John Marshall

Physician Executive Director, Medstar Washington D.C. Integrated Hematology Oncology Division; Director, The Ruesch Center for the Cure of GI Cancers, Washington, D.C., USA

Citation: EMJ Oncol. 2023; DOI/10.33590/emjoncol/10308998. https://doi.org/10.33590/emjoncol/10308998.

Q1 You have always been very passionate about gastrointestinal (GI) cancers, and advocating for their treatment. Where did the interest in GI cancers come from initially?

You have to remember that I am a very old oncologist. So, when I first started, there was almost nothing in the world of GI cancer. I was very interested in new drug development, early Phase I and Phase II clinical trials, but less interested in large randomised clinical studies. GI cancer was a huge unmet need, and huge opportunity for new drug development; I was just drawn to the disease group.

Q2 Can you tell our readers a little about the aims of the Otto J. Ruesch Center [for the Cure of GI Cancers] at Medstar Georgetown University Hospital in Washington, D.C., and the work you do there?

One thing that is important to note is that I was raised in a cancer centre that was famous for breast cancer, and so lots of resources and energy was spent on breast cancer research, recruitment, and studies, etc. I was trying to take care of patients with GI cancer, which represents the most common and most fatal group of cancers on our planet. And yet, there was this disconnect of prioritisation. I am lucky enough to have met Otto J. Ruesch, unfortunately because he had pancreas cancer. He and his wife, Jeanne Ruesch, were determined to try and level the playing field by helping to support the effort. The concept of the Ruesch Center was to emphasise all of the work that needed to be done to draw attention to the huge gaps that exist in focus and resources for GI cancers.

We started the programme in 2009. At the beginning, we had a big debate about whether 'cure' should be in our title; should we just make a much lower goal than cure? I felt very strongly that it needed to be there. This is what our patients are seeking. This is what the objective of cancer research is. Sure, survival is important. Sure, quality of life matters to people; but what they're seeking, and what we are all seeking, is a way to get rid of these diseases. And so, I thought that was an important element for our overall goals.

We have made some progress in this space: not so much in pancreatic cancer, although some, but a lot of progress in colorectal cancers, liver cancers, and gastric cancers. However, we have miles to go.

Q3 You mentioned the lack of awareness and advocacy surrounding GI cancer. Do you think there is still a lack of awareness, and what are the disadvantages of this?

The second most important cancer, if you measure it by money investment and awareness, is actually something called the Leukemia & Lymphoma Society (LLS). Number one is breast cancer. The number two, LLS, is a collection of more than 200 different kinds of cancers; the society has come together to increase awareness, advocacy, and research in that group

> "When I first started, there was almost nothing in the world of GI cancer."

as a collective. One of the things we've really tried to do in the Ruesch Center is to bring that together. One of the areas we're most proud of is the formation of something called the GI Cancer Alliance, which, I believe, now has as many as 80 different advocacy groups from the various GI cancers working together.

Now, to your question, we have miles to go. In Western society, colon cancer is our most common cancer from the GI tract. We've made some good progress in that space with awareness and advocacy. But sadly, one of the reasons why that's become more successful is because young people are starting to get the disease. We don't know why 20-year-olds, 30-year-olds, and 40-year-olds are suddenly getting colon cancer when they didn't at the beginning of my career. But this phenomenon has further shone light on the problem of, specifically, colon cancer. Pancreas cancer has very strong advocacy and awareness, but honestly, without major impact in understanding what makes this cancer tick, if you will, so that we can improve things there. And then you get to cancers like liver cancer, stomach cancer; some of these are bad behaviour cancers. They're associated with choices, life choices, whereas pancreas cancer and colon cancer are not so much. So, we have to make sure that we are bringing everyone along in this. The more we divide into the different cancers, and then into their different molecular subgroups, the smaller the clubs are, and therefore, the smaller the voice is. So, on some level, we need to make sure that while it's important to have our individual voices, we must come together and speak as one when that's appropriate.

Q4 The Ruesch Center has recently decided to focus on increasing access to cancer care for all patients. Please tell us more about the ways in which you plan to do this.

I spent the middle part of my career thinking more globally. It was really my Don Quixote period, where I was trying to take whatever influence I could bring along with me to try and level the access problem on a global scale. We know that only about one in seven people on our planet has access to cancer care the way I get to deliver it, for example. And so I was trying as best I could to globalise the access. And I realised that that was crazy, after a while, because cancer care is so complicated, and so expensive, quite honestly, that for most of the planet, it is not even on their radar, when water and food is the primary goal.

And so, in the last portion of my career, I have decided to look at that not on a global scale, but just in my own backyard. I now oversee cancer care in two hospitals here in Washington, D.C. The reality is that the two hospitals are 3 miles apart, but there is a 1-year difference in the survival of colon cancer between those two hospitals. That's not the problem of resources; these are insured people. This is a problem of health literacy, of socioeconomic barriers on the patient side. How does one consume cancer care? How do you use your resources to the greatest benefit? On one side of town, I've got a very educated, driven patient population that wants to get everything they can out of our system, whereas on the other side of town, it's hard for them just to take time off work to go and get treatment. So, what we're trying to do now is level that playing field, just the local one, to try and close that simple 1-year gap, with a strategy to intervene on behalf of the healthcare system and the community to provide those bridging resources. Our hope is that we will demonstrate that this model works, and is translatable, not just to GI cancers, but to all different types of cancer, and cities around the world.

Q5 Have you begun to see any change in outcomes amongst patients who now have increased access to care that they may have previously struggled to receive?

No. And the main reason is that we are still in the collection phase. So, we're proving that all of the things I just said to you are true, with the 1-year difference in the metrics. The plan is to begin the intervention this fall.

Q6 Do you think that once you start interventions, based on your results in the community, that those interventions can be applied on a national, or international, scale?

They’re very basic endpoints: did the patient get started on treatment in time, and did they get the recommended treatment, pure and simple? Secondly, was the proper molecular testing done, and are they in the right subgroup? And thirdly, were they offered a clinical trial, or at least an opportunity to be part of the future of cancer care? We think that if those three metrics are equal, then survival will be equal.

Q7 Having had the personal experience of being a caregiver to a cancer patient, when your wife was diagnosed with breast cancer a few years ago, do you think this experience has been influential in your approach to medicine and patient interactions since?

Totally. I then saw what it was to be on the other side of the room. And I thought, I was pretty good at this before, but until you experience it, you really can't understand the emotions and the complexity of receiving cancer care. My wife got care at our centre. It was a very familiar world that I was in, whereas most patients don't have that. And so, as Director of the centre, I became driven to try and provide that level of care that we received to everyone we could. This actually resulted in mostly frustration, realising that, no matter how hard we worked, there was no way we could provide that level of oversight and care to all of our patients. That ended up being something that actually resulted in my burning out from being an oncologist. The emotional cost, the wear and tear of taking care of very sick patients, got to me. In the end, we lived for 4 or 5 months in Oxford, and were able to write our story about it into a book, called Off Our Chests, which was quite therapeutic as well. But the arc of that story is that it had a dramatic impact to a point of recognising our shortcomings, which I think also brings back around this attempt to just try and help those who are socioeconomically challenged to receive cancer care, a little bit closer.

The healthcare team is a very complicated, large network of people, all pointing to that one person trying to take care of that one person; it's not just the physician, it's all the people around that person. It's our team, and there has to be a team on the other side, too. It's not just an individual; it's their family, maybe spouse, maybe sick child, and their friends and family who are helping to support them. The importance of engaging that whole team became very, very critical to me.

Q8 The 14th Annual Ruesch Center Symposium is approaching; what topics do you think are going to be of particular interest this year in the field of GI cancers?

We have decided to dedicate the entire weekend to young people with GI cancers. So firstly, what do we know? Why is this happening? To help increase our knowledge, we've invited a select group of scientists to attend the day before, in what we're calling a thinktank around this, to try and just understand the current knowledge; not only the background as to why this is happening, and the specific interventions that are needed, but also the psychosocial impact of this. It's one thing to have a bad cancer and be 75-years-old; it is another thing to have a bad cancer and be 45-years-old, or 35-years-old with kids around the house. So, we're trying to better understand that. Many of our speakers from the thinktank are also then carrying forward discussions around what we know, the impact, and where we need to go. As part of this, we always have a patient portion, which will be focusing on subjects related to this that are important to the patient community. ●