PRESIDENT'S MESSAGE

Quality Cancer Care and Malpractice: The Elephant in the Room

BY GEORGE KOVACH, MD

One major concern regarding the Affordable Care Act was its failure to address malpractice reform as a means to control healthcare costs. Under the umbrella of malpractice costs lurks the slippery issue of defensive medicine (i.e., a medical practice designed to avert possible future malpractice suits).

Mello and colleagues writing on "National Costs of the Medical Liability System" in *Health Affairs* [2010;29(9)], state: "Although most scholars of malpractice agree that defensive medicine is highly prevalent, reliable estimates of its cost are notoriously difficult to obtain....." With that caveat, the authors did arrive at an estimated overall cost of defensive spending for both physicians and hospitals in 2008 of $45.6 billion.

Although a fraction of overall healthcare expenditures, defensive medicine is a pivotal reflection of a broken healthcare system. And if malpractice reform is not adequately addressed, continued liability fears will likely inhibit physicians moving toward cost-effective care delivery.

On the one hand, we have recent examples of potential cost-effective changes in care delivery, such as the recommendations by the American Board of Internal Medicine Foundation, in conjunction with nine specialty boards, toward reducing 45 tests or procedures that have limited medical value. ASCO provided five cost-effective changes (*http://choosingwisely.org*) addressing treatment of advanced refractory solid tumors, staging of prostate and breast cancers, surveillance of post-adjuvant breast cancer patients, and the use of cytokines. Recently, the United States Preventive Services Task Force (USPSTF) made its controversial recommendations regarding PSA screening. As a practicing oncologist for 35 years, I find the ASCO recommendations very appropriate. The USPSTF recommendations, I view with skepticism, an indication of the reality that these approaches will require time for universal acceptance. NCCN has provided excellent treatment guidelines as a proof of concept and such similar guidelines should be encouraged.

On the other hand, in Oct. 2011, the Washington State Supreme Court recognized "loss of chance" as a new cause of action. Just what do those words mean? The "loss of chance" doctrine was affirmed by the Ninth Circuit Court in 1972, involving "what might have been" if medical treatment occurred earlier in the diagnosis of a disease, limiting damages if there was less than a 50 percent chance of survival or improvement. More recently, however, less than 50 percent has been accepted. Liability for future potential medical problems is also gaining popularity. Therefore, failure to monitor is becoming an acceptable tort, with precedent set in Massachusetts in 2009, and now accepted in Ohio and West Virginia. How will this factor affect the new ASCO and PSA guidelines? I would expect cautious and slow acceptance of the guidelines in order to avoid liability, impeding attempts to lessen defensive medicine practices.

What's the solution? Any solution must involve discussion of tort reform along with the medical community doing a better job of defining best practices and guidelines for clinicians and educating the public on the best treatment options and outcomes. Collaboration within the oncology community can lead to rapid determination and development of evidence-based diagnostic, treatment, and survivorship guidelines. We need to address the "elephant in the room" before others do it for us. OI

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