Fences

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My wife and I relax on weekends by walking in the woods of east Texas. Generally we try to get lost on the family farm. I have noticed a habit of the cattle that share the land with us. On a well-worn trail that circumscribes the property, they walk the fence line as if continuously looking to the “other side.” I have come to realize that on most walks, my wife and I follow the same pattern, including the fence line perimeter walk. As if the present space is not enough, we—and the cows—desire something more.

In an era of dramatic change in medicine, I sense the same spirit. That spirit motivates us to look beyond barriers to find the better therapy and best care-giving practices. But there is another side to this paradigm, that of policy that determines how we spend our limited health care dollars. If every landowner is looking over his or her fence and coveting the adjacent property, there comes a time of limits, and conflict of values ensues. We stand at the threshold of a limiting fence, in the form of the present political debate that will determine the priorities of government. There are no longer unclaimed frontiers on the other side. There are territories claimed by others, and we must figure out how to prioritize our resources within these limits. The state of oncology practice in today's United States was defined by policy decisions made over the last decade, and we clearly know more dramatic change is on the horizon. The broad thinkers in our midst are beginning to discuss how we can rearrange the fences to deliver better, more equitable health care while spending less money. Marsland et al present a position statement that foresees the need for practices to work closer with payers to preserve the delivery of quality care, addressing the paradigm by envisioning moving some fences.

In this issue of *Journal of Oncology Practice* (JOP) we focus on the present. The issue is anchored by Towle and Barr's annual contribution, which describes the economics of practice and provides benchmarks to which a practice may compare itself. This information is unique in that nowhere else can oncologists find this published research. The authors put their data into context by reviewing change over the past 5 years. They note the shifting of care to larger practices and institutions and demonstrate the narrowing gap between practice total revenue and total expense, defining in real terms the struggle for practices to stay afloat. On the positive side, practices are clearly becoming more efficient. As coalescence is occurring, more practices are taking advantage of professional management techniques to provide good care with less expenditure.

Also in the present is the reality that these shifts of care are painful. The classic mechanism of health care delivery in our country has been the entrepreneurial, small-practice, local doctor. Oncology is no exception; just a few years ago it was noted that most oncology care in this country was delivered in practices of one to three physicians. Small practices cannot tap into the economies of scale required to stay afloat. Two voices with a common perspective are presented. Keech describes his practice life over the past 5 years, since he was featured in these pages promoting the benefits of solo practice. In his Perspective, Provenzano writes as a modern-

day Job, with his fist raised to heaven, asking “Why”? He rightly points out that we will lose something as a profession and country with the loss of the small solo practice.

More in the present: Phillips et al describe the changes that have occurred in their ability to deliver a complex therapy in their office. Because of financial issues, they now shift all women who need intraperitoneal (IP) chemotherapy from their practice to the local institution. They describe a declination in service, satisfaction, and quality associated with those shifts. Many practices are shifting patients who need chemotherapy to outside service sites as a result of economic variables. Do the issues these authors raise about the delivery of IP therapy apply to the delivery of routine chemotherapy? Are our institutions able and willing to take on this aspect of oncology care as practices are more challenged? The accompanying commentary by Neuss and Guidi speaks not only to the specific issues related to IP therapy, but also to the more general concerns raised as delivery of chemotherapy leaves oncology offices.

And more present than ever: With Congress undergoing its annual convulsion regarding the Sustainable Growth Rate-mandated cuts in Medicare reimbursement, more physicians are examining practice finances to see if they can continue to participate in the program. Indeed, in many communities primary care physicians have severely limited the volume of Medicare patients in their practices or have walked away from the program. McAneny's Perspective and Tompkins' Practical Tips provide information on this issue. In truth, it is hard to visualize what an oncology practice would look like without Medicare patients. The reader's attention should focus on the arcane rules of Medicare participation and assignment that many likely have not considered since they applied to the Medicare program.

Further, the harsh present of the undocumented worker: This issue's Ethics Vignette reflects a dark and difficult side for practices throughout the country. The political storm around immigrants without defined legal status has left unanswered questions for oncologists facing an individual human being with a life-threatening illness and no legal status. What can we do?

Filling out this issue of JOP are submissions in our ongoing series, Attributes of Exemplary Research and Strategies for Career Success. This issue of the JOP presents various snapshots of our present reality. Might we always be looking over the fences for a better one!

Comments and perspectives on the issues presented within JOP are welcome at jopeditorsdesk@asco.org. Good reading!

Accepted for publication on July 27, 2010.

DOI: 10.1200/JOP.000128