Medical Xpress

Oncologists hold key to curbing cancer costs

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(Medical Xpress) -- The cost of cancer care is threatening to bankrupt our healthcare system. New drugs are prolonging life, but at staggering costs. This coupled with aging baby boomers and an increasing population mean the U.S. will spend $173 billion annually on cancer care by the year 2020. This trend is not sustainable; however, there are evidence-based ways to maintain or improve the quality of care while saving money for the new therapies being discovered every day.

So argue VCU Massey Cancer Center researchers Thomas Smith, M.D., and Bruce E. Hillner, M.D., in an article in The New England Journal of Medicine, in which they present 10 changes medical oncologists can do to flatten costs, maintain or improve care and save money for future medical advances. Smith is a nationally recognized oncologist and Endowed Chair of Palliative Care Research at VCU Massey Cancer Center, and Hillner is a professor and eminent scholar in the Department of Internal Medicine at the VCU School of Medicine and member scientist at VCU Massey Cancer Center.

In a challenge to their colleagues one week before the annual meeting of the American Society of Clinical Oncologists (ASCO), the authors suggest changes in the behaviors and attitudes of medical oncologists that could save the nation billions of dollars.

“First, we take curative care and clinical trials off the table. They are vital to advances and save lives,” says Smith. “However, we must critically examine our current practices for ways to reduce costs in order to maintain quality cancer care for all of our patients while continuing to

advance medicine. This raises difficult issues that impact physician income and requires a new level of open and honest communication between doctors and patients. But the longer we wait to address these issues, the worse it will be for future patients."

The authors focus on the treatment of patients with incurable solid tumors, and many of their recommendations reinforce current ASCO and National Comprehensive Cancer Network (NCCN) evidence-based guidelines. Some of their proposals call for more frank discussions about end-of-life care between physicians and patients, and others urge increased scrutiny when using expensive treatments and surveillance tests. They argue that by establishing these guidelines, oncologists would be less likely to continue treatments in situations where the treatments no longer beneficial for the patient.

"It is important that we are compassionate and honest with our patients about when continuing chemotherapy causes more harm than good," says Hillner. "Two simple but critically important points: we should stop routinely giving chemotherapy to patients who are so weakened by the disease that they cannot walk unaided into the clinic. And when the cancer has grown through three successive regimens, it is time to switch teams and use hospice. Research has shown that for patients in these situations it is highly unlikely that continued chemotherapy will prolong life."

The authors suggest the following changes in oncologists' behavior:

• Limit surveillance testing or imaging to situations in which a benefit has been shown.
• Limit second-line and third-line treatment for metastatic cancer to sequential single-agent chemotherapy for most solid tumors.
• Limit chemotherapy to patients with good outcomes, with an exception for highly responsive disease.

• In metastatic solid cancers, replace the routine use of white-cell-stimulating factors with a reduction in the chemotherapy dose.
• For patients who are not responding to three consecutive regimens, limit further chemotherapy to clinical trials.

The authors suggest the following changes in oncologists' attitudes and practice:

• Recognize that the costs of care are driven by what we do and do not do.
• Set more realistic expectations both for doctors and patients.
• Realign compensation to value cognitive services, rather than chemotherapy, more highly.
• Better integrate palliative care into usual oncology care (concurrent care).
• Accept the need for cost-effective analysis and for some limits on care.

"Our recommendations redefine current oncology practices, and we recognize that these raise tough questions," says Hillner. "But now is the time to talk about how we can preserve money to ensure all patients receive the best available care while setting aside funds for new and advanced therapies. We have outlined the starting points for discussion and hope a much-needed national dialogue will follow."

More information: The study is published in The New England Journal of Medicine.

Provided by Virginia Commonwealth University

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