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ACS ASKS $1.5 BILLION FOR NCI; WAXMAN CONSIDERS REQUIRING NIH TO SEND BUDGET DIRECTLY TO CONGRESS

The American Cancer Society asked that NCI's authorization level be increased to $1.5 billion a year, while Congressman Henry Waxman (D.-Calif.) blasted the Reagan Administration for the "shortsighted" budget request for NIH and suggested he might consider legislation re-

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In Brief

KRIPKE, FIDLER TO LEAVE FCRF FOR M.D. ANDERSON; GEORGE TODARO TAKES JOB WITH NEW SEATTLE FIRM

MARGARET KRIPKE and **ISAIAH FIDLER**, two of the outstanding scientists at the Frederick Cancer Research Facility, will leave later this year to accept appointments as department chairmen at the Univ. of Texas M.D. Anderson Hospital & Tumor Institute. Kripke will be the first chairman of the new Dept. of Immunology, and Fidler will be chairman of the Dept. of Cell Biology and director of the Div. of Interferon Research. Fidler and Kripke, who are husband and wife, are employees of Litton Bionetics, contractor for the basic research program at FCRF, Fidler as director of the Cancer Metastasis & Treatment Laboratory, Kripke as director of the Cancer Biology Program. They will start their new jobs Aug. 1. Fidler this week received the Ernst W. Bertner Memorial Award at M.D. Anderson's 36th annual Symposium on Fundamental Cancer Research. The award recognizes his leadership in basic research in metastasis and for development of a treatment for metastatic disease. **ETHAN LERNER** received the Wilson S. Stone Memorial Award which is given for outstanding achievement in biomedical sciences accomplished by a student. Lerner conducted research in monoclonal antibodies while completing his MD and PhD degrees at Yale. . . . **GEORGE TODARO**, another major figure at the Frederick Cancer Research Facility, left last week for his new job as scientific director of Oncogen, a Seattle firm that is a joint venture of Genetic Systems Inc. of Seattle and Syntex Corp. of Palo Alto. He also will be professor of pathology at the Univ. of Washington Medical School. Todaro was chief of the Laboratory of Viral Carcinogenesis in NCI's Div. of Cancer Cause & Prevention; the branch was moved to FCRF two years ago. He played a key role in NCI's virology program over the past decade and a half. . . . **ALEXANDRA LEVINE**, associate professor of medicine at the Univ. of Southern California, has been appointed deputy clinical director of the Kenneth Norris Cancer Hospital. . . . **CORRECTION**: Albert Einstein School of Medicine will have received a total of $1 million from NCI for renovations when it gets $300,000 this year, not $1.3 million as reported last week in ***The Cancer Letter.*** The total cost of renovating Einstein's Forchheimer Building will be $13 million.

WAXMAN BILL AUTHORIZES $1.136 BILLION FOR NCI, HAS LINE ITEM FOR CENTERS

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quiring NIH to submit its budget directly to Congress.

Those developments occurred at the hearing last week by Waxman's Health Subcommittee on his bill to renew biomedical research authorizations. That bill, the Health Research Extension Act of 1983 (HR 1555), would renew the National Cancer Act along with other NIH authorities. It is similar to the bill Waxman pushed through the House last year but died when the Senate failed to act on it or on the reauthorization bill sponsored by Sen. Orrin Hatch (R.-Utah).

The Waxman bill includes a number of controversial provisions opposed by the Administration, including establishing a separate arthritis institute and mandating a number of changes in the way NIH operates.

Waxman's bill calls for an authorization of $1.136 billion for NCI in the 1984 fiscal year (the Administration requested $989 million). It also includes a line item authorization for cancer centers.

Frank Rauscher, ACS senior vice president for research and former NCI director, called on the subcommittee to increase the authorization to $1.5 billion in 1984. Rauscher noted that NCI this year "will have to turn down approximately 1,870 approved applications of the 2,600 they will receive. They will be able to fund only approximately 760 grants, 45 fewer than last year's 805 funded grants, despite a $40 million increase in their budget."

Rauscher said the ACS Board of Directors decided to ask for $1.5 billion "because we believe that that is the funding level necessary to restore the momentum of the cancer program, to bring present programs back to earlier vigor and to permit the new and innovative research begun in recent years to come to successful fruition."

Waxman opened the hearing with a statement in which he said the President's budget proposal for FY 1984 "represents an unprecedented reduction in our nation's research capacity. It is totally unacceptable."

Waxman said the budget would result in new and competing awards being cut by 25 percent; indirect costs cut by 10 percent; direct costs cut by four percent, and "1,000 fewer young physicians and scientists will be offered the chance to pursue a career in research.

"These proposals are shortsighted," Waxman continued. "They jeopardize our nation's continued progress toward developing more effective and less expensive health care services. Far from frugal, the policies are costly in lives and health care resources. They threaten a future in which the diseases we most fear will not shadow the lives of our children.

"The Administration's proposed 1984 budget is the single strongest argument for changing the law and requiring that NIH submit its budget proposal directly to Congress."

Waxman said the authorization levels in his bill "are not as high as I would like." They include an allowance for inflation plus an additional 10 percent "to assure room for real growth in our health research programs."

The bill also "makes a number of important changes to promote the more effective and efficient management of NIH," Waxman said. "These changes include procedures for peer review of intramural research and contracts, as well as establishment of a system for investigating reports of scientific misconduct."

The bill also places emphasis on prevention research and authorizes establishment of 25 new prevention centers.

Rauscher said that the ACS budget for research grants and projects is $62 million, "and we can fund only about 11 percent of our approved grants." He said he was proud of ACS' accomplishments "and frustrated by the fact that we can fund so few scientifically meritorious projects. . . . I known firsthand how many worthwhile, exciting research projects are underway in the cancer field. I also know firsthand how it feels to say no to the majority of those who submit projects and to hope that somehow those investigators will find the necessary funds elsewhere, realizing that in all likelihood they will not. The people at the National Cancer Institute also know the frustration, the sadness, the fear that the one you turned down for whatever reason might be the one that could have made the difference for thousands of people who will die of some form of cancer in the coming years."

Rauscher reviewed the progress that has been made since the National Cancer Act was passed in 1971 and the improvements in cure rates for a number of cancer sites.

"Much of this good news and many other important breakthroughs have come about as a result of the care, interest and money provided by the federal government. Truly, the progress in cancer research is a testament to government and science working together to make life better for our citizens.

"I was fortunate to be the director of the National Cancer Institute during the beginning of the implementation of the National Cancer Act. I was there through the golden years, the years of the building of a cancer research and treatment network second to none in the world, the years of extraordinary breakthroughs in treatment and prevention, the years of momentum, the years when young scientists rushed to get into the cancer field because they knew that was where the action was. To many of us who witnessed what the infusion of government money and

interest could do, these last few years have, in comparison, been years of sad winding down.

"We in the cancer community feel a loss of momentum. We feel the loss of interest by many bright, young researchers who do not believe there will be sufficient interest or funds in cancer research for them to work on their best and most interesting ideas. We feel the frustration of out-of-date equipment in our cancer laboratories funded by the federal government.

"NCI information shows the Cancer Centers Program improves treatment within a radius of 300 miles around each of the 63 centers because of improved physician awareness and training and offers of support services. Our cancer centers and participating community hospitals are the essential element in any regional cancer control network. They are the best equipped facilities for specialized cancer treatment such as bone marrow transplants and new chemotherapy regimens or for interferon trials which are also supported by the National Cancer Institute and the Cancer Society.

"We are distressed by cuts in the Organ Site Program which has demonstrated the effectiveness of chemotherapy in advanced regionalized prostate cancer, the value of preoperative radiation in bladder cancer, and has led to the interesting new discovery of monoclonal antibodies which may be found in increased amounts in the blood of patients with localized pancreatic cancer. If this proves valid, it may lead to earlier detection and possible cure.

"We have suffered cuts in the drug development program which gave us chemotherapeutic agents that are responsible for dramatically increased survival rates for cancer patients. The drug development program has been cut by 30 percent in the last couple of years. Overall, research grants and contracts have taken yearly four percent cuts since 1980 translating into over 50 grants that could not be funded last year.

"As someone who has been inside the NCI and is now viewing it from the outside, I cannot but wonder how Dr. DeVita and his staff have managed so well to utilize smaller and smaller amounts of money. He can no longer do that. We at the American Cancer Society are concerned."

Rauscher concluded by saying, "This could be the most exciting time ever in the history of cancer research. . . . It is up to me and my colleagues. We accept that responsibility. However, it is also up to you and your colleagues. Once again we are asking you to continue to accept this responsibility, to take pride in the program you initiated in 1971—the most visible, emotional, important, and successful health program in the biomedical history of any nation."

Claude Pepper (D.-Fla.) appeared at the hearing as a witness to make a pitch for the separate arthritis institute and for more money for cancer research. Noting that only 26 percent of approved applications would be funded by NCI, Pepper said, "Who can dare to say what might be found in the rest? The key might be there to unlock the secrets of cancer."

Pepper said that "we in Congress got timid when spending for cancer research got to a billion dollars. We didn't stop at a billion in going to the moon. If we had, we would never have got there. . . . This disease kills almost half a million people a year. We've got plenty of money for missiles and everything else, but when we get to cancer, we get timid. The people who get cancer don't think we're spending too much."

NCI's budget should be determined, Pepper said, "by bringing in the Cancer Institute people and asking, 'How much can you wisely spend?' Then that's what we ought to give them."

Waxman said he agreed. "There is no reason why we should spend less than necessary to accomplish our objectives."

Edward Brandt, HHS assistant secretary for health, presented the Administration's case. He asked for reauthorization of NCI, National Heart, Lung & Blood Institute, and National Library of Medicine, for five years, rather than three as in Waxman's bill. He also supported reauthorization of various elements of the National Institute of Arthritis, Diabetes & Digestive & Kidney Diseases, and the National Research Service Awards. "However, my support and that of the Administration does not extend to the many other provisions of HR 1555."

Brandt said he sees two underlying principles in Waxman's bill:

- First, that there is a need to change the manner in which NIH manages research programs.
- Second, that there is a need to change the current organizational structure of NIH.

I believe that in neither case are sweeping changes scientifically or administratively necessary to the continued progress of the nation's biomedical research endeavor.

The first principle implies that NIH is neither effective in administering its programs nor responsive to public concern. It also suggests that additional statutory language is the only way to modify or redirect our research programs.

Current legislation has served the NIH, the research community, and the public very well. Section 301, the general research authority of the Public Health Service Act, enables NIH to pursue its mission in a manner consistent not only with emerging scientific opportunities but also with changing health needs. Title IV of the PHS Act exists not simply as an independent authority, but primarily for the purpose of carrying out in greater detail and specificity the mandate of Section 301.

HR 1555 proposes to recodify Title IV and create a self-contained, exclusive source of authority. All references to Section 301 which now exist in Title IV would be deleted and replaced by a combination of enumerated authorities and general delegation provisions. We believe that such extensive changes in the language of Title IV would disrupt the orderly management and operating procedures of both NIH as a whole and of the individual institutes.

We also believe the degree of detail and specificity in the

bill would create organizations and procedures that are too rigidly defined and, in fact, represents an attempt to micromanage the NIH. For example:

• Certain sections assign specific managerial responsibilities to the Secretary, the NIH director, and the various institute directors. Current, the secretary has management authority (with some exceptions), which is delegated administratively to the appropriate operating officers. This arrangement has the advantage of working efficiently and providing needed flexibility, while at the same time maintaining traditional and necessary lines of authority.

• The additional responsibilities proposed for the national advisory councils for the institutes and to the NIH Health Advisory Board would make them participants in, rather than advisors to, the decision-making processes at NIH, thereby diminishing the management authority of the secretary and NIH officials. These additional responsibilities would also overextend the capabilities of the councils by involving them in operational decisions beyond the scope of their expertise. Similarly, creation of the Director's Advisory Committee in statute would inappropriately involve it in the actual execution of management functions, a responsibility far exceeding its current role of providing policy advice.

• Reference is made in the bill to payment of indirect costs according to the system prescribed in the Office of Management & Budget Circular A-21. Circular A-21 defines costs that are allowable for reimbursement. The net effect of HR 1555 would be to create an entitlement program for indirect costs and to give indirect costs a preferential share of the award. As you know, indirect costs have been consuming an ever larger fraction of total awards since 1966; in fiscal year 1983, indirect costs accounted for 30 percent of awards whereas the fraction was 20 percent in 1972.

We must recognize that NIH programs are fundamentally grants in aid to assist faculty and other researchers to conduct research of interest to them and to the federal government. Research has historically been a fundamental aspect of teaching, and the costs have never been regarded as solely and completely a federal responsibility. There is no requirement for NIH to fund the "full costs" of such projects, and researchers and institutions are free to accept or not to accept the grant at the particular funding level. We recognize that these are difficult decisions for institutions, but everyone must recognize that these are difficult times. It should be clearly noted that any level of sharing of indirect costs adds to the total funds available to institutions.

• Creation in statute of the NIH Office for Medical Applications of Research (OMAR) is unnecessary. OMAR is a staff office of the NIH director. It performs a coordinating role and does not function independently. The director of NIH must be permitted to administer his staff offices and to use them to the greatest advantage of the NIH and its research programs.

• A separate authorization of appropriations for cancer research and demonstration centers is unwarranted. No appropriations are available to support the centers beyond that requested in the budget. The extra money that would be used to support an increase for centers would have to be taken from existing programs with a probable decrease in funds for investigator-initiated grants.

Moreover, current law provides the authority necessary for the conduct of other activities described in HR 1555.

• Without additional legislation, the Public Health Service, with NIH as lead agency, has already started to systematize its approach to real or apparent scientific misconduct. This includes a description of the responsibilities of both awardee institution and PHS staff, as well as detailed procedures governing PHS activities before, during, and after formal investigations. I recently approved in principle the recommendations of a PHS task force along these lines and we will shortly be issuing guidelines to the agencies and awardee institutions.

While the provision to require awardee institutions to establish units to investigate scientific fraud is not directed at the NIH, I believe such a requirement is inappropriate. It seems to condemn every scientist; whereas the number of incidents of real or apparent misconduct is a miniscule fraction of the total number of active projects. It will also add considerably to the indirect cost that institutions will pass on to NIH.

• This bill specifies in great detail the size and expertise for institute membership requirements for advisory councils. The various advisory councils are now based on the breadth and the size of each institute's programs and the expertise needed to evaluate those programs. If changes are necessary, they can be accomplished administratively, as was done recently for the Aging Council which increased in size from 12 to 18. On the other hand, not all councils require 18 members nor need representation from such specialized fields as law, economics, and management.

Let me now turn to the consideration of the second underlying principle of the bill. It implies that the current structure of NIH is inadequate to respond to either the evolution of science or the changing nature of health care problems. It also suggests that the NIH be given additional responsibilities in areas related to health services.

NIH's mission is clear and unambiguous—to improve the health of the nation through the conduct and support of research, and, in particular, the generation of knowledge. NIH does not provide health services and its regulatory responsibilities are limited to setting standards for human subjects research. The current organization of NIH, which has evolved over a period of 50 years, is sufficiently broad to accommodate changes in scientific direction and scope and to collaborate with other PHS agencies in transferring knowledge into the health care system. I am deeply troubled, therefore, about the impact on NIH and its research programs of proposals that would create an arthritis institute, establish statutory prevention related staff offices, and transfer other components of the PHS to NIH.

Brandt contended that creating a separate institute for arthritis would channel research funds to administrative costs, and claimed there is no evidence arthritis is being slighted by being part of the larger institute. He objected to prevention offices and centers being established by statute because "prevention of disease and disability is the ultimate goal of all NIH research programs, but research into prevention must rest on a firm scientific base and be closely linked with other research efforts. Where the scientific base exists, serious attention is being paid to research into prevention of disease." He noted that some institutes, including NCI, have administratively established offices to coordinate prevention activities.

When Waxman asked Brandt if the Administration was satisfied with being able to fund only 3,800 new and competing renewal grants in FY 1983 instead of the goal of 5,000, Brandt gave the department's response which has been in effect since the President's budget was sent to Congress—that the goal of 5,000 remains in effect and the department is negotiating with the White House on the issue.

"Will you take money away from other areas, or will additional money be provided?" Waxman asked.

Brandt said that is one of the items under discussion.

Waxman asked NCI Director Vincent DeVita if "it is time now for new initiatives" in cancer research, in light of suggestions by some of important progress.

"I think you are referring to oncogenes," DeVita said. After describing those findings, DeVita said, "It is not unreasonable to expect a major paradigm change in our lifetime."

DeVita was careful as usual not to allow himself to be pushed into a position where it might seem he was asking for more money than requested by the President. Waxman tried again.

"Are we doing all we can?" Waxman asked.

"We are putting all we can into that research," DeVita answered, still referring to oncogenes, although Waxman's question seemed to include the entire cancer program.

"Are we doing all we can in prevention?" Waxman asked.

DeVita cited numerous leads arising from epidemiological studies and said NCI is responding with several chemoprevention studies. "We have on the books several of those studies, and more are planned. It is a high priority."

Responding to a question from Congressman William Dannemeyer (R.-Calif.), DeVita said NCI could be criticized for not emphasizing diet and nutrition studies sooner than it did. "We can begin to see differences in incidence due to diet modification within 10 years," DeVita said. "I think we will see that in this decade."

Waxman said he had heard that NCI was slow in awarding grants for studies of acquired immunodeficiency syndrome (AIDS). DeVita said four awards had been made to investigators responding to an NCI RFA, and eight others were awaiting site visits. The process for awarding AIDS grants took no more time than is usually required, DeVita said.

"The normal process of making competitive awards with peer review does take time," Waxman acknowledged.

Congressman Howard Nielson (R.-Utah) asked Rauscher if it "is realistic that (NCI) could grow that much in one year" in Congress appropriated $1.5 billion.

"Absolutely," Rauscher answered. "Since 1975, there has been no increase in real dollars. The last year I was director, we paid 50 percent of approved grants. That money could be used very, very well."

"What would it do to the other institutes?" Nielson asked.

"I hope that others would get increases also," Rauscher said. "I'm not advocating that this would be at the expense of the others. It can be shown that since 1972, when we got our first big increase, all the other institutes got good to moderate increases. Cancer expenditures can't be viewed as having been at the expense of the other institutes."

DCT BOARD TO CONSIDER REISSUING RFA FOR PLANNING SURGICAL RESEARCH UNITS

The Board of Scientific Counselors of NCI's Div. of Cancer Treatment will be asked to consider the concept of reissuing the request for applications and program announcement in surgical oncology at the Board's June meeting.

Board members and DCT Director Bruce Chabner agreed to place reissuing the surgical RFA and program announcement on the June agenda after a report by the Board's Surgical Oncology Research Development Subcommittee (SORDS) made that recommendation.

"We are faced with a diminishing number of academically oriented surgical oncologists in centers," SORDS Chairman Philip DiSaia said. "The most difficult person to recruit is a surgical oncologist."

DiSaia reviewed the recent history of DCT's efforts to encourage surgical oncologists. A program announcement a few years ago resulted in "somewhat of a disaster," DiSaia said. SORDS members were unhappy with the review, contending surgeons were not adequately represented on the study section. A few grants were awarded to the few applications with fundable priority scores, but SORDS felt they did not accomplish much toward bringing new surgeons into cancer research.

A second round, with a new RFA and program announcement, culminated last year in the award of seven R01 grants (out of 51 reviewed), one program project (eight reviewed), and five P20 (planning) grants.

"The question now is how to continue this emphasis and correct the problems," DiSaia said. He summarized the recommendations offered by SORDS:

1. Physician investigator development awards. The Div. of Resources, Centers & Community Activities has a program which provides about 36 awards a year. They consist of $30,000 for salary and up to $10,000 for support, limited to those who are two to seven years past their MDs.

"This seemed tailor-made for the kind of stimulus surgical oncology needs," DiSaia said. "We felt that 100 would be enough. It turns out that eight are going for surgical oncology. Bruce said that if there are meritorious applications by surgeons not funded by DRCCA, he is willing to use DCT funds to pay at least eight more."

Chabner, however, said, "There is no way to allocate eight to a specialty," in DRCCA's program. "It is our intention to see that at least eight (in surgical oncology) are funded. If it is less than eight, and there are others of merit, DCT will put up the rest of the money. We will try to fund at least eight."

2. "SORDS is interested in overcoming the problem perceived by surgeons that review of R01s and

often, P01s, is biased because there are no surgeons on the study sections," DiSaia said. "To correct this situation, SORDS asked Bruce to consider establishing a special study section, predominantly with surgeons. Then NIH dissolved special study sections, but (the Div. of Research Grants) has said there may be hope. The developmental therapeutics study section will soon be split into basic research and clinical research. We hope that surgical oncology R01s will go to the clinical research group, with surgeons on it. We hope it would be the type of study section we desire."

3. SORDS asked Chabner to designate extramural surgical oncology within DCT an "activity" and arrange for all surgical grants to go through the head of the Surgery Section in the Clinical Investigations Branch. Ernest deMoss is the section head. That would require approval by the NCI Executive Committee, an action which was deferred because Chabner could identify only $3 million in surgical oncology grants, sometimes not enough to warrant designation as an "activity."

4. Clinical education grants. This is another program managed by DRCCA, one which has been cut back substantially. "SORDS members felt that program has been very helpful in the past," DiSaia said. "It is missed now. We hope the Executive Committee will reconsider, and possibly help with some affirmative action in surgical oncology."

5. The program announcement soliciting R01 and P01 applications in surgical oncology brought in "some excellent responses. We felt this should be reissued, with a broadened scope," DiSaia said. The committee defined surgical oncology research "as any research by a surgeon, not just that which is surgery related."

6. Reissue the RFA for P20 grants. The five successful respondents "did exactly what we asked them to do," DiSaia said. "This encourages surgeons to go into oncology and keep them in academic careers. But there were only five. In June, we hope the Board again will set aside funds for this, through a new RFA."

Carmack Holmes, chairman of SORDS when he was a member of the Board, said, "The business of trying to establish surgical oncology as a quality discipline in the armamentarium in the attack on cancer is not a wholly altruistic act on the part of other disciplines." He said the quality of surgery in surgical adjuvant trials is "clearly inadequate" in a significant number of cases, causing the results to be obscured. "We need to develop training, early in careers, and the P20 grants do that, so individuals can compete effectively for R01s and P01s."

William Shingleton, director of the Duke Univ. Comprehensive Cancer Center and a surgeon, said that the "perception that surgeons have not been full participating members in oncology research is correct. In the 10 years since the National Cancer Act was passed, multidisciplinary treatment has developed tremendously, with surgeons as vital members. We need to upgrade the participation of surgeons."

John Durant, president of Fox Chase Cancer Center, said, "As the non-surgeon on SORDS, I agree with everything that has been said. I would like to stress that it is a long term commitment."

Board member Samuel Wells objected to the two to seven year "window" following the doctorate as an eligibility criterion for the physician investigator awards. "Some residencies in surgery are not finished until eight or nine years," he said.

"The intent is to attract people in training," Chabner said. "My impression is that that rule is flexible."

Responding to other recommendations, Chabner said that all surgery related R01 grants would be reviewed by the clinical trials study section; and that $3 million is not too small to be established as an "activity" with the grants to be channeled to a program director who would "seek out, encourage, shepherd, and watch over." He will submit the issue to the Executive Committee, and the Board unanimously approved a resolution urging that surgical oncology be established as an activity.

Chabner noted that clinical education grants administered by DRCCA support development of cancer related curricula in undergraduate education. The emphasis now is on epidemiology, nutrition, and prevention. "My feeling is that surgery is not adequately represented. We have to reach good people in medical schools."

Chabner said NCI Director Vincent DeVita supported discontinuing the medical oncology portion of the clinical education grants "because it was felt that there is plenty of interest now in that area. He said he would be willing to consider adding surgery."

The Board approved a motion asking the NCI Executive Committee to consider doing that.

DiSaia said the recommendation to reissue the RFA for P20 grants "may be the most important one." On the amount of money to be set aside, "SORDS felt the half a million last time was too small."

Chabner said the first P20 RFA, for planning surgical oncology research units, brought in 25 applications, of which five were funded. The funding plan was brought to the Board, Chabner reminded, and the Board approved, with the cutoff line at a 204 priority score. Nineteen were above the NCI payline of 175. "If we were required to spend $3 million, it would have required going to a payline of 380," Chabner said.

Chabner said an RFA concept approved in June would leave enough time to solicit, review and fund applications with FY 1984 money. That would require completion of review by spring of 1984 for submission to the NCAB in May.

DCT Deputy Director Saul Schepartz, reporting on an analysis of NIH study section scoring of grants, said, "There are differences that will be factors in which grants get funded, depending on the final payline."

NIH abandoned use of normalized scores two years ago. That system attempted to take into account variations in assigning priority scores from one study section to another. NIH now uses raw scores, with variations from 82 to 85 percent, Schepartz said.

One suggestion which has been considered is to establish a fixed percentage of grants to be funded from each study section. That would result in some being paid without justification, "or in a hot area, we couldn't fund as many as desired," Schepartz said.

NCI has decided to look at raw score variations as possibly one factor in making funding exceptions, Schepartz reported.

Board member Brigid Leventhal pointed out that the system of assigning priority scores was set up "primarily to assure that no grossly inappropriate application gets funded. In those days, most of the approved grants were funded. Now, there are different demands on the system. When it is a score of 175 vs. 176, there is no difference, but one is funded, one is not. That is unfair and distressing. It is hard for study section members to vote, when they feel their vote carries that kind of weight. Executive secretaries should try to sort that out. If not, it must be done by NCI staff."

"The feeling at NIH is that there is no difference within five points," Schepartz said. "Twenty points, maybe."

"We're aware of the importance of small differences (in paying grants) and how meaningless they are," Chabner said. "We've asked program directors to be very familiar with grants in their areas which are not funded, and during the year we may be able to pay some. A number of R01s and P01s last year between 185 and 190 were funded."

"Brigid has put her finger on the problem," Board member Paul Marks said. "I don't know the answer. It might be interesting, after a study section votes, to go through and ask if they really think this grant should be funded. It would be interesting to see how many 'yesses' are funded."

Board member Mortimer Elkind asked if executive secretaries could average the score after a vote and then have the members look at the scores again. Dani Bolognesi said that system is used by the leukemia society and the American Cancer Society, "but when we tried that at the NIH virology study section, we were told we couldn't do it."

"A larger issue is how much money is required to have vigorous science," Elkind said.

"There is the feeling that there are some things we would like to fund that we are not funding," Schepartz acknowledged.

Board Chairman Samuel Hellman said the percentage of approved grants which are funded "is not too meaningful. I doubt if anyone getting a three really should be funded.

"The difference between 185 and 300 is the key issue for the country," Elkind said. "What is that costing us?"

Board member Paul Calabresi commented that grant applications fall into four categories. Two are obvious, the outstanding ones which everyone agrees should be funded, and the weak ones which should be disapproved. "In the third are those which could be funded if there is enough money. Category two is the important one, where we should spend some time and do some fine tuning."

"The problem may be that 40 percent are in category one and only 30 percent are being funded," Hellman said.

Chabner, reporting on the recently implemented program of monitoring clinical trials by cooperative groups and cancer center grantees, said, "We have seen cause for concern about the way cooperative group satellite investigators are operating."

The monitoring program looks at informed consent, institutional review boards, use of investigational drugs, reporting on side effects, and verifying accuracy of results reported.

"There is an extensive number of satellites—some in the cancer control outreach program, others with more informal affiliations with group members—who are not communicating as closely as is required for regular group members," Chabner said. "An intensive effort to evaluate each satellite member in the next 12-18 months will be made." Also, group chairmen are drawing up guidelines for satellites, how they are chosen, what information they expect to receive. "I feel they (the satellite members) are making a positive contribution. It's just a matter of bringing them into closer communication with the groups."

"I can't conceive how satellites can operate without going through an IRB," DiSaia said. "In the group I'm associated with, that function goes through the parent institution. There are followup forms for each patient. I hate to see a lot of effort made to monitor satellites when that monitoring should be by the parent institutions."

"The point I'm trying to make is that there hasn't been," Chabner said. "There are significant deficiencies with some of the satellites. These are important elements."

"On the clinical trials portion or the cancer control portion?" DiSaia asked.

"Both," Chabner said. "Our monitoring shows some significant deficiencies."

"I'm concerned that NCI is thinking of making a

major effort on satellite monitoring," Leventhal said. "That ought to be the responsibility of the institutions. If it is not being done, the institution should be judged."

"We accept that," Chabner said. "But the member has to know what is going on in the satellite." Chabner said guidelines are being formulated, and Daniel Hoth, chief of the Investigational Drug Branch, said the Cooperative Group Executive Committee has agreed unanimously on the need for guidelines.

Chabner reported that the preliminary announcement on the National Drug Discovery Groups brought in 200 responses, from academia, industry, and other private institutions. Each respondent will receive a list of all the others, an effort to encourage various groups to work together when they submit their grant applications. An RFA will be published sometime this spring.

DCT will earmark $3 million to support the groups in the first year, and Chabner said he hopes four groups will be funded. The schedule now calls for the awards to be made in March 1984.

The RFA for studies on treatment of Kaposi's sarcoma resulted in 45 applications, Chabner said. Ten were disapproved, 27 were approved, four were funded, and site visits are being conducted on eight more.

The four which were approved for funding by the NCAB last month will receive about $400,000 of the $1.25 million set aside in the RFA. Those requiring the site visits were the larger and more complicated applications, and the individual awards to them will be larger than with the first four. Priority scores of those four extended somewhat past the 175 payline.

Chabner said that to date, 960 cases of acquired immune deficiency syndrome had been reported, 70 percent in the last year. Thirty-five percent have been Kaposi's sarcoma, and a larger number have been lymphomas, mostly large cell. Many are head and neck, and 10 are cerebral. "These are cancers you only see in immunosuppressed patients. It's following the same pattern as in transplant patients. It is disturbing that we are finding some in hemophiliacs."

Schepartz discussed the legislation aimed at encouraging the pharmaceutical industry to develop drugs for rare diseases, the so-called "Orphan Drug Act."

Some forms of cancer might qualify as rare diseases. "That has to be defined," Schepartz said. "It would not include bronchogenic carcinoma, but islet cell carcinoma could be considered rare."

"Does that cover just drugs or biologicals as well?" Bolognesi asked.

"I'm certain it would apply to biologicals," Chabner said.

The Board previously had urged, after a review of the intramural Medicine Branch in DCT's Clinical Oncology Program, that the branch work closer with or be merged with the NCI-Navy Medical Oncology Branch (the Medicine Branch is located in the NIH Clinical Center, the Navy Medical Branch across the street in the National Naval Medical Center).

"It was the perception of the site visit team that many of the very worthwhile clinical trials (by the Medicine Branch) suffer from a severe lack of numbers," DiSaia said. "That could be improved if they were done jointly by the two branches. The resource across the street is tempting."

Chabner said he took exception to that view, that the Medicine Branch has had good accrual in ovarian and Hodgkin's studies. "There is no question we can use patients from the Navy."

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. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs to the individual named, the Blair building room number shown, National Cancer Institute, 8300 Colesville Rd., Silver Spring, Md. 20910. RFP announcements from other agencies reported here will include the complete mailing address at the end of each.

RFP NIH-ES-83-50016

Title: *Toxicology research and testing program health and safety support*

Deadline: *April 25*

The scope of activities in the toxicology research and testing program (TRTP) involves research and testing of wide ranges of potentially hazardous materials. The program resources component of the National Toxicology Program is interested in establishing a contract to provide the TRTP office of Health and Safety with information, data and results on all TRTP health and safety efforts carried out under contract.

The contractor shall furnish state of the art services, qualified personnel, material, equipment, and facilities, not otherwise provided by the government, as needed to perform the work. A five year task order contract is anticipated for the effective pursuit of this project.

Contract Specialist: Mary Anne Yeary
RCB, Blair Bldg. Rm. 105
301-427-8774

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