Reducing your cancer risk with John Whyte, MD, MPH

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Featured topic and speakers

WebMD's Chief Medical Officer, John Whyte, MD, MPH, discusses the latest on cancer screenings, prevention, lifestyle changes for patients, and why cancer death rates declined in the U.S., but late-stage prostate and colorectal cancers have risen in young people. AMA Chief Experience Officer Todd Unger hosts

Speaker

- John Whyte, MD, MPH, chief medical officer, WebMD

Transcript

Unger: Hello and welcome to the AMA Update video and podcast series. Today, we're talking about controlling your cancer risk and what physicians need to know about the latest developments in cancer prevention and mortality rates. I'm joined by Dr. John Whyte, the chief medical officer of WebMD in Washington, D.C. I'm Todd Unger, AMA's chief experience officer in Chicago. Dr. Whyte, welcome back.

Dr. Whyte: Thanks for having me. It is always great to spend time with you.

Unger: Well, thank you. When we last spoke about a year and a half ago, you had just released a new book Take Control of your Cancer Risk. And now you must have 40 books.

Dr. Whyte: Not quite 40, a couple more.
Unger: That's fantastic. And I've seen you all over the news. I've seen interviews with Dr. Phil. You've really done amazing stuff over the past year and a half. So congratulations.

Dr. Whyte: Well, thank you.

Unger: Let's talk a little bit more about your book because there's a lot that's really interesting in here. Starting kind of with the assumption, which I think a lot of patients think of their cancer risk as something that's out of their control—it's kind of a genetic issue or bad luck. But according to your book, that's not exactly the case. Why don't you explain where you're coming from on this?

Dr. Whyte: And you're right there's this big misconception that our genes determine our cancer risk. And there is some element of genetics, but it's only about 20%. The data is consistently shown that about 80% of cancers are really caused by lifestyle, what we eat, how much we weigh, how active we are, the environment in which we live. And it's kind of good news, bad news.

I mean, the good news about this is that often we can control those elements. We can control to a large degree, what we eat and how active we are, the quality of our sleep. So that can be encouraging news.

You know, Todd, I think part of the challenge is we hear so much about these genetic tests that are available. And that's exciting. But, remember, those look for inherited mutations, which, again, is a small percentage of the overall risk for cancer.

Unger: And these kind of misconceptions, they are not just among patients. In fact, as we talked about last time, many physicians don't realize the effects that even things like food can have on our cancer risk. How has the medical community and physicians, in particular, responded to your book? Have you been able to narrow this information gap or is there still more work to do?

Dr. Whyte: Yeah. Well, I've got a lot of positive comments from patients that will often say, oh, I didn't know that information or I really appreciate the specific information about what I should eat. In general, physicians, my colleagues, and friends have been very supportive of providing a resource for patients, as well as the clinical community.

The challenge is that we're not taught these things in medical school. We're not taught about the role of nutrition. But we know that food is as powerful as a prescription drug. We tell patients you need to lose weight. But we don't tell them how to do it because many of us don't quite know what we should be telling them or what we ourselves should be doing.

We know there is overweight and obesity in a lot of physicians. So the response has been very positive and just goes to the fact that we need to be providing this type of information to our patients. And we need to be learning it ourselves.
**Unger:** Well, let's talk a little bit more about that because we've talked before on different episodes about the lack of nutrition training in medical school. It's no wonder that it's not necessarily a strength among physicians to talk about it. You mentioned this issue of being able to really counsel patients on this particular aspect. How do we do a better job of making sure that physicians have this information so they can help patients understand what they can and can't control?

**Dr. Whyte:** The AMA has had some excellent resources really describing how do we help patients understand about the DASH diet, which we know can improve hypertension, blood pressure control. There's been multiple programs that you have had in terms of CME programs about Mediterranean diet and how that impacts cardiovascular disease but also just in terms of some healthy eating programs that the AMA has done. I think we need to continue to do that. I think we need to advocate that there's adequate payment.

Right now, you're not paid a lot to talk to patients about lifestyle in terms of that the counseling code. So we really need to encourage adequate reimbursement so physicians have the time and the resources to be able to do it. That's what I'd like to see more of.

**Unger:** Been in the headlines recently a study that was published by researchers from the American Cancer Society that found that cancer death rates have dropped by about a third since 1991, which is good news. We often hear about this in terms of doom and gloom, but it seems like this is a piece of good news. What factors are driving a decrease like this?

**Dr. Whyte:** It is a piece of good news. We're looking over 30 years, so that's a pretty significant amount of time to have a good assessment. But the biggest reason for that decrease in the last 30 years is the decrease in smoking. If you think about 30 years ago, how many people were still smoking?

A while back, a lot of listeners would be too young, they were smoking on planes. Restaurants would still have smoking sections. So that's been probably the biggest reason why we've seen this decrease in cancer deaths. Again, lifestyle.

The other issue has been we have much better screening strategies over the last 30 years. Think of the number of options that we have in colorectal cancer. We have much better screening strategies for breast cancer and new technologies and devices for mammography. So those really are the biggest reasons, as well as some of the advancements that we've had in treatments.

So that's what's really exciting. But we have to also keep in mind that 600,000 plus people die every year from cancer. So even though we've made these significant advances, especially over the last 30 years, it's still a leading cause of death. And hundreds of thousands of people die every year. And there's still a lot of morbidity associated if you do develop cancer. So the key has to be prevention, and our health care system, Todd, no matter what we really want to do, it doesn’t encourage prevention.

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Unger: And that is a problem. Now interesting to juxtapose what we just talked about in terms of reduction in cancer-related deaths against a recent report from the CDC that shows a decline in life expectancy in the U.S. for a second year in a row. And it's now at its lowest since 1996. So what is going on?

Dr. Whyte: Well, as you know, much of this over the past three years has been related to the COVID pandemic and million plus people who have died from COVID and even more from related illnesses. So that has played a big role. There's also been a big uptick in terms of mental health challenges, in terms of depression, anxiety, substance abuse. We're seeing increases in substance abuse, increases in suicide.

And we're not always recognizing the mind-body connection that there really can't be any physical health without mental health and mental health without physical health. But we're so siloed taught in terms of how we think about health. And we really need to recognize the impact that mental health has had over the past three years and that it's going to continue to have over the next probably decade. So I expect we'll see improvement in the next report mostly because we really have gotten a handle on COVID. But we're going to start to see mental health challenges and significant morbidity and mortality from that area.

Unger: Now, Dr. Whyte, even though the overall cancer deaths have dropped over the last 30 years, we've also seen an increase in some cancers, including late stage prostate cancer diagnoses, particularly among Black men, why is this? And what should we be doing about it?

Dr. Whyte: Yeah. And let's put this in perspective. African Americans have a 70% greater increase than Caucasians do in terms of the incidence of prostate cancer. And often when they do get prostate cancer, it's at a more advanced stage. And this is a great example where we think about the role of the medical community.

And in terms of PSA screening, prostate cancer screening, we really have had different strategies over the last 20 to 30 years. Whereas early on in my training because I've been around for a while, we ordered a PSA on everyone over 50. And then we kind of said, oh, hold off, hold off on that. We really shouldn't be doing that on everyone, that really we should have this shared decision making approach and talk to patients about it.

So as opposed to automatically being a test, we made it really optional when to have a discussion. And I think a lot of people opted out of it. And I think many doctors didn't really talk to patients about it because that's not really our strength at times, sharing that decision making.

And now we're starting to have an approach, again, about having a comprehensive strategy for screening for prostate cancer. So I think in many ways, it's been we became a little more liberal in terms of how we think about prostate cancer screening, that we didn't always do it. Also, we have an
aging population. Prostate cancer like colon cancer is really a disease of aging. For the most part, cancer is.

And as we get older, we're going to see more prostate cancer. So that's one component, that's the increase, but it's also because of these changes in screening guidelines, which can be confusing. Do you order a PSA? Do you not order a PSA?

What year do you start screening? What year don't? And that's where we really need the medical community to come up, especially as it relates to primary care to say this is what good care looks like for prostate cancer screening.

Unger: Now when we think about inequities like we just talked about in the realm of prostate cancer and there are, of course, many others, what legislative action would you like to see introduced that would help address those in cancer prevention and treatment?

Dr. Whyte: Yeah. And there has been a lot of improvement based on the Affordable Care Act. But what we need to make sure is that people don't incur a cost. Even a co-pay can be too much for some people in terms of screening procedures. And right now, most of it is if the U.S. Preventive Services Task Force recommends it, then it has to be covered.

And as I just mentioned, in prostate cancer screening, they've had a lot of different strategies over the years in terms of what should be done. So we really need to have no cost, whether you're insured or uninsured, for screening tests for cancer. And we need to be much more aggressive about screening tests. We know for lung cancer, for low dose CT scans—I mean, we're talking in the teens the number of people that qualify that actually get that low dose CT scan done for a certain history of lung cancer.

So we need to make these things low cost. We need to make them easily accessible. If you're 10, 20 miles from a physician's office or a hospital or health center, it can be hard getting to some of these procedures. So we need to make that more accessible as well, perhaps more mobile screening as we've done with mammography in terms of bringing the exam to patients. So I'd like to see that.

And then I'd like more discussion in the clinical community about what those recommendations are. As you said, they can be confusing. I see physicians can get confused, and I've gotten too confused in the past of what constitutes family history when you're really interviewing the patient in terms of what's a first degree relative versus a second degree relative and the age of the diagnosis at screening. So we really need to have a more robust discussion with patients. And I want to have greater clarity around these genetic tests.

But I'll tell you, Todd, I'll have patients that have taken a genetic test and will be like, oh, I'm not at risk. I don't need to get screened. And I'm like that's only looking at a few variants, whether it's for breast cancer or colon cancer or some prostate cancer. And that's all in the fine print, literally the fine print,
on some of these tests.

Most people don’t read that. It’s very hard to find online. So we need to give good guidance to patients as well as to when they’re eligible for screening, when they should get screening, how often they should get screening.

**Unger:** Yeah, just as you mentioned there, the genetic part is just a small part. And then all of those lifestyle decisions don’t sit on the sidelines there. Now, Dr. Whyte, interesting other news showing up in the headlines. We’ve been seeing cancer showing up in younger people that we didn’t expect.

Colon cancer is a great example of that. And it actually drove a recent change in screening guidelines. Tell us more about that change and why this disease seems to be showing up kind of unexpectedly in younger people.

**Dr. Whyte:** I mean, the data were surprising because, typically, we see colorectal cancer after age 50. It’s a slow growing tumor. And it’s usually something that occurs in older people not younger people. So we don’t know exactly why that’s occurring.

Part of the reasons are probably relating to as we talked about that there is a growing epidemic of obesity. Many of us are overweight. We’re not eating healthy foods.

In terms of red meat, processed meat, the consumption of those have increased significantly over the past few years. There’s also issues of substance abuse that we’re seeing in younger populations. So all of those together are probably contributing to this increased rate of colon cancer.

I mean, the good news about it, though, is that the medical community has been responsive to it and is saying, hey, we need to think about screening guidelines and changing that age of when we need to start screening. So that’s a great example of how the medical community has responded to the data and has taken action to try to stop that increase in a younger population.

**Unger:** So I guess what I’m hearing from you is we’ve got a lot of good news but obviously a long way to go before cancer is completely eradicated if that’s even possible. But when you look at the future, what excites you the most about these areas of prevention and treatment efforts?

**Dr. Whyte:** Todd, I'm really interested in the role of tech. And what I'm excited by is we really have the capability to bring health care into the home because health happens outside the doctor’s office. So we’re all wearing smart watches, what I’m calling the smart jewelry, the wearables. But I've been learning about nearables. Heard it here first, Todd.

**Unger:** All right, what is that?
Dr. Whyte: A light bulb. These devices that are near you and collect your biometric data. So a light bulb that is in your home that's going to measure your heart rate, your sleep score, is going to detect a fall. I mean, it's amazing the technology that we're developing, the use of video cameras that could be incorporated into Zoom to tell me about blood pressure. It's the use of miniaturizing labs.

And there's multiple companies that are doing this, that you're going to put in your toilet bowl. Not making this up. The bathroom is the future doctor's office where it's going to monitor my urine every time you go to the bathroom.

And on average, it's seven times a day for people. And it's going to tell me whether or not I'm at risk for diabetes. It's going to tell me whether I have developed a UTI.

Also, there's another device that's going to look at stool. It's looking for blood. So it's going to tell me about hemorrhoids, perhaps a proxy for cancer. But think about it. Ultimately, we're going to get there. It's going to be iterative. It might be able to tell whether or not I have any cell fragments that represent cancer.

So what I'm excited by is the use of these different technologies to provide me personalized data, my data, over time that's not just in the doctor's office that happens once or twice a year or once every other year for many people. And that's going to allow me to have better health. And, hopefully, as a physician, that's going to make my job easier because I'm going to have early warning signs of disease.

And I'm going to be able to monitor people over time, not just the infrequent visits to my office. That's where I think the future is, Todd, and that's exciting. I think we've got a little bit of time to go. But these processes are iterative. And they're only going to get better.

Unger: That is exciting. And I think we'll end on that note. That wraps up today's episode. Dr. Whyte, thanks so much for joining us again and for all the work that you're doing.

Dr. Whyte: Thanks for have me. Any time, any time for you, Todd.

Unger: For more information on cancer prevention, you can find Dr. Whyte's book Take Control of your Cancer Risk at bookstores. Dr. Whyte, what's next up for you in the writing world?

Dr. Whyte: I've been thinking about it. I haven't made any commitment. But the other area that I get a lot of questions about is the gut, the microbiome. And we're learning a lot about the role of the gut, especially in terms of immune function. So stay tuned on that one.

Unger: I'd love to see that book because that's an area of my interest as well. And so much to learn there. But look for more about Dr. Whyte book in the link in the description of this episode. And we'll
be back soon with another episode. In the meantime, you can find all our videos and podcasts at ama-assn.org/podcasts. Thanks for joining us today. Please take care.

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