

A point-counterpoint discussion

Prove that community oncologists put patients before profits

By Brian Klepper, PhD

A recent *Health Affairs*¹ article, given play in *The New York Times*,² showed that the prescribing behaviors of oncologists caring for Medicare patients between 1995 and 1998 were influenced by the lucrative economics of their drug retailing arrangements. The study's investigative team was comprised of prominent researchers, including a Dana-Farber oncologist. When interviewed, the investigators were emphatic that the study found strong links between oncologists' financial interests and their clinical decisions.

Few healthcare professionals outside the oncology community were surprised. It is common knowledge that most oncologists integrate drug revenues into their practices to bolster their incomes.

The apparent importance of the findings notwithstanding, the Community Oncology Alliance (COA) flatly rejected the news.³ COA released an e-mail bulletin, "The Remarkable Story of Community Oncology," just after the articles broke. The opening sentence called the study's findings "incredibly outrageous and unsubstantiated" and "an unbelievable rehash." Sentence two referred to "incomprehensible statements by government bureaucrats, so-called oncology advocates, well-paid consultants, non-practicing physicians, payers, and specialty pharmacies." In other words, COA cast aside the study, presumably because critics cannot appreciate oncology's complexities and because they are almost certainly misguided or harbor malevolent intent.

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Not acceptable

There are many reasons why this kind of reaction is unacceptable, but the most obvious is that there appears to be a real problem here. The study's investigators are reputable, the journal is credible, and the findings are damning. True, the data were as much as a decade old and from Medicare patients only, but the practice in question—oncologists' prescribing decisions being altered to optimize drug revenues—is still widespread. There is little reason to believe that another analysis with updated data would obtain a different result.

But COA protested too much. It refused to admit that the practice represents a potential conflict. It claimed that community oncologists provide the "highest quality care" but failed to offer data in support of that statement. Ultimately, it avoided the issue entirely, deflecting attention to other, more praiseworthy aspects of oncology practice. And it ridiculed the credibility of the professionals who broached the issue.

To the non-oncologist, such a dismissive response is viewed as self-serving and protectionist. It demeans oncologists' important work and confirms critics' suspicions that an unsavory but hidden practice is ongoing. But worse, it suggests a higher regard for financially rewarding drug arrangements than for patient quality of care. An appropriate response might have soberly acknowledged the findings. It would have then refuted those findings with other data, or committed to addressing the issue.

Getting serious

These are serious issues that demand serious responses. The American health system is rapidly approaching wholesale collapse due to exploding costs, in large measure because a lack of transparency has created a culture of opportunism and waste exploited by groups throughout the continuum of supply, care, and finance. The *Health Affairs* article suggests that community oncology is squarely part of the problem.

In the interests of transparency and the reputations of its practitioners, community oncologists should immediately develop a response to the concerns raised by the article. You should release data on:

- the prevalence of the practice of oncologists profiting from the drugs they prescribe;
- the markups involved, and how those revenues translate to income;
- oncologists' adherence rates to evidence-based chemotherapy guidelines; and
- differences in the practice patterns of oncologists who do and do not financially benefit from the drugs they prescribe.

You should follow this information with proposed guidelines to resolve potential conflicts between clinical practice and financial incentives.

Providing leadership

More than any group, physicians lay claim to a higher purpose and so must also provide the leadership that can help reestablish trust in our doctors and a more effective healthcare

system. Community oncologists can and should provide that leadership.

You could advocate for and implement pricing transparency in oncology drug treatment. As Jerry Reeves, MD, urged in a recent interview,⁴ the charges to patients and other payers should be transparent and open, not hidden. And conflicts of interest should be avoided.

Of course, oncologists should be paid fairly for the services they provide. Continuing to work with Medicare and private payers, you should aim to transition practices away from indirect drug revenues and replace those with higher direct fees for professional services.

As Dawn Holcomb⁵ and Linda Bosserman⁶ argued last year in this journal, you could lead an effort to develop data on clinical outcomes and cost that can drive future practice and policy change. You could accelerate positive change within your profession by encouraging incentives for patients to choose doctors who have demonstrated care that is safer, more effective, and more efficient.

Anything less will be merely protecting the interests of oncologists over the interests of patients.

References

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