THE CANCER LETTER INTERACTIVE

PO Box 9905 Washington DC 20016 Telephone 202-362-1809

Vol. 25 No. 14
April 9, 1999

Quality Of Cancer Care Uneven, IOM's National Cancer Policy Board Concludes

A report by a board of the Institute of Medicine found that no uniform standards exist for measuring the quality of cancer care, and that evidence collected piecemeal suggests the quality of care is uneven at best.

As a result, patients routinely embark on care without having a clear strategy, and procedures proven to be effective for some diseases are not always performed, the National Cancer Policy Board concluded in the report released earlier this week.

"We started out planning to develop a consumer checklist," said Joseph Simone, vice chairman of the board and medical director of

(Continued to page 2)

In Brief:

Riley Becomes ACCC President; Rep. Green Urges Support Of Cancer Treatment Act

MARGARET RILEY, director of oncology at Saint Joseph's Hospital of Atlanta, became president of the Association of Community Cancer Centers at the association's meeting in Washington March 26. She succeeds **Robert White**, director, medical education, radiation oncology, at Washington Hospital Center, Washington, DC. Riley has served on the ACCC board of trustees since 1992 and was treasurer from 1997-98. Riley is a member of the Oncology Nursing Society and is on the executive board of directors of the Metro Atlanta chapter of the American Cancer Society. She is a member of the American Nursing Association and the Georgia Nursing Association. . . . **REP. GENE GREEN** (D-TX) urged ACCC members and other oncology professionals to contact their Congressional representatives to encourage them to co-sponsor HR 1090, the Medicare Full Access to Cancer Treatment Act of 1999, which he introduced on March 11 with more than 20 bipartisan co-sponsors. Speaking at the association's 25th annual national meeting, Green said the Act would separate cancer treatment from the outpatient prospective payment system and exclude outpatient cancer drugs or biologicals used "as treatment, supportive care, or both" from Ambulatory Payment Classifications currently proposed by the Health Care Financing Administration. Green said HCFA's proposed rule for the prospective payment system "fails to recognize the complexities of cancer treatments and the wide range and individual needs of each patient with cancer. As a result, the new payment system could threaten the quality and availability of cancer treatment for Medicare beneficiaries." Under the HCFA plan, the lowest reimbursement rate for some cancer treatments would be

(Continued to page 8)

Click Here for
Photocopying Guidelines

Higher Volume Generally Results In Better Outcomes

(Continued from page 1)

Huntsman Cancer Foundation and Institute. “We found that we couldn’t develop a checklist, because we didn’t have sufficient information,” Simone said at a press conference April 6.

The standing committee—operated by IOM and the National Research Council and funded by NCI, Centers for Disease Control and Prevention, and the American Cancer Society—is still many steps away from a checklist. However, the committee is taking a leadership role in addressing an extraordinarily complicated problem that has not been systematically addressed.

Though it has become something of a medical tradition to blame managed care for all the ills of the health care system, the committee came to a radically different conclusion. “The report, generally, has come to the conclusion that the problem is quality; it’s not managed care,” said Jane Sisk, professor at the division of health policy and management at the Joseph Mailman School of Public Health at Columbia University.

Kenneth Shine, president of IOM, said the findings of the Cancer Policy Board are consistent with the findings of the IOM Round Table on Quality, published in the Journal of the American Medical Association last September.

“The [Round Table] report said there is a substantial gap between average and best care in almost all areas of health care in America,” Shine said at the press conference. “That report demonstrated that the differences did not depend on whether it was managed care or not managed care. The [Cancer Policy Board] report is entirely consistent with that conclusion.”

The quality gap is particularly visible in high-risk surgical procedures and some forms of chemotherapy, the panel found in its review of literature. Institutions that perform many surgical procedures on the esophagus and the pancreas have dramatically higher short-term success rates than institutions that perform few of those procedures.

“Where care is given can be critical,” Simone said. “There are a few studies—in very limited areas, like pancreatectomy and esophagectomy—highly technical and difficult procedures in which there is a clear relationship between higher volume and better outcomes. These studies are few and descriptive, but the pattern is consistent from study to study. We believe it is prudent to presume that for highly technical, difficult procedures, we should assume that this is a generalizable statement.”

The IOM committee has organized two working groups to consider future directions in addressing the problem of measuring and defining quality of care:

—First, the committee has to address the question of quality of available data. The options are (1) To enhance existing databases to capture data on quality of care, and (2) To launch new databases or studies. These issues are expected to be explored at a workshop next fall.

—Next, the committee will explore the volume/outcome relationship. Here, the committee would have to recommend a strategy for isolating procedures that are more effectively performed at higher-volume centers, and recommend incentives for steering patients to such centers. These issues are expected to be considered at a workshop early next year.

In a related development, the President’s Cancer Panel on April 5 issued its report on quality cancer care (story, page 7).

The interest in the quality of cancer care transcends the narrow circle of policy cognoscenti.

On March 3, after the National Comprehensive Cancer Network, a coalition of 18 cancer centers, issued a breast cancer guideline written for patients, its web site received 1.2 million hits. Through that

THE CANCER LETTER

Member, Newsletter Publishers Association

World Wide Web: http://www.cancerletter.com

Editor & Publisher: Kirsten Boyd Goldberg
Editor: Paul Goldberg

Editorial: 202-362-1809 Fax: 202-362-1681
PO Box 9905, Washington DC 20016
E-mail: kirsten@cancerletter.com or paul@cancerletter.com

Customer Service: 800-513-7042
PO Box 40724, Nashville TN 37204-0724

Subscription $275 per year worldwide. ISSN 0096-3917. Published 48 times a year by The Cancer Letter Inc.

Founded Dec. 21, 1973 by Jerry D. Boyd

week, the site averaged between 800,000 and 900,000 hits. On the second week, this volume dropped to 600,000 hits per day, and has now dropped to 175,000 hits per day.

The IOM committee's recommendation that some complicated procedures should best be performed by institutions that perform a high number of such procedures is likely to be controversial.

Citing multiple published analyses of data obtained from Medicare and the NCI Surveillance, Epidemiology and End Results database, the report said procedures best performed at higher-volume institutions include esophagectomy, pancreatectomy, hepatic resection, and pelvic exenteration.

Nonetheless, low-volume facilities perform a large share of these high-risk procedures. Thus, 62 percent of esophagectomies, 53 percent of pancreatectomies, 60 percent of hepatic resections, and 36 percent of pelvic exenterations were performed at low-volume centers, the report says.

Several studies suggest that higher volume providers produce better outcomes for breast and prostate cancers.

Turning to chemotherapy, the report cites a 1992 study by the International Bone Marrow Transplant Registry that found that higher volume centers produced lower treatment-related mortality in patients receiving transplants for early leukemia. The report also cites a 1993 Scottish study that suggests that higher-volume centers produced better outcomes in chemotherapy for non-seminomatous germ cell testicular tumors.

Does the report suggest that patients should avoid their local doctor?

Not quite, said Diana Petitti, director of research and evaluation at Kaiser Permanente Medical Care Program.

"I am going to point to very specific evidence for which there is very strong volume-outcome data, where small hospitals are not able to demonstrate the kinds of outcomes than hospitals do with higher volume procedures," Petitti said at the press conference.

"I don't think it is fair, based on the evidence, to generalize to every possible procedure," Petitti said.

However, the link between the volume and outcome deserves further investigation, said IOM president Shine.

"As a cardiologist, I can't sit down without reminding you that our experience in New York State clearly demonstrates that volume counts for almost all procedures," said Shine, referring to studies of hospital-specific data on heart surgery that are collected by the New York State Department of Health.

"I will call your attention to a paper in the June 1999 Pediatrics, in which we looked at pediatric cardiac surgery, and we took on the question of whether simple things could be done at community hospitals," said Shine. "What we found was even the simplest cardiac surgical procedure in a child is done more effectively in institutions that do greater volume.

"This panel is not extrapolating beyond the evidence, but, certainly, evidence in the cardiovascular area suggests that we need to look much more closely for what the relationship is between experience, volume and outcomes for all kinds of treatments for cancer," Shine said.

Data on the quality of cancer care are collected sporadically, Shine said.

"With regard to the issue of evidence guiding care, I'll remind you that the NIH budget is of the order of $13 billion, and going up, whereas the budget of the Agency for Health Care Policy Research is of the order of $200 million," Shine said. "At least until recently, the country's investment in evidence-based outcomes has been dramatically inadequate. Moreover, it is not always in the best interests of the providers to provide this information, or to provide it in the form which allows comparability."

The report presented several disquieting snapshots of the gap separating knowledge from practice.

"We know that women who have lumpectomies should have radiation follow-up," Simone said at the press conference. "Yet, a study has shown that only 24 percent of women over the age of 80 received radiation after lumpectomy. We don't know why that's the case. Were they offered radiation treatment and refused? Were they not offered the treatment because of age? That kind of information is simply not available. "

Robert Young, president of Fox Chase Cancer Center and chairman of the board of NCCN said interventions that have been proven effective are nonetheless erratically applied in the clinic.

"You find extraordinary levels of variation," Young said. "In the case of postmenopausal breast cancer patients with positive nodes at surgery, there is now persuasive evidence that the use of tamoxifen reduces the recurrence rate and improves survival."

Nonetheless, literature suggests that only 60 percent of women receive tamoxifen following surgery. "That seems to fall far short of what one would expect," Young said.

"In the case of rectal cancer, there is persuasive evidence that radiation therapy reduces local recurrence, a devastating complication," Young said. However, about 40 percent of the population studied about 10 years ago in a General Accounting Office report received radiation.

"As we go along and look for things that we would expect to see occurring, they simply don't occur as frequently and as consistently across the population of cancer patients," Young said.

One of the central recommendations in the report is not supported by data, and is based on the National Coalition of Cancer Survivorship Imperative for Quality Cancer Care, published in 1995.

The recommendation lists seven elements of quality cancer care, which include access to specialists, a need for a strategic approach, access to clinical trials, and psychosocial support.

"Some elements of care simply make sense—that is, they have strong validity and can reasonably and can reasonably be assumed to improve care unless and until evidence accumulates to the contrary," the report states.

"This recommendation amounts to a statement of the ideal, based on principles of cancer care articulated by cancer survivors."

The 236-page report is available at http://www2.nas.edu/cancerbd/.

Excerpts of the report's summary follow:

The National Cancer Policy Board began its deliberations on quality by trying to describe what an ideal cancer care system would look and feel like from the vantage point of an individual receiving cancer care. The NCPB suggested that, for many, excellence in cancer care would be achieved if individuals had: access to comprehensive and coordinated services; confidence in the experience and training of their providers; a feeling that providers respected them, listened to them, and advocated on their behalf; an ability to ask questions and voice opinions comfortably, to be full participants in all decisions regarding care; a clear understanding of their diagnosis and access to information to aid this understanding; awareness of all treatment options and of the risks and benefits associated with each; confidence that recommended treatments are appropriate, offering the best chance of a good outcome consistent with personal preferences; a prospective plan for treatment and palliation; a health care professional responsible (and accountable) for organizing this plan in partnership with each individual; and assurances that agreed-upon national standards of quality care are met at their site of care.

The NCPB then described at least some aspects of a cancer care system that would support such an ideal state of care. A system of ideal cancer care would: articulate goals consistent with this vision of quality cancer care; implement policies to achieve these goals; identify barriers to the practice and receipt of quality care and target interventions to overcome these barriers; further efforts to coordinate the currently diverse systems of care; ensure appropriate training for cancer care providers; have mechanisms in place to facilitate the translation of research to clinical practice; monitor and ensure the quality of care; and conduct research necessary to further the understanding of effective cancer care.

The NCPB has concluded that for many Americans with cancer, there is a wide gulf between what could be construed as the ideal and the reality of their experience with cancer care.

There is no national cancer care program or system of care in the United States. Like other chronic illnesses, efforts to diagnose and treat cancer are centered on individual physicians, health plans, and cancer care centers. The ad hoc and fragmented cancer care system does not ensure access to care, lacks coordination, and is inefficient in its use of resources. The authority to organize, coordinate, and improve cancer care services rests largely with service providers and insurers. At numerous sites in the federal government, programs and research directly relate to the quality of cancer care, but in no one place are these disparate efforts coordinated or even described. Efforts to improve cancer care in many cases will therefore be local or regional and could feasibly originate in a physician's practice, a hospital, or a managed care plan. Because cancer disproportionately affects the elderly, the Medicare program could be an important vehicle for change....

Based on the best available evidence, some individuals with cancer do not receive care known to be effective for their condition. The magnitude of the problem is not known, but the National Cancer Policy Board believes it is substantial. The reasons for failure to deliver high-quality care have not been studied adequately, nor has there been much investigation of how appropriate standards vary from patient to

Click Here for
Photocopying Guidelines

patient.

The means for improving the quality of cancer care, which involve changes in the health care system, are the first five of 10 recommendations....

Cancer care is optimally delivered in systems of care that:

Recommendation 1: Ensure that patients undergoing procedures that are technically difficult to perform and have been associated with higher mortality in lower-volume settings receive care at facilities with extensive experience (i.e., high-volume facilities). Examples of such procedures include removal of all or part of the esophagus, surgery for pancreatic cancer, removal of pelvic organs, and complex chemotherapy regimens....

Recommendation 2: Use systematically developed guidelines based on the best available evidence for prevention, diagnosis, treatment, and palliative care....

Recommendation 3: Measure and monitor the quality of care using a core set of quality measures.

Once effective care has been identified through the research system, mechanisms to develop and implement measurement systems are needed. Translating research results into quality monitoring measures is a complex process that will require significant research investments. There is now a broad consensus about how to assess some aspects of quality of care for many common cancers (e.g., cancers of the breast, colon, lung, prostate, and cervix), but specific measures of the quality of care for these cancers are still being developed and tested within health delivery systems.

Systematic improvements in health care quality will likely only occur through collaborative efforts of the public and private sectors.... A public-private collaborative approach has recently been recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, and some initial implementation steps are being taken....

To ensure the rapid translation of research into practice, a mechanism is needed to quickly identify the results of research with quality-of-care implications and ensure that it is applied in monitoring quality....

Cancer care quality measures should be used to hold providers, including health care systems, health plans, and physicians, accountable for demonstrating that they provide and improve quality of care.

There are many opportunities to exert leverage on the health care system to improve quality. Quality assurance systems are often not apparent to consumers, but have the potential to greatly affect their care: large employer groups are holding managed care plans accountable for quality performance goals; the Health Care Financing Administration requires Medicare and Medicaid health plans to produce standard quality reports; and state Medicaid programs are beginning to include quality provisions in their contracts with plans and providers.

Six of ten new cancer cases occur among people age 65 and older and, consequently, Medicare is the principal payer for cancer care. There is generally a lack of quality-related data from fee-for-service providers from whom most Medicare beneficiaries receive their care. Information systems are, however, in place that allow the reporting on a regional basis of some quality indicators (e.g., cancer screening rates) relevant to those in fee-for-service systems. For Medicare beneficiaries in managed care plans, accountability systems should incorporate core measures of quality cancer care.

Cancer care quality measures should be applied to care provided through the Medicare and Medicaid programs as a requirement for participation in these programs....

Cancer care quality measures should be disseminated widely and communicated to purchasers, providers, consumer organizations, individuals with cancer, policy makers, and health services researchers, in a form that is relevant and useful for health care decision-making....

Recommendation 4: Ensure the following elements of quality care for each individual with cancer: that recommendations about initial cancer management, which are critical in determining long-term outcome, are made by experienced professionals; an agreed-upon care plan that outlines goals of care; access to the full complement of resources necessary to implement the care plan; access to high quality clinical trials; policies to ensure full disclosure of information about appropriate treatment options; a mechanism to coordinate services; and psychosocial support services and compassionate care....

Recommendation 5: Ensure quality of care at the end of life, in particular, the management of cancer-related pain and timely referral to palliative and hospice care....

Quality Assessment Research Needs

How can we improve what we know about the quality of cancer care? For many aspects of cancer care, it is not yet possible to assess quality because the first step in quality assessment has not been taken—the conduct of clinical trials....

Recommendation 6: Federal and private research sponsors such as the National Cancer Institute, the Agency for Health Care Policy and Research, and health plans should invest in clinical trials to address questions about cancer care management.

For some questions regarding cancer management, a health services research component could possibly be integrated into a clinical trial designed to assess the efficacy of a new treatment. For other questions, innovative units of randomization could be used, for example, randomizing providers (instead of patients) to test different clinical management strategies....

Recommendation 7: A cancer data system is needed that can provide quality benchmarks for use by systems of care (such as hospitals, provider groups, and managed care systems). Toward that end, in 1999, the National Cancer Policy Board will hold workshops to: identify how best to meet the data needs for cancer in light of quality monitoring goals; identify financial and other resources needed to improve the cancer data system to achieve quality-related goals; and develop strategies to improve data available on the quality of cancer care.

The second step of quality assessment involves surveillance—making sure that evidence regarding what works is applied in practice. Ideally, quality assessment studies would include recently diagnosed individuals with cancer in care settings representative of contemporary practice across the country, using information sources with sufficient detail to allow appropriate comparisons. The available evidence on the quality of cancer care is far from this ideal.

Two national databases are available with which to assess the quality of cancer care, but each has limitations.

1. The Surveillance, Epidemiology, and End Results cancer registry, maintained by NCI, when linked to Medicare and other insurance administrative files, has been valuable in assessing the quality of care for the elderly and other insured populations. It is also useful in identifying a sample of cases for in-depth studies of quality-related issues. The SEER registry, however, covers only 14 percent of the U.S. population in certain geographic locations, so it may not adequately represent the diversity of systems of care. Finding ways to capture measures of process of care, treatment information, and intermediate outcomes—and to improving the timeliness of reporting—would enhance the registry's use in quality assessment.

2. The National Cancer Data Base, a joint project of the American College of Surgeons Commission on Cancer and the American Cancer Society, now holds information on more than half of all newly diagnosed cases of cancer nationwide and includes many of the demographic, clinical, and health system data elements necessary to assess quality of care. A limitation of the NCDB is the absence of complete information on outpatient care. The NCDB has not yet been widely used to assess quality of care, but has great potential for doing so.

Existing data systems must be enhanced so that questions about quality of care can be answered comprehensively, on a national scale, without delays of many years between data collection and analysis. An effective system would capture information about individuals with cancer; their condition; their treatment, including significant outpatient treatments; their providers; site of care delivery ; type of care delivery system; and outcomes.

It may be costly and difficult to obtain all of the desired data elements for all individuals with available sources, so sampling techniques could be used to make the task manageable for targeted studies. Alternatively, it may be feasible to link some databases (e.g., those describing structural aspects of care such as hospital characteristics) to other existing databases. It is unlikely that one single database can meet all of the various objectives of such systems, for example, cancer surveillance, research, and quality monitoring....

Recommendation 8: Public and private sponsors of cancer care research should support national studies of recently diagnosed individuals with cancer, using information sources with sufficient detail to assess patterns of cancer care and factors associated with the receipt of good care. Research sponsors should also support training for cancer care providers interested in health services research.

Grants to support the analysis of data that focus on pressing health policy questions, especially about how the organization and financing of cancer care affect the processes and outcomes of care, should be a high priority. Methodologic research is also

Click Here for
Photocopying Guidelines
◀ ▶

needed to improve the quality of cancer-related health services research, for example, to develop tools for "case-mix" adjustments to reduce the potential for bias inherent in observational cancer research....

Access To Quality Care

Recommendation 9: Services for the un- and underinsured should be enhanced to ensure entry to, and equitable treatment within, the cancer care system.

Recommendation 10: Studies are needed to find out why specific segments of the population (e.g., members of certain racial or ethnic groups, older patients) do not receive appropriate cancer care. These studies should measure provider and individual knowledge, attitudes, and beliefs, as well as other potential barriers to access to care.

President's Cancer Panel Issues Report On Quality

The President's Cancer Panel earlier this week released a report, "Cancer Care Issues in the United States: Quality of Care, Quality of Life," from a series of meetings held last year.

The report is available on the web at http://deainfo.nci.nih.gov/advisory/pcp/reports/97-98recomend.htm. Following are the report's conclusions:

The Panel believes that important steps are needed now to address the rapidly emerging issues related to defining and providing quality cancer care and improving quality of life. These steps are needed to ensure that all of the American people have access to the care best able to prevent and treat cancer, and to safeguard the research processes by which we achieve continuing advances against the suffering and death caused by cancer. The Panel recommends:

1. The welfare of the patient—related both to his or her disease and to quality of life—must inform the quality of cancer care. Evaluations of quality must place priority on the patient over short-term cost. Cost, while relevant, should not be the arbiter of quality care.

2. Definitions of quality should take into account both the concerns of the individual and public health as a whole.

3. Quality definitions and clinical practice guidelines that may be derived from them should not be so rigid as to inhibit innovation in cancer care. Guidelines must be updated frequently to maintain their consistency with advances in knowledge, technology, and practice and to avoid barriers to reimbursement.

4. Evidence is one of several components in quality of care evaluation. The randomized controlled trial (RCT) is the gold standard of evidence for evaluating clinical care. In the absence of data from one or more large, well-designed RCTs, other forms of evidence should be evaluated according to commonly accepted methodologies determined by consensus. Quality evaluations should also take into account quality of life, economic survival of the patient and family, and related issues including employment and insurance ramifications.

5. Data are needed in areas that are integral components of quality of care, e.g., socioeconomic status, cultural values, quality of life perceptions, the impact of cancer on family members, and patient-focused outcomes. These data are needed at the local and regional levels, and for diverse population groups and subgroups of major population segments, to support the development, implementation, and evaluation of tailored interventions to improve the quality of cancer care.

6. All of the stakeholders in the definition and provision of quality cancer care—health care payers of all types; research sponsors including government, voluntary agencies, and the pharmaceutical and biotechnology industries; employers; employees and other health care consumers—must bear their fair share of the cost of quality evaluations, guideline development, and the data collection and analysis needed to support these efforts.

7. A full spectrum of participants should be responsible for organizing and coordinating the development, dissemination, and updating of cancer care guidelines across the continuum of care, and for the data collection activities that support these efforts. Without a central focus, present issues concerning the lack of standards for certain aspects of cancer care, inconsistent or duplicative guidelines, lack of relevant data to define quality and evaluate guidelines, uneven reimbursement for care, and insufficient communication to health professionals and the public will not be resolved.

8. Training is needed to improve the ability of physicians and other health professionals to:

—Understand evidence and how to implement definitions of quality care

—Facilitate patient understanding of current standards of care and care options

—Make appropriate recommendations concerning cancer prevention and screening

—Understand clinical trials and facilitate patients' understanding of and access to clinical trials

—Recognize and provide for appropriate rehabilitation services for cancer survivors, including psychosocial services and life-long surveillance for delayed treatment effects and second tumors

—Acknowledge that death and end of life issues are a part of the cancer experience for some patients, and provide more comprehensive and compassionate care to dying patients and their families

—Better understand, explain, and protect the privacy of genetic risk information

—Better address the cancer care needs of the growing elderly population; collaborative efforts between geriatrics and oncology should be fostered.

9. Mechanisms must be developed to educate patients, their families, and the public at all educational levels and from differing cultures to effectively evaluate care options and recommendations.

10. Continued funding across the research spectrum is needed to continue the flow of discovery that leads to improvements in care across the cancer continuum. Research efforts should focus particularly on improving interventions in the areas of cancer prevention, cancer control, rehabilitation, palliation, and end of life care, and on outcomes research. In addition, targeted funding may be needed for behavioral and other research to improve quality of care in vulnerable populations, including those with low income and/or educational levels, differing cultures, the elderly, and rural populations.

11. To improve our understanding of and ability to address the short-and long-term issues associated with surviving cancer, greater emphasis and research support should be directed to studies of survivorship issues, including but not limited to long-term effects of treatment, family issues, socioeconomic status, and employability. Contemporary definitions of survival that reflect both treatment advances and quality of life factors should be developed.

12. Current concerns should be investigated to assess whether cancer care quality is being impeded by payer restrictions on appointment durations, off-label use of medications for which growing clinical evidence indicates efficacy; and access to appropriate treatments, oncology specialists, and clinical trials. Identified barriers to appropriate care should be corrected, and coverage of patient care costs for participants in approved clinical trials should be provided routinely.

13. Participation in quality clinical trials should become part of the standard of care for cancer. To ensure access to promising investigational treatments, guidelines should provide recommendations for when a patient should enter a clinical trial, but guidelines should not be permitted to become a barrier to access to such care. In addition, guidelines must not be used to exclude patient choice of effective treatment alternatives and payers should not erect barriers to such care.

In Brief:

ACCC Celebrates 25th Year; James Hospital Gets Donations

(Continued from page 1)

$52.70, which is expected to include supportive care, Green said. "Moreover, under the proposal, new drugs, which are defined as anything approved after 1996, would be reimbursed at this lowest rate," Green said. "Such a policy would not only hurt the patient with cancer, but also have a crippling effect on research and development of new drug therapies." Green represents the 29th District of Texas, which includes Houston. . . . **PRESIDENT BILL CLINTON** praised ACCC for its 25 years of service to the oncology community in a letter to the association. "Through your advocacy efforts, education programs, and support of community research, you have helped your members to continually improve oncology care, bringing hope and help to countless people living with cancer," Clinton wrote. ACCC, based in Rockville, MD, was founded in 1974. **Lee Mortenson** is the executive director. . . . **JAMIE YOUNG** received the Edward L. Moorhead Award from ACCC in recognition of his contributions to improving cancer treatment in the community. Young was the association's director for state societies and government relations from 1991 to 1998. Young is manager of medical economics at Immunex Corp. in Columbus, OH. . . . **CHARITABLE GIVING:** Comprehensive Cancer Center-Arthur G. James Cancer Hospital and Research Institute at Ohio State University received a pledge of $3 million toward lung cancer research from the family of **Barbara J. Bonner**, who died of cancer last year. The center also received a pledge of $1 million over three years from **Samuel and Shelia Davis**, in conjunction with the Samuel B. Davis Fund of Jasam Foundation. The gift will support a cancer molecular angiogenesis research program.

Click Here for
Photocopying Guidelines

Copying Policy for The Cancer Letter Interactive

The software that comes with your issue allows you to make a printout, intended for your own personal use. Because we cannot control what you do with the printout, we would like to remind you that routine cover-to-cover photocopying of The Cancer Letter Interactive is theft of intellectual property and is a crime under U.S. and international law.

Here are guidelines we advise our subscribers to follow regarding photocopying or distribution of the copyrighted material in The Cancer Letter Inc. publications in compliance with the U.S. Copyright Act:

What you can do:

--Route the printout of the newsletter to anyone in your office.

--Copy, on an occasional basis, a single story or article and send it to colleagues.

--Consider purchasing multiple subscriptions. Contact us for information on multiple subscription discounts.

What you can't do without prior permission:

--Make copies of an entire issue of the newsletter. The law forbids cover-to-cover photocopying.

--Routinely copy and distribute portions of the newsletter.

--Republish or repackage the contents of the newsletter.

We can provide reprints for nominal fees. If you have any questions or comments regarding photocopying, please contact Publisher Kirsten Boyd Goldberg, phone: 202-362-1809, email: kirsten@cancerletter.com

We welcome the opportunity to speak to you regarding your information needs.

Click Here for
Photocopying Guidelines ◀ ▶