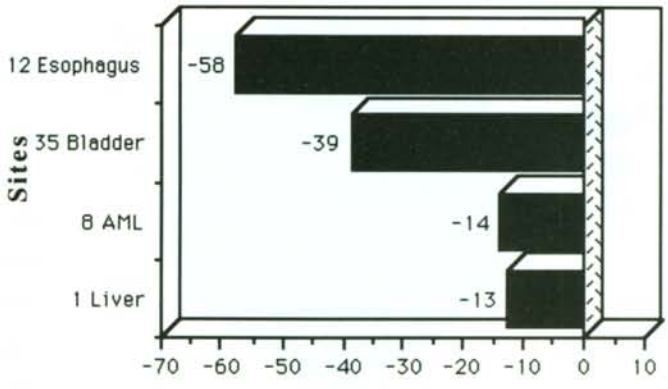
EXHIBIT 9

MMC DRG Major Loss Sites



ty—a factor that may take on increasing importance as the profit margin on all patients decreases. Non-small cell lung cancer patients, for example, had billings of $972,000, but a modest net profitability of $16,000. While breast cancer cases had total billings approximately one-quarter as large ($224,000), profitability was five times greater ($86,000). These types of comparisons provide cancer program managers with a great deal of food for thought. Very likely some mixture of profitable and high volume cancer patients should be targeted in the program's marketing and promotional campaigns. Certainly, such strategies will be necessary to offset cancer cases that consistently fall below the profit line.

Exhibits 8 and 9 illustrate total profit and loss by cancer site, providing yet a third look at the cancer program product line. Here we see the importance of a group of GYN patients and the potential losses generated by a few esophageal, bladder, AML, and liver cancer patients.

Overall, the ability to sort DRG and financial information by cancer site should provide many cancer programs with the necessary additional information for programmatic decisionmaking. The survival of community cancer programs requires senior managers to be able to integrate clinical, quality and financial information with strategic decisionmaking.

The cancer program product line is unusually complex, but, in many cases, accounts for 10 to 20 percent of hospital revenues. (Hospitals that intend to be dominant in cancer programming will need to take several additional steps if they are to have appropriate information for decisionmaking. Those that do not take these steps are likely to make incorrect strategic decisions.) ■

[1] Young, John L., and others. "Hospital Reimbursement, Charges, and Profit and Loss for Cancer and Cancer-Related DRGs," *Oncology Issues*, 3:4, Fall 1988, p. 9.
[2] Mortenson, Lee E., and others. "Variations In Cancer DRG Profit and Loss by Hospital Size and Region of the Nation," *Oncology Issues*, 3:4, Fall 1988, p. 16.

ONCOLOGY SYMPOSIUM SCHEDULED

An international symposium entitled, "Quality of Life in Current Oncology Practice and Research," will be held on February 25 at St. Mary's Medical Center, Long Beach, CA. The hospital, which is affiliated with the UCLA School of Medicine, will be offering seven hours of CME and Nursing Continuing Education Contract Hours to attendees.

For registration information, contact St. Mary's Department of Medical Education, 1050 Linden Ave., P.O. Box 887, Long Beach, CA 90801. Phone: 213/491-9352.

LETTERS

Proposed RCT Category Draws Fire

I was much interested in the request from the Oncology Nursing Society for ACCC's opposition to the American Medical Association's (AMA's) proposal for the development of a new category of health care provider, a Registered Care Technologist (RCT). (See the "President's Corner," *Oncology Issues*, Fall 1988.)

When this was brought up at the AMA last June, I was strongly opposed to its creation. I see no reason to have another category of nursing. We need to go back to the old registered nurse training schools where nurses are trained to take care of patients directly in the hospital. I am bitterly opposed to academic training without primarily training the nurse to take care of the patients at the bedside. I have been interested in this issue for a good many years.

At one time, I served on the Committee of the Pennsylvania Medical Society for Relationships with Allied Professions. At that time, the National League of Nursing was promoting baccalaureate nursing programs and wanted to do away with registered nursing schools. We are now paying the penalty for this attitude, both in the lack of nurses and in the quality of bedside nursing care. The old RN schools should be reinstated with the addition of the academic studies that are now present in most of the RN schools that still exist.—Joseph M. Stowell, M.D., Director of the Cancer Program, Altoona (PA) Hospital.

It appears that the AMA is trying to create a monster with the RCT program. Who would train these people? What would be the licensing mechanism? How could one establish and maintain quality control?

Over the years, nursing has had identity problems with BSNs, MSNs, AAs, Diploma Nurses, and LPNs. Recently, however, nursing seems to be evolving into a true profession with educational and professional standards, clinical specialization, and even Board Certification. The RCT program seems to be a major step backward.—*Carl G. Kardinal, M.D., Principal Investigator, Ochsner CCOP, New Orleans, LA.* ■