Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

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To cite this article: Marilyn M. Mannisto (1991) Oncology Practices in the 1990s, Oncology Issues, 6:1, 10-13, DOI: 10.1080/10463356.1991.11905019

To link to this article: https://doi.org/10.1080/10463356.1991.11905019

Published online: 19 Oct 2017.

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ONCOLOGY PRACTICES IN THE 1990s

by Marilyn M. Mannisto

This article presents the views of oncologists in a variety of practice settings, from a solo, private practice to a large cancer center. These physicians discuss the major challenges they face in their current practice setting, as well as their predictions for future trends in oncology practices.

A Solo, Private Practice

Irvin D. Fleming, M.D.,
Surgical Oncology
Memphis, TN

Dr. Fleming represents what may be a dying breed: the oncologist in solo, private practice. Fleming has maintained his private practice since 1964. He also serves as part-time faculty at St. Jude's Children's Hospital and Methodist Hospitals of Memphis.

The reimbursement challenges that Fleming faces as a private practitioner are, he believes, leading many young physicians to join group practices. "It's easier if you have a business office that has developed mechanisms to deal with reimbursement problems and negotiations with third parties. I think young physicians are being overwhelmed by such hassles." In fact, Fleming thinks that "it is easier to build up a private practice than it is to cope with reimbursement issues."

From a practice aspect, Fleming says his greatest challenge is the increasing "intrusion by third-party payors into how you take care of patients"—a fact of life that he says pertains to about 70 percent of his patients. "I have one staff person who virtually spends 80 percent of the time communicating with third-party payors," he says. "They all primarily want to know, 1) should the patient be admitted, 2) is the treatment appropriate, and 3) how long should they be kept in the hospital? These questions are primarily answered on the basis of matching the patient's diagnosis with the norm," Fleming says. If his staff "absolutely has no success" with those negotiations, Fleming must get involved.

Fleming has contracts with two PPOs, primarily through his affiliation with Methodist Hospitals of Memphis. He doesn't view his dealings with PPOs as any worse or any better than other third-party payors, but he resents the "time and energy" they require, the end result of which, he contends, is "not reflected in improved health care." Such intrusions and current reimbursement policies force Fleming to occasionally do, what in his view, is "second best" for his patients. For instance, he points to the current, widespread policy of admitting almost everyone on the day of the procedure, instead of the night before. "That's fine 90 percent of the time, but totally inappropriate for the other 10 percent of patients, particularly debilitated patients."

Moreover, he points to problems with HCFA's peer review mechanism for Medicare. "About one year after the patient has been treated, they'll write me a letter inquiring about the appropriateness of the treatment, regardless of the patient's outcome." In short, Fleming says, "we are forced to make the patient's care fit their rules."

The biggest change in his practice has been economic, Fleming says. "My fees have been frozen since 1984," he says. Regarding the advent of RBRVS, Fleming notes that "surgeons are used to being paid a global fee; the idea is not new to us. The question is how it will shake out as far as the bottom line is concerned. HCFA thinks it can adjust fees for different specialties and not affect availability of care or access to care. To a point that's true, but beyond that point the new system could absolutely affect where physicians practice."

Another downside to private practice, Fleming says, is that "you must cover for yourself or you must arrange coverage." Nevertheless, he points out that, in a group practice setting, "you must negotiate everything you do. There is also the problem of productivity; that is, what to do about the physician in the group who is not working as hard as the others." Finally, he raises the difficulty of allocating costs and expenses, particularly in a small group. All in all, he enjoys the "flexibility of a small, private practice over the more rigid structure inherent in large organizations or group practices." Still, he predicts "fewer and fewer physicians will start private, solo practices in the future. Look at me, I'm a dinosaur of types, but I've been in private practice for so long, I'm comfortable with it."

An Office-Based Group Practice

Burton Schwartz, M.D.,
Medical Oncology
Minneapolis, MN

Dr. Schwartz has been part of a large office-based practice for the past six years. The 11-oncologist practice maintains offices both in downtown Minneapolis and the suburbs. Practice members are on staff at a number of area hospitals. Schwartz, who specializes in both medical oncology and hematology, says the group administers chemotherapy in both offices—a shift to the outpatient setting that he believes will continue. And the practice is getting busier. In fact, trying to keep up with the patient load is one of the group's challenges, he says. However, at the same time, the move to outpatient care is "affecting the hospitals we're affiliated with. Although the partners will occasionally hospitalize a patient (e.g., when a patient needs a high dose of cisplatin), we're seeing too many hospital beds unfilled," Schwartz says. As a result, one local hospital may be closing, which is necessitating a "restructuring of how we practice," he says. In addition, "heavy HMO infiltration in the area is negatively affecting reimbursement for chemotherapy and some office codes."

As for future plans, "we are trying to stay in the forefront," Schwartz says. To

that end, the group plans to become "more involved in fourth modality technologies," most likely through a cooperative group. Currently, two partners perform autologous bone marrow transplants at a Minneapolis-based hospital; a role he sees expanding. The partners are already heavily involved in clinical research. In fact, Schwartz says, in addition to cooperative groups, "we are now involved in studies directly with drug companies." The group's physicians also provide outreach services at rural hospitals. Finally, other partners are helping develop two separate cancer centers in the area.

The group may be one of the first to set up its own quality assurance program. "We're starting with a simple system we hope to have in place within the next couple of years," Schwartz says. "One physician in the group is in charge of the program, and is being assisted by staff at a local hospital who have experience setting up quality assurance programs at the hospital level." It's the group's view that, eventually, all group practices will have quality assurance programs in place, "if not because of a mandate by the government, then at the prompting of insurance companies."

A Multidisciplinary Clinic

Albert B. Einstein, Jr., M.D., Medical Oncology Seattle, WA

Dr. Einstein has been a medical oncologist at the Virginia Mason Clinic since 1976. He also serves as Medical Director for the Virginia Mason Cancer Center, President of the Virginia Mason Research Center Board of Trustees, and Principal Investigator for the Virginia Mason CCOP Program. He spends about 40 percent of the time on management functions and the rest in clinical practice.

Einstein is an employee of the clinic, as are all of Virginia Mason's 250 multidisciplinary physicians. New physicians are "associates" for the first two years, and then become members at which time they sign a contract, Einstein explains. "The contract is automatically renewed; there are no negotiations. A committee of physicians determines compensation levels based on productivity, professional attainments, and their perception of a physician's achievements within the organization."

One of the major challenges for Einstein is "balancing administrative, clinical research, and clinical practice responsibilities in a setting where there is a strong emphasis on medical practice." He explains that while "physicians play a strong role in management, they never give up the practice of medicine. There are no full-time physician administrators; even the CEO practices medicine." From an administrative standpoint, Einstein emphasizes the challenge of working with other administrators. "You must have good administrative people to rely on, particularly when you are a part-time administrator. You also need a good working relationship between physicians and administrators. The advantage I perceive [in this practice setting] is that we are all a part of the organization. Unlike a community hospital where physicians and administrators frequently have different agendas, we work collaboratively because we have the same goals."

Nevertheless, the clinic as a whole is facing some major challenges. "How to continue to have a positive bottom line in an environment of decreased reimbursement and increased overhead costs; how to manage expenses and, at the same time, provide quality care, consumes a majority of our time and actions," he says. "It also impacts the development of new services and places constraints on staff recruitment." For instance, he says, "I just hired a full-time administrative director for the cancer program, which took eight years." Einstein is proud of that accomplishment, explaining that "at Virginia Mason, administrative people have always been responsible for multiple programs; this position, dedicated solely to the cancer program, is a first."

Another issue is "how we keep the CCOP running when a large part of the budget needed to support it must come from our own institution." As Principal Investigator, Einstein "must continually justify the need for those resources." Fortunately, he says, "we receive donated funds specified for cancer research, so we are not competing with other types of programs for funds. But that pot is not large; CCOP budget needs are increasing while NCI funding is decreasing." Such budget constraints are particularly true for cancer control research, which he says is "underestimated in terms of the necessary time and resources needed to perform research; there are hidden costs the NCI is not acknowledging."

Einstein believes the future holds a "closer alliance between physicians and hospitals, both geographically and organizationally. Seattle hospitals are building medical office buildings adjacent to the hospital to help identify physicians with the institution. We are also seeing physicians moving from private practices into larger group and multi-group practices," he says. Einstein also predicts that, although "it's hard to know where reimbursement issues are going to take us," he believes that "chemotherapy and laboratory testing will be less a part of physicians' practices. Once RBRVS is in place, "physicians will be receiving more of their compensation based on the time they spend with patients."

An Independent Medical Oncology Group

William Dugan, M.D., Medical Oncology Indianapolis, IN

Dr. Dugan has a private practice, is the Principal Investigator for a CCOP, and is President of Indiana Community Cancer Care (ICCC), a free-standing corporation that contracts with more than 20 hospitals throughout Indiana to provide oncology care.

ICCC currently is composed of 12 oncologists from multiple private practice groups who participate in the corporation's outreach programs, as well as eight office staff members. The corporation's contractual services include training nurses at local hospitals in the administration of chemotherapy, setting up tumor registries, establishing cancer committees, writing annual reports, providing subspecialty consultations, performing all quality assurance, and educating nurses toward certification. The physicians are paid on a fee-for-service basis by third parties, and the corporation is governed by a board of directors. ICCC was formed in 1982 and began its first program in 1983. This past year, its physicians saw 2,000 new cancer patients.

According to Dugan, "the number one challenge is obtaining adequate reimbursement. The number two challenge is that, in order to remain competitive, we need a large critical mass that can afford the technologies that will allow us to deal

with the 1990s." For instance, Dugan points to oncologists' ability to "buy scanning computers that can print out consultations and be handed to patients before they leave. The solo practitioner can't afford that kind of technology," he says.

"My belief is that for medical oncologists to be successful in the 1990s, they must be bigger than any one hospital they network with," Dugan contends. He believes that "networking is the buzzword for the 1990s;" that it should be occurring "between practicing physicians, with primary and secondary hospitals, and at every other level. The ACCC is a network; CCOPs are a network. You can no longer have a simple, one-person practice without networking." Dugan believes that "networking will allow private practitioner's to survive and succeed."

"The other advantage of networking between multiple hospitals, in this day and age of managed care, is that if I see a patient in consultation, but can't admit that patient to the hospital I'm affiliated with, because of restrictions [on sites of care], I can refer that patient to another physician in the group, and at least we don't lose the patient entirely."

Furthermore, Dugan is committed to preventing the "unnecessary duplication of services in hospitals." That is the purpose of Cancer Center Associates, Inc., Indianapolis, of which Dugan is vice president. The organization is owned by 15 oncologists, including medical oncologists from competing group practices and, most recently, pediatric oncologists. "It's not a money-making organization for the oncologists, but a practical affiliation wherein we can support bone marrow transplants and other new technologies in the future. The group was formed to ensure that oncologists have an effective voice in preventing the duplication of services by hospital administrators," Dugan explains. He believes that such a voice is necessary. "Frankly," he says, "hospitals will compete until the cows come home. And although that's not necessarily bad, I believe that medical resources are too precious for the duplication of oncology services and technologies."

The goal of Cancer Center Associates is to determine that "Hospital A will do bone marrow transplants, Hospital B will be the area's gynecologic oncology center, etc." The group "hasn't achieved that goal yet," Dugan says, but it has formed a freestanding corporation that hired a bone marrow team to perform both autologous and allogeneic transplants at Methodist Hospital. "We can't tell hospital's they can't offer bone marrow transplantation, but if they have difficulty finding patients on which to perform transplants at their institution, that should effectively impede duplication of services."

An Independent Radiation Oncology Group

Thomas Sawyer, M.D., Radiation Oncology Orlando, FL

Dr. Sawyer has been an assistant professor of radiation therapy at a university hospital, affiliated with a community hospital through a diagnostic radiology group. an independent practitioner at a freestanding radiation center, and the president of a private corporation of radiation oncologists. One year ago, Dr. Sawyer retired from practice and is currently enrolled in law school.

"At the time that I started my radiology residency, it was during a period of transition, in which the subspecialties of diagnostic and therapeutic radiology were evolving," Sawyer explains. "In fact, I was the first resident at the University of Florida in radiation therapy. At that time, there were only about 50 full-time practitioners in the country."

After stints in a private practice and as an independent radiation oncologist at a freestanding center, Sawyer joined the staff at an Orlando community hospital with the "understanding that [the hospital] would build a separate radiation therapy department, its medical staff would be recognized as such, and the three or four physicians on staff would be functioning as full-time radiation oncologists."

Shortly afterward, the group "had an offer from a hospital 20 to 30 miles north to build and manage a radiation therapy department for it. Due to constraints, such as certification of need (CON), this hospital decided to contract with a group of physicians to build and operate the center." When Sawyer left the group about a year ago, there were 10 physicians in the group, 6 physicists, 7 dosimetrists, and, in all, the practice was employing or supervising about 100 people and treating approximately 250 patients per day. The group was managing five hospital departments and a private facility. Moreover, the group had just contracted with the M.D. Anderson Outreach Corporation to provide radiation oncology services for its planned comprehensive cancer center in Orlando, and it had plans to develop another private facility.

"What started out as a small practice became, over the next 15 years, one of the largest, if not the largest radiation oncology practice in the country," Sawyer notes. The corporation's rapid growth and the logistics of partners practicing in multiple sites made management difficult, Sawyer says. "We started off using democratic principles of management; physicians were brought in as partners. That worked well when we were a small group operating out of one department. As we grew, it became harder to communicate and everyone wanted to have a say in every decision. We held monthly meetings, which helped, and we tried to implement phone conferences, but from a management standpoint, the practice was cumbersome and I didn't feel that it had long-term stability. I felt we needed major structural changes in the way the practice was managed. In addition, M.D. Anderson indicated that our practice would double in the next 5 to 10 years, and we were talking about opening another private center, which meant an additional 10 to 15 partners."

According to Sawyer, however, "the group was unwilling to make major structural changes, such as establishing an executive board for decision making." Moreover, "there was discontent internally, because of the agreement with M.D. Anderson—some partners were for it, others were against it. I was a visionary and I think physicians tend to be conservative. We ended up with people who didn't have the same vision and people who simply wanted to preserve the status quo."

Sawyer not only left the group, but he enrolled in law school and is no longer practicing medicine. "I hope to come out of law school with a strong service orientation and to do patient advocacy; not in terms of malpractice, but there are enormous changes radiation oncology is facing, especially in terms of reimbursement."

Sawyer has strong views about the future of radiation oncology. "I think the specialty is vulnerable, because medical oncologists have become the gatekeepers." He contends that, increasingly, "where the

choice of radiation therapy or medical oncology is an equivalent, or largely equivalent, measure of treatment, medical oncologists, as gatekeepers, select chemotherapy. I see increasing competition with radiation oncology and in the future, I think radiation oncologists could see a sharp decrease in the number of patients they treat."

There are also going to be "decided changes in reimbursement" for radiation therapy, Sawyer says. "It has been noted that radiation oncology is the most highly paid specialty; that will certainly change with the advent of a RBRVS system of payment. I think radiation therapy may have seen its heyday, and it may not remain dominant over more than the next decade. As newer methods of treatment come along that minimize the damage that occurs with radiation, as medical oncology improves, and as other modalities, such as genetic therapies, come on line "there will be less and less need for radiation therapy," he predicts. "It's true that the field is working on sensitizing agents, but I think that research is limited. In my experience, radiation oncologists seem less willing to participate in research studies than medical oncologists. And I think that will lead to medical oncologists gaining the upper hand." If the specialty is to continue to be successful, "we need to test a variety of sensitizing agents and to develop new techniques and strategies," Sawyer says. "I don't see that being done by radiation oncologists in private practice. Being the highly-paid specialists that we are, we need to devote more of those resources to research, even if it means decreasing our patient loads and, thus, our revenues. As physicians, we have a responsibility to continually try to make improvements in patient care."

A Cancer Center Medical Director

Albert M. Brady, M.D., Medical Oncology Denver, CO

Dr. Brady spent 12 years in a medical oncology group practice before he accepted a full-time position as Medical Director of the Cancer Care Center at Porter Memorial Hospital, Denver. While he was in private practice in Portland, OR, he had a number of administrative responsibilities, including Director of the oncology unit at Good Samaritan Hospital, Vice Chairman of the hospital's cancer committee, and Chairman of the hematology oncology section.

"I moved to Denver about 20 months ago to take on the full-time position of Medical Director. I still do consultations and some work at rural clinics in the area but, in all, only 10 percent of my time is devoted to clinical practice." Brady made the shift to full-time administration because he "wanted the opportunity to develop an oncology program and to develop site-specific programs and activities at the cancer center. I wanted to be affiliated with an institution that was willing to make a commitment to oncology program development, both administratively and financially."

As Medical Director, Brady says his number-one challenge is to "develop a mode of practice that is compatible with private practice and to develop activities that promote the center." He believes that site-specific activities at centers will be "the wave of the future." Physicians "who have an interest in a particular disease should perform patient workups and make the treatment recommendations," he contends. But, he admits, "its difficult to balance the tensions between the traditional health delivery system and services that will benefit patients." According to Brady, the Denver area is dominated by small, single specialty practices and "oncologists have mixed feelings about site-specific activities being developed in the center. They fear it will hurt their practices. And the concept is so foreign that physicians are intimidated and try to either stall or prevent their implementation. Clearly, without physician participation in such clinics, they won't be viable. On the other hand, we can't build a coordinated program that is attractive to the public unless we have a focused program."

Another high priority for Brady is clinical research. "There are plenty of opportunities to participate in clinical research. My challenge is to mesh those opportunities with the prejudices and interests of the institution and its medical staff." Brady believes medical directors have a major role to play in improving accrual to research trials. "Medical directors should make it a priority to help physicians who are having logistical problems with protocols, to make it as easy as possible to enroll patients on trials, and to increase the medical staff's awareness of, and participation in, clinical trials. Physicians' need to have inculcated in them a thought process that always considers the possibility of entering each patient they see on a clinical trial. Our institution accrues about two-thirds of all the patients on trials through our CGOP. I think that in large measure, that's because of my efforts as medical director."

Another challenge that Brady emphasizes is procuring capital funds for the oncology program. "How to politic for your program and ensure that it's a high-priority in the institution is an ongoing challenge." Moreover, "specialty societies seem to have withdrawn from their attempts to develop standards of care"—a situation that Brady hopes will be rectified. "It's too difficult to try to develop standards on a single institution basis. I hope the societies get involved in standard development. Societies could much more readily develop standards that reach down to every level of care and across the broad spectrum of oncology, which would improve the quality of care, diminish lengths of stays, and improve the reimbursement situation for hospitals." For instance, he says, "it is unacceptable to have a patient hospitalized for 30 days for pain or 15 days for hypercalcemia." Unfortunately, "there is a conflict between physicians and hospitals; the longer a patient is in the hospital, the more money a physician makes, but the reverse is true for hospitals."

In the future, Brady predicts that "small, single specialty groups will coalesce into larger group practices" both to improve their "financial viability" and to facilitate "changes in lifestyles" that will free up more of their time. He also believes that the successful group practices will be the ones that are "working more closely with cancer centers and supporting their activities."

As far as medical directors are concerned, Brady thinks that full-time directors will "become more common. For part-time directors, there is a constant pull between their private practices and their salaried positions. It's difficult to maintain a balance. But as institutions become more sophisticated, I think they will begin demanding that medical directors fulfill their contracts in terms of the tasks they perform and the time they devote to those tasks. When that happens, I think we will see a proliferation of medical directors." ■