THE CANCER LETTER FAX

Vol. 22 No. 39
Oct. 11, 1996

Price $265 Per Year US
$285 Per Year Elsewhere

NCI, FDA Courting Drug Sponsors To Add Clinical Trials To PDQ Database

Facing pressure from Congress and cancer patient advocates, NCI and FDA are trying to convince drug companies to submit their protocols for listing on Physician Data Query, an NCI computer database.

PDQ automatically lists NCI-sponsored trials, but does not include trials funded entirely by private companies unless the protocol is submitted voluntarily to NCI. Few industry-sponsored trials are listed on PDQ, and federal officials are trying to find out why.

In a one-year pilot project, NCI and FDA will attempt to add 100 industry-sponsored breast cancer trials to PDQ. The project was funded

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In Brief

ACCC Honors Henry Lynch; Gunderson Named Chair, Mayo Oncology Department

HENRY LYNCH, professor and chairman of preventive medicine and public health, and professor of medicine at Creighton University School of Medicine in Omaha, NE, received the Association of Community Cancer Center Award for Outstanding Contributions to Clinical Research at the association's conference Sept. 18 in San Francisco. Lynch was honored for his work in establishing the hereditary basis for certain cancers and his leadership in developing the cardinal principles of cancer genetics. . . **LEONARD GUNDERSON** was named chair, Department of Oncology, Mayo Clinic, Rochester, MN. **Charles Loprinzi** was named vice-chair of the department and will continue to serve as chair of the Division of Medical Oncology. **Matthew Ames** is chair of the Division of Developmental Oncology Research. A search is continuing for a new chair for the Division of Radiation Oncology. . . . **PEARL MOORE**, executive director of the Oncology Nursing Society, received the Distinguished Merit Award of the International Society of Nurses in Cancer Care. The award honors Moore's career in oncology nursing and accomplishments on behalf of ONS. . . . **SAM DONALDSON**, co-anchor of the ABC television news program "PrimeTime Live," has been elected to the Board of Directors of Research!America, a non-profit organization that advocates for federal funding for medical research. Donaldson is working on a documentary on cancer, dealing in part with Donaldson's experience with melanoma, the organization said in a statement. The program is schedule to air in October.

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NCI, FDA Seek To Enhance PDQ Clinical Trials Listings

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through a $100,000 grant from the National Action Plan on Breast Cancer.

Though patients and their physicians currently have better access to clinical trials and treatment information than they did when PDQ was begun 13 years ago, the gap in information about industry trials is widening as drug sponsors conduct an increasing number of cancer clinical trials without NCI participation.

Patient advocates, government officials, drug sponsors, and physicians say a comprehensive database for cancer clinical trials is a good idea. However, there is little agreement about the type and the depth of information the database should contain. The question of who is best suited to provide the information is debated as well.

For NCI and FDA, the pressure to improve PDQ intensified last August when two Senators introduced a bill that would require the Public Health Service to set up a public information service listing clinical trials for all life-threatening diseases. The service would have been mandated to include privately funded trials as well as federally funded ones.

The bill, S.2024, introduced by Sens. Diane Feinstein (D-CA) and Olympia Snowe (R-ME), grew out of frustration with PDQ, said Barbara Brenner, executive director of Breast Cancer Action, a San Francisco group that that was instrumental in the development of the bill.

"When you call 1-800-4-CANCER, they only give you part of the information," Brenner said to **The Cancer Letter**. "As more and more studies are funded entirely by pharmaceutical companies, people are not able to find out what the most current trials are, which means they are not able to take advantage of the most current therapy."

Brenner said the model for the bill was legislation that created the AIDS Clinical Trials Information Service (1-800-TRIALS-A) operated by PHS. The database lists both federally and privately funded clinical trials for AIDS.

Expecting companies to list their trials voluntarily will not yield the results patients want, Brenner said. "Until the FDA requires companies as part of the approval process to list their trials, I can't imagine it will happen on a universal basis," she said.

A companion bill, H.R. 4257, was introduced in the House by Rep. Rick Lazio (R-NY). Neither bill has been approved.

PDQ contains summaries of about 1,500 cancer clinical trials and the names of physicians and hospitals involved in the trials. PDQ information is available at no charge by calling NCI's Cancer Information Service at 1-800-4-CANCER, or by fax by calling 301-402-5874. Physicians may access PDQ via computer with a PDQ access code, or through a medical library.

As of Oct. 1, PDQ clinical trials became available for the first time at no charge on the ICIC home page on the World Wide Web (http://cancernet.nci.nih.gov/trials).

Educating Companies About PDQ

The joint FDA-NCI effort to enhance PDQ grew out of discussions last year of two working groups of the National Action Plan on Breast Cancer. The idea was to create a complete list of all active clinical trials in breast cancer.

It was clear that patients needed more information about trials, and pharmaceutical companies needed more information about PDQ, said Patricia Delaney, associate director of the FDA Cancer Liaison Program, and a member of the Action Plan's clinical trials working group.

"This is part of a plan we have to educate the public about clinical trials," Delaney said to **The**

THE CANCER LETTER

Founded 1974
Member, Newsletter Publishers Assoc.

Editors: **Kirsten Boyd Goldberg, Paul Goldberg**
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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.

Cancer Letter. "According to NCI, less than 5 percent of cancer patients participate in clinical trials. As the former NCI director Vincent DeVita used to say, if we could only get 10 percent of patients involved in trials, we could get answers to studies in a year's time, rather than three or four years."

The FDA Cancer Liaison staff proposed to begin a one-year project to get companies to list their breast cancer trials. FDA's role is to seek out companies and survey them to find out why they may be reluctant to submit protocols.

NCI's role in the project is to process the protocols for listing on PDQ. The grant funds pay for the data processing, which costs $1,000 per protocol.

To launch the project, last December FDA held a meeting of 45 representatives from pharmaceutical and biotechnology companies, FDA and NCI officials, and patient advocates. Terry Toigo, FDA associate commissioner for AIDS and special health issues, discussed the ACTIS database, and Susan Hubbard, director of the NCI International Cancer Information Center, gave a demonstration of PDQ.

After the meeting, companies submitted about six protocols to PDQ.

Next, NCI and FDA mailed a letter to 140 individuals at companies conducting studies of cancer therapies.

"We would like to include your company's active cancer research studies in NCI's PDQ database," said the July 1 letter, signed by Michael Friedman, FDA deputy commissioner for operations, and NCI Director Richard Klausner.

"The Cancer Information Service responds to 600,000 requests per year from patients and the public for cancer information," the letter said. "The PDQ Search Service conducts hundreds of clinical trials searches each month for physicians looking for treatment options for their patients. If your studies are included in the database, patients will have better access to your study and you will have more access to potential subjects."

PDQ received 12 protocol submissions from nine companies in response to the letter.

This underwhelming response has prompted FDA and NCI to conduct a survey of companies to learn the reasons for their reluctance to submit protocols to PDQ.

"We didn't get a fantastic response," NCI's Hubbard said. "But the survey will give us for the first time some hard data on why companies don't submit protocols to PDQ."

NCI would like more than industry-sponsored breast cancer protocols, Hubbard said. "When FDA came to us with this idea, we decided to use this as a stalking horse to let companies know we are interested in all protocols," she said. "I'm enthusiastic about the project. It could give us a lot of information about why they don't choose to submit data to any clinical trials database."

It was natural for FDA to act as the go-between for NCI and drug sponsors, Hubbard said. "FDA has an ongoing relationship with companies," she said. "What we're doing is working with FDA to help us get the information. If there are things we can do to make it easier for companies to work with us, we will do it."

NCI's budget for PDQ has been about $2 million a year over the past four or five years, Hubbard said. Twelve editorial boards review the materials posted on the database.

Views From Industry

FDA and NCI officials said the industry's attitude toward PDQ has been hard to gauge.

"There have been a lot of hypotheses," Hubbard said. "There are comments that PDQ is not user-friendly, that drug companies don't see any benefit to them of listing trials."

The one question raised regularly by industry officials is whether it is necessary for the PDQ Editorial Board to review protocols that have been reviewed and approved by FDA, Delaney said.

The PDQ review, approval and entry of a protocol into the database takes about two to three months. "We will help companies do anything we need to do, including changing anything that needs to be changed, to get their trial listed," Delaney said. "We're serious about this."

John Hohneker, US director of oncology clinical research for Glaxo-Wellcome Inc., said that after attending the FDA meeting, he was interested in talking further with FDA about PDQ.

"We support efforts to enhance patient access to clinical trials, including PDQ," Hohneker said. "However, those programs have to be designed to balance patient access with our need to maintain proprietary information.

"We support the availability of protocol names, descriptions, site locations, eligibility criteria, and a

contact person and phone number for enrollment," he said.

The PDQ review process may not be fast enough for some of the company's trials, Hohneker said. "Some phase I or phase II trials open and close so quickly that even a three-month delay to get on PDQ would cut into the usefulness of the listing for patients," he said. "It may be more useful for randomized trials in which large numbers of patients are required."

Another concern is the confidentiality of proprietary information, Hohneker said. "The issue is sometimes trial design or innovative approaches to statistical analysis," he said. "Or specifics on the molecule, or formulations. Those are intellectual properties that distinguish us."

Douglas Jones, Glaxo associate director of regulatory affairs, said company officials are preparing a policy statement on working with national registries of clinical trials. "We are interested in providing the appropriate information and working with FDA," Jones said. "We are also meeting internally because of the requests of patient groups. Each patient group has its own interest in information, and we want to work with them."

Glaxo officials declined to comment on the Snowe-Feinstein legislation.

The pharmaceutical industry trade association, PHARMA, has not taken a position on the Snowe-Feinstein bill, said John Siegfried, deputy vice president for regulatory and scientific affairs.

"There's a lot of discussion going on," said Siegfried, who attended the FDA meeting on PDQ last December. "There are about three concerns from the pharmaceutical industry:

—"First, if you do it for AIDS and cancer, then should you add Alzheimer's and heart disease, and then, should you do all clinical trials?

—"Second, companies are reluctant to put all that information on the Internet, telling their competitors who their investigators are and in what direction their research is headed.

—"Third, the concern is that this could move beyond a registry of the names of trials, to how many people were in the studies, why did they drop out, what were the adverse reactions. It would be a rolling picture of what your clinical trial is doing. From a company point of view, it would be detrimental."

"It's hard to argue against motherhood and apple pie, but not all mothers are good and not all apple pies are tasty," Siegfried said.

However, the FDA-NCI effort to enhance PDQ is modeled on the ACTIS database for AIDS, which emphasizes the listing of late phase II and phase III studies, Siegfried said. That minimizes concerns about confidentiality.

"By the time you get to that stage, your work is getting publicized," he said.

ACTIS has not presented problems for companies, Siegfried said. "The caveat is that AIDS and cancer are unique," he said.

Glaxo official Hohneker said he was not concerned about the issue of keeping lists of investigators confidential. "Our competitors can talk to an investigator and find out whether they are doing our study or not," Hohneker said. "That's not a major issue."

PDQ Doesn't Live Up To Potential

PDQ needs more than the addition of industry-sponsored studies, several patient advocates said.

The 13-year-old database needs to be expanded and overhauled to make it easier to use, said Brenner of Breast Cancer Action. "PDQ is insufficient," she said. "It's insufficient to tell patients, 'Here are the trials, talk to your doctor.' Doctors are as uninformed as the rest of us."

The database should list emerging treatments, including negative results, Brenner said.

"PDQ gives you the most recent results from research, but it doesn't tell you about pending research," she said. "For a lot of people, by the time they turn to PDQ, the existing treatments have already failed them."

PDQ falls far below its potential, said Kay Dickersin, co-chair of the Action Plan's clinical trials working group, a member of the National Cancer Advisory Board, and a associate professor of epidemiology and preventive medicine at University of Maryland School of Medicine.

"PDQ could be this incredibly rich resource that serves as a model," Dickersin said. "A registry of all trials is desperately needed."

The Snowe-Feinstein legislation is a good step, but the bill as written has several problems, Dickersin said. "I just don't know how to define a life-threatening disease," she said. "What about a woman with breast cancer who is concerned about weight gain while taking chemotherapy? She might want information about protocols for nutrition. And what

about prevention trials?"

An alternative would be to require Institutional Review Boards to register all clinical trials, Dickersin said. "Trial registration is important, not simply to accrue people to trials, but for the ethics," she said. "Patients are told they are helping all of science by participating, but if scientists are not publishing their results, they are violating that trust."

Studies have found that trials with positive results are published about three times more often than trials that had negative results, Dickersin said.

A Competing Registry?

The limitations of PDQ prompted the National Breast Cancer Coalition to begin a national project to build its own registry of breast cancer trials, said Fran Visco, NBCC president.

"PDQ is not user-friendly, and it is not a complete listing," Visco said to **The Cancer Letter**. "We want to train our local member organizations so they look at clinical trials as a research issue, not solely as providing care to an individual."

NBCC plans to help its members establish local registries of clinical trials and investigators. "We want NBCC members to be involved with industry and investigators to help accrue the trials," Visco said. "It's not an issue of competition [with PDQ]. It's an issue of getting the trials accrued and finding the answers."

NBCC has raised about half the funding for the database, has hired staff and is forming an advisory committee, Visco said.

Visco declined to disclose the estimated cost of the project.

NCI Promises A More User-Friendly PDQ

NCI official Hubbard agrees that PDQ needs to become more user-friendly.

Working with the National Alliance of Breast Cancer Organizations, the Institute is writing new, "easy-to-read," 10-line summaries of 150 PDQ protocols for breast cancer. These will be listed in PDQ and on the NABCO Web site (http://www.nabco.org).

After the breast cancer protocol summaries are done, NCI plans to write summaries for all PDQ protocols, including those submitted by industry, Hubbard said. The project is expected to be completed by next spring.

"We want advocates to look at these and tell us what they think, so we can make any refinements," Hubbard said. "Then we will make these summaries available to any patient group for posting on their own Web sites."

Every protocol summary has a hypertext link back to PDQ, enabling anyone interested in a protocol to read or print out the longer text.

The new summaries include a glossary, Amy Langer, executive director of NABCO, said to **The Cancer Letter**. Medical terms and names of drugs are underlined. When a user clicks on the unfamiliar word, a definition pops up on the screen.

"Unlike PDQ, it does not involve plowing through endless information," Langer said. "PDQ is so complete that it is difficult to read and understand."

Langer said she has heard oncologists say that patients sometimes bring them 30 to 40- page printouts from PDQ. This amount of paper is discouraging for patients and physicians, she said. "If you don't overwhelm people with information about trials, they may proceed step-wise to learn about them, and eventually enter a trial," Langer said.

"We have an extremely low percentage of patients on trials," Langer said. "We need a way for treatment information to become automatically provided to patients with a diagnosis of cancer."

Richard Bloch's Dream

From the outset, PDQ was intended to be used by patients as well as physicians, said Richard Bloch, former member of the National Cancer Advisory Board.

Bloch, the "R" of the H & R Block income tax preparation service, said he had brought the idea for the database to then-NCI Director Vincent DeVita in 1982. Though NCI had been working on a similar database, Bloch's vision and his advocacy gave the project the boost it needed, Hubbard said.

For Bloch, PDQ wasn't a mere database, but a means for empowering patients to play a role in their care. Earlier, Bloch, who had a highly treatable form of lung cancer, was told that he had no chance of long-term survival.

Convinced that his experience was not atypical, Bloch decided he would help other survivors obtain information about treatments and clinical trials.

"My goal was to open PDQ to patients, to make patients aware of it, so they would take the information to their physicians," Bloch said to **The Cancer Letter**. Bloch heads the Bloch Cancer

Foundation, a Kansas City, MO, based not-for-profit organization that provides information for cancer patients.

"The good physician gets the information, no question," Bloch said. "Really good physicians know they don't know everything. But I'm not worried about them. I'm worried about the Americans who don't go to top doctors."

"We know that many people are dying though they do not have to, because their physician is unaware of what is available," he said.

Originally called "Protocol Data Query," the database was intended to convert an existing NCI database called CLINPROT to "a system more easily available to physicians, patients and anyone else with access to a home or office computer," **The Cancer Letter** reported on Feb. 12, 1982.

First, NCI needed more office space for the International Cancer Information Center, which would operate PDQ. Bloch and his wife Annette donated the major portion of the $1.4 million purchase price for a building across the street from the NIH campus (**The Cancer Letter**, Dec. 10, 1982).

As PDQ went on-line in 1983, NCAB debated whether the database should include the names of members of professional oncology societies.

Some NCAB members feared this would encourage "self-referrals," a practice then discouraged by the medical establishment. Bloch and the proponents of the lists prevailed in that dispute (**The Cancer Letter**, Oct. 7, 1983).

Another battle ensued over whether patients should have access to the "second-generation" PDQ, sometimes called PDQ-II. The NCAB decided the system would be restricted to physicians.

Sometime between 1983 and 1984, NCI changed "Protocol Data Query" to "Physician Data Query."

"The basis of that decision was that doctors were unwilling to share medical information with patients," said Helene Brown, director, Community Applications of Research, Jonsson Comprehensive Cancer Center at University of California, Los Angeles, who served on the NCAB at the time. "It's a different world now. Patients can work with their doctors if they want to."

In February 1984, Bloch commended NCI for making the information available to physicians. However, a certain disappointment came through in his remarks to NCAB:

"PDQ II is excellent. It contains a wealth of knowledge, written in understandable language, catalogued, referenced and cross-referenced magnificently. The material is in the computer to help physicians world wide give their patients the best chance of beating or controlling cancer. And that's what it is all about.

"To say PDQ is not what I dreamed it would be is only a matter of personal taste or opinion," Bloch said to the board. "It would be pointless to debate it.

"I have certain fears as to whether it is friendly enough to not frighten off some unsophisticated physicians." (**The Cancer Letter**, Feb. 17, 1984)

NCI had difficulties in striking deals with companies that wanted to make PDQ available online. Companies would have to ensure that non-physicians could not get access to the database.

Compuserve, then owned by H & R Block, wanted to distribute PDQ as a public service. To pave the road for that deal, Bloch retired from the company and sold his shares of stock, he said. "[After the sale] no one could say I was promoting PDQ for my personal benefit," Bloch said (**The Cancer Letter**, Dec. 7, 1984).

However, Compuserve and several other vendors lost interest when it became clear that NCI would not allow the firms to provide the database to non-physicians, Bloch said.

After another year of debate, NCAB's Committee on Information, which Bloch chaired, recommended that NCI make PDQ available to patients at the request of their physicians. The committee said patients should be encouraged to request PDQ statements through the Cancer Information Service (**The Cancer Letter**, Jan. 11, 1985).

Finally, in 1986, the NCAB voted to remove its restrictions on the promotion of PDQ, allowing NCI staff to decide who would have access and how to publicize the system (**The Cancer Letter**, Feb. 7, 1986).

"PDQ has not had nearly enough promotion," Bloch said to **The Cancer Letter** earlier this week. "PDQ should be nearly mandatory for every newly diagnosed cancer patient. That would take a tremendous amount of publicity. I don't think NCI has the resources to do that."

"For the doctor, there is not a downside to getting a PDQ statement, other than spending a few minutes of his time," Bloch said. "That's why PDQ should be condensed."

Bloch said he prefers to use Oncolink, an online

service provided by the University of Pennsylvania. "Oncolink has taken PDQ and made it user-friendly," Bloch said. "You can download two or three pages, and the list of references are at the end of the text, rather than in between each statement."

As for the FDA and NCI initiative to increase the PDQ listings of industry-sponsored studies, Bloch said he was surprised to learn that some companies might be hesitant to list their trials on PDQ.

"I don't know anyone in this field who isn't interested in helping human beings," Bloch said.

"If a company were talked to properly, I would think they would be totally in favor of sharing the knowledge."

Professional Societies

Three Groups To File Brief In Bernard Fisher's Appeal

Three professional associations received permission from a federal judge to introduce a friend-of-the-court brief in the case of the cancer researcher Bernard Fisher.

Fisher's suit, now in the US Court of Appeals for the District of Columbia, claims that the NIH had violated the scientist's rights under the Privacy Act when it altered the government-run databases to state that Fisher's work may have been affected by scientific misconduct. Fisher was never found to have committed scientific misconduct.

Fisher is appealing a decision of a lower court, which ruled for the NIH (**The Cancer Letter**, July 5).

The societies that filed a motion in support of Fisher include the American Society for Microbiology, the Federation of American Societies for Experimental Biology, and the National Asssociation of State Universities and Land Grant Colleges.

The three societies obtained the court's approval to participate as *amici curiae* in the Fisher case.

In court documents, the societies said their individual members and member institutions would be directly affected by the court's resolution of Fisher case.

"The vast majority of the individual members, as research scientists, have their records in the Medline or Cancerlit databases," the three societies said in a motion. Medline and Cancerlit, both run by NIH, are the databases central to the case.

"Many of the institutional members lease Medline and Cancerlit databases. As such, the institutional members have an abiding interest in the accuracy of the Medline entries," the societies said.

Also, the societies said they could provide the court "an analysis of the research process and how the research community views and uses Medline and Cancerlit entries, and the impact that government annotations can have on the credibility of those databases."

Attorneys for NIH filed a motion in opposition to the introduction of the brief by the societies.

NCI News

NCI Seeks Partners To Develop Public Education Programs

The NCI Office of Cancer Communications is seeking partnerships with non-federal organizations to conduct public awareness programs on cancer research, patient education, clinical trials, screening, prevention, genetics education, and cancer risk communication.

According to a notice in the Sept. 26 Federal Register, partnerships with private sector organizations are intended to "bring the resources of several partners to bear on cancer-related problems that are too complex or massive for any one organization to handle alone."

The partnerships will not involve grants or contracts, but will be formalized through Memorandum of Agreements, the notice said.

NCI Director Richard Klausner asked OCC to increase the number of partnerships with voluntary and private organizations, John Burklow, special assistant in the OCC, said to **The Cancer Letter**.

NCI has worked with other organizations to put together educational efforts such as the U.S. Postal Service's Breast Cancer Awareness Stamp, and has helped forge partnerships between patient advocacy groups and private companies to produce patient education programs, Burklow said.

"We hope to really step up our partnership efforts and focus on clinical trials education, patient education, genetics education, and science awareness," Burklow said. "This notice formalizes the process and lets people know we are interested in working with them."

OCC is working with the prostate cancer patient

group US TOO to develop a prostate cancer education program, as well as with the National Coalition on Cancer Survivorship on survivorship issues, Burklow said.

"Our role in part is linking groups who need to work together, providing content, and helping people reach their audiences through community outreach," Burklow said. "We also are planning to work more closely with the cancer centers."

For more information, contact John Burklow, NCI Office of Cancer Communications, tel: 301-496-6631.

Letter to the Editors

In Warm Glow Of The Increase, Keep Up Advocacy For NIH

To The Editors:

The most recent issue of **The Cancer Letter** (Oct. 4) was appropriately celebratory with regard to the 6.9 percent increase which the Omnibus Appropriations Bill provided for NIH. While the medical and cancer research community invest these resources in many worthy and pressing scientific endeavors, we must not lose sight of the fact that support for NIH as a national priority was not accidental; nor should it be taken for granted.

The NIH has enjoyed a strong bipartisan support from many influential members of Congress. Over the years, the mantel of Congressional leadership for the NIH has been worn with great care and respect by elected officials who believe passionately in the humanitarian and economic contributions NIH has made to our nation: Lister Hill, Silvio Conte, Warren Magnuson, Mark Hatfield, Bill Natcher, Tom Harkin, John Porter, Arlen Specter, as well as others. This support has been carefully nurtured by many: researchers on the front lines of discovery; advocates who have benefited from the progress realized through medical research; industrial partners in the process of discovery; and incredible individuals who make pilgrimages to Congressional offices because their only hope for a brighter tomorrow is a cure through medical research.

Can we now return to business as usual? No. It is vital that in the glow of the past several years—a time when NIH has enjoyed funding increases envied by other science agencies—that we not lose our enthusiasm for, nor diminish our commitment to, advocating for NIH. In fact, a vigilant guard is imperative for several reasons:

1. Congressional champions cannot do it alone. We must be diligent in broadening the base of Congressional support for, as well as understanding of, the important contributions of medical and cancer research. Altogether, 535 Members of Congress vote on funding for NIH and NCI. We must be sure that the majority support our Congressional champions in making NIH an exceptional national priority.

2. Tightening federal resources. If budget targets previously agreed to are used as the course to guide fiscal solvency, domestic discretionary programs will decrease from 18 percent of the overall federal budget to 13 percent of the overall budget by the year 2002. In other words, reductions of approximately 10 percent in real (not adjusted for inflation) dollars from 1996 levels will be required. This will create an environment of unprecedented competition in the allocation of federal resources for non-defense discretionary programs.

3. Competition among domestic discretionary spending programs. The Public Health Service is now 66.5 percent of the discretionary spending account in the Labor-HHS Appropriations Bill. The NIH comprises 42 percent of the Public Health Service budget. In fact, NIH is the single largest discretionary account in the entire Labor-HHS appropriations bill.

Right now, if the addage "follow up is the chariot of genius" is to be believed, the current Members of Congress should be innundated with expressions of thanks. Let Congress know that their support for the NIH was noticed, appreciated, and that the resources allocated to NCI will be effectively used in addressing a catastrophic disease.

On the first Tuesday in November, a new Congress will be elected. On the second Tuesday in November, we should turn our attention toward educating the newly elected 105th Congress on the humanitarian and economic contributions of medical research and cancer research.

Before the 105th Congress takes office in January 1997, we ought to be sure that we have swelled the ranks of Congressional champions for the NIH and the NCI. Given the long term budget outlook, this will be a vital step if we are to maintain a stable and predictable funding base for the NIH.

Marguerite Donoghue
Deputy Executive Director
National Coalition for Cancer Research