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The Implications of the Report of the Warren Cole Committee

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THE WARREN COLE COMMITTEE REPORT IS scheduled to be released for general distribution in 1970. Its recommendations should interest all physicians, other health professionals, and Americans, in general, for it calls for better utilization of personnel and facilities to assure quality care of patients who are faced with diagnostic, therapeutic, and rehabilitative procedures related to cancer. The committee's suggested guidelines are realistic and in keeping with good current practice. However, I believe that health professionals and representatives of voluntary and governmental health agencies must be involved as equal partners in structuring and implementing programs which will utilize these recommendations. Even though the Division of Regional Medical Programs is altered or replaced because of lack of funds or changes in the administrative structure of H.E.W., its goals and programs will be part of the federal governmental health programs.

The President's Commission on Heart Disease, Cancer and Stroke made its report to President Johnson in December 1964. Some of its recommendations, with appropriate modifications, were translated into legislation during the spring and summer of 1965, and PL 89-239, or the Heart Disease, Cancer and Stroke Amendments of 1965, was signed into law on October 6, 1965. That legislation has served as a basis for the development of the Regional Medical Programs, which have now been funded in 55 Regions covering the entire United States, as well as the Virgin Islands, the Commonwealth of Puerto Rico, Guam, American Samoa, and the Trust Territories. The Division of Regional Medical Programs was established to administer the law. Initially located within the National Institutes of Health, the Division was transferred to the Health Services and Mental Health Administration in 1968.

The goal of Regional Medical Programs is to assist physicians and hospitals throughout these Regions in providing the benefits of the latest advances in diagnosis and treatment (including prevention and rehabilitation) to patients with heart disease, cancer, stroke, and related diseases. This goal is to be achieved through grants supporting the development of cooperative arrangements between all the appropriate health interests of a Region, but without disturbing the prevailing pattern of medical practice or physician-patient relationships.

Each Regional Medical Program has defined its own boundaries in cooperation with adjoining Regions and established its own Regional Advisory Group made up of representatives of the principal health interests of the Region, including minority groups and consumers. With the advice of this group, each Region has proceeded to determine its existing resources of health manpower and facilities, to identify its own health needs and, through local initiative, to develop sound proposals to meet those needs. Through programs of continuing education, research, demonstration, and training, a major effort is being made in all Regions to accelerate the flow of new knowledge from the medical teaching centers to practicing physicians, nurses, members of the allied health professions, and the public.

PL 89-239 is particularly concerned with making available to all our people the highest quality of medical care American medicine can provide. Section 907 of the law reads as follows:

> The Surgeon General shall establish, and maintain on a current basis, a list or lists of facilities in the United States equipped and staffed to provide the most advanced methods

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> and techniques in the diagnosis and treatment of heart disease, cancer, or stroke, together with such related information, including the availability of advanced specialty training in such facilities, as he deems useful, and shall make such list or lists and related information readily available to licensed practitioners and other persons requiring such information. To the end of making such list or lists and other information most useful, the Surgeon General shall from time to time consult with interested national professional organizations.

To implement this provision of the law in respect to cancer, the Division of Regional Medical Programs held discussions with experts in the diagnosis and treatment of this disease, officers of national professional and voluntary health organizations, the Director of the National Cancer Institute, and others. Upon their recommendations, the Division negotiated a contract with the American College of Surgeons whereby the College agreed to coordinate the efforts of appropriate national professional organizations to define criteria of cancer care for medical facilities meeting the requirements of Section 907. Subsequently, the Commission on Cancer of the American College of Surgeons established a Committee on Guidelines for Cancer Care whose members officially represent national professional and voluntary health organizations capable of making a significant contribution to this task. Some of these organizations were already members of the College's Commission on Cancer; others joined the Committee on Guidelines for Cancer Care by invitation. Warren H. Cole, MD, formerly Professor and Chairman of the Department of Surgery, University of Illinois College of Medicine, and a past president of the American Cancer Society, was appointed chairman.

The Committee has extensively studied the current requirements for optimal care of patients. In particular, it has concentrated on examining what a hospital or related institution needs in terms of organization, personnel, and facilities if it is to achieve excellence in the diagnosis of cancer and the treatment of cancer patients. One of the positive results of the Committee's deliberations has been the development of guidelines for the management of head and neck cancer. This has been a cooperative effort between the otorhinolaryngologists, plastic surgeons, and general surgeons who are doing head and neck work. It has long been recognized that members of these specialties have expertise which can contribute to better care of the head and neck cancer patients. With the cooperation of members of all 3 of these disciplines, realistic guidelines have been presented which should be tremendously valuable in the management of this important group of patients.

The Committee's guidelines will be made available to those who can use the information most effectively, particularly practicing physicians (to aid them in the management and referral of their cancer patients); hospitals (as a guide to the improvement of facilities and resources for the management of cancer patients on a regional basis); and to other interested and concerned individuals and agencies.

These guidelines apply primarily to those hospitals able to render definitive diagnosis and treatment of cancer. Although, in the management of such patients, some measures can and should be taken in a physician's office, and others in a smaller hospital or specialized institution, certain essential procedures can and should be executed only in a hospital meeting special requirements. Such a hospital should be able to support an expert multidisciplinary staff which can provide a team approach to the management of the cancer patient; to accommodate the number of cancer patients which is needed for the adequate and continuing experience and education of the staff; and, lastly, to justify the staff and equipment required for definitive diagnostic and therapeutic procedures.

Regional Medical Programs should strive to make certain that appropriate medical institutions will be aided in their development so that, eventually, every patient within the 55 Regions may have convenient access to a hospital or hospitals providing definitive cancer care in accordance with these guidelines.

Regional Medical Programs should also endeavor to help practicing physicians develop an awareness of opportunities and benefits available to their patients through appropriate referral, either to specialists in the patient's own community, or to an institution offering a multidisciplinary team of specialists for consultation, as well as the necessary equipment for definitive diagnosis and treatment.

Regional Medical Programs can accelerate the development of arrangements, already initiated in many areas, whereby the medical specialists of the larger hospitals and medical

centers establish, through programs of continuing education and various types of consultation and assistance, a partnership with practicing physicians in the smaller hospitals from which patients may be referred. Under such cooperative arrangements, responsibility for the continuing care of cancer patients rests upon well-informed practicing physicians who, while using local facilities to the limits of practicality, seek and avail themselves of the opportunities for consultation and assistance which the nearest major teaching facility, well equipped and well staffed for more specialized cancer care, readily provides. Moreover, the local physician can thus be responsible for assuring optimal care in the life-long follow-up of each diagnosed cancer patient and can keep the hospital cancer registry informed of the patient's course and final outcome. Finally, under such cooperative arrangements, which offer the latest advances in diagnosis and treatment, we can look forward to a steady improvement in the care of cancer patients, and, as a basis for still further improvement in the future, to the accumulation of valuable information about the course of cancer and the results of various forms of treatment.

It is my understanding that the deliberations as to the implementation of the recommendations of the Committee as related to the Surgeon General's responsibilities defined in Section 907 of PL 89-239 have not been finalized. Undoubtedly, professional organizations, including the specialty colleges, and voluntary health agencies will be asked to assume an active role. The manpower requirements for this task are so formidable that governmental agencies could not do the job alone.

Participating members and staff of these organizations must be knowledgeable and diplomatic if their efforts are to result in the compilation of the required lists of facilities in the United States equipped and staffed to provide the most advanced methods and techniques in the diagnosis of heart disease, cancer, and stroke. It seems to me that if we practicing physicians do become involved in this task of designating specific facilities as quality installations and help others in the health industry to do a better job, we must strive to preserve proven effective methods of the delivery of health care. In times of change, unproven innovations and activities unrelated to quality performance have been known to become the central core of a program which had been worthwhile before its so-called "modernization."