# WILL GOOD FAITH WORK?*

In the last edition of *Oncology Issues* (Summer 1989, "The Cancer Care Reimbursement Crisis: Rallying Public Support") I described the recently passed legislation in Michigan as being a major problem; a disaster that reflected the need for coordination among pharmaceutical companies, national cancer organizations, and local/state cancer organizations. The bottom line was a series of clauses that could compromise the quality of cancer patient care; drive oncologists crazy as they attempted to defend current, standard therapies for off-label indications to an unsympathetic Blue Cross/Blue Shield organization; and potentially jeopardize hospital payments by requiring the physician to obtain an informed consent every time a drug was prescribed for an off-label indication. I suggested that the presence of an informed consent in virtually every hospital record might allow the Blues to systematically deny every patient hospital admission, in addition to creating a bureaucratic nightmare of informed consents for the 50 percent of chemotherapy that is currently prescribed for off-label indications. In my judgment, it was a typical "Chinese fire drill."

In response to that article, John Burrows, M.D., President of the Michigan Society of Hematology and Oncology, suggested that I had my facts wrong and concluded that state oncology organizations should be wary about accepting, without question, the advice of "outsiders" on these types of issues. "The Michigan Society is proud of the state legislation that was passed and that none of the awful predictions that were made are happening," Burrows says. "New indications are being paid for, there has been no 'rollback' to FDA-labeled indications, only informal comments about consent are being entered in hospital charts, and the Society is developing a good working relationship with the Blues," he says.

Obviously, Burrows and I have been doing some thinking and communicating about our mutual feelings. This is indeed the same elephant and we both have our facts right. I still believe in the potential negative impact of the final language of the bill, if it is strictly interpreted and enforced. If the same bill was enacted in another state and enforced in a hard-line fashion, there would be trouble.

Burrows points out that there is "better rapport with the Blues; oncologists appear to be getting a good deal of attention and support from the Blues. In fact," he adds, "the Blues are going out of their way to work with the Society. For instance, senior staff for the Blues are rapidly processing bills for recently-approved indications. They are also working with the Society to ensure that its recommendations are conveyed to self-insured companies in the state, for whom the Blues serve as the third-party administrator (60 percent of the Blues' business), and which need not follow state mandates or directives."

As we have reviewed the situation, there are several issues that have become clear to us.

First, what you see is not necessarily what you get. If the Michigan legislation is strictly interpreted, it could be a terrible bill. But the Blues are being supportive of the Society and loose in their interpretation of the legislation. There is no question on coverage of standard chemotherapies.

Second, good faith is part of the formula. In Michigan, it all boils down to the interpersonal relationships and bonds that have developed informally during the multiple compromises that were worked out during committee meetings and with House and Senate sponsors. In other words, a great deal of the immediate, positive result is based upon the good faith of the involved parties.

Third, things change. "The society," Burrows points out, "has solidifed its position by working with the Insurance Bureau, which regulates the Blues." Yet there is no guarantee that the next generation of Blues administrators will keep the informal promises of this generation. We will have to wait and see if the relationships that are currently forming between the Michigan Society and the Blues hold together or come unglued.

*(Continued on page 16)*

patients and visitors found smoking on M.D. Anderson property. Prior to implementation of the policy, brief one-page fliers were prepared for the police officers to give to anyone seen smoking on the grounds of the institution, which informed them of where they could smoke and about the impending smoke-free policy.

Since the enactment of the policy, police officers politely ask anyone who is seen violating the policy to extinguish their cigarette in accordance with institutional policy. To date, this strategy has been successful and there have been no incidents where any additional action has been required.

Overall, compliance with the institutional smoke-free policy has been outstanding, although not perfect. There are still occasional reports of smoking in stairwells or in bathrooms. However, the overall objectives of the smoke-free policy have been achieved.

## Smoking Cessation Programs

To increase the acceptance of a smoke-free policy, it is important to offer smoking cessation options, particularly for employees, and, ideally, to all who are affected by the policy. The availability of smoking cessation opportunities, particularly if they are subsidized and offered, at least partially, during work hours, sends a strong message to employees that while the institution is restricting where smoking can occur, it is also making a financial commitment to help employees who would like to quit.

While the availability of smoking cessation programs will aid in the acceptance of the smoke-free policy, actual participation may be disappointing. Although according to national surveys, most smokers would like to quit smoking if there were an easy way, most do so on their own and few tend to enroll in organized programs. At M.D. Anderson, programs were financially subsidized, offered during work time, and extensively promoted to employees. Even with this level of effort, only 24 out of an estimated 750 smoking employees participated in organized smoking cessation groups. Another 118 sets of self-help materials were requested.

## Summary

***Overall, compliance with the institutional smoke-free policy has been outstanding, although not perfect***

Overall, the smoke-free policy at M.D. Anderson can be considered a resounding success. While compliance may not be 100 percent, our two specific objectives have been met: the air quality is noticeably improved; and there have been no dismissals, resignations, or legal actions, attributable to the policy. We estimate that, excluding staff time, it cost approximately $13,000 to prepare the communications materials, purchase the smoking cessation materials, and develop the smoke-free signage. We consider this modest expenditure to be a wise investment and would encourage all hospitals to consider becoming smoke-free. ■

*Michael P. Eriksen, Sc.D., is Assistant Professor of Medicine, and Director, Behavioral Research Program, Department of Cancer Prevention, The University of Texas M.D. Anderson Cancer Center, Houston, TX.*

*Michael P. Eriksen, Sc.D.*

## FROM THE EDITOR

*(Continued from page 3)*

Fourth, there is no question that ACCC and state organizations need to work together. In Michigan, oncologists were initially caught off guard and had to organize as they went along. There were no precedents and there were many interested parties, all of whom were attempting to ensure that their individual perspectives were reflected in the legislation. An important function of ACCC is to facilitate the exchange of experiences among state organizers. Michigan could have used some of the support that ACCC intends to provide to state organizations, including coordination with national organizations, suggested legislative language, grants to help underwrite educational efforts, and so forth. Certainly, ACCC needs state-level, front-line involvement to know whether proposed compromises will work; whether or not various players are trustworthy; and to build local support among legislators, agency officials, and the press.

We need to build a national organization that has strong, state-level components to resolve problems. Without our mutual efforts, we will suffer a loss of experience and insight, we will not have the best resources, and we will not make the best use of the resources we have. There are too few of us, with far too limited resources, to end up squabbling amongst ourselves. We need to build strong bonds at the community oncology level, and we need to balance good faith with specific legislative language.

We will continue to monitor the situation in Michigan with the recognition that a change of heart by the Blues could destroy the fragile faith that is being built. Our presumption, for now, is that good faith will work in Michigan. However, just because you are paranoid doesn't mean that you are not being followed around. In other words, some paranoia is healthy in these times of rapid change.

*(Prepared in collaboration with John Burrows, M.D., President, Michigan Society of Hematology and Oncology.)*

**Lee E. Mortenson, M.S., M.P.A.**
**Senior Editor,**
**ACCC Executive Director**