Dying in the Queue and Where Is My Nurse?

My colleagues who treat multiple myeloma have been blessed with many new treatments, including cellular therapy, for their patients in recent years. And patients with this difficult disease are living longer and longer with much improved quality of life. But I have been hearing in the “trenches” that access to cellular therapies is difficult for many. Two cellular therapies have been approved by the FDA: idecabtagene vicleucel and ciltacabtagene autoleucel. Both are CAR T cells designed to target B-cell maturation antigen (BCMA). Both approvals were for patients who received heavy pretreatment. In December 2022, an abstract was presented at the annual meeting of the American Society of Hematology about access to this care that really made a powerful statement.

In this abstract, Al Hadidi et al presented retrospective data on how many eligible patients with relapsed/refractory multiple myeloma actually received the CAR T-cell therapy and in what time frame.1 Keep in mind that these patients are very sick and literally can succumb to a lethal infection or some other complication at any time. Unfortunately, only 3.8% of patients received this care by 3 months, and 26% died waiting for therapy. The authors indicated that the main issue was limited production, and they cited additional concerns about equitable access. But what if the production pipeline could be improved? Could we manage all these additional treatments with our current healthcare infrastructure?

These results somewhat emphasize a point that I have made many times. We are really great in the United States about designing new treatment strategies, but we have not paid enough attention to building the infrastructure needed to support their use. And I am not just talking about factories and healthcare facilities. You can have many beds available, but they are useless without appropriate staffing.

It is no secret that there is a huge nursing shortage. I am sure burnout from COVID-19 contributed to this, but my institution, as an example, was dependent on traveling nurses long before the pandemic began. Just imagine how different this situation would be if some of the investment in new drugs and devices was used to provide tuition support for nurses and medical assistants, and bonuses were used to incentivize nurses to stay in their positions.

I also think that we don’t always let nurses practice at the top of their license, something that brings most people great satisfaction. I believe an experienced nurse should be contributing to patient care decisions, not charting exhaustively in something that brings most people great satisfaction. I believe an experienced nurse should be contributing to patient care decisions, not charting exhaustively in something that brings most people great satisfaction.

Although I am not quite sure how we get out of this situation, I do think that healthcare systems need to address this problem head-on. Maybe they should start by listening to nurses. Until we understand this problem from their perspective, we can’t fix it.

Reference

WHAT DO YOU THINK? To submit a Letter to the Editor, email JNCCN@nccn.org or log into www.editorialmanager.com/JNCCN.

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