Foundation Stone of a Clinical Trials Network

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For decades, oncologists have been trained in their craft by mentored caring for patients in clinical trials. In the early 1980s, oncologists who had been trained in cancer institutes or teaching universities began practicing in community settings but wanted to continue to participate in cutting edge cancer research. At that time, as always, NCI was looking at ways to provide the best quality of care to cancer patients regardless of their location. It was felt that participation in clinical trials, the cutting edge of medical oncology, would be mutually beneficial for community physicians and their patients.

My colleagues and I in the Division of Resources, Centers, and Community Activities, now the Division of Cancer Prevention, saw other potential benefits from including community hospitals and physicians in clinical trials. Doctors, nurses, and other health professionals who take part in clinical trials have a sense of ownership of the process and the outcome in a way that people reading results in a journal simply do not have. This integration of the community into changing medical practices meant that the diffusion and adoption of newly proven and state-of-the-art cancer practices would be quickly available to more people than ever before. Community level participation in cancer research would help NCI directly connect to and with the public, helping people relate to progress in clinical cancer research.

In 1983, this simple concept became a reality. The Community Clinical Oncology Program began to link community cancer specialists, primary care physicians, and other health care professionals to the Cooperative Groups and Cancer Centers. In time, the spectrum of research broadened to include chemoprevention and cancer control, including symptom management, continuing care, and quality of life.

There were some skeptics who doubted that community physicians and hospitals could do as well as academic centers in the rigor of clinical trials. On this 20th anniversary of the Community Clinical Oncology Program, I am happy to say that fully one-third of all patients in NCI-sponsored treatment trials and NCI-sponsored prevention clinical trials come from the CCOPs, and that some of the highest quality data for these trials come from CCOPs.

In these 20 years, we have gathered solid evidence that community physicians can make major contributions to cancer clinical trials. Through the CCOP Program, the Cooperative Groups and Cancer Centers have developed their cancer control research agenda. These investigators have become the primary force behind prevention, cancer control, symptom management, and quality of life research. The most important cancer prevention clinical trials ever conducted may never have been launched without the CCOPs. The CCOPs have built a strong program of medical approaches to cancer prevention. They are in the forefront of wide-scale testing of preventive interventions, and conduct them with exemplary quality and efficiency.

The Community Clinical Oncology Program has become one of the foundation stones of the clinical trials network of the National Cancer Program. This straight-forward concept, which was sown in 1983, has reaped a multitude of successes.

It has been a pleasure and a privilege to be a part of the CCOP ideal over the past two decades.

Why I Am A CCOP Physician

The treatment of cancer is an evolving process. The knowledge we gain from the results of clinical trials ultimately determines what the standard treatment for a particular type and stage of cancer will be.

During our residencies at academic centers we learn the value of evidence-based medicine. We study the landmark clinical trials that have influenced our current treatment recommendations and we participate in new clinical trials that are destined to influence future standards. We learn to recognize the value of clinical trials in helping to improve the care of cancer patients.

When we complete our residencies, we must choose whether to stay in the academic world or join the ranks of community physicians. Many of us struggle with this decision because we enjoy the stimulation of the university setting, and we feel the good that comes from the knowledge that we are working to advance the treatment.

For those of us who choose to go into private practice, we don't give up our intellectual curiosity and our desire to help advance the knowledge of cancer treatment. The ability to participate in clinical trials allows us to continue to contribute to our profession and to help improve the quality of care we provide to our patients. The CCOP mechanism provides us with that opportunity.

For me, participation in the North Central Cancer Treatment Group (NCCTG) has provided a framework for ongoing collaboration with my academic colleagues. Collaborations like this, along with attendance at semiannual group meetings, allow community physicians the opportunity to stay informed about new developments in oncology.

To summarize, why do I participate?

1. I want to help improve cancer care.
2. I want to be able to offer my patients the most up-to-date treatment possible.
3. I want to be part of a collaborative process with academic physicians in order to continue my own professional development and acquire knowledge related to new developments in oncology.

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July 2003