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## From ivory tower to next-door neighbor Cancer centers, community physicians, access to cancer care

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**T**he spectrum of medical oncology care was traditionally defined by the comprehensive cancer center at one end of the spectrum and the solo community practitioner at the other end. Common stereotypes attributed expert but fragmented and less emotionally vested care to the cancer center physicians and warm, consistently available, but not quite state-of-the-art, care to the community practitioner. These stereotypes are long dead and buried, even if the conventional media and many cancer patients are not cognizant of the fact. In their place, a more textured and complex system has developed.

More and more, large healthcare institutions have spread their geographic wings. This idea was probably pioneered by the Mayo Clinic and The Cleveland Clinic, both located in cities not particularly convenient to large segments of the American population. As the migration to the Sunbelt proceeded, these institutions opened satellite centers that retain the staff-model approach of the parent institution in more seasonable climates, such as Arizona and Florida.

The largest cancer centers have taken new outreach approaches recently, which have begun to impact medical oncology practice. In this issue of *Community Oncology* (see page 171), Dr. Michael Buchholtz, a practicing community oncologist in Huntington, New York, and Dr. Philip Schulman, chief of medical oncology of the Commack, New York, satellite of Memorial Sloan-Kettering Cancer Center (MSKCC), discuss their viewpoints on the local impact of cancer center satellites. (*Editor's disclosure: Dr. Schulman is a personal friend and mentor of mine.*) Their honest, forthright, and compelling commentaries frame several broad questions that demand attention: What constitutes quality in medical oncology care? What is the value of advertising? How best do we address the growing issue of access to medi-

cal oncology care as the number of uninsured and underinsured grows?

### What constitutes quality?

It seems to me that a number of factors—including reimbursement changes; chronic, expensive therapies; and the growth of medical information technology—will compel oncologists to provide quality measures of care in order to justify the rising cost of treatments. Drs. Buchholtz and Schulman provide insight into the debate over what quality means and some of the factors that must be taken into account as we struggle with this issue.

Both agree that there is value in obtaining consultative recommendations from physicians who focus on a given type of cancer and therefore have great expertise in that particular area. It hardly seems controversial; when one is faced with a patient with a rare cancer, referral to a comprehensive cancer center physician who deals with five cases a month, compared with one per year in the community, offers a level of comfort and expertise that cannot be matched by the community oncologist.

This argument could be extended to certain oncologic surgical procedures, where centers with higher volumes and experience provide better outcomes. For instance, in my community, testicular cancer patients are still commonly referred to a cancer center for RPLN dissection following chemotherapy. Our urologists, who take a lot of pride in their abilities, nonetheless recognize the value of these referrals.

However, a surgery is a well-defined event that, once completed, does not require long-term inte-



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grated care. The situation gets a lot murkier when dealing with common cancers on an ongoing basis. The cancer center physician certainly has additional resources available compared with the community physician. Within the institutional arrangement, cancer center physicians—even if practicing in a satellite clinic—have access to weekly cancer-specific multidisciplinary conferences and an array of expertise that can be easily leveraged to aid in a difficult diagnosis or treatment decision. The fundamental question remains: Do generalist oncologists offer inferior treatment recommendations for standard cancers? With today's available technology for dissemination of the latest phase III results, virtually all oncologists have access to top-level knowledge and treatment recommendations.

Currently, I have a patient who flies several hundred miles every 3 weeks to receive Adriamycin and Taxotere for adjuvant treatment of node-positive breast cancer at a comprehensive cancer center. She is not part of a clinical trial. Is she receiving better care? Or is she just spending a lot of extra money to get the satisfaction of treatment at this institution?

One aspect of quality mentioned by Dr. Buchholtz is the continuity of care, particularly important in the context of the medical emergency. Unfortunately, cancer patients are prone to developing life-threatening complaints that require emergency room visits and hospitalization. More often than not, these visits and hospital stays take place locally, and the relationship built up by the local medical oncologist and his medical staff at the hospital facilitates testing and treatment. There is no doubt that such relationships can grease the gears of movement through a sometimes labyrinthine hospital maze, resulting in faster and perhaps better emergent care. Satellite clinics must, by necessity, build bridges with local non-oncology practitioners to help patients struggling with morbidities related to their diseases and palliative care at the end of life. These relationships form with the same community-based physicians that the community oncologist uses.

On the other hand, it is disappointing that the experience and expertise of comprehensive cancer centers freely offered by the satellite clinic to community oncologists have not been more effectively embraced. Having access to radiologists and pathologists who focus entirely on cancer can make the difference in a diagnosis or staging and may greatly impact the patient's results. Participation in a conference where such expertise is available could

improve the quality of the community oncologist's care. A second opinion from a practitioner at a comprehensive cancer center satellite, particularly when it agrees with the community oncologist's recommendation, enhances everyone's stature. Cooperation could and should be a win-win situation, especially when the individuals involved are fair-minded people who clearly respect one another and put the patient's well-being first, as is the case with our interviewees.

## **Advertising—is competition good?**

Whether or not the reason for MSKCC to open a satellite was to better serve patients who were traveling to New York City anyway to expand its patient base is beside the point. Any time there are new doctors or entities in an area offering oncology services, competition increases. I believe competition is a good thing. In my city (Memphis), consolidation of medical oncology groups led to a sea change in the way these groups presented themselves. It is not uncommon to see multiple practices marketing cancer services in newspapers and magazines, television advertisements, and even billboards. Clearly, major cancer centers have a financial advantage in their ability to mount such campaigns. It remains to be seen whether such advertisements make a wholesale difference in referral patterns.

In my experience, most cancer patients either accept their referring physicians' recommendation of an oncologist (or the recommendation of family or friends who have had positive experiences) or they have preconceived notions about getting an opinion from a major cancer center because of their knowledge base or socioeconomic standing. Advertising is unlikely to change this. However, advertising shines a bright light on the advertiser. If you show yourself off, you are liable to be more careful with what you are doing. I suspect the bar for cancer care on eastern Long Island has indeed been raised, not because community medical oncologists were inferior before, but because the entire medical community is now more exposed to the variety of cancer care available and its nuances. Surgeons, radiologists, and pathologists who treat cancer as only part of their daily routines must now step up to the plate to compete with cancer-only providers in these specialties.

## **Access to care and the future**

From where we stand today, there are clouds on the horizon of quality cancer care. The Medicare

Modernization Act of 2003 will continue to have profound ramifications. Dr. Buchholtz speaks eloquently about providing care to indigent patients through his network of hospital and professional associations. This care will be threatened in the future, as cutbacks in revenue force all community oncologists to look carefully at noncompensated services if they are to survive to care for any cancer patients in the outpatient setting. It is perhaps disappointing that the comprehensive cancer centers, quick to establish alliances in far-off developing nations who also need quality care, have not looked closer to home and developed cancer delivery systems for those who cannot afford them. Since so much of the cancer centers' revenue derives from the federal government in the form of grants from the National Cancer Institute and the National Institutes of Health, this is doubly unfortunate.

It is entirely plausible that the changes of 2005 will immediately result in cancer centers and their satellite clinics being flooded with patients for whom reimbursement will not be favorable under the new system. Such institutions as MSKCC receive reimbursement for chemotherapy by mechanisms outside typical Medicare processes and may be able to maintain financial integrity. At the same time, community-based oncologists will also

likely be overwhelmed as older practitioners cut office hours, small satellite offices close, and ancillary noncompensated services dwindle. As Drs. Buchholtz and Schulman suggest, there are more than enough patients to go around. Faced with an unprecedented increase in cancer incidence reflecting baby-boomer demographics coupled with a stable number of oncologists in training, none of us should worry that we will be idle. Quite the contrary: Who will take care of all the people who need cancer treatment?

As always in a crisis situation, there is an opportunity. I, for one, can envision a new partnership between the major cancer centers and community oncologists in which funds used for marketing and other nonclinical activities are instead invested in developing a system that provides state-of-the-art cancer care for those presently without access. A comprehensive cancer center could provide the bricks, mortar, and infrastructure for community oncologists and satellite physicians to work together, providing care to the underinsured and uninsured in a way that would alleviate the burden from each group's current operations. We could end up offering all patients better and earlier treatment. *That* would be an unequivocal improvement in hometown quality of care!



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