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# "Leadership Vacuum" At NCI Allows NIH To Look At Reorganization, Varmus Says

The resignation of two NCI division directors leaves a "leadership vacuum" and raises the prospect of reorganization of the Institute, NIH Director Harold Varmus said to an advisory group this week.

Varmus asked a special committee of the National Cancer Advisory Board to examine NCI's organizational structure, as well as use of money, personnel and space, in the Institute's intramural program.

Until the Ad Hoc Working Group on NCI Structural Organization reaches its conclusions, "it would be a mistake" to replace the two division

(Continued to page 2)

*In Brief*

## FDA Oncology Div. Director Burke To Leave; Reed Is Branch Chief; NCAB Blasts Tobacco

**GREGORY BURKE**, director of the Oncology and Pulmonary Drug Products Division of the Food and Drug Administration, announced he will leave the agency Nov. 10 for a job in clinical drug development and research with Sandoz Pharmaceutical Co. in Basel, Switzerland. Burke has been at FDA for 11 years, five of those as division director. . . . **EDDIE REED** has been appointed chief of the Clinical Pharmacology Branch in the NCI Div. of Cancer Treatment, succeeding Charles Myers, who left to become director of the cancer center at the Univ. of Virginia. Reed came to NCI in 1972 as one of the first student trainees to work in the branch. He is an expert in platinum pharmacology, DNA repair, and in ovarian cancer trials. . . . **NATIONAL CANCER** Advisory Board, at its meeting last month, passed two resolutions regarding tobacco. One resolution called for regulation of nicotine as a drug, stating: "Tobacco products should be regulated as a drug and [be] subject to a health-based, disease-preventing regulatory regime by the FDA, according to the applicable standards of safety and efficacy." The other resolution said the NCAB "condemns the tobacco industry's aggressive advertisement campaign in other countries." . . . . **CORRECTION**: NCI Div. of Cancer Treatment Director **Bruce Chabner** came to NCI in 1967 after internship and residency at Peter Bent Brigham Hospital in Boston, not from Yale as reported last week. Chabner received a BA from Yale College in 1961 and an MD from Harvard Medical School in 1965. After two years as a clinical associate at NCI, Chabner was a senior resident at Yale-New Haven Medical Center for a year, and then was a research associate at Yale Univ. School of Medicine. He returned to NCI in 1971.

# Varmus: A Mistake To Recruit Division Directors Until NCAB Intramural Review Completed

(Continued from page 1)

directors, Varmus said. He asked for the group's conclusions in six months.

"Tell us what is working well and what is not working well," Varmus said to the working group. "Tell us what we're spending money on wisely, what we're spending money on not wisely."

Although the working group reports to the NCAB, NIH will be interested in the group's work, Varmus said.

"Naturally, those of us in the central NIH administration will be watching extremely closely as you progress," Varmus said to the working group.

The working group's next meeting is scheduled for Dec. 7.

**First Institute To Be Reviewed**

NCI is the first of the institutes to undergo what is expected to be a detailed review of the Institute's intramural research program, as well as other programs conducted internally by NCI staff. NIH will conduct similar reviews of all of the institutes, Varmus said.

The review follows the report last spring by a subcommittee of the NIH Director's Advisory Committee. The group was chaired by Paul Marks, president of Memorial Sloan-Kettering Cancer Center, and Gail Cassell, chairman of microbiology, Univ. of Alabama at Birmingham. The Marks-Cassell report made 42 recommendations for change in the NIH intramural research program, including the review of laboratories, oversight by advisory groups, rebuilding the NIH Clinical Center, and appointment to tenured positions (**The Cancer Letter**, May 20).

"It is not an accident that [NCI] has been chosen as the first individual program for that kind of review," Varmus said to the NCAB working group. "It is the largest intramural program. NCI spends the highest percentage of its budget on the intramural research program."

Though NCI's intramural research budget "is not something that is inherently wrong," its size attracts attention and needs to be justified, Varmus said.

Another reason NCI was asked to go first was the retirement last August of Richard Adamson, director of the Div. of Cancer Etiology, Varmus said. Adamson left for a job with a trade association (**The Cancer Letter**, Aug. 12).

Adamson's resignation, announced last June, "made possible our reconsidering one of the atypical aspects of NCI, namely that there are four divisions as opposed to a single intramural program," Varmus said to the working group.

"That situation has become accentuated this week with the announcement that [Div. of Cancer Treatment Director] Bruce Chabner will be leaving NCI for Massachusetts General Hospital, leaving a leadership vacuum in two of the four intramural programs," Varmus said.

Chabner plans to leave NCI next May (**The Cancer Letter**, Oct. 28).

"The Institute is under pressure to deal with these crises of leadership," Varmus said. "I think it would be a mistake to initiate a search for their replacements when we are considering the broad sweep of the organization of the program."

Varmus asked NCI to provide the working group with the budgets of the four divisions over the last four years, and a description of how funds are allocated among the divisions.

**Contraction Of NCI's Workforce**

NCI is unlike some of the other institutes in that it has large contract programs and a large drug development program, Varmus said to the working group. "These unconventional aspects also attract attention and we have to look at it very closely," he said.

"We are undergoing at NIH as everyone in government is, a streamlining. Some call it downsizing," Varmus said. "Our budgets aren't decreasing, they are keeping pace with inflation just barely. We have a mandate to reduce our FTEs [full

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time equivalent positions] and that is a mandate we take very seriously."

Varmus asked the working group to review "how NCI does its business intramurally with respect to FTEs... See where the dollars are going, how our space is used, and tell us whether the investment in personnel, space and money are useful investments or not."

NCI Director Samuel Broder encouraged the group to review not only the intramural research and laboratories, but everything the Institute does "in-house."

This includes the programs NCI carries out as part of its statutory mission and in response to Congressional legislation.

As part of the "reinvention" and streamlining of government under the Clinton Administration, NCI will have experienced a 10 percent drop in its workforce from 1993 to 1995.

From 1995 to 1999, NCI will experience another 10 percent drop in FTEs. Over the six-year period, NCI will have lost 499 FTEs, a 19 percent cut in its workforce.

The FTE level is set by NIH, Varmus said.

"This is not comparable to the usual freeze and thaws in federal labs," Broder said. "This is a true contraction of the workforce." In effect, Broder said, "NIH has had 500 FTEs transferred to other agencies."

While NCI has met its current FTE ceiling, other agencies in the Public Health Service have not. Until the agencies meet the ceilings, NCI will be under hiring restrictions, Broder said.

**Expansions Balanced By Cuts**

So far, NCI has dealt with the contraction through "the conscious failure to replace non-tenured individuals," as well as early retirements and buy-outs, Broder said.

NCI has not had what the government would define as a reduction in force, he said.

Still, NCI will have to examine everything it does, Broder said. "It is impossible to discuss only the intramural program," he said. "Individuals will have to wear multiple hats. We cannot realistically talk about expansion of efforts without talking about what we will give up."

Earlier this year, NCI conducted emergency auditing in response to the crisis in the National Surgical Adjuvant Breast & Bowel Project. That required NCI physicians and scientists to stop working on other projects, Broder said.

Congressional legislation often places restrictions or requirements on NCI's budget, Broder noted. The NIH Revitalization Act of 1993 required the Institute to increasing its spending on cancer prevention and control research to 10 percent of its total budget by fiscal year 1996.

The same legislation also required NCI to conduct a study of breast cancer on Long Island, the result of lobbying by activist groups. "This was a very labor-intensive activity that required substantial allocation of our resources," Broder said.

A large proportion of NCI's intramural research budget goes directly to support the NIH Clinical Center, Broder said. NCI has the largest clinical research program of all the NIH institutes, and provides 40 percent of the Clinical Center's budget.

Broder asked the working group specifically to examine NCI's drug development program. "It forces us to do some non-scholarly things, like make capsules," he said. He also invited review of the Frederick Cancer Research and Development Center.

**Freeze On Promotions "Catastrophic"**

While the drop in FTEs is a major challenge, a more serious problem is NCI's inability to promote individuals from the GS-13 to GS-14 level, Broder said.

"This in my view is catastrophic," he said to the working group. "We need to have certain high-grade professionals."

In October 1993, the Public Health Service put a freeze on promotions from GS-13 to GS-14, in response to President Clinton's executive order to reduce high-grade positions.

NCI currently is 20 positions over the ceiling assigned last year, sources said. A special exception is required for such promotions.

Generally, a GS-13 is a PhD or MD with at least three to seven years of professional experience. NCI branch chiefs usually are GS-14 or above.

The freeze "has the unintended effect of backing up career development all down the line," Broder said.

**May Alert President's Cancer Panel**

Unless NCI can get a reprieve from the restriction on promotions, Broder said he would have to alert the President's Cancer Panel.

Under the National Cancer Act of 1971, the NCI director is required to identify barriers to the progress of the National Cancer Program and report those

barriers to the panel. The panel may investigate the problem and alert the President.

**BSC Guidelines Ready**

Michael Gottesman, NIH deputy director for intramural research, told the working group that his office is writing an implementation plan in response to the Marks-Cassell report.

NIH has put into place some of the report's recommendations, including a new tenure track process, a loan repayment program for increasing diversity, and new guidelines for Boards of Scientific Counselors.

The new BSC guidelines are ready for review by the institute directors, Gottesman said. The guidelines will give institute directors more responsibility for the selection of BSC members.

In an overview of NCI's process for site visiting intramural laboratories, DCT Director Chabner told the committee that BSC chairman will select BSC members, and the NCI director will have the "final sign-off."

The Marks-Cassell report said BSCs should be responsible for the review of scientific directors, but the new guidelines will leave that responsibility to the institute directors, with the help of committees when necessary, Gottesman said.

Members of the NCAB Ad Hoc Working Group on NCI Structural Organization are: Co-Chairs, J. Michael Bishop and Paul Calabresi; Judah Folkman, Louise Strong, David Livingston, Bert Vogelstein, John Minna, Samuel Wells, and Cecil Pickett.

Varmus said David Baltimore will be added to the committee before the group's next meeting.

## *BRCA1 Discovery:*

## NIH, Myriad Could Not Agree On CRADA, Varmus Writes

In a response to a congressional inquiry, NIH Director Harold Varmus wrote that questions of intellectual property rights to the BRCA1 hereditary breast cancer gene have been under discussion for nearly two years.

In a letter to Rep. Ron Wyden (D-OR), Varmus said a Cooperative Research and Development Agreement between the National Institute of Environmental Health Sciences and Myriad Genetics Inc. of Salt Lake City and the Univ. of Utah was first proposed early in 1993, but was nixed by Myriad's partner, Eli Lilly & Co.

According to Varmus, Lilly, which had ultimately licensed the rights to drugs developed by using technology based on the gene, objected to the "reasonable pricing" clause that is part of CRADA agreements.

In his letter to Wyden, Varmus disclosed for the first time that on Oct. 6, NIH filed a patent application for its contribution to the isolation of the breast cancer gene and that the Institutes have begun negotiations to license those rights to Myriad.

The disclosure indicates that NIH had filed the patent application before a paper announcing the gene's isolation appeared in the journal Science.

"We anticipate receiving a license application from Myriad shortly," Varmus wrote to Wyden.

Varmus's letter, dated Oct. 27, was a response to Wyden's questions, contained in a letter dated Oct. 19 (**Cancer Economics**; October 1994).

**Myriad: Licensing Agreement Not Imminent**

"The NIH has contacted both the Univ. of Utah and Myriad to see if we have an interest in licensing their patent rights," Peter Meldrum, president and CEO of Myriad, acknowledged in an interview with **The Cancer Letter**.

However, Meldrum said a licensing agreement was anything but imminent. "Until the Univ. of Utah and the company have the opportunity to discuss the NIH position with them, it is premature to talk too much about licensing," Meldrum said.

No meeting has been scheduled, he said.

Meldrum also took issue with the statement by Varmus that Myriad's collaborator Lilly had stopped Myriad from entering into a CRADA with NIH in 1993. "It was Myriad's decision not to do a CRADA," he said.

According to Varmus, Mark Skolnick, a scientist with the Univ. of Utah and Myriad and head of the team that isolated the BRCA1 gene, received $4.6 million in NCI funds to support his search for the gene over the past nine years. Altogether, Skolnick received $15.5 million starting in 1975.

"The intramural research support to this project consisted of the activities of the two NIEHS scientists, estimated at $863,000 in direct and indirect costs, including salaries, supplies, and overhead," Varmus wrote.

Wyden, chairman of the Subcommittee on Regulation, Business Opportunities and Technology

of the Committee on Small Business, has a track record of challenging NIH on its technology transfer practices.

The letter to Varmus was cosigned by Rep. Larry Combest (R-TX), the ranking Republican on the subcommittee.

**The excerpted text of Varmus's letter to Wyden follows:**

As reported by the media, two scientists from the National Institute of Environmental Health Sciences collaborated with scientists at both the Univ. of Utah and Myriad Genetics Inc. to identify the gene.

Soon after the gene was identified, the NIEHS scientists reported the discovery to the NIH Office of Technology Transfer, and an inquiry was initiated as to whether the NIEHS scientists were coinventors who should be named on patent applications filed by the Univ. of Utah and exclusively licensed to Myriad.

The omission from a patent application of a true inventor could render any patent issuing from that application invalid. Thus, it is in the best interest of all parties to make a bona fide determination of inventorship.

The preliminary opinion of the outside patent counsel advising OTT was that the NIH scientists are properly co-inventors with the scientists at the Univ. of Utah and Myriad.

Based on this finding, NIH patent counsel and OTT staff contacted senior officials at the Univ. of Utah and Myriad and their patent counsel to begin discussions about coinventorship and licensing.

In addition, to preserve possible rights in the face of a pending disclosure of patentable information, OTT directed our outside patent counsel to prepare and file a patent application naming the nine individuals that we believe are inventors, including scientists from NIH, the Univ. of Utah, and Myriad.

This application was filed with the US Patent and Trademark Office on Oct. 6, 1994, the day before publication of the work in Science magazine.

NIH is currently engaged in active discussions with patent counsel for the Univ. of Utah and Myriad.

We have exchanged patent applications and are about to exchange each party's analysis of the contributions of its scientists to the invention. Each party must make a full analysis of the activities of its scientists before inventorship can be resolved.

I underscore the preliminary nature of our current position since we are at a very early stage of this inquiry.

I think all the parties would agree that solid, legally enforceable patent protection is important to foster the full range of potential commercial applications of this discovery, from diagnostic test kits to possible therapeutic uses.

In addition, we have initiated licensing discussions with a senior Myriad official. Both parties agree that it is in the best interest of expeditious commercialization to have negotiated the licensing rights in the event NIH is determined to have coinventorship, and thus co-ownership.

Again, these discussions are at a very early stage but to date have been positive and collegial. We anticipate receiving a license application from Myriad shortly.

Your letter expresses concern that the NIH provided valuable assistance to this project absent a written agreement.

Of course, not all interactions between the NIH intramural research program and academia or industry are formalized in writing, and NIH scientists undertake many valuable collaborations informally.

Nevertheless, in this case, NIH, the Univ. of Utah, and Myriad attempted to formalize their collaboration in early 1993 and executed a letter of intent to enter into a Cooperative Research and Development Agreement.

However, no CRADA was subsequently approved due to the objection of Eli Lilly & Co. to the NIH's "reasonable pricing" clause.

We understand that Lilly has funded certain research and development activities of Myriad and has licensed rights from Myriad for the development of possible therapeutic applications of BRCA1.

However, we do not expect this sublicensing arrangement to complicate our negotiations with the Univ. of Utah and Myriad. Indeed, this relationship will likely strengthen Myriad's application to NIH for an exclusive license because it provides Myriad with the ability to develop the two important fields of use, diagnostic and therapeutic, concurrently.

It is also important to understand that a CRADA formalizing this collaboration would not have prevented the current inventorship inquiry. A determination of inventorship is based solely on a person's activities; participants in a research collaboration cannot agree in advance (such as through a CRADA) who will be an inventor, nor can they agree in settlement of a dispute to add or delete

one who would not be a true inventor under prevailing law.

Nor is authorship on scientific publications dispositive or even indicative of inventorship rights, authorship being much more inclusive and governed by traditions of scholarship rather than law.

Under US patent law, an inventor is someone who has contributed to the conception and reduction to practice of an invention. Regardless of [whom] the applicants name as inventors, the PTO will examine the application for proper inventorship if an interference or question of deceptive intent arises.

More importantly, any patent that issues will be subject to challenge on any grounds, including inventorship, by those seeking to practice the invention without a license.

## House Committee Report Says NCI Ignored Data, Procedure In Making Guideline Change

NCI failed to follow established procedure and disregarded important evidence as it considered a change of recommendation for mammography screening of younger women, a congressional report said.

The report, "Misused Science: the NCI's Elimination of Mammography Guidelines For Younger Women," stopped short of asserting that political manipulation was a factor in NCI's decision to alter its stance on mammography for younger women.

However, the report published last month by House Committee on Government Operations, said NCI failed to follow procedure for consensus conferences, stacked its advisory panel with known adversaries of mammography screening of women between ages 40 and 49, misinterpreted data from studies and failed to provide documentation for crucially important decisions made on the level of NCI executive committee.

The report was a follow-up to a particularly confrontational hearing held last spring by the committee's Human Resources and Intergovernmental Relations Subcommittee, chaired by Rep. Edolphus Towns (D-NY) (**The Cancer Letter**, March 18).

NCI has made no official statement about the committee's report, but NCI Director Samuel Broder in an interview last month said he stood by the Institute's revised stance on mammography screening and reiterated that science was the Institute's sole consideration as it examined the evidence on efficacy of mammography.

In the interview, Broder said the Institute's goal should be to avoid getting involved in debates over reimbursement (**The Cancer Letter**, Oct. 28).

The committee report drew praise from the American College of Radiology, one of the most vocal opponents of the change in NCI mammography screening guidelines.

"ACR agrees with the finding of the House Operations Committee that NCI's process for reviewing its mammography guidelines was flawed," the group said in a statement. "ACR agrees that the process was not sufficiently objective and that NCI did not follow the guidelines established for NIH consensus conferences."

**"Confusion Among Women"**

The report said NCI's statement on mammography screening has caused confusion among women of all ages, not just younger women.

While the Institute's statement said that "randomized clinical trials have not shown a statistically significant reduction in mortality for women under the age of 50," according to the report, "Most people will probably interpret this statement to mean that mammography screening is not beneficial for women between 40 to 49."

As the Institute proceeded with a change of guidelines, despite protests from 20 professional and patient advocacy organizations, "the elimination of guidelines for women in their forties sent the message to younger women that they do not have to think about early detection until they are in their fifties," the report said.

Moreover, the Institute lacked a scientific basis for its statement, the report said. "Randomized clinical trials did not have enough women in the 40-49 age group (aside from the flawed Canadian study) to reach statistical significance given the length of time for follow-up," the report said.

According to the report, the procedure used by the Institute in issuing its statement on mammography was flawed in the following ways:

- The International Workshop on Mammography in February 1993 was not structured as an NIH consensus conference and therefore was not safeguarded against bias. "NCI began preparing for the 1993 International Workshop in 1991, leaving plenty of time to organize a consensus conference,"

the report said.

• The chairman of the workshop, Susan Fletcher, was a known opponent of mammography screening for younger women. Had NCI designated the workshop as a consensus conference, Fletcher's leadership role would likely have been found inappropriate, the report said. According consensus conference guidelines, panel chairpersons "should not be identified with strong advocacy of the conference topic."

• The workshop considered data from eight trials and excluded data from NCI's Surveillance, Epidemiology and End Results program and the Breast Cancer Detection and Demonstration Project, which showed that 40-49 year old women benefited from mammography screening, the report said.

"The BCDDP was the largest study on breast cancer screening ever conducted by NCI," the report said. "The exclusion of the BCDDP data is inconsistent with NCI's stated intention to gather all the facts."

Moreover, the trials considered did not adequately reflect US data, especially data on minority women, the report said.

• The final report of the workshop did not include "minority or alternative views," as consensus conference rules would have required. "At the International Workshop, [Daniel] Kopans [of Harvard Univ.], one of the participants, requested that a minority report, critical of the data reviewed and excluded, be attached to the summary of the International Workshop," the report said. "His request was denied."

• Though the National Cancer Advisory Board recommended against a change of guidelines in late November 1993, the NCI Executive Committee disregarded that recommendation.

According to the report:

"The subcommittee requested transcripts of the Executive Committee meeting where this decision was made, but NCI did not have any records or transcripts. To date, the subcommittee has been unable to trace by whom, where and when the actual decision was made.

"NCI has also been unable to inform the subcommittee whether the decision was actually made at this meeting or at another closed-door meeting. The absence of any documents recording the persons and discussion involved in making such a momentous policy move is troubling to the subcommittee," the report .

"NCI has not stated what basis it used to overturn the NCAB. Further the fact that no record exists tracing this decision reflects a certain indifference to the import of NCI's new policy.

"It also suggests an unwillingness by NCI staff to take responsibility for overruling the Presidentially appointed NCAB and for creating NCI's new policy on mammography. Finally, the absence of documentation concerns the subcommittee because it has hindered the subcommittee's ability to conduct oversight and to investigate the internal processes that lead to this decision," the report said.

**Recommendation: Do It Again**

The report recommended that NCI conduct a formal consensus conference on mammography screening of younger women, conduct further research to determine the efficacy of mammography screening of American women in the 40 to 49 age group, and consider data beyond the results of randomized clinical trials.

Also, the Institute should abandon its statement on mammography, and instead adopt the statement from the International Union Against Cancer (UICC) meeting in October 1993, the report said. The UICC statement, while acknowledging that the data are unclear, noted a slight advantage in survival among younger women who undergo mammography screening.

In another recommendation, the report said NCI should maintain better records of its internal proceedings.

"NCI's recordkeeping at a crucial stage in the guidelines debate leaves unanswered who the decisionmakers were, what they based their decision on, and how strong a consensus there was behind that decision," the report said.

"NCI should maintain records sufficient to allow a public recounting of its decisions and of its decision-makers."

## DCPC To Reorganize, Merge Surveillance, Cancer Control

The NCI Div. of Cancer Prevention and Control has proposed a reorganization that will merge two of the division's programs.

The division has proposed merging the Cancer Control Science Program and the Surveillance

Program, forming a new "Cancer Control Science and Surveillance Program."

The program will be headed by Brenda Edwards, chief of the Surveillance Program.

In addition, DCPC has requested, and the NCI Executive Committee has approved, a reorganization within the Chemoprevention Branch, which is under the Cancer Prevention Research Program.

Gary Kelloff, chief of the Chemoprevention Investigational Drug Unit, will be named chief of the Chemoprevention Branch.

The current branch chief, Winfred Malone, will head a new Applied Chemopreventive and Environmental Research Section.

**Stronger Programs The Goal**

Though the division's budget has grown by nearly $80 million over two years, the staff level is falling due to mandated cuts in positions, DCPC Director Peter Greenwald said to the DCPC Board of Scientific Counselors last month.

"Our intent with this consolidation is to make our programs stronger, not weaker," Greenwald said.

Staff of the two programs that are to be merged had been "spread too thin," but have complimentary talents, he said.

"We particularly want to build up behavioral research, including related community research, environmental and occupational cancer control research, and policy research," Greenwald said.

"We want to incorporate selected population groups into the full array of cancer control research, building on experience of the past decade," he said. "Surveillance is a natural fit with cancer control. It helps to identify research targets and measure progress against them."

The combined Cancer Control Science and Surveillance Program will have five branches due to the elimination of the Computer Systems Branch. The functions of that branch will be absorbed by the Applied Research and Cancer Statistics branches.

Any sections that do not have permanent section chiefs will be abolished, Greenwald said.

Greenwald suggested the BSC conduct site visits soon of the Cancer Statistics Branch and the Special Populations Branch.

## NCI Contract Award

Title: Laboratory Rodent and Rabbit Facility
Contractor: ROW Sciences Inc., Rockville, MD, $2,318,880.

## NIH Cuts 2 Forms Required For Non-Competing Renewals

NIH has reduced the requirements for annual financial documentation for grantees receiving a non-competing award, the institutes said last week.

Since budgets for competitive awards are negotiated at the time of the initial award, there is no need for two of the five documents NIH required each year for non-competing awards, according to a notice in the Oct. 28 NIH Guide to Grants and Contracts.

NIH required a progress report and four financial documents each year for each grant: a budget for the next budget period, an estimated report of expenditures for the current budget period, a financial status report, and a federal cash transaction report.

NIH now requires only a modified progress report, the federal cash transaction report, and the financial status report.

The simplified process applies to R01, R03, R13, R15, R18, R21, R24, R25, R29, R37, R42, R44, and all K series mechanisms.

For further information, grantees should contact the grants management specialist or program administrator responsible for the administration of the award.

## RFA Available

**RFA OD-95-001**
Title: **Extramural Associates Research Development Award**
Application Receipt Date: Jan. 13

The Extramural Associates (EA) Program is soliciting applications from academic institutions with significant minority student enrollment and women's colleges for participation in the January and June 1996 sessions of the EA Program. The award will enable the participating institution to establish or enhance an office of sponsored research and to provide for other research infrastructure needs through the newly established Extramural Associates Research Development Award.

Eligibility is limited to domestic academic institutions that have a significant enrollment of minorities (African Americans, Hispanics, Asians, Native Americans), or are women's colleges, and who wish to nominate a faculty member who has not participated in the NIH Extramural Associates Program since 1992.

Inquiries: Matthew Kinnard, Office of Extramural Programs, NIH, Bldg. 31 Rm 5B38, Bethesda, MD 20892-2182, Tel: 301/496-9728, FAX: 301/496-7060, Email: KinnardM@NIHOD31.NIH.GOV.