THE CANCER LETTER

Vol. 7 No. 30

July 24, 1981

Subscription $125.00 per year

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HOP DEVELOPMENT PROCEEDING; GUIDELINES FOR NEW, REVISION OF EXISTING CONTROL GRANTS BEING WRITTEN

NCI's embryonic Hospital Oncology Program will be moved farther along in its development at two meetings scheduled for this summer—one, of the Div. of Resources, Centers & Community Activities Board of Scientific Counselors Committee on Community Oncology & Technology Transfer; the other, of the Assn. of Community Cancer Centers Clinical Research Committee.

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In Brief

SHINGLETON "UNRETIRES" AS DIRECTOR OF DUKE CENTER; O'BRIEN INTERIM HEAD AT USC WHEN HAMMOND LEAVES

BILL SHINGLETON'S "retirement" as director of the Duke Univ. Comprehensive Cancer Center (***The Cancer Letter***, July 10), was short lived. The search committee set up to find a new director "strongly and unanimously" recommended that Shingleton be appointed to another three year term as director, and he accepted. "The meeting took three minutes," **WILLIAM ANLYAN**, vice president for medical affairs, commented. . . . **RICHARD O'BRIEN**, director for research and education of the Univ. of Southern California Comprehensive Cancer Center, will serve as interim director of the center when Denman Hammond leaves the directorship Aug. 5. A search committee will be formed to assist in recruiting a new director. **ALLEN MATHIES JR.**, dean of the USC School of Medicine, said the comprehensive cancer center and the Norris Cancer Research Institute owe their existence to Hammond's vision, planning, organizational skills, and drive. . . . **UNIV. OF NEBRASKA** Medical Center is inviting nominations and applications for the position of director of Eppley Institute for Research in Cancer & Allied Diseases. Qualifications include "an earned doctorate, outstanding research accomplishments, and administrative skills," the university said. Applications and nominations accompanied by CV and three references may be submitted by Oct. 1 to Dr. David Purtilo, chairman of the search committee, Univ. of Nebraska Medical Center, 5001 Wittson Hall, 42nd & Dewey Ave., Omaha 68105. . . . **SEN. HOWARD METZENBAUM**, responding to the letter from **HERBERT KERMAN**, president of the Assn. of Community Cancer Centers, supporting the reappointment of NCI Director Vincent DeVita, said: ". . . Dr. DeVita has satisfied my skepticism about the research grant process by enumerating the various procedures he has instituted since assuming the directorship of NCI. I fully support the continuation of Dr. DeVita as head of the Institute." . . . **CORRECTION**: Robert Byrne, who died of a heart attack two weeks ago, was acting director of the National Institute of Allergy & Infectious Diseases' Extramural Activities Program, not of the Institute. Richard Krause is director of NIAID.

NEW, REVISED CONTROL CORE GRANTS WILL NOT BE LIMITED TO CANCER CENTERS

(Continued from page 1)

The Board of Scientific Counselors committee will meet July 31, at the Grand Royale Hotel in Minneapolis. The committee is chaired by Charles Moertel.

The ACCC committee will meet at the Chicago Marriott Hotel Aug. 27-29. Edward Moorhead is chairman.

William Terry, DRCCA acting director, and Stephen Carter, chairman of the Board of Scientific Counselors, will attend both meetings, as will a number of others involved with both organizations. A consensus on the scope and elements of HOP from the two meetings without further consultations probably would be expecting too much. ACCC members and NCI executives agree they would like to move as fast as possible to get HOP ready for initial funding in the 1982 fiscal year.

To do that, the program would have to undergo concept review by the BSC at either its October or January meeting, preferably the former. Completing the RFP or RFA process (depending on whether the funding mechanism is contracts or cooperative agreements) normally would require more time than January concept approval would allow, before the 1982 fiscal year ends Sept. 30, 1982. Some parts of the program might be implemented, however.

When NCI Director Vincent DeVita first suggested a new, broadened community program with emphasis on clinical research, he said the total number of hospitals which might be involved could be between 100 and 200. Later, when pressed for an estimate of the annual cost, he said it could be about $10 million. More recently, he told the Clinical Cancer Investigation Review Committee that the $10 million figure probably was too high.

Some of those involved in planning the program have different thoughts about the cost. They feel that $10 million for 100 hospitals might be sufficient to cover costs of participation in clinical research, but they want the program to be more than that. Establishing and upgrading hospital cancer programs and development of other community cancer control efforts represent the tradeoff they are seeking in return for improved access to vast new numbers of cancer patients for clinical protocols.

DeVita has suggested that resources other than NCI dollars might be offered—control by HOP participants of Group C drug distribution in their areas, which would help develop their contacts with practicing physicians; assistance, through centers and cooperative groups, with data handling and analysis; access to other services from centers and NCI.

While HOP might be envisioned as a nationwide network of community cancer programs, no one is suggesting that it will start immediately with 100 or 200 hospitals. It probably will be phased in slowly, perhaps starting with 10, then picking up the successful CHOPs (the existing Community Hospital Oncology Program), eventually reaching 100 or more in no less than five years—all depending on the program's viability as it goes. Further modifications would be inevitable.

Meanwhile, Terry and his DRCCA staff and advisers have been wrestling with other new concepts in cancer control, primarily development of a new core grant and revision of guidelines for the present core grant which supports outreach activities at centers.

The new core grant was proposed by the DRCCA Board's Cancer Control Committee, chaired by Lester Breslow (***The Cancer Letter,*** June 26). It would support "Cancer Control Research Units" at institutions (not necessarily cancer centers) and would be limited to research with "defined populations."

The guidelines for CCRUs proposed by Breslow's committee were unacceptable to the Board. Members of the Board, Terry, and Carter met earlier this month to work on a new draft. Their efforts were turned over to Terry's staff, and a new draft will be presented to the division's Board in October.

Terry originally had hoped that the new guidelines which will replace the outreach core grants could be completed in time for the 1982 renewal cycle. That is not now possible, so the decision was made to permit one year competitive renewals for those whose grants expire this year. DRCCA staff is writing new guidelines now, and a draft will be presented to the Board in October.

The existing cancer control core grants were designed to support outreach only at cancer centers. Also, it was NCI's policy, in force since the National Cancer Act of 1971 gave the Institute cancer control responsibility, that cancer control money would not be used to support research, except for rehabilitation research.

The new guidelines will scrap both policies. These core grants, like those supporting CCRUs, will be available to any qualified institution and will not be limited to cancer centers. And they specifically will permit support of cancer control research.

The policy prohibiting research with cancer control money probably was the most criticized aspect of the Cancer Control Program. Technology transfer, the prime mission of cancer control, was too narrowly defined, and there are a great number of questions which must be studied in cancer control methodology, critics have argued.

NCI expects that the number of CCRUs which will be supported in the first years of the program to be no more than four to six. There are 15 existing cancer control core grants, and NCI executives feel that this number under the new guidelines could

eventually reach 25.

Still another issue the DRCCA Board is handling is the suggestion by DeVita that the existing Cancer Center Support Grant (core grants, not to be confused with the cancer control core grant) may not be the best mechanism to support centers engaged only in laboratory research.

The Board's Centers Committee, chaired by Harry Eagle, met last week to discuss the issue. Committee members are writing summaries of the discussion, each covering various aspects, and Eagle will incorporate them into a document to be presented to the Board in October.

HHS TO DETERMINE FEASIBILITY OF OVERALL CHOP EVALUATION

An HHS sponsored program to evaluate certain of the department's health related activities will undertake an evaluability assessment of the Community Hospital Oncology Program.

CDP Associates Inc. has the overall HHS evaluation contract and will do the CHOP assessment under a task order, estimated to cost $100,000 in FY 1981 funds.

CDP will not do the evaluation itself under the task order. This study will be limited to determining what questions can be answered by CHOP and whether an evaluation is feasible. If NCI decides to proceed with an evaluation, that project would be competed through an RFP.

The CHOP RFP included a requirement for each contractor to conduct an evaluation of its own efforts but did not provide for an overall evaluation of the program's impact. Fifteen of the 23 CHOPs are coordinating their evaluations with Elm Services Inc. providing support. NCI expects that if it proceeds with an overall evaluation, it would be in collaboration with the Elm project.

The justification for the evaluability assessment follows, in part:

The Community Hospital Oncology Program is to be a field test of a clinical oncology program approach, or basic model, to community cancer program development. The ultimate objective of this program is to provide models for community planned and organized clinical oncology programs to effect nationwide improvements in the quality of cancer care at the level of the primary community. CHOP was developed in response to congressional mandates calling for development of locally initiated education and demonstration programs in communities that complement NCI cancer research and control initiatives through comprehensive and university cancer centers.

The model to be tested in CHOP evolved from the Clinical Oncology Program, initiated by NCI in 1974, in which seven programs were developed in diverse community settings, and planned and implemented based on specific community needs. This model is grounded in the principle that community programs are most successful when planned and developed by those who will use and be most affected by the program.

CHOP is a contract supported program, with contracts awarded to 23 community hospitals out of 60 submitting proposals. Each of the 23 community programs has negotiated contracts within the past six months to complete the 18 month planning phase. Implementation of the program will follow, and will be based on approved plans developed by the communities. Evaluation plans are also required of the contractors, to reflect not only evaluation at the individual community level but also participation in an overall evaluation of the national program.

The ultimate purpose of this task order is to define the national CHOP evaluation; i.e., agreed upon program objectives and performance measures; an evaluation approach and basic design, along with a common data set required of all contractors that is feasible and cost effective, and yet provides the information needed to assess the effectiveness of the model approach; and a plan for a national program evaluation.

As presently envisioned, this evaluability assessment would be completed by December 1981, in time for incorporation into the contractor's implementation and evaluation plans, the first draft of which are due by February 1982. Final plans are due by June 1982.

This evaluability assessment is greatly needed at this time for a number of reasons:

1. There has been almost a two year lapse in time since the issuance of the RFP and the implementation of the planning phase of the CHOP projects. Significant events have occurred during that time that need to be assessed from a program management perspective.

2. Since the time that the COPs were initially funded and the CHOP RFP released, NCI has undergone reorganization that has affected the previously established Div. of Cancer Control & Rehabilitation through a merger of programs and division management into a new Div. of Cancer Resources, Centers & Community Activities. In addition, between the time from the RFP release to the funding of the programs, NCI has a new director, the division has a new board of scientific counselors, and the program responsibility within the division is under a new director. Because of these critical changes, there is a need to assess the expectations of the new leadership regarding CHOP.

3. CHOP was developed in response to congressional interest in the mid-1970s. Because cancer control programs are congressionally mandated, it will be important to determine if CHOP is consistent with the mandate.

4. CHOP is a highly visible NIH program with Congress, NCI, and the professional community. The Assn. of Community Cancer Centers has strongly endorsed CHOP. Therefore, it is of utmost importance to ensure that the program is structured and evaluated under optimum conditions.

5. Early NCI experience in developing effective evaluation designs for cancer control programs has resulted in recognition of the need to carefully plan future cancer control evaluation programs.

6. The program officer and the director of the division are highly supportive and interested in properly evaluating CHOP in light of these various concerns. This interest is evidenced by inclusion within the RFP and the negotiated contracts of the requirements that not only the individual program evaluation be conducted but also that the projects participate in a specific task for national collaborative evaluation that would facilitate overall program evaluation.

7. The project officer has conducted a survey of the principal investigators of funded CHOP projects to assess their perception of evaluation needs. The results of this survey have indicated strong support for evaluation activities not only at a local level but on a national program level.

8. A limited exploratory program (COP) that was initiated five years ago provided the basis for the new expanded CHOP. Therefore, although the CHOP contractors are still currently in the planning phase, there is an opportunity to obtain information from participants of the previous COP to identify needs based on their experience.

9. This is an ideal time to conduct an evaluability assessment, not only because of the resources cited above, but also because the individual CHOPs are just entering the planning phase, with actual implementation and evaluation plans due no earlier than December 1981. Thus, the findings from this effort would be available in time to incorporate into these plans to ensure development of information needed to support an overall program evaluation; and yet initial ideas and concepts developed by individual communities can be incorporated into this study.

The COP, which gave rise to the model to be tested in the CHOP, is completing an evaluation of the program after four years of federal funding. Reports of these evaluations, due by August 1981, and persons involved in the COPs should provide useful information for this effort.

CHOP contractors and principal investigators are:

SINGLE HOSPITAL

Bergen-Passaic Community Hospital (Hackensack Hospital), Hackensack, N.J., Charles Violotti; California Medical Center, Los Angeles, Joseph McKernan; Deaconess Hospital, Evansville, Ind., Thomas Lutz; Georgia Baptist Medical Center, Atlanta, Mario Ravry; Marshfield Medical Foundation, Marshfield, Wisc., Robert Greenlaw; Memorial Medical Center, Savannah, Ronald Goldberg; Mercy Hospital, Scranton, Pa., William Heim; Our Lady of Lourdes Memorial Hospital, Binghamton, N.Y., Robert Enck; Riverside Methodist Hospital, Columbus, Ohio, Joseph Bonta; South Fulton Hospital Tri-City, East Point, Ga., John Ray; St. Luke's Hospital, Bethlehem, Pa., Richard Torpie; St. Paul Hospital, Dallas, Ronald Garvey; and St. Vincent Medical Center, Los Angeles, S. Barry Sakulsky.

SMALL COMMUNITY

Southwest Washington Hospital, Vancouver, Wash., Richard Heitsch.

MULTI-HOSPITAL

Borgess Medical Center, Kalamazoo, Mich., Leo Zelkowitz; Brooklyn Consortium (Methodist Hospital), Brooklyn, Sameer Rafla; Christ Hospital, Cincinnati, Richard Meyer; Roanoke Memorial Hospitals, Roanoke, Va., Charles Crockett; Southern Colorado (Penrose Hospital), Colorado Springs, Paul Anderson; St. Francis Hospital, Wichita, Kan., Harry Hynes; St. Louis Park Medical Research Foundation, Minneapolis, J. Michael Ryan; St. Peter's Hospital, Albany, N.Y., Robert Sponzo; and Toledo Clinical Oncology Program, Toledo, Charles Cobau.

AACI CONSIDERS CANCER CONTROL ISSUES, OFFERS SUGGESTIONS FOR THEIR SOLUTION

Many of the issues currently under debate regarding cancer control, including development of guidelines for new cancer control grant programs and revising guidelines for existing ones, were addressed by a panel at the recent meeting of the Assn. of American Cancer Institutes at Duke Univ. Comprehensive Cancer Center.

The panel was chaired by Joseph Cullen, deputy director of the UCLA Jonsson Comprehensive Cancer Center. Other members were Richard Steckel, director of the UCLA center, and Herbert Kerman, president of the Assn. of Community Cancer Centers and chief of the Dept. of Radiology at Halifax Hospital in Daytona Beach.

Excerpts from each of the presentations follow:

CULLEN (opening statement)

There is clearly a sense of unrest in the direction, policy and funding for cancer control in the United States today. There has been for several years, perhaps as long as the advocacy for cancer control itself. It is with that unrest that this panel has been convened to examine cancer control in a forum attached to one of the major consistuencies of the National Cancer Program, the cancer centers. However, as this organization has done in the past, it is not limiting its perspective solely to its own interests but also to the interests of the broad cancer community as well.

There are and have been over the past several years representatives at our organizational meetings of the ACCC. These representatives have added. an impor-

tant element to these conventions with their comments, cooperation, and certainly through their active participation at the congressional level in influencing legislation related to the National Cancer Program. Therefore, this is an excellent opportunity to put all of our perspectives together as they relate to cancer control and thereby support, and influence, NCI staff and its respective advisory panels.

However, I would like also to state a bias in setting the stage for the panel and discussion. There is clearly a cancer control constituency in the United States today. There always has been. But until the passage of the Cancer Act in 1971 this lobby was less vocal or at least less able due to its positioning in the federal superstructure and its modest budget. In my estimation and that of many others, cancer control is now properly attached to the correct agency and has a budget which, though modest compared to the whole, is relatively adequate given the state of the art.

There is no logic in the notion that, if control dollars are diverted to other pockets of interest. . . these individuals will stand by and allow this "gerrymander" to occur. On the contrary, I predict they will not. Rather they will raise their voices in Congress and the end result will not be pleasant or beneficial to the future of the National Cancer Program. Such a confrontation will only add to the apparent misperceptions of those in Congress who seem to be looking for opportunities to reduce the NCI budget in accord with current fiscal policies. Since the cancer control budget is a line item allocation, it will be most vulnerable to excision. This is certainly not in the interst of anyone in this room or their affiliations.

STECKEL--Cancer control at cancer centers

A number of new concepts and definitions of cancer control have surfaced lately. These new concepts and phrases include "baseline standards' assessments"; "defined study population". "closing the feedback loop" (between the community clinicians and cancer centers), and several others. Furthermore, there is tension between academic cancer centers that currently have cancer control programs or aspire to have them, community hospitals which feel that they have a unique role to play in cancer control at the "grassroots" level, and the leadership of the National Cancer Institute which sees the control program as a major opportunity to enhance patient and physician participation in clinical cancer trials.

Quite obviously, none of the current concepts is completely antithetical to what has occurred earlier in cancer control, nor are they necessarily in competition with one another. However, in my view what is conspicuously missing from much of the discussion which is now occurring about the future of cancer control is an open acknowledgement that differing expertise and specialized resources for control activities exist at centers of various types, and that there is a need to differentiate specifically which institutions are best qualified to perform (and evaluate) different types of control interventions.

The draft guidelines for evaluation of cancer control programs developed by AACI's own Task-12 group do in fact take notice of the considerable differences in resources that exist between our centers, and I commend this draft to you for your careful consideration.

It should be clear that cancer centers have individualized and sometimes quite extraordinary resources at their disposal for instituting and evaluating control programs of various types. These range from schools of public health with epidemiology research capabilities, social services research groups, psychologic and behavioral units at medical schoosl and at various psychiatric institutes which are allied with our centers, and many other unusual capabilities that differ from institution to institution.

A forward-looking plan for cancer control must take careful note of these differences in institutional capabilities, as well as vast differences in the communities to which they relate; it must also take into account the differences between community cancer centers and academically based centers, as well as between the academic centers and consortia involving multiple institutions in a region, when defining criteria for cancer control programs at various centers and institutes.

Current proposals to the (DRCCA) Board of Scientific Counselors which would allow any institution, governmental agency or group of institutions to compete for a single cancer control core grant for a region, should be revised to take note of the varying capabilities of different institutions and agencies and their differentiated roles within a cancer control system serving a given region.

While I am reluctant to add further to the current proliferation of concepts and phrases which are attempting to define the scope and requirements of cancer control programs, I would like to suggest a somewhat different way of looking at the spectrum of cancer control activities that is possible at our widely differing institutions, as well as at the community cancer centers with which we relate. I believe it is useful to compare cancer control activities, by analogy, with the "pre-clinical", phase 1, phase 2, phase 3, and phase 4 clinical trials that are familiar to clinical cancer investigators.

By drawing an oversimplified analogy between phase 1 through phase 4 studies in cancer control and those in clinical cancer research, I do not intent to suggest that cancer control and clinical research are in any way synonymous. It is the concept of a progression in studies of new techniques from the laboratory bench to the community that I wish to em-

phasize by this scheme. In defining phase 1, phase 2, phase 3 and phase 4 cancer control studies and demonstrations, I also wish to point out that there may be unique roles for different types of academic and community centers at various points along this broad spectrum of activities. I will also point out that not all cancer control activities, particularly those which are in their early phases of development, need to be performed in a "defined study population" in order to be regarded as "good cancer control."

Furthermore, while baseline standards' assessments obviously have a role in channelling energy and resources into productive control interventions, one must first know what is new and what is possible in the way of new interventions before one can even suggest what is optimal for a community or region. To this extent, not all cancer control studies, particularly early phase investigations at academic institutions, need to be guided solely by a prior definition of baseline community standards.

Finally, the scheme which I will present is not one just for "closing the feedback loop" between clinical oncologists in the community and the cancer center, and/or for bringing more patients into conjoint clinical trials. Cancer control is a much broader and long-range activity than just clinical trials, but it can subtend community trials along with many other types of control interventions in a given community or region.

(Steckel's slides accompanying his remarks offered the following definitions of his "cancer control demonstration/evaluation spectrum):

A—In house laboratory and clinical research. Not cancer control but may lead to new control interventions. Leads to identification of possible new prevention, diagnostic, therapeutic, and continuing care techniques, through intramural research. Primary locus of this activity—academic research centers.

B—Phase 1-2. Early trials of new cancer control interventions. Dictated in part by baseline standards assessment to identify unmet cancer control needs. Initial evaluation, in a clinic or community setting of a cancer control interventional strategy. Identifies potential efficacy as well as shortcomings of the proposed new control techniques. Locus of phase 1-2 studies—clinic or limited subpopulation. Institutions best suited to conduct phase 1-2 studies—academically affiliated cancer centers and their associated institutions.

C—Phase 3. Cancer control trials. These evaluate effects of applying pretested cancer control interventions to a defined study population, using case control or similar study design techniques. Locus of phase 3 studies—multiple cooperating institutions within a region including (sometimes) governmental and/or voluntary agencies. Leadership institutions in a phase 3 trial—academically based centers and/or community cancer centers.

D—Phase 4. General applications of new interventions to an entire population. Not cancer control, in the current sense. Requires widespread voluntary compliance, and may require governmental regulation and/or encouragement. Education is critical. Phase 4 applications should be subject to rigorous evaluations, including epidemiologic and demographic assessments of outcome over a period of years.

KERMAN—Cancer control through community resources

Community resources for cancer control like centers resources for cancer control can be said to be plentiful and of varying levels of intensity, development and effectiveness. This bounty of resources to be effective must be organized and directed. At this very moment the opportunities to mobilize these resources and mount effective control programs have never been greater. The opportunity also for concomitant research in all the intervention areas of control programs is also enormous and merely awaiting catalyzation—If it can be said that academic, comprehensive and specialized centers provide the laboratories for fundamental research, then it must also be stated that the communities provide the laboratory for cancer control research.

These can conveniently be divided into resources which are available everywhere throughout the country and consist essentially of cancer programs approved by the Commission on Cancer of the American College of Surgeons, the member institutions of the ACCC, and the American Cancer Society.

The most significant of these resources are those organized cancer programs which meet the basic standards for approval of the Commission on Cancer of the American College of Surgeons. These programs, now numbering over 1,000, manage well over half the cancer patients in the United States. The basic requirements for an approved program have evolved over decades, and to the credit of the College are continuing to evolve in response to constructive criticism and changing needs. It must be emphasized, however, that the basic requirements are just that—*basic* and represent only the framework for an organized program. Other components of cancer programs have been suggested by ACCC to add to the scope and activity of these basic cancer programs. Many of these basic programs will have the interest and potential to continue to expand their horizons and further their activities. The ACCC has suggested guidelines for increased levels of components and activities to progressively enhance programs.

ACCC now numbers 175 delegate members and 364 general members and their estimated clinical cancer management in 1979 involved 111,545 cancer patients. It should also be noted that better than 80 percent of the delegate members of ACCC are institutions of 300 or more beds. The American College of Radiology Patterns of Care studies have indicated

that equivalent care is isually available in community hospitals of this size as compared with academic institutions so we can anticipate a high level of performance in these institutions for controlled clinical investigations.

It is also notable that only a few of these programs have developed with federal funding. For every member institution which is primarily supported by federal funding, there are eight programs that have received no funds from sources outside of their own communities. One is led to wonder how many more communities and effective programs and patients could be affected with a small amount of investment capitol from federal sources.

Another most important nationwide community resource for all cancer activities is the American Cancer Society. Highly organized, visible, effective—they not only support research but provide public and professional education and influence public policy. A truly magnificent resource whose strength lies in its grass roots—the community volunteers comprising the various community units and state divisions.

These generic resources are complemented in different geographic areas by what I might term site specific resources and will greatly vary from one area to another.

The community cancer center offers the most effective mechanism to increase public and professional awareness of cancer at the community level and provide for rapid translation of new methods of cancer control into practice in our pluralistic health care system. It also offers almost untapped resources for clinical investigation.

These community resources have the potential to "reduce the incidence, morbidity, and mortality of cancer" (which is the stated goal of cancer control) if they can be properly molded into programs of activities in all the cancer intervention areas. A unique opportunity exists for all of the "cancer centers," i.e., the comprehensive, specialized and community centers, to become partners and unite with the National Cancer Institute to expand cancer control efforts.

An example of comprehensive center activity linked with community center activity is that demonstrated by the Ohio State Univ. Comprehensive Center in its continuing efforts in sponsoring programs to "develop community hospital programs" and more significantly in its Community Hospital Cancer Planning Grant Program. This "seed money" minigrant method of stimulating communities to become active and develop their own commitment is truly a significant and pertinent example of the outreach effort of a comprehensive center. I am sure that other centers have similar activities and I note with interest that this is a high priority item for new direction of your Task 12 Committee. I should think it would be incorporated into the new guidelines for cancer control for all the centers.

Opportunities for research abound in every intervention area of community cancer control, all of which can be made to stand the test of critical peer review and merit the support of the National Cancer Program. These can be efforts for (1) developmental studies, (2) operational methodology research, and (3) original fundamental investigations. A look at the needs assessment for community cancer control and research suggests that expertise in experimental design, statistical and data collection methodology, and evaluation are necessary to support an adequate research program. Funds, of course, must be available for administration, communication, data collection, as well as to provide qualified personnel for the technology that is needed.

CULLEN—Directions and opportunities for the future

(Referring to language in the National Cancer Act relating to cancer control) I would like to draw your attention to several features inherent in these statements. First, there is a great breadth in the scope of cancer control as Congress sees it. Congress felt that there is an armamentarian of resources available (clinical and otherwise) which is not filtering down to benefit all residents of the United States. (The statements) point to the necessity for interventional thrusts in prevention, detection, diagnosis, treatment, rehabilitation and continuing care. They also assert "that the comprehensive cancer center offers the best organizational structure for the expanded attack on cancer," yet recognizing that these efforts should include locally initiated liaisons/networks with community resources, health professionals and institutions. They underscore the importance of research, but set it in perspective as part of a cycle from technology development to technology transfer. Cancer control is seen as an outlet for research findings more than research itself.

Given the nearly decade of activity that has ensued in implementation of cancer control activities by NCI, one needs to carefully and impartially examine the results. I would like to draw your attention to a series of meetings which has started and will continue over the next several years codifying "progress in cancer control." I call your immediate attention to a book by that very title which resulted from a conference held recently at Roswell Park and participated in by many of you. This document, edited by Drs. Curtis Mettlin and Gerald Murphy, should be viewed by all those who are serious about evaluating cancer control for its successes and not merely its glibly referred to failures. As an NCP priority, cancer control is just as important today as in 1971. Meaningful foundations have been erected in many communities and numerous activities have resulted that deserve your critical judgment and, I predict, your

acclaim and approval if so examined. Furthermore, Congress still feels strongly about the need for technology transfer.

The original Goal and Statement of Objectives for cancer control and rehabilitation (to identify, field test, evaluate, demonstrate, and promote the widespread application of available and new methods for reducing the incidence, morbidity, and mortality from cancer) are not really outdated. Before we throw out the bath water we should be sure there is no baby in it. Furthermore, careful examination of the specific objectives relating to prevention, detection, diagnosis, treatment, rehabilitation and education reveals that they are still as reasonable as ever.

Rather than trying to circumscribe cancer control by a narrowly defined context (e.g., it really should be money spent on clinical trials), or limit the interventions subtended by it (e.g., cancer control research units may address only prevention, only treatment, or both) or set down guidelines which are proscriptive and heuristically limiting (e.g., because of the regional nature of control research, and because NCI will fund only a limited number of CCRUs, potential applicant institutions that are physically close to one another should seriously consider being joint applicants, either through one of the institutions, or through the creation of a consortium), there should be enough breadth and flexibility in the program that the entire armamentarium of resources referred to by Congress be exploited.

Each of the disciplines we represent has moments of triumph and periods of apparent failure. Cancer control is no exception. Under the best of circumstances, it is difficult to change behavior, be it the behavior of professions, systems and traditions, or people. My basic scientist and clinician friends are not apologetic about the vast expenditures applied to viral research or adjunctive immunotherapy regimens. Rather, they assert, and are justified in doing so, that the scientific base accruing from their labs and clinical settings may be unprecedented in the history of cancer research and medicine.

Cancer control was originally proscribed from being a research program (with the exception of rehabilitation allowances). It was characterized as demonstrational. Yet those of us who spend our days in planning and implementing control activities have found that some of the glib language about available technology to transfer, is just that, glib. Research needs to be done. This, however, does not change the need for technology transfer; it only changes the process. But rather than abandoning the notion of technology transfer, or demonstration, what we should be saying is "technology development and transfer." If cigarette smoking prevention and cessation will lead to a reduction of numerous diseases, including cancers, then it is a worthy objective of cancer control to achieve that end. Those of us who have tried to do so, nevertheless, are dissatisfied with the state of the art in the technologies available to approach the problem. Does that mean we abandon the effort? No! The potential gains are tremendous.

Let's work on developing and strengthening the technologies. Let's learn from our Dept. of Defense friends. Their research and development budget quadruples the entire NIH budget. Similarly, cancer centers are known for their capabilities to carry out research. They have the resources, the experience, the expertise, the tradition, and the willingness. If there's anything they can do well, it's research. There are even times that many of use believe that cancer centers, particularly comprehensive cancer centers, are ideal places to launch cancer control activities.

But there are also community hospitals, community physicians and other health professionals throughout our country who are not part of cancer centers who can also provide technology development and particularly technology transfer. These ought not to be neglected. So rather than saying one or the other should be the emphasis, why not both? What is magic about doing anything one way?

Recently the DRCCA Board of Scientific Counselors issued a statement on cancer control specifying the goal of the cancer control program, its operational components, and supportable activities (***The Cancer Letter***, Feb. 6). A subcommittee of Task 12 along with ACCC membership representation examined this statement and agrees with its content and intent. In fact, the subcommittee recommends that the guidelines for cancer control core grants and project grants should issue from this statement.

It should be noted however that Task 12 feels quite strongly that any guidelines which are forthcoming should be issued in such a way that there is a suitable time period for comment by those constituencies which will be most affected by them. Clearly, AACI and ACCC are such constituencies.

What happens to cancer control in the next few years essentially rides on the efforts of all of us. The stakes are high. We welcome all of your inputs, including those who have been silent in the past for whatever reason. In the words of Dr. DeVita, "a major goal of cancer control (is closure of the) feedback that can flexibly deal with day-to-day changes in and interplay between science and medicine."

The Cancer Letter _Editor Jerry D. Boyd

Published fifty times a year by The Cancer Letter, Inc., P.O. Box 2370, Reston, Virginia 22090. Also publisher of The Clinical Cancer Letter.