THE CANCER LETTER

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NCI BYPASS BUDGET REQUEST FOR FY 1982 SEEKS $1.192 BILLION; WOULD FUND 40% OF COMPETING R01s

NCI's "bypass" budget request for the 1981 fiscal year will ask $1.192 billion—$192 million more than the institute is getting in the current, 1980 fiscal year and $184.2 million more than the President's budget request for FY 1981.

"That may seem like pie in the sky," said Frederick Seitz, chairman of the National Cancer Advisory Board's Subcommittee on Planning & Budget when he presented the 1981 preliminary budget to the Board

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In Brief

COLUMBIA'S MARKS REPORTEDLY WILL MOVE TO MSK; FDA COMMITTEE TO CONSIDER THC FOR GROUP C LIST

PAUL MARKS, director of the Columbia Univ. Comprehensive Cancer Center, will move across town to become director of Memorial Sloan-Kettering Comprehensive Cancer Center when Lewis Thomas retires later this year, sources have told *The Cancer Letter*. Thomas will remain with MSK but in a less active role, probably with the title of chancellor. Neither MSK officials nor Marks would comment on the report. . . . **FOOD & DRUG** Administration's Oncologic Drugs Advisory Committee will consider the request by NCI's Div. of Cancer Treatment to add THC to its list of "Group C" drugs, which would make it available for distribution free to physicians who agree to follow DCT protocols in its use and report on results. The active ingredient in marijuana has been found effective in controlling nausea and vomiting associated with anticancer chemotherapy. The committee also will discuss whether phase 1 safety monitoring in DCT's master file and phase 1 safety parameters in FDA's proposed clinical guidelines for antineoplastic drugs require expansion in view of the new animal toxicology guidelines previously approved by the committee. The committee will undertake what FDA hopes is the final review of the clinical guidelines. . . . **CONDICT MOORE**, director of the Univ. of Louisville Cancer Center, is the new president of the Society of Surgical Oncology. Jerome DeCosse, chief of surgery at Memorial Sloan-Kettering, is president elect; Gerald Murphy, director of Roswell Park Memorial Institute, is vice president; Robert Hutter, director of the department of pathology at St. Barnabas Medical Center, is treasurer; and Victor Denbrow was reelected secretary. . . . **SYMPOSIUM ON** the nature, prevention and treatment of clinical toxicity of anticancer agents, sponsored by NCI and the European Organization for Research on Treatment of Cancer, is scheduled Sept. 25-27 in Brussels. Abstracts for free communications, in English, 250-300 words, will be accepted to Aug. 1. Send to, and register with, M. Staquet, EORTC Coordinator, Institut Jules Bordet, 1 rue Heger-Bordet, 1000 Brussels, Belgium.

NIH EYES FCRC FOR MORE INTRAMURAL SPACE AS CONTRACT RECOMPETITION NEARS

Since the day that President Nixon ordered NCI to take over the Army's biological warfare facility at Ft. Detrick in Frederick, Md., and hammer it into a swords-to-ploughshare instrument of the National Cancer Program, NCI executives have agonized over what to do with it. They saw it first as a resource production facility, but the National Cancer Advisory Board demanded that it have a strong basic research component. They negotiated the biggest contract in NIH history to provide the services, resources and perform the research and have worried ever since if they were doing the right thing. They listened to complaints from those who felt that the millions going into the contract should instead go to the extramural program. And they listened to grumbling from NCI intramural staff members who did not like the prospect of being shipped away from the Bethesda campus.

Eight years, countless reviews and one contract renewal later, most of the criticism has turned to praise, the superb quality of the basic research program under the direction of Michael Hanna has been demonstrated, the value of the biological and chemical carcinogenesis studies under Ray Gilden and Willie Lijinsky has become appreciated, and the resource production has proven to be noteworthy. Yet the future of the operation as it is now being conducted remains very much in question.

Intramural research operations at NIH have bumped up against space limits; there is little or no room for further major expansion of research facilities. This led NCI division directors two years ago to suggest that the Frederick Cancer Research Center might be converted from a GOCO (government owned, contractor operated) facility into "NIH North." The $25 million a year contract with Litton Bionetics Inc. could be phased out, they said, with NCI and other NIH intramural labs moving into the vacated space as needed.

The Administration's determination to limit personnel increases throughout the government made it unlikely that enough growth would occur in the foreseeable future to warrant any substantial move by NIH labs to FCRC. NCI Director Arthur Upton and NIH Director Donald Fredrickson issued a joint statement early last year which said:

"Although it is foreseen that additional elements of NIH intramural research will eventually be located at FCRC, the number, size and identity of such elements cannot be specified at present nor can the timing with which they may be established there. In any event, there can be expected to be a need for maintaining indefinitely a combination of contractor research activities and intramural research activities at FCRC. Because such a combination will be highly advantageous if the two types of activities are programmed to be mutually complementary, long range plans for FCRC should take this into account. . . . As these plans develop and as NCI re-evaluates its commitments at FCRC in the light of a no growth budget presumed for 1980, the need for orderly changes will be addressed jointly by the government and contractor (*The Cancer Letter*, Feb. 9, 1979)."

The need to get started with these long range plans was thrust onto Acting Director Vincent DeVita by the fact that Litton Bionetics' contract will expire Sept. 25, 1982. The recompetition necessitates the issuance of an RFP at least a year ahead of that date. DeVita decided that development of the RFP workscope would have to begin by September 1980, and therefore the policy affecting the general direction of the new contract would have to be firmed up this summer.

Another factor has emerged which has added some urgency to the situation and could change the prospect of a wholesale move of NIH labs to FCRC from the distant to the immediate future: seven buildings at the NIH campus—Bldgs 2,3,4,5,7,8, and 9—have been declared unsafe and must be cleared for extensive renovations. A few labs can be absorbed in existing space on campus, and more administrative offices will be moved to rented space in the Bethesda area. But much more lab space will be required than those solutions will provide, and Fredrickson is eyeing FCRC as the solution. The prospect is thus opened that NIH will not have to wait for growth of the intramural program and the new positions that would be required to take over FCRC lab space.

Fredrickson asked DeVita to present the situation to the National Cancer Advisory Board this week, coinciding with the Board's long-planned visit to FCRC.

DeVita gave the Board a statement recounting FCRC's history and suggesting consideration of four options.

"Since NIH and NCI have decided that the long-term (5-10 years) objective for FCRC is to gradually transform the facility from a contractor to a federal operation (that may be news to some; it was not exactly what Upton and Fredrickson said in their statement last year), discussion of options for the future operation of the facility are concerned primarily with two issues:

"* Selecting the type of contracting approach to be used, i.e., single vs. multiple.

"* Establishing the mix of management vs. program responsibilities for the contractor and the federal staff during the transition period.

"Since the speed with which the transition can take place will continue to be constrained by the allocation of new federal positions to NIH and NCI, and the time it takes to plan and execute the movement of major programs and staffs from one facility to another, participation of a contractor(s) in the opera-

tion of the facility will be necessary for the foreseeable future.

"If a federal agency has decided that some aspects of its mission are best carried out by a GO-CO operation, a single contractor is usually the preferred approach from the standpoint of overall efficiency, cost-benefit, and management control with a minimum of federal staff.

"If the agency wants to enhance competition, experience lower individual contract costs, has adequate staff for program and contract management and is willing to sustain higher overall costs—then multiple contracts are preferred. The number of individual contracts is limited by program considerations and number of federal staff available for contract management.

"In 1979, at the request of Secretary Califano, a study was performed comparing the advantages and disadvantages of single vs. multiple contracts for the operation of FCRC."

The advantages and disadvantages of each as determined by the study were:

Single—advantages—least expensive overall, focused responsibility, workload fluctuations more easily absorbed, single audit trail. Disadvantages—may not receive broad competition (when the contract was offered for recompetition in 1977, no one else even tried to take on Litton Bionetics).

Multiple—advantages—enhanced competition, lower individual contract costs, greater individual contract efficiency, tighter checks and balances on each contract is possible. Disadvantages—higher overall costs to the government, additional government personnel required, numerous lines of communications, scattered responsibility.

"In addition," the statement continued, "in the multiple contract approach, an interested contractor need apply only for that part of the total procurement in which he has the most competence and experience. For example, a consortium of universities would be more likely to submit a bid for the research portion than it would for the general support activities.

"Within the framework of single vs. multiple contracts and the mix of federal vs. contractor responsibilities, it is possible to develop a wide range of contract options with minor differences which would effect equally minor impact on program operations. The options described here represent the most basic and least complicated approaches.

OPTION 1—Termination of the GO-CO Contract

"Federal contracts can be terminated for a variety of reasons ranging from nonperformance to 'for the convenience of the government'. From a technical contract standpoint, termination of a large GO-CO contract is no different than terminating a contract that supports an individual investigator. However, the immediate and long term impacts of terminating a contract involving over 800 contractor personnel, $25-30 million of program, and over 800,000 square feet of space are obviously different.

"This option would reduce the resident staff to about 150 federal employees (NCI, NINCDS, NIAID), assuming all currently contemplated moves from Bethesda to Frederick take place (not including transfers from the renovated buildings). Space utilization would be reduced from approximately 790,000 to 370,000 square feet. Total costs would be reduced from $25-30 million to approximately $8-12 million, including a general support contract.

"The major features of this option are:

"* The current single GO-CO contract would not be recompeted thus terminating all contractor management and program responsibilities.

"* Initially, competition would be held for a general support contract to provide engineering, renovation, maintenance, glass washing, animal care, etc. for the NIH/NCI programs remaining with the contract either maintained or phased out as more federal capability increases.

"* The program at FCRC would be rebuilt with federal staff until desired level of operation is reached (smaller, same or larger than current level).

"From a contract standpoint, this option could be efficiently executed in the time available to the contract anniversary (September 1981).

OPTION 2—Continue Single Contractor Operation with Gradual Phaseout of all Contractor Responsibilities

"The essential features of this option are:

"* The single GO-CO contract for the operation of FCRC would be recompeted.

"* The contract would include specific agreements and time-targets for the gradual and phased shift of selected program and management responsibilities from the contractor to federal staff until all aspects of the operation are federal responsibility, and until the desired program size is reached.

"This option would accomplish the complete shift to a 100 percent federal facility. The target program size selected and the availability of federal staff to match the program size are the constraining factors on the speed with which this option can be completed. For example, the one-to-one replacement of the 850 contractor staff with federal staff could not be accomplished in the foreseeable future (again, without considering moves from the renovated buildings).

OPTION 3—Continue Single Contractor to Phaseout of Program and Management Responsibilities—Retain Support Contract

"This is the same as Option 2 with one major difference:

"* After all program and selected management responsibilities have been shifted from contractor to federal staff, competition would be held for a private contractor to provide the research resources and

(Continued to page 6)

NATIONAL CANCER INSTITUTE 1
BUDGET HISTORY BY MECHA

	1973 ACTUAL		1974 ACTUAL		1975 ACTUAL		1976 ACTUAL	
	DOLLARS	PERCENT OF TOTAL	DOLLARS	PERCENT OF TOTAL	DOLLARS	PERCENT OF TOTAL	DOLLARS	PERCENT OF TOTAL
Group I—Investigator Initiated								
Regular Research Grants	$ 73,412	21.1	$ 99,415	21.5	$112,258	20.8	$129,021	22.3
Clinical Cooperative Groups	12,791	3.7	16,196	3.5	19,213	3.5	23,263	4.0
Program Projects	52,008	14.9	71,997	15.6	83,468	15.5	77,805	13.5
Radiation Development Program	—	—	—	—	4,005	.7	3,836	.7
Clinical Education Program	—	—	—	—	5,033	.9	7,698	1.3
Research Career Program	1,818	.5	1,673	.4	2,806	.5	3,243	.6
Fellowships and Training	13,888	4.0	23,562	5.1	23,104	4.3	18,160	3.1
Organ Site	3,950	1.1	10,007	2.2	11,167	2.1	14,090	2.5
Cancer Centers—Core Support	13,002	3.7	17,575	3.8	30,096	5.6	47,803	8.3
Rehabilitation Grants	—	—	—	—	1,495	.3	1,438	.2
Subtotal	170,869	49.0	240,425	52.1	292,645	54.2	326,357	56.5
Group II—Co-Initiated								
Cancer Res. Emphasis Grants (CREG)/RFA	—	—	—	—	—	—	2,577	.4
Research Contracts	57,187	16.4	89,964	19.5	94,976	17.6	99,924	17.3
Subtotal	57,187	16.4	89,964	19.5	94,976	17.6	102,501	17.7
Group III—NCI/NCP Initiated								
Resource Contracts	68,838	19.8	77,365	16.7	93,016	17.2	108,109	18.7
Interagency Agreements	10,136	2.9	13,031	2.8	11,593	2.2	13,262	2.3
Subtotal	78,974	22.7	90,396	19.5	104,609	19.4	121,371	21.0
Group IV—Other Resources								
Planning Grants	2,500	.7	2,880	.6	2,568	.4	2,803	.5
CCPDS	—	—	—	—	—	—	—	—
Construction Grants	34,737	10.0	31,692	6.9	30,000	5.6	20,000	3.5
Construction Contracts	4,067	1.2	6,398	1.4	14,976	2.8	4,721	.8
Subtotal	41,304	11.9	40,970	8.9	47,544	8.8	27,524	4.8
Total	348,334	100.0	461,755	100.0	539,774	100.0	577,753	100.0
Percent of Total NCI Budget		81.9		79.5		77.2		75.9
In-House Research	33,032	7.8	40,364	6.9	50,532	7.2	61,243	8.0
Management & Support	39,072	9.2	46,169	7.9	61,935	8.9	69,876	9.2
(NIH Management Fund)	(15,194)	(3.6)	(16,754)	(2.9)	(20,248)	(2.9)	(23,037)	(3.0)
Cancer Control (Grants & Contracts)	4,969	1.1	32,826	5.7	47,079	6.7	52,578	6.9
Subtotal	77,073	18.1	119,359	20.5	159,546	22.8	183,697	24.1
Total NCI	**$425,407**	**100.0**	**$581,114**	**100.0**	**$699,320**	**100.0**	**$761,450**	**100.0**

CENTERS, GROUPS, CONSTRUCTION GET INCREASES IN 1982 BYPASS BUDGET

(Continued from page 1)

Monday. "But this budget will be made up (for submission to Congress) after the election. You can't tell what will happen then."

The FY 1982 budget will be for the year starting Oct. 1, 1981. NCI will submit this budget directly to the President in September, 1980—bypassing NIH and HHS, as permitted by the National Cancer Act. NCI also will submit another budget through those channels, giving both NIH and HHS (Health & Human Services, formerly HEW), the opportunity to slash it, which they invariably do. NCI's portion of the President's budget which goes to Congress will be the latter.

The bypass budget, however, is NCI's chance to demonstrate its optimal prospects—what the Cancer Program could do if it only had the full amount of money which could be spent wisely. The bypass budget establishes the goal, the President's budget the floor. The congressional appropriation falls somewhere between, depending on how well Cancer Program advocates present their case to the appropriations subcommittees and their own representatives.

Features of the preliminary budget include:

* $93.8 million would fund 39 percent of approved traditional competing (new and renewal) R01 grants, up from an estimated $65.3 million funding 29 percent of approved competing R01s in FY 1981. Grants would be funded to a priority score of 227, compared with 203 predicted for 1981.

* Competing program projects would be funded with $58.7 million, with 80 percent of the renewals and 56 percent of new grants funded. Only 51 percent of the approved renewals and 13 percent of approved new P01s will be funded in 1981, unless Con-

PRELIMINARY BUDGET
SM (IN THOUSANDS)

1977 ACTUAL		1978 ACTUAL		1979 ACTUAL		1980 ESTIMATE		1981 ESTIMATE		1982 ESTIMATE	
	PERCENT OF TOTAL	DOLLARS	PERCENT OF TOTAL	DOLLARS	PERCENT OF TOTAL	DOLLARS	PERCENT OF TOTAL	DOLLARS	PERCENT OF TOTAL	DOLLARS	PERCENT OF TOTAL
),156	22.8	$158,186	24.4	$188,488	27.3	$ 206,411	28.1	$ 228,981	31.1	$ 273,200	31.1
,121	4.4	29,774	4.6	32,021	4.6	35,534	4.8	32,847	4.5	40,500	4.6
,211	13.3	85,373	13.2	93,953	13.6	100,447	13.7	102,424	13.9	129,892	14.8
,245	.5	3,215	.5	—	—	—	—	—	—	—	—
,996	1.5	9,952	1.5	11,404	1.7	10,904	1.5	10,000	1.4	11,210	1.3
,507	.6	4,399	.7	4,771	.7	4,283	.6	4,000	.5	4,484	.5
,791	3.2	20,129	3.1	20,139	2.9	27,114	3.7	22,657	3.1	27,000	3.1
,711	2.4	16,194	2.5	17,032	2.5	17,261	2.3	16,500	2.2	18,497	2.1
,132	9.0	60,348	9.4	64,364	9.3	66,435	9.1	66,435	9.0	74,498	8.5
,121	.4	1,987	.3	1,279	.2	1,844	.3	1,968	.3	2,709	.3
,991	58.1	389,557	60.2	433,451	62.8	470,233	64.1	485,812	66.0	581,990	66.3
,266	1.2	9,412	1.5	7,894	1.1	6,760	.9	4,196	.5	2,937	.3
,240	15.9	97,459	15.0	81,119	11.8	71,594	9.8	65,360	8.9	72,482	8.2
,506	17.1	106,871	16.5	89,013	12.9	78,354	10.7	69,556	9.4	75,419	8.5
,729	17.6	110,706	17.1	130,161	18.8	147,016	20.0	158,182	21.5	173,228	19.7
,414	3.2	21,621	3.3	20,734	3.0	22,603	3.1	19,885	2.7	21,203	2.4
,143	20.8	132,327	20.4	150,895	21.8	169,619	23.1	178,067	24.2	194,431	22.1
,199	.2	632	.1	271	—	200	—	200	—	200	—
,434	.2	1,617	.2	—	—	—	—	—	—	—	—
,000	2.6	12,000	1.9	12,452	1.8	11,000	1.5	1,000	.1	21,000	2.4
,992	1.0	4,544	.7	4,878	.7	4,000	.6	2,000	.3	6,000	.7
,625	4.0	18,793	2.9	17,601	2.5	15,200	2.1	3,200	.4	27,200	3.1
,265	100.0	647,548	100.0	690,960	100.0	733,406	100.0	736,635	100.0	879,040	100.0
	75.0		74.2		73.8		73.3		73.1		73.7
,855	8.3	79,217	9.1	88,944	9.5	103,862	10.4	107,137	10.6	125,849	10.6
,184	9.8	86,594	9.9	91,167	9.7	99,574	9.9	105,428	10.5	121,971	10.2
,817)	(3.3)	(30,150)	(3.5)	(35,622)	(3.8)	(38,076)	(3.8)	(39,913)	(4.0)	(45,000)	(3.8)
,653	6.9	59,010	6.8	65,625	7.0	63,960	6.4	58,600	5.8	65,140	5.5
,692	25.0	224,821	25.8	245,736	26.2	267,396	26.7	271,165	26.9	312,960	26.3
,957	100.0	$872,369	100.0	$936,696	100.0	$1,000,802	100.0	$1,007,800	100.0	$1,192,000	100.0

gress adds money to the President's budget. The total amount available for competing awards would be triple that estimated for 1981, to a large extent because of the greater number of carryover noncompeting projects to be funded in 1981.

The total bypass budget figure for 1982 R01s, including noncompeting renewals, is $273.2 million; for program projects, $40.5 million.

* Cancer center core support grants would get $74.5 million in 1982, up from the $66.4 million in the current fiscal year and the same amount requested for 1981. An estimated 19 out of 20 approved renewals and one out of two approved new core grants would be funded.

* The Clinical Cooperative Groups would get $40.5 million, up from the $32.8 million in the President's budget for 1981. The 1981 request was a cut of about $2.5 million under the 1980 amount for the groups and some of that probably will be restored, depending on what happens with the final appropriations legislation. In the narrative justifying the bypass budget, NCI said the Cooperative Groups "will receive additional support in order to incorporate necessary elements of quality control in the area of statistics, radiation physics, and pathology. Efforts will also continue in the development of multimodal therapy capability and the development of geographically oriented groups."

* Organ site programs, which were cut from $17.3 to $16.5 million in the FY 1981 budget, are listed for an increase to $18.5 million in the 1982 bypass budget.

* Research manpower development, slashed from $44.4 million to $38.7 million in the 1981 budget, would get all of that cut and a little more restored in the 1982 request of $45 million.

* Construction, the favorite whipping boy when the budget has to be cut, almost wiped out with a

1981 budget of only $1 million for grants (unless reversed by Congress), would be brought back to life with the 1982 budget reqeust of $21 million for grants. Another $6 million (shown in the budget as contracts) would be available for upgrading federal cancer facilities, including those at Frederick Cancer Research Center.

* Cancer control, cut $2 million from 1979 to 1980 and another $5 million in the 1981 request, would go back to $65 million for 1982.

NCAB OPPOSES LINE ITEM IN CANCER ACT RENEWAL BILL FOR CENTER CORE GRANTS

The National Cancer Advisory Board went along with the NCI staff position against congressional earmarkings and line items in the budget and voted without objection against a line item for cancer center core grants in the Cancer Act renewal legislation.

Chairman Henry Waxman of the House Health Subcommittee, at the request of the Assn. of American Cancer Institutes, added the line item for centers in his bill, H.R. 7036. The first year, FY 1981, would have $90 million authorized; the President's budget requests $66 million.

Frederick Seitz, chairman of the Board's Subcommittee on Planning & Budget, reported that the subcommittee strongly backed the staff's opposition to line items. Board member Robert Hickey argued that "the only way you can defend some aspects of the budget is with a line item," but he drew no support.

No votes were cast against the motion opposing the line item, and Board Chairman Henry Pitot said the vote in favor was "unanimous," although Hickey and possibly a few others appeared not to vote for it.

Hickey, retiring NCAB member William Shingleton and other AACI members indicated after the meeting they would continue to press in Congress for the line item.

The companion Senate bill, S. 988, has no authorization figures at all and thus no line item for any program.

DEVITA SUGGESTS FOUR FCRC OPTIONS; NCAB DELAYS ITS RECOMMENDATIONS

(Continued from page 3)

general support services (e.g., virus production, animal production, engineering, maintenance, etc.)

"This option provides for the conduct of research and key management functions by federal staff and would make the best use of critical personnel slots for these activities rather than for general support functions.

OPTIONS 4A and 4B—Continue GO-CO with Multiple Contracts

"The multiple contractor approach can vary from the aggregation of all management and program activities into a minimum number of contracts greater than one to the competitive contracting of each individual project or task.

"With the current level of FCRC operations, the latter could result in the requirement to process as many as 50 individual contracts, each requiring a federal project officer. Options 4A and 4B represent two viable approaches that would serve to enhance competition and also minimize the number of federal personnel required for contract administration activities. The estimated dollar amounts shown with each contract area are based on the current contract level of approximately 24 million.

Option 4A—Six Contracts

"1. Central Management Support – $7.1 million. General operations include engineering, renovation and construction, maintenance, etc. Administration includes personnel, purchasing, business/accounting, travel, etc.

"2. Science Research—cancer biology, biological carcinogenesis, chemical carcinogenesis, biological markers—$10.5 million.

"3. Science Research—virus production, fermentation pilot plant—$3.0 million.

"4. Animal Services—animal production, animal holding, diagnostic health laboratory—$2.3 million.

"5. Biohazards/Environmental Control and Safety —$0.6 million.

"6. Science Services—chemical services laboratory, central histopathology service, mycoplasma testing, media preparation—$0.8 million.

Option 4B—Three Contracts

"1. Central management and administrative support and general services (engineering, maintenance, renovation, etc.)—$7.1 million.

"2. Research—cancer biology, biological carcinogenesis, biological markers—$10.5 million.

"3. Research resources and services—fermentation plant; virus production; animal production, holding, and testing; biohazards control and safety; chemical and histopathology services, mycoplasma testing, media preparation—$6.7 million."

After presentations by Litton Bionetics and NCI staff describing FCRC research programs and a tour of the facilities, NCAB members discussed the options and added some of their own.

Board Chairman Henry Pitot said that in view of the need to develop some direction for the recompetition before the next meeting of the Board, "we should try to come up with something now." He asked if a fifth option, offered earlier by Hanna in his presentation, could be considered: the status quo.

"Not unless it included some provision to accommodate more NIH personnel," said William Terry, who represented DeVita at the session. "It would not be consistent with the intent of Drs. DeVita and Fredrickson to relieve some of the intramural pressures."

Hanna, who is now director of FCRC for Litton Bionetics (and has appointed Margaret Kripke to succeed him as director of the basic research (now called the biology) program, noted that there is still room for expansion without affecting the current operation. There is still 150,000 square feet of unrenovated space, and Hanna pointed out that the impending move of George Todaro's Laboratory of Viral Carcinogenesis to FCRC will be absorbed within existing renovated space.

Board member Sheldon Samuels said that he did not feel the Board had enough information to make a decision on which option to take. "This is not just a question of moving components of a program from one place to another. The fact is, there is something unique here, something that could be destroyed if whole elements of another scientific community are moved here and try to operate side by side. . . . I'm not sure a homogenized NCI intramural and FCRC operation would be good."

Board member Harold Amos was suspicious. "We're asked to make a contribution to a decision about which NCI is not being candid. We have no idea what NIH is thinking. Clearly, there is a lot more going on than we're told, or there is nothing going on and there ought to be."

Terry insisted that "unless you can tell us what you want to know and haven't been told, we've laid it out clearly. The decision has been made this has to be developed as a satellite campus, and it is only a question of when and how."

"That says there is more than we've been told, when you use the term satellite campus," Amos said.

Louis Careese, NCI associate director for program planning and analysis, said a study by his staff determined that if FCRC were to be converted to a 100 percent federally staffed facility, it would cost the government $25 million a year, compared with the $23.5 million cost of the contract with Litton Bionetics. Most of the difference can be accounted for by the higher cost of the federal retirement system, Careese said.

Samuels suggested still another option: "Creation of a national laboratory to focus on cancer. None of the four options presented to us does that."

Board member Janet Rowley said, "I've been very impressed with the research here, and I was one of those in the scientific community who felt that an awful lot of money was being spent here that perhaps was not being spent wisely. Dr. Hanna and his people have worked very hard to put together a very good program. We should tread carefully and not do something that would damage it."

Samuels, who has sometimes been critical of FCRC, said, "I agree with everything Dr. Rowley has said, without qualification. I would add that if this is to be a national laboratory, it appears it will be an NIH operation."

"It is clear we are not going to come up with a recommendation today," Pitot said. He appointed Amos, Rowley, Samuels and Board member Morris Schrier as a subcommittee to discuss the situation with NCI, NIH and FCRC staff for a report to the Board at its October meeting. "That will be after NCI has formulated the program, but it still will not be too late to have some impact."

NCI AVOIDS SHOWDOWN OVER GUIDELINE CHANGES; NCAB, NEW BSC TO STUDY THEM

NCI backed away from a confrontation with cancer center directors and any allies they may have on the National Cancer Advisory Board over the issue of the proposed revisions in center core grant guidelines.

Acting Director Vincent DeVita told the Board this week that center directors have expressed to him their "great concern" over the proposals. He emphasized that the revisions still were in draft form. "I'm sure you will want to debate this in detail," he said, reversing the earlier position that NCI intended to complete the revisions and implement them before the Board's next meeting in October.

DeVita also noted that the Centers Program would be located in the new Div. of Centers, Community Activities & Resources, when the reorganization is approved. "There will be a new Board of Scientific Counselors for that division which will want to look at the guidelines, and maybe revise them even more. The guideline revisions will not be implemented until the new division is operational."

Acting Centers Program Director William Terry discussed the various problems which led the staff to conclude that revisions were necessary. Noting that the Assn. of American Cancer Institutes had held a special meeting to discuss the changes, Terry quipped, "They decided that what was needed most was to lynch Bill Terry."

Outgoing Board member William Shingleton summarized AACI's objections. "The real question is how to control excesses and the size of grants. Our (AACI) members felt that the peer review system worked well and that actual awards have not been at a greatly increased pace. There is a tremendous diversity among the 60-odd centers and this makes it difficult to apply a formula to restrict the size of the grant. Diversity adds strength to the program. I think it is important to continue the dialogue, particularly with the new Board of Scientific Counselors when the new division is established."

Terry argued that peer review "is a monumental job" and that restricting the size of the awards "should not be a function of peer review. Peer review should be concerned with the quality of science."

When Board Chairman Henry Pitot said the members should decide whether or not they wanted to become involved with the issue, Harold Amos said,

"I don't see how we can avoid our responsibility." His motion to refer the guideline revisions to the Board's Subcommittee on Centers, with a report to be made at the October meeting, was approved unanimously.

Pitot said that with the new members coming onto the Board, the subcommittee membership will be revised. Shingleton had been chairman of the Subcommittee on Centers, and his term on the Board has expired.

DEVITA ASKS THAT CARCINOGENESIS TESTING PROGRAM BE MOVED TO NIEHS

Vincent DeVita has spent his entire career in the federal government, and if he has learned one thing, it is that a bureaucracy must have a clear line of responsibility to the top.

Reacting to the predictable and continuing conflicts arising from the divided authorities built into the National Toxicology Program, DeVita told the National Cancer Advisory Board this week that he was recommending that the NCI component of NTP be transferred completely to the National Institute of Environmental Health Sciences. He said David Rall, who heads both NTP and NIEHS, agreed with that decision, as did NIH Director Donald Fredrickson. The NCAB went along with their decision.

NTP is made up of the NCI Carcinogenesis Testing Program and units of NIEHS, National Institute of Occupational Safety & Health, and Food & Drug Administration. Each of those components remain as employees of the parent agencies, and the four agencies contribute to the entire budget of NTP. NCI's contribution this year is over $40 million and was destined to be $65 million in FY 1981.

Rall previously had reached the conclusion that most, if not all, of the Carcinogenesis Testing Program would eventually have to be moved to the NIEHS quarters in North Carolina.

NCI executives and many of the institute's advisors have not been comfortable with the practice of NTP getting its support second hand through NCI. DeVita said the new arrangement, as he is proposing it, would require NTP to get its support through NIEHS from Congress.

The Carcinogenesis Testing Program primarily involves routine animal bioassays, but it also includes test development and test validation. NCI's Div. of Cancer Cause & Prevention will still have a large carcinogenesis research program, and NCI will continue to be represented on NTP's Executive Committee and its other advisory groups.

HHS Secretary Patricia Harris will have to approve the proposed move. Her office has been studying NTP's operation with the intention of recommending organizational changes if it determines any are needed. Presumably, if the NCI component is moved to NIEHS, the NIOSH and FDA components would be, too. The FDA component is the National Center for Toxicological Research in Arkansas.

NCI CONTRACT AWARDS

Title: Maintenance and operation of the division information system for the Carcinogenesis Extramural Program
Contractor: JRB Associates, $59,414.

Title: Children's Cancer Study Group—cancer control program for Clinical Cooperative Groups, three month extension
Contractor: Univ. of Southern California, $182,485.

Title: Procurement of melanoma cell vaccine and in vitro assay for humoral and cellular cytotoxicity
Contractor: Litton Bionetics, $135,348.04.

Title: Large scale tissue culture virus production for cancer research, continuation
Contractor: Pfizer Inc., $414,300.

Title: Production of avian and mammalian oncogenic viruses and antisera, continuation
Contractor: University Laboratories Inc., Highland Park, N.J., $59,993.

Title: Immunoprevention of spontaneiously occurring neoplasia, continuation
Contractor: Microbiological Associates, $37,100.

Title: Activation of oncogenic viruses and induction of cancer by immunologic and non-immunologic methods, continuation
Contractor: Massachusetts General Hospital, $30,390.

Title: Epidemiology Contracts NCI histocompatibility testing center, continuation
Contractor: Duke Univ., $85,483.

Title: Cancer End Results, continuation
Contractor: Connecticut State Dept. of Public Health, $580,386.

Title: Population based cancer epidemiology research center in Iowa, continuation
Contractor: Univ. of Iowa, $93,820.

Title: Detroit SSMA population based cancer registry, continuation
Contractor: Michigan Cancer Foundation, $414,000.

The Cancer Letter _Editor Jerry D. Boyd

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