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Editorial

Should the prescription of oral anticancer drugs be restricted?

1. Introduction

In the year 2010, the Spanish Society of Medical Oncology (SEOM) published an editorial[1] in the *Annals of Oncology* entitled "Treatment of cancer with oral drugs: a position statement by the Spanish Society of Medical Oncology". The main premise of the editorial was a call to grant medical oncologists the exclusive right to prescribe all anticancer drugs, whether administration is intravenous or oral. As might be expected, that editorial has ignited a fierce and ongoing debate in Spain.

The first medical society to respond was the Spanish Society of Radiation Oncologists (SEOR) via a letter to the editor[2] to rebut the radical stance taken by the SEOM. The SEOR also followed up that letter with an editorial in the Spanish journal *Clinical and Translational Oncology* (CTO).[3] Several months later, endocrinologists representing the Spanish Society of Endocrinology and Nutrition (SEEN) also responded to the original SEOM editorial with a letter to the editor of Annals of Oncology.[4]

We believe that the outcome of this intense debate, which is taking place in a well-known international journal, has implications for all specialists who currently prescribe oral anticancer medications.

2. Interdisciplinary approach

Cancer is a complex disease requiring the intervention of specialists from many different fields. Awareness of the need for a collaborative approach to cancer care has increased dramatically in recent decades.[5–7] All of the Spanish medical societies involved in cancer care (including the SEOR and SEOM) made an explicit commitment to this approach at a conference organized by the Spanish Ministry of Health. The conclusion of that meeting was the approval (and subsequent publication) of a position statement titled "Institutional declaration in favour of the development of interdisciplinary cancer care in Spain".[8]

This declaration makes it clear that the treatment and care of patients with cancer requires an interdisciplinary approach involving a wide range of specialists: haematologists, radiation oncologists, endocrinologists, pulmonologists, neurologists, gynaecologists, rheumatologists, dermatologists, gastroenterologists, and others. Each specialty has unique knowledge and skills and all have important contributions to make. Most specialists are well-acquainted with this interdisciplinary model because they participate in it on a daily basis through multidisciplinary tumour boards and clinical treatment units.[9,10]

Despite the growing appreciation and support for the interdisciplinary approach, the SEOM editorial appears to propose an outdated model in which care would be centred around a single specialist, the medical oncologist. As radiation oncologists, we know that cancer treatment must be interdisciplinary, and we certainly see little value in narrowly restricting the prescription of oral drugs to a small minority of physicians.[11] Indeed, if such restrictions were to be imposed, the result would surely be counterproductive, as specialists would be forced to refer any patient needing medical treatment to a medical oncologist, thus leading to an increase the number of patient consultations, costs, and waiting times. All of this would delay treatment and, in all likelihood, worsen outcomes.

3. Are patients really at risk?

The main argument given to support imposing restrictions on the right to prescribe anticancer drugs is patient safety. However, radiation oncologists (and other specialists) have been routinely prescribing anticancer drugs for decades now, without any harm to patients. Unsubstantiated claims of "patient risk" are poor arguments; moreover, as highly trained specialists, we find these claims to be disrespectful. Radiation oncologists receive extensive training in oncology (and in internal medicine) and radiotherapy, and we are eminently prepared to prescribe and monitor the use of anticancer medications.

4. Why now?

It seems reasonable to ask why medical oncologists suddenly seem so concerned with restricting the right to prescribe oral drugs. Patient safety cannot be the real issue, as we explained in the preceding paragraph. Could the real issue be that medical oncologists perceive that oral drugs and targeted therapies present a threat to their specialty? Intravenous administration of drugs is a technique that requires specialized skills and knowledge. However, times have changed and improvements in the bioavailability of new drugs make it possible to deliver most chemotherapy agents orally. Moreover, the increasing use of targeted molecular agents (delivered orally) reduces the need for intravenous delivery. It would appear then that the fiercely protective and restrictive stance of medical oncologists is a misguided form of self-protection.

5. Other arguments

One proposal put forth in the SEOM editorial is that medical oncologists should have a role that is analogous to that of a family doctor, with the overall treatment of cancer coordinated by the medical oncologist. Although this idea has some merit, we believe that it would lead, inevitably, to redundancy; patients would be shuttled back and forth between the "cancer doctor" and the various specialists. In our opinion, it would make more sense to assign a primary physician based on the main treatment modality (surgical, medical, or radiotherapeutic). The primary physician could thus be a surgeon, a radiation oncologist, a haematologist or other specialist depending on the illness and likely treatment. In any case, since 60% of all cancers are also treated by radiotherapy,[3] it would make more sense to assign the radiation oncologist as the primary physician in most cases, particularly because radiation oncologists are, as the name implies, also oncologists.

A final "argument" made in the SEOM editorial is that research and clinical care must be linked. In this vision of care, medical oncologists would be optimally positioned to evaluate clinical response, protocol adherence, and the inclusion of patients in clinical trials. However, as the authors must surely be aware, clinical trials are necessarily interdisciplinary events, and treating cancer patients requires an interdisciplinary approach. No single specialist can or should control the treatment.

6. Conclusion

It is important to point out that limiting prescription rights to medical oncologists would contradict the Core Curriculum of European Radiation Oncologists, which was recently revised and approved by most European countries.[12] This curriculum clearly states that the radiation oncologist is responsible for the delivery of drugs when combined with radiotherapy, in collaboration with other specialists, if appropriate. Current clinical practice in radiotherapy requires the prescription of oral medications, and restrictions would severely hamper our ability to effectively treat patients. Moreover, the specialty of Radiation Oncology in Spain and in the European Union includes training in chemotherapy, new biological drugs, and, especially, in combined radio-chemotherapy treatments.[13] The proposed restrictions directly challenge Article 23 of the Spanish Code of Medical Deontology[14] (July 2011), which specifically and unequivocally states that "the physician must have the right to prescribe medications, respecting the scientific evidence and authorized indications, that allows him/her to act independently and to guarantee quality".

To conclude, we do not expect these misguided efforts to restrict our ability to prescribe oral drugs to succeed. Yet we believe that vigilance is necessary. What is happening in Spain is, at the moment, only a local problem. However, unless we take a stand now, this campaign to restrict our rights could gain momentum and eventually become an important problem in other European countries.

We realize that the views expressed in this editorial may not be shared by all. Healthy debate is important to scientific progress, and we encourage readers who wish to voice their opinions to submit a letter to the Editor.

Conflict of interest

None declared.

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