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NCI Clinical Research Too Similar To Work By Extramural Community, Report Finds

Clinical research in NCI's intramural program is largely duplicative of research in universities and cancer centers around the country, according to the Working Group on the NCI Intramural Program.

In a report submitted to the National Cancer Advisory Board, the group said innovation in NCI's intramural clinical research has declined, patient enrollment has dropped, and the clinical training program has become less attractive to young investigators.

The group recommends gathering all NCI intramural research into a single division, encouraging collaboration and translational research, consolidating NCI and Navy medical oncology programs, and moving the Biological Response Modifiers Program from Frederick to Bethesda.

The report also critiques NCI's reliance on AIDS funding and recommends greater use of the Institute's drug development resources by other NIH institutes and extramural researchers.

Following is the text of the final sections of the report. Prior sections were published in the July 7 and 14 issues of ***The Cancer Letter****.*

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House Panel Recommends $642 Million Increase For NIH; $31 Million Increase For NCI

After months of talk about impending budget cuts at NIH, a House panel recommended the opposite: a funding increase of about $642 million over this year's level.

As it marked up its bill, the Labor, HHS & Education Subcommittee of the House Appropriations Committee last week recommended that NIH receive $11.939 billion in fiscal 1996. This recommended level is $166 million above the President's request of $11.773 billion and $642 million above the current budget of $11.297 billion.

The subcommittee recommended a $2.251 billion budget for NCI. This would represent a $31 million increase over the President's budget proposal of $2.22 billion, and a $115 million increase over the current budget of $2.136.

Several Capitol Hill observers pointed out that the good news can turn sour at many steps along the way.

One immediate threat is inherent in the manner in which the subcommittee carved out funds for the increase. To come up with new funds for NIH, the panel recommended cuts in other health, labor and education programs. It is safe to predict that the constituents of those programs will strike back sometime during the appropriations process.

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Translational Research Should Dominate NCI Clinical Program

(Continued from page 1)

VI. Clinical Research In The IRP

The IRP [intramural research program] of NCI should provide a flagship for clinical research on cancer that leads the way in developing novel measures for the prevention, detection, and treatment of the disease. Moreover, increasing constraints of managed care on clinical research at academic medical centers may leave the NCI as one of the few institutions where this kind of research can be done. Yet this major resource for funded clinical research in the United States remains underutilized.

NCI studies in the NIH Clinical Center are an important component of the NCI intramural program. The Center serves as the site of innovative clinical research and as a training ground for clinical investigators. The participation of NCI in planning for a new Clinical Center is critical, as NCI is consistently the heaviest user of NIH clinical facilities. In 1994 NCI logged over 20,000 inpatient days and over 30,000 outpatient visits in the Clinical Center. Of the $220 million Clinical Center cost allocation in FY 1994, 42 percent was for NCI.

In reviewing the clinical programs of the NCI IRP, the Working Group evaluated the processes used to set priorities for clinical trials, train clinical investigators, accrue patients, and coordinate clinical investigation across the NCI IRP and with the extramural community. The Working Group also reviewed the need for IRP clinical research to be conducted at three separate sites: Bethesda, the Frederick Cancer Research and Development Center, and the National Navy Medical Center (NNMC).

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Strengths of Clinical Research in the IRP

As part of its charge in 1994, the EAC [External Advisory Committee to the Director, NIH] reviewed clinical programs of the entire NIH and concluded that they are an essential, if not key, component of NIH intramural research programs. The Working Group recognizes that for NCI a crucial asset of the Clinical Center complex is the flexibility it offers to respond to new opportunities and needs by rapid redirection of resources. In addition, the existence of a high caliber staff on-site, with expertise in clinical research, allows for the rapid implementation of new initiatives. The close proximity of laboratories to patient care facilities is an advantage and should be of considerable value in facilitating translational research because of enhanced interaction among basic and clinical scientists.

The Clinical Center, with its appropriate facilities and support staff, allows scientists to conduct long-term clinical studies of individual patients and large families that would be difficult, if not impossible, in the extramural community because of the lack of sufficient and long-term funding. *The ability to see, evaluate, and treat patients who are not billed for services is conducive to their recruitment into studies.* The Clinical Center also provides an excellent setting for the training of clinical investigators. In principle, the IRP is well positioned to fulfill its mission in clinical research. NCI plays a particularly determining role in the future health of the Clinical Center.

In addition, the Working Group acknowledges the advantages to the IRP of the interagency agreements with the Navy and the Uniformed Services University of Health Sciences. The combined NCI and Navy Medical Oncology Branch (NMOB) at NNMC offers the NCI intramural program a fully functioning hospital. The combined Navy and NCI Hematologic-Oncology Clinic administers to 1,600 new cases of cancer and 15,000 visits annually. The NCI and Navy are fully integrated with respect to training, protocol development, and patient care for medical oncology. Currently there are 26 clinical trials ongoing at the NCI-NMOB. In short, the NCI-NNMC agreement is a model of government interagency cooperation.

Problems in the Intramural Clinical Research Program

In the face of this attractive portfolio, there is widespread concern among the biomedical community that clinical research in the IRP is not thriving as it should. The Working Group shares this concern,

sustained by reports of reduced patient enrollment, diminished luster of the training program, and a loss of regard among the research community at large.

Potential explanations for this decline include increased competition from cancer centers around the country; lack of innovation in IRP clinical protocols; decreased attention to patient needs and care; and an insufficient cadre of optimally trained clinical investigators to design and conduct research, especially in translational areas. A major failure of the NCI IRP is that it has not achieved its potential in translational research, which should represent the predominant component of clinical research in the NCI IRP. Clinical research of all kinds in the IRP lacks a rigorous, centralized process for peer review. Amid a complex layer of review for clinical protocols, the Working Group could not perceive an assessment of scientific quality that was sufficiently removed from the sponsoring units to be considered objective. There is also a lack of prioritization and financial assessment of clinical/translational research in the IRP.

It is the view of the Working Group that current clinical research in the NCI IRP is, in large part, similar and duplicative of work going on in the extramural community. Allowing this situation to prevail fails to take advantage of the special characteristics of the NCI intramural clinical research program. There has been a general failure of collaboration and cooperation, both among clinical programs and between the clinical and basic research programs of the NCI IRP. Some, but not all of this failure can be attributed to a geographic dispersion of clinical/translational research off-site at the FCRDC. It is clear that the Biological Response Modifiers Program (BRMP) is entirely independent of the rest of the IRP clinical effort, and given the large financial resources devoted to this program, the NCI IRP is not well served by its geographic isolation.

There are deficits in the training of clinical investigators, mentorship for young investigators, tenure review, and salary scales. These difficulties are compounded by the frequent need for a team effort in the conduct of clinical and translational research. In addition, the availability and quality of subspecialty care for patients participating in clinical trials has been criticized.

Summary and Recommendations

Innovative clinical research has been, and will continue to be, an essential part of the mission of the NCI IRP. Increasing constraints of managed care on clinical research at academic medical centers may leave the IRP as one of the few institutions where this kind of research can be done. In recent years this major resource for funding novel clinical research in the United States has been underutilized. In an effort to restore the clinical research in the IRP to preeminence, the Working Group recommends the following.

1. All intramural clinical research at NCI should be gathered under one division, the proposed Division of Cancer Prevention, Diagnosis, and Treatment. This should encourage interactions across disciplinary boundaries and facilitate strategic planning.

2. The IRP should establish a Protocol Review and Monitoring Committee similar to those required in NCI-designated cancer centers to provide more rigorous and uniform scientific review of proposed clinical trials and to set priorities for the trials.

3. Translational research should become predominant in the clinical program of the NCI IRP and should weigh heavily in the selection of the Division Director. There should be a major effort to recruit and train investigators in the IRP to perform clinical and translational research.

4. Activities that require interdependence between basic and clinical investigators should be encouraged. This should specifically include studies crossing programmatic and divisional boundaries.

5. The NCI IRP clinical research program should complement rather than duplicate the research programs of extramural cancer centers and NCI-sponsored clinical trials.

6. NCI would be well served by a Clinical Center with a smaller inpatient and larger outpatient facility. This consideration should be given great weight in planning future development of the Clinical Center.

7. The Working Group recommends that the NCI IRP explore whether the NCI and Navy Interagency Agreement could be expanded, so that more NCI IRP cancer patients who require inpatient care could be hospitalized in the National Naval Medical Center facility.

8. The Working Group recommends consolidation of the Medicine Branch, including the BRMP, and the NCI-Navy Medical Oncology Branch into one branch with one chief. This would address several current problems at the Clinical Center, including a lack of house staff, poor quality and availability of specialty consultation, and insufficient exposure of medical oncology fellows to standard oncologic

practice. Similar collaborations between NCI and the Navy should be considered for training programs in pediatrics and radiation therapy.

9. The clinical and related laboratory research effort of the BRMP should be relocated from Frederick to the Clinical Center. This consolidation would substantially benefit clinical research in the IRP. The production facility could remain at Frederick.

10. The Working Group endorses the clinical research training program recently proposed by the Director of the Clinical Center. By that means and others, the NCI should augment training in clinical research through its IRP.

11. NCI IRP clinical research staff should become knowledgeable of NCI-sponsored extramural clinical research activities.

12. Clinical investigators should be subject to the same equitable and rigorous peer review for promotion as laboratory investigators. The tenure review committee should recognize the differences in methodology, the different venues for publication, and the frequent requirement for a group effort in research that characterize clinical investigation.

VII. AIDS Related Activities Of The IRP

Tumors such as Kaposi's sarcoma and lymphoma are common complications of infection with HIV, and the study of these clearly falls within the NCI mandate. In addition, HIV is a retrovirus—a type of virus most extensively studied for its ability to cause cancer. These circumstances have given NCI a particularly central role in AIDS research. The life cycle of HIV, and the cell biology and immunology of HIV infection are all natural areas for NCI involvement.

Funds appropriated for AIDS research within the IRP now constitute approximately 35 percent of the intramural budget. These include both monies directed to the IRP budget itself and expenditures for contracts at FCRDC. For example, 60 percent of the budget for drug screening by the Developmental Therapeutics Program at Frederick is allocated for AIDS research. Moreover, half of the other contracts supervised by the Developmental Therapeutics Program are for work on AIDS. All told, the IRP of NCI is now spending approximately $213 million on AIDS research annually.

Strengths of NCI Intramural AIDS Research

AIDS research in the IRP of NCI has a laudable history of wide-ranging responsiveness, innovation, and discovery. It is fair to say that, in the early days of the emerging challenge of AIDS, NCI led the way in the research response.

There is a strong rationale for NCI to continue with research on AIDS. First, the quest for remedies to infection with HIV represents a pressing national need that should be addressed by all suitable arms of the research community. Second, certain tumors are prevalent in individuals infected with HIV, and these are clearly the province of NCI. Third, the IRP of NCI has historic involvement in AIDS research and brings special strengths to the study of the disease. These strengths include expertise in research on retroviruses in general and HIV in particular; the experience of NCI in drug development, and the commonality of structure that underlies some of the drugs useful against either cancer or AIDS; and the strong program in pediatric AIDS developed in the NCI IRP.

Problems in NCI's Intramural AIDS Program

Early in the AIDS epidemic, NCI had a special role because of its historic position in retrovirology and drug development. However, as the amount of money available for IRP AIDS research rose in subsequent years—and the money for IRP cancer studies declined—AIDS research has come to occupy a larger fraction of NCI IRP efforts. This raises the issue of whether the NCI IRP has become overly dependent on AIDS funding. It also conceals a disappointing decline in support for cancer research within the IRP.

The growth in AIDS funding within the IRP is, in part, attributable to increasingly liberal definitions of what research might be related to AIDS, and it has not been accompanied by effective coordination or strategic planning of the NCI AIDS effort. The failure to coordinate applies to both the IRP itself and interaction between NCI and the Office of AIDS Research (OAR).

The newly established OAR lacks clear jurisdiction over the AIDS budget of the NCI IRP. This is because the IRP budget is considered part of the "commitment base," that is, a portion of the budget which has been obligated and is not subject to negotiation. OAR has no purview over this base, only over new or additional monies. Thus, only increases in the IRP budget would be considered by OAR, and then only in the year the increases were recommended, after which they become part of the commitment base. OAR can only use its moral suasion to affect the directions of NCI IRP research

in AIDS.

Although it might seem a useful recommendation for NCI to rethink its distribution of AIDS funds between the intramural and extramural programs, the purview of the extramural program is limited to HIV-related malignancies, whereas the IRP has no such limitation. Thus, the ability of NCI to redistribute AIDS funds is largely restricted to the IRP. Reprogramming of NCI IRP funds to the ERP would have to be done by OAR, through other institutes.

Summary and Recommendations

The NCI IRP and contract program in AIDS research is, in aggregate, a large enterprise with *limited central direction* or control. It has grown from a small number of appropriate activities into a substantial fraction of the NCI IRP. This makes the NCI IRP particularly vulnerable to any reduction in AIDS funding. The AIDS program also lacks a clear rationale, and some of its elements seem thematically inappropriate.

1. The NCI DDIR and DDER [deputy directors for intramural and extramural research] should be responsible for coordinating AIDS research within the Institute.

2. NCI should undertake an expeditious and comprehensive review of all of its AIDS research. This review should be done in cooperation with the Office of AIDS Research (OAR), which has the mandate to coordinate all NIH AIDS research. The review should focus on quality of programs; redundancy with activities in the ERP, the entirety of NIH, and industry; oversight and management of contract activities; and the future of the NCI IRP if AIDS funding were to decrease. Efforts should be made to redirect NCI funds, gradually and logically, while retaining truly meritorious research on AIDS.

3. The OAR director should have more influence over the use of AIDS research funds within the NCI IRP so that they can be seen as a considered part of the national effort. The Working Group believes that a significant reduction in the NCI IRP AIDS program may be in order, and that the released funds should be able to increase the pool available to extramural research on AIDS, even if that means putting the funds under control of a different institute. The NCI DDIR and DDER should work directly with the OAR Director to allocate and redirect funds as needed.

VIII. NCI At The Frederick Cancer Research And Development Center

The Frederick Cancer R&D Center (FCRDC) is a government-owned, contractor-operated facility located in Frederick, Maryland, approximately 37 miles from the NIH Bethesda campus. The genesis of the FCRDC had its origins in two actions by President Richard Nixon, exemplifying how executive and legislative mandates have influenced the National Cancer Program. President Nixon's executive decision to terminate federal research on reagents for biological warfare vacated a large laboratory facility at Fort Dietrick in Frederick, Maryland. His advocacy of the National Cancer Act provided both the resources and an implicit mandate for NCI to use that facility.

The FCRDC has grown to a point where it now consumes 25 percent of the IRP budget, or a total of approximately $ 140 million annually. There are three major components to the budget at Frederick: a large support contract, of roughly $95 million (recently recompeted and awarded to Science Applications International Corporation); a contract for the Applied Biosciences Laboratory (ABL) ($14 million), which conducts fundamental research on cancer; and funds spent from the intramural budget proper for IRP laboratories located at Frederick. These funds together support a staff in excess of 2,000 of whom perhaps 350 are in the IRP proper. Thus, the FCRDC is a major entity within NCI and should be expected to enhance markedly the research of the IRP.

Strengths of the FCRDC

The FCRDC represents a substantial and complex satellite of the NCI IRP, some of whose components display considerable merit. Both fundamental and translational research are represented by excellent programs. The development of research at Frederick has been facilitated by the availability of ample research space, the productive use of contracts, and a relatively low-cost environment. Moreover, the site appears to have great potential as a core facility for all of NIH.

Problems in the FCRDC

Although the Working Group found evidence that excellent work was under way at the Frederick facility, a significant portion of the research does not appear to be well integrated among the various components of the FCRDC or with aspects of the NCI IRP in Bethesda. Greater opportunities at FCRDC for space expansion, hiring, and flexibility in operations have led to the growth of its programs, which are only

loosely connected to the research program in Bethesda. Of necessity for its own activities, the FCRDC duplicates facilities maintained on the Bethesda campus. This diversion of funds is costly and fails to enrich the overall NCI IRP. Moreover, substantial new construction is now in progress, implying a long-term commitment to the site and discouraging thoughts of appreciably downsizing, or even closing, the facility.

The various components of the FCRDC do not comprise a coherent whole. They are not well integrated among themselves or with other aspects of the IRP of NCI. ABL itself is a successful research unit, intellectually self contained, productive, and well regarded. But it does not serve the IRP directly and appears to have little impact on it. A number of truly intramural laboratories are also situated in the Frederick facility. Their location at Frederick has no strategic purpose: it is simply a means by which to find more space, and many of the affected scientists now find themselves intellectually isolated from the main intramural program.

The BRMP represents one intramural entity that has thrived at Frederick. It has developed a self-contained unit, with both laboratory and clinical components. Its relatively remote location, however, deprives the IRP mainstream of what could be a strong positive influence on the tenor and quality of clinical and translational research. As one example, the Working Group notes that the BRMP presently makes little contribution to clinical training, even though this is one of the more vigorous elements in the intramural clinical program.

Elimination of these problems should be a major priority of NCI. Their resolution will require time and cannot be accomplished in one phase, given the present limitations of space on the Bethesda campus.

Summary and Recommendations

NCI activities at Frederick are not well integrated, either among themselves or with other aspects of the IRP. For programmatic and budgetary reasons, it would be wise to reorganize and consolidate the Frederick programs, as follows.

1. The Frederick facility should be a core facility, a "cost-effective center," for the entire NIH. The computer center, drug screening and development programs, and animal facilities at the Frederick center could serve many NIH needs.

2. The Working Group recommends that three components of the Frederick unit be moved to Bethesda, in the following order of priority.

a) All clinical and laboratory components of the BRMP should be moved to the Clinical Center. The production facility could remain at Frederick. The Working Group repeats this recommendation here in order to emphasize that it was reached from two different vantage points. (See also Clinical Research in the IRP.)

b) Return the remainder of the noncontract IRP operation to the Bethesda campus.

c) When feasible, the operations of the ABL program should be moved to the Bethesda campus. Every effort should be made to retain current ABL operating practices. Relocation of ABL to Bethesda would dramatize the need to achieve parity in salary and benefits between federal workers and contract employees. The Working Group recognizes the difficulty of such a relocation, but believes it would be in the best interest of the NCI IRP over the long term.

IX. Drug Development In The IRP

The development of effective therapeutic agents remains one of the most challenging and important pursuits in cancer research. The NCI IRP has a long and meritorious history of research in drug development. Much of this activity takes place via in-house research programs and extramural contracts in the Division of Cancer Treatment's Developmental Therapeutics Program (DTP).

Strengths of Drug Development in the IRP

The facilities and programs for drug development and testing in the IRP have become an international resource, available to academic and commercial investigators alike. Examples include a distinctive screen for cancer therapeutics, a facility for the extraction and banking of natural products, and pioneering work on therapeutic agents for AIDS.

Problems in Intramural Drug Development Activities

A major problem identified by the Working Group is the fact that the resources of the drug development programs in the NCI IRP have been underutilized by both the intramural and extramural communities of NCI. Drug development activities are intellectually isolated, in part because most of the effort is based at Frederick and in part because of failure to reach out to a larger community of scientists. Perhaps as a result of this isolation, the program has not displayed much flexibility in its tactics and strategies. Failure to communicate with a broader community of

scientists denies NCI its potential to serve as a national resource in drug development.

The Working Group also identified problems with accountability and review. Drug development programs appear to have less than adequate cost control, and extramural contracts administered by the DTP have escaped all but the most superficial review for mission, quality, and cost effectiveness.

Finally, the program has only limited support from medicinal chemistry, a crippling flaw that should he corrected

Summary and Recommendations

The development of effective therapeutic agents is one of the most challenging and important pursuits *in cancer* research. The justifications for NCI's historical involvement in drug development are numerous and persuasive, but have been challenged lately. Critics have questioned the relevance and appropriateness of the program, and the scientific credibility of some of its methods and approaches to drug discovery. The Working Group has reviewed the drug development activities of the NCI IRP and makes the following recommendations.

1. The Developmental Therapeutics Program at NCI should be continued.

2. Serious consideration should be given to how NCI's drug development programs could become core facilities for the entire NIH. Thus, its drug development capabilities could be made more broadly available for research on a variety of diseases. Why should this unique facility be supported in the future by NCI alone? For example, there has been a justifiable increase in the use of this resource for AIDS research, and this should be reflected in the way the facility is funded.

3. The responsible BSC should be instructed to review the viability, progress, direction, and orientation of NCI's intramural drug development programs. In particular, with the assistance of additional extramural experts, BSCs should explicitly review the overall mission of the Developmental Therapeutics Program at intervals of three years.

4. Standard review of individual investigators should proceed as elsewhere in the IRP.

5. Although concerns have been expressed about the applicability of the new tenure policy to investigators in drug development, the Working Group found no reason to believe that this policy will adversely affect scientists working in drug development programs.

6. The extramural contracts administered by the IRP require full review carried out periodically and systematically. The reviews should be conducted by the appropriate BSC, assisted by scientists from the academic and industrial communities, and should examine the goals of accelerating and improving preclinical drug development and appraising resource allocation.

7. Collaborative opportunities related to the drug screening program should be increased and accelerated within NIH and beyond. There needs to be a considerable increase in communication and collaboration between scientists in the Developmental Therapeutics Program and those in the rest of the NCI IRP and ERP, especially with regard to the availability of the natural products collection and the screening capacity.

X. Implementation Plan

In 1994 the EAC concluded its report by requesting a formal plan for implementation within on year.

Similarly, the Working Group recommends that NCI submit an implementation plan to the NCAB at the time of the Board's May 1996 meeting. After May 1996 the NCAB should review the progress of the implementation plan annually until it deems review to be no longer necessary.

XI. Conclusion

The Working Group has offered more than 60 recommendations designed to improve the quality and efficiency of the NCI IRP. Some of these recommendations are straightforward and require only will and energy to implement; many echo recommendations in previous reports that have gone unheeded. But, in the spirit of the IRP, other recommendations "push the frontier" of precedent, convention, habit, logistics, received wisdom, and perhaps even statute.

The Working Group offers all of these recommendations in the spirit of adventure and urgency. The NCI is a large and vital public resource, poised for change. All of those who care for the Institute should be willing to look at it from a new perspective, to see how it might be reshaped so as to better seize the day and meet the future. Recent progress in research has made the eventual conquest of cancer a realistic prospect. The best hope for realizing that prospect is NCI. This requires that we make the Institute the best that it can be.

In Brief

Candlelighters Founder Monaco Wins Bentsen Award

GRACE POWERS MONACO, a founder of the Candlelighters Childhood Cancer Foundation, received the ninth annual Lloyd Bentsen Award at the Candlelighters' 25th anniversary conference last week in Arlington, VA. The award, named for the former senator and Secretary of Treasury, and established by the Kelsey-Seybold Foundation for Medical Research and Education, is given to individuals who have made an outstanding contribution to community based care for children with special health needs. Monaco, whose daughter died of leukemia in 1970, joined with other parents to found Candlelighters. She started the group's Ombudsman Program to help families cope with insurance, employment and educational issues. . . . **JOHN MONTGOMERY**, vice president of research and chief scientific officer, BioCryst Pharmaceuticals Inc., is the recipient of the 1995 Smissman-Bristol Myers Squibb Award, American Chemical Society Div. of Medicinal Chemistry. The award will be presented during the society's national meeting in Chicago, Aug. 21. Montgomery and colleagues were pioneers in the development of structure-based drug design. He is a distinguished scientist at Southern Research Institute and serves as adjunct senior scientist at the Univ. of Alabama at Birmingham Comprehensive Cancer Center. . . . **UNIV. OF PITTSBURGH** received a $2.5 million National Cooperative Drug Discovery Grant from NCI to develop drugs that selectively inhibit the ras gene. **Said Sebti**, principal investigator for the grant and associate professor of pharmacology, and **Andrew Hamilton**, professor and chairman, Dept. of Chemistry, have reported the development of a molecule that successfully blocks mutant ras from triggering cancerous cell growth but does not appear to have the toxicity that has been seen with other ras inhibitors. . . . **J. CARL BARRETT** has been appointed scientific director, National Institute of Environmental Health Sciences, Div. of Intramural Research. Barrett has served as acting scientific director since last December. He has been chief of the NIEHS Laboratory of Molecular Carcinogenesis since 1987. Scientists in his laboratory were part of the team that isolated the breast cancer susceptibility gene. Last May, Barrett and colleagues identified a gene that suppresses the spread of prostate cancer.

House Panel: No Earmarks, No Separate AIDS Allocation

(Continued from page 1)

Though the subcommittee is yet to draft a report, its outline, a copy of which was obtained by **The Cancer Letter**, is expected to contain the following:

- "Language would indicate that the Committee believes that NIH should allocate its funding on the basis of scientific opportunity... There are no earmarks by disease or research mechanism.
- "The Committee has not provided a separate appropriation for the Office of AIDS Research. Funding for AIDS research would be included within the individual Institute appropriations. The NIH Director would determine how much of the total appropriation would be directed to AIDS activities. The Committee continues to support the OAR within the Office of the Director and its planning function, and it would expect the NIH Director's decision on AIDS funding allocations to be fully consistent with the plan developed by OAR.
- "The committee has transferred responsibility to NIH for continued support of the AIDS research program presently funded by the Department of the Army.
- "Language would indicate that $20 million has been provided within the National Center for Research Resources appropriation for extramural facility construction.
- "The bill-wide 7.5 percent reduction in federal administrative costs would apply to NIH research management and support costs, but would be plowed back into research.
- "No further funds are provided to support the NCI study of tobacco industry campaign contributions to state legislators."

The study of lobbying by the tobacco industry is conducted under an NCI grant by Stanton Glantz, of the Univ. of California at San Francisco.

RFA Available

RFA CA/DA-95-013 Title: **Pharmaco-Behavioral Treatment of Nicotine Dependence** Letter of Intent Receipt Date: Aug. 11; Application Receipt Date: Sept. 21

NCI and NIDA announce an RFA to develop controlled, randomized trials to determine the most effective, generalizable, cost-efficient, and durable adjuvant behavioral therapies to support the pharmacological treatment of nicotine dependence. Inquiries: Thomas Glynn, NCI DCPC, 6130 Executive Blvd Rm 320, Bethesda, MD 20892, tel: 301/496-8520.