National Institutes of Health

National Cancer Institute

NATIONAL CANCER ADVISORY BOARD

Summary of Meeting
January 30-February 1, 1984
Building 31
Conference Room 6
National Institutes of Health
Bethesda, Maryland

Department of Health and Human Services
Public Health Service
National Institutes of Health
National Cancer Advisory Board

Summary of Meeting*
January 30-February 1, 1984

The National Cancer Advisory Board (NCAB) convened its 49th regular meeting at 8:30 a.m., January 30, 1984, in Conference Room 6, C Wing, Building 31, National Institutes of Health (NIH), Bethesda, Maryland. Dr. Tim Lee Carter, Chairman, presided.

Board Members Present

Mr. Richard A. Bloch
Dr. Roswell K. Boutwell
Dr. Victor Braren
Dr. Ed L. Calhoon
Dr. Tim Lee Carter
Dr. Maureen M. Henderson
Dr. Robert C. Hickey
Dr. Geza J. Jako
Dr. J. Gale Katterhagen
Mrs. Rose Kushner
Ann Landers
Dr. LaSalle D. Leffall
Dr. William E. Powers
Dr. Janet D. Rowley
Mr. Sheldon W. Samuels
Mr. Morris M. Schrier

President's Cancer Panel

Dr. Armand Hammer
Dr. John A. Montgomery

Ex Officio Members

Dr. Elizabeth Anderson, EPA
Dr. Allen Heim, FDA
Dr. F. Kash Mostofi, DOD
Dr. David P. Rall, NIEHS
Dr. Gordon Wallace, OSTP
Dr. Ralph E. Yodaiken, LABOR
Mr. William E. Muldoon, NIOSH

Absent

Mrs. Angel Bradley
Dr. Irving J. Selikoff
Dr. William P. Longmire, Jr. (President's Cancer Panel)

* For the record, it is noted that members absented themselves from the meeting when discussing applications (a) from their respective institutions or (b) in which conflict of interest might occur. This procedure does not apply to "en bloc" actions.

Liaison Representatives

Mr. Alan Davis, Vice President for Governmental Relations, American Cancer Society, New York, New York, representing the American Cancer Society.

Dr. Judi Johnson, Cancer Services Coordinator, North Memorial Medical Center, Robbinsdale, Minnesota, representing the Oncology Nursing Society.

Dr. Raymond Lenhard, Jr., Associate Professor of Oncology and Medicine, Johns Hopkins Medical Institute, Baltimore, Maryland, representing the American Society of Clinical Oncology, Inc.

Dr. Edwin A. Mirand, Associate Institute Director of Administration, Roswell Park Memorial Institute, Buffalo, New York, representing the Association of American Cancer Institutes.

Dr. John F. Potter, Director, Lombardi Cancer Research Center, Georgetown University, Washington, D.C., representing the Society of Oncology, Inc., and American College of Surgeons.

Members, Executive Committee, National Cancer Institute

Dr. Vincent T. DeVita, Jr., Director, National Cancer Institute
Dr. Richard H. Adamson, Director, Division of Cancer Etiology
Mr. Philip D. Amoruso, Associate Director for Administrative Management, National Cancer Institute
Mrs. Barbara S. Bynum, Director, Division of Extramural Activities
Dr. Bruce A. Chabner, Director, Division of Cancer Treatment
Dr. Peter J. Fischinger, Associate Director, National Cancer Institute
Dr. Peter Greenwald, Director, Division of Cancer Prevention and Control
Dr. Jane E. Henney, Deputy Director, National Cancer Institute
Dr. Alan S. Rabson, Director, Division of Cancer Biology and Diagnosis
Ms. Iris Schneider, Director of Staff Operations

In addition to NCI staff members, meeting participants, and guests, a total of 18 registered members of the public attended the meeting.

I. Call to Order--Dr. Tim Lee Carter

Dr. Carter, Chairman, called the meeting to order and welcomed members of the Board, the President's Cancer Panel, liaison representatives, guests, staff of the National Cancer Institute (NCI), and members of the public. Dr. Carter announced that Mrs. Angel Bradley, Dr. William Longmire, and Dr. Irving Selikoff were all unavoidably absent; they expressed regret and disappointment in not being able to attend. Dr. Carter then introduced the liaison representatives.

Procedures for the conduct of Board meetings were reviewed. Members of the public who wished to express their views on any matters discussed by the Board during the meeting were invited to submit their comments in writing to the Executive Secretary of the NCAB within 10 days after the meeting.

II. Future Board Meeting Dates

Future Board meeting dates were confirmed as follows: May 14-16, September 24-26, and November 26-28, 1984; February 4-6, May 13-15, October 7-9, and December 2-4, 1985.

III. Consideration of NCAB Minutes of November 1983

The minutes of the November 1983 meeting of the National Cancer Advisory Board were approved without objection.

IV. Report of the President's Cancer Panel--Dr. Armand Hammer

Dr. Hammer reported that the Panel held its final meeting of 1983 on December 1. Panel members were brought up to date by Dr. DeVita on certain matters; they discussed problems and issues projected for 1984, particularly those related to the goal of reducing cancer mortality by 50 percent by the year 2000. Dr. Fox reported that an adequate study of the construction needs of the Nation's cancer community would take 1 year and cost approximately $150,000. Such a study would form the basis of a request from the Panel to the Administration and the Congress to lift the $1 million ceiling on construction. Because a Government-wide survey with similar goals is under way, the concept was not approved by NIH. Since the Panel did not think the Government-wide survey would necessarily address issues specific to NCI, Dr. Hammer proposed to donate $75,000, if matched by some other private organization, to defray the cost of the study.

The Panel received a report on the peer review system at the December 1 meeting and agreed that NIH should establish a mechanism to implement the recommendations of the report.

In its 1984 meetings, the Panel will focus on the cancer centers throughout the country and will consider current undertakings in cancer research, plans

for the future, and particularly how the centers can effectively meet the needs of their communities. The first meeting is scheduled for March 9, at the Southern Research Institute in Birmingham, Alabama; over the next 2 years similarly structured Panel meetings will be held on the West Coast, in the Midwest, and finally, on the East Coast.

The Second Annual Armand Hammer Cancer Prize was recently awarded, in Los Angeles, California, to four distinguished scientists for their work on oncogenes.

V. Director's Report, National Cancer Institute--Dr. Vincent T. DeVita, Jr.

Dr. DeVita distributed certificates of appreciation to those NCAB members whose terms expire with this meeting.

Announcements

(1) Dr. Michael Boyd has accepted the position of Associate Director for Developmental Therapeutics in the Division of Cancer Treatment.

(2) The Radiation Epidemiology Section in the Division of Cancer Etiology shortly will be raised to the level of a branch within the Division.

(3) Dr. Lance Liotta is the recipient of the Warner Lambert/Parke Davis Prize.

Followup Items

(1) The Board is nearing the point where a decision must be made regarding the outstanding investigator grant, which will be discussed on Wednesday, February 1. The one issue still needing discussion and action will be the mode of grant review.

(2) We have met with the Society of Surgical Oncology; issues in this area will be discussed later by Dr. Chabner.

(3) The National Center for Health Services Research will serve as the coordinating agency for assessing the impact of diagnostic-related groups (DRG's) in a variety of areas. NIH has established a corresponding committee, headed by Dr. Thomas Malone, Deputy Director of NIH; Dr. Jerome Yates is NCI's representative on the NIH committee.

(4) The budget for fiscal year 1985 will be available on Wednesday, February 1. The FY 1985 bypass budget is $1.189 billion. The FY 1984 budget of $1.077 billion will allow us to fund 923 of the 5,000 new and competing grant applications for NIH. We expect the payline to reach 175 and the average funding rate to be approximately 31 percent of approved applications.

(5) NIH uses the Basic Research Application of the Results of Research and Development (BAD) System to classify all nonmanagement programs into basic, applied, and developmental categories. NCI's amount in basic research has

increased from 33 percent of the 1980 budget to 51.2 percent of the 1983 budget. Of the $958 million that could be classified in this way in 1983, $481 million were in basic (51.2 percent), $329 million were in applied (34.4 percent), and $138 million were in developmental (14.5 percent).

Three evaluation programs were approved for 1984: 1) a study assessing the factors critical to research findings, i.e., research areas that have been responsible for major changes in the field; 2) an evaluation of information programs for their impact on the public; and 3) an integrated evaluation of the Community Cancer Care Program.

(6) PDQ Update:

- The production system for the Protocol Data Query (PDQ) system is complete; it can be connected to "user-friendly" format with any home computer. Negotiations continue with 11 vendors for vending the system.

- Dr. Daniel Ihde, Senior Investigator and Head of the Clinical Oncology Section, Medicine Branch, Navy Hospital, will serve as Editor-in-Chief of the Standard Editorial Board that will operate PDQ. He will be assisted by 20 persons: 7 NCI staff members and 13 scientists or clinicians from the area. A Second Tier Editorial Board consists of 40 associate editors who will receive information on each of the diseases and continual update of the state of the art. The Editorial Board's first meeting is scheduled for late February.

New Items

(1) Dr. DeVita met with the House of Delegates of the American Medical Association and with their Cancer Caucus.

(2) He also met with Premier Zhao Ziyang of China, and affirmed the development of close relations between NCI and China.

(3) In early February, Dr. DeVita will travel to Japan to reaffirm NCI's interest in that country, and he hopes to receive Japan's reaffirmation of the NCI-Japan bilateral arrangement to continue research.

(4) NIH has asked that the Board review and provide an opinion on the issue of NIH itself being a recipient of a National Research Service Award (NRSA) grant for training postdoctoral and predoctoral fellows. Pertinent materials are in the members' meeting books.

(5) Summary Statements ("pink sheets") will now be sent automatically to investigators, with their priority scores, as soon as they are complete.

(6) In late February, NCI will announce its Cancer Prevention Awareness Program under the heading "Cancer Prevention: The News is Getting Better All the Time." The program will have two phases: 1) mass-media phase, with the goal of increasing the public's knowledge of the risks associated with certain behaviors; and, 2) area-specific phase, aimed at promoting cancer prevention activities in areas such as nutrition, smoking, and occupational exposure.

Congressional Hearings

Dr. DeVita discussed the NCI staff preparation for the congressional hearings. At a 3-day retreat in January, the Executive Staff went over the budget and developed guidelines for reaching the goal of reducing cancer mortality by 50 percent by the year 2000. Cancer prevention is expected to improve through diet and nutrition initiatives, specifically by reducing fat and increasing fiber in the diet. Information programs will communicate dietary needs to the American people in a way that is usable regarding specific foods.

A second phase of planning for the hearings is the NCI presentation to the NIH planning session. Highlights included: research as the area of highest priority; the SEER program to monitor progress; initiatives in nutrition, chemoprevention, and smoking prevention; expected expansion in invasion and metastases; and the rapidly moving field of oncogenes. Two ongoing programs that were emphasized are the Clinical Trials Program and Cancer Centers Program.

Legislative Update--Dr. Mary Knipmeyer

Reauthorization continues to lag, although there has been much debate on the House floor, with a compromise bill substituted for the Waxman bill in November. This bill eliminates many line items for many of the Institutes, including the line item for the Cancer Centers. Other factors influencing the lag include the issue of fetal research, discussion on establishing an Arthritis Institute and an Institute of Nursing, mandating an Assistant Director for Prevention in most of the Institutes, extending the funding for cancer research and demonstration centers from 3 to 5 years, and expediting the review and award of research relative to public health emergencies.

The Senate bill is much simpler. Features of interest include the increase from $35,000 to $50,000 in direct costs that could be awarded without NCAB review and approval and the extension of the research and demonstration centers to 5 years.

HR 4192 calls for establishing a Government agency to review risk assessment and to set up a central board of experts at the National Academy of Sciences.

VI. Surgical Oncology--Dr. Bruce Chabner, Dr. Samuel Wells, Dr. Steven Rosenberg

Dr. Chabner reviewed the Division of Cancer Treatment's support for surgical oncology research. Surgery is the primary therapy for about one-half of the 800,000 newly diagnosed cancer patients each year and is curative for about 50 percent of these patients. Most surgical research dollars are spent in attempting to improve the prognosis for patients whose disease has already metastasized at the time of diagnosis. Basic surgical procedures have changed little during the past 20 years, but the results of surgery have been greatly enhanced by radiotherapy and chemotherapy. These specialties have created the need for specialized training programs in surgical oncology.

To promote undergraduate and graduate education in surgical oncology, Cancer Professional Education Awards and National Research Service Awards were established. The Clinical Investigator Development Award encourages recently trained physicians to undertake research careers in oncology.

Increased attention has been focused on clinical research trials through the Cooperative Groups and the Intergroup studies of the Division of Cancer Treatment. More than 20 percent of the Clinical Cooperative Group Trials budget is allocated to surgical studies and totals about $11.4 million.

During the past year, the NCI Executive Committee approved the designation of surgical oncology as a cancer activity. This designation identifies the funding of grants in this area as a separate budget item and creates a referral center for the surgical oncology grants.

Dr. Samuel Wells, Chairman of the Board of Scientific Counselors (BSC), described the functions and membership of the Surgical Oncology Research Development Committee. Potential avenues for increasing research support of surgical oncology include:

- Creating a special study section for surgical oncology grant review.
- Placing more surgical oncologists on existing grant review committees.
- Developing divisions or departments of surgical oncology within medical centers and establishing a board of surgical oncology.
- Supporting workshops or seminars in surgical oncology.
- Providing grants or other means of financial support for training surgical oncologists in the laboratory.

Dr. Wells urged the DCT and the NCAB to focus attention on providing increased funding for fellowship training in basic sciences for 2- or 3-year periods so that surgical oncologists can successfully compete for grant support.

Dr. Steven Rosenberg, Chief of the Surgical Oncology Branch, described the activities of NCI's surgical oncology unit as a prototype for surgical oncology activities at other institutions. The Branch is organized into five major sections: tumor immunology, colorectal cancer, thoracic oncology, surgical metabolism, and urologic oncology. Ten senior staff surgeons are responsible for both clinical and laboratory research efforts and a training program for young investigators. In the past 5 years, Surgery Branch Clinical Associates have won five of the ten national research awards given by the Society of Surgical Oncology. After their training, about 80 percent take positions at major universities in departments of surgical oncology.

Dr. Rosenberg described several clinical research studies conducted by the Surgery Branch. Adjuvant chemotherapy after surgery for soft tissue sarcoma was conclusively demonstrated to be of statistically significant

benefit. Limb sparing surgery followed by aggressive radiation therapy and adjuvant chemotherapy was shown to be as effective as amputation plus chemotherapy. Intraoperative radiation therapy trials are under way for pancreatic cancer, gastric cancer, and retroperitoneal soft tissue sarcoma. As an example of laboratory research, Dr. Rosenberg described animal studies in the area of adoptive immunotherapy of tumors. A clinical trial is planned to investigate the efficacy of this treatment approach.

VII. NIH Consensus Development Conferences--Dr. J. Richard Crout

Dr. Crout, Director of the Office of Medical Applications of Research (OMAR), Office of the Director, NIH, presented an overview of the Consensus Development Program. This program sponsors Consensus Development Conferences (CDC's), an important NIH mechanism for health technology assessment and information transfer. The purpose of a CDC is to evaluate publicly scientific information concerning a biomedical technology and arrive at a consensus statement that will be useful to health care providers and the public. CDC's are cosponsored and administered by OMAR, NIH Institutes, or other Federal health agencies.

A planning committee made up of members of the cosponsoring Institute and outside consultants selects the consensus questions, conference speakers, and the consensus panel of 12 to 14 persons. This panel consists of research scientists, medical specialists, methodologists, and representatives of the public. The panel listens to about 1-1/2 days of scientific data presented by experts in the chosen topic, synthesizes the information presented, and develops responses to a series of four or five questions previously posed by the Planning Committee.

These responses constitute the consensus statement, which is then presented to the conference for public comments and amended if necessary. Following the conference, the statement is disseminated to the medical community and the public. Public participation is one of the factors that makes the conferences particularly credible to those outside the medical establishment.

Since 1977, when the program began, 11 Consensus Development Conferences have been held on topics cosponsored by NCI; 2 more are planned for 1984 and 1985.

VIII. National Hospice Study--Dr. J. Gale Katterhagen, Dr. Vincent Mor

Dr. Katterhagen reviewed the importance of effectively organized and administered hospice programs for patients dying from cancer, described the accreditation/certification process, and discussed the financial problems hospices have with the recently enacted Tax Equity Fiscal Responsibility Act (TEFRA). Many hospice programs are unwilling to apply for certification or to accept papers of certification because of the apparent obligation to participate in the TEFRA program, which, it is feared, will not provide enough money for adequate care, and may lead the institution to bankruptcy.

Dr. Katterhagen discussed the definition of hospice and the fundamental principles of quality hospice care developed by the Joint Commission on Accreditation of Hospitals.

Dr. Vincent Mor, Brown University Medical School, introduced his presentation on the National Hospice Study (NHS) by describing hospice as both a philosophy and a system of terminal care. As a philosophy, hospice confronts the dying process openly, and by stressing personal autonomy, prepares people to experience dying as an inevitable, natural phase in the life cycle. As a system of care, hospice has evolved in just 10 years into a major movement encompassing almost 1,000 organizations of various sizes and configurations. This system claims to be more effective than conventional care in easing patients' pain and in improving the quality of life of terminally ill patients and their families.

The NHS was designed to assess whether hospice attains its stated goals and whether it is superior to conventional care (and if so, how) and to provide the Federal Government with a data base for hospice policy formulation. Dr. Mor discussed the commissioning of the study, its funding, and its methodology.

Dr. Mor presented data comparing pattern of care, quality of life, and costs in three settings: the hospital-based hospice (with in-patient beds), the home-care-based hospice, and the conventional care facility. Different patterns of care are provided to patients in the hospice and nonhospice setting.

Hospice legislation was based on the assumption that hospice care is less costly than conventional care; however, the NHS found that cost relationships between hospice and conventional care are very complex and admit no simple assumptions.

Public policy based on the results of the NHS should recognize hospice as a viable alternative for the care of some terminal patients. Incentives should encourage the use of home-care hospices since they are less costly and more likely to keep patients in their home environments. Other circumstances, however, make the hospital-based hospice a better alternative for patients. Limitations imposed by regulations and administrative costs may tend to force some volunteer-oriented, freestanding hospices without in-patient facilities out of the field, which would have great impact on the hospice movement. Dr. Mor concluded that the NHS has demonstrated that objective evaluation can make important contributions to the development of health service policy and legislation.

IX. Update on Ovarian Cancer--Dr. Robert C. Young, Dr. Robert Bast

Dr. Young reported that an overall improvement in survival of patients with ovarian cancer has been observed during the past decade. The most important factor in survival is the stage of the disease at diagnosis.

Unfortunately two-thirds of ovarian cancer patients have advanced disease at the time of diagnosis.

Recent statistics for women with early disease (Stage I or II), show that 80 to 90 percent survive for at least 5 years. For those patients with advanced disease for whom the 5-year survival was in the range of 5 percent 10 years ago, combination chemotherapy is achieving 25 to 30 percent 5-year survivals.

Dr. Young described the findings of several clinical trials of patients with ovarian cancer. For patients with localized disease, 2-year results appear to indicate that chemotherapy does not improve survival; 95 percent of patients treated only with careful surgical exploration still are surviving. Patients with poorer prognosis received either melphalan or intraperitoneal P_{32}; 85 percent are surviving in contrast to 60 percent before this treatment. Combination chemotherapy has been shown to be superior to therapy with a single alkylating agent in achieving a higher percentage of long-term survivors. Intraperitoneal chemotherapy has been shown to be effective as a method to reduce residual disease.

The availability of human ovarian cancer cells in culture has made possible studies of the regulatory effects of hormonal manipulation on tumor growth, dose-response relationships with antitumor agents, detection of antitumor effects of new drugs, patterns of drug cross-resistance, and enhancement of the effectiveness of existing chemotherapeutic agents. Human ovarian cancer cell lines may permit creation of tailored chemotherapy approaches to this disease.

A major breakthrough has occurred in the treatment of women with germ cell tumors of the ovary. Combination chemotherapy produced 70 to 100 percent survival rates for Stage I or II patients. Even for patients with advanced disease, 50 to 60 percent long-term survivals are now observed; previous therapy was uniformly unsuccessful and all such women died. In addition, current combination chemotherapy regimens preserve fertility whereas earlier aggressive surgery and radiation therapy resulted in sterility.

Dr. Robert Bast, Associate Professor at the Dana Farber Cancer Institute, reported the development of a method to detect circulating antigens to ovarian cancer and to monitor the effect of chemotherapy. A murine monoclonal antibody, CA125, has been developed against human ovarian carcinoma that was shown to bind to ovarian cancer cells but not to normal ovarian cells. Antigen levels, quantified by radiolabeling techniques, were found to correlate with disease regression, stability, or progression. Elevated levels of CA125 were detected in sera from more than 80 percent of patients with surgically demonstrable epithelial ovarian cancers. If these data are confirmed by an ongoing double blind study, this test may be the first generally useful marker for studying response to therapy in patients with epithelial ovarian cancer.

Preliminary studies suggest that CA125 may serve as the basis of a method for the early detection of ovarian cancer. Levels of CA125 in the sera of patients with benign disease were observed to be below the level of 65 units, whereas sera from most patients with ovarian cancer showed antigen

levels above this cut-off point. A large trial involving some 50,000 women over 2 years is proposed to determine the sensitivity and the specificity of this test as well as its lead time in detecting ovarian carcinoma.

X. Outstanding Investigator Grant--Dr. Elliott H. Stonehill

Dr. Stonehill reviewed the history of the Outstanding Investigator Grant (OIG) proposal and presented the most recent draft of the proposal developed by the President's Cancer Panel Ad Hoc Working Group.

The OIG is a new award intended to provide stable, flexible, non-restrictive financial support for established investigators to pursue innovative research over a long, but defined, period of time.

The working group was charged with developing parameters for eligibility, application procedures, review, award size, and conditions. The current draft reflects comments provided by the scientific community, including:

- An investigator who has recently demonstrated outstanding research productivity for at least 5 years is eligible to apply.
- Prior notice of intent to apply is not required but would be appreciated.
- The recipient of an OIG is required to commit 75 percent of his time and effort to the research supported by the award and will be permitted to receive 25 percent from other sources.

XI. Subcommittee Reports

Ad Hoc Subcommittee on Program Project Grants--Dr. Maureen M. Henderson

Dr. Henderson presented for the Board's approval the report of the Ad Hoc Subcommittee on Program Project Grants. She summarized the report's conclusions pertaining to the nature and importance of the Program Project Grants. Good program projects are integrated, synergistic, and cost-effective. The three chartered review committees use more or less the same criteria and apply a similar, high quality review. Rewritten guidelines codify the procedures for applicants and some of the procedures for review. Concerning the construction of the priority score, the subcommittee agreed unanimously that no form of arithmetic weighting would be an adequate and fair substitute for the current process of individually assessing the merits of projects.

Two recommendations were highlighted: 1) that the staff of the Division of Extramural Activities, NCI, develop explicit guidelines for reviewers to follow and that they be included in the book of guidelines; 2) that, after the revised guidelines for applicants and reviewers have had an impact on program project grant development and review processes, consideration

be given to undertaking a study to identify and quantify factors that make a grant proposal fundable. The Board unanimously accepted the report.

Ad Hoc Subcommittee on Innovations in Surgical Oncology--Dr. Ed L. Calhoon

Dr. Calhoon reported that the Board of Scientific Counselors, Division of Cancer Treatment's group on Surgical Oncology Research Development (SORD) reviewed the history of surgical activities at NCI and a study of grant mechanisms relating to surgical oncology at NCI, reaffirmed the importance of the role of surgical oncology, and discussed the necessity of identifying and developing demonstration programs in surgical oncology. The NCAB subcommittee plans to meet with SORD's members and with representatives of the Society of Surgical Oncology and of the American Medical Association. The report, as amended, was approved by the Board.

Subcommittee on Organ Systems Program--Dr. William E. Powers

The subcommittee discussed the mechanism for information exchange between the Organ Systems Program and other NCI programs, the review mechanisms for the organ systems grant applications with a summation of applicants' scores in 1983, and the funding history of the Organ Systems Program.

A motion to include the subcommittee's recommendations in the minutes of the May 1983 meeting was approved unanimously.

Subcommittee on Cancer Control and the Community--Dr. J. Gale Katterhagen

The subcommittee discussed the possibility of nonrandomization in clinical trials, the need for increased effectiveness in cancer screening and prevention on a national level, and the impact of DRG's on cancer patients in general and on the cancer patients to be entered in clinical trials. The Board accepted the report unanimously.

Subcommittee on Environmental Carcinogenesis--Mr. Sheldon W. Samuels

Mr. Samuels reported that the subcommittee completed its work on quantitative analysis some 3 months ago and has begun work on reviewing the progress and direction of the programs related to occupational cancer. A further report will be sent to Board members. Mr. Samuels provided the Board with some historical background related to environmental carcinogenesis and reported on discussions of NCI's mandate to support and conduct research and to support control functions.

XII. Adjournment--Dr. Tim Lee Carter

A request was received to include in the minutes of this meeting the statement Mr. Bloch read to the Board on Tuesday, January 31, 1984, and a copy of the letter of appreciation sent to Dr. Mary Fink, who has recently retired from Government service. These are appended as Attachment I and Attachment II.

The 49th meeting of the NCAB was adjourned at 10:15 a.m., on Wednesday, February 1, 1984.

MAY 2 1984

Date

Tim Lee Carter, M.D.
Chairman
National Cancer Advisory Board

ATTACHMENT I

Statement Read to the National Cancer

Advisory Board

by

Mr. Richard A. Bloch

STATEMENT READ TO THE NATIONAL CANCER ADVISORY BOARD

by

Mr. Richard A. Bloch

Yesterday afternoon, I was privileged to see a test preview of PDQ II. I have to, in this closed session, go on record to congratulate Vince and everyone else who worked on it for the tremendous job you have done. You have accomplished a super human task. PDQ II is excellent.

It contains a wealth of knowledge written in understandable language, catalogued, referenced and cross referenced magnificently. The material is in the computer to help physicians world-wide give their patients the best chance of beating or controlling cancer. And that's what it is all about.

To say PDQ II is not what I dreamed it would be is only a matter of personal taste or opinion. It would be pointless to debate it. I have certain fears as to whether it is friendly enough to not frighten off some unsophisticated physicians. Being a perfectionist, I am concerned that some doctors may not take the time to read everything relating to a type of cancer and may miss some phases of the recommended treatments. Being human, some doctor will not press the button to see the next frame and will miss the key testor. These I believe as a businessman will be corrected in time.

The important thing is, the job of getting the information in the computer. That enormous feat has been done. It is all there to enable any physician to obtain all the tests to offer the best therapy known today. The next task? Get enough publicity to be certain the very physician who needs it the most will use it. That is going to be an equally super human task.

I would presently urge you not to waste any effort on publicity to physicians in mailings or medical publications other than any write ups they want to give you. If it costs money, its not worth it. Remember, the job is not to get the "good" doctors to use it. They are using every source of knowledge they can find today. They will welcome this and use it without any urging. The few physicians, the ones who already know everything, the elderly thoracic surgeon who told me three years ago I had not had lung cancer because everyone knows lung cancer can't be cured--if I had it I would be dead--he is the one who must be made to use PDQ.

This can only be accomplished through tremendous publicity to the public at large so that they will make their doctor use it. Our motive is not to make life easier for the qualified and dedicated physician, even though this will be accomplished. Our mission is to reduce the morbidity and mortality of cancer and this can only be done when that physician who knows the patient is untreatable learns there is a treatment.

PDQ II is knowledge, nothing more. It is a better textbook. But if it is not used for the benefit of the patient who needs it, it is worth no more than an unopened book.

Vince, I take my hat off to you and your entire staff. What you have accomplished approaches the impossible. I have full confidence you will be able to move mountains and get all the media, television, radio, news services, newspapers, and periodicals to give you tremendous initial and continued free publicity.

1/30/84

ATTACHMENT II

Letter of Appreciation from NCAB

to

Dr. Mary Fink

National Cancer Advisory Board

National Cancer Program | National Cancer Institute | Bethesda, Maryland 20205

February 1, 1984

Mary A. Fink, Ph.D.
9414 Locust Hill Road
Bethesda, Maryland 20014

Dear Dr. Fink:

Because we can each remember specific examples of your helpful attention to the resolution of questions regarding various grants, and because we feel an especial sense of indebtedness for your competent assistance in conducting the Special Actions Subcommittee meetings, we have chosen to express our gratitude as part of the official record of the January National Cancer Advisory Board meeting:

> "We, the members of the National Cancer Advisory Board, wish to acknowledge the substantial contributions that Dr. Mary Fink has made to the effective function of the Board, especially with regard to our oversight of the review of investigator initiated grants."

Best wishes for your retirement.

Sincerely,

Tim Lee Carter, M.D.
for the National Cancer Advisory Board

January 9, 1984

NATIONAL CANCER ADVISORY BOARD

CHAIRMAN (1984)

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Carter Clinic
805 North Main Street
Tompkinsville, KY 42167

Mr. Richard A. Bloch 1988
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Ed L. Calhoon, M.D. 1988
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Robert C. Hickey, M.D. 1986
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Geza J. Jako, M.D. 1988
President, Institute for Research in Laser Surgery
Surgeon, Research Professor in Otolaryngology and Head/Neck Surgery
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Joseph Gale Katterhagen, M.D. 1986
Director of Oncology for Consolidated Hospitals
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Mrs. Rose Kushner 1986
Executive Director
Breast Cancer Advisory Center
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LaSalle D. Leffall, M.D. 1986
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William E. Powers, M.D. 1986
Chief
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Janet D. Rowley, M.D. 1984
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Mr. Sheldon W. Samuels 1984
Director
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Washington, DC 20006

Mr. Morris M. Schrier 1984
Legal Consultant
MCA, Inc.
445 Park Avenue
New York, NY 10022

Irving J. Selikoff, M.D. 1984
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