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THE CANCER LETTER

Vol. 15 No. 18

May 5, 1989

Price $185 Per Year North America
$200 Per Year Elsewhere

P.O. Box 2370 Reston, Virginia 22090 Telephone 703-620-4646

Broder Hopes To Help "Fundable" Centers, Stops Short Of Promising Compliance With All IOM Points

NCI Director Samuel Broder says he will do everything he can to fund those competing cancer center core grants with priority scores "in the fundable range" but will not make

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In Brief

NCAB Vacancies Remain Unfilled; AHF's 20th Anniversary To Be Celebrated In NY May 24

TWO VACANCIES on the National Cancer Advisory Board still have not been filled, with a little more than a week remaining before the May 15-16 meeting. The vacancies were created by the appointment of **Louis Sullivan** as secretary of the Dept. of Health & Human Services, and by the defection of **Louis Gerstner** to the tobacco industry (Gerstner resigned from the NCAB after accepting an offer to head RJR Nabisco--**The Cancer Letter**, March 24). Gerstner had served only one year of the six year term. Sullivan's term will expire in 1992. He will continue on the Board, in the ex officio seat accorded the HHS secretary. If he attends a meeting, it will be a first for a cabinet officer. . . . **AMERICAN HEALTH** Foundation will celebrate its 20th anniversary May 24 at the Helmsley Palace in New York. Surgeon General **Everett Koop** will receive AHF's Dana Award; also honored will be **David Mahoney**, AHF chairman emeritus and founding trustee. . . . **GENNADY BELITSKY**, chief of the Laboratory of Carcinogen Screening Methods at Moscow's All Union Cancer Research Center, will be one of the first scientists coming to the U.S. under a bilateral agreement for exchange of information in the U.S./U.S.S.R. Cancer Program. Belitsky will spend six weeks at the American Health Foundation's Naylor Dana Institute for Disease Prevention. As part of the exchange, AHF Associate Director Dietrich Hoffmann will visit Moscow where he and Russian colleagues will compare research data on tobacco use and cancer. . . . **NEW APPOINTMENTS** in NCI's Office of Cancer Communications: **Jeff McKenna**, chief of the Health Promotion Section, and **Katherine Crosson**, chief of the Patient Education Section, both in the Information Projects Branch. . . . **PATRICIA MCGOVERN**, nurse on the Clinical Oncology Research Unit at Columbia Univ. Comprehensive Cancer Center, will receive the center's first award for oncology nursing. It will include an expense paid trip to the annual congress this month of the Oncology Nursing Society in San Francisco.

Broder Hopes To Find More Money For Centers But Won't Make Promises

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any promises on the extent to which he will go along with recommendations of the Institute of Medicine's committee which reviewed the Cancer Centers Program (**The Cancer Letter**, April 28).

The committee recommended that Broder "take immediate steps" to "avert a crisis" by reprogramming up to $6 million into center core grants in the current fiscal year. Otherwise, five centers competing for renewal of their grants (or a combination of five competing renewals and new centers with priority scores which in previous years would be in the fundable range) will go unfunded.

"Every effort will be made to provide the money to centers in the fundable range," Broder told **The Cancer Letter**. But he would not commit himself to a specific dollar figure on the amount to be reprogrammed.

Are there any dollars available for reprogramming?

"We will look at the money that may be available, and will try to spend it as best we can to meet the total needs of the institute. Keep in mind that the National Cancer Institute is an organic whole, a delicate ecological system. We are facing major problems this year, and will next year."

Broder singled out as areas with major problems in addition to centers: basic research, as measured by the drop in the number of research project grants from 980 in FY 1988 to an estimated 715 this year (expected to go up to 822 in 1990); the cut in number of National Research Service Awards, brought on largely by an increase in stipends without additional money to pay for them; clinical trials and the flat cooperative group budget; cancer control including the Community Clinical Oncology Program, where the plans for modest expansion are threatened by lack of a modest budget increase; research and development contracts, where cuts are crippling drug development, epidemiological studies and some cancer control efforts; and even research management and support, where a projected five percent cut in 1990 threatens Office of Cancer Communications and Cancer Information Service activities.

"The cooperative groups are an exceedingly high priority," Broder said. "We will not meet our Year 2000 goals if we do not solve the problem of adequate support for the groups."

The NRSA shortfall appears to be the most serious problem weighing on Broder's mind. "That's our future. We're eating our seed corn." Cuts in research project grants also are serious, and will hurt centers, Broder contended. "The vitality of cancer centers will shrink without (adequate support for) ROIs and NRSAs. Cancer centers have a definite link with what happens to ROIs and NRSAs."

Obviously, pressures have been building for whatever money may be available for reprogramming from all underfunded programs, which means just about everything. At the moment, Broder is keeping his options open.

What about other recommendations in the IOM committee's report?

The suggestion that a substantial increase in the core grant budget be made in 1990 now rests in the hands of Congress (see following article). But the committee also suggested that organizational changes be made internally at NCI.

Former Director Vincent DeVita, acknowledging the discontent of cancer center directors over what they perceived as lack of visibility for the program within NCI and limited access to the highest decision making level, had decided to move it from the Div. of Cancer Prevention & Control into his office. He was waiting for the National Cancer Advisory Board's Committee on Cancer Centers to come up with its recommendations, but then everything was put on hold when he decided to leave NCI for Memorial Sloan-Kettering.

Has Broder reached any conclusion about that issue?

"I've been reviewing the organizational structure of the centers program, as well as many other areas of NCI," he said, a comment certain to arouse more than a little interest in Bethesda and environs. "I'm new at this job.

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Published forty-eight times a year by The Cancer Letter, Inc., also publisher of The Clinical Cancer Letter and AIDS update.

Until I was appointed director, I had never attended a meeting of the Executive Committee (the NCI director and his deputy, the division directors and the NCI administrative officer). Flying a 747 is quite different as a passenger than as the pilot. I was an intramural scientist, with one viewpoint.

"I'm looking over every aspect of the institute that I can, trying to learn about areas of which I have no specificic knowledge. I've been to Frederick. I'm looking at people power needs, and how people are deployed."

Does he look back wistfully at the time when all he had to do was to run the Clinical Oncology Program and search for cancer and AIDS cures?

Never. "This is the best job someone like me could ever hope to have, a rare privilege to help alleviate suffering and death from disease. There have been only 10 directors of NCI, and I'm one of them.

"I have a lot of different challenges," Broder continued. "This is not an easy job. One saving grace is that I've not seen any inherent irreconcilable differences in any element of NCI. All of the elements are synergistic and each makes all other elements better. That's a theme I hope to get across. Research project grants and centers are integrally tied together. An excellent center becomes a tool to do better cancer research, where better grants can be developed. The cooperative groups are tied to centers. And everything is tied to the NRSA pool.

"If we take X million dollars away from training now, what will that mean five years from now? Twenty years from now?

"The excellence of the intramural program dpends on the extramural community, for people and ideas. That is blindingly clear."

Broder is concerned by the impending departure of NIH Director James Wyngaarden and the question of who will replace him.

"The director of NIH is of surpassing importance to the academic and practicing oncology community," Broder said. "On every policy issue, the fate of research project grants, centers, construction, NRSA, intramural research--all these require participation of the NIH director."

DeVita's relationship with Wyngaarden was rocky, which may be an understatement. DeVita did not hesitate to user the powers in the National Cancer Act which permitted him to go public, through the National Cancer Advisory Board and the President's Cancer Panel, with differences between NCI and NIH, as well as other agencies, most notably the Office of Management & Budget and FDA.

Wyngaarden resented it when DeVita went over his head and finally exploded when **The Cancer Letter** asked if he opposed renewal of the National Cancer Act, referring to the NCI director's use of the Cancer Panel and suggesting that NCI's bypass budget authority was no longer needed (**The Cancer Letter**, March 18, 1988).

Broder said he views differences that may arise between the NCI and NIH directors as something that "can be remedied with dialogue. I've had good dialogues with Dr. Wyngaarden." The issue of the National Cancer Act "was never raised. It is almost 20 years old and has served the country well."

Broder said he believed that DeVita and Wyngaarden "always argued issues on principle. People of good principle must take positions with which others may not agree. But a statute is a statute. In my view, the President's Cancer Panel was designed to serve as a special mechanism not only to bring out what has gone wrong, but also what is going right. It is also a conduit of information to the scientific community and the public. The Panel has played a critical role on such issues as cancer mortality among minorities."

Ross McIntyre, director of the Norris Cotton Cancer Center and current president of the Assn. of American Cancer Institutes, said he was "very happy with the recommendations" of the IOM committee.

"It was wonderful for centers to have an independent group the stature of the Institute of Medicine committee to look at centers and come to those conclusions. It vindicates those far sighted individuals who originated the centers concept of providing links between the laboratory and the clinic.

"The administrative problems pointed to by the committee needed to be addressed by NCI and will lead to a strong program if that advice is taken," McIntyre continued. "I'm very happy with the outcome."

McIntyre noted that "it was the feeling of the committee that the necessary funds probably could be met from within NCI, so that highly qualified centers will not go down. I realize the difficulty, with money as short as it is, to find any extra. On the other hand, the report is an accurate portrayal of the situation in which centers find themselves."

Members of the House Labor-HHS-Education

Appropriations Subcommittee commented at the public hearing on the 1990 budget last week about the "real possibility some centers with good priority scores might not be funded," McIntyre said. "Others pointed out that golden opportunities might be missed because a relatively minor amount of money can't be found somewhere.

"The amount spend on research is a drop in the bucket. I don't feel guilty being an advocate for more money for cancer research. Even a portion of the amount needed would make all the difference in the world. It is frustrating that this tremendous resource we have in the National Cancer Program is drying up. It represents a tremendous investment which could be wasted."

Harkin, Bumpers Express Concern Over Cancer Centers Flat Funding

Sens. Tom Harkin (D-IA), chairman of the Senate Labor-HHS-Education Appropriations Subcommittee, said he is concerned about the impending loss of cancer centers due to the flat Cancer Centers Program budget.

Questioning NCI Director Samuel Broder at a hearing this week on the NIH 1990 budget request, Harkin noted that cancer centers are important in the transfer of cancer technology to communities.

Four or five cancer centers will lose their core grants in fiscal 1989, Broder told the subcommittee, and the same number will lose their funding in fiscal 1990.

The Administration has requested about $101 million for the centers program for 1990, the same amount as the current year.

Broder said the decision was made to drop some centers in favor of maintaining funding for the remaining centers at 85 percent of recommended levels because funding at less than 85 percent would, "in effect, nullify the peer review recommendation process."

"In order to meet the funding realities and not go below 85 percent, certain centers will have to lose their core grants," Broder said.

"These centers are exceedingly important. The three major priorities of the Cancer Institute are basic research, clinical trials and our Cancer Centers Program," Broder continued. "They are an important component, particularly the comprehensive cancer centers, in disseminating information on cancer and technology, early diagnosis, teaching prevention and introducing state of the art technologies to communities.

"I think communities that lose cancer centers will feel the effect," he said.

According to a recent General Accounting Office report, only one third of doctors around the country are using state of the art cancer treatment techniques, Harkin said.

"If some of the centers have to close down, then you would expect to not reach even that one third," Harkin said. "That bothers me."

In response to a question from Sen. Dale Bumpers (D-AR), the only other member of the subcommittee to attend the hearing, Broder said it would cost $5 million to $6 million to save the five centers in fiscal 1989 and that amount plus another $6 million to save the centers that would have to be dropped in fiscal 1990.

A report by the Institute of Medicine recommended that the NCI director "take immediate steps to avert a crisis" in the Cancer Center Program's 1989 funding and to work with Congress to "develop an adequate budget" (**The Cancer Letter,** April 28).

Neither senator specifically promised to add money to the Cancer Centers Program.

However, both Bumpers and Harkin indicated they will support adding some money to the NIH budget overall, and increase funding for the training programs.

In his testimony, NIH Director James Wyngaarden said the Office of Management & Budget is now considering an NIH request to "reprogram" some funds to pay for more training slots.

The number of training slots will fall from 11,329 to 10,021 (not including AIDS slots) in fiscal 1989 if the reprogramming is not allowed.

Some reprogrammed money would be made available by increasing the downward negotiations on research project grants by 1 percent. That would add about 510 slots.

Wyngaarden said funds have been "identified" to enable another 300 slots to be added. Some funds are from trainee slots that have not been filled.

The 1990 budget includes funding for only 10,206 trainee positions, "the smallest total number in probably 10 years," Wyngaarden said.

In response to Harkin's question about the training program's needs, Wyngaarden said the number of trainees should be increased by about 1,000 a year for the next few years.

"We'll work on this and see what we can find in the budget," Harkin said.

Bumpers said he was concerned about the

drop in the percentage of approved grant applications that NIH is able to fund, from 34 percent in recent years to about 24 percent this year.

"Are there meritorious applications you wish you could fund?" he asked Wyngaarden.

Wyngaarden replied that NIH should strive to fund 45 to 50 percent of approved applications. That would take about $800 million more than the $6.7 billion NIH budget request for fiscal 1990, he said.

Bumpers asked NIAID Director Anthony Fauci whether his institute's budget was sufficient.

"Our request was more than the President's; if by definition that means it is not enough, then it's not enough," Fauci replied.

The difference between the amount NIAID requested and the Administration's budget request was $137 million, he said.

"I think there is the possibility we can make up that," Bumpers said. "I can conclude the 1990 budget request is not sufficient."

Later in the hearing, however, Harkin expressed concern over the large funding increase for AIDS activities, about 25 percent overall, compared to the small increases in other programs, including cancer.

"What if we leveled off AIDS at a 20 percent increase and invested in other biomedical research?" Harkin asked Fauci. "That saves about $75 million."

"I think this would be under the heading of robbing Peter to pay Paul," Fauci replied. "We feel that money in AIDS is needed, but the non-AIDS funding increases are not commensurate with the scientific opportunities that are available now."

Harkin responded: "We're going to try to get all the money we can. There are some hard choices to make."

Bumpers noted that the Reagan Administration had pushed for consolidating all of the AIDS money into a block grant that would be overseen by the assistant secretary for health.

Fauci said he did not support that proposal. "My feeling always has been that money should be appropriated as directly as possible to the unit that is responsible for the research involved. To add another layer to the process may slow things down. My preference is to go directly to the institutes."

Some additional funding should be set aside in the NIH director's office that could be used for AIDS research or other opportunities, he said.

"I support that," Wyngaarden said. "I think the next director should have some discretionary money. I never had a nickel of discretionary money." Wyngaarden announced last week that he is leaving Aug. 1.

The 1990 budget requests $25 million for an NIH director's discretionary fund. "The assistant secretary, who has departed, already has obligated about $20 million of that, but the principle is correct," Wyngaarden said.

"I can see why you're leaving, Dr. Wyngaarden," Bumpers said.

"I'm free to say anything I want to say," Wyngaarden replied.

"Very liberating, isn't it?" Bumpers replied.

Wyngaarden said that if he had a discretionary fund in the current fiscal year, he would have put the money into the research training program.

"That would have been our top priority for discretionary funds, we would not have had to rebudget and we would not have had all these complaints from the extramural community about the straits that this has created," he said.

LeMaistre Blasts 'Merchants Of Death' Encouragement Of Cigarette Exports

Charles (Mickey) LeMaistre was one of the principal authors of the 1964 Surgeon General's report which condemned cigarette smoking as the major cause of lung cancer. He has not lost any zeal for the antitobacco crusade that report launched; if anything, it is more intense than ever.

The president of M.D. Anderson Cancer Center was in Washington D.C. last week to address the Texas Breakfast Club, a group of Texans working in the nation's capitol who get together once a month.

"Before 1900, there were only 134 cases of lung cancer in all the annals of medical literature," LeMaistre said in reciting a brief history of smoking and its relationship to cancer. "When I was in medical school, lung cancer was so rare that when we had a case, everyone had to see it. In the 1930s, Ochsner reported on the relationship of smoking and cancer but few believed him. We shouldn't have been so dumb."

The tobacco industry "has created the greatest producer of cancer in the history of man," LeMaistre continued. "It causes 30 percent of all cancers." Tobacco as a cause of cancer "is the single most carefully studied subject in the history of medicine, and that conclusion has not been shaken in the 25

years since the Surgeon General's report.

"It is a political, social and moral problem. When I was in medical school, five year survival of lung cancer patients was eight percent. Now, it is 13 percent. It has not yielded to therapy. So all we can do now is to say, don't start. This is an easily preventable disease. Don't smoke."

It is a "disgrace," LeMaistre said, that Congress does not recognize tobacco as a drug, which would permit much tighter regulation of tobacco products. "That's ridiculous. It is a drug that is more addictive than heroin.

"Tobacco companies are merchants of death. When you include cardiovascular disease, emphysema and other diseases caused by tobacco in addition to cancer, 390,000 Americans die of tobacco caused disease every year. The Nazi holocaust pales in comparison.

"It does not make me proud to be an American when our government encourages exports of cigarettes, without even the warning labels we require for those sold in our country. We must really think a lot of our trading partners.

"We are the first society to have a chance to eliminate cancer as a major health problem. We can prevent its occurence; cancer is not inevitable.

"It's about time we take on the tobacco companies. They have to work very hard to replace the one million Americans who quit smoking every year, and the 390,000 who die from it. The industry spends $2.7 billion a year on advertising and promotion, most of it trying to get young people to start.

"If you think I have no respect for the people who sit on the tobacco company boards, you are correct."

LeMaistre reminded his fellow Texans (he's an adopted Texan, having been born in Alabama) that Texans played key roles in creating and passing the National Cancer Act of 1971, "the most significant activity in the history of cancer." Since then, "we have learned more about human biology than we had in the entire history of man." That legislation "provided a greater yield than anything else in the history of medical research."

The National Cancer Act grew out of an initiative taken in 1970 by Texas Sen. Ralph Yarborough, who established an independent Panel of Consultants on the Conquest of Cancer. Texas native Benno Schmidt was cochairman of the Panel along with Lee Clark, LeMaistre's predecessor as president and founder of M.D. Anderson.

"Texans have had a lot to do with progress in cancer research, and I expect they will do a lot more," LeMaistre said. He specifically mentioned the work of three adopted Texans at M.D. Anderson--Margaret Kripke, "who unravelled the relationship of ultraviolet light to skin cancer and is working on its relationship to melanoma;" W.K. Hong, "who has turned precancerous lesions back to normal;" and Isaiah (Josh) Fidler, "who is teaching the body how to eat cancer cells. It sounds like star wars."

Chronobiology Review Still Delayed; NCI May Settle For The "Best People"

The matter of finding knowledgeable reviewers for grant applications submitted in response to the RFA for studies of chronobiological effects in cancer treatment (**The Cancer Letter**, April 28) has not yet been resolved, Robert Browning, chief of NCI's Grants Review Branch, said last week.

Browning acknowledged that apparently most U.S. chronobiologists had responded to the RFA, thus eliminating themselves as prospective reviewers. The problem was exacerbated by the departure of Robert Hammond as chief of the Research Programs Review Section in Browning's branch. Hammond had worked in chronobiology and Browning had been counting on him to head up the review. Hammond has moved to the National Institute of Diabetes & Digestive & Kidney Diseases.

"It is a limited field. We have some reviewers lined up, but it is not complete," Browning said. He probably will settle for getting "the best people we can find and rely on their judgment."

The Div. of Cancer Treatment has set aside $500,000 for first year funding of the grants and hopes to make two or three awards. It was anticipated that the grants could start with FY 1989 money, but the National Cancer Advisory Board, which must approve the awards, meets May 15-16. Since initial review has not even started, the grants obviously cannot go to the NCAB then. The Board's final meeting of the fiscal year is scheduled for Sept. 18-19. That would still permit using 1989 funds (the fiscal year ends Sept. 30), but NCI would prefer to make the awards sooner.

Browning said that Div. of Extramural Activities Director Barbara Bynum has approved NCAB review by mail during the summer, if the initial review is completed in time.

Duke, M.D. Anderson To Receive Bristol-Myers Unrestricted Grants

Bristol-Myers Co. has announced that it will award unrestricted grants totaling $1 million for cancer research to the Duke Comprehensive Cancer Center and M.D. Anderson Cancer Center. Each institution will receive $100,000 a year for five years.

This brings the company's program of no strings attached grants for cancer research to $12.34 million in 25 grants to 23 institutions in the Unites States and abroad.

Directors of the recipient cancer research programs, Robert Bast, director of the Duke Comprehensive Cancer Center, and Irwin Krakoff, head of M.D. Anderson's Div. of Medicine, will administer the grants.

Bast's group will use the grant to strengthen several different programs and facilities at Duke, including development of clinical pharmacology, coordination of multi-disciplinary care for patients with breast and lung cancer, and the purchase of instruments to be shared by basic scientists.

"The Bristol-Myers grant is particularly welcome because there are no strings attached and we will have the freedom to apply it where it will do the most good," Bast said.

Krakoff said that most of the M.D. Anderson grant will be used to help young investigators who have novel ideas for better treatment strategies, including chemotherapy and biologic therapy for particularly resistant forms of cancer.

"The Bristol-Myers grant is critical because no matter how creative they are, young scientists without an established track record have a hard time competing for support from the traditional funding agencies," Krakoff said. "This grant will provide seed money that can make the difference between success and failure."

ONS Adopts Position Statement Rehabilitation of Cancer Patients

One of the perks received by the president of the Oncology Nursing Society is the President's Grant, funded by Smith Kline & French. The president, limited to one two year term, is free to use the grant in any constructive manner she desires.

Deborah Mayer, whose term expires at this month's annual ONS congress in San Francisco, used her President's Grant to support an invitational conference last summer entitled, "Addressing Barriers to Successful Cancer Rehabilitation." The conference produced a position statement on "Rehabilitation of Persons with Cancer" which has been adopted by ONS.

"There were several reasons why I used the grant to focus on rehabilitation within oncology," Mayer said. "Historically, rehabilitation has not been included as a systematically or consistently integrated process in cancer care. However, other specialities, like cardiology, have established successful rehabilitation phases as an extension of the patient's total care plan. With more and more cancer patients surviving, it is important that oncology specialists not only continue to address diagnostic and treatment issues, but also demonstrate concern about the patient's ongoing quality of life.

"Additionally, specialists in pediatric oncology have long addressed rehabilitation issues for their young cancer patients. Their work in helping children grow and mature as cancer survivors can serve as a model for professionals working with adult cancer survivors who also benefit from this extension of services."

Mayer expressed her appreciation for the funding and support provided by Smith Kline & French. "This generous grant enabled me, as ONS president, to focus attention on an undeveloped area of cancer care. It is my hope that these recommendations are the first steps to integrating rehabilitation as a vital phase of oncology care."

The position statement, coauthored by Mayer and Linda O'Connor, a member of the ONS Board, recommends broadening the focus of cancer care to include the structure, process and outcome of rehabilitation in the care of the individual with cancer.

Specifically, ONS has identified a number of recommendations, some of which are already being implemented. The recommendations include that:

* Research will be funded and conducted to build systematic and cumulative knowlege of rehabilitation interventions best suited to the individual with cancer.
* Cancer education curricula will include rehabilitation of individuals with cancer.
* Cancer publications and standards will address cancer rehabilitation.
* Cancer legislation will reflect rehabilitation issues.
* Reimbursement for rehabilitation services to individuals with cancer will be provided.

* Inter and intraorganizational efforts will be conducted on an ongoing basis to heighten awareness about cancer rehabilitation.

* Collaborative interdisciplinary rehabilitation efforts are to be fostered.

Another outcome of the grant is the development of a special symposium jointly sponsored by ONS and the American Society of Clinical Oncology. Entitled, "Age Specific Cancer Rehabilitation," the 90 minute symposium will be presented twice on Sunday, May 21, at the Moscone Convention Center in San Francisco. It is open to all attendees of the ONS 14th Annual Congress May 17-20 and the 25th ASCO annual meeting May 21-23.

Cancer and health care organizations represented at the conference last summer included NCI, American Cancer Society, ASCO, Assn. of Community Cancer Centers, National Coalition for Cancer Survivorship, National Assn. of Oncology Social Workers, American Physical Therapy Assn., Assn. of Rehabilitation Nurses and the American Assn. for Cancer Education.

The position paper notes that "rehabilitation is a process by which individuals, within their environments, are assisted to achieve optimal functioning within the limits imposed by cancer. Historically, rehabilitation has not been included systematically or consistently as an integrated process in cancer care. Philosophical and attitudinal differences amongst health professionals and the public are a major obstacle. Lack of coordinated care and poor interdisciplinary collaboration, lack of adequate reimbursement for services, and a paucity of research supporting the efficacy of rehabilitation interventions also contribute.

"Rehabilitation services will be available to address the physical, psychological, spiritual, social, vocational and educational potential of the individual. A team of oncology and rehabilitation care providers and volunteers are needed to provide these services. The most important members of this team are the individuals with cancer and their families.

"The other team members include, but are not restricted to, nurses; physicians; physical, occupational and recreational therapists; social workers; speech pathologists; dentists; nutritionists; psychologists; clergy; and volunteers.

"One of these must assume responsibility for the coordination of care. Significant contributions are made by all members of the team. However, the nurse is most often the key link in coordinating these services. The structure of this program may range from a formal rehabilitation service to a network of individuals or organizations available to provide this care.

"Services are provided according to the preventive, restorative, supportive, or palliative needs of the individual. The rehabilitation assessment is initiated at the time of diagnosis. Reassessment occurs periodically throughout the individual's lifetime. This assessment is conducted within a holistic framework which evaluates individuals with cancer in the context of the family and community. Interventions should be goal oriented and have measurable outcomes. Referrals to available resources are based on identified preventative, restorative, supportive or palliative needs. Selected information is available on a variety of national, regional, and local resources that currently exist and is published annually in the 'Oncology Nursing Forum.'

"Individuals achieve optimal functioning within the limits imposed by their cancer. A definition of optimal functioning is based on a realistic appraisal by the individual and the rehabilitation team. Variables which may influence an optimal functional status include type and extent of disease and treatment, concurrent illnesses or disabilities, age, physical and psychosocial abilities, physical environment, and the utilization of appropriate available resources."

Medical Oncology Among Specialties Fostering Long Term Relationships

Long term relationships between physicians, patients and families are characteristic of practice in medical oncology, pediatrics and rheumatology, according to physicians who participated in a study by Glaxo Inc.

"The life and death issues of oncology require that an honest and trusting relationship be developed based on mutual respect," one medical oncologist commented.

More than 1,740 physicians from 33 board certified specialties participated in the "Glaxo Inc. Medical Specialties Survey" as part of the pharmaceutical company's Pathway Evaluation Program. The program, a supplement to medical school career counseling efforts, is designed to help students in career decisions.

Some specialists, including emergency medicine, infectious diseases and radiology, said they generally don't develop long term relationships with patients.