LETTERS TO THE EDITOR

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 populations. 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 reexamination 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.) ■