Response to "Cancer drugs, survival, and ethics" by the Association of Cancer Physicians | The BMJ

We read with great interest the analysis from Dr Wise on the benefits or otherwise of systemic treatments for cancer, and the ethics surrounding their use (1). As health professionals in the UK who specialise in the treatment of cancer using drugs, we of course have a vested interest in the subject but feel that his analysis strays into the territory of opinion piece rather than balanced assessment.

We are aware of the points he raises and welcome his discussion of issues that we are constantly debating and evaluating ourselves. His article is perhaps a useful counterpoint to some of the hyperbole we often see in the media surrounding some of the more incremental improvements in treatment. However, we feel that Dr Wise is taking an overly cynical position, and conflating issues from several different healthcare systems, whilst not giving enough credit to specialists such as ourselves to maintain high standards of ethics, and awareness of the limitations of the treatments we offer. Certainly, there are issues surrounding conflicts of interest and these may be most clearly demonstrated in the United States where reimbursement through the Medicare system currently means that doctors may benefit from prescribing more expensive drugs; fortunately, in the UK within the NHS there are no such perverse incentives. Whether a patient chooses chemotherapy or supportive care alone makes no difference financially to the oncologist, in fact with current overwhelming pressures in terms of workload and oncology unit capacity there are arguable incentives to reduce chemotherapy prescribing. The UK is also unique in the world in having established an England-wide single database of chemotherapy activity through which we are increasingly able to benchmark physician practice and outcomes against results of peers, and those described in licensing trials.

Dr Wise describes the approval of many drugs with evidence of only marginal gains in survival. However, he does not mention that many of those drugs will not be approved by NICE in the UK or be in routine use by UK oncologists. We are aware of the minimal benefit of erlotinib in pancreatic cancer alluded to by Dr Wise and therefore it is not approved for use in the NHS for that indication. However significant advances in survival due to systemic treatments have been seen in both the adjuvant and metastatic setting. Over the years, stepwise improvement in outcomes for those with metastatic breast (2), colorectal (3), and lung cancer (4) have occurred. Our focus now is on stratified medicine - the science of choosing the most effective treatments for individual patients. We understand that whilst some patients in our clinics benefit significantly from treatment, others may suffer toxicities without extending life. In this country we are amongst the leaders in the field thanks to the Cancer Research UK Stratified Medicine programme (5) which aims to match patients to the right drug treatments based on the molecular “fingerprint” of their individual cancer.

The Association of Cancer Physicians (ACP) and its members are very involved in initiatives to improve the efficacy and quality of care. These include, supporting data collection and the recent publication of mortality within 30 days of systemic anti-cancer treatment (6), organising educational workshops, which have recently focused on caring for elderly patients with cancer and, last month on patient centred and integrated cancer care, which featured prominently the issues of quality of life, holistic needs, and communication challenges. The ACP, in collaboration with patients, has also produced a strategy document to help drive improvements in cancer care (7). In addition, to

encourage improved information for patients we have worked with Cancer Research UK on developing regimen-specific consent forms to clearly list the incidence of side-effects and other risks of treatment including death (8). They confirm that the person taking consent has discussed alternative options including no treatment; and indications for treatment (eg neoadjuvant, adjuvant, curative, maintenance, or palliative). This encourages a full and frank discussion with the patient before the decision to treat is finally made.

In short, oncologists in the UK are very conscious of the financial constraints on the healthcare systems here and around the world, we are keen to continue work with patients, charities, research institutions, government, and yes pharmaceutical companies, to develop more effective treatments, target them appropriately, and to explain to patients all the options, including that of palliation of symptoms alone. Supporting patients at the end of life to make the best decisions for them and their family, with empathy and kindness is one of the facets of our job that makes it so rewarding and why we choose it as a career. A common question patients ask us is what we would choose for ourselves or our family and hopefully the advice we give articulates as closely as possible our honest view.

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