The Urology Group: Balancing Expansion With Commitment to the Community

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An artist's rendering of The Urology Group's $20 million campus in Norwood, Ohio.

The week that *Urologists in Cancer Care* was scheduled to speak with members of The Urology Group in Cincinnati, Ohio was a hectic one. The American Urological Association (AUA) had just wrapped up its annual meeting, and urologists were contending with some bad news: The US Preventive Services Task Force (USPSTF) confirmed its recommendation against routine prostate cancer screening with prostate-specific antigen (PSA) testing.

The Urology Group took action without hesitation, releasing its own position statement within 48 hours of the USPSTF edict. "We are more than disappointed with the task force's recommendation," said Gary M. Kirsh, MD, president of The Urology Group in Cincinnati, in the statement. "We will continue to offer free prostate cancer screenings in underserved areas of Greater Cincinnati as part of our community outreach program because we know early detection saves lives."

Making such bold moves is not new to this practice. In its relatively short 16 years, this 35-physician group has become one of the largest single-specialty groups in the country. Headquartered in Cincinnati, the practice has 19 other locations, extending beyond Ohio to Kentucky and Indiana. This summer, the group will move to a $20 million, 55,000-square-foot campus in Norwood, Ohio.

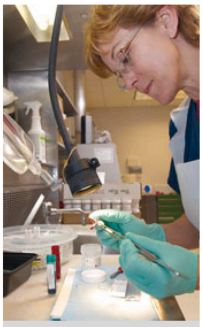
In tough economic times when many medical practices have scaled back or even shut down, The Urology Group has flourished. *Urologists in Cancer Care* spoke with Kirsh, along with Chief Medical Officer Phillip J. Buffington, MD, and Bernard L. Hertzman, MD, director of Clinical Research, about their phenomenal growth.


Gary M. Kirsh, MD

Consolidation and Community

The Urology Group came together in 1996, the product of many smaller practices joining forces. "In order to meet the challenges of the healthcare system, you just couldn't exist effectively as a two- or three-person practice," Kirsh said. "Consolidation of our industry was needed in order to bring efficiencies. And by efficiencies, I don't mean lowering overhead. It was about gaining access: access to professional management; access to information services: access to human resources; access to legal advice for contracts; access to market power."

But getting a disparate group of urologists together to "super-size" was not easy. As Kirsh pointed out, physicians have no history of corporate culture. "When you take physicians who have already established themselves in practice and try to bring them together, that's going to be a challenge. Physicians are generally not followers. They are used to making individual decisions about patient care on a day-to-day basis. They are used to being in charge, whether it's in the clinic or in an operating room."


Technician Linda Lohr performs a histology exam of a tissue sample in The Urology Group's lab.

One of the first steps the group took toward meeting this challenge was to ensure that the leadership understood their roles. "Physicians like me, who are essentially business people now, we weren't trained for that," Kirsh said. Next was to bring the group members on board with regard to accountability—measuring productivity and quality outcomes, as well as developing and adhering to clinical guidelines.

Another key to its success has been community outreach. To that end, the group has sponsored everything from 5K walk/runs for prostate cancer awareness, to underwriting a comical play about menopause, to "adopting" two classes at a local school as part of a mentoring program.

"If our group is viewed as an indispensable community asset, then we are going to be a pretty secure business," Kirsh pointed out. "That means delivering highquality, subspecialized, streamlined, measured, cost-effective care. We have to be a community asset."

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Consolidation = Critical Mass

Another boon of consolidation was the ability to achieve enough critical mass for its physicians to subspecialize. For example, when robotic surgery first came on line, many physicians in the group were interested in learning this new technique. But getting everyone trained in robotic prostatectomy or cystectomy wasn't realistic, Buffington said.

"The learning curve [for robotic surgery] is rather steep," he explained. "Clearly, it was going to be awhile by the time all 35 doctors in our practice mastered robotic surgery. Instead, we trained three physicians, and they've became our robotics people. As a result, we have three people [led by Mark G. Delworth, MD] who have become well-known on a national level. That kind of subspecialization is not something that you can do so easily at a small practice."

Buffington and his colleagues agreed that prostate cancer is the disease state for which urologists will be called upon to put these specialized skills to the test. While the aging population will mean a higher incidence of the disease, Buffington pointed out that the prostate cancer treatment armamentarium of today is far superior to when he started in his career.

"I remember the 'old days' when I did my training in the 1980s, and we didn't have PSA screening back then," he said. "Pretty much everyone with prostate cancer presented with back pain and sudden onset of paralysis from metastases. It was invariably advanced disease."

In addition to robotic prostatectomy, Buffington cited immune therapy and personalized medicine as new weapons that urologists will have the opportunity to deploy in their patients. The group currently offers image-guided radiation therapy and brachytherapy in prostate cancer; intravesical chemotherapy for bladder cancer; and cryoablation for kidney tumors.

"Urology is really a unique specialty, in that we are with our cancer patients from beginning to end. We are the ones who make the diagnosis, and we often render the treatment…we are the physicians who are best equipped to treat those problems."
– Phillip J. Buffington, MD

Buffington stressed that "watch and wait" is also a viable and widespread treatment option, thanks in part to PSA screening. That's an important point that USPSTF failed to consider in their guidelines. "The task force didn't really look at what's going on in clinical practice in terms of the overtreatment issue," he said. "We treat people less and less these days; we definitely do more surveillance. We aren't nearly as aggressive with treatment, and I don't think the task force really took that into account."

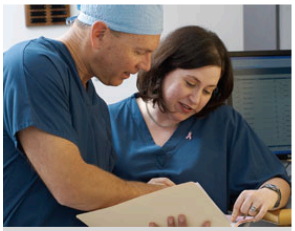
Unlike other specialties where patients make short-term stops, urologists have the opportunity to form long-lasting ties with their cancer patients, which fits in The Urology Group's vision of being in service to its community.

"Urology is really a unique specialty, in that we are with our cancer patients from beginning to end. We are the ones who make the diagnosis, and we often render the treatment," Buffington said. "But even if the patient is referred to the oncologist, he is likely to come back to us to address the complications associated with the cancer treatment—like urinary problems, erectile dysfunction—we are the physicians who are best equipped to treat those problems."

Clinical Trials: It Takes a Community

There's no doubt of the importance of research to the advancement of medicine, but for many practices, clinical trials are best left to academia. For Hertzman, The Urology Group, with its extensive patient pool, is really the ideal venue for research.

"I think basic research is where academics excel," he said. "But sponsors are understanding that private practice is a great resource: Adapting the protocol, getting through the regulatory requirements in a quick manner, recruiting the patients, enforcing good clinical practice, that's where groups like ours have an advantage."



Dr. Buffington consults with an oncologic nurse at The Urology Group.

An oft-voiced complaint in the research arena is how difficult it is to recruit patients to participate in trials. Hertzman said he understands why patients may have reservations about taking part in a trial when benefits are not guaranteed. That patient hesitancy needs to be addressed when trials are designed.

"We try to devise trials so that there is some advantage [to the enrollees]. Let's say it's a short trial that only takes three or four months," he explained. "At the end, a patient who received placebo got nothing out of it so there should be some 'perk.' We'll do an open-label, extension study, and we'll let those patients go on the [study] drug and see how they do. That's perfectly acceptable."

The Urology Group participated in the trial for the vaccine sipuleucel-T (Provenge, Dendreon) for patients with early-stage metastatic prostate cancer. Urologic cancer trials that it is currently engaged in include:

- An open-label, double-blind placebocontrolled study of apaziquone in early bladder cancer
- An open-label study of mycobacterial cell wall-DNA complex versus mitomycin C in recurrent or refractory nonmuscle invasive bladder cancer
- An open-label study of abiraterone acetate (Zytiga, Janssen) plus prednisone in advanced nonmetastatic prostate cancer
- Safety study of denosumab (Xgeva, Amgen) or placebo for incidence of cataracts in patients with prostate cancer on continuous hormone therapy for treatment

Hertzman objects to the level of media attention that controversial trial results garner, which can also make patients shy away from participation. "I think we are up against a lot of misconceptions about research," he said. "It's always the 'bad apple' that gets the attention. There are those rare instances where people will abuse the system or misuse their privileges, but that gets hyperpublicized."

Mitigating that public mistrust requires a two-pronged approach in Hertzman's estimation. First, he is a proponent of the certified physician investigator program, which is administered by the Association of Clinical Research Professionals, for "maintaining the integrity of the research system."

> "It's important for the site investigators to devise ways to make trials more reasonable and palatable to patients…it's about figuring out how to make the trial work best for everyone, researchers and patients."
> *– Bernard L. Hertzman, MD*

Second, Hertzman encourages clinical site investigators to become more involved in trial design. "It's important for the site investigators to devise ways to make trials more reasonable and palatable to patients. It's not about getting together at a nice spot and playing golf; it's about figuring out how to make the trial work best for everyone, researchers and patients."

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