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NCI Considers 'Decentralization' Of Group C To Provide Wider Access, Local Flexibility

NCI is tentatively considering "decentralizing" the Group C mechanism to allow some cancer centers to distribute selected investigational drugs, NCI Director Samuel Broder said last week. "We are exploring the possi-

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In Brief

Broder Invokes Cancer Act Provision To Inform Hammer, Bush Of Potential Damage Of 32% Cut

NCI DIRECTOR Samuel Broder invoked a provision of the National Cancer Act to formally notify the President's Cancer Panel of the damaging effect that a 31.9 percent budget sequestration would have on the National Cancer Program. With a massive deficit looming, the Gramm-Rudman-Hollings automatic sequestration would be triggered if Congress and the President do not agree on a package of spending cuts and tax increases. **Armand Hammer,** chairman of the President's Cancer Panel, conveyed the concerns to President Bush when he, Broder and HHS Secretary Louis Sullivan visited the Oval Office on Aug. 15 to transmit a copy of the Lasagna Committee's report. "It was a very important symbol for the President to meet with us, since it was in the middle of the Iraq crisis," Broder said. . . . **ADD PITTSBURGH** Cancer Institute to the growing list of comprehensive cancer centers. PCI, where former NCI scientist Ronald Heberman is the director, received its comprehensive designation last month following administrative review by the NCI Executive Committee and Joseph Simone and John Durant, chairmen respectively of the Cancer Center Support Grant Review Committee and the National Cancer Advisory Board Centers Committee. That brings to 24 the number of centers recognized as comprehensive by NCI, with more to come. PCI received its first core grant from NCI about two years ago. . . . **JOHN FROST**, director of the Div. of Cytopathology at Johns Hopkins Medical Institutions from 1959-1989, died of cancer Aug. 29 at Johns Hopkins Hospital. He was 68. Frost directed the Postgraduate Institute for Pathologists in Clinical Cytopathology for more than 30 years. . . . **DEWITT STETTEN**, retired NIH deputy director and former director of the National Institute of General Medical Sciences, died Aug. 28 of congestive heart failure. He was 81. . . . **EDWARD SONDIK** has been officially appointed deputy director of NCI's Div. of Cancer Prevention & Control. He has been acting deputy to Peter Greenwald since Joseph Cullen left last year to head the AMC Cancer Research Center. Sondik had been DCPC associate director and director of the division's Surveillance Program.

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NCI Considering 'Decentralization' Of Group C; Lasagna Report Praised

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bility of, at least for some Group C drugs, decentralizing Group C. The idea would be to let certain cancer centers, possibly some comprehensive cancer centers, serve in a distribution system for Group C drugs," Broder told **The Cancer Letter.**

Allowing cancer centers to distribute Group C drugs which currently have to be obtained directly from NCI might serve to make some investigational drugs more accessible to physicians and their patients. "It would provide more flexibility and more local options," Broder said.

Broder stressed that the idea is only in the discussion stages, "and we reserve the right to retract this statement." He said he is seeking advice from investigators and others about the feasibility of this approach.

Broder's comments came on the heels of a report released by the National Committee to Review Current Procedures for Approval of New Drugs for Cancer and AIDS, which advocated expedited approval of and wider access to investigational drugs for patients with life-threatening diseases.

The committee, otherwise known as the Lasagna Committee, after its chairman, Louis Lasagna of Tufts Univ., submitted its report last month to Armand Hammer, chairman of the President's Cancer Panel. Hammer, Broder and HHS Secretary Louis Sullivan presented the report to President Bush in the Oval Office on Aug. 15. Bush, while still Vice President, had asked the Cancer Panel to investigate the drug approval process. Bush served as chairman of the Presidential Task Force on Regulatory Relief.

The committee's recommendations will not come as a surprise to anyone who attended its 10 hearings between January 1989 and last April. In its meetings, committee members agreed that still unapproved therapies may represent the only hope for patients with advanced cancer and AIDS, and noted that patients are willing to accept greater risks associated with new therapies. The committee consistently encouraged more flexibility in the drug approval process and at times criticized previous FDA decisions.

However, the report acknowledged that a major problem has diminished since the committee's inception--NCI and FDA no longer have the contentious relationship they had in the past. Broder also pointed out that fact.

"I think the spirit of many of the committee's recommendations have already been implemented over the last year and a half," Broder said. "We have working meetings with FDA every month. We make every effort we can to resolve issues. We've seen some real changes. The Lasagna Committee served a very important role as a catalyst." It was as a result of a Lasagna Committee meeting that NCI and FDA created a joint program to train future FDA regulators in clinical trials and future NCI investigators in regulatory issues, he said.

The report outlined steps that FDA, NCI, and the National Institute of Allergy & Infectious Diseases could take to speed testing and approval of new drugs. Following are the 20 recommendations, with excerpts from the report:

▸**A permanent policy and oversight committee,** appointed by and reporting to the Secretary of Health and Human Services, should be established to monitor FDA needs and performance with regard to the regulation of drugs and biologics for human use.

▸**The need for more and better drugs for cancer and AIDS.** A national policy should be adopted to foster the development of new drugs for AIDS and cancer in order to meet the needs of all patients who suffer from these diseases. The remarkable advances in drug development and in molecular and tumor biology will inevitably make available candidate molecules for the treatment of these ailments.

▸**Expediting approval of important new drugs.** FDA has the legal authority to approve, and in fact has approved, new drugs on the basis of one scientifically valid study, and on the basis of phase 1 and phase 2 clinical studies without the need for a phase 3 clinical study. The committee agrees with FDA that, particularly in the area of drugs for AIDS and cancer, this statutory and administrative flexibility should increasingly be used to approve drugs for marketing at the earliest possible point in their development,

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and commends the agency for its leadership in early approval of important new AIDS drugs. By relying more heavily on the opinion of the qualified experts who serve on the agency advisory committees, FDA should approve new drugs for cancer as well as AIDS earlier than has been true in the past.

▸The FDA standard for effectiveness of new drugs. Because of its special relevance to issues faced today in developing new drugs for cancer and AIDS, the FDA needs to pay particular attention to the congressional intent in requiring substantial evidence of effectiveness prior to approval of a new drug application, as described in the Senate Report on the Drugs Amendments of 1962:

"The term 'substantial evidence' is used to require that the therapeutic claims for new drugs be supported by reliable pharmacological and clinical studies. When a drug has been adequately tested by qualified experts and has been found to have the effect claimed for it, this claim should be permitted even though there may be preponderant evidence to the contrary based on equally reliable studies. There may also be a situation in which a new drug has been studies and its effectiveness established only to the satisfaction of a few investigators qualified to use it. There may be many physicians who would deny the effectiveness simply on the basis of a disbelief growing out of their past experience with other drugs or with the diseases involved. Again, the studies may show that the drug will help a substantial percentage of the patients in a given disease condition but will not be effective in other cases. What the [Senate] committee intends is to permit the claim for this new drug to be made to the medical profession with a proper explanation of the basis on which it rests. In such a delicate area of medicine, the committee wants to make sure that safe new drugs become available for use by the medical profession so long as they are supported as to effectiveness by a responsible body of opinion and scientific fact."

By applying these principles, patients suffering from AIDS and cancer will have available to them new drugs for the treatment of their disease at the earliest stage at which there is responsible scientific evidence to justify marketing.

The [Lasagna] committee recognizes that, by making new drugs available for marketing at this early stage, when there is substantial evidence but not yet definitive evidence of effectiveness, there is an attendant greater risk of serious adverse reactions that have not yet been discovered. Cancer and AIDS patients have made it clear to the committee, however, that in light of the seriousness of the diseases involved, they are willing to accept this greater risk. Earlier approval of new drugs will mean that the patient will bear greater responsibility, along with the physician, for understanding and accepting the risks involved.

▸Surrogate endpoints in clinical trials. The committee applauds the willingness of FDA to be flexible with regard to appropriate treatment endpoints in clinical trials and believe that the contract between FDA and the Infectious Diseases Society of America to review endpoint disagreements in the field of antibiotics may provide a prototype for similar future arrangements in other disease areas. The committee sees need, however, for three additional developments:

1. Research by industry, academia and NIH--specifically NCI and NIAID--is needed on the correlative data on surrogate and ultimate endpoints required to justify the use of such surrogates.

2. FDA, NCI and NIAID, perhaps with the advice of appropriate advisory committees, should continue their work to reach agreement on general principles on surrogate endpoints and to respond to specific needs regarding surrogate endpoints as they arise with regard to a new drug for AIDS or for cancer or a given cancer type.

3. More attention needs to be given to the use of subjective and objective quality of life assessments that can serve per se as a basis for regulatory approval of new drugs.

Phase 3 cancer studies often address comparative activity of a marketed drug and an investigational drug. This makes possible randomized clinical trials in which an active control is used and therefore no placebo group is required. Since effectiveness but not superiority is required for NDA approval, equality between the two drugs demonstrates sufficient effectiveness for marketing approval. **Effectiveness, not comparative efficacy, should be the basis for approval or disapproval of a drug.** Since phase 2 studies determine efficacy and phase 3 studies comparative efficacy, such phase 3 studies should not be required during the pre-NDA period.

Since survival differences for many slow growing tumors such as ovary, breast, colon and other common tumors may take years to demonstrate, survival is in general an impractical and unethical endpoint for cancer drugs. Of the anticancer agents currently on the market, very few have been shown independently to affect survival. Most of these agents are capable of producing tumor regression in certain diseases. When such agents are used in combination for selected tumors, a major improvement in survival and cure has occurred. It is only after initial NDA

approval of the drug as a single entity that its full potential is realized, because physicians are then free to use it in combination with other drugs in accordance with their best clinical judgement. While still under investigation, such combination uses occur only infrequently and with little opportunity for full clinical exploration. For all of these reasons, large phase 3 studies have been and should continue to be conducted in the postapproval setting.

Drugs that produce, in phase 2 studies, a significant rate of tumor regression (in excess of 20-30 percent) should be approved. This approach is supported by FDA statistics which indicate that over 90 percent of agents found to be active on the basis of phase 2 studies were confirmed to be active in follow-up phase 3 studies. Thus phase 3 studies, which represent a major effort and delay, have not contributed significantly to NDA approval prospects. Historically, it is in the period after regulatory approval that the ultimate utility of anticancer drugs (either alone or in combination) is delineated.

The development of AIDS drugs could be facilitated by approving drugs that are shown to have an unequivocal beneficial effect on an accepted surrogate marker (e.g., CD4 cells) as well as improvement in the quality of life (e.g., improved functioning, weight gain, decreased incidence of opportunistic infections) in controlled clinical trials. Proof of prolongation of life need not be a requisite for FDA approval.

▸**Community based clinical trials.** The committee urges that groups that advocate or conduct early clinical investigation with drug candidates for AIDS and cancer do so through mechanisms that will generate useful data for clinical, scientific and regulatory purposes. We endorse the development of community based trials that permit widespread access to investigational drugs without sacrificing statistical analysis of drug effectiveness and thus that can lead to early regulatory approval.

▸**The relationship between FDA and drug sponsors.** Sponsors of new drugs have a responsibility to expedite regulatory approval by planning, executing and analyzing clinical trials and by preparing NDAs in an efficient and competent manner. FDA properly points out that poorly planned and executed clinical trials, and inadequately prepared NDAs, can be a major factor in delaying the approval of important new drugs.

FDA is criticized if it fails to provide helpful guidance to drug sponsors, resulting in clinical trials that are inadequate to justify approval of the drug, or if it gives too much guidance, and thus is seen as "micromanaging" clinical trials that are properly the responsibility of the sponsor and the investigators. The committee recognizes that there is no perfect solution to this dilemma. FDA reviewers must be sensitive to the fact that even routine suggestions can be interpreted as rigid commands, and sponsors and investigators must recognize that FDA advice is intended to be helpful but that they bear full responsibility for the clinical trial that is to be undertaken. More open discussion, and involvement of advisory committees where appropriate, should lead to greater mutual respect and trust.

If the drug development and approval process is to proceed expeditiously, it is essential that there be free and open communication between FDA and drug sponsors at all times. The relationship between FDA reviewers and drugs sponsors must be informal, highly interactive and foster a spirit of mutual cooperation. An atmosphere of arms length formality will slow down the process, raise artificial barriers to drug development and approval, and seriously harm the public health. The development and approval of AIDS and cancer drugs depends upon helpful cooperation, not adversarial isolation.

Communications should most frequently be by telephone, fax and computer to provide current information, quick responses to important questions and a feeling of genuine partnership. The artificial barriers that have been erected through years of criticism on the part of both the regulators and the regulated have created a serious threat to rapid development and approval of new drugs, and can no longer be tolerated.

▸**Patient advocacy groups.** The committee commends FDA for its recent efforts to be responsive to the needs of patient advocacy groups. The growing importance of such groups advocating more rapid therapeutic trials and access to proposed remedies for AIDS and cancer represents both an opportunity and a threat. The opportunity resides in the ability of such groups to force government, academia, industry and FDA to increase the pace of drug development and approval. The threat resides in the possibility that too easy access to investigational drugs will lead to delays in recruitment of subjects for clinical trials and thus delay ultimate FDA approval and marketing.

FDA is properly charged with the responsibility for reconciling these different challenges by enhancing the opportunity for expedited drug approval and reducing the threat of impediments to clinical investigation, and we recommend that FDA continue its efforts in this area.

▸**FDA advisory committees.** FDA's technical advisory committee system for human prescription drugs is not

consistently performing the functions needed by the public. The committee recommends a fundamental restructuring of this system. The committees should have their own independent staff and should be appointed by, and report directly to, the Office of the FDA Commissioner. Recommendations for membership should be actively sought from professional societies, the Institute of Medicine, the pharmaceutical industry and the general public, as well as from FDA, and not solely by announcements in the "Federal Register," but also by active solicitation of nominations.

The tasks of these committees could include discussion of issues brought up by FDA, industry, the public or committee members themselves. The committees should meet more frequently than they do at present, at fixed intervals, and manage their own agenda. They should be involved at an early stage in the history of the evaluation of a drug in humans, at least to the extent of being available for advice. The committees should also monitor the progress of investigational new drugs (including any formal or informal "clinical holds" by FDA) and new drug applications, provide oversight for the priority ranking of drugs (and the need for change in ranking over time), serve as arbiters in disputes between sponsors and FDA, routinely vote on recommendations regarding approval for cancer and AIDS drugs, and conduct oversight on the implementation by FDA of committee recommendations. Uniform procedures should be in place for all such committees, including the adequate briefing of new members with regard to relevant statutes, regulations and the process of drug development.

▸**FDA, NCI and NIAID cooperation.** The joint efforts of FDA, NCI and NIAID in solving clinical endpoint and other drug development and approval problems are commended and should be continued.

▸**Cross membership in NCI, NIAID and FDA advisory committees.** To foster close relationships between the government agencies involved with AIDS and cancer drugs, NCI, NIAID and FDA should each have a permanent representative sitting as a voting member of the appropriate advisory committees in other agencies. Thus, an FDA employee would sit on the NCI and NIAID committees to inform them about the regulatory process, and NCI and NIAID employees would sit on appropriate FDA committees to inform them about critical drug development and clinical needs.

▸**IRB review of phase 1 clinical studies.** The cost, complexity and paperwork burdens of phase 1 clinical studies need to be reduced. Sponsors should have the right, as a voluntary alternative to the current system of submitting an IND to FDA, to obtain the approval of an institutional review board specifically constituted to provide the technical expertise (in such disciplines as pharmacology and toxicology) required to review the IND for safety consideration. Criteria for the appropriate expertise for members of such an IRB need to be delineated.

▸**IRB review of phase 1 and 2 noncommercial clinical research studies.** The many INDs for phase 1 or 2 studies filed with the agency by noncommercial academic investigators studying a possible new use for marketed drugs now consume a significant amount of FDA time and could also be handled, as a voluntary alternative, by IRB review without involving FDA. FDA has exempted some, but not all, academic research on marketed drugs, and should expand this exemption.

▸**Reduction of FDA clinical holds.** The committee is concerned about the large number of INDs currently experiencing either formal or informal "clinical holds" for reasons that have little to do with safety concerns. Formal clinical holds range from 10 to 15 percent of all INDs, and informal holds run higher. This practice inhibits clinical research and hinders drug development, and should be reduced to the minimum needed to assure human safety.

▸**The treatment IND.** The committee commends FDA for codifying the treatment IND in published regulations. The committee agrees with FDA that the regulations codifying this concept represent appropriate scientific and regulatory standards. Patient advocacy groups have complained, however, that the regulations are being interpreted too conservatively by FDA. They argue that, under the wording and intent of the regulations, a treatment IND should be permitted earlier in the drug development process. Consistent with their overall philosophy, they state that desperately ill patients are prepared to accept the greater risks inherent in treatment INDs that are approved at such an early stage, and argue that a treatment IND should not be reserved for use as a "bridge" to NDA approval after the drug has already been shown to be safe and effective. With one exception, treatment INDs have been approved by FDA relatively late in the drug development process.

The committee agrees that, with the exception of ddI, FDA has thus far implemented the new treatment IND process in a conservative manner. The committee recommends that FDA be more flexible, and permit the use of treatment INDs earlier in the process where alternative therapies are unavailable. Although this will clearly present greater risks to patients, because some of the drugs may eventually be found either to be ineffective or to present an unacceptable

benefit/risk ratio, patients with life-threatening diseases who have no alternative therapy are entitled to make this choice.

▸**The expanded access (parallel track) IND.** Because of continuing frustration with the conservative implementation of the treatment IND concept, patient advocacy groups have pushed for additional mechanisms to permit early access to investigations drugs for life-threatening diseases where no acceptable alternative exists.

Expanded access permits the use of an investigational drug as early as the end of phase 1 for all patients who cannot be accommodated in a clinical trial or a treatment IND, and for whom no alternative treatment exists. Thus, there is even less evidence of safety and effectiveness for a drug made available through an expanded access IND than there is for a drug that is approved for use in a treatment IND.

The committee recognizes the serious potential for abuse of this system. Expanded access should be permitted only where there is assurance that adequate clinical trials are in progress and will not be compromised. Once this assurance exists, however, the committee supports the rights of patients to obtain investigational drugs under these circumstances. Faced with the consequences of a lack of therapy for AIDS and cancer, an expanded mechanism for early access to investigational drugs in morally, ethically and scientifically justified.

▸**Outside review of NDAs.** Congress has placed many new responsibilities on FDA in the last decade, while the number of employees in the agency has decreased. Because in the short term no quick solution is apparent to these inadequate resources, we believe that ways to decrease the burdens on FDA should be identified.

One possibility is to expand on a concept long in place within the agency, i.e., paying outside experts to review sections of an NDA. With properly selected outside experts, this has worked well, and has allowed review to proceed more expeditiously. If the principle works for sections of an NDA, it should apply to an entire NDA. Sponsors should have, as a voluntary alternative to the present system, the option of paying FDA for outside review by qualified experts who have no conflict of interest, perhaps most easily supplied through an external contractor, with the expectation that review would be both competent and timely. Critique from such outside review would be forwarded to FDA for additional scrutiny and judgment, but not for total re-review, which would defeat the purpose of this mechanism.

▸**Supplemental NDAs for technical changes.** Most supplemental NDAs relate to changes in manufacturing and other technical modifications to an approved NDA. These consume a great deal of FDA resources to no great social purpose. The handling of changes in manufacturing and other technical supplemental NDAs should be expedited by imposing a mandatory 180 day review period for final approval unless the application is rejected for particular safety reasons. If FDA does not respond within 180 days with a detailed and specific reason why the change would result in a safety hazard, the supplemental NDA should be considered approved.

▸**Insurance coverage for investigational drugs and ancillary costs.** Insurance coverage of investigational drugs, and of marketed drugs prescribed for unlabeled indications, should rely primarily on their approval by expert government agencies for therapeutic use (such as the NCI approval of Group C cancer drugs and FDA approval of drugs under treatment INDs) or their status in authoritative medical compendia (such as the three that were intended for use under the Medicare Catastrophic Coverage Act of 1988). Usage approved by such expert authority is more valid as a basis for reimbursement than FDA approval of an NDA, since NDA approval may not as yet have been sought by the manufacturer, and in fact for some drugs or uses might never be sought. Coverage should be identical under Medicare, Medicaid and private insurance, whether they are paid for directly or under a prospective payment system, and should not vary from region to region or carrier to carrier.

Coverage should be automatic once the usage is approved in one of the compendia. Individual carriers should have no discretion with respect to such matters. This policy should apply equally to impatient services, outpatient drugs administered by a physician and self-administered prescription drugs if that benefit becomes effective. For indications or drugs that are approved by experts but have not yet found their way into authoritative compendia, an independent advisory committee may be needed to authorize reimbursement of unapproved drugs or unapproved uses.

The touchstone of drug coverage should be the medical judgement of the attending physician. We are here consonant with the decision of Weaver v. Reagan (8th Circuit 1989) that Missouri Medicaid could not lawfully deny coverage of AZT to AIDS patients because, even though the drug was still investigational and not yet approved by FDA, nonetheless it was determined to be medically necessary by the attending physician.

Accordingly, the court ordered Missouri Medicaid to pay for the use of AZT by any AIDS patients

"whose physicians have certified that AZT is medically necessary treatment."

Coverage for the hospital, physician and other medical care costs for patients involved in cancer and AIDS clinical trials should take cognizance of the fact the peer reviewed, scientifically sound trials provide state of the art treatment for patients desperately needing such treatment but for whom currently available drugs are ineffective. For such patients, scientifically meritorious investigational drug therapy is the best available treatment and together with ancillary medical care should be covered by all health insurance agencies.

▸**FDA resources.** FDA resources, building facilities and data processing capability are grossly inadequate for the important responsibilities for approval of new drugs delegated to FDA and deserve prompt attention by Congress.

Div. of Cancer Treatment Director Bruce Chabner, who attended many of the Lasagna committee meetings, praised the report for taking the same position he has held with regard to faster drug approval and surrogate endpoints. "It is a very positive step in encouraging changes in the way we approve drugs," Chabner said. "In general, if a drug shows activity, for those diseases for which there aren't standard therapies, the drug should be approved."

Chabner, too, noted that NCI's relationship with FDA has improved, but he said there are still some problems.

"We're now having problems with INDs for biologicals. It's a cumbersome process," he said. The committee's recommendation to allow institutional review boards to approve some INDs "would relieve FDA of the burden," but not all institutions would have the expertise to review INDs, Chabner said.

FDA should not take all the blame for problems in the drug approval process, Broder said. "The FDA we deal with today is not the same FDA as the mid-'70s or early '80s," he said.

"These are important recommendations and we need to look at them, but we have to realize there are a lot of things that FDA doesn't limit, that really don't involve the FDA. It's important not to blame the FDA as an agency, even if we have disagreements," he said. "Where we disagree, we should disagree, but we should not make their job more difficult."

Broder emphasized the need for flexibility in drug approval. "We have to go case by case. I think it's worthwhile to stress that there are occasions in which the oncology medical community itself does not achieve a consensus. There are times when FDA itself has very significant experts disagreeing and it is not always possible to achieve a consensus. In cases like that, we need to do whatever is necessary to mobilize our own thinking and come to the FDA with a consensus when possible."

However, Broder differed with the committee's recommendation that drugs in phase 2 studies that produce tumor regression in excess of 20 to 30 percent be approved.

"I have a slightly different point of view. It's not a good idea to put down a general target. You should have very, very broad guidelines, and you have to judge each on case by case basis. For a cancer which is otherwise untreatable, it might not take very many responses to demonstrate activity. There could be substantial regressions in even a small number of patients. I don't want to say 20 percent. We have to keep an open mind about it.

"I don't have any problem with taking 20 percent as a general rule of thumb, but it might be reducing a significant level of flexibility."

He noted that FDA "has shown a great deal of sympathy" with the need for surrogate endpoints.

Broder was cautious about the committee's recommendation on IRB approval of INDs. "This has to be looked at case by case. Some INDS might be appropriate for IRB approval, but some might be highly technical. Not all IRBs have the expertise.

"We've made a lot of progress in phase 1 studies. There has been close cooperation with FDA in getting phase 1 studies underway. When disagreements occur they are not usually over phase 1 studies."

Broder noted that NCI's Group C mechanism was the prototype for the AIDS expanded access program.

"It is critical for people who have life-threatening illnesses to have as rapid access to investigational therapies as possible," Broder said. "It is important for us never to say you can't have access to a potentially life-saving drug."

FDA Center for Drug Evaluation & Research Director Carl Peck said at a press briefing held to respond to the Lasagna Committee report that using outside experts to review NDAs for AIDS and cancer drugs might lengthen review times.

"I can assure you that review times would be expanded significantly," Peck said. FDA "can review AIDS and cancer drugs for a well-developed, persuasive NDA in a matter of a few months. That simply could not be done with an outside reviewer or an outside review group."

Peck maintained that reviewing an NDA, "which

comprises many volumes of data of many clinical trials, is well beyond the ordinary expertise of a practicing clinician and often of an academic scientist."

The committee's recommendation on changing the advisory committee system reflected the report's "significant misunderstandings," Peck said. "We are perplexed at the lack of understanding of the current practice of advisory committees that this recommendation presupposes."

He also said the recommendation on IRB review of INDs contradicts Bush Administration initiatives aimed at increasing interaction with FDA in phase 1.

Including Lasagna, members of the committee were Theodore Cooper, Upjohn Co.; Gertrude Elion, Burroughs Wellcome Co.; Emil Frei, Dana Farber Cancer Institute; Samuel Hellman, Pritzker School of Medicine, Univ. of Chicago; Peter Hutt, Covington & Burling; Charles Leighton, Merck Sharp & Dohme; Thomas Merigan, Stanford Univ. Medical Center; and Henry Pitot, McArdle Laboratory for Cancer Research.

Freeman Lists Steps For Dealing With Socioeconomically Disadvantaged

Harold Freeman, former president of the American Cancer Society, presented a list of recommendations to address the problem access to cancer care by socioeconomically disadvantaged Americans. Calling poverty "an offense that is punishable by death" in addressing a conference on cancer and minorities earlier this year (**The Cancer Letter**, July 13), Freeman listed these steps which could be taken by appropriate agencies and institutions:

* Efforts should be made to improve the cost effectiveness of cancer screening, with the ultimate goal of providing all Americans at risk with this preventive measure, through advocacy and/or direct involvement.

* The cooperation of appropriate health agencies should be enlisted in a major initiative to stimulate adequate financial support and provision of health services to the socioeconomically disadvantaged.

* Adequate access should be provided to patients with signs and symptoms of cancer to promote early detection, treatment, and rehabilitation, regardless of ability to pay.

* Funding mechanisms, both direct and indirect, should be developed to screen indigent populations at high risk for specific cancer sites.

* Emergency rooms and clinics should have outreach programs, including mobile vans for screening. Persons in high risk categories presenting themselves for treatment of other illnesses at primary care clinics and emergency rooms should be encouraged to avail themselves of cancer screening.

* Federal and state governments should consider the feasibility of assuming responsibility for insurance programs for catastrophic illness.

* Since any improvement in the health care system must ultimately depend on the will of the American people, the public must be made aware of the importance of financing early diagnosis, treatment, and rehabilitation for everyone, but especially for the socioeconomically disadvantaged.

* All epidemiological and clinical research should include data on socioeconomic status and ethnicity as determinants of cancer incidence and survival.

* Studies should be performed to determine the most effective strategies for smoking cessation among the socioeconomically disadvantaged.

* Additional research is needed on the factors affecting the cancer incidence and survival of Hispanic, Asian, and other populations.

* There is a need to examine the factors that influence the seeking of medical care to determine any differences according to socioeconomic status or racial or ethnic composition.

* Research funding is needed for major studies of possible correlations between economically linked biochemical or immunologic differences in the growth of tumors.

* Materials should be designed to reflect the socioeconomic composition and ethnic diversity of the U.S., both in words and pictures; materials should be specific to each targeted group.

* To facilitate program planning and implementation, profiles should be developed of each community to be served, with the principles based on encouraging people to modify their behavior to help reduce the risk of cancer.

* Emphasis should be placed on encouraging the lifestyle and behavior changes that might help reduce the risk of developing cancer.

* A major effort should be made to educate health professionals about the important role of socioeconomic health factors in the incidence and mortality of cancer, particularly cervical, prostate, lung, esophageal, laryngeal, and oral cancers, since many of these sites lend themselves to risk reduction through altering lifestyle factors such as smoking and drinking.

* Strategies should be developed to enlist and train the socioeconomically disadvantaged to serve as volunteers in their own communities.

* Innovative communication strategies should be devised to reach the socioeconomically disadvantaged with specific messages about cancer control.