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Stop Cancer Foundation's Future In Question, May Not Deliver All Of Funds Promised To NCI

When Armand Hammer died last month, his Stop Cancer Foundation lost its guiding force and most prominent fundraiser. Now, officials of the cancer research fundraising group are trying to decide who should lead the foundation, or whether, in the words of its executive director, Stop Cancer should simply "close up shop."

Hammer, chairman of Occidental Petroleum Corp. who died Dec. 10 at age 92, started the Stop Cancer Foundation in 1988 as a four year

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In Brief

Healy Nominated To Head NIH; Hammond, D'Angio To Step Down As Group Chairmen

BERNADINE HEALY, chief of the Research Institute at the Cleveland Clinic, has been nominated by President Bush to serve as director of NIH, ending the Administration's protracted search for an NIH director. If confirmed by the Senate, Healy would be NIH's first female director. . . **NEW AND IMPENDING** lineup changes in the clinical cooperative groups: **Denman Hammond** has announced that he will not run for reelection as chairman of the Childrens Cancer Study Group. His current term will expire November 1992. The group will vote on a chairman elect at its meeting in St. Louis in April. Hammond has been chairman since 1968, and joined the group as an investigator since 1957. At that time, acute lymphoblastic leukemia was 100% fatal, with median survival of six months. Now, more than half of children treated for that disease since 1972 on cooperative group protocols are still alive, survival at seven years or more exceeds 70%, and duration of treatment is three years or less. **Guilio D'Angio**, chairman of the Wilms' Tumor Study Group since it was founded in 1969, will turn that position over June 1 to **Daniel Green**, Dept. of Pediatrics, Roswell Park Cancer Institute. Green has been a member of the group for 12 years and has been the Pediatric Oncology Group's representative. Wilms' tumor survival in 1969 around the world was about 60%; it is now 80 percent or more, and higher for those with favorable histology. Also, most patients now are treated with two drugs and no radiation except for 25% considered high risk. D'Angio will serve as the group's coordinator for at least a year, replacing **Audrey Evans**, who has resigned that role. Finally, **James Cox**, chairman of the Radiation Therapy Oncology Group and physician in chief of M.D. Anderson Cancer Center, has been elected chairman of the Cooperative Group Chairmen's Committee. He replaces **Teresa Vietti**, chairman of the Pediatric Oncology Group, whose two year term expired.

Stop Cancer May Stop Fund Drive Unless Hammer Successor Is Found

(Continued from page 1)

effort to raise $500 million in private money, ostensibly from sources that had never before been tapped for cancer research. All the money raised by the foundation and matched dollar for dollar by the federal government was to go to the National Cancer Institute.

Even before Hammer's death, the foundation had fallen $7.5 million short on its pledge last year to deliver $12.5 million to NCI, while the federal government had delivered its $12.5 million.

In addition, the foundation faces questions about its mission. Early on in the campaign, Hammer, through his personal and business contacts, had successfully tapped several major donors.

However, later in the campaign, Stop Cancer changed its fundraising strategy to include appeals to small individual donors through television drives and other techniques used by the more established cancer fundraising groups.

"We don't need another foundation to raise money like the American Cancer Society does," said Helene Brown, one of two representatives from the cancer research community on Stop Cancer's board of directors. "I would think Stop Cancer would have to fold its tent and slip away" unless someone of Hammer's stature assumes the role Hammer played in the effort, she said.

Other board members reached this week said they simply did not know what would happen with Stop Cancer.

Ted Mann, a Stop Cancer board member and chairman of the Mann Theaters Corp. based in Los Angeles, said, "It's so soon after Dr. Hammer's demise that I don't really know" what will happen with the foundation. "I presume it would continue."

But the foundation's executive director told **The Cancer Letter** he did not know whether Stop Cancer would continue, and said that decision is the board's to make.

"I don't really know what the future of Stop Cancer is," said Denver Frederick, executive director of the foundation. "Somebody would have to step forward to assume leadership of the organization and we would move forward for the remaining two years. There is the possibility that this would happen. However, with the economic times we are in, perhaps we should take our cue and close up shop."

Hammer's executive assistant at Occidental, Eleanor Connors, said Hammer apparently left no instructions for Stop Cancer's future. "I guess it would be finished, unless somebody else wanted to head it up," Connors said.

Frederick said he is planning a board meeting to be held sometime in the next few weeks "to review the options and the programs we have in place."

The question of the foundation's future arose at Hammer's funeral in Los Angeles earlier this month. "Some board members said we should move ahead, but others thought we should not," Frederick said. "There hasn't been time to focus on the question" so soon after Hammer's death, he said.

Glitzy Beginning

Hammer launched Stop Cancer in the fall of 1988 with the goal of raising $500 million from private sources, to be matched by federal funds over the next four years, for a total of $1 billion.

He promised that Stop Cancer was "a one time effort" that would seek new sources of funding and would not compete with other cancer fundraisers. The $1 billion then was the one-year difference between NCI's actual budget and its bypass budget, the professional needs budget the institute submits each year to the President.

The foundation had a glitzy beginning that October with an innaugural benefit in the Winter Garden of New York's World Financial Center. Guests paid $2,000 each to dine and hear Mstislav Rostropovich conduct the Philadelphia Orchestra and violinist Isaac Stern.

The benefit raised $2 million, according to the "Los Angeles Times," and Hammer received a proclamation from New York Gov. Mario Cuomo declaring Oct. 12 "Stop Cancer Day" in New York State.

Hammer said then that the foundation had already raised $10 million.

THE CANCER LETTER

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Hammer likened the effort to the March of Dimes, which provided funds for polio research in the 1930s, but called Stop Cancer "the march of dollars."

In January 1989, the "New York Times" published an opinion piece Hammer wrote titled "Funds Are Lacking, Cancer Is Gaining," in which Hammer outlined his belief that "with the extra effort these funds would finance, we would succeed in eliminating cancer by the year 2000."

"Stop Cancer really did bring new money into the field," said Brown, who is director of community applications of research for the Div. of Cancer Control, Jonsson Comprehensive Cancer Center at UCLA. "I became a member of the board because Dr. Hammer was able to open corporate doors that were not open before."

For instance, Hammer convinced Randolph Hearst, chairman of the Hearst Corp., to commit his firm to a $1 million donation, Brown said. Others followed.

"When the American Cancer Society or cancer centers go out [seeking donations], they don't get in those doors," Brown said. "They get money from corporate employees with their payroll deduction plans. While that's important money, it's a different pot of money."

Gifts from corporations themselves are probably no more than eight to nine percent of all dollars given in the U.S. each year, Brown said.

Promised $12.5 Million

In 1989 Hammer said Stop Cancer had raised $12.5 million for NCI and sought one-for-one matching funds from Congress, which were appropriated that fall in the FY 1990 budget.

At a meeting of the National Cancer Advisory Board in January 1990, Hammer presented NCI Director Samuel Broder with a check for $2.5 million, which, including a previous donation of $500,000, brought Stop Cancer's total donation to NCI to $3 million. Accompanying Hammer at the presentation was Sen. Tom Harkin (D-IA), who was instrumental in providing the matching funds. Harkin said that any funds Stop Cancer raised would be matched by Congress.

Hammer said then that the remainder of the $12.5 million would be given to NCI later in the year. At last September's meeting of the NCAB, Hammer again promised the remaining funds by the end of 1990. Hammer became too ill to travel soon after that meeting, according to news reports.

According to an NCI summary, Stop Cancer had provided $4.75 million by the end of the fiscal year last Oct. 1.

Frederick said the actual figure now stands at "a little over $5 million."

Brown said she plans to raise the issue at the next Stop Cancer board meeting of the remaining funds promised to NCI. "Whatever money is in the bank would be better used by NCI than simply sitting in the bank," she said.

If the foundation had raised $12.5 million and had given about $5 million to NCI, that would leave $7.5 million outstanding. Yet, it is far from clear exactly how much is left in the bank.

Frederick said recent rumors that the foundation was having trouble getting corporate donors to make good on their pledges were "not true." However, the "major pledge" of one donor, Drexel Burnham Lambert Inc., most likely will not be paid, since the firm is in bankruptcy. He said he could not say how much Drexel had pledged.

If the board decides to close the foundation, "we would take the remaining assets of the corporation and give them to NCI," Frederick said.

But he raised the possibility that firms and individuals who have pledged money to Stop Cancer may decide not to donate to an organization planning to close its doors.

"There are a lot of people who have every intention of paying, but you have to put that in the context of what if the campaign closes down," Frederick said. "If for whatever reason a leader did not step up to assume the chairmanship and the board decided the campaign had to be concluded, those people may decide not to commit their funds."

Hammer assistant Connors said she did not know whether Hammer provided any money to Stop Cancer in his will, which has not yet been made public. Most of the estate is said to be committed to Hammer's newly opened art museum in Los Angeles.

Loss Of Focus

Hammer's strategy of personal appeals for donations to corporate and entertainment executives may have paid off for the foundation in the short run, but it had a price. To outsiders, Stop Cancer seemed unable to focus its fundraising efforts.

Hammer spoke of holding a celebrity "gala" last year and an effort to enlist cable TV companies in the campaign. "We've had fundraising on the East Coast and now we'll move it to the West Coast," Hammer told **The Cancer Letter** last year (Feb. 2).

At the time of Hammer's presentation of a check to NCI early last year, Frederick said Stop Cancer would intensify its fundraising with a "national awareness campaign," a television special, promotions with grocery stores, hotel and movie theater chains, and ski resorts.

After the NCAB meeting, Hammer said Stop Cancer

"would have no trouble raising $500 million" if American families "just give $5 or $10."

However, the organization did find some novel sources of funding. Last fall, runners in the New York City Marathon were asked to seek pledges for every mile run, the first time the marathon had ever been dedicated to charity. Brown said that effort raised over $1 million.

"When you lose somebody of the stature of Hammer--and he is so closely identified with the campaign--you have to get somebody with a similar stature before you can move ahead," Frederick said. "The sense is, let's hold on here and decide what we're going to do and where we're going to go."

Half Spent On Grants

In a summary prepared for the Div. of Cancer Treatment Board of Scientific Counselors, the total STOP Cancer funding for FY 1990 was shown as $4.75 million. Along with the $12.278 million Congressional appropriation ($12.5 million with the across the board reductions taken), total funding was $17.028 million.

NCI directed $9.037 million, or 53 percent of the STOP Cancer and matching funds, to research project grants. Other mechanisms and the amounts received were: Cancer centers--$750,000; cancer education--$75,000; small grants--$522,000; research and development contracts--$1.1 million; intramural research--$5.544 million (33 percent of the total). The management fund received $1.5 million.

DCT received $3.85 million of the total, and about half of that was directed toward research in immunotherapy. NCI Surgery Branch Chief Steven Rosenberg received $600,000 for "Experimental and Clinical Studies of Adoptive Immunotherapy and Gene Therapy," and $550,000 for "Molecular Studies of Tumor Antigens and Immunotherapy." Rosenberg's LAK and TIL laboratories received another $600,000.

Michael Lotze and Douglas Schwartzentruber received $400,000 for "Experimental Studies of Interleukin-2 in Humans," and James Yang received $400,000 for "Study of Specific Antitumor Immunity in Murine Models."

In DCT's Biological Response Modifiers Program, $25,000 went to Bruce Wiltrout for "Use of Modified Monoclonal Antibodies for the Treatment of Human Tissues in Mice," and $25,000 to Dan Longo for "A Study of Cell Cycle Control of Human B-Lymphoma Cells."

Also in the intramural program, Carmen Allegra received $100,000 for "Thymidylate Synthase Studies."

The Cancer Therapy Evaluation Program received a total of $1.15 million in STOP Cancer funds. These were allocated as follows:

--$700,000 for a research and development contract to investigators Lobuglio, Murray and Larson of Univ. of Alabama, M.D. Anderson, and Memorial Sloan-Kettering for "Therapeutic Development of Radioconjugated Monoclonal Antibodies."

--$142,000 small grant to Herlyn for "Phase 1 Clinical Trial with Monoclonal Anti-Idiotype."

--$131,000 small grant to Reaman for "Anti-GD3 Monoclonal Antibody Therapy of T-Cell ALL."

--$39,000 small grant to Schuchter for "Evaluation of Interleukin-4 Therapeutic and Biological Effects."

--$138,000 small grant to Sondel for "BRM Monitoring of Pediatric Neuroblastoma/Osteosarcoma."

STOP Cancer Board

Besides Brown and Mann, members of STOP Cancer's board are: Merv Adelson, Warner Communications; Stewart Blair, United Artists Communications; John Chalsty, Donaldson, Lufkin & Jenrette; Alec Courtelis, Curtelis Co.; Marvin Davis, Davis Cos.; Renato Dulbecco, Salk Institute; Bram Garber, Peerless Carpet Corp.; Guilford Glazer, Guilford Glazer & Associates; Diane Glazer; Arthur Groman, Mitchell, Silberberg & Knupp; Randolph Hearst, Hearst Corp.; Veronica Hearst; Frederick Joseph, Drexel Burnham Labert; Leo Kelmenson, Bozell; John Kluge, Metromedia Co.; Arthur Krim, Orion Pictures; Ann Landers, syndicated columnist; Sherry Lansing, Jaffee-Lansing Productions; Rhonda Mann; Louis Nizer, Phillips, Nizer, Benjamin, Krim & Ballon; Rev. Norman Vincent Peale; Dear Abby (Mrs. Morton Phillips); Albert Reichmann, Olympia & York Developments Ltd.; Robert Schuller, Crystal Cathedral; Robert Seiple, World Vision; Rosemary Tomich, Occidental Petroleum Corp.; and Ted Turner, Turner Broadcasting System.

Group Chairmen Cool About Them, But High Priority Trials To Continue

The high priority clinical trials program for the cooperative groups apparently will continue despite lack of enthusiasm of some group chairmen and despite any assurance that additional money for those trials will be available.

The issue of whether to have a Series 4 round of high priority trials was debated by group chairmen at their meeting last week. No formal vote was taken, but NCI's Cancer Therapy Evaluation Program executives strongly support continuing them, and they probably will be continued.

Richard Ungerleider, chief of CTEP's Clinical Investigations Branch, suggested that the chairmen develop their suggestions for new high priority trials

before the next chairmen's meeting, May 31.

Ungerleider pointed out that several high priority trials in Series 1 and 2 will be closed later this year, most of them having reached accrual targets ahead of schedule. If money is available to continue the practice of paying a bonus for each patient entered in the designated high priority trials, new trials will be needed. That extra money, about $1.4 million, was provided out of NCI end of the year money specifically for the high priority payments; if not used for that purpose, it would revert to the U.S. Treasury.

Charles Coltman, chairman of the Southwest Oncology Group, suffered a "very mild" heart attack during the Jan. 11 meeting of cooperative group chairmen. He was taken to Suburban Hospital in Bethesda, where tests and an EKG comparison showed a mild abnormality. After medication and rest over the weekend, he was "feeling great" Monday and expected to leave the hospital and return to San Antonio Friday.

Others at the meeting were unaware of Coltman's problem. He said he had been feeling some chest pain all day, and when it worsened about an hour before the meeting ended, he left without saying anything and asked NCI staff member Michael Hamilton to drive him to the hospital.

Charles Moertel, chairman of the North Central Cancer Treatment Group, has never liked the high priority trial concept. "I question whether they ought to continue," he said. "A great majority of these patients are on the colon and rectal trials. In the past, we had to deal with untreated controls. Now, there are none, so the patients flock in. I wonder if this designation adds a darn thing."

"That makes me think that we should not designate colon and rectal trials for high priority," Ungerleider said. "They don't need it, but that doesn't speak to trials that might need the designation, such as occult breast cancer."

Moertel also objected that the money paid by NCI for high priority trial patients "is not a peer reviewed distribution of funds. It is arbitrary, and not an appropriate way to distribute funds. Distribution of funds should be on the basis of peer review recommendations, not just who gets the most patients."

"Cooperative groups are peer reviewed to do clinical trials in cancer," Ungerleider said. "This money is going to cooperative groups."

CTEP Director Michael Friedman joined in. "We had a terrible time accruing to rectal trials, but have made incredible progress. High priority status has made a big difference in accrual to rectal studies."

Moertel argued that whatever extra money becomes available should be used to help bring funding of groups closer to the levels recommended in the most recent review of their NCI cooperative agreements.

"We're hung up on a discussion of how to feed lions," Ross McIntyre, chairman of Cancer & Leukemia Group B, said. "You either decide on how to do it fairly, or you feed the strongest lion. One way would be to have all the money up front, for minority trials, CCOPs, high priority, whatever, all on the basis of peer review.

"The initial high priority and minority supplements will be reviewed the next time the group is reviewed," Ungerleider said.

"I believe the high priority designation is an activity of its own, independent of money," James Cox, chairman of the Radiation Therapy Oncology Group, said. It has led to collaborations and has otherwise improved the clinical trials process, he added. "One way of testing that would be to go ahead with designation of new high priority trials without the additional money."

Charles Coltman, chairman of the Southwest Oncology Group, had another suggestion. "Since we don't have money yet for high priority trials, my position is that we wait until we do. What is high priority then may be different that what it is now."

"My own feeling is that high priority designation creates two classes of studies," Bernard Fisher, chairman of the National Surgical Adjuvant Breast & Bowel Project, said. "In my view, they are all high priority. But if the money is there, we are all willing to accept it. Is there an imaginative way to better use this money?"

""Do you mean reprogram the money to the groups, with no high priority trials?" Ungerleider asked.

"Yes, if we can keep the money," Fisher said.

"We're not at liberty to reprogram money into the groups now," Ungerleider said. "We have to wait until the end of the year."

Ungerleider commented on the "casual nature" of selecting trials for high priority status, and asked for suggestions on how to improve the process.

Denman Hammond, chairman of the Childrens Cancer Study Group, pointed out that one criteria for determining if a study should be high priority is the size of the cancer problem (numbers diagnosed each year with the type of cancer involved). "That almost eliminates pediatric cancer trials, no matter how important the scientific question."

Ungerleider indicated that that would be taken into consideration in the selection of the next round of trials.

The selection process starts with recommendations from group chairmen. After they debate the respective merits at one of their semiannual meetings, they decide on those that will be sent to the next stop, the Div. of Cancer Treatment Board of Scientific Counselors. If ratified by the board, they are then considered high priority, eligible for the bonus payments and for promotional efforts by the groups and by NCI's Office of Cancer Communications.

The group chairmen agreed on three new high priority trials (Series 3) at their meeting last June (**The Cancer Letter**, July 6). They were supposed to go to the DCT board at its meeting in October, but in the press of other matters, "we simply forgot it," Ungerleider said. They will be presented to the board in February, and in the meantime, CTEP will proceed in the assumption the board will concur.

These are (all phase 3 studies):

--EST-3489, three intensive post remission therapies in adult acute nonlymphocytic leukemia: comparison of autologous bone marrow transplantation, intensive chemotherapy, and allogeneic bone marrow transplanta-tion. Drugs involved are busulfan, cytosine arabinoside, 4-DMDR, cyclophosphamide, allopurinol, 4-HC.

--INT-0114, rectal adjuvant protocol. Therapy includes 5-FU, leucovorin, levamisole, radiation.

--NCCTG 89-46-51, evaluation of 5-FU combined with levamisole and leucovorin as adjuvant treatment for resectable colon cancer.

The chairmen also agreed in June on the revision of the Series 2 high priority trial of 5-FU and levamisole, eliminating the untreated control arm and adding other arms. That was continued as a Series 2 trial, although it was reported then as a new high priority trial.

No one last week had any suggestions for improving the selection process, other than Hammond's plea for criteria that does not exclude pediatric studies.

Ungerleider presented a summary of cooperative group patient accrual which offers some rather conclusive support for the impact of high priority status on accrual:

* High priority trials account for six percent of currently active phase 3 studies, but are accruing 24 percent of current phase 3 patients.

* Overall accrual for the nine open Series 1 and 2 studies is nearly 450 patients per study per year, well beyond the current average of 120 patients per study per year for all cooperative group phase 3 trials.

Here's how it went for each series:

Series 1

--Initially five phase 3 studies were designated high priority trials. Three of these are still open.

--NSABP-C-03 closed in April 1989 having accrued 1,100 patients in about half the time anticipated.

--Intergroup rectal study (NCCTG 86-47-51) which opened in 1987 closed in September 1990 having accrued 680 patients in half the time projected.

--NSABP rectal study (RO2) is now entering patients more rapidly than originally planned and should close on or before target date.

--Lymphoma intergroup trial (INT-0067) is now at 95 percent of accrual target and should be closing soon.

--Bladder intergroup study (INT-0080) continues to accrue patients at about half the planned rate and will require an extended accrual period.

Series 2

--Six additional trials received the high priority designation in June 1989. Although they are large studies, their planned accrual periods are only 3.3 years or less.

--INT-0096, small cell lung cancer study, and INT-0102, node negative breast cancer study, are accruing patients at about twice their projected rates and should close about a year early.

--NSABP breast study B-21 (occult stage 1 disease) continues to enter patients slowly. At the current rate, accrual will take over 10 years.

--INT-0089, a study of levamisole in colon cancer, was revised and expanded. This study is accruing over 1,000 patients a year and should close on schedule.

--The overall average accrual currently for all six open Series 2 high priority trials is nearly 600 patients per study per year.

Series 3

--The NCCTG study of levamisole as adjuvant treatment for resectable colon cancer has accrued about 350 patients as planned.

--The intergroup study (EST-3489) in adult myeloid leukemia and the intergroup study (INT-0114) of levamisole as adjuvant treatment for rectal carcinoma were both recently opened and are still building their accrual.

The chairmen differed with Friedman over the use to which the "Five Year Plan" in development during the past year should be put.

"An important question is, what do we do with the document?" Coltman said. "That's a pivotal question, because it is not clear of CTEP staff can use the document to lobby for more money. It is going to be up to the chairs to take the document to Congress."

"This five year plan exercise is a management tool,

for us and for the groups," Friedman said.

"It needs to be a thematic approach, with consistency from chapter to chapter," Coltman said. "We need a writing committee to take this on."

"The purpose is not to have a document for lobbying purposes," Friedman insisted. "It's a management document. We know we need the best advice from you, what to do about hard decisions. We need to get your priorities, a sense of direction."

Hammond recalled that a few years ago, CTEP was talking about restructuring the cooperative groups. "Somehow, I thought that would help CTEP become more effective in competing for NCI funds. We need to take ownership of this document [the Five Year Plan] away from CTEP. It's most important use [will be as a tool for competing for more NCI funds, and for selling Congress on the need for more money for clinical trials]. You're denying that use," Hammond said.

"I'm not denying that use," said Friedman, aware of restrictions against lobbying by government employees. "I'm disowning it."

Hammond was adamant. "Here we have a program [the cooperative groups] which is the major resource of the National Cancer Institute and the National Cancer Program in applying new knowledge. We need a group to plan and write this document, with multiple purposes."

Hammond recalled that a few years ago, congressional appropriations committees in their reports on their money bills said that they had added several million dollars to NCI's budget for clinical trials. "I was dumbfounded to see how many pockets that went into," Hammond said, referring to prevention, diagnosis, and clinical research areas other than the cooperative groups.

"Will this be a lobbying document or an educational document?" Moertel asked.

"Properly designed, it could be both," Coltman answered.

"We'll leave that up to the writing committee," said Teresa Vietti, chairman of the Pediatric Oncology Group and of the Chairmen's Committee.

Cox volunteered to chair the writing committee, and Hammond agreed to assist him.

Federal Physician Bonus Denied Some Agencies; NIH Status Unsure

At a time when the federal government has been agonizing over difficulties in recruiting and retaining physicians, especially scientist physicians at NIH, the most important financial incentive for them is being denied to some agencies.

The Physicians Comparability Allowance, which provides bonuses of up to $20,000 a year for federal MDs, was reauthorized in legislation approved last fall by Congress and signed by the President. That legislation is flexible, however, in that it requires agencies to demonstrate to the Office of Personnel Management that the bonus is necessary to retain physicians, and some agencies are not doing that.

The Dept. of Defense has not yet made its case for the bonus to OPM, with the result that civilian physicians within DOD's various agencies are not getting the bonus as their year to year contracts expire.

One medical oncologist who works at a military installation told **The Cancer Letter** that he had submitted his resignation, to take effect if his bonus is not restored within a month. "I can't afford to work for the regular salary," he said.

The Dept. of Health & Human Services has not yet submitted its justification to OPM, which leaves the issue up in the air at NIH. A spokesman for the NIH Compensation & Classification Branch said HHS officials were working on it, although final decisions had not been made on which agencies within the department would be recommended for PCA.

A total of 318 physician scientists at NIH receive PCA, 93 of them at NCI. There are 40 at the National Institute of Allergy & Infectious Diseases; 33 at the National Heart, Lung & Blood Institute; 28 at the National Institute of Diabetes & Digestive & Kidney Diseases; 27 at the National Institute of Neurological & Communicative Diseases & Stroke; 25 at the National Institute of Child Health & Human Development; 25 at the NIH Clinical Center; 11 at the National Eye Institute; and the remainder at various other NIH entities.

Loss of the physician bonus is not the only compensation problem afflicting NIH because of 1990 legislation.

Congress, in a move which was initiated primarily for its own members, passed a bill that strictly limits acceptance of fees for writing and speaking. It was designed to eliminate abuse of "honoraria" paid to congressmen and senators by special interests.

When the bill was moving through Congress, some members decided that the new limits should be applied to members of the Executive Branch as well.

"That has caused a great deal of consternation at NIH," an NCI executive said.

The Office of Government Ethics, which was established to implement and enforce ethics related legislation, has developed guidelines implementing the law. It provides very little leeway in fees for writing.

Honoraria for speaking is prohibited unless it can be classified as "teaching." A speech or lecture might qualify as teaching if it includes a question and answer session.

The new law apparently does not prohibit outside income from moonlighting jobs or other employment that can be considered ongoing. Some government physicians earn extra money by working weekends or other part time hours in private practice or hospital settings.

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 Executive Plaza South room number shown, National Cancer Institute, Bethesda MD 20892. Proposals may be hand delivered to the Executive Plaza South Building, 6130 Executive Blvd., Rockville MD. RFP announcements from other agencies will include the complete mailing address at the end of each.

RFP NCI-CP-15602-40

Title: Support services for clinical epidemiologic studies

Deadline: Approximately March 15

This project involves the managing and conducting of support aspects of NCI's Div. of Cancer Etiology, Clinical Epidemiology Branch's research in the clinical epidemiology of cancer. The contractor shall identify study subjects, prepare and use questionnaires; abstract and code forms and their accompanying manuals; recruit, train and supervise interviewers, medical record abstractors and data editors; and provide computer services such as systems design, programming, data entry, proofing, editing, records management and tabulations. The contractor shall obtain blood samples and biological specimens from study subjects; arrange for transportation of such samples/specimens; and review medical and family histories of study subjects.

Contract Specialist: Teresa Baughman
RCB Executive Plaza South Rm 620
301/496-8611

RFA Available

RFA CA-91-03

Title: Clinical treatment and correlates of upper GI carcinoma

Letter of Intent Date: February 25

Application Receipt Date: April 8

NCI's Div. of Cancer Treatment invites research grant applications from interested investigators to assess new clinical correlates and develop new treatment modalities in upper gastrointestinal carcinoma by means of an integrated research program of laboratory experimentation and concurrent clinical trials. New, as well as experienced, investigators in relevant fields and disciplines may apply to fund new therapeutic clinical trials or new correlative laboratory studies related to clinical trials.

Relatively few investigations are supported in upper gastrointestinal carcinoma to move new advances in the laboratory into the clinic. For example, monoclonal antibodies directed against GI tumor specific antigens have been developed, characterized, and applied for diagnostic purposes. The potential of these antibodies to improve clinical management and/or therapy of these diseases needs further investigation. Clinical correlations of oncogenes, growth factor, or markers of drug resistance may prove useful in subsets of patients.

The major goals of this RFA are to foster interactions between basic science laboratories and clinicians performing clinical trials in upper GI carcinoma to improve treatment results and clinical outcome. Two types of studies will be supported: 1) development of new therapeutic clinical trials and 2) new correlative studies relevant to clinical trials. Applications should be focused on integrating clinical goals with laboratory research areas.

This RFA envisions funding new therapeutic clinical trials in upper GI carcinomas that test and exploit basic findings concerning drug resistance or cellular targets of treatment. Clinical studies should be designed to improve cancer treatment. New clinical studies dealing with treatment using chemotherapeutic drugs, biologics, radiation, or surgery, whether used as a single agent/modality or in combination, are appropriate. (1) Examples of therapies for overcoming drug or radiation resistance; (2) treatment therapies based on novel mechanisms of action; (3) biologics in combination with drug or radiation regimes; (4) immunotherapies including monoclonal antibody therapy, radioimmunotherapy, and the use of new immunotoxins; (5) new therapies combining endocrine manipulations with chemotherapeutic agents; (6) more effective combinations of chemotherapy and radiation therapy; or (7) radiation modifiers to enhance cell kill or protect normal tissue.

This RFA has a second research goal of funding new correlative laboratory studies that are relevant to therapeutic clinical trials. Some examples of therapeutic correlates include: (1) phenotypic or genotypic alterations which appear to correlate with the development of drug or radiation resistance; (2) oncogenes, growth factors, and specific antigen expression on tumor cells for antibody development; (3) pharmacokinetic and pharmacodynamic measurements; and (4) biochemical pharmacologic parameters. The therapeutic correlates must have a future clinical application such as development of new treatment strategies or identification of patient subsets for specific treatment therapies. This RFA does not support research investigations on diagnostics markers or clinical correlates that will have no impact on the clinical treatment of patients. The laboratory assays must utilize patient specimens from new or ongoing clinical trials and have been demonstrated to be applicable to tissue samples and/or body fluids, etc. Investigators are encouraged to obtain patient specimens from multi-institutional clinical trials to ensure adequate sample size for statistical analysis.

Approximately $1,500,000 in total costs per year for three years will be committed to this RFA; 6 to 8 awards will be made. The total project period should not exceed three years. The earliest start date for the initial award will be December 1, 1991.

Nonprofit and for profit organizations and institutions are eligible. Applications can be from single institutions or multiple institutions.

Prospective applicants are asked to submit by February 25 a letter of intent that includes a descriptive title of the proposed research, the name and address of the Principal Investigator, the names of other key personnel, the participating institutions, the number and title of the RFA in responses to which the application is being submitted. Although a letter of intent is not required, is not binding, and does not enter into the review of subsequent applications, it is requested in order to provide an indication of the number and scope of applications to be reviewed.

The letter should be sent to: Diane Bronzert, Program Director, Cancer Therapy Evaluation Program, Div. of Cancer Treatment, NCI, Executive Plaza North, Room 734, Bethesda, MD 20892, phone 301/496-8866.