References

1. Legant P: Oncologists and medical malpractice. *J Oncol Pract* 2:164–169, 2006
2. Morris D, Carr B: Counseling patients of the risk of myelodysplasia from oral melphalan or chlorambucil. *Blood* 100:334b, 2002
3. Morris D, Eytel C, Kerns A: Unrealistic expectations in the diagnosis and treatment of ovarian cancer. *N Engl J Med* 328:664, 1991
4. Morris D: Second opinions in surgical pathology. *Am J Clin Pathol* 107:497–498, 1997
5. Morris D: Training physicians to be competent communicators. *South Med J* 91:218, 1998

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

DOI: 10.1200/JOP.0719003

ERRATUM ERRATUM ERRATUM ERRATUM ERRATUM

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.

DOI: 10.1200/JOP.0719501