ASCO's Clinical Practice Committee

Who Will Take Care of Us When We Get Sick?

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By *Therese M. Mulvey, MD*

As July and August pass by and the youthful white coated men and women pass from medical student or resident to intern or fellow, one often hears the all too familiar lament, "Who will take care of us when we get sick?" We all remember, in the not so distant past, our first awkward blunder in front of a senior attending. Over the years we all pass from the inexperienced to seasoned physician and then ask the same question of

the next generation of neophytes. This cycle repeats itself year after year with a cadence similar to the natural rhythms of bird migration. This year, however, the lament takes on new meaning in the wake of the American Society of Clinical Oncology workforce study.¹

For some years now, those directly involved in patient care have squeezed in extra patients, promised to be more organized and efficient, and fallen farther behind with the e-mails in the inbox and the stacks of journals gathering dust on the shelves. As former CPC Chair, John Cox often speaks of the "tyranny of the urgent"; the phone calls to be returned, the family waiting, the chemotherapy orders to be prepped. Where is the time to sit and think? Are we simply inefficient or are the demands greater because of increased patient load and administrative burdens? Or are we distracted by the lure of the Internet ever-present on the desktop? Likely, most of us are more efficient as we integrate electronic tools into our practices. The *Journal of Oncology Practice* workforce study supports our concerns that there are simply too many patients and not enough of "us" now and the gap will only grow in the future.¹ The question of who will take care of "us" is no longer fueled by the inexperience of the intern or fellow; they will learn and mature, we all did. No, the real concern is truly who will take care of us, the baby boomers, as we age? Where will the manpower emerge from? Will young interns and residents choose careers in oncology and if so, will they care for us or will the lure of industry or lifestyle keep them out of the clinic?

These concerns about manpower are exacerbated by training programs that limit work hours and patient loads. The laws of unintended consequences may come to bear just as the workforce reaches its nadir. How will those young physicians be able to handle the demand of the ever increasing workload with no prior experience from a training program that specified the numbers of patients seen or hours worked? How do we continue to maintain quality care, keep up with the current science, and have any professional satisfaction in the future? By clearly

defining the roles oncologists play in the initial management, treatment planning, and ongoing prevention and survivorship of a patient, we will continue to define those aspects of being an oncologist that provide real service to our patients and professional rewards to the physician. By clearly defining those aspects of practice that are administrative burdens with little downstream health care benefit for the patient, we will delineate areas that are counterproductive to an integrated health care plan for a patient actively seeking treatment or for a survivor living after cancer treatment. Bringing new oncologists into the workforce will depend on clearly stated goals and expectations. Dissatisfaction is a powerful motivator for early retirement and mid-career changes.

Nonphysician ("midlevel") practitioners will increasingly play a role in oncology. The nurse practitioner (NP) role has been in evolution in oncology for more than 20 years. As a fellow, NPs taught me how to do a breast exam, manage symptoms of a patient undergoing chemotherapy, and guided me through the discussions of death and dying long after the attending left the room. The skill sets that NPs and now physician assistants (PAs) bring to the patient encounter are invaluable. However, as the demands on our time become more pressured, we need to make more strategic decisions when we delegate to NPs and PAs, with a focus on enhancing their abilities to be integrated into the care plan of a patient and improving their professional experience. NPs or PAs who become the midcycle count provider or supportive care drug visit provider experience less job satisfaction, thereby risking this valuable resource.

Social workers, nutritionists, and pain management specialists will also play an active role in the care of our patients as the demands for our specific skills increase. Reimbursement in a rational and fair manner will be essential to integrating these skilled workers into the cancer care workforce.

We will need to continue to be vigilant, measure the workforce, be creative, and as always, advocate for our patients as well as ourselves. Educating ourselves about the issues and remaining current in the best practice models, practice efficiencies, and use of midlevels will help. But this is only a part of the solution. Effecting real change in the reimbursement for cancer care is likely to be the most difficult factor but also the single factor that will lead to long-term sustainability.

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Reference

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