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FROM THE EDITOR

One Man's Ceiling Is Another Man's Floor

by Lee. E. Mortenson, D.P.A.

Guidelines.

The word spreads terror in the hearts of oncologists. Although the word "protocols" has varied connotations, it is so different...and far less threatening. Guidelines sound like cookbook medicine, as if somebody is trying to tell you what to do.

I've said all this myself, although I was principal investigator on an evaluation of the NCI-funded Community Hospital Oncology Programs (CHOP), which formulated patient management guidelines during the 1970s. The CHOP program was intended to use guidelines to measure whether community hospitals could deliver high-quality cancer care. The guidelines were developed by community physicians on one level, and then a national set was developed by the principal investigators of a large number of the programs. Although these guidelines included pretreatment evaluation and suggested diagnostic tests and treatment paths, they lacked specific recommendations on therapy.

So, why talk about guidelines now? For two reasons. First, insurance companies are now promulgating guidelines on their own. Second, guidelines are likely to play a key role under health care reform.

At ACCC's recent meeting, one Blue's Vice President presented his initial ideas for guidelines for payment of patient follow-up visits and tests and his preliminary analyses of physician profiles by cancer site. The suggestion was that oncologists who regularly cost more in their management of, for example, breast cancer cases were likely to be cut out of his plan's oncology PPO or that those tests and visits beyond his guidelines will simply not be reimbursed. So, Blues may be formulating their own guidelines on various aspects of cancer care without our input.

Of course, there are a million good objections to doing guidelines, but let's talk about the really tough ones.

First, are they really going to limit what you can do? Sure. Insurance companies, however, already limit what you can do. The real question is whether one can develop a mechanism for establishing and updating guidelines that reflects the variation in the state of the art, i.e., allows CMF, CAF, and/or CMF-VP. If a guideline were to suggest that any one of these three can be considered standard therapy, many of our objections would disappear.

Then there's the big question: Who will develop and update the guidelines?

Most academics will be slow to agree to develop guidelines, although they will be quick to say they are the only ones who should. Community oncologists are likely to be more willing, since they see the frontline reimbursement problems...but they will have less time. If ASCO does them, what about ASH? If these two get together, what about ACR, ASTRO, and the College of Surgeons? And how are we going to handle the questions from pediatrics, gynecology, urology, and dermatology?

What are the chances that these behemoths will actually produce something quickly? Not very good, I'd guess. Which is why I think that we should begin now. Assuming that we start to put together the infrastructure and mechanisms, say, next Wednesday at noon, we should be ready by 1997 or 1998...just in time.

Composer and singer Paul Simon said, "One man's ceiling is another man's floor." Guidelines may have gone one step further. They may have moved from oncology's ceiling to a needed floor that protects patient care.