Disparities in Cancer Care for Older Adults

In regards to the September 2006 issue of the *Journal of Oncology Practice* about disparities in cancer care, I was dismayed to see that you did not include older adults, particularly the very old, among your highlighted populations. The disparity in elderly accrual to clinical trials actually exceeds the disparity of racial minorities.¹ The magnitude of this under-accrual is likely to increase as the baby boomers continue to age, and it is an issue that deserves

special emphasis. In addition, older patients are undertreated, stage for stage, off protocol, even when controlling for comorbidity.² I would hope in similar future issues you lend more time and reflection to these important geriatric issues.

Noelle K. LoConte, MD, Assistant Professor
University of Wisconsin Comprehensive Cancer Center,
Madison, Wisconsin

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In Response to “Oncologists and Medical Malpractice”

I would like to expand on the excellent article by Patricia Legant, MD, “Oncologists and Medical Malpractice.”¹ Regarding informed consent issues (“Potential Areas of Litigation,” point 4),¹ there is wide variation in practice on what is appropriate and necessary. As an example, we reported on the wide variation of informing patients on the leukemogenic potential of chemotherapy drugs.² With that said, I believe that ASCO should provide on its Web site consent for chemotherapy narratives, not just patient information materials, but actual consent documents for patients to sign. The current situation seems to be that each practice needs to “re-invent the wheel.”

I note Dr Legant’s choice of words that physicians should “make an effort” and “mention” to patients possible events such as infertility, death, and late second malignancies. I thought the word choices were curious, and I wonder if the author herself is ambivalent. Dr Legant wisely goes on to elaborate some of the difficulties involved in the interactions of patients and families under enormous stress in discussing these issues. The ambiguous language may reflect the mixed emotions that are shared by many practitioners, which is why my own findings of how physicians handle this type of issue revealed such variable practices on this issue.² Since the practice of what to tell a patient is imprecise to say the least, making a claim (ie, a lawsuit) against a physician could be relatively easy since an attorney probably could readily find an expert who has a different viewpoint of how much should be included. For what it is worth, my own practice is that my consent form does list death as well as fatal forms of leukemia.

While I question Dr Legant on the seemingly weak wording highlighted above, I also note that she employs stronger language later in the article that states, “Current calls for

cancer patients always to get a second opinion are often no more than thinly disguised marketing ploys, and also serve to erode patient trust in all their oncologists” (“Ways to Avoid Litigation,” point 5).¹ We have previously commented on the dangers of cancer care becoming commercialized and the marketing that follows.³ The potential downside of second opinions (eg, treatment delays) is rarely discussed. However, physicians in private practice, as I am, do enjoy the legal protection that second opinions confer, as well as the camaraderie it provides with our academic colleagues. These advantages are typically done at public expense (typically Medicare), and the financial costs of this “benefit” is rarely discussed, let alone the opportunity costs of important projects that are not funded as a result of what must be a significant expenditure. I have previously questioned the practice of pathology review of all patients at tertiary care centers.⁴

I would also like to expand on the issue of good communication (“Ways to Avoid Litigation,” point 1).¹ My colleagues remind me, as does Dr Legant, that good communication with patients is important in preventing lawsuits. I have previously written on this challenge.⁵ However, many times, the problem comes about from a family member who lives out of town, and/or whom I have had no contact with, and the “questions” come about after the patient is deceased. My colleagues seem to believe that their excellent relationship with their patients and their spouses will prevent malpractice problems. Meanwhile, a patient’s family member, with whom the physician has had little or no contact, could represent the real threat. All the more reason to heed the other advice in the article by Dr Legant.¹

Daniel J. Morris, MD
Naples, Florida

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In Reply

Dr Morris offers some helpful and provocative observations on my article on oncologists and malpractice.

Regarding the required elements of informed consent for chemotherapy, it may be difficult not to be ambiguous. This is an area in which accepted practices varies widely, in part for the practical reasons mentioned in the article (eg, trying to communicate risks truthfully while avoiding frightening the patient away from a treatment that, despite toxicity, may extend his or her life). Dr Morris worries that one could find an expert witness who would disagree with a particular physician's approach to this matter. Nevertheless, I suspect that one could also find a counterbalancing expert for the defense.

Dr Morris wonders whether ASCO could generate template consent forms for various chemotherapy regimens. While these might be convenient, I would worry that they might be hard to keep complete and updated. One might alternately offer some of the various patient information sheets on drugs that are published online by other reliable sources, such as the American Cancer Society or People Living With Cancer (www.plwc.org). Then one might refer to them in the documentation of consent, whether this is in a progress note or in a formal signed consent form. As I am not a lawyer,

I don't know what the legal ramifications of this process would be.

In addition to my concerns about the impact of second opinions on patient trust and understanding, Dr Morris alludes to several other aspects, both positive and negative, of second opinions. These include physician collegiality, medical expense, and treatment delay. This is a complex subject that deserves a fuller, more candid assessment than I believe is currently available, and should be considered as a future topic for the *Journal of Oncology Practice* to address.

Finally, I agree entirely with Dr Morris' last point, that it is often the family member who has been least involved in the patient's care who becomes a later malpractice risk. In oncology circles, we recognize this "California syndrome," in which the family member who appears late on the scene then, perhaps for reasons of guilt and/or grief, finds fault with the local caregivers, both family members and physicians. It may just be an unavoidable risk of our profession, including for those who practice in California (who tell me it is known as the "New York syndrome").

Patricia Legant, MD, PhD
Salt Lake City, Utah

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In the July 2006 *Journal of Oncology Practice*, the online supplementary material for pages 193-195 of What's New in JCO? contained errors in the table on drug dose and schedule recommendations for antiemetic regimens.

For high emetic risk, dexamethasone was recommended on days 1, 2, and 3 only, but it should have continued on day 4 at 8 mg. Also, the dosage for dexamethasone on day 1 was given as 20 mg/12 mg with aprepitant, but it should have been 12 mg only.

These corrections have been made online.

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