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ER

703-620-4646

Vol. 14 No. 20

May 13, 1988

Subscription: $175 year North America, $190 year elsewhere

DCPC Board Kills Cost Sharing For CIS, Rejects Primary Care Prevention Effort Evaluation Budget

A somewhat cantankerous Board of Scientific Counselors of NCI's Div. of Cancer Prevention & Control killed the proposal by the division's staff to require cost sharing from Cancer Information Service contractors when the program is recom-

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In Brief

Delores Esparza President Elect of ONS; Brown Demands Jako Retract "Insulting Remarks"

DELORES ESPARZA, director of nursing for Salick Comprehensive Cancer Centers, was elected president elect of the Oncology Nursing Society last week at the organization's 13 annual congress in Pittsburgh. She will assume the presidency next year upon the expiration of Deborah Mayer's three year term. Esparza was at M.D. Anderson for 13 years beforing joining Salick. The office of vice president has been eliminated, and the president's term will now be one year. Marilyn Frank Stromborg was reelected secretary and Joanne Hayes was reelected treasurer. New directors at large are Sandra Schafer, Pittsburgh; Linda O'Connor, Springfield, MA; and Christine Miaskowski, San Francisco. Holdover directors are Colette Carson, Catherine Hogan and Judith Shell. . . . **HELENE BROWN**, member of the National Cancer Advisory Board, has demanded a public retraction by former Board member Geza Jako of comments he made in letters to certain members of Congress and to NIH Director James Wyngaarden (**The Cancer Letter**, April 15). "Your letter is insulting to a group of very responsible people," Brown wrote. "To indicate in any way that a 'blank check' is given to NCI is to completely disregard the integrity of those who are NCI as well as those who labor on committees and boards . . . To further accuse members of the NCAB of being less than objective in their attempts to guide the Institute because they 'receive major grant support' is defamatory." Brown said that if retractions "are not accomplished in a timely fashion, I will take action that I feel is necessary". . . . **LLOYD EVERSON** has left Fargo, ND, to become director of the Community Hospital Cancer Center in Indianapolis. . . . **NCI DIRECTOR** Vincent DeVita told the DCPC Board of Scientific Counselors that the President's FY 1989 budget for cancer centers would result in either a reduction of 30 percent from recommended levels in core grants, or elimination of five competing grants if funding is at full recommended levels.

DCPC Board Okays Implementation Of $42 Million Heavy Smoker Trial

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peted starting later this year. The Board also directed DCPC to rework the evaluation budget for the proposed "Prescribe for Health" project which will be aimed at encouraging primary care providers to undertake prevention and early detection measures in the course of their practices.

Both actions will result in delay of the RFP (for the CIS recompetition of contracts) and RFA (for the Prescribe for Health cooperative agreements), although staff members said the award date targets may still be met.

The Board's actions on those matters went against strong recommendations from its own committees which had previously considered the concepts. It was the second and third time within a year that the Board had overriden its committees on major projects, the first last September when a committee's recommendation to drop the Women's Health Trial was reversed, at least temporarily.

Not all of the Board's actions were negative. It gave unanimous and enthusiastic approval for implementation of the $42.5 million, 99 month heavy smoker trial, known as COMMIT (Community Intervention Trial for Smoking Cessation). Also receiving concept approval was renewal of the Surveillance, Epidemiology & End Results (SEER) contracts, which will be noncompetitive, plus expansion of the program to include additional geographic areas and ethnic groups, which will be competitive. The SEER budget will expand from the present level of $10 million a year to an estimated $15.5 million in FY 1996.

Concept approval also was given to reissuance of an RFA for prevention clinical trials, a new RFP for master agreements to produce chemopreventive drugs, and recompetition of three other contract supported projects.

The Board had approved the CIS concept for recompetition of the contracts a year ago, although the staff's proposal for cost sharing met with some objections. Approval then was qualified, leaving the cost sharing issue open.

Cost sharing was suggested as a way of spreading available funds over more CIS offices. Sixteen offices have been fully funded by NCI, one by the American Cancer Society and eight others by institutions and other sources. The eight independents have received CIS literature for distribution as needed, and work from the same toll free phone number (1-800-4-CANCER). They are permitted to refer to themselves as part of the CIS system.

DCPC staff had proposed opening the door for support of some and perhaps all of the eight independents, and possibly others wishing to join the system, by funding all contracts in the recompetition at no more than 75 percent of the costs.

The 16 funded offices, 14 of which are located at comprehensive cancer centers, objected. Helene Brown, affiliated with the CIS office at UCLA and a member of the National Cancer Advisory Board, led the fight against cost sharing.

Virginia Ernster, chairperson of the Board's Cancer Control Science Committee, and Donald Hayes, member of the committee reported that the committee strongly recommended approval of recompetition of the program. Ernster noted that while the committee went along with the cost sharing proposal, "It's become apparent that if the Board of Scientific Counselors strongly supports expansion, it must strongly support" cost sharing.

William Darity, another member of the committee, said he voted for cost sharing because "it opens up the opportunity for new CIS offices."

Kate Duffy, DCPC CIS program director, described the key points made by opponents of cost sharing:

1. It would jeopardize participation by some comprehensive centers. "It is clear some feel they can't compete because this program is not a high priority for institutional funds. I agree this is the case at some university based centers."

2. If located at other than comprehensive centers, the quality would suffer. Duffy did not agree. "Quality assurance is a problem, but we feel it does not make any difference in that regard where it is located. Quality depends on leadership, staff and resources."

3. It is difficult to secure outside funding for ongoing programs. Duffy agreed.

4. Cost sharing would make the program vulnerable to exploitation as a marketing tool, with abuses likely on referrals in particular. "Our policies do not allow that," Duffy said, adding that the funded offices could lose their contracts over such abuses. Although NCI does not have that leverage over the independent offices, she said she was not aware of any problems like that with them.

5. The proposal would not save any money because cost sharing is already taking place at

several institutions. "That's true, but some more than others. Not all are sharing 25 percent."

Duffy noted that in the last competition, 32 institutions competed, 29 of them were considered good enough for funding, but the budget permitted only 16 to be funded.

Board members Donald Iverson and Mary-Claire King argued that the cost sharing proposal's validity depended on the actual amount of existing cost sharing. Staff had estimated that a saving of $2.5 million would result, based on an estimate that the contractors presently were picking up an average of eight percent of the costs.

Edward Bresnick suggested that if a detailed analysis of existing cost sharing reduces the estimated saving, and the 25 percent proposal resulted in replacing existing groups with new ones, startup costs could eat up most of the amount saved.

Frank Meyskens pointed out that NCI Director Vincent DeVita had said that CIS had been responsible for part of the increase in accrual to patient trials. "If that is true, some of the CIS budget should come out of the clinical trials budget," Meyskens said. "I have always felt that working through the public is the best way to increase accrual."

Philip Cole argued that if cost sharing were to be required for RO1 grants, "you could fund 33 percent more of them." DCPC Director Peter Greenwald responded that cost sharing was intended to provide access to CIS by more of the country's population. "Hell, require 50 percent cost sharing and cover even more," Cole said.

Johanna Dwyer said she would have to vote against cost sharing. "It's hard to raise funds for an activity like this. I've been enormously impressed by the (CIS operation) in Massachusetts. They do a fine job, but the public doesn't have a thousand pockets."

Lloyd Everson pointed out that other NCI programs involve cost sharing. "It's true of centers, it's true of CCOP. I think 25 percent is perfectly reasonable."

Cost sharing "tells you if that center is truly interested in the community," Meyskens said. "They can raise tremendous amounts for centrifuges, but this is truly for the community. The fact is that nine centers are unfunded and doing well. It wouldn't bother me if some comprehensive centers couldn't compete."

Kenneth Warner asked how many additional offices could be funded with cost sharing, but Iverson said that could not be determined without knowing exactly how much cost sharing exists now.

Brown insisted that quality would suffer if comprehensive centers are forced out, suggesting that the wide range of expertise available to offices located there would not always be available to others.

Fund raising for CIS efforts would be difficult, Brown said. "The public does not want to pay for anything except finding a cure for cancer."

Brown argued that making it easier for institutions which are not NCI funded cancer centers to compete for CIS awards would encourage use of the system as a marketing tool. She quoted from an ad she said was placed by one of the independent CIS offices affiliated with a 340 bed hospital (without identifying the office or hospital). The ad, Brown said, described CIS as being "associated with some of the most respected cancer centers in the country. We are designated by NCI to distribute information on cancer. That tells you something about the quality of cancer care right here at home."

"You better believe it is an exploitable tool," Brown said.

Iverson's motion to table the concept until after staff determines the present cost sharing status was defeated 8-6 with one abstention. The vote to approve the proposal, with cost sharing, was defeated 9-5, with Darity, Everson, Meyskens, Warner and David Sencer voting to support it. Those voting against it made it clear that they supported continuation of CIS, but not as presented.

Board Chairman Paul Engstrom said he would convene a panel of staff, Board members and possibly others to develop a new proposal.

Prescribe for Health likewise was strongly supported by the Board, but it ran into trouble when members objected to the estimated cost of evaluating the five year project, along with other budget concerns. Evaluation, as presented in the concept proposal, would cost more than $10 million, equaling and possibly exceeding the cost of developing and carrying out the intervention.

The concept had been discussed previously by the Board, and sent back for further refinement by staff. Goal of the project would be to improve the routine office practice of selected preventive services by primary care practices, including physicians, physician assistants, nurses, nurse practitioners and

other personnel involved in the delivery of primary care medicine. Primary objectives would be to:

*Characterize the level of practice of selected preventive services by primary care providers.

*Design interventions through intermediary organizations to improve the routine office practice of selected preventive services by primary care providers.

*Conduct a demonstration/evaluation (phase 5) of the effectiveness of interventions through intermediary organizations to improve the routine office practice of selected preventive services by primary care providers.

Intermediary organizations are defined as physician professional societies for adult primary care specialties, large HMOs, health and hospital corporations, community health centers and public health clinics, alone or in combination with universities, specialty boards, residency training programs, third party payers and/or other organizations with influence in the primary care practice of preventive services.

A secondary objective would be to determine the predictors of diffusion of preventive services among primary care providers and their practice partners.

The project's cost, especially the evaluation, was immediately challenged by James Holland. "That's $10 million to evaluate a study that costs $10 million to do," he said. "Do you really plan to give $2 million to the American College of Physicians (one of the potential intermediary organizations which could compete for the award)? That's more than they get from dues. That's a lalapalooza."

William Mayer, Prescribe for Health project officer, said the evaluation cost would be done by telephone followup of patients and physicians, with an estimated cost of $15 per call.

"You should have an economy of scale," Holland said. "With 77,000 calls, I'm not sure it would cost $15 for each call." When Mayer responded that that cost was based on previous followup studies, Holland said, "Then find some other way to do it."

Meyskens compared the evaluation cost to that being done for the Community Clinical Oncology Program. "CCOP is at least as complicated and requires even more contact," he said. "We're spending $10 to 12 million a year on CCOP, and it is costing $2 million to evaluate. This seems way out of line."

Holland objected to built in raises for the project directors and principal investigators listed in the budget. The salary of the project director of the evaluation unit was listed at $57,600 for the first year, rising to $97,284 in the fifth year. The salary of the project director for the intermediary organization, for 50 percent of his/her time, was listed at $52,480 for the first year, increasing to $88,637 in the fifth year.

"A director making $100,000 a year is awfully well paid," Holland said. "We on the outside are required to submit grants budgets that are lean and mean. This one is larded with fat."

Mayer responded that the estimates were intended to take inflation into account. "Some inflation," Holland snorted. "We won't have that again unless we get some wooly headed liberal as President."

Iverson offered a motion to approve the concept with a request to come back with another budget.

"That's not the way to do it," John Ultmann said. "I won't be here next time to vote against it." His term on the Board expired with last week's meeting.

Iverson withdrew his motion, and Darity made the motion to defer. It was passed 14-1.

Second Try Fails

All that transpired on the first day of the meeting. When the Board reconvened the next morning, Mayer appeared again and said that "informal discussions with Board members" after the previous day's action had led him to believe the Board would approve proceeding with the first stage of the project, provided a 20 percent ceiling were placed on evaluation costs.

"This is an extraordinary shift," Warner said. "There were problems with other budget figures, especially the 15 percent a year inflation factor. If we do this, we should do it right. I'm dumbfounded that you have come back in already."

Holland raised the issue that the intervention should include breast self examination, not mentioned in the concept proposal. "That's something that can be done free. For NCI to do only high tech screening is absurd."

"I'm concerned about patching up something overnight," King said. "It is unwise to ram it through just to get it started. We would be better served if we could see it again, the whole project, at the next meeting."

Holland's motion to approve initiation of phase 1 with the evaluation cap and including breast self examination, with phase 2 to be

considered at the next meeting, was defeated, 7-6.

Cole had the final word. Overnight approval of a "patchwork" proposal would not "send the correct message to division staff," Cole said. "We should reconsider only if there had been a fundamental misunderstanding. This would not encourage quality research."

Cole provided the only opposition to continuation of the SEER Program, at least as presently constituted and planned for continuation with the $5 million a year expansion.

"In the war on cancer, SEER is a blunderbuss when what we need is a laser rifle," Cole said. "The proposal would cost $15 million a year, every year. That will outstrip COMMIT two to three times. It's right up there with the Women's Health Trial."

SEER's emphasis on providing incidence data drew Cole's criticism. He suggested that mortality data are more pertinent. "Mortality to a large extent is readily available and it is free."

Cole presented figures which he said show the "true costs" of gathering cancer survival data. These include all tumor registries in the country, in addition to the 11 now supported by SEER. The total cost of all registries including SEER's is at least $60 million a year and more likely $80 million, Cole said.

"That's simply for counting cancer patients, with some followup. I can't see spending more money on gathering more data when the data we have are not adequately analyzed."

Greenwald disagreed and called the concept "the most important one we have." The proposed expansion would add 4 million persons to SEER's rural population base, add over 750,000 Hispanics, and increase the number of blacks in the base by more than 1 million.

The 11 registries and the statistical center now in the program will be continued with noncompetitive awards. The three to four additional registries involved in expansion will be added through competitive contract awards.

Calum Muir, deputy director of the International Agency for Research on Cancer and an international authority on cancer registries, chaired a committee which reviewed SEER and made the recommendations for expansion. He asked Cole what he would suggest as a replacement for SEER, and added that mortality data are not free.

"I did not suggest that SEER be abandoned, or that mortality be a substitute. Only that it supplement incidence data. I asked the question, what are we getting for $80 million? Why should the program be increased from $10 million to $15 million a year when there is no track record, and it is tearing us apart? Are we or are we not interested in improving cancer survival?

"All you are saying is, give us more money to collect more data. You are not telling us how to improve the system. I want a better SEER."

Edward Sondik, chief of DCPC's Operations Research Branch, agreed that "we haven't scratched the surface in analyzing data. We did not put funds into this concept to expand analysis. We have to expand (data collection) to meet the recommendations of the Muir committee. . . . There are hospitals across the country collecting data, and God knows what they do with it, down a black hole if that far. We see SEER as taking the lead to do something about it. We need to cover more blacks and Hispanics, to improve the power of our data from those populations, and also more in rural areas. We see it as getting a base to provide better cancer care for those groups."

The concept was approved for continuation of the program as presented by staff, for seven years. Cole cast the only vote against it.

There was no controversy over the request to proceed with implementation of COMMIT. Approval was unanimous, although there were some questions.

Joseph Cullen, DCPC deputy director who has become the federal government's "point man" in the campaign against tobacco (or at least the executive point man behind Surgeon General Everett Koop), said implementation of COMMIT is necessary to continue the momentum against tobacco use, pointing out that cigarette smoking among adult Americans has been dropping about two percent a year.

The program involves 11 community intervention centers which provide matched communities as controls. The 11 and their PIs are American Health Foundation, New York, Ernst Wynder; Fred Hutchinson Cancer Center, Seattle, Maureen Henderson; Kaiser Foundation Research Institute, Berkeley, Lawrence Wallack; Lovelace Medical Foundation, Albuquerque, Neill Piland; New Jersey Univ. of Medicine & Dentistry, Norman Hymowitz; Oregon Research Institute, Eugene, Edward Lichtenstein; Research Triangle Institute, Research Triangle Park, NC, Tyler Hartwell;

Roswell Park Memorial Institute, Buffalo, Michael Cummings; Univ. of Iowa, Iowa City, Paul Pomrehn; Univ. of Massachusetts Medical School, Worcester, Judith Ockene; and Waterloo Research Institute, Ontario, Allan Best.

Information Management Services, with Janis Beach as PI and Carol Giffen as co-PI, operate the coordinating center.

"How are you going to keep the control communities from doing what the media and all the health experts are advocating (that is, don't smoke)?" Holland asked.

"We built that factor into the sample size," said Iverson, who chairs the project's Policy Advisory Committee. "There will be a greater level of activity and pressure against smoking in the intervention communities."

Holland suggested that tobacco companies might target the intervention communities "for special deals, giveaways and such" to combat the program. The effort by some elements of the industry against Northwest Airlines in retaliation for that company's total ban against in flight smoking was mentioned.

"We'll monitor it," Iverson said. "We don't have a ready solution."

Holland pointed out that some of the tobacco companies have moved strongly into the food industry, suggesting that a boycott movement against "their profitable lines" might be considered as a weapon if they interfere with COMMIT.

Iverson noted that while the government could not participate in a boycott, community organizations participating in COMMIT have no such restrictions.

Holland suggested that help might be offered to tobacconists who may be driven out of business, in the form of special bank loans.

Private Cancer Information Services Are Operational, More On The Way

Whether or not NCI is able to expand the Cancer Information Service, two companies in the private sector are moving ahead with their privately financed, hospital based public information services which are frankly designed to enhance the competitive positions of the parent institutions.

CDP Services Inc., headquartered in Atlanta, has signed up nine organizations for its Cancer HelpLink program. ELM Services Inc., of Rockville, MD, has its first six CanHelp services operational, with six more "in the pipeline."

Both services are built around a toll free phone service, which are promoted in their respective communities through various advertising media and other activities. Both offer to answer cancer related questions, including the key questions such as where to go for second opinions and where to seek cancer treatment.

ELM's CanHelp works with a phone service established at the participating institution, with ELM training the personnel and providing the various materials and sources required to answer the questions. "We can individualize the service for each community," ELM President Lee Mortenson said. "Most of the calls involve questions on local resources, and our people have the answers at their fingertips."

CDP's Cancer HelpLink works through a switchboard in Atlanta. "It is our belief that we can provide higher quality responses" with the centralized answering service, Ron Gilden, CDP vice president for marketing, said. "When a caller asks for physician referral, the call is networked back to our hospital's physician referral service."

Gilden said the experience so far indicates that about 50 percent of calls will lead directly to physician referral. "We haven't handled enough calls yet to be sure, but that fits with the research that was done with CDP and NCI programs."

Mortenson said that analysis of CanHelp calls has found that his system's messages "are targeting the groups we want to reach--cancer patients, their families and friends." Fifty two percent of CIS calls are from the general public, while only 22 percent of CanHelp's calls are from that group. Patients account for 31 percent of CanHelp calls, compared with 18 percent for CIS. Spouses, friends and relatives make up 45 percent of CanHelp calls, compared to 30 percent for CIS.

Mortenson attributes the difference to the fact that most of CanHelp responses are generated by the professionally designed advertising programs, whereas CIS relies on public service messages.

"I have a lot of respect for the folks who put CIS together," Mortenson said. "It comes across as a public service, and gets people to deliver quality care."

Gilden agreed. "CIS plays a vital role," he said. "I'm sorry that the program isn't being fully funded. It's ironic, that at the same time, we're doing what we're doing, seeing an unmet need. It's obvious that public access to quality, site specific information, is needed."

CanHelp and Cancer HelpLink both make use of CIS literature and frequently use NCI's

PDQ to find answers to clinically related questions.

The six existing CanHelp services are located in Moline and Springfield, IL; Dayton, Indianapolis, Amarillo and Nashville.

Cancer HelpLink services are operational at two hospitals in the Michigan Health Systems, in Ann Arbor and Detroit; Premier Hospital Assn. in Oakbrook, IL (near Chicago); St. Mary's Hospital in Richmond, VA; Mercy Hospital in Des Moines, IA; Grossmont Hospital in La Mesa, CA; Medical Center of Central Georgia, in Macon; Richland Memorial Hospital in Columbia, SC; Mary Washington Hospital in Frederickburg, VA.; and Mercy Hospital, in Altoona, PA.

"We're providing information that clarifies choices for cancer patients," Gilden said. "It is not only providing information, it is also making people aware that this information exists."

The only significant difference between CIS and the privately funded services is that the latter utilize paid advertising, Gilden said. "The hospitals pay for it. If they get some marketing value, okay."

Mortenson said that CanHelp offices are getting from 60 to 250 calls a month, although that can increase dramatically when special events are promoted. One recently received 20,000 calls in three weeks in response to a mammography screening program.

New NCAB Appointees Include Some Old Hands; Korn Renamed Chairman

President Reagan announced the six new appointments to the National Cancer Advisory Board last week, and they included some old hands around NCI.

The new appointees are Erwin Bettinghaus, dean of the College of Communication Arts & Sciences of Michigan State Univ.; David Bragg, chairman of the Dept. of Radiology at the Univ. of Utah School of Medicine; Louis Gerstner, president of American Express; Walter Lawrence, director of the Massey Cancer Center at the Medical College of Virginia; Howard Temin, professor of oncology at the Univ. of Wisconsin McArdle Laboratory; and Samuel Wells, chairman of the Dept. of Surgery at the Washington Univ. School of Medicine.

Temin's was a reappointment, since he has been filling out the unexpired term of the late Tim Lee Carter.

Bettinghaus had not been cleared by the White House when the NCAB met Monday, so he attended as an observer.

Bettinghaus has just finished a term on the Div. of Cancer Prevention & Control Board of Scientific Counselors, the last two years as its chairman.

Bragg, who is probably the first diagnostic radiologist appointed to the NCAB, Lawrence and Wells all have served on the Div. of Cancer Treatment Board of Scientific Counselors.

Gerstner also never leaves home without some knowledge of the cancer program, quite a bit in fact. When he isn't running American Express, he serves on the Memorial Sloan-Kettering Cancer Center Board of Directors.

Gerstner and Bettinghaus were named to the two vacant lay seats on the Board, replacing Barbara Shook and Richard Bloch.

David Korn, who still has two years to go on his term as a member of the Board, was reappointed for his third consecutive two year term as chairman.

Noting that both Lawrence and Wells are prominent surgical oncologists, Korn commented that "surgeons are now well represented on the Board."

"It's about time," responded William Longmire, member of the President's Cancer Panel and professor emeritus of surgery at UCLA.

NCAB notes: Longmire read a statement sent by Panel Chairman Armand Hammer, who did not attend Monday's meeting. In it, Hammer said that he had obtained commitments from House Speaker Jim Wright and Health Appropriations Subcommittee Chairman William Natcher to support his plan to match with federal funds $500 million Hammer is trying to raise from the private sector. Hammer said he has formed a not for profit corporation, "Stop Cancer," to raise the money and has hired Denver Frederick, who helped Lee Iococca raise the money to refurbish the Statue of Liberty, as executive director. Rep. Tony Coelho (D-CA) has agreed to head the effort in Congress, Hammer said.

Hammer said he is in the process of contacting key members of the Senate. He pointed out that the matching funds from the government would be in addition to NCI's regular appropriations.

Board member Enrico Mihich urged that the extra money not be allocated for any one budget year. Hammer had started with the premise that since NCI's appropriation in FY 1989 likely would be $500 million under the

bypass budget request, the additional $1 billion would make up that shortfall for two years.

Director Vincent DeVita reported that no decision had been made yet on the various reorganization proposals. A new possibility has surfaced: the Cancer Information Service, now managed out of the Div. of Cancer Prevention & Control, and the International Cancer Information Center, now under the Office of International Affairs, would be moved to the Office of Cancer Communications.

Of all the proposed moves being considered in the NCI bureaucracy, those are the most likely to happen. No one is opposed, and in fact most of those concerned are all for it. Susan Hubbard, ICIC director, told **The Cancer Letter** that she supports the change, that ICIC's components ("JNCI," PDQ, Cancergrams, etc.) logically belong with OCC.

"Whether we move or not doesn't make much difference," Hubbard said. "Paul (Van Nevel, OCC director) and I already collaborate when appropriate and will continue to do so."

DCPC Peter Greenwald supports the move of CIS, which was originally started by OCC and moved into the division with cancer control responsibility because of funding considerations.

DeVita noted that the NCAB Centers Committee will consider the location of the Centers Program at the workshop scheduled for July 21-22, and that he probably will have a recommendation for the Board at its October meeting. Most likely prospect: His office, along with organ systems, construction, training (he didn't say that).

DeVita did say that it is possible that what is left of DCPC after all those programs move out might be combined with the Div. of Cancer Etiology, into one division.

"We're also thinking about moving epidemiology (from DCE to DCPC). That's the most controversial, and I've had several letters from the DCE Board of Scientific Counselors. There's another alternative--develop a second epidemiology program, on the contention that you can't have too many epidemiologists."

The changeover to ad hoc review of program project grants is nearly completed, although "NIH has not fully agreed. Other institutes have this for PO1s. I can't understand NIH's reluctance to accept our plan."

RFAs Available

RFA 88-CA-11
Title: NCI comprehensive minority biomedical program cancer centers minority enhancement awards
Letter of intent date: June 1
Application receipt date: Aug. 2

The Div. of Cancer Prevention & Control and the Div. of Extramural Activities invite applications for supplemental support to cancer center grants to expand minority involvement in cancer control research. Cancer centers would promote the participation of minority groups in cancer control research by broadening their operational base to facilitate the expansion of cancer control research efforts in early detection, prevention, screeing, pretreatment evaluation, treatment, rehabilitation, and the increased involvement of minority population primary care providers early in the course of clinical treatment.

The program effort would also promote the participation of minorities in treatment clinical research that utilizes institutional protocols. The effort would seek to support programs carrying out cancer control research activities related to diet and nutrition and would hopefully coordinate the contributions of investigators from various relevant disciplines, e.g., behavioral psychology and nutrition science.

This RFA announcement is for a single competition. Applications should be prepared and submitted in accordance with the aims and requirements described in the complete RFA.

This program effort would promote the participation of minorities in cancer control activities at those cancer centers with funded cancer center support grants which access large or predominantly minority populations. A supplement to a cancer center support grant (P30 core grant) would provide money for increased minority involvement in a variety of activities by the centers including the enrollment of increased numbers of minority patients on cancer treatment and cancer control protocols.

Support will be provided through a competitively awarded core grant supplement at a maximum projected annual direct cost of $150,000. Funds may be requested to support data management, supplies, salaries of professional and/or support personnel, computer time, administrative expenses, etc., in accordance with PHS grant policies for cancer center support grants. This request must be justified in the budget section of the application.

It is anticipated that five awards will be made subject to receipt of meritorious applications and continued availability of funds.

Letters of intent should be sent to, and complete copies of the RFA and additional information obtained from, Dr. Lemuel Evans, Program Director, Comprehensive Minority Biomedical Program, Div. of Extramural Activities, NCI, Bldg 31 Rm 10A-04, Bethesda, MD 20892, phone 301/496-7344.

NCI CONTRACT AWARDS

Title: Services for retrovirus epidemiology and natural history on hemophiliacs and their sexual partners
Contractor: Research Triangle Institute, $3,914,451

Title: Tracing through other sources and resources to determine the vital status and current address of patients treated in New York City hospitals
Contractor: Tracers, $148,230

The Cancer Letter _Editor Jerry D. Boyd Associate Editor Patricia Williams
Published forty-eight times a year by The Cancer Letter, Inc., P.O. Box 2370, Reston, Virginia 22090. Also publisher of The Clinical Cancer Letter.