

MEMBERSHIP SURVEY RESULTS

For the past nine months, ACCC headquarters has been receiving responses to the membership survey that was mailed in the Fall of 1988. ACCC received responses from 68 percent of delegate institutions, and 55 percent of general members.

In both the delegate and general membership categories, the majority of members first heard about the ACCC through a current member (delegate institutions, 66 percent; general members, 37 percent). A significantly higher number of general members first heard about the Association through its journal (27 percent) than delegate members (12 percent).

The five most important topics that members believe should be addressed in the journal and/or at future ACCC meetings are listed in the box at right.

NATIONAL ALLIANCE SEEKS EXEMPTION FROM STARK BILL

The National Alliance of Outpatient Cancer Therapy Centers is seeking an exemption for all outpatient cancer therapy centers from Rep. Fortney (Pete) Stark's (D-CA) proposed legislation (H.R. 939) on physician referrals. If enacted, Stark's bill, the "Ethics in Patient Referral Act" would prohibit, with few exceptions, Medicare payments for physician referrals to facilities in which they have a financial interest.

Daniel G. Harwitz, M.D., of the Alliance, likens cancer therapy centers to renal dialysis centers, which the health subcommittee of the House Ways & Means Committee recently exempted from the proposed legislation. "Stark's bill is designed to go after diagnostic and laboratory centers, because of concerns about over-utilization and unnecessary costs. Cancer therapy centers are not subject to such over-utilization and cost problems," Harwitz says.

Members of the Alliance, which was founded by Cancer Treatment Holdings, Inc., a Florida-based, publicly-traded company with interests in outpatient cancer therapy centers, explain that any serious fraud and abuse problems in the

FIVE TOP ACCC CONCERNS

A recent survey of ACCC members revealed the following topics as the most important for the association and its journal to address:

DELEGATE INSTITUTIONS		GENERAL MEMBERS	
Third-party reimbursement	66%	Third-party reimbursement	66%
Quality assurance	60	Quality assurance	52
Marketing	54	Regulation/Legislation	40
DRGs	44	Marketing	38
Regulation/Legislation	41	Clinical trials	37

cancer therapy area would require a conspiracy between the referring physician and the treating radiation oncologist to commit indefensible medical malpractice and, as such, are highly unlikely.

For more information on the Alliance and its lobbying efforts, contact Joseph Miltenberger, Executive Director, National Alliance of Outpatient Cancer Therapy Centers, 104 North Carolina Ave., S.E., Washington, DC 20003. Phone: 202/547-9447.

NOMINATIONS FOR ACCC OFFICERS AND TRUSTEES

The ACCC Nominating Committee is soliciting nominations for the following 1990-1991 board positions:

- President-Elect
- Treasurer
- Four Trustee Seats

The term of President-Elect is one year. The Treasurer and Trustee positions are two-year terms. Although nominees are not required to be the voting representative of their institution, they must represent an ACCC Delegate Institution.

Letters of nomination should be sent to the ACCC Executive Office, citing the nominees' names and their respective Delegate Institution, along with a copy of their curriculum vitae. **Nominations must be received no later than December 1, 1989.**

Further information about the nomination process may be obtained from Lee E. Mortenson, Executive Director, ACCC Executive Office (301/984-9496).

CALL FOR PROPOSED BYLAWS AMENDMENTS

The ACCC Bylaws, adopted by the House of Delegates in March 1984, state: "These Bylaws may be amended by the vote or written assent of two-thirds of the Delegate Representatives voting. Written notice of proposed Bylaws amendments must be sent to voting members at least 30 days prior to the meeting at which they are to be acted on."

Any delegate representative who wishes to suggest a Bylaws change must inform the ACCC Executive Office of that intent no later than December 1, 1989, for consideration by the House of Delegates in March 1990.

All suggested amendments should be sent to the attention of Lee E. Mortenson, Executive Director, ACCC, 11600 Nebel St., Suite 201, Rockville, MD 20852.

COLLEGE OF PHYSICIAN EXECUTIVES SEEKS CERTIFICATION FOR PHYSICIAN MANAGERS

The American Board of Medical Management (ABMM), which was created by the American College of Physician Executives in January of this year, is seeking recognition of medical management as a specialty of medicine. The Board filed an application for membership with the American Board of Medical Specialties (ABMS) in March of this year. If the

Accolades

Congratulations to Lee Mortenson on an excellent editorial in *Oncology Issues*, Winter 1989, "Starve Them or Shoot Them."—*H. D. Kerman, M.D., Director, Regional Oncology Center, Halifax Hospital Medical Center, Daytona Beach, FL.*

Setting the Record Straight

I appreciated the honor of speaking at the ACCC Awards Luncheon on April 1, 1989. I am concerned, however, that a number of inaccuracies appeared in the *Oncology Issues* report of my talk. (See Spring Issue, page 21.) Since these issues are vital ones, and a clear understanding of the National Cancer Institute's position is important in achieving our common objectives, I decided to write to set the record straight.

I was quoted as saying that socioeconomic factors, for the most part, cannot account for increased mortality rates in a "number of cancers" in minority populations. Actually, I have been struck by the fact that poverty can, in many ways, be considered a major risk factor for cancer and, in most cases, plays an important role in the disproportionate burden of cancer mortality in blacks. When I speak of "poverty," I am using a shorthand term to refer to all of the differences in access to health care, education, and standards of living that impinge on an individual's ability to seek early diagnosis and state-of-the-art prevention and treatment.

This has been my explicit theme at virtually every presentation since my swearing-in, and the ACCC meeting was no exception. In fact, I showed a slide illustrating declining death rates for selected cancers in whites and increasing death rates in blacks. The differential death rate was expressly linked to issues of access to the technologies of prevention, diagnosis, and treatment that have been developed with support by the NCI.

I did point out that in two specific tumors; namely, prostate cancer and multiple myeloma, socioeconomic factors do not offer an adequate explanation for the fact that the rates are higher and increasing in blacks as compared to other popula-

tions. But this observation does not refute my main premise about the significance of poverty. I have asked that NCI scientists approach this issue from the standpoint of epidemiology and basic research so that we may better understand this differential.

The NCI and the FDA are working together to advance drug development for cancer and AIDS drugs and, in that regard, I'd like to note another error. I was quoted as saying that "...why shouldn't a drug, which was approved by the FDA 20 years ago, have to reprove its worth?" I believe that my remarks addressed many points regarding the need for faster drug approval and third-party coverage. One of my theses was that we have been using many drugs for a number of years and, therefore, why should we need to "reapprove" (for regulatory or insurance purposes) agents when we use them in combination? I would object to unreasonable regulatory or insurance-based re-examination of drugs that we know work alone or in combinations.

I do favor consideration of a special provisional approval mechanism with post-marketing surveillance and review, if necessary, to resolve debate about when to approve certain new drugs and when third-party payers should cover therapy. I see the failure of third-party payers to cover certain new treatments and clinical trials as a serious problem. The main issue is to approve new drugs, whether they are used alone or in combination, and to get third-party payers to respond so we can make sure we can minimize death and suffering from cancer as rapidly as possible. Moreover, our regulatory apparatus should be judged by drugs approved, not just by the drugs held back. The *Oncology Issues* report definitely conveys the wrong impression and does not reflect my talk.—*Samuel Broder, M.D., Director, National Cancer Institute.* ■

IN THE NEWS

(Continued from page 4)

application is approved, the Board will be granted certification status, and medical managers will join the 23 other medical specialties that are currently certified by ABMS member boards.

However, the approval requirements are stringent, and Richard Schenke, Executive Vice-President of the College, has told the College's membership that he "expects the process to take two to three years." The timeframe is representative of the average length of time it has taken other medical specialties to obtain membership approval, such as the American Board of Emergency Medicine, which was incorporated in 1976, but was not approved for membership by ABMS until 1979.

The application will be reviewed at the next meeting of the ABMS' Liaison Committee for Specialty Boards, which will be scheduled for September or October. Meanwhile, the College is proceeding with certification testing (to date, the College has conducted five examinations, with a sixth and seventh scheduled for November and February, respectively). A spokesman for the College says that there are plans to "grandfather fellows who have passed the examination into diplomate status on the board, if, of course, they meet all of the other qualifications."

Those qualifications are as follows:

Stature as a Physician. Applicants must be licensed as an M.D. or a D.O. and be board-certified.

Management Experience. Applicants must spend a minimum of 25 percent of their time on management duties for a minimum of two years. (Note: The product of these two requirements must equal 100 percent. That is, applicants who only spend 25 percent of their time on management must have four years of experience; managers who spend 50 percent of their time on such duties must have two years' of experience.)

Management Education. Applicants must have completed 150 hours of management education over the past 10 years (i.e., graduate management courses, courses approved for CME credit by the College, or University-sponsored physician management programs.) ■