

## Thoughts on the “Cancer Industry”

Recently, someone I met—an educated, reasonably intelligent, otherwise very personable man—told me he truly believes that the “cancer industry” is a big con. He said that cancer will never be cured because it is too profitable to all involved. Further, he thinks that, although I “apparently believe in” what I do, my job—supervising the development of NCCN’s clinical information—is loathsome.

My first reaction was shock that someone I actually knew thought like this, but the conversation forced me to think about and evaluate what I think about cancer and its treatment. This list is what I have come to believe in the past 20 years of working in and around oncology:

1. **CANCER IS BAD.** I wish it didn’t exist. If I could make it disappear today, I would, even if that meant I had to be a dentist or wash windows in high rises for a living. I suspect most oncologists feel the same way.
2. If a “cure” were suddenly invented, I believe it would be immediately available. I know that when important new data are released, we immediately incorporate those data into guidelines, regardless of the financial impact whether positive or negative.
3. Many in the cancer community do have vested interests in cancer treatment—the pharmaceutical industry, payors, organized medicine, and clinicians. These people and companies are dealing with complex, interrelated, and sometimes competing issues of cancer economics. Within each of these industries, there are dedicated individuals trying to solve these problems.
4. Most of the people personally involved in oncology care truly are interested in the welfare of the patient and are frustrated when they cannot provide a cure.
5. A good technician with a poor bedside manner sometimes offers better treatment than a nice guy.
6. **People are sick NOW.** They need treatment now. The treatments we have, albeit clearly imperfect, work for some people. The problem is that we can’t prospectively tell who will benefit most. Patients need to be better informed about the probability of benefit from the care they are offered. It is difficult, especially under duress, for people to grasp statistical prognosis figures and understand that they can’t predict what will happen to an individual patient. If people hear that a particular cancer carries a 75% chance of 5-year survival, few really internalize that they could be in *either* the 75% or the 25%. Furthermore, you cannot be 75% cured; you are cured or you are not. Even if the likelihood of a successful treatment is only 15%, any individual could be in that lucky 15%, and many people are willing to gamble that they will be lucky, even when told of possible adverse events and that they are unlikely to benefit, . . . and a few are.
7. Fewer chemotherapy chairs would not lead to fewer people needing them.
8. Doctors are sometimes overly optimistic about probable outcome, because they are human, too.
9. As a society, we allocate insufficient resources to basic research on the biology of cancer, and without this investment, answers are unlikely. Young investigators are finding it increasingly difficult to find funding for creative new research. We must do better.
10. Commitment to evaluating the existing data and recommending which therapies are most likely to work for which diseases and patients is important so that less futile care is provided. Allowing the marketplace to determine what treatments are given without regard to data is not helpful and is likely to result in more futile care not less. Dedicated clinician researchers know the data and can make recommendations based on their understanding. That is the role of our NCCN Guidelines panels. I am proud to work with them and you, our colleagues in helping people with cancer live longer and better lives.



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