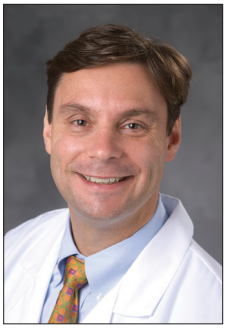
A Common Cause



Practicing in Durham, North Carolina, I have the privilege of caring for a wide range of patients—Black and White, old and young, rich and poor. People come from around the region, representing rural and urban counties. But one thing they all have in common is cancer. It is therefore striking to see cancer research, which should be a common cause in this current social climate in which everything seems politically divided, undercut.

Over the years, our patients have benefited from the expansion of treatment options available to them—from cytotoxic chemotherapies and broad hormonal agents to more targeted therapeutics and immunotherapies. Many novel agents are now being developed in a biomarker-defined population, further increasing their effectiveness. Coupled with today's improved imaging, radiotherapy, and surgical techniques, progress across cancer is happening faster than ever, fueling much of what we cover in this journal and others. Exciting, right? Except that one of the major cogs in the engine driving this progress has been shut off.

Most can agree that improvements in government efficiency and national deficit reduction are needed; however, the method of sudden and drastic cuts in federal funding for contracted cancer research has created an immediate and potentially lasting effect on our field.

The National Cancer Institute (NCI) was established in its current form in 1971, when its director was granted broad authority to set a national cancer program through the NCI and other federal and nonfederal programs. What has transpired over the last 50-plus years has been nothing short of transformative—from the discovery of oncogenes, tumor suppressor genes, and other hallmarks of cancer to the clinical translation of these cancer drivers into many of the therapeutic approaches in use today. These discoveries have led to the formation of hundreds of US biotechnology companies and tremendous economic growth. Now, for the first time since its creation, the NCI—as well as the entire National Institutes of Health (NIH) and the more recently established Congressionally Directed Medical Research Program (CDMRP)—is undergoing unprecedented budget cuts, including the cancellation of hundreds of existing grants and contracts.

The short-term effects of this dramatic change in policy have already led most if not all universities and health systems that engage in cancer research to reduce their staff, infrastructure, and financial support for cancer research. More reductions are sure to follow. These changes could not happen at a worse time, as the momentum of the last 10 years has been tremendous. With our present arsenal of therapeutics and diagnostics, both realized and under development, we could be on the verge of even greater breakthroughs with novel combinations and sequencing of treatments. However, without continued robust support of the clinical research infrastructure, we are likely to see a regression rather than an expansion of this work. More cancer clinical trials are already conducted outside the United States than within it, and this trend is now likely to accelerate. Longer term, defunding cancer research is likely to turn many would-be cancer researchers and other cancer providers away from our field. With fewer basic science discoveries and translational research, we can expect to see fewer breakthroughs 10 to 20 years from now. The United States may lose its position as the leader in biomedical research. So, what should we do about it?

First, it is important to recognize our role as oncologists in advocating for the work that has led to the current state of our field. Who needs to hear this advocacy? Our patients of course, but also anyone who is destined to develop cancer in their lifetime or who knows someone with cancer. Basically, everyone. Advocacy can come in many forms, including by educating the people in our communities. Cancer is not political; it affects people indiscriminately. But make no mistake, cancer is an elephant in the room, accounting for nearly 1 in 5 deaths in the United States.

Second, we need to recognize and articulate our dependence on clinical data in this field. Like it or not, we are dependent on the pharmaceutical industry as well as federal and foundation funding of cancer research to supply us with the data needed to justify and support our treatments. Without these data, we do not have the ability to practice the way we do. Helping the public understand and appreciate the difference between evidence-based and non–evidence-based practice is critical to our field.

Lastly, we need to support our cancer research leaders. Regardless of politics, cancer is our common cause, one we should unite around, even if we disagree on other issues. I am hopeful that NIH, NCI, and CDMRP funding will eventually be restored, but until then, it is our job to keep the engine of progress moving for our patients and for the future.

Sincerely,

Daniel J. George, MD