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FROM THE EDITOR

# The Three Rules

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

How do you save money in the new world of Medicare HMO risk contracts? The medical director of Pacific Care offered one set of solutions to Washington State oncologists at a recent ACCC regional meeting. He used overheads, so we wouldn't be confused. No problem. Everybody got the message.

Rule number one for primary care physicians was: "Never abdicate control of the patient to the oncologist." As soon as the chemotherapy is over, he wants patient control returned to the primary care physician. In fact, he wants the primary care physician to continue to monitor the patient when receiving chemotherapy and take care of every other little complication. So, if you believe that an oncologist should follow a patient, should be the one who checks for progression and complications of therapy, forget it. That's the primary care physician's territory.

Rule number two was interesting: "Question all second-line therapy." Often second-line doesn't work, so the rationale goes. Cancer patients should not be left in the hands of medical oncologists, mercenaries who might all too frequently prescribe inappropriate second-line therapies. The primary care physician's job is to put on the breaks.

Rule number three was even more interesting: "NEVER third-line." If two courses of chemotherapy don't work, a third one never will. "Never" is a dangerous word. Dave King, M.D., chair of ACCC's Ad Hoc Committee on Reimbursement, was standing in the hallway with several members of the Washington State leadership discussing one patient of his who was responding to fourth line. Dave, well known for his conservative management, was flabbergasted.

What can we do about these draconian measures? My guess is that it will take a combination of hard data, lawsuits, and education. The days when a management philosophy can be politely discussed have long passed. Hard data will be vital. The oncology community will need to demonstrate the relative effectiveness of second-line and third-line therapies. We will need to codify these findings in guidelines, along with access to cancer specialists for appropriate follow-up. We will need the support of local oncologists to assure that guidelines will hold up as the local patterns of care in court proceedings. What about survival data? Can we demonstrate that these draconian measures are measurably impacting those patients under the management of these types of plans? Yes, we probably could, except: 1) we would have to wait five or more years for the findings and 2) all the patients under treatment would have to stick with that plan. The reality is that the oft-cited ability to credential insurers on the basis of their survivals is simply not going to happen. People change insurers. Businesses switch plans. And five years is far too long to wait to indicate that a particular year's worth of this management style was prematurely fatal for a cohort of patients.

I doubt that Pacific Care intends to kill patients for profit. This is just the first of a number of proposals limiting access to care. In some cases, it may have that effect. In other cases, it may reduce the quality of life. As a group of individuals dedicated to assuring quality cancer care, we need to be prepared to respond—not so much with hard data about survivals but with cost-efficient management of cancer patients.