Oncology Issues

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

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To cite this article: (1993) An Interview with ACCC's New President Albert B. Einstein, Jr., M.D., Oncology Issues, 8:2, 19-22, DOI: 10.1080/10463356.1993.11904421

To link to this article: https://doi.org/10.1080/10463356.1993.11904421

PROFILE

An Interview With ACCC's New President Albert B. Einstein, Jr., M.D.

The ACCC's new President for 1993–1994, Albert B. Einstein, Jr., M.D., has recently assumed the position of Associate Director of Clinical Affairs at the H. Lee Moffitt Cancer Center in Tampa, Fla. Previously, he was a medical oncologist, cancer center medical director, and CCOP principal investigator at the Virginia Mason Medical Center, Seattle, Wash. He has served in many leadership positions within the Association. In this interview Dr. Einstein examines the ACCC's priorities, goals, and future direction.

How has your experience prepared you to take over leadership of the Association of Community Cancer Centers?

From 1976 until recently, I was at the Virginia Mason Medical Center in Seattle,Wash. Starting about 1980, I began to exert leadership in developing a cancer care program, which already included all the major components—radiation oncology, medical oncology, and surgical oncology—but which lacked coordination, support services, and cohesiveness. Ultimately, I assumed the position of Medical Director in 1989. My experiences at Virginia Mason have led me to understand the challenges and rewards involved in developing a community cancer program.

My involvement with the ACCC has been stimulated by the opportunity to be a part of the leadership at the national level that is uniquely devoted—with significant vision, mission, and resources—to promoting development of multidisclipinary community cancer programs. I have a strong commitment to assuring that the ACCC will represent, serve, and support its multiple constituents, who include physicians, medical directors, administrators, nurses, and others involved in cancer program development. ACCC will continue to serve the multidisciplinary team involved in providing cancer care.

How can the ACCC remain in close contact with legislators responsible for developing national, state, and regional policies that affect insurance coverage, especially coverage for off-label drugs?

At the national level ACCC's counsel is in the process of developing relationships with the Clinton Administration through which we can provide input and help influence health care policy. ACCC is also helping to promote relationships among state legislators, medical oncologists, and the community. In the future we may want to help patients themselves advocate for health care issues by letter or by personal contact with their legislators. We can try to rally that level of support at a grassroots level by encouraging physicians and nurses to advocate directly for their patients.

How should ACCC work with other professional organizations such as NCI, ACS, ONS, and ASCO?

Clearly, these major organizations and ACCC share concerns about cancer patients and cancer care. Therefore, we have similar legislative agendas. I strongly believe that rather than each group pursuing its own course we should use every opportunity to come together to support common causes. The recent President's Retreat is a good example of how ACCC can work well with other cancer organizations on important issues.This process will continue on a regular basis. ACCC should work with NCI and ACS, for example, to facilitate communication and coordination of activities. The bottom line is that the ACCC Board and committee interactions with these organizations will be beneficial.

How will the quality of cancer care be affected?

For the past 19 years ACCC has been working to improve the quality of cancer care in the community. The issues that are critical to assure continuation of the level of cancer care that we have worked so hard to achieve are as follows:

- Will patients be assured access to appropriate cancer care programs where they can receive quality multidisciplinary care?
- Will the primary-care physician be the gatekeeper who refers patients to cancer care?
- Will patients be locked into a health care system that prevents them from receiving cancer care outside the system that provides their primary care?
- Will there be support for cancer care associated with clinical trial research and will research continue to play a major role in health care delivery?
- Will we be able to continue to translate new technology at an early stage to the bedside?
- What will be the effect on cancer control research, such as prevention trials on otherwise healthy patients, if we have capitated reimbursement for care?
- To what degree will cancer screening be included in the basic package of health care reform?
- What will be the ability of cancer programs to continue to provide support activities, such as psychosocial care, dietary consultation, patient and family

education, and nursing support, particularly if we have a capitated system of health care.

In this age of managed competition and health insurance purchasing cooperatives, should the primary-care physician who is treating cancer patients fear for his or her practice?

If primary-care physicians are going to be penalized by the results of cancer treatment for their patients, certainly the physician will fear for his or her practice. I fear for the patient under those circumstances. The patient may lose access to sophisticated, appropriate cancer care if the primary-care physician is the gatekeeper. Once the diagnosis is made, care for the cancer patient should probably be reimbursed under a system in which the medical oncologist is the gatekeeper rather than the primary-care physician. The medical oncologist is better qualified to determine which treatments and tests are best for the patient and cost effective. I do believe oncologists will need to practice more cost effective medicine than they currently do.

Even if an independent, small clinic of 10 specialists is doing a wonderful job treating patients, an acquisition or merger can come along and—poof—the clinic is out of business. Does ACCC have a role in helping to prevent this from happening?

ACCC has presented and will continue to present programs that look at the relationship between physicians and hospitals, a relationship that is an important feature of any health care reform program. Specialists in a small clinic will probably have to align themselves in a network—probably an insurance-centered or hospital-centered network. They will need to develop new professional and financial relationships that preserve their ability to take care of their patients and assure their access to their patients. Clearly, however, specialists in a small clinic are not going to be as independent as they used to be.

With cost containment, the potential for practice guidelines, and the need for determining clinical outcomes, physicians' practices will probably have to become more standardized within any health care system. The days of the independent practitioner making independent decisions are numbered.

Albert B. Einstein, Jr., M.D.

"ACCC has evolved into a mature, credible organization that has provided leadership in cancer program development"

Obviously ACCC is concerned about the economics of health care reform. Do we run the risk of forgetting ACCC's mission of patient advocacy and ensuring access to high-quality care?

ACCC must maintain a balance in its efforts. We must support the needs of patients and help assure their access to high-quality care. At the same time we must help our membership be more knowledgeable and more effective in dealing with the reality of the financial side of health care. If the economics do not make sense, then patient care is going to suffer. Patient advocacy and the economics of health care reform are intertwined rather than separate issues.

Will health care reform discourage innovation?

Although it has the potential to discourage innovation, I certainly hope that reform is not structured in such a way as to do so. The federal government already has a lot invested in the future of cancer research, and I doubt this investment will be abandoned. Health care reformers should be concerned about the fact that optimal cancer care depends on continuing cancer research. However, if the costs of doing clinical trials does not enjoy continued support, progress will clearly be slowed.

How may health care reform affect hospital/physician relations?

As I mentioned before, physicians will need to become more aligned with hospitals in their community, probably in network relationships. Physicians will need to develop major leadership roles in the institution in which they are practicing. Hospital administrators will need to recognize and accept medical leaders as partners in delivering health care and vice versa. Hopefully, collaborative relationships between medical staff and administrators will lead to better patient care because of increased coordination, increased cost efficiency, better standardization of care, and better outcomes.

What role does ACCC play in helping members expand their research base?

ACCC has been a strong proponent for Community Clinical Oncology Programs (CCOPs) even before they were initiated in 1983 and has continued to be: 1) a forum for discussion of issues regarding CCOP management and 2) an advocate for their increased congressional support.

Another ACCC project has been the Collaborative Research Group (CRG). Recognizing the community oncologists' interest and capability in performing clinical research, ACCC formed the CRG to work with pharmaceutical manufacturers to enable our membership to participate in research trials sponsored by the pharmaceutical industry. Currently we have 50 CRG members, within 57 institutions, participating in this program. Our hope is that in the near future the number of protocols available to our members will be increasing. In addition ACCC along with other cancer organizations has been promoting the need for legislation to provide reimbursement for patient care associated with clinical trials. This effort is in response to private insurers who have refused to pay for care of patients involved in clinical research.

Finally, ACCC has also worked with NCI and its staff in the development of

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Articles

Articles submitted to *Oncology Issues* for consideration for publication should be no longer than 8 to 10 double-spaced manuscript pages in length. Submissions should include the original manuscript and two duplicate copies. Author(s)' identification (title and affiliation) should be included. If there are multiple authors, one author should be designated as correspondent.

Review and Corrections

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cancer control trials. Discussions have focused on the difficulties physicians encounter when trying to put patients in these trials. ACCC has been a leader in communicating the need for an increased number and higher quality of cancer prevention trials.

What is the future of clinical research and how can ACCC promote further development of research activities at the community level?

In the area of cancer research, our goals should be:

1. to continue to communicate our concern on behalf of our membership about the role of clinical research in health care reform,
2. to work for reimbursement for patient care during clinical trials, and
3. to work for expanded support of CCOP programs, and, obviously, to increase the number of CCOPs available to our membership.

Is cancer prevention cost effective and, if so, who pays for the prevention package?

Nondiscriminatory cancer prevention and screening are not cost effective. Therefore, high-risk groups of patients must be identified for screening and prevention programs. Clearly, these activities require much more research to identify appropriately who might best be suited for these programs. ACCC can promote and support cancer control efforts that look at defining which populations of patients are best served by chemoprevention and cancer screening.

Is ACCC in the forefront of the development of clinical indicators to evaluate the processes of patient cancer care and patient outcomes?

ACCC recognizes the need for clinical guidelines and outcome measurements in this age of health care reform. Clinical indicators will be important in determining quality of care as well as in promoting cost efficiency. ACCC's role will be to work with other cancer organizations to determine the best way to develop these guidelines at an early stage of health care reform rather than waiting for regulatory agencies to impose these guidelines on health care providers. We want to be as proactive as we can be.

Biotechnology industry representatives met recently with ACCC. Why is ACCC interested in pursuing this relationship?

If we look at the future of cancer treatment and the potential new pharmaceutical agents that will be available, many fall under the umbrella of biotechnology, which represents the more sophisticated or rational approach to cancer treatment compared with traditional agents. Education and involvement of our membership in trials using the new agents is a mission of the Association. Finally, because the newer agents are usually associated with increased cost of cancer care, our responsibility is to help define for our membership appropriate indications for the use of these agents and to facilitate the potential reimbursement of the costs of these agents so patients will have appropriate access to them.

In which direction is ACCC headed?

In the community I would like to see the Association function as a strong patient advocate by ensuring that the high-quality programs we have worked so hard over the years to develop remain intact and have the opportunity to improve during this transition period of health care reform.

Regarding the Association's internal organization, I would like to see ACCC serve the needs of all of its constituencies in a fair and balanced way and encourage their interactions. We have made progress this past year and will continue to do so through increased organizational and financial support for the Special Interest Groups and committees and through an enhanced commmunication between the SIGS and committees and the Board.

In the legislative arena, we are vocal advocates for patients and for care providers.

ACCC has evolved into a mature, credible organization that has provided leadership in cancer program development and in the promotion of increased availability of clinical research to the community. I look forward to the Association's ability to continue to function forcefully in these capacities on behalf of its membership.