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FULL FUNDING OF INDIRECT COSTS, OTHER MANDATES BY CONGRESS CHEW UP MOST OF NCI'S EXTRA MONEY

Although Congress appropriated almost $90 million for NCI above the President's request for the 1984 fiscal year ($89,561,000 to be precise), Director Vincent DeVita's concern that precious little of that would be available for discretionary allocation turned out to be well founded. DeVita

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In Brief

VP-16 NDA APPROVED BY FDA ONLY FOR REFRACTORY TESTICULAR CANCER; REMOVED FROM GROUP C LIST

VP-16, ALSO known as etoposide and now by its Bristol-Myers brand name, VePesid, has finally been approved for marketing by the Food & Drug Administration. The approved indication is for refractory testicular cancer. Bristol also had asked for its approval in treatment of small cell lung cancer, but that was not forthcoming. The company said it would continue to develop evidence of its efficacy for that and perhaps other indications, and expected approval for small cell lung cancer in the near future. VP-16 has been the drug in greatest demand through NCI's Group C free distribution to physicians, costing a half million dollars a year plus a like amount for use in NCI supported clinical trials. NCI made a deal with Bristol last year, with the company supplying the Group C demand at no charge. Now that it is commercially available, it will go off the Group C list. . . . NCI HAS received 151 letters of intent in response to four RFAs in smoking related research. They have come from a variety of universities, cancer centers, commercial organizations, local school districts, and state and county government agencies. . . . FORTY ONE grant applications were submitted for research on cancer and the elderly. Fifteen were approved, and six probably will be funded at a total of $771,000 in direct costs. Those likely to be funded had priority scores of 142, 148, 158, 162, 174, and 191. Fifty letters of intent have been received in response to another RFA NCI is supporting in cooperation with the National Institute on Aging. . . . HHS SECRETARY Margaret Heckler has decided to cut the basic payment rate for the new Medicare hospice program to $45.48 per routine day. She earlier had proposed $53.17 but went part way to Office of Management & Budget demands for a $36-38 rate.

CANCER CONTROL BUDGET INCREASED BY $3.6, CONTRACTS $7.4 MILLION

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reported to the National Cancer Advisory Board Monday on how the extra money would be spent, and only about $2 million had not been committed through congressional earmarks. NCI decided to put that into the RO1-PO1 grant pool.

Another $7.4 million added by Congress for contracts without further direction leaves NCI some flexibility on where that will be spent. Best guess now is that some of that will go into the drug development program which has been severely cut in recent years. However, the $7.4 million does not add any money over the 1983 level for contracts but merely restores the amount proposed for cutting in the President's budget.

Congress also increased the line item for cancer control by $3.6 million without further direction on how that will be spent. Peter Greenwald, director of the Div. of Resources, Centers & Community Activities, told The Cancer Letter that no decisions had been made yet on which cancer control programs would benefit from that increase.

By far the biggest beneficiary from the extra money will be what the congressional appropriations committees called "research projects," and what NIH has interpreted as RO1 and PO1 grants. The committees directed that those grants be funded at their full recommended levels, rather than being cut by some percentage as NCI has done in recent years to stretch available dollars over more grants. Congress also directed that full indirect costs be paid for all grants, and the two directives required that NCI add $52 million to the RO1-PO1 pool. Of that amount, $$13.2 million was required to pay the additional 10 percent in indirect costs proposed for cutting in the President's budget.

NCI decided to add about $2 million to the RO1-PO1 pool in order to fund more grants, bringing the total of additional money in that category to $54.2 million. That will add an estimated 50-70 more grants, bringing the total of new and competing renewal grants which will be funded in 1984 to an estimated 923, compared to 891 supported in 1983. That will fund 33 percent of approved competing grants, down one percentage point from 1983. The priority score cutoff is estimated at 177.

Cancer centers received the next largest increase over the President's budget, $20.8 million, to restore the amount cut when HHS and NIH decided to play games with the White House in an effort to get enough money to support 5,000 competing grants which NIH has decided is the number to achieve "stability." When the Office of Management & Budget refused to add enough money to meet that level, NIH responded by cutting massive amounts from centers and other congressionally favored programs, with the predictable result that Congress put all that money back into the appropriations bill.

The centers budget now has enough to fund all 20 of the core grants which are up for renewal this year, provided of course that they compete successfully.

The budget for the clinical cooperative groups was boosted by $2 million, but that will do little to placate those grantees angered over being left out of the mandate to fund at full recommended levels (see story on the cooperative group chairmen's meeting, page 4). The six groups recompeted in FY 84 will be funded at an average of 80 percent of the recommended levels, even with the extra $2 million. All groups, however, will receive 100 percent of indirect costs, which requires $1.3 to $1.4 of the $2 million to cover the 10 percent which had been proposed for cutting.

The remaining portion of the $2 million was placed into the groups' budget to cover an increase expected in the number and budgets of grants transferred to the cooperative group program from the bladder and prostatic cancer programs. Those are the clinical trials segments of the National Bladder Cancer Project and National Prostatic Cancer Project which had been included in the old Organ Site Program.

Some groups may well end up being funded at close to their recommended levels, and some considerably less than the 80 percent, depending on how they fare in peer review. DCT staff had decided not to cut back severely or eliminate a group merely to increase the funding of others; however, at least one group reportedly may be trimmed drastically based on review results, making much of its funding available to others.

Other lesser additions to the budget and earmarked by Congress included $614,000 for clinical education; $317,000 for research career awards; and $500,000 for intramural research in AIDS. Three million dollars of

the RO1-PO1 additional money also was earmarked for AIDS research.

That left $180,000 in the category, "other research grants," which had not been otherwise allocated.

The total for NCI research projects, including noncompeting grants, is $467.2 million, an increase of 15 percent over 1983; $134.6 million for contracts, down .6 percent from 1983; and $181.2 million for intramural research, up 4.1 percent over 1983.

RELATIVE SURVIVAL UP TWO MORE PERCENT IN YEAR; DEVITA SAYS NOW IS OVER 50

Cancer patient survival continues to increase, according to information from NCI's Surveillance, Epidemiology, and End Results Program (SEER), with relative five year survival now at 48 percent, compared to 46 percent reported by SEER last year, NCI Director Vincent DeVita reported to the National Cancer Advisory Board Monday.

The SEER data reported last year were based on patients diagnosed from 1973 through 1979. data released this week added one year.

Five year relative survival is the probability of escaping death from cancer for five years following diagnosis. Rates are calculated by an actuarial, or life table, method and therefore include information on patients under observation for less than five years. patients diagnosed between 1973 and 1980 were followed through December 1981. Complete five year followup was conducted for patients diagnosed in 1973, 1974, 1975, and 1976. The survival rates were revised upward this year because an additional year of followup, 1981, was completed and because of inclusion of patients diagnosed in 1980.

DeVita told the NCAB that "I don"t have the slightest doubt that we are already over 50 percent. This is a landmark achievement."

DeVita said that he feels five year survival is a strong indicator of curability because long term studies have shown that 85 percent of patients surviving cancer at five years are alive (unless they have died of other causes) at 20 years.

The 48 percent survival rate was for all races combined. The news was not so good for black patients, with a five year relative survival rate of 37 percent, although that also was up two percent from last year.

Some of the cancers with the most encouraging five year relative survival rates, all races combined, are: thyroid, 92 percent; endometrium, 87 percent; testis, 82 percent; melanoma, 79 percent; bladder, 72 percent; prostate, 67 percent; uterine cervix, 67 percent; female breast, 73 percent; Hodgkins disease, 70 percent; and larynx, 66 percent. Survival continues to be poor for cancers of the lung, pancreas, stomach and esophagus.

For whites, the five year relative survival rate is 49 percent for patients diagnosed with cancer between 1973 and 1980, compared to 47 percent last year.

Survival rates were calculated separately for white children under age 15. The rate for these children diagnosed with cancer between 1973 and 1980 is 57 percent for all cancers, up from 54 percent last year. A rate could not be calculated for black children because the number of patients in the SEER registries was too small.

The SEER program recently added an 11th registry, in New Jersey, specifically to increase the number of blacks and Hispanics covered by the program.

DeVita said that further improvements in survival are expected, based on analysis of survival rates of less than five years. Increases in these rates suggest that five year survival rates will be even greater after sufficient time has elapsed to observe all of these patients a full five years. For example, the two year relative survival rate for testicular cancer was 83 percent for white men diaganosied between 1973 and 1976. The rate increased to 91 percent for white men diagnosed between 1977 and 1980. The four year relative survival rate for white children under 15 years of age with acute lymphocytic leukemia increased from 53 percent for patients diagnosed between 1973 and 1976 to 73 percent for those diagnosed between 1977 and 1980. For small cell lung cancer among whites, the one year relative survival rate increased from 21 percent for patients diagnosed from 1973 to 1976 to 30 percent for those diagnosed from 1977 to 1980.

In considering cancer death rates, SEER found that the number of people dying of cancer yearly per 100,000 population has remained fairly level from 1969 through 1980, with an average increase of only .4 percent yearly. The annual number of newly diagnosed cases per 100,000 population (incidence rate) has also remained constant from 1973 through 1980, increasing an annual average of .6 percent.

However, remarkable decreases in death rates occurred for some of the major cancers.

The decreases are measured by the percent of change in the death rates between 1969-70 and 1979-1980. For women, there were substantial decreases in the death rates for all cancers of the genital organs and a slight decrease for breast cancer. Cervical cancer was down 40 percent; endometrial cancer, down 15 percent; ovarian cancer, down 10 percent; and breast cancer, down one percent.

Even more striking were the decreases in death rates for women under age 50: for cervical cancer, a decrease of 43 percent; endometrial cancer, decrease of 40 percent; ovarian cancer, down 33 percent; and breast cancer, down 13 percent.

Disheartening, however, was the increase in death rate for lung cancer among women, nearly doubling during the decade.

GROUP CHAIRMEN UNHAPPY ON EXCLUSION FROM FUNDING AT RECOMMENDED LEVELS

Cooperative group chairmen let NCI know they are not happy at being excluded from the congressional mandate to fund grants at their peer review recommended budget levels, but they left last week's chairmen's meeting feeling a little better about their 1984 funding prospects.

Robert Wittes, who heads the Div. of Cancer Treatment Cancer Therapy Evaluation Program, and DCT Director Bruce Chabner, told the chairmen that:

—Noncompeting grants (actually, cooperative agreements) would receive the negotiated six percent increase over the 1983 budgets, rather than the four percent previously anticipated by NCI (The Cancer Letter, Nov. 11).

—If more money becomes available to CTEP for clinical trials, it will be allocated to those programs within groups, including those being recompeted this fiscal year, where the science and budget needs indicate it will best be spent. Both Chabner and Wittes seemed confident that some additional money would be available.

In other matters, the chairmen discussed and approved an NCI proposal to "formalize" the process whereby NCI program directors and individual group chairmen working together initiate efforts to upgrade areas of persistent weaknesses they may identify between review cycles, with the possibility that if no improvement is seen in a reasonable time the chairmen may redirect funds to more productive areas within their groups.

The chairmen also heard that they and other research base directors will have the final say on whether qualified affiliates and members of Community Clinical Oncology Programs may participate in early phase 2 studies. NCI's Div. of Resources, Centers & Community Activities had previously sent out a memo to CCOPs and research bases saying that CCOP participation in early phase 2 trials "is unnecessary" and while "research bases may make exceptions to this rule on an individual basis with notification to DRCCA staff. . . this will generally be discouraged." (The Cancer Letter Nov. 11).

The chairmen were angry over the NIH policy which applies the congressional directive to fund research projects at their full recommended levels only to individual investigator initiated (RO1) and program project (PO1) grants. The language in the reports of the two appropriations committees refers to "projects" and "research project grants" in the sections ordering that full recommended levels be paid. No mention of ROl, PO1, basic research, investigator initiated, etc. Congress has traditionally been strongly supportive of clinical research, and there seems little doubt that if asked, members of those committees would include clinical research with those projects they intended to be fully funded.

Instead, NCI's plan to fund the five groups being recompeted this year, and any new ones which compete successfully, at 80 percent of their recommended levels will stand—for now.

"It sounds to me as if there is a double standard," Emil Frei, chairman of Cancer & Acute Leukemia Group B, commented. "But diluting group budgets by arbitrary cuts is deleterious. Why the different standard?"

Wittes explained that, once a definite sum had been allocated to the total for cooperat ive groups, there was not enough money to fund all of the competing groups at recommended levels unless one group were to be phased out. "An a priori decision by NCI staff to demolish one group would be one with which I would be uncomfortable," Wittes said. "We could consider targeting for demolition groups that are modality oriented, or groups that are primary site oriented, but those groups meet a definite purpose. And the groups, to an amazing degree, are non overlapping. I throw the question back to you. Maybe considering the budgetary limits this is not the time to field some studies. Maybe it is time cut back."

"Many of us have cut back sharply," Frei said, "on advice of CCIRC (Clinical Cancer

Investigation Review Committee), NCI staff, or by internal decisions. When we cut back on high priority programs, service tends to get cut back."

Charles Coltman, chairman of the Southwest Oncology Group and current head of the Chairmen's Committee, noted that one new group—the Brain Tumor Study Group—will be funded this year and that there had been talk of another new group for head and neck cancer studies.

Wittes responded to the question about whether there will be a new head and neck group, "Absolutely not." Instead, intergroup studies will be encouraged, with one or more existing statistical offices collaborating rather than a new one being established.

Denman Hammond, chairman of the Childrens Cancer Study Group, said that funding competing groups at 80 percent "puts heavy contributing, long term organizations at a disadvantage."

"I can assure you that if more money becomes available to CTEP, it will go into clinical trials," Wittes said. "Not necessarily flat across the board. We will look at individual programs, including perhaps some type 5s (noncompeting) which may be underfunded. We feel exactly as you do, without getting into type 5s vs. competing."

Paul Carbone, chairman of the Eastern Cooperative Oncology Group, said he agreed it is important that no more new groups be added now (other than BTSG). But, "I hope that in the long term strategy, the major cooperative groups can be looked upon in the same way as RO1s. Clinical research is being looked upon as something different than lab research. It is, but you can learn biology in clinical research. Groups should have the same budget considerations as RO1s."

Charles Moertel, chairman of the North Central Cancer Treatment Group, said, "The concept that we should narrow our base by cutting out unnecessary studies, the accrual builder uppers, I can applaud, but there is a catch 22. Groups do look at areas that are ripe for cutting, but when we present that to peer review, we lose that and still have 20 percent cut from what's left."

"I hope to make the peer review mechanism part of this, make them part of the process," Wittes said. "Secondly, the 80 percent is not fixed in stone. We can make up for that kind of thing administratively. We will not penalize you for pruning."

Wittes suggested that the justification for giving special consideration to RO1s and PO1s is the "idea that we don't have enough biological knowledge to attempt more clinical research."

"The word is research," Frei said. "You can conduct a well planned clinical trial that will tell you a lot about biology. Over the last 20 years, a lot of leads to major biological advances have come from the clinic. It goes both ways. When money is tight, we should fall back on the research bases."

"There are a large number of cancers of children that are curable today, from relentless clinical investigations," Hammond said, "although we don't know what causes them. Thediscoveries came out of clinical research."

Wittes later explained that the 80 percent of recommended levels will not be applied evenly throughout a group. Group chairmen can make adjustments within their groups, with the option of funding some members higher, some lower. Those decisions will be based on members' priority scores. Each competing group will average 80 percent of recommended levels, however, unless more money is allocated to CTEP by NCI, which is likely.

The chairmen approved NCI's recommendation for a policy for renegotiating type 5 awards. With the trend toward awards of more than three years, some policy for interim adjustments has become feasible and necessary, Wittes commented.

"If an institution is funded by a cooperative agreement on a five year award, with a high priority score and high funding level, and then the quality drops, it becomes a problem in the absence of the ability to renegotiate distribution of funds," Coltman agreed. "Type 5 funding continues ad nauseum. It is unfair to evolving groups and to groups doing high quality work."

The policy suggested by NCI and approved by the chairmen:

1. Review of grantee performance within a group.

A. Basically this is a requirement and responsibility of the group. The performance of each grantee is reviewed annually by the group membership committee and this should be sufficient.

B. A mechanism should be developed so each group chairman will review performance of grantees within the group with the NCI program director. The chairman could at that

time recommend or discuss any funding changes within the group.

C. If funding is reduced for a grantee, the funds may remain within the group if the group as a whole is meeting the goals identified in peer review (as in the pink sheet) and providing adequate justification is given. Technically, there could be a requirement for submission of a new application or supplemental application if an approved funding mechanism is not available. Additional funds can be provided as a restoration for a principal investigator with an approved grant which was funded at less than recommended.

2. Review of performance across groups.

A. An annual review of each group by a committee is not necessary.

B. Major problems can and should be identified by group chairmen, program directors and CTEP staff during the regular assignments of reviewing group minutes, attending group meetings and reviewing group protocols.

C. When a major problem is identified by staff the program director should discuss it with the group chairman and the group. No formal special review is required.

D. If a major problem has not been resolved and progress not been documented after one year, there should be a formal review of that group relative to the identified problem. The group chairman should have prior written notification in order to supply appropriate information.

E. An ad hoc review committee consisting of CTEP staff, ad hoc reviewers from appropriate study section (CCIRC or CRSRC) and from the previous site visit will be selected to conduct a review of the group relative to the identified problem. The committee will make appropriate recommendations for a solution and funding changes, if indicated. It will be essential that the selection of reviewers be considered appropriate and acceptable to both NCI staff and the group chairman. It would be anticipated that the CTEP staff would be represented by about three members, and that the other ad hoc reviewers would be a balanced representation from the appropriate study section and the previous site visit. The program director, Clinical Investigations Branch, will have primary responsibility for selecting the ad hoc site visit team following consultation with the chairman of the group to be reviewed.

F. Program staff would decide on appropriate action and funding changes after communicating the results of review to the group chairman.

George Omura, chairman of the Southeastern Cancer Study Group, objected to what he said was a lack of definition of satisfactory performance. "I can see the same problems coming up over and over again, every year. What can you do to better define it?"

"We're going to avoid nickle and diming you to death," Wittes said. "I can assure you of the good will and intentions of the people at this end. I don't know how better to say it."

Coltman pointed out that the groups would have a year "to fix things before becoming subject to review. In view of the budget limits, to stand by and see nonsensical things go on is nonsense."

"I can see this as opening up more extensive review over nitpicking," Moertel said. "If some group does not perform well and its funds go down, the question is, who gets it?"

"It is not the intention to transfer funds to another group," Wittes said. "I can imagine only a limited repertory of things a group can get into which would cause it to lose funds."

"But this will be a whole new review process added on," Moertel insisted.

"It is not something new," Edwin Jacobs, CIB deputy chief, said. "Program directors for RO1s and PO1s have always had to sign off on grants each year. Our position is that program directors (for cooperative groups) should not do this independently. One person should not be making those decisions. This policy is putting into the hands of the group chairmen the things that need to be done. Program people will meet with the chairmen a year ahead of time, and if progress is not made during the year, then invoke the review process."

"So it is adding another level of review," Moertel said.

"It is only formalizing what should be done anyway," Wittes said.

George Lewis, chairman of the Gynecologic Oncology Group, commented, "From my own experience, I appreciated the advice and help of staff. This policy is something that is needed."

The policy was approved without a dissenting vote.

The Childrens Cancer Study Group, one of the five recompeted for the 1984 fiscal year, may be the first in the history of NCI supported cooperative groups to receive a five

year award. CCSG is headquartered at the Univ. of Southern California.

SSO WORKSHOP CALLS FOR IMPROVED SURGICAL ONCOLOGY TRAINING PROGRAMS

The Society of Surgical Oncology workshop on progress and plans in surgical oncology included a working group session on training and manpower which concluded that the role of the surgical oncologist in academic and community centers "in light of the growing field of medical oncology" could be "re-established" by improving training programs, increasing the number of surgical oncologists and thereby increasing their visibility, and enhancing recognition through better awareness of that role and "better marketing of the training programs."

Overall workshop recommendations and specific recommendations by working groups on research and education were reported in the previous two issues of The Cancer Letter.

The training and manpower working group considered the guidelines for surgical oncology training programs developed at an NCI sponsored workshop in 1978. The group reaffirmed support of those guidelines, with some revisions. They are:

A. Length of training period. A minimum of two years of post residency training in surgical oncology, over and above that required by the American Board of Surgery, is required for approval. A minimum of one year should be devoted to clinical oncology.

1. Research year. If one chooses to obtain research experience, there should be a minimum of one year of research experience. During this year of research, the trainee may not necessarily have his time totally involved in research pursuits. Any spare time available may be utilized for further clinical oncology exposure. This time could include core curriculum, didactic lectures, tumor clinics and conferences, pathology seminars, slide sessions, and other similar pursuits. None of these activities should detract, however, from the research experience.

2. Clinical oncology year. There should be a minimum of 12 months in clinical oncology training. Depending on the requirements of the institution, it may be even longer. This year should consist of total involvement in clinical oncology and must occur after completion of the general surgical residency. Any time spent in clinical oncology prior to completion of the general surgical residency cannot be applied toward this requirement.

The content and format of this clinical year cannot necessarily be defined precisely but should be left as a responsibility of the program director to provide adequate exposure to the surgical oncology disciplines as well as the nonsurgical oncology disciplines. . .

In certain circumstances, a particular institution could establish a formal, planned arrangement with a categorical cancer center for rotating the trainee into a cancer hospital, during various periods of the clinical exposure, and supplementing any deficiencies in the program offered at the sponsoring institute. The clinical oncology period would include time spent with both radiation and medical oncology, preferably early in the training period and with further longitudinal exposure throughout the clinical year.

In the remainder of the clinical year, the rotation should assure adequate exposure to malignancies of the esophagus, stomach, lower intestinal tract (including colon and rectum), liver and biliary tract, breast, as well as soft tissue sarcomas and melanomas. Experience with the head and neck service, especially with tumors of the salivary glands, thyroid, and parathyroid, is desirable. If further experience in intraoral neoplasms is desired, an additional period of head and neck training is suggested. For those trainees who plan to involve themselves with rectal and pelvic neoplasms, some exposure to the gynecology service is recommended. Elective rotation on thoracic services, genitourinary services and bone services may depend on the trainee's future interests and plans.

B. Core curriculum studies. In order to avoid duplication of lectures, a common core curriculum could be shared by the various oncologic disciplines. The didactic lectures should ensure adequate exposure to and knowledge of immunology, biostatistics, radiation biology, pharmacology and cell kinetics, epidemiology, cancer prevention and detection, as well as special procedures including vascular access. Additional exposure to methods of rehabilitation, prosthesis and psychosocial aspects of cancer is desirable.

C. Operative experience. Adequate operative experience of the trainee must be achieved and will depend on the prior general surgical experience and the surgical oncology training experience. Documentation of the cumulative experience of each trainee should be available at the time of the site visit of the surgical oncology program.

D. Special exceptions. There may be special circumstances where the surgical oncology trainee may have been involved in structured, supervised oncologic research one to two years prior to completion of general surgical training. This period of time, however, must be time over and above that required by the American Board of Surgery for certification. Any variations in the time sequence of this research component will be examined carefully by the site visit survey team of the Society of Surgical Oncology when approval status is requested.

E. Evaluation of the trainee. The progress of the trainee during the training period should be evaluated periodically by the surgical oncology program director and faculty. At the completion of the training period, an examination should be given to the trainees to determine the effectiveness of the program. It was suggested that some consideration be given to administering a similar preliminary examination at the beginning of the training program and that results be compared at the completion of the program.

F. Followup activities of the trainee. Periodic followup should be maintained by the program director who will assess the post training activities of the trainee in clinical and research areas of surgical oncology. The information on previous trainees of the surgical oncology program should be available to a site visit survey team.

The working group agreed that SSO should encourage institutions to seek approval of programs that conform to the guidelines and that adequate funding be available for such programs. That objective could be accomplished by, the group suggested:

1. Encouraging NCI to provide funds.

2. The American Cancer Society proposed Clinical Oncology Fellowship to encourage academic careers in clinical oncology would help. The three year fellowships offering salaries of $25,000, $30,000, and $35,000 is awaiting approval.

3. Using local funds on patient care income from a department of surgery or the medical school. Classifying the trainee as an instructor, or below professor rank, may facilitate this approach.

4. Exploring the possibility of per diem reimbursement from the hospital.

Working group members were unable to determine predictions of manpower needs. The group agreed that investigation of needs in both academic institutions and community settings is required, as follows:

* Academic needs. There should be a survey of academic department of surgery chairmen to determine up to date numbers of divisions of surgical oncology or similarly designated program components. If there is no division, the rationale should be explained. Plans for divisions should be requested. The names of surgical oncology program directors should be obtained. After the initial survey, there should be an in depth assessment of the oncology programs in university departments of surgery concerning the type and length of their programs. Inquiries on the number of trainees and affiliation with satellite hospitals should be made. This survey also could be done by the SSO Executive Committee in conjunction with the Training Committee.

"Presumably, 10-12 academic institutions will develop approved programs," the report said. "There will be an average of two-three trainees per year, and in five-seven years these programs barely should be able to develop enough academic surgical oncologists to fulfill the needs of academic institutions."

* Community needs. These can be assessed by reviewing all hospitals with radiation oncologists to determine whether they have a consulting surgical oncologist on the staff. An assessment of all hospitals over 500 beds can be made to see whether a surgical oncologist is available. These reviews can be made, with the help of the American College of Surgeons Commission on Cancer as well as the American College of Radiology, and may give a rough estimate of deficiencies in the community setting.

The working group was chaired by Robert Schweitzer. Other members were Myles Cunningham, Jerome DeCosse, Howard Ozer, Edward Scanlon, Harold Wanebo, and Richard Wilson.

The final workshop report, that of the working group on liaison activities, will appear next week in The Cancer Letter.

The Cancer Letter _Editor Jerry D. Boyd

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