterine cervix or corpus, who were considered "cured" three years after treatment, to determine outcomes by treatment type and stage. A committee report in 1924 concluded that surgery and radiation therapy were equally effective for early stage disease of the uterine cervix and that palliation and survival for advanced stage disease were improved by radiation therapy.

In 1921 the concept of registries was introduced by Ernest Codman, MD, FACS, who established a bone sarcoma registry. In 1925 similar studies were conducted for cancers of the breast, mouth, tongue, colon, and thyroid.

In 1930 the committee was renamed the Committee on the Treatment of Malignant Disease. Standards were published that year, titled *Organization of Service for the Diagnosis and Treatment of Cancer*. The activities defined in the text centered around evaluation of cancer clinics and registries. In 1940, the committee was renamed the Committee on Cancer, and with a grant from the American Cancer Society in 1947 initiated a survey of cancer detection centers. The cancer liaison effort was established in 1947. This grassroots effort involved identification of a surgeon at the hospital level to promote and oversee the programs of the committee.

by **Murray F. Brennan, MD, FACS,** New York, NY,
Rosemarie E. Clive, LPN, CTR, and **David P. Winchester, MD, FACS,** Chicago, IL

The standards were then refined, and a new publication, *Manual for Cancer Programs,* was published in 1954. These standards included mandates for a multidisciplinary cancer committee, tumor boards, and methods for monitoring and reporting end results. In 1956 the requirements for an approved hospital cancer program were expanded to include a cancer registry, which incorporated diagnostic, staging, treatment, and annual lifetime follow-up of all cancer patients.

In 1965, the committee was expanded to include members from liaison organizations and was renamed the Commission on Cancer (COC). The multidisciplinary Commission on Cancer comprised four standing committees: Approvals, Field Liaison, Patient Care and Research, and Education. The executive committee conducted the interim business of the commission.

With the publication of a revision to the newly titled *Cancer Program Manual* in 1974, the standards were expanded to address various levels of performance for hospitals by categories. In 1976, the commission introduced the first national patient care evaluation study, which examined the frequency of primary tumors of the liver and the relationship to estrogen use. Similar studies have been designed and conducted since that time. To date, 20 studies of 17 primary sites have resulted in analysis of more than 500,000 cases and the publication of more than 75 papers. Since 1980, the data have been presented at cancer symposia at the Clinical Congress. With the 1980 revision, the *Cancer Program Manual* addressed for the first time the requirement for annual patient care evaluation studies. The details of the requirements for the registry component were published separately in the *Cancer Registry Manual.*

Recognizing the need for greater access and ease in data collection and analysis, the College and the commission initiated a dialogue with hospital and central registry leadership to address how the standards for approval could be met by a computerized registry. This initial effort prompted the development of software for personal computers that would provide access to computerization for hospital cancer registries. In 1980, only 25 percent of the approved hospital cancer programs had a computerized cancer registry. Today, more than 80 percent of the approved cancer programs use a computerized system to manage their registry data. There are more than a dozen registry software packages, including CANSUR®/Net, which is distributed by the College. This switch to computerized data management has been integral to expansion of state registries and to the National Cancer Data Base.

A two-day course in the multidisciplinary management of oncologic diseases was developed in 1983. The Cancer Management Course was designed primarily for surgeons, and included "skill stations" and a syllabus. It was offered at the local level by local and national faculty. To date, the course has been offered in 42 states and six countries. In 1992, it was decided that the original Cancer Management Course would be offered only in international settings, and an advanced course in Cancer Management, with a varied curriculum, would be offered at the Spring Meeting of the College. The first such course was well received at the 1993 Spring Meeting, where the 280 participants gave the course an excellent evaluation.

The *Cancer Program Manual* was revised in 1986 to incorporate refinements to the requirements and included, for the first time, standards for a computerized registry. The four components of an approved program were: cancer committee, cancer conference/tumor board, patient care evaluation, and cancer registry. Published also was the *Data Acquisition Manual,* a handbook for operation of a registry.

In 1990 the National Cancer Data Base (NCDB) project was launched with a grant from the American Cancer Society. Data transfer specifications were defined that allowed hospitals with computerized cancer registries to respond electronically to the NCDB Call for Data. The first *Annual Review of Patient Care* was published in 1992.

The early interest of the Cancer Campaign Committee in the effectiveness of various treatments for different types of cancers and the development of standards to improve patient care helped shape the role of the Commission on Cancer, and has greatly influenced patterns of care and the use of resources to deliver that care and to monitor patient management in hospitals

Table 1

Evolution of the Commission on Cancer
American College of Surgeons

Cancer Campaign Committee (1913)	Committee on Treatment of Malignant Disease (1930)	Committee on Cancer (1940)	Commission on Cancer (1965)
Dr. Codman establishes bone sarcoma registry (1921)	First standards published (1930)	Survey process instituted (1947)	Multidisciplinary membership
Report of first study (1924)		Cancer liaison effort implemented (1947)	Cancer Program revised (1974)
		Manual for Cancer Programs published (1954)	First Patient Care Evaluation study (1976)
		Cancer Registry requirement (1956)	Cancer program rewritten (1980)
			Data Acquisition Manual published (1980)
			CANSUR®/Net introduced (1980)
			Cancer Management Course (1983)
			National Cancer Data Base (1990)
			PCE and NCDB merged (1993)

throughout the United States. An overview of the evolution of the present-day commission is shown in Table 1, above.

Current status

The commission has maintained a leadership position in standards, education, clinical practice, and outcomes evaluation for oncology. The scope of the commission's role has broadened to include patient care evaluation, a grassroots clinical communication and technology transfer effort, and a national cancer database. There has been a corresponding shift from a totally surgical membership to a multidisciplinary one, consistent with current accepted management of oncologic disease.

This multidisciplinary posture emulates that required in a commission-approved cancer program, and has served as a stimulus for other interdisciplinary collaborative efforts, such as the consensus guideline on the management of minimal breast cancers. It has also enhanced the interest in and growth of the commission and its programs. There are 30 oncology organizations represented on the commission, with a combined membership of 31 individuals, slightly greater than one-third of the commission's total membership. The organizations represented on the com-

Table 2

Commission on Cancer liaison organizations

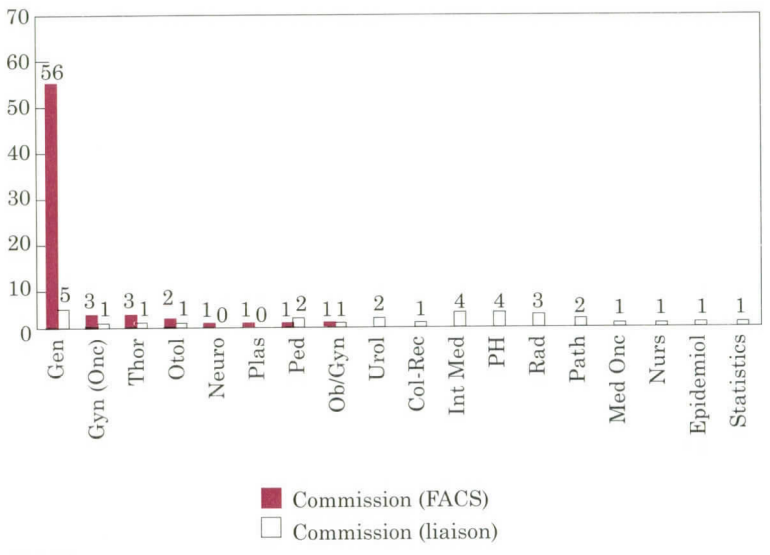
American Academy of Pediatrics
American Association for Cancer Education, Inc.
American Cancer Society, Inc.
American College of Obstetricians and Gynecologists
American College of Oncology Administrators
American College of Physicians
American College of Radiology
American College of Surgeons
American Hospital Association
American Joint Committee on Cancer
American Medical Association
American Pediatric Surgical Association
American Society for Head and Neck Surgery
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society of Therapeutic Radiology and Oncology
American Urological Association
Association of American Cancer Institutes
Association of Community Cancer Centers
College of American Pathologists
Department of Defense
Department of Veterans Affairs
Health Resources and Services Administration of the Department of Health and Human Services
National Cancer Advisory Board
National Cancer Institute SEER Program - Cancer Therapy Evaluation Program
National Cancer Registrars Association, Inc.
Oncology Nursing Society
Society of Gynecologic Oncologists
Society of Head and Neck Surgeons
Society of Surgical Oncologists

mission are shown in Table 2, above. Liaison members have full voting privilege, and may serve on committees and chair a subcommittee. They may not chair a standing committee or hold office. They are nominated by their respective organizations and are elected by the commission for a three-year term. They are eligible for re-election for one additional three-year term upon renomination by their respective organizations. Their expenses for commission activities are supported by the liaisons' parent organizations.

The representatives of the Fellowship of the American College of Surgeons are nominated by the Nominating Committee of the commission. Past and present chairmen of the commission and the standing committees, commission members, field staff surveyors and consultants, members of the Board of Regents, and staff are invited to submit names for consideration. Members are selected based on consideration of: needs of the various commission programs, surgical specialty, professional leadership in an oncology-related

Figure 1

Fellowship representation on the commission



N = 99

field, geographical representation, and interest in or history of association with commission programs.

A recent revision in the term of service has established three levels of membership for representatives of the Fellowship:

- *Associate* members are elected for an initial two-year term in which they may serve on one standing committee and have full voting privileges, but may not chair a committee or hold office.
- *Active* members are elected for a three-year term and are eligible for reelection to a second three-year term. They retain the privileges of associate membership and may hold office and chair a committee. They also may serve on multiple standing committees.
- *Senior* members are elected for a two-year term. They may serve on committees, but may not vote, chair a committee, or hold office.

For meetings of the various committees, the members are supported by the College. Members support their expenses for attendance and participation in the meetings of the commission. The commission and the committees and programs were evaluated recently to determine their adherence to the goals and objectives of the College, their responsiveness to their audiences, the services they perform, and the effectiveness of their overall structure and function. Addressed were:

- *Size and specialty representation.* The size of the commission has increased from 60 members in 1980 to 100 members in 1993. This growth is primarily influenced by the increase in the number of liaison organizations represented on the commission. Reviewed also was the representation of the surgical subspecialities and that of the nonsurgical specialties, such as medical oncology, radiation oncology, and diagnostic radiology. The composition of the membership by specialty is shown in Figure 1, this page.
- *Role of liaison organizations.* The potential for greater collaborative support and involvement in the programs of the commission was explored.
- *Committee structure.* The functions of the Patient Care and Research Committee and the National Cancer Data Base Governing Board were merged into one standing committee, the National Cancer Data Committee. The membership of the Cancer Liaison Committee was modified to include the nine regional Cancer Liaison Chairmen. The Nominating Committee was established. Vice-Chairmen were appointed for the four standing committees: Approvals, Cancer Liaison, Education, and National Cancer Data. A research and development subcommittee of the Approvals Committee was established and charged with evaluating the current and future direction of this program and the approvals pro-

cess as well as identifying new opportunities to expand the program.

- *Responsibilities and tasks.* The responsibilities and tasks for each committee and program were evaluated and selected tasks were shifted from volunteers to staff.
- *Demands on volunteers.* In addition to shifting some tasks to staff, the committee procedures and committee member responsibilities were revised. The number, length, and locations of meetings were reviewed and a new, streamlined schedule of meetings was adopted by the commission. These changes reduced the demands made on volunteers for time away from academic, clinical, and administrative practice.
- *Infrastructure and staff support.* The services and programs of the commission were categorized into six major components: Standards, Education, Approval, Clinical Information, Data Management Support, and Leadership Services. Staffing patterns were realigned along these lines.
- *Cost-effectiveness.* Internal and external activities were assessed and cost-savings actions initiated.

Two major areas were identified that have yet to be addressed: strategic positioning and funding. As the reputation of the commission and the scope of its programs have expanded, there has been a corresponding growth in opportunities for new programs and services. Some of these opportunities have surfaced as outgrowth of existing programs; others have been requested by others. The fact that commission involvement is sought is indicative of the success and leadership that it has gained. However, the demands for growth require careful evaluation as to their appropriateness for the goals of the commission and the College, their value to oncology and health care, their threat to the position of the commission and/or the College, and available resources.

Future direction

The COC leadership has held a steady course for more than 70 years. In addition to the reputation gained through its affiliation with the American College of Surgeons, the commission represents multidisciplinary leadership in oncology. This multidisciplinary organization adds credibility and strength to the role of the commission in setting standards of care for oncology patients, monitoring both trends and adherence to standards of quality, and communicating information to professional and lay communities.

Well-known among oncology care providers, the commission needs to expand its visibility among regulatory, research, and public and private agencies. There are many groups exploring how to set guidelines for care: how, when, and by whom care should be delivered, what subpopulations would benefit from what types of treatment, and what descriptors of quality care should be. The work of the commission touches many of these areas. Through strategic planning and positioning, the commission can serve as the fulcrum for patient care standards, regulatory affairs, research, and education for oncology.

The role of the commission has already been identified by external organizations. For example, the Blue Cross Blue Shield Association (BCBS) has initiated a pilot program in 11 BCBS plans to review determinants of quality as related to care of the cancer patient. Five plans will test the proviso that requires that cancer patients who are BCBS subscribers must be diagnosed and treated in facilities that have cancer programs approved by the Commission on Cancer. In addition, there is considerable interest by several groups in the outcome data from the National Cancer Data Base as a benchmark for quality.

There are many new players on the field, such as the Centers for Disease Control and Prevention, recently appointed as the administrative branch for the National Cancer Registries Act. Without proactive decision making, the commission may find many of its current activities subsumed by other agencies or organizations.

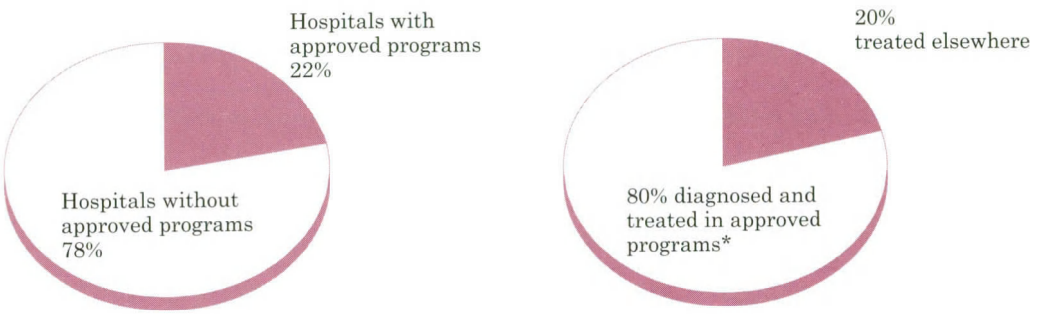
Patient care guidelines. The commission must establish minimal standards of care for patients with specified malignancies. As a broad-based, multidisciplinary body, the commission can facilitate the necessary consensus-building and validate outcomes using the data from the Patient Care Evaluation and NCDB studies.

Regulatory affairs. The Approvals Program will continue to expand and become a major force in the definition of standards and quality of care for the cancer patient in the United States. An estimated 80 percent of new cancers will be treated in approved programs (see Figure 2,

Figure 2

Annual analytic caseload of approved programs

Cancer programs in U.S. hospitals



General surgical facilities including Puerto Rico = ~6000

Estimated new cancer patients in 1992: 1,130,000

*Based on a survey of 1,333 approved programs (January 1994).

Cancer facts and figures, 1992, American Cancer Society

this page). To this end, the commission must increase representation of all disciplines involved in the care of the cancer patient. It is expected that this approvals process will be used by third party carriers and regulatory agencies for defining the minimal standards for settings that deliver cancer care, hospitals, clinics, freestanding facilities, and so forth. A vigorous supportive approach to this process would be continued to underscore the commission and the College's leadership in the maintenance of standards of care.

Research. Participation in the National Cancer Data Base will continue to expand. There has been considerable interest by external agencies in tapping into this valuable resource to monitor trends and quality. As 80 percent of patients are cared for in approved cancer programs, the National Cancer Data Base will experience a parallel growth. This will be facilitated by increased computerization of cancer registry data. The content and scope of the registry data set will also be refined to include more clinically relevant data items as well as ancillary data sets designed to respond to specific clinical questions. Improved systems of follow-up will need to be initiated with outcome analysis that relates to the cost of care. This will be a matter of some sensitivity but must be approached in a critical scientific manner. The patterns of care analysis will continue to be done to identify areas of the country where patterns of care differ widely from what may be subsequently defined as the norm.

Education. The commission has the unique opportunity to use modern communication technology to advance the programs of the College and to meet the needs of clinicians involved in the management of patients with cancer. Interactive access to national data bases, special teleconferencing, and network links will augment the existing educational efforts. The commission will continue to develop and conduct postgraduate state-of-the-art Cancer Management Courses and symposia, the latter based on data from the Patient Care Evaluation studies.

The locally hosted Cancer Management Course will be targeted to the international community. International members of the College,

who on occasion may have felt disenfranchised, can be incorporated into the mainstream of the College and the commission through the Cancer Management Course, and may then expand their activities to the other programs of the commission. This is a relatively low-cost, high-yield endeavor for the College. The need for the College to maintain its international leadership among surgical colleges cannot be underestimated.

Response to the Fellowship. The surgeon can play an increasing, rather than a diminishing, role in the management of the cancer patient. To do this requires a willingness to be informed and to take a leadership position, something surgeons tend to do well. Securing that leadership position is not a passive role. It requires setting standards, engaging in political and societal dialogue, and being open to innovation in techniques and in processes, alliances, and communication.

The multidisciplinary commission is an ideal forum for developing processes that cross both professional and nonprofessional management of cancer patients. More and more we will see this integrated approach to care.

Administrative/fiscal responsibilities. Expansion of the commission's role is accompanied by an increased fiscal responsibility. The American Cancer Society has a long history of collaboration with the commission and of significant funding of selected programs. We are appreciative of this support, but recognize that this is not an unlimited resource. Development of optional funding sources, endowments, grants, and contacts is critical to the continued growth of the commission. Not only do these sources need to be vigorously pursued, but the commission needs to design avenues to increase its visibility with potential funding sources. This visibility campaign needs to target the public in order to attract private benefactors.

Recent reorganization of staff, tasks, and committees has resulted in significant progress in streamlining operations and reducing costs. This process should be an ongoing activity. Innovative approaches, such as computer- and teleconferencing, should be explored. The multiple committees and task forces of the commission are ideal groups to pilot modern telecommunications, reducing the costs of travel and meetings.

The future of the Commission on Cancer as an integrative national leader devoted to improving the care of the patient with cancer and as an arm of the American College of Surgeons is bright. Through development of standards, education, and approvals processes, the commission is uniquely qualified in these changing times to assume the leadership in defining standards of care, monitoring trends and quality of care, and communicating outcomes to appropriate audiences. In addition, the commission can be a significant force for reaching out to the international Fellowship. Ω

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Ms. Clive *is Administrative Director, ACS Cancer Department, Chicago, IL.*

Dr. Winchester *is Medical Director, ACS Cancer Department, Chicago, IL.*

NQF endorses measures developed by the ACS Commission on Cancer

In a move more than two years in the making, the first nationally recognized hospital-based performance measures for quality of care for breast and colorectal cancer were endorsed by the National Quality Forum (NQF). The pioneering effort to develop these measures was led by the American College of Surgeons' Commission on Cancer (CoC) in concert with the American Society of Clinical Oncology (ASCO) and the National Comprehensive Cancer Network (NCCN). The NQF first issued a call for breast and colorectal measures in 2004 and 2005.

The CoC is a consortium of more than 40 professional organizations, including representatives from all medical disciplines that treat and care for cancer patients and are dedicated to improving the survival and quality of life for cancer patients. The CoC accredits more than 1,400 cancer programs across the U.S. that are committed to providing the best in cancer care and are able to comply with established standards.

"This is an important advancement for the public and for the health care community because it marks the first time we have nationally accepted measures of quality for treating people with breast and colon cancer," said Stephen Edge, MD, FACS, who co-led the CoC's effort as Chair of its Quality Integration Committee. "These measures help close the loop on quality improvement. Data collected by hospitals and submitted nationally to the CoC can now be used by hospitals and doctors to assess how they perform in comparison to others, and to address any issues in quality. The public can now have confidence that when their hospitals perform well in using these measures, they are receiving the nationally recognized standard of care as put forth by the nation's leading cancer organizations."

The measures endorsed by the NQF include the following:

Breast cancer

- Radiation therapy is administered within one year of diagnosis for women younger than 70 who receive breast-conserving surgery for breast cancer.
- Combination chemotherapy is considered or administered within four months of diagnosis for women younger than 70 with hormone receptor-negative breast cancer that is either larger than 1 cm with no nodal or distant organ metastasis, or has spread to involve regional lymph nodes but has not metastasized to organs outside the breast.
- Tamoxifen or third-generation aromatase inhibitor is considered or administered within one year of diagnosis for women with hormone receptor-positive breast cancer that is either larger than 1 cm with no nodal or distant organ metastasis, or has spread to involve regional lymph nodes but has not metastasized to organs outside the breast.

Colon cancer

- Postoperative chemotherapy is considered or administered within four months of diagnosis for patients younger than 80 with colon cancer that involves regional lymph nodes.

"The endorsement of these new cancer care measures by the NQF is an important step forward," said Carolyn M. Clancy, MD, director of the Agency for Healthcare Research and Quality and a NQF board member. "These measures, championed by leading cancer organizations and others, will help set clear standards for treating breast and colorectal cancer and help patients receive the best care possible."

In developing the measures, the organizations' members made the deliberate decision to evaluate the performance of hospitals and health care systems, not individual physicians.

"Treating and managing cancer is an interdisciplinary, not a solo, practice; therefore, it was essential that we focused on hospitals and systems," according to Clifford Ko, MD, FACS, Director of the ACS Division of Research and Optimal Patient

Care and co-leader of the initiative.

Through its Cancer Program Practice Profile Reports and Electronic Quality Improvement Packets effort, the CoC has positioned itself over the past two years to assist its approved cancer programs to prepare for the arrival of these quality measures. The goal of these feedback reports has been to foster preemptive awareness of the importance of charting and coding accuracy and the improvement of clinical management and coordination of patient care in the multidisciplinary setting.

Commenting on this significant advancement in cancer patient care, Thomas R. Russell, MD, FACS, ACS Executive Director, said, "Through its Electronic Quality Improvement Packets effort, the ACS has already demonstrated that improvements in data quality and patient care are possible when the entire cancer community supports system-level enhancements to ensure complete and precise documentation."

"When credible quality measurement standards like these are in place, from a clinical perspective we think it is appropriate to link reimbursement by health insurance plans to standards of care," Dr. Ko said. "Consumers, patients, and others need tools like these agreed-upon standards of care to measure quality of care. This is an important step in the pay-for-performance initiative."

The standard of care measures for breast and colon disease are now posted on the ACS Web site at *http://www.facs.org/cancer/qualitymeasures.html*. The measures are also on the Web sites of the ASCO (*http://www.asco.org/qualitymeasures*) and NCCN (*http://www.nccn.org/*). These organizations will also proactively distribute the measures to the entire cancer community.

ACS endorses National Time Out Day

The American College of Surgeons has given its endorsement to the 4th annual National Time Out Day, on June 20. This day is promoted among all members of the surgical team to highlight The Joint Commission's Universal Protocol and other initiatives that have been developed to reduce medical and surgical errors. The Universal Protocol took effect July 21, 2004, and is a requirement for all hospitals, ambulatory surgery centers, and office-based surgery facilities accredited by The Joint Commission. National Time Out Day is sponsored by the Association of peri-Operative Registered Nurses and has been endorsed by The Joint Commission.

The surgical time out provides an opportunity for the surgical team to identify inconsistencies in reviewing the patient's case and to prevent errors in the operating room. It also serves to reinforce the third element of The Joint Commission's Universal Protocol, which is as follows:

- Preoperative verification process
- Marking of the operative site
- Time out immediately before starting the procedure

"The American College of Surgeons views National Time Out Day as an important event for the entire surgical care team," ACS Executive Director Thomas R. Russell, MD, FACS, said. "This is an important patient safety initiative that reminds all members of the operating room team about the importance of maintaining clear communication as they review the case of the patient before them and during the actual surgical procedure. The day reinforces the good practice of overall clear communication, which should always be part of a surgical team's routine."

Dr. Russell continued, "It is one of our best safety tools for preventing medical errors. We encourage all surgeons to take the lead in serving as facilitators of this process."

For more information, visit the following Web sites:

- *http://www.jointcommission.org/PatientSafety/UniversalProtocol/*
- *http://www.facs.org/fellows_info/statements/st-41.html*
- *http://www.facs.org/public_info/correctsite.html*
- *http://www.aorn.org/toolkit/*
- *http://www.patientsafetyfirst.org/*

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The 2010s

CoC® Chair
reflects on evolution of cancer care

New patient-centered standards represent another milestone

by Jeannie Glickson

When the new Commission on Cancer (CoC) Patient-Centered Standards take effect January 1, 2012, they will represent another milestone for this consortium of nearly 50 member organizations that sets standards and monitors cancer care, developing programs for prevention, research, and education. The CoC strives to enhance both the quality of care and cancer patients' quality of life. For Stephen Edge, MD, FACS, and Chair of the CoC, the new standards are additional proof that the group is "stepping up to the plate," he said, and providing vital guidance for delivering patient-centered care to cancer patients throughout the U.S.

Dr. Edge (pictured, this page), the Alfiero Family Charitable Foundation Endowed Chair in Breast Oncology and medical director of the Breast Center at Roswell Park Cancer Institute in Buffalo, NY, is convinced that the new standards will further elevate cancer care and improve patient outcomes. A graduate of Case Western Reserve University Medical School in Cleveland, OH, Dr. Edge completed his residency at University Hospitals of Cleveland, and served a fellowship at the National Cancer Institute in Bethesda, MD. Dr. Edge has established himself as a national leader in uniting the subspecialties of cancer care and in develop-

ing the concept of continuous quality improvement in cancer management.

A surgical oncologist for 25 years who began his career practicing at the University of Virginia Medical Center in Charlottesville, Dr. Edge has witnessed a "revolution" in oncology care—and he fully expects the advances to continue.

"We are light years ahead of where we were just two generations ago," he said, "and there's no reason to believe that we won't be many more light years ahead in another couple of generations. It's amazing. We have made that much progress in enhancing outcomes for cancer patients."

Rigorous CoC Standards enhance quality of care

CoC Standards effectively standardize cancer care through a process that began more than 80 years ago. It was in 1930 that the American College of Surgeons (ACS) first established standards to evaluate a cancer clinic's performance. By 1933, 140 clinics had gained accreditation, and that number has grown steadily. Nationwide, there are now more than 1,500 hospitals and cancer programs in the CoC-accredited network. These programs treat more than 75 percent of patients who are newly diagnosed with cancer each year.[1]

To become CoC-accredited, a cancer program must demonstrate its commitment to providing quality care through compliance with more than 40 rigorous standards and a commitment to continuing education, data collection and measurement, feedback, and continuous quality improvement. Cancer treatments don't happen overnight, and because of the complexity of the disease, most positive outcomes in cancer patients are a product of multidisciplinary efforts, according to Dr. Edge. Participating in accreditation programs, he added, does not guarantee high-quality care, but it does reflect a commitment to these goals.

Knowledge of cancer biology

"We understand cancer biology so much better today," said Dr. Edge. "We can target treatment to abnormal patterns of cancer, and we can save patients who, 30 years ago, would have succumbed to the disease," he said. "We have a number of tools at our disposal now to treat the cancer patient."

But the stakes are high, and cancer continues to hit close to home. Currently, nearly 12 million Americans have a cancer diagnosis, with approximately 1.3 million new cases diagnosed each year.[2]

"Current screening of patients, early diagnoses, improved local therapy, and systematic treatments have all led to a dramatic reduction in cancer mortality," according to Dr. Edge. But he does not discount the reality that cancer treatment today may be inequitable. The quality of care still varies widely, and scientific and technological advances aside, many cancer patients in the U.S. do not receive the high quality of care that is possible.

Many cancer patients still receive insufficient care, the wrong kind of care, or unnecessary procedures. CoC standards help ensure quality, comprehensive cancer care delivery for all cancer patients—which is why Dr. Edge became involved with the Commission on Cancer.

"I have always viewed my involvement with CoC as a way to have an impact on cancer care, community-wide," Dr. Edge said.

He noted an example of care he recently provided to a breast cancer patient. Through the CoC program of quality monitoring—the Rapid Quality Reporting System (RQRS)—a woman with breast cancer who needed chemotherapy had canceled and missed key appointments, and her chemotherapy had not started. The RQRS system alerted Dr. Edge's cancer registrars that the allotted time for beginning therapy was nearly overdue, and his group contacted the patient again to be sure she received the critical therapy. This quality measure was proposed by the CoC and approved by the National Quality Forum, and the RQRS system is being implemented nationwide to provide the assistance to all accredited programs.

IOM: Ensuring quality cancer care

The CoC has evolved with advances in scientific knowledge and treatment of cancer. The National Cancer Policy Board responded in 1999 to the American public's concerns about cancer care by reviewing the effectiveness and quality of cancer services and delivery systems, as well as the barriers in the U.S. to cancer care. The independent, not-for-profit medical think tank, the Institute of Medicine (IOM), in turn, issued its influential report, *Ensuring Quality Cancer Care*, which summarized knowledge about quality cancer care and established a number of recommendations for improving cancer care.[3] The report played a key role in developing the new

CoC standards that focus on the needs of patients.

The IOM report recommended bold changes in cancer care, including the requirement that cancer care facilities employ quality measures and benchmarks to monitor the quality of care. The CoC has embraced this recommendation by including Standards 4.4: Accountability Measures, and 4.5: Quality Improvement Standards, which require that cancer patients are treated according to nationally accepted accountability and quality improvement measures endorsed by the National Quality Forum and measured through the CoC's National Cancer Data Base reporting tools.

The National Cancer Data Base, a joint program of the CoC and the American Cancer Society, is a nationwide oncology outcomes database for accredited cancer programs in the U.S. and Puerto Rico.

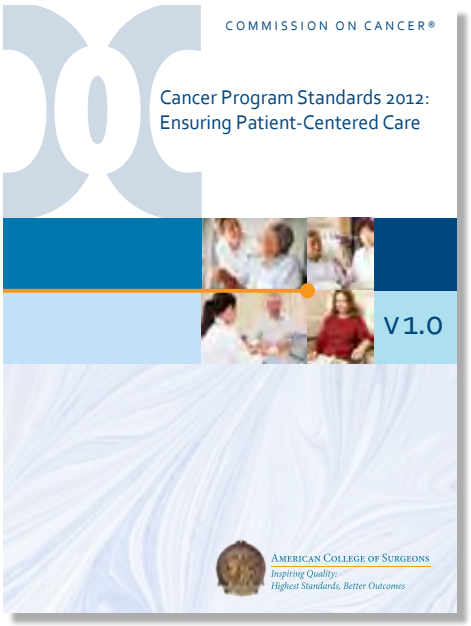
The IOM also recommended that every person diagnosed with cancer receive key elements of quality care, including treatment by experienced professionals, an agreed-upon care plan, and access to resources that will make the care plan possible. The IOM report also called for access to clinical trials, full disclosure of information about treatment options, coordination of services, and psychosocial support.[3]

The IOM report was issued 12 years ago, and yet, the CoC is the only program in the U.S. that provides the standards, data system, quality metrics, and multidisciplinary approaches that embrace the IOM recommendations.[4]

"Through the CoC, providers come together and define for specialists how they should relate to one another for the benefit of the patient, and how they should practice and document their work," Dr. Edge said. "And as they do that, they must ensure that they measure results so that they are always striving for continuous quality improvement."

Health care systems to treat cancer

Hospitals and other cancer care centers must continually demonstrate compliance with CoC standards in order to maintain accreditation. The result, according to Dr. Edge, is that health care organizations have proper systems set up or available through referrals to treat cancer, including high-quality tumor boards, pathology labs, diagnostic labs, blood banks, 24-hour physician staffing, social services departments, respiratory therapy departments, and advanced diagnostic equipment. CoC standards, Dr. Edge noted, accommodate large hospitals as well as the small ones.



The cover of the new edition of the standards manual.

"Standards can be applied appropriately to all types and sizes of hospitals," Dr. Edge said. Today, he said, most organized cancer care provided in the U.S. is based on the CoC framework.

"Most cancer care in the U.S.," Dr. Edge added, "is community-based. It takes place in community hospitals around the country. Where necessary, these hospitals may access and refer patients to the services of larger hospitals."

The CoC reviews its standards and survey processes routinely and revises them every five to seven years to reflect current cancer care practices. The standards have generally focused on structure and some process, but as in other areas of health care, outcomes are emerging as a key measure of effectiveness.

Dr. Edge added that the Commission is proactive when it comes to changes in cancer care. The CoC responds when there are wide reports of difficulties meeting compliance with certain standards, or when issues regarding changes in cancer care have been identified.

CoC consortium

The CoC has worked for more than 10 years with its current roster of the ACS and 47 other member organizations (see sidebar, page 16). CoC members are medical specialty societies, government agencies, and patient advocacy and support groups. Each organization appoints one representative to serve on the CoC for a three-year term, with eligibility to serve a

second term. The CoC holds meetings of all member organizations twice annually. The CoC Member Organization Steering Committee develops and evaluates collaborations and communication among member organizations.

In recent years, the CoC has taken major steps to bring more patient-based groups to the table, in addition to its long-time partner, the American Cancer Society. These include LIVESTRONG (the Lance Armstrong Foundation), the National Coalition for Cancer Survivorship, and the Cancer Support Community. All of these groups work with the multitude of needs that face cancer patients and their families, and provide support through research, patient services, education, and empowerment. These organizations are full members of the CoC and each has a voice and a vote.

Dr. Edge emphasizes that developing and applying the CoC Standards requires the work of many individuals, including a number of volunteers. "First and foremost are the staff of the Accreditation Program at the Commission on Cancer, led by Asa Carter, Connie Bura, Andrew Stewart, and David P. Winchester, MD, FACS," noted Dr. Edge, adding that key volunteers in the development of the new standards include Frederick Greene, MD, FACS, of Charlotte, NC, former Vice-Chair of the Standards Revision Committee; Diana Dickson-Wilmer, MD, FACS, of Wilmington, DE, who chaired the Standards Revision Committee; and Daniel McKellar, MD, FACS, of Greenville, OH, Chair of the CoC Accreditation Committee.

CoC's new patient-centered standards

The patient-centered standards that will become effective at the start of 2012 address vital patient issues. Standard 2.3: Risk Assessment and Genetic Counseling, calls on the staff at cancer facilities to assess a patient's personal and family medical history, which is performed on-site or by referral to a qualified genetics professional. This personal history should include medical information about the patient's first, second, and third relatives, as well as gathering information about paternal and maternal family history and ethnicity.

"A family with a history of cancer can use the information from genetic testing and cancer screening," Dr. Edge said. "Identifying patients at high risk has impor-

CoC member organizations

- American Academy of Hospice and Palliative Medicine
- American Academy of Pediatrics
- American Association for Cancer Education
- American Cancer Society, Inc.
- American College of Obstetricians and Gynecologists
- American College of Oncology Administrators
- American College of Physicians
- American College of Radiology
- American College of Surgeons Oncology Group
- American College of Surgeons Resident and Associate Society
- American College of Surgeons Young Fellows Association
- American Dietetic Association, Oncology Nutrition Dietetic Practice Group
- American Head and Neck Society
- American Hospital Association
- American Joint Committee on Cancer
- American Medical Association
- American Pediatric Surgical Association
- American Psychosocial Oncology Society
- American Radium Society
- American Society of Breast Surgeons
- American Society of Clinical Oncology
- American Society of Colon and Rectal Surgeons
- American Society of Radiation Oncology
- American Urological Association
- Association of American Cancer Institutes
- Association of Cancer Executives
- Association of Community Cancer Centers
- Association of Oncology Social Work
- Cancer Support Community
- Centers for Disease Control and Prevention
- College of American Pathologists
- Department of Defense
- Department of Veterans Affairs
- Veterans Health Administration
- LIVESTRONG (Lance Armstrong Foundation)
- National Cancer Institute
- Applied Research Program
- SEER Program
- National Cancer Registrars Association, Inc.
- National Coalition for Cancer Survivorship
- National Comprehensive Cancer Network
- National Consortium of Breast Centers
- National Society of Genetic Counselors
- National Surgical Adjuvant Breast and Bowel Project
- North American Association of Central Cancer Registries
- Oncology Nursing Society
- Society of Gynecologic Oncology
- Society of Nuclear Medicine
- Society of Surgical Oncology
- Society of Thoracic Surgeons

tant consequences for early detection and outcome."

The standard requires both pre-test and post-test counseling. In the pre-test, the cancer facility must obtain the patient's psychosocial assessment, either on-site or by referral. A CoC-accredited facility also will be required to evaluate a patient's risk for developing a specific type of cancer and whether a patient carries a heritable or germ line mutation of a cancer gene. The cancer facility must also follow through by educating the patient about the suspected hereditary cancer syndrome. If genetic testing is recommended, the facility must obtain the patient's informed consent. In the post-test, the facility must disclose test results, the patient's medical management options, and the impact of the test results to the patient.

Standard 2.4: Palliative Care Services, dictates the availability of care, either on-site or by referral, that focuses on the pain, symptoms, and stress of serious illness. Palliative care relieves, rather than cures, cancer symptoms and can help patients live more comfortably.

Palliative services refer to patient- and family-centered care that optimizes the quality of life. Palliative care serves a range of functions, including team-based care planning that involves the patient and family, pain and non-pain symptom management, communication among patients and families, and continuity of care across a range of clinical settings and services.

Standard 3.1: Patient Navigation Process, focuses on the continuum of care services, requiring the cancer committee of a facility to conduct an annual assessment of barriers to care for patients with cancer. Patient navigation refers to individualized assistance offered to patients, their families, and caregivers to help overcome barriers to care, whether through the health care system or the environment. Through navigation, the cancer center facilitates timely access to high-quality medical and psychosocial care that begins before the final diagnosis and continues through all phases of the cancer experience.

Cancer is a complex disease that has a major impact on patients and families, and the consequences of the disease affect all areas of the patient's life—psychologically, socially, financially, and behaviorally. Standard 3.2: Psychosocial Distress Screening, emphasizes the importance of screening patients for distress and psychosocial health needs as a critical first step in providing quality cancer care and requires systematic follow-up and re-evaluation. The psychosocial representative on the facility's cancer committee—an oncology social worker, clinical psychologist, or another licensed mental health profession—must lead this effort and issue annual progress reports.

Every cancer patient should have a plan for survival, which is covered in Standard 3.3: Sponsorship Care Plan, requiring the cancer committee to develop a process for disseminating comprehensive care summary and follow-up plans for patients who are completing treatment.

A privilege to care for cancer patients

The new patient-centered standards may increase the demands of CoC accreditation, requiring new programs and, to some extent, more administrative work and recordkeeping from cancer facilities. Dr. Edge recognizes the added demands, but he stresses their importance in addressing the needs of cancer patients and their families. "At some point, it is a privilege to care for cancer patients, and providing comprehensive care is not optional," he said.

"There's no question that the new patient-centered standards set a high bar," Dr. Edge said, "but it is a level that the CoC has found that most accredited programs not only can meet but do want to meet." Ω

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Common origins:

The two ACSs—

100 years of collaboration to improve the lives of cancer patients

by LaMar S. McGinnis, Jr., MD, FACS

When we talk about medical history, we often focus on the way events unfolded, but never really think deeply about why they happened. I maintain that history-making events are usually the result of persistent people with vision and ideas that respond to the problems in their environment at the time. Historic events often happen in groups of individuals who push themselves to resolve the problems of their era, and we need to cultivate these types of individuals today as we look forward to the future.

The successful collaboration between the American College of Surgeons and the American Cancer Society can be attributed to our common origins, our common evolution, and the common goals set forth by our founders and subsequent leaders. Progress is not happenstance. In our active, busy, digitally propelled lives, it is good to take a little time to look back at how we arrived where we are and to envision where we are going. A shared centennial in 2013 seems to be a proper time for organizations with shared beginnings to jointly celebrate their accomplishments.

Seneca said, "The journey is long by way of precepts, but short and effective by way of example." This article shares the stories of some of the individuals who have led us to where we are today.

Early efforts

Let us set the stage. At the beginning of the last century, the medical and surgical professions, despite the presence of some considerable giants, were in a sad and undesirable situation. We were losing one-third of the U.S. population in childbirth or from disease by age five. Life expectancy was 45 years. Communicable diseases were rampant. Hospitals were to be avoided. Operations were rare and usually ended in infection, which led to death. Physicians were able to offer little but comfort and morphine, and medical education at the time was a scandal.

Four entities—the College, the American Cancer Society, the American Joint Committee on Cancer, and The Joint Commission—began with the belief that medicine and surgery needed to develop higher standards for patient care, particularly cancer care. We shared a commonality of threads of origin, which has enabled our success and survival.

In the early 1900s, cancer was viewed as a dangerous, fatal disease. It was not very prevalent because most people did not live long enough to develop cancer, and those who did usually presented at a very advanced stage and did not survive long after the diagnosis. It seemed that not much could be done for cancer patients. There was both public and professional despair and resultant indifference.

A few physicians defied these notions. One of them was J. Marion Sims, MD, a South Carolinian who practiced surgery in Alabama and then was called to New York to establish the Women's Hospital of New York. Dr. Sims had a reputation for successfully applying surgical techniques in the treatment of fistulas in women and for performing hysterectomies and other gynecologic procedures. While at the Women's Hospital of New York, he developed a keen interest in cancer. He knew that it was against the rules of the hospital to admit cancer patients because many health care professionals and members of the public thought cancer was contagious and incurable. He admitted cancer patients anyway. Dr. Sims has been dubbed "the father of gynecology" and was the first American physician to have a statue erected in tribute. It still stands in New York City's Central Park.

As a result of his defiance, however, he was thrown off the hospital staff, but he had two potent allies, Elizabeth Cullum and Augusta Astor. Mrs. Astor was the wife of the tycoon, John Jacob Astor, and Mrs. Cullum was the granddaughter of the illustrious Alexander Hamilton and the widow of the General in Chief of the Union Army. Mrs. Cullum had a child with cancer, and she enlisted her cousin, Mrs. Astor, in an effort to reach out to the business community to raise money to establish the New York Cancer Hospital, which subsequently became the Memorial Hospital for Cancer and Allied Diseases in 1899. That hospital eventually became Memorial Sloan-Kettering Cancer Center, which has played such an instrumental role in the development and leadership of the American Cancer Society. These women brought cancer out of the closet, enabling a more open dialogue on the subject. Unfortunately, Mrs. Cullum's only child died of cancer, and she subsequently died of cancer, as did Mrs. Astor.

Thought leaders

Several other individuals revolutionized medicine in the last century. One such individual was Abraham Flexner. Mr. Flexner was a first-generation son of immigrants from Europe. His father was a pharmacist in Louisville, KY. Mr. Flexner became an excellent and noted educator, and the Carnegie Foundation

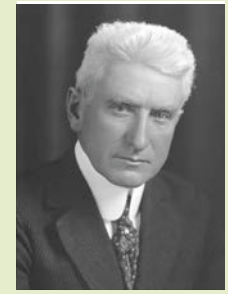
gave him a charter to survey all of the 163 existing U.S. medical schools. At the time, many of these institutions were diploma mills, with no requirements for entering medical school, no practical training (lectures only), and no requirements for graduation other than the payment of fees. Medical education was in a terrible and vexing state.

Mr. Flexner did a remarkable job. He did visit every medical school, traveling by train, and he wrote an impactful report on medical education that has become a classic. He recommended the closing of 124 of the 163 schools extant at the time. Soon after his findings were published, many of these proprietary facilities were closed. The whole pattern of medical education was changed.

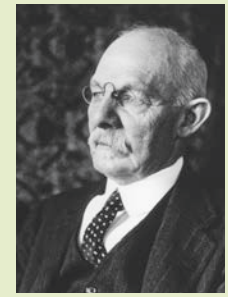
Another key figure dedicated to improving surgical education was Franklin H. Martin, MD, FACS (see photo, this page). Dr. Martin was a tall, redheaded country boy from Wisconsin who went on to practice in Chicago, IL, and became a very well-known surgeon. He established the journal *Surgery, Gynecology & Obstetrics* (now known as the *Journal of the American College of Surgeons*) as one means of educating surgeons. He established the Clinical Congress of North America as a forum where surgeons could meet and learn about surgery and watch surgeons apply excellent technique, and he was the principal person responsible for establishing and sustaining the College through its formative years. Dr. Martin altered surgical history and began our heritage.

Ernest A. Codman, MD, FACS, was perhaps the most interesting of the group (see photo, this page). He was a Boston Brahmin. Educated at Harvard University, he married the daughter of the professor of anthropology (Bowditch) at Harvard. He established an active surgical practice at the Massachusetts General Hospital (MGH) in Boston and was a leader in the use of diagnostic X ray. He was also an expert in the shoulder. Everything was going right, but Dr. Codman had strong ideas and an abrasive personality. He had the notion that if a physician was going to do something to a patient in a hospital, then it was important that the health care professional and the institution keep accurate records, document the outcome, and be very transparent with the findings. "Don't just operate and discharge the patient; see what happens and learn from that," Dr. Codman famously said. He also had the unusual (for the time) belief that hospitals should have some quality standards. Dr. Codman established a bone sarcoma registry,

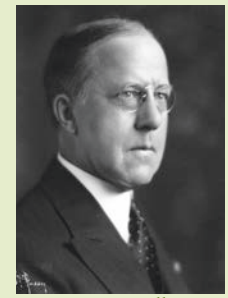
Thought leaders


Dr. Martin

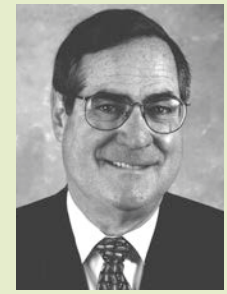

Dr. Codman


Dr. Halsted


Dr. Greenough


Dr. Crowell


Dr. Copeland


Dr. Winchester

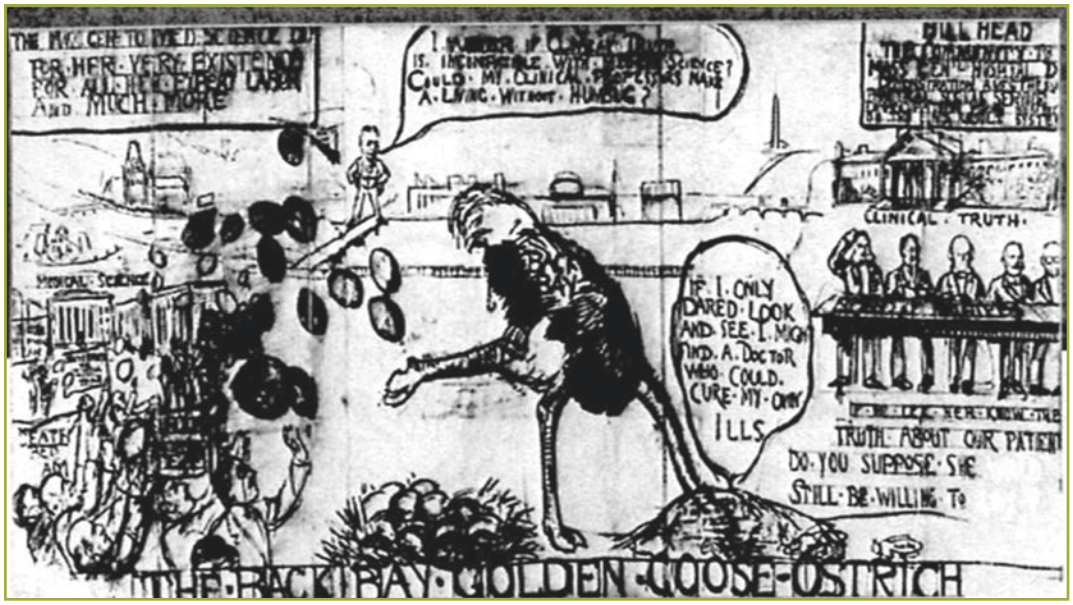


Figure 1

which was the first collection of cancer data. He was an extemporaneous person. He was brilliant. His ideas were different and challenging, and he managed to offend nearly every group with which he worked. Dr. Codman stated that it might be 100 years before his ideas would be accepted. He was a true visionary.

W. Hardy Hendren III, MD, FACS, recently sent me a restoration of the original cartoon that Dr. Codman drew (see Figure 1, this page). He was lampooning the medical profession in Boston. In the comic he depicted his belief that as long as the Back Bay Peacock was laying golden eggs, the medical establishment there saw no need to collect and examine data. With that presentation to the Suffolk Massachusetts District Surgical Society, he was removed from the society and from the staff at the MGH. He then established his own hospital (the End Result Hospital) and continued to collect and publish data on each and every patient. He was outspoken, thus offending his peers. As a result, he received no referrals and the hospital failed.

Dr. Codman's accomplishments were many; he established the first morbidity and mortality conference, at MGH; with his Harvard classmate, he developed what they called "the ether record" and what is today referred to as the anesthesia record; he published books on the shoulder and on bone sarcoma; he established the "end-result" idea; he is now known as the father of outcome studies and evidence based medicine; he believed in transparency of data; he was appointed the first Chair of the Standards Committee of our burgeoning College and was responsible for developing the Minimum Standard for Hospitals, issued in 1917, focusing on medical staff organization, on critical evaluation of clinical practice, and on medical record standards. Following the publication of the Minimum Standard, hospitals were surveyed relative to the Standard, by the College. The results, reported at a meeting at the Waldorf Astoria hotel, revealed that only 89 of 692 hospitals met the standard. Following the meeting, the results of the report were burned and never released.

With all of his many contributions, many are just coming into acceptance today (as he predicted). Dr. Codman died in 1940 of melanoma, was a virtual pauper, and chose to be buried in an unmarked grave in the famous Mt. Auburn Cemetery (Cambridge) so as to not impose the expense of a headstone upon his widow. I believe that The Joint Commission, the American Cancer Society, the American College of Surgeons, and the American Academy of Orthopaedic Surgeons should erect a headstone at the grave site to properly acknowledge

this visionary and our debt to him. Our centennial year would be the perfect time for this to occur.

William Halsted, MD, FACS, who was the first chair of surgery at Johns Hopkins University, Baltimore, MD, revolutionized surgery in this country (see photo, page 8). His accomplishments were many, and I will enumerate only a few of them in this article. He requested that the Goodyear Company make the first pair of rubber surgical gloves for his nurse and future wife—Carolyn Hampton, niece of the South Carolina Gen. Wade Hampton—because she was allergic to carbolic acid. He encouraged the use of fine sutures and ligatures and advocated treating tissues with respect, with an emphasis on gentle handling. Dr. Halsted developed thyroid surgery. He evolved local, regional, and spinal anesthesia. He created the surgical training program that became the model for virtually all surgical resident training programs in the last century. He introduced radical mastectomy. Dr. Halsted has since been castigated for the latter, but we should acknowledge that at that time, hardly anyone survived breast cancer, and that the Halsted mastectomy resulted in a 40 to 45 percent five-year survival rate. He revolutionized surgical practice and training and established a paradigm regarding the way in which cancer spread, which survived over the last century.

Thomas Cullen, MD, FACS, and Clement Cleveland, MD, FACS, together were the founders of the American Society for the Control of Cancer (ASCC) in 1913, which subsequently became the American Cancer Society. They were general surgeons with a focus on gynecologic surgery. Dr. Cullen analyzed his cases of cervical cancer and reported his findings to the American Gynecological Society in 1912, noting that at five years, only 23 percent of his patients were surviving. Around that same time, the Prudential Insurance Company had noted a marked increase in the incidence of cancer. Cancer was becoming a very prominent clinical problem. Dr. Cullen, practicing in Baltimore, MD, was appointed head of a committee of the evolving American College of Surgeons, to collect and to promulgate data regarding cancer. Joining forces with Dr. Cleveland in New York, NY, these two men put together a group of physicians and laypeople with the purpose of collecting data about cancer and educating the public about the condition. As a result of their activities and the group they brought together, the ASCC was established to continue those efforts.

Their patient education efforts led to the publication of an article in the May 1913 issue of the *Ladies Home Journal,* titled "What can we do about cancer?" This article—which was also noted in *Collier's* and *McClure's* magazines—is believed to have been read by 11 million people, revolutionizing the public's understanding of the disease and educating people that with early detection, cancer was treatable—although treatment options were limited at the time. The concept of fight-

Timeline:
The evolution of collaboration

1913	The American Society for the Control of Cancer The Cancer Campaign Committee *Thomas Cullen* *Clement Cleveland*
1921	Registry for Bone Sarcoma *Ernest A. Codman*
1922	The American College of Surgeons Committee for the Treatment of Malignant Disease by Xray and Radium *Robert Greenough*
1927	Program for Survey and Approval of Cancer Facilities
1930	The American College of Surgeons Committee on the Treatment of Malignant Disease *William Greenough*
1931	Organization for a Service for Diagnosis and Treatment of Cancer *Bowman Crowell*
1939	The American College of Surgeons Committee on Cancer *Frank E. Adair*
1970	The American College of Surgeons Commission on Cancer R. Lee Clark

ing cancer by educating the public had begun. John Bowman, PhD, was the first director of the College at that time (1915 to 1921) and began establishing hospital standards for the cancer program.

Dr. Cullen became a leader in cancer care through his work with Joseph Bloodgood, MD, a pathologist at Johns Hopkins Hospital. Together, they established the frozen section as a diagnostic tool for cancer. They also created and publicized a list of the "danger signals of cancer," which was translated into 22 different languages; more than 700,000 requests for these signals were received. When they started this activity in 1910, the average delay in diagnosis of cancer was one year from the onset of symptoms. By 1923, it had fallen to four months, so the impact was significant.

Evolution of collaboration

On page 10 there is a timeline depicting the evolution of collaborative efforts between the American College of Surgeons and the American Cancer Society. It is interesting to note that in 1913 the Prudential Insurance Company published a bulletin called "The Menace of Cancer," which showed a rapid increase in the incidence of cancer (from tenth to fourth). In that same year, the College and the ASCC were established. The epidemiologic influence on cancer began to occur. In 1923, epidemiologist George Soper, MD, managing director of the ASCC, began to criticize the organization's Cancer Campaign Committee for being too optimistic about cancer, and he asked, "Should we motivate the public by optimism or by fear?" This is an interesting question, even today. In 1914, this committee established a New York office with a budget of $5,000. In 1923, it was legally incorporated.

Meanwhile, Dr. Codman's registry for sarcoma had been established and led to the formation of other cancer registries and to the collection of appropriate data. In 1922, the College formed the Committee on the Treatment of Malignant Disease by X-ray and Radium, which subsequently became the Committee on Cancer. The first chair, Robert Greenough, MD, FACS, of Boston (see photo, page 8), established the first consultative U.S. tumor clinic at the MGH. He emphasized the need for microscopic confirmation of the diagnosis of cancer, and called for the collection of five-year survival rates. Dr. Greenough subsequently became President of the American College of Surgeons in 1934 and was president of the ASCC in 1937, the year of his death.

Table 1

The Committee on Cancer of the American College of Surgeons

1952	Cancer Committee membership expanded to American Cancer Society, National Cancer Institute, American College of Radiology, American College of Physicians, and College of American Pathologists
1953	Cancer Registry approved by the county medical society
	Terminated approval of cancer detection centers
1954	Manual for cancer programs
1947–1953	Regionalization concept—cancer detection centers
1950	*Cancer Is Curable* brochure
1960	Field Liaison Program
1960–1973	Emphasis on quality of care
1965	The Commission on Cancer
1966	Cancer Program Manual
1983	Cancer Management Course
1990	National Cancer Data Base

The ASCC's Committee on Cancer precipitated the 1927 formation of the Program for Survey and Approval of Cancer Facilities. The ASCC (later known as the American Cancer Society) funded that activity, and it should be noted that from 1926 to 2005, the Society spent $26 million dollars to fund this program.

Bowman Crowell, MD, a pathologist from Nova Scotia, was an important figure in these early efforts, as he took over the bone sarcoma registry in 1926 (see photo, page 8). He began to further emphasize the wider collection of data so that the cancer facilities that the Cancer Society had urged to be formed could be evaluated properly. By 1930, there were 198 approved cancer centers in the country; and by

1943, 380 cancer clinics had been approved by the College, with 80,000 patients a year being seen in those facilities. Dr. Crowell was very influential. As Co-Director of the College, he led the organization's quality improvement efforts and accomplished much for the College. He gave an address at the 25th anniversary of the American Society for the Control of Cancer, and in 1949, he became the first person to receive the Medal of Honor from the American Cancer Society. It should be noted that in addition to the Medal of Honor, Dr. Crowell was given a cigarette lighter!

In 1930, Dr. Greenough was appointed to chair the College's Committee on the Treatment of Malignant Disease, which would become the Committee on Cancer. Again, the American Cancer Society—which was still the ASCC at the time—gave a grant to the College to develop standards for surveying oncology centers. This step marked the beginning of the Hospital Cancer Approvals Program. In 1931, a service for the diagnosis and treatment of cancer (cancer clinics) was again led by Dr. Crowell. That same year, there was a joint meeting of the boards of the American Cancer Society and the College to study and to further develop this issue. By 1935, 25,000 patients were listed in the cancer database with information indicating who had died or survived, and 2,800 patients were in the bone sarcoma registry.

In 1936, a significant act of the ASCC, now led by Clarence Little, MD, was the formation of the Women's Field Army, which became the primary fundraising unit and the service unit for this burgeoning organization. It should be noted that Dr. Cullen was the first to recognize the importance of women in the battle against cancer. As he noted, "They direct the family in health care," a fact that persists to the present.

I have recognized the importance of women in the American Cancer Society, and devoted my year as president (1995) to not only the women in the American Cancer Society but to cancer in women. At that time, there had been only one female chairman of the board, no society president, and few leadership positions for both female volunteers and staff. Since then, considerable improvement has occurred for women, with the appointment of six national board chairs, three presidents, and multiple senior staff officers.

With vigorous support from both the American Cancer Society and from the College, in 1937, the National Cancer Institute Act was passed, and the National Cancer Institute was formed. Progress has occurred but, admittedly, at a slower than desired pace.

In 1939, the College created its Committee on Cancer, with Frank E. Adair, MD, FACS, as Chair (see Table 1, page 11). Dr. Adair was a prominent surgeon at Memorial Sloan-Kettering and was president of the American Cancer Society in 1945. In 1953, the Cancer Society and the College came together to form cancer detection centers, with the Cancer Society providing funding for the College's efforts to survey these cancer detection centers. However, that collaboration only lasted two years because it was so difficult to establish and evaluate standards. In 1952, the committee became multidisciplinary (American College of Surgeons, National Cancer Institute, American College of Radiology, American College of Physicians, and the College of American Pathologists), and in 1970, the College's Committee on Cancer became the Commission on Cancer under the direction of R. Lee Clark, MD, FACS, who was also the founder of the MD Anderson Cancer Center in Houston, TX. There has been a continuing expansion of multidisciplinary members on the Commission.

Table 2

Commission on Cancer directors

Bowman C. Crowell	Andrew Mayer
Charles F. Branch	Charles R. Smart
Walter Batchelder	David P. Winchester
Andrew Myers	Monica Morrow
James B. Mason	David P. Winchester
Owen McDonald	

Table 3

AJCC

1950	Joint Committee on Reporting Cancer End-Results
1953	Murray Copeland—Committee on Clinical Stage Classification & Applied Statistics of the International Union Against Cancer
1958	American Joint Committee for Cancer Staging & End Result Reporting
1980	American Joint Committee on Cancer

Continuing evolution

Dr. Little was the managing director of the ASCC, beginning in 1929, and he focused on professional and lay education and the regionalization of the organization. He formed the Women's Field Army mentioned previously. He encouraged the society to support the National Cancer Institute (NCI) Act of 1937 and led the reorganization of the Cancer Society in 1941.

Mary Lasker is generally recognized as the person who made the modern American Cancer Society what it is today. She was the wife of a prominent advertising executive in New York City; she had connections. She became very interested in cancer because one of her household staff had the disease, and she was amazed at how poor the care was. Under her direction, the Cancer Society's fundraising capabilities were remodeled and she raised $4 million in the first year—which totally revolutionized what was happening in the organization. There was some regionalization at the time, and the 60 percent (division)/40 percent (national) split of funds began. She insisted that the organization be led by 50 percent laypeople and 50 percent health care professionals, and that arrangement has persisted. She insisted that 25 percent of the funds raised be directed toward research efforts. Isn't it interesting that that expectation continues to be in place? Also, she insisted that the name be changed from the ASCC to The American Cancer Society. Ms. Lasker was a strong and highly principled person, and her influence continues today.

Elsie Mead became Chair of the ASCC, following Dr. Clement Cleveland (her father). She was a fundraiser par excellence, and she is the individual who involved the American Federation of Women's Clubs with the organization. Ms. Lasker and Ms. Mead laid the strong foundation that has enabled the American Cancer Society to become the largest, best-recognized volunteer health organization in the world today.

Post-World War II, the Mary Lasker influence took hold; Lane Adams was the chief executive officer of the Cancer Society at that time. He moved the organization forward, increased visibility, increased prominence, increased patient services, and increased the local presence.

Table 4
Combined presidents

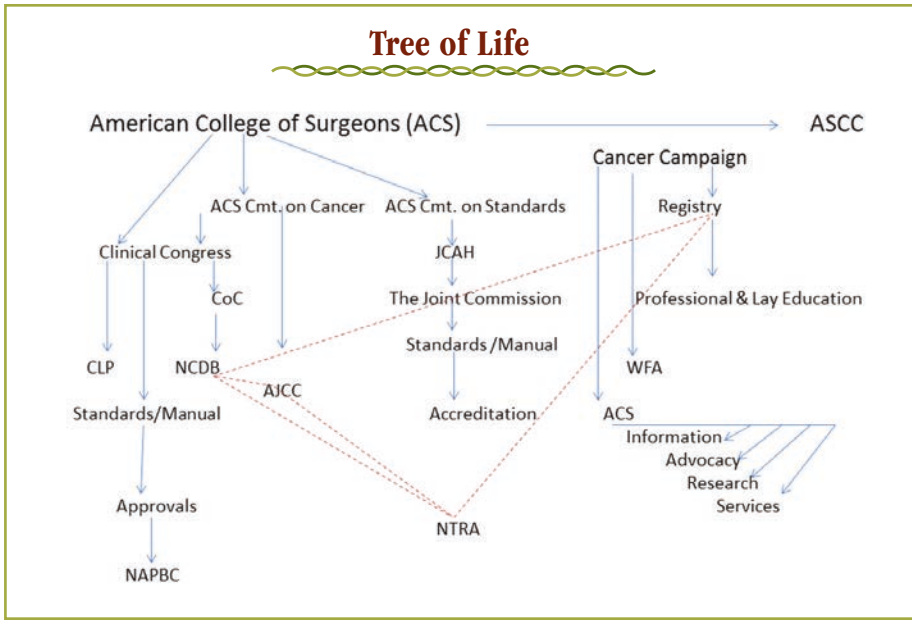
	American College of Surgeons	American Cancer Society
Alton Ochsner, MD, FACS	1951–1952 (31st)	1950 (15th)
Isadore Ravdin, MD, FACS	1960–1961 (41st)	1963 (28th)
Jonathan Rhoads, MD, FACS	1971–1972 (52nd)	1970 (34th)
LaSalle D. Leffall, Jr., MD, FACS	1995–1996 (76th)	1979 (43rd)
LaMar S. McGinnis, Jr., MD, FACS	2009–2010 (90th)	1995 (52nd)

During this era, the College worked to establish what we now know as The Joint Commission because the College could no longer afford to sustain its hospital standards inspection program. The College had spent $2 million on this effort, so a group composed of representatives from the College, the American Medical Association, the American Hospital Association, the American College of Pathologists, and the Canadian Medical Association was brought together to form the Joint Commission on Accreditation of Healthcare Organizations. Today, The Joint Commission accredits approximately 20,000 national organizations and 450 international institutions. The Joint Commission's accreditation is the gold standard.

The Directors of the Commission on Cancer (CoC) are listed in the Table 2 on page 12. I became active with the CoC when Andy Mayer, MD, FACS, a Vanderbilt University (Nashville, TN) surgeon, was Director of the Commission. It was interesting at the time; not only did Dr. Mayer smoke cigarettes, but every member of his staff smoked. The first meeting I attended was in Richmond, VA. I checked into the hotel and received a message to join the group for dinner. I joined the group at this big round table; everyone was smoking. The smoking went on throughout Dr. Mayer's entire tenure as director. Further, he stated that he would never have a computer in the CoC. Then Charlie Smart, MD, FACS, came on as Director. He was from Utah, a Mormon—there was no tobacco to be found, and he was very computer-oriented.

Needless to say, things evolve. David P. Winchester, MD, FACS (see photo, page 8), took over as director in 1984, and continuing progress has occurred. The CoC has been responsible for the modern Hospital

Figure 2



Cancer Approvals Program, with nearly 1,500 approved programs, where 70 percent of U.S. cancers are treated; the Cancer Liaison Program; the National Cancer Data Base (NCDB) (with 26 million patients, making it the largest in the world); hospital tumor registries; cancer management courses; the annual CoC Oncology Lecture at the College's yearly Clinical Congress; the National Accreditation Program for Breast Centers (NAPBC); the *Cancer Program Manual;* the Cancer Quality Improvement Program; and so on. Many of these programs have been funded and developed in collaboration with the American Cancer Society. It has been impossible in the allotted space to properly note the strong leadership provided over time by many volunteer surgeons serving in a variety of roles.

The evolution of the many important efforts that have been carried out through what we now know as the American Joint Committee on Cancer (AJCC) is outlined in Table 3 on page 12. The AJCC was first formed in 1950 as the Joint Committee on Reporting Cancer End-Results. Dr. Lee Clark and Murray Copeland, MD, FACS (see photo, page 8), were the most important figures in the development of the AJCC. Dr. Copeland, at that time, was the chair of the department of surgery at Georgetown University in Washington, DC, and he headed the Committee on Clinical Stage Classification and Applied Statistics of the International Union Against Cancer, which subsequently became, in 1958, the American Joint Committee for Cancer Staging and End Result Reporting, and in 1980, the AJCC. The AJCC has been essential to progress in the staging of cancer, which is the basis for cancer therapy. The TNM classification of malignant tumors staging system and the *Cancer Staging Manual,* now in its seventh edition, are only two of the important contributions of the AJCC—another product of the collaboration between our College and the American Cancer Society.

Five surgeons have been privileged to be President of both the American College of Surgeons and American Cancer Society. Looking at Table 4 on page 13, it is interesting to note the timing between when a surgeon was President of one and then the other organization. It is further evidence of the integration that has occurred over time.

Tree of Life

The Tree of Life depicted in Figure 2 on this page shows the essence of the integration and evolution of all that has gone on. It shows how the American College of Surgeons and the American Cancer Society, through their various synergies, formed the Commit-

tee on Cancer, the Committee on Standards—which led to the Joint Commission on Accreditation of Hospitals, now The Joint Commission; the Commission on Cancer; the NCDB; the AJCC; the National Tumor Registrars Association (NTRA); and all of the different products and committees that are involved in the organizations' efforts to improve care for cancer patients. My question now is: What follows? Where are we going? New outcomes measurement programs are being instituted, including the NCDB's Rapid Quality Reporting System. An effort is under way to combine and analyze data from the College's National Surgical Quality Improvement Program (ACS NSQIP®) and the NCDB. In addition, the College is working with the Centers for Medicare & Medicaid Services to use the ACS NSQIP as the basis for evaluating surgical quality improvement.

In addition, NTRA—now the National Cancer Registrars Association—was formed, and is continually striving to increase quality and efficiency in data collection and to maintain the pool of trained registrars. The understanding and management of cancer is changing rapidly and substantially and all cancer professionals must remain current and collaborative. We have many opportunities to grow and come together.

As we move forward, I would assert that collaboration works and that protective silos stymie progress, that significant impact is usually the result of persistent visionaries working in the right environment, and, finally, that a focus on improving health care is the only reality for health care professionals.

Today, cancer is the second leading cause of death in the U.S. and the leading cause of death among the non-communicable diseases worldwide. It takes us too long to achieve improvements and to creatively change, thus it ever-more essential for us to continue to be visionary, collaborative, and effectively productive. As Margaret Mead said, "We are continually faced with great opportunities which are brilliantly disguised as unsolvable problems." Ω

Editor's note: *This article is an adaptation of a presentation given to a joint meeting of the American Cancer Society, the American College of Surgeons, and the American Joint Committee on Cancer, in Atlanta, GA, October 3–4, 2011.*

Acknowledgements

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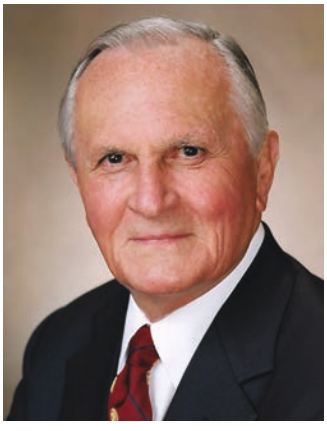

AMA House of Delegates (HOD) meeting, June 7–11, 2014, in Chicago, IL: John H. Armstrong, MD, FACS; Jacob Moalem, MD, FACS; Leigh Neumayer, MD, FACS; Richard Reiling, MD, FACS; and Patricia L. Turner, MD, FACS. Assisting the delegation was Timothy Kresowik, MD, FACS, a vascular surgeon from Iowa, and Kenneth Louis, MD, FACS, a neurosurgeon from Florida. With this meeting, Dr. Reiling completed his 22-year tenure as a member of the ACS delegation. He chaired the delegation from 2006 through 2010 and was the first Fellow to be elected to an AMA Council as a nominee of the College. The delegation recognized his leadership, and he was on the list of retiring delegates presented to the HOD.

Chapter Lobby Day Grants 2015

Chapters were asked to apply for lobby day grants in 2015. Under the program, chapters may receive up to $5,000, with the expectation that the chapters provide a 50 percent match. In 2014, 17 states received a grant. As of the October board meeting, the Health Policy and Advocacy Group (HPAG) confirmed that the following chapters would be receiving grants for 2015:

- Alabama
- Brooklyn/Long Island
- California
- Connecticut
- Florida
- Georgia
- Indiana
- Kansas
- Massachusetts
- Michigan
- Tennessee
- Virginia

Other states expecting to conduct lobby days in 2015 are Louisiana, North Carolina, Ohio, Oregon, Texas, and Washington.

Cancer programs

The Commission on Cancer (CoC) has accredited a total of 1,507 cancer programs in the U.S. and Puerto Rico. Annually, these centers treat 71 percent of all newly diagnosed cancer patients. The CoC conducted 433 cancer program surveys in 2013–2014, and 27 new cancer programs joined the accreditation program. The CoC presented Outstanding Achievement Awards to 79 cancer programs, and eight new physician and nonphysician surveyors were recruited and participated in initial training.

CoC's Best Practices Repository was reformatted, and additional content was approved by the Standards Advisory Group for Excellence. In addition, the site for CoC Accreditation was launched for distribution of certificates and Outstanding Achievement Award trophies and the purchase of related promotional materials. Furthermore, in 2013, more than 1,000 individuals registered on the CAnswer Forum site, and more than 2,000 questions were submitted. Most inquiries focused on cancer registry coding guidelines.

The National Cancer Data Base's (NCDB) Cancer Program Practice Profile Reports have been expanded to include two new sets of quality measures. Three breast measures were released in March 2014. Three additional measures will be included along with the 2012 data release, two for non-small cell lung and one for gastric, bringing the total released measures to 12. Multiple societies are collaborating to develop and harmonize additional measures to be evaluated by the Quality Integration Committee, and, if approved, implemented through an NCDB reporting tool.

Interest in the NCDB Participant User File (PUF) program grew in 2014; 227 applications (up from 178 the previous year) were reviewed for technical feasibility of research aims. Researchers using PUF data have generated 19 breast, 15 colorectal, nine esophagogastric, one melanoma, three ovarian, three pancreas, one sarcoma, two thyroid, and four bladder papers/presentations.

The number of programs participating in the Rapid Quality Reporting System (RQRS) grew in 2013–2014 from 54 percent of CoC-accredited programs/networks to 71 percent currently.

The Prospective Payment System (PPS)-exempt contract, received in October 2012, completed its second year.

The 11 members of the Alliance of Dedicated Cancer Centers (ADCC) submitted data to the RQRS system. Quarterly data files containing quality measure rates for three measures (two for breast cancer, one for colon) are generated and submitted to CMS for public reporting. CMS hosted a meeting in June 2014 with representatives of the facilities and contractors to discuss progress to date. The ACS received notice of renewal for the second option year of the contract in September 2014.

The CoC's second Annual Advocacy Committee Planning Meeting took place in San Francisco, CA, on October 25, 2014. The CoC has been actively engaged in several legislative and regulatory policy issues this quarter, including support of the AMA resolutions on genetic testing and biomedical research legislation.

The College's Clinical Research Program (ACS CRP) Cancer Care Standards Development Committee has submitted the manuscript, *Operative Standards in Cancer Surgery,* to the publisher. Production began in September 2014, with a targeted publication date of February 2015. All 23 CoC-accredited institutions have volunteered to pilot-test the data collection tool and electronic interface; pilot-testing began in September 2014.

In addition, the ProvenCare Lung Cancer Collaborative leadership met to discuss the expansion of the collaborative to include medical and radiation oncology. Data elements for these specialties have been developed and will be finalized through conference calls in October 2014. The expanded program, Phase III, is set to launch in early 2015, in which nine institutions are participating.

Content development for the American Joint Committee on Cancer (AJCC) *Cancer Staging System 8th Edition* began in October 2014. The infrastructure is now in place to support more than 500 volunteers, 18 expert panels, five cores, and the editorial board. The AJCC continues to administer the Collaborative Stage Data Collection System (CS) through a cooperative agreement with the Centers for Disease Control and Prevention (CDC). Collaborative Stage CS Version 02.05 was released in November 2013.

Two new educational presentations were developed specifically for the registrar community to assist in the transition from CS to directly coded AJCC Staging. This transition will take place January 1, 2016. The CDC has provided funding for the development of educational offerings. The initial two presentations were made available for the state registrar meetings, and over the coming year an additional 12 presentations will be rolled out as part of a comprehensive curriculum from registrars to reinforce their knowledge of AJCC staging.

The National Accreditation Program for Breast Centers (NAPBC) has now accredited more than 560 breast centers in the U.S. Reaccreditation rates for 2014 and 2015 remain at 99 percent. Approximately 20 percent of centers request to be surveyed with their CoC program. A small team of cross-trained surveyors perform these collaborative surveys. Efforts are under way to validate NAPBC-accredited centers that are affiliated with a CoC program.

The CoC collected video testimonials from Survey Savvy attendees. The videos have been completed, are being used at trade shows, and will be posted to the College's YouTube channel.

Division of Education

The Committee on Residency Training ("Fix the Five") has met regularly and has identified seven principal areas of focus:

- Organizational commitment
- Transitions during surgery residency
- Structured curricula, assessment, proficiency-based training and advancement
- Appropriate autonomy for residents
- Environment of residency education, including duty hours, fiscal resources, and support systems

ACS CoC creates awareness of cancer issues at state and federal levels

HIGHLIGHTS

- Describes the ACS CoC's role in advocating for quality cancer care
- Provides an update on state and federal activities regarding the following issues:
  - Raising the age for purchasing cigarettes
  - Creating parity for coverage of oral chemotherapy treatments
  - Regulating the use of tanning beds
  - Screening for colorectal cancer
- Informs readers about how they can advocate for cancer patients

by Tara Leystra Ackerman

Commission on Cancer®

The American College of Surgeons (ACS) Commission on Cancer (CoC) established an Advocacy Committee in 2013, which is responsible for identifying, evaluating, and recommending positions on legislative and/or regulatory issues that come before the state and/or federal government and that have the potential to affect CoC-accredited cancer programs and cancer patients. The ACS CoC Advocacy Committee meets annually to establish a list of priorities and conducts regular conference calls to discuss ongoing developments.

For the last two years, the ACS CoC Advocacy Committee has hosted briefings on Capitol Hill to promote the CoC and the value of accreditation. Furthermore, in February the Advocacy Committee held its first Lobby Day to promote the CoC and discuss cancer research funding, among other issues.

Policy issues related to cancer care often begin in the state legislatures before any federal action is taken. This pattern is especially true for cancer

prevention policies, as well as some cancer treatment insurance coverage and access to care issues. In fact, state governments led the way in establishing smoke-free workplaces, raising the legal age to smoke or use tanning beds, regulating e-cigarettes, administering screening and early detection programs, and addressing related health insurance coverage issues. This article focuses on several key cancer issues that state legislatures are addressing this year.

Raising the smoking age

Many cities and a few pioneering states are attempting to raise the legal smoking age to 21 from 18 years old. The movement began in **Needham, MA**, which in 2005 became the first municipality to increase the minimum age for the purchase of tobacco products to 21. A study showed that after the ordinance's implementation, the number of Needham youths who smoked declined more sharply than in surrounding communities.[1] According to the Centers for Disease Control and Prevention, nearly nine out of 10 cigarette smokers first tried smoking by the time they were 18, and preventing tobacco use among youth is critical to reducing the number of people who become addicted overall.[2] Cutting the number of smokers is vital to improving the nation's public health, as tobacco use is a leading cause of cancer and death from cancer. More than 100 cities have since followed Needham's example, including **New York, NY**, which increased its legal smoking age to 21 in 2013.[3]

Last year **Hawaii** became the first state to increase its smoking age to 21. The **New Jersey** legislature passed a bill that called for raising the smoking age to 21 in January of this year, but Gov. Chris Christie (R) pocket vetoed it by taking no action on the legislation. In March, both the **California** Senate and Assembly had passed a bill (S.B. 7) that would raise the smoking age to 21 and address other tobacco-control related issues. As of press time, it is awaiting action by Gov. Jerry Brown (D). **Massachusetts, New York, Oregon, Rhode Island, Utah, Vermont, Washington,** and the **District of Columbia** also considered bills to increase the smoking age to 21 in 2015, but none of them moved to the next stage of the legislative process.[4] **Pennsylvania, Tennessee,** and **Utah** all have bills active in their 2016 legislative sessions.

A bill also was introduced in the U.S. Senate by Sen. Brian Schatz (D-HI) to raise the legal smoking age to 21 throughout the nation. The Tobacco to 21 Act (S. 2100) prohibits the sale or distribution of tobacco products to individuals under the age of 21. The bill is unlikely to advance in 2016.

Parity for oral chemotherapy

Access to care is another priority issue for the CoC, including improving the availability of new chemotherapies that are administered orally instead of intravenously. Traditional intravenous (IV) anti-cancer medications have been covered health care benefits under most health insurance plans, including Medicare and Medicaid. Cancer patients may only need to make a copayment, or they may incur no cost at all for this treatment. However, many new anti-cancer medications are taken orally, and are covered under a health plan's pharmacy benefit. These drugs can be expensive, and often health plans require that patients pay coinsurance, which is a percentage of the overall cost of the prescription drug. This payment can be financially burdensome for some cancer patients, and, consequently, many of these patients are unable to fill their prescriptions or complete the entire regimen.[5]

Legislation was introduced in the states to address this problem by requiring health plans to provide equal coverage for a patient's out-of-pocket costs for oral and IV therapies. This legislation does not mandate coverage of oral chemotherapy, but it does require health plans to cover treatment equally, meaning patients' out-of-pocket costs must be the same, regardless of how the therapy is administered. A total of 40 states and the **District of Columbia** have passed this type of legislation. In 2015, **Mississippi, New Hampshire,**

North Dakota, South Dakota, West Virginia, and **Wyoming** passed legislation that provides parity for copayments for intravenous and oral chemotherapy. Similar bills are under consideration this year in the following states: **Alabama, Alaska, Michigan, North Carolina, Pennsylvania,** and **Tennessee**. The states that have yet to take action are **Arkansas, Idaho, Montana,** and **South Carolina**.

Federal legislation that addresses equal coverage for oral and IV therapies also has been introduced. The Cancer Drug Coverage Parity Act would require health insurance plans that cover traditional IV or injectable chemotherapy to provide comparable coverage for orally administered anti-cancer prescription medications. This bipartisan legislation was introduced in the U.S. House of Representatives by Reps. Leonard Lance (R-NJ) and Brian Higgins (D-NY) as H.R. 2739 and in the Senate by Sens. Mark Kirk (R-IL) and Al Franken (D-MN) as S. 1566. The ACS CoC has voiced support for the legislation because it ensures that a patient's treatment plan is based on the physician's recommendation, not on the costs associated with an outdated policy.

Tanning bed regulations

In the last few years, states have increased regulations on tanning devices, including banning their use by individuals younger than 18 years old. Use of tanning devices by minors is banned in 13 states: **California, Delaware, Hawaii, Illinois, Louisiana, Minnesota, Nevada, New Hampshire, North Carolina, Oregon, Texas, Vermont,** and **Washington**. In addition, 42 states regulate the use of tanning devices in some manner. In 2016, the College will work with a coalition in **Kansas** to advance legislation (H.B. 2369) that would ban the use of tanning beds by individuals under the age of 18.

Although at present no federal legislation bans the use of tanning devices by minors, the U.S. Food and Drug Administration did propose a rule on December 22, 2015, that would restrict the use of these devices to individuals 18 years of age and older.

Colorectal cancer screening coverage

The Affordable Care Act mandates coverage of colorectal cancer screenings, including colonoscopies, sigmoidoscopies, and fecal occult blood testing, without any cost sharing. The extent of this coverage isn't always clear and has created confusion in a number of instances. For example, if someone gets a positive result on a fecal occult blood test, a follow-up colonoscopy is required. However, it may be unclear whether the colonoscopy is covered as part of the original screening, or is considered a separate diagnostic test.

In the last year, at least six state legislatures have considered legislation attempting to clarify this distinction and address other gaps in colorectal cancer screening. For example, an **Oregon** bill (H.B. 2560) was signed into law in 2015, which requires health care insurers to cover the cost of a colonoscopy for individuals who are 50 years of age or older and have had a positive fecal test result. The law also requires health benefit plans to cover the cost of a colonoscopy for individuals ages 50 and older and who have a positive fecal immunochemical test result. Other state legislatures that are considering bills aimed at increasing colorectal cancer screenings include **Florida, Hawaii, Kentucky, Massachusetts,** and **New York**.

Activity related to colorectal cancer screening also is taking place at the federal level. When the Affordable Care Act was first passed, there was confusion regarding polyp detection and removal during a colonoscopy screening and whether it was part of the screening test or a separate therapeutic procedure. Some health care insurers treated it as the latter and sent bills to patients for some or all of the procedure's costs. In 2013, the Obama Administration clarified that polyp removal is part of the screening process and should be covered without cost sharing. However, this directive did not address Medicare coverage. The Removing

Barriers to Colorectal Cancer Screening Act (H.R. 1220/S. 624) would address this gap. The ACS CoC has previously supported this legislation to ensure that Medicare beneficiaries have access to the full benefits of colonoscopies without bearing responsibility for cost sharing.

Promoting CoC accreditation

One important goal of the ACS CoC Advocacy Committee is to promote CoC accreditation at both the state and federal levels. **Florida** Gov. Rick Scott (R) in 2013 approved legislation creating the Cancer Center of Excellence Award to recognize hospitals, treatment centers, and other providers in the state that demonstrate excellence in offering patient-centered, coordinated care to patients receiving cancer treatment and therapy. To be considered for the award, the provider must have CoC accreditation. The state Surgeon General appoints a team of independent evaluators to determine award eligibility. Last year, four cancer centers were the first to earn the Cancer Centers of Excellence designation. This award is an example of how a state can promote CoC accreditation.

At the federal level, in late 2015, Reps. Lynn Jenkins (R-KS) and Richard Neal (D-MA) sponsored H.R. 487, a nonbinding resolution that recognizes the importance of CoC accreditation to ensure patient access to high-quality, comprehensive cancer care. Visit *www.surgeonsvoice.org* to learn more about this resolution and to ask your representative to sign on.

If you are interested in getting more involved in advocating for the CoC in your state, contact your CoC State Chair (information available at *facs.org/quality-programs/cancer/clp/statechresource/statecontact*). To learn more about getting involved in state advocacy, contact ACS State Affairs staff at state_affairs@facs.org. To learn more about the ACS CoC Advocacy Committee, contact Nina Miller, MSSW OSW-C, Cancer Initiatives Manager, at nmiller@facs.org. ♦

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Commission on Cancer®

A QUALITY PROGRAM *of the* AMERICAN COLLEGE OF SURGEONS

CoC Chair Dr. Shulman works to improve quality of cancer care

by Matthew Fox

The new Chair of the American College of Surgeons (ACS) Commission on Cancer (CoC), Lawrence N. Shulman, MD, FACP—the first medical oncologist to lead the Commission—aims to continue the CoC tradition of being the standard-bearer for high-quality cancer care while using his experiences as a clinical oncologist and health care organization leader to further advance the program.

Dr. Shulman's October 2016 election to lead the CoC, the multidisciplinary consortium of health care organizations that the ACS established in 1922 to improve the quality of oncologic care, speaks to an accomplished career in comprehensive cancer care. He currently is deputy director for clinical services, Abramson Cancer Center; director, Center for Global Cancer Medicine, University of Pennsylvania (UPenn); and professor of medicine, Hospital of the University of Pennsylvania Perelman School of Medicine, Philadelphia. In addition to being an active practice physician since graduating from Harvard Medical School, Boston, MA, in 1975, he was a key participant in several clinical innovations while he practiced for affiliated Harvard Medical School hospitals. Examples include leading the development of the Harvard Community Health Plan's first dedicated hematology-oncology unit; leading a team to develop one of the first computerized chemotherapy order entry systems in the U.S. at Brigham and Women's Hospital, Boston; leading the development of multidisciplinary disease-based clinical programs and quality programs at Dana-Farber Cancer Institute, Boston; and leading the development of a nationally recognized cancer care network throughout New England via the Dana-Farber/Brigham and Women's Cancer Center.

Since joining UPenn in 2015, he has served as the lead for clinical cancer services for all the university's hospitals, a role that parallels his responsibilities as Chair of the CoC. "At UPenn, I share responsibility for operations, quality, cost negotiations with payors, and other related activities. In several ways, my work with the Commission is a reflection of the work I do at my home institution," Dr. Shulman said.

Dr. Shulman served on the American Society of Clinical Oncology (ASCO) Quality of Care Committee,

"At UPenn, I share responsibility for operations, quality, cost negotiations with payors, and other related activities. In several ways, my work with the Commission is a reflection of the work I do at my home institution," Dr. Shulman said.

eventually as its chair. Partly based on this work, ASCO nominated him to be one of their two representatives on the CoC. Dr. Shulman's work in quality for ASCO contributed to his selection as Chair of the CoC Quality Integration Committee. Due to his success in that role, he was nominated and elected as CoC Chair.

David P. Winchester, MD, FACS, Medical Director for ACS Cancer Programs, noted the significance of Dr. Shulman's election: "Dr. Shulman was selected from a large group of surgeons and other cancer professionals as the first medical oncologist in the history of the CoC to serve in this important leadership role. Since assuming this position in October 2016, Dr. Shulman has demonstrated a broad knowledge of the workings of a complex organization dedicated to the cancer patient. His leadership crosses all disciplines related to cancer," Dr. Winchester said.

Beyond his extensive clinical and leadership background in cancer care, Dr. Shulman's tenure as Chair of the CoC's Quality Integration Committee and his prominent role in developing quality cancer infrastructure in low-resource settings around the world are unique experiences that provide context for his appointment and for the importance of developing, maintaining, and advancing cancer care in the U.S. and globally.

Developing the CQIP report

In the modern health care landscape, "quality" is the unifying watchword for physicians, patients, and health care organizations. The College has a leading presence in the area of surgical quality improvement through several programs, such as the ACS National Surgical Quality Improvement Program and the Trauma Quality Improvement Program. That commitment to quality improvement also is apparent in the CoC through its National Cancer Database (NCDB) and Cancer Quality Improvement Program (CQIP).

CQIP is a product of the Quality Integration Committee, which Dr. Shulman chaired from 2013 to 2016. The period during which he presided over the committee was significant, as the first CQIP report was released in 2013 to the more than 1,500 CoC-accredited cancer centers in the U.S. The cancer data in the CQIP 2013 report were far-reaching and novel in a report of this size, providing short- and long-term quality and outcomes data, which Dr. Shulman and the CoC maintain are particularly useful when delivered directly to the centers. "There's a tremendous amount of data that we thought needed to be codified and sent out to the programs to say, 'You need to look at all these data and share them throughout your program and hospital,'" he said.

"We felt these data should be seen by the registrars and the cancer committees of the individual hospitals, but also by the leadership of the hospitals, including the chief executive officer, chief financial officer, chief operating officer, and so on. We put together a report that focused on a number of quality metrics, including the ones we routinely measure, and started increasing that number," Dr. Shulman said. "We looked at 30- and 90-day surgical mortality for six complex cancer surgeries. We looked at both unadjusted and risk-adjusted survival for a number of the more common cancers and a number of other parameters, including insurance status, miles traveled to the cancer center, and the time from diagnosis to first treatment." Disbursing these data directly to the cancer centers and to all levels of leadership allows for a level of standardized quality control that previously would have been impossible. And using these data is not only a suggestion—since the first CQIP report was released, the requirements for CoC reaccreditation have included bringing in hospital leadership to understand the data and providing evidence that the organization is actively applying the data in their treatment centers.

In developing the CQIP report, the Quality Integration Committee also worked to develop disease- and condition-specific quality metrics and collaborated with specialty organizations to be sure they harmonized with quality efforts from the CoC's partners. "For example, when we developed bladder cancer quality metrics, we partnered with the American Urological Association; when we did melanoma metrics, we partnered with the Society for Surgical Oncology;

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Outside of the Butaro District Hospital in Rwanda, from left to right: Dr. Shulman; Agnes Binagwaho, MD, Rwandan Minister of Health; Chelsea Clinton; President Bill Clinton; Jeff Gordon, philanthropist and former NASCAR driver; and Dr. Farmer

and so on. We didn't want these to be done by the Commission in isolation—we wanted these to be done with our fellow organizations, to capitalize on their expertise, and to gain consensus," Dr. Shulman said.

He also worked to develop a group of Commissioners, now known as Site-Specific Leaders, who had expertise in those disease groups so that the CoC can link with the specialty societies and act as resources for the NCDB staff when they have disease-specific questions.

Global cancer care development

Cancer care in the U.S. and other developed nations is a sophisticated, multidisciplinary process that has built upon more than a century of medical infrastructure. But cancer is a global health care issue, and despite its omnipresence in the developed world, its burdens are felt disproportionately in low-income, low-resource areas and countries, which are often ill-equipped to handle the patients it afflicts.

To address these disparities, Dr. Shulman has dedicated a significant share of his career to improving cancer care in several under-resourced countries. He entered this field by way of two well-known names in global health care—Paul Farmer, MD, PhD, Kolokotrones University Professor of Global Health and Social Medicine, Harvard Medical School, and Jim Yong Kim, MD, PhD, President of the World Bank. Drs. Farmer and Kim co-founded Partners in Health (PIH), a not-for-profit health care organization that brings modern medical interventions to low-resource settings. Both were trainees under Dr. Shulman's supervision at Harvard Medical School in the late 1980s.

"Paul was working in Haiti primarily through the 1990s and early 2000s, and he would call me about cancer patients who would show up at his clinic," Dr. Shulman said. "In 2008, he and [Dr.] Kim contacted me and asked if I could help to set up cancer care infrastructure in Rwanda and Haiti, and I said yes." Dr. Shulman has been materially involved with the work as PIH's senior oncology advisor since 2011. Through a partnership with the Dana-Farber Center for Global Cancer Medicine, of which he has been director since 2012, Dr. Shulman and PIH have been able to establish comprehensive cancer care centers in Rwanda and Haiti.

The Butaro Cancer Center of Excellence, Burera, Rwanda, which opened in 2012, has been a notable success for the Center for Global Cancer Medicine, Dr. Shulman said. It is a primary cancer treatment center for the nation, providing treatment at no cost to patients. In addition to patient care, oncologists from Dana-Farber work closely with Rwandan physicians via weekly consults, and clinicians from Dana-Farber, UPenn, and Dartmouth College's Geisel School of Medicine, Hanover, NH, regularly make extended consulting visits.* The center provides treatment to approximately 1,500 new patients a year and, to date, has taken care of more than 5,000 patients since it opened. "I think the center has become a model for what you can do in a very resource-constrained setting, which Rwanda clearly is," Dr. Shulman said.

The center at the Hôpital Universitaire de Mirebalais, Haiti, also has brought much-needed care to a region that historically has lacked it, but the journey was more complicated because of the 2010 earthquake that ravaged the country. "At the time the earthquake occurred, we were building a small hospital to take the place of the clinic in Cange [the site of the original PIH location], where Paul had originally worked,"

*Dana-Farber Cancer Institute. Center for Global Cancer Medicine: Rwanda Partnership. Available at: www.dana-farber.org/Adult-Care/Treatment-and-Support/Treatment-Centers-and-Clinical-Services/Center-for-Global-Cancer-Medicine.aspx#Rwanda_Partnership. Accessed May 18, 2017.

Part of understanding where the CoC should be heading involves looking into cancer care in the U.S. and seeing the areas where it is lacking—where quality could be better—and developing interventions to improve care and increase value.

Dr. Shulman said. "The government came to us and asked us to help build a national hospital," he said, which turned out to be the Hôpital Universitaire de Mirebalais that opened in April 2013. As in Rwanda, Dana-Farber clinicians and staff assist with treatment, train local physicians and nurses, and lay the groundwork for cancer care.[†] Treatment is, again, provided free of charge.

As director of the UPenn's Center for Global Cancer Medicine, Dr. Shulman now leads the cancer care program in Botswana, a nation in which UPenn has had a presence in other medical areas for 15 years. Dr. Shulman's expertise in medical oncology has allowed them to expand their former human immunodeficiency virus-focused treatment to include cancer care, and his ties with PIH have opened their sites to UPenn trainees, students, and staff of all levels.

Identifying gaps, increasing value

Dr. Shulman was elected to head the Commission at a time of considerable change in U.S. health care. Aside from broader political uncertainty regarding health insurance coverage, "The challenge that is facing us as a nation is the intersection between quality and cost," Dr. Shulman said, and attempting to increase the former without increasing the latter. His goals as Chair, and the direction of the CoC's attention, will in part be dedicated to balancing the two sides of the health care equation to provide the greatest value to patients.

Part of understanding where the CoC should be heading involves looking into cancer care in the U.S. and seeing the areas where it is lacking—where quality could be better—and developing interventions to improve care and increase value. "There are areas where we aren't doing as well as we could," Dr. Shulman said. "Rectal cancer, for instance, is one of those areas where we can see that treatment is more consistently of higher quality in Europe than in the U.S., which is an unnerving finding." To increase the quality of cancer care in the U.S., the CoC plans to launch the National Accreditation Program for Rectal Cancer (NAPRC) this year. As the ACS National Accreditation Program for Breast Centers does for breast cancer, the NAPRC will accredit cancer centers that hold to high standards of rectal cancer treatment. As Chair, Dr. Shulman wants to identify other areas in which cancer care is of variable quality.

Another area where Dr. Shulman believes the CoC can play a more direct role in addressing quality and cost concerns is with oncology medical home accreditation. An oncology medical home is a primary oncologist or oncologic practice that acts as the focal point for coordinating the patient's comprehensive cancer care. Having a dedicated coordinator for patients' cancer treatments and the processes in place to better care for patients can have a positive effect on quality, efficiency, and cost of care.[‡] "This Commission hasn't been very involved in that space previously, but we did a pilot test of Oncology Medical Home accreditation visits, which is in the domain of trying to improve quality and cost effectiveness of care," Dr. Shulman said. The CoC has performed approximately 10 pilot surveys and is now determining whether to pursue the program on a national scale.

The CoC also has been engaged in ongoing talks with national payors and insurers, such as Blue Cross Blue Shield Association, about what they can learn from the organization about measuring quality and how it relates to cost. Dr. Shulman believes that the CoC, a national leader in driving quality of cancer care, needs to stay relevant in the quality and cost space. "We have over 1,500 accredited hospitals, which covers about 70 percent of cancer patients in the U.S. There's no other organization that's attached in such a direct way to the performance of so much of cancer care in the country," Dr. Shulman said. "I think we're in a special position where we can both influence the direction of cancer care and try to help solve some of the overarching problems in U.S. health care, as well." ♦

[†]Dana-Farber Cancer Institute. Center for Global Cancer Medicine: Haiti Partnership. Available at: www.dana-farber.org/Adult-Care/Treatment-and-Support/Treatment-Centers-and-Clinical-Services/Center-for-Global-Cancer-Medicine.aspx#Haiti_Partnership. Accessed May 5, 2017.

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