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In the Literature

LOST OPPORTUNITIES: PHYSICIANS' REASONS AND DISPARITIES IN BREAST CANCER TREATMENT

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Despite the fact that adjuvant therapies for breast cancer—supplementary treatments like radiotherapy, chemotherapy, or hormonal therapy—can increase the chances of survival, many women do not receive them.

In some cases, patients may decline treatment, or physicians may not recommend it, but many other women simply slip through the cracks of the health care system. In the Commonwealth Fund-supported study, "Lost Opportunities: Physicians' Reasons and Disparities in Breast Cancer Treatment," (*Journal of Clinical Oncology*, June 20, 2007), researchers found that one-third of women did not receive adjuvant therapies for breast cancer because of "system failures"—a breakdown that occurs despite the surgeon's recommendation for treatment and the patient's willingness to receive it.

System failures are even more common among vulnerable women: minority women and women receiving Medicaid were more likely to suffer from system failures than were white women or those with Medicare or commercial insurance, the study finds.

The research team, which was led by Nina A. Bickell, M.D., M.P.H., of the Mount Sinai School of Medicine, explored the reasons why guideline-recommended adjuvant therapy after surgery for breast cancer—the second most common cause of cancer deaths among women—is often not administered.

In an earlier study phase, the researchers identified 677 women who had early-stage breast cancer surgery in 1999–2000 at one of six New York teaching hospitals. Of these women, 151 (22%) did not receive treatment that was consistent with national cancer guidelines. For the current study, the researchers interviewed 35 surgeons between 2003 and 2004 about the reasons 119 of these patients did not receive adjuvant therapy.

Why Do Women Fail to Get Treatment?

The responses fell into two main groups: 1) surgeons recommended therapy and thought it should have been administered (65%), and 2) surgeons did not recommend therapy (35%). The reasons given for not advocating treatment included: the patient was considered too old, frail, or sick to tolerate or benefit from it; the patient's prognosis was good and therefore additional treatment was unnecessary; there were contraindications to adjuvant therapy; and patients wished to maintain their fertility.

In cases where the surgeon recommended treatment, 37 women declined therapy. For the other 41 women (34%) who were advised to undergo treatment, the surgeons could not identify a reason for underuse. "We classified this group as system failures," write the authors, "because they indicate that despite the surgeon's recommendation for treatment and the patient's willingness to receive it, a breakdown occurred in the delivery of care; the loop from recommendation to treatment was not closed."

Vulnerable Women at Higher Risk

System failures were more common among minority women than white women (73%

vs. 54%), and also more common among uninsured women or those receiving Medicaid compared with those with Medicare or commercial insurance (54% vs. 19%). System failures were also more common among women seen at municipal hospitals compared with nonmunicipal hospitals (82% vs. 36%). The referral practices at municipal hospitals point to breakdowns in communication and coordination and may aid in explaining the system failures. At those hospitals, women were more likely to be scheduled to visit a clinic than a specific person and were less likely to be given the name of an oncologist. Their surgeons were significantly less likely to talk with their oncologist about their status and less likely to report working very closely with oncologists.

Conclusions and Policy Implications

The authors find the large proportion of system failures in this study "particularly troubling." They attribute these breakdowns to poor interactions between surgeons and medical oncologists, and between physicians and patients. "Notably, few of the surgeons surveyed had established mechanisms to ensure that patients attended recommended referrals or followed through with recommended treatments," they write.

In settings without close interactions between oncologists and surgeons, a system that feeds referral results back to surgeons may aid in coordination and overcome the lack of close working relationships. In addition, to help patients who are wary of speaking with doctors, patient assistant providers can help facilitate conversations and coach patients in asking key questions about their treatment options. These navigators can also remind patients about upcoming visits, help connect them with oncologists, and assist in addressing issues like lack of insurance or transportation.

The researchers point out that one municipal hospital differed from the others. At this site, treatment rates were very high, with no instances of underuse because of system failures. The hospital had a single breast cancer clinic where both surgeons and oncologists could see patients in the same visit. It also offered accessible psychosocial support and information from community volunteers about breast cancer and its treatments. "These features address issues reported more commonly among minority patients with cancer: namely, poorly coordinated care, poor communication about health and treatment information, and poor psychosocial care," write the authors. Unfortunately, this hospital is challenged by Medicaid policies, under which only a single physician office visit per day may be reimbursed.

"Policymakers should reconsider reimbursement strategies that inhibit coordinated cancer care," the authors conclude.

Race and Primary Reasons for Underuse of Breast Cancer Treatment

Reason	Total (N=119)	White (N=53)	Black (N=41)	Hispanic (N=21)	Asian and other (N=4)
Surgeon recommended therapy					
Patient declined	31%	32%	32%	24%	75%
System failure	34	21	44	52	25
Surgeon did not recommend therapy	34	47	27	25	0

Notes: Percentages may not sum to 100 percent because of rounding.

Source: Adapted from N. A. Bickell, F. LePar, J. J. Wang et al., "Lost Opportunities: Physicians' Reasons and Disparities in Breast Cancer Treatment," *Journal of Clinical Oncology,* June 20, 2007 25(18):2516–21.