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HCFA Draft Document Dampens Jubilation Over Clinton Plan To Pay Patient Care Costs

Last week, when President Clinton ordered HHS to begin reimbursement of routine care for patients involved in clinical trials, cancer groups responded with praise and jubilation.

A week later, jubilation in oncopolitical circles was transformed into trepidation over a draft document in which the Health Care Financing Administration described its vision of implementation of the President's orders.

The memorandum in question, a copy of which has been obtained by **The Cancer Letter**, has not been published or implemented—and

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In Brief:

NCI Hires Harold Freeman To Direct New Center For Study Of Health Disparities

HAROLD FREEMAN, chief executive officer and president of the North General Hospital, Harlem, and chairman of the President's Cancer Panel, was appointed to a newly created position of associate director for health disparities at NCI, Institute Director **Richard Klausner** said. Freeman will work as a part-time "special governmental employee" to establish the NCI Center for the Study of Health Disparities, which will consolidate the Institute's health disparities programs, Klausner said to the National Cancer Advisory Board at its meeting June 13. Freeman said he will retain his appointments at North General and on the Cancer Panel, and will work at NCI approximately one or two days a week. An internal working group will take most of the summer to develop specific plans and a budget for the center, Klausner said. "We owe Harold a dept of gratitude for being willing to spend some of his time with us," Klausner said to the NCAB. . . . **SENATE FINANCE** Committee approved the Breast and Cervical Cancer Treatment Act, which would give states the option of providing Medicaid coverage to women diagnosed with breast or cervical cancer through the CDC Breast and Cervical Cancer Early Detection Program. While the bill recently passed by the House includes a match of 75 percent federal to 25 percent state funds, the Senate bill provides a higher percentage of federal funds to less wealthy states. . . . **SAMIR ABU-GHAZALEH** was appointed to the National Cancer Advisory Board, the White House said earlier this week. Abu-Ghazaleh is a gynecologic oncologist at the Avera Cancer Institute, of Sioux Falls, SD, and a member of the North Central Cancer Treatment Group, the

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Advocates Hope HCFA Plan Is Headed For The Shredder

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cancer advocates hope that it ends up in the biggest, fastest shredder in Washington.

Meanwhile, White House officials are scrambling to assure miffed advocates that the document represents a vision of HCFA career bureaucrats, and is not what the President had in mind when he signed the executive memorandum to HHS last week (**The Cancer Letter**, June 9).

The Cancer Letter has learned that copies of the HCFA memo began circulating in the White House and at HHS and its agencies before the President's announcement, and the document apparently was not scrapped after the President signed the memorandum with great fanfare on the South Lawn of the White House.

The HCFA draft document is dated June 12, which means that five days after the announcement, someone at the agency was still looking for creative approaches to restricting payment for routine costs associated with clinical trials.

The HCFA program memorandum, which was intended for contractors who process claims for Medicare patients, relies on a series of hypothetical scenarios distinguishing services that qualify for coverage from those that do not. According to the draft, Medicare will continue to deny payment for patient care costs associated with direct participation in clinical trials, but would pay for subsequent services.

For example, the program would not pay for scans performed before infusion of an experimental chemotherapy agent. Similarly, it would not pay for the use of antiemetics received during treatment, or for any other services and procedures performed in conjunction with the experimental treatment. However, should the patient experience severe toxicity and end up in an emergency room after receiving the treatment, the program will pick up the bill.

Patients and physicians needn't feel excessively grateful for this proposed policy. According to a recent report by the Institute of Medicine, contractors who process the claims are not always able to distinguish clinical trials from standard care, which means that Medicare unwittingly pays for a substantial portion of routine patient care associated with clinical trials.

The report, "Extending Medicare Reimbursement in Clinical Trials," recommends that patient care costs associated with clinical trials should be reimbursed the same way as costs incurred in standard care.

The report is available on the IOM web site: http://www.nap.edu/html/medicare_reimbursement/.

Should the scenarios described in the HCFA draft memorandum become policy, Medicare could tighten its procedures, and reimbursement of patient care costs in trials may actually drop, observers say.

Ironically, the HCFA measure throws a wet blanket on a political gesture that could endear the Administration to an important constituency—the elderly—just in time for the 2000 Presidential elections. And, as it happens, the White House memorandum on clinical trials dovetailed with Vice President Al Gore's policy speech on cancer.

On June 6, the evening before Clinton signed the memorandum, the White House initiated a conference call with the cancer groups, asking the advocates and professional societies to hold press conferences and to issue press releases about the Administration's move.

On June 7, hours after the memorandum was signed, at a press conference on Capitol Hill, praise for the new policy came down like a summer rainstorm.

Even the retiring Sen. Connie Mack (R-FL), whose efforts to solve the cancer clinical trials

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reimbursement problem through a Medicare "demonstration project" were upstaged by the White House, threw in a thank-you.

"For several years, we have advocated Medicare coverage for approved clinical trials, and today's announcement is the culmination of our bipartisan effort," Mack said in a statement issued that day.

The President was promising more than Mack envisioned. While the demonstration project, co-sponsored with Sen. Jay Rockefeller (D-WV), proposed a four-year test program limited to cancer clinical trials, the President directed reimbursement for all clinical trials for all diseases, starting now.

"I am disheartened after reading the HCFA memorandum, and I anticipate that it simply represents a disconnect between the White House and the agency," said a patient advocate who spoke on condition of not being identified by name. "I know that the President and the Vice President would not have facilitated so much enthusiasm in the patient community only to see this enthusiasm entirely smashed by this memorandum."

HCFA officials declined to comment on the draft memorandum. "Unofficial bootleg things are dangerous," said a HCFA spokesman. "It may not even be the final rule. We just don't get into the game of commenting on things before they are done."

A Matter Of Definitions

The HCFA document states that "Medicare excludes from coverage eligibility only those services that are clearly 'specific to' non-covered services," but would pay for "items or services that are necessitated by complications… arising after the delivery of a non-covered service, whether or not they are caused by the non-covered service."

For those who can't follow HCFA-speak, the agency listed hypothetical scenarios that included the following:

—"A non-covered test to detect breast cancer in asymptomatic women is performed. The non-covered screening test and the fee to administer the test is not covered. However, the person performing the test is interested in comparing the non-covered result with a conventional mammogram. The conventional mammogram would be covered as long as it is consistent with the Medicare statutory benefit. However, if the person also wanted a CT scan to compare with the non-covered screening test, the CT scan would be non-covered, unless there are other signs or symptoms necessitating the CT scan.

—"A non-covered cancer chemotherapeutic drug is administered. The anti-emetic drugs and services needed in preparation to delivery and needed during delivery of the non-covered chemotherapeutic drug are all non-covered. However, after the delivery (i.e., after the `payment episode' of the non-covered chemotherapeutic drug) if the patient's signs or symptoms require further antiemetic treatment, this would be covered.

—"A non-covered surgery is performed on a patient in an ambulatory surgical center. The ambulatory surgical center visit, the physician's service, and the pre-operative workup labs and the post-operative follow-up (in the absence of signs or symptoms) would not be covered. However, if following non-covered surgery, the patient developed complications, or signs, or symptoms requiring medical attention, then the services reasonable and necessary for the diagnosis and treatment of that patient are covered."

Will the White House convince patient advocates and professional societies that these scenarios run counter to the intent of the Administration? Will a better plan emerge? Will the Rockefeller-Mack legislation come to the rescue?

One thing is certain: the issue of reimbursement for patient care costs in clinical trials did not go away the day President Clinton signed his executive memorandum to HHS.

NCI Programs:

Institute Plans Research To Reduce Cancer Disparities

NCI has released a plan for reducing the disproportional incidence of cancer and unfavorable outcomes observed in some populations.

The plan, which lays out a broad research program involving population studies, improvements in data collection, as well as increases in funding to cancer centers and cooperative groups, is part of the NIH-wide effort to increase research in health disparities and coordinate research now being done at the Institutes.

Over the past year, NIH has been subjected to Congressional pressure to increase its portfolio and improve its coordination of such research.

The text of the 28-page document is available on the NCI web site (http://www.cancer.gov/announcements/healthdisp.html) where it is posted

for public comment. In addition to providing a global picture of NCI's efforts, the document lists specific funding opportunities that will be announced in upcoming months.

"Our overall goal is to understand the causes of health disparities in cancer and to develop effective interventions to eliminate these disparities," the report states. However, the document points out that as a science-based agency, NCI can only develop interventions, leaving implementation to other entities.

"Research is only one part of the solution," the report said. "As a partner in the national cancer control effort, NCI is also planning new initiatives with other federal agencies, local governments, and private entities to disseminate and diffuse effective evidence-based interventions to reduce cancer-related health disparities and improve the health and well-being of underserved communities."

Comments on the plan may be sent to Health_Disparities@pop.nci.nih.gov.

The document lists the following objectives and research questions:

—**Expand the capacity to conduct fundamental cancer control and population research.** The relative contribution of social causes to the development of new cancers versus the factors that lead to unequal cancer treatment and differential outcomes is a fundamental question that must be answered if we are to reduce cancer-related health disparities. However, to answer this question we must improve the capacity for conducting basic or fundamental research in cancer control and prevention.

—**Expand the ability to define and monitor cancer-related health disparities.** As we explain the complex determinants of cancer-related health disparities through basic and fundamental cancer control research, the relative importance of different determinants will vary as a function of how the disparity manifests itself. Thus, a key question is how to best measure and monitor the cancer-related health disparities across the spectrum of cancer incidence, stage of disease at diagnosis, disease recurrence, quality of life, and cancer mortality?

—**Support intervention research in prevention, early detection, treatment and communications that may reduce cancer-related health disparities.** While fundamental research can shed light on the complex determinants of cancer-related health disparities and will improve our ability to define and monitor these disparities, another key question is to what extent can prevention, early detection, treatment, and communication interventions effectively reduce, if not eliminate, cancer-related health disparities?

—**Expand research dissemination and foster collaborations with allied agencies and organizations to facilitate the translation of evidence into practice.** Fundamental and intervention research and surveillance are necessary, but probably not sufficient to eliminate cancer-related health disparities. Two related questions are: a) how can NCI best disseminate the research evidence of effective cancer prevention and control interventions to institutions and agencies with the direct service mission to reduce the cancer burden of underserved populations, and b) how can NCI best partner with other federal (e.g. CDC) agencies and national voluntary (e.g. ACS) organizations to expand the channels for research dissemination and diffusion?

—**Strengthen training and education in health disparities research and increase the number of minority scientists working in cancer control science.** Alleviating cancer-related health disparities will require training new investigators well versed in the challenges of understanding these disparities and eliminating their causes. A key question remains how to expand the number of competitive investigators coming from the communities affected by heavier burdens of cancer?

Cancer Control & Population Research

—The Institute will create extramural *Centers for Population Health* to: 1) research the social and other causes of cancer-related health disparities, 2) develop new hypotheses for cancer control at social, institutional, and policy levels, and 3) develop, apply, evaluate, and disseminate interventions to improve population health. The concepts for the centers are expected to be presented to the NCI Board of Scientific Advisors in November, and awards would be made in late 2001 and early 2002.

—In June, BSA will review revised concept for *Cancer Care and Outcomes Research and Surveillance Initiative.* The initiative is intended to correlate quality of care to outcomes in adult cancer patients and pinpoint the reasons for disparities in outcomes of cancer care, particularly for sites like breast, colon-rectum and lung.

—*An initiative in basic biobehavioral research*, intended to support developmental research to test behavioral measures for their applicability to

diverse ethnic and socioeconomic groups. The concept for the initiative, which will use the R21 grant mechanism, is expected to be presented to BSA in 2002.

—The program announcement *Diet, Lifestyle, and Cancer* in U.S. special populations to stimulate epidemiologic studies of cancer etiology and behavior.

Intramural studies will include:

—*A comprehensive biologically-based epidemiologic investigation, among African Americans and whites* in the southeastern, northwestern and other parts of the U.S. is planned to identify determinants of prostate cancer in high-risk and low-risk populations.

—*Development of models for projecting the individualized absolute risks of breast cancer for minority women.*

—*A study of rapid onset cervical lesions in a Hispanic population in Costa Rica*, where cervical carcinoma rates are high due to ineffective screening programs.

—*Evaluation of factors influencing participation rates in population-based epidemiologic studies among African Americans.*

—*A case-control study of renal cell cancer among African Americans and Caucasians in the U.S.*

—*A study of prostate cancer in Africa.*

—*Inflammatory breast cancer in African American and white women.*

—*Breast cancer in young African-American women.*

Surveillance Research

—*Increase Coordination of National Cancer Surveillance Research & Control Programs.* NCI, Centers for Disease Control, and National Center for Health Statistics plan to hold a meeting in the spring of 2000 to develop a multi-year plan for collaboration in analysis and dissemination of cancer-related health survey, health survey methodology, and techniques for improving the quality and availability of data pertinent to measuring population-based health disparities.

—*NCI plans expand SEER* to include populations with differential cancer rates that are currently under-represented (e.g., Non-Mexican Hispanics, rural African Americans, American Indians, high poverty, and high cancer death rates). If the expansion is feasible, in fiscal 2001, the Institute will add up to four cancer registries to SEER through an RFP issued last March.

—*Provide technical assistance and training to non-SEER registries.*

—*Quality of cancer care initiative*. The initiative, started last year, seeks to develop and implement the Cancer Outcomes Research and Surveillance Consortium that will address issues of quality of care and health disparities in clinical trials.

—*Enhance national and regional data systems to measure health disparities in cancer-related health behaviors and screening practices.*

—*Link screening information with cancer incidence and mortality data.*

—*Expand cancer communications survey research.*

—*Enhance National Tobacco Surveillance*. NCI's efforts to articulate priorities, within a global tobacco surveillance plan, are expected to be complete by summer 2000.

—*Sustain the Cancer Intervention and Surveillance Modeling Network.*

—*Expand Methodologic Research.* NCI plans to hold a workshop in 2002 to identify advances in research methods and approaches to incorporate socioeconomic status measures in health and other surveillance.

—*Expand Geographic Studies.*

Intervention Research in Prevention, Detection, Treatment, and Communications

—*Transdisciplinary tobacco use research centers.* Provide supplemental funds to TTURCS to address differential uptake and quitting among underserved populations. Seven TTURC's currently are funded.

—*Pilot research to overcome the digital divide*. Provide NCI-funded CIS offices the opportunity to apply for one-year supplements to develop research activities that increase access to online cancer information resources. Release this in 2000 and again in 2002.

—*Support cancer communications centers of excellence.* A concept for this project is expected to be submitted to BSA later in 2000.

—*Encourage research on health disparities in survivorship.* The Institute plans to offer three-year supplements to cancer center grants in fiscal 2001 to stimulate developmental research elucidating the ethnic and cultural context of survivorship, and the similarities and differences in the survivorship experience across ethnic minority and medically

underserved groups. Also, the Institute plans to develop concept for a Program Announcement for release in fiscal 2002 to expand psychosocial and behavioral intervention research among minority and underserved cancer survivors and their families that has the potential to improve quality and length of survival.

—Expand diet and physical activity intervention research. The Institute plans to develop an RFA in collaboration with with NHLBI and present it to the BSAs for approval during fiscal 2002. The intervention studies will test theory-based, multiple risk factor reduction strategies in high-risk, underserved populations.

—Fund colorectal cancer screening use and follow-up research. A concept will be submitted to BSA in the spring of 2001.

—Fund breast cancer screening use and maintenance of use research. A concept is expected to be presented to BSA in spring 2001.

—Redesign the Clinical Trials System. The institute plans to test systems for identifying the best trials, improving trial planning, speeding trial activation, and improving availability of trials to patients throughout the country. In coordination with the overall clinical trials restructuring efforts, NCI is coordinating the development of an up-to-date national informatics physician communications module for clinical research with Howard and Meharry Universities. This can enable the linkage, transfer, and analysis of biomedical information relating to cancer and involve underrepresented physicians and other health care professionals in the conduct of clinical trials.

—Expanded participation project. The EPP will be extended to a second historically black institution, Meharry University. Howard University is currently a member of the EPP, a partnerships between NCI and several health plans and physician practice groups not active in NCI trials, includes a menu of protocols as well as informatics to facilitate accrual and data collection.

—Use supplements to enhance cooperative group involvement in health disparities research.

—Evaluative variations in pharmacokinetics and toxicity of chemotherapeutic agents by age and race. Expand current research to include additional agents and populations through supplements to the Clinical Trials Cooperative Groups and investigator-initiated grant applications.

—Sustain Minority-Based Community Clinical Oncology Program, which provides for the establishment of partnerships between the NCI-supported research programs and community-based health service providers.

—Increase Collaborations with Minority Professional Organizations. Over the last three years, NCI has sponsored the attendance of more than 100 National Medical Association members at meetings of the Eastern Cooperative Oncology Group. Now the Institute plans to increase number of NMA physicians involved in current collaboration and increase dialogue with Hispanic, Asian, and other professional groups.

—Enhance the Prostate, Lung, Colorectal, and Ovarian screening trial. Enhancements to the PLCO Trial would include keeping high minority accruing centers open for several years after the accrual goal of 148,000 is reached in order to over-accrue an additional 3,000 minority participants. These participants would be randomized and would follow the standard protocol, including seven annual screens and at least 13 years of annual follow-up.

—Increase minority participation in current cancer prevention trials. The Study of Tamoxifen and Raloxifene and the Selenium and Vitamin E Efficacy Trial are involving a number of minority physicians, nurses, and data managers in the design of the studies and of recruitment strategies.

—Expand Veterans Administration & Department of Defense hospitals and clinics involvement in NCI clinical trials. Provide additional data management support to VA and DOD hospitals that have high potential for minority accrual.

—Use supplements to enhance cancer center involvement in health disparities research. Supplement up to 20 cancer center grants for developmental research in cancer-related health disparities.

—Improve outcomes research in clinical treatment and prevention trials. Fund the cooperative groups to analyze currently available socioeconomic status data and correlate with outcomes. Fund the cooperative groups to prospectively collect increase socioeconomic status relevant data for further analysis.

Research Dissemination

—Model and monitor impact of research dissemination and diffusion. This initiative inclides: (1) Developing state-specific cancer burden profiles for cancer control program planning using incidence, mortality, screening, and health behavior and health

status measures from SEER and NPCR registries, the NCHS vital statistics, Behavioral Risk Factor Surveillance Survey (BRFSS), NHIS, and other health data systems; (2) Providing supplements to CISNET grantees to model the impact of dissemination and diffusion of cancer control interventions to underserved populations at the regional and/or national level. Provide mechanisms for public and private partners to participate in special sessions of the consortium meeting to discuss questions and data sources for application of modeling techniques; (3) Collaboration with CDC and ACS to track progress of states and regions respectively, based on mortality reduction models, and (4) Exploring mechanisms to track NCI, CDC and ACS cancer control intervention (research, education and service) investments by state and region.

—*Facilitate adoption of evidence-based cancer control interventions*. This involves (1) Institution of regular regional meetings between NCI, CDC, and the ACS National Office and regional cancer control directors to review cancer-related health disparity reduction objectives; (2) Identifying state, regional and national indices of program impact; (3) Completing annual reviews of published evidence on best practices to reduce cancer-related health disparities; (4) Meeting with consumers of research evidence (e.g. state health departments, policy makers, advocacy groups) to identify most useful formats for presenting intervention research evidence that increases probability of its use; (5) Publishing and posting on the NCI Dynamic Evidence in Cancer Control Web Site annual intervention evidence reviews (with ACS) and best practices (with Agency for Healthcare Research and Quality and CDC) in formats preferred by users.

—*Develop Special Partnerships*. The Institute will work with ACS Regional Cancer Control Planning Efforts of the mid-Atlantic Region to pilot collaborative efforts to review regional needs assessment data, regional infrastructure and intervention evidence as a model for assisting other regional organizations and State Agencies to improve the quality of cancer control program planning. Also, the Institute will provide staff support for DC Department of Health registry regional advisory committee, tobacco control program and CDC-funded breast & cervical cancer screening.

Training and Education

—*Special Populations Networks for Cancer Awareness, Research, and Training.* The network provides research infrastructure funds for the underserved communities to collaborate with academic cancer centers and NCI. The NCI will initiate a Cancer Control Academy for Community Partners in FY 2000-2001 .

—*Strengthen training in minority colleges and universities.* An RFA will be issued to support the planning or implementation of collaborations and partnerships between institutions with high minority student enrollments and NCI-designated Cancer Centers.

—*Facilitate participation of minority students and faculty of minority schools* by encouraging increased participation of minority students, scientists and faculty of minority schools in academic cancer meetings. The Institute has sponsored two programs providing funds to the American Association for Cancer Research to bring minority scientists to its annual meetings.

—*Support promising young minority high school and undergraduate minority students.* The Institute has provided supplements to 12 Cancer Center Grants (P30) to support the placement of approximately sixty promising young minority high school and undergraduate minority students in cancer center laboratories to provide them with research experiences. Now, the Institute plans to increase the number of participating centers to 25.

—*Attract underrepresented minorities into cancer-related research activities*, increasing the promotion of the minority supplements program and expand the funding of the program by 50%.

—*Expand support for the Science Enrichment Program*, a six-week science camp for approximately 120 tenth and eleventh grade students. The program is held at two universities. The Institute plans to increase the number of sites to four and enrollment to 240 students.

—*Expand the Cancer Prevention Fellowship Program* by developing a new track in the NCI Cancer Control Fellowship Program focused upon research and training activities designed to better understand and reduce health disparities. Two fellows per year will be recruited to the program and focus on health disparities research within the Office for Special Populations Research or the Division of Cancer Control and Populations Research.

—*Encourage cancer centers to partner with health care institutions in underserved communities* in order to apply for R25 training grant

support that provides community-based clinical and cancer control research training opportunities.

—Sustain the Office of Special Populations Research. The office is responsible for planning and coordination of special populations research within the NCI and interacts with other institutes and offices on issues relevant to cancer research and special populations. An important aspect of this charge is to assess the scientific literature and at times the raw data to define the real scientific questions most pertinent to improving the health of these special populations. The issues of special populations are often emotive and enthralled in politics, but relevant questions need to be articulated and discussed in a scientific forum and require some coordination.

In Brief:

NCI's Kramer Named Director, NIH Medical Applications Office

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Gynecologic Oncology Group, and the American College of Gynecologists. He is a fellow of the American College of Surgeons and the American College of Obstetricians and Gynecologists. Abu-Ghazaleh received a MB.B from Ain Shams University Medical School in Cairo. He completed his residency in obstetrics and gynecology at the University of South Dakota Affiliated Hospital from 1972-76, and in gynecologic oncology at Duke University from 1976-78. . . . **BARNETT KRAMER**, deputy director of the NCI Division of Cancer Prevention since 1996, has been appointed by NIH Acting Director Ruth Kirschstein as director of the Office of Medical Applications of Research, effective June 18. "Dr. Kramer has a distinguished record of leadership at the NIH and we are delighted that he is taking the helm at OMAR," Kirschstein said. "He's a seasoned clinician, scientist, and administrator who will bring strong managerial skills and innovative thinking to OMAR and the NIH Consensus Development Program." Kramer is editor-in-chief of the Journal of the National Cancer Institute and a clinical professor in the department of medicine of the Uniformed Services University of the Health Sciences. . . . **ONCOLOGY NURSING FOUNDATION**, of Pittsburgh, as raised more than $16 million to create a national Center for Leadership, Information, and Research to provide a forum for nurses to increase their leadership skills and provide research to enhance their work, the foundation said. . . . **TODD GOLUB**, a pediatric oncologist at Dana-Farber Cancer Institute and research scientist at the Whitehead Institute Center for Genome Research, received the Discover Magazine Award for Technological Innovation in the "health" category for his work using DNA chips to diagnose cancers. . . . **A NEW ENDOWMENT** has provided more than $1.8 million in funding for the University of Texas M.D. Anderson Cancer Center. The Frank T. McGraw Memorial Endowment for Cancer Research awarded the funding, which awarded three faculty members an endowed chair and more than $610,000 for their research. **Ellen Gritz**, chairman of the Department of Behavioral Science, received the Frank T. McGraw Memorial Chair in the Study of Cancer. **Donald Berry**, chairman of the Department of Biostatistics, received the Frank T. McGraw Memorial Chair in Cancer Research. **Eduardo Bruera**, chairman of the Department of Symptom Control and Palliative Care, received the Frank T. McGraw Memorial Chair in the Treatment of Cancer. . . . **ANDREW YEAGER** has been appointed director of the Stem Cell Transplantation Program in the Division of Hematology/Oncology at the University of Pittsburgh. He also will direct the Hematopoietic Stem Cell Transplantation Biology Program in the University of Pittsburgh Cancer Institute. Yeager was director of the Interdisciplinary Stem Cell Biology and Transplantation Program and director of the Division of Pediatric Hematology/Oncology and Bone Marrow Transplantation at Emory University School of Medicine. Recently, he developed a pioneering unrelated cord blood cell transplant that effectively cured sickle cell disease in a young patient. . . . **HOWARD UNIVERSITY HOSPITAL** awarded its Legacy of Leadership Awards to three health care professionals recently: **Lovell Jones**, professor of gynecologic oncology, biochemistry and molecular biology at The University of Texas M. D. Anderson Cancer Center; **Richard Alcorta**, medical director for the state of Maryland's Institute of Emergency Medical services; and **Carolyn Aldigé**, president and founder of the Cancer Research Foundation of America. . . . **WORKING MOTHER** magazine will no longer accept cigarette advertising, the magazine's editor-in-chief **Lisa Benenson** announced in an e-mail to readers earlier this month. The new policy was established after the magazine received letters protesting an ad for Virginia Slims in its June 2000 issue.

DIRECTOR
HIPPLE CANCER RESEARCH CENTER

The Hipple Cancer Research Center (HCRC), an endowed basic cancer research center in Dayton, OH (est. 1975) with strong community support, has recently re-focused its mission and seeks a Director to establish a cancer prevention research program. Complementary to the core cancer prevention research program are screening, education and prevention outreach activities, to be carried out in a variety of community settings.

The Director will possess a doctorate-level degree, and will have extensive experience in obtaining extramural funding for and conducting cancer prevention research. Experience in developing service-and research-oriented relationships with a wide variety of community organizations and agencies is an important qualification.

The Director position carries with it a faculty appointment at the Wright State University School of Medicine, at a level commensurate with experience in an academic setting, at least at the associate professor level. Wright State is a community medicine-oriented medical school affiliated with several major hospitals in the Dayton area, and with a wide range of community health and prevention programs in many sites. The HCRC is affiliated with Premier Health Partners, the largest health system in Dayton, which includes hospitals, outpatient facilities, home health and related healthcare services.

Applicants should send a letter describing their qualifications and interest in the position, and a curriculum vitae via e-mail to Paul F. Engstrom, M.D., Senior Vice President for Population Science, Fox Chase Cancer Center, 7701 Burholme Avenue, Philadelphia, PA 19111, e-mail pf_engstrom@fccc.edu, or to Kurt Stange, M.D., Ph.D., Professor of Family Medicine, Epidemiology & Biostatistics, Oncology and Sociology, Case Western Reserve University, 11011 Cedar Avenue, Cleveland, OH 44106, e-mail kcs@po.cwru.edu.

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