**Concordia res parvae crescent**

Recently I have been thinking about “doing good”, which is to say I have been considering how best to do good, rather than the possibility that I might abandon my wicked ways. The poet W. H. Auden, whom I have acknowledged previously as an inspiration [1], said “We are here on Earth to do good to others,” adding “What the others are here for, I don’t know.”

So consider that idea: we are here on Earth to do good to others. As physicians we are schooled in the ethical concept of beneficence, of doing good, but it stands with several other fundamental ethical concepts: non-malfeasance, autonomy and justice. Increasingly, I find my own work forces me to concede the importance of justice as a means of achieving beneficence. In this issue of *Annals of Oncology* Woods et al. [2] review the association between cancer survival and socioeconomic status, an association that has been observed for several different cancers, in different clinical and geographic settings. Moreover, Woods et al. argue that explanations based on stage of presentation and treatment differences, though powerful, are not completely satisfactory. More research is clearly necessary, but we must accept that such disparities are susceptible to intervention.

And if we are talking about justice, we must acknowledge that cancer is a global disease, and that disparities exist between the countries of the world. The WHO estimates that as we approach 2020 there will be potentially 16 million new cases of cancer per year and that the proportion of those patients living in developing countries will approach 60% [3]. That would make around 10 million new cancer cases in developing countries each year. Our capacity for good should not necessarily simply respond to weight of numbers, but here that weight, those numbers, are compelling. I repeat, we must accept that such disparities are susceptible to intervention.

The question arises then how can we intervene meaningfully in the lives of millions, perhaps billions, of people?

The answers I want to offer here are not new ones. My contention is that most of us understand already how to be good, even if we do not always act on that understanding. My answers? Education, collaboration, research – and the courage and will to take them where they are needed. Don’t tell me you didn’t know.

I hope that we have been able to find space for these ideas in *Annals of Oncology*, see, for example, the Recommendations for a Global Core Curriculum in Medical Oncology [4], and the Statement by members of the Ponte di Legno group on the right of children with leukemia to have full access to essential treatment for acute lymphoblastic leukemia [5].

What we do not need is developed-world paternalism or, I can barely write it, imperialism. Collaboration must be real and honest. My friend Vinod Raina has in these pages explained how Indian oncologists are working to develop clinical research in India, through the INDOX trials network (www.indox.org.uk) and the benefits that such work can bring to daily clinical practice [6]. More recently I attended the International Conference of the African Organization for Research and Training in Cancer (www.aortic.org) in Senegal and heard at first hand of the work African colleagues are doing. I am proud to be involved, in however small a way, with these people and their initiatives, for how we, as cancer professionals, can work to achieve public health goals at the global level is something that should concern us all. Through collaboration, using science to inform our decisions, and considering the real needs of our populations, we have the possibility to shape the future for the better.

Pride brings me, inevitably, to *Annals of Oncology*. It has become customary in these annual commencement editorials for me to recap the previous year’s achievements and trail those of the coming year. I have left myself but little space, and a good job too, though I might say much: last year *Annals* received a record number of new manuscripts, some 1200, served the best part of a million full-text articles from its website, and recorded another record increase in impact factor, to 4.335. Online publication ahead of print accepted articles routinely published online within 5 weeks of acceptance. We celebrated 30 years of ESMO [7], launched online CME and E-letters, and produced some rather attractive promotional T-shirts. By which I mean I in no way intend to trivialize the quality of the articles published or the work of editors, referees and staff. *Concordia res parvae crescent* indeed. Particular mention should be made here of José Baselga who steps down now as an Associate Editor and whose contribution has been such that I have named two new Associate Editors, Alex Eggermont and Howard McLeod (Welcome!) to replace him.

Another significant step taken in the last year has been the move to make all *Annals* articles free online after 12 months. Further, through initiatives operated by Oxford University Press, the World Health Organisation (WHO) and the International Network for the Availability of Scientific Publications, over 900 not-for-profit institutions in developing and middle-income countries have registered for free or greatly discounted online access to the journal. A small step for beneficence and justice.

In the coming year we plan to repeat the process of awarding prizes recognizing the best paper published over the preceding 2 years in each of the following categories: translational science; phase I; phase II; and phase III. I am confident that we will find this process as rewarding as last time [8], but I am bound, as I was then, to acknowledge some wonderful work that will not be eligible for prizes: insightful editorials (see, for example, [9–11]), rewarding reviews (see, for example, [12–14]) and fundamentally important projects, such as the International
Expert Consensus on the Primary Therapy of Early Breast Cancer 2005 [15].

This year, let’s do some good.

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