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P.O. Box 2370 Reston, Virginia 22090 Telephone 703-620-4646

BCTF MEMBERS MIFFED WHEN NCI REFUSES TO DELAY NEW BREAST CANCER RFA TO ALLOW THEM CHANCE TO STUDY IT

A controversy involving an old element of the new Organ Systems Program has developed which could be a portent of things to come, unless the various parties concerned fully understand the new program and how it is supposed to work.

Some members of the Breast Cancer Task Force were miffed last month when they learned that NCI had developed a major, costly new initiative in breast cancer research without consulting them. Although their opinions were sought before the RFA was finalized, a few members have indicated they may resign from the task force unless they receive assurances that their advice will receive more consideration in the future. *(Continued to page 2)*

In Brief

BRIAN HENDERSON NAMED NEW DIRECTOR OF USC COMPREHENSIVE CANCER CENTER, NORRIS HOSPITAL

BRIAN HENDERSON, who has been interim director of the USC Comprehensive Cancer Center since interim director Richard O'Brien left last October, has been named permanent director of the center. The job also includes heading the new Kenneth Norris Jr. Cancer Hospital & Research Institute. Henderson, 45, will continue to serve as chairman of the Dept. of Prevention & Family Medicine in the USC School of Medicine, and as head of the highly respected unit on cancer epidemiology and biostatistics. Henderson is a graduate of the Univ. of California (Berkeley) and received his MD from the Univ. of Chicago. O'Brien took over as interim director when the founding director, Denman Hammond, gave that up to concentrate on his work as chairman of the Childrens Cancer Study Group. O'Brien left to become dean of the Creighton Univ. School of Medicine. . . . **CORRECTION:** Comments from the meeting of cancer center executives at NCI last month referring to the recompetition of the Biological Response Modifers Program master agreement, in which it was stated that the agreement was being recompeted after three years although it had been awarded for five years, were not correct. The Div. of Cancer Treatment Board of Scientific Counselors had approved the master agreement for five years, but DCT held it to three years when the agreement was awarded to 27 institutions. It was brought to the DCT Board last January for concept approval of the recompetition because the three year award is expiring. . . . **POSTGRADUATE NURSING** seminar, "New Interventions in Cancer Therapy," is scheduled for April 21-22 at Vincent Lombardi Cancer Center, Georgetown Univ. Contact Ann Crowley, telephone 202-625-7721.

BCTF SUGGESTIONS WILL BE CONSIDERED IN NUTRITION STUDY RFA, NCI SAYS

(Continued from page 1)

The task force will be one of five working groups which will be included in the Organ Systems Program. The program will consist of an Organ Systems Coordinating Center external to NCI (see last week's issue of ***The Cancer Letter*** when the RFA was published for the OSCC); and specific site disease oriented working groups, starting with pancreas, prostate, large bowel, bladder, and breast. The first four will be moved from the old program, in which each had headquarters external from NCI, each generated research ideas, and reviewed grant applications.

The Breast Cancer Task Force has always been headquartered at NCI, and originally generated ideas for contract supported research. That was changed to grants several years ago, and the task force has never reviewed those grants, that being done by various NIH and NCI study sections.

The Breast Cancer Task Force will now be operated the same as the other four working groups. Like the others, its function will be to maintain surveillance of research in its area, promote communications among investigators through newsletters, workshops, etc., and, when a gap is observed, offer recommendations for NCI supported initiatives to fill it. Those recommendations will be referred to the appropriate NCI division, for presentation to that division's board of scientific counselors for concept approval. If approved, the result could be an RFA, for grants or cooperative agreements; an RFP, for contracts; or a program announcement, intended to result in increased R01 or P01 applications in the particular area. All applications will be reviewed by NIH or NCI study sections.

The new initiatives which aroused the Breast Cancer Task Force were the two dietary studies in which (1) breast cancer patients will be randomized to normal and low fat diets to determine if the latter reduces recurrence, and (2) women at high risk of breast cancer are randomized to normal and low fat diets to determine if the latter reduces the incidence of the disease.

These ideas did not originate with the task force, but were presented to NCI by Ernst Wynder, president of the American Health Foundation which has had considerable experience in nutrition studies.

The first study will cost an estimated $1.5 million a year for at least three years, and a lesser amount for five more years of followup. The second will cost an estimated $2.5 million a year for the earlier years, and possibly lesser amounts for the five to eight years of followup.

The proposals had been presented first to the Div. of Cancer Treatment Board of Scientific Counselors. Members of that Board were reluctant to approve an RFA, and suggested instead that Wynder seek support through an R01 or program project. Some members felt the nature of the project, and number of patients needed, would require participation by at least one cooperative group.

The project next was taken to the Div. of Resources, Centers & Community Activities, which was looking for good ideas in nutrition and prevention research. The DRCCA Board of Scientific Counselors gave its concept approval in January (***The Cancer Letter,*** Jan. 28).

When William DeWys, director of DRCCA's Prevention Program, brought the proposals to the Breast Cancer Task Force at its March 14 meeting, some members were unhappy because they felt that they should have had first crack at it, before concept approval by the division's Board.

"That isn't the way this is going to work," DeWys later told ***The Cancer Letter.*** "The working groups are not the only place where ideas can originate. But we do intend to present ideas to the working groups, and get their input. That's what we were doing when we took those proposals to the task force."

Task force members said they needed more time to consider the proposals and asked DeWys to delay issuing the RFA until a committee of the group could look at it. DeWys refused, since a delay could throw the program off schedule and not allow it to be funded with FY 1984 money. The RFA is due to be published in June.

DeWys said that the discussion with the task force produced some suggestions, which he asked be put into writing. Those suggestions will be taken into consideration when the RFA is drafted, he said.

The Organ Systems Working Groups will be an "important kind of review" for research concepts, DeWys said, but they will not have the prerogative of saying yes or no. That will be the province of the boards of scientific counselors.

When the boards of scientific counselors give concept approval to a project, they usually assume that it will be implemented without major changes from the proposal submitted to them, especially in the maximum amount of money allocated for it. If that is the case, should not the working groups have an opportunity to review and comment on the proposals before they go to the division boards?

"We will try to run them through the groups (prior to submission to the boards) when the calendar of events makes that possible," DeWys said. When that is not possible, and the working groups recommend substantive changes in a proposal already approved by a board of scientific counselors, the proposal will be returned to the board for its action on those changes before the RFA, program announcement, or RFA goes out.

DeWys said that the major issues raised by the

Breast Cancer Task Force were those already considered by the DRCCA Board. He said he intends to report to the Board on the task force's recommendations but did not plan to make any substantive change in the RFA based on them.

The DRCCA Board's approval of the concept was conditioned on DeWys supplying members with information which would convince them that dietary compliance in the study was feasible and could be monitored. DeWys had referred to a previous study which did demonstrate that feasibility but which had not been published. That study now is planned for publication, and preprints have been sent to the Board members.

Whether that will satisfy members of the Breast Cancer Task Force remains to be seen. Leonard Davis, Los Angeles radiologist, expressed his ire in a letter to Rose Kushner, member of the National Cancer Advisory Board who has followed closely the activities of the task force.

"I felt that our requests that the RFA be delayed pending our review of the proposal were deftly moved aside and, in fact, ignored," Davis wrote. "In many of our minds, the study seemed flawed and deserved a serious review, in detail, before being approved. . . . If the Breast Cancer Task Force is to have substance as a member of the Organ Systems Program, our expressed desire to be of assistance should not be treated lightly. We do not come to these meetings to act as a rubber stamp of approval. Nor do we wish to be sychophants, looking on in awe because a proposal presented to us had had the prior benefit of 'the opinions of outside experts'."

If the working groups are going to be unhappy when the boards of scientific counselors give concept approval to projects before the groups have an opportunity to look at them, how are they going to feel when the reverse occurs?

The primary mission of the working groups will be to generate research ideas and recommend them to NCI. They will be presented to the boards of scientific counselors for concept approval. Those boards are certain to reject some of the proposals, for a variety of reasons (but mostly budgetary) which may seem reasonable to them and to NCI staff but will deeply offend the groups.

With the old Organ Site Program, the working groups generated the ideas, reviewed the subsequent proposals, and within their budget limits, funded those they wanted. With the new system, they will be limited to idea generation.

The Breast Cancer Task Force has been functioning in that manner since 1978 and has experienced rejection at the hands of the boards of scientific counselors. "They're used to it," Kushner said. "They didn't like it, but they accepted it."

Stay tuned.

DEVITA UPSET ABOUT "MISINFORMATION" CIRCULATING ON ORGAN SYSTEMS PROGRAM

NCI Director Vincent DeVita, referring to the "considerable interest and in some quarters, concern" about changes in the Organ Site Program, sent out a special communication to members of the scientific community last week to set the record straight.

"In some cases, this concern is generated by misinformation," DeVita said in the communication. He reviewed the recent history of actions by the National Cancer Advisory Board in reviewing the Organ Site Program and in drawing up the revisions, changing it to the Organ Systems Program with one coordinating center.

"Many of the scientists most involved with the Organ Systems Program are concerned that NCI staff will not faithfully implement the Board's recommendations," DeVita said. "You have my assurance that we will do so. Misperceptions about proposed changes in the Organ Site Program and NCI's response have caused enough anxiety that the matter has been brought to the attention of the President's Cancer Panel."

NCAB member William Powers, who is chairman of the Board's Organ Systems Committee, and member Rose Kushner have challenged NCI's interpretation of actions taken by the Board at its February meeting. After Powers presented the Committee's report, developed at the two day meeting prior to the Board meeting, several revisions in the recommendations were suggested by Robert Hickey and Victor Braren. The revisions were discussed back and forth, accepted by Powers and the rest of the Board, but were not written out word for word, as was the committee's original recommendation.

NCI staff later pored over the transcript of the meeting and came up with the recommendations which DeVita said were those adopted by the Board.

Powers and Kushner contend that staff overlooked several items, some of which probably would not significantly change the thrust of the recommendations. One that might relates to funding. Kushner says, and ***The Cancer Letter*** report on the meeting agrees, that the recommendation on funding includes this sentence which was left out of the NCI report:

"NCI will adjust funding, as available, to provide for additional working groups that may be established in the future."

The complete recommendations approved by the Board were published in ***The Cancer Letter*** Feb. 11. The sentence on the funding of new groups was the only substantive difference between ***The Cancer Letter's*** version and NCI's.

"Without that assurance, if we decide to start a new working group, we might have to take money from the others to support it," Kushner said. "I think

that provision is important. Otherwise, I think we should give this a chance."

DeVita said in his communication that Hammer had written to Powers, stating that:

"Dr. William Longmire, a member of this Panel, attended the sessions of the National Cancer Advisory Board meeting at which the Organ Systems Program was discussed, indeed debated. At the meeting in Houston, the Panel members had the opportunity to study the final document produced from those sessions. After discussing the document, it is the conclusion of the Panel that the final document prepared by NCI does not differ from the final recommendations of the National Cancer Advisory Board to any appreciable extent. It seems to us that all changes which the Board recommended will be carried out by NCI, and we wish to go on record as stating that we have full confidence in the ability and determination of Dr. DeVita and the NCI staff to carry out the wishes of the Board and operate and maintain an effective and viable Organ Systems Program."

DeVita continued, "The RFA for the external coordinating organ systems headquarters has been issued, and NCI is proceeding to implement the NCAB's carefully considered recommendations. Therefore, it is distressing to learn that, in spite of over two years of intense effort by both the NCAB and NCI, inaccurate information is being provided to members of Congress which may detract from our ability to emphasize the many positive developments in basic science, clinical research and the applications of the results of research, including the Organ Systems Program, at the upcoming hearings."

JOHN MONTGOMERY OF KETTERING-MEYER NAMED TO PRESIDENT'S CANCER PANEL

John Montgomery, senior vice president and director of Kettering-Meyer Laboratories, Southern Research Institute, has been appointed by President Reagan to the President's Cancer Panel, joining Chairman Armand Hammer and William Longmire.

Montgomery, 59, is an organic chemist and has been involved in the synthesis of cancer chemotherapeutic agents.

Montgomery replaces Harold Amos, whose term had expired. All three members of the Panel now are Reagan appointees.

Panel members are also ex officio members of the National Cancer Advisory Board, and Amos' departure marks the first time since 1972 that he has not served on one body or the other. No one has put in more time as an advisor to NCI.

Amos was always one of the few NCAB members to attend all three days of the meetings. He attended most committee meetings and served as chairman of several. As a professor of microbiology, he brought a deep understanding of basic science to the Board, yet was quick to appreciate the clinical issues and was outspoken in urging the Board to take an aggressive position in promoting and defending the National Cancer Program, especially in regard to funding.

NCI Director Vincent DeVita pointed out at last month's meeting of the Panel in Houston that Amos had missed only one meeting out of 45 held by the NCAB and Panel during his tenure. "That's a record someone would have to work very hard to beat," DeVita said.

The Panel meeting in Houston followed the format of previous Panel sessions held around the country, with scientists from the area invited to state their concerns and suggestions regarding the peer review system and awarding of NCI grants.

Many of the suggestions coming out of those meetings have been incorporated by NCI into practice, including the decision to fund grants at less than recommended levels in order to support more of them, and to initiate the new Outstanding Investigator Awards.

Excerpts from the presentations at Houston, as prepared by Panel executive secretary Elliot Stonehill and further edited by ***The Cancer Letter:***

Emil Freireich, M.D. Anderson—I find that the majority of peer review groups are actually not qualified as peers in the estimation of the reviewee. Executive secretaries should encourage investigators to submit lists of individuals who in their judgment are genuinely competent to review their proposals. If peer review is to function properly, I think more attention to the identification of people who are genuinely peers, not only in the eyes of those responsible for the review process, but in the eyes of the reviewee.

The second point that I wanted to address was the complete lack of an appeal process. I have made in my written statement a positive suggestion for an appeal mechanism which I think would not increase the amount of reviewing that a grant gets at all. In my view, if the pink sheet is drafted after an on site committee report, the reviewee should have an opportunity to make factual contributions in response to comment. Then the parent review committee, when it assigns a priority score, would have an opportunity to review both the on site committee report and the comments of the reviewee.

The last two items which I want to cover (include) a strong defense of clinical research. As Dr. DeVita pointed out, when budget is constrained there is always more attention to those items which are more costly in research budget. It's my contention that basic clinical research does exist. If there is "basic" clinical research, it has a characteristic which is unique, and that is that it is going to be inordinately more expensive than laboratory based research. That expense is incurred because of the attendant expenses of caring for patients and because of the involvement of multiple professionals in such research,

and in my view that's the backbone of the P01 mechanism.

I find it impossible to conceive of advances in cancer which do not include clinical investigation. It is certainly true that basic research may need defense, but certainly not from me, because I believe that is extraordinarily important as all other components of the NCI program.

And then the final item I want to address is the one about the accomplished investigator. I feel that the suggested Accomplished Investigator Award is an excellent program and I support it.

Stephen Schiaffino, deputy director of the NIH Div. of Research Grants, responded that investigators have the right to suggest names of those they feel suitable to review their applications. He also said that DRG is working on development of an appeals system which they hope to have in place by the end of 1983. "It will focus on appeals in three different areas—prereview, post review, and post awards," Schiaffino said.

Jonathan Uhr, Univ. of Texas (Dallas)—I have three points to make. The first deals with the issue brought up by Dr. Freireich of peer review. In contrast to his viewpoint, I think that peer review works quite well. I think we're pushing peer review to the limit of its capacity and I think it's responding as well as it can under the circumstances, and I would not suggest monkeying around with the system to any significant degree.

The second point I want to make is to reinforce my feeling that money spent on basic research pays off handsomely in the long run. I think in contrast to the first speaker, if I had my druthers, I'd put more effort at the basic level rather than the enormous amount of funding that goes into clinical trials.

The final point is that I'm concerned about a possible gap in the funding system to handle a grant which is relatively basic but which has a mission orientation. These grants do very poorly in study sections. Protestations to the contrary, study sections want basic research. So I think it's important to have some mechanisms for allowing this type of hybrid between mission orientation and basic research to flourish.

DeVita—Dr. Uhr, when we were in Boston, Dr. Sheldon Penman felt that RFAs issued by the Institute in specific areas were very often the way to break the study section's reluctance to see basic research applied in an area in the way you described it. There were people who felt that we shouldn't, in time of tight budget, ever issue RFAs, so we got contrasting advice. I personally think Dr. Penman is correct, that when the advice comes from the outside for us to issue an RFA in a certain area that in fact we can effect a paradigm change of that kind.

Patricia Buffler, Univ. of Texas School of Public Health—I share Dr. Uhr's support for our current peer review system in that both as a reviewer and a reviewee I can see minor areas that could be polished. I think we should contribute our responses and our suggestions to colleagues that are involved in the process and my experience has been quite favorable in doing that. I would encourage wider use of outside opinions in the review process. I endorse what Dr. Freireich has recommended.

With regard to the funding crisis, I think it's been accentuated greatly by the use of priority scores as presently assigned. There is wide variability, as I understand it, in the degree of compression that's occurring in priority scores within study sections. Some study sections are more attuned to the game. Other study sections may not respond to the same degree and I wonder if other systems have been considered, possibly using the rankings without the raw scores and funding the highly ranked proposals without reference to the specific score?

DeVita—About the comment that Dr. Buffler made on compression, our program directors look at that, with the advice of the National Cancer Advisory Board, the Panel, and the divisional boards. But when we do this, we look at percentile funding in order to correct for study sections that will compress all their grants into the funding range. So the program directors are looking at the overall programmatic interest as well as the priority score, as well as the percentile funding, that is the track record of that particular study section.

Garth Nicholson, Univ. of Texas System Cancer Center—First, I would like to dispel two popular myths on R01 and P01 funding if I might. These concern the so called sliding scale and capped proposals for redistribution of grant monies so that more applicants can be brought into the pool of funded investigators. It doesn't take much of a statistician to show that there is just not enough money to operate a sliding scale and still deliver even partial funding to grants of priorities down to 250 or even 225 without reducing the awards of excellent grants. Thus, I do not believe that the sliding scale, as proposed, is workable, assuming the FY 83 grants fall into approximately the same categories in terms of percentages and monies requested.

Second, I believe that expending administrative energy on trying to determine a suitable cap, or upper funding level, for individual investigators in widely diverse fields would not bring about a dramatic increase in funded R01 grants. In FY 81, out of 2,015 funded applicants, 1,608 had one R01 grant and no other support. Only 207 PIs had multiple sources of support from an agency. A sample of FY 82 grants indicates a similar distribution. I suggest that cutting back on the approximately 400 multiple grant PIs would not cause a significant increase in additional funding.

The next major area that I would like to discuss

concerns the peer review system. It takes way too long between submission and award of an individual proposal. One way that this might be speeded up is by allowing each investigator to place in 1-2-3 priority the study section of his or her choice, spending less time in rewriting the pink sheets for review summaries, and perhaps including an additional secondary reviewer on each grant in each study section.

My next point is a major one. I strongly and emphatically believe that all NIH funding should receive peer review using the same mechanism. I'm mainly referring to the intramural research program and the NCI initiated research support contracts.

My next major point is allocation of NCI resources. I believe that we have seen a gradual but significant shift away from investigator initiated peer review type research funded by NCI. In terms of scientific productivity, is this ratio cost effective? I suggest to you that it is not, in part, because of the lack of study section peer review of the in house programs which can result in weak as well as strong programs continuing unabated.

The next major point I would like to make is that there are other NCI budget categories which seem to be out of control, and I'm referring now to the indirect costs which eat up the monies available for research. Current average percent indirect cost is approximately 46.3 percent of direct costs and I know of some institutions whose negotiated overhead rates are as high as approximately 130 percent. I realize that this is not NCI's fault. HHS auditors have failed to hold the line.

John Costanzi, Univ. of Texas (Galveston)—I would like to start by endorsing Dr. Freireich's comments about reviewees' rebuttal and selecting study section and reviewers. I concur with him wholeheartedly. We must not lose sight of the fact that a track record must start somewhere, and I do not feel that this process as it exists does hurt the young investigator.

I feel that all the applications should be looked at equally, conscientiously, and if the science is good and the application has convinced the peer reviewers that the young investigator and his institution can carry out what he is intending to, then this person should be funded. I think we are funding the future and not the past and this should be first and foremost in the study section and peer reviewers' minds.

I recommend that good priority proposals be funded for at least five years and that the principal investigator be required to submit very detailed annual progress reports that are very carefully studied by the NIH to make sure that the research is following the lines for which it was funded and originally intended.

It all comes down to a simple number, the priority score. It is this little number that is supposed to summarize the objectivity of the process. I am very concerned at the way this number is reached. I feel that there is an enormous responsibility placed on that number and I question whether this mechanism is truly a just one.

And I'd like to close by saying a few words about the announcements and the RFPs and RFAs. Over the past five-six years I've received at least seven or eight of these on my desk with less than two weeks to the deadline.

DeVita—There's never been an RFA or an RFP that's ever been announced in the history of the National Cancer Institute with a two week deadline. They are announced with a minimum 45 days. On a rare occasion we'll break a rule and go to 30, but I can't remember one in a long time. It's a minimum 45 days. The RFAs are usually 90 days. So, somehow or other, your mail system is doing something to do.

I'd like to talk about Dr. Nicolson's comments, because I do feel very strongly about one thing, and that is, that every institution has a right to exist as long as it exists on its merit. I'm quite satisfied that our site visit process is equivalent now to any site visit process, or any peer review process, that is going on now for extramural programs and I'm prepared to defend that on any basis that you want, any match that you would like, for the Frederick facility, which has the most elegant site visit and peer review group overlooking it now, or the current intramural program site visits. I think we have our share of people who are in the process of losing their ability in science, as other institutions do, but I don't think we're overloaded with them.

Your tables are probably out of date, because there will be no eight percent increase in the intramural program in 1983, there will be a four percent increase. I assure you that in 1983 the intramural program will be treated the same way the extramural program is treated.

I fail to understand at all your comments about the shift away from investigator initiated research. Between 1980 and 1983, we reprogrammed $85 million and shifted the majority of it into the R01/P01 pool for investigator initiated research and I don't know what else we can do to show where our heart is. In fact, if we've taken any criticism in the last year or so, it has been that we have put too much emphasis on the R01/P01 pool to the cost of the Organ Site Program, which has been cut in half in three years. Clinical trials has remained flat for three years. The peer review system for contracts now is as close as it can be to grants.

Amos—I think it's only fair, to mention that the review of contracts has been developed over the last three or four years because of Dr. DeVita's initiative. I think if one could know it in detail, you would be reassured that the scrutiny is really very, very serious and that these efforts have been produc-

tive of shifting large sums of money—I'd say tens of millions of dollars—out of contracts into R01s and P01s. The NCAB over the last five-seven years has been pushing in the direction of as much investigator initiated research as possible.

George Schroepfer, Rice Univ.—The reason we're here today is largely related to the state of the economy. We must translate our discoveries, not solely in the cancer area, but in terms of all biochemical and scientific research, into dollars for this country.

I would raise a question about the so called small business grant program which is about to be initiated and it's my understanding that this will amount to one percent of the federal budget for research and development in the health fields and other fields. One percent of this is $40 million. This would support 100 investigators at a level of $400,000 a year. Now are these small business operations likely to achieve more breakthroughs than individuals funded through regular R01s?

I believe strongly that there is a need for very experienced and very highly respected senior scientists on study sections at this time. I very highly support the appointment of women and minority scientists to the study sections, but it has to be realized that at the young stage these young women and minority scientists are at a very critical period in their careers.

I really don't see, except as an honor, any need or compelling reason for the institition of an Outstanding Investigator Award whose review would be any different than any other scientist.

DeVita—I wish I could answer your question in reference to small business set asides. I really don't know. It's a congressional mandate now, so that we have to set aside a certain amount of money, and if we don't spend it, it doesn't revert to other programs, it goes to the Treasury. So the NIH has put out an announcement and brought in small business.

Lester Peters, Univ. of Texas Cancer Center—It's very difficult to obtain a sufficient number of qualified people to do all the site visits that are required. My suggestions are these: That site visit teams should be smaller, and that grant periods should be longer. I think programs should be funded for a minimum of five years. If these two things are implemented, I think you'd be able to attract more senior scientists to go on site visit teams.

In terms of stretching research dollars, I feel very sensitive about the pressures on the program project system at the moment. I think it fulfills a very important function in clinical research.

Alfonso Zermeno, Univ. of Texas System Cancer Center—My first observation is a consequence of the popular philosophy of 'fund people, not projects.' The one sin is that we attribute the track record to the wrong man. I don't believe our present system of review and recordkeeping gives any consideration to the role of the co-investigator. Perhaps we should reinstitute the practice of multiple PIs, as followed now by the National Science Foundation.

My second point concerns the increase or influx of new high technology into biomedical research and reflects the needs of the bioengineering community. My concern now is whether the study sections are prepared? Will these men find peers within their study sections?

I submit that there is a need for industrial-academic relations if we are to maintain this country's position as world leaders in high technology development and application. A close industrial relationship can increase the effectiveness of new technology

I strongly support the establishment of a network of teleconferencing centers throughout the United States, linked via satellite, the overall impact of which would be a streamlined system of grant review and award resulting in shorter turnaround times and the savings of thousands of dollars of travel funds.

Sam Barranco, Univ. of Texas (Galveston)—One of the problems that may have already had some solutions is the right of appeal and the appeal process when the occasion arises about a particular grant. The principal investigator should have a right to appeal for another review. Although appeals are possible, the mechanism by which ones makes an appeal is fairly unknown, both to the principal investigator, and the personnel at the NIH. Perhaps an appeals committee should be established that is separate from the study section that reviewed the grant. The appeals committee would be composed not only of NIH administrators, but also, hopefully, the peers of the person making the appeal.

Every effort should be made to clarify and simplify the appeals process so that it is a fair and speedy means of reversing mistakes.

Harris Busch, Baylor Univ.—I'm very much concerned about the question of appeal, largely because I see a pyramiding bureaucracy of enormous magnitude involving both the time and effort of the scientist and staff at NIH. If we devote huge sums of money and scientists' time to the progressively large number of unfortunate applicants whose programs are not funded, we may cut out far more grants than we save.

Schiaffino—For the last few years we've been running what we call an informal appeals process and it's two stages. It'll be two or three years this June that we ran a notice in the "Guide to Grants and Contracts" about an informal appeals system and we've been operating them under these points, but we are in the process of formalizing the whole process.

Lovell Jones, Univ. of Texas System Cancer Center—As a young investigator I find that the system is not working. In talking to my peers and other persons that I know, the number of young investigators that is being funded today is dropping drastically. It seems

to me that NCI is mortgaging its future with regards to future scientists.

Dr. DeVita mentioned the idea of the Young Investigator Award. The young investigator may get that award, but when he comes into the regular granting system, has a serious difficulty in getting an R01 following that, so you may be just delaying the inevitable.

Courtney Townsend, Univ. of Texas (Galveston)—I think that we have forgotten that peer review is us and that peer review means peer participation. We have been talking 'They do this,' 'They won't give any five years.' They are us, and what we have to do is remember our responsibility to maintain peer review to the standards at which it has been working in the past. I think there should be strict requirements for participating in peer review, and the level of participation should be evaluated when people's own research proposals are being rereviewed.

If we're going to—as Dr. Hammer exhorted us today—cure cancer by the end of this decade, and if not by then, by the end of the century, it'll have to be done in the clinic and clinical scientists must be educated in the appropriate scientific method and we must support the young investigator.

Paul Peters, Univ. of Texas (Dallas)—I have three points I want to make. Number one, I think it's important to continue to support intramural research, subject to the same constraints of peer review. That's where a core of our future leaders are going to come from.

Number two, fund the investigator's idea, not the investigator. Let the university today support the basic salary. I think our universities should provide an environment in which the man feels financially secure to pursue his ideas and his independent thoughts.

Number three, establish research priorities and fund those capable of carrying out the work. I feel that there is a central need for people such as Dr. DeVita and his coworkers to make those areas, if you want to call it contract research, make people aware of needed areas in which expertise may exist. So I feel it's time to get more basic information to approach the treatment of cancer intelligently and I find myself, as a clinician, in the unusual role of wanting to support the basic scientist. I think we need those who are directing the research to help us select the proper timing of such goal directed research in a time when we don't want to waste our money.

R. Lee Clark, president-emeritus of Univ. of Texas System Cancer Center and one of the original members of the President's Cancer Panel—We need more money. I think many of the things that we deliberated upon during the 70s have held up very well. I feel confident that we could spend a billion and a half right now without any difficulty of justifying it and of giving fine returns for the money used. Also, the money that would come back to this country from such research has been more than amply demonstrated by the 12 years since the Act was passed on Dec. 23, 1971, in that we are curing now another 10 percent of people and returning them to a useful life and saving useful funds that are more than paying for the pittence in comparison to the defense budget.

The Panel's next meeting, at Northwestern Univ. Medical School April 18, will continue the discussions on NIH peer review and NCI grant award procedures which the Panel has taken around the country. Sixteen scientists from the upper midwest were invited to speak.

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-N01-CM-37613-64

Title: *Master agreement: Clinical trials of biological response modifiers*

Deadline: *Approximately June 5*

The master agreement is an unfunded competitively negotiated contract awarded to more than one contractor judged to be technically and scientifically qualified to compete for future master agreement order RFPs. NCI is seeking to identify those institutions with the capacity and expertise to study clinically the many biological response modifiers which are available or will be developed for clinical trials.

For purposes of award of master agreements, offerors shall submit three theoretical clinical protocols which include A) Phase 1 evaluation of IL-2; B) Phase 1/2 evaluation of monoclonal antibody to melanoma; and C) Phase 1 evaluation of gamma interferon.

Contract Specialist: Z. Tums
RCB, Blair Bldg. Rm. 212
301-427-8737

The Cancer Letter _Editor Jerry D. Boyd

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