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COOPERATIVE GROUP LEADERSHIP CHANGES: DECOSSE HEADS CCIRC, HOOGSTRATEN CHAIRMEN'S COMMITTEE

Recent changes in the leadership of the Clinical Cooperative Group Program have coincided with the end of an era of "turmoil and change"

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In Brief

RHODE ISLAND, LOS ANGELES APPROVED FOR NCI COMMUNITY IMPLEMENTATION AWARDS; HAWAII CLOSE

FINAL DECISION has been made on awarding implementation contracts in the Community Based Cancer Control Program to Rhode Island and Los Angeles. NCI is now negotiating with the Rhode Island Dept. of Health and Los Angeles Community Cancer Control on how each will spend the approximate $1 million a year budgeted for their projects. Meanwhile, Hawaii has moved closer to receiving its implementation award, and Connecticut is still alive with planning money for another nine-12 months. . . . RICHARD BATES, former NCI staff member who defected to FDA, will return as director of carcinogenesis research at the Div. of Cancer Cause & Prevention. . . . JIMMIE HOLLAND, associate professor of psychiatry at Albert Einstein College of Medicine, has moved to Memorial Sloan Kettering Cancer Center as chief of psychiatry service, and to Cornell College of Medicine as professor of psychiatry. . . . JULIUS RICHMOND has finally been confirmed by the Senate as HEW Asst. Secretary for Health. He also assumes the post of surgeon general, the first time that position has been filled since Jesse Steinfeld left during the Nixon Administration, and medical director of the Public Health Service Regular Corps. . . . WHITE HOUSE is still stalling on which, if any, NCI advisory committees will be abolished. Members of the National Cancer Advisory Board have expressed concern that the quality of outside advice may be diminished by reduction in non-government advisors. Board member Philippe Shubik suggested that NCI should make it clear that dropping the Diet & Nutrition Advisory Committee and the Tobacco Working Group (as recommended by Acting Director Guy Newell at HEW's insistence) "does not mean we are losing interest in diet and nutrition and tobacco problems. . . . The Tobacco Working Group has done a superb job in getting recalcitrant members of industry involved in dealing with the problem." Board member Harold Amos said that "the Frederick program suffers from not having a continuous committee." Newell commented that TWG's work led to development of the new generation of less hazardous cigarettes and insisted its function would not be abolished. "The same role can be maintained either as state of the art working groups or as planning and program consultants. We will have to use other means (than through chartered committees)." In other words, dropping the committees is a cosmetic exercise that will save little if any money.

DEVITA ON D'ANGIO DURING TURMOIL: "HIS GREATEST PROBLEM WAS ME"

(Continued from page 1)

in that program, changes which eliminated some groups, strengthened others and broadened its emphasis from chemotherapy to multimodal clinical research.

Giulio D'Angio, who was chairman of the Cancer Clinical Investigation Review Committee throughout the period of change, went off the committee June 30. The new chairman will be Jerome DeCosse, chairman of the Dept. of Surgery at the Medical College of Wisconsin.

CCIRC is the group which reviews the grant proposals submitted by the cooperative groups. The terms of three other members of the committee also expired June 30—Theodore Grage, Univ. of Minnesota; William Levin, Univ. of Texas Medical Branch (Galveston); and Nell Sedransk, State Univ. of New York (Buffalo).

New CCIRC members are Simeon Cantril, former director of the NCI Centers Program now with the West Coast Cancer Foundation in San Francisco; Norman Breslow, Univ. of Washington; Robert Goodman, presently at Harvard who will move to the Univ. of Pennsylvania in August; George Higgins, Veterans Administration Hospital in Washington, D.C.; and Ralph Vogler, Emory Univ.

Another recent change in the cooperative group leadership was the election of Barth Hoogstraten, Univ. of Kansas, to head the group chairmen's committee. He succeeded James Holland, Mt. Sinai, who headed the committee during its first year of existence. The chairmen had demanded more of a voice in developing NCI policy on clinical research after the Cooperative Group program was moved from the Div. of Cancer Research Resources & Centers to the Div. of Cancer Treatment. DCT Director Vincent DeVita agreed to a more or less informal organization which meets periodically to let NCI know how the chairmen feel about various issues and to permit NCI staff to brief them on DCT programs.

The chairmen's committee originally set up a five-member executive committee, but that was abolished at the group's meeting in June. At the same time, the chairmen agreed to bring in representation from the statisticians who provide the data management and analysis for the Cooperative Group Program.

DeVita, in acknowledging D'Angio's departure, said that his chairmanship had occurred during a time of "turmoil and change. . . He approached the problems with great equanimity. His greatest problem was putting up with me."

D'Angio said that "cooperative clinical trials are the most vital things going on" in cancer research and "they indubitably have led to better care of the cancer patient. The key to the program is this committee."

During the shakeup process in the last two years, "the committee helped in pulling some people back from the abyss and helped channel their efforts into more productive areas," D'Angio said. "The surviving groups are highly organized and efficient. . . . The committee made possible a sharpening of the science of clinical trials."

D'Angio warned that "the committee is not outside the mainstream. I wish there was a better understanding among the group members and the chairmen that we're a review group—nothing more, nothing less. We must jealously guard that function. The committee must disregard pressures from inside and outside, and look at individual proposals on their merit."

The entire Cooperative Group Program will get a thorough review sometime next year, probably at either the spring or fall meeting of the DCT Board of Scientific Counselors. The impact of the emphasis on multimodality, the question of whether the move of the program into DCT has permitted better coordination of NCI-supported clinical trials, whether or not that move has benefitted the groups or has afforded them more opportunity to compete for more clinical research money, and whether the performance of the groups has been improved by all the changes presumably will be items for discussion.

RESPONSIBILITY ON SURGEONS FOR GREATER ROLE IN COOPERATIVE GROUPS, CCIRC SAYS

Theodore Grage has been carrying the ball on the CCIRC for greater participation of surgeons in the Cooperative Group Program. In his final act as a member of the committee, Grage presented a report on the role of surgeons in the group, saying "it is clear there are opportunities that need exploiting."

Those opportunities include increased participation in adjuvant trials, Grage said—in head and neck cancer, local excision in treating osteogenic sarcoma instead of amputation, and combined with radiotherapy in breast cancer. "We can try to achieve the same survival rate with less damage to the patient."

Grage suggested "an increasingly aggressive approach" in treating metastatic cancer with surgery.

To enhance the role of surgeons in cooperative group efforts, Grage said the CCIRC should:

- Recognize the principle of partnership.
- Provide funding.
- Establish an ad hoc subcommittee on surgical oncology.
- Maintain a close watch on multimodal studies, know the number of patients treated in those studies and "know what are the actual results."

Grage said that surgeons must be responsible for:

- Defining surgical oncology.
- Improving the content of surgical training.
- Establishing surgical oncology divisions in medical schools.
- Encouraging the leading surgeons in the cooper-

ative groups to organize themselves into a committee.

"The major responsibility is on surgical oncologists themselves to increase their participation for the greatest impact," Grage concluded.

CCIRC member and new chairman Jerome DeCosse, who is a surgeon himself, observed that "there is a great deal more cancer care and cancer research by surgeons going on than we are aware of. Surgery departments tend to have more money." DeCosse said it was his "philosophical" feeling that "someone other than Ted should have given that report. When we are here, we represent the entire cancer research effort. We're not an amalgamation of disciplines, each representing his own."

DeCosse said, "Surgeons have caused their own problems. People like Ted and Bernie Fisher are attempting to change them. I don't think CCIRC will be able to have an impact on intrasurgery problems."

CCIRC member Edward Beattie, chairman of the Sloan-Kettering Dept. of Surgery, said, "Basically there are two problems—convincing all surgeons they should be cooperative, become more active and cooperate with all disciplines; and the feeling among surgeons that cancer is not a surgical specialty."

Franco Muggia, who heads DCT's Cancer Therapy Evaluation Program, commented that he is trying to expand the Clinical Investigation Branch to include a variety of specialties. Muggia said he would welcome applications from medical, surgical and radio therapists.

CCIRC member John Horton, head of the Div. of Oncology at Albany Medical College, noted that some specialties still were not represented on CCIRC, pathology for instance. Chairman Giulio D'Angio agreed that some specialties were not well represented and reminded committee members that they should make recommendations to NCI staff on new members.

George Higgins, VA surgeon who is a new member of the committee, said that "20 years ago there was a big surgical input" into cancer research. "But when immediate results were not forthcoming, many lost interest. Fisher's group and our group are the only ones remaining. Now, with the positive results coming along, there will be more interest. . . . Surgical results have not improved much in the last 10-20 years. For improvement, we need to add something to surgery. Many surgeons around the country are totally turned off by this."

David Ahmann, CCIRC member from the Mayo Clinic, noted that "At many institutions, people are given the option of the department of surgery or department of oncology. There's no question where they go."

Higgins cited problems involved in comparing radiotherapy instead of surgery in carcinoma of the esophagus. "If you get a patient with a tumor for which the prognosis is good (treated by surgery), the surgeon is very reluctant to randomize him. I don't know how to answer that, but it's an answer we need."

"For a randomized study, one must have a sufficient degree of disbelief that one really knows the answer," DeCosse said.

"Randomization of surgical questions per se is very difficult," D'Angio said.

D'Angio wound up the discussion. "The ball is back to the surgical members of this committee, to determine what their goals are, to define surgical oncology, and to better review grants."

NEW "YOUNG INVESTIGATORS" GRANTS AVAILABLE; $25,000, THREE YEAR LIMIT

NCI has officially announced its new "Young Investigators Research Grant Program" designed to encourage postdoctoral scientists to enter cancer research and, hopefully, to bring with them bright new ideas. The program, previously called "New Initiative Awards," was revealed in May (*The Cancer Letter*, May 27) when money for it was provided in the 1978 budget proposal by the National Cancer Advisory Board.

NCI plans to award 25 YIRG awards a year. They will provide a maximum of $25,000 in direct costs per year, with the investigators' salaries limited to no more than $15,000.

The announcement said the program is intended to support early stages of cancer relevant research by newly trained investigators. "This special grant program is designed to provide modest initial support for exploratory research testing the feasibility of new techniques or approaches, performing developmental or pilot experiments, and gathering and analyzing preliminary data. Both basic and clinical research projects are encouraged, providing that they have clear relevance to one of the following programs of NCI: Carcinogenesis, clinical oncology, detection and diagnosis, drug development and pharmacology, epidemiology, immunology, radiation therapy, radiation biology and physics, tumor biology, and viral oncology."

NCI said it anticipates that the research accomplished with these grants will "in the majority of cases provide the basis for successful competition in the regular research programs of NCI." In other words, they will help the young scientists get their feet wet in cancer research and prepare them to compete with their more established colleagues for the bigger grants.

To be eligible, the project must be:

* Relevant to the cause, prevention, diagnosis, treatment or biology of cancer.
* Exploratory research with analysis of associated findings.
* Designed so that preliminary studies can be completed in three years or less.

* Acceptable in accordance with recognized criteria for scientific merit.

Investigators must:

–Provide a satisfactory research plan for the project period requested.

–Have received a doctoral degree within a four-year period prior to submitting an application or have completed a clinical residency program within two years prior to submitting an application.

–Not have been the recipient of a Research Career Development Award nor have been the principal investigator on an NIH grant or contract or equivalent, either at present or in the past; however, NIH fellows or trainees are not excluded.

–Agree to devote at least 50% time and effort to the project.

Awards will be made to non-U.S. institutions only under unusual circumstances, generally where unique capability available at the foreign institution is essential for the project.

Applications will be reviewed by the NIH Div. of Research Grants staff for relevance to NCI programs. The scientific and technical merit review will be conducted by DRG study sections. NCI said successful applicants may plan to go to work as early as six months after whichever project deadline they meet– Nov. 1, March 1, July 1. Deadline for the first round is Nov. 1, 1977, with the earliest start date May 1, 1978.

Since the awards are under $35,000, they do not require approval of the National Cancer Advisory Board, except in the case of foreign investigators.

The salary limit of $15,000 includes fringe benefits. The salary requested must not exceed the amount justified by time and effort devoted to the project. Other allowable costs include technicians' salaries, supplies, equipment, travel, consultants' fees, and any other items allowable in budgets for traditional research grants.

Indirect costs will be provided in accordance with established HEW policies for regular research grants.

The project period may not exceed three years. Applications for grant support beyond that period will be treated as renewal applications in the traditional research grants program.

Questions or requests for further information should be addressed to the staff of the NCI program area to which the research will be directed. For referral to those programs, call the NCI Referral Officer, 301-496-7903.

Samuel Price, acting assistant director of the Div. of Cancer Research Resources & Centers, commented in a memo to NCI staff on the new program that "NIH is now concerned about the many variations of small grants programs in different institutes and will probably move (at a snail's pace) to develop a unified policy."

Applicants should use the regular research grant application Form NIH 398.

THREE DIET/NUTRITION RFPS WITHDRAWN DUE TO "VAGUENESS;" TO BE REWRITTEN

Three NCI RFPs for diet and nutrition research have been held up by NIH associate director for collaborative research Leon Jacobs because he felt the language in the workscope was too vague.

Gio Gori, director of the Diet, Nutrition & Cancer Program at NCI, was asked to rewrite the RFPs with the help of experts in the fields covered by the proposed projects. Gori was out of the office this week and not available for comment.

Jacobs was ill this week and also unavailable, but an NIH spokesman told ***The Cancer Letter*** that Jacobs felt "some of the language was too vague . . . there were some semantic problems. . . some of the tasks were not clearly spelled out."

NCI sometimes deliberately avoids specificity in RFPs in efforts to permit flexibility for investigators to enable them to pursue leads and develop their research with a minimum amount of direction. The NIH spokesman said that Jacobs agrees that a certain amount of vagueness is sometimes desirable, but that this was not the case with the three RFPs at issue.

The RFPs will be reissued at a later date, when Gori and his staff complete the task of rewriting them. They are:

RFP NO1-CP-75925-69, Development and Validation of Standard Procedures for the Nutritional Assessment and Monitoring of Adult and Pediatric Cancer Patients.

RFP NO1-CP-75923-69, The Role of Nutritional Supplements in the Maintenance of Cancer Patients During Outpatient Therapy (Announcements of the above two RFPs appeared in ***The Cancer Letter*** June 17).

RFP No1-CP-75921-69, Evaluation of Calorie/-Nitrogen Ration of Oral Solutions Used in Feeding Cancer Patients (***The Cancer Letter,*** June 10).

NCI PLANS MEDIA BRIEFING JULY 13 ON X-RAY INDUCED THYROID CANCER

Following the determination that x-ray treatment given until a few years ago to children and young adults for a variety of benign diseases has been responsible for an increase in thyroid cancer incidence, NCI's Div. of Cancer Control & Rehabilitation undertook a program to educate the public and physicians about the problem.

This effort included distribution of millions of leaflets through supermarkets, a project now under way. An additional effort will be made July 13 when a special briefing for the media is scheduled at NIH. NCI's Office of Cancer Communications hopes to attract the mass media, including television, to help spread the word.

NCI has estimated that more than a million persons may have been exposed to x-ray treatments involving the head or neck. From the experience of

recall programs at several medical centers, it is estimated that a quarter to a third of the individuals irradiated eventually may develop thyroid tumors. A third of those tumors may be malignant.

The nationwide education program undertaken by NCI is aimed at briefing physicians on how to examine, diagnose and treat irradiation-related thyroid tumors, and at urging the population at increased risk to be examined by a physician.

Participants in the briefing will be Diane Fink, DCCR director; Margaret Sloan, DCCR program director for the education effort; Oliver Beahrs, director of the Div. of Surgical Oncology at Mayo Clinic; Jacob Robbins, chief of the Clinical Endocrinology Branch of the National Institute of Arthritis, Metabolism and Digestive Diseases; Norman Telles, from the FDA Bureau of Radiological Health; and representatives of the American Thyroid Assn., the American College of Radiology; and the American Cancer Society.

Beahrs and Robbins will demonstrate how to examine the neck for suspicious areas in the thyroid.

The briefing will start at 10:30 a.m. in Jack Masur Auditorium.

SENATE OKAYS $920 MILLION FOR NCI, DEFEATS ATTEMPT TO CUT ALL NIH

The Senate completed its action on the 1978 HEW appropriation bill last week, with $920 million for NCI, after beating back an amendment by Sen. Henry Bellmon (R.-Okla.) to cut the entire NIH budget by $91 million, reducing it approximately to the level approved by the House.

NCI is now assured of getting somewhere between $832 million, the House figure, and $920 million, probably around $875 million. This will permit the funding of 40-45% of approved competing grants.

The Senate voted 68-24 against the Bellmon amendment, after listening to arguments opposing it by Warren Magnuson (D.-Wash.), chairman of the HEW Appropriations Subcommittee; Birch Bayh, (D.-Ind.), Hubert Humphrey (D.-Minn.), and Charles Mathias (R.-Md.). Edward Brooke, ranking Republican on Magnuson's subcommittee, argued in favor of the full appropriation before Bellmon submitted his amendment.

Brooke said that the committee "has attempted to restore some balance to the funding of the various institutes." Most of them received a 15% increase over the 1977 appropriation (Bellmon's amendment would have cut that to 10%). "Because its appropriation has been rising rapidly, Brooke said, "the National Cancer Institute was given an increase of over 12% to $920 million. . . . Clearly our committee is not in the least downgrading the battle against cancer. Cancer's appropriation is rising and is now nearing the $1 billion mark. We believe that ever so gradually cancer research is paying off and that the program is on the right track, although the research is expensive and time consuming, NCI must, as our report points out, have adequate financial resources to continue its humanitarian work."

Bellmon argued that his amendment would not cut NIH funds under the current level or under the President's budget, and that it would provide for adequate growth and new initiatives. "The idea of jumping 15% in the operation of NIH to me seems to be extravagant. It is simply going to promote waste in that agency."

"I understand that," Magnuson responded, "and the Senator understands ours problem in this. The Senator himself presented an amendment, as I remember it, to add $20 million to diabetes."

"And take $20 million out of another item," Bellmon said.

"To take $20 million out of cancer," Magnuson said. "I do not like to see these things traded off like that. They have to stand on their own feet." Magnuson referred to progress in eye and heart research. "Heart cases have gone down 7.5% in the past year, and probably 16% over the last three years, much of that due to the hypertension screening that we have initiated in this bill.

"We are also pressing some buttons on cancer. . . . The first bill I ever authored when I came to Congress was to establish the cancer institute. I got the big sum of $2 million to establish it, and that started NIH we know today. At that time four out of five people who had cancer died. We have it down now to 2.5. . . I would rather err a little on the other side than to pick on NIH and biomedical research." That is the most sensitive program we have in this bill. We wanted to keep moving ahead and we though 15% would give us leeway in the conference (with the House)."

Bayh said, "There are people now living with their loved ones, walking, talking, playing, because we had the courage to put that money in there five years ago. For the first time in history ... we have had the number of people dying from heart diseases, stroke and heart related incidents, go down this year. . . . We have people now, children, living because of the progress made in cancer research in childhood leukemia. Breast cancer and other kinds of this disease have been effectively dealt with. . . . When we have the enemy on the run, I say let us pour it to them."

Humphrey said, "I have spoken at length on the need to fund the Cancer Program adequately at a level that permits us not only to maintain momentum but to advance toward greater understanding of the diseases that afflict Americans."

FOUNTAIN DISPLAYS SOME STATESMANSHIP, ATTACK ON CRUSADERS NEVER DEVELOPS

L.H. Fountain has been the congressman from Tarboro, N.C., since 1953, and he has pointed out on a number of occasions that he represents the leading tobacco growing area in the United States. It should

not surprise anyone when he appears at various committee hearings to argue against bills which tobacco growers consider are against their best interest and votes against such legislation on the few times it reaches the House floor.

When Fountain announced his Intergovernmental Relations Subcommittee of the House Government Operations Committee was planning hearings on the National Cancer Program, there were some who feared that he would use the hearings to counterattack the anti-smoking crusaders, particularly the American Cancer Society.

Through the first round of hearings, no such counterattack has developed. In fact, Fountain has been positively statesmanlike in permitting slashing attacks on cigarette smoking by one witness after another.

Dorothy Rice, director of the National Center for Health Statistics, pointed out that sharply increased cancer mortality can be accounted for primarily by lung cancer deaths, and that the lung cancer rate for women is climbing, coinciding with increased smoking by women.

Nobelist Howard Temin commented that cigarettes are the single most important carcinogen in the environment and that "we need to do more to stop cigarette smoking, the only measure available to make a real impact on cancer death rates."

Solomon Garb argued that it would be pointless to spend a greater share of NCI's budget on prevention, considering that NCI already has identified most of the carcinogens, and that even when one so obvious as cigarette smoking has been identified, it has not had much impact on smoking habits.

This is the kind of talk that has on other occasions moved less gentlemanly tobacco state congressmen into polemic tirades. But all Fountain did was to comment that he had been a three-pack-a-day smoker for 30 years. "I didn't stop because I feared cancer but because my throat was sore and my chest hurt, and I was uncomfortable."

"That's how it starts," needled John Wydler, the senior Republican on Fountain's committee.

"I figured I had paid my dues to cigarettes," Fountain said.

Fountain did point out "to all of you who made statements about lung cancer and smoking" that lung cancer showing up now "if it was caused by cigarettes, was caused by cigarettes made before 1970," when tar and nicotine content were higher than they are now.

Fountain also objected mildly to statements "against smoking per se that don't take into account those who may smoke only five cigarettes a day, or one."

Temin agreed that some data exist which indicate there is a lower lung cancer rate among those who smoke the lower tar and nicotine cigarettes. "But we still have the problem of heart disease," Temin said. "If we reduce tar and nicotine, some might smoke more cigarettes and get more carbon monoxide and more heart disease."

"But how about the smoker who doesn't inhale? There are hundreds of thousands of them," Fountain persisted.

When Irwin Bross suggested that the "mystery of the falling heart disease rate is likely due to the sharp reduction in tar content of cigarettes," Fountain responded, "How about temperance and moderation instead of scare tactics."

Finally, when Benno Schmidt made a particularly strong statement that cigarettes cause 40% of all cancers, Fountain displayed just a hint of impatience. "Just what evidence do you base that on?" he demanded.

Schmidt seemed to relish the opportunity. "The experimental evidence includes skin painting tests, in which smoke condensate has produced tumors on animals. It's based on evidence we have that some chemicals identified in tobacco smoke, like polycyclic hydrocarbons, are known carcinogens. It's based on the fact that over 90% of squamous cell lung cancer victims are heavy smokers. And that cigarettes contain combustible products that we know are carcinogens."

Fountain asked for evidence that cigarettes cause cancers in addition to lung cancer "that make up the rest of the 40%."

Schmidt said NCI epidemiological studies have shown a relationship between cigarette smoking and bladder and esophageal cancer, among others." He acknowledged that the increase in lung cancer "may be due in part because we get a lot of other pollution" in addition to cigarette smoking.

"Whether someone is a heavy smoker or a light smoker or doesn't smoke at all should be an individual decision, shouldn't it?" Fountain asked.

"And whether or not to inhale," Schmidt agreed.

PROBE FINDS FARBER GRANT "CONFLICT" BUT DOESN'T TELL THE ENTIRE STORY

An incident that arose during the hearings on the National Cancer Program conducted by Congressman L.H. Fountain's Intergovernmental Relations Subcommittee demonstrated how an imcomplete investigation can totally distort the story of what really happened.

Congressman John Wydler, ranking Republican on the subcommittee, was questioning Cancer Panel Chairman Benno Schmidt on possible conflicts of interest posed by membership on the National Cancer Advisory Board by representatives of institutions which receive NCI grants and contracts. Wydler had referred to NCAB member Philippe Shubik and the questions about his institution's (Eppley) contract with NCI.

"The fact that Eppley receives NCI funds doesn't bother me in regard to his being on the Board,"

Schmidt said. "We have mechanisms to eliminate the problem of conflict of interest." Grants and contracts are awarded according to peer review, "and the Board seldom overrides the reviewers," Schmidt said.

"But isn't it like members of the board of directors of a bank voting on each other's bank loans?" Wydler asked.

Schmidt expalined that Board actions on grants have to do with approving or disapproving recommendations of NIH study sections, members of which have no connections with the grantees. "I've had as much business experience as anyone here," Schmidt said. "I know what back scratching is. If there was any going on with the Board members, I would know it. . . . As long as the Board is acting on the impartial recommendations of a study section, and the Board member (whose grant is being considered) has no active part in the deliberations, it isn't a conflict of interest. I haven't seen anything like a bank board sitting around loaning each other their depositors' money."

"It think it is most dangerous if Board members are in a position to vote on each other's projects," Wydler insisted. "Board members and members of the peer review groups do talk to each other. There is a great potential for conflict."

"I understand," Schmidt said. "But is the answer to have a know-nothing Board? I don't think so. I came into this business with great scepticism. I was worried about the old boy kind of thing. But having looked and watched, I think the peer review system is the best system we have of distributing government funds. I wish money was distributed as well elsewhere in government. If it were, I would have a lot more confidence when I write my check to the IRS."

Fountain staff aide Delphis Goldberg then referred to an action taken by the National Cancer Advisory Council, the NCAB's predecessor, in the 1960s. Goldberg said his investigation revealed that the late Sidney Farber of Harvard, who was a member of the Council, "did receive special consideration from the Council. The study section saw no merit" in a grant proposal submitted by Farber. "The Council allowed him to make a private presentation, and then funded it."

Schmidt pointed out that the rules have since been changed and that "that couldn't happen now." The only action the Board could take would be to refer the grant back to the study section or to another study section if it disagreed with the original study section findings.

NIH Director Donald Fredrickson noted that members of all NIH boards and councils must exclude themselves from meetings when their grants are being considered. "Now, they must not attend any part of the meeting," Fredrickson said.

Neither Goldberg nor anyone else mentioned what had been involved in the Farber incident. Solomon Garb, scientific director of the American Medical Center at Denver who had already presented his statement to the subcommittee, asked if he could respond but was told to submit his comments in writing for the record.

The fact is that NIH study sections have not been easily persuaded to fund clinical research. Farber's proposal that the study section "saw no merit in" opened new doors in chemotherapy and, among other accomplishments, led directly to development of adjuvant chemotherapy that is probably curing more than half of osteogenic sarcoma patients.

Wydler asked Schmidt about the present role of the Cancer Panel. "Is it different than with the previous two Presidents?"

"The role is not different, but the modus operandi us," Schmidt said. "We deal now with the HEW secretary, not directly with the President."

"Is this more or less effective?" Wydler asked.

"Time will tell," Schmidt replied. "So far, I have no difficulty in getting along with the secretary."

"Getting along with him wasn't my question," Wydler said. "Is this more effective?"

"I don't care if I get along with him socially," Schmidt said. "If I can be effective dealing with the office boy, that's okay with me. It gives me no satisfaction to go to the White House. If we get to the point where I can't be effective (dealing with the HEW secretary), then I will go to the White House. If that doesn't work, I'll give up the job. I won't hesitate to go over the secretary's head, if that is the only way. I have the strong impression, however, that would be very difficult."

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute, unless otherwise noted. Write to the Contracting Officer or Contract Specialist for copies of the RFP, citing the RFP number. Some listings will show the phone number of the Contract Specialist, who will respond to questions. Listings identify the respective sections of the Research Contracts Branch which are issuing the RFPs. Their addresses, all followed by NIH, Bethesda, Md. 20014, are:

Biology & Diagnosis Section – Landow Building
Viral Oncology & Field Studies Section – Landow Building
Control & Rehabilitation Section – Blair Building
Carcinogenesis Section – Blair Building
Treatment Section – Blair Building
Office of the Director Section – Blair Building
Deadline date shown for each listing is the final day for receipt of the completed proposal unless otherwise indicated.

RFP NCI-CM-87164

Title: *Frozen tumor bank*
Deadline: *Approximately Aug. 11*

NCI requires the operation of a frozen tumor bank consisting of approximately 20,000 vials of human and animal tumors stored in liquid nitrogen for experimental use in cancer research. This effort involves

processing, freezing, and recovering human and animal tumors, checking human and animal tumors for viability; and shipping human and animal tumors in vivo and in vitro.

Access to an international airport is necessary as foreign shipments will be made. The principal investigator must be trained in cell biology and tumor biology preferably at the PhD level, or equivalent in experience. Other key personnel must be experienced in segments of the effort for which they are proposed. It is anticipated that a contract will be awarded on an incrementally funded basis for a period of five years. The level of effort will be three technical years of effort per year.

Contract Specialist: John Thiessen
Cancer Treatment
301-427-8125

CONTRACT AWARDS

Title: Cells involved in the immune response to tumors
Contractors: Harvard College, $68,709; and Robert B. Brigham Hospital, $62,741.

Title: Prototype network demonstration project in head and neck cancer, renewal
Contractors: Northern California Cancer Program, $321,008; Univ. of Kansas Medical Center, $296,670; and Emory Univ., $198,458.

Title: Modified tumor cell membranes as immunotherapeutic agents
Contractor: Stanford Research Institute, $68,998.

Title: Immune status and effects of immunostimulants in patients receiving localized radiation therapy
Contractor: Univ. of California (San Francisco), $95,787.

Title: Purification of antigens; preparation of antibodies
Contractor: George Washington Univ., $179,704.

Title: Immunotherapy in outbred cat lymphoma and leukemias
Contractor: Harvard College, $79,123.

Title: In vitro study of the nature of interaction between chemical and viral carcinogens
Contractor: Ohio State Univ., $127,277.

Title: Immunotherapy of mouse tumors using immunoresponsive cells sensitized in vitro, continuation
Contractor: The Wistar Institute, $93,672.

Title: Diagnosis of human leukemias
Contractor: Univ. of Massachusetts, $83,130.

Title: Human tumor or organ-associated antigens diagnostic application
Contractor: Sloan-Kettering Institute, $72,973.

Title: Assays of monocyte-macrophage function
Contractor: Ohio State Univ., $89,524.

Title: Role of macrophages in tumor immunology
Contractor: Univ. of Minnesota, $75,365.

Title: Quantitative assays of monocyte-macrophage function
Contractor: Robert B. Brigham Hospital, $118,800.

Title: Purification of human tumor associated antigens
Contractor: Eastern Virginia Medical Authority, $77,283.

Title: Therapy of tumors in mice with tumor necrosis factor
Contractor: Sloan-Kettering Institute, $84,818.

Title: Immunotherapy of C3H murine mammary carcinoma, continuation
Contractor: Univ. of Pittsburgh, $74,000.

Title: Immunotherapy of herpes virus lymphomas in marmosets
Contractor: Southwest Foundation, $139,344.

Title: Immunotherapy in the L_2C guinea pig leukemia
Contractor: Univ. of Texas System Cancer Center, $123,130.

Title: Active specific immunotherapy in acute myelogous leukemia, continuation
Contractor: UCLA, $77,336.

SOLE SOURCE NEGOTIATIONS

Proposals are listed here for information purposes only. RFPs are not available.

Title: Prototype comprehensive network demonstration project in head & neck cancer, renewal
Contractor: New York State Dept. of Health, Roswell Park Div.

Title: Study of oncogenesis and other late effects of cancer therapy, continuation
Contractor: Children's Hospital of Philadelphia.

Title: Comprehensive Cancer Center communications network
Contractor: Illinois Cancer Council.

Title: Prototype comprehensive network demonstration project for breast cancer, renewal
Contractor: State Univ. of New York (Albany).

The Cancer Letter—*Editor* JERRY D. BOYD

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