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Harold Freeman To Direct NCI Center To Reduce Cancer Health Disparities

Responding to criticism from patient advocates and researchers, NCI has established a center for studying disparities in the cancer burden experienced by some populations.

According to a draft of the NCI Bypass Budget for fiscal 2002, the Institute would like to spend $2 million for operations and $42.6 million for research projects administered through the new Center to Reduce Cancer Health Disparities.

By calling the new entity a "center," NCI signaled that it is giving the health disparities effort a higher profile than it has in the past.

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In Brief:

Marc Lippman To Leave Georgetown For Michigan To Head Internal Medicine; Five Named To DCLG

UNIVERSITY OF MICHIGAN Medical School has appointed breast cancer specialist **Marc Lippman** as chairman of the Department of Internal Medicine, pending the approval of the U-M Board of Regents. His appointment will be effective Feb. 1. Lippman also will hold the title of John G. Searle Professor of Medicine. Lippman directs the Vincent T. Lombardi Cancer Research Center at Georgetown University Medical Center, and serves as chairman of the Department of Oncology. He is also a professor of medicine and chief of the Division of Hematology-Oncology at Georgetown Medical School. "Dr. Lippman has a distinguished track record as a physician-scientist in the field of oncology," said **Allen Lichter**, dean of the U-M Medical School. "He brings a wealth of experience in leading academic programs and translating research findings into important patient care advances. We are fortunate and delighted to have him taking this critical leadership role in our largest department." Before arriving at Georgetown in 1988, Lippman headed the Medical Breast Cancer Section of the NCI Medicine Branch. He went to NCI as a research fellow following residency training at Johns Hopkins University. . . . **NCI APPOINTED** five cancer patient advocates to the Director's Consumer Liaison Group, a chartered federal advisory committee that helps the Institute increase its involvement with the cancer advocacy community. The new members are: **Barbara LeStage**, Wrentham, Mass.; **Pamela McAllister**, Fitchburg, Wis.; **Nyrvah Richard**, New York, NY; **Henry Porterfield**, Hinsdale, Ill.; and **Paula Simper**, Rancho Palos Verdes, Calif. They will serve three-year terms on the 15-member committee. . . . **NANCY ANN MIN**

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New Center To Replace NCI's Office Of Special Populations

(Continued from page 1)

The center replaces the Office of Special Populations Research, which was created four years ago to coordinate research in health disparities. OSPR didn't have the funding or institutional support it needed to be effective, say critics of the Institute's approach to the problem of health disparities.

The center's origins were, to say the least, unusual. On March 3, at a meeting of the Special Populations Working Group which advises OSPR, several members leveled sharp criticism at the Institute for what they described as a lack of commitment to studying the problem.

The argument began when the working group learned that OSPR Director Otis Brawley had not been invited to a meeting where NCI officials discussed the role of health disparities research in the Bypass Budget. Later that night, Klausner called Harold Freeman, a member of the working group and chairman of the President's Cancer Panel. Responding to criticism, Klausner challenged Freeman to come to work at NCI and establish the center.

Freeman's appointment as director of the center was made official earlier this week, a few hours after he discussed his plans for the center with the National Cancer Advisory Board.

Freeman will work part-time at NCI while keeping his other appointments. In addition to his position on the Cancer Panel, Freeman is an NCI-funded investigator, CEO of North General Hospital in Harlem, a consultant in surgery to the Breast Service at Memorial Sloan-Kettering Cancer Center, and a member of the Board of Directors of the American Cancer Society.

As a "special governmental employee," Freeman will be allowed to work up to 130 days in any 365-day period, according to NIH ethics rules.

"I thank Richard Klausner for making the decision to develop the Center for Reducing Cancer Health Disparities, and for having the confidence that I could lead it," Freeman said to the NCAB at its Sept. 12 meeting. "This is daunting task, but one that I believe is doable.

"This is not a new activity at NCI, but perhaps it is an opportunity to synergize a lot of things that are going on," Freeman said. "We do not believe the center should reinvent any wheels that have already been invented. We believe that it should look at the wheels that have been invented and make sure they are on the same vehicle."

Freeman's presentation contained few organizational details and no discussion of funding.

Klausner: Confidence In Freeman

NCI will begin a search for a deputy director of the center and an assistant deputy director for interagency partnerships, Freeman said. The center will initially contain three branches: Special Populations Research, Communications, and Health Policy.

Freeman did not address—nor did any NCAB member ask—how he planned to handle potential conflicts or the appearances of conflicts that may arise from his various positions.

While Freeman's potentially conflicting responsibilities worry some NCI and NIH officials, patient advocates, and minority researchers, few were willing to openly discuss their concerns.

"The biggest concern being discussed by many people is whether NCI's commitment is really there," said Lucile Adams-Campbell, director of the Howard University Cancer Center and a member of the NCI Special Populations Working Group. "The NCI plan for the center is fine, but I think it will be difficult to implement even with a full-time director. To find out that it's only a part-time position, I think sends a bad message. The position needs to be 100 percent without any strings attached."

"The intent to establish a center on cancer health

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World Wide Web: http://www.cancerletter.com

Editor & Publisher: Kirsten Boyd Goldberg
Editor: Paul Goldberg
Editorial Assistant: Shelley Whitmore Wolfe

Editorial: 202-362-1809 Fax: 202-362-1681
PO Box 9905, Washington DC 20016
E-mail: kirsten@cancerletter.com or paul@cancerletter.com

Customer Service: 800-513-7042
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disparities is very timely and extremely important," said Sandra Million-Underwood, professor of nursing at University of Wisconsin-Milwaukee School of Nursing and chairman of the Special Populations Working Group. "It's essential that NCI make a strong statement and provide the necessary staff and financial support that will allow the achievement of the goals, because without it, we will fall short. Both within and outside of NCI, we must have the leadership and support to do the jobs that need to be done."

In an interview this week, Klausner said he was confident that Freeman would be able to direct the center on a part-time basis.

"It is very clear that this center requires leadership at multiple levels, and most of the center leadership will be full time and that will fall to other people," Klausner said to **The Cancer Letter**. "I've found that part-time individuals—such as Al Knudson and Ed Harlow—have been unbelievably valuable, and the worry about whether an individual can be part-time isn't a concern. It is not a statement about the value and importance of the center."

Klausner brought in Knudson, from Fox Chase Cancer Center, and Harlow, from MIT, to reorganize NCI's genetics and basic science programs soon after his appointment as NCI director in 1995.

"I don't rule out there being other part-time people in the center," Klausner said. "We want people to come in and out of NCI to participate in our programs. We want to create a think tank for some of the issues surrounding the center, where people can come, to write, review literature, and serve as visiting scholars."

Klausner said conflicts that may arise from Freeman's position on the Cancer Panel and his NCI employment would be manageable.

"Most of what goes on in any aspect of NCI is public information and it will be helpful for him to speak about what the center is doing, and to hear what ought to be done," he said. "He will also be involved in the generation of ideas for funding, and those cannot be publicly discussed.

"We reviewed all of his activities to make sure that we and the Office of General Counsel and the ethics offices are comfortable with managing any conflicts that many arise," Klausner said. "We and the general counsel also are comfortable with his maintaining his position on the ACS board. We encourage NCI employees to be involved in whatever community they are involved in, but these have to be reviewed up front to address conflicts of interest."

How Freeman Got The Job

A 1999 report by the Institute of Medicine, "The Unequal Burden of Cancer," made 27 specific recommendations to NCI to enhance research and reporting on cancer health disparities (**The Cancer Letter**, Jan. 22, 1999). NCI accepted most of the recommendations, although the Institute disagreed with the report's accounting methods for tracking research in special populations.

However, more than a year later, members of NCI's Special Populations Working Group expressed their frustration that the Institute had not moved quickly enough to increase funding for the Office of Special Populations Research, enhance the role of the office and its director, Otis Brawley, and increase funding for the Special Populations Research Networks, a grant program.

Members of the working group expressed their frustration at a meeting March 3. Working group members said they were particularly upset that Brawley was not invited to a meeting where top NCI officials decided that the FY2002 Bypass Budget would contain a special section on reducing cancer disparities among special populations. The working group learned about the Bypass Budget meeting from Susan Sieber, NCI's director of communications.

Freeman said NCI would have to show greater commitment to the office, and raised the threat posed by a bill introduced by Rep. Jesse Jackson Jr. to establish an institute for health disparities at NIH.

"Unless you empower this man—I am not speaking of Otis, not personally—you have to empower that office to convince a group like this, or else the Jesse Jackson thing is going to have to go the other way," Freeman said, according to an official transcript of the March 3 meeting.

Klausner had decided that special populations projects should not be moved from the NCI divisions to the OSPR, Sieber said. "Rick's philosophy has been, as I think you have heard, that rather than pull out these projects and have them supported as an entity, sort of in isolation from the rest of the Institute's activities, he felt that these activities should be integrated into the fabric of the Institute and into the scientific expertise of the operating divisions," she said.

FREEMAN: Do you need an Office of Special Populations [Research]?

SIEBER: Yes.

FREEMAN: Why do you need it?

SIEBER: In order to coordinate activities, to

make sure than in each division activities are well coordinated.

FREEMAN: That is a good point. Does [Brawley's] office coordinate those activities?

SIEBER: Yes, he is responsible for knowing what is going on across the divisions.

FREEMAN: He may know what is going on, but does he coordinate it?

BRAWLEY: What is your definition of coordinate?

FREEMAN: I know that Otis knows what is going on. Otis is not coordinating that activity. He is not. He knows about it…. Does Otis really coordinate the activities that you were talking about? I don't see that happening.

SIEBER: Can you provide us with input as to how we can develop that coordination?

FREEMAN: I would love to do that. And I will come to Bethesda to help you with that. I would love to do that.

SIEBER: But that is what we want.

JUDY KAYE (assistant professor of nursing, Medical College of Georgia): I would agree with Dr. Freeman that you have to empower it and structure it and provide money. If it is too dissipated and washed out into other programs, then you lose any real meaning of the special populations really being looked at and studied and followed through in cancer control.

FREEMAN: I think a committee like this is very sincere. These people, as you know, around this table, are not just whistling Dixie on this issue. If there were a genuine movement in this area, we would clearly support it. I am not sure there is…. I think Rick is a very passionate man when he makes up his mind to do something, as you know, and we are trying to reawaken this giant on this issue a little more. He has the passion, but we have to reawaken him a little bit more, to coordinate these very critical issues for the entire American public, not just for black people or Hispanics. This is a human set of issues. It may be the most important set of issues the NCI could deal with…. It would still need some coordination, not just the decision of the director of a part of the agency to do one part, but someone who would have some oversight power to help direct it. Not power over it, but somebody to pull it together. Not Otis sitting where he sits with $6 million and you call him the special populations person. That is not enough. To convince us will only take an honest effort. Otherwise this may go a different direction, as you know.

SIEBER: As I said, we would truly welcome your advice on how best we can proceed. What I am hearing is, we need to establish a way the Office of Special Populations Research has a greater sphere of influence over NCI's—

FREEMAN: You may need a broader approach because one person probably cannot do this….

NGINA LYTHCOTT (National Black Women's Health Project): …. I am willing to buy your thing that we don't want separate, we want it integrated and woven within, but who is making sure that is happening, that the right questions are being asked? Who is making sure that when the research is being funded that it is being disseminated to the primary care docs and the oncologists? You have to have somebody at the table very high up that has the status and the money to make sure that is happening…. We need a coordinator with a capital "C" so that when people look at him and see him, they think he has Rick's ear. He sits on these committees. He can say to a grant PI, if you will ask these questions, we will put in an additional $2 million into your research funding, or something like that…. It blows my mind to think that we are to be happy with the crumb of $6 million, although it is so much more than it was, and I am eternally grateful for that. But $6 million is a crumb out of [the NCI budget of] $3 billion.

SIEBER: It is a start. This is an attempt to establish something to build upon, to create something that really does not exist. We have to start somewhere.

LYTHCOTT: I agree and all I want to say is that NIH and NCI can continue to expect to get this kind of treatment from Congress when the structures and the processes that exist are beginning to change but are not yet reflective. You would have quite a defense to make to Rep. Jackson if you could say, or if [Acting NIH Director] Ruth Kirschstein could say that every single institute has an apparatus that looks at special populations research, that they have an operating budget and an programmatic budget and they sit on the senior staff such that we believe that this model is a more effective model than the one you are proposing.

But what you have done is you have picked one model, under-funded it, under-resourced it, under-positioned it in the organization so that this one isn't going to work either, and it is going to create more support for the Rep. Jacksons and new voices to push for dramatic change….

DONALD COFFEY [Johns Hopkins University]: Jackson said, set asides are not what is required—and here comes the punch line—minorities must have

a seat at the power table.

FREEMAN: Can't argue with that.

COFFEY: Do they have a seat at the power table? That is the question.

SIEBER: They have a seat.

COFFEY: They have a seat—is it at the power table? I don't know.

SIEBER: Tell me what you would view as a seat at the power table?

LYTHCOTT: It means that, when Rick has senior staff together, no matter what they talk about, that the Office of Special Populations Research has to have somebody there. It means that, whether it is the budget, whether it is setting research priorities, whether it is setting the research agenda, there has to be a representative, and usually the chief of the office, present. There has to be an operating budget that allows him or her to hire appropriate staff and consultants….

FREEMAN: … I think you need to elevate this with somebody like Otis or whoever, who would be in a position to sit at the tables where the decisions are made, not just on this, but across the board. Then put the person in the position of really coordinating the war against cancer as it regards people who are underserved.

"Challenge" Requests Funds For Center

Brawley's role in the center remains undetermined, though NCI sources said he will have a position. Brawley declined to comment to **The Cancer Letter**.

The planning of the center has been done by Jon Kerner, assistant deputy director for research dissemination and diffusion in the NCI Division of Cancer Control and Population Sciences, working with Freeman, Klausner, and DCCPS Director Barbara Rimer.

NCI plans to include a section on reducing cancer-related health disparities as a special "Challenge" section of the FY2002 Bypass Budget. A draft of the section provided to **The Cancer Letter** outlines the Institute's objectives and associated funding requests.

Highlights of the funding request:

1. Create a new and comprehensive plan to organize, coordinate, and monitor NCI activities in health disparities research, education, training, and health services support: $2 million.

2. Improve capacity and accelerate knowledge through fundamental cancer control and population research: $12 million.

3. Expand our ability to define and monitor cancer related health disparities: $3 million.

4. Expand cancer control intervention research in prevention, early detection, treatment, and communications: $17.5 million.

5. Expand the channels for research dissemination and diffusion: $7 million.

6. Strengthen training and education in health disparities research: $1.6 million.

7. Management and support: $1.5 million.

"Define What We Mean By Race"

Excerpts of Freeman's remarks to the NCAB follow:

Three things rise to the top in my experience over the last 32 years in studying these issues. No. 1, I believe poverty is a overwhelming factor that is associated with a lack of resources and lack of knowledge.

I think that the culture people live within is extraordinarily important in determining what diseases they will develop and how they will respond when they need to do something about it. The relationship between lack of resources and culture is something we need to know a lot more about.

The third factor that comes to the top is the effect of social injustice in our society. I believe that when people are denied opportunities because of lack of economic or educational advancement related to injustice, that also influences what causes health disparities. So we will be building this new center by the desire to understand these very complex human factors.

There's no question that profound advances in biomedical science have occurred over the last several decades, particularly beginning with the passage of the National Cancer Act. This putting of resources into discovery has been extraordinarily important and has contributed greatly to increased longevity and improve quality of life for many Americans. However despite his progress, the heavier burden of disease is borne by some population groups in the U.S., particularly the poor and underserved.

What the center must do is to more precisely define who these populations are that are not well served. It is not so clear to me that belonging to a socially and politically determined category drives disparity itself, unless the social injustice factor is the major cause of this disparity.

I believe the unequal burden of disease in our

society is a challenge to science as well as a moral and ethical dilemma for nation. So I would urge us not to just look at these things from the point of view science, because I really believe that the people who created the National Cancer Act were fundamentally interested in helping the American people with this disease, to improve results, to increase mortality, increase survival, and improve quality of life. This becomes a moral and ethical issue, because doesn't seem morally acceptable to me we can have the country doing well in many respects against cancer, but some parts of our society are not doing well at all.

There's a critical disconnect between research discovery programs and delivery of the results. This disconnect is, in and of itself, a key determinant of the unequal burden of cancer in our society. Barriers to prevent the benefits of research from reaching all populations, particularly those who bear the greatest disease burden, must be identified and removed.

Racial classifications have been socially and politically determined, and have no basis in biology. The President's Cancer Panel in a report three years ago indicated that there's no biological basis for racial classification. Though race does not exist from biological perspective, it has been invented, racism does exist in our society. We need to distinguish society's treatment of people in those categories from whether or not people are really biologically different.

Here is what I propose at this time, this is not written in stone. What is now called the Office of Special Populations Research is already in existence and has done some very good work. Seventeen major grants were given out in the spring, up to $60 million over the next five years, for the Special Populations Research Networks. This is a significant movement in the right direction to create research entities throughout our nation where you bring people who are in communities in connection with cancer centers, which will have many positive effects. The hope is that we can train some scientists that are not currently in the picture from certain minority groups, that maybe within five years these now-junior scientists could be moved to the point where they could compete for an R01. This is a wonderful plan.

I think now we need to elevate this discussion. So we're going to elevate the current Office of Special Populations Research to higher level where there is more deep dialogue on what should be done….

I believe it's very critical to determine what are real variables that cause disparity. It simply not enough to go with assigned categories as we have in the past, and almost assume that being in the category is the cause of the problem. I would hate it to be true and I don't believe it's true, that being an African-American person myself, according to the way they label me at this point, I'm already a victim of having a greater chance of dying in earlier time for cancer. I don't believe it's true.

I think it's time now to focus deeper into those categories and find out what are the real causes health disparities and generalize those variables across all human beings. I think in the future when we use racial categories we should say what they mean. They are used in various ways. Sometimes they're reflecting a belief in determination, sometimes believing that the racial category reflects the cultural difference. The think we should define what we mean by race, and then we can debate whether the assumptions are correct or not.

Reimbursement:

HCFA Abandons Plan To Cut Cancer Drug Payments

The Health Care Financing Administration last week abandoned its plan to lower Medicare reimbursement for cancer drugs administered at physicians' offices.

Instead of unilaterally slashing payments, HCFA said it will study actual expenses associated with administering chemotherapy, and increase the oncology practice expense formula simultaneously with lowering reimbursement for drugs, the agency's administrator Nancy-Ann Min DeParle wrote in a letter to Capitol Hill.

DeParle's letter signaled the Administration's retreat on its proposal to eliminate markup charged by physician practices on drugs administered to Medicare patients. While the existing scale relies on industry-determined "average wholesale prices" of drugs, the Administration proposed an alternative: a different AWP scale recalculated by the Department of Justice.

"We are instructing [Medicare] carriers not to consider DOJ data on 14 oncology drugs… while we gather more information… and propose administrative changes for chemotherapy drug administration," DeParle said in the letter dated Sept. 8. Three clotting factors used by hemophiliacs were also excluded from the list.

The letter indicates that the Administration has accepted the argument the opponents' argument that

physicians' markup on drugs makes up for shortfalls in the practice expense formula. Physician and patient groups said reliance of the reimbursement scale proposed by DOJ would drive office-based oncology practices out of business, thereby shifting patient care to the hospitals.

"In next year's physician fee schedule regulations, we intend to propose modifications to the practice expense formula or legislation that would increase payments for cancer chemotherapy administration," DeParle wrote. "Our goal would be to have more accurate pricing for both chemotherapy drugs and chemotherapy administration in place at the same time."

The study of the reimbursement formula for cancer care was first mandated by Congress in 1987, but is yet to be initiated by HCFA.

"We would like to acknowledge HCFA's willingness to work with the cancer community on this important issue," Lawrence Einhorn, president of the American Society of Clinical Oncology, said in a statement.

"We are pleased that HCFA has agreed to postpone any action until they can further study this matter," Einhorn said. "We intend to work with HCFA as they undertake the important task of updating the physician fee schedule for 2002."

Lloyd Everson, president of Houston-based U.S. Oncology Inc., said a rational system of reimbursement for cancer care would strengthen the Medicare program.

"The cancer community has engaged in a constructive dialogue with HCFA for many years in the hope that a stable reimbursement system would be created for cancer care," Everson said in a statement. "This announcement confirms the value of this initiative and will result in a stronger Medicare program for beneficiaries with cancer."

HCFA's instructions to carriers may need to be corrected since the agency appears to have missed three cancer drugs: mitomycin, Lupron and immunoglobulin. The first of the three drugs, mitomycin, is almost certain to be excluded from the new reimbursement schema.

Lupron, a drug used to treat prostate cancer, may not be severely affected by being left on the DOJ list since Medicare does not always reimburse its full cost. Instead, reimbursement is pegged to the lower-cost alternative, Zoladex. Immunoglobulin, a therapy widely used in medicine, may be an example of the practical difficulty of delineating cancer drugs from non-cancer drugs.

Negotiations over definitions of cancer drugs may become moot before they are resolved, since several members of Congress are considering introducing legislation to preclude HCFA from using the DOJ reimbursement scale altogether. Legislation of this sort could well be inserted into one of the monstrously long omnibus bills that are likely to conclude the current legislative session.

Unless stopped by Congress, the HCFA plan to use the new reimbursement scale could go in effect Jan. 1, 2000.

HCFA faced considerable political pressure to make an exception for cancer drugs and proceed with a study of oncology practice expenses.

The patient led Cancer Leadership Council sent a letter to President Clinton, urging him to stop the HCFA plan. The issue was brought up by Republican Presidential contender George W. Bush and New York senatorial contender Rick Lazio.

The administration also received three letters from Capitol Hill. One letter, drafted by ASCO, was signed by 89 House members. Another letter, which originated from the office of Rep. Rosa DeLauro (D-CT), was signed by 34 House members. Yet another letter was signed by all nine Republican members of the House Rules Committee.

Funding Opportunities:

American Society for Blood and Marrow Transplantation and Fujisawa Healthcare New Investigator Award

Application Deadline: Nov. 30, 2000

Applications are being accepted for a $25,000-per-year award for new investigators. The two-year research award encourages clinical and laboratory research in the field of blood marrow transplantation. Applicants must be at the junior faculty level and be an ASBMT member or sponsored by an ASBMT member.

Inquiries: ASBMT Executive Office, 85 W. Algonquin Rd., Suite 550, Arlington Heights, IL 60005, fax 847-427-9656; e-mail: new.investigator@asbmt.org

Lymphoma Research Foundation of America 2001–2002 Research Grants

Applications must be postmarked on or before Dec. 15, 2000.

Lymphoma Research Foundation of America is accepting research proposals for:.

Fellowship Research Grants provide up to $45,000 per year for salary and are available to researchers working on lymphoma-specific studies. Applicants must hold a Ph.D., M.D., or equivalent degree.

M.D. applicants must be at least a third year fellow.

Junior Faculty Grant awards up to $75,000 in support of projects led by investigators who have a proven history of research specific to lymphoma.

Inquiries: Lymphoma Research Foundation of America, 8800 Venice Blvd. Suite 207, Los Angeles, CA 90034; 310-204-7040; fax 310-204-7043; e-mail LRFA@aol.com

RFAs Available

RFA CA-01-011: Technologies for Comprehensive, Sensitive, and Quantitative Protein analysis in Human Tumors: Phased Innovation

Letter of Intent Date: Dec. 11, 2000

Application Receipt Date: Jan. 18, 2001

Technology Development Branch of the Cancer Diagnosis Program, Division of Cancer Treatment and Diagnosis, NCI, and the Functional Analysis of the Genome Program, Division of Extramural Research, National Human Genome Research Institute, invite grant applications proposing the development of technologies for the sensitive quantitation of the comprehensive spectrum of proteins present in human tissues.

Inquiries: Min Song, Division of Cancer Treatment and Diagnosis, NCI, Executive Plaza North, Rm 6035, Bethesda, MD 20892, phone 301-402-4185; fax 301-402-7819; e-mail: ms425z@nih.gov

RFA CA-99-001: Research in State and Community Tobacco Control Interventions

The initiative encourages research applications for new or existing tobacco control interventions, including prevention and cessation, at the community, state and multi-state level. Outcomes of this research are intended to guide tobacco control programs across the nation to increase program effectiveness and produce reductions in the prevalence of tobacco use.

Inquiries: Bob Vollinger, Tobacco Control Research Branch, phone 301-496-0273; e-mail bv26n@nih.gov

NCI Small Grants: Cancer Control Behavioral Research

Small grants are available for new investigators for pilot projects, development and testing of new methodologies, secondary data analyses, or innovative projects in: screening and early detection, cancer control sciences, tobacco prevention and cessation, applications research, health communications and bioinformatics, basic behavioral research, surveillance, survivorship, diet and nutrition.

Inquiries: Veronica Chollette, NCI, Executive Plaza North Rm 4048, 6130 Executive Blvd, MSC 7332, Bethesda, MD 20892-7332, fax 301-480-6637; e-mail vc24a@nih.gov; Web site http://dccps.nci.nih.gov/funding.html#brp

In Brief:

DeParle Leaves HCFA; Speyer Promoted At NYU Center

(Continued from page 1)

DEPARLE, administrator of the Health Care Financing Administration, plans to resign Oct. 1 to teach at Harvard University. She will become a fellow at the Institute of Politics, affiliated with the John F. Kennedy School of Government. She has served as HCFA administrator since 1997. . . . **JAMES SPEYER**, professor of clinical medicine at the NYU School of Medicine and an attending in medicine at NYU Hospitals Center and Bellevue Hospital, was appointed associate director for clinical affairs of the NYU Kaplan Comprehensive Cancer Center. . . . **RAYMOND DUBOIS**, Mina Cobb Wallace Professor of Cancer Research and associate director for cancer prevention at the Vanderbilt-Ingram Cancer Center, was selected for membership into the Royal College of Physicians for his contributions to the field of medicine. . . . **MAUREEN BAKER** was named director of development and external relations at the Virginia Commonwealth University Massey Cancer Center. Baker was president and CEO of the Hospital Hospitality House Inc. . . . **UNIVERSITY OF IOWA** received a $25 million gift for cancer research, education and treatment from the Holden family and is seeking approval from the Board of Regents to name its facility the Holden Cancer Center. The UI cancer center was recognized as an NCI-designated center last July. . . . **UNIVERSITY OF VIRGINIA** School of Medicine received $20 million for prostate cancer research from the estate of Paul Mellon. It is the largest gift in the medical school's history and the fourth largest for the university. The funds will be used to establish the Mellon Prostate Cancer Research Institute, co-directed by **William Steers**, chairman of the Department of Urology at the university, and microbiologist **Michael Weber**, director of the U.Va. Cancer Center. The institute plans to recruit four researchers in functional genomics. . . . **ELLEN GLESBY COHEN**, president and founder of the Lymphoma Research Foundation of America, died Aug. 23. Cohen had undergone a bone marrow transplant for non-Hodgkin's lymphoma earlier this year and developed a fungal infection. She was 51 and was being treated for her second recurrence of NHL. Cohen founded the Los Angeles-based non-profit foundation in 1991. It has awarded nearly $3 million to support 92 lymphoma research projects.

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