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President, Congress Decry Practice Of "Drive-Through Mastectomies"

"Drive-through mastectomies" have become one of America's more visible political issues in recent weeks.

President Clinton mentioned the practice in his State of the Union address. First Lady Hillary Rodham Clinton urged the passage of a bill that would ban third-party payers from insisting on outpatient mastectomies.

Altogether, three House bills and two Senate bills addressing the issue have been introduced.

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In Brief

FDA Commissioner Kessler Named Dean, Yale Medical School, Effective July 1

DAVID KESSLER, FDA commissioner, will become dean of the Yale University School of Medicine effective July 1. Kessler succeeds **Gerard Burrow**, dean since 1992. Burrow will return to the faculty and will serve as special adviser for health affairs to Yale President **Richard Levin**. Kessler announced last November that he would leave FDA after serving six years under Presidents Bush and Clinton (**The Cancer Letter**, Nov. 29). Kessler, a graduate of Harvard Medical School, University of Chicago Law School and Amherst College, was medical director of the Hospital of the Albert Einstein College of Medicine from 1984 until 1990. He also was affiliated with the Julius Silver Program in Law, Science and Technology at the Columbia University School of Law, where he taught food and drug law. From 1982 to 1984, he was special assistant to the president of Montefiore Medical Center, and served as a consultant to the Senate Committee on Labor and Human Resources. "This is a time of enormous opportunity for biomedical science and medical education, and Dr. Kessler has the intelligence, energy and vision to enhance the quality of Yale's distinguished Medical School and to help it establish a new standard for excellence in education, research, and patient care," Levin said. Yale ranks fourth among American medical schools in research dollars granted by NIH and has an annual research budget of more than $200 million and a staff of 4,000, the university said in a statement. . . . **NIH CONSENSUS PANEL** has endorsed the use of behavioral intervention programs including needle exchange, drug abuse

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"Drive Through" Mastectomies Become Washington Issue

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At the same time, HHS, instructed all HMOs involved in the Medicare program that the department would not tolerate requirements for outpatient breast cancer surgeries.

An argument can be made that drive-through mastectomies are a perfect Washington issue:

1. Clearly, a sufficient number of these procedures have been performed to yield witnesses for White House appearances and imminent Congressional hearings;

2. No one in their right mind will defend forcing women to undergo the ordeal of being sent home involuntarily following painful surgery.

While Congress is eager to get involved, many observers wonder whether it is useful to aim legislation at a single procedure rather than the broader problem of the erosion of a physician's and patient's ability to decide the course of care.

Anecdotal evidence suggests that surgeons are being pressured by third-party payers to discharge patients within 23 hours following radical and modified radical mastectomies.

Similarly, patients are often threatened with having to come up with sizable co-payments if they are admitted.

"The system puts the onus on the physician as the intermediary," said Kirby Bland, chief of surgery at Brown University and president of the Society of Surgical Oncology.

Bland said his decisions to admit mastectomy patients for more than 23 hours are challenged by insurers in about one out of three cases. "I have never been turned down once I've explained what I have to do," Bland said to **The Cancer Letter.**

However, Bland said, many of his colleagues have been turned down by insurers.

Hospitalization for radical and modified radical mastectomies should be at least 48 hours in order to control the pain and to observe the drainage, Bland said.

"There is no way other than IV narcotics to control the early pain of a mastectomy, unless the patient very stoically toughs is out and lives in misery for a while," said Bland.

Bland said he would support legislative action that would dictate the minimum length of hospital stay for mastectomies. "If it's going to take some kind of legislation to make insurance companies abide by what's best for the care of the patient, that's what it will take," he said.

Norman Wolmark, chairman of the National Surgical Adjuvant Breast & Bowel Project, said addressing the issue of drive-through mastectomies could give the legislators the opportunity to address broader problems.

"If they want to legislate, they should legislate a broad-based policy that is not oriented to a specific procedure," said Wolmark, professor of surgery and chairman of the department of human oncology at the Allegheny University of the Health Sciences.

"I can assure you that there are equally inappropriate demands being put on surgeons in connection with other procedures," Wolmark said. "The legislation I would like to see would mandate that the patients are treated in accordance with the best judgment of the surgeon and in the interests of the patient, regardless of what procedure is performed."

Uncertain Number of Outpatient Procedures

It is unclear how many outpatient mastectomies are performed in the US. It is even less clear how many of these procedures are performed despite objections by patients and physicians.

According to a study commissioned by the American Association of Health Plans, a managed

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care trade group, 8 percent of radical and modified radical mastectomies were performed on the outpatient basis in 1993 and 1994.

Also, 19 percent of simple mastectomies and 20 percent of partial mastectomies with lymphadenectomy were performed on the outpatient basis.

The figures, compiled by the Medstat Group of Ann Arbor, MI, indicate that patients would be as likely to have an outpatient procedure whether they were enrolled in an HMO, a PPO or an indemnity plan.

The estimates were based on an analysis of claims generated by 7 million privately insured individuals nationwide, and excluded Medicare, Medicaid and Workers Compensation data.

Is Managed Care the Culprit?

At least at this stage, managed care companies have been the target of rhetoric in debates of the issue.

Last week, in a letter to 350 managed care plans involved in the Medicare program, HHS Secretary Donna Shalala banned requirements for outpatient surgery or limitation on hospital stays for breast cancer surgery.

Shalala described the action as an "immediate first step to ensure that women are not sent home prematurely following a mastectomy."

The letter, dated Feb. 12, did not mandate a minimum length of stay for Medicare patients.

"The decision about appropriate length of stay following surgical treatment for breast cancer should be made by a woman and her doctor," Shalala said in a statement.

"We are telling managed care plans that they *may not impose sweeping, generalized* policies that might endanger a woman's health," she said.

Medicare paid for more than 84,000 mastectomies last year, about a third of all mastectomies performed in the US.

Responding to Shalala's letter, the American Association of Health Plans said fee-for-service Medicare patients are more likely to be pressured to undergo an outpatient mastectomy than their counterparts in a managed care Medicare plan.

The statement by Karen Ignagni, AAHP president and CEO, cited the statistics collected by the New York State Department of Health.

According to New York officials, in 1995, 72 women had undergone outpatient mastectomies in fee-for-service Medicare programs. At the same time, only two Medicare patients enrolled in HMOs had undergone the procedure as outpatients.

AAHP, a group that represents over 1,000 HMOs and PPOs, has been preparing to confront the political firestorm over outpatient mastectomies since last year.

On Nov. 14, 1996, the group's board of directors issued a statement opposing mandatory outpatient mastectomies:

"It is the policy of AAHP that the decision about whether outpatient or inpatient care best meets the needs of a woman undergoing removal of a breast should be made by the woman's physician after consultation with the patient. Health plans do not and should not require outpatient care for removal of a breast. As a matter of practice, physicians should make all medical treatment decisions based on the best available scientific information and the unique characteristics of each patient."

On the same day the American Cancer Society issued a similar statement:

"ACS commends AAHP and its members for its taking a stand on mandatory length of stay for mastectomy patients. ACS believes that treatment decisions for women with breast cancer should be made by the physician in consultation with the patient, based on what is medically appropriate. As long as the physician determines that there are no complications following surgery, there is sufficient support in the home, and it is the desire of the patient to be released, then outpatient surgery is appropriate.

"It is the position of ACS that the quality of care is of utmost importance when the lives of cancer patients are at stake."

The Quality of HMOs

Policy statements notwithstanding, women are being routinely pressured to undergo outpatient mastectomies.

Some attribute this to failure by physicians to advocate effectively for their patients, failure by the patients to challenge the dictates of their insurers, or failure by the health plans to abide by the pronouncements by the board of directors of AAHP.

It is likely that the problems raised by outpatient mastectomies also include the wide variation in quality of cancer care offered in the US.

Even in the case of managed care companies,

standards of care are far from uniform.

Only 270 HMOs, fewer than half of the 630 such plans operating in the US, have gone through the voluntary accreditation process offered by the Washington-based National Commission on Quality Assurance. Moreover, only nine states require accreditation for HMOs.

In the case of NCQA, a company's insistence on outpatient mastectomies would certainly be a barrier to certification, said Barry Scholl, a spokesman for the group.

"For NCQA, the key question is whether physicians and patients are making decisions that are appropriate for a specific clinical situation," Scholl said. "It is very likely that a health plan that is willing to override the opinion of a surgeon who is caring for a woman who has had a mastectomy would have other issues that would become apparent in an accreditation survey.

"An issue like that would not exist in a vacuum," Scholl said.

Five Bills In Congress

A list of bills addressing mastectomy issues follows:

- "Breast Cancer Patient Protection Act." (HR 135). Sponsored by Rep. Rosa DeLauro (D-CN), and referred to the Subcommittee on Health and Environment. A corresponding bill in the Senate (S143) was introduced by Sen. Ton Daschle (D-SD) and referred to the Committee on Labor and Human Resources.
- "Reconstructive Breast Surgery Benefits Act." (HR 164). Sponsored by Anna Eshoo and referred to the Subcommittee on Health and Environment.
- A bill to require health plans to provide coverage for a minimum hospital stay for mastectomies and lymph node dissection and coverage for reconstructive surgery and secondary consultations. (HR 616). Sponsored by Rep. Susan Molinari (R-NY), and referred to the committees on Commerce, Ways and Means, and Education and the Workforce. The committees are expected to determine the issues of jurisdiction.
- "Women's Health and Cancer Rights Act." (S249). Sponsored by Sen. Alfonse D'Amato (R-NY) and referred to the Committee on Finance.

In Brief

Consensus Panel Endorses HIV Prevention Programs

(Continued from page 1)

treatment and youth education on safer sex as a step in reducing new HIV infection in the US. The panel urged government leaders to make policy changes to encourage these proven public health strategies. The NIH Consensus Statement on Interventions to Prevent HIV Risk Behaviors is available by calling 888/644-2667 or from the web site: http://consensus.nih.gov. . . . **JULIO GARCIA-AGUILAR** joined University of Minnesota Cancer Center to develop a colorectal cancer research program combining basic science and clinical research. He completed residency in colon and rectal surgery at University of Minnesota and served as associate professor of surgery at University Hospital-San Carlos in Madrid, Spain. . . . **SMITA BHATIA** joined City of Hope National Medical Center and Beckman Research Institute, Duarte, CA, as a pediatric hematologist/oncologist. Bhatia is funded to conduct two studies on the development of breast cancer following Hodgkin's disease. She completed a postdoctoral fellowship at University of Minnesota. . . . **MEG SNYDER**, a staff member of the Senate Labor, HHS and Education Appropriations Subcommittee for the past five years, has joined Capitol Associates Inc., a government relations firm based in Washington, DC. . . . **THAILAND'S GOVERNMENT** honored three American scientists with Gold Medals of Merit in Science. The medals were presented Dec. 2 to **Frederick Becker**, vice president for research at the University of Texas M.D. Anderson Cancer Center, NCI Director **Richard Klausner**, *and* ***David Baltimore***, the Ivan R. Cottrell Professor of Molecular Biology and Immunology at Massachusetts Institute of Technology. Becker was chairman for the Second Princess Chulabhorn Distinguished Lectures Symposium, held to recognize the 50-year reign of Thailand's King Bhumibol Adulyadej. Becker received a similar award last year from Princess Chulabhorn, who has a Ph.D. in organic chemistry. They have worked together to promote the advancement of science in Thailand. . . . **ROBERT CHAMBERLAIN**, deputy chairman of the Department of Epidemiology, M.D. Anderson Cancer Center, received the 1996 Julie

and Ben Rogers Award for Excellence, presented annually to an M.D. Anderson staff member by Board of Visitors member Regina Rogers. . . .

CORRECTION: In the story on the Senate mammography hearing in the Feb. 14 issue of **The Cancer Letter**, the word "defensible" was mistyped as "defensive" in a comment by NCI Director Richard Klausner. The quote, on page 3, should have read as follows: "I felt the conclusion was very defensible, that women need to be informed to make a decision."

FDA News

Rule On Youth Tobacco Sales Goes Into Effect Feb. 28

FDA has begun a nationwide outreach effort to inform retailers, parents and community leaders about the provisions of the agency's rule to protect children from tobacco products.

The first provisions of the rule—making 18 the age for the purchase of tobacco products nationwide and requiring photo IDs for anyone under 27—become effective on Feb. 28.

The FDA is holding 10 regional outreach meetings around the country and one national televised outreach meeting, and has mailed to more than 400,000 retailers information about the provisions of the new FDA rule.

In addition, informational brochures for retailers and consumers will be distributed nationwide, and a toll-free telephone number (1-888-FDA-4KIDS) has been established for retailers to obtain further information.

FDA will enforce the new rule by working with state and local officials in conducting spot checks *of retail outlets. The nationwide toll-free telephone* number has also been designed so that anyone can report potential violations. Retailers can be subject to penalties of $250 or more for selling tobacco products to minors.

"We are going to work with store owners to make sure they understand their responsibility not to sell tobacco products to anyone under 18," said HHS Secretary Donna Shalala. "Our kids deserve a life free from the deadly disease that comes with using tobacco."

Nearly 3,000 young people become regular smokers each day, and nearly 1,000 of them will die early from their use of tobacco products, FDA said.

Professional Issues

AMA Identifies Mutual Funds For Tobacco-Free Investing

The American Medical Association has begun a coalition of mutual funds that have pledged not to invest in 17 identified tobacco stocks.

The AMA's Coalition for Tobacco-free Investments is a group of 53 US mutual funds that do not hold tobacco investments and have pledged not to purchase tobacco stocks and bonds in the future. Its membership includes Stein Roe's Young Investor Fund, as well as institutional investors such as the American Hospital Association Investment Program.

In April 1996, the AMA called tobacco a "ruinous and enslaving product that has brought misery, disease, anguish and death," and urged investors to divest of tobacco stocks and 1,474 mutual funds identified as invested in the manufacture or processing of tobacco products or tobacco companies. Since then, the AMA has invited all mutual funds traded in the US to join the AMA's coalition by making the tobacco-free pledge.

Members of the coalition are authorized to use the "AMA Coalition for Tobacco-free Investments" logo and will have their names published annually in AMA publications and on the association's World Wide Web site.

Tobacco Stocks Banned By AMA

The AMA list of tobacco stocks is derived from a universe of tobacco equities tracked by the Investor Responsibility Research Group, a non-profit research firm based in Washington, DC. The firm identified 17 tobacco manufacturers traded in the US exchanges: American Brands; B.A.T Industries PLC; Brooke Group Ltd.; Caribbean Cigar Corp.; Consolidated Cigar; Culbro Corp.; DiMon, Inc.; Empresas La Moderna; Loews; Mafco Consolidated Group, Inc.; Philip Morris Cos., Inc.; RJR Nabisco Holding Corp.; Sara Lee Corp.; Schweitzer-Mau dit Intl.; Standard Commercial Corp.; UST, Inc.; Universal Corp.

AMA's call for divestment of tobacco stocks and mutual funds follows its decision in 1986 to divest tobacco stocks in the AMA's portfolio.

Other public health organizations that divested during the 1980's included the American Heart Association, American Lung Association and the

American Cancer Society.

Since the AMA's latest call in April, more attention has focused on tobacco investments. The Massachusetts House of Representatives approved divestment legislation for the state employees' $17 billion Public Retirement Investment Trust. Also, the $55 billion New York State Teachers' Retirement System sold nearly $100 million of tobacco stocks to "underweight" its financial exposure. Other pension funds, including the $45 billion New York City Employees' Retirement System, are reviewing their tobacco stock holdings now.

"We appear to be entering a third phase of tobacco divestment activity," said Doug Cogan of the IRRC. "Public health associations like the AMA were among the first to shun tobacco investments in the 1980s, followed by some large universities with medical schools in the early 1990s.

"Now that attention is turning to mutual funds and pension fund investments in tobacco, the equity capital at stake is greater than ever," Cogan said.

Information on the AMA Coalition for Tobacco-free Investments is available from the AMA homepage at: http://www.ama-assn.org.

Young Molecular Biologists "Optimistic," Survey Finds

Despite earning half the national average for their age group, fighting to capture shrinking government research dollars, and waging an uphill battle to gain public recognition for their contributions, young molecular biologists are surprisingly satisfied with their career choice and optimistic about the prospect of advancing medical science, according to a national Roper survey.

In addition to career satisfaction, a significant number of the 300 molecular biologists between the ages of 18-32 surveyed predict that future scientific breakthroughs will yield cures for AIDS and cancer and guide effective gene therapy.

The survey, conducted on behalf of Pharmacia Biotech, co-sponsor of the Pharmacia Biotech and Science Prize for Young Scientists program, was released at the released at the annual meeting of the American Association for the Advancement of Science in Seattle Feb. 14.

Satisfied With Profession

Nearly all (91%) of the young molecular biologists surveyed said they were "satisfied" with their career choice. More than half (53%) indicated they were "very satisfied" with their profession.

The survey found that satisfaction remains high in spite of pessimism concerning the field in general. For example, more than half the respondents (56%) believe that the "overall state of affairs"—including funding, governmental politics, research trends—makes working as a molecular biologist "more difficult" than 10 to 20 years ago.

In addition, 73% of young molecular biologists surveyed believe the public does not appreciate the value of their research. In fact, 15% believe the "public does not understand the value of molecular biology at all." The media received only lukewarm praise in their coverage of advances in molecular biology research: nearly 40% said the media are "somewhat or completely inaccurate" in their reporting.

"There is bad and good news here: the bad news is that the students do not feel valued by the public and do not feel their work is understood, and they are not hopeful about their future funding prospects," said Shirley Malcom, head of the AAAS Directorate for Education and Human Resources Programs. "The good news for society is that they are still willing to invest many years of education, hard work and forgone wages to make discoveries today that will change the future of medicine."

The survey also found that molecular biology is not the road to wealth. While the average annual salary for this age group (18-32) according to Roper Starch Worldwide is $34,400, only 1 in 10 molecular biologists surveyed earn $35,000 or more. On average, the annual salary reported by respondents was nearly 50% less than their peers, or $18,600.

Similar to the national average, women reported earning slightly less than men ($16,300 compared to $19,700 annually, respectively).

Measures Of Success

How do young molecular biologists measure success? While only a minority (5%) claim wealth as a measure of success in their field, most want to see their work recognized. While the minority (19%) of those surveyed currently write or publish articles, the majority (68%) cite "number of articles published" as a personal measure of success. Other success measures reported included "grants received (33%), "prestige among colleagues" (31%), and

"making important scientific contributions" (22%).

The majority of respondents (73%) cited polymerase chain reaction, the DNA amplification technique, as the greatest recent discovery in the molecular biology field.

Looking ahead, the young molecular biologists predicted that effective gene therapy (36%), followed by a cure or vaccine for AIDS (25%), and a cure or better understanding of cancer (21%) will be among the most important breakthroughs in their field over the next 10 years.

When asked how they like to "relax and have fun," the most frequent responses, were sports and exercise (39% and 33%, respectively). While virtually all respondents (98%) are connected to the Internet, the majority reported spending a minimal amount of time each day on the information superhighway: 60% spend less than one hour a day cruising the Web.

Roper Starch conducted a telephone survey of 300 molecular biologists between the ages of 18-32 from June 1 through Aug. 29, 1996. Sample lists were obtained from several sources including major US universities and AAAS. Ninety-two percent of the young molecular biologists polled were in graduate school and/or employed by either a university or college; the remainder work for the federal or state government (2%); hospitals (2%); research institutions (2%); biotechnology companies (1%) or somewhere else (2%).

The data in the survey is subject to a sampling error of plus or minus seven percentage points, and should be viewed as directional rather than projectible to the entire population of molecular biologists within this age group, the Roper organization said.

Cancer Meetings Listed From March To June

March

Basic and Clinical Aspects of Breast Cancer—March 7-12, Keystone, CO. Contact American Association for Cancer Research, tel: 215-440-9300, fax: 215-440-9313.

Supportive Care in Cancer—March 9-13, Banff, Alberta, Canada. Contact Kelli Gregg, CME director, tel: 214-820-8434, fax: 214-820-8224.

Association of Community Cancer Centers Annual Meeting—March 19-22, Washington, DC. Contact David Walls, ACCC, tel: 301-984-9496, fax: 301-770-1949.

American Society of Preventive Oncology Annual Meeting—March 23-25, New Orleans, LA. Contact Judy Bowser, ASPO, tel: 608-263-6809.

NIH Consensus Development Conference on Management of Hepatitis C—March 24-26, Natcher Conference Center, NIH, Bethesda, MD. Contact Conference Registrar, TRI, tel: 301-770-0610, fax: 301-468-2245.

April

Diagnosis and Treatment of Neoplastic Disorders—April 3-4, Baltimore, MD. Contact Program coordinator, Johns Hopkins CME office, tel: 410-955-2959, fax: 410-955-0807.

Management of Cancer & AIDS Pain: Challenges and Opportuntities Within a Changing Health Care Environment—April 4-5, Memorial Sloan-Kettering Cancer Center, New York City. Contact Myra Glajchen, tel: 212-639-2097.

National Consortium of Breast Centers Inc. Annual Meeting—April 4-6, Orlando, FL. Contact NCBC, tel: 219-267-8058, fax: 219-267-8268.

Nuclear Oncology: From Genotype to Patient Care—April 7-9, Baltimore, MD. Contact Program coordinator, Johns Hopkins CME office, tel: 410-955-2959, fax: 410-955-0807.

International Symposium on Recent Advances in Hematopoietic Stem Cell Transplantation—April 10-12, San Diego, CA. Contact CME office, University of California, San Diego, tel: 619-534-3940, fax: 619-534-7672.

American Association for Cancer Research Annual Meeting—April 12-16, San Diego, CA. Contact AACR tel: 215-440-9300, fax: 215-440-9313.

Skeletal Complications of Malignancy—April 19-20, NIH Natcher Conference Center, Bethesda, MD. Contact The Paget Foundation, tel: 212-229-1582, fax: 212-229-1502, email: pagetfdn@aol.com.

Biennial Symposium on Minorities, the Medically Underserved and Cancer—April 23-27, Washington, DC. Contact Ruth Sanchez, tel: 713-798-5383, fax: 713-798-3990.

UNC Lineberger Comprehensive Cancer Center Annual Symposium—April 30-May 1, Chapel Hill, NC. Contact Sarah Rimmer, tel: 919-966-2997.

May

Oncology Nursing Society Annual Congress—May 1-4, New Orleans, LA. Contact ONS, tel: 412-921-7373.

Molecular Aspects of Myeloid Stem Cell Development—May 4-7, Annapolis, MD. Contact Patti Hall, FACS, tel: 410-658-2882, fax: 410-658-3799, email: hall3915@dpnet.net.

Multidisciplinary Radiation Oncology Conference—May 9-10, Washington, DC. Contact Fox Chase Cancer Center, Kathy Smith, tel: 215-728-5358, fax: 215-728-5359.

Cutaneous Melanoma: Clinical Symposium for Primary Care Practitioners—May 16, New York City. Contact Memorial Sloan-Kettering Cancer Center, tel: 212-639-6754, fax: 212-717-3140.

American Lung Association/American Thoracic Society International Conference—May 16-21, San Francisco, CA. Contact ATS, tel: 212-315-8808.

American Society of Clinical Oncology Annual Meeting—May 17-20, Denver, CO. Contact ASCO, tel: 703-299-1050, fax: 703-299-1044.

American Brachytherapy Society Annual Meeting—May 18-23, Palm Beach, FL. Contact American Brachytherapy Society, tel: 215-574-3183, email: abs@acr.org.

Current Issues in Anatomic Pathology 1997—May 22-24, San Francisco, CA. Contact University of California, San Francisco, tel: 415-476-5808.

June

Critical Issues in Tumor Microcirculation, Angiogenesis and Metastasis—June 2-6, Boston, MA. Contact Carol Lyons, Massachusetts General Hospital, tel; 617-726-4083, fax: 617-726-4172.

National Race for the Cure—June 7, Washington, DC. Contact Susan G. Komen Foundation, Race Information, tel: 703-848-9364.

AACR Special Conference: Cancer of the Central Nervous System—June 7-11, San Diego, CA. Contact American Association for Cancer Research, tel: 215-440-9300, fax: 215-440-9313.

NCI-EORTC Symposium on New Drugs in Cancer Therapy—June 16-19, Amsterdam, The Netherlands. Contact: European Organization for Research and Treatment of Cancer, PO Box 7057, 1007, MB Amsterdam, The Netherlands, tel: 31-20-4442768, fax: 31-20-4442699, email: nddo@euronet.nl

RFA Available

RFA HL-97-004

Title: **Rat Gene Catalog And Expressed Sequence TAG (EST) Map**

Letter of Intent Receipt Date: March 28

Application Receipt Date: April 23

Purpose of this RFA is to expand the Rat Genome Project by soliciting applications for research projects to accomplish three objectives: 1) arraying and distributing existing rat cDNA libraries, 2) developing Expressed Sequence Tags (ESTs) from those libraries, 3) mapping a subset of those ESTs. The goal is to construct a rat gene catalog and EST map to facilitate mapping genes in the rat and increase the value of the rat as a biomedical research model. The NIH R01 mechanism will be used; $3.5 million (including direct *and indirect* costs) is available for year -01 and $1 million for year -02. Three to six awards may be made.

Inquiries: Grace Shen, NCI, 6130 Executive Blvd Rm 501, MSC 7381, Rockville, MD 20892-7531, tel: 301/496-7815, fax: 301/496-8656, email: gs35r@nih.gov

Program Announcement

PAR-97-027

Title: **Centers for AIDS Research**

Application Receipt Date: June 18

Participating institutes of NIH [NCI, NHLBI, NIAID, NICHD, NIDA, NIMH] invite center core grant (P30) applications to support Centers for AIDS Research. CFAR cores provide infrastructure and promote basic, clinical, behavioral and translational AIDS research activities at institutions that receive significant AIDS funding from multiple NIH Institutes or Centers. CFARs foster synergy and improve coordination of research, support emerging research opportunities, and promote economy of scale through resources shared by multiple independent laboratories. CFARs also encourage other activities that serve the requirements of AIDS research. CFARs are not intended to be "Centers of Excellence" in specific areas of AIDS research, but instead are intended to promote all AIDS research efforts at CFAR institutions.

Inquiries: Janet Young, Div. of AIDS, NIAID, Solar Bldg Rm 2C36B-MSC 7620, Bethesda, MD 20892-7620, tel: 301/496-6714, fax: 301/402-3211, email: jy6r@nih.gov