



Daniel P. Mirda, MD

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Keeping Up in the Community

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Editor's note: As detailed in the Oncology Watch editorial in this issue (page 753), Margaret Tempero, MD, contacted Daniel P. Mirda, MD, president of the Association of Northern California Oncologists (ANCO), to ask questions about the challenges community oncologists face in keeping up with the details of treatment for a wide array of malignancies. This interview is below.

Tempero: *How in the world can a community oncologist keep up to date with new treatment options for patients with cancer?*

Mirda: There are many challenges to treating patients with the latest and best therapies tailored to their particular situation, while also providing a supportive and empathetic environment. We are clearly in the era of personalized medicine, including genomics, biomarkers, immunotherapies, targeted therapies, and improved chemotherapy. These therapies are ever-expanding choices for our patients' care, and they show dramatic responses, never seen in similar situations. I'm sure we all embrace these gratifying changes that are improving our patients' lives, but with that embrace comes great responsibility to be informed and knowledgeable about these therapies.

In approaching a patient's treatment, much of the evaluation remains the same, but we now have more data to gather and understand. Most important is the patient interview and examination, which starts a very intense personal connection, critical for a trusting and supportive relationship. Then, from various digital sources, we must evaluate pathology, genomics, imaging, and laboratory results to characterize our patient's condition. Then I use my knowledge and experience from the clinical articles, meetings, national guidelines (eg, NCCN Guidelines), digital sources (UpToDate), and consultation with university experts (if needed) to decide on the safest and most effective therapy.

Electronic medical records (EHRs) can provide some of this information, but discussion with the patient and presenting treatment options with prognosis, potential outcomes, and precautions (toxicities), and listening to patient concerns are still the essential ingredients in this shared-decision process to decide on the right therapy. But it also takes a village to accomplish the best outcomes, including staff (eg, scheduling, medical assistants, nurses), hospital services (eg, social workers, homecare), family members, and others to support the patient on therapy.

I am president of the Association of Northern California Oncologists (ANCO), an organization that also provides multiple educational opportunities for members by partnering with pharmaceutical companies to get the most current information out quickly and—most importantly—through unbiased presentations from our academic institutions. ANCO serves as an intermediary to prevent bias. Finally, staying current with the volume of clinical literature is particularly challenging. The number of articles is mind-boggling, especially since each day has only 24 hours. So I read what I can, and I also rely on close ties with university experts for advice and consultations. We are fortunate to have 3 universities close by and accessible. We must do all this while empathetically listening to patients and making shared decisions in the context of their values, goals, and financial concerns, among other issues.

Tempero: *But what about future innovations, and how do we stay current?*

Mirda: Of course there will be more treatment options in the future and we are now encouraged that this will continue to change how we treat patients. "Big data," more sources of digital information, and potentially cognitive technology (such as IBM's

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Watson Oncology) will innovate how we get information. I still enjoy interacting with colleagues and experts at meetings, but this may not be the most efficient way to enrich knowledge. New and better ways of accessing information are expected although difficult to predict at this time.

Tempero: *In a perfect world, what would you like to see as a quality indicator for professional competence?*

Mirda: It is important to discuss the current requirement of Maintenance of Certification (MOC) testing instituted by the American Board of Internal Medicine (ABIM). In light of the demands on physicians, including EHRs, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), clinical competence, and ongoing advocacy for our patients, the additional burden of MOC has contributed to frustration, loss of control, increased depression, and poor job satisfaction, leading many older physicians to consider early retirement and younger, highly talented physicians to reconsider alternatives to clinical work. So, in addition to many hours of work related to supporting our patients and staying current with new therapies, we must take additional hours to prepare and take exams for MOC that have little relevance to how we care for and treat patients in oncology and hematology. Preparation for the MOC exams requires spending 2 to 3 days away from office or university practice to take review courses, undergoing 3 to 5 hours of testing every 2 years after completing 100 MOC points of activity every 5 years, and taking the MOC exam every 10 years. In addition to the many hours of study and review, the direct costs include \$200 to \$500 yearly for accumulation of MOC points, \$1,000 to \$1,500 for preparation courses, and \$2,590 for the MOC exam. Considering the increased demands on our time at greater expense due to MOCs, decreasing insurance reimbursements together with increasing costs of initial medical education, and increasing loan repayment obligations, placing this additional burden on already stressed physicians is not reasonable.

The ABIM has instituted MOC without any proof that these tests and requirements improve physician competence or patient outcomes. For example, why a university cancer expert in breast or lung cancer would be tested on testicular cancer or other cancer that he would never see or treat is incomprehensible. Similarly, a community physician will treat a testicular cancer possibly once every 1 or 2 years, and at diagnosis will evaluate and stage the patient to decide on the best treatments. Furthermore, at the point of care or when treatment decisions are made, the physician has access to current treatments via NCCN and UpToDate, and the ability to confer with university colleagues on the best therapy given the diagnosis, clinical features, and stage. Of course, specialty referral to a university center is a reasonable option as well.

In our digital age, treatments are decided based a large array of data, and most importantly, at the point of care, the patient contributes to shared and value-based decisions. Physicians coordinate many aspects of patient care, including discussions of prognosis, therapy options, personalized medicine approaches to care, and coordination of services (eg, surgery, infusion services, social services, home care, hospice). We routinely access national databases (eg, NCCN, ASCO, ASH) to provide current therapies. We also have direct contact with experts at major universities with the latest therapies and clinical trials. Physicians are professionals, and in the era of personalized medicine and the digital world, MOC has little relevance. For oncology and hematology in particular, the information we routinely access, including national guidelines, interactive databases, clinical trial results, educational meetings, consultations with university experts, and the clinical literature, can be tabulated and recorded to document certification without ABIM's expensive and burdensome MOC process. UpToDate provides seamless and less burdensome options for MOC. In

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a similar approach, I hope that organizations such as ASCO, ASH, and NCCN can provide better, less burdensome, and less expensive sources of certification than ABIM.

I am heartened that many other national organizations have similarly questioned the relevance of MOC, such as associations in rheumatology, nephrology, pulmonary medicine, and anesthesia, to name a few. I have discussed the lack of relevance of this MOC with colleagues at universities and in the community, and have found uniform distrust of the motivation and financial incentives of the ABIM and no clear evidence of a benefit to physicians or patients. The MOC or lack thereof is a threat to competent physicians' employment, insurance participation, and hospital privileges. The challenges to the ABIM MOC process are many, and I suggest that we all resist the imposition of MOC requirements on physicians in the absence evidence of its benefit.

Tempero: *Are there any other challenges that you think the oncology community is facing?*

Mirda: The upcoming implementation of MACRA and Medicare pose additional challenges. This will be a major change for oncology and hematology—for all of medicine—and how we care for patients and are reimbursed by Medicare. This will potentially affect reimbursement and the delivery of care outside of Medicare as well, meaning private insurers. Moving away from fee-for-service and into a "value-based" care model will be difficult, and we are only beginning to figure out how this will happen. Although the law is in place, we do not know all the "rules." Practices in the Oncology Care Model (OCM) are trying to figure out the requirements, but it is very difficult even in a sophisticated practice. I am concerned that the small practices, which were challenged by EHR implementation, will have a significantly greater challenge with MACRA. They are at risk of failing, or at least of joining larger organizations. I think this could be the end of smaller practices (but I hope not).

MACRA implementation will require more resources, and I'm not sure we are all ready for it, although it will be in full swing in about 2 years. The acronyms are multiple and hard to remember, let alone understand—APM, MIPS, PBM, OCM, ACO, etc.

Besides MACRA, we are faced with many challenges: new and innovative therapies, better information through big data, better EHRs (I hope!), cognitive computing technology (IBM Watson Oncology), and others. It is an exciting time, and we must continue to work through our state and national organizations to make sure these changes are for the better of medicine and not detrimental. I understand that our patients are not well informed about these upcoming changes, but I worry that many practitioners are not fully aware either.

Tempero: *You've given us a lot to think about. If you had to distill this into the 3 most important points, what would they be?*

Mirda: There are many issues and demands on our time. An important take-home message for physicians is to prepare for MACRA now, as it will be implemented over the next 2 to 3 years. Next, they should stay involved with national organizations—ASCO, ASH, and NCCN—and their state societies, because a collective voice is important to influence change in a proper way. And finally, despite the changes in medicine, the physician–patient relationship must be preserved for the well-being of both the patient and the physician.