Five Pieces of Silver

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Journal of Oncology Practice gives voice to issues facing practicing oncologists. I would posit that one of the greatest challenges our profession faces is the perception of conflicts of interest inherent in the model of care we have inherited, based on “buy and bill” for chemotherapy drugs. Early in our profession’s growth, buy and bill made sense and provided for the rapid expansion of expert sites of service for cancer therapy, enabling patients to be treated close to home. With time, practices and oncologists became dependent on profit margins from drugs to cover the cost of practice and maintain incomes. Over the last decade, shrinking drug margins have fostered efforts to diversify practice income streams through investments in imaging technologies. However, oncologists are increasingly held accountable by patients and payers for the use of ever more expensive drugs and for troubling relationships regarding physician ownership and utilization of imaging. A true conflict of interest is present when we rely on the margins of drugs and imaging to pay overhead costs of the practice and maintain our incomes. It is increasingly difficult to resolve this tension. Practicing within the bubble of an institution, academic center, or large group does not remove these economic conflicts. Though an oncologist may not directly benefit from these margins, the department, institution, or group clearly does. Admittedly, any business requires positive margins; however, when close to 60% of all personal bankruptcies in this country are the result of health care costs, especially for life-threatening illnesses like cancer,¹ the perceptions and realities raised by our profession’s conflicts are important to address.

All of us recognize the wonder new therapies bring. Yet when we are at the end of the supply chain providing the drugs, as the buy and bill system positions us, the practicing oncologist stands front and center as an apologist for these high costs.

Compounding this dilemma is the lack of awareness of many oncologists concerning the actual costs of the therapies prescribed and their retreat from responsibility to educate patients about the marginal benefits of many treatments relative to their costs. Patients and payers alike are increasingly dismayed when examining the costs of oncology care and the lack of meaningful conversations related to costs in the context of their illnesses. Frustrations grow with the recognition that a large percentage of these costs occur within the final months of a patient’s life.

What can we do as a profession to change these perceptions? The first steps require that we acknowledge the problem. The justifications that we are simply “offering patients the best therapies available,” that “the malpractice environment demands that all care be offered, even futile care” and that somehow one

can “avoid any taint of self interest by remaining ignorant of the costs” no longer ring true. Not when the therapies prescribed cost thousands of dollars per month and have huge impacts on patients’ personal well-being as well as society’s priorities in spending health care dollars.

Beyond awareness, we must advocate for new payment models that change the incentives in our systems of care. Commercial and government payers are evaluating a host of schemes that pay for quality and for the cognitive and coordinating services that oncologists provide. Our practices need to engage with the payers and lead innovative efforts to ensure preservation of the distributed sites of care for patients while moving away from reliance on buy and bill. Getting rid of the buy and bill conflict would strengthen our voice as advocates for our patients and practices.

As a profession, we also need to become informed relative to costs and the drivers of costs of oncology care. Over the past year, ASCO has taken part in an effort spearheaded by the American Board of Internal Medicine (ABIM) to identify five treatment practices that are widely used, costly, and for which no evidence exists to support their value (the campaign by ABIM is entitled “Choosing Wisely: The Five Things Physicians and Patients Should Question”).² ASCO’s Cost of Care Taskforce has identified five areas that oncologists should recognize. Highest on the list is the use of cancer-directed therapies in patients with solid tumor who have a poor performance status, have not benefited from prior lines of therapy, and are not eligible for a clinical trial. The next three items relate to the lack of evidence for complex imaging in the initial assessment of patients with early-stage prostate and breast cancer and the use of such imaging in the surveillance of patients with early-stage breast cancer treated with curative intent. Last is the inappropriate use of white cell-stimulating factors for primary prevention of febrile neutropenia in patients at low risk of this complication. This Top Five list for oncology (Table 1) and the rationale for each were recently published in *Journal of Clinical Oncology*.³ All practicing oncologists and oncology service line managers should embrace these efforts.

Accepting responsibility for discussions related to costs and benefits of care is central to implementing these efforts in practice. As physicians, we do not usurp our patients’ treatment decisions; however, we are teachers. We have a responsibility to inform and educate our patients concerning all of the issues that bear on making a clinical decision. When dealing with the emotions and drama of the life-threatening diseases of cancer, it is often easiest to “do something” rather than to sit and engage patients and their families in an informative discussion. We take the easy way

Table 1. Top Five List in Oncology

The American Society of Clinical Oncology (ASCO) is a medical professional oncology society committed to conquering cancer through research, education, prevention and delivery of high-quality patient care. ASCO recognizes the importance of evidence-based cancer care and making wise choices in the diagnosis and management of patients with cancer. After careful consideration by experienced oncologists, ASCO highlights five categories of tests, procedures and/or treatments whose common use and clinical value are not supported by available evidence. These test and treatment options should not be administered unless the physician and patient have carefully considered if their use is appropriate in the individual case. As an example, when a patient is enrolled in a clinical trial, these tests, treatments, and procedures may be part of the trial protocol and therefore deemed necessary for the patient's participation in the trial.

1. Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.¹⁰⁻¹⁵

- Studies show that cancer directed treatments are likely to be ineffective for solid tumor patients who meet the above stated criteria.
- Exceptions include patients with functional limitations due to other conditions resulting in a low performance status or those with disease characteristics (e.g. mutations) that suggest a high likelihood of response to therapy.
- Implementation of this approach should be accompanied with appropriate palliative and supportive care.

Sources:

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- Engstrom PF, Benson AB 3rd, Chen YJ, et al: Colon cancer clinical practice guidelines. *J Natl Compr Canc Netw* 3:468-491, 2005.
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- Peppercorn JM, Smith TJ, Helft PR, et al: American Society of Clinical Oncology statement: Toward individualized care for patients with advanced cancer. *J Clin Oncol* 29:755-760, 2011.

2. Don't perform PET, CT and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.¹⁶⁻¹⁸

- Imaging with PET, CT or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
- Evidence does not support the use of these scans for staging of newly diagnosed low grade carcinoma of the prostate (stage T1c/T2a, PSA < 10 ng/ml, Gleason score ≤ 6) with low risk of distant metastasis.
- Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

Sources:

- Makarov DV, Desai RA, Yu JB, et al: The population level prevalence and correlates of appropriate and inappropriate imaging to stage incident prostate cancer in the Medicare population. *J Urol* 187:97-102, 2012.
- National Comprehensive Cancer Network: NCCN clinical practice guidelines in oncology (NCCN guidelines)—Prostate cancer. Version 4.2011.
- Thompson I, Thrasher JB, Aus G, et al: Guideline for the management of clinically localized prostate cancer: 2007 update. *J Urol* 177:2106-2130, 2007.

3. Don't perform PET, CT and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.¹⁹

- Imaging with PET, CT or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
- In breast cancer, for example, there is a lack of evidence demonstrating a benefit for the use of PET, CT or radionuclide bone scans in asymptomatic individuals with newly identified DCIS, or clinical stage I or II disease.
- Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

Source:

- Carlson RW, Allred DC, Anderson BO, et al: Invasive breast cancer. *J Natl Compr Canc Netw* 9:136-222, 2011.

4. Don't perform surveillance testing (biomarkers) or imaging (PET, CT and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.^{12,20-23}

- Surveillance testing with serum tumor markers or imaging has been shown to have clinical value for certain cancers (e.g. colorectal). However, for breast cancer that has been treated with curative intent, several studies have shown there is no benefit from routine imaging or serial measurement of serum tumor markers in asymptomatic patients.
- False-positive tests can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

Sources:

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5. Don't use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20% risk for this complication.²⁴

- ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia, secondary to a recommended chemotherapy regimen, is approximately 20% and equally effective treatment programs that do not require white cell stimulating factors are unavailable.
- Exceptions should be made when using regimens that have a lower chance of causing febrile neutropenia if it is determined that the patient is at high risk for this complication (as a result of age, medical history, or disease characteristics).

Source:

- Smith TJ, Khatcheressian J, Lyman GH, et al: ASCO 2006 update of recommendations for the use of white blood cell growth factors: An evidence based clinical practice guideline. *J Clin Oncol* 24:3187-3205, 2006.

NOTE: These items are provided solely for informational purposes and are not intended to replace a medical professional's independent judgment or as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their health care provider. New evidence may emerge following the development of these items. ASCO is not responsible for any injury or damage arising out of or related to any use of these items or to any errors or omissions.

Abbreviations: CT, computed tomography; DCIS, ductal carcinoma in situ; PET, positron emission tomography; PSA, prostate-specific antigen.

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out and simply order a therapy or a test. In many eyes, we do this for motives that are not patient centered. One way to begin addressing the perception of conflicting interests is to take up the banner of the Choosing Wisely campaign and exchange our pieces of silver for an open and transparent conversation with our patients about costs and benefits.

It should not surprise the reader that, in every issue, *JOP* touches on aspects of these concerns. This issue presents an interesting narrative from a Turkish oncologist regarding practice in his country. Every perspective submitted describing practice in other areas in the world underlines how much in common we have with other health systems. All struggle to provide high-value care to their patients, and all struggle with costs. Other papers address diverse issues, including trends in neutropenia-related inpatient events, effects of funding on erythropoietin-stimulating agent use in patients with cancer, and a wonderful perspective from former ASCO president David Johnson on recertification. In May's *ASCO Post*, the reader can also find a perspective by James Stewart on recertification along with a recounting of ASCO's work in supporting members in this effort.⁴

As always, the editors appreciate feedback on the *Journal* and its content. Please contact us at jopeditorsdesk@asco.org.

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Conquer Cancer Foundation of the American Society of Clinical Oncology

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