



In the News

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Social Workers' Role Is Crucial

As a licensed clinical social worker with a background in oncology, I was greatly disappointed with the lack of any reference to psychosocial concerns in the Spring 1990 *Oncology Issues*. In an otherwise excellent compilation of articles, comments, and expositions, there was essentially nothing documenting the crucial role the oncology social worker can assume to supplement and complement the cancer center's care of patients.

I am assuming the ACCC is aware of new legislation that will permit psychosocial counseling reimbursement by Medicare as of July 1990. This certainly offers an opportunity to broaden the range and scope of social workers' contributions to cancer care. Your own organization's standards clearly spell out the expectations of a social worker in an oncology setting.

As you are also likely aware, there is a very strong and viable National Association of Oncology Social Workers which could, and likely will be able to, assist in filling the "Leadership Gap" referred to in the "From the Editor" column.

While kudos are to be extended to *Oncology Issues* for an excellent issue, it should also be admonished for the oversight of an important and crucial dimension of "Cancer Care in the 1990s."

—Lance Sams, LCSW, Social Service
Department, Mease Health Care,
Dunedin, FL.

NIH PANEL FOCUSES ON EARLY-STAGE BREAST CANCER

Breast conservation treatment is "an appropriate method of primary therapy for the majority of women with stage I and II breast cancer," according to a recent consensus statement developed by members of an NIH panel. The panel concluded that breast conservation followed by radiation therapy is "preferable" to mastectomy "because it provides survival equivalent to total mastectomy, and it also preserves the breast."

However, at a press conference, William Wood, M.D., Chairman of the NIH Consensus Development Panel and Chief of Surgical Oncology, Massachusetts General Hospital, Boston, admitted that, at present, "breast preservation is used in a minority of women in this country"—a fact that he attributed to "variables in implementation." However, the consensus statement "doesn't mean that conservation should be employed in the majority of women," Wood said, noting that "many women elect to have a mastectomy" rather than breast conservation and radiation therapy.

As far as adjuvant systemic therapy is concerned, Wood said it is the Panel's hope that the consensus statement will help to decrease adjuvant therapy for women at a low risk of recurrence and, alternately, increase adjuvant therapy for women who are at high risk. The Panel's major recommendations were as follows:

- The recommended technique for breast conservation includes local excision of the primary tumor with clear margins, level I-II axillary node dissection, and breast irradiation to 4,500–5,000 cGy, with or without a boost.
- The many unanswered questions in the adjuvant systemic treatment of node negative breast cancer make it imperative that all patients who are candidates for clinical trials be offered the opportunity to participate.
- The rate of local and distant relapse following local therapy for node negative breast cancer is decreased by both combination cytotoxic chemotherapy and by tamoxifen. The decision to use adjuvant treatment should follow a thorough discussion with the patient regarding the likely risk of relapse without adjuvant

therapy, the expected reduction in risk with adjuvant therapy, toxicities of therapy, and the impact on quality of life.

- While all node negative patients have some risk for recurrence, patients with tumors less than or equal to one centimeter have an excellent prognosis and do not require adjuvant systemic therapy outside of clinical trials.
- Future research should focus on refining existing prognostic factors, developing risk factor profile systems with sufficient accuracy and reproducibility to allow identification of subgroups, improving systemic chemotherapy regimens, and gathering further data concerning tamoxifen.

AMA REVOKES RCTS

The AMA has scratched its plan to establish a registered care technician (RCT) category in health care. In AMA committee discussions, it was reported that, to date, not a single hospital or nursing home had agreed to sponsor an RCT training program because of intense opposition from nurses.

PRUDENTIAL TO EXPAND IQ NETWORK

The Prudential Insurance Company of America plans to expand its "Institutes of Quality" (IQ) program to include a network of hospitals that perform autologous bone marrow transplants. The intent of the program, which was initiated in July 1988, is to guide beneficiaries to select major institutions for high-tech medical procedures. Prudential believes the program will improve health outcomes and help to control costs.

To date, Prudential has established IQ networks for centers specializing in one or more major organ transplants (heart, kidney, and liver) and in allogeneic bone marrow transplants. The company uses quality criteria to identify hospitals for possible inclusion in the networks (i.e., organ transplant programs must be at least two years old, have physicians with special training and extensive experience in transplants, perform a minimum number of transplants annually, and meet patient survival rate standards). Prudential further narrows its selections based on geographic considerations (i.e., proximity

to a sufficient number of beneficiaries), and its ability to negotiate financial arrangements with eligible institutions.

According to Prudential, incentives for patient utilization include travel expenses to the facility for the patient and a companion, coverage for other necessary expenses the companion incurs during the patient's confinement, and enhanced benefit levels.

To date, seven institutions are participating in Prudential's allogeneic bone marrow transplant network: Johns Hopkins Medical Institutions, Baltimore, MD; City of Hope National Medical Center, Duarte, CA; Fred Hutchinson Cancer Research Center, Seattle, WA; University of Minnesota Hospital and Clinic, Minneapolis; the Medical Center at the University of California, San Francisco, CA (pediatric only); Barnes Hospital and the Washington University School of Medicine, St. Louis, MO; and Shands Hospital at the University of Florida, Gainesville.

Other planned networks for the future, in addition to autologous bone marrow transplants, include coronary artery bypass and angioplasty, brain and spinal cord injury rehabilitation, and select neurosurgical procedures.

ONS SALARY SURVEY

Salaries for oncology nurses range from almost \$13 per hour for entry-level staff nurses to almost \$19 per hour for clinical nurse specialists, according to the *1989 National Survey of Salary, Staffing, and Professional Practice Patterns in Oncology Nursing* by the Oncology Nursing Society. The survey also found that the methods for awarding routine salary increases for staff nurses included merit, based on performance evaluation (70.5 percent); across-the-board administrative increases (43 percent); and fulfillment of a contractual agreement (18.6 percent).

Overall institutional vacancy rates for professional nurses ranged from a low of 7.36 to a high of 12.83. The turnover rate on oncology units averaged 14.8 percent, ranging from 13 percent in pediatric oncology units to 32.5 percent in hematology units. The average number of FTE staff nursing positions by type of oncology unit ranged from 26 positions in a bone marrow transplant unit with a median of

11 beds to 15.5 positions in a gynecologic oncology unit with 32 beds. The average professional nurse/patient ratio ranged from 8.45 on the night shift of a combined medical/surgical oncology unit to 0.57 on the day shift in a biological unit.

CALL FOR PROPOSED BYLAWS AMENDMENT

ACCC Bylaws, adopted March 1984 by the House of Delegates, state: "Bylaws may be amended by the vote or written assent of two-thirds of the Delegate Representatives voting. Written notice of proposed Bylaws amendments must be sent to voting members at least 30 days prior to the meeting at which they are to be acted on."

Any delegate representative who wishes to suggest a Bylaws change must inform the ACCC Executive Office of that intent no later than Dec. 1, 1990, for consideration by the House of Delegates in March 1991.

All suggested amendments should be sent to the attention of Carol Johnson, Director, ACCC, 11600 Nebel St., Suite 201, Rockville, MD 20852.

CALL FOR OFFICER AND TRUSTEE NOMINATIONS

The ACCC Nominating Committee is soliciting nominations for the following 1991-1992 board positions:

- President-Elect
- Treasurer
- Four Trustee Seats

The term of President-Elect is one year. The Treasurer and Trustee positions are two-year terms. Although nominees are not required to be the voting representative of their institution, they must represent an ACCC Delegate Institution.

Letters of nomination should be sent to the ACCC Executive Office, citing the nominees' names and their respective Delegate Institution, along with a copy of their curriculum vitae. **Nominations must be received no later than December 1, 1990.**

Further information about the nomination process may be obtained from Carol Johnson, Director, ACCC Executive Office (301/984-9496). ■

From The Editor

(Continued from page 3)

the Association's reimbursement initiatives are directed toward helping make practice survival possible. The new brochure with information for patients on better insurance language should help. Our efforts to back up ASCO's initiatives with HCFA on coding and the RVS method of physician payment should help. Our state-level efforts to develop and pass legislation that guarantees reliance on the three compendia and the involvement of state organizations in resolving disputes with carriers should also help.

What about new technology? Our new technology forums provide a simplified way for program administrative managers and physician leaders to review new technology that is ready to be introduced to the community setting, and to evaluate how it might be useful to developing cancer programs. And, clearly, the ACCC's Collaborative Research Group will serve as a mechanism to gain access to new technology that is unobtainable through traditional pathways.

In terms of bonding physicians and developing programs that are current and viable, the Association's Program Committee will, no doubt, continue to secure conference speakers who are experts on Federal legislation and rulemaking, program development, leadership, marketing, facilities management, reimbursement alternatives, and physician arrangements. These are the topics that speakers will be addressing at this fall's meeting in Las Vegas.

Of course, ACCC can't solve all of the problems that confront the profession. Indeed, the trends that I've outlined above are going to make the challenges ahead far more difficult than any of us could have predicted just two or three years ago. But, if the Association can provide some of the help you need, on some of the issues that you face everyday, then your investment in us is paying off.

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