May 1965

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Recommended Citation
Available at: http://epublications.marquette.edu/lnq/vol32/iss2/14
Reports of Successful Research Activities: Cancer and Cancer Chemotherapy

DONALD R. KORST, M.D., F.A.C.P.

The purpose of this report is to describe the development, the need, and the management of a cancer program in a community hospital with a large referral service and an affiliation with the University of Michigan Medical School.

THE HOSPITAL

The hospital is a 520-bed institution with 19,000 admissions annually and an emergency service seeing 24,000 patients each year. The staff is comprised of 190 physicians representing all specialties, and 35 physicians in medical and surgical specialties who have offices in the hospital and are geographically full-time to that institution, as well as a comprehensive pathology group, an x-ray department, a radiisotope service and a complete medical records section. The hospital is affiliated with the University Medical School which provides consultation, a postgraduate training program, visiting lecturers, rotation of some residents and medical students, and many externs during free periods of the medical curriculum.

Each year there are approximately 600 to 800 new cases of malignant disease diagnosed and treated at the hospital. The overall staff participation in the diagnosis and treatment of cancer is inspected and approved by the Cancer Committee of the American College of Surgeons, supported also by the American College of Physicians. This program requires the full cooperation and approval of the medical staff.

THE MEDICAL STAFF

The medical staff functions are organized under the direction of the cancer committee appointed by the executive committee of the hospital to include representatives of the major departments. The committee supervises the tumor registry, the tumor conference and cancer education program of the hospital, as well as the cancer fund. The secretary of the cancer committee serves as the full time secretary in charge of the tumor registry, which maintains current data, abstracts and follow-up of each patient. This data is available at any time to the staff, and regular meetings of the cancer committee are held to inspect the abstracts for completeness and accuracy. Advice in maintaining the tumor registry is obtained from the American Cancer Society and the secretary attends an annual workshop.

Tumor conferences are held each month as one of several combined conferences on the training schedule, with lectures on specific subjects and visiting speakers. Cancer educational booklets and material are also provided to the school of nursing as needed. A cancer fund is maintained from personal donations and support of the local chapter of the American Cancer Society, which provides a means to continue treatment in near indigent patients or hardship cases.

THE CANCER CHEMOTHERAPY PROGRAM

During a 15-year period, the importance of cancer chemotherapeutic control of many patients with malignant disease has increased. There are currently available to all physicians a number of proven helpful drugs. The knowledge of the indication, the usefulness, and the toxicity of these drugs is important for every physician to know and equally important is the clinical decision as to which patient should be selected for cancer chemotherapy and when the treatment should be started. By definition, cancer chemotherapy in its present state is the oral, intravenous or intra-arterial administration of chemicals and drugs to patients with regional or disseminated malignant disease in order to produce remission or palliation. Five year remissions or possible cures have been induced in an occasional woman with choriocarcinoma or a child with acute leukemia or Wilm's tumor.

Perhaps as many as one-third of the patients seen today at the time of diagnosis of cancer are candidates for chemotherapy. This has meant a great deal to patients and physicians in managing what a few years ago was considered a completely hopeless situation with patients turned away from the hospital. These patients are no longer relegated to the false cancer cures or to the high cost of dubious treatments.

The management of the patient receiving cancer chemotherapeutic drugs by various routes of administration requires close supervision of nursing and house staff. Management can be augmented considerably by having the service of an efficient semi-intensive specialized care area. Centralization improves staff training and is particularly advantageous during the use of catheter infusions given by pumps and slow intravenous drips, which often are maintained on an around-the-clock basis. Morale of the patients, or of the staff, on this type of ward has not been a problem; in fact, the opposite is true. Our patients request re-admission to this area and are quite disappointed if the beds are filled. An additional advantage in this type of service is a close proximity of the physicians' offices, outpatient examining rooms, and a special hematology laboratory to maintain the needs of this group of patients.

Many new drugs are evaluated on a chemotherapy service and a day-to-day flow sheet of drug dosage, response, weight, performance status,
and laboratory data is maintained, for a close continuity between the inpatient and the outpatient management. In addition to evaluation of new drugs, there are new methods of administration such as intraarterial catheterization and slow infusion apparatuses that can be investigated on such a service. Also under study is a hospital pharmacy control of all new drugs. These types of investigation may be in cooperation with the Cancer Chemotherapy National Service Center of the National Institutes of Health, many pharmaceutical companies, or cooperative medical study groups and provide means of reporting to medical meetings and the medical literature. In addition, an organized observation on a group of patients provides improved data on survival and on the natural course of malignant disease, which is a much needed type of clinical research. Criteria of response to treatment and methods of administration such as intraarterial catheterization and slow infusion apparatuses can be evaluated under controlled conditions where the research committee is in a position to promote and support investigations, and where one individual’s efforts would probably not be of sufficient stature or where he would not have sufficient time to devote to a project, to warrant a large individual grant. Each year it is getting more and more difficult to raise funds from the community. It has been particularly more difficult to raise funds from the pharmaceutical associations in the past year or two and therefore support from large organizations is going to be imperative to continue good clinical research programs in the community hospital.

Space has not been critical, but the major expense of our program has been maintaining areas in the hospital and in surrounding buildings for such purposes. We maintain a dog laboratory, which doubles in teaching (e.g., dog surgery to medical students and residents), and we maintain a small animal laboratory for mice, rats, etc. These areas require air conditioning, daily maintenance and constant supervision, whether or not a project is in progress and thus represents the major cost of the program. The hospital staff has been most cooperative in allowing use of clinical facilities for research which includes the radioisotope laboratory, the x-ray depart-

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The clinical research program of the hospital which, in turn, might be supported by a granting agency on an annual basis as long as the program is productive. A program support of this type would be most feasible for our own institution where the research committee is in a position to promote and support investigations, but where one individual’s efforts would probably not be of sufficient stature or where he would not have sufficient time to devote to it, to warrant a large individual grant. Each year it is getting more and more difficult to raise funds from the community. It has been particularly more difficult to raise funds from the pharmaceutical associations in the past year or two and therefore support from large organizations is going to be imperative to continue good clinical research programs in the community hospital.

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ment and the cardiac catheterization unit. We have not found that the program requires expensive items of equipment, but that much of the equipment used in a specialized referral community hospital can double very adequately in a clinical research program.

Future support of clinical research programs is necessary in order to maintain the development of good ideas in clinical medicine that benefit many patients. Support is also necessary to maintain an inquisitive attitude on the part of the house staff and attending staff in a large teaching program, and it is very important in augmenting the training program in postgraduate medicine that is becoming a major responsibility of the community teaching hospital.

**SUMMARY**

The community teaching hospital affiliated with a university is growing into a major teaching and clinical research activity. The development of cancer research programs serves as an example of one facet of this growth emphasizing the contributions to society medical, scientific advancement, and the medical profession. Support of growth in research and teaching activities to the large community teaching hospitals must be considered to maintain good programs.

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**Medical Missionaries in Peru and Bolivia**

English-speaking missionary doctors, nurses, and medical technicians and personnel from seventeen different religious organizations, the Papal Volunteers and Catholic Families from Latin America working in Peru and Bolivia recently met in Chivato, Puno, Peru, to discuss their problems, exchange experiences, and to meet those who work in the health field. This religious assembly gathering brought together missionaries from the arid coast of Peru, the high Andean Sierras—"the altiplano" of Peru and Bolivia, from the dense jungle of the Peruvian Amazon and the Bolivian tropics. They work in or staff parish clinics, government health posts, public and private hospitals, and nursing schools.

Several papers were read and panel discussions held. Representatives from the WHO, the Peruvian health ministry, the Peruvian Red Cross, and members of the clergy spoke before the groups during their three-day seminar. Special emphasis was given to public health work, social and economic factors affecting the health apostolate, nursing education, and the role of the medical workers in the missions today.

A result of this meeting is the formation of an organization.

The Conference of Health Service Personnel — for the mutual education, renewal and development of the apostolic spirit of its members; for the deepening of their understanding of the people for whom they labor; and for the opportunity to plan together to better develop the Christian Apostolate.

Due to the success of this meeting, plans are being made for another in October of this year, to be held in Arequipa, Peru. Those interested in this meeting and this organization can contact:

Brother Francisco P. Tanega, M.D.
Hijos de Maria
Av. Grau 365
Miraflores, Lima, Peru

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**CURRENT MEDICAL-MORAL COMMENT**

Thomas J. O'Donnell, S.J., **

The question of prolongation of life in terminal illness comes up constantly in the current medical literature. While individual cases are not always easy to assess, the basic principles to be considered are reasonably clear. In any human context, whether it be religious, civil or medical (and these are the three areas which become involved in this problem) as long as the phrase "under God" rises naturally to men's lips, it is readily recognized that man is not the absolute Lord and master of human life. Man rather carries with him, both as a right and as a duty, the wise stewardship of his human life — toward the fulfillment of his human personality, his participation in the brotherhood of men, and his love and service of God.

Out of these concepts arise the conviction that man is not free to arbitrarily terminate human life, either his own or another's; that he must, moreover, take customary care of his life and health; but that since ultimate dissolution on the brink of eternity is a part and parcel of our common clay, he need not go to extraordinary and exotic lengths to stave off the moment of approaching death.

In our times of advancing medical and surgical techniques the question of what is ordinary and what is extraordinary has become more difficult to decide. A hundred years ago no one doubted that a purge was a quite ordinary therapeutic procedure, and that the amputation of a leg (without anesthesia and with the likelihood of lethal complications) was more than the concept of stewardship of one's life demanded.

But with the advent of modern medicine, of antibiotics and intravenous feeding, of the iron lung and cardiac surgery, colostomies and home dialysis, the distinction between ordinary and extraordinary becomes more difficult to discern.

The modern techniques cannot be judged as ordinary or extraordinary in themselves. They must be considered in relation to the proportion between what is to be hoped for in human values and the cost in terms of human resources, both personal and material. Hence, it would seem that while the use of a resuscitator is most vital at a critical moment, its continued use after very extensive and irreversible brain damage is