ASCO's Clinical Practice Committee

Cancer Care Is Costly

By *Therese M. Mulvey, MD*

Cancer care is costly. This statement seems obvious. Much has been written about why cancer care costs so much. The high cost of cancer care is most often attributed to advances in technology and their attendant costs, the US health care delivery system and the insurance industry, and the usual target of drug costs. Little if any attention

is put on the cost of malpractice protection or the cost of defensive medicine. Although oncologists are infrequently sued, much of what an oncologist does in the course of the work day is spent indirectly practicing defensive medicine. The added time, technology overuse, testing, and treatments near the end of life that a patient with cancer is subjected to are often primarily born out of a defensive medicine strategy.

The practice of defensive medicine is ever present in oncology across diverse practice models in the United States. The discussion of tort reform—one potential method to reduce malpractice costs—is usually relegated to the surgical specialties. Oncologists are usually immune to the general fervor of the tort reform discussion. Yet much that has changed in the last few years that has affected our daily practice is a result of actual or threatened malpractice actions. The current climate of “quality initiatives” is a direct outgrowth of error prevention. Over the last 10 years, oncology has become the torch bearer for “quality.” Much of this effort was stimulated by a few well-publicized chemotherapy ordering errors which resulted in significant patient harm. As oncologists, we are acutely aware of the toxicity of chemotherapy. Managing and anticipating chemotherapy toxicity is an integral part of treating a patient with cancer. In fact, fellowship programs and board certification are primarily directed to teach and assess the skills necessary to manage the potentially toxic effects of chemotherapy and other cancer treatments.

It is therefore obvious that oncologists would spearhead safety and quality measures in this tenuous and threatening environment. Over the last several years, both paper- and computer-based chemotherapy ordering systems have been developed to enhance safety. Quality oncology practice

initiative, physician quality reporting initiative, and pay-for-performance are part of the everyday parlance in an oncology office or clinic. Many of these safety and quality efforts are indirect outgrowths of the malpractice cases related to chemotherapy errors.

A new challenge has recently emerged for oncologists. In Massachusetts, the Supreme Judicial Court agreed to hear a case on appeal that involved the prescribing of narcotics to a lung cancer patient who, while driving, struck and killed a child. The physician was sued for failing to warn the patient that narcotics could alter his sensorium. Although this case has far to go and the ultimate outcome is not clear, the implications are ominous. Not only are we to provide informed consent formally to our patients receiving chemotherapy, we now may be held to this same standard for all of the supportive care drugs we prescribe just as we are with the chemotherapy drugs. In a perfect world, all patients would have ample time for questions and be receptive to teaching regarding every drug. The reality is unfortunately far from this ideal. This is in large part why there are pharmaceutically driven educational tools, pharmacists, and drug warnings on every prescription. If this Massachusetts case and others like it continue and become law, new defensive measures will be developed. They may be deemed an enhancing quality by some, but will in fact be defensive at heart. Yes, many strategies will enhance quality, but the cost cannot be overlooked. It has become time for oncology providers to engage in the tort reform debate.

Unless the trend that all poor outcomes are the result of malpractice and that the solution is for someone to pay fades, we will continue to lose the battle to control the cost of cancer care on one front that our colleagues in other specialties are waging. Controlling the cost of cancer care will require a multifaceted approach. By addressing our behaviors and recognizing how we arrived at the current standards of practice, we can proactively begin to affect change. Practicing quality oncology care in the future will require all oncology providers and patient advocates to recognize what is defensive and separate this from what is best for the care of the patient.

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