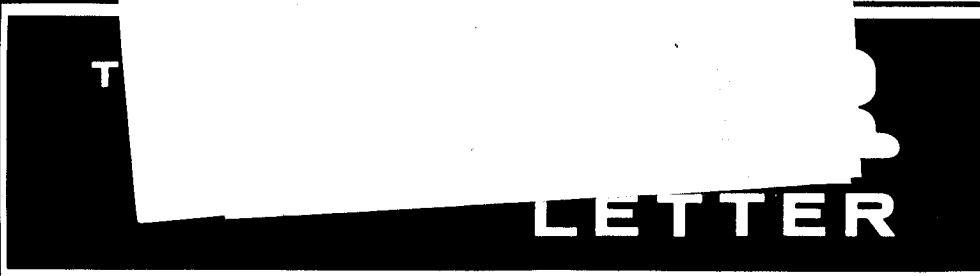


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## Hammer's "March Of Dollars" Starts Collecting Money; Four Year Campaign Kicks Off Oct. 12

The "March of Dollars," the effort organized by Armand Hammer to raise an extra half billion dollars for NCI from the private sector, which congressional leaders have promised to match with federal funds, is up and running, with \$5-6 million  
(Continued to page 2)

### In Brief

### Chabner Says He "Has No Intention Of Leaving NCI;" Yarbrow Named Clinical Indicators Chairman

BRUCE CHABNER, director of NCI's Div. of Cancer Treatment, denied a rumor going around NIH last week that he was going to leave for a job somewhere else. "I have no intention of leaving," Chabner told *The Cancer Letter*. "I want to see this Institute survive and prosper, and it will. There are still a lot of good people here. We are going to prove that this is not a one man show". . . . JOHN YARBROW, professor of oncology at the Univ. of Missouri and former president of the Assn. of Community Cancer Centers, has been appointed chairman of the Clinical Indicators Committee of the Joint Commission on Accreditation of Health Care Organizations. . . . NEW GUIDELINES for NCI program project grants go into effect Oct. 1. The changes have been reported on several occasions over the past two years. A comprehensive document is available with the guidelines, including relevant NIH and NCI policies, definitions of terms, delineation of roles of NCI program and review staff, detailed instructions for preparation of applications, and a description of the new single tiered initial review process. For copies, write to NCI Referral Officer, Westwood Bldg Rm 848, NIH, Bethesda, MD 20892. . . . PIEDMONT ONCOLOGY Assn. will hold its ninth annual symposium Sept. 30-Oct. 1 at the Sheraton Inner Harbor Hotel in Baltimore. Two sessions, one for physicians and one for nurses, will run concurrently. Topics will include treatment updates for physicians on sarcoma, ovarian cancer and lung cancer, and for nurses, biological response modifiers, bone marrow transplants and issues in survivorship. Contact Sue Elliott, Cancer Center/POA, Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, NC 27103, phone 919/748-4464. . . . ROSE KUSHNER, author, national leader on breast cancer issues and former member of the National Cancer Advisory Board, will be named one of America's 100 most important women by the "Ladies Home Journal" in its October issue.

PRI's Frederick  
Fee \$903,866 For  
First Six Months  
Of New Contract  
... Page 2

NCI To Implement  
Breslow Committee  
Recommendations,  
Sondik Says  
... Page 4

More Minorities,  
Women, Fewer MDs  
On Study Sections  
... Page 5

M.D. Anderson, Madrid  
In Joint Program  
... Page 3

Straus Asks To  
"Set Record Straight"  
... Page 3

Cancer Letter Skips  
Next Two Weeks  
... Page 3

RFP Available  
... Page 8

## Hammer's "March Of Dollars" To Kick Off Oct. 12 In New York

(Continued from page 1)  
already collected or committed.

Denver Frederick, who led the successful nationwide campaign for contributions to refurbish the Statue of Liberty, has been retained by Hammer to head the NCI fund raising drive.

The campaign will officially begin Oct. 12 with a glittering kickoff party to coincide with opening of the Wintergarden complex in New York's World Trade Center. "We hope to raise a substantial amount at the kick off," Frederick told *The Cancer Letter*. Entertainers and other celebrities will appear, and Merv Griffin will be the master of ceremonies.

Frederick is focusing now on corporate contributors, with pledges of \$1 million each from Drexel Burnham, Hearst Corp. and John Kluge Metromedia. "We certainly will concentrate on wealthy individuals and corporate donations, but our approach primarily will be grass roots," Frederick said. "We have to get every citizen involved."

The effort is being coordinated with the American Cancer Society, which gets most of its \$150 million budget from "grass roots" donations collected by volunteers in door to door campaigns every April.

"I have met with ACS, and we have developed a relationship that is one of cooperation," Frederick said. "We are pulling in the same direction. The last thing we want to do is just take money and move it around."

Frederick said he hopes to involve fraternal organizations and service clubs, at the national level.

When Hammer, who is chairman of the President's Cancer Panel, first started talking about ways to beef up NCI's budget, he indicated it would be a two year program. Hammer would like NCI to get its full bypass budget request, which for FY 1989 was \$2 billion, about \$500 million more than NCI actually will receive. The extra billion dollars would make up the shortfall over two years.

Reality has set in, however. Frederick said the target date for completion of the campaign is Oct. 12, 1992, four years after next month's kickoff.

"That would be the 500th anniversary of the discovery of America by Columbus," Frederick said. "His was a voyage of discovery, and every contribution we receive moves us farther along in our voyage of

discovery to find ways to prevent and cure cancer."

Frederick said the timing of transfer of funds to NCI, along with the federal matching funds, "still needs to be refined. There will be some kind of order to it. I expect that when we have a substantial amount in hand, we will go to Congress and ask for the matching money."

Former (as of Sept. 1) NCI Director Vincent DeVita said at the time of Hammer's initial discussion of the campaign that extra money would be used to bring expenditures up to levels in various categories spelled out in the bypass budgets--funding 50 percent of approved competing grants at full recommended levels, increasing the number of cancer centers 50 percent by 1992, triple spending for prevention and control by 1992, double the number of patients treated under research protocols by 1992, supporting 1,600 research trainees, and awarding up to \$50 million a year in construction grants.

It was DeVita's hope that once the shortfall is made up, Congress would keep it at that level and add annual increases comparable to the bypass budget requests. The bypass budget level is intended to support the research programs, national networks of cancer centers and clinical trials, and information dissemination required to meet the Year 2000 goal of reducing cancer mortality by 50 percent.

## PRI's Frederick Fee For First Six Months Of New Contract: \$903,886

The three contractors at NCI's Frederick Cancer Research Facility did quite well in the first six months of their new contracts, as measured by the award fees each received for that period. Those do not include the contract for basic research held by Bionetics Research Inc., which has a negotiated fee system.

The four contracts (one contractor has two of them) utilize the award fee system for determining the profits to be paid to each firm for each six month period. A figure has been established in each contract for how much potential award fee will be available for each period. An NCI staff committee reviews contractors' performances and determines how much of the fee will be paid to each.

The largest of the contracts is held by Program Resources Inc. for operations and technical support. It is in fact the largest contract ever awarded by an NIH agency,

nearly \$900 million for seven years, which will probably swell to more than \$1 billion if NCI and other NIH activities at FCRF continue to grow.

For the first six months of the new contract, from Sept. 26, 1987 to March 31, 1988, PRI received \$903,886 as its award fee out of a total of \$1,323,987 that was available. The award amounted to 68.27 percent of the available fee.

That represented a healthy increase over the award fee for the final six months of the previous contract. PRI received then \$849,358, which was 62.87 percent of the amount available.

With the new contract, PRI initiated a new profit sharing plan, in which half of the award fee is distributed among key employees. It appears those employees will be splitting up about \$1 million a year.

The smaller contracts paid off at considerably higher percentages of the available awards, but far lesser amounts were involved. All were close to the amounts paid for those contracts during the final six months of the previous contracts.

Harland Sprague Dawley Inc., with the animal production contract, received \$53,700 out of \$63,738 available, 84.25 percent. In the last six months of the previous contract, the company earned \$53,600 out of \$63,334, 84.63 percent.

Data Management Services Inc., with the contract for scientific library services, received \$16,704 out of \$18,330, or 91.13 percent. For the previous period, DMS received \$19,602 out of \$21,306, 92 percent.

DMS also now holds the contract for computer services, previously held by Information Management Services Inc. DMS received \$22,733 out of \$24,845, 91.5 percent. IMS received in the final six months of its contract \$31,010 out of \$34,077, 91 percent.

BRI's fixed fee for the first year of the new basic research contract, which ends Sept. 25, is \$652,454, compared with \$523,083 for the last year of the previous contract.

## **Cancer Letter To Skip Next Two Weeks, Resume Publication Sept. 23**

The Cancer Letter will take its summer sabbatical the next two weeks, with no publication scheduled for Sept. 9 or Sept. 16. The next issue, Vol. 14 No. 37, will be published Sept. 23.

The office will be closed from Sept. 6

through Sept. 19. Messages will be received through the telephone answering machine and will be checked from time to time. Those requiring immediate attention will get a response then; others will be answered after Sept. 20.

## **M.D. Anderson, Madrid Agree On Plan For Education, Prevention Programs**

The Univ. of Texas M.D. Anderson Cancer Center has signed its first international agreement, with the state of Madrid, for education programs for Spanish physicians and scientists and to establish cooperative efforts in cancer prevention.

Frederick Becker, vice president for research at M.D. Anderson, and Pedro Sabando Suarez, minister of health for the state of Madrid, recently signed an initial five year agreement in Madrid.

After returning from a two week tour of Spanish medical facilities, Becker said, "I am excited about this unique opportunity to train clinicians and scientists from Madrid, to set up a series of exchange professorships and to institute mutually beneficial studies in preventing cancers caused by smoking. In time, we may develop some joint treatment protocols."

Angel Martin Municio, president of the Royal Academy of Sciences of Spain, and Pedro Garcia-Barreno, medical director of the Gregorio Maranon General Hospital in Madrid, participated with Suarez in meetings leading to the new agreement. The trio visited M.D. Anderson last May.

A specialized cancer institute is being organized at the Gregorio Maranon General Hospital, a 2,600 bed facility that is the largest in Spain. Becker said Garcia-Barreno and his staff "are keenly interested in the way we combine fundamental research and clinical care at all levels."

## **Straus Wants To 'Set Record Straight,' Says He Did Not Falsify Trials Data**

Marc Straus, who was accused of falsifying data in clinical trials he headed at Boston Univ. Medical Center in 1978, took exception to an account of those charges which accompanied the report of the death of Robert Polackwich (*The Cancer Letter*, June 17).

Polackwich was involved in making those accusations against Straus, who was banned from participation in NCI supported clinical

trials and who later lost a grant because of pressures generated by the charges against him. Polackwich was a medical fellow under Straus.

"Because the living as well as the memory of the dead are affected by the notice in your [newsletter] concerning the death of Dr. Robert Polackwich, the record should be set straight," Straus wrote in a letter to the editor.

"Dr. Polackwich did not 'find what he thought were irregularities' [as described by *The Cancer Letter*] in data kept by the medical oncology unit which I headed at Boston Univ. Medical Center in 1978." Straus said that two nurses "made false data entries unbeknownst to me. No government agency has ever found to the contrary."

Straus said that his signature had been forged to the forms containing the inaccurate data, "which hardly would have been necessary had I been a willing participant in making false data entries."

Straus said Polackwich aided the two nurses "in making false accusations against me. Your report that there was severe criticism of Dr. Polackwich for making these charges is correct. That criticism was fully justified."

Straus said that he was held responsible for the data falsification "because the law does not care whether I, as principal investigator, was the victim of sabotaged data. I, as principal investigator, was held responsible. . . because my ignorance of the false data entries was no defense under the law. I believe the unfairness of the law was one of the reasons why Vincent DeVita was reluctant to take action against me."

DeVita had been director of NCI for only a short while when, after Straus left Boston, he received a large program project grant from the institute. DeVita later was severely criticized by members of Congress for making that award despite knowing of the charges against Straus. DeVita responded that no legal action had been taken against Straus other than barring him from NCI clinical trials and that he felt that until Straus was proven guilty, the presumption of innocence made it obligatory for him to go along with peer review (which had scored Straus' application very high) and make the award. DeVita acknowledged that he had been remiss in not advising the National Cancer Advisory Board of the charges against Straus when the grant came before it. At least some members of the initial review group did know of them and

gave it a top score anyway.

The program project grant later was terminated for various alleged deficiencies, which Straus said was "strictly a political decision" because of the pressures on DeVita and NIH.

## NCI Will Implement Measurement Of Progress Recommendations: Sondik

Recommendations of the Extramural Committee to Assess Measures of Progress Against Cancer (*The Cancer Letter*, Aug. 12) are or will be implemented, if they are not already being done, to the degree possible, Edward Sondik chief of the Operations Research Branch in the Div. of Cancer Prevention & Control, said this week.

Those recommendations basically involve strengthening NCI's incidence and survival reporting, expanding the Surveillance, Epidemiology & End Results Program, carrying out patterns of care studies, tracking and reporting the translation of research results into practice, reviewing and reporting spinoffs from cancer research, carrying out research on accuracy of incidence and mortality rates and on their relation to survival, and conducting research on how cancer statistics are affected by changes in other causes of death.

Sondik told *The Cancer Letter* that DCPC intends to implement all of those recommendations to the extent possible. "Many of them are things we are doing, but there is a lot of room for development."

One of the more intriguing recommendations was for a new death rate measure, using instead of the general population as the denominator the number of diagnosed cancers in a base year.

"That is a very important suggestion," Sondik said. "I can see us trying to develop that, but it will be hard to do. We want to discuss that with the National Center for Health Statistics. Everyone knows that current measures don't capture everything. It is not an easy task. There is no perfect measure. It is clear that standard mortality rates do not capture everything we want."

Sondik, who served as the committee's executive secretary, said "we could see in the committee's deliberations that everyone realized it's not as if the right measure were there, awaiting development. This will take a lot of analysis. It's sobering, and tricky."

The committee's report "raised a lot of issues, and includes a lot of direction," Sondik

said. "The committee saw statistics not just in isolation, but melded with statistics on knowledge of cancer, behavior, percentage being screened, smoking, and health care statistics in general. The mortality data and our SEER information is just the tip of the iceberg. We need to understand all this if we want to understand the control of cancer. This is a real challenge."

#### **Critic On Committee**

The committee, chaired by Lester Breslow of UCLA, included in its membership John Bailar, a frequent critic of NCI statistics on progress against cancer and the cancer program in general. Bailar was the first director of NCI's Cancer Control Program, after it was created by the National Cancer Act of 1971. He is now professor of epidemiology and biostatistics at McGill Univ. in Montreal.

Bailar outraged much of the cancer establishment, particularly NCI Director Vincent DeVita, with an article in the "New England Journal of Medicine" two years ago, in which he charged that NCI's statistics were inaccurate and that no meaningful progress against cancer has been made.

DeVita later decided that critics should be offered the opportunity to bring their views to bear where policy is being developed (in less polite vernacular, put up or shut up), and Bailar was invited to serve on the Breslow committee.

"Working with John Bailar was an absolute delight," Sondik said. "I enjoyed it very much."

### **More Minorities, Women, Fewer MDs On NIH Study Sections, Report Says**

NIH study section members were a little older in 1986 than they were in 1977 but had less experience as grant reviewers, there were more of them, fewer of them were MDs, and more of them are minorities and women.

That information is included in the annual Div. of Research Grants report on Peer Review Trends, which compares the status of DRG study sections, institute review groups, advisory councils and boards for 1977 and 1986.

Initial review groups (study sections) managed by DRG have the primary function of initial review and evaluation for scientific merit of applications for research grants and research training awards. These panels are composed of experts grouped according to scientific discipline. In October 1986, DRG study sections included 1,413 members, an 84

percent increase over the 769 members active in October 1977.

Scientific review groups managed by the bureaus, institutes and divisions (BIDs) have diverse review responsibilities including multidisciplinary requests and specialized proposals as well as contracts. These BID review groups had 682 members in 1986, a five percent decline since 1977. The decline reflects a reduction in contract review members from 196 to 104.

Program advisory committees offer advice and make recommendations on policy and matters of significance to the missions and goals of the BIDs they serve as well as to the national health needs. In 1986, program advisory committees included 523 members. Of these, 231 were members of advisory councils or boards (such as the National Cancer Advisory Board) which provide the second level of grant review for program relevance and adequacy of initial review. Together with institute directors and staff these councils advise on funding decisions. An additional 292 members served on policy advisory committees without extramural grant review, special committees for programs or projects which provide advice on scientific and other aspects of research programs, or on boards of scientific counselors for intramural research.

The number of regular DRG study section members increased from 769 in 1977 to 1,413 in 1986 (an increase of 84 percent) with a substantial part of this growth occurring since 1981. The formation of chartered flexible committees with multiple subcommittees in 1982 and 1983 caused the large membership increase in these years.

Growth in membership from 1981 to 1982 (214 members) was greater than any other year. Most of the 1982 growth was in members with PhDs--162 of the 214 additional members compared to an increase of 51 MDs (including joint MD/PhD). A second relatively large increase of 104 members from 1982 to 1983 added more MDs (57) than PhDs (49) with most of the MDs holding joint degrees (44). Net growth of 69 members in 1986 was all PhDs with a decline in MDs. Preliminary 1987 data indicate a further decline in members with MD or MD/PhD degrees and an increase in PhDs.

New appointments during these years would be substantially larger since they would include replacement of at least 25 percent of members as their term expired in addition to this growth in membership. These data exclude ad

hoc committees and special study sections.

One of the most visible trends in DRG study section membership has been a steady shift toward members with PhDs (or equivalent). Members active in 1974 were evenly divided between PhDs and MDs (including joint MD/PhD). This balance has gradually shifted toward PhDs who now comprise 66 percent of the active members. The proportion of MDs serving on study sections continues its downward trend and by October 1986 only 33.2 percent of the members held MD or MD/PhD degrees--down two percentage points from 1985. This trend among peer review members parallels that found in RO1 applicants. Recently available 1987 data indicate a further drop to 30.7 percent.

Throughout this report, members with DDS, DMD or DVM degrees have been included with MDs. Their inclusion increased the proportion shown as MDs by 2.3 percentage points in 1977 (18 members) and 1.4 points in 1986 (20 members). PhDs include members with EDD, DENG, DPH and DSC degrees. These degrees made up one percent of the members in both 1977 and 1986.

Members with joint MD/PhD degrees have usually been included with MDs. The proportion with joint degrees steadily declined from 9.6 percent in 1977 to only 4.4 percent in 1981. However, members with joint degrees then increased, remaining between eight and nine percent since 1983.

More than half of the members of DRG study sections are employed by medical schools. The proportion of these members who hold MD or MD/PhD degrees declined from 60.1 percent in 1977 to 44.7 percent in 1986, a drop of 15.4 percentage points. Members employed by other health professional schools showed a similar decline in MD holders, down 16.3 points from 39.2 to 22.9 percent. All other institutions of higher education now employ an insignificant proportion of members with MDs. Independent hospitals are the only organizations that still show a majority of members with MDs, 68.3 percent declining to 54.8 percent in 1986.

The proportion of MDs serving on DRG study sections, though declining, remains higher than the proportion of principal investigators on competing RO1 applications who are physicians. The percent of RO1 applications from MDs declined from 32.5 in 1977 to 26.4 in 1986. MDs on study sections declined from 46.4 percent to 33.2 percent. The lag between the proportion of MD applicants and

study section members may predict continuing declines in the availability of MDs to serve on study sections.

About two thirds of the 1986 study section members reported doctorates in six areas--biochemistry (16.8%), internal medicine (15.6%), other medical specialties (9.6%), microbiology (8.4%), chemistry (7.9%), and physiology (7.1%). For the first time since these data have been collected, more members held doctorates in biochemistry than in internal medicine. The principal change in the doctorate field has been a decline in the proportion with doctorates in internal medicine and other medical specialties. At the same time, the percent of members with doctorates in biochemistry, microbiology, and genetics increased. These shifts are consistent with the continuing tilt away from members with MD degrees.

In most years, about 60 percent of the regular members of DRG study sections are in the first or second year of their current appointment. The remaining 40 percent usually include only about 15 percent serving their fourth year.

In recent years, about 15 percent of active members have indicated prior NIH committee membership, down from about 18-20 percent in 1977-81. Most of this prior membership refers to another study section or institute review group, with less than three percent with prior service on advisory councils and boards or other advisory committees.

Although study section members are usually appointed to overlapping four year terms, not all members serve the full four years. After a completed term, immediate reappointment within one year to the same or another chartered HHS committee, or simultaneous service on more than one committee, is prohibited except by special permission of department officials. No more than one member of the same organization may be appointed to any one committee, except by special permission. However, in multicampus universities each campus is considered a separate institution.

The average age of members has gradually increased from a low of 44.6 in 1979 to the present 45.4. This primarily reflects a continuing drop in the proportion of members 40 years or less since 1979--from 31.3 percent to only 24.4 percent in 1986, and includes a decline in members under 36 years from 5.3 to only 1.8 percent. Preliminary 1987 data show a continuation of this trend.

In all years, more members were between 41 and 45 years of age than in any other five year age group. Members over 60 increased from 2.0 percent in 1979 to 3.4 percent in 1986.

The average age of members is two to three years greater than PIs on competing ROI applications. The decline in younger members may reflect the decline in younger applicants. The continuing decline in younger 1987 applicants may contribute to a continuation of this age trend for future members.

The academic rank of members employed by institutions of higher education changed somewhat from 1977 to 1986. Although the majority of these members still hold the rank of full professor, this percent has declined by 11 points, from 74.1 to 63.2. Preliminary 1987 data show a further drop, to 62.2 percent. Declines are especially evident among younger members. Members with the lower rank of associate professor increased from 22.8 percent to 32.4 percent, and assistant professors increased from 1.6 percent to 3.2 percent.

The American Assn. of University Professors reports that the percent of full time faculty at U.S. institutions with academic rank holding the rank of full professor increased from 27 in 1976-77 to 36 in 1986-87. Similarly, AAMC reported the percent of full time medical school faculty as full professors increased from 25.8 in 1977-78 to 27.2 in 1986-87.

Minority representation on chartered study sections has almost tripled since December 1977, from 4.7 percent of regular members to 14.5 percent in October 1986. This represents an increase of 167 minority members--37 in 1977 compared to 204 in 1986. Of these 204 minority members, 32, or 15.7 percent, were women.

The largest minority category is Asian/Pacific Island origin (9% in 1986), followed by Hispanic (3.5%), Black (1.6%) and American Indian/Alaskan native (.4%). The distribution of minority membership on study sections reflects the minority representation among NIH grant applicants.

DRG study section members show a slightly larger minority representation than NIH research project applicants (14.5% of members in 1986 compared to 12.3% of applicants).

The number of women serving as regular members of DRG study sections has more than doubled since 1977, increasing from 106 to 243 in 1986. Their percent of study section membership increased from 13.8 in 1977 to a

high of 19.8 in 1982, but then declined annually to 17.2 percent in 1986. However, preliminary 1987 data indicate a recent jump in women members to 283 or 19.5 percent.

Women have greater representation in the executive secretary positions--21.6 percent in 1977 increased every year to a high of 30.8 percent in 1984, but then dropped to 26.2 percent in 1986 and 23.8 percent in 1987.

Women represent a gradually increasing proportion of research project applicants and awards, going from 10 to 20 percent of 1987 applications and from 10 to 17 percent of awards.

Women have differing levels of representation on the scientific review sections. In 1986, the highest proportion of women were in manpower review (22%) and behavioral/neurosciences sections (21%) followed by 20 percent on the biological sciences sections. The smallest proportion of women were found on physiological sciences sections and clinical sciences, both with 13 percent women. These were also the two sections with the highest proportion of MDs.

The proportion of women members (employed by institutions of higher education) who were full professors is substantially lower than men in all years. This difference ranged from 40 points lower in 1978 and 1979 to 25 points lower in 1984.

Both showed declines in the percent who were full professors. Women dropped from 43.6 percent in 1977 to 39.3 percent in 1986; men showed a greater decline, from 79.1 to 68. However, about three to four percent of the 1985 and 1986 members can still be expected to file forms indicating a promotion to rank of full professor.

Differences between men and women members are especially evident in the proportion who are department chairmen. Only a small percent of women members were chairmen of their departments, 2.1 percent in 1977 declining to only one percent in 1986. Men who were department chairmen represented a much larger but also declining share of members, 15.7 percent in 1977 dropping to 9.4 percent in 1986.

#### **Study Section Members With Grants**

In each year of membership from 1977 to 1986, between 60 and 67 percent of regular members were found to be principal investigators on one or more NIH extramural awards from that fiscal year's funds. About one fourth of the members had more than one research grant. An additional 17 to 20 percent received



some type of NIH support in the immediately preceding fiscal year. Awards from other than the immediately preceding or current year were not tabulated. In addition, data are not available for member support from other federal, state or local government sources or from private industry. These other (non-NIH) sources represent the majority of health R&D support--64 percent of the national total in both FY 1985 and 1986.

Here's how the figures break down by mechanism, with the percent of members with NIH/PHS awards for 1977 and 1986, the first figure being for 1977, the second for 1986:

ROI, 72.3%, 70.7%; other research projects, 5.1%, 4.7%; research centers, 2.9%, 1.5%; other research, 8.7%, 6.9%; contracts, 6.4%, 1.2%; training grants, 13.3%, 6.4%; non-NIH PHS support, 4.7%, 1.9%; none, 12.9%, 14.4%.

The criteria for membership selection on DRG study sections include competence as an independent investigator. Members' proficiency is evidence by significantly better (lower) priority scores than nonmembers. Since 1970, at least 13 Nobel Prize laureates have been former members of DRG study sections. In all years, both current and former study section members received substantially better scores on their traditional research project (ROI) applications than nonmembers.

Nonmembers submit a much higher proportion of amendments to their applications than do members, particularly competing renewals.

One of the most consistent trends in priority scores has been the deterioration in mean scores with increasing age of the applicants. The difference was generally greater among new applications than renewals. With few exceptions, the inverse relationship between age and quality of applications was found among current and prior study section members as well as nonmembers.

Requests for a comparison of scores that study section members receive on their own applications before, during and after membership prompted this study. A consistent trend was not found; however, from 1980 to 1984, new applications averaged better scores before membership than during or after. In 1985 and 1986, members seemed to do slightly better during membership than before, but again showed poorer scores after membership.

Scores of applications by members show many of the same patterns as other applicants except that members' applications are substantially better. Age is a factor. In members age 41-50, scores are usually better after membership than before. Current and former members have higher success rates for both new and competing renewal applications.

## RFPs Available

Requests for proposals described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Blair Building room number shown, National Cancer Institute, NIH, Bethesda, MD 20892. Proposals may be hand delivered to the Blair Building, 8300 Colesville Rd., Silver Spring, MD, but the U.S. Postal Service will not deliver there. RFP announcements from other agencies will include the complete mailing address at the end of each.

### RFP NCI-CM-97584-08

Title: Master agreement for chemical synthesis

Deadline: Approximately Oct. 7

The Drug Synthesis & Chemistry Branch of the Developmental Therapeutics Program of NCI's Div. of Cancer Treatment is interested in receiving contract proposals from and establishing master agreement contracts with organizations with the capability of providing services for the synthesis of a variety of organic and inorganic compounds.

A master agreement is the instrument issued to sources which responded to a master agreement announcement (MAA), and which were judged to be qualified to compete for future orders issued under the general project area or areas described in the master agreement. Master agreements are competitively negotiated and awarded to more than one organization. This type of agreement is designed to accomplish highly circumscribed pieces of work as promptly as possible. The master agreements which will be awarded under this RFP will not be funded per se. After award, master agreement holders will be invited to propose competitively on master agreement orders as they are issued.

A master agreement order is a bilateral award document issued to the master agreement holder who successfully competed for the requirements described in a master agreement order RFP. Individual master agreement orders will be issued on either a completion or term (level of effort) basis, whichever is deemed appropriate by the contracting officer.

The objectives of these master agreement orders will be the resynthesis of known compounds of varying degrees of complexity for conformational testing, the synthesis of unique compounds with reported biological activity, the resynthesis of compounds identified by *in vitro* anticancer and anti-AIDS screens as candidates for secondary testing and the synthesis of unique compounds in support of the intramural program.

Contracting Officer: Karlene Ruddy

RCB Blair Bldg Rm 216  
301/427-8737

## The Cancer Letter — Editor Jerry D. Boyd

Associate Editor Patricia Williams

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Bulletin:

## Rabson Confirmed As NCI Acting Director; Reagan Intends To Make Permanent Appointment Soon

Alan Rabson, director of the Div. of Cancer Biology & Diagnosis, has been confirmed as acting director of the National Cancer Institute, effective Sept. 1. Rabson had been recommended for the position by NIH Director James Wyngaarden (*The Cancer Letter*, Aug. 26), and the official appointment was made by HHS Secretary Otis Bowen this week. Vincent DeVita's last day as director was Aug. 31.

After going to press this week, *The Cancer Letter* learned that the White House is not planning on waiting until the next administration is in office before naming a permanent director. White House staff has drawn up a list of prospects which does not include any current NCI staff member, sources said. *The Cancer Letter* was not able to learn whether an effort will be made to obtain the concurrence of Presidential candidates George Bush and Michael Dukakis on the selection. A new director appointed by President Reagan would be subject to reappointment or not by the new President.