LETTER FROM THE EDITOR

When I came to the National Cancer Institute (NCI) in 1984, I had been recruited to manage the hematology and transplant “portfolio.” I was originally hired for a few months as a contractor, with the title of “Cancer Expert.”

At that time, the Cancer Therapy Evaluation Program (CTEP) of the NCI funded about 23 cooperative groups. These included national and regional multidisciplinary groups, modality- and disease-specific groups, and pediatric groups. The NCI also provided funding to a number of international groups in Europe, Canada, and South America.

During their existence, each of these groups made important contributions to the treatment of patients with cancer. However, budgets became constrained and many groups did not fare sufficiently well in peer review to survive. We were left with 3 multidisciplinary adult groups and 1 pediatric group, and a limited number of disease and modality groups. When budgets tightened further, the groups were forced to reduce accrual and, when money again became available, they were expected to rapidly readjust. CTEP appointed staff to serve as liaison to various groups. I was assigned Cancer and Leukemia Group B (CALGB), SWOG, the Southeastern Cancer Study Group, the Mid-Atlantic Oncology Program, and the Leukemia Intergroup. We worked as a team with group investigators to develop the best trials. In those times, there was no promiscuity: an investigator could only put patients on a study in his or her own group, except for designated intergroup studies.

Change in leadership brings change in policy, and not always for the better. Not too long before I departed in 2002 (not purely coincidental), internal decisions were made to create bureaucratic systems to manage the groups. A central institutional review board and Cancer Trials Support Unit were formed, and steering committees organized to come up with the most compelling ideas and impose them on the group system. The first 2 remain, and the third failed miserably. A few years ago, the steering committee concept was resurrected along with disease-specific subcommittees; the latter also died. Various reviews by the Institute of Medicine and other bodies felt that the groups had much to offer, but needed streamlining, a more hypothesis-based study focus, and more money.

What has arisen instead is the NCI National Clinical Trials Network (NCTN). Their stated purpose is “to transform the previous NCI-sponsored Clinical Trials Cooperative Group Program from supporting several individually operating Cooperative Groups into a new consolidated and integrated” NCTN program, and their overall goal is “to conduct definitive, randomized, late phase clinical treatment trials and advanced imaging trials,” as well as “smaller developmental studies preliminary to the definitive trials.” In other words, their goal is the development of trials by committee. What can we expect from multiple layers of committees but the stifling of innovation, and a lack of opportunity for multiple studies? With a limit to the number of trials, we may even see competition among diseases.

When the new iteration of subcommittees was announced, I inquired as to why these would be expected to succeed when the others had not, but received no satisfactory answer.

To paraphrase my friend John Leonard who was attempting to phrase the goal of the Lymphoma Subcommittee: if we were involved in the development of a work of art, our role would not be to paint the picture (that is the role of the cooperative groups) or to critique the painting (that is the role of the steering committee). Our job would be to define the canvas and frame, and to determine which object needs to be painted.

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When one looks up quotations about committees, several seem relevant:

“If you want to kill any idea in the world, get a committee working on it.” —Charles Kettering

“A committee is a group that keeps minutes and loses hours.” —Milton Berle

“A committee is a group of people who individually can do nothing, but who, as a group, decide that nothing can be done.” —Fred Allen

I can hardly imagine what might be said about a subcommittee!

The fate of the US clinical trials process is now, sadly, in the hands of committees. As was reported 2 weeks ago, the groups will have to “function” with a 40% budget cut. Moreover, funding for the former Community Clinical Oncology Programs (CCOPs) was to cease as of June 1. Following considerable backlash regarding the CCOPs, the NCI responded that this was just a communication error.

I have been involved in the clinical trials process since 1977. The relationship between the NCI and the groups, once collegial and helpful, now seems adversarial. It remains to be seen if the new system will improve the quality of trials, or if it we have seen the last of the groups as we know them.

Until next month . . .

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