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IN MY VIEW

From Opera To Chemoprevention

By Rodger Winn, M.D.

I vividly remember my parents mandating that I would accompany them to the opera. My adolescent protestations were useless against their argument that, one day, I would thank them for forcing me to expand my vistas and for adding a rich and fulfilling dimension to my life. If memory serves me correctly, I pointed out, quite emphatically, that they were "dictatorial, out of touch with reality," and "completely and utterly incapable of making any rational choices about how I should lead my life." The denouement, of course, is that I now love opera and count it as a blessing that I was given the opportunity to immerse myself in it.

I see a very similar scenario unfolding in the world of community research. I think it is fair to say that community research, especially as represented by the CCOP program, has now reached a phase of swaggering adolescence. The accomplishments of the program have been considerable and, of even greater import, its almost limitless potentialities have begun to be apparent. In this setting, parental demands (i.e., NCI requirements), may be reflexively rejected, with a heels dug in, over-my-dead-body attitude.

In 1986, the initial reaction to the CCOP II cancer control research requirements was a purely defensive posture. In fairness, the sudden imposition of a paraclinical trial research agenda left no real time for planning or modification of the basic CCOP structure. At the same time, the research bases felt abused as they were precipitously called upon to provide a full menu of succulent cancer control protocols. Adolescence is a dynamic process, however, and the ill-at-ease pubescent teenager becomes, in four or five years, the lithe, confident individual on the brink of full maturity. Similarly, the cancer control research network has ripened during the past several years, and a new and confident model of community organization is developing.

What are the manifestations of this maturation process? What is the shape and form of the new organizational body? I think the metamorphosis to adulthood will be marked by four modulations in community research structure. The elements undergoing change will involve current investigators, current non-participants, support personnel, and community orientation.

First, the expansion to a preventive oncology agenda will lead to the redefinition of the medical, radiation, and surgical oncologists' role. These oncologists will no longer conceive of themselves as pure therapists, but will also include in their purview the delineation and amelioration of risk in the patients and families they serve. At present, most of us dutifully document family histories in breast and colon cancer patients, but pay only secondary attention to the findings. How different the orientation will be as oncologists adopt a public health profile. In this setting, there would be active recruitment of family members for risk assessment and possible inclusion in chemoprevention or nutritional trials. After adjuvant ministrations, the emphasis in patient care would then shift to prevention of second neoplasms. Thus, the entire spectrum of oncologic management will be greatly amplified, with resultant intellectual and humanitarian paybacks.

The next development will be the mobilization of non-oncologists into the research loop. Gastroenterologists, gynecologists, dentists, primary care specialists, and a broad panoply of other specialists will be enlisted to participate in the prevention trials. Part of the organizational challenge in participating in these large studies will be determining who should be the primary researcher. Thus, in the upcoming tamoxifen trial, many CCOPs and NSABP institutions have been suddenly confronted with the question of designating investigators. For the first time, non-oncologic practitioners will actively participate in a cancer trial. In preparing those physicians for this task, special training sessions and monitoring are undoubtedly in order. The rigorous methodology of a clinical trial is not casually accomplished, and structured reinforcement will probably be necessary to ensure physician compliance. The organizational concomitant of this expanded physician base will have to include discipline- or trial-specific committees. In addition, innovative communication channels, which facilitate investigator interactions, will have to be devised. The development of facile electronic mail systems and computerized bulletin boards that even brontosauran physicians can use will be major components of the prevention research organization. The third major change will be the evolution of the oncology nurse into independent prevention investigators. Given that prevention trials treat well populations with essentially non-toxic agents, oncology nurses will perform all of the essential functions of a study—subject recruitment, eligibility testing, drug

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administration, compliance surveillance, toxicity monitoring, and end-point determinations. A physician needs to be involved in a trial only for management of the rare instances of severe toxicity and for evaluation of end-points requiring medical intervention. The issue of compensation for nurse practitioners will have to be addressed as this process evolves. In a real sense, oncologic practices will consist of physician-nurse partnerships, each supplying their independent expertise to the management of the full range of oncology patients/clients.

Finally, the community clinical oncology programs will have to add on new layers of outreach commitments as their superbly efficient clinical trial machines are subsumed within sophisticated community applications systems. The mobilization of large population segments for prevention trials will not be able to proceed on an ad hoc basis. A research infrastructure which includes formal community ties and access to community leaders will be essential as the complexity of these studies increases. Community health entities will have to develop ongoing relationships with the corporate world it serves in order to initiate appropriate interventions as they arise. Since a major thrust of prevention trials may eventually involve specialized populations such as ethnic groups, rural workers, or the underserved, standing linkages with the appropriate social, religious, and health service bodies will have to be established and nurtured. These outreach affiliations will truly place the emphasis on COMMUNITY. The successful forging of these ties will most certainly represent a major asset to the universe of cancer research.

If the analogy to adolescence holds true, we can reasonably expect that, in the near future, a fully capable, freestanding, mature system will be in place. This transformation cannot be assumed, however. The crucial formative period leading to maturity must be guided, and the appropriate resources and milieu provided. The parent and society must back up their commitment with material support. Perhaps, taken by surprise by the explosive growth of its precocious off-spring, the Division of Cancer Prevention and Control (DCPC) has not fully come to grips with the new requirements placed upon it. Just as the teenager's trousers may be constantly above his ankles, so too the staff and support of a CCOP organization may be woefully inadequate.

I would propose that the NCI "keepers of the purse" give maximal consideration to assuring that they are fulfilling their nurturing role. I would suggest that now, at the start of the major tamoxifen trial, they convene a strategic planning meeting for all community participants to discuss the new configurations that will be necessary to accomplish this huge undertaking. This meeting should be constructive, not carping. As part of the process of developing cancer control research, the NCI funded a major study to elucidate the organizational models and imperatives for this type of network. Perhaps these findings could be used as the foundation for a dialogue between parent and child. What are the resource implications of this new model?

In advance of these findings, I would hope that DCPC would seriously consider some immediate supplements to community researchers. I realize that NCI is not the ultimate provider, but it is the allocator. Dollars spent on an adolescent are highly leveraged and pay back enormous multiples in the future.

As an initial step, I would propose the funding of a Prevention Research Core in each CCOP. This Core would consist of two dedicated cancer control personnel. First, an oncology nurse, perhaps with nurse practitioner credentials. The complementary position would be occupied by a Masters-level public health or community educator. The function of this individual would be to mobilize and structure community resources so that the outreach demands of prevention trials could be met.

Secondly, I would award a large nugget of funds to be ear-marked for special training sessions. Attendance by a few selected staff at Cooperative Group meetings will not serve the needs of complex chemoprevention trials. Travel funds are needed to send a broad range of study participants to focused training sessions.

Third, increasing support must be given for promotional activities related to these trials. Media announcements, 800 numbers, videos, and a smorgasbord of support information must be provided on an ongoing basis. Recruitment to large trials is not finished on day one of a study; it must be sustained over a period of years. Much of this material can be produced centrally at the NCI, but funds must also be made available to support local promotional activities specifically directed to the linkages established by the community coordinator.

In summary, we are witnessing a turbulent but wonderful phase in community research development. I have no doubt that in the future, prevention research will become as fulfilling as opera. In the Magic Flute, Sarastro, the father figure, advises his minions, "It is our duty today to watch over this virtuous youth and extend to him the hand of friendship." Later, the youth Tamino, having passed the tests, avers, "I gladly follow the bold way." I hope parent and adolescent will heed this operatic lesson. ■