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IVAX Agreement With Rival BMS Appears To Buttress BMS Control Of Paclitaxel

IVAX Corp. last week announced a collaboration with its long-time rival, Bristol-Myers Squibb Co., whose grip over the paclitaxel market it has been trying to break.

The three-year global agreement in oncology and inhalation technology appears to strengthen the BMS efforts to maintain global control over the sales of the drug that is expected to contribute $1.47 billion in sales to BMS in 1999.

At a minimum, the alliance announced by IVAX on Nov. 19, appears to eliminate the immediate threat that the European Union's approval for

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FY2000 Appropriations:

NIH Gets $17.9 Billion, A 15% Increase, In Final Budget Agreement; $3 Billion To Be Delayed

Now it's official, and it just might be a trend: Congress passed and President Clinton signed a fiscal year 2000 appropriations bill giving NIH a 15 percent, $2.3 billion, increase over last year for a total budget of $17.9 billion.

In two years, federal funding for biomedical research has grown by $4.3 billion.

The final budget agreement requires NIH to delay $3 billion in funds until the end of the fiscal year. A bill vetoed by Clinton earlier this month would have delayed $7.5 billion of the NIH budget, and would have applied an across-the-board cut of nearly 1 percent.

A provision in the appropriations bill requires a .38 percent across-the-board cut to federal discretionary programs, which could reduce the NIH budget by about $68 million. However, Congress gave the administration discretion over how to apply the reduction. It is uncertain whether NIH would be exempted. A decision was to be made late this week, sources said.

The appropriations law gives NCI $3.332 billion, an increase of $438 million over last year's funding of $2.8 billion.

NCI officials, leaders of professional societies and cancer patient advocacy organizations, and members of Congress who pressed for the increase, expressed elation at the final outcome of the budget negotiations.

"We are all very pleased and grateful for this year's level of funding increase," NCI Director Richard Klausner said to **The Cancer Letter**.

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IVAX First-To-File Position May Lock Out Other Generics

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the IVAX version of paclitaxel in the treatment of KS would be used to sell the drug off-label in 15 EU countries. International sales are expected to account for $542 million—more than a third—of global Taxol sales.

BMS bought an option to license an IVAX technology for making an oral version of paclitaxel and licensed an IVAX inhalation technology that would be used for asthma compounds now under development at Bristol. BMS does not currently market pulmonary drugs.

Officials at the two companies say the deal has no relevance to patent infringement and antitrust litigation over generic paclitaxel now pending in the U.S. The trial in that case is scheduled to begin Feb. 29, in the U.S. District Court for the District of New Jersey. The case consolidates five lawsuits involving BMS and generic paclitaxel sponsors.

The case resulted from the BMS patent infringement claims against the generics. Defendants seek to invalidate the pioneer company's patents for preparation and injection of the drug and are claiming violations of antitrust law.

So far, Miami-based IVAX has borne most of the burden of preparing for trial in the consolidated case, sources said. The company holds the rights to the first abbreviated New Drug Application for paclitaxel. That application, originally filed by Immunex Corp. and licensed by IVAX, entitles the company to six months of market exclusivity for the generic.

Being the first to file makes IVAX a key target for attack or largesse. If the IVAX development efforts are frustrated, other generics would have to file separate actions to get around the first-filer.

Has the deal enabled BMS to eliminate its principal challenger, or weaken its determination to fight?

Not at all, said Sara Wilkins, the IVAX director for investor relations and corporate communications. "This is not a settlement," Wilkins said to **The Cancer Letter**. "We are still in litigation with Bristol for injectable paclitaxel in the U.S. This is a collaboration and a development services agreement. They are going to work with us on several fronts. We are both continuing to seek and expand new uses of our paclitaxel compounds."

"The deal does not affect the U.S. litigation and has no effect on our U.S. business, as it relates to our injectable paclitaxel," said Jane Kramer, the BMS director of public policy.

Attorneys for other generics are skeptical. "We are very concerned about how this arrangement between IVAX and BMS is going to affect IVAX's enthusiasm for pursuing this case to judgment," said an attorney for one of the defendants. "We will be carefully watching IVAX's litigation behavior to see whether that company's dealings with BMS will affect the thoroughness and vigor of their litigation effort."

Federal law prohibits anticompetitive "collusive settlements," and in recent years the Department of Justice has been investigating potentially collusive settlement agreements in litigation involving pioneer drug companies and generics.

Observers said that a settlement on the courthouse steps would probably be too simplistic an outcome in this case. BMS stands to gain the most if the case proceeds at an excruciatingly slow speed.

Even the loss of market exclusivity would not necessarily pose a severe problem for BMS if IVAX takes its time getting its generic paclitaxel to market, thus allowing the pioneer to continue to ring up sales.

The legal and regulatory issues of what happens when a pioneer settles with the first-to-file competitor are uncertain, sources said. However, one thing is beyond doubt: Any effort to get around IVAX would

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Founded Dec. 21, 1973, by Jerry D. Boyd

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require other generics to litigate—and that takes time.

The IVAX-BMS deal contains the following features:

—The two companies agreed to "respect each other's data protection rights" in the European Union.

The term "data protection rights" is a creature of the European Union law, which precludes applicants from relying on data previously submitted by others. If a company wants to submit a European regulatory dossier, it should either rely exclusively on its own data, or wait until the previous filer's exclusivity expires.

In most EU countries, data exclusivity is protected for six to ten years. However, some companies have found loopholes in EU data protection laws. Thus, last year in the Netherlands, BMS thwarted an effort by Yew Tree Pharmaceuticals to use BMS data in its paclitaxel submission.

Ultimately, Yew Tree went out of business, and its parent company, Pharmachemie, settled with BMS and, in a separate move, dropped out of the New Jersey consolidated suit.

The recent deal also appears to restrict or eliminate the possibility of off-label marketing of the IVAX paclitaxel in EU.

Last July, the European Commission granted Baker Norton, an IVAX subsidiary, an approval to market a paclitaxel, trade name Paxene, for AIDS-related Kaposi's sarcoma patients who failed prior liposomal anthracycline therapy.

Since the KS indication is miniscule, industry observers say its real value to IVAX lies in opening the door for off-label use. Now, that threat to Bristol's domination of the market seems to be neutralized.

"We are not getting into marketing for anything other than KS, the indication for which [Paxene] was approved, and we want to be very clear about this," said IVAX spokesman Wilkins. "It's KS only, and we are very vigilant about this."

"It's an acknowledgement of each other's legal obligations," said BMS spokesman Kramer said about the agreement.

The agreement does not limit either company from developing its paclitaxel for indications held by another, Kramer said. Industry sources said the IVAX clinical development program for injectable paclitaxel has been inactive for about a year. In Europe, Taxol is approved for breast and ovarian cancers.

Both companies declined to discuss pricing of Taxol and Paxene.

Paxene has U.S. approval for the KS indication, but the drug cannot be marketed until 2004, because of the BMS exclusivity under the Orphan Drug Act.

—The real value of Bristol's option to obtain the worldwide license for oral paclitaxel is difficult to assess.

Phase I studies of that technology were presented at the 1999 annual meeting of the American Society for Clinical Oncology. The licensing would be handled "on terms to be agreed upon," IVAX said in a press release.

Both IVAX and BMS declined to identify the U.S. patent. However, industry observers said the deal is likely to include the technology described in U.S. Patent No. 5,968,972, titled "Method for Increasing the Oral Bioactivity of Pharmaceutical Agents." The patent was issued on Oct. 19.

The technology is also covered in an Australian patent.

"The possibility of a collaboration with Bristol-Myers Squibb in developing and commercializing our oral system for administering paclitaxel, the most important oncology drug in the world, is another significant step in the advancement of IVAX's oncology program," said Phillip Frost, IVAX chairman and CEO.

— The terms of the BMS-IVAX deal to combine a patented IVAX inhalation technology with BMS molecules for the treatment of asthma would be determined later, the press release said. The IVAX inhalers would be manufactured by IVAX and purchased by BMS.

"The technology that we now have rights to is highly competitive," Kramer said to **The Cancer Letter**. "It may open the door for a new franchise."

Increase Will Fund High-Priority Initiatives, NCI Director Says

(Continued from page 1)

"With over $400 million new dollars for NCI, we will be able to continue to expand critical research programs and to fund high priority initiatives described in our Bypass Budget.

"It is thrilling that this level of support continues just as we can articulate so many exciting and productive avenues of research and development," Klausner said.

Even though the budget increase for NIH wasn't under contention going into the budget negotiations last week, the outcome was better than most had expected, said Dave Kohn, spokesman for

Rep. John Porter (R-IL), chairman of the House Labor, HHS, Education Appropriations Subcommittee.

"Congressman Porter was very pleased with the final appropriations for NIH and was pleased that the negotiators agreed to greatly reduce the amount of funding that was a delayed obligation for NIH, which was of concern," Kohn said. "The final agreement will provide significant new resources to NIH and help advance research across the board and not impede research."

Carolyn Aldigé, president and founder of the Cancer Research Foundation of America, and this year's president of the National Coalition for Cancer Research, said advocates now have a powerful tool for working toward continued budget increases for NCI and NIH and the doubling of the NIH appropriations.

"When several of us met with Congressman Porter in September, he told us he felt this was the critical year to get the 15 percent increase," Aldigé said. "If we got that, it would set the floor and make it easier for next year.

"Needless to say, there was a lot of rejoicing on Friday afternoon [Nov. 19] when we heard the final numbers," she said. "They got it right and fixed the problems. We were ecstatic."

Aldigé said the work on this year's appropriations is not complete, however.

"We should spend the month of December writing thank-you notes," she said. "It's important for members of Congress to know how grateful we in the cancer community are. I think the message is, the money can be spent productively."

In another victory for NIH, the budget agreement did not include language that would make embryonic stem cell research ineligible for funding. Thus, NIH will be able to support such research, as outlined in an HHS legal opinion. In that opinion, HHS said the existing ban on embryo research does not preclude NIH grantees from working with embryonic stem cells derived with private funding.

The budget agreement also includes a provision that permanently exempts certain NCI-designated cancer centers from the outpatient Prospective Payment System, thus saving those centers millions of dollars a year. The provision was pushed through by Sens. Connie Mack (R-FL) and Daniel Moynihan (D-NY).

The provision applies to 10 NCI-designated comprehensive cancer centers.

Letter to the Editor:

A Victory For Research Funds, But The Real Work Lies Ahead

The American Association for Cancer Research Public Education Committee and many of our members worked hard on appropriations this year, paying several visits to our Congressmen and ultimately the leadership to explain why it is so important to both double the NIH over five years and increase funding for cancer research—especially now.

We supported (and continue to support) the recommendations of The March Research Task Force, emphasizing to the Appropriations Committees, and later to the leadership, that we must make the eradication of cancer a high national priority and appropriate sufficient funds to achieve our collective goals through a multiyear program.

We spoke about the need for a five-year plan and a target of $10 million in five years for the National Cancer Program, realizing that we were not likely to get a doubling of the NCI this year. However, we believe that we must face the reality of what needs to be done to launch a full-scale final assault to prevent and cure cancer for all Americans and adopt at least a five-year outlook and plan. It is extremely difficult to undertake critical multiyear national initiatives in cancer prevention, therapy and early detection when we have to face the issue of a reduction in funding every year.

Our previous investments in research are paying off, but we now need to translate these findings into new prevention and treatment strategies and deliver these advances to all of our citizens, especially those that are hardest hit by cancer—medically underserved (including the elderly) and minority populations. In addition, we are not done in terms of basic research. There is still a great deal that we need to discover to maintain our momentum.

The bottom line is that we need to advance on all fronts, NOW. Overall from the perspective of AACR, this year is a great first step, but the real work is in front of us. The research community feels the ever-increasing sense of urgency from cancer patients, survivors and their families to prevent and cure this tragic disease, and we know that we have to do more in terms of communicating to Congress as to what is possible.

The appropriation this year is a victory for everyone who worked so hard to educate Congress

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on the value of cancer research. However, our challenge lies ahead: avoiding the "disease wars," while delivering our message of a sense of urgency to prevent and cure cancer.

Ann Barker
Chairman, AACR Public Education Committee

Commentary:

A Blueprint For Research That Shouldn't Be Bypassed

Few government documents provide as much practical information about where an agency is headed and what its administrators are thinking than NCI's annual professional judgment budget. For cancer researchers interested in the Institute's assessment of the most promising areas of research, the new version of the NCI budget proposal provides a wealth of information and a preview of future grant funding opportunities.

The National Cancer Act of 1971 requires the NCI director to prepare an annual report to the President assessing funding needs for cancer research. Because the budget proposal is supposed to go directly to the White House without changes by NIH or the Department of Health and Human Services, it became known as the "Bypass Budget."

In typical Washington fashion, the document was born of political compromise. Negotiations over the Act had reached a roadblock upon the insistence of cancer research advocates that NCI be given independent status, separate from NIH. The Bypass Budget, giving NCI the authority to publicize cancer research funding needs, was one of the bones thrown to the advocates.

Over the years, the document waxed and waned in its influence with Congress, the White House, and cancer researchers, and even in its importance as a planning document for the Institute.

In the past four years, NCI has repaired and polished that old skeleton to a brilliant sheen. This budget proposal shouldn't be bypassed; it's a useful, living reference work.

"As we stand on the threshold of the 21st century, we can marvel at how far we've come in the battle against cancer," NCI Director Richard Klausner writes in an introduction to the budget proposal. "A hundred—even fifty—years ago, cancer was a poorly understood disease that killed the great majority of people who had it. Today, we are learning more each day about how cancer arises from a single cell that behaves abnormally, dividing uncontrollably and leading, eventually to the development of a tumor."

With that first note of optimism, Klausner sets the tone for the document, which clearly reflects his vision of the future of cancer research: It's all in the molecules. Find out how they work and find ways to detect them and zap them out of existence. Fortunately, the budget proposal avoids this sort of simplification, but lays out a convincing series of plans for getting there.

Obviously, a one-time increase won't do the trick. The plan requires sustained funding over many years. Nearly every page of the budget proposal outlines the need for new technologies, new infrastructures, new opportunities, new strategies, new large-scale studies, new models, new methods, new programs, new archives, new repositories, new diagnostics, and that catch-all, "new knowledge."

The 2001 budget proposal continues the Institute's recent practice of providing a three-part funding plan, primarily aimed at members of Congress:

—Good: Do you want NCI merely to sustain its "proven, productive" research programs? That will cost $3.158 billion in FY2001.

—Better: Would you like NCI to "seize extraordinary scientific opportunities made possible" by the Institute's previous discoveries? You'll have to up the ante to $3.538 billion.

—Best: The "NCI Challenge" level gives you all of the above, and then some. NCI will "create and sustain mechanisms that build the capacity to allow the scientific community to apply rapidly evolving discoveries and emerging technologies for the benefit of human health." That will cost $4.135 billion, but what a great feeling you'll have.

Last week's appropriation gave NCI $3.332 billion, which exceeded the Institute's seize-the-opportunities request of $3.179 billion in the FY2000 Bypass Budget, but did not reach the "NCI Challenge" level of $3.873 billion for this year.

The goal will be to coax Congress to a higher giving level next year. Another 15 percent increase would give NCI $3.83 billion, still $300 million short of the aptly named "Challenge" level for FY2001.

In 1996, NCI identified four areas of research as "extraordinary opportunities" for reducing the burden of cancer: cancer genetics, imaging technologies, defining the signatures of cancer cells, and preclinical models of cancer. These four areas

are the supporting structure around which the Institute has built several large funding programs.

With the 2001 budget proposal, NCI adds three new extraordinary opportunities: molecular targets of prevention and treatment, research on tobacco and tobacco-related cancers, and cancer communications. NCI also proposes to broaden its investment in cancer genetics "to include the complex ways in which genes interplay with the environment to affect cancer susceptibility and risk."

Cancer researchers and clinicians will want to delve into each specific area of the budget proposal that is most relevant to their work. Suffice to say that the budget proposal reads well, and seems better organized and more persuasive than the previous three editions.

The document takes a high-gloss approach that is designed to enhance its appeal to everyone: Congressional staff and cancer center administrators, journalists and geneticists, politicians and physicians.

Interspersed are short items that tell little stories or help get a point across. There are "features" on topics including "Understanding Clinical Trials" and "The Consumer Advocate's Role at NCI." Research "spotlights" explain several subjects including the NCI intramural program, special populations research, and preventing cervical cancer. There are fewer vignettes on people with cancer in this document than in previous versions. Two "People's Stories" about colorectal cancer and lung cancer are written in Q-and-A format, but don't read like conversations. Small type at the end explains the incongruence: These are a "composite of experiences."

Finally, the length of the document should be noted, only because Klausner made its previous heftiness an issue in his first year as director. The 2001 document is 100 pages long, 10 pages longer than last year's proposal, which was 10 pages longer than its predecessor, which was more than 400 pages shorter than the document the previous year.

NCI should hold the budget proposal to 100 pages; any more than that seems unnecessary, and fewer would be better. Still, if the current rate of "page creep" continues, it would take 50 years for the budget to return to the pre-Klausner page count of 600.

The official title of the document is "The Nation's Investment in Cancer Research, A Budget Proposal for Fiscal Year 2001." That title is more descriptive than the "Bypass Budget" moniker and can't be confused with a common procedure in cardiology or funding for federal highways. Perhaps it's time to banish that nickname.

As we stand on the threshold of the 21st century—to borrow a phrase—we can see a new superstructure emerging for cancer research and cancer care, and we can hope that the builders work well and fast, and compete the job as quickly as possible.

"The Nation's Investment in Cancer Research, A Budget Proposal for Fiscal Year 2001" is available at http://2001.cancer.gov/ or may be ordered by fax at 301-330-7968, by e-mail at cisocc@nih.gov or by phone at 800-4-CANCER.

—Kirsten Boyd Goldberg

Science Policy:

Second-Hand Smoke Linked To Lung Cancer, Other Effects

NCI announced the availability of the most comprehensive report on the health risks of secondhand smoke ever conducted.

The monograph, "Health Effects of Exposure to Environmental Tobacco Smoke: The Report of the California Environmental Protection Agency," links secondhand smoke, also called environmental tobacco smoke, not only with lung cancer, but with heart disease, sudden infant death syndrome, nasal sinus cancer, and a host of other diseases in both adults and children.

In a preface to the 430-page report, U.S. Surgeon General and Assistant Secretary for Health, David Satcher, said the public health burden caused by ETS "more than justifies public policies creating smokefree workplaces and public areas."

Previous reports issued by the U.S. Surgeon General in 1986 and the U.S. Environmental Protection Agency in 1992 concluded ETS caused lung cancer, but that too few studies were available to assess its relationship to heart disease. The new report compiled by the California Environmental Protection Agency includes 18 epidemiological studies linking ETS to coronary heart disease.

"The weight of the scientific evidence is now more than sufficient to conclude that the relationship between environmental tobacco smoke and heart disease is real," Satcher said.

Copies of the monograph are available by calling 800-4-CANCER, or at http://rex.nci.nih.gov/NCI_MONOGRAPHS/INDEX.HTM.

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Funding Opportunities:

NCI Request For Applications

RFA CA-00-001: Interdisciplinary Research Teams for Molecular Target Assessment

Letter of Intent Receipt Date: Feb. 1, 2000

Application Receipt Date: March 15, 2000

NCI invites research grant applications to discover, develop and validate the research tools that will make mechanism assessment in clinical trials and preclinical cancer models a reality.

Preclinical and clinical research with novel agents for cancer treatment and prevention requires usable tools to determine that the intended molecular target has been affected by the agent. The major objective of the initiative is the development of methods to assess the effects of interventions directed at specific molecular targets that produce the cancer phenotype or are associated with it. We seek molecular assays, molecular and cellular imaging probes, and other tools that provide information on the extent to which molecular targets are affected in vivo by interventions in preclinical models and in proof-of-principle early clinical trials.

The request for applications invites investigators to form interdisciplinary research teams. The teams should include investigators with expertise in critical biological processes that encompass high-priority targets for cancer treatment or prevention; in chemistry; in molecular and cellular imaging science and technology; in invasive and/or non-invasive evaluation of the molecular effects of drugs; in preclinical models; and in early clinical trials. A team may have investigators from several institutions; these may include the intramural programs of NIH. Teams may focus on more than one target and may utilize agents originating from any source (industrial, academic and government). For whatever targets it selects, each team will advance knowledge of the pertinent biology, defining what events are most likely to be informative in the context of this initiative's goals, and focus on the development of relevant and practical assays, probes, and other tools to assess the effects of drugs on that target class in vivo.

The teams will define the molecular basis for these research tools and develop and validate novel biochemical, pathological, pharmacologic, immunologic, molecular, or imaging methods and reagents to measure the effect of new target-directed drugs in proof-of-principle laboratory models and clinical trials. The methods and reagents must, therefore, be suitable for in vivo use in animal models and in human beings. Examples of target areas include, but are not limited to, angiogenesis, invasion and metastases, and other microenvironmental processes; signal transduction; cell-cycle control; apoptosis; immune effectors; antimutagenesis (e.g. reverse mutations at specifically mutated gene targets) and antioxidant response elements.

The RFA will use NIH cooperative specialized center (U54) award mechanism. The U54 mechanism may support any part of a full range of research development from very basic to clinical. The U54 is a cooperative agreement, an assistance mechanism (rather than an acquisition mechanism) in which substantial NIH scientific and/or programmatic involvement with the awardee is anticipated during the performance of the activities. Under a cooperative agreement, the purpose of NIH is to support and stimulate the recipient's activities by involvement in and otherwise working jointly with the award recipient in a partner role. NIH staff work cooperatively with the award recipients and do not assume direction, prime responsibility, or a dominant role in the activity. The total project period for an application submitted in response to this RFA may not exceed five years. The anticipated award date is Dec. 1, 2000.

An estimated total of $6.3 million (including direct costs and costs for facilities and administration) will be available for the first year of the program, which will support approximately 6-8 teams, although the actual funding plan will depend upon the scientific opportunities presented and are contingent upon the availability of funds and the receipt of a sufficient number of applications of outstanding scientific and technical merit. An applicant may request a project period of up to five years. Because the nature and scope of the proposed research will vary, the sizes of the awards will also vary.

Inquiries: Louise Grochow, Chief, Investigational Drug Branch, CTEP, DCTD, NCI, Executive Plaza North, Room 715, 6130 Executive blvd, Rockville, MD 20850, phone 301 496 1196; fax 301 402 0428 (fax requests for supplemental instructions to Marylou Macgregor,IDB Administrator; e-mail macgregorm@ctep.nci.nih.gov); e-mail grochowl@ctep.nci.nih.gov.

Program Announcement

PA-00-010: Mentored Clinical Scientist Development Award

Agency for Health Care Policy and Research invites applications for its Mentored Clinical Scientist Development Award in health services research.The K08 mechanism provides specialized study support for trained professionals committed to a career in research. Because of the focus on progression to independence, the prospective candidate should propose a period of study and development consistent with his needs, and previous research or clinical experience. The proposed length of the award must be well explained and justified. Support will only be provided for the period deemed necessary to achieve independence, as recommended by peer review and agency decision making.

Inquiries: Division of Research Education, Office of Research Review, Education, and Policy, Agency for Health Care Policy and Research, 2101 East Jefferson Street, Suite 400, Rockville, MD 20852, phone 301 594 1452; e-mail: Training@AHCPR.gov

In Brief:

NCI Communications Director Paul Van Nevel To Retire

PAUL VAN NEVEL, director of the NCI Office of Cancer Communications since 1974, announced his retirement, effective Dec. 31, after 26 years at the Institute. Van Nevel joined NCI as deputy director of the communications office in 1973, from the Johns Hopkins Medical Institutions. He was deputy director of public relations at Hopkins for a year, and then served as director of the office for four years. Prior to joining Hopkins, Van Nevel was director of public information at the University of Wisconsin Medical Center from 1961-62 and 1964-68. His work at Wisconsin was interrupted by Army service. He served as a journalism instructor at the U.S. Army Information School from 1962-64. He graduated in 1961 from the University of Wisconsin, Madison. Van Nevel has been editor of the news section of the Journal of the National Cancer Institute since 1988. He recently received the Presidential Rank of Meritorious Executive from President Clinton, and earlier this year received the Award for Distinguished Service to Journalism and Mass Communications from the University of Wisconsin, Madison, for being a "pioneer in the way professionals in the United States and throughout the world communicate about cancer and other health issues." Following his retirement from NCI, Van Nevel plans to provide communications consulting services to companies and organizations in the health fields. . . . **ROBERT COMIS** was re-appointed to a second term as the group chairman of the Eastern Oncology Cooperative Group at the group meeting in Tampa, FL. His five-year term will begin July 1. Comis is president of the Coalition of National Cancer Cooperative Groups, chairman of the Cooperative Group Chairs for NCI and director of the Clinical Trial Research Center at MCP-Hahnemann University. . . . **DAVID CLAYTON,** senior scientific officer at Howard Hughes Medical Institute, was elected vice president for science development. Clayton was professor of pathology and development at Stanford University. **GERALD RUBIN** was elected vice president for biomedical research at HHMI. Rubin is an HHMI investigator at the University of California at Berkeley where he is John D. MacArthur Professor of Genetics in the department of cellular biology. .The appointments of Clayton and Rubin were announced by **Thomas Cech**, president-designate of HHMI. . . . **GEN. NORMAN SCHWARZKOPF**, a prostate cancer survivor, was given the Leadership Award by the Multiple Myeloma Research Foundation at a benefit that raised $1 million for cancer research. . . . **DAVID RALL,** former director of National Institute of Environmental Health Sciences, will be remembered at memorial programs Dec. 3, from 3 to 5 p.m. at the Natcher Center on the campus of NIH in Bethesda, Md., and Dec. 6 from 9:30 a.m. to noon at the Rodbell Conference Center on the South (Main) Campus of NIEHS, 111 T. W. Alexander drive in Research Triangle Park, N.C. Rall, 73, died Sept. 28, after an automobile accident near Bordeaux, France. . . . **LANCE ARMSTRONG FOUNDATION** awarded five medical research grants totaling $500,000 at its third annual Urologic Oncology Symposium in October. Award recipients include: **Dartmouth Medical School, Indiana University, Memorial Sloan-Kettering Cancer Center and Yale University**. . . . **JOHN YOUNG**, of Harvard Medical School department of microbiology and molecular genetics, was appointed Howard M. Temin Professor in Cancer Research, department of oncology, McArdle Laboratory for Cancer Research, at the University of Wisconsin-Madison. Prior to joining Harvard, Young was on the faculty of the University of California, San Francisco, where he did post-doctoral research under the direction of **Harold Varmus**, current director of NIH. Young's discoveries relating to programmed cell death and characteristics of cell receptors for retroviruses have important implications for basic research as well as for human gene therapy, according to McArdle Director **Norman Drinkwater**. . . . **ALFRED KNUDSON,** Fox Chase Cancer Center scientist and 1998 Albert Lasker Award winner, was awarded the John Scott Award for Scientific Achievement at the College of Physicians of Philadelphia Nov. 19. Knudson was given the award for his work in retinoblastoma and his theory of cancer causation. . . . **TIMOTHY EBERLEIN** was named director of the Alvin J. Siteman Cancer Center, operated jointly by Washington University School of Medicine and Barnes-Jewish Hospital. Eberlein has been interim director of the center for the past 22 months. Eberlein, an expert in breast cancer, gastrointestinal malignancies and soft-tissue sarcomas, is Bixby Professor and head of the department of surgery at WUSM and surgeon in chief at Barnes-Jewish Hospital.

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