DMS was recently awarded multiyear grants to study colon cancer prevention ($19 million), lung biology ($10.5 million), and the effects of exposure to toxic metals ($14.5 million).

A case of "just say no" not working

Consider two drugs that relieve severe pain. There's no evidence that either one works better or is safer than the other. But one is much more expensive. If tax dollars are buying one of these painkillers, which should it be?

Alternatives: Every day doctors prescribe controlled-release (CR) oxycodone (better known by the brand name OxyContin) instead of comparable but cheaper alternatives. Since state Medicaid programs often cover medications for low-income patients, several states have set policies to deter physicians from prescribing the expensive drug.

OxyContin's value as a street drug may be a factor, says Morden.

How well do such policies work? That was the focus of a study led by Nancy Morden, M.D., M.P.H., a family physician and outcomes researcher at Dartmouth. "For most drugs," says Morden, prior authorization, the term for such policies, "is highly effective." But, she and her coauthors reported in *Medical Care*, this drug seems resistant to prior authorization.

Strict: Between 2001 and 2004, 21 states implemented prior authorization for CR oxycodone. Twelve set strict policies, such as requiring a phone call from the physician. Nine had more lenient policies; the right phrase on a prescription might be sufficient. In the aggregate, strict policies seemed to work better, resulting in a 34% drop in oxycodone use. Several states with lenient policies, however, saw an increase in use, and only a few saw a big decrease. Nationwide, CR oxycodone use among Medicaid beneficiaries grew 66% a year from 1996 to 2002.

In the end, the policies didn't cut costs. On average, states saw only a 31¢ drop per daily dose of long-acting opiates—not much given the price gap between CR oxycodone and its alternatives. In 2004, the average wholesale cost of a daily dose of CR oxycodone was $10.18, versus $4.90 for sustained-release morphine and 45¢ for methadone.

Cost: "There are prescription drugs that really pay off in the short term and the long term," says Morden. "There are prescription drugs that are maybe good for society but [that don't] save money downstream, and that's okay. . . . And then there are prescription drugs that just cost us . . . [that are a] waste of money." Morden puts CR oxycodone in the last category.

She's not sure why prior authorization didn't work but thinks patients may be loyal to the OxyContin brand and doctors may resist restrictions on pain management. OxyContin's value as a street drug may be a factor, too. And she and her coauthors believe misleading marketing plays a role. In 2007, OxyContin's manufacturer was fined $600 million and "pled guilty to a felony count of misbranding a drug with intent to defraud," according to the Food and Drug Administration.

Tax: "How much of our money should we spend on oxycodone," Morden muses, a note of frustration in her voice, "given that there is no literature to support it as being in any way at all superior to the generic cheaper products on the market? . . . Should your tax dollars pay for even one of these pills?" JENNIFER DURGIN

JON GILBERT FOX

Morden studied the effect of drug coverage policies.

The truth about consequences

In a recent study of women with breast cancer, DMS researchers identified a puzzling consequence of invasive forms of the disease. There have been concerns for some time that powerful chemotherapy treatments can cause a decline in mental capacity. The DMS team wondered if maybe the cancer itself might affect cognitive performance before treatment even began. They showed in *Breast Cancer Research and Treatment* that this was, indeed, the case for some women with invasive breast cancer. Women with noninvasive cancer, however, did not suffer any pretreatment cognitive decline.

Does change have the upper hand?

Not all change is for the better, concluded a study by DMS orthopaedist Kenneth Koval, M.D. He reported in the *Journal of Bone and Joint Surgery* that between 1999 and 2007, many early-career surgeons began using a different technique to treat broken wrists—without producing better outcomes. The shift from percutaneous fixation (in which the bone is aligned using pins inserted through the skin) to open treatment (an invasive procedure using screws or plates to set the bone) may, he said, reflect pressure "to offer new techniques to a medical market that is constantly searching for the latest in technological advancement."