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To Improve Clinical Trials Participation, Groups Plan An Awareness Campaign

Oncology professional societies and patient advocacy groups tentatively agreed last week to begin planning a national public education campaign on cancer clinical trials.

The organizations, which took part in a three-day "Summit Series on Clinical Trials" in Arlington, Va., said cancer patients often don't know that clinical trials are available and that participation in a trial may offer state-of-the-art therapy. The aim of the campaign would be to increase accrual to clinical trials.

Only about 2 to 3 percent of adult cancer patients are entered onto

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In Brief:

Three Win Nobel Prize In Medicine; Irving Center Awarded $10M For Breast Cancer Research

NOBEL PRIZE in Physiology or Medicine was awarded to **Arvid Carlsson** of the University of Gothenburg, **Eric Kandel** of the Center for Neurobiology and Behavior at Columbia University, and **Paul Greengard** of the Laboratory of Molecular and Cellular Science at Rockefeller University for their discoveries in signal transduction in the nervous system. Together their work has improved treatments for Parkinson's Disease, schizophrenia, and depression, and holds promise for the improvement of memory in various types of dementia. NIH provided more than 30 years of support for the work by Kandel and Greengard. . . . **HERBERT IRVING COMPREHENSIVE CANCER CENTER** at Columbia Presbyterian Medical Center was selected to receive a $10 million gift from the Avon Breast Cancer Crusade to advance breast cancer research and provide comprehensive breast cancer care to medically underserved women as part of the Avon Products Foundation Breast Cancer Research and Care Network. **Karen Antman** is the director of the Irving center. The gift will establish the Avon Products Foundation Breast Cancer Research Laboratories for basic research, enable the center to expand screening and comprehensive breast cancer care to indigent women in northern Manhattan, and endow the Avon Products Foundation Chair in Breast Cancer Clinical Research with a preference for a geneticist. . . . **DAVID TUCK** was appointed associate director for clinical trials at Yale Cancer Center. Tuck, an oncologist and hematologist, joins Yale after six years in research at Bristol-Myers Squibb, where he worked on the development of anti-cancer drugs at the molecular level. He will be responsible for the

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Survey Finds 85% Of Patients Are Unaware Of Clinical Trials

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trials. According to the results of a survey presented at the conference, 85 percent of cancer patients are unaware that clinical trials are an option for their treatment.

"Patients don't demand clinical trials and doctors don't talk about them," Charles Balch, executive vice president and chief executive officer of the American Society of Clinical Oncology, said at the summit conference, which drew about 200 participants. "If patients demand them, and if doctors know what patients want, they will find a way to enroll them. We need to incorporate trials into our value system."

A public education campaign might include advertising, working with the press, and lobbying Congress, state legislatures, and government agencies, the participants said. Participants considered several successful awareness campaigns, including the state-funded "Truth" campaign targeting youth smoking in Florida and a nursing awareness campaign.

"The sponsoring organizations of the summit will work together and with other major players in the country to come up with a plan for a comprehensive, long-range awareness campaign," Robert Comis, president of the Coalition of National Cancer Cooperative Groups, said to **The Cancer Letter**. "We are definitely going to try to lead the way in this area. It was clear that this is the most important thing that we need to do."

The summit conference, the fourth such meeting of cancer organizations since 1998, was convened by the Coalition of National Cancer Cooperative Groups, the Cancer Leadership Council, the Cancer Research Foundation of America, and the Oncology Nursing Society. The summit received financial support from ASCO, the Susan G. Komen Breast Cancer Foundation, and several pharmaceutical companies.

Beliefs Preclude Participation

In previous summit conferences, participants called for surveys of patient and physician attitudes toward clinical research as the first step in developing a strategic plan to increase clinical trial participation to 10 to 15 percent of cancer patients.

Last year, the four organizations that convened the conference collaborated with Harris Interactive to conduct six surveys, of the public, the news media, cancer patients, family members of cancer patients, primary care physicians, and oncology nurses and physicians. Results of the public and patient surveys were presented at the conference last week.

The survey contacted 1,000 adults by phone, including over-samples of 200 African-Americans and 200 Hispanics. Additional phone interviews were conducted with 538 cancer patients. An online survey was conducted with 5,377 cancer patients.

According to the results Comis presented at the summit:

—Of the 5,980 patients surveyed, 85 percent were unaware that participation in a trial could be an option.

—Of the 14 percent who were aware of trials, 26 percent said they had participated in one, and 71 percent did not participate.

—Patients who participated were more likely to say their doctor informed them about clinical trials and helped them find a suitable trial.

—Patients who participated in a trial said it was a positive experience; 97 percent said the care they received was "good" or "excellent" and they were treated with dignity and respect.

—Few participants said they had unnecessary tests or procedures.

—Among the patients who chose not to participate in trials, the reasons cited were: standard treatment was thought to be better (37 percent); fear of receiving a placebo (31 percent), fear of being treated like a "Guinea pig"; distance they would have

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to travel (21 percent); and concern about insurance coverage (20 percent).

—When adults without cancer were asked whether they would consider a clinical trial if they were diagnosed with the disease, 80 percent said they would.

Comis said he was surprised by the number of people who said they feared receiving a placebo in a trial. "It doesn't happen in cancer clinical trials," he said. "This placebo issue is a major issue, and it's a pubic relations and marketing issue."

The concern about having to travel to participate in a trial also may be based on misinformation, Comis said. "Patients don't realize that they can get excellent care in clinical trials in their communities," he said.

Recent studies including one presented at the ASCO annual meeting last May, have found that insurance companies are, for the most part, paying for the patient care costs of participation in cancer clinical trials, Comis said. "If the insurance companies would come to the plate and work with us, we can conquer the real problem, which is fear," Comis said.

Medicare recently began to reimburse patient care costs incurred by participants in clinical trials.

Comis said the results of the six surveys are still being analyzed and will be submitted to oncology journals and other publications.

Most of those surveyed said they would trust information from advocacy organizations and their doctors, but not from the government, said Ellen Stovall, executive director of the National Coalition of Cancer Survivorship. "The most provocative finding, in my opinion, was the issue of whom do you trust," she said. "The vast majority of people said they would be willing to participate in a trial as their initial treatment."

Advice From Marketing Experts

The organizations that convened the summit are working with national newsmagazines and television programs to develop a series of advertising sections that would include educational messages about cancer clinical trials, Comis said.

A sustained national education campaign could be costly. The "Truth" campaign in Florida cost $25 million a year, its strategist, David Zucker, senior vice president of Porter Novelli, said at the summit conference. Funding came from the state's legal settlement with tobacco firms. However, youth smoking in Florida dropped 54 percent two years after the campaign began. The campaign's Web site is: http://www.wholetruth.com.

Lisa Wyatt, vice president of public affairs and marketing at Washington Hospital Center, estimated a national awareness campaign that relied on a significant amount of "free" exposure through news articles or television news programs would cost at least $1.2 million a year, including salary for five full-time employees.

"Clinical trials is a great product," said Sharyn Sutton, chief executive officer of Sutton Social Marketing, of Washington, DC. "It shouldn't be that difficult."

"It doesn't look that tough to me," said William Novelli, associate executive director of the American Association of Retired Persons and one of the founders of Porter Novelli. He advised the summit participants to "apply creativity at each stage of the process."

Comis said the summit conveners appreciated the advice. "We realize the magnitude of the challenge, and we will develop the financing plan and strategy over the next year or so," he said.

Capitol Hill:

Congress Approves Payments For Treatment Of Women Diagnosed In CDC Program

The Breast and Cervical Cancer Treatment Act was passed unanimously by the House and Senate and is on the way to the White House.

The bill (H.R. 4386/S.662) provides treatment for women diagnosed with breast or cervical cancer through the screening program run by Centers for Disease Control and Prevention.

Since the federal program doesn't guarantee treatment, women who have no health insurance yet are not eligible for Medicaid get double bad news: You have cancer and there is no money to treat you. The bill will give states the option to change their Medicaid eligibility requirements to provide coverage for these women.

"This legislation is vitally important to our mothers, daughters and sisters and we could afford to wait no longer," said Fran Visco, president of the National Breast Cancer Coalition, a grassroots advocacy group.

Though the treatment bill has all the attributes of a measure no one can afford to oppose in public, over the past three years NBCC overcame significant resistance from legislators, administration officials, and

several advocacy groups.

"This legislation will put an end to the cruel hoax of a program that diagnoses women with breast cancer but then turns its back on them once they are in need of treatment," Visco said.

The Senate passed the bill by unanimous consent on Oct. 4, and President Clinton said he stood poised to sign it. All that's needed is the House vote on the amended legislation. The House passed the bill on Oct. 21.

* * *

Rep. Deborah Pryce (R-OH) earlier this week introduced a bill that would create a five-year "demonstration project" that would allow NCI to bypass many of the government's purchasing and contracting regulations, giving the Institute the authority similar to that of the Defense Advanced Research Projects Agency.

Since the bill (H. R. 5419) has no Senate counterpart, observers don't expect it to be enacted as Congress rushes to complete its business before the elections. Sources said the measure failed to get the endorsement from top HHS officials.

Still, the bill is significant because it reflects the thinking of many important players in oncopolitical circles, which could mean that the measure may resurface in the next Congress. The measure is co-sponsored by Rep. Lois Capps (D-CA).

The work on the bill was carried out by Podesta.com on behalf of Friends of Cancer Research, the American Society of Clinical Oncology, the American Association for Cancer Research and the American Cancer Society.

The idea of eliminating bureaucratic constraints on NCI was aired in the recommendations of the Research Task Force of The March, a 1998 event. The report, co-written by Ellen Sigal, president of Friends of Cancer Research and Anna Barker, president of BioNova Inc. of Portland OR, recommended elimination of "burdensome policy constraints that represent significant barriers to achieving the authority, flexibility, efficiency and effectiveness required to optimize the efforts of all sectors and accelerate progress toward our national goal of curing and preventing cancer." The document also recommends using NCI as a "reinvention laboratory as one approach to relieve bureaucracy."

"At a time of rapid growth and discovery in the world of medicine, we need to be as thoughtful in forming the institute that leads our nation into the battle against cancer as we are in choosing the science that will help us to win," said Pryce, introducing her bill Oct. 6.

Though no one expects the bill to pass, Sigal said the measure is likely to re-emerge next year. "We are not giving up on this," she said. "We can't always look at funding. We have to look at all the barriers that impede progress."

Under the bill, the director will have the authority to "establish a comprehensive competitive human resources system."

The director would appoint individuals for work at the Institute, obtain the services of experts or consultants; have the authority to hire personnel, and negotiate trades of employees on loan with other agencies.

The director would have greater latitude in using contracts, cooperative agreements, and grants to carry out basic, applied, and advanced research projects. The director will establish a program of "high-impact, cutting edge research" designed to undertake research projects with maximum flexibility and speed.

Under the program, the director would be able to select new initiatives, after an expeditious peer review with requisite expertise, for further development and research; identify partners and collaborators for such initiatives; select the funding mechanism for such initiatives; reprogram up to 2 percent of the amounts appropriated to the NCI to support such initiatives and research; and make awards with respect to new initiatives and research.

The director would be able to convene groups of federal and non-federal employees, to obtain consensus advice or recommendations, bypassing the requirements of the Federal Advisory Committee Act.

Overall, the director would be able to redirect within the NCI as much as 5 percent of the amount appropriated for the Institute for new, high-priority initiatives.

The director would not have to get the advice of the National Cancer Advisory Board for grants or cooperative agreements of under $300,000. The current threshold is $50,000.

The director would make a salary determination for senior contract research scientists employed at the federally funded research and development centers of the Institute consistent with the salary levels applicable for Institute staff.

Monitoring the project, the NCI director would submit to the NIH director a report concerning the activities that may have a potential benefit for NIH.

* * *

President Bill Clinton last week made cancer the subject of his Saturday radio address. In the speech Oct. 7, Clinton mentioned the colorectal cancer event taking place in Washington that weekend, the breast and cervical cancer treatment bill pending in the House, and the Patient Bill of Rights.

"For eight years now, the Vice President and I have made the fight against cancer one of our top priorities, nearly doubling funding for cancer research and treatment," Clinton said. "We've also accelerated the approval of cancer drugs, while maintaining the highest standards of safety. We've strengthened Medicare to make prevention, screening and clinical trials more available and more affordable."

Clinton said NCI would invest $30 million over the next five years to expand and improve screening procedures for colorectal cancer. "We need to address the chronic under use of these life saving tools, and this new investment will encourage physicians to make regular use of the most effective procedures," Clinton said in the address. Also, starting next year, Medicare recipients will get screening reminders, starting with one on colorectal cancer, every time they go to their doctor or use Medicare's toll-free line.

Clinton urged Congress to pass legislation that expands Medicare to include colorectal cancer screening and eliminate all cost-sharing requirements for colorectal screening and other preventive procedures under Medicare.

Professional Societies:

Declining Support Among Oncologists For Euthanasia

Results of a survey of 3,299 members of the American Society of Clinical Oncology indicate support among U.S. oncologists for euthanasia and physician-assisted suicide of terminally ill cancer patients declined dramatically in recent years.

The survey, sponsored by ASCO, also found that oncologists who had been trained in end-of-life care were less likely to support or carry out euthanasia or physician-assisted suicide.

The survey's results, published in the Oct. 3 issue of the Annals of Internal Medicine, emphasize the need to educate physicians about ways to provide high-quality pain management and palliative care to dying patients, said lead researcher Ezekiel Emanuel, chief of the NIH Department of Clinical Bioethics.

"End-of-Life and palliative care need to be formally taught and incorporated into physician training programs and continuing medical education," Emanuel said. "Physicians who receive better training in end-of-life care seem less likely to perform euthanasia or physician-assisted suicide."

The survey, conducted in 1998, is the largest to assess the attitudes and practices of physicians about euthanasia and physician-assisted suicide. When researchers compared these results to a similar survey conducted in 1994 by Emanuel, they found that oncologists' support for euthanasia for dying cancer patients in excruciating pain declined by nearly 70 percent—from 23 percent in 1994 to just below 7 percent in 1998.

Support among oncologists for physician-assisted suicide in the case of a terminally ill cancer patient with unremitting pain declined by over 50 percent–from 45 percent to 22 percent in the same four years.

The overall decline in support for euthanasia and physician-assisted suicide may reflect an improved ability by some oncologists to provide appropriate care for their dying patients, Emanuel said.

In fact, oncologists who said they could get their dying patients all the care they needed were far less likely to perform euthanasia than those who reported administrative, fiscal or other barriers to providing care.

"ASCO believes that physicians have an obligation to talk to their terminally ill patients and their family about their options for palliative care and what type of symptomatic management will be provided. We urge physicians to assure their patients that they will not be left to make these difficult decisions on their own." said Charles Balch, executive vice president and chief executive officer of ASCO. "ASCO has pledged to take every responsible measure to assure that all physicians are well versed in providing optimal end-of-life care and to remove all barriers to the delivery of such care."

More than 70 percent of patients using euthanasia and physician-assisted suicide have cancer, ASCO said. As a result, oncologists are more likely to have to address the issue of euthanasia and physician-assisted suicide more often than other physicians.

Of those oncologists surveyed in 1998, almost 16 percent said they would be willing to provide physician-assisted suicide and 2 percent would be willing to carry out euthanasia. Least likely to support euthanasia or physician-assisted suicide were physicians who had sufficient time to talk to their dying patients about end-of-life care and those who were religious.

Nearly one-third of the oncologists surveyed also said they would be reluctant to increase the dosage of morphine for a dying cancer patient in excruciating pain. This reticence to relieve patients' pain seems to reflect some physicians' fears that increasing the dose of morphine may also raise a patient's risk of respiratory depression and death, which might be construed as a from of euthanasia.

"Unfortunately, equating increasing morphine for pain relief with euthanasia seems to lead to inadequate pain management for patients, which is troubling," said Emanuel. "Physicians must be educated about the ethical and legal acceptability of increasing narcotics for pain control, even at the risk of death."

"These study results underscore the need for physician education of optimal pain and palliative care practices," said Robert Mayer, vice chair for academic affairs, Dana-Farber Cancer Institute, professor of medicine, Harvard Medical School, and past president of ASCO, under whose leadership the study was initiated. "Physicians who are better informed about end-of-life issues feel less need to use euthanasia and physician-assisted suicide."

Seventeen percent of oncologists surveyed were female and 33 percent worked in an academic setting; two-thirds said that 25 or more of their patients had died in the past year.

Oncologists' attitudes did not differ by age, sex, geographic region, year of graduation from medical school or the number of their patients who died in the previous year. Sixty-three percent of oncologists had received requests for euthanasia and physician-assisted suicide during their careers, and 31 percent had received such requests during the previous 12 months. Overall, nearly 11 percent of respondents had performed physician-assisted suicide and almost 4 percent had carried out euthanasia.

NCI Programs:

Nine New Grants Awarded In The "Director's Challenge"

NCI has awarded nine additional grants for the second round of funding for a major new initiative called "The Director's Challenge: Toward a Molecular Classification of Tumors."

The nine new projects will join 10 projects that were funded last year to define the patterns of molecular changes in tumors. These molecular profiles will lay the foundation for the precise molecular diagnosis of cancer.

"These new awards expand our activities aimed at transforming our approach to classifying and diagnosing human cancers," said NCI Director Richard Klausner. "This project is one of the most immediate applications of genomics and other emerging techniques to change the care of the cancer patient."

The newly funded investigators will work to develop profiles of molecular alterations that will help identify clinically relevant subsets of tumors from seven different organ sites and hematopoietic cancers. The cancers to be analyzed include breast, prostate, colon, lung, ovarian and brain tumors; adult and pediatric sarcomas; chronic and acute leukemias; and several different lymphomas.

As part of the initiative, investigators will work collaboratively, with the assistance of NCI staff, to identify ways to present research data so that other cancer researchers can interpret and analyze it. They also will develop strategies for publicly releasing research data. This approach to data sharing should significantly increase the value of the data and should maximize the impact of the NCI investment in molecular-based tumor classification research. NCI also anticipates that approaches to data sharing pioneered by the Director's Challenge investigators will serve as future models for the cancer research community.

The nine five-year grants, totaling nearly $4.2 million for the first six months, were awarded to:

—Montefiore Medical Center, Leonard Augenlicht, to develop gene expression profiles that will lead to improved prognosis in Dukes' B2 and C colon cancer, $537,266.

—Memorial Sloan-Kettering Cancer Center, Jeffrey Boyd, to develop a comprehensive molecular classification scheme for ovarian cancer, $102,532.

—Case Western Reserve University/University Hospitals Ireland Cancer Center, Sanford Markowitz, to identify patients at risk of advanced colon cancer by developing gene expression profiles that identify prometastatic cells in primary colon tumors, $718,093.

—University of Pittsburgh, George Michalopoulos, to develop a new molecular classification scheme for prostate tumors, $308,319.

—University of California, Los Angeles, Jonsson Cancer Center, Stanley Nelson, to develop a molecular classification scheme for brain tumors based on gene expression profiles, $339,113.

—Duke University Medical Center, Gregory Riggins, to develop expression-based classification schemes for brain tumors using Serial Analysis of Gene

Expression, $354,274.

—Childrens Hospital Los Angeles, Timothy Triche, to develop molecular profiles of sarcomas from pediatric and adolescent patients, $714,544.

—University of New Mexico Health Sciences Center, Cheryl Willman, to develop expression-based molecular classification schemes for acute myeloid leukemia and acute lymphoid leukemia, $466,875.

—H. Lee Moffitt Cancer Center and Research Institute, Timothy Yeatman, to develop molecular profiles to identify colon cancer patients at risk of metastatic disease, $627,669.

NIH Programs:

NCCAM Awards To Establish Two Cancer Research Centers

The National Center for Complementary and Alternative Medicine plans to award $16 million over five years to establish two specialized centers to conduct basic and clinical research on complementary and alternative medicine therapies for cancer.

The funding will be awarded to Johns Hopkins University and the University of Pennsylvania, bringing the total of NCCAM-supported centers studying CAM therapies to 15.

Recent national surveys have found that the majority of patients in treatment for cancer use some form of complementary or alternative medicine, such as herbs, vitamins, or meditation. "These approaches have not yet been proven effective," said NCCAM Director Stephen Straus. "Moreover, some herbs may cause harmful interactions with other drugs used as standard treatment by cancer patients. These Centers will promote high-quality research and provide the resources necessary to facilitate rigorous scientific investigation to determine the safety and effectiveness of several popular CAM cancer therapies in use by the American public."

The Johns Hopkins Center for Cancer Complementary Medicine headed by Adrian Dobs plans four research projects: 1) examine anti-oxidant effects of herbs in cancer cells; 2) use four established animal models that reflect different aspects of pain in cancer patients. The animals will be fed soy and tart cherry, which are felt to possess antioxidant and anti-inflammatory properties; 3) investigate the safety and efficacy of PC-SPES, a popular mixture of Chinese herbal medications, in men with prostate cancer; 4) examine the effects of prayer on disease recurrence, immune and neuroendocrine function in African American women with breast cancer.

Stephen Thom heads the University of Pennsylvania Specialized Center of Research in Hyperbaric Oxygen Therapy, which uses oxygen at greater than-atmospheric pressures to treat a variety of disorders. The center proposes four projects to examine mechanisms of action, safety and clinical efficacy of hyperbaric oxygen therapy for the treatment of head and neck tumors: 1) evaluate treatment outcomes for patients who have undergone laryngectomy; 2) examine the effects of hyperbaric oxygen on growth of blood vessels and tumors; 3) characterize the effects of hyperbaric oxygen on cell adhesion and growth of metastatic tumor cells in the lung; 4) test the effects of elevated oxygen pressures on cellular levels of nitric oxide.

Funding Opportunities:

Program Announcement

TPA-01-005: Molecular and Cellular Biology of Metastatic Tumor Cells

The initiative will provide funds for preliminary research projects of future R01 applications to investigate metastasis. The intent is to promote collaborative research between investigators with basic molecular and cellular biological and biochemical research experience, and those with experience in metastasis research, and increase the number of laboratories and investigators addressing issues of metastasis.

Inquiries: Suresh Mohla, chief, Tumor Biology and Metastasis Branch, Division of Cancer Biology, NCI, phone 301- 435-1878; e-mail sm82e@nih.gov

Addendum: Cancer Care Outcome Research and Surveillance Consortium (RFA-CA-01-013)

NCI is informing applicants of three changes to this RFA: First, a change to minimum enrollment for each primary data collection and research site applicant. Second, given the reduction of the minimum sample size allowed, all PDCR site applicants are encouraged to target 1,000 patients per cancer type, if resources permit, in order to achieve the sample size objective of 6,000 patients per cancer within the CanCORS Consortium as a whole. The third change is a clarification of the definition of principal investigator. The RFA can be found at http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-01-013.html

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In Brief:

Tuck To Direct Clinical Trials At Yale; Arceci Joins Hopkins

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center's Protocol Review and Monitoring System, and will work with the Medical Informatics Program. Tuck graduated from Harvard University and University of Vermont. After training at University of Connecticut in hematology/oncology, he continued as an assistant professor of medicine and associate director of the stem cell transplant program. . . . **ROBERT ARCECI** joined the Johns Hopkins Oncology Center as director of the Division of Pediatric Oncology. Arceci previously was director and Jacob Schmidlapp Professor of Pediatric Hematology and Oncology at the Children's Medical Center in Cincinnati. He has held leadership positions in pediatric oncology cooperative groups. He received both his medical degree and a doctorate from the University of Rochester School of Medicine and Dentistry, completed his fellowship training at Children's Hospital in Boston, and was a faculty member at Harvard University until 1994 when he was recruited to Cincinnati. Arceci succeeds **Curt Civin**, who served as the division's director for 16 years and has assumed increased leadership responsibilities in hematopoiesis research. . . . **PHILIP LEE**, emeritus professor at the University of California, San Francisco, Institute for Health Policy Studies, will receive the Institute of Medicine's Gustav O. Lienhard Award on Oct. 16 at the Institute's annual meeting. Lee is being honored for his contributions to improving personal health services as a practitioner, advocate, researcher, policy-maker, administrator, and public leader. . . . **NIH AWARDED** 19 grants, totaling $165.5 million over five years, to research institutions located in states that had not fully participated in NIH funding in the past, through its Institutional Development Award Program. The National Center for Research Resources awarded the grants to: University of Arkansas, Fayetteville; University of Delaware, Newark; University of Idaho, Moscow; University of Kansas Center for Research Inc., Lawrence; University of Kentucky Research Foundation, Lexington; University of Louisville, Kentucky; Maine Medical Center Research Institute, Portland; University of Montana, Missoula; University of Nebraska, Lincoln; University of Nevada, Reno; Oklahoma Medical Research Foundation, Oklahoma City; Oklahoma University Health Science Center, Oklahoma City; Brown University; University of South Dakota, Vermillion; University of Vermont and State Agricultural College, Burlington; West Virginia University; University of Wyoming, Laramie (two grants); University of Puerto Rico. Each grantee will establish a Center of Biomedical Research Excellence to be led by an established investigator who will direct a multidisciplinary effort to focus on a basic or clinical research theme. The research team will include promising investigators who are to develop their research skills to enhance the pool of competitive investigators among the IDeA-eligible states. States eligible to apply for IDeA grants are those that received less than $70 million in NIH funding from 1994 to 1998 or had an NIH grant award success rate of less than 20 percent over that period. In FY 2001, the IDeA program is expected to receive $100 million from Congress. A summary of a recent NIH workshop on the program is posted at http://www.ncrr.nih.gov/resinfra/rimtgs.htm. . . . **FIFTY-SIX CHILDREN'S HOSPITALS** are receiving payments totaling about $38 million for medical education, the U.S. Department of Health and Human Services said last week. The funding represents the first payments under a new program supporting independent children's teaching hospitals, similar to support provided to other teaching hospitals through Medicare. The children's hospitals receive less than $2 million annually in federal support for continuing education, while other teaching hospitals share about $7 billion each year from Medicare to support their graduate medical education programs. Congress created the Children's Hospitals Graduate Medical Education Payment Program in 1999 and appropriated $40 million for the program in FY 2000. The funds are administered by the Heath Resources and Services Administration's Bureau of Health Professions. . . . **TWO WORKING GROUPS** of the National Committee on Vital and Health Statistics, the National Health Information Infrastructure Workgroup, and the Health Statistics for the 21st Century Workgroup, plan to hold a public hearing on Oct. 30, 9 am-5 pm at Canterbury Hotel, San Francisco. The committees seek public opinion about issues raised in the interim reports of these two workgroups: "Toward a National Health Information Infrastructure" and "Shaping a Vision for 21st Century Health Statistics." The reports may be downloaded at: http://www.ncvhs.hhs.gov/. For further information about the hearing, contact Patrice Upchurch, phone 301-458-4540; e-mail pupchurch@cdc.gov.

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