ASCO's Clinical Practice Committee

Collaboration

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While policy experts concern themselves with the complicated dynamics of caring for an aging population, we are caught up in the day-to-day, minute-to-minute pressures and rewards of our practices. To us, the term “physician extenders” means more than the professional colleagues who obtain histories, perform exams, and assess and prescribe treatments on our behalf. Clearly, the people who greet and schedule our patients, ready them for the examination room, answer the phones, post charges and payments—the people, in other words, who keep the patients moving through our offices—have a critical impact on how smoothly our days run. More than advanced practice nurses and physicians assistants, they influence how many patients we are able to see and how much attention we can give to each of them. The average oncology practice has eight or more employees per full-time physician, and all might be considered physician extenders. On average, only one of these is an advanced practice nurse or physician’s assistant.¹ But all of these employees are important to the team that makes outpatient oncology care efficient and as pleasant as possible for those who find themselves in need of our care.

The focus of this *Journal of Oncology Practice* issue is on one increasingly involved member of this team, so called NPPs, which, depending on your outlook, serves as abbreviation for either “non-physician practitioner” or “nonphysician provider.” Though studies in oncology are lacking, it is clear that in primary care, NPPs provide services that patients find equally satisfactory to that provided by physicians. Furthermore, quality metrics demonstrate that this care is, on average, as good as or better than that provided by physicians, at least within certain constrained circumstances.² Additionally, these visits are accomplished at lower cost. It should come as no surprise that everyone is looking to NPPs to step in and help care for a growing population of patients with cancer in the face of what appears to be an inadequate supply of medical oncologists.³ Much has changed in the 2 short years since this issue was discussed in this column,⁴ as we now take it as a given that NPPs should be integrated into our practices, which are strained both by the increased load of patients and the current era of tightening financial constraints.

References

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Doctors who work with NPPs see more patients on average than those who do not, as was demonstrated in 2005, 2006, and 2007, when physicians working with NPPs saw on average 358, 436, and 379 new patients, respectively, compared with their non-extended peers’ 275, 266, and 341 evaluations, respectively.⁵

Collaboration with NPPs is in evidence throughout oncology. Our colleagues in other oncology-related medical fields have effectively integrated NPPs into their practices. Examples include pathology where physician assistants perform gross examination of specimens, surgery where NPPs assist in the operating room, and anesthesiologists who have long delegated authority to nurse anesthetists. The variable ways that NPPs are used result from local custom, state medical and nursing board policy, hospital and organizational privileging bodies, and most importantly, the collaborative delegation and acceptance of responsibility between physicians and NPPs.⁶ This takes a lot of work, particularly as roles are initially defined. And just as importantly, this is not a one-size-fits-all concept, any more than one ladder, one set of stilts, or one scaffolding works in all situations when one is trying to reach higher.

It is collaboration and individualization that allow this to work for patients, physicians, and NPPs to their satisfaction and benefit. This requires careful discussion of expectations of how the NPPs will decide when to check in with their collaborating physicians, understanding of individual insurance plan rules and Medicare policy, and how to vary behavior (and billing) within different payment plans.

Finally, we should not forget that primary care physicians are also available to see our patients, particularly in the follow-up phase of treatment for those who have completed adjuvant or curative treatments.⁷ Like NPPs, these practitioners succeed through collaboration, with carefully defined pathways for survivorship care, and explicit definition of the nature of specialist communication and input to a primary care physician and Medical Home.

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