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ASCO Proposes Compromise To Limit Payment Cuts Proposed By Congress, CMS

Through most of the current legislative session, lobbyists for cancer specialists have been trying to moderate the oncology reimbursement cuts proposed by the House and Senate in their Medicare reform bills.

In August, the game changed radically, as the Centers for Medicare and Medicaid Services published a proposed rule that would change the formula for reimbursement of oncologists under Medicare Part B.

Suddenly, the Congressional Medicare reform bills came to represent

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In Brief:

Moses, Earp To Lead AACI; Blayney Named Medical Director, Michigan Cancer Center

ASSOCIATION OF AMERICAN Cancer Institutes has elected new officers and members of its board of directors. **Harold Moses**, director of the Vanderbilt-Ingram Cancer Center, will begin a two-year term as president following the AACI 2003 annual meeting, Oct. 26-28, in Washington, D.C. **H. Shelton Earp III**, director of the University of North Carolina Lineberger Comprehensive Cancer Center, Chapel Hill, will serve a two-year term as vice president and president-elect. Directors-elect are: **William Dalton**, CEO and center director, H. Lee Moffitt Cancer Center and Research Institute; **Frank McCormick**, director, University of California at San Francisco Comprehensive Cancer Center and Cancer Research Institute; and **George Vande Woude**, director, Van Andel Research Institute. The directors will serve three-year terms. . . . **DOUGLAS BLAYNEY** was named to the newly-designated post of medical director of the University of Michigan Comprehensive Cancer Center in Ann Arbor, said **Max Wicha**, Distinguished Professor of Oncology and director of the University of Michigan Comprehensive Cancer Center. Blayney, who will also serve as a clinical professor of medicine at the University of Michigan, will oversee clinical services in the more than two dozen cancer care clinics within the Center, and will treat both breast cancer and lymphoma patients. He joins the U-M from a private oncology practice, the Wilshire Oncology Medical Group in Pasadena, California which he joined in 1986 and led since 1992. . . . **WENDY DEMARK-WAHNEFRIED** was appointed director of the Duke Comprehensive Cancer Center Cancer Prevention, Detection and Control Research Program, said **H. Kim Lyerly**, director, Duke Comprehensive Cancer Center. Demark-Wahnefried, a nutritionist, is

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Oncologists Hope To Limit Cuts Through Legislation

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the only hope for thwarting the CMS rule that is now scheduled to go in effect on Jan. 1.

As the entire structure of oncology—reimbursement for drugs and drug administration—hang in the balance, there is no assurance that Congress will get around to Medicare reform, and some observers predict that the two reform bills will fall by the wayside, as legislators focus on the Administration's proposal to spend $87 billion on post-war Iraq and Afghanistan.

Both bills—S.1 and H.R.1—propose the Medicare drug benefit, a big-ticket item, which, according to many Hill-watchers, is becoming more controversial as war spending and the tax cuts propel the federal deficit to a record level.

Under the Congressional proposals, Medicare reimbursement for oncologists will be cut severely. However, if the Medicare reform bills fail to clear Congress, the CMS rule would simply kick in, drastically cutting reimbursement. The oncologists' only hope is to change the language of the Congressional bills and moderate the cuts, lobbyists say.

On Sept. 10, the American Society for Clinical Oncology presented a compromise proposal to the Congressional committees, sources said. The proposal includes a multi-year transition from the controversial reimbursement schema based on the artificial "average wholesale price" of cancer drugs to reimbursement based on the "average sales price."

Also, the compromise plan calls for a new study to determine how oncologists should be compensated for professional services and practice expenses.

The players in this struggle include ASCO, the long-time leader in the battles over Medicare reimbursement, U.S. Oncology, a for-profit company that depends on the "spread" between the acquisition price and the price charged to Medicare, and Community Oncology Alliance, a new group that holds that ASCO has not been making its case with sufficient vigor.

Patient groups, too, are involved, mostly on the side of oncologists.

Oncologists and their allies argue that doctors aren't adequately reimbursed for providing cancer care, and that the money they earn on drugs covers the shortfall from inadequate Medicare reimbursement for professional and office expenses.

Oncologists and patient groups argue that if these revenues disappear, many doctors would be forced to close their practices, or refer their Medicare patients to the hospitals, which would be ill-equipped to cope with the onslaught. As a result, Medicare patients would have difficulty obtaining cancer care, and the quality of available care would suffer, doctors and patients contend.

The House and Senate are working in conference to reconcile their versions of the Medicare bill.

—Under the House bill, physicians would present chemotherapy prescriptions to vendors, who would provide the chemotherapy drugs. These vendors, selected through a competitive bidding system, would be responsible for dealing with Medicare and collecting the co-payments from patients. An alternative approach described in the bill would allow doctors to accept reimbursement at 112% of the manufacturer's average sales price in 2005-2006, which would drop to 100% of ASP in later years.

—The Senate bill calls for dropping reimbursement to 85% of the average wholesale price, a decrease from the current formula that pays for 95% of AWP. In cases where CMS learns that the drugs are widely available at a lower price, that price would be used instead.

—The CMS proposal suggests four alternative

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approaches, stating that one of them would be ultimately chosen. These include limiting Medicare payments to what contractors pay for the same drugs provided to their private policyholders; lowering the reimbursement to 80% or 90% of AWP; and using market data to adjust reimbursement for drugs at widely available market prices.

The fourth option, based on the House bill, would make oncologists acquire chemotherapy through a "competitive acquisition program" run by intermediaries or accept reimbursement based on the average sales price.

According to CMS, as much as $27.6 billion could be squeezed out of the system over 10 years. Meanwhile, the agency proposes increasing the oncologists' reimbursement for professional services and practice expenses by $175 million a year.

The agency's draft rule, dated Aug. 20, is available at http://cms.hhs.gov/providers/drugs/AWP_NPRM_082003.pdf.

Public comment period ends on Oct. 14.

The compromise proposal presented by ASCO earlier this week builds conceptually on one of the options in the House plan, but calls for a longer—three-year—transition to the reimbursement level of 112% of the average sales price of oncology drugs. The House plan and Option Four in the CMS plan call for using 112% of ASP as the starting point, and moving toward 100% of ASP.

The society's proposal doesn't suggest using an intermediary, an option described by the House and CMS.

Also, ASCO is asking that the Medicare Payment Advisory Commission determine proper reimbursement for professional services and practice expenses oncologists incur as they care for Medicare patients. The society has described the CMS proposal of a $175 million increase as unrealistic, but CMS has rejected ASCO's methodology for estimating costs. MedPAC is an independent government commission that advises Congress on Medicare.

Four Senate members recently sent a letter seeking to change the oncology reimbursement provisions of the House and Senate bills.

"The Medicare prescription drug bills passed by the U.S. Senate and House of Representatives contain provisions that will have the unintended consequence of jeopardizing patient access to quality cancer care," states the letter originally signed by Sens. Sam Brownback (R-Kan.), John Warner (R-Va.), Bill Nelson (D-Fla.) and Dianne Feinstein (D-Calif.). "We have serious reservations about the proposed cuts, and fear they will have a profound effect on the delivery of cancer treatment across the country."

Altogether, over 30 Senate members have signed the letter, sources said.

Last summer, ASCO conducted a survey of oncologists, which showed that more than half of the doctors would limit the number of Medicare patients in their practices, and almost one in five would decline to care for Medicare patients.

The survey was sent to 2,900 private practice oncologists, and more than 900 responded. Over half of the respondents said that Medicare beneficiaries comprise a major portion (41-60%) of their practices.

Oncologists said that if the Medicare legislation passed:

—73% of physicians would send chemotherapy patients to a hospital instead of treating them in an office setting. (Many hospitals have said they would not be able to handle the new influx of patients.)

—53% would limit the number of Medicare patients they treat, and 19% would stop treating Medicare patients entirely

—42% would stop conducting clinical trials in their offices

—44% of physicians (55% of those over age 55) would retire from practicing medicine earlier than they had originally planned

ASCO's survey of cancer center directors indicated that the centers with satellite offices would scale back these operations, and that clinical research would be adversely affected.

Cancer Rates:

Cancer Incidence, Mortality Leveling Off, Report Finds

Rates of cancer incidence and death in the U.S. are leveling off after declines in the 1990s, requiring a greater effort to meet national health goals, according to the annual report on cancer statistics.

In 2003, there will be an estimated 1,334,100 cases of cancer diagnosed in the U.S. and 556,500 deaths, Brenda Edwards, associate director for the NCI Surveillance Research Program, said to the National Cancer Advisory Board at a Sept. 10 meeting. Prostate, breast, lung, and colorectal cancer represent more than half of the cases and almost half of the deaths.

Cancer mortality rates increased from 1975

through 1990, stabilized through 1994, and declined from 1994 through 1998 before becoming stable from 1998 through 2000, according to the "Annual Report to the Nation on the Status of Cancer, 1975-2000," written by the American Cancer Society, NCI, the Centers for Disease Control and Prevention, and the North American Association of Central Cancer Registries.

The report was published in the Journal of the National Cancer Institute on Sept. 3.

"There appears to be a flattening [in mortality]; in part, this seems to be due to a flattening in the death rate for women," Edwards said to the NCAB. "We continue to see a decline in men. We do think this stabilizing trend is in a large part due to the change in the way in which we classify cancer deaths, but there are probably other reasons as well.

"The picture is complex," Edwards said. "It's not being driven by any one cancer site."

According to the latest incidence data from CDC and the NCI Surveillance, Epidemiology and End Results program, cancer incidence rates for all types of cancers combined increased from the mid-1970s through 1992, declined from 1992 to 1995, and then stabilized from 1995 to 2000. For the most recent time period, an increase in breast cancer and prostate cancer was offset by a long-term decrease in lung cancer in men.

"Although considerable progress has been made in reducing the burden of cancer in the U.S. population, a greater effort will be required to meet national health goals, such as the Healthy People 2010 and ACS 2015 challenge goals," the report concluded.

"Furthermore, as the population of older Americans increases, the number of people diagnosed with cancer is expected to double in the next several decades," the report said. "Because more of these patients are living longer after a diagnosis of cancer, the strain on cancer control and health care resources to provide treatment and palliation services will increase."

Reduction of the cancer burden in the U.S. can be made through new research discoveries and "systematic dissemination of existing knowledge into practice," the report said. "In the future, existing collaborative efforts need to be enhanced among federal, state, and private organizations."

NCI Director Andrew von Eschenbach said the report shows that research has made progress against cancer, but further work is required. "The good news is the death rates from the four most common cancers—lung, breast, prostate, and colorectal—continue to decline," von Eschenbach said to the NCAB. "But the rate of decline has apparently stabilized for many of these cancers. This is a very important indicator of the fact that we are making progress, that our ability to eliminate suffering and death due to cancer is a reality.

"We need to continue to be vigilant about how we can further accelerate that rate of decline and how we can capitalize on the progress that we are making in biomedical research and address the ability to truly have an impact on people's lives," von Eschenbach said.

"Obviously, with the goal to eliminate the suffering and death due to cancer by 2015, this really is a clarion call for a continued commitment and continued focus and continued strategic process to look at cancer as a disease process and determine how we can best effectively impact upon it," von Eschenbach said.

In an editorial in JNCI accompanying the report, M.J. Quinn, director of the National Cancer Intelligence Centre in the UK Office for National Statistics, wrote that new technologies would have "major impacts" on cancer prevention, diagnosis, and treatment, but that the application of these technologies would take another decade or longer.

"It seems unlikely that cancer death and suffering will be completely eliminated by 2015," Quinn wrote in a direct reference to von Eschenbach's goal. "In Europe… a more modest target has been set of a 20% reduction in the number of cancer deaths compared with the number expected if the rates in 2000 remained unchanged."

A Better Denominator, More Accurate Rates

This year's report provides better estimates of cancer incidence and death rates in ethnic groups than in previous years, because it uses population estimates from the 2000 Census, rather than estimates based on the 1990 Census, the report said.

The report examined recent patterns of cancer among whites, African Americans, Asian and Pacific Islanders, American Indians/Alaska Natives, and Hispanics. From 1992 through 2000, cancer rates among each of these groups differed considerably, but showed declines in some of the most prevalent cancers.

The more years it has been from a Census, population estimates—the denominator used to

develop cancer incidence and death rates—become more inaccurate. The total U.S. population in the 2000 Census was 281 million, 6 million more than the projected 275 million that NCI used previously, Edwards said.

This underestimate, called "error of closure," led to undercounting of racial and ethnic groups by 2 percent overall, the new Census numbers showed, Edwards said. For some groups, the undercounting was substantial in previous cancer statistics reports. American Indians were undercounted by 22 percent; Asian and Pacific Islanders by 7 percent; blacks by 4 percent; Hispanics by 9 percent; and whites by 2 percent.

When looking at cancer statistics at a local level, or in ethnic groups, an error in the denominator can lead to miscalculation of rates, as Emory University professor and SEER contractor John Young found last year in examining black/white cancer incidence in the Atlanta metropolitan area (**The Cancer Letter**, Sept. 20, 2002, Vol. 28 No. 34).

Young at first thought he had found a major health disparity: In 1999, it appeared that the incidence of breast cancer in black women in the Atlanta area was higher than the incidence in white women. Nationally, black women have a lower incidence of breast cancer than whites. Young discovered that the problem was in the population estimates. Young said that if he was right, the 2003 annual report would show a slightly higher incidence rate of breast cancer for whites, but significantly lower for blacks, in Atlanta, and possibly nationwide.

Edwards specifically addressed breast cancer incidence in Atlanta in her remarks to the NCAB.

Under the new population estimates, breast cancer incidence among white women in Atlanta for 1995-1999 was 142 per 100,000, or 3 percent higher than the 138 per 100,000 using the old population estimates. Breast cancer incidence among black women in Atlanta was 122 per 100,000, or 16 percent lower than the 145 per 100,000 using the old population estimates.

"Certainly at a local level, in certain geographic areas, the change in population with regard to various racial/ethnic groups, or by small geographic areas, was such that when we corrected populations this time, we are seeing what can be reported as a higher incidence rate of breast cancer in white women, compared with the old population [estimate], so it's much more in line with the rest of the U.S.," Edwards said.

According to the Annual Report, "Improved accuracy of population estimates did not have a major impact on cancer rates at the national level, but may have had substantial impact for smaller populations, particularly for specific race/ethnicity, age, or county subgroups."

The new data point to "a growing disparity" between whites and blacks for colorectal and breast cancer death rates, the report said. Blacks may not have experienced the same benefits from screening and treatment as whites. "These patterns in the death rates indicate that disparities in deaths from some cancers are increasing and that methods are needed to disseminate advances in prevention, screening, and treatment to all segments of the population," the report said.

For the first time, in the 2000 Census, respondents were able to identify themselves as multiracial. To report long-term trends in disease rates for single-race groups, CDC developed a method to bridge the multiracial populations into single-race categories. This method was used by the U.S. Bureau of the Census, with funding from NCI, to produce single-race census (2000) and intercensal (1990-2000) estimates for white, black, Asian/Pacific Islander, American Indian/Alaska Native and Hispanic populations.

The full text of the report and supplemental materials can be found at http://seer.cancer.gov/report_to_nation/1975_2000/.

Funding Opportunities:
RFPs Available

RFP N01-CM-47001-28: Preparation of Radiolabeled Materials

Developmental Therapeutics Program of the NCI Division of Cancer Treatment and Diagnosis is seeking an organization having capabilities, resources and facilities for the preparation, storage and distribution of radiolabeled materials. The objective is the synthesis of radiolabeled compounds of high purity in 1 to 50 millicurie quantities. The synthesis of a wide variety of compounds such as nucleoside, heterocyclic, alkaloids, peptides, natural products, dyes, purine and the like will be requested. Text of the RFP is available at http://rcb.nci.nih.gov/.

Inquiries: Carolyn Barker, Research Contracts Branch, NCI, Executive Plaza South, Rm 6050, e-mail cb123d@nih.gov; fax 301-402-6699; phone 301-496-8620, and MaryAnne Golling, phone 301-435-3819; fax 301402-6699; e-mail mg345x@nih.gov.

RFP N01-CM-37027-23: Pediatric Preclinical Testing Program

Proposals Receipt Due Date: Oct. 6, 2003.

NCI Cancer Therapy Evaluation Program is seeking support to test agents in childhood cancer pre-clinical models. The primary objective is to identify and calibrate a panel of predictive pediatric pre-clinical models to inform pediatric oncologists' prioritization of new agents for evaluation in children with cancer. The contractor will systematically test 10-15 agents or combinations of agents per year against a panel of pre-clinical models of the childhood cancers that occur most commonly in children.

Text of the RFP is available at: http://rcb.cancer.gov/rcb-internet/.

Inquiries: Doris Rosenblatt, Treatment, Biology, and Sciences Section, RCB, Executive Plaza South, 6120 Executive Blvd., Rockville, MD 20892-7193, phone 301-496-8620; fax 301-402-6699; e-mail dr220a@nih.gov.

RFA Available

RFA-CA-04-005: Academic Public Private Partnership Program AP4 Planning Grant

Letter of Intent Receipt Date: Oct. 21, 2003

Application Receipt Date: Nov. 20, 2003

The NCI Developmental Therapeutics Program invites academic cancer researchers to participate in the AP4 initiative which supports formation of new partnerships or expansions of existing partnerships among academia, industry, non-profit institutions, and government entities. The partnerships will conduct cancer therapeutic, prevention, diagnostic, and imaging intervention-directed research. The goal of the research will be to speed the translation of newly discovered cancer interventions to clinical trials. The RFA will use the NIH U56 award mechanism. The RFA is available at http://grants1.nih.gov/grants/guide/rfa-files/RFA-CA-04-005.html.

Inquiries: Jill Johnson, phone 301-496-8720; fax 301-402-0831; e-mail johnsoji@mail.nih.gov.

RFA-RR-03-014: Centers of Biomedical Research Excellence

National Center for Research Resources invites applications for COBRE from investigators at independent biomedical research institutes or biomedical research institutions that award doctoral degrees in the health sciences or sciences related to health within IDeA-eligible states. The application must have a thematic scientific focus in a specific research area, such as neuroscience, cancer, structural biology, immunology, or bioengineering, and may use basic, clinical or both research approaches to attain the goals of the proposed center.

The objectives are: (1) to strengthen an institution's biomedical research infrastructure through the establishment of a thematic multi-disciplinary center and (2) to enhance the ability of investigators to compete independently for complementary NIH individual research grant or other external peer-reviewed support. The RFA will use the NIH exploratory grant award mechanism P20. The RFA is available at http://grants1.nih.gov/grants/guide/rfa-files/RFA-RR-03-014.html.

Inquiries: Lawrence Yager, Division of Research Infrastructure, National Center for Research Resources, NIH, 6701 Democracy Blvd., Rm. 930, Bethesda, MD 20892-4874, phone 301-435-0760; fax 301-480-3770; e-mail yagerL@mail.nih.gov.

Program Announcements

PAR-03-158: Specialized Programs of Research Excellence in Human Cancer for the Year 2004

Letter of Intent Receipt Date: Myeloma and Genitourinary Cancer SPOREs: April 1, 2004. Breast and Gynecological Cancer SPOREs: Aug. 1, 2004.

Application Receipt Date: Myeloma and Genitourinary Cancer SPOREs: June 1, 2004. Breast and Gynecological Cancer SPOREs: Oct. 1, 2004.

Organ Systems Branch of the Office of the Deputy Director for Extramural Science at NCI invites grant applications P50 for SPOREs in organ-specific cancers. Applicant institutions must be able to conduct the highest quality, balanced, translational research on the prevention, etiology, screening, diagnosis, and treatment of a specific organ-site cancer. A SPORE must develop and maintain human cancer tissue resources for the particular organ-site that will benefit translational research; promote extended collaborations in areas of research need with laboratory and clinical scientists within the institution, as well as in other institutions; and participate with other SPOREs on a regular basis in sharing positive and negative findings, assessing scientific progress in the field, identifying new research opportunities, and promoting Inter-SPORE collaborations. Funding for the performance of a phase I or II clinical trial can be requested in a SPORE application. The PA is available at http://grants1.nih.gov/grants/guide/pa-files/PAR-03-158.html.

Inquiries: Jorge Gomez, chief, Organ Systems Branch, e-mail jg1w@nih.gov; Jane Fountain, program director (Gynecological SPOREs), e-mail jf227t@nih.gov; Peter Ujhazy, program director (Myeloma SPOREs, e-mail pu5s@nih.gov; Andrew Hruszkewycz, program director (Genitourinary SPOREs), e-mail hruszkea@mail.nih.gov; Rashmi Gopal-Srivastava, program director (Breast SPOREs), e-mail gopalr@mail.nih.gov. Phone 301-496-8528; fax 301-402-5319.

PAR-03-157: Industry-Academic Partnerships for Development of Biomedical Imaging Systems and Methods That Are Cancer Specific

Letter of Intent Receipt Dates: Oct. 22, 2003; Oct. 20, 2004. Application Receipt Dates: Nov. 19, 2003; Nov. 17, 2004.

The initiative encourages industry-academic partnerships by making seed grants available for collaborative in vivo imaging research projects directed at cancer. Support for the exchange of scientists between industry and academia can be requested under the initiative. The goals are to provide grants to establish and/or expand industry-academic partnerships for biomedical imaging systems and methods that are cancer specific whether or not preliminary data or a history of prior collaborations have been established; support partnerships and pilot projects that may result in commercialization of imaging technologies; target partnerships that address high-risk/high-gain research and development of new approaches for early cancer detection, diagnosis, image-guided interventions, and assessment of drug therapy. The PAR will use the NIH exploratory/developmental R21 grants award mechanism. The PA is available at http://grants1.nih.gov/grants/guide/pa-files/PAR-03-157.html.

Inquiries: Guoying Liu, Biomedical Imaging Program, NCI, 6130 Executive Plaza, Suite 6000, Bethesda MD 20892-7412, Rockville MD 20852 (for express/courier service), phone 301-496 9531; fax 301-480-3507; e-mail liug@mail.nih.gov and Laurence Clarke, Branch Chief, Imaging Technology, Development Branch, , Biomedical Imaging Program, NCI, phone 301-435-9190; e-mail lclarke@mail.nih.gov

Other Funding Notices

NOT-DK-03-007: Type 1 Diabetes—Rapid Access to Intervention Development

Request receipt dates: Nov. 1 and April 1.

National Institute of Diabetes and Digestive and Kidney Diseases, in collaboration with NCI, invites requests for the T1D-RAID special mechanism. The mechanism makes available resources to move molecules and concepts from the laboratory to the clinic for proof-of-principle clinical trials, using the NCI contract research mechanisms. Services that would be available include: production, bulk supply, GMP manufacturing, formulation and toxicology. The notice is available at http://grants1.nih.gov/grants/guide/notice-files/NOT-DK-03-007.html.

Inquiries: T1D-RAID, Myrlene Staten, senior advisor, Diabetes Research Translation, Division of Diabetes, Endocrinology, and Metabolic Diseases, NIDDK, NIH, 6707 Democracy Blvd., Bethesda, MD, 20852-5460, phone 301-402-7886; fax 301-480-3503.

NOT-CA-03-035: Activities to Promote Research Collaboration

Receipt due dates: Nov. 3, 2003 and March 1, 2004.

Division of Cancer Biology of NCI announces fiscal 2004 supplemental funds availability for existing DCB-supported research projects that promote collaboration among DCB grantees, as well as with other members of the scientific community. Examples of collaborative activities include, but are not limited to, initiating new collaborative research projects, sharing resources and reagents, developing novel technologies, and organizing cross-disciplinary meetings/workshops. The Notice is available at http://grants.nih.gov/grants/guide/notice-files/NOT-CA-03-035.html.

Inquiries: John Sogn, deputy director, Division of Cancer Biology, NCI, NIH, Executive Plaza North, Rm 5050, 6130 Executive Blvd., Bethesda, MD 20892-7150, phone 301-594-8782; fax 301-496-8656; e-mail js150x@nih.gov.

In Brief:

Von Hoff To Direct Arizona Cancer Therapeutics Program

(Continued from page 1)

associate professor of surgery at Duke University School of Medicine and Allied Health Programs and has been a member of the Cancer Prevention, Detection and Control Research Program since 1991. She assesses risk factors for prostate cancer, determines causes and prevention of weight gain during treatment for breast cancer and delivers diet and exercise interventions aimed at either primary or secondary prevention. She leads four NIH-funded studies on diet and physical activity programs for breast and prostate cancer patients. Demark-Wahnefried received a 2003 Professor of Survivorship Award from The Susan G. Komen Breast Cancer Foundation. . . . **DANIEL VON HOFF** has accepted a statewide position as director of the Arizona Health Sciences Center Cancer Therapeutics Program, said **Raymond Woosley**, vice president for health sciences. Von Hoff was director of the Arizona Cancer Center. In his new position, he will facilitate the AHSC emerging collaborations with Arizona State University, Northern Arizona University, the International Genomics Consortium and the newly formed Translational Genomics Research Institute. **Raymond Nagle** will serve as interim director of the Arizona Cancer Center. . . . **MEREDITH MULLINS** was appointed senior vice president of research administration of the Barbara Ann Karmanos Cancer Institute. Mullins has served in biomedical research administration since 1989 and for NCI-designated cancer centers since 1995. For the last two years she was vice president for research administration at the H. Lee Moffitt Comprehensive Cancer Center. . . . **AMERICAN CANCER**

SOCIETY awarded clinical research professorships to two scientists for the translation of basic biology to the treatment of cancer: **Graham Colditz**, of Channing Laboratory, Brigham and Women's Hospital; and **Kenneth Pienta**, director of the Urologic Oncology Research Program at the University of Michigan Comprehensive Cancer Center. Each researcher will receive $300,000 over a five-year period, with the option of a five-year renewal. . . . **STORY LANDIS** was named director of the National Institute of Neurological Disorders and Stroke. Landis was scientific director of the NINDS intramural program. Her appointment began Sept. 1. . . . **JEREMY BERG** was appointed director of National Institute of General Medical Sciences, beginning in November. Berg is director of the Institute for Basic Biomedical Sciences and professor and director of the Department of Biophysics and Biophysical Chemistry at Johns Hopkins University School of Medicine. Berg will replace **Judith Greenberg**. . . . **LOUIS LASAGNA** died of lymphoma Aug. 7 at Newton-Wellesley Hospital in Newton, Mass. He was 80 and was dean emeritus of the Sackler School of Biomedical Sciences at Tufts University. Lasagna was known for his findings on the placebo effect. Although he valued the power of science in disease prevention and cure, Lasagna also advocated the importance of quality of life issues for patients. "Otherwise, existence is nothing but the bored, molecular unwinding of a dismal biological clock," he wrote in one of his two books, "The Doctors Dilemma." He also wrote "Life, Death, and The Doctor." Lasagna served as chairman of the National Committee to Review Current Procedures for New Drugs for Cancer and AIDS, appointed in 1988 by the President's Cancer Panel in response to a report on drug approval by then-Vice President **George H.W. Bush**. The committee became known as the "Lasagna Committee" and made many influential recommendations for promoting insurance coverage of patient care costs in clinical trials, off-label drug use, better cooperation between NCI and FDA, and faster approval of drugs for cancer and AIDS (**The Cancer Letter**, Sept. 7, 1990, Vol. 16 No. 34). . . . **THOMAS KEARNS**, 66, former chief of the Management Analysis Branch in the Office of Administrative Management at NCI, died Aug. 25, at his home in Brookville, Md., after a heart attack. He began his career at NCI in 1963 and retired in 1994. He received the NIH Director's Award in 1979.

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