My Knee Hurts!

Reading that title, I know some of you are wondering how in the world I can tie it to oncology, but honestly, I can. Here's the story.

I spent Labor Day weekend icing my knee, which hurt like the dickens. As soon as the sun came up on Tuesday, I e-mailed my favorite orthopedic surgeon explaining my symptoms and asking for a cure—before I even had a diagnosis. He politely suggested I see the noninterventionist (what is that?) in their group practice to get a diagnosis and said we would go from there. So I limped in to see the doctor he recommended. She did a very thorough job of poking around my knee, made a clinical diagnosis, and recommended an MRI.

I had the temerity to ask why she was a noninterventional orthopedist since I assumed everyone went into a surgical specialty because they like to operate. She patiently told me that she was a family medicine doctor with sports medicine training and that diagnosing things is what she likes to do. So there!

While I was limping out of her office, it struck me that this was a pretty good practice model. People who like diagnostic work are doing it, and people who like to do procedures keep their scalpels busy. And I learned later, they have a practice revenue-sharing model that properly rewards all the doctors for their work.

Oncology practices, especially large multispecialty ones, could learn a lot from this. In medical oncology, we have a looming workforce shortage. Aside from the suggestion of deploying thousands of physician extenders and engaging palliative care specialists, I haven't heard much about how we might work with general internists and family medicine practitioners to extend our reach. Think about it. We should be busy with the care of folks who need active treatment for cancer. We are not really trained to manage surveillance for patients at high risk for cancer, nor are we trained to manage the many needs of the growing numbers of long-term survivors. Many patients with genetic risk for multiple cancers really flounder in our system because they often have to find multiple providers, each focused on a different organ site. Long-term survivors have problems left over from their disease or their treatment, and have incidental comorbidities as well. They need a comprehensive approach to their care.

Having new training programs on cancer risk and survivorship for generalists seems pretty attractive to me. I would think that this training could be completed in as little as a year or be integrated into other training programs in large academic centers. Incorporating this new talent into large provider groups to ensure continuity of care seems like a “no-brainer” to me. I haven't done the homework on the whole financial model, but my guess is that we'd raise all ships by joining forces.

Well, that's the lesson I learned from my sore knee. And in case you're wondering, I'm getting better!

Margaret Tempero, MD

Margaret Tempero, MD, is a Professor of Medicine and Director of the UCSF Pancreas Center and editor-in-chief of *JNCCN*. Her research career has focused on pancreatic ductal adenocarcinoma, especially in the area of investigational therapeutics. Dr. Tempero has served on the ASCO Board of Directors and as ASCO President. She currently serves on the ASCO Conquer Cancer Foundation Board. She codirected the AACR/ASCO Methods in Clinical Cancer Research and taught this course and similar courses in Europe and Australia. She was founding Chair of the NCI Clinical Oncology Study Section and served as a member and Chair of the NCI Board of Scientific Counselors Subcommittee A. She is a member of the Scientific Steering Committee and Chair of the Clinical and Translational Study Section for the Cancer Prevention & Research Institute of Texas. She is or has been on the Scientific Advisory Boards of the Lustgarten Foundation, the Pancreatic Cancer Action Network, the V Foundation, The Alberta Canada Cancer Board, and the EORTC. She served as a member of the Oncology Drug Advisory Committee for the FDA. She has served as Deputy Director and Interim Director for the UNMC Eppley Cancer Center. She is Chief Emeritus of the Division of Medical Oncology at UCSF and served as the founding Deputy Director and Director of Research Programs at the UCSF Helen Diller Family Comprehensive Cancer Center.

What do you think? Please e-mail correspondence (include contact information) to JNCCN@nccn.org.

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