I am both deeply honored and humbled to be the 4th Editor-in-Chief of Endocrine-Related Cancer, and am cognizant that I begin this term in the ‘best of times and the worst of times’ (with apologies to Charles Dickens).

Why the best of times? I follow in the hallowed footsteps of my predecessors, Professors Vivian James, Marc Lippman, and most recently, James A Fagin, who have molded this journal into the pride that it is today: increasing the quality, slowly but surely over the years, and giving it its character by breadth and depth. My editorial team and I will follow in this successful trajectory and continue to increase the quality of the journal on all fronts.

The intersection of research, technology, and health care makes this one of the most exciting times to be in. The fall out of the Human Genome Project and the boom of scientific discovery in the last two decades, in particular, have gifted us with basic, translational, and clinical research evidence that has informed the practice of personalized health care. It is only appropriate that many new discoveries in endocrine cancer have led the way as paradigms for personalizing medical management, not only for the patient but also for their families. As merely one example, the discovery of the RET protooncogene as the susceptibility gene of the relatively uncommon multiple endocrine neoplasia type 2 (MEN 2) led to an explosion of gene-based molecular diagnosis, predictive testing, and genotype-specific cancer risk assessment and management for many heritable syndromes, involving endocrine neoplasia and beyond. The dissection of signaling pathways and nonhuman models of endocrine neoplasias led logically to molecular-targeted therapies. The endocrine neoplasias field has led the way in personalizing health care. Surely, these are the best of times.

Why the worst of times? We are, around the world, in the midst of scientific funding and healthcare conundrums. The very heart of innovative health care and healthcare delivery, evidence based on rigorous research has been and is threatened at the very core. Funding is at an all-time low and even outstanding translational and clinical research is not being funded. The in ‘buzz’ words both help and hurt us: personalized medicine, translational medicine, comparative effectiveness research, and so on. We all practice personalized medicine and utilize comparative effectiveness research and have for a long time: ABO blood typing for safe blood transfusions is an example of genetics-based personalized health care dating to World War II. These days, however, I hear only too often that personalized medicine or translational medicine is only pharmacogenomics and developmental therapeutics based on molecular targets. Indeed, these are important but represent only a small subset of the much broader personalized healthcare pipeline. Personalized health care spans the broad spectrum from accurate diagnosis and subsetting of people into risk categories all the way to tailored clinical management, which in and of itself spans behavior modification, heightened surveillance, and prevention to (heaven forbid, if prevention fails) therapeutics. Healthcare organizations are themselves, at times, confused about personalized medicine that they appoint inexperienced neophytes and those ill-prepared to lead these efforts and under-resource them. These haphazard, under-resourced efforts will eventually hurt personalized health care by dooming it to failure from the beginning, not help it.

During these ‘best of times–worst of times,’ Endocrine-Related Cancer is poised to lead the way in rapidly publishing the highest quality primary research-based evidence from basic, translational, and clinical investigation, and timely scholarly reviews will inform the practice of personalized health care in our field. I call upon you, readers, authors, and reviewers, to help lift us to the next, higher level.

‘The pen is mightier than the sword.’
– att. Edward Bulwer-Lytton, British Playwright, 1839