THE CANCER LETTER FAX

Vol. 22 No. 29
July 19, 1996

Price $265 Per Year US
$285 Per Year Elsewhere

NCI Finds Physician Recommendation Drives Patient Demand For ABMT

For more than a year, NCI has been seeking to understand the reasons for low accruals in the studies of bone marrow transplantation and high dose chemotherapy for breast cancer.

Is it patient demand that's making physicians provide ABMT off-protocol? Or is it recommendations from physicians that lead women to demand the investigational procedure?

(Continued to page 2)

In Brief

Baltimore Developer Donates $10 Million To Univ. of Maryland Medical System

UNIVERSITY OF MARYLAND Medical System and University of Maryland School of Medicine has received a $10 million gift from Stewart Greenebaum, a Baltimore real estate developer, and his wife Marlene, who is a five-year survivor of breast cancer and a volunteer at the University of Maryland Cancer Center. Stewart Greenebaum is chairman of the Medical System Board of Directors. . . . **LABOR-HHS-EDUCATION** Appropriations bill was passed by the full US House of Representatives last week. However, Congress is unlikely to complete most appropriations bills by Oct. 1, the start of the fiscal year. One scenario being discussed on Capitol Hill is the passage of a large "continuing resolution," to avoid another government shutdown and enable members to go home to campaign. . . . **WILLIAM BLOOMER**, professor of radiology at Northwestern University Medical School, was named the first incumbent of the Anna Hamann Chair in Radiation Medicine at the Evanston Hospital. The $1 million endowment was a gift of the Radiation Medicine Institute and honors the hospital's first chairman of radiation medicine. . . . **ONCOLOGY NURSING** Certification Corp. said 205 nurses, or 72 percent, passed the Advanced Oncology Nursing Certification Examination, held May 1 in Philadelphia. Currently, there are 431 advanced oncology certified nurses. ONCC said 450 nurses, or 82 percent, passed the Generalist Oncology Nursing Certification Examination held the same day. Of those who passed, 230 are newly certified, 138 renewed their credential, and 82 were repeating the exam. There are 16,154 oncology certified nurses. For information, contact ONCC, tel: 412/921-8597. . . . **JASMINE MELZER** was named director of corporate relations for the Skin Cancer Foundation, based in New York City. The foundation provides certification to manufacturers of sunscreen and sunglass products that meet the foundation's standards for sun protection.

NCI Finds Better Information Key To ABMT Trial Accrual

(Continued from page 1)

The answers depend on whom you ask:

● Conducting focus group discussions with oncologists, Institute officials learned that pressure from patients to receive the most aggressive treatment available was among the most formidable barriers to enrollment in ABMT trials.

● Conducting focus groups with patients, Institute officials learned that recommendations from physicians were key to the patients' decisions to undergo the procedure.

"What was interesting was the dichotomy between what the physicians said and what the patients said," said Jeffrey Abrams, senior investigator at the NCI Cancer Therapy Evaluation Program.

"The patients said we depend on our physicians, and physicians pointed out to us the barriers to participating in clinical research and said that sometimes the patients come to us with their minds made up," Abrams said to **The Cancer Letter**.

"There was a feeling on the part of physicians that if they didn't offer this to their patients, they were potentially harming them or not offering them the latest available treatment for breast cancer," Abrams said.

"When we tried to find out if they were using the different materials than the NCI Office of Cancer Communications published, there was not a lot of recognition on the part of the doctors that these publications even existed," he said.

Since physicians were unfamiliar with the OCC materials, it was hardly a surprise that in focus groups and interviews conducted a year later, patients said they were similarly unaware of the Institute's publications on ABMT trials.

The first report, "Patient Referral to the NCI ABMT Clinical Trials: The Physician's Perspective" was based on focus groups convened at the 1995 annual meeting of the American Society of Clinical Oncology in Los Angeles.

The second report, "The Road to ABMT Trials: Breast Cancer Patients' Decision-Making Process," was completed earlier this year and is circulated in draft form. Both reports were commissioned and written by the NCI Office of Cancer Communications.

Physicians Speak

Both studies attempted to explain low enrollment in three "high-priority trials," Intergroup 0121; Intergroup 0163 (CALGB 9082); and PBT 01 (**The Cancer Letter**, June 7).

In focus groups and in-depth interviews that were conducted at the ASCO conference, oncologists said randomization was a difficult concept to explain to patients.

"When descriptions of the treatment arms imply either aggressive or standard treatment, patients are not willing to get randomized to standard treatment," the report said.

"Physicians are reluctant to deny their patients treatment for many reasons, the major one being their belief that patients have the right to choose."

Other highlights of the report include:

● "Women who do not have metastatic disease but may be appropriate candidates for the trials do not understand that there is a strong possibility of their breast cancer recurring; thus these women do not tend to opt for the trials.

● "Some participants were concerned that their patients' confidence in them is shaken when they admit to not having definitive treatment answers and recommend enrollment in a clinical trial.

● "The requirement to receive treatment far from home is perceived to be a deterrent because many of the patients are young mothers who want to be near their families and their employment.

● "Some physicians, though not all, believed that

THE CANCER LETTER

Founded 1974
Member, Newsletter Publishers Assoc.

Editors: **Kirsten Boyd Goldberg, Paul Goldberg**
Founder: **Jerry D. Boyd**

P.O. Box 9905, Washington, D.C. 20016
Tel. (202) 362-1809 Fax: (202) 362-1681
Editorial e-mail: kirsten@www.cancerletter.com
Subscriptions: subscrib@www.cancerletter.com
World Wide Web URL: http://www.cancerletter.com

Subscription $265 per year US, $285 elsewhere. ISSN 0096-3917. Published 48 times a year by The Cancer Letter Inc., also publisher of The Clinical Cancer Letter.

the problems at the National Surgical Breast and Bowel Project may have made some patients skeptical of clinical trials.

● "Physicians who do not belong to a CCOP indicated that they can no longer afford to support nurses [who act as data managers and implement the consent process] through their practices.

● "Some physicians stated that the cooperative groups have various standards, procedures and protocols that necessitate different practices, and they expressed frustration with keeping track of revisions to protocols and contradictory rules.

● "The consent forms are long and arduous and take an inordinate amount of time to explain to the patients, many of whom then decide not to enroll in the trial.

● "The time involved in enrolling a patient on a trial can be lengthy. In most cases a patient wants treatment to begin immediately, and may therefore demand off-trial treatment or seek treatment elsewhere. Some physicians questioned why they cannot start treatment before randomization.

● "Many physicians pointed out that they are facing price wars among competing practices and managed care organizations. As a result, these physicians have to spend less time with patients and can receive only a limited reimbursement for treatment, especially for clinical research. To reduce overhead, some are eliminating staff positions. At the same time, these physicians and their staffs must spend more time with insurance case managers.

● "Although some physicians said that they will not offer bone marrow transplantation as an option unless the patient is on a clinical trial, many physicians succumb to pressure from the patient. Considering that a transplant costs approximately $60,000, it is possible that transplant centers are biasing patients toward transplants, and not to randomized clinical trials for financial reasons.

● "Transplant centers where patients can either self-refer or be referred by a physician for a bone marrow transplant off trial are a source of competition. Some physicians believed that bone marrow transplant centers to which patients are referred in the process of enrolling in an NCI trial are sometimes persuading women to get a transplant off-trial through `bait and switch' tactics.

● "Academic researchers who are conducting phase II trials are also competing with randomized trials. Some physicians felt that the two adjuvant trials may also be competing with each other.

● "Physicians believed that patients are possibly being influenced by the nursing staff, who may be biased in favor of transplantation.

● "According to participants, the public perceives that physicians, as well as NCI, are essentially denying treatment to breast cancer patients because they are encouraging patients to enter a randomized trial where they may not receive their treatment of choice.

● "There did not appear to be a clear-cut preference among participants regarding a trial with four to nine axillary nodes, although physicians agreed that it is important to determine the efficacy among such patients. While physicians agreed that the answers are important, they voiced some of the same concerns as with the existing trials.

● "All of the oncologists agreed that the ability to educate and thereby persuade patients was critical.

● "None of the physicians was familiar with NCI patient education resources. Most do not use the patient booklet, `What Are Clinical Trials All About?'

The oncologists suggested that NCI sponsor a public education campaign to improve the image of clinical trials, build coalitions with advocacy groups and insurance companies to promote trials, simplify the data management and consent processes, and offer incentives for physicians to participate in phase III trials, the report said.

Patient Perspective

To explore the patients' perspective, NCI convened a series of mini-groups, dyads, and one-on-one interviews with women eligible for, and offered participation in one of the three ABMT trials.

The study included patients who participated in one of the trials and were randomized to the transplant arm, patients who participated in one of the trials and were randomized to the non-transplant arm, and those who were offered participation in NCI trials, but elected to receive treatment off-protocol.

The conclusions of the study follow:

● "From the patient's perspective, physicians are key to trial accrual. Most participants expressed overwhelming confidence in their physician and his or her recommendation for treatment. Reliance on physicians is increased by patient's emotional state after learning about the stage of their disease and the sense of urgency that results with regard to making a treatment decision.

● "The ABMT trials seem to appeal to women who want to pursue their cancer as aggressively as possible and those who regard the trial as their best chance for survival. While these attitudes may be inherent in some patients' personalities, they appear to manifest themselves in certain other women when they are presented with a life-threatening disease like cancer. Rather than giving in to their disease, they mobilize themselves to fight it.

● "While patients are largely unfamiliar with clinical trials at the time of diagnosis, they have little difficulty in understanding the ABMT trials. Patients do vary in the amount of information they want about their condition or treatment options. Some patients wanted as much information as they could get their hands on; others were satisfied with what they received; and a few perceived too much information as being anxiety-producing.

● "Randomization was generally accepted and understood. Although some participants had a preference for which arm of treatment they wanted to receive, many assumed a spiritual attitude in terms of randomization, believing that God or fate would determine which was best for them. Although only a few admitted they would have left the trial if they had not received the transplant arm, knowing they had the option to leave the trial may have made it easier for certain patients to enroll

● "Physicians should be encouraged to present the option of a bone marrow transplant to patients within the context of an ABMT trial. Comments from some participants suggest that when a physician recommends a bone marrow transplant before introducing the trial, it may bias the patient toward transplant, making them less willing to undergo randomization and more likely to seek a transplant off-trial

● "The consent form is not a major barrier to patients. Although many women admitted that the form was overwhelming and at times scary, they had been informed about most of the trial specifics by their physicians before seeing the form and had already made up their minds to participate. Reading the actual consent form had little effect on this decision. Interestingly, earlier focus group research with oncologists had indicated the consent from to be a major obstacle; physicians stated that when potential participants first saw the information in the consent form, it frightened them away from enrolling. It is possible that providing patients with an adequate explanation of the trial prior to their seeing the consent form, as well as emphasizing that they will not necessarily have all the side effects listed, may be what differentiates these two points of view.

● "While physicians in the earlier report noted that their women patients were not concerned about historical significance and contributing to science, many of the participants in the current study said that contributing to an advance in science was very important, especially for the sake of their progeny. This benefit, however, was very much secondary to what they perceived as the primary value of trial participation—bettering their chances for survival.

● "As in the physician study, two of the biggest barriers to trial participation from a patient point of view are medical insurance coverage and travel from home. These two factors add an inordinate amount of stress to patients' lives.

● "While physicians in the previous report felt that negative publicity about clinical trials may have made some women skeptical of trial participation, women in this study had only a vague familiarity with clinical trials, suggesting that it was unlikely to have affected their decision making.

● "Linking potential ABMT trial participants with trial survivors should be considered, since a number of women in this study expressed an interest in and need for this interaction. In this regard, it should be noted that the majority of participants in this research were supporters of the trials, emphasizing during their interviews that they wanted to take an active part in helping to educate others.

● "Overall, physicians need to be made more aware of the critical role they play in patient decision making with regard to ABMT trial enrollment. In the earlier physician research, oncologists reported that their patients lost confidence in them when they offered a clinical trial, because they were looking for a definite treatment answer, and a clinical trial by definition cannot guarantee a cure. Findings from the current study underscore the high value and trust that patients place in their physicians' recommendations. The findings also suggest that when physicians present an ABMT trial to patients, they need to present both arms of the trial positively, emphasizing that one arm has not been proven to be better or more effective than the other. At the same time, as appropriate, physicians should stress that the trial represents the patient's best chance of survival and that knowledge obtained from the trial

will be important to all women, including their own progeny."

Beyond Dichotomy

Besides pointing out the dichotomy, the focus groups yielded a strategy for bridging it, Abrams said.

Both physicians and patients said they were not aware of NCI literature on clinical trials of ABMT for breast cancer.

"There is an educational process that needs to go on," Abrams said. "The focus groups have suggested new strategies to us: target physicians and patients.

As a result, NCI has revamped its educational materials, making the descriptions of the ABMT trials shorter, both in the version written for physicians and the version written for patients.

Also, the Institute has been working with grass roots and advocacy organizations to distribute the materials, Abrams said.

"Giving our educational materials to the grass roots organizations is a more effective way to reach people," he said.

Letter to the Editors

Payers Must Determine Most Appropriate Therapies

To the Editors:

Re: "Insurers Increasingly Willing to Cover ABMT for Breast Cancer, GAO Finds," in The Cancer Letter, June 7, 1996.

Once again the twin issues of paying for new treatments and studies to assess their effectiveness surface in the context of coverage for, and clinical trials on, ABMT for breast cancer.

Health insurers and managed care organizations face two daunting tasks: deciding what to pay for and when to pay for it. The situation is particularly difficult with a new treatment that advocates claim produces much better outcomes for patients suffering from a dreaded disease, especially one with political and emotional overtones.

Why should payers not simply pay for any treatment a provider proposes?

Payers have a fiduciary responsibility to manage their clients' premiums wisely. Otherwise, they increase group plan health care costs to the point that clients insist on containing them by cutting back or eliminating services.

Payers can also be said to have an implied fiduciary responsibility to inform patients' choices. New and expensive high technology procedures that have not been proven scientifically to be more effective than existing standard care are obvious cost containment targets. Patients may complain that payers fulfill their financial responsibility at the expense of denying them coverage for beneficial treatments, not recognizing their plan may be required to disclose to them hard truths about their chosen treatment.

Payers must decide two questions for a new treatment:

—Is it effective (or, at least generally assumed to be effective by qualified practitioners?) for some types of patients, or, conversely, is it experimental, which is not the same as being investigational?

—Is it appropriate for a particular patient?

To answer the first question, payers may establish mechanism to assess the effectiveness of technologies. For the most part, they rely on studies in the medical literature, supplemented by expert opinion. This approach rests on the existence of usable data. Many studies of the medical literature have shown that most research reports do not contain usable data, and for emerging technologies there may be no completed studies.

Pressure to pay for treatment based on providers' claims, inadequate studies, and early results of clinical trials can become irresistible, especially when demanded by patients who have exhausted all available therapies or have been led to believe that the new treatment will save their life.

As the treatment diffuses into medical practice, often encouraged by payers' favorable coverage decisions, it becomes harder to deny coverage for a treatment, even though the treatment may never have been proven to provide patients with a greater health quality of life than standard therapy, and even when a provider's recommendation is demonstrably inappropriate for a particular patient.

Determining in the abstract the types of patients that a technology benefits does not help determine if it is appropriate for a particular patient. A treatment is appropriate if the patient meets the profile of patients for whom the procedure is known or assumed to be effective and there are no contraindications to the procedure or other factors that make it inadvisable, for example, the existence of an alternative treatment that has lower risk and equal benefit.

To answer this second question, payers are

increasingly asking our academic-affiliated expert panels to review complex and contentious procedures—including high-dose chemotherapy for breast and other cancers with various forms of stem cell rescue. In about half of the cases we review, the recommended treatment is not appropriate for the patient.

With increasing pressures to pay for unproven treatments, more and more patients may be receiving inadvisable treatments. Patients are unwilling to accept their physician's advice against a treatment and find another doctor who will provide it, and payers are not prepared to review all cases involving risky procedures.

Knowledge about a treatment's effectiveness rests on doing the requisite studies.

Traditionally, government has paid for most research on procedures, including patient care costs. There are three substantial problems. First, there is not enough money to do all of the trials that should be done. Second, the government appears unwilling to return to its previous level of support. Third, eligible patients are often not being referred to national studies because they are led to believe that "new" automatically means "better," or because providers have a greater interest in enrolling them in institutionally-sponsored studies.

We must find alternative ways to research the effectiveness of treatments. Either payers step in to fill the void or needed studies will not be done.

Even if payers are willing to step up to the plate, clinical trials, for example, are only feasible if patients will enroll in them. Payers can give patients this incentive by, for example, only covering the cost of new an emerging treatments performed in the context of sound research. Once again, difficulties emerge.

Payers are reluctant to judge the scientific value of studies. We have responded to their desire for an independent, objective review of the merits of studies by assessing their scientific importance, design, etc., and by determining if a particular patient qualifies for a specific study.

Society would likely have to reinforce payers' resolve by granting them immunity from suit for nonpayment if they did pay for patients' participation in sound studies designed to illuminate the effectiveness of treatments, and had in place reasonable mechanisms for deciding such issues. Paradoxically, the advent of managed care may provide payers with both incentives and means to conduct or fund such research as part of a comprehensive quality improvement program.

Since September 1991, we have provided a process to enhance patients' early access to appropriate treatments and trials. Medical Care Ombudsman Program provides payers and patients with an independent, objective review of medical facts.

Our 380 reviewers have reviewed over 3,500 cases for our over 100 corporate and other clients. To our knowledge, less than on half of one percent have proceeded to litigation. None in which the client followed our recommended procedures resulted in judgment against the client.

Further, we believe the program has resulted in patients receiving beneficial treatments they might not otherwise have receives, a reduction in the number of patients receiving treatments that were unlikely to have benefited them, and an increase in the number of patients made aware of clinical trial options available to them.

In the short run, it may be easier and cheaper for payers to cave in to patients' demands than to exercise their fiduciary responsibility, especially when faced with a conflict between a tangible coverage decision for a particular patient and the abstract concept of value for money. But, in the long run, this policy harms the patient, the payer and the public.

The patient may receive an inadvisable treatment that diminishes quality of life. The payer sets a precedent for paying for procedures that may be ineffective, and are certainly unproven. Payers and the public pay for treatments that have little or no value, increasing the cost of an impairing our ability to provide universal access to affordable, quality health care.

Peter Goldschmidt
Grace Monaco
Medical Care Management Corp.
Bethesda, MD

ONS Grants Available

The Oncology Nursing Society and the Oncology Nursing Foundation are accepting proposals for 1997 small research grants program.

Nurse clinicians are invited to submit proposals. Letter of intent is due Sept. 16, deadline is Nov. 1

Contact ONS Research Dept., tel: 412/921-7373 ext. 280, fax: 412/921-6565.

NIH To Abolish RAC, Establish New Committee

NIH last week announced its intention to abolish the Recombinant DNA Advisory Committee (RAC) and relinquish approval responsibility for human gene transfer experiments to the Food and Drug Administration.

In a notice in the July 8 Federal Register, NIH announced its intention to propose amendments to the NIH guidelines for research involving recombinant DNA molecules.

According to the proposed amendments, NIH oversight of human gene therapy will be conducted through a new Office of Recombinant DNA Activities (ORDA) Advisory Committee (OAC), periodical Gene Therapy Policy Conferences on scientific merit and ethical issues related to gene therapy, and continuation of the NIH database of human gene transfer clinical trials.

The new advisory committee would have a standing membership of six to 10 individuals representing the scientific, legal, ethical, and public advocacy communities. According to the NIH announcement, the OAC would advise ORDA regarding relevant gene therapy issues, identify and prioritize proposed conference topics and participants, and review and analyze data submitted to the NIH gene therapy database.

The OAC would also administer, propose modifications, and promulgate amendments to the NIH Guidelines, which set forth principles, practices, and procedures under which investigators and institutions may conduct recombinant DNA research.

Gene Therapy Policy Conferences would be held three to four times a year to discuss a single topic related to scientific merit or safety of human gene therapy clinical trials, NIH said.

"These may include topics such as basic research on the use of novel gene delivery vehicles and applications to human gene therapy, novel applications of gene transfer, or relevant ethical/societal implications of a particular application of gene transfer technology," NIH said. "Although NIH will no longer be responsible for the approval of gene therapy protocols, these modifications do not preclude the use of a novel protocol as a focus for a conference discussion, i.e., a novel protocol captured by the NIH database could be added by OAC, in consultation with ORDA, to a list of potential policy conference topics."

The findings and recommendations of these conferences would be submitted to the NIH Director, FDA and the Office for Protection from Research Risks. "The NIH Director anticipates that this expanded public policy forum will serve as a model for interagency communication and collaboration, concentrated expert discussion of novel scientific issues and their potential societal implications, and enhanced opportunity for public discussion of specific issues and the potential impact of such applications on human health and the environment," NIH said.

NIH plans to continue to administer gene therapy clinical trial data management functions through ORDA and in consultation with the OAC. NIH plans to continue to capture protocol information, data (including adverse and significant clinical events), and long-term follow-up data.

Investigators would continue to be required to register human gene transfer experiments with ORDA to ensure continued public access to the comprehensive human gene transfer clinical trial database, NIH said.

NIH said written comments on the proposed changes must by August 7, 1996. Written comments should be submitted to the Office of Recombinant DNA Activities, Office of Science Policy, NIH, 6000 Executive Blvd, Suite 302, Bethesda, MD 20892-7010. Fax: 301/496-9839. Information: Debra Knorr, Office of Recombinant DNA Activities, tel: 301/496-9838.

Following is the excerpted text of the announcement:

In 1974, the National Academy of Sciences established a Committee on Recombinant DNA Molecules which was charged with examining the risks associated with recombinant DNA research and recommending specific actions or guidelines. The NAS Committee report requested: 1) that certain experiments be voluntarily deferred; 2) that plans to construct recombinants with animal DNA should be carefully weighed; 3) that the NIH Director establish a committee to oversee a program to evaluate hypothetical risks, to develop procedures to minimize the spread of recombinant DNA molecules, and to recommend guidelines to be followed by investigators; and 4) that an international meeting be convened to review progress and discuss ways to deal with potential hazards.

In that same year, the Department of Health, Education, and Welfare (currently HHS) chartered a

committee (later called RAC) in response to the NAS report. In 1975, RAC held its first meeting to establish appropriate biological and physical containment practices and procedures that were later developed into a set of guidelines for the safe conduct of recombinant DNA research. Subsequently, the NIH created ORDA to provide administrative support to the RAC.

In 1982, an examination of the broad ethical implications of human gene therapy research, The Social and Ethical Issues of Genetic Engineering with Human Beings (Splicing Life), was published by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Splicing Life proposed that, "since laboratory biohazards related to recombinant DNA research were no longer regarded as urgent matters, the NIH should extend its purview over recombinant DNA research beyond environmental issues to human gene therapy."

They recommended that the membership of the RAC should be broadened to include a combination of Federal and non-Federal scientists, lay public participants, and ethicists. In response to Splicing Life, the NIH established the RAC Human Gene Therapy Subcommittee which subsequently became RAC.

In recognition of the committee's critical role in maintaining public accountability for recombinant DNA research, the NIH Director weighed a variety of factors prior to announcing NIH's intent to change and enhance its current oversight responsibilities for recombinant DNA research.

Since its inception, NIH has continuously relinquished oversight of various elements in the field of recombinant DNA research, as such elements reached maturity. From l979-l983, several major revisions were made to the NIH Guidelines when putative risks to the public did not materialize and the initial restrictions were deemed unnecessary. In 1991, the NIH's oversight of environmental release of genetically modified organisms was relinquished and these responsibilities were ceded to the U.S. Department of Agriculture and the Environmental Protection Agency. These changes were, in part, motivated by the recognition that NIH did not have the statutory authority or the "tools" to function as a regulatory agency.

In 1995, a similar devolution of NIH oversight of human gene therapy occurred. By this time, the RAC had reviewed and approved 113 gene therapy protocols and over 1,000 patients had been enrolled in world-wide trials. The RAC, the scientific community, and the public had a substantial base of information regarding the use and safety of many of the vectors employed in, and target diseases addressed by, human gene therapy. Subsequent analyses revealed that the human health and environmental safety concerns expressed at the inception of gene therapy clinical trials had not materialized. Absent evidence for substantial safety concerns for gene therapy protocols which have been previously tested, on March 6, 1995, the RAC voted to recommend approval of amendments to the NIH Guidelines that would eliminate RAC review and approval of human gene therapy experiments not considered to be novel. Under this mechanism, all protocols determined not to represent a novel gene therapy delivery strategy or target disease that could adversely affect human health were considered exempt from RAC review and approval and were forwarded directly to the FDA.

This streamlined process, which became known as the NIH and FDA Consolidated Review, eliminated unnecessary and time consuming duplication of effort by the NIH and the FDA. On April 17, 1995, the NIH Director approved these amendments to the NIH Guidelines. Once again, the NIH relinquished a portion of its oversight of recombinant DNA research to the agency (FDA) with statutory responsibility to approve such protocols.

Since the implementation of consolidated review in July 1995, only six of the 36 protocols submitted to ORDA required RAC review and approval; and five of those six protocols were already in the system before consolidated review. The consolidated review process proved to be so successful in eliminating the need for RAC review and approval, that NIH canceled both the March and June 1996 RAC meetings due to the lack of novel protocols requiring RAC attention.

The NIH Director has concluded that the proposal to enhance NIH oversight of recombinant DNA activities is timely and appropriate based on the current base of knowledge, the need for substantial discussion of gene therapy techniques which are not yet being tested in humans, and the duplication of review and approval by the NIH while the FDA holds the statutory authority. Thus, the NIH Director proposes the termination of RAC, relinquishing of all protocol approval to the FDA and the creation of two new entities to enhance the depth and breadth of public discussion of gene therapy issues.