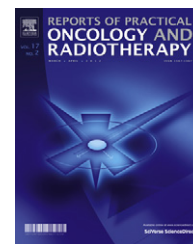


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## Editorial

# The prescription of oral anticancer drugs: Another perspective

A recent editorial in this journal argued against restricting the right of non-medical oncologists to prescribe oral anticancer drugs.<sup>1</sup> As representatives of the Latin American Association of Radiation Oncology (ALATRO), we fully support the position expressed by the Spanish Society of Radiation Oncologists (SEOR) in that editorial. We believe the outcome of this ongoing debate in Europe<sup>2,3</sup> has the potential to shape the future of cancer care around the world. For these reasons, we feel compelled to make our own views of this issue known.

Some—though we presume not all—medical oncologists believe that only they should control the prescription of oral cancer medications. However, most other cancer care specialists strongly disagree.<sup>4,5</sup> The authors of the aforementioned editorial argue that the campaign being carried out by medical oncologists is largely a defensive manoeuvre. The diminishing use of intravenously delivered anti-cancer drugs—long the domain of medical oncology—coupled with the rise of newer, orally administered drugs and targeted molecular agents, could pose a threat to the very existence of the speciality of medical oncology. This threat may be real, but we believe that such an aggressive response to this perceived danger is misguided. The field of oncology needs greater collaboration, not less.

Radiotherapy is increasingly used in combination—either adjuvantly or concurrently—with chemotherapy and it is not possible to separate the two. What would happen to our speciality if we were no longer able to prescribe the radiosensitizing and radio-potentiating oral drugs used in most current radiochemotherapy regimens?<sup>6–8</sup> The clear message we wish to send to our colleagues in medical oncology is that aggressive tactics to preserve their speciality are neither constructive nor necessary. In our opinion, the world will not end if several different, but related, specialities continue to maintain their long-established practice of prescribing oral cancer drugs.

The complex nature of cancer care requires the intervention of numerous specialists. While great strides have been made in recent years towards greater collaboration, some resistance to the multidisciplinary approach to cancer care still remains. This less-than-complete willingness to join in a fully collaborative approach to care is problematic.

However, this is not the only impediment to developing a stronger multidisciplinary model: another obstacle is the lack of clearly defined roles. Many of the functions of cancer care specialists can—and do—overlap, and while this is not a major problem, it can sometimes cause confusion with regards to the responsibilities of each specialist.

In this editorial, we wish to make two important points. First of all, a greater effort needs to be made to promote an *authentic* multidisciplinary approach to cancer care, in which specialists fully embrace the spirit of positive collaboration and teamwork. We believe that we should view each other as colleagues, not competitors. Secondly—and this point is closely related to the first—we believe that the roles of the various cancer care specialists need to be more precisely defined, so that our individual responsibilities are clear.

## 1. The need to strengthen the multidisciplinary approach

Medical care has become increasingly specialised in recent years, and oncology is no exception. Cancer is a complex, multifactorial disease with diverse treatment options and advances in our understanding of this disease and in new treatments (e.g., robotic surgery, radiosurgery, drugs, genetics, and advanced radiotherapy techniques) mean that input from diverse specialists with unique knowledge is increasingly necessary. The response to this increasing complexity has been the widespread adoption of the multidisciplinary approach.<sup>9,10</sup>

From the perspective of the radiation oncologist, the need for a multidisciplinary approach to cancer is obvious.<sup>11,12</sup> In many countries our speciality relies almost entirely on referrals from other professionals, and for this reason radiation oncology has a long tradition of good communication with other physicians. Moreover, because radiotherapy can be either a primary or adjuvant treatment, specialists in this field are accustomed to collaborating closely with other specialists.

Several approaches could be taken to increase collaboration. For example, the multidisciplinary approach to cancer

should be the standard model of care taught to medical students and residents. In addition, countries that have yet to adopt this model, which includes interdisciplinary tumour boards and treatment units, should be encouraged to do so. Much of these efforts need to come from the top through closer collaboration among the relevant medical societies who must work together to improve the model and to resolve any conflicts.

## 2. The need to better define the role of cancer care specialists: the case of Radiation Oncology

Some of the controversy surrounding proposals to limit the right to prescribe oral drugs arise from confusion about the role of the various specialities in a comprehensive cancer care model. It sometimes seems that the role of the radiation oncologist is misunderstood, even within the field of oncology. We are not simply technicians skilled at delivering radiation to the tumour site; rather we are clinical oncologists with a strong background in medicine that includes training in internal medicine. We are not **RADIATION** oncologists, but rather radiation **ONCOLOGISTS**, as Zietman so astutely observed.<sup>13</sup>

Let us consider the historical perspective. Radiation itself has been used as a cancer treatment practically from its discovery at the end of the 19th century.<sup>14</sup> In addition, Radiotherapy was the first oncological specialty to be recognized (in 1922, at the Congress of Oncology in Paris).<sup>15</sup> The academic field of radiation oncology grew out of radiology, as a distinction was made between radiation for imaging and therapeutic radiation. This separation from radiology occurred only 30–40 years ago, and radiation oncology as a medical specialty is still a relatively young field. In fact, for decades the only truly effective cancer treatments available were surgery and radiotherapy. As a result, from its very beginning, the practice of radiation oncology was eminently clinical and the role of the radiation oncologist extended from the moment of diagnosis through terminal care. When it was discovered that certain chemotherapeutic agents potentiate the effects of radiotherapy, these new agents were administered in combination with radiotherapy. Logically, it was the radiation oncologist who was responsible for managing the administration of these agents. Indeed, in many parts of the world (e.g., the United Kingdom) the same physician, called a “clinical oncologist”, is still responsible for the non-surgical treatment of cancer, and prescribes chemotherapy as well as radiotherapy. This is important since having only one specialist in charge of treatment reduces costs and, most importantly, saves time between diagnosis and initiation of treatment.

Regardless of whether we are known as clinical or radiation oncologists, our main function continues to be clinical. As clinicians, we require a strong foundation in general medicine, including a solid understanding of the histology and pathology of cancer. Not only must the radiation oncologist be skilled at performing physical examinations and in interpreting diagnostic and planning images, but he/she must know how to combine all of this information into planning the appropriate treatment. Fortunately, we are well-prepared for clinical work by our medical education and rotations

in relevant specialities—including internal medicine—during residency. A large part of our speciality involves the study and understanding of radiobiology because it is essential that we understand the impact of both older drugs and more modern targeted therapies on tissues, particularly in conjunction with radiotherapy.

Our speciality has, without a doubt, a large technical component. Perhaps for this reason, non-oncologists sometimes associate us with the high-tech tools of our trade: linear accelerators and other advanced machines. However, what they fail to see is the large clinical component of our work involving patient care from diagnosis to long-term follow-up. Clearly, we have an obligation not only to keep abreast of the latest technologies, but also the latest advances in molecular and systemic therapies. This all requires constant effort on our part, and for this reason we have learned to delegate to other professionals (medical physicists, and radiation oncology nurses and technologists). Our focus is and will continue to be on the clinical aspects of our specialty. In this sense, we believe that there are some parallels with surgical oncology: the practice of surgery is not mutually exclusive with the practice of medicine, and the same is true for radiotherapy.

## 3. Conclusion

As we have argued in this editorial, attempts to restrict the prescription of oral drugs to medical oncologists are simply ill-advised. Medical and radiotherapeutic treatment of cancer are virtually inseparable these days, and in most cases, clinical guidelines indicate concomitant radiochemotherapy.

Let us be clear. In this complex field of oncology, we strongly believe that it is essential that all specialists work together as a team to deliver the best patient care. We also believe that this model will work only if all participants believe in the value of the model and in each other. We must always keep foremost in our minds that regardless of our specialty, we are all physicians, and our primary responsibility is the well-being of the patient, not the survival or predominance of our specialty.

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