How Legal Services Are Supplementing the Work of the Cancer Care Team for Certain Psychosocial Issues

BY ERIC T. ROSENTHAL

Appropriate and timely triaging by medical professionals to legal professionals advocating for cancer patients helps patients and families cope with legalistic issues that can affect overall well-being.

Page 24
Re: Simone’s OncOpinion: ‘An Interesting Model for Improving Cancer Care & Reducing Cost’ (3/25/10 issue)

I n his column in the March 25th issue, Joseph V. Simone described a program of external utilization review for cancer care. He concluded with several questions: Is it an effective model for improving quality and reducing costs? Does it make sense for the average oncologist? As summarized, the program seems to perpetuate an antiquated model of utilization management by payers. It imposes external controls on the process of patient care. It polices and attempts to direct the care process from outside the process. It does not fundamentally improve the patient care process itself. Whether we’re talking about manufacturing wafers or treating cancer, external inspection control is not the path to continuing quality improvement and sustainable cost control. It is the process itself that must be changed—from the inside.

The program increases administrative costs for oncology groups. Compliance imposes costs: supplying information required by the external review company, responding to questions and requests for more information, reviewing the results of reviews with the reviewers, negotiating authorization for treatment from payers when the oncologists and reviewers do not concur. And in scenario #2, where oncology practices themselves pay the external review company for reviewing treatment plans, oncologists bear both the direct and indirect costs of the program.

The program disrupts patient care. By design, the external review process is imposed between the oncologist and patient. In addition, the process takes time. How long does it take the external reviewers to render their verdict on the appropriateness of the proposed treatment plan? All hour, a day, a week? Consider the impact on patients of having to wait as their oncologists wait for the verdict of the outside reviewers.

The program reduces practice revenue. Under prevailing reimbursement, the oncologist who reduces costs for payers reduces practice revenues. How ironic…Under this model, the external review company gets paid. Win. Net program savings accrue to the payer. Win. The only loser? The oncology practice.

Finally, and possibly most importantly, the program fails to achieve the true quality and efficiency gains to both practices and payers through standardizing care and driving to a single best therapy for each stage and state of disease. No external UM program has the infrastructure or the clinical knowledge set to define such best practices and, therefore, must always rely on national guidelines, which, by their nature, are broad and inclusive of a wide range of treatments and associated costs.

The program has one thing right. Independent, evidence-based treatment protocols are the way to go. But evidence-based information is most properly used at the point of care to enable the oncologist to identify a best treatment for each individual patient based on state and stage of disease.

If oncology practices step forward and adopt clinical pathways, payers could eliminate the middleman and direct what they would have spent on fees to the external review company to paying oncologists for doing the right thing.

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‘Simone’s Maxims’

I loved Dr. Joe Simone’s 1999 editorial in Clinical Cancer Research (1999;5: 2281-2285), where he described several academic “eras” in medicine, ending with the “for profit” era (1980- ). I wonder: In the 11 years since he wrote that, does he have any addendums or updates? How would he describe our current era?

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Reply from Dr. Simone:

I don’t have a clear answer for you but I will give it a shot.

While it is true that “eras” do not have sharp boundaries and several of them coexist at any one time, we try to make some sense of the times we live in. Thus, we often arbitrarily choose a point when one “era” is over and becoming more dominant than the others. That is what I did for the article a decade ago.

I believe we are still in the “for-profit,” era which has become even more dominant over the years, but its DNA has mutated into an ominous variant—i.e., the “commercialization era.” This is driven by several factors that have grown exponentially in the past decade or so, including these examples:

1. The unfettered dominance of Wall Street and business in all spheres of life, including medicine and science, for (at least) the eight years up to the economic crash of 2008-9.

2. Direct marketing of prescription drugs to the public, creating uninformed demand for expensive and often unnecessary new products along with the complete disruption between the wants of patients (consumers may eventually become a more accurate term) and their responsibility for the costs—not unlike a no-limit credit card.

3. Physicians grouping and becoming large for-profit corporations that sneak through the Stark Law loopholes and turn away low-pay patients.

4. A bizarre and counter-productive physician reimbursement system that encourages and rewards the unlimited use of technologies and procedures of no proven value (but huge costs) for what they are mostly used for, e.g., proton beam therapy, robotic prostatectomy, and cryoablation, to name a few.

5. Scientists and physicians with lucretive ties to industry, often becoming agents for new drugs or appliances and burdening themselves and their scientific independence with a conflict of interest.

6. The commercialization (“to further science”) of our academic medical centers, setting an example and providing a patina of respectability for actions that faculty and trainees may then emulate without compunction.

7. The evolution of cancer clinical trials in many practices primarily into lucrative “profit centers” that promote Pharma’s mindless and reckless treatment trials instead of using the opportunity to learn and advance the field.

Thank you for causing me to rethink this issue! I welcome any comments you may have.

New Logo for ESMO

T he European Society for Medical Oncology (ESMO) has a new logo and tagline—“Good Science. Better Medicine. Best Practice”—designed to reflect, a news release notes, the Society’s significant role in the ongoing evolution of cancer treatment.

“Oncology is a field of medicine that has undergone radical progress in recent years and will continue to do so,” said ESMO President Professor David Kerr, MD, DSc.

And as medical oncology evolves, ESMO is also changing. Our goal is to provide the best possible support for the many health profession orals who bring those improvements to patients around the world.”

The organization explains that the bold colors of the new logo “represent the diverse professionals involved in medical oncology, and the variety of innovative and forward-looking services ESMO offers to its members.”

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