

PRESIDENTIAL PANEL

The Gynecologic Oncologist in Academic Departments¹

Report of Survey

GEORGE W. MORLEY, M.D.²

University of Michigan Hospitals, Ann Arbor, Michigan 48109

Discussions

HERVEY E. AVERETTE, M.D.

University of Miami School of Medicine, Miami, Florida 33124

RICHARD C. BORONOW, M.D.

Private Practice, Jackson, Mississippi

LEO J. DUNN, M.D.

Medical College of Virginia, Virginia Commonwealth University, Richmond, Virginia 23298

JAMES H. NELSON, JR., M.D. President

Harvard Medical School, Massachusetts General Hospital, Boston, Massachusetts 02114

Now that the subspecialty of gynecologic oncology is well established within the specialty of obstetrics and gynecology, it seems timely to evaluate the pros and cons, the strengths and weaknesses of such a program as it interrelates with other programs in an academic department. A survey is presented which reflects the beliefs of both members and candidate members of the Society of Gynecologic Oncologists on such issues as gynecologic oncologists as chairmen of departments; teaching demands; time commitments to patient care and research in an academic institution; and surgical privileges for gastro-intestinal and urologic procedures in various hospitals. Financial and budgetary items are also discussed. Perspectives from three different points of view are presented as a discussion of the report of the survey.

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² To whom reprint requests should be addressed: Department of Obstetrics and Gynecology, University of Michigan Hospitals, Rm. L5020 WH, Box 007, Ann Arbor Mich. 48109.

PRESIDENTIAL PANEL

JAMES H. NELSON, JR., M.D., President
Society of Gynecologic Oncologists, 1981-1982

This Presidential Panel was conceived by Dr. Leo Lagasse, the Immediate Past President of the society. It should be pointed out that Dr. Lagasse is the current Director of the Division of Gynecologic Oncology of the American Board of Obstetrics and Gynecology. His position as such makes the conception of this panel even more strikingly important in the current scene in this country. First, the United States is the first country in the world to identify a subspecialty of gynecologic oncology, and I might add amid more than moderate opposition. Those early years when I served as one of the original five directors of the Division of Gynecologic Oncology of the American Board were turbulent years to say the least. I finished my five-year term on the division feeling proud and happy in regard to the accomplishments. I truly believed and still believe that we had created a very worthwhile, indeed a vital, need in the specialty of obstetrics and gynecology. In addition, we had recognized the importance of the nonsurgical aspects of the field of obstetrics and gynecology, namely, the other two Divisions of the American Board: Fetal and Maternal Medicine and Reproductive Endocrinology. I personally felt that the formation of subspecialty divisions was the savior of our specialty because it offered broad horizons for the graduating medical student wrestling with the question of how to use his medical education.

The developments of the past several years, however, have shaken my feelings of triumph but these misgivings have come from areas I would never have anticipated. Gynecologic oncologists are leaving academic departments to enter private practice with surprising regularity. Is this happening because of economics, is this happening because of the nature of the beast who goes into gynecologic oncology? Today's Presidential Panel was constructed toward the objective of answering that question, namely, why are gynecologic oncologists leaving academic departments. I believe this is a critical question and, therefore, I felt it fitting for this society to spend this time in an effort to answer the question. Dr. George Morley has been kind enough to take on this task and has searched the minds of the membership in an effort to answer the question.

REPORT OF SURVEY

GEORGE W. MORLEY, M.D.

In early 1981, a Task Force³ was appointed by the Executive Council of the Society of Gynecologic Oncologists to evaluate the status of gynecologic oncology within Departments of Obstetrics and Gynecology in the United States. A questionnaire was developed by this Task Force which included such important issues as practice profile, hours committed to medicine and to the subspecialty, surgical

³ Task Force Members: Hervy E. Averette, M.D.; Samuel C. Ballon, M.D.; David L. Barclay, M.D.; Richard C. Boronow, M.D.; Leo J. Dunn, MD.; Robert D. Hilgers, M.D.; Leo D. LaGasse, M.D.; James N. Nelson, M.D.; C. Paul Morrow, M.D.; Hugh M. Shingleton, M.D.; and George W. Morley, M.D., Chairman.

procedures one was permitted to perform in the hospital, the value of the gynecologic oncologist to the Department of Obstetrics and Gynecology, financial and budgetary issues and fringe benefits, and answers to certain assumptions. The questionnaire was mailed to all members and candidate members⁴ of the Society of Gynecologic Oncologists.

The results of the questionnaire were tabulated in the Computer Center at the University of Alabama in Birmingham and reported in January of 1982 at the 13th Annual Meeting of this Society as a Presidential Panel with Dr. James N. Nelson, Jr., the presiding officer. Two hundred fifty-eight questionnaires were mailed out to the members and candidate members with a 62% (161) return on the first mailing. Once the summary of the survey was presented, a discussion followed.

In presenting a summary of the survey, the median age of the members was 47; the median age of the candidate members was 37. Sixty-two percent of the members and sixty-nine percent of the candidate members were either salaried or were geographic full-time in a university. Eight percent of the members and ten percent of the candidate members were in private practice. Sixteen percent of the members and seven percent of the candidate members were chairmen of their own departments of obstetrics and gynecology. In departments where the responder was not the chairman, forty percent of the chairmen were certified subspecialists. When asked why more gynecologic oncologists were not chairmen of departments, the responses showed that our subspecialty was too specialized; that the patient care and teaching demands were too great to allow for administration and research; and that if they did become chairmen, this would lessen their contribution to gynecologic oncology and decrease their revenue production. Eight percent of those responding left academic medicine during the previous five years because of "frustrations with academia and inadequate salaries from the university."

In an analysis of the time commitment to the profession, both groups reported the median number of hours per week devoted to all aspects of medicine at 63 with 90% of this time being spent in gynecologic oncology. When asked if they spent too much time in medicine, the answer was equally divided between "yes" and "no." In addition, 59% (94) of those responding felt that they spend too much time in patient care; whereas 5% stated that they needed more time for teaching; and 92% needed more time for research.

One of the most important aspects of the questionnaire analyzed the frequency with which the members from both groups were permitted to perform nongynecologic procedures in their hospitals, e.g., procedures involving the gastrointestinal tract or the urinary system. The responses were quite similar in both groups. As noted in Table 1, approximately 90% of the responders were "always" permitted to perform sigmoidoscopy, diverting colostomy, and closure of colostomy on the in-patients when they were indicated. Over 80% were "always" permitted to perform bowel resection, bypass anastomosis, surgery for the alleviation of

⁴ Members: Full membership in the Society of Gynecologic Oncologists; Candidate Members: eligible for certification of special competence, American Board of Obstetrics and Gynecology.

TABLE 1
GASTROINTESTINAL PROCEDURES "ALWAYS"
PERMITTED TO PERFORM IN RESPONDER'S
HOSPITAL^a

	Candidate	Member
1. Sigmoidoscopy	89%	91%
2. Diverting colostomy	90%	92%
3. Closure of colostomy	90%	87%
4. Bowel resection	86%	83%
5. Bypass anastomosis	86%	82%
6. Intestinal obstruction	82%	80%
7. Radiation enteritis	81%	81%

^a "Never" was at the 2-4% level!

intestinal obstruction, and correction of radiation enteritis. The answer "never" was at the 2-4% level. Stated in another way, when the question was asked if general surgeons do *part* of the total pelvic exenteration, 85% said "never."

In regard to urologic procedures as noted in Table 2, approximately 65% of the responders were "always" permitted to perform cystoscopy on their patients when indicated; whereas 24% said "never." Eighty-six and one-half percent were permitted to treat ureteral obstruction and eighty-seven percent were allowed to perform urinary diversion "most of the time"⁵ when indicated on their patients. Nephrostomies were not considered a part of the gynecologic oncologists' armamentarium. When asked if urologists do *part* of the total pelvic exenteration, 76% said "never."

Next, the interpretation of how valuable a gynecologic oncologist is to the department of obstetrics and gynecology as a member of this department was attempted. Whereas specific figures recorded are available, it must be realized that these answers were from gynecologic oncologists and not from other members of the department; therefore, they are omitted from the report of this survey. A summary of the comments made by gynecologic oncologists, however, showed that they were a valuable addition to departments of obstetrics and gynecology. The positive comments suggested that the gynecologic oncologist is the primary consultant to the department for complex surgery and surgical complications and that this individual provides most of the teaching of anatomy and surgical techniques to the residents. The negative comments revealed the presence of a significant amount of ambivalence among the faculty members and resident-fellow conflicts exist because of an apparent decrease in the number of surgical cases for which the resident was responsible. However, 75% of the responders stated that the fellowship strengthened the residency most of the time. Finally, it is thought that other members of the department think there is too much focus of attention on gynecologic oncology. It also should be noted that 66% of the gynecologic oncologists did not take obstetric night call.

⁵ "Most of the time" defined as: 75% of the time or greater.

TABLE 2
UROLOGIC PROCEDURES "ALWAYS" OR "MOST OF
THE TIME" PERMITTED TO PERFORM IN
RESPONDER'S HOSPITAL

	Candidate	Member
"Always" ^a		
Cystoscopy	69%	60%
Ureteral obstruction	73%	74%
Urinary diversion	80%	78%
"Most of the Time" ^b		
Cystoscopy	74%	67%
Ureteral obstruction	86%	87%
Urinary diversion	84%	90%

^a 24% said "Never."

^b 75% of the time or greater.

A disclosure of the median wages for both groups from the financial and budgetary section of the questionnaire is considered somewhat meaningless and, most importantly, inaccurate since all of these figures would have to be "cross-referenced" with the fringe benefits, the age of the individual, and the responder's academic rank. Much more meaningful, however, is the observation that 75% of the members and 40% of the candidate members were reasonably satisfied with their total professional income and most of the responders were satisfied with the fringe benefits that were provided for them through their own institution. Over 50% thought that the salary of the gynecologic oncologist should be based on their generated incomes.

Given that most people desire a greater income, 60% of the members and 47% of the candidate members were satisfied with their current income as it compared to the other subspecialists in the department; and 63% of the members and 43% of the candidate members were satisfied with their incomes when compared to the nonspecialists in the department. Fifty-six percent of the members and seventy percent of the candidate members considered themselves overworked and underpaid; 33% of the members and 57% of the candidate members have considered leaving academia for financial reasons. (See Table 3).

A number of assumptions were addressed by the questionnaire. In assuming that obstetrics and gynecology remains a combined specialty, 90% of the responders stated that gynecologic oncology should remain a division within the department of obstetrics and gynecology; however, it was suggested that the lure of greater financial reward will eventually overcome the intellectual reward of academia. It is to be noted that according to the results of the questionnaire there will be a definite increased exodus of subspecialists from academic medicine into the private sector practicing in community hospitals and that some fellows are taking gynecologic oncology fellowships to improve their surgical skills with the full intention of doing obstetrics and gynecology in the future with a special interest in gynecologic oncology—probably in the community hospital.

TABLE 3

	Candidate	Member
QUESTION: Are you overworked and underpaid?		
Yes	70%	56%
No	13%	26%
No answer	17%	19%
QUESTION: Have you considered leaving academic medicine for financial reasons?		
Yes	57%	33%
No	24%	51%
No answer	19%	16%

Finally, in reporting general observations about the future, a significant number of responders replied that there will be a marked decrease in the number of patients available for resident training in the universities; that only the better fellowship programs in gynecologic oncology will survive; that private gynecologic oncologists will teach part-time in the academic institutions; that there will be an oversupply of gynecologic oncologists in the near future; that university departments will get the "poor pay and indigent" patients; that the residents in nonfellowship programs will get the best of both worlds if a gynecologic oncologist is on the staff; and that the cancer patient will want continuity of care in their community hospital leaving the area only when appropriate care is unavailable locally.

In summary, it appears that the three most important issues are a desire for a greater professional income; a need to relieve the frustrations associated with academic medicine; and a realization that the patient wants continuity of care in the local or nearby community hospital if it is available.

THE PERSPECTIVE OF A DIVISION CHIEF

HERVY E. AVERETTE, M.D.

Thank you, Mr. President, for the privilege of commenting on the survey conducted by the Society and so thoroughly analyzed by Dr. Morley.

At the Fifth Annual Meeting of the Society, in January 1974, the Presidential Panel was entitled, "The Role of the Gynecologic Oncologist in the Community Hospital, the University Hospital, and the Cancer Center." Since at that time none of the 82 members in the Society was in private practice, John Mikuta discussed liaison with the Community Hospital, John Lewis described the Cancer Center Program, and I discussed the University Oncology Program. From my presentation on January 8, 1974, I will read what I said at the conclusion of my presentation since it seems pertinent in 1982 from the survey that we have heard, and it is as follows:

My last comments regarding the University-based gynecologic oncologists are related to the problems, or potential problems, that he must face.

First, he must have total support by the Chairman of the Department of Obstetrics and Gynecology through delegation of authority to conduct all activities of the Gynecologic Oncology Service. The oncologist should be responsible for insuring that treatment protocols are strictly adhered to for all cancer patients since there is no place for whimsical decisions made by numerous faculty or attending physicians who infrequently treat gynecologic cancer. The Department Chairman, also, should support the gynecologic oncologist if any confrontation results with other disciplines such as urology, general surgery, or medical oncology. Urologic and gastrointestinal surgery as well as chemotherapy related to the overall care of gynecologic cancer patient rightfully belong within the area of gynecologic oncology, and any division of responsibility inevitably results in poor patient care. Although this problem has diminished in most University centers in recent years, I am aware that some chairmen continue to offer little support to their oncologists.

Another potential problem for the gynecologic oncologist is lack of support from hospital administration and the ancillary services. Too often administration, nursing service and the anesthesia department look upon an admission to the obstetrics and gynecology service as just another vaginal hysterectomy or tubal ligation, and little will be required of them for the short hospitalization. In contrast, they expect and do provide specialized nursing and intensive care for an admission to the cardiovascular or neurosurgical service. All of the hospital supportive services must be educated regarding the importance of adequate hospital laboratory facilities as well as the necessity for intensive nursing care for the oncology patient. The anesthesiologist must be aware that a pelvic exenteration is not just another hysterectomy. In our own institution, we demonstrated several years ago that 45% of our postoperative deaths from pelvic exenteration probably were preventable. Since that time, we have had the necessary supportive care and only one postoperative death.

Although there are many other important aspects that could be considered for the University oncologists, I will summarize what seem to be the major problems that must be solved—namely, priorities and proper allocation of his professional effort. By necessity, the University oncologist must be involved with graduate education at all levels—students, residents, fellows and postgraduate programs. Easily he could spend all of his time in this area. He is expected to carry out an active research program, both clinical and laboratory. There is no need to emphasize to this group the time one can spend preparing research grant proposals with progress reports as well as clinical research protocol reports. Other commitments invariably arise for the faculty member in the University Hospital. Not only is he involved with the usual activities of the teaching program, he must find time to serve on various committees of the University, which can be very time consuming. He is expected to publish the results of his investigation as well as present the material at meetings. Although he may excel in all other areas listed, unless this obligation is met, his position for advancement within the academic ranks will be in jeopardy with the promotions and tenure committee of the University.

Lastly, I mention patient care, which certainly is not the least important activity of the oncologist. Although he may have an able staff of assistants, he must devote personal attention to the patient, the family, and referring physicians. The last area will be time consuming for the oncologist in the community hospital, the Cancer Center or the University Program. The first three categories may be less demanding in a setting other than the University Hospital.

In summary, I have attempted to describe the development of a single University Gynecologic Oncology Program including commitments the oncologist has as well as problems or potential problems that he must manage. I will end with a personal comment. I find that the University oncologist who usually is compulsive and demanding, has many things to do, most of which are not easy and usually require a lot of time. Under such circumstances, frustration often results, which probably is the greatest problem he must confront and manage properly.

That concludes my presentation in January 1974. It is clear from the data summarized by Dr. Morley that problems and potential problems that I referred to in 1974 exist now. Of those who have entered private practice in the past five

years, many left because of "academic frustrations" rather than salary—a figure that surprised me. Failure for complete support from the chairman was of primary importance and I suppose part of this related to surgical privileges. A figure of importance is that approximately 20% of members do not do their own gastrointestinal surgery. Clearly, these individuals are working under adverse circumstances while trying to offer total care to the patient with gynecologic cancer.

The last figure that was revealed in the survey on which I will comment is the response that 88% of members and 69% of candidate members believe there will be an increase in the move from academic to private practice. This I expected since most medical schools have recruited oncologists, and, in private practice, many of the responsibilities of academia are relieved. I think it is appropriate that gynecologic oncologists move into the community hospitals to enhance care for more women with gynecologic cancer. Since this is an inevitable trend, I hope that in 1982 the younger people in the audience who plan such a move do so with care. In February 1970, shortly after this society had its first organizational meeting at Key Biscayne in January 1969, we were referred to, at a national meeting, as a "splinter group" called the *SOGS*, or the "Society of Oncologic Gynecologists." Well, the *SOGS* formed, and I think successfully, into a sound organization that has accomplished much to centralize and standardize therapy for women with cancer. The most threatening problem I see to our new discipline in 1982 is—to paraphrase from the 1970 reference—the emergence of a new breed that I call the *POGS*, or the "Peripatetic Oncologic Gynecologists." Although they are small in number—in the past few months, I have heard of their proliferation on the West Coast, Midwest, and East Coast—these are the few individuals who, rather than develop a strong, well-supervised oncology program in one larger medical center, yield to the call of the private obstetrician to come to his hospital to "scrub in" and do the cancer operation so that he may assist—and I might add—collect the surgical assistant's fee. Postoperatively, the patient is left in the hands of the generalist who often is ill equipped to care for the seriously ill patient. Indeed, adjunctive therapy is often left to the radiologist or medical oncologist in the small hospital, often because the gynecologic oncologist does not have those privileges. This decentralization of well-supervised patient care is, to me, clearly the major threat to advancement of our young discipline. My final comment—for those young people who plan a career in the private sector—develop your own oncology referral program in a medical center and hope that the era of the *POGS* will be short lived.

THE PERSPECTIVE OF ONE WHO LEFT ACADEMIA TO ENTER PRIVATE PRACTICE

RICHARD C. BORONOW, M.D.

As one who spent twelve years in academic medicine and then the last five years in full-time private practice, I would like to comment on the problem of attrition from academia to the private sector and some of the reasons, given and otherwise, for this attrition.

As this questionnaire was evolved, there was the feeling among many that all was not well with the gynecologic oncologist in his Department of Obstetrics

and Gynecology; that there was a tendency toward moving from academia to the private sector; and that this attrition would have an unfavorable impact on University communities in terms of clinical investigation, research, and teaching.

Clearly there is some truth to each of these concerns, and, of course, these concerns are not unique to gynecologic oncology. In his Del Regato Lectureship a few years ago, the distinguished Gilbert Fletcher lamented over the proliferation of community radiotherapy "centers," suggesting that they were sapping material from the larger more sophisticated centers where more clinical and investigative work is going on [1]. In fact, Leighton Cluff in the January 8, 1982 issue of *Journal of the American Medical Association* discusses this problem for all of medicine in a penetrating report from the Robert Wood Johnson Foundation [2]. This is must reading for all. We must first, however, place this attrition in perspective.

The questionnaire discloses that in the last five years 12.9% of the members and 12.1% of the candidates moved from full-time academia to either part-time or full-time private practice. In spite of some attrition, the survey reflects that 81% of members and 93% of candidates remain in academic medicine, either full-time, geographic full-time, or on a cancer institute staff. The converse is that only 19% of members and only 7% of candidates are in nonacademic settings.

To compare this with other medical fields, it is of interest to inspect data from the AMA Masterfile for Selected Specialties using "office based practice" as a reasonable definition of the non-academic-based private practitioner. While comparisons may not be entirely precise, they are close and our 19 and 7% "private practice" groups seem almost insignificant compared to the 69%, for example, in therapeutic radiology and 94% in the subspecialty of colorectal surgery. So the fear of attrition to private practice may not be as great as some would believe.

The clustering of gynecologic oncologists in medical school settings will inevitably change somewhat with time as has, for example, the distribution of cardiovascular surgeons and therapeutic radiologists. It seems appropriate that most be in educational settings, however, as the academic environment remains in the forefront of new information, clinical trials, and research. Nevertheless, high-quality work can and is maintained in the private practice setting. And where the patient volume and physical support and professional staff justify it, this seems entirely appropriate in the context of the scenario of American medicine—lest we are socialists. A real problem that I can foresee is the men or women who, despite their training, are able in practice to generate only a small to moderate cancer practice and who must, by economic necessity, do the spectrum of gynecology and obstetrics to make a living. I feel we must be essentially in full-time oncologic practice to remain current, irrespective of our practice setting. I caution, therefore, that part-time gynecologic oncologists, like part-time cardiac surgeons, may well lose their competency.

It is my personal view that entry into the private sector for those who may wish to pursue this course is best delayed for at least several years for our subspecialists for several reasons: (1) the requirement for advanced certification mandates an additional two years of clinical experience in an entirely suitable setting; (2) trainees can pay their dues by contributing much in terms of academic

teaching responsibilities, participating in clinical studies, cooperatives, and the like, and preparing formal and informal talks and presentations, manuscripts, and other forms of scientific scholarship; (3) additional clinical experience inevitably matures and seasons the neophyte clinician [3]. The words of Hemingway seem appropriate here: "There are some things that cannot be learned quickly. And time—which is all that we have—must be paid heavily for their acquiring." Some, however, are impatient. They have that right.

A large segment of the questionnaire was dedicated to economic considerations. The mean, total, professional income of responding members was analyzed. Add to this the sizable package of fringe benefits most received, such as malpractice insurance, professional travel, dues, and subscriptions, not to mention secretaries, nurses, and space, etc., and the overall package is quite sizable. All of this is out of our own pocket in private practice.

When asked how much more income they thought they should have, the most common answer for both members and candidates was 50% more. Private practice overhead expenses are large and probably not fully appreciated by the academician. Yet 33% of the members and 57% of the candidates have considered leaving academic medicine for financial reasons. Over 50% of both groups feel they are "overworked and underpaid" and many feel their workload is much heavier than that of most of the academic department. Well, really, isn't that sad! Do you know how many who do not feel that way? Have we not heard of Mr. and Mrs. Average American Worker, the AFL-CIO, the UAW or PATCO! Really, these figures only admit that we're better off than the average American.

Ultimately, the unspoken reasons came from within. It seems to me that our group comprises "achievers." Our temperaments, our personalities, our energies, our needs—indeed our agitation about our work—are all a reflection of our inner self, and we do not generally know that inner self as well as we might think we do. Most of us are "workaholics." Either full blown or borderline! This syndrome is rampant among what 20th-century America refers to as "the successful." When we can come face to face with the fact that we live to work, rather than work to live—we are workaholics.

Achievement is not an altogether pure virtue. In fact, this mixed blessing is usually the product of very intense inner drives and needs. We are generous with ourselves by calling this "motivation." But satisfying our deepest needs becomes the "monkey on our back" that results in workaholism. This intensity is fierce; this drive is highly stressful. Workaholics are particularly subject to "life's deadly D's: dissatisfaction, depression, divorce, disease, and death." This intensity can be destructive.

So regarding the attrition to private practice, I see three special challenges that relate to some of the frustrations of some of our leadership.

1. The first challenge is to the universities, the deans, the department chairmen, who must reevaluate traditional concepts of fixed or semifixed salaries for the scientific scholarship of their teaching physicians. Many schools and departments have evolved fair, even generous formulas to reward productivity and effort, thereby retaining desirable faculty. This approach has always seemed fair and sensible to me. While fair and sensible, it is also extremely prudent in days of

dwindling soft Federal money. Deans and chairmen must give the formula approach a more open-minded "second look."

2. The second challenge is to town and gown. There exists a clear mandate for cooperation among medical schools, clinical faculty and community physicians as community "medical centers" achieve more and more diverse specialized competence.

3. The third challenge is to ourselves as individuals. We must acknowledge as best we can that our work is part, and hopefully not all, that is required for the fulfillment of our own needs.

Our education and training experiences imbue us with an idea of the essentials for quality medical practice which are (1) knowledgeability, (2) availability, and (3) affability. These three were enunciated to me during my residency by Edward F. Scanlon, M.D. [personal communication], recent Past President of the American Cancer Society and also a Past President of the Society of Surgical Oncology.

In the academic setting, there is the stimulus of clinical investigation and the challenge to excellence from peers and trainees. We like to think of ourselves as students of the diseases we treat not just "treaters." This intellectual stimulation and gratification will always be the most important part of the reward equation in academic medicine, even with improvement in economic benefits.

The practicality of the "real world," however, is very clear. Scanlon reminds us that the "essentials" referred to above are not so subtly altered. The essentials for private practice are (1) affability, (2) availability, and (3) knowledgeability! The appreciation, even worshipful adoration, by patients for their physicians has long been an extremely important part of the reward equation in private practice. It has been said that "physicians take care of their patients." It may be more accurate to say that "patients take care of their physicians." Virtually anyone and everyone can make a good living in private practice. But I can tell you that "keeping current" is more difficult. And peer review is far, far less evident.

Each sector marches to different drummers, but we are all in the same parade. In the final analysis, each must look at our own work and assess its role in the fulfillment of the spectrum of our own needs.

Regarding work in academia, we must thoughtfully evaluate—in the context of these needs—the price to stay in and the price to leave. For each person, it becomes a highly individual appraisal. Finally, as we better appreciate the "workaholic" in ourselves, we must strive for modification, so that we can reach the goal of "working to live" rather than "living to work." We must recognize it and modify this before it is too late.

THE PERSPECTIVE OF A DEPARTMENTAL CHAIRMAN

LEO J. DUNN, M.D.

The first comment I would like to make is to in regard to the validity of the questionnaire. You must recognize that this questionnaire was given only to gynecologic oncologists and therefore the response cannot be regarded as being specific to that group. It is entirely possible that the same response would be received from other individuals in academic medicine. Furthermore, some of the question items might have had different responses if asked of other individuals.

Specifically, those items regarding how well accepted or regarded the gynecologic oncologist is by other groups may very well have produced different information if those groups had been asked. Finally, some questions have predictable responses. As an example, I would ask, when you heard someone say that they earned too much money or even enough money? How often (even outside of gynecologic oncology) does one hear that one is overworked? Therefore, positive responses to these questions are virtually predictable and this should be realized in analyzing the data.

I have broken down my comments regarding specific items reported on the questionnaire into several segments and would like to present them under various categories.

Old Truths Rediscovered

1. "Private practice is more lucrative than academic positions." This fact has been well known in the past, remains true at the present time, and it seems that it will continue to be so. Therefore, the document has not uncovered something unique regarding Gynecologic Oncologists.

2. "Private hospitals are easier to work in." This also has always been true. It is unfortunate that private hospitals are more physician and patient oriented and that university hospitals tend to lose their competitive edge. However, this also is not a new discovery uncovered by this document.

3. "Private hospitals are more attractive to patients." This is also true for the reasons stated above.

4. "Doctors work long hours." This has been traditionally so. It has also been demonstrated that physicians in academic medicine often work longer hours than physicians in practice situations. How they spend that time is, of course, frequently very different.

5. "Far off fields look greener." This is one aspect of human nature that leads everyone to believe that the other fellow has it better. It is not restricted to persons in academic medicine but exists in private practice and in other professions or occupations.

6. What are the problems as the oncologists see them? The gynecologic oncologists primarily seem to be concerned with the belief that their salaries are not commensurate with their output. Since their output is largely related to patient care situations they feel that personal income should be closely linked to productivity from their practices in the academic setting. From the standpoint of a department chairman you must recognize that creating this type of direct linkage of salary to private practice productivity absolutely discourages efforts in teaching and research. The individual who would spend any substantial period of time in teaching or research would be clearly penalized financially for doing so. One should also note that this questionnaire indicates that the gynecologic oncologist is frustrated because of lack of time for teaching and research. This complaint then goes in the opposite direction of the issue of salaries. From an administrative standpoint it is illogical to complain about both of these issues since solving one would worsen the other.

Each academic faculty member must recognize the financial problems faced by the department as a whole. Close linkage of salaries to private practice

productivity would create a disadvantage in recruiting new faculty members, since their private practice productivity is almost zero for the first six months and very little for the second six months. Therefore, new faculty need to be supplemented and these dollars must come from somewhere. One must also realize that the practice income for the aging physician generally declines whereas the academician continues to increase his or her salary to the time of retirement. These dollars must be made up from somewhere as well. Furthermore, many faculty look only at their gross income and forget that, considering the usual costs of practice, the net income is less than half. In addition, fringe benefits often come from these practice dollars and must be included when one is calculating overall income. This includes such items as travel, memberships to academic societies.

Gynecologic oncologists have also complained that their personal lives become restricted because of the demands of their work which does not allow them to "paint their own homes," "cut their own grass," etc. This is a real problem because we have not as yet reached the number of certified gynecologic oncologists that was predicted as our need. Therefore those who are practicing this subspecialty are still in the position of handling a very large workload. However, you must recognize there is also a personality issue involved here. Even in this survey the gynecologic oncologists recognize their compulsive natures. You are sitting in a room with two hundred obsessive/compulsives who, if given the opportunity to have free time, would find some work with which to fill it. This is not necessarily a negative trait as compulsiveness is a desirable trait in physicians, in my opinion.

The Problems as Departmental Chairmen See Them

These comments come from talking to a few departmental chairmen who have dealt with gynecologic oncologists within their departments. One complaint is that the oncologist does not take an active interest in the affairs of the department. They stay somewhat isolated from the remainder of the department. This criticism may have real validity. This survey does indicate that the gynecologic oncologist does not regularly participate in departmental grand rounds, as an example. Furthermore, the long working hours of present day gynecologic oncologists probably make it difficult for them to participate in committees and other similar activities within the academic setting. One must recognize that these issues can give the impression of a lack of interest or desire to associate with the department as a whole.

There has been expressed the reluctance of the oncologist to share in obstetric call schedules. This varies a good deal with the size of the department and the method of funding within the department. One must recognize that in small departments there is the problem of manpower to cover the labor and delivery unit over nights and weekends. There are also a number of departments who depend upon supervision of such insured patients as a major part of faculty funding. These situations are not uniform and they vary a good deal from one center to another. I would expect that these problems will lessen as departments grow in size and there will be concern as to how current an oncologist will be in obstetric judgment.

The departmental chairmen also feel the oncologist can have an unreasonable expectation regarding their income. I point out that it is not possible to be functioning in an academic setting and to be paid as a private practitioner. This problem gets close to a real issue since gynecologists do spend their time in patient care much as a practitioner does. Unless they develop time and skills that bring them the rewards of academic life, there will continue to be this type of dissatisfaction.

It is stated that the oncologist's research effort is small. This appears to be very true and almost uniform. Not only is the research effort small but it is considered to be at a very primitive level. Much of the "clinical research" still amounts to statistical studies of how many cases had a five-year cure and how many complications occurred, etc. This type of research is viewed as being at a much lower level than that being accomplished by other specialists within the same department. I believe there is some truth to this and I think that this society and the Division of Gynecologic Oncology must be acutely aware of the fact that we are only training practitioners in gynecologic oncology as research training has been largely neglected.

Why Is There Unrest?

I believe that the following are reasons for the unrest among gynecologic oncologists. First, these individuals find themselves being a desirable commodity at the present time. Therefore, they are presented with a number of options and this means making a decision. Since the options continue, the individual is constantly presented with the inducement of change to something more attractive. This leads to a certain amount of unrest. There also has been implied some concern about gynecologic oncologists leaving academic medicine and entering private practice. I think we must realize that there was never any requirement that the graduates of fellowships for special competence had a requirement to devote their careers to academic medicine. There is no prohibition against entering private practice in any of these areas. Considering the fact that fewer than 10% of the graduates of residencies in general obstetrics and gynecology enter academic medicine, we should be impressed by the fact that fewer than 10% of the graduates of fellowships in gynecologic oncology enter private practice! The trends are almost exactly opposite. Therefore, if this trend continues, the academicians of the future disproportionately will come from fellowships and have a great influence on the future of the specialty. In a sense we should have less concern about the gynecologic oncologist who enters private practice than our specialty should about the influence on our future by gynecologic oncologists who stay in academic medicine.

The next item of unrest is the income differential between academic medicine and private practice. This differential, as I have previously stated, has always existed. The concern has been further expressed that this differential will cause a sudden and complete abandonment of academic posts by gynecologic oncologists, all of whom will enter private practice. I seriously doubt that this will happen. Although there is significant income differential between academic and private practice income within gynecologic oncology, we have to recognize that this

differential has always existed in urology, orthopedics, and cardiac surgery. It also currently exists in reproductive endocrinology for those individuals who do microsurgery. Therefore, gynecologic oncology is not unique in this regard, and since these other specialties have continued to attract academicians, I see no reason why the outcome will be any different for gynecologic oncology.

There is also a generation gap that exists between the young graduates of training programs and those in the grandfather category. I think we see a difference in the expectations and goals of our medical students and residents from those of us who graduated some long time ago. Their experiences are very different from ours and therefore they seem to have differences in their philosophy.

There is a very definite financial crunch within academic departments at the present time. There is a greater dependence upon practice dollars to support these departments. This is particularly true of obstetrics and gynecology, which is trying to increase its academic strength at a time when there are declining federal dollars.

There is the reality of workload in gynecologic oncology, as I previously mentioned. There are not enough gynecologic oncologists to fill all the needs at the present time, but of course one anticipates that this is a self-limited problem.

There is a real problem in the oncologist as an academician. First, I think an oncologist is primarily trained to be a practitioner. Second, I think there is a significant educational gap that exists for a resident who enters a fellowship in gynecologic oncology. The informational and skills gap that exists between the graduate of residency and what is needed for the fellow in reproductive endocrinology and the fellow in maternal-fetal medicine is far less than that which exists for gynecologic oncology. Therefore, much of the time in a fellowship in gynecologic oncology is taken up with filling this educational gap. This in part explains the lack of research training in gynecologic oncology fellowships. One must recognize the degree of commitment that exists in the other two subspecialties toward research. In some programs, a full 50% of the time of training is spent in laboratory research. In most oncology fellowships, very little if any time is actually spent in learning research tools. This is an issue about which this Society and the Division of Gynecologic Oncology should have a special concern. Unless something is done, the excellent growth that gynecologic oncology has had in this country will plateau and the other subspecialties will clearly exceed it in achievement. New information and new discoveries in gynecologic oncology should be the responsibility of the certified gynecologic oncologists and should not be left to the scientists in other disciplines. Clearly the gynecologic oncologist will be an unhappy academician if he or she has never been trained in academic pursuits.

Finally, the question has been raised as to why gynecologic oncologists are not more frequently sought after as chairmen. They are not overlooked as far as chairmanships are concerned and the claim is not true. However, I think there is some problem since there has become a practice of appointing pediatricians as chairmen of search committees for departments of obstetrics and gynecology. These individuals will favor obstetricians and perinatologists in their searches and may have an undue influence on the future of our specialty. I think this

should be pointed out to deans who probably make these repetitive appointments inadvertently.

What Are the Prospects for the Future?

I believe the following things will be seen in the future. The uniqueness of the gynecologic oncologist will fade as supply-and-demand ratios change. We will produce enough gynecologic oncologists to fill the need. Oncologists will enter private practice and will compete with medical centers as have other practitioners before. I believe both groups will survive. The oncologists will not split off from obstetrics and gynecology. Were this to happen, it would be a group of 300 individuals trying to make their way in the morass of federal legislation and other political changes as compared to over 20,000 practitioners of obstetrics and gynecology. It is clearly to our advantage to remain with the parent specialty.

In regard to the academic oncologists, I believe they will (a) become more specialized, (b) become more research oriented, (c) spend less of their time in clinical work, and (d) still complain.

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