

Making the Choice Between Academic Oncology and Community Practice: The Big Picture and Details About Each Career



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How do you choose a career path? Can you change the one you're on? Unless oncologists have walked both paths, it is difficult to understand the differences between academic and community practice careers beyond differences in call schedules and misconceptions about compensation. Most oncology trainees have little exposure to community oncologists. In many communities the competition between the town (private practice) and gown (academia) has done little to facilitate mutual understanding, and often creates negative perceptions of community practice among academic trainees. Further, even after 2 or 3 years of fellowship, it is rare for trainees to sit with a

faculty member and discuss the requirements of a clinical research career. The literature on this topic is helpful but sparse.¹

We highlight characteristics that distinguish academic medicine from private practice. Several caveats are necessary for this effort. First, these insights are the personal observations of the authors, who have enjoyed oncology practice in both settings. Second, by academic oncology practice we refer to a clinical research career—in which patient care is a vital component—rather than a laboratory-based physician-scientist. Third, those well into their career might find some of these conclusions to be over-generalizations; certainly there are abundant variations about how practices and academic institutions are organized. Finally, it's the job of the Fellow looking for work to thoroughly explore the particulars—contractual issues, compensation, expectations, space, research and clerical support—and all the other details that contribute to high productivity and job satisfaction.

What Are the Distinguishing Characteristics Between Academic and Community Oncology Practice?

Most physicians will find more similarities between community practice and academic oncology than differences. Both require careful attention to patient care, close communication with other members of the health care team, service to the hospital and community, and careful time management. The differences that define the environment and feel of each career are summarized in this section and in Table 1.

Mission

In community practice, the mission is clear: Create an up-to-date, safe, and efficient office practice to deliver cancer care. This must be a successful business that provides value to patients and payers, and provides excellent patient care. The mission of patient care drives the operational details, such as how many support staff are hired, what information system is used, and whether compensation to the physician is based on seniority or productivity incentives. Because the physicians are usually the owners, the system is commonly adjusted to increase the owners' efficiency, as well as ensure that the owners have time available for other professional activities or for leisure.

The academic mission is complicated by the multiplicity of customers—patients, research funding agencies, and trainees at all levels. To be effective, the academic center must devote resources not only to patient care but also to laboratory and clinical research, to teaching, and to the administration of a large organization. This is a good thing; patients and society benefit from the success of the research mission. However, multiple missions often lead to problems with efficiency and accessibility and to competition for money and resources that can be allocated to investments in patient care.

Governance

The structure of community practice is flat. The most common model of community practice is a small corporation in which the physicians are the owners. A doctor joins as an employed associate. After a 2- to 5-year probationary period, the employed physician may be offered an ownership interest (i.e., partnership), and begins to share in the monetary failures and success of the corporation. Mechanisms for decisions about ownership, space, personnel, and finances are specified in the corporate bylaws. Decisions usually require agreement among the shareholders.

Table 1. Comparison of Selected Dimensions Between Community and Academic Oncology

Dimension	Community Oncology	Academic Oncology
Mission	Patient care; running a successful business	Multiple, including patient care, teaching, research, service
Governance	Flat; usually a doctor-owned corporation with all owners equal; majority vote of shareholder settles an issue	Hierarchical; multiple layers between physician and ultimate authority
Collegial relationships	Referring doctors and specialists	Referring doctors plus institutional partners and national collaborations
Finances		
Revenue	Charges for patient care visits, chemotherapy drugs, chemotherapy administration; ancillary services such as laboratory tests, imaging, clinical trial income, and other sources possible	Public and private grants, patient care, state support, philanthropy, and sometimes hospital; faculty practice plans may incorporate elements of private practice
Expenses	Employees, space, chemotherapy drugs, and business expenses	Similar but (usually) without pharmaceuticals; services and space support shared with others at medical center
Margin	Apportioned among owners	“Taxed” and shared at multiple levels to support the multiple missions
Reputation	Local	Local and national

Academia is more hierarchical. Everyone has a boss who works under another boss. Expectations and priorities are set by the leadership. Salaries and productivity expectations follow from these priorities. A faculty member may lead a program, but rarely has a voice in larger decisions about the institution’s patient care delivery system. As their careers progress, academic physicians may need to shift their focus towards administration and departmental leadership to ensure a stake in the goals or outcomes of their organization. In the meantime, they are still required to obtain grant and patient care revenue, publish manuscripts, and achieve national recognition. To help their doctors meet these career goals and requirements, some academic centers have recently created new patient care or clinical tracks to address burgeoning patient referrals and still give the clinical researcher time to pursue grant funding and to write and publish articles.

Taking Care of Patients

The community doctor is the intern, resident, Fellow, and attending all rolled up in one. Most community oncologists care for patients with a variety of cancers. Further, they also perform most of the hematology and coagulation consults in their respective hospitals. Rare diseases or diseases that require resources not available in the community may be referred to a regional academic center.

A small, patient-focused community practice corporation can be organized around the needs of the owners. As a result, the physician-owners can decide when they start and stop seeing patients, to schedule a half-day off, or to otherwise make arrangements to suit their practice style. In the office, there are many levels of support—clerical, nursing, and sometimes nurse practitioners or physician’s assistants—meant to increase efficiency of the clinical operation. Furthermore,

community doctors often care for people they see in the grocery store, worship with, or sit behind in the car pool lane. For most, this aspect of community practice is personally rewarding, but occasionally this is an awkward intrusion into their private life.

Many find the least pleasant aspect of community practice to be night and weekend call. The frequency and intensity of work “on call” depends on the number of doctors in the practice. In a big practice, it’s not uncommon on weekends to do rounds at three or four hospitals and admit patients to a fifth hospital at night.

Patient care in the academic world is different. The academic oncologist usually specializes in one or two specific malignancies. For some, that specialization is very important; for others, it’s confining. Academic oncologists see a higher proportion of patients with unusual diseases, patients referred for clinical trials, and patients who may have exhausted conventional remedies who have traveled great distances hoping for a cure. Research is woven into the fabric of academic practice, but is usually much more variably integrated than in the community.

At the academic medical center (AMC), the doctor is “on service”—doing inpatient rounds and teaching—a specified and limited period of the year. Although there is support from interns, residents, and Fellows, the amount of time and energy spent at the hospital during service months may be considerable. The night call at the AMC is likely to be lighter; going to the emergency room in the middle of the night at the AMC is rare, but not unheard of. Further, to make time for research, teaching, and administration, the AMC doctor rarely has office practice more than 1 to 3 days a week, unless

on a purely clinical track. Table 2 highlights various aspects of patient care in both environments.

Money

The business of medical oncology is increasingly complicated. Revenue is generated from office visits and hospital consults or follow-up, chemotherapy administration services, and chemotherapy drug charges—and in some practices, from research, imaging, laboratory work, and radiation therapy. It is expensive to fund a practice; oncology practices that administer chemotherapy require five to eight staff per physician to safely administer treatments, bill, answer the phone, draw blood, and perform myriad other functions. The physician-owners are at financial risk for the property they own or rent, as well as the salaries and benefits of their employees. For example, a practice of 10 oncologists who operate an infusion center from their office commonly write checks to cover pharmaceutical expenses for more than \$1 million a month. As a result, there is financial risk in private practice; abrupt changes in the revenue stream—delayed collections, loss of a physician from protracted illness, billing failures, employee theft or fraud, or bankruptcy of a payer all have the potential to be financially devastating. The risk is highest in practices that are poorly managed; therefore, it is recommended that businesses with this degree of cash flow consider professional management. It is usually difficult for a newly minted oncologist, entering practice, to understand the complexities of cost of share purchase, ownership of equipment and property, and obligations to retiring owners to be successful professionally or financially. The purchase of legal and accounting advice is often money well spent.

On the other hand, the financial rewards of private practice may be significant. First year associates salaries range from \$175,000 to \$250,000 nationally. Five years later, at the ownership level, compensation can more than double. These ranges are dependent upon many factors, including the risk one is willing to assume, patient load, ancillary revenue, and the local payer mix and reimbursement. Table 3 summarizes an informal survey that compares recent compensation levels between tracks. These figures are not stable because the reimbursement environment keeps changing from year to year.

The compensation structure of academia is more straightforward. Academic doctors are rarely at financial risk. The patient care–related costs are spread among the hospital and the clinical departments, and may be cushioned by government support. In most academic centers, oncologists do not purchase pharmaceuticals or realize margin from chemotherapy administration because the hospital usually employs the staff and supplies the chemotherapy. Furthermore, revenue from medical oncology is often shared among other departments that may have lower or negative margins. As a result, compensation levels among academic oncologists are lower. The informal survey in Table 3 shows

that academic doctors begin at the assistant professor level from \$120,000 to \$170,000. Complicated compensation formulas incentivize academic doctors who secure research grants or generate large patient revenues. Salaries at the professor level can more than double starting salaries. AMC doctors regarded as national experts often augment their salaries by speaking at conferences, running symposia, testifying as experts, or becoming consultants and members of advisory boards.

Collegial Relationships

Private practice is driven by the relationships between doctors who make patient referrals to one another. More than any other source, a newly diagnosed cancer patient relies on the primary care doctor's referral to see an oncologist. The relationships among doctors can be the source of great collegiality, and are one of the more rewarding aspects of practice. However, it can be uncomfortable when the oncologist is referred a patient who has had an incomplete workup or inadequate treatment, or is requesting chemotherapy when it is not indicated or when it's too late for meaningful therapy. The best physicians in private practice create systems of communication and informal education that promote excellence among the doctors with whom they work. Honest and direct communication is the best way to manage these situations. Community physicians often attend weekly multidisciplinary tumor boards to ensure communication for difficult cases and to bring recent advances in care to a broad group of providers.

The nature of the academic center, where physicians practice together in multidisciplinary environments, reduces practice variation. These groups create systems to ensure that clinical information is collected and critical data is reviewed and re-reviewed. Informal consultations with more experienced colleagues are available. Because AMC consultations often have the advantage of hindsight, AMC faculty may correctly interpret a series of events in retrospect that were difficult to understand as they unfolded one at a time. Managing these potentially emotionally charged situations can be difficult. Academic physician relationships rely on both local physicians and on the institutional reputation for patient referrals. Academic oncologists have close interactions with physicians in their own hospital; extended relationships with colleagues at the national level are common. This local and national network of colleagues is a personal reward of the academic setting.

Flexibility

Academic doctors have career flexibility. If the clinical research track isn't fruitful or personally rewarding, there are other choices, including private practice, academic administration (e.g., running the training program, hospital quality director, etc.), an expanded teaching role, or leaving academia for a corporate role in the pharmaceutical or insurance industry. Peter Drucker, the management theorist

Table 2. Patient Care in Community and Academic Oncology

Dimension	Community Oncology	Academic Oncology
Patient population	Usually insured, often older, sometimes friends and neighbors	Varies; often younger at superspecialty centers
Case mix	General oncology plus lots of hematology, including coagulation	May be general; often site or disease specific
Research effort	Widely variable from none to hundreds of clinical trial accruals per year	Integrated into mission; significant support at major centers
Hospital work	Single to multiple hospitals visited daily	Usually single hospital, limited time on inpatient service
Doctor role	All levels of service, including procedures	Varies widely; billing rules now require same levels of service as in community practice

who coined the term “knowledge worker” wrote about knowledge workers’ second careers.² The foundation for a second career is laid in the first career. The better the national reputation, the more complete the planning, and the broader the experience in the first career, the wider the choices may be for a second career.

Some doctors don’t enjoy private practice or find the physical demands of call to be difficult. Although the second career options may not be quite as broad as for a nationally known academic physician, there are plenty of examples of doctors leaving practice to enter into a clinical academic track or the pharmaceutical industry if they had previously maintained a clinical research record in their community practice. Government positions and organized medicine can attract doctors away from the bedside.

Critical Success Factors

The ultimate career goal should be satisfaction—pride and a sense of accomplishment—whether from building a research program or a community practice. To achieve career satisfaction, there are some common elements.

First, any physician—whether laboratory based, in clinical research, or in a community hospital—must build a reputation based on quality. This is the cornerstone of success in either career track. Reputation is the sum of the quality of the work, the interpersonal interactions with colleagues, and the respect among patients and staff.

Second, satisfaction requires balance between personal and professional lives. Some doctors work 16 hours a day, and

others work 7. The hours don’t matter; what’s important is that a balance is struck that fits the personal needs of the doctor and their family.

Third, it’s not about the money. Although one doctor’s compensation may be greater than another’s, there is little difference between the satisfaction of “rich doctors” and “not-so-rich doctors.” Making early career decisions solely on the basis of income will only intensify the later need for more income and intensify dissatisfaction if the work is not gratifying of its own merit. Conflicts surrounding money split up practices and collegial relationships all too often.

There are some differences in what makes a private oncologist and academic oncologist successful, and some of these are outlined in Table 4. The reputation of a private practice doctor is built on the three A’s: affability, availability, and ability. (In the past, there was a fourth A, affordability, but that hardly seems apropos today.) The reputation of a community practice oncologist is inextricably linked to fostering collegial relationships (*affability*) with primary care doctors and surgeons to build a referral base. In community practice it’s exceedingly important to be available for new consults, referring-physician phone calls, talks to the community, and tumor board meetings (*availability*). The community oncologist has to demonstrate *ability*: willingness to communicate their status as the local cancer expert among colleagues, patients, and referring doctors. Finally, the community oncologist will benefit from paying attention to the finances of the practice, perhaps not as an expert, but to understand and anticipate problems.

Table 3. Compensation in Community Oncology and Academic Oncology

Dimension	Community Oncology	Academic Oncology
Payment schedule	Varies; usually base salary and quarterly bonuses	Varies; usually salary and occasional bonuses
Incentives	Varies; some base bonuses on productivity, some on seniority. Productivity formulas vary widely.	Incentives based on productivity (external funding and patient care) are increasingly common
Compensation*		
First year	\$175,000-\$250,000	\$120,000-\$170,000

* Based on an informal survey of seven private-practice doctors and four doctors from academic oncology.

Table 4. Critical Success Factors in Community Oncology and Academic Oncology

Community Oncology	Academic Oncology
Build reputation as local expert	Focus on area of expertise
Be available to referring doctors and senior partners	Ward off roles that reduce ability to focus
Pay attention to finances; understand the incentive system	Apply and reapply for external funding
Value and reward practice support staff	Choose a successful and influential mentor
Acknowledge and nurture role in the community	Build a national reputation; write and publish
Spend enough time to build a successful practice—it takes an average of 5 years	Spend enough time to be successful—it takes an average of 5 years

In academia, focusing is essential to success. For some, it's the hardest thing to do; if you can't do it, pick a different career path. The successful academic oncologist will choose one or two areas and become an expert. Clinical work should revolve around research goals. Pressures to increase patient care and teaching should be avoided during the formative phases of a career. A willing mentor can make or break the oncologist in academia. A good mentor will give advice as to protecting time and maintaining focus, and can help turn ideas into funded grants and published papers. Successful academic doctors get involved at the national level on study sections, cooperative groups, and data presentations at research

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meetings. The gratification of academia is delayed. It may take years to build a research program and a portfolio of articles and projects that influence the standards of oncology practice. Finally, the successful clinical research oncologist must think 5 to 10 years ahead to anticipate technology and plan research projects. Although finances aren't the same concern as in private practice, new academic doctors should require written objectives and review them yearly to make sure that you and your boss are on the same page regarding career advancement.

Conclusions

There is an anticipated shortage of both community and academic oncologists.³ If this proves to be true, Fellows just starting out and established oncologists interested in a career change will have a wide array of choices. A better understanding of the different paths available to young and seasoned doctors will lead to greater personal and professional satisfaction.

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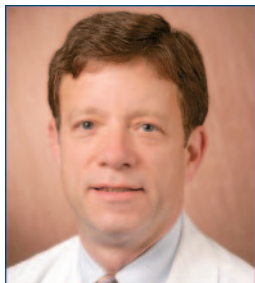
ASCO's Clinical Trials Workshop Increases Clinical Trial Participation at Community Practices

ASCO's workshop Clinical Trials for the Community Oncology Team is resulting in much-needed increases in clinical trial participation at the community practice level. To date, two annual workshops have drawn nearly 100 oncology teams to learn about developing, integrating, and conducting clinical trials. A follow-up survey of attendees of the first workshop demonstrated increased participation in clinical trials according to several key indicators, including the number of participants screened and enrolled, the number of subinvestigators participating, and the total number of open trials.

The workshop, which is developed in collaboration with the Oncology Nursing Society (www.ons.org) and the

Coalition of National Cancer Cooperative Groups (www.cancertrials-help.org), has consistently earned high praise on program evaluations and comments about enhanced knowledge of the practical aspects of conducting clinical trials. Now, the results of the follow-up survey strengthen that positive feedback with a better reflection of the actual behavioral influence of the workshop. "The survey results validate the methodology of the workshop," says Alan P. Lyss, MD, of the Heartland Cancer Research Community Clinical Oncology Program (CCOP; St. Louis, Missouri), and a co-chair of the 2005 workshop. "The outcomes data show that this program is successful in increasing clinical trial participation by community oncologists and their patients."

Approximately half of the teams at the 2004 workshop responded to the survey, and the findings represent changes in practice that occurred within the 9 months following the



Alan P. Lyss, MD

workshop. Lyss and Robin T. Zon, MD, FACP, of Michiana Hematology-Oncology, PC (South Bend, Indiana), also a co-chair of the 2005 Workshop, note that all of the follow-up outcomes are “impressive” (Table 1) and can be related directly to education provided at the workshop. For example, Lyss says, “The workshop includes a session on how to choose trials. The fact that a high number of attendees said that the total number of open trials increased demonstrates that the message of that session got across.”



Robin T. Zon, MD, FACP

Of the respondents who said that the number of open trials increased, 75% said the number had increased by as much as 25%. Other promising findings were that 78% of respondents noted increases in the number of patients screened for trials, and 65% reported an increase in the number of patients enrolled. Increases in enrollment of up to 25% were

reported by 75% of the respondents who noted an increase; 25% of respondents reported even larger increases.

The number of respondents who indicated that an increased number of participants were remaining on trial and compliant was more modest (35%) than the other increases. “Increases in accrual are paramount to clinical trial research, but ultimately the results are only as good as the strength of the data collected,” says Zon. Nonetheless, both she and Lyss believe that the increase is promising.

Table 1. Increases in Key Indicators of Clinical Trial Participation Noted in Follow-up Survey of Attendees of the 2004 Workshop

Increase	Respondents (%)
No. of patients screened	78.3
Participation of subinvestigators in screening and enrollment	70.8
Total No. of open trials	68.2
No. of patients enrolled	65.2
No. of research staff	58.3
Amount of dedicated time for research staff	41.7
No. of enrolled patients who remain on trial and compliant	34.8

The Impact of the 2005 Workshop

“The diversity of the institutions attending, coupled with the similar hurdles we face in community-based research, brought dynamic discussions. One of our key obstacles is the relationship with the local institutional review board. We took notes at the meeting and agreed that dollars would be well spent to improve the relationship. We have since arranged to bring one of the speakers from the ASCO meeting to our local area to speak to both the community researchers and the institutional review board.”

—Lyndon Evans, a research manager at Greenville CCOP, Greenville, South Carolina

“Attending the Clinical Trials Workshop along with my research clinical nurse specialist gave us a deep and thorough understanding of the research process. The workshop had several immediate benefits to our practice

1. We have formed a research team that consist of a clinical research nurse, a regulatory coordinator, a practice manager taking the role of a financial manager, a clinical nurse supervisor who will facilitate the implementation of the program, and myself as a physician and principal investigator. The research team is meeting weekly to expedite launching of the research program.
2. We have implemented an electronic system to manage the research process from A to Z, and another electronic system to manage research documents. The system will allow us to accurately calculate the cost of conducting any specific research protocol, which is an important factor in negotiating our contracts.
3. We have networked with an experienced CCOP in our state, and a highly reputed academic clinical research organization, and we are in the process of establishing partnerships with them.
4. We have become much more enthusiastic about conducting clinical research in our community.

I highly recommend the Clinical Trials Workshop to anyone interested in or currently conducting clinical research. There is room for learning to all.”

—Wael Harb, MD, Horizon Oncology Center, Lafayette, Indiana

The survey also asked participants about their accrual goals for the next 12 months. More than 50% of respondents said their goal was one to 50 participants. “These accrual goals are much more realistic than the goals that we saw on applications,” says Lyss, “so this finding really shows that attendees learned from the workshop.”

Zon notes that care must be taken in interpreting some results because of the diverse backgrounds of the research teams that

attended. “We had some teams from CCOPs that were already enrolling 100 or more patients a year, and we had other teams representing very small practices enrolling only a few patients a year,” she says, “but the results are still very encouraging.”

Perhaps the most meaningful survey result is that 71% of respondents said that subinvestigator participation had increased. Zon notes that this finding reflects the “peer pressure” aspect of the workshop. “Attendees are not only getting the take-home message of the workshop, but they are sharing it with their colleagues and they are having a positive influence,” she says.

The workshop was established 2 years ago to meet a goal set forth in the 2004-2007 ASCO Strategic Plan: “promoting high-quality clinical and translational research in oncology, with a focus on patient accrual to clinical trials.” The 2-day workshop is designed to target community oncologists who are currently involved in clinical trials but want to become more efficient and increase their accrual. The workshop provides practical tools that are not currently offered in fellowship training programs or continuing educational materials.

Commenting on the need for the workshop, Joseph S. Bailes, MD, ASCO’s interim executive vice president and CEO, says, “ASCO remains committed to supporting the educational needs of all oncologists involved in research and recognizes that the community oncologist may face unique issues or barriers to research inherent in their practice setting.”

The workshop focuses on four themes: the role of the oncology team, processes and procedures, resources and reimbursement, and selection of trials. Didactic lectures on these topics are followed by small-group breakout sessions that allow attendees to discuss strategies for effectively employing the techniques presented in the lecture. Feedback from the first workshop helped shape improvements to enhance the learning experience of the 2005 program. At the 2005 workshop, attendees had the opportunity to hear a wider breadth of perspectives through the addition of patient advocates as presenters and moderators and the use of panel discussions. In addition, learning was made more interactive with the availability of mentors during meal breaks.

Enhance Your Knowledge of Clinical Trials and Increase Participation: Attend the 2006 ASCO Clinical Trials Workshop for the Community Oncology Team

October 27 to 29, 2006

Renaissance Schaumburg Hotel and Convention Center

Schaumburg, IL (outside of Chicago)

Application process information will be available online at www.asco.org/CTW2006 beginning May 2, 2006.

Co-Chairs

Robert M. Langdon, MD, Oncology Hematology West, Omaha, Nebraska

James N. Atkins, MD, Southeast Cancer Control Consortium, Goldsboro, North Carolina

A distinguishing aspect of the workshop is its emphasis on the team-oriented approach, which is integral to the success of clinical trials in the community practice setting. As such, participants apply for the workshop as a research team—a physician investigator and a research nurse or clinical research associate. The ultimate goal of the workshop is to help increase enrollment of adults on all clinical trials, which has remained at 3% to 5% for several years. Capitalizing on the increasing number of patients with cancer who are treated in the community setting is essential to enhancing enrollment in clinical trials. Increasing access and availability of cancer control and prevention studies at the community level offers additional opportunity for participation in clinical trials.

ASCO plans to continue offering the annual Clinical Trials for the Community Oncology Team workshop, and online applications will be available on May 2, 2006, at www.asco.org/CTW2006 for the 2006 event. “ASCO is committed to fostering clinical research in the community, where the majority of oncology patients receive their treatment,” says ASCO President Sandra J. Horning, MD. “High-quality clinical investigation in all practice settings is essential to the timely development and evaluation of new therapeutics that are vital to patients with cancer.”

