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Minority Accrual Low In Prevention Trials; NCI Plans Programs To Boost Enrollment

Study findings released last week indicate that blacks and Hispanics are under-represented in cancer prevention and screening trials, while their enrollment in treatment trials is proportional to the number of cancer cases in these ethnic groups, NCI officials said.

"We are not doing badly in terms of proportional accrual in treatment trials," NCI Director Richard Klausner said last week at a conference on minority accrual to clinical trials. "That does not mean that this issue is not important and does not requireconstant attention. In contrast, we are

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In Brief

Folkman Selected For Karnofsky Lecture; Sporn To Give ACS Lecture At ASCO

JUDAH FOLKMAN, director, Surgical Research Laboratory, Children's Hospital, Boston, was selected to give the 27th Annual Karnofsky Lecture at the American Society of Clinical Oncology annual meeting May 18-21, in Philadelphia. Folkman's presentation is titled "What Is Tumor Dormancy: Can It Be Prolonged Therapeutically?" . . . **MICHAEL SPORN**, professor of pharmacology and medicine, Dartmouth Medical School, was selected to give the American Cancer Society Lecture at the ASCO annual meeting. . . . **JAMES COX** was appointed head of the Division of Radiotherapy at M.D. Anderson Cancer Center. Cox, a member of the M.D. Anderson faculty since 1988, served as coordinator of the center's interdisciplinary program development. He holds the Hubert L. and Olive Stringer Chair in Oncology. He is also chairman of the Radiation Therapy Oncology Group. . . . **VICTOR VOGEL** will leave M.D. Anderson Cancer Center to lead a newly established joint breast cancer program of the University of Pittsburgh Cancer Institute and Magee-Women's Hospital. As director of the program, Vogel will coordinate the integration of breast cancer services including risk assessment, genetic counseling, cancer prevention, imaging, and other screening and diagnostic procedures, treatment, and research. He will also join the University of Pittsburgh as a professor of medicine and epidemiology. . . . **CRAIG FRIEDMAN** has become a member of the head and neck section of the Fox Chase Cancer Center surgery department. Friedman was director of facial plastic and reconstructive surgery and an assistant professor of surgery at Yale University School of Medicine.

NCI Plans Grant Programs To Increase Minority Accrual

(Continued from page 1)

not doing well at all in prevention and screening trials."

To improve minority accrual to prevention trials, the Institute plans to set aside funds for three new grant programs, Klausner said.

NCI released Requests for Applications for two of the programs last week (see page 4):

—A program to provide $5 million over four years to fund investigator-initiated grants for research to develop, test and implement interventions to improve the participation of women and minorities as subjects in cancer prevention and screening trials.

—A program to provide $400,000 a year for two years to fund small grants to develop strategies to improve participation of women and minority groups in prevention and screening research.

The third program, to be announced in a matter of weeks, would provide funding to help minority physicians obtain training in medical oncology. The goal of the program would be to increase the number of minority physicians involved in clinical research, Klausner said.

"Adequate, equitable, full and meaningful participation in clinical trials is good medicine and good public policy," Klausner said at the conference Jan. 26.

"It is the right thing to do and to strive for less is unacceptable."

Urgent Effort To Comply With Law

Giving urgency to the efforts to achieve equitable representation in trials is a 1993 law that requires NIH to ensure that women and minorities are included as subjects in clinical research. NIH guidelines written in 1994 outlined the new requirements placed on investigators. The law went into effect in fiscal 1995.

The most controversial provision of the NIH Revitalization Act, from the standpoint of clinical trial design, is the requirement that trials must "provide for a valid analysis of whether the variables being studied in the trial affect women or members of minority groups differently than other subjects in the trial."

The law left it to NIH to define a "valid analysis." A strict interpretation could potentially require all clinical trials to enroll sufficient numbers of women and minorities to ensure that a subset analysis would have high statistical power to detect differences. Investigators complained that thousands more participants would be required, and the costs of trials would skyrocket.

An NIH committee that wrote the guidelines decided to apply the provision only to phase III clinical trials. The committee said a "valid analysis" does not require high statistical power, but must reflect an "unbiased assessment" of outcomes. "Such an assessment will, on average, yield the correct estimate of the difference in outcomes between two groups of subjects," NIH guideline documents said.

Investigators now are required to report accrual data for women, minority groups and their subpopulations, Vivian Pinn, director of the NIH Office of Research on Women's Health, said at the conference.

Under the guidelines, the determination of compliance with the law is left to the Institutional Review Boards of the institutions involved in the trials. In addition, as peer review groups assign funding priority scores, they are mandated to assess the plans for recruitment of women and minorities into proposed trials.

The guidelines also require NIH advisory councils to prepare biennial reports describing each institute's compliance with the guidelines.

NIH established a tracking system to capture racial and ethnic accrual data and compiled accrual

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data for the first year of the program.

Pinn said she had planned to present the data at the conference last week, but the report was delayed by the three-week federal government shutdown. Complaints about the law and the guidelines have come from areas of the US where populations are mostly white, such as Vermont, where only 800 blacks were counted in the 1990 census, Pinn said. The guidelines encourage investigators to collaborate in order to achieve racial equity.

NCI Treatment Vs. Prevention Trials

NCI officials said minority accrual to cancer treatment trials was not as low as many researchers had thought.

Until 1990, investigators were not allowed to ask trial participants to identify their race or ethnic group. Then, legislation in 1990 required NIH studies to ask participants to identify their race.

"There has always been the assumption that we didn't have a large number of blacks and Hispanics in trials," said Otis Brawley, a senior investigator in the NCI Division of Cancer Prevention and Control. "Then we began getting this data."

At first glance, it appeared that enrollment of minorities on treatment trials was low, Brawley said. For example, the Institute found that 8 to 9 percent of women on breast cancer treatment trials are black. By comparison, 12 percent of the US population is black.

An NCI fellow, Herberto Tejeda, proposed that the comparison with raw population data was flawed, Brawley said.

The black population in the US is a few years younger than the white population, and thus should experience a lower rate of breast cancer. In addition, black women tend to have a lower risk for breast cancer than white women.

Using 1990 US Census figures and data from the NCI Surveillance, Epidemiology and End Results program, Tejeda found that the percentages of blacks and Hispanics in treatment trials closely matched the percentages of blacks and Hispanics with cancer.

The data on racial proportionality in cancer treatment trials surprised NCI officials, Brawley said.

"We never dreamed this would be true," Brawley said to **The Cancer Letter**. "However, when you consider that the majority of the cooperative groups and their member institutions are located in large cities, it starts to make sense."

Brawley presented the results of the study at the conference last week. The highlights of the findings include:

—Treatment trials of prostate cancer accrued 4,497 subjects, of which 82.8 percent are white, 14.7 percent black, and 2.5 percent Hispanic. Cancer registry data estimate that of Americans diagnosed with prostate cancer each year, 87.9 percent are white, 9.4 percent black, and 2.7 percent Hispanic.

—Treatment trials for colorectal cancer accrued 6,903 subjects over age 50; 89 percent of participants were white, 8.2 percent black, and 2.8 percent Hispanic. Cancer registry data indicate that of Americans over age 50 diagnosed with colorectal cancer each year, 8.4 percent are black, 89 percent white, and 2.5 percent Hispanic.

—Colorectal trials accrued 992 participants between the ages of 20 and 49, of whom 84.5 percent were white, 10.2 percent black, and 5.3 percent Hispanic. Of Americans in that age group diagnosed with colorectal cancer, 79.5 percent are white, 14 percent black, and 6.6 percent Hispanic.

The following results were found for breast cancer treatment trials:

—Ages 20-49: Participants were 83.8 percent white, 12.1 percent black, and 4.1 percent Hispanic. Americans in that age group with breast cancer are 83.7 percent white, 11.4 percent black, and 4.9 percent Hispanic.

—Over age 50: Participants were 88.9 percent white, 8.6 percent black, and 2.5 percent Hispanic. Americans over 50 with breast cancer are 90.5 percent white, 6.7 percent black, and 2.8 percent Hispanic.

The following results were presented by age group totaling accrual to all NCI treatment trials for all cancer sites:

—Under age 19: Participants were 77 percent white, 11 percent black, and 12 percent Hispanic. Americans under age 19 with cancer are 79.3 percent white, 11.1 percent black, and 9.5 percent Hispanic.

—Ages 20-49: Participants were 84.6 percent white, 10.6 percent black, and 4.8 percent Hispanic. Americans in that age group with cancer are 84.3 percent white, 10.6 percent black, and 5.1 percent Hispanic.

—Over age 50: Participants were 89 percent white, 8.5 percent black, and 2.5 percent Hispanic. Americans over 50 with cancer are 88.7 percent white, 8.6 percent black, and 2.7 percent Hispanic.

Brawley said the cancer registry data may under-

represent the Hispanic cancer rate because there is no registry located in the Southwest or in Florida, which have large Hispanic populations.

"Treatment trials are available to minority cancer patients, and minority patients enter trials in numbers that are proportional to the incidence of cancer in the population," Brawley said.

However, a different dynamic is at work in cancer prevention and screening trials, Brawley said.

"The same hospitals and clinics that give us good proportionality in treatment trials are unable to give us proportionality in prevention trials," he said.

Minority enrollment on the Prostate Cancer Prevention Trial is about 8 percent, he said.

In addition, participants in prevention and screening trials tend to be better educated and have higher incomes.

"Poor people, black or white, are not being accrued to prevention trials," Brawley said. "The burden of poverty is incredibly high. It is not that the system is not offering trials to these people, it is that these people have too many things on their plate. There is no apparent clear benefit."

Brawley reviewed minority accrual on NIH-sponsored prevention trials since 1970. The only trials that had high minority accrual were studies funded by the National Heart, Lung and Blood Institute on prevention of heart and renal disease. The minority subjects on the NHLBI trials tended to have hypertension.

"They thought they had a problem and they wanted it treated," Brawley said.

RFAs: Research To Improve Accrual Of Minorities, Women

RFA CA-96-003

Title: **Women And Minority Recruitment: Small Grant Program**

Letter of Intent Receipt Date: Feb. 20

Application Receipt Date: April 18

The NCI Early Detection Branch, Division of Cancer Prevention and Control, invites Small Grant Program applications (R03) to perform pilot studies, test new ideas, or gather information that will lead to the development of effective models and strategies to improve the participation of women an minority groups as subjects in cancer prevention and screening phase III research.

Approximately $400,000 in total costs per year for two years will be committed to fund four to five applications. Each award will be limited to $50,000 in direct costs per year, not to exceed two years.

Inquiries: Nancy Simpson, DCPC, NCI, 6130 Executive Blvd, Rm 305 MSC 7342, Bethesda, MD 20892-7342, tel: 301/496-3893, fax: 301/496-8667, e-mail: simpsonn@dcpcepn.nci.nih.gov

RFA CA-96-004

Title: **Women And Minority Recruitment: Intervention Testing**

Letter of Intent Receipt Date: Feb. 20

Application Receipt Date: April 18

The NCI Early Detection Branch, Division of Cancer Prevention and Control, invites investigator-initiated grant applications (R01s) for research to develop, implement, and test well-defined, hypothesis-based interventions to improve the participation of women and minority groups as subjects in cancer prevention and screening clinical trials. Proposed phase III research should build on current knowledge and research findings concerning clinical trial participation and patient recruitment, compliance, and retention and physician referral factors.

Approximately $1.25 million in total costs per year for four years will be committed. Four to six applications are expected to be funded. The project period of each award may not exceed four years.

Inquiries: Nancy Simpson, DCPC, NCI, 6130 Executive Boulevard, Room 305 MSC 7342, Bethesda, MD, 20892-7342, tel. 301/496-3893, fax: 301/496-8667, e-mail: simpsonn@dcpcepn.nci.nih.gov

Public Meeting Planned Feb. 26

NRC Considering "Escalated" Enforcement Action Against NIH

The Nuclear Regulatory Commission said it is considering an "escalated enforcement action" against NIH for what the regulatory agency described as problems with security of radioactive materials as well as problems related to bioassays, external dosimetry and radiation safety training.

A letter accompanying a report of an inspection team that came to NIH following an internal contamination incident last summer said NRC planned to conduct a "predecisional conference" Feb. 26. The conference, to be held at the agency's offices

in Rockville, will be open to the public.

"An area of significant concern is the recurring weakness identified in your program for the security of licensed material," Charles Hehl, director of the NRC Division of Nuclear Materials Safety, wrote in a letter dated Jan. 29.

The letter, addressed to Michael Gottesman, NIH deputy director for intramural research, accompanied a redacted copy of a report of the "augmented inspection team" that inspected NIH following the ingestion of phosphorus-32 by 27 individuals including a pregnant NCI researcher (**The Cancer Letter**, Nov. 3, 1995).

According to the letter, the NCI researcher, Maryann Wenli Ma, received a total effective dose of 8 to 12.7 rem, while the fetus received 5.1 to 8.1 rem. The highest exposure permitted for an occupationally exposed, non-pregnant individual is 0.1 rem per year.

In addition to the inspection that followed the ingestion, NRC officials conducted two unannounced inspections at NIH, finding what the agency described as persistent problems with security (**The Cancer Letter**, Jan. 5.)

The conference, where NIH officials will be invited to present their case, will begin at 9 a.m. Feb. 26, at the NRC auditorium, 11545 Rockville Pike.

NIH Priority: Pay 4,000 Grants; Send Summary Statements

As NIH officials strive to catch up with the backlog of work caused by the federal shutdown and the record-setting blizzard, their first priority is to pay the 4,000 grant awards approved following the October round of meetings of the advisory councils, NIH officials said.

According to NIH officials, initial review group meetings, which have been most affected by the shutdowns, are being rescheduled.

Consequently, many review meetings have had to be postponed. The goal is to reschedule meetings to take place by March 30 to have requisite material available for the May round of Council meetings, officials said.

The postponements would mean that summary statements will be received by applicants later than usual.

Since some applicants had not received summary statements in a timely manner or had difficulty reaching NIH staff prior to submitting applications, receipt dates have been changed. Amended applications, for instance, are now due on March 15, instead of March 1.

Extramural Associates Research Development Awards (RFA: OD-96-001), originally due on Jan. 19, are now due on Feb. 21. The Feb. 1 receipt date for new applications remained in effect, as did the March 1 deadline for competing continuation and supplemental applications.

For additional information, contact Wendy Baldwin, Deputy Director for Extramural Research, e-mail: DDER@nih.gov; or Office of Extramural Outreach and Information Resources, tel.: 301/435-0714, e-mail: girg@drgpo.drg.nih.gov

NIH is expected to remain in operation even if another partial shutdown occurs since the FY 1996 appropriations bill that includes funding for the institutes has been passed by Congress and signed by the President.

Ralph Yarborough, Initiator Of Cancer Act, Dead At 92

Ralph Yarborough, the Texas liberal Democrat who initiated the effort that led to the passage of the National Cancer Act of 1971, died Jan. 27 at his home in Austin. He was 92.

Yarborough served in the Senate from 1957 until his defeat in a primary in 1971 by Lloyd Bentsen.

Yarborough was chairman of the Health Subcommittee of the Senate Labor and Human Resources Committee when he was approached by R. Lee Clark, president of M.D. Anderson Cancer Center, and philanthropist Mary Lasker to consider increasing federal support for cancer research.

Yarborough formed the National Panel of Consultants, headed by Benno Schmidt Sr., to make recommendations for a major new initiative. He introduced legislation that incorporated the panel's recommendations, including an NCI appropriations of $400 million for fiscal 1972.

Following Yarborough's defeat, Sen. Edward Kennedy (D-MA) became chairman of the Health Subcommittee and introduced the panel's recommendations as new legislation in the 92nd Congress. The bill, with some changes in conference with the House, was signed into law by then-President Richard Nixon on Dec. 23, 1971.

In addition to support for cancer research and

increased health care, Yarborough led other causes including opposition of the war in Vietnam. He sponsored a bill that extended GI benefits to 5 million veterans who had served after World War II. He helped write the first Bilingual Education Act and a bill that increased Social Security benefits.

Yarborough was born the seventh child in a family of 11 children on a farm in Chandler, TX. He graduated from the Univ. of Texas Law School in 1927. He was a Texas district judge from 1936 to 1941, and served in Europe and Japan during World War II.

Following the war, Yarborough practiced law in Austin and made three unsuccessful attempts to win the gubernatorial nomination. In 1957, he won the Senate seat that Price Daniel had given up to run for governor.

Survivors include his wife Opal, and three grandchildren.

Freeze Med School Classes, Reduce Residencies, IOM Says

A report by the Institute of Medicine called for a freeze on class sizes in medical schools and recommended that no new medical schools be opened.

Moreover, the IOM report called on the federal government to reduce the number of medical residency positions it funds.

The changes would be needed to reduce the overall number of physicians-in-training in the US, while protecting access to health care for underserved populations, said the report issued by an IOM committee.

"Having more physicians has not meant having more care of the right kind, at the right place, or at the right cost," said Don Detmer, co-chairman of the IOM committee and senior vice president at the University of Virginia.

"In the past two decades, the number of physicians has grown 1.5 times the rate of the general population, increasing from 150 per 100,000 people in 1970 to 245 in 1992," Detmer said. "Yet for all this growth we have seen too little improvement in the cost or quality of, or access to, health care."

Left unchecked, the rising number of physicians may crowd the physician labor market to the point where promising US students might forego a career in medicine, the report said.

"Producing more physicians than the nation requires is a waste of both human resources and the federal resources spent on residency training. said co-chair Neal Vanselow," professor of medicine at Tulane University.

Link Between Payments, Training Faulted

The link between payments for health services and for graduate medical training needs to be broken, the committee recommended.

Under today's system of funding, hospitals are compensated by the federal government for each resident they train.

This system should be revamped to bring the total number of positions funded closer to the number of graduates from US medical schools.

With no cap on the number of residency positions funded, there is an incentive for cash-strapped hospitals to increase residency positions in order to bring in more federal funds.

Meanwhile, some hospitals—particularly in the inner city and rural areas—have trouble attracting US-educated doctors for residency training. These institutions depend on an influx of international medical graduates (IMGs) who come to the US for government-funded residency training, and eventually, to practice.

IMGs, who comprise the fastest growing segment of the physician work force, bring funding to help provide care for underinsured, uninsured, and poor populations.

Replacement Funding Suggested

To make up for the loss of income that a cut in residency positions could bring, the federal government should develop a system of "replacement funding" that directly supports the health care of needy populations, rather than funnel such support through residency training, the committee said.

Replacement funding would enable hospitals to use federal support more efficiently by catering spending decisions to the needs of the patients, the report said.

Some hospitals may elect, for example, to replace resident physicians with nurse practitioners and physician assistants.

The committee said the demand for doctors will remain in flux as managed care continues to grow in relation to the traditional fee-for-service delivery system.

Noting that a record number of students are

continuing to apply to medical schools in the US, the committee recommended that up-to-date information on career opportunities in medicine be made available to prospective medical students.

The report further recommended that the US Department of Health and Human Services fund research on physician work-force issues, including the relationships among physician supply and health care costs, quality, and access.

From 1988 to 1993, the total number of IMGs in residency or fellowship training increased by 80 percent—from 12,433 to 22,706—while the number of US graduates held steady at about 17,500, the report said.

Seventy-five percent of IMGs who come to the US for residency training remain here to practice.

NIH, Engineering Group Hold Facility Design Meeting

NIH and the International Society for Pharmaceutical Engineering will sponsor a symposium to introduce the NIH biomedical facility design guidelines.

The emphasis will be on the design of biomedical research laboratories, the application of the NIH guidelines, and arm chair tours of the most recently constructed NIH laboratories.

The symposium is geared for researchers, architects, engineers, research management, and others involved with the design or operation of biomedical research facilities.

The NIH has pioneered the development of design guidelines for the intramural NIH biomedical research facilities. As a result, NIH receives many questions asking how NIH designs facilities and what design changes NIH anticipates in response to emerging research needs.

The conference will take place March 4-6 at the Natcher Conference Center on the NIH campus. The registration fee is $645.

The meeting will present the technical aspects of the NIH guidelines for biomedical research facilities, officials said. Presentations will include an overview as well as the discipline-specific information for the design and construction of biomedical research facilities at NIH.

Also, the meeting will include sessions on applications of the guidelines, including the guidelines for the laboratories, the vivaria, and the other support spaces within the facilities.

For additional information, contact the International Society for Pharmaceutical Engineering Headquarters, 3816 W. Linebaugh Avenue, Suite 412, Tampa, FL, 33624, tel.: 813/960-2105, fax 813/264-2816.

RFAs Available

RFA CA-96-002

Title: **Dietary Exposure To And Effects Of Plant Food Constituents**

Letter of Intent Receipt Date: Feb. 20

Application Receipt Date: April 18

The NCI Division of Cancer Prevention and Control invites investigator-initiated research project grant applications (R01) to assess dietary exposure to constituents of plant foods that may affect cancer risk and to assess their biological effects relative to cancer prevention in humans. The ultimate goal of the research to be supported is to increase knowledge of the role of plant food constituents in order to refine dietary guidance for the prevention of cancer in the population. Up to $2 million in total costs per year for up to four years will be committed to fund up to eight to 10 awards.

Inquiries: Susan Pilch, DCPC, NCI, Executive Plaza North Rm 212, Bethesda, MD 20892, tel: 301/496-8573, fax: 301/402-0553, e-mail: PilchS@dcpcepn.nci.nih.gov

RFA RR-96-001

Extramural Research Facilities Construction Projects

Letter of Intent Receipt Date: March 22

Application Receipt Date: April 19

The National Center for Research Resources is authorized under Public Law (PL) 103-43, Sections 481A and 481B of the Public Health Service Act (PHS), as amended by the NIH Revitalization Act, to "make grants to public and nonprofit private entities to expand, remodel, renovate or alter existing research facilities or construct new research facilities" for biomedical and behavioral research and research training. The President's FY 1996 budget request for the NIH includes $11 million in the budget of the NCRR for extramural facilities construction grants to be awarded competitively, with special provisions made for institutions of emerging excellence, designated under section 739 of the PHS Act as revised in PL 102-408, and the Regional Primate Research Centers. Eight to ten new awards (C06) at different levels are expected to be made.

Inquiries: Charles Coulter, Research Infrastructure Area, National Center for Research Resources, 6705 Rockledge Dr., Room 6148 MSC 7965, Bethesda, MD 20892-7965, tel.: 301/435-0766, fax 301/480-3770, e-mail: charlesc@ep.ncrr.nih.gov

Program Announcements

PA-96-014

Title: **Models For HIV Disease And AIDS-Related Malignancies**

This Program Announcement is a reissuance of PA-95-021 with a similar title, which appeared in the NIH Guide, Vol. 24, No. 2, Jan. 20. The purpose of the reissuance is to expand the scope to include refinement of mathematical models and new paradigms of HIV pathogenesis.

This PA reflects a continuing joint effort by the NCI and the National Institute of Allergy and Infectious Diseases to encourage investigators to develop useful and predictive biochemical, cellular, in vivo and mathematical models for the preclinical evaluation of new therapies against HIV disease and AIDS-related malignancies.

The availability of well-characterized in vitro and in vivo models would accelerate the pace of evaluation of different paradigms of disease progression and would facilitate the discovery of successful treatments, including drugs, vaccines, gene therapy, and immune modulators.

Research support mechanisms for this PA include the investigator-initiated research project grant (R01) or FIRST (R29) award.

Inquiries: Nava Sarver, NIAID Division of AIDS, 6003 Executive Boulevard, Room 2C01 MSC 7620, Bethesda, MD, 20892-7620, tel.: 301/ 496-8197, fax: 301/ 402-3211, e-mail: ns18p@nih.gov

Mary Wolpert, NCI Division of Cancer Treatment, Diagnosis, and Centers, 6130 Executive Boulevard, Room 832 MSC 7450, Bethesda, MD, 20892-7450, tel.: 301/ 496-8783, fax: 301/496-8333

PAR-96-015

Small Grant Program For Conference Support

The Agency for Health Care Policy and was established to improve the quality, appropriateness, and effectiveness of health care services and access to these services.

These purposes are achieved by supporting research and by promoting improvements in clinical practice and in the organization, financing, and delivery of health care services. Also, AHCPR supports conferences on issues relevant to health services research. Some are supported by the awarding of small grants (grants with direct costsof $50,000 or less).

This program announcement describes the procedures and criteria for the AHCPR Small Grant Program for Conferences. Examples of the types of conferences eligible for support include those with purposes in Research Development, Design and Methodology, or Dissemination. This program announcement supersedes the small conference grant portion of "Health Service Research Conference Grants," PA-91-61, published in the NIH Guide on May 31, 1991 and in the Federal Register on July 15, 1991.

Inquiries: Christine Williams, Center for Health Information Dissemination Agency for Health Care Policy and Research 2101 East Jefferson St., Suite 501, Rockville, MD 20852-4908, tel.: 301/594-1360, ext. 145, fax: 301/594-2286

PAR-96-016

Grants For Health Services Dissertation Research

Application Receipt Dates: May 1 and Nov. 15 annually

The Agency for Health Care Policy and Research announces the small grant (R03) program for Health Services Dissertation Research, which supports research undertaken as part of an academic program to qualify for a doctorate. Through this support, AHCPR seeks to increase the number of researchers who study health care systems and the cost, quality, and impact of health care services.

Applications are accepted from students seeking a doctorate in disciplines relevant to health services research. Total direct costs, under this program announcement, must not exceed $30,000 for the entire project period.

This PA supersedes "Grants for Health Services Dissertation Research," HS-95-002, published in the NIH Guide, Vol. 23, No. 31, Aug. 19, 1994.

Inquirues: Global Exchange Inc., 7910 Woodmont Av., Suite 400, Bethesda, MD 20814-3015, tel.: 301/ 656-3100, fax: 301/652-5264

PA-96-017

NCRR Shared Instrumentation Grant

Application Receipt Date: March 27

The National Center for Research Resources announces the availability of a PA intended to continue the competitive NCRR Shared Instrumentation Grant (SIG)Program initiated in FY 1982. The (1992) National Report on Academic Research Equipment and Equipment Needs for Biological Sciences, cosponsored by the NIH and the National Science Foundation, identified research equipment of the type provided through this program as top-priority.

The objective of the program is to make available to institutions with a high concentration of NIH-supported biomedical investigators expensive research instruments that can only be justified on a shared-use basis and for which meritorious research projects are described.

Awards under this PA will use the Shared Instrumentation Grant mechanism (S10).

Inquiries: Marjorie Tingle, Director, NCRR Shared Instrumentation Grant Program, 6705 Rockledge Dr., Room 6154 MSC 7965, Bethesda, MD, 20892- 7965, tel.: 301/435-0772, fax 301/480-3775, e-mail: ig@ep.ncrr.nih.gov