THE CANCER LETTER

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Will Insurers Pay Patient Care Costs? Stay Tuned For Act II Of This Oncodrama

Welcome to oncopolitical theater.

In this episode, Charles "Chip" Kahn, chief operating officer and president-designate of the Health Insurance Association of America, is *confronted* by two US Senators, one patient advocate, and president of the American Society of Clinical Oncology.

Kahn's adversaries have the following goals:

(a) Convince him that the insurance industry is wrong in its policy

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In Brief:

Breast Cancer Stamp Unveiled; Payne Moves To MSK; Survivor To Bike Across U.S.

FIRST LADY Hillary Rodham Clinton unveiled the Breast Cancer Research stamp at a ceremony at the White House July 29. Eight cents of every sale of the 40-cent postage stamp is to be given to NIH and the Department of Defense medical research program for breast cancer research. . . . **RICHARD PAYNE** has been named chief of the Pain and Palliative Care Service at Memorial Sloan-Kettering Cancer Center. He was chief of the Section of Pain and Symptom Management at M.D. Anderson Cancer Center. Payne replaces **Kathleen Foley**, who has stepped down from her administrative position to focus on national policy issues while continuing with patient care and research at MSK. . . . **DANI GRADY**, a breast cancer survivor from San Diego, is leading a 70-day, 3,600-mile "Conquer Cancer Coast to Coast" bike tour from California to Washington, DC. First stop was a rally organized by the Sidney Kimmel Cancer Center in La Jolla. Cyclists across the country are invited to join the tour, which will participate in rallies at 23 other cancer centers. The ride will culminate Sept. 26 at "The March: Coming Together to Conquer Cancer" on the Mall in Washington. A contingent from San Diego, including SKCC President **Ivor Royston**, will join Grady on the last leg of the tour. For information on joining or supporting the ride, contact 877-THRIVERS (847-4837), or visit the website at http://www.thrivers.org. . . . **AFLAC CANCER** Center for Children at Egleston Children's Hospital in Atlanta opened this week. Egleston is located at Emory University. The new cancer center is the largest pediatric cancer institution in the Southeastern U.S. It is part of ESR Children's Health Care System Inc., which combines Egleston Children's Health Care

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In Debate Over Patients Rights Bills, Advocates Score Points

(Continued from page 1)

of declining reimbursement for patient care costs associated with clinical trials, or (failing that);

(b) Rip his argument into small pieces in a public place (a hearing of the Senate Cancer Coalition July 16), thereby demonstrating that unless the industry shows some flexibility in a hurry, it would remain a target for a legislative fix.

Before Kahn settles into a witness chair, Bruce Zetter, Harvard Medical School professor of surgery and cell biology, delivers a talk about the promise of anti-angiogenesis compounds. Then, ASCO president Allen Lichter turns Zetter's science lecture into a trap:

"Let's say that two years from now, Dr. Zetter and I get together and design a research trial of [radiation and Angiostatin, an anti-angiogenesis drug under development] in head and neck cancer," Lichter said.

"I would say to a patient, 'If you enroll on this trial, we will add Angiostatin to standard radiotherapy.'

"The patient would ask me, 'Are my costs covered by my insurance company if I enter this trial?' And I would have to say, 'I am not sure. Your insurance company may not cover the cost of this treatment because you are on a trial.'

"And the patient would say to me, 'Wait a minute. If I don't get Angiostatin—if I just get the radiation—will my costs be covered?' I would say, 'Yes, completely.'

"So we have a real dilemma. The patients are either placing themselves at risk for huge expenses or else they don't go on the trial. This is not a way to promote high quality cancer research in this country," Lichter said.

Though the coalition has no jurisdiction, it has the moral authority of being led by Dianne Feinstein (D-CA), whose husband died of cancer, and Connie Mack (R-FL), a cancer survivor whose belief in the invisible hand of the market sometimes clashes with his understanding of the needs of the clinical trials system.

The oncodrama staged by the Senate coalition is significant because it played out publicly—and at great length—the issues that figure in the context of other high-profile legislation.

In the two "patient rights" bills currently dueling on Capitol Hill, the Democratic proposal contains a provision for reimbursement of patient care costs in clinical trials, while the Republican legislation does not cover clinical trials.

Capitol Hill observers say the Democratic bill has low chances of clearing Congress, while the Republican bill is expected to be vetoed by the President.

A related proposal, by Sens. Jay Rockefeller (D-WV) and Mack which required HHS to establish a "demonstration project" to evaluate the impact of clinical trials coverage on Medicare, recently took a nosedive together with the tobacco bill to which it was attached.

"To Draw The Line"

Enter Kahn.

"HIAA supports voluntary efforts, where appropriate, to further medical research," Kahn said. "But we—as a matter of public policy—have concerns about any subsidy of this kind of research, as we have concerns about indirect subsidies for other kinds of activities in the health care system that are not directly related to the accepted, medically-necessary patient care that's covered under a contract for insurance."

"Would you say half-a-loaf?" suggested Feinstein, inviting Kahn to negotiate.

KAHN: It's not a question of half-a-loaf, it's a question of when you're developing insurance

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coverage, and concerns about costs of that coverage by the payment-makers—which are primarily employers and employees of this country—actuaries have to come to some judgment as to what the costs are.

The question is, at what point is it a private responsibility, and at what point does it become a public policy matter? Clearly, who can say all this research shouldn't be done? Or that these people shouldn't be involved in it? But at some point, you do need to draw the line, legally, between where health insurance coverage is provided and how research is paid for.

MACK: I think I'm going to try to have a little dialogue here. You have heard Dr. Lichter talk about the individual who wanted [the policy to cover] radiation treatment. But if you add [Angiostatin], then none of the treatment would be paid for. It seems to me there's got to be some room in there to come together.

KAHN: If the government was going to come in and mandate under all circumstances any approved program—

MACK: Let's get away from the mandate now. We're sitting down and trying to walk through a rational way to respond to the need to cover more clinical trials or to cover more procedures, as Dr. Lichter pointed out.

KAHN: I know Blue Cross in many communities participates in trials. And their medical directors work with physicians at academic health centers and others doing research in the community with regard to specific types of cancer or specific types of treatments.

It's perfectly reasonable, and I would see it as acceptable, for our companies to participate in some of those programs. But the trouble is that they have to draw the lines. At some point, if you cooperate in one area, what happens regarding cancer and any number of maladies where there is research going on on a daily basis?

And the medical director of that insurance company or the health plan at some point has to make a judgment — is this something that we ought to pay for? They have to make a judgment. And saying that it's open-ended makes it very difficult.

Rigidity Vs. "Invisible Hand"

MACK: It's not difficult to put your hat on, and understand that you are running a business. You do have your customers that you have to be concerned with, you are concerned with cost, and so forth. I understand that. But the issue that was raised by Dr. Lichter, that is the—the drug that was going to be used in conjunction with the radiation was going to be paid for by the manufacturer, and there would be no additional cost to the insurance company.

When you [deny coverage is such cases], to most of us doesn't sound rational. And by saying no, we're not going to do this, we never get a chance to have a dialogue to figure out what is the rational thing.

If there is a clinical trial in which you are getting some early information that says that there's not a great remission rate that's taking place here, it might be very logical to say, well, that's a clinical trial we don't think that we would participate in. But you might find another clinical trial in which, in fact, that clearly the data indicates that there is a rather significant impact.

To just blinded say we are not going to be engaged in covering clinical trials, just doesn't sound like a rational position to me.

KAHN: One of the reasons that [the Health Care Financing Administration] has been very rigid about contending they are not in the business of clinical trials is that there are other government agencies that do that.

Because even though it has some medical expert to make judgments about what [clinical trials] are, it still is a very complicated process for them to make that decision.

There are many procedures, and treatments, and drugs that come down the line every day for them to make judgements about.

They don't have the expertise to make the judgement about a test, something that still in the experimental stage that doesn't have a literature in existence about it or is only—or such a literature is being developed.

I don't know if they're rigid. But if you put yourself in the place of a medical director or an actuary at an insurance company who are working together to try to come up with the cost of the value of a health plan that has to be ultimately charging premiums to the consumers who are buying that coverage.

And then understand that even if [the medical director] is a very good doctor, [he] has only the knowledge at hand that's in the literature, and accepted practice.

It is very difficult to make these judgments. And

one of the other problems is that—the example [Lichter] gave us is a perfect one. But if there were 15, or 20, or 30, or 40 of those examples, which he could probably come up with for different kinds of treatments, at what point does the medical director draw the line? What criteria do they use in each of those cases?

MACK: But that is the process of your business, in essence. You do that every single day for all kinds of procedures.

KAHN: When there is a body of knowledge for them to make judgments on, there is an accepted community practice. When there is a body of knowledge or experts for them to go to, that's one thing.

But when there is something that admittedly is a trial, it's a different matter, because they have to draw a line.

I'm not saying they shouldn't participate in such trials. I'm just saying it's not so simple, particularly in today's world, where there are so many advances being tried all the time.

And also, as I said, there are pressures on these companies to keep premiums in line.

MACK: If the industry just says to us over and over and over again, 'We're just not going to do it,' then it drives the political body to say, 'If you are not going to do it, we'll make you do it,' and I don't think that's the best way to go about this.

KAHN: I agree with you. It's not the best way. And that's why I think that doing demonstrations with Medicare may be a good way to begin to find mechanisms so you can set some criteria.

And maybe if there were some criteria set rather than mandates under circumstances under which these kinds of things would be tried, I think that's something that we could consider.

MACK: *You know, HMOs are engaged in these discussions now. I can't say what the outcome might be, but obviously many of us are hopeful, so there may be a possibility of not just Medicare or government-funded programs that might be more engaged in clinical trials, you might see this in HMOs as well.*

KAHN: That's true. There are discussions with NIH about these matters. But I think we need to be careful with expectations, though. Because there is only so far health plans can go.

The pressure on the health plans in the current environment is to provide a product—health coverage for a reasonable cost, keeping inflation of that cost in line.

It's The Media

FEINSTEIN: I agree with Sen. Mack. The day is going to come when, if the industry doesn't work out something voluntarily, the government is going to mandate it, because of the patient population, and because some of the highest risk groups have the least access to the clinical trials for economic reasons.

If what the insurance [industry] wants is progress in medicine—and I've got to assume it does—then this becomes a compelling factor for you to provide an element of coverage. Could you respond, please.

KAHN: Who can say you don't want these advances to take place?

Sure, we can mandate a set of benefits that would include all types of research and other kinds of activities. That is going to increase the cost of premiums. And the question at the end of the day is, is that the right place to load up the indirect subsidization of research, or should there be a direct subsidy from the taxpayers, because it's a societal decision?

The question is who is going to pay for it?

The trouble with our health care up to this point has been that we have had many indirect subsidies. And for years the society put up with cost inflation that was reflected from those indirect subsidies, and said that was acceptable. A few years ago, people started saying, wait a second, that's not acceptable.

The insurance companies are middle men caught in-between in this public concern, whether it's care for the poor that comes out of the premium payers that are paying for services, or whether it's research, or payment for teaching hospitals. We need, as a society, to make a judgment. The trouble is, if you keep putting too much pressure on the private system, ultimately the private system is going to break down.

And you are also asking medical directors to make judgments that are very difficult to be made, and to meet their various missions.

Their primary mission is to provide health coverage as defined by a contract with the payer, and to keep that coverage within some kind of reasonable cost that that premium payer has an expectation of....

I'm troubled, too, as a representative of the insurance industry. I have been watching CNN, watching the networks cover every kind of anecdote they can find.

The fact is that there frequently is not a full explanation of what these anecdotes are. How these anecdotes compare to how many problems people have in the old fee-for-services are never discussed. When you consider that 150 million Americans have private coverage, to say that there would be 1,000 or 1,500, or 2,000 particular problems actually statistically is necessarily not that big a deal.

So, if the current debate were held in a thoughtful [manner], looking at statistically significant research regarding problems involving health plans, I'd be sympathetic.

Got A Problem? Get a Lawyer

FEINSTEIN: Dr. Lichter, you haven't had a chance to participate in this.

LICHTER: We believe very strongly that we can work with the health insurance industry to perform this research without increasing their costs.

We believe that firmly. We believe that the demonstration project will prove it. We would love to open a dialogue with the industry and begin to work out these problems.

FEINSTEIN: Have there been attempts to do so?

LICHTER: There have been, and the industry has remained fairly steadfast with its position.

FEINSTEIN: Have they been willing to engage in talks?

LICHTER: *[Turns to Ellen Stovall, executive director of the National Coalition for Cancer Survivorship]* Ellen, will you help me out with that?

STOVALL: There have been discussions between NIH and NCI and industry. I know the patient groups have had some limited contact with third party payers. We are frequently referring people to lawyers, to get an intermediary between the insurance industry and the physician, because that's the best thing we can offer someone in the course of a day. Recommend to see a lawyer.

That doesn't seem quite right. So I would say indirectly we have some contact with the insurance industry, but it's hard to get them on the phone to discuss this.

FEINSTEIN: Mr. Kahn, I think you've got a very compelling statement from a very distinguished professional.

KAHN: Well, all I can say is—*[pauses]*. The fact is that provision of more services—

FEINSTEIN *[Interrupts.]:* Right. And I could say, Show me.

KAHN: I can tell you, with all due respect, services cost money. There is nothing wrong with that. If those services are considered safe and effective, and part of the community standard, then they ought to be involved in what health care insurance, whether it's Medicare or the private sector, pay for.

But we are kidding ourselves when we say that all of this will save money. It will increase costs. That's why we have to be very careful about the gate between what's allowed in and allowed out.

LICHTER: I would just interject— The most expensive cancer patient is the patient we fail to cure. We can spend substantially more on a therapy if we needed to. And if that therapy was curative, the total cost of that patient with cancer experience goes down.

When patients are not cured, they go on to second- and third- and fourth-line treatments. They have palliative radiation, they have surgical procedures that correct problems, etc., etc. There is absolutely no question that if we do a clinical trial that shows that the cure rate of disease goes up, the cost of treating that population over time goes down. It's irrefutable.

STOVALL: I work for a nonprofit organization that spends about $500 a month paying my insurance premium. That's not an unusual amount. It's fairly average, and I'm a high risk-individual.

It's not very comforting to me to know that with all those dollars paid in, the contract that was suggested by Chip Kahn between him and me is virtually no good. It's null-and-void if I have a recurrence of cancer and have to go on a clinical trial.

And yet, the [insurance] company benefits from that loss to me. I don't think that's right. There's something critically out of balance in that arrangement. I don't have the same problem if my car gets dented and I have an insurance contract.

There's an inequity there that doesn't seem right. We are paying for people to be treated for cancer with therapies that are outdated. They have been proven to be effective, but they are outdated and outmoded.

And where is the future generation of lives saved going to come from if we don't take this much more seriously? I can't quite accept this debate, because it seems so one-sided.

FEINSTEIN: Let me give you the last word, if I may. I think this was an excellent last word.

[Curtain.]

NCI Programs:

Seven Institutions Win Awards For Cancer Genetics Network

Seven institutions have received eight cooperative agreement awards to form the Cancer Genetics Network and an informatics group, NCI said this week.

The network is designed to support collaborative investigations into the genetic basis of cancer susceptibility. NCI plans to provide up to $6 million in total costs for first-year funding of the awards.

"The Cancer Genetics Network will develop scientific resources and provide access to study populations not currently available to most individual cancer genetics programs," NCI Director Richard Klausner said in a statement earlier this week. "This new research infrastructure will position us to capitalize on the remarkable advances taking place in understanding hereditary susceptibility to cancer."

Three institutions received awards for the Informatics and Technology Group, which will serve as information, data management, and statistical centers for the network. The awardees, their principal investigators, and first-year funding amounts:

—Yale University, Prakash Nadkami, PI, $279,270

—Massachusetts General Hospital, Dianne Finkelstein, PI, $519,342

—University of California, Irvine, Hoda Anton-Culver, PI, $481,809

The award to UC Irvine will support the existing NCI-funded Cooperative Family Registries for Breast and Colon Cancer Studies, a group of 12 research centers in the U.S., Canada, and Australia, the university said in a July 24 statement.

The five universities that will form the basis for the network, their PIs and funding amounts:

—University of California, Irvine, Hoda Anton-Culver, PI, $561,680

—Georgetown University, Caryn Lerman, PI, $504,325

—Johns Hopkins University, Gloria Petersen, PI, $758,493

—Duke University, J. Dirk Inglehart, PI, $628,137

—University of Utah, Ray White, PI, $805,782

Three additional cooperative agreements for the network remain to be funded, an NCI spokesman said to **The Cancer Letter**.

Over the next year, the awardees are expected to plan and begin to put in place the infrastructure needed to support the network. Then the network will recruit individuals with a high risk of cancer as potential study participants. Individuals will receive information about cancer genetics, and their participation will be confidential. When studies are begun, these individuals will be invited to participate.

"The aim is to create a multi-center and interdisciplinary collaborative structure that will enable the participating institutions to draw upon each other, and to have access to research resources, information, and expertise beyond the scope of any single institution," said Barbara Rimer, director of the Division of Cancer Control and Population Sciences.

NCI plans to form a steering committee to review and approve proposed studies. Other than pilot studies sponsored by the network, research costs will be funded by separate grants to individual research applicants.

Scientific program coordinators for the network are Susan Nayfield and James Hanson, both of DCCPS.

Funding Opportunities:

Lymphoma Foundation Offers Two-Year Fellowship Grants

The Cure For Lymphoma Foundation, a not-for-profit organization, is seeking candidates for fellowship grants.

The intent of the Cure For Lymphoma Foundation Fellowship is to encourage careers in lymphoma research. The goal is to promote the transfer of basic research findings to clinical usefulness.

Research may be laboratory or clinic based, but the results and conclusions must be relevant to the etiology or treatment of lymphoma.

The two-year grants will provide salary support of $40,000 for the first year and $45,000 for the second year.

The grant will also provide $5,000 each year for additional support (including fringe benefits but excluding indirect costs), and $5,000 each year for the research project.

Applicants must hold an M.D., Ph.D., D.D.S., or equivalent degree and must have completed at least two years of postdoctoral research. Only one candidate may be proposed by a sponsor who will

supervise the candidate's research. There are no restrictions for applicants as to age, race, sex, creed or national origin.

The grant application deadline is Nov. 15, 1998. Grants will be announced in February 1999 and will begin July 1, 1999.

Grant applications will be reviewed by the Scientific Advisory Board, chaired by Joseph Bertino.

Other members include James Armitage, George Canellos, Charles Coltman, Vincent DeVita, David Golde, Mary Gospodarowicz, William Hryniuk, Stanley Korsmeyer, Lee Nadler, Saul Rosenberg, and John Ultmann.

For applications and further information, contact: Cure For Lymphoma Foundation, 215 Lexington Avenue, New York, NY 10016 or call 212-213-9595 (fax 212-213-1987).

RFA Available

RFA CA-98-021

Title: **Minority Based Community Clinical Oncology Program**

Letter of Intent Receipt Date: Aug. 27

Application Receipt Date: Sept. 24

The Div. of Cancer Prevention of NCI is continuing the established cancer control effort which involves practicing oncologists who serve large minority populations in the NCI clinical trials program. The Community Oncology and Rehabilitation Branch invites domestic institutions with the capability and intent to serve new cancer patients largely from minority populations to apply for cooperative agreements in response to this RFA. *Currently funded minority* based CCOPs are also invited to respond to this RFA.

The NCI clinical trials program provides a network of support for clinical research in cancer centers, major university centers, and community programs. The purpose of this program is to support as a national resource those physicians involved in the care of minority cancer patients who are available for treatment and cancer prevention and control clinical trials research. The linkage of minority cancer patients to the current clinical trials network will also facilitate the transfer of new technology in treatment and cancer prevention and control practices to minority communities and their physicians.

The minority based CCOP will provide support for expanding clinical research in minority community settings; bring the advantages of state of the art treatment and cancer prevention and control research to minority individuals in their own communities; increase the involvement of primary health care providers and other specialists in cancer prevention and control studies; establish an operational base for extending cancer prevention and control and reducing cancer incidence, morbidity, and mortality in minority populations; and examine selected issues in minority based CCOP performance (e.g., patient recruitment, accrual, eligibility).

Institutions, organizations and/or physician group applicants for the minority based CCOP must have greater than 40 percent of newly diagnosed cancer patients from minority populations. Other eligibility requirements for new applicants and currently funded programs are described in the RFA.

It is anticipated that up to $0.6 million in total costs per year for 3 years will be committed. It is anticipated that up to three awards will be made. The anticipated amount of the direct cost awards will range from $100,000 to $250,000 per year. Awards for research bases affiliated with minority based CCOPs will be made through cooperative agreements under the Community Clinical Oncology Program RFA.

The anticipated date of award is June 1, 1999, following review by the National Cancer Advisory Board in February. Written and telephone inquiries concerning this RFA are encouraged.

Inquiries may be directed to, and copies of the RFA obtained from, Lori Minasian, Div. of Cancer Prevention, NCI, 6130 Executive Boulevard, Room 300-D, MSC-7340, Bethesda, MD 20892-7340, phone (301) 496-8541, FAX (301) 496-8667, email: lm145a@nih.gov.

Letter to the Editor:

NCI Should Continue Supporting Special Populations Research

To the Editor:

The response to the NIH guidelines of 1994 for the inclusion of minorities and women in clinical trials has been successful because of the support of NCI Director Richard Klausner for the Office of Special Populations Research. That is why I feel compelled to comment on **The Cancer Letter** of June 19 ("IOM Panel Considering NCI Approach to Research in Minorities, Underserved").

I agree with Dr. Klausner's assessment that the evidence is clearly mounting on the side of equal outcome with equal care. This has been shown in retrospective review of clinical trials. However, prospective efforts require more, not less funding with discretionary funding power to quickly move where the highest return can be obtained on one's investment of tax dollars.

Yes, oversight is necessary, so money is not wasted along the wrong path.

We are fortunate at this time to have able and scientifically sound leadership chosen by Dr. Klausner in the Office of Special Populations Research. This is not the time to consider reducing this nation's input into special populations research. If we are going to win the "war on cancer," then all groups must have the same start out of the blocks.

Unfortunately, because of the situation many African Americans find themselves socio-economically, they are already a few laps behind the rest of America, and cancer is no exception. We have not had the kind of support we are receiving from the Office of Special Populations Research long enough to make further positive impact on those who shoulder a disproportionate share of the cancer burden in this country.

The founder of Tuskegee, Booker T. Washington, once said to his people "to lift yourself up by your bootstraps," but we have to have the boots (or funding) first to get out of the quagmire of unequal access and educational opportunity as a people, not just the fortunate few in the black middle class. We must increase the size of the pie, so there are more slices for everybody, not just those in academic centers, where African Americans are still shut out for the most part.

I agree with Dr. M. Alfred Haynes that we need more funding for studies such as the one conducted by Dr. Brian Henderson looking at cross-cultural nutrition. This requires an injection of more money, not just through the National Academy of Sciences mechanism, but the National Cancer Institute granting mechanism.

NCI under the leadership of Dr. Klausner has created an office with strong and trusted leadership that can reach out to the physician whose patient-base is the underserved.

Oscar E. Streeter Jr.
Associate Professor of Clinical Oncology and
Chief of Radiation Oncology
USC/Norris Comprehensive Cancer Center

In Brief:

Deconti Promoted At Moffitt; Koprowski Chair Endowed

(Continued from page 1)

System and Scottish Rite Children's Medical Center. AFLAC (American Family Life Assurance Co. of Columbus) is a supplemental insurance company in the U.S. and Japan. . . . **RONALD DECONTI** has been appointed medical director of the Moffitt Cancer Center and Research Institute. A medical oncologist, DeConti has been deputy medical director at Moffitt since 1995. . . . **HILARY KOPROWSKI** Endowed Professorship has been established at the Wistar Institute, Wistar's first endowed chair. Named for the director of the institute from 1957 to 1991, the professorship will "provide long term support for distinguished scientists and set a precedent for establishment of additional professorships at Wistar," **Giovanni Rovera**, director and CEO, said. Koprowski is professor laureate of Wistar and professor of research medicine at the Univ. of Pennsylvania. Selection of the first chair holder will be made by Rovera, Koprowski, and **Barry Cooperman**, who with Koprowski co-chairs the Wistar scientific advisory committee. . . . **DR. RALPH AND MARIAN FALK** Medical Research Trust has renewed its support of **Carlo Croce**, director of the Kimmel Cancer Center at Thomas Jefferson Univ. The new grant of $2.025 million follows previous awards of $1.5 million and $1.8 million, all in support of research by Croce and his team with the ALL-1 gene and its relationship to leukemia, lymphoma, and other types of cancer. . . . **EUGENE FLAMM** has left his position as chairman of neurosurgery at the Univ. of Pennsylvania to join Beth Israel Medical Center as co-chairman of the Dept. of Neurosurgery and director of adult neurosurgery. . . . **THE GROUP ROOM**, a sydicated weekly radio talk show about cancer, will cover cancer genetics in its Aug. 2 program. Host **Selma Schimmel** will talk to **Jeffrey Weitzel**, director of clinical cancer genetics at City of Hope, and **David Euhus**, assistant professor of surgery, University of Texas Southwestern Medical Center at Dallas. The program airs live each Sunday at 4 p.m. EDT (1 p.m. PDT, in major markets including New York, Los Angeles, Washington DC, Dallas, Houston, and Toronto. The show can be heard live on the Internet at http://www.vitaloptions.org. Calls during the show can be made to 800-GRP-ROOM.