An Interview With Dr. Charles McKay, CEO, Tennessee Oncology

Charles McKay, MD

Charles McKay, MD, is the founder and CEO of Tennessee Oncology, a practice of 41 medical oncologists and 400 employees in 36 locations throughout the state of Tennessee. It is considered a model of regional cancer care, and Dr. McKay is widely recognized for his vision. He was kind enough to share the history of this practice with the Journal of Oncology Practice.

JOP: First of all, what motivated you to enter medicine, and then choose oncology?

CM: My father was a physician, so I'd grown up with it and always wanted to be one myself. As I went through training, I found oncology to be the most interesting topic. I knew I'd never be bored with it. Also, several of our family members had been touched by cancer.

JOP: The field was relatively new back then.

CM: Yes. I'm 53, and when I was in medical school, it was just moving to the forefront. Universities had small oncology divisions. Vanderbilt was no exception. You had Bob Oldham and Tony Greco, and that was it. It was very early in the development of the specialty.

JOP: When did you first get the idea for Tennessee Oncology?

CM: I was working at Vanderbilt as a Fellow in 1982, and was fairly independent. I probably drove my bosses crazy, and made it fairly clear that I wanted to leave. One of the radiation oncologists from the academic center had gone into private practice in Nashville, and he spoke to Dr. Frist, senior, the gentleman who set up Hospital Corporation of America [HCA]. Dr. Frist visited me at Vanderbilt, and asked if I would like to come over and work what was then known as Parkview Hospital, and would later become HCA's flagship Centennial Medical Center. He wanted me to join Dr. Stuart Spigel and begin an oncology center at his hospital. So I was there when HCA was being formed, and it was through that association that I ended up where I am today.

JOP: The growth of Tennessee Oncology has been remarkable. Was it guided by strategic planning?

CM: We employ a formalized strategic process now, but back in the early days, we just had a feel for what we wanted to be. I went back to Vanderbilt in 1984 and got an MBA, which left me keen to expand the business.

JOP: How did the practice grow?

CM: You can almost divide the development into four stages. In stage I, in 1989, we added a third oncologist, Dr. Raefsky, and began aggressively covering peripheral clinics in other cities. We could easily have stayed within the confines of downtown Nashville; that would have been an easy way to make a living. But we thought it would be important to expand, and that simple decision drove us to establish a presence in many areas that would become stand-alone facilities. We also expanded our personnel. So stage I was our growth phase, and it lasted through the 1980's.

Stage II began in about 1993 with a huge strategic decision. At that time, Dr. Anthony Greco and Dr. John Hainsworth were in research at Vanderbilt. Tony had been my boss, and John was an old colleague. They approached us and asked if we'd like to establish a research division within Tennessee Oncology. That would make us a pioneer among private practices, doing substantive research. We agreed, they joined, and that division ultimately became a major component of the practice. In due time it welcomed Dr. Burris, Dr. Yardley, Dr. Spigel, Dr. Meluch, and Dr. Waselenko, all of whom predominantly do research. Having a research component made us unique. This stage of development continues today.

Stage III began about the year 2000, and was our diversification strategy. This isn't unique, but we may have been a little quicker than some of the other large practices. We began by buying PET CT scanners. We now own two, and may expand to three. We have a radiation facility and are getting ready to purchase a stand-alone CT facility. We have extensive lab facilities. Stage III diversified our product lines.

Stage IV is where we are right now, actually spinning off some of the peripheral businesses. Most recently, we spun off research as an independent business. This provided it with better capitalization. In all of these divestitures, our physicians have the option to retain equity positions, even if they choose to retire from Tennessee Oncology. Everybody wins.

If I may predict, there will be a Stage V, and it will be the evolution of the typical oncology business. Up until very recently, oncology made most of its income on the arbitrage between wholesale and retail pricing of drug therapy. With the MMA and other things, that is more problematic. Tennessee Oncology's fifth stage will be as a disease management company specializing in cancer. For that we'll need to upgrade information systems, standardize therapies, and maintain a close and continued relationship with our research division.

JOP: With that many people, how do you reach consensus on major decisions?

CM: That's a big issue which takes a good bit of my time. Quite often my colleagues come up with excellent ideas, and the management team reviews them with me. If they have merit and are workable, we put together a pro forma to present to the board. We build consensus with phone calls, e-mails, and meetings.

For decisions not related to business growth, we also spend a lot of time on the phone. Take call coverage, for example: one of the most contentious of all issues! Because of our size, call coverage may change, depending on adding or subtracting a location. We sit with the physicians, and often go through a prolonged process of formally putting many ideas out for discussion, and then trying to take the two or three best ones and build a consensus. All this requires many e-mails and calls.

I've tried to run Tennessee Oncology as a true corporation, that is, led by a board of directors, but with me making those decisions that are rendered within my skill set and job description. That has allowed us to move fairly efficiently, but when any decision impacts the physicians directly, I need to take it to them first. Ultimately it's still a partnership, and the onus is on me to achieve consensus. We employ the same process for small decisions as for multimillion-dollar capital equipment upgrades. We put together a pro forma to present to the physicians and the board.

JOP: For day-to-day running of the partnership, do you use contract management?

CM: We'll retain consultants on occasion, but for day-to-day affairs, we're all internal.

JOP: What is your process for hiring new associates?

CM: With our size, that process has become more formalized. I'll develop a list of needs, whether to replace a physician who is retiring, or to cover new areas including geographic areas. I'll present it to the board with my recommendations. Usually we have a consensus, and then we'll begin our search, either through a headhunter or a recruitment organization, or through personal contacts. Ultimately those physicians will be brought in for interviews and meeting the other physicians, especially the ones they would be dealing with on a day-to-day basis. A corporate committee then formally evaluates their training, licensure, and referrals.

JOP: What was the evolution of the Sarah Cannon Cancer Center?

CM: That's an interesting story that goes back to 1993, when Drs. Greco and Hainsworth first came aboard to establish a research division. With the help of HCA, they also established the Minnie Pearl Cancer Foundation. This was

named for the comedienne who always wore a price tag on her hat. Minnie Pearl's real name was Sarah Cannon, and she donated her name to establish what became a cancer research network of physician groups spread across the country. We put clinical trials through this network, including investigator-initiated trials from our research division. The doctors served as sub-investigators. We have had as many as 2,000 patients per year on clinical trials in this system, making it as big as some cooperative groups.

Approximately 1 year ago we sat down with Hospital Corporation of America to talk about spinning off our research division, with HCA owning 50%, and us the other half. The operation needed to grow, and to do that, it needed more capital. An agreement was reached, and the new entity became known as the Sarah Cannon Research Institute. Obviously there are other advantages to working with HCA and their hospital network. The Sarah Cannon Research Institute is now developing closer working relationships with a number of the large oncology groups across the country.

JOP: Care of indigent patients has always been a particular point of pride for your practice. How do you do it?

CM: Tennessee Oncology currently takes care of all indigents and all Medicaid clients. Tennessee's Medicaid plan is known as TennCare. To this point in our history, we have never sent a patient to the hospital for therapy if they didn't need to go there for other reasons.

Today, like many practices, our margins on chemotherapy are somewhat lessened, to say the least. Treating the uninsured is going to be more difficult. We have spoken with the state of Tennessee and are working closely with it to get these folks covered. We hope to have the state cover the true cost of chemotherapy, and between that and our research trials, to continue to provide full care for Medicaid patients and the indigent. We've got some work to do, but we see it as an obligation, and if I can just find some way to cover the cost of these drugs, we'll also find a way to continue treating these patients in our offices.

JOP: Does any one thing stand out as a particular milestone?

CM: Once upon a time, physicians were highly respected, almost revered. The recent debates in Washington have struck many folks as being somewhat selfish, and further eroding the respect for physicians among the general public. I would hope that as physicians and oncologists we would continue to look for ways to treat the poor, and work with governments to sort through some of the expensive therapies. We went into medicine for a higher calling, and I would not like to see the economic issues pushed to such a degree that they get us away from our true calling—the care of patients.