A Paleontology Primer for Oncologists

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I read with great appreciation John Cox's editorial "Access, Quality, and Cost" in *Journal of Oncology Practice*.¹ The editorial highlighted health care reform efforts that are predicted to change the way we practice oncology. Just as a blazing meteor wiped out large dinosaurs, health care reform may eliminate solo practitioners like me.² And I am not sure that the systems of care that will replace me are better for the patient. Private oncologists and institutions across the country are scurrying to join forces so that they can benefit from economies of scale, but in fact, many of these large groups are collapsing under the weight of their own fixed and operational costs as reimbursement dwindles and erodes already narrow margins. I fear that survival in such a system will focus on growing volumes and will result in overutilization of services and drugs. Last spring I invited the CEO of ASCO, Allen Lichter, to visit my office and showed him that dinosaurs can still deliver cost-effective, high-quality oncology care. Nonetheless, I will soon be forced to assimilate with either my hospital or another dust cloud of physicians who aspire to become big enough to avoid bankruptcy.

I foresee no immediate remedy for the plight of the dinosaurs. The "invasion of the doctor snatchers" is well underway. However, I would like to outline several points that express some doubt as to whether these critical masses will succeed in solving quality and access problems. Also, I would like to challenge readers to consider how we can best utilize a growing treasure of soon-to-be-retired health care professionals.

- *Economy of Scale Versus Intrinsic Costs*—Although solo practice is virtually impossible given today's economic challenges, groups that are too large do not guarantee optimal delivery of seamless care. Someone needs to be in charge of the patient, and this is increasingly difficult to achieve with large groups for which demands have become more complex. Community hospitals throughout the country have many small oncology groups on staff that have adapted to the changing landscape without the inertial barriers inherent in supergroups. Large groups do offer electronic medical records for their staff and are able to negotiate better contracts with payers. But they also encourage utilization of in-house labs and imaging, which could drive up costs. Many older oncologists are caught in a transformed health care delivery system, which they are unprepared for and unwilling to support. Economic and time constraints have resulted from decreasing reimbursement, increasing regulatory demands, and increasing practice costs and are crushing small physician practices.

- *Increased Dependence on Support Staff*—Some of my colleagues who have joined larger groups report loss of control that may lead to undesirable outcomes and less patient satisfaction. Solo or small groups have a better handle on what is happening, with fewer opportunities for a disconnect between oncologists and patients. Solo oncologists often maintain some contact with patients, even while on vacation, via text messaging or being available for phone interaction with the covering physician. This may sound tedious, but many dinosaurs have resorted to this type of seamless contact with patients to minimize errors and to enhance patient care efficiency. Such involvement can ensure that the process works for both patients and physician even when nurse practitioners and physician's assistants are involved.

- *One Cannot Legislate Quality*—Regulators would like to see larger groups. Large groups of providers are easier to track and perhaps allow better accounting of aggregate costs. My fear is that this focus on large systems will not recognize some of the best providers. They will remain "off the radar" and will not be recognized for the years of high-quality, cost-effective care they have delivered. Many solo practitioners have developed remarkably effective teams of care in their community. These optimal small communities of care may not be measured by standard population-based metrics.

How can a vibrant though heterogeneous group of older dinosaurs who are struggling to survive be utilized to capture their wisdom, their insights into personal clinical care, and their love of the profession?

- *Incentivize Older Oncologists*—Most older oncologists are not retiring anyway and want to work in some capacity other than being in the unsustainable position of keeping our chairs fully occupied in order to cover our expenses. This does not imply overutilization but rather shifting focus away from the face-to-face patient encounters that we desire. We can avoid end-of-career burnout by spending more productive time with patients. One way to achieve this would be to develop a task force to create a career transition specialty that takes into consideration factors such as age, personal health issues, retirement goals, and individual pursuits of professional satisfaction that are as yet unmet because of the demands of a busy practice. The goal of such an effort would be to define modes of practice that are attractive to physicians whose forte is the personal relationship with patients.

- *Reallocate Human Resources in a Sensible Way*—If older oncologists are given special considerations, they can be used as a per diem or second opinion pool, especially in areas where physician supply is inadequate. Older oncologists can be trained to help enroll patients in clinical trials. Give transitioning oncologists more freedom to pursue patient care that best utilizes the shrinking supply of specialists without the rigidity inherent in many current practice models. This could mean hospital- or clinic-based duty that is compensated in part by public and matching private funds. Oncologists can apply for different positions if they choose retirement but still want to work. Greater incentives, both financial and nonfinancial, would be given to oncologists who serve for a period of time in truly underserved areas with the most challenging health care issues.
- *Create a Public Health Initiative for Cancer Care That Is Fueled by Career Transition*—This requires a commitment by oncologists in advance of retirement so manpower needs can be anticipated for future oncology initiatives. This would create an “oncology corps” cushion. The commitment would be voluntary and would create a pool of oncologists who could serve patients where the need is greatest. For instance, after discharge from the hospital, cancer patients often spend time in skilled nursing facilities where care is often lacking. Transitioning oncologists could help facilitate ongoing follow-up, coordination of care, and treatment schedules in an efficient manner. They could help to set up special “oncology nursing home” units that would serve patients without having to arrange for transportation back and forth to hospitals and emergency rooms. These oncologists could also help by serving on ASCO committees that deal with manpower shortage issues and thus help shape policy for the future.
- *Reset the Compass and Hoist the Sails*—Older oncologists, as a new demographic of physicians, can concentrate on primary prevention, lifestyle changes, and environmental issues as we broaden our horizons and focus less on intense intervention for established cancers.
- *Have Older Oncologists Assist in Screenings, Survivorship, Palliative Care, and Other Programs*—Oncologists can help existing cancer programs with these important initiatives or create new ones where the need exists. Many oncologists are too busy treating patients and serving on other committees to find the time to assist with these worthwhile ventures.

- *Recultivate the Creativity and Curiosity that Made Oncologists Choose a Career in the Biologic Sciences*—Economic pressures and other factors have an increasingly negative impact on physician careers. Heterogeneity implies differing needs. Over decades, older oncologists have nurtured our talents, which have gone unnoticed by many who judge the quality of health care as an aggregate, quantifiable entity without examining the virtues of those who help deliver it. Much of the care we deliver is undercompensated given the enormous time we spend with our patients. And so, we concentrate on the dwindling compensation for office-administered chemotherapy and biologics. We increasingly relegate face-to-face encounters to ancillary staff such as nurse practitioners, physician’s assistants, and secretarial staff, who are also overloaded with work. It would be wonderful if during our preretirement years we could have the time to attend the conferences we couldn’t when we were younger and discover outside interests that would enhance our knowledge of oncology and perhaps lead to new discoveries.

It took me decades to become an experienced and sage practitioner who has built up a huge following, not because of some innate talent, but because of the hard years of refining skills I first developed in my fellowship through the entrepreneurial and academic freedom to grow. I never based my practice on the number of chairs in my chemotherapy room but by the respect I gained from colleagues and patients, who knew that I offered the best advice and care on an individualized, evidence-based platform. I no longer can promise my patients that I will be able to deliver that kind of care in the future, but I will keep on trying because I truly love what I do.

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