THE CANCER LETTER

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HAWKINS CALLS FOR JOINT CANCER CENTER-COMMUNITY EFFORT TO DEVELOP BETTER TECHNOLOGY TRANSFER

Sen. Paula Hawkins (R.-Fla.), following a hearing conducted by the Investigations & General Oversight Subcommittee which she heads, said she was going to ask HHS Secretary Richard Schweiker to appoint a group of comprehensive cancer center and community hospital representatives to study ways to improve technology transfer.

"Steps must be taken to make sure that community hospitals have access to the latest information," Hawkins said. "We have established today that all is not well with the Cancer Program. Congress emphasized

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In Brief

HOUSE, SENATE PASS RESCISION BILLS; NCI COMPROMISE FIGURE PROBABLY ABOUT $10 MILLION CUT FOR FY 1981

HOUSE, SENATE have both approved bills rescinding portions of 1981 fiscal year appropriations, including NCI's. The Cancer Program would lose $14.3 million (from an appropriation of $1 billion, 1 million) in the Senate bill, $7.7 million in the House measure. Final figure probably will be a compromise at about $10 million, which means NCI will be able to put back about $15 million sliced from a variety of programs when the White House proposed a rescision of $25.6 million. . . . **NCI DIRECTOR** Vincent DeVita has interviewed more than 40 candidates for the vacant division director positions. He has made his selection for only one, so far—the Div. of Extramural Activities. That name is on its way to HHS Secretary Richard Schweiker, who if he follows his predecessor's policy, will insist on reviewing every Senior Executive Service appointment. . . . **NATIONAL TOXICOLOGY** Program Board of Scientific Counselors Technical Report Peer Review Committee will review bioassay reports on seven compounds at its June 23 meeting in Research Triangle Park. They are polybrominated biphenyls (Firemaster FF1), asbestos amosite, asbestos chrysotile, allyl isothiocyanate, pentachloroethane, 2-biphenylamine, and stannous chloride. . . . **JOHN ZIEGLER** will leave his position as editor of the *Journal of NCI* next month to become associate dean for medical education at the Univ. of California (San Francisco). . . . **FREDERICK PHILLIPS**, secretary-treasurer of the American Assn. for Cancer Research for the past three years, will give up that position following AACR's annual meeting next year in St. Louis. He had agreed to take on the job only for four years when he succeeded Hugh Creech. Members are voting by mail on a proposal to establish a salaried position of executive director; if approved, the Board will appoint someone to start Jan. 1, 1982. The office of secretary-treasurer will continue but with many of the responsibilities transferred to the executive director.

COMMUNITY REPRESENTATIVES DEMAND INCREASE IN CANCER CONTROL BUDGET

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in the National Cancer Act of 1971 and its amendments the important concept of technology transfer. Yet we are told that it is not being done. The subcommittee will continue its investigation."

The Assn. of American Cancer Institutes and the Assn. of Community Cancer Centers previously had agreed to work together in developing suggestions for improvement in cancer control. Their joint committee has held one meeting and will meet again in September.

Three community oncologists testified at the hearing, and it was their comments which helped convince Hawkins that "all is not well." They were Edward Moorhead, director of the Grand Rapids Clinical Oncology Program; Thomas Sawyer, director of radiation oncology at the Orlando Regional Medical Center; and William Dugan, director of clinical oncology and community outreach at Methodist Hospital in Indianapolis.

Moorhead described the Grand Rapids COP and its accomplishments, which included major improvements in outcome for patients treated according to guidelines developed in the program. "It is remarkable that this was achieved in a community combining five competing community hospitals in a citywide cooperative program," Moorhead said. "While we believe quite strongly in the regionalization concept that we utilized in this program, we admit fully that this program would not have been possible without the stimulation and support of the National Cancer Institute.

"The war against cancer is a long and difficult battle with very many worthwhile ideas and programs competing for attention and support. It is my belief that the National Cancer Institute has done an excellent job of balancing these competing forces within its limited ability through funded support programs. . . . The National Cancer Institute has not been perfect in its administration of the Cancer Program, but when one considers the National Cancer Act was passed only 10 years ago, the achievements in that period are truly staggering when compared to the achievements up to that time in medical history.

"I fully support the high priority given to basic clinical research, for if there is no new technology, we are doomed to failure. At the same time, I would point out the need not only to continue, but to extend the programs of cancer control. These programs are aimed at the delivery of a complex, developing technology used to treat more than 85 percent of cancer patients at their local/community hospitals. I believe that appropriate community organizations can be developed to work more closely with the National Cancer Institute and other groups in delivering to the cancer patient in the community whatever excellence is available at this particular time in medical history."

Sawyer was more critical. Noting that large numbers of patients now have access to trained oncologists practicing in communities, Sawyer said, "This migration of oncologists into the community setting unfortunately took place in the absence of any preexisting communicative network. In most cases, the lines of communication between the community hospitals, universities and cancer centers are ill defined or nonexistant. A danger exists . . . which does and will increasingly affect the transfer and application of information. Under no circumstances should you as lawmakers permit the separation of the concept of transfer of information from its application. Publication of an article does not constitute effective transfer," Sawyer said, citing the impossible task of keeping up with all the oncology journals.

"We need a national transfer system which can effectively convey our technological advances," Sawyer continued. "Matching funds to community hospitals to establish a national network of closed TV for weekly cancer conferences could be made available through the National Cancer Institute or through the National Institutes of Health. Such a network could apply not only to cancer related topics but other general medical problems, as well. Matching funds to assist community hospitals or oncology practices for utlization of the computerized Cancer Line at the Library of Medicine would be of value."

Sawyer urged that a national classification system, including methods of staging to facilitate comparison, be made mandatory. "In most states, cancer is not a reportable disease. Data collection systems are costly and time consuming requiring years for accrual and analysis of data. Most community hospitals are unwilling or unable to make this commitment. There is no accountability because there is no responsibility. There are no national standards of how patients are to be catalogued and unless uniform methods of analyzing the extent of cancers are employed, no comparisons are possible. We have no national standards and to my knowledge none are being developed. The National Cancer Institute, the comprehensive cancer centers, the universities, the community hospitals all have no defined responsibility. . . . While the National Cancer Institute might argue that trial programs to develop community standards are in progress, it is only through the force of the Assn. of Community Cancer Centers and several of the panelists in this room who lobbied the halls of Congress . . . that funding was appropriated for the Clinical Hospital Oncology Program. Unfortunately, these monies were not line items in the NCI budget and the full force of the programs were not implemented on the basis of priorities established by NCI. . . .

"Let me ask what specifically are the responsibili-

ties of the National Cancer Institute and Comprehensive Cancer Centers to community hospitals as you in Congress see them? What amount of money should be assigned to assess and improve the quality of cancer care at the community level? The National Cancer Institute's Community Hospital Oncology Program, and the American College of Surgeons Tumor Accredited Program permit some analysis of care in approximately 900 institutions; however, how are we to assess the quality of care in the remaining majority of 17,000 hospitals who haven't bothered to participate? It appears to me that there is a disproportionate amount of the National Cancer Institute's billion dollar budget assigned to basic research versus evaluation of transfer and implementation factors. The value of basic research is fundamental, but there is a danger because of its open-endedness which disallows assessment of much of its effort. There is a danger that increasing monies will be spent on unrewarding projects. When accountability cannot be assigned, as in basic research or failed projects, how are we to assess their value? Lastly, without effective transfer and implementation and assessment of the lowest as well as the highest level of community cancer practice, the full value of this research may not only be misinterpreted but even lost altogether," Sawyer concluded.

Dugan was even more severe in his criticism of NCI's priorities. "Basically I'm very supportive of the National Cancer Act," he said. "I only wish we had $2 billion to spend each year in the fight against cancer.

"The money spent thus far has been responsible for important and impressive advances against what are well over 100 different diseases. I am, however, extremely concerned because of what I view as a frightening misapplication of priorities.

"Cancer control only gets five percent of the total NCI budget. For the past two years the budget has been around $1 billion. Of this billion dollars only $50 million is going to cancer control.

"What is cancer control? A lot of people have spent a lot of time trying to define cancer control. In its simplest terms, it is 'technology transfer.' In Indiana, we call it 'getting the word to the herd.' All the research in the world isn't worth a nickel if you can't get the results to the grass roots.

"Dr. Rubin from Rochester, New York has written a well distributed book titled *Clinical Oncology for Medical Students and Physicians.* In the preface is a paragraph which states, and I quote, 'The first decision in cancer management most often determines whether the outcome will be successful. Rarely can a patient be salvaged once relapse occurs. . . .'

"The importance to this paragraph is that 85 percent of the cancer in this country is treated at the community level and next to nothing is being spent to insure that research advances are being properly utilized. . . .

"I also have the feeling that the leadership of NCI believes that clinical trials programs are all that cancer control should be. I believe in clinical trials, and I think they are terribly important; but to substitute clinical trials for cancer control is totally inappropriate. . . .

"I have another bone to pick over what I consider to be an important issue. . . . We still don't have a common data base for the country. As a practicing physician, I want to compare our institutional results across the board with all cancers, all stages, all performance levels with the centers of our country, and I can't do it. Everyone has a somewhat different data set. The comprehensive centers have one, the American College of Surgeons has another, the World Health Organization has another, and so on.

"I'm paranoid enough to believe somebody doesn't want to compare results. Every time I ask at NCI, the American Cancer Society, or whoever, I'm told, 'Oh, it can't be done.' I say, 'Hogwash!' Congress could solve this problem with the stroke of a pen. Language could be introduced into the Act to make a common data base a prerequisite for institutional receipt of any NCI monies."

"What I've said may all sound negative," Dugan said, "and I don't want to leave that impression. A number of important changes have occurred and are occurring. We now have a community doctor on the National Cancer Advisory Board. We probably ought to have another one. More communities are participating in clinical research programs. And more community physicians are participating in the NCI machinery at all levels. This increases dialogue and will help all of us work together better."

NCI Director Vincent DeVita, testifying earlier, hit upon what is developing as the major point of contention between his view of cancer control and that of community representatives—that in his opinion the major emphasis in cancer control should be on clinical trials.

"The very fact of entering patients into research studies, although at times anxiety provoking for cancer patients, provides instant feedback to community physicians from our research centers because the practicing doctor becomes immediately aware of treatments being developed in the research setting," DeVita said. "This in my view is the true definition of cancer control."

DeVita said that "in spite of the substantial national improvements in survival rates for many types of cancer, we have yet to develop a completely satisfactory approach for linking care at the community level to the research institute where new treatments are developed. Closing the feedback loop between the practicing community and NCI's research effort is our most serious operational problem as we enter

the 1980s.

"The application and transfer of new treatments outside of the research environment is a double edged sword," DeVita continued. "As more physicians are trained in medical oncology, more patients are treated in the community, mortality rates fall, but fewer enter new research studies to improve results of current treatments.

"Though I don't have a complete solution yet to this problem of technology transfer, we are taking these steps to reorient existing programs:

"—We are expanding the Community Hospital Oncology Program to assure support for community centers, asking in return that they participate in clinical research.

"—We are creating a new version of the Clinical Cooperative Groups to emphasize geographic relationships of centers with their surrounding communities.

"—We plan to assure that cancer centers' outreach programs complement activities of the cooperative groups and community centers.

"This is a difficult area. Financial and institutional barriers stand in the way. A final solution to this problem will probably depend on working out appropriate roles for both government and the private sector in delivering health care to cancer patients."

DeVita commented to reporters after the hearing that, on the need for a common data base, "I agree, but I don't know anyone willing to give up his own. If you want government to order the acceptance of a data base, that is a very serious thing to do."

Harold Amos, who is a member of both the National Cancer Advisory Board and the President's Cancer Panel, took a different view on what NCI's role should be regarding cancer control.

"The questions of technology transfer from laboratory to clinical and from center to community hospital and private practice are currently assumed to be the responsibility of NCI by much of the concerned public," Amos said. "That view should and must be challenged as a threat to divert NCI from the one thing it was created to do and can do admirably, namely conduct and develop programs in research into the etiology, diagnosis, prevention, and treatment of cancer. In that role its resources are already overtaxed. The establishment of its most significant advances as clinical practice throughout the land, admittedly of utmost importance, must be the task of some other network already in place."

Hawkins insisted that the Cancer Act "assumed technology transfer to be a responsibility of NCI. You say that must be the task of some other network. Who would that be?"

"What I am talking about in technology transfer is high level, high quality treatment and diagnosis and its dissemination to medical practice throughout the land," Amos said. "Even the most liberal interpretation of the Cancer Act does not mandate that dissemination to NCI, but only the demonstration."

Hawkins responded that communication with the help of computers is cheap and easily available. "We are missing the opportunity of taking a giant step in taking advantage of the latest technology to disseminate the latest technology over telephone lines to physicians and small community hospitals," she said.

"Perhaps I haven't put it well," Amos said. "I would like to see the Cancer Institute take a catalytic role. The distinction is between a catalytic role and the actual dissemination."

Contract Awards

ROANOKE MEMORIAL ADDED TO CHOP

Roanoke Memorial Hospital in Virginia has been awarded a Community Hospital Oncology Program planning contract for $111,713 by NCI. That brings the number of CHOP awards announced so far to 21, with two remaining.

The Roanoke award was for 16 months, through Aug. 15, 1982. Most of the CHOP planning awards were for 18 months, with another two years of implementation to follow if the planning is successfully completed.

Other NCI contract awards include:

Title: Operation of an animal diagnostic laboratory
Contractor: Univ. of Missouri, $717,027.

Title: Incorporation of one additional alteration/-renovation/maintenance/upgrading project necessary to support the research program at Frederick Cancer Research Center; modification
Contractor: Litton Bionetics, $522,190.

CONSTRUCTION GETS EXTRA $1 MILLION, NCAB APPROVES FUNDING OF SIX GRANTS

NCI's construction grant program, after a long decline that saw it drop from $44 million in 1972 to $1 million originally budgeted for the 1981 fiscal year, may have turned the corner before it disappeared altogether.

A windfall of nearly $1 million became available when bids for renovation projects at Frederick Cancer Research Center came in substantially lower than had been anticipated. Director Vincent DeVita decided to put the savings into construction grants, doubling the amount budgeted in that category for 1981.

The National Cancer Advisory Board promptly distributed it all last week in approving six grants, as follows:

- Northwestern Univ., $318,000 for biohazard containment, Nathaniel Berlin, principal investigator.
- Univ. of Washington, $558,503, radiation biology, Janet Rosey, PI.
- Univ. of Rochester, $315,560, radiation therapy, Robert Cooper, PI.

• Columbia Univ., $426,938, outpatient clinical research, Sol Spiegelman, PI.

• Univ. of Arizona, $32,918, medicinal chemistry, Jack Cole, PI.

• Cal Tech, $374,530, tumor biology and immunology, Lee Hood, PI.

The Board also approved at a fundable priority score a $2,454,000 grant for radiation biology research facilities at Stanford Univ., with Robert Kallman the principal investigator. DeVita intends to ask the House and Senate Appropriations Committees for permission to reprogram enough money from other areas of the budget to fund the Stanford grant this year.

It was not necessary to obtain congressional approval to transfer the FCRC savings to construction grants, since that money had been included in the 1981 appropriations for construction, under contracts.

The NCAB action clears up the existing backlog of approved, fundable construction grants. NCI is actively encouraging institutions with construction needs to develop applications for 1982 grants. The deadline for applications for FY 1982 funding is Oct. 1, 1981.

Donald Fox, chief of NCI's Research Facilities Branch, told the NCAB that the downward spiral in construction funding had led to a decline in expectations and in the number of applications submitted.

More than two years ago, the NCAB voted to put $20 million a year for at least five years into construction grants, but HHS and the Office of Management & Budget would not go along. Congress did not add anything to the White House budget requests of $10 million in 1980 and $1 million in 1981.

The White House request was also $1 million for 1982 despite the bypass budget figure of $20 million. Congress may be more in a mood to beef up construction funds this year, however, considering Sen. Harrison Schmitt's interest. The chairman of the Labor-HHS Appropriations Subcommittee has indicated he feels research facilities construction should not be downgraded.

Fox reminded the Board of the survey NCI conducted which found that current and five year projected needs would require NCI support of about $150 million for clinical and standard research labs, animal facilities, and bio/chemo hazard containment.

Developments that create a need for facilities support include new research, new technology, and new risks, Fox said. New research includes both developing and expansion of existing programs; new technology includes such developments as neutron therapy, chemoprevention, and computerized axial tomography; and new risks include recombinant DNA, genetic engineering, and viral research.

Although the survey is more than two years old, there has been "precious little progress in meeting any of those needs," Fox said. "We do have a defined, quantitative need for construction support."

Harold Amos, member of the Board and the President's Cancer Panel, commented that NCI funding has been "catalytic" in construction funding. Grantees are required to match NCI funds, and in most cases exceed those amounts. "It is important to have a grant around which an institution can organize a drive for a construction project. We need to develop a more seductive approach to construction funding."

"I'm open to ideas on how to be more seductive," DeVita said.

Board Chairman Henry Pitot noted that bio and chemo hazard regulations "can lead to an institution's being shut down. We tried to anticipate that two years ago, but it didn't get through to anyone beyond NCI."

DeVita said "there has been some misinformation afoot, that (amounts for construction in the President's budget) was all NCI wanted. We were limited by the department."

Board member Morris Schrier suggested that a case be presented to Congress for a special appropriation for construction. "If we can't get it, then we should structure the budget so that we will have the money available."

Board member Gale Katterhagen said he "totally" agrees with the need "but I suggest that we may have painted ourselves into a corner by creating too many centers."

Board member William Powers, saying he was playing the devil's advocate, commented, "If we have a lot of people not doing research because of underfunding of grants, we must have facilities that are not being used. That's OMB's argument."

"I don't believe there are facilities not being used," DeVita said.

Denis Prager, ex officio Board member representing the White House Office of Science & Technology Policy, said the construction need survey was based on "self reporting and thus is not impressive."

DeVita agreed that although the survey may be accurate it may not be impressive and suggested that an independent survey might be more so.

Amos commented that at least in one respect, self reporting may have understated the need. "One of the problems we found with the survey of animal facilities was that at some places theywere in such bad shape and so far from meeting the standards, they didn't want anyone to know."

DENNY HAMMOND RESIGNS AS DIRECTOR OF USC COMPREHENSIVE CANCER CENTER

G. Denman Hammond has resigned effective Aug. 5 as director of the Univ. of Southern California/Los Angeles County Comprehensive Cancer Center. He will assume the position of associate dean of the USC School of Medicine with responsibility for mid- and

long-range planning and will continue as chairman of the Childrens Cancer Study Group.

Hammond has been director of the center since it was organized 10 years ago. He said a search committee will be formed to recruit a new director "as soon as possible." A new building to house the center's clinical and basic research facilities is due to be completed by the summer of 1982 and will be opened no later than the fall of that year.

Hammond told ***The Cancer Letter*** that "I never intended to stay in this job forever. . . . I believe my forte is in planning, building, and developing," and that the center has reached the point where the director is more involved in administrative details than in development.

Another factor in making the change, Hammond said, is that it will permit him to double the amount of time he spends working with the CCSG. "I am very committed to the group and enormously proud of what it has accomplished. I believe it is one of the best clinical treatment cooperative groups in the world. Its members are extremely talented, and are the cream of pediatric oncologists, surgeons, radiotherapists, and immunologists."

The group 12 years ago was following only 400 patients, now follows over 6,000. The group with its staff of 29 will continue to be headquartered at USC, with the chairman's office, administrative and statistical offices there.

Hammond said a growing disagreement with university officials did not precipitate his decision to resign the directorship, but admitted it was a major factor. "There has not been agreement with my views on the direction of our clinical programs. The job has changed a lot. For eight years, most of the decisions were made in my office. During the last couple of years, they were made elsewhere. . . . I'm not leaving the job in a huff. I do have some strong disagreements with some people and will continue to do so." He will continue an association with the cancer center as a senior advisor, Hammond said.

NCAB APPROVES CONCEPTS OF FOUR OD CONTRACTS, STILL ARGUES OVER "CONCEPT"

Although some members of the National Cancer Advisory Board are having as much difficulty understanding the concept of "concept review" as have Boards of Scientific Counselors of NCI's divisions, they nevertheless approved the concept of four contract supported projects in the Office of the Director.

The Boards of Scientific Counselors do most of the concept review, but the several contracts originating in the director's office do not come under the purview of any Board. Director Vincent DeVita decided that they should be the NCAB's responsibility. An NCAB subcommittee chaired by Robert Hickey was appointed to hear staff proposals for new or recompeting contract programs and to make recommendations to the full Board.

Largest of the four concepts recommended for approval by the subcommittee, and subsequently approved by the Board, was the $1 million a year contract for support of the Office of Cancer Communications. That contract has been held by the Washington D.C. firm of Porter, Novelli & Associates. It will be recompeted for an award of three years, projected at $900,000 for FY 1982 and $1 million each for the 1983 and 1984 fiscal years. The firm received $938,000 in 1979, $1.22 million in 1980 and an estimated total of $824,000 in 1981.

OCC Director Paul Van Nevel said there is a possibility that the support contract will be considered for a small business set aside and that that might preclude Porter, Novelli from competing for it.

The contractor provides technical services to assist OCC in carrying out its mandate to disseminate cancer information and to improve communications approaches and techniques for motivating both health professionals and the public. Objectives of those programs are to decrease exposure of individuals and groups to carcinogens; increase use of early detection techniques; and promote the use of improved diagnostic, treatment, and rehabilitation programs.

Robert Denniston, chief of OCC's Information Projects Branch, described the program and presented the justification for it:

"While OCC provides a variety of information services directly to the public, including answers to public inquiries, press calls, and the development of fact sheets, pamphlets, press advisories and news releases, new approaches are required to meet the increased need for specific information programs. OCC can best work toward these objectives by reaching out to the public and to individual health professionals through intermediary or 'access' groups. This means that OCC normally cooperates in the development of cancer information programs with those intermediaries that can effectively, efficiently, and directly address the public, patients, and health professionals. Such intermediaries are those institutions, organizations, and associations which already have established channels of communications to large numbers of people, especially those at highest risk to cancer and those desiring such information. This approach enhances the program's credibility and multiplies the impact of the limited government resources available (Denniston called it "leveraging" OCC dollars).

"The contractor will provide technical support to help develop and implement this intermediaries program. In addition, the contract will also help support the exhibits program; a collection of health communications research studies; design and graphics services; special information campaigns; research and evaluation projects; meetings and conferences; implementation of the Health Message Testing Service;

evaluation program support; the development and maintenance of mailing lists; and support of communication activities of the NCI divisions."

Board member William Powers objected to the geographic limitation which will be in the RFP, requiring that the contractor's office be located within 50 miles of the Bethesda campus. "There are other organizations elsewhere looking for jobs like this, and fully qualified for it."

Van Nevel pointed out that close interaction with OCC staff was necessary, but agreed that distant firms could qualify by demonstrating their willingness to establish a local office.

Board member Janet Rowley suggested that cancer control money should fund the contract, and Denniston responded that it does to a large extent. In fact, cancer control money, plus some from the department, accounted for $700,000 in 1979, $760,000 in 1980, and so far all the 1981 estimate of nearly $824,000.

Board member Rose Kushner complained because OCC has no professional education program. Gale Katterhagen disagreed. "We don't need to add NCI to the long list of organizations sending out file 13 material," he said.

DeVita asked what OCC would do without the contract. "We would shut down," Van Nevel answered. OCC responds to about 235,000 inquiries a year.

The subcommittee approved two new projects for noncompetitive (sole source) contracts, both interagency agreements with the Brookhaven National Laboratory, which is operated by the Dept. of Energy. The Low Level Radiation Branch, which eventually will be transferred to a program division, asked for approval to support the projects which will be conducted by Brookhaven.

One will total $968,000 over four years to study genetic effects of ionizing radiation of different linear energy transfers. The cells to be studied will be those of the stamen hairs of the tradescantia plant. "These experiments should give a firm experimental and theoretical base to the effects of low levels of environmental hazards in producing genetic, and presumably carcinogenic, effects in higher eukaryotic systems," the justification statement said. Oddvar Nygaard, chief of the branch, described the program to the subcommittee.

The other, which will total $635,000 over three years, will study the leukemic effects on mice of a variety of radiation doses and dose rates. James Murray made the presentation to the subcommittee.

The subcommittee went along with recompetition of the Financial Management Branch's contract for support in the planning, formulation, presentation and execution of NCI's budget. This contract, presently held by JRB Associates, will cost $645,000 over three years. The RFP has already been released, and in fact the deadline for proposals was scheduled for May 26. Branch Chief John Hartinger described the program.

"If you don't approve this one, I'll jump out the window," DeVita cracked.

When Hickey presented the recommendations to the full Board, it became obvious that some members remain confused over concept review.

"I think this is dangerous," Harold Amos said. "We are compromising ourselves. We advise on overall policy of the Institute, and now we are being asked to implement that policy with contracts."

"I don't see it as a conflict," DeVita said.

"I don't feel uncomfortable with this," Hickey said. "We only approved the principle. These now will go to competitive bidding and merit review," pointing out that the NCAB will not be involved in the selection of the contractor.

DeVita pointed out that the NCAB did a concept review on recompetition of the Frederick Cancer Research Center last year, although the term "concept review" was not used. The Board also in past years has approved the concept, again without calling it that, of such major contract supported efforts as the Viral Oncology Program and the Community Based Cancer Control Program.

LaSalle Leffall asked whether disapproval of a concept would kill a proposed contract program, and DeVita assured him it would. "That's more than an advisory role," Leffall said.

Morris Schrier disagreed. "The responsibility for going ahead or not is the director's," he insisted.

"I never once as director of the Div. of Cancer Treatment overruled a concept decision by our Board," DeVita said. "If we can't explain it well enough to get it approved, something is wrong with it. We once overruled a merit review decision, because we felt the merit review committee got into the concept, and the concept had been approved by the Board of Scientific Counselors."

Amos insisted the Board's FCRC review was not concept review. "We were asked to approve a specific proposal by the director," he said. "Concept review should allow us to generate ideas."

"No, never," DeVita said. "We will always present the proposal from staff at the conceptual level. How we get there involves many different ways—workshops, staff discussions, discussions and suggestions by others. It would be a conflict if you generated the proposal (and then reviewed the concept)."

Hickey suggested that, to avoid the conflict seen by Amos, the concept review subcommittee "could disassociate ourselves from the NCAB and reconstitute ourselves as a separate group."

"That would be devious and a subterfuge," Amos said.

The vote to approve the OD concepts was not unanimous, with Leffall voting no and Amos abstaining.

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR JUNE, JULY, FUTURE

Large Bowel Cancer Review Committee—June 1-2, O'Hare Holiday Inn, Chicago. Open June 1, 1:30—5 p.m.; June 2, 8—8:30 a.m.

Assn. Francaise pour l'Etude du Cancer—June 1, Paris. Annual meeting. Federation Nationale des Centres de Lutte contre le Cancer, 101 rue de Tolbiac, 75654 Paris.

Summer Program in Methods of Immunologic Research & Diagnosis—June 1-13, Buffalo. Contact Dr. James Mohn, Director, Ernest Witebsky Center for Immunology, SUNY (Buffalo) Rm 210 Sherman Hall, Buffalo, N.Y. 14214, phone 716-831-2901.

Div. of Resources, Centers & Community Activities Board of Scientific Counselors—June 4-5, NIH Bldg 31 Rm 8, 8:30 a.m. both days, open.

Pancreatic Cancer Review Committee—June 4-5, New Orleans Tidewater Place. Open June 4, 8:30 p.m.—10 p.m.; June 5, 8 a.m.—adjournment.

Associazione Italiana di Oncologia Medica—June 4-6, Turin. S. Monfardini, Associazione, Via Venezian 1, 20133 Milan.

Progress in the Management of Upper Gastrointestinal Cancer—June 6, Roswell Park continuing education in oncology.

Congress of European Nuclear Medicine Society and World Federation of Nuclear Medicine and Biology—June 7-13, Pisa. Nuclear medicine in diseases of the breast and lungs. P. Rigo, Institut de Medecine, 66, bd de la Constitution, 4000 Liege, Belgium.

Cancer Control Grant Review Committee—June 8-9, NIH Bldg 31 Rm 7, open June 8, 8:30—9 a.m.

New York Academy of Sciences Conference on Aging—June 8-11, New York. Contact Renee Wilkerson, Conference Asst., NYAS, 2 E. 63rd St., New York 10021.

Gordon Conference on Mammary Gland Biology—June 8-12, New London, N.H. Contact Dr. D. Jane Taylor, Chief, Breast Cancer Program, DCBD, NCI, Rm 4A22 Landow Bldg., Bethesda, Md. 20205, phone 301-496-6718.

National Toxicology Program Conference on Phthalates—June 9-11, HHS Main Auditorium, 330 Independence Ave. S.W., Washington D.C., 8:30 a.m.—5 p.m. Registration requested: Winona Herrell, NTP, Bldg 31 Rm 2B-55, NIH, Bethesda 20205.

Bladder Cancer Review Committee—June 10-11, Hershey Lodge & Convention Center, Hershey, Pa. Open June 10, 1—1:30 p.m.

Div. of Cancer Treatment Board of Scientific Counselors—June 11-12, Chevy Chase Holiday Inn, 5220 Wisconsin Ave. Open June 11, 8:30 a.m.—4 p.m.; June 12, 8:30 a.m.—adjournment.

President's Cancer Panel—June 12, Chevy Chase Holiday Inn, 8:30 a.m., meeting jointly with the DCT Board of Scientific Counselors.

Therapeutic Advances in Solid Tumor Oncology—June 12, Univ. of Alabama (Birmingham). One program for physicians, another for nurses. Contact Dr. John Durant, 205-934-5077.

Endocrine Society 63rd Annual Meeting—June 17-19, Cincinnati. Contact Endocrine Society, 428 E. Preston St., Baltimore 21202, phone 301-528-4259.

Assn. of American Cancer Institutes—June 21-23, Duke Univ. Comprehensive Cancer Center, semiannual meeting.

Conference on Biostatistics in Clinical Oncology—June 21-26, New York. Contact Valerie Miké, PhD, Biostatistics Laboratory, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., New York 10021.

National Toxicology Program Board of Scientific Counselors Technical Reports Peer Review Panel—June 23, NIEHS, Research Triangle Park, N.C., Bldg 10, 9 a.m.

FDA Oncologic Drugs Advisory Committee—June 25, Parklawn Bldg., Conference Rm. M, Rockville, Md., 9 a.m.

Parents, Patients & Professionals: Expanding Horizons Together—June 26-28, The Candlelighters Foundation 1981 Conference. Washington Univ., St. Louis. Write to Candlelighters St. Louis Chapter, Box 451, Wentzville, Mo. 63385, or phone conference coordinator, Cheryl Moellenhoff, 314-625-3052 after 6 p.m. central time.

Breast Cancer Task Force Workshop on Monoclonal Antibodies & Breast Cancer—June 29-30, Bethesda Holiday Inn, Versailles Rm., 8:30 a.m. both days. Contact Amey Rulon-Miller, CSR Inc., 805 15th St. N.W. Suite 500, Washington D.C. 20005.

Cancer Special Programs Advisory Committee—July 13-14, Bethesda Marriott. Open July 13, 9—10 a.m.

Conference on Gastrointestinal Cancer—July 13-17, Brisbane. Pathology, early diagnosis, management of carcinoma of stomach and large bowel. Contact N. Davis, c/o Colorectal Project, Princess Alexandra Hospital, Brisbane 04102, Australia.

12th International Congress of Chemotherapy—July 19-24, Florence. Contact Organizing & Scientific Secretariat, 12th International Congress of Chemotherapy, Via della Scala, 10, 50123 Florence, Italy.

Gynecologic Oncology Group—July 23-25, Sheraton West Hotel, Indianapolis, business meeting.

Biometry & Epidemiology Contract Review Committee—July 30-31, NIH Bldg 31 Rm 9, open July 31, 9—9:30 a.m.

Cancer Center Support Grant Review Committee—July 30-Aug. 1, NIH Bldg 31 Rm 6, open July30, 8:30—10 a.m.

FUTURE MEETINGS

Current Issues in Pediatric Oncology: Legal & Ethical Aspects of Treatment for the Child or Adolescent with Cancer—Oct. 29-30, Hyatt on Union Square, San Francisco. Sponsored by the Assn. of Pediatric Oncology Nurses. Contact Margaret Stewart, National Program Chairman, Illinois Cancer Council, 36 S. Wabash Ave., Suite 700, Chicago 60603.

UICC Conference on Clinical Oncology—Oct. 29-31, Lausanne. Open to all physicians as a forum for presentation of original research in all clinical aspects of multidisciplinary treatment of cancer patients. Held jointly with the 7th annual meeting of the European Society of Medical Oncology and hosted by the Swiss Cancer Leauge, with the European Organization for Research on Treatment of Cancer. Contact UICC Conference, Secretary General, PO Box 248, 1000 Lausanne 6, Switzerland.

Current Concepts on Cancer Management: Successful Treatment & Its Consequences—Nov. 13-14, Fairmont Hotel, San Francisco. Postgraduate symposium sponsored by the Claire Zellerbach Saroni Tumor Institute of Mount Zion Hospital & Medical Center. Contact that institution, PO Box 7921, San Francisco 94120, phone 415-567-6600, ext. 2125.

23rd Postgraduate Institute for Pathologists in Clinical Cytopathology—March 22-April 2, 1982. Johns Hopkins Univ. School of Medicine & Hospital, Baltimore. Intensive refresher for certified (or qualified) pathologists. Apply before Jan. 27, 1982, to John Frost, M.D., 610 Pathology Bldg., Johns Hopkins Hospital, Baltimore 21205.

The Cancer Letter _Editor Jerry D. Boyd

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