Subspecialization in Community Oncology: Option or Necessity?

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It is not news to any practicing oncologist that staying clinically current is a huge challenge. How would it feel to narrow the scope for which you are primarily responsible to just, say, genitourinary cancers or breast cancer? What would it mean to your community? What are the pros and cons for you and your group?

We talked to several medical oncologists in community practices to explore some of the implications of subspecialization for their practice group, their community, and themselves.

Advances in Science and Patient Sophistication Place Demands on Oncologists

The pressure that practitioners feel because of the explosion of knowledge in medical oncology has to a great extent driven subspecialization. As noted by Detroit oncologist Ayad Al-Katib, MD, who specializes in lymphoproliferative disorders, “Targeted therapy requires a deeper knowledge on the part of oncologists about cancer in general and how this monoclonal antibody works against this type of cancer.”

Oncology is harder hit by the knowledge explosion than are other specialties, asserts Stuart Bloom, MD, who specializes in breast and prostate cancer in Minneapolis, MN. “The amount that is known in hematology and oncology is changing much more rapidly than in any other field—more so than in cardiology, pulmonology, or nephrology, for example.”

For Larry J. Geier, MD, an oncologist in a large community practice in Kansas City, MO, the expansion of science and technology has allowed him to specialize in a field that didn’t even exist 20 years ago: cancer genetics and risk assessment. Several years ago, some nurse practitioners in his practice pointed out that the physicians were not adequately attending to patients’ cancer risk. Adding a genetics counselor to the staff did not serve to answer the need, and the group decided a physician would provide a better solution. Geier eagerly took on the role and began educating himself in this area.

Patients’ growing sophistication has produced pressure, too. Magazines and newspapers include sections on health and medicine. The Internet is a treasure trove of health guides and medical explanations, reliable or not. Al-Katib notes, with a rueful laugh, “They say, ‘Here is a list of clinical trials. What do you have?’ or ‘What do you know about NF-kappaB?’”

Although subspecialization has been a way that some oncologists have dealt with the growing demands of science and patients, this is not what patients need, argues Barbara McAneny, MD, CEO of an Albuquerque, NM, practice with eight medical oncologists. “In a community practice it’s a good

marketing ploy for someone to be a breast oncologist,” she states. “You can have the breast oncologist and the heme oncologist because those patients tend to do well and are a real joy to take care of. But what happens to the guy who ends up being the pancreatic cancer oncologist or the sarcoma oncologist? A subspecialist is what the patients need if they happen to have the disease that is specialized in. What about the others? We need community oncologists who are comfortable taking care of everyone.”

Changes in the Medical Practice Environment Have Implications

Changes in the medical community and delivery systems have also had an impact on specialization within oncology. The relationship between academic centers and community practices is one of the areas that is changing. Geier comments, “In the past, university programs tended to say ‘we have oncologists who specialize,’ while we in community practices tended not to say that. Now practices are keeping referrals in the community, because that’s what both referring physicians and patients want.”

In addition, the size and sophistication of some oncology practices puts them in a position to compete with academic centers. Bloom’s practice, with 55 medical oncologists, is an example. “We’re not competing with the other community hospitals; we’re competing with the Mayo Clinic and the University of Minnesota,” Bloom says. “We have access to the same data about how to take care of breast cancer patients as the Mayo and University physicians. And we all have access, for the most part, to the same clinical trials. So if we want to maintain market share we have to cultivate expertise in specific cancers.”

Hospitals can play a major role in how cancer care is delivered in private practice. Tracey F. Weisberg, MD, a medical oncologist in Portland, ME, began specializing in breast cancer in 1996, when the local hospital decided to start a breast care center and asked her to help plan it. The breast cancer center has grown and was certified in 2010 by the National Accreditation Program for Breast Cancer Centers, sponsored by the American College of Surgeons. While Weisberg’s specialization in breast cancer grew, others in her group focused on brain tumors, upper GI cancer, and lung cancer. Two colleagues practice only hematology. “The demand that the hospital is placing on us drives the system. Everything is moving toward working through patient navigators, and it’s easier for navigators to have one go-to person for a patient rather than nine go-to people.”

McAneny comments that oncology departments in academic centers have placed too much emphasis on subspecialty

areas, to the detriment of cancer care in the community. “Training in subspecialty tracks is becoming alarmingly more common and will make the workforce issues more acute as the need for cancer care continues to exceed the availability of providers. Academic institutions definitely need to have specialization among oncologists for their area of research. But in addition they need to make sure they are training good generalist oncologists who can take care of everybody.”

Becoming a Subspecialist

Each subspecialist we talked with had taken a different route to gain expertise. Al-Katib focused on research of the lymphatic system during training at Sloan-Kettering and then ran a research laboratory and academic clinical service in Detroit before establishing a private lymphoma clinic.

Bloom moved from general oncology to breast cancer over a period of time. He began presenting brief reviews about new developments in breast cancer at the hospital’s breast conferences. This exercise helped him gain expertise while building his reputation in the community. “Over time I learned a lot more about breast cancer, doctors heard good reports from patients they referred to me, and I slowly built a specialty practice.”

Peter D. Eisenberg, MD, in an 11-oncologist practice in Marin County, CA, specializes in lung cancer and GI cancer. He says that he and some others in his practice followed their interests and studied specific areas; one partner had begun specializing in lymphoma under a mentor during her fellowship.

Geier reports that his eagerness to pursue cancer genetics arose from an interest he had always had. During 25 years of practice, he always longed to be “more on the prevention side.” He says, “When a young woman would come in with breast cancer I would say, ‘how did we not see this coming?’ For me, it was the right thing for the right person at the right time. I climbed the learning curve with gusto—putting together articles, reading books. I attended every course or symposium I could find.”

Seeing Patients Outside One’s Subspecialty

Does the subspecialist manage cancers outside of his or her specialty? Among those contributing to this article, all but Al-Katib did. They take their turn in their group, covering call or working in new patients.

Bloom acquires non-breast cancer patients when he covers the emergency department while on call. McAneny would support this continuation of care. “When you see a patient on call, that first consultation with the patient is really a bonding experience,” she comments, adding that subsequently turning care over to someone else would be like “dumping” the patient.

Eisenberg says, “I’ll see anybody who walks through the door, and I’m the go-to guy to work somebody into my schedule.” He likes seeing a lot of different kinds of cancers because “it’s challenging and interesting.” Eisenberg does sometimes pass on patient care to one of his partners who specializes. For example, he may work up a patient with a newly diagnosed

Pros and Cons of Subspecializing

Pros

- Easier to stay current in focused area; possibly increases quality of care in subspecialty area
- Affords comfort level and confidence in patient management
- Fosters efficiency in tumor board attendance
- Provides readily available consultant, go-to expert in group
- Promotes consultation, referrals
- Cultivates clinical team’s depth of expertise, knowledge

Cons

- Harder to stay abreast in other areas; possibly decreases level of care in other areas
- Not possible in small practices
- Not possible in rural areas with low volume of patients
- Deprives subspecialist of variety in patient mix
- Requires group compensation plan that obviates competition for patients
- May exacerbate workforce shortages

lymphoma and then transfer care to the lymphoma specialist in his practice. “I find that patients appreciate being transferred to someone with special skills in our practice,” he says.

Weisberg, whose practice is 90% breast cancer, notes, “I have to work a little harder to stay up to date in other cancers. It takes me a half hour of preparation if I know I’m going to see a patient with a bile duct tumor, for example. I have to make sure I’ve updated myself with the latest findings, while in breast cancer I can recite them in my sleep.”

Advantages of Subspecializing

Subspecialists report a number of advantages to subspecializing—for themselves, for their partners, and for the medical community. Bloom comments, “A lot of us want to know every single thing possible about a cancer. Subspecializing in oncology is a win-win situation—it’s satisfying to you and satisfying to the patient.”

Al-Katib says that specializing gives him confidence and comfort. “I know what needs to be done. I’m always ready, always prepared.” He notes that it is also very satisfying to be recognized as an expert. “More than half of my patients are second opinions. It’s a great satisfaction to me that patients recognize that I have the expertise.”

Efficiency in tumor board participation for her and her partners is a benefit cited by Weisberg. “The nine of us can’t go to every tumor board. If I were to have 15% breast cancer, 15% GI, 15% brain tumors, and 10% hematology, I’d be going to a tumor board every day. It’s more efficient to specialize.”

Weisberg also points out that because she specializes, her clinical team is “very in tune with everything that breast cancer patients need. The nurse practitioner, for example, can focus in on genetics and survivorship. The nurse that works with me has a depth of resources.”

Al-Katib states that he makes himself available and freely offers advice to referring doctors. "I get calls from oncologists asking, 'what would you do?' or 'what is the newest treatment in this type of lymphoma?' In the future, if a patient asks for a second opinion, the doctor is going to think of me."

As a genetic consultant, Geier sees some different benefits in his practice. "My partners love it because they don't have to spend all that time learning about genetics and talking to patients about it. If they see a patient that may have some genetic involvement, they can say 'I have a partner down the hall who is an expert in all of this.'"

Working It Out Within the Group

Equity in reimbursement and workload is cited as a barrier to specialization within a group practice. Some types of cancer generate more reimbursement, leading to competition for patients if compensation is based on production. The subspecialists we spoke with all had the same answer to the inequitable compensation barrier: divide revenue equally among all of the shareholders. In groups that did so, distribution of profits applied to all shareholders, including those who practice only hematology, an area with significantly lower reimbursement levels. Eliminating the production model of income or modifying it in a way to allow specialization may be the only way to address the problem of income inequity inherent in subspecialization.

The personal satisfaction derived from seeing a variety of patients is also a barrier to subspecialization for many. Bloom commented that physicians in his group were "not completely thrilled" with his growing breast cancer focus, not because of any compensation problems but because they liked treating breast cancer. He understands this, commenting, "I would feel a little bereft if I didn't get a chance to see breast cancer any more." In his group, therefore, no one's practice is 100% subspecialized: "Everybody sees everything."

Geography and group size are also significant factors. Oncologists in small towns or rural settings must see everybody. In Weisberg's 14-oncologist practice, nine oncologists practice primarily in Portland, and the others practice in offices in three rural towns and travel to even more remote areas for once-a-week clinics. These oncologists must generalize, and the general cancer care offered in these communities is a significant patient service. "When you had cancer 20 years ago, you went to Portland," Weisberg says. "Now patients with cancer are able to be treated closer to home."

5 Years From Now? 10?

Whether they embrace subspecialization or lament it, individuals see subspecialization as a growing trend, driven by the

increasing complexity of cancer care, the changing delivery systems, and patient demand.

"In 5 to 10 years, specialization within oncology will be much more common," Al-Katib predicts. "The pressure will come from both directions. The oncologist will feel pressure by falling behind in the ability to keep up with new knowledge. The other pressure will come from the community. The younger people who are Internet savvy are going to become cancer patients and come with questions. The oncologists who are not specializing are going to see a loss of patient referrals."

McAneny also sees a trend toward specialization but fears it will leave gaps. "We will not have the workforce to take care of patients if we further subdivide ourselves into specialties. We will need general oncologists who can take care of 90% of the types of cancer, and then use specialists for referrals for patients with a very specialized need."

Regarding the challenge to oncologists to keep up with scientific advances, McAneny says, "I see decision support as having a huge value. Pathways will help that, so that decisions are made as a group." Ironically, Eisenberg uses a similar argument in commenting on the advantages of having subspecialists in a practice: "People working together can do a better job than the smartest individual."

Speaking of future trends, Geier says, "Patients want this. They want to feel like they are going to someone who really knows their stuff." He also believes subspecialization improves the quality of care. "If you do it all day every day, you are going to get better and better. I believe in the movement as long as people are doing it with passion."

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