Oncology Issues

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Cancer Care in the 1990s: Expected Advances, Potential Problems

CANCER CARE IN THE 1990s:
EXPECTED ADVANCES, POTENTIAL PROBLEMS

Oncology Issues *asked leaders in the areas of cancer treatment, patient care, administration, research, and data management to share their thoughts on expected advances in the 1990s, and the potential issues those advances may raise.*

HOSPITAL ADMINISTRATION

Robert T. Clarke
Chief Executive Officer, Memorial Medical Center Springfield, IL

Advances in cancer care in the 1990s will occur in a health care industry that has been turned upside down in many respects. Technological developments will allow many more tests to be done, not only on an outpatient basis and in doctors' offices, but also at home. Often these tests will be self-administered. Acute care hospitals will become intensive care units. Those that cannot afford the transition will fail. Quality assurance will focus on outcome rather than input and processes of care. Research grants to study medical care effectiveness will increase. None of the surviving hospitals will discontinue treating cancer patients but, because of fiscal constraints, few will be enthusiastic about adopting new, expensive technologies. Improvements in technology will exceed the industry's ability to pay for them.

Hospitals will be challenged to maintain a "high touch" image in a "high tech" environment. Efforts will intensify to provide the payors of care with tangible evidence of alleged "higher quality," using newly acquired information systems. Patients and their families will have greater difficulty accessing the surviving intensive care hospitals if home care and outpatient care are not options. Maintaining high professional morale will be difficult in those clinical areas where hospitals deliberately choose not to invest in new technology. Physicians will continue to resist participation in cost-benefit decisions until their financial incentive system is restructured and eliminates fee-for-service practice. In summary, it will be a decade of excitement, tension and turmoil. Hospitals that are well managed will be the big winners.

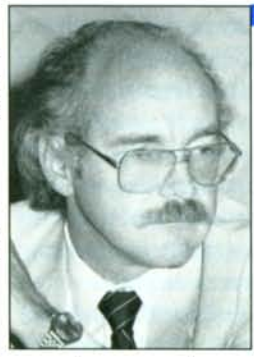
CANCER PROGRAM ADMINISTRATION

Jennifer L. Guy, B.S., R.N.
Administrator of Oncology St. Anthony Regional Oncology Center Columbus, OH

It is my deepest desire that the advances of the 1990s will occur in technology related to tracking the oncology product line. In specific, areas that will enable ongoing, prospective analyses of market share data. I hope this technology will allow us to analyze our individual institutions' market share based on primary site and stage, incidence of complications, referral patterns, and payor mix. Such analyses will allow us to make better judgments in negotiations with third-party payors.

I think the major problem facing cancer program administrators in the 1990s will be how to maintain the delivery of high-quality patient care in a method that is cost effective and in an environment of increased constraints by third parties (i.e., peer review systems and managed care systems). Management of clinical data between multiple sites, which is often the result of multiple payor systems or restrictive payor systems, will present significant challenges to community cancer care providers if they are to ensure that data are assimilated and available for clinical decisionmaking in a manner that does not dramatically escalate the cost of caring for patients. My worst fear is that the systems that restrict providers (i.e., mandate specific laboratory providers) will result in inadequate clinical data being available to clinicians when they are forced to make treatment decisions. Alternatively, problems in the flow of clinical data through multiple locations often result in delays in decisionmaking which, when dealing with malignant diseases, can certainly be fatal.

MEDICAL DIRECTORS



Lloyd K. Everson, M.D.
Medical Director The Indiana Regional Cancer Center Indianapolis, IN

Medical directors will play an increasingly important role as facilitators and mediators as the pressures on physicians in practice, as well as hospital administrators, begin to forge a new and increasingly close administrative and planning alliance. The role of the medical director in expanding cancer programs will be absolutely indispensable and extraordinarily influential in determining the direction that these combined organizations will take in the 1990s.

Medical directors will continue to face the challenge of bridging the gap between the practice of medicine and the administration of hospital and clinic groups. They will continue to confront issues raised by their administrative and physician colleagues, not from the perspective of either one of the two groups, but as a hybrid of both. That, in itself, will take an extraordinary effort on the part of medical directors if they are to effectively bridge this credibility gap.

Nevertheless, I am convinced that unless physicians play an increasing role in management and administration positions, the health care system in this country will decline in its ability to deliver state-of-the-art care to patients and families.

Physicians who continue to develop careers as health care executives and medical directors will need continued and expanded educational opportunities. One of the challenges that medical directors will face is in convincing both their physician and administrative colleagues of the absolute necessity of such continuing education.

There will continue to be tremendous pressure, from not only a cost containment perspective, but from a quality perspective, to produce a consistent health care policy for our nation. This will more than likely evolve into some type of national health system that is an amalgam of government- and business-subsidized mandatory health care for all citizens. I think this will prove especially true as the number of uninsured in the 1990s is expected to climb in excess of 37 million people. As a result, the role of the medical director, in providing a hybrid perspective on management and clinical patients in the system, will be absolutely invaluable and essential in ensuring a quality health care system.

Nursing

Catherine Harvey, R.N., M.S.N.
Oncology Nurse
Grossmont Hospital
La Mesa, CA

As cancer treatment moves from the inpatient to the outpatient arena, nursing will increasingly influence patients' and families' ability to cope with that treatment. Emphasis on rehabilitation, education, and the development of patient autonomy will be among the roles of the oncology nurse and will positively influence the course of treatment.

Among the changes significant to nursing will be the influx of new high tech delivery systems, more sophisticated automation and data management systems, and the development of new drugs and biologicals. Each will result in the development of new competencies and practice patterns.

The 1990s will be a time of transition for hospitals and health care providers. Faced with new methods of reimbursement, a graying population, and rapidly changing technology, nurses will be challenged to examine clinical practice and utilization of scarce resources; among them, nurses themselves.

The simultaneous emphasis on productivity, cost containment, and quality will stimulate an identity crisis in many nurses, but will ultimately result in the development of new practice patterns and nontraditional alternatives to care.

Creativity will be an imperative for the nurse of the nineties. "Working smart" will become a byline and will result in oncology nurses who coordinate care and serve as advocates for patients and their families.

Data Management

Dolores Michels, ART, CRT
Tumor Registrar
Allegheny Hospital,
Pittsburgh, PA

The integrated, automated registry system will be viewed as a corporate asset by the health care industry. The database will provide information to clinicians and administrators that can effectively and efficiently assist them in managing the bottom line while assessing the quality of patient care and outcome. Critically dependent on the success of this information system venture is the selection of a knowledgeable clinical/administrative human resource. This registrar administrator will be selected to serve as the facilitator between the users and the information system programmers.

There must be institutional commitment to the long-range underwriting of costs, and to providing knowledgeable personnel to develop a systematic and coordinated hospital-wide integrated relational database system.

Radiation Oncology

Simeon T. Cantril, M.D.
Radiation Oncologist
Children's Hospital of San Francisco (CA)

Over the next decade, radiation oncology will experience an ever increasing sophistication in the integration of computer applications, linking the anatomical information available from CT and MRI scans to the treatment planning process and, ultimately, to the operation of therapy equipment. This will allow for increased accuracy in defining tumor volumes and in limiting the amount of normal tissue included in the radiation beam; thereby allowing for more precise targeting and higher tumor doses while sparing normal tissue.

At least the first generation of these anticipated computer applications are already here. They are exceedingly costly, yet the reimbursement for radiation therapy treatments does not reflect this increase in treatment sophistication.

The new applications will also require additional skills of radiation oncologists if they are to utilize them effectively, as well as more highly trained dosimetrists, technologists, and physicists—all of whom are already in short supply. Because of these factors, these advanced treatment capabilities will tend to be concentrated in larger centers and will only be available to a small portion of the cancer population that might benefit from their application.

Medical Oncology

Albert B. Einstein, Jr., M.D.
Medical Oncologist,
Virginia Mason Cancer Center,
Seattle, WA

Progress in medical oncology during the 1990s promises to be very excit-

ing as our knowledge of the genetics, molecular biology, and biochemistry of the cancer cell rapidly expands. Mechanisms of drug resistance will be elucidated, and strategies to overcome them will be developed. Enhanced drug activity through the utilization of other drugs that potentiate the biochemical effects of cytotoxic drugs will be accomplished. Dose limiting toxicities of cytotoxic drugs will be modified by protective agents or biological agents to permit dose intensification. New cytotoxic drugs will be engineered based on new knowledge of the biochemical changes inherent in neoplastic cells. As new, more effective cytotoxic chemotherapy regimens are developed, a greater emphasis on neoadjuvant or adjuvant utilization of these regimens will follow.

Complementing the improvements in cytotoxic chemotherapy will be the emergence of immunotherapy as a valid fourth modality of cancer treatment. The mysteries of the body's immune system will be elucidated, which will permit the development of biological reagents capable of enhancing or altering the immune defense against cancer cells. Genetic engineering will facilitate the programming of immune cells to specifically attack cancer cells. Immune cells, monoclonal antibodies, and lymphokines will be routinely used following chemotherapy, surgery, and radiation therapy to eliminate the "last cancer cell."

Unfortunately, the funding for the basic science and clinical trial research necessary for these advances will continue to be a major problem. Government-sponsored research will not expand commensurate with need, because of fiscal limitations. Corporate-sponsored research, focused on providing marketable therapeutic products, will play an increasing role in the development of new drugs and biological agents. Insurance companies will be forced by public pressure to be more supportive of clinical research therapies. Despite these problems, the rapid advances in knowledge and new therapies during the 1990s will be overwhelming.

Surgical Oncology

Irvin D. Fleming, M.D.
Surgical Oncologist
Methodist Hospitals of Memphis (TN)

It is apparent with the rapid advancement of techniques and endoscopy—particularly laparoscopy and laser applications using these techniques—that these uses need further refinement and definition. These techniques will be utilized more with management of surgical oncology patients in diagnosis, in treatment, and in evaluation of response. The trend continues toward increasing outpatient surgery for oncology procedures, particularly minor surgery and diagnostic procedures. The use of combination therapy (particularly pre- and post-operative radiation therapy and neoadjuvant chemotherapy) in conjunction with surgery, will continue to be defined in the 1990s.

One of the prime concerns is the increasing need for surgical oncologists who are comfortable working in the multidisciplinary setting. At present, there are less than 25 surgical oncology training slots in the United States. This number does not nearly approach current needs in teaching centers or in the community for individuals who are committed to a career in the surgical management of cancer.

A second area of concern is cost. In light of the limited resources available, the use of sophisticated techniques and technologies (i.e., lasers, endoscopy, laparoscopy, etc.) present a very difficult problem in keeping down the costs of the surgical aspects of the management of cancer.

Clinical Research

Cary Presant, M.D.
Clinical Researcher
Queen of the Valley Hospital
West Covina, CA

In medical oncology, the new classes of biologicals produced by recombinant DNA technology will significantly increase tumor response rates, length of survival, and quality of life by producing better cell kill, by decreasing drug resistance, and by modifying patient immune response. Many new agents will be proven to reduce patient toxicity compared to conventional and current investigational agents. New therapies will emerge both for primary multidisciplinary curative therapy and palliation, even in highly drug resistant patients. New hybridization probes and methods will allow earlier detection of cancer with oncogene point mutations making significant downstaging possible in certain diseases. A few cancers will demonstrate frequent associations with easily detectable genetic mutations, allowing selected prevention measures for screening populations.

Most of the new technologies will be very expensive, although all will be easily used in most communities. Many payors will refuse to reimburse for these more expensive therapies, despite better results, arguing that cost-benefit thresholds are not exceeded. Health maintenance organizations and other capitated programs will place oncologists in an unfavorable position with professional utilization reviewers, primary physician gatekeepers, patients and legislators, as well as hospitals to which doctors will, of necessity, cost shift the new technology uses. Increased time will be required of oncologists to plead for access to treatment and reimbursement, and to explain to the public the reasons for access denial. Patients and families will be disenchanted with oncologists and health care payors. Third-party payors will experience problems evaluating payment for expensive technologies such as genetic screening, the prophylactic removal of organs that are at very high risk for cancer development, and molecular hybridization probes for earlier cancer detection. It will be increasingly difficult for oncologists to apply proven technologies to patients in need, leading to the decreased entry of qualified physicians into the specialty and, possibly, psychological reactions in current practitioners. ■