Vincent DeVita, MD, was director of the National Cancer Institute and the National Cancer Program from 1980 to 1988 and director of the Yale Cancer Center from 1993 to 2003. His new book, titled *The Death of Cancer* and cowritten with his daughter, Elizabeth DeVita-Raeburn, came out late last year.

The *New Yorker* piece about your book describes it as an angry book. Do you see it that way? No, not really. People have asked me about that. It’s a matter of interpretation. It’s a very truthful book, and sometimes the truth is a bit stark and that can be interpreted as angry.

**How do you view it?** It’s a memoir of my trip through the war on cancer. It’s how I saw it.

The first part of the book is full of vivid descriptions of your early days at NCI during the early ’60s—that unforgettable party scene with Tom Frei carrying a woman on his shoulder, Jay Freireich calling Evan Hersh a murderer when he didn’t check a patient’s magnesium levels. You’ve headed large organizations in your career. Have you had to protect people like this—people who might be seen as misbehaving? I’ve had to protect people like this, including Jay. When I became director of the National Cancer Institute, it was not rare to have to protect Jay from himself because he’s a very rambunctious sort of person. He did some brilliant stuff, but I think people would react to his personality and not pay attention to his work. So yes, there were several people like him that I have had to protect. Sometimes I had to do something with the people who are being offensive, but it wasn’t common.

My own personal feeling is when you’re dealing with people who are major contributors, they tend to be high strung, and they can sometimes do this sort of thing, and you have to make allowances for it.

The incident with Evan Hersh, I was there, and it was startling to me at the time, but as I pointed out in the book, Evan worked with Jay at MD Anderson for something like 20 years. I mean, people understood him.

**Your discussion of the development of MOPP [a combination treatment for Hodgkin’s disease] is fascinating.** It turned out well. But it might not have, and meanwhile, you put patients through hell. Did you have doubts along the way? Sure. There was no guarantee that, one, patients would survive it, and, two, that it would work. But it was based on a pretty sound rationale based on the information that we had at that time. And we were saying, “Hey, we want to cure this disease. We don’t want to just fool around with it. We want to cure it.”

We didn’t have all these drugs that you use today to prevent nausea and vomiting. When I walked into a room, the patients would vomit. Not very flattering. But it was like a Pavlovian response. They knew they were going to get drugs that would make them sick; they would see me; they would get sick.

We were young then, and the patients had to turn themselves over to doctors who looked young, and they knew they had an illness that was reported to be universally fatal. They had to make choices about whether they were going to put their confidence in us or not, and they did. And I think they are the real heroes. They are the ones who had to look at us and say, “Okay, I’ll do this.”
You tell a story in the book about a young girl with leukemia who was put on a respirator because of nerve damage caused by vincristine. You write that all of you thought she was “living dead” and wondered if Freireich was “just covering his ass.” But she recovered. And you learned a profound lesson from Freireich—never to give up on anyone. Well, not to give up on anybody when there’s a chance.

There’s a lot of interest these days in palliative care. You come down pretty squarely for taking a very aggressive approach to treatment. That’s something that maybe we didn’t make as clear as we could have. I think if you ask a patient, “would you rather be cured or rather be palliated?”—come on, every patient will tell you they want to be cured. The question is, you have to recognize when there’s a possibility of doing something good that will give the patient long-term survival. I mean, if you’ve got a patient who’s got metastasis from pancreatic cancer everywhere, you palliate them and try to control their pain. I’m not foolish. I don’t keep people alive unnecessarily.

But if there’s a chance that we can put a patient into remission, then I wouldn’t give up on them. I have had lots of patients that we didn’t talk about in the book that went into renal failure and had to be dialyzed. People said, “What are you doing? They have cancer.” But they had responded to chemotherapy. We weren’t sure whether or not they were going to stay in remission, but we didn’t want to give up on them because there was still the possibility of recovery.

One of the recurring themes of your book is how turf wars got in the way of treatment advances. You mention the hostile reaction of radiotherapists to MOPP and all the trouble Bernie Fisher had. Has this eased up any? I think it’s still there. I don’t think it’s as blatant as it used to be. I remember the lecture that Bernie Fisher gave at Memorial Sloan Kettering like it was yesterday. I mean, I had never seen anger like that. Those people were really, really angry at Bernie Fisher. I don’t think they saw themselves as doing it for economic reasons. But, in fact, the impact economically on them was important. The people who only did mastectomies suddenly saw their incomes cut by half because Bernie showed that in many cases you now only had to do a lumpectomy with adjuvant therapy.

Today I see doctors looking for the easiest treatment that they can use—that they can deliver efficiently.
melanoma. We had a system that worked. I describe it in the book.

The Group C system? Right. The NCI would determine whether the drug went into Group C and the doctor at the bedside determined if the patient was a candidate. Now some guy is sitting in Washington, often 3,000 miles away, deciding whether a patient who needs the drug should get it. And the silliest thing, they have to decide that it will not interfere with NCI’s clinical trials, which is garbage. There’s absolutely zero evidence that any compassionate use of drugs interferes with clinical trials. None. Zero.

And I think the Right to Try legislation that’s floating around right now is close to the Group C system. Not quite the same, but the same idea.

Essentially the FDA has become the oncologist. They’re telling the bedside doctor exactly when they can use drugs…. So, I think the FDA is slowing the system down....

What do you think about the prices that drug companies are charging for cancer drugs? The costs are astronomical now. I sat on a couple of boards, and we went through these arguments about what you should charge for drugs. Some of these drugs are costing $800 million to develop. So, the CEOs and the boards have a duty to the shareholders to make sure that the company doesn’t go broke. Otherwise you won’t have these drugs. Some of the prices do seem to be astronomical. I think it’s a question that needs to be discussed.

You don’t see the high price of drugs also maybe resulting in drugs not reaching people. If the patient has to pay for them, yes. You’re right. I’m talking about compassionate use. Now the FDA approves them, and all of a sudden the insurance company is picking up the tab for $150,000 for every lung cancer patient that goes on it. So, the patient doesn’t see that. The insurance company does. So, it is potentially driving up the cost of health care. Once the drug is approved, I don’t see it denying access.

What about clinical pathways? Insurers are trying to move away from buy-and-bill and trying to motivate oncologists in different ways economically. Do you have any thoughts on that? Keep in mind, I am not in private practice and never have been. So I have the luxury of a lot more flexibility. I tend not to like guidelines because I think they look backwards. On the other hand, if you look at delivery of cancer care in other countries, the fall-off between care in the large cities, say, in Paris or in Milan, and a small town is very large. In this country, it’s not. You can get very good care in the local community hospital. The patient gets served very well. I don’t know if that’s due to guidelines. I think it’s due to pressure to provide a standard of practice that’s acceptable.

You were diagnosed with prostate cancer in 2009. How are you doing? I’m fine, knock wood. I’m free of cancer at the moment and hopefully will stay that way.

What’s it like on the other side of the doctor–patient relationship? The problem is, and I point this out in the book, I mean—I’ve seen all the scenarios that you can go through. So, you immediately start thinking about how you’re going to die with this particular disease. Being a doctor means that those things are up in front. Most patients have enough anxiety with the diagnosis, but they aren’t aware of all the examples of what can happen. So, it’s anxiety provoking. And I realized that my looking for the right thing for me is compromised by the fact that I want to see what I want to see. That’s why I asked Steve Rosenberg [chief of surgery at NCI] to intercede for me. And he did exactly what I do for patients, and what he does many time for patients. He found what turned out to be the right place for me to go, and the right surgeon to go to, and it was a huge help to me. But it was anxiety provoking. I felt what it was like to be a patient. I felt like if I could have avoided the experience, it would have been great, but there it is. 

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