Change the cancer conversation

The 'war on cancer' has run off course. Efforts must refocus on the best interests of patients, says **Colin Macilwain**.

When Angelina Jolie had a double mastectomy in 2013 after genetic tests revealed her susceptibility to certain cancers, she urged others to consider their own risk. Even more people will do so now, after the actress revealed that she has undergone a procedure to have her ovaries and Fallopian tubes removed as well. There is a positive effect to this, of course: greater awareness and reduced stigma can only help people with cancer.

But Jolie's story, of optimal diagnosis, advice and treatment, is not relevant to most people with cancer. Rather, it may serve to sustain unrealistic expectations that victory is pending in the 'war on cancer'.

Cancer, the rhetoric of this conflict holds, is an enemy that can be defeated with sufficient will and the right weapons. Unfortunately, like the 'wars' on drugs and terror, the war on cancer has become more about those doing the fighting and less about the best interests of those they are trying to serve.

It is surely time to concede defeat, or declare victory, or whatever — and build a more realistic and constructive approach to cancer prevention, treatment and care.

The most glaring failures of the war on cancer are burgeoning global costs and inconclusive progress on mortality rates. Collateral damage includes a misdirected biotechnology industry, misleading public debates on payment for exorbitant drug treatments, the self-interested promotion of unhelpful diagnostic tools, warped research priorities, mistreatment of patients (especially the elderly) and timid policy action on environmental causation.

The global war on cancer arguably began 44 years ago, with US President Richard Nixon's 1971 State of the Union address — although he did not actually invoke the phrase (see M. P. Coleman *J. Cancer Policy* **1,** e31–e34; 2013).

The idea of turning defence against an enemy into a political patronage machine is much older. The Great Wall of China, for example, is anything but contiguous. Invaders could simply go through the gaps. But the wall was not built just to keep enemies out. It helped to keep the Chinese emperors in. In all such cases, fortifications end up being constructed primarily for the benefit of those who build them.

Take the biotech industry. Since its foundation, the search for cancer treatments has been at its core. That is because US health insurers (and, to a lesser extent, insurers and public-health providers elsewhere) will cough up silly money for treatments proven to prolong life by three to six months. The biotech model is largely predicated on the prospect of huge returns from cancer drugs.

That, in turn, leads to one of the most visible manifestations of the war on cancer in the United Kingdom: the public-relations battles to obtain payment for these drugs. Patient groups, often industry-funded, unearth individual cases to put on front pages and press public agencies to approve payment for a treatment.

AWARENESS FOCUSES ON TESTS AND TREATMENTS, RATHER THAN ON CAUSE AND PREVENTION.

But the most bothersome facet of the fight is the state of doctor–patient interactions. To maintain the appearance of progress, and to meet key performance indicators, physicians are obliged to offer multiple approaches — such as chemotherapy and radiotherapy — to almost every patient. This is now extending into genetic testing and experimental therapies, such as stem-cell transplants. Much of this happens despite decidedly mixed evidence over whether patients really benefit. (Yes, some cancer survival rates are up, but that masks a complicated debate about how much of the increase is due to better and earlier diagnosis.)

Then there is the cancer-awareness industry. Corporations including the Ford Motor Company and American Airlines are now major sponsors of the Race for the Cure, the highest-profile US 'awareness' event. When these companies get credit for what was originally a grassroots anticancer action, something has gone badly wrong. Awareness focuses on tests and treatments, rather than on cause and prevention.

The cancer-research agenda is similarly skewed. The percentage of the US National Cancer Institute (NCI) budget that is devoted to prevention and control slipped from 11% in 2003 to 6% in 2013. Outcomes research — measuring the effectiveness of treatments — is neglected, in cancer as in other fields. Environmental-health research remains politically contentious and poorly funded.

Harold Varmus, who this week retires as director of the NCI, has called for the 'war on cancer' metaphor to be discarded. But it is still in widespread use. And despite its weak track record, the war is a model that politicians are now in danger of adopting for another great health-care challenge for rich countries: neurodegenerative disease.

The area has had an upsurge of political interest of late, exemplified by the first Ministerial Conference on Global Action Against Dementia, held last month at the World Health Organization in Geneva, Switzerland. The wolves are already circling around neurodegenerative disease. The usual suspects — drug companies, equipment makers, university departments — all want a seat at the table. Policy-makers should be wary of them. The priority instead must be to improve quality of life. Despite the shiny promises of genetics and diagnostics, that in reality means more investment in the basics of shelter and care.

Otherwise, in 40 years' time, elderly and infirm people may be treated just as shabbily as they are now. And another Great Wall of special interests will be leaching off their pain. ■

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