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HHS Drops Misconduct Allegations Against NCI's Gallo Days Before Appeals Hearing

The HHS Office of Research Integrity last week withdrew its determination that NCI's Robert Gallo committed scientific misconduct in the discovery of the AIDS virus in 1984.

Recent decisions by the Research Integrity Adjudications Panel established a new definition of scientific misconduct "as well as a new and extremely difficult standard for proving misconduct," ORI said in a Nov. 12 statement. The panel was scheduled to hear Gallo's appeal of the ORI's

(Continued to page 2)

In Brief

Senate Committee Confirms Varmus; Albertini Directs Vermont Cancer Center

HAROLD VARMUS was confirmed as NIH director by the Senate Labor and Human Resources Committee last week. The full Senate is expected to vote on the nomination soon. . . . **RICHARD ALBERTINI** is the new director of the Vermont Cancer Center following a national search. He served as interim director of the NCI-designated comprehensive cancer center following the departure of **Roger Foster Jr.** for Emory Univ. in 1992. Albertini is a geneticist who conducts research on environmental mutagenesis and carcinogenesis. He has been on the Univ. of Vermont faculty for 20 years, and was a member of the planning committee for the cancer center in the mid-1970s. . . . **TERESA VIETTI**, professor of pediatrics at Washington Univ., has stepped down from the position of Chair, Pediatric Oncology Group, after more than a decade. Vietti was honored by group members for her achievements at the fall POG meeting held in Chicago last month. **Sharon Murphy**, professor of pediatrics, Northwestern Univ. Medical School, and chief of hematology/oncology, Children's Memorial Hospital, succeeds Vietti as the new chair of POG. . . . **SOCIETY FOR RADIATION** Oncology Administrators named **A.R. (Roy) Threet** chairman of the board of the 550-member professional group. Threet is chief operating officer of the Cancer Therapy & Research Center, San Antonio, TX. Members of SROA represent academic, free-standing, and community cancer centers throughout the U.S. . . . **"ONCOLOGY NURSING** Review: A Computer-Assisted Instruction Program," is an updated computer program to help oncology nurses prepare for the certification exam. The Oncology Nursing Society released the program this month, with funding from Glaxo Inc. for develoment and distribution.Contact ONS (412/921-7373). Cost of the program is $80 ONS members, $100 non-members. . . . **MARLUCE BIBBO** was named the first Warren R. Lang professor of pathology and cell biology at Thomas Jefferson Univ.

ORI Withdraws Misconduct Case Against NCI's Gallo

(Continued from page 1)
misconduct finding on Nov. 15.

ORI created the appeals panel last year after criticism that scientists should have more rights in defending against misconduct charges. ORI has not won any cases since.

In recent decisions, including the Nov. 3 decision clearing former NCI researcher Mikulas Popovic (**The Cancer Letter**, Nov. 12) the panel ruled that ORI must prove deliberate intent to deceive, that a false statement have a material or significant effect on the research conclusions of the paper, and that there be no possibility of honest error.

Last month, the appeals board threw out three of the five pending charges against Gallo due to ORI's inability to meet these standards.

Ends Years Of Gallo Investigation

Last week's action ends four years of federal investigation of Gallo stemming from allegations first publicized in an article in The Chicago Tribune. Gallo was accused of misappropriating the AIDS virus from French researchers and misleading colleagues to gain credit for himself.

An NIH investigation in 1992 cleared Gallo of misconduct. ORI reversed those conclusions in a December 1992 report (**The Cancer Letter**, Jan. 8, 1993).

"ORI found that Dr. Gallo misstated the role that the French virus, LAV, played in his work with the AIDS virus," Lyle Bivens, ORI director, said in the Nov. 12 statement. "We also found that he failed to identify, in a timely manner, the origin of the cell line used to propagate the virus and that he inappropriately restricted access to the cell line."

Following the panel's decision in the Popovic case, Bivens said, "it is clear that the panel now applies different standards from those applied by ORI to review findings of scientific misconduct.

"ORI maintains that the standards applied by the panel reflect a fundamental disagreement with ORI as to the importance of clarity, accuracy and honesty in science," Bivens continued. "However, because ORI is bound by the panel's decisions, it will not continue its proceeding against Dr. Gallo. As a practical matter, the panel's recent decisions have made it extraordinarily difficult for ORI to defend its legal determination of scientific misconduct regarding Dr. Gallo."

HHS plans to establish next year a Congressionally mandated advisory board, the Commission on Research Integrity.

ORI plans to change the definition of misconduct to include situations where a researcher "knew or should have known" that statements were false. Such a change will require approval of the new commission.

"We believe that ORI's approach to determining scientific misconduct is the correct course of action," Bivens said. "We are confident that the new commission will reinvigorate our efforts to maintain the highest scientific standards and to deal effectively with misconduct. While dismayed by the panel's pronouncements, we remain committed to protecting the integrity of Public Health Service research."

"You Have To Prove Your Case"

Joseph Onek, Gallo's lawyer, said ORI should not blame the appeals panel.

"The fact is, ORI has made false statements against Dr. Gallo," Onek said to **The Cancer Letter**. "It is not that the panel's standards are too high, it is that they have the standard of any tribunal. You have to prove your case."

Onek continued: "ORI could not prove its case against Dr. Gallo just as it could not prove its case against Dr. Popovic because the charges were false and irresponsible."

Gallo plans to continue his work at NCI, where he is chief of the Laboratory of Tumor Cell Biology. "Dr. Gallo now can return to science," Onek said.

What do the appeals panel's requirements mean for scientists in the long run? "As long as the appeals panel exists, as long as there is a fair tribunal, ORI

THE CANCER LETTER

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will no longer be able to make false and irresponsible statements," Onek said.

Under the regulatory definition, scientific misconduct includes "fabrication, falsification, plagiarism, or other practices that seriously deviate from those that are commonly accepted in the scientific community for proposing, conducting, or reporting research. It does not include honest error or honest differences in interpretations or judgements of data."

Lawyers for the Paris-based Pasteur Institute said last week that ORI's action dropping the Gallo case has no bearing on their claims for full credit and royalties for the AIDS blood test.

Michael Epstein, of the Washington law firm Weil, Gotshal & Manges, said the Pasteur Institute will continue to press HHS and NIH to reconsider the 1987 decision that split the credit for the AIDS blood test between France and the U.S.

Capitol Notes

Cuts In Medicare Proposed In Budget Bill Amendment

Amendments to the President's rescission bill both in the House and the Senate are aiming to cut Medicare by as much as $40 billion over the next five years as well as cap indirect costs for universities engaged in federally funded research.

Both the House and the Senate measures are based on a plan by Reps. Tim Penny (D-MN) and John Kasich (R-OH) to reduce government spending by about $100 billion over five years.

In the Senate, a measure similar to Penny-Kasich is expected to be introduced by Bob Kerey (D-NE), Bob Graham (D-FL), John Chafee (R-RI), Hank Brown (R-CO) and Joseph Lieberman (D-CT).

The President is asking for about a $2 billion reduction in the fiscal 1994 budget. Both the House and Senate are expected to vote on the rescission by Nov. 22.

Critics said the measures would in effect set policy without due consideration by Congress.

"It is bad public policy to pursue deficit reduction in this fashion," Marguerite Donoghue, vice president, research and regulatory affairs, at Capitol Associates said to **The Cancer Letter**. Capitol Associates represents the National Coalition for Cancer Research.

"Each of the more than 30 provisions in the Penny-Kasich should be considered individually, on their merits," Donoghue said. "To lump all of these programs together is akin to shooting a gun blindfolded."

It is not clear how the measures could affect cancer research or cancer care. Research could be affected by the Penny-Kasich provision that imposes a 50% cap on payments to universities performing government-funded research. In 1990, such costs averaged about 46 percent.

Cancer care could be affected by "means-testing" Medicare Part A and B, in effect making Medicare recipients living on higher incomes pay higher premiums as well as higher deductibles.

Under the House measure, means-testing begins at the annual income of $75,000 and subsidies are phased out entirely for Medicare recipients earning $100,000 or more. The Senate measure calls for means-testing at $50,000. Both measures call for copayment on lab work and home care.

The measures also call for cutting the federal workforce by 252,000 and cancellation of programs throughout the government.

Senators Support Breast Cancer Report

Sens. Connie Mack (R-FL) and Dianne Feinstein (D-CA) gave another strong endorsement to the recently released report by the National Cancer Advisory Board's Special Commission on Breast Cancer.

"It would be a tragedy if this report sat on the shelf collecting dust," Mack said. Mack and Feinstein are cofounders of the Senate Cancer Coalition.

The report, which supports the NCI bypass budget funding of breast cancer programs, landed in the center of controversy recently, when the National Breast Cancer Coalition called for a different strategic plan that would declare breast cancer a key national priority and launch an multi-agency research effort to combat the disease.

In mid-December, HHS Secretary Donna Shalala is expected to hold hearings on a strategic plan for breast cancer.

In a statement endorsing the report of the NCAB special commission headed by Nancy Brinker, Mack said: "The bottom line is: America needs a national cancer strategy. While this commission was appointed by another Administration, I hope that the Clinton Administration will put politics aside and use the report as a tool to help develop a long-overdue strategy to eradicate cancer."

WHI Community Prevention Study Approved In Concept

NCI's Div. of Cancer Prevention & Control Board of Scientific Counselors have approved in concept the plans for the NIH Community Prevention Study as part of the Women's Health Initiative.

The Community Prevention Study is one of three main areas of the WHI. The other two areas are the clinical trial and the observational study.

NIH plans to spend $45.75 million over five years to fund the CPS.

Following is an excerpt from the concept statement:

Women's Health Initiative Community Prevention Study. Concept for new RFA, cooperative agreements, total $45.75 million over five years, 15 community centers grants, one study coordinating center grant.

The goal of this concept is to stimulate the design and evaluation of community-based programs for achieving the adoption of healthful behaviors in women from racial/ethnic groups, medically underserved, or socioeconomically disadvantaged populations, and who have high risks for chronic diseases that can be reduced through preventive intervention strategies. This proposal will be developed in two phases. The objectives of the two phases of the initiative are to:

Phase I - Developmental:

—foster the cooperation and interaction of coalitions (such as researchers, community leaders and organizations, policymakers, private and public health collaborators and institutions) to define community needs and plan intervention strategies for improving health behaviors in women within their cultural setting;

—define community needs and develop a process for a systematic approach to behavioral change using existing channels and resources;

Phase II - Testing and Evaluation:

—test community intervention strategies for improving healthful behaviors in women such as improved diet and nutrition, smoking cessation, increased physical activity, improved oral hygiene, early disease detection, and weight control;

—develop integrative models of approaches to health promotion and chronic disease prevention that are cost-effective and that can be used for further intervention testing and adoption by other communities; and

—evaluate the community approach and intervention strategies for achieving risk factor reduction in women from racial/ethnic groups, medically underserved, or socioeconomically disadvantaged populations.

The Community Prevention Study is designed to promote the development and testing of intervention strategies for achieving the adoption of healthful behaviors, including improved diet and nutrition, smoking cessation, increased physical activity, improved oral health, weight control, and early disease detection in women from diverse racial/ethnic groups, medically underserved, or socioeconomically disadvantaged populations with high risks for chronic diseases.

This concept invites applications for collaborative research among community groups, each of which will design, develop, test, and evaluate the efficacy and/or effectiveness of community-based intervention strategies for reducing the risk of chronic disease in women. The groups will focus on communities containing women from one or more racial/ethnic subgroup (e.g., African-American, Hispanic, Native American, or Asian-American/Pacific Islander), medically underserved, or socioeconomically disadvantaged population, and who have high risks for chronic diseases that can be modified or prevented through behavioral change interventions. The effectiveness of teams of researchers, community leaders and organizations, policymakers, and other private and public health collaborators to plan and implement programs for promoting lifestyles of healthful behaviors among women using existing channels specific to their cultural milieu will be evaluated.

This project is divided into two phases:

Phase I - Developmental: includes development of coalitions and structures, defining priority health education and disease prevention needs and strategies for community intervention, assessing appropriate risk factors for Intervention, identifying appropriate channels for intervention, developing appropriate instruments for assessing behavioral change in the targeted population, and establishing evaluation plans for local programs.

Phase II - Testing and Evaluation:I includes testing of risk factor reduction strategies in targeted populations using existing community channels and resources, evaluating progress, and assessing effectiveness of behavioral change models. Plans should include an integrative approach to intervening on multiple risk factors.

Community center applicants will be responsible for the planning, direction, and execution of the proposed project. A separate study coordinating center will be selected to assist in the development and standardization of common protocols, in data collection, and analyses. Community center applications may be submitted by academic or by community organizations or institutions with demonstrated experience and expertise in this area of research. Applicants must demonstrate an understanding of the target community and

the ability to involve the community structure in the process of change. The community centers will work cooperatively with the WHI Project Coordinator and other NIH staff, the coordinating center, and other successful applicants in developing common protocols for process measures, culturally appropriate instruments, and will participate in network meetings of the study group.

Applicants for community centers may modify existing programs to accommodate requirements of special populations, incorporate existing but previously untested intervention strategies, or propose new intervention initiatives to be tested. Two or more risk factors appropriate to the target population should be selected. Interventions should target at least one of the following areas: diet and nutrition, smoking cessation, physical activity, weight control, oral health, or early disease detection. Applications should provide information on the appropriateness of the risk factors selected and the intervention strategies proposed, target population, outcomes measures, and evaluation plan.

Community center researchers must address the procedures to be used for qualitative and quantitative evaluation. Applicants should define the process and the behavioral change measures that will be used to assess the efficacy and effectiveness of their program and interventions, including the type of behavioral change measurements and instruments to be used. Outcome variables to assess behavioral changes may use accepted, validated instruments and techniques or propose the development of new tools and procedures. Applicants are encouraged to address issues relevant to effectiveness of the program in diverse community settings, efficiency of the intervention with respect to use of existing channels and resources, and cost-effectiveness of the project. Applicants should provide plans for continuation once federal funding has ceased.

This concept invites applications for a study coordinating center. The coordinating center will participate with the community centers, NIH/WHI Project Coordinator and NIH staff in developing culturally appropriate data collection instruments; preparing common intervention protocols, where appropriate; assessing effectiveness of intervention strategies in targeted populations; analyzing and reporting study results.

Applicants for the coordinating center should demonstrate experience in working with academic and community organizations, have experience in the design and development of instruments and procedures and for standardization of common data collection measures across multiple study centers, knowledge of quality control and quality assurance procedures, have experience in survey research, and in data analysis and reporting.

More US Men Are Ex-Smokers Than Current Smokers: NCI

More U.S. men now are ex-smokers than current smokers, according to NCI.

New estimates based on nearly 100,000 interviews conducted in September 1992 for the U.S. Census Bureau's Current Population Survey show that among men ages 20 and older, 27.4 percent were smoking cigarettes at the time of the interview, but 28 percent had quit. This is the first time that more men were recorded as former than as current smokers.

While 22.2 percent of women ages 20 and older were smoking in 1992, 18.8 percent had quit. Overall, the smoking rate for male and female adults is now just below 25 percent.

Still, more than 43 million Americans smoke, and an estimated 400,000 Americans die annually due to cancer, respiratory diseases and cardiovascular disease, NCI Director Samuel Broder said.

The smoking control program implemented by NCI in partnership with the American Cancer Society--the American Stop Smoking Intervention Study--currently is moving from its first phase, planning and organization, to its second, implementation phase.

The primary objective of ASSIST is to reduct adult smoking to 15 percent or less by the year 2000. The state-based demonstration project is expected to reach 91 million people in 17 states. It was begun in October 1991.

NCI Funding 56 CCOPs, Ten Research Bases; Current List

Following is a list of the 48 principal investigators and institutions receiving Community Clinical Oncology Program awards as of last month. They are listed in order by state.

Arizona—David King, Greater Phoenix CCOP.

California—Scott Browning, San Diego Kaiser Permanente. James Feusner, Bay Area Tumor Institute. Cary Presant, Central Los Angeles, St. Vincent Medical Center.

Delaware—Irving Berkowitz, Medical Center of Delaware CCOP.

Florida—Enrique Davila, Mount Sinai Medical Center. James Talbert, Florida Pediatric CCOP, Florida Assn. of Pediatric Tumor Programs.

Georgia—Ernest Franklin, Atlanta Regional CCOP, St. Joseph's Hospital.

Iowa—Roscoe Morton, Iowa Oncology Research Assn. CCOP. Martin Wiesenfeld, Cedar Rapids Oncology Project.

Illinois—Illinois Oncology Research Assn. CCOP. Alan Hatfield, Carle Cancer Center. Janardan Khandekar, Evanston Hospital. James Wade, Central Illinois CCOP, Memorial Medical Center.

Kansas—Henry Hynes, Wichita CCOP.

Louisiana—Carl Kardinal, Ochsner Cancer Institute.

Michigan—James Borst, Grand Rapids Clinical Oncology Program, Butterworth Hospital. Philip Stott, Kalamazoo Community Oncology Program.

Minnesota—Patrick Flynn, Metro-Minneapolis CCOP. James Krook, Duluth CCOP. Robert Marschke, Scottsdale Community Clinical Oncology Program, Mayo Foundation.

Missouri—Jorge Paradelo, Kansas City Clinical Oncology Program, Baptist Medical Center. John Goodwin, Ozarks Regional CCOP. Patrick Henry, St. Louis-Cape Girardeau CCOP.

North Carolina—James Atkins, Southeast Cancer Control Consortium CCOP.

North Dakota—Ralph Levitt, Merit Care Hospital CCOP, Roger Maris Cancer Center.

New Jersey—Richard Rosenbluth, Bergen-Passaic CCOP, Hackensack Medical Center. Jack Goldberg, South Jersey Oncology Group CCOP. Arnold Rubin, Saint Michael's Medical Center Tri-County CCOP.

Nevada—John Ellerton, Southern Nevada Cancer Research Foundation CCOP.

New York—Jeffrey Kirshner, Syracuse Hematology-Oncology CCOP. Sameer Rafla, Brooklyn CCOP, Methodist Hospital of Brooklyn. Vincent Vinciguerra, North Shore Univ. Hospital CCOP.

Ohio—Howard Gross, Dayton Clinical Oncology Program. Leslie Laufman, Columbus CCOP. Paul Schaefer, Toledo Community Hosptial Oncology Program.

Oklahoma—Alan Keller, St. Francis Hospital/ Natalie Warren Bryant CCOP.

Oregon—Keith Lanier, Columbia River Oncology Program.

Pennsylvania—Albert Bernath, Geisinger Clinical Oncology Program. William Heim, Mercy Hospital CCOP. Reginald Pugh, Allegheny CCOP, Allegheny-Singer Research Institute.

South Carolina—James Bearden, Spartanburg CCOP, Spartanburg Regional Medical Center.

South Dakota—Loren Tschetter, Sioux Community Cancer Consortium CCOP, Central Plains Clinic.

Virginia—Nicholas James Robert, Fairfax Community Clinical Oncology Program, Fairfax Hospital.

Vermont—H. James Wallace Jr., Green Mountain Oncology Group, Rutland Regional Medical Center.

Washington—Paul Weiden, The Virginia Mason Clinic. H. Irving Pierce, Northwest CCOP, Tacoma General Hospital.

Wisconsin—Tarit Banerjee, Marshfield Medical Research Foundation CCOP, Marshfield Clinic.

Minority-Based CCOPs

Following is a list of the eight Minority-based Community Clinical Oncology Program principal investigators and institutions.

Alabama—Marcel Conrad, Univ. of South Alabama MBCCOP, USA Cancer Center.

Georgia—Melvin Moore, Grady MBCCOP, Grady Memorial Hospital.

Illinois—Thomas Lad, Univ. of Illinois MBCCOP.

Michigan—Clarence Vaughn, MBCCOP of Metropolitan Detroit, Southfield Oncology Institute.

New York—C. Julian Rosenthal, Kings County MBCCOP, SUNY Health Science Center/Brooklyn.

Puerto Rico—Louis Baez, San Juan City MBCCOP, VA Medical Center.

Texas—Richard Parmley, South Texas Pediatric MBCCOP, Univ. of Texas Health Science Center.

Virginia—Christopher Desch, MCV/CMH MBCCOP of Virginia, Massey Cancer Center.

Research Bases

Following is a list of the 10 CCOP Research Base awardees and their principal investigators.

Cooperative Groups: Children's Cancer Group, Denman Hammond. Eastern Cooperative Oncology Group, Douglass Tormey. Pediatric Oncology Group, Jeffrey Kirscher. North Central Cancer Treatment Group, Michael O'Connell. Cancer & Leukemia Group B, Ross McIntyre. National Surgical Adjuvant Breast and Bowel Project, Bernard Fisher. Southwest Oncology Group, Charles Coltman.

Cancer Centers: Miles Robert Cooper, Comprehensive Cancer Center of Wake Forest Univ. Gary Morrow, Univ. of Rochester Cancer Center. Rodger Winn, Community Oncology Program, Univ. of Texas M.D. Anderson Cancer Center.

NCI Program Announcement

PA-94-011

Title: **Economic studies in cancer prevention, screening and care**

NCI's Div. of Cancer Prevention and Control and the Agency for Health Care Policy and Research invite investigator-initiated grant applications for research directed at increasing the knowledge base in the area of the economic aspects of cancer prevention, screening and care. The goal of this program announcement is to generate new economic knowledge that will promote the optimal design of cancer prevention and control trial studies and interventions and will facilitate the formulation of effective health care policy related to cancer prevention and control. This initiative requests research applications on new methods development, the synthesis and extension of existing methods, and innovative data gathering strategies. Applications that propose to implement actual data collection on a pilot or full-scale basis as well as analytical studies that use existing data and methodology will be entertained.

Support will be through the NIH research project grant (R01). Sizes of awards may vary. Direct costs per award will vary from $50,000 to $500,000 per year.

This initiative supports research directed at increasing our understanding of economic aspects of cancer prevention, screening and care. Studies that cover the national population of all ages on an episodic basis fail to capture an adequate sample of cancer patients or the full scope and duration of cancer costs. Studies that focus on a convenience sample of cancer patients in a single health care delivery setting or community can be criticized as lacking external validity. Studies proposed in response to this PA will be expected to address these issues and propose innovative methods of overcoming these limitations.

The purpose of this PA is to solicit collaborative research between academics in the fields of health economics and health services research and clinical researchers in cancer.

The research goals are:

1. The cost of cancer treatment and care in various organizational settings.

—To develop and validate methods for collecting reliable and representative data on longitudinal patterns of health care resource use, expenditures and costs for cancer prevention, screening, diagnostic, treatment, and care in various organizational settings.

—To develop and validate methods for collecting reliable and representative data on the cost of continuing care for cancer patients. These costs include not only out-of-pocket costs for medical treatment and related expenses but also other monetary and non-monetary disease and treatment costs to the cancer patient and the family of the cancer patient.

—To explore alternative proposed and existing models of out-patient and home-based continuing care for cancer patients in order to determine efficient modes of organization that provide access to and meet the continuing care needs of cancer patients and their families.

2. Collection of economic data in the context of clinical trials and the use of economic data and analysis in the design of trials.

—To determine the cost of the health care intervention (e.g., cancer prevention, control, treatment or rehabilitation) in NCI sponsored trial settings compared to standard cancer control and treatment settings.

—To determine the feasibility of collecting data on direct and indirect lifetime costs in the context of clinical trials.

—To collect data on direct and/or indirect lifetime cost in the context of a clinical trial.

3. Cost-effectiveness of cancer prevention and screening trials and cancer prevention and control interventions.

—To review and evaluate the existing conceptual basis, methodology and application of cost effectiveness analysis to cancer related interventions. Studies should identify conceptual, methodological and data collection problems unique to cancer related interventions and propose solutions to these problems. Studies should also include an evaluation of the appropriate role of cost effectiveness analysis in policy formulation related to cancer and how this role relates, or should relate, to medical ethics, equity and fairness, and community values.

—To determine the cost effectiveness of NCI sponsored cancer prevention and screening trials. Studies should include an analysis of the important determinates of cost effectiveness, the level of uncertainty of these determinates, and how these determinates might be effected by alternative trial designs.

—To determine the cost effectiveness of cancer prevention and control interventions as implemented through the health care system. Studies should include an analysis of the important determinates of cost effectiveness, the level of uncertainty of these determinates, and how these determinates might be effected by alternative health care delivery settings and health care policies. The relevance of cost effectiveness analysis for the particular question studied should be demonstrated by showing that it contributes additional information to the health care decision making process than would be available from clinical trial efficacy information alone.

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Or, Michael Hagen, Program Officer, Agency for Health Care Policy and Research, 2101 East Jefferson Street, Suite 502, Rockville, MD 20852-4908, Tel. 301/594-1354.

Nominations Sought For ACS-Disney Research Professorship

The American Cancer Society invites nominations for the Walt Disney-American Cancer Society Research Professorship in Breast Cancer.

This award, using the income from a donation by Mrs. Walt Disney, is intended for an outstanding investigator whose past research is clearly relevant to the breast cancer problem, and whose work reveals an aptitude for innovation in the control of this disease.

Nominees, who must be U.S. citizens or permanent residents, may be clinical or basic scientists, or epidemiologists. They should have at least 10 years of experience beyond receipt of the doctoral degree. In general, they will be at the rank of full professor or equivalent. Individuals employed by for-profit organizations, federal agencies, or agencies supported entirely by the federal government are not eligible.

The awardee will be chosen by a peer review process emphasizing past contributions and future potential, but most importantly, innovation in the field and ability to attract young scientists into this area. The professorship will be awarded for five years, renewable every five years until retirement from the institution, provided that the individual's research continues to excel.

The terms of appointment are for partial salary support at $50,000 per year plus an additional $10,000 in discretionary funds. The awardee will be expected to be a spokesperson for the ACS and for breast cancer research.

Nominations are due Feb. 15 for a starting date of July 1, 1994. Nomination forms are available from Dr. John Laszlo, Senior Vice President for Research, American Cancer Society, 1599 Clifton Rd. NE, Atlanta, GA 30329, Fax 404/321-4669.

Letter to the Editor

NCI Workshop Not A Formality, As Kopans Suggests: Baines

To the Editor:

Before very long Dr. Kopans' propensity for flogging his particular view of the screening universe and the individuals therin will be recognized by the Guiness Book of Records: the most lines written in letters and editorials on one subject in the shortest period of time by one person alone or in combination. And he still complains. He'd like more space to express himself, even though he gets more than two and a half pages in the eight page Sept. 24 issue of **The Cancer Letter** and lots of pages elsewhere, too.

To decry the NCI Workshop on Screening as a "mere formality" is absurd to anyone who attended it, and also, I hope, to anyone who has taken the trouble to read the report published in the Oct. 20 issue of the Journal of the National Cancer Institute.

To those weary or confused about the breast cancer screening controversy (with respect to women under 50 years of age), it may be interesting to reflect that the very same screening studies which Dr. Kopans wishes to ignore with respect to younger women become quite acceptable when it comes to results in women 50 and over. This can be called the eat-your-cake-and-have-it-too syndrome which manifests itself in the scientific context as: any trial (or portion thereof) which confirms my beliefs I'll accept and any trial which doesn't shall be excoriated.

Of course, Dr. Kopans often reminds everyone that all screening studies conducted thus far, alone or combined, lack power to rule out a benefit in women under age 50. Hundreds of thousands of women, he continues, are required to provide adequate power. He is undoubtedly right. But then it must be acknowledged that very large sample sizes are an indication that the benefit sought is very small.

In his second letter (**The Cancer Letter**, Oct. 15), Dr. Kopans claims I have freely acknowledged that the analysis of the Canadian National Breast Screening Study was premature. It is difficult to understand how anything I have said could have been so interpreted. The first analysis was based on seven year followup from entry into the study as has been true for all other studies. Results from our analysis are preliminary in the sense that followup will continue for years. I would agree that, at seven years, it is premature to draw final conclusions about the efficacy of screening in the NBSS or any other screening population.

What is remarkable is than an intelligent professional in 1993 is prepared to advocate the use of a screening technology in a specific population before it has been demonstrated to be efficacious in a way which achieves consensus among experts both within and outside the field.

One thing is beyond dispute. Dr. Kopans' energy is limitless!

Cornelia Baines
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