On the road to a single European cancer society

Anna Wagstaff

Members of the Federation of European Cancer Societies are debating how to present a united front to win a better deal for research and treatment. But how can disciplines with different priorities and agendas speak with one voice?

ECCO 13, that great meeting and mixing place for the cream of Europe's oncology researchers and clinical practitioners, gathers in Paris this October against a background of momentous changes in oncology and Europe.

Rapid advances in molecular biology are opening a new era of targeted treatments, requiring scientists in basic, translational and clinical research to work together in an unprecedented way. At the clinical level, there is an accelerating trend towards specialisation of treatment by organ. The process, although uneven, is associated with better outcomes, raising questions of whether patients should be treated only by practitioners and units accredited for the relevant organ. Meanwhile, the expansion of Europe is opening up opportunities to disseminate knowledge and best practice. Debates over how heavily Europe invests in research, how it organises its research effort, what support it gives to clinical and paediatric research all require the cancer community to make its voice heard.

But concerns that the voice of European oncology is weak and divided have prompted a heated debate over the need to reform – or replace – the Federation of European Cancer Societies (FECS), the body that organises the biennial ECCO conferences. This debate is expected to culminate in the announcement of the launch of a single European cancer society.

FECS has been the voice of oncologists in Europe for a quarter of a century. It is an umbrella organisation for the six main oncology disciplines: the European Society for Therapeutic Radiology and Oncology (ESTRO), the European Society of Surgical Oncology (ESSO), the European Society for Medical Oncology (ESMO), the International Society of Paediatric Oncology, Europe (SIOPE), the European Oncology Nursing Society (EONS) and the European Association for Cancer Research (EACR).

But critics argue that FECS is fundamentally flawed. It is organised chiefly along disciplinary lines and does not represent thousands of clinicians who treat cancer patients but identify themselves as organ specialists rather than cancer specialists – gynaecologists, urologists, or gastrointenstinal surgeons for example. Being a federation, it is difficult to speak with the full weight and authority of Europe's oncologists, unless the six member societies have a common line. Furthermore, while each member society continues to hold separate congresses, showcasing their

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Harry Bartelink: We want everyone under one roof, with one front facing the outside world and much closer contact between disciplines

achievements and highlighting their own issues, Europe's oncologists will never have the public profile or lobbying power that ASCO (the American Society of Clinical Oncology) offers to colleagues in the US.

Even the critics agree that FECS was a wonderful creation, bringing together oncology disciplines at a time when the concept of multidisciplinary treatment was in its infancy. Luigi Cataliotti, president of the European Society of Surgical Oncology (ESSO) remembers his first ECCO conference, 20 years ago, as a unique forum. "It was a completely different way to approach cancer. The principal of an ECCO conference is to listen to speakers you would not normally hear; to listen to basic researchers, or as a surgeon go to a medical oncology symposium."

However, almost everyone, including Cataliotti, agrees that FECS must adjust to some new realities.

Harry Bartelink, outgoing president of FECS, has led calls for oncologists to work more closely with one another. He says that, despite FECS nominally bringing everyone together, and despite its emphasis on multidisciplinarity and on bringing basic research to the clinic, member societies have always worked on their own. "The only overlapping item was the ECCO conference. Now we want to bring them under one roof, with one organisation, and one front facing the outside world, and taking great care to create much closer contact between the disciplines, as well as incorporating the organ-oriented specialists."

Bartelink believes that the current fragmentation is fatally undermining the efforts of the cancer community to make its voice heard. One result, he claims, is that cancer is missing out on research money, despite its high level of scientific credibility. "Other areas are getting more attention. That is somewhere that we failed, and others were stronger in promoting their own area."

His big fear is that the era of targeted drugs, each with a higher price tag than the last, could lead to a US-style two-tier health system developing in Europe, where only people who can afford a higher insurance premium get access to the latest therapies. He is convinced that a united voice from European oncologists will be far more influential in persuading governments and health insurance systems to provide the funding needed to ensure equal access to quality treatment, than if the task is simply left to medical oncologists. He also believes that a united oncology voice could play a role in persuading the industry to charge affordable prices.

Lex Eggermont, president of the European Organisation for Research and Treatment of Cancer (an affiliate of FECS), is another champion of the proposed European cancer society. For the last year he has been gearing up EORTC, which conducts most of Europe's clinical trials, for the new era of molecular biology and targeted treatments. The strategy is to make sure that, wherever possible, clinical trials comparing one outcome against another include a translational research element, using techniques such as gene profiling or genomic or proteomic analysis to distinguish which patients will benefit from which treatments.

Everything depends on getting basic/translational and clinical researchers to work closely – and to get the research funds. The EORTC is assembling a network of core academic institutes and cancer centres that are able to collect and store tissue, and have the labs and scientists to carry out high-tech analysis. It is building its own academic research fund with a view to providing seed money for what could be costly trials, and is hoping to convince the EU that its work is worth funding. It is advising research teams how to cope with the obstacles posed by the way the clinical trials directive has been implemented in each Member State, and is putting pressure on the EU to revise the directive.

Eggermont believes there are huge prizes to be won from exploring targeted treatments, so long as the cancer community can convince the public and politicians. He points out that EORTC receives funding from the US National Cancer Institute, while the EU refuses to contribute, a situation he describes as madness. "You need a unified organisation that is so powerful that the politicians could not avoid seriously dealing with it. I would argue for an organisation that would bring together the science and the clinical parts of the oncology world, represented on a board that will define policy, and prioritise programmes, education and training. By

bringing these all together within one organisation you would have a real powerhouse."

This sounds like the task FECS set itself three years ago, which included aiming to "promote the field of oncology by fostering a favourable environment in Europe for research, treatment and care, with the ultimate goal of providing optimal access to the best possible treatment for all European cancer patients."

But Eggermont believes that FECS failed to achieve its potential impact, largely because of its structure. "It is difficult for a federation to have a unified voice," he says, "because you have a conglomerate of independent bodies that are – I would not use the word 'obsessed' – but focused on their own world." He wants everyone to agree on priorities for a common, science-driven agenda.

These arguments have been around a long time, but at the end of last year they came to a head when the medical oncologists warned that if radical changes were not made, they would pull out and go it alone. This was no empty threat, because it is the medical oncologists – the ones who sign prescriptions and carry out clinical trials – who attract lucrative pharmaceutical industry interest in the ECCO conferences, and FECS and some of its member societies rely on this money to a greater or lesser extent, to finance their work. Consequently, much of this year has been taken up with discussions to find a way forward that everyone can live with.

This is not just a case of medical oncologists holding a gun to the head of other FECS societies. The need for change is recognised well beyond the ranks of ESMO. Eggermont, for example, is a surgeon, while Bartelink is a radiation oncologist. Moreover, there are many medical oncologists in the ESMO leadership, including its president Paris Kosmidis, who are deeply committed to the multidisciplinary approach and very reluctant to break ranks with other FECS societies.

At issue here is not *whether* European oncologists need to change the way they are organised, so much as *how*. In particular, how to achieve a more powerful unified voice for oncology as a whole, while ensuring that all parts of the European professional oncology world are effectively represented and able to address their particular challenges. How to strike this balance within the structure of a unified cancer society is the subject of heated debate between FECS members, who must each defend their own specialities, while benefiting oncology and the treatment of cancer patients as a whole.

ESMO

WHAT'S DRIVING ESMO?

Paris Kosmidis: A single, powerful European cancer society is essential so that Europe's top oncologists can win better recognition nearer to home

Europe's medical oncologists crave recognition. They look at the ASCO conference – that glittering US stage where medical oncologists parade in front of the world's media – and they want it. And with some reason. Despite a seven-fold gap in research funding, 50% of presentations at ASCO come from Europe, including a good proportion of papers presented at the prestigious plenary sessions.

The contrast could hardly be greater with Europe, where medical oncology is not universally recognised as a specialist discipline. ESMO president, Paris Kosmidis, says that this damages patient care, more than it wounds his members' pride.

"If you go to the US, in which medical oncology is the leading force for oncology, and you look at five-year survival and the treatment outcomes of cancer patients, it is much better than in Europe. They have well-organised training programmes, they have officially qualified physicians, and each cancer patient receives the proper and right treatment."

By contrast, in Germany, patients are routinely prescribed chemotherapy by gynaecologists whose primary training is in surgery, or by physicians who lack specialist oncology training. In other European countries, drugs may be prescribed by 'clinical oncologists' who are also responsible for delivering radiotherapy.

ESMO has been campaigning for years for medical oncology to be recognised as a specialist discipline. The society is conducting Europe-wide research into medical oncology services to establish, country by country, how many medical oncologists there are, how they were trained, the number of comprehensive cancer centres, which drugs are available and whether all cancers are treated properly.

ESMO has also built a network within EU countries working towards

greater homogeneity of training, with a minimum of five years. Where such training doesn't exist, ESMO tries to fill the gap. Currently ESMO is focusing on training programmes in Central and Eastern European countries, including Estonia, Latvia, Poland and Romania. "The progress they have made is really amazing," says Kosmidis. "We see these people coming to our conference and presenting their own research work." Medical oncology societies have been springing up fast in these countries, and are now busy disseminating the latest knowledge and lobbying their own politicians.

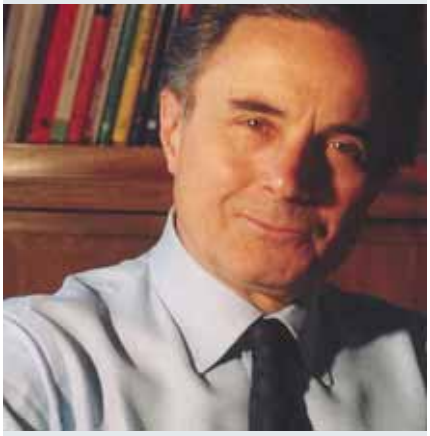
However, it is slow progress, and many European medical oncologists feel they are being held back by the lack of a public platform equivalent to ASCO. They hope the proposed single European cancer society may be able to offer such a platform. If not, the demands to go it alone will continue.

Kosmidis looks to ASCO as his model for the new unified society. This is a controversial choice, because although it is a society of 'clinical oncologists', it is dominated by medical oncology to the virtual exclusion of all else. Kosmidis argues this is justified by research and clinical reality. "If you compare the progress that has been made in surgery, radiotherapy and medical oncology, the difference is tremendous. The progress that has been made in the survival, quality of life and disease free survival is related absolutely and directly to the treatment of chemotherapy. If you look at colon, breast and lung cancer, you will see that all the most recent prolongation of life has come through targeted treatments. One example is Herceptin [trastuzumab], which will probably soon be given on an adjuvant basis. These patients live longer and certainly some of them will be cured. We've never seen that before."

Kosmidis would like to see the proposed European cancer society open to all disciplines, but based on individual members. "Members give power to the society. We feel that one society which is really multidisciplinary is an absolute necessity for Europe to make progress in treatment, prevention, palliation, education and in more powerful lobbying of politicians. It is our obligation as leaders."

ESSO

THE SURGEONS' CASE FOR UNITY



Luigi Cataliotti: A single society could provide space for multidisciplinary organ-specialist groups like EUSOMA, which cancer surgeons could relate to

Kosmidis will look in vain for other FECS societies to share his enthusiasm for the ASCO model. However, he can count on many in the surgeons' society, ESSO, to support a single, membership-based society, albeit from a different perspective.

The president of ESSO, Luigi Cataliotti, points out that surgery remains the single most important curative treatment for cancer, and becomes ever more central with early diagnosis. He wants an organisation that can attract all the surgeons who operate on cancer in Europe, many of whom do not see themselves as 'cancer surgeons'. Most of these surgeons do not work exclusively with cancer and identify themselves primarily as general surgeons, gynaecologists, urologists, head and neck surgeons, and so on. It has been difficult for ESSO to recruit them. While the Italian Society of Surgeons alone has a membership of 6000 – a large proportion of whom do cancer operations – ESSO's entire European membership languishes at around 2,000 surgeons.

Paradoxically, Cataliotti believes a single cancer society could be the answer, because by breaking down the boundaries between disciplines it would provide a space for multidisciplinary organ-specialist groups that cancer surgeons could more readily relate to. This would also tackle what he sees as the main professional issue facing ESSO – persuading surgeons to become part of a truly multidisciplinary culture.

"The first thing that a surgeon has to lose is the principle of being a 'prima donna'," says Cataliotti. "A 'prima donna' surgeon is not a good

"The first thing that a surgeon has to lose is the principle of being a prima donna"

Between 60% and 80% of drugs given to child cancer patients are not licensed for use in children

surgeon treating cancer, because you have to accept the collaboration of others. When we visit a patient with breast cancer, we start together, the radiologist, the pathologist, the surgeon, the plastic surgeon, the radiotherapist and the medical oncologist, from the beginning – not after the surgical treatment. Patients have to follow a very well-defined pathway. This is the main issue, to create this mentality."

ESSO has discussed turning itself into a federation to which organ based societies could affiliate, but the latest proposals for a single European cancer society are now seen as a possible way forward, although enthusiasm within ESSO for dissolving into a larger society is by no means universal.

Cataliotti is also currently President of EUSOMA, the European Society of Mastology, which has blazed a trail with guidelines on training and accreditation of all the disciplines involved in treating breast cancer, and accreditation of specialist breast cancer units. He is convinced that organising around multidisciplinary organ-based groups is the way to go, and talks of fledgling groups already in existence for urologists, coloproctologists, lung surgeons and others.

"Very often small hospitals exist in Europe where patients with a gastric cancer, for example, are treated by a surgeon who at the same time operates breast, colorectal, and thyroid cancer. Governments have to be convinced that to improve cancer outcomes, they have to accredit units, accredit specialists, and insist on proper training." He believes that a strong unified European cancer society would be ideally placed to convince them.

Cataliotti can foresee ESSO as a 'faculty' within a new cancer society, while EUSOMA will probably be the organ group for breast cancer multidisciplinary treatment. But he doesn't underestimate the problems in making such far reaching changes. "We can imagine what will happen in 5 or 10 years, but the first period will be difficult. We have a reality that has to be respected. ESSO exists, and the members of ESSO don't want to lose their identity. They want to recognise themselves. At the same time, EUSOMA members want to preserve the identity of a society of specialists who work under the umbrella of breast cancer, because it has been terribly efficient and constructive. The new society has to guarantee that surgeons or breast specialists can work together as a faculty or as a group."

The key question is whether cancer surgeons who did not join ESSO can be persuaded to join a unified European cancer society. "What ESSO members are saying is: 'Please take it slowly. Not in a few months, but in a few years, or we will lose the chance to encourage surgeons in all specialities with an interest in cancer to be members of the new society and to give their contribution to the multidisciplinary approach to cancer treatment."

SIOP EUROPE

PAEDIATRICIANS IN SEARCH OF A VOICE

Günter Henze: The voice of cancer in Europe must be strong; a paediatric faculty would provide adequate representation for the paediatric oncologists

The other group most inclined to value unity over autonomy is the paediatric oncology society, SIOPE. Paediatric oncologists have never had a problem with their own identity, but they feel appallingly let down by the political establishment and are looking for a powerful voice that can compel governments and the EU to pay more attention to children with cancer in Europe.

Between 60% and 80% of drugs given to child cancer patients are not actually licensed for use in children. The potential for lifelong damage by these powerful drugs and by radiotherapy is all the greater in bodies that are still developing. Paediatricians are desperate to see

targeted drugs developed for their patients, and for molecular markers that can tell them which children need intensive treatment, and which can be spared.

SIOPE president Günter Henze says that paediatricians do what they can with limited resources. They have a strong culture of international networking, reflected in the fact that the majority of child cancer patients (as high as 95% in Germany) are enrolled in treatment optimisation trials. He argues that this research-driven approach to treatment has caused mortality rates to fall faster in childhood cancers than in other cancers in recent decades. "We analyse the results, we look for strengths and weaknesses, and then adapt the subsequent trials to the results."

Because childhood cancers are too rare to be of much interest to the pharmaceutical industry, and in the absence of significant government funding, child cancer research is heavily dependent on charity funding – and vast quantities of unpaid overtime. But this fragile research base has been badly damaged by the EU clinical trials directive, which has made trials more bureaucratic and has more than doubled the cost of conducting a trial.

The paediatric system of research based treatment is not just underfunded, but is actually penalised in some countries. In Germany, health insurance companies have, on occasion, refused to pay for patients treated within clinical trials because they say it is science and not health care. Now the EU clinical trial directive is increasing the costs, particularly of international trials. Henze believes that this added burden is unsustainable, and says if the EU makes laws, it must also provide the financial support to make it possible to comply with them.

With the support of FECS, SIOPE has convinced MEPs to sponsor amendments to the Draft Regulation on Medicinal Products for Paediatric Use to guarantee that the needs of the academic sector are taken into account. Most of these were accepted at the first reading of the draft legislation in early September. However, the main focus of the Regulation is on encouraging pharmaceutical companies to undertake clinical trials for paediatric indications, by extending their patents for six months.

Henze says, "Trial protocols – highly complicated treatment plans – are being written by paediatric oncologists in the evenings and on weekends and holidays. This is serious work, and it has to be paid for. We cannot have a situation where pharmaceutical companies say 'we need this price' and the manufacturers of equipment say 'we need this price', and there is no money left for physicians and nurses. We are treating life-threatening malignant disease, and everything that has to do with these diseases cannot be an issue of charity."

Unlike the other FECS societies, SIOPE is not an independent society, but part of the international SIOP network. With no full-time secretariat of its own, and a pressing need for a greater voice at the political level, the prospect of being part of a powerful unified European cancer society is attractive, provided paediatric oncologists can trust that society to fight for them. Henze clearly believes they can. "The voice of cancer in Europe must be strong, and if we have a paediatric faculty within the society, I think this would give a reasonable representation for paediatric oncology."

ESTRO

RADIOTHERAPISTS ARGUE FOR A HALF-WAY HOUSE

Michael Brada: A cooperative of societies that could join forces where appropriate would be best. If everyone merges into a single structure, individuals may feel lost

Of all the FECS member societies, radiation therapists and oncologists are probably most happy with the status quo. There are no issues about recognition, as radiotherapists work almost exclusively with cancer, in tightly organised multidisciplinary teams concentrated in the larger hospitals and cancer centres. They are also relatively confident in their powers of political lobbying. Their priority, according to ESTRO president Michael Brada, is to ensure equity of access to high standards of radiation everywhere in Europe and promote research into improving treatment results.

Radiotherapy, he says, is given to 50% of all cancer patients and is the second most important curative treatment after surgery. It is also the most technical of the three clinical oncology disciplines.

A good service requires up-to-date equipment, adequate mechanisms to ensure that the equipment

works as it should, and investment to update radiation oncologists, physicists, biologists and technologists in the latest techniques and multidisciplinary approaches.

ESTRO recently completed a study of the radiation oncology needs in each country together with a survey of the availability of equipment and skilled personnel. The findings, says Brada, document huge discrepancies across Europe, and should provide a potent lobbying tool. "We want to make this information available for each individual country so that the societies within each of these countries can appeal to their governments that this is the standard that is required."

ESTRO has also put into place EQUAL, a Europe-wide quality assurance programme. Radiotherapy currently involves complex techniques, some of which allow far higher radiation doses than were previously possible, making the accuracy of dose delivered particularly critical. EQUAL developed quality assurance tools, and has a centre in Paris that provides quality assurance tests throughout Europe. At the same time ESTRO is encouraging radiation oncologists to lobby for quality assurance programmes within their own countries.

Education is also a priority, with 13 annual ESTRO courses as well as conferences. Brada says: "We feel that this education should spread to all European countries and everybody should have access to it, regardless of the wealth of the country." Attendances from Eastern and Central European countries in particular have been strongly encouraged through heavy subsidies.

ESTRO can point to notable lobbying success at EU and national levels, resulting in significant investment programmes in the UK and the Netherlands, improvements that Brada hopes will be replicated in other European countries.

ESTRO has also done better than other FECS societies in getting its hands on EU research grants, to finance – amongst other research – their work on quality assurance and the research into disparities across Europe.

Brada accepts that FECS needs to find ways to appeal to a broader layer of cancer professionals, and he is not hostile to the idea of a single European cancer society. But he would prefer a "cooperative" of societies rather than an individual member society. "I'm not sure our members want to be part of some enormous organisation where their voice gets lost.

"It would be much simpler if each organisation remains autonomous, but joins forces in activities that are better carried out together, such as PR, lobbying, annual conferences and educational activities. Beyond that, each one should be able to do what they need for their own professionals.

"If a single very big structure is created, individuals disappear and the leadership is just some distant headquarters. It is likely that everybody will get disenchanted and create a repeat of their own society."

EACR

Whose research is it anyway?

Bill Gullick: Even if the societies do merge, it won't be enough to make governments sit up and listen. It is the views of patient organisations that politicians care about

IF anyone has cause to be disenchanted, it is probably basic cancer researchers. EACR President Bill Gullick maintains an impeccable diplomatic silence, but he is clearly not happy with the direction of the debate. It could be that, as past president of FECS, he values the Federation and sees no need for change. But he and his members may also wonder what basic researchers will get from an organisation that cynics may claim has been created to satisfy the medical oncologists' desire to capture the limelight.

The targeted treatments that medical oncologists want to parade at a European equivalent of the ASCO conference are, after all, the result of decades of work by basic scientists,

Availability of radiotherapy equipment and skilled personnel varies enormously across Europe

"It is an exciting time for basic cancer researchers – the science is progressing at a dizzying speed"

delving into the way our bodies regulate themselves: identifying signalling networks, documenting genomic profiles, visualising and describing the genes, proteins and other components in molecular detail. Furthermore, the contribution of basic and translational researchers will be essential to the introduction and evaluation of any individualised cancer drugs in the future.

Gullick says: "This is a challenge for all of us. It involves a number of groupings who have not worked very closely before – basic scientists, translational researchers, biotech companies and pharmaceutical companies – as well as organisations such as the patient advocacy groups who can affect political decisions as to whether these types of medicines are made available."

Gullick's own laboratories at the University of Kent, UK, are currently investigating why only 30% of breast cancer patients who test Her+ respond to trastuzumab (Herceptin). Finding an answer to this question may prove vital in persuading governments to make this drug available as an adjuvant.

They are also trying to develop simpler tests that do not require DNA sequencing, and can be done in a standard hospital pathology lab.

Gullick sees resources for research as the biggest challenge. Like many others, he was shocked by the findings of a survey that showed Europe spends one-seventh of the amount invested in cancer research in the US. "Most of the problems of translational research are due to funding.

"There are three countries in Europe that invest around 400 million euro each – the UK, France and Germany. Then there is a group of countries such as the Netherlands, Sweden and Italy that invest around 50 million euro, and the rest have effectively no spend on cancer research at all. So one of the issues is: why is there such an enormous heterogeneity of activity?"

Despite lack of investment and poor career opportunities, which cause many young scientists to opt for other professions, this is a stimulating time for basic cancer researchers.

The science is progressing at a dizzying speed and scientists are enjoying the experience of working close to the clinical frontline and seeing the impact they are having on patients.

Gullick is excited by the younger generation who do opt for cancer research. "We've just chosen the EACR Young Cancer Researcher Award, and to say I was impressed is an understatement. We had five or six candidates who were simply outstanding. We are going to sponsor them to go to ECCO to present their work to give an opportunity for other scientists to hear these results and learn from them."

He is equally excited by the potential of young scientists from Eastern and Central European countries. EACR has been making considerable efforts to draw them in, particularly through its fellowship programme, which offers a chance to work in some of Europe's leading cancer research institutes.

One result is that the EACR conference has been rapidly growing in both size and stature – Gullick is particularly pleased to be welcoming leading medical oncologists like José Baselga to the next EACR conference.

More than 700 people attended last year, among them an American researcher who said that if a conference of such a high scientific level had taken place in the US, it would have had an attendance of 7,000. That shows, says Gullick, that the problem is not with the quality of Europe's scientists.

Given the pressing need to convince the politicians to put more money into cancer research, the prospect of a single, powerful cancer society might seem attractive. But Gullick believes governments only listen to patient organisations, and think that scientists are interested in science for its own sake. "We are seen as a special interest group and treated as any other special interest group."

A unified cancer society could deprive researchers of the public profile they are beginning to build, after decades of pioneering work. If the new society bears any resemblance to ASCO, they have every reason to fear the spotlight will fall on clinical researchers, eclipsing the contribution of basic research and their need for resources.

EONS

Nurses on the sidelines

Jan Foubert: I think we will get more by working with European nursing organisations, but if there is a new European cancer society, we will keep the door open

Oncology nurses are equally sceptical about a new unified cancer society, although for different reasons. EONS president Jan Foubert argues that FECS never acted as a truly multidisciplinary society and that the proposed new structure is likely to be even more narrowly focused.

The Federation, he says, never lobbied for the nurses' cause, though Foubert accepts part of the blame, saying that EONS should perhaps have demanded more. But he says that while EONS did participate in meetings, they never felt their voice was heard. He cites as one example the lack of response by the other societies to EONS' suggestions for adding a nursing research element to proposed clinical studies.

"When they talk about multidisciplinary, they mean the surgeon, the radiotherapist and the oncologist. For me, and for most nurses, it also means nurses, psychologists, dieticians, physicians – all the people who are taking care of the cancer patient."

Well-trained cancer nurses, he argues, are absolutely essential to providing adequate patient care. They spend more time with patients. They support them and their families, advising on nutrition and ways to cope with stress, nausea and fatigue. They play a key role in symptom management, advising patients about treatments to alleviate pain, anaemia or neutropenia, and teaching them to recognise when symptoms need immediate attention. In short, good oncology nurses are vital for addressing the problems that cancer patients find hardest to live with.

The trouble is, only a few countries offer nurses the training or responsibility to fulfil this role, and there are wide discrepancies across Europe. In some countries becoming a cancer nurse requires a full extra year of training; others require only a one-day course, or modules. EONS is campaigning for oncology nursing to be fully recognised as an accredited speciality throughout Europe, but fundamental differences in cultural approaches to nursing make this an uphill struggle. While some countries see it as an academic profession, with degree and PhD courses, others regard nursing as strictly vocational. In some countries, you can become a nurse at 16 years of age.

The focus of EONS has therefore been on education. They have put together a core oncology nursing curriculum, which details contents, contact hours and how the courses should be taught. However, it is not a recognised European standard, and each country chooses its own approach.

A new EU initiative, the Bologna Agreement, is set to change all this, through a common European model for higher education. Under its terms a nursing qualification will be defined as a bachelor's degree, and further bachelor standard qualifications will be required for specialist nursing. This offers a uniform system where nurses need a degree and a further degree in oncology nursing. EONS is restructuring its core curriculum to fit the competency-based Bologna model, and wants its course to be the starting point for discussions on an oncology nursing curriculum.

EONS has also constructed courses on such topics as fatigue management, nutrition, and most recently on haematological toxicities (TITAN). The take up of courses is increasing as oncology nurses become more organised and as EONS gains experience in administering courses for different nursing cultures in many languages.

In eight years, the number of national societies in EONS has risen from 22 to 28, with Bulgaria the latest of an influx of countries from Eastern and Central Europe. The fact that 23 societies expressed an interest in the TITAN course illustrates the impact that EONS is having.

EONS has gained respect and self-confidence and now seems to have escaped from the shadow of the medical disciplines in FECS. "We have become an independent organisation, with our own strategy, business plan and sponsoring, our own good conference and our own partnerships with industry," says Foubert. It has also found itself a new strategic umbrella group, in the recently formed European Federation of Nurses (EFN), a body with EU status that has as its aim to "strengthen the status and practice of the profession of nursing and the interests of nurses in the EU and Europe". EONS is part of the European Specialist Nursing Organisations section of the EFN and has a seat on the EFN General Assembly.

Foubert says bluntly, "I think we would have more chance to have oncology nursing recognised as a specialty by working with European nursing organisations than by working with the current FECS." However, he is advising the EONS council to keep the door open to any new European cancer society: "We should participate in the months and years ahead to see how this new society will look. You have to keep talking and hope these people will listen to you."

Did somene say unity?

Six FECS societies reflect six different sets of problems, and conflicting priorities. With the inevitable arguments over where research, money, training and equipment, should be concentrated, could a unified European cancer society ever be a runner? Bartelink, who as President of FECS speaks as somewhat of a father figure, has little doubt.

"This is really the strong argument for the new society. Because this debate should happen inside the society. It is much better to have this multidisciplinary approach within the board or wherever, rather than have medical oncologists say 'all patients need Herceptin', and two days later ESTRO says 'we need modern linear accelerators' and ESSO says 'all hospitals need modern laparoscopic surgery'. That would be a disaster, because none of the three will get the money."

The question for the FECS societies is who will be the dominant voice? Will everyone have an equal say, or will some end up trapped, with neither power nor profile, within a European ASCO?

Eggermont, from the EORTC, acknowledges this concern, particularly among smaller organisations, but argues that it is when each society fights for itself that only the most powerful voices are heard. "I think that precisely the smaller organisations – for instance the scientists in the EACR, or the surgeons – have everything to gain from the creation of a European cancer society, because hardnosed discussions and scientists will drive the agenda. I don't think those discussions would necessarily be dominated by medical oncologists. They would be dominated by realistic priority setting, by agreeing that everything will be science and evidence driven. It is a much better platform to create a political and representative agenda."

Bartelink is clear that most European oncologists do not want to adopt the ASCO model or to single out medical oncologists as contributing the most to progress in cancer treatment. "Let us not forget that surgery and radiotherapy are still the treatments that cure most cancer patients. Progress has come from all the disciplines. Surgeons have developed techniques that are less mutilating, radiation oncologists have significantly improved their technology, producing less severe side-effects, and higher cure rates, and, of course, medical oncology, thanks to new research developments, has contributed too."

Despite these assurances and Kosmidis's insistence that ESMO has no wish to eclipse other disciplines, many see it as inevitable that money and influence from close ties with industry will make ESMO top dog in a single organisation. Whether that turns out to be the case, depends in part on the hard bargaining that is still going on within the Federation to determine how much autonomy and financial resources different disciplines will have, and how the leadership of the proposed society will be determined.

Lex Eggermont: A single European cancer society will set realistic, science-driven evidence-based priorities. The smaller FECS societies have most to gain

Getting this right could set the scene for the blossoming of a multidisciplinary organ-specialist approach, and give Europe's cancer professionals a unified and powerful voice that can secure desperately needed investments in research and services. Getting it wrong could set back the cause of a truly multidisciplinary approach that recognises that progress in cancer care means a great deal more than new and better drugs.

"It is when each society fights for itself that only the most powerful voices are heard"