



Letters to the Editor

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Patients 'CAN ACT'

I am responding to Lee Mortenson's interesting editorial, "Tying Patients to the Battlements," (Fall 1990 edition of *Oncology Issues*), as both a cancer patient advocate and a former cancer patient.

I happily endorse his thesis that cancer patient activism is needed, and I want to assure him that it is here. But his underlying assumption is something with which I take issue, and I hope he will consider this letter as part of a dialogue between allies.

Basically, he is questioning the ethical position of health care professionals using patients to lobby for changes that benefit both groups. That is very different from cancer patients choosing on their own to do that.

The AIDS lobby was not effective because "they" mobilized patients, but because they are patients. Cancer patients understood that implicitly, and recognized that we must learn from the AIDS experience, not from the cancer establishment.

Mr. Mortenson suggests that the goals of pharmaceutical companies and others who profit from our needs are the same as ours. That is not always true; in fact, there are many areas of conflict. We are going to have to be very single-minded about our issues, and do what is right for patients. The fact is that the efforts of cancer professionals to improve the drug release and reimbursement situations for patients have not been very successful, possibly because too many special interests are involved. I acknowledge that its not been for want of trying. If mobilized patients cannot do better than what has already been done, we're in big trouble. The stunning successes of the AIDS groups have made that clear.

AIDS activists fear that AIDS will become, in fact, just like cancer—that is "normalized"—and lose its urgency. Ironically, we fear the opposite: that we will be shut out of the FDA's new, flexible procedures because AIDS is the favored disease.

I wonder how twinkly and optimistic Jay Freireich would have been, several years later, if he had heard Dr. James Allen, Assistant Surgeon General and Director of the National AIDS Program Office at the meetings of the American Society of Law and Medicine last November. When asked

why cancer patients were excluded from the proposed parallel track system of clinical trials, he responded that they weren't excluded, they were simply not included! He went on to say that cancer patients had Group C designations to accomplish the same thing. I am sure you know a lot more than I do about Group C, but we both know that it wasn't designed to expedite access of drugs to people who need them.

Cancer is being systematically excluded from discussions about implementation of the Lasagna report, true, but mostly because the discussions are taking place under the aegis of AIDS groups. Cancer patient groups recognize now that inclusion is up to us, and we are doing something about it. The founding of the Cancer Patients Action Alliance (CAN ACT) has met a widely perceived need: the empowerment of the cancer patient.

I would like to propose that Mortenson and his colleagues jump off the ramparts and onto the bandwagon. We need your help and your involvement. This is our fight, and cancer patients are going to be the generals as well as the foot soldiers.—*Beverly Zakarian, President, CAN ACT, Brooklyn, NY.*

Breast Cancer Controversies in the 1990s

A one-day symposium for physicians and other health professionals will provide an overview of some of the most current and controversial issues in the diagnosis and treatment of women with breast cancer. Sessions will address controversies in primary therapy, early breast cancer, breast reconstruction, and medical-legal issues.

The symposium, sponsored by the Cancer Institute, Good Samaritan Hospital, and the Cancer Care Institute of San Jose Medical Center will be held on Saturday, March 9, at Good Samaritan Hospital, San Jose, CA.

For registration information, contact Cindy Taormino, Good Samaritan Hospital, Cancer Institute, at 408/559-2458. Six Category I, CME credits/Continuing Education Units are available.

Yet Another View of Coding

I read with great dismay Dr. Ross L. Egger's letter in the Fall 1990 issue of *Oncology Issues*. I would like to take strong issue with Dr. Egger's phrase, "It is dishonest to bill for supervising an IV while making rounds on other patients, when what was provided was subsequent hospital care." Dr. Egger must be aware that, for years, Medicare and Medicaid, the Blues, and other private insurers have recognized supervision and "interpretation" charges separate from normal or usual hospital or office visits. Medical oncologists, as well as these underwriters, have long recognized that there are two components of a medical oncologist's bill. First, the patient visit fee, which encompasses the charge for professional services regardless of location. Second, the antineoplastic charge, which varies according to the site of the patient visit (i.e., office versus hospital).

For Dr. Egger to say, "It is dishonest to bill. . ." is at gross variance with the facts. Only in 1990, in the CPT 4 coding, was this issue used as a divisive method to either establish global charging and/or eliminate the antineoplastic charge for patients visited in the hospital. Dr. Egger owes us a written apology for his overzealous accusation.

Moreover, his comments on "unbundling" do not accurately reflect the correct coding of chemotherapy administration charges in all instances. To correctly code, and thereby achieve higher reimbursement, is not intrinsically wrong. On the other hand, inappropriate unbundling or improper coding to produce greater reimbursement for the same services could be ethically questionable. The real issue is whether cognitive services (administration, supervision, interpretation, etc.) should be coded separately and in what manner those services should be reimbursed.

Several solutions have been offered including, beginning in 1992, a charge system based on the time spent with the patient. Other solutions will undoubtedly be forthcoming. However, in my opinion, the real issue is that of reimbursement for cognitive services separate from the routine office or hospital visit. I believe this issue should be included in any poll attempting to determine national opinion on these issues—*Douglas Westhoff, M.D., Medical Director, Memorial Community Hospital Cancer Center, Jefferson City, MO.* ■