THE CANCER LETTER INTERACTIVE

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Bailes: ASCO To Strengthen State Affiliates, Begin Quality Of Care Study, Talk With FDA

NEW ORLEANS—Over the next year, the American Society of Clinical Oncology plans to strengthen its state and local affiliate organizations, conduct a study on the quality of cancer care, review its selection process for plenary session abstracts, and increase its interaction with the Food and Drug Administration, Joseph Bailes, ASCO's 1999 president, said in an address to the society's annual meeting last week.

Bailes, whose term as ASCO president ended at the May 20-23 meeting, touched on three major themes in his speech: that ASCO

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In Brief:

Einhorn Begins Term; Salmon, Blum Honored; Gore Gives Award To IntraMall, Piloted At NCI

LAWRENCE EINHORN, distinguished professor of medicine at Indiana University and expert in testicular cancer, began his term as president of the American Association of Clinical Oncology on May 23, the opening day of the association's annual meeting in New Orleans. "His clinical expertise will be a tremendous asset, and will help guide ASCO through a very exciting time in cancer research," said **Joseph Bailes**, immediate past president of ASCO. **Larry Norton**, of Memorial Sloan-Kettering Cancer Center, was elected president for the 2001 term. . . . **JOAN SALMON** accepted ASCO's Distinguished Service Award for Scientific Achievement on behalf of her husband, the late Sydney Salmon, who was director of the Arizona Cancer Center. . . . **DIANE BLUM**, of Cancer Care Inc., received ASCO's Special Recognition Award for her work in cancer patient advocacy. . . . **NIH INTRAMALL TEAM** received **Vice President Gore's** Hammer Award presented to federal employees who develop programs that increase governmental efficiency. The IntraMall system, a partnership between NIH and BioSpace, is an e-commerce program that provides product information, on-line ordering, accounting and budget functions for federal procurement. The IntraMall was developed at NCI. . . . **MASSEY CANCER CENTER**, at the Medical College of Virginia campus of Virginia Commonwealth University in Richmond, received a 5-year, $1 million training grant in cancer biology from NCI. **Gordon Ginder**, director of the center, is the principal investigator. . . . **MATTHEW ELLIS** was appointed director of the Clinical Breast Cancer Program at Duke University, effective July 1. Ellis is an assistant professor at the Lombardi Cancer Center at Georgetown University.

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Inclusiveness, Quality Of Care, And Research: ASCO Themes

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strengthen its inclusiveness by continuing to build relationships with oncology subspecialists and oncologists outside the U.S.; that high-quality cancer care must continue to be one of the society's most important goals; and that the society should renew its support for clinical cancer research.

Following is the text of his remarks:

As my presidential term draws to a close, I want to share with you some of the events and initiatives of the past year, as well as some of our expectations as we move forward. As you well know, our society has grown over the past several years, not only in number, but also in reputation. ASCO has increasingly become a preeminent, credible source for cancer education, information, and commentary.

To continue along this path, our efforts must ensure three things: One, that ASCO remains as inclusive as possible for the benefit of all our members. Two, that we practice in an arena characterized by quality care. Three, that we continue to support clinical cancer research to achieve the best therapy for our patients.

ASCO is enriched by the multidisciplinary and international perspective of its members. It is clear to me that this diversity is one of ASCO's greatest strengths, and it is paramount to our success. There is an increased attendance of non-U.S. based oncologists at our annual meetings. Cancer is an international challenge, and if ASCO wishes to define the future of clinical cancer research, it must reach beyond our shores. In order to facilitate this result, we have in the past year developed new ways in which to incorporate international voices into our leadership. We have instituted an international Board of Directors seat and this year, you elected Dr. Alan Coats from Australia as our first international board member.

Another important element of ASCO's diversity is the fact that it is home to a variety of oncologic subspecialties, not only medical oncologists, but radiation oncologists, surgical oncologists, gynecologic oncologists, and pediatric oncologists. Every one of these specialty areas is important to our mission, just as multidisciplinary approaches are essential modern cancer therapy. Going forward, we intent to make clear to each of these vital constituencies of ASCO that they are integral to ASCO's mission.

During the past year, for example, we have made a special effort to serve the needs of our pediatric oncology colleagues and will be working closely with the leadership of the American Society of Pediatric Hematology and Oncology to discuss ways in which ASCO can address the special needs of pediatric oncology, ranging from advocacy on pediatric issues, to scientific programs at the annual meeting. There is no better success story in cancer than the substantially increased cure rates reflected in many childhood cancers. We all will benefit if the public and policymakers are made aware of how cancers of childhood have been addressed through the discipline of clinical research. ASCO's initiatives in this arena will help bring attention to pediatric oncology issues, and we hope to do the same for many other subspecialties among our membership.

As many of you know, my oncology experience stems largely from the private practice setting. Over the years, ASCO has worked to create a welcome environment not just for academic oncologists, but also for private practice oncologists, who form roughly half of our domestic membership. It has been, and will continue to be, the policy of ASCO to bring community and academic oncologists together for join action on issues of common concern.

Both academic and community physicians are facing similar constraints as a result of the profound changes in the health care environment. Managed care has arrived in academic medical centers, and

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no one there can be unmindful of practical issues like reimbursement and coverage. And, an increasingly enlightened patient population now demands that their community physicians offer access to clinical trials, as well as other benefits traditionally associated with academic institutions.

The lesson is, that our differences are not nearly as important as the common issues we all share. Our society will be strong so long as we are united in our desire to offer quality care to people with cancer in every venue.

One way of assuring unity of purpose between community and academic oncology is through the strengthening of ASCO's state and regional affiliates program. Under the auspices of the Clinical Practice Committee, we conducted a comprehensive review of the manner in which ASCO relates to oncologists who are organized at the state and local levels. We are committing additional resources to improve our communication and coordination with affiliate members who are organized locally, and we expect that their contribution will make ASCO more effective in its overall public policy and education objectives.

As part of our efforts on behalf of our ASCO state affiliates, we will:

—organize educational meetings that potentially would include local "Best of ASCO" programs,

—offer a menu of administrative and other services that state affiliates can obtain from ASCO to address the needs of members at the state and local levels,

—provide financial support for selected ASCO-related activities undertaken by state affiliates,

—facilitate an improved grassroots communication system for oncology issues that will serve oncologists at the state and local levels, and strengthen collaboration with patient advocates and others interested in oncology issues,

—encourage and facilitate participation in state oncology societies by ASCO members with academic affiliations, in order to make the membership of these organizations more closely mirror that of ASCO.

We have made great strides in recent years in pulling together the academic and private practice communities. Together, we are now poised to achieve even greater success, and to address more issues of importance to clinical oncologists and cancer patients in the future.

Interaction With NCI And FDA

It is this very openness to full participation by the various segments of a large and quite diverse membership of ASCO that is essential to the long-term health and growth of our society. ASCO's spirit of inclusiveness should and will extend to our members in the federal government. We have long reached out to our colleagues at the National Institutes of Health and National Cancer Institute, who from time to time have played an important role in ASCO programs. We value our relationship with the NCI, which we believe has never been better than under the stewardship of Dr. Richard Klausner.

In addition, there is another key government agency with which we need to have more interaction, and that is the Food and Drug Administration. We hope to change that. We have commenced discussions with the FDA to determine how we could better collaborate with this critical federal agency. Our goal would be to enhance the understanding of ASCO members about the FDA's role as the gatekeeper to new drugs, biologicals, and devices. Perhaps more fundamentally, however, we would like to ensure that FDA's decision-making processes are informed by the sound science of clinical oncology that we know is necessary for appropriate review of new oncology products.

Our patients deserve the best we can offer them, and with many new agents on the horizon, we need to understand what FDA's reasonable expectations are for drug development. Likewise, FDA decisions should be consistent with what our best minds in oncology believe will lead to quality patient care.

In short, ASCO's tent is big enough to include: first, all oncologic subspecialties; second, both academic and community physicians; third, government and private sector oncologists. We must, and we will, continue to be inclusive to continue to be inclusive to assure the best results for our patients.

National Initiative on Cancer Care Quality

Beyond inclusiveness, a second important theme of my presidency has been ensuring quality cancer care. There can be no more important mission for ASCO than to ensure our patients receive cancer care that is current, compassionate, and of the highest quality. Over the course of the past few years, ASCO's board has demonstrated its willingness to dedicate ASCO resources to data-driven projects that address important issues of quality and advance the cause of cancer treatment and research.

For example, two years ago, during Bob

Mayer's presidency, the society conducted an important survey about physicians' attitudes toward end-of-life issues, which became the centerpiece of a very successful Presidential Symposium on this important topic. This effort resulted in a formal ASCO policy statement outlining barriers and needed improvements in how we deliver care at the end of life. This statement of principles has been widely circulated and serves today as an important framework for national policy-makers and others in shaping effective and compassionate care in the last phase of life.

Last year's Presidential Symposium reported the results of a series of studies designed to collect important data about the conduct of clinical cancer research in this country. Sponsored by ASCO, under the leadership of president Allen Lichter, these were groundbreaking studies which have been exceedingly important in a variety of contexts. First, they emerged at precisely the same time as a series of negative newspaper accounts about clinical research, and thus provided cancer advocates with ammunition to reassure both the public and our patients about the relative health of the cancer clinical trials program. Second, the information from these studies enabled us to answer questions posed by legislators in connection with various legislative initiatives, but particularly our efforts to obtain coverage of cancer clinical trials. The power of valid data is undeniable in a world where too much reliance is placed on opinion or rush to judgment about important public health issues.

This year's initiative was stimulated by the Institute of Medicine's National Cancer Policy Board report issued in April of last year. Coming just before I assumed the presidency of ASCO, this report suggested that a significant number of patients are not receiving care we know to be effective treatment for their cancer. Although this report raised serious questions about quality of cancer care, the report also pointed to wide gaps in our knowledge about the extent and nature of the problem. In fact, the IOM strongly urged additional study of this critically important issue. ASCO, as the preeminent organization for clinical cancer research, could not resist that call. The ASCO board very quickly accepted the challenge to begin collecting data necessary to answer the important questions raised by this report. I fully expect ASCO's effort, formally called the National Initiative on Cancer Care Quality, to extend beyond my presidency. With the help of ASCO's expert task force and nationally recognized researchers from Harvard University and the RAND Corp., it will represent a groundbreaking effort that could eventually have significant impact on how cancer care is delivered across the United States.

The methodology for ASCO's quality study was developed under the guidance of an expert panel led by Dr. Ezekiel Emmanuel of NIH, who was also the lead investigator in last year's study of cancer clinical trials. Initially, the study will examine the feasibility of a monitoring system that is able to measure variations from expected standards of quality cancer care. We will focus the pilot study on two common malignancies, breast and colon cancer, and their adjuvant therapy, where our expert panel felt treatment was fairly standardized.

Medical record reviews will be complemented by surveys soliciting experiences and perceptions of the patients themselves. The link between medical record information and how our patients perceive their care is one of many elements that set this study apart from any other.

ASCO's quality study will consider not only the treatment itself, but also a variety of surrounding circumstances that we know can make a contribution to the quality of care. In our view, these include: ready access to screening and diagnosis; timely referral to a specialist for treatment; direct access to cancer specialists; access to state-of-the-art therapy, including participation in high-quality clinical trials; access to psychosocial and other supportive care services; and access to end-of-life care.

We view the proposed study as a way of validating these very important elements of quality patient care, as well as identifying other components of quality care that may not have been previously recognized. As the study gets underway, we are extremely proud that ASCO has made this commitment and quite hopeful that it is an initial step toward a comprehensive national system for monitoring quality.

Aside from the ambition of the goal, we are particularly delighted that we have had input from patient advocates and that the study will actually ask patients what they thought of their treatment experience. We are also encouraged by the fact that organizations that represent the oncologic subspecialties, as well as oncology nurses, have signed on as partners to our study, thus enhancing likelihood of widespread acceptance of the study's findings. I am very grateful to the ASCO board for being willing

to devote ASCO's own resources when I proposed this study. In addition, other funding sources stepped forward to participate in this important project, notably, my good friend Nancy Brinker of the Susan G. Komen Breast Cancer Foundation. The Komen Foundation is the major sponsor of this initiative, and is a partner and has been an important contributor to development of this study. We have also enjoyed the support of many of our friends in the pharmaceutical industry. Beyond that, we will continue to engage leading health-related foundations, which may also provide funding in light of the significance of these issues.

This study is but the first step in a long process of helping to quantify possible variations in practice that may affect quality cancer care. But it is a step we must take, if we are to maintain credibility with our patients, with third-party payers, with a variety of government officials interested in the issue of quality. My commitment to this effort is strong, and I hope you will join me in making it a success.

Support For Clinical Cancer Research

Beyond inclusiveness and quality cancer care, ASCO will continue to be dedicated to support for clinical cancer research. As clinicians and researchers, we understand the importance of clinical research as the engine of progress towards better treatment for people with cancer. We must renew our commitment to assuring that this engine is powerful enough to sustain today's scientific and clinical momentum.

Three important challenges face us today: maintaining public confidence in clinical research; increasing patient participation in clinical trials; and assuring a health care delivery system that will accommodate significant shifts in how we view and treat cancer. A challenge for ASCO and for clinical cancer research generally is to maintain confidence in the integrity of the clinical trials process by the general public, policymakers, and most importantly, our patients.

In February of this year, the ASCO leadership was alarmed to find that there had been what was described as a serious breach of scientific honest and integrity. This occurred at last May's ASCO meeting in the reporting of a trial of high-dose chemotherapy and stem cell rescue in women with high-risk breast cancer. ASCO took immediate steps to communicate information about the alleged misconduct to our membership, to 1999 annual meeting attendees, to the patient community, and to the media.

This incident was a cause of grave concern to ASCO, as well as patients, investigators, and research sponsors. As I'm sure all of you are aware, ASCO's review process meets or exceeds the high standards of medical societies for accepting research for presentation. Nonetheless, because plenary session papers may be expected to gain heightened attention in the scientific community or popular press, ASCO is currently reviewing its selection procedures for these abstracts to determine what adjustments should be made, including second-tier reviews, in order to further protect against this kind of incident in the future.

After consultation with the National Cancer Institute, an audit team under the leadership of Drs. Roy Beveridge, Robert Rifkin, and Ray Weiss were sent to examine the raw data and uncovered the substantial deficiencies in the trial. Their quick and incisive conclusions provided a great service to the medical community and to thousands of breast cancer patients. Scientific integrity is one of the values we as physicians hold most dear. Any breach of that integrity affects us all and it has a tremendous impact on our patients.

Another challenge that has occupied ASCO for many years, and that may finally be approaching successful resolution, is fair reimbursement for routine patient care costs incurred by our patients enrolled in cancer clinical trials. This has been a priority issue for ASCO for the better part of the last decade. Now, as you heard, thanks to the steadfast support of friends in Congress like Sen. Mack, legislation that will guarantee that important right appears to be closer to realization than ever before. Hopefully, successful passage of appropriate coverage provisions in the Patient's Bill of Rights and in Medicare will eliminate reimbursement as one of the impediments to participation in cancer clinical trials.

Finally, a brief word on cancer care and its integration into an increasingly constrained health care delivery system. As a result of several decades of research investment, we are now in a position to begin moving out of the era of relatively nonspecific cytotoxic cancer therapy into one characterized by more targeted treatments, some expected not to eradicate disease, but to control its spread on a long-term basis. In other words, we are beginning to think of cancer as a chronic disease for the longer term as well as an acute disease initially, a major change in the way we look at this life-threatening illness. Many

of the new therapies can be delivered orally or otherwise self-administered. But while these products were originally expected to be less toxic, some do have toxicities that still require close physician and other health care professional supervision.

All of these developments are promising for patients, no doubt about it. But because of the limitations of our health care system here in the United States, they pose potential difficulties in terms of access and coverage. Third party payers, both public and private, have not been accustomed to viewing cancer in this fashion, and there will be some resistance to payment methodologies that take into account the physician and other services which are required to monitor and manage the administration of chemotherapy in this new format.

Those of us who care about the future of cancer research and who wish to see continued progress in cancer prevention, diagnosis, and treatment, need to monitor the progress of these various developments to ensure that research incentives are not undermined. Our progress against cancer has been impressive, although much remains to be done. Friends of cancer research must stay vigilant if all the promise of our biomedical science is to be realized.

We can take pride in the strides we have made in the past year on behalf of our members, the oncology community, and most importantly, cancer patients. Even as my presidency comes to a close, I expect to remain dedicated to and involved in these core issues: First, support for a diverse and inclusive ASCO membership; second, assuring our patients receive the highest quality cancer care; and third, continuing support for a strong clinical trials program.

It is a privilege to be on the podium today with some of the greats of patient advocacy, Congressional leadership, and clinical cancer research. To be president, following Allen Lichter, and to be able to hand the baton of ASCO leadership to Larry Einhorn, is truly humbling and an honor. To all of you, to my international colleagues, my fellow community oncologists, those in academia, and to the patient advocates who work so closely with us, I thank you for your support during this past year and I look forward to continuing to work with you on all the issues that bring us together in the oncology community.

Sen. Mack Calls For "National Crusade" Against Cancer

NEW ORLEANS—Sen. Connie Mack (R-FL), a key advocate in Congress for increased funding for cancer research, encouraged oncologists to work with legislators to focus attention on the need for continued support of basic and translational research.

"The war on cancer must become our new national crusade," Mack said in remarks at the annual meeting of the American Society of Clinical Oncology. "With every pioneering discovery which you and your patients undertake, we move one step closer to the goal we are all striving to achieve: a cure for every form of cancer."

ASCO President Joseph Bailes presented Mack with the society's Public Service Award. "Sen. Mack has been among the greatest supporters of ASCO's primary legislative goals: required coverage of routine patient care costs for patients in clinical trials," Bailes said. "Although ASCO has a group of loyal friends in Congress who have consistently supported our positions, Sen. Mack stands alone for his unprecedented advocacy for cancer clinical research and cancer research generally. We owe him a great dept of gratitude for his years of support and untiring leadership on behalf of the cancer community."

Mack, a melanoma survivor who plans to retire from Congress at the end of his term, said his family history of cancer motivated him to work on legislative issues of interest to cancer patients and physicians.

Following is the text of Mack's remarks:

Each of us attending this important scientific conference shares a common bond. Our lives have been touched by cancer. For some, it has been a commitment to explore the causes of cancer and to develop new methods of early detection and treatment. For others, it has been to provide the highest possible quality of care for cancer patients. Many of you have been given the life-altering news that you have been diagnosed with cancer. Others have lost loved ones, and you have dedicated your personal and professional lives to help others who are fighting the disease.

While our motivations and efforts may be different, we are all committed to one guiding principle which brings us together today, and that is the commitment to eradicate cancer. My efforts started with the death of my younger brother Michael, in 1979. He was diagnosed with melanoma at the age of 23. I was 27. It was at that moment that the true meaning of the word "cancer" exploded in my mind. Michael and Dennis, my brother, and I were the three closest friends one could have. I was deeply affected by the loss of

Michael.

In 1989, after I had won my first race for the U.S. Senate, I, too, was diagnosed with melanoma. I don't believe I will forget the day that my wife, Priscilla, came home and said to me, "You'd better sit down. I have news for you. I've discovered a lump in my breast." And sure enough, she had breast cancer, and mastectomy. I thought, selfishly, about how I would live without her. I wondered whether she could survive.

Interestingly enough, when I made the decision to run for the House in 1982, Priscilla said, "It's great, but there are two things I don't do. I don't speak to the media, and I don't give speeches." Well, ever since she was diagnosed with breast cancer and has now survived for nine years, she has testified before Congress and she has spoken all around our country on the importance of early detection.

Priscilla and I are fortunate that our daughter, Debbie, is a survivor of cervical cancer, but unfortunately, both my mother and father died of cancer. Dad of esophageal cancer and mother of kidney cancer.

It is largely out of my own family history with cancer that has motivated me as a lawmaker to dedicate my efforts in the war against cancer. Working with a bipartisan group of senators and members of the House of Representatives, we have helped to focus the attention of Congress on three areas of cancer control: early detection, research, and treatment. The early detection of cancer saved my life. If it hadn't been for Michael's death, I may never have discovered the melanoma on my side early enough to have dealt with it. It saved the lives of my wife Priscilla and our daughter Debbie. Officials of the American Cancer Society told me back in the '80s that we could increase the survival rate of roughly 50 percent where it was then to 75 percent through early detection and prompt treatment.

At the same time, we know that low-income Americans and the elderly have high rates of cancer. As a result, Congress has attempted to focus some of our energy and efforts on these vulnerable patient populations. Recognizing the importance of early detection, in 1990, Congress established the CDC's Breast and Cervical Cancer Screening Program, now in its 10th year. This program has provided more than two million screening examinations to low-income women who have no coverage through either private health insurance or the Medicaid program. Nearly 6,000 cases of breast cancer, 31,000 pre-cancerous cervical lesions, and 500 cases of cervical cancer have been diagnosed and treated through this program. I know many of you have volunteered your services to provide diagnostic, treatment, and follow-up care to women who participated in this program, and I commend you for your involvement.

To assist the elderly, Congress now provides access to cancer screening and treatment through the Medicare program. America's seniors now have coverage of early detection tests for breast, cervical, colorectal, and beginning this year, prostate cancer. As new cancer screening tests become available, it is essential that Congress continue to update federal health programs to ensure that patients have access to the life-saving benefits of early detection.

One of the highlights of my career has been the opportunity to meet with scientists to gain a first-hand understanding of the wide array of scientific research being conducted in cancer and in other diseases. My initial venture into biomedical research began when I read the book, The Transformed Cell, by Dr. Steven Rosenberg. Prior to reading Dr. Rosenberg's book, I was aware of only three modalities for treatment: surgery, radiation, and chemotherapy. My imagination was captivated by the potential of immunotherapy and gene therapy.

I then spent the next several years conducting dozens of meetings with other cancer researchers both in Florida and around the country. I also met with researchers who helped to educate me about similar progress being made in the battle against Alzheimer's, Parkinson's, AIDS, sickle cell anemia, and a host of other diseases. The meetings led me to two fundamental conclusions. First, there is a legitimate role for the federal government to play in funding basic scientific research, and second, these were revolutionary times, in which scientific progress was moving at such a rapid pace that a significant increase in funding was warranted, and could be used effectively.

Therefore, in 1997, I proposed to my Republican colleagues in the Senate that funding for the National Institutes of Health should be doubled in five years. I was elated by the overwhelming support that that idea received. I then offered an amendment to the 1997 budget resolution to express the sense of the Senate that NIH should be doubled over a five-year period. The resolution passed unanimously. Each consecutive year since then, Congress has appropriated the largest, single-year increase in the history of the NIH. Last week, the Senate Appropriations Committee approved a $2.7 billion increase for next year, the largest single-year increase in history, and when approved and signed into law, the total funding for NIH will be more than $20.5 billion.

To put some historical perspective on this figure, when I was first elected to Congress in 1982, the total budget for NIH was $3.6 billion. We now provide more funding for the National Cancer Institute than was provided to the entire NIH when I first took office.

The end point of the research investment being made by our government and the private sector must ultimately be the translation of basic science into clinical applications which will save or extend life, or

improve the quality of life for patients with cancer and other diseases. The transition from the laboratory bench to the patient's bedside will be realized only if we have a clinical research agenda that fully matches our basic research efforts in both scope and energy. An essential element of clinical research is the ability of patients to enroll in clinical trials. The threat of reimbursement denial is unquestionably a powerful deterrent to clinical trial enrollment, even if such denials are relatively infrequent or may be appealed when they occur. The fact that research oncologists feel compelled to include warnings of potential reimbursement denials as part of the informed consent process is strongly suggestive of the need for reform. Patients who are preoccupied with concerns about their prospects for survival do not need also to endure the risks of financial ruin in order to obtain the treatment their doctors tell them they need.

We are now working to enhance clinical cancer research by guaranteeing that Medicare and private insurers will pay routine patient care costs for individuals enrolled in qualified cancer clinical trials. It is wrong that people with cancer might be denied by either Medicare or their insurer the ability to participate in a potentially life-saving clinical trial by simply refusing to reimburse routine patient care costs. Congress must act to end this practice, and we do so this year.

Another area of cancer care which I believe deserves more attention is pain management. The subject of pain management is one that has affected my family and me in a very personal way. I want to relate the very different experiences of how pain was managed for two of my family members who died of cancer. During the last 30 days of my brother Michael's life in 1979, Dennis and I stayed with Michael in his hospital room in Atlanta. At various times, Michael was in severe pain. However, his doctors told us they could not give him a certain type of medication because they feared Michael would become addicted. In 1997, my father was losing his battle against esophageal cancer, and while he also experienced severe pain, his treatment was very different from Michael's. The hospice caregivers who treated my father provided state-of-the-art pain management. Consequently, my father died relatively pain-free and able to spend quality time with his family, a precious gift I will cherish forever.

Patients and their families must have confidence that health care professionals have access to the latest information on pain research. We must take steps to help ensure that health care professionals are properly educated and trained in pain management. To help achieve these goals, I was pleased to join Sen. Ron Wyden in introducing the Conquering Pain Act.

As we discuss pain management, it is impossible to ignore the issue of assisted suicide. As Congress continues to consider the best approach to these complex issues, I believe three key principles must be addressed. First, the federal government needs to send a clear message that assisted suicide and euthanasia have no place in the practice of medicine in the United States. Second, doctors and other health care professionals should not fear government retribution for treating pain aggressively. Finally, Congress must take steps to respond to one of the main reasons why a patient might seek assisted suicide—the inadequate treatment of pain.

Let me conclude my remarks by first thanking you for what you do each day to improve the quality of life for cancer patients. I know that you view yourselves as advocates for your patients, and I believe that one way in which you can serve in this patient advocacy role is to remain involved in ASCO's efforts in Washington. It is important for lawmakers to hear directly from you about how the public policies we are debating will affect your ability to advance research and to provide the best care for your patients.

We are already seeing the benefits of our nation's commitment to cancer research, early detection, and treatment. On Monday, it was announced that between 1995 and 1997, overall cancer mortality rates declined at the largest rate ever. Colon cancer incidence rates have fallen steadily since 1985. Prostate cancer rates are dramatically down. Lung cancer mortality among men has been declining since 1990. The death rate for melanoma appears to have leveled off. These statistics show that the messages of cancer prevention and early detection combined with improved methods of treatment are having a real and lasting impact upon the lives of our loved ones.

While our nation should take pride in this achievement, we must not be complacent. Indeed, now is the time to rededicate ourselves to continue this remarkable progress. One of the greatest achievements of the 20th century was the space program. It galvanized our citizens and it brought a great sense of national pride when Neal Armstrong took those historic first steps on the moon. The war on cancer must become our new national crusade. With every pioneering discovery which you and your patients undertake, we move one step closer to the goal we are all striving to achieve: a cure for every form of cancer.

You and your patients are the new explorers venturing into undiscovered areas of science and mapping the brave new world of cancer treatment. Each of us—patients, scientists, doctors, nurses, government, and activists—has a vital role to play in this most important fight. After your scientific conference has concluded, I hope we will all return to our endeavors with a renewed sense of dedication, confidence, and hope.

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