THE CANCER LETTER

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NCI Advisors Approve $24 Million For Patient Navigator Research Program

Advisors to NCI approved the Institute's plan to set aside $24 million in cancer control funding over the next five years to support research grants to develop methods to help cancer patients get access to appropriate health care.

The NCI Board of Scientific Advisors voted 16-6 in favor of the proposal by the Center to Reduce Cancer Health Disparities to establish a Patient Navigation Research Program. Center Director Harold Freeman, who established a patient navigation program at Harlem Hospital, has long advocated the idea of assigning a volunteer or a health-care worker to

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In Brief:

David Hohn Elected NCCN Board Chairman; Moon Chen Wins ACS Humanitarian Award

DAVID HOHN was elected chairman of the Board of Directors of the National Comprehensive Cancer Network, an alliance of 19 cancer centers. Hohn is president and CEO of Roswell Park Cancer Institute, one of the NCCN founding member institutions. NCCN develops, updates, and disseminates clinical practice guidelines. William McGivney is CEO of NCCN. . . . **MOON CHEN JR.**, professor of epidemiology and preventive medicine at University of California, Davis, School of Medicine and Medical Center and head of the UC Davis Cancer Center Cancer Control and Prevention Program, received the American Cancer Society Humanitarian Award for his work in public health. ACS said it recognized Chen for improving the health of Asian Americans and Pacific Islanders. Chen is the principal investigator of an $8.5-million NCI-funded project to eliminate disparities in cancer incidence, awareness, and early detection among Asian American populations. He also serves on the National Cancer Advisory Board. . . . **ABRAMSON CANCER CENTER** of the University of Pennsylvania has hired two breast cancer surgeons. **Marcia Boraas,** of Jeanes Hospital and the Fox Chase Cancer Center, is clinical associate professor of surgery and **Julia Tchou** is assistant professor of surgery. . . . **JOURNAL OF CLINICAL ONCOLOGY** said it will provide free online access to original research articles older than one year. The journal is available online at www.jco.org. . . .**SKIN CANCER Foundation** has established the Dr. Rex and Johnnie Amonette Circle in observance of it 25th

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Launch, Then Steer Navigator Program, NCI Director Says

(Continued from page 1)

socioeconomically disadvantaged patients to help them understand and navigate through the cancer care system. Several organizations have been examining ways of using patient navigators, including the American Cancer Society, C-Change, and the American Society of Clinical Oncology. The idea has surfaced in some Congressional legislative proposals as well.

Putting this idea into widespread practice, however, is a potentially costly proposition. How to test the effectiveness of such programs also is a controversial area. The NCI concept for the research program failed in attempts to pass the Institute's Executive Committee over the past year.

Several BSA members said the concept for the program was too broad. NCI Director Andrew von Eschenbach urged them to approve the proposal.

"It's an issue that fits into the model which I have described to you before, in which it's not 'ready, aim, fire,' but more 'ready, fire, and then, steer,'" von Eschenbach said. "This is a project that we need to launch, but then recognize that it's going to require guidance and steerage, because we don't know all the things ahead of time that we need to know."

The board formed a subcommittee to help NCI revise the concept.

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The concept statement and board discussion follow:

Patient Navigation Research Program. Concept for a new RFA (cooperative agreement), estimated cost $24 million over five years for six awards. Program director: Roland Garcia, Center to Reduce Cancer Health Disparities.

The NCI Center to Reduce Cancer Health Disparities is challenging principal investigators to develop effective patient navigation interventions. These interventions must address access barriers to quality, standard cancer care. The purpose of the PNRP is to develop interventions to reduce the time to delivery of standard cancer care services--non-cancer resolution or cancer diagnosis and treatment--after identifying a cancer-related abnormal finding.

For this program, patient navigation for cancer care refers to the support and guidance offered to persons with an abnormal cancer-related finding in accessing the cancer care system and overcoming any barriers to quality, standard care. Navigation spans the period from an abnormal cancer finding through necessary cancer diagnostic tests to completion of cancer treatment. Professionals, specialists, or volunteers working in primary care venues, community health centers, and hospitals will offer this support and guidance using a variety of existing programs and service delivery systems. The basic goal of patient navigation is to facilitate timely access to quality, standard cancer care in a culturally sensitive manner for all patients.

The patient navigator should assist patients and their families through the cancer care continuum. Examples of navigation services may include: arranging various forms of financial support, arranging for transportation to and childcare during scheduled diagnosis and treatment appointments, identifying and scheduling appointments with culturally sensitive caregivers, coordinating care among providers, arranging for translation/interpretation services, ensuring coordination of services among medical personnel, ensuring that medical records are available at each scheduled appointment, and other services to overcome access barriers encountered during the cancer care process. The patient navigator will link patients and families with appropriate follow-up services.

Presently, many outpatient organizations have to "shop" for providers willing to treat underserved populations. Formal arrangements among primary care and community health centers with hospitals will assist patient navigators in overcoming health care system

access barriers that should result in decreased time between abnormal finding, diagnosis, and resolution for patients in the program.

This research grant program will develop effective patient navigator interventions to reduce or eliminate disparities in clinical outcomes related to lack of timely access to quality, standard cancer care among racial/ethnic minorities, people of lower socioeconomic status, residents of rural areas, and other underserved populations. Improving timely access to standard cancer care will contribute to substantial progress towards the Healthy People 2010 goal of eliminating cancer health disparities as well as NCI's 2015 Director's Challenge goal of eliminating suffering and death due to cancer. The proposed research concept focuses on developing a variety of effective patient navigator interventions. The program will encompass the four cancers with the greatest disparity in screening and follow-up: breast, cervical, prostate, and colorectal. These Patient Navigation Research Projects will conduct formal qualitative and quantitative evaluations to demonstrate effectiveness.

Research results of this Patient Navigation Research Grant Program will:

--Improve NCI's knowledge and understanding of how to best support racial/ethnic minorities, people of lower socioeconomic status, residents of rural areas, and other underserved populations with cancer-related abnormal screening findings in accessing and navigating the cancer care system.

--Assess the impact of patient navigators on timely provision of quality, standard care and patients' adherence to standards of care.

--Elucidate characteristics of institutional and patient-related barriers to quality, standard cancer care.

--Encourage research collaborations and partnerships across cancer care delivery systems and organizations (e.g., primary care facilities, community health centers, hospitals, and academic centers). The major research question for this program is: what are the most effective strategies, from the point of abnormal cancer finding, to reduce and/or eliminate access barriers, resulting in more timely access to quality, standard cancer care for all patients, regardless of race/ethnicity, gender, age, socioeconomic status, geographic location, and/or health insurance/ability-to-pay status? Plans will be made to conduct long-term cancer patient follow-up to measure increases in cancer survival and reductions in cancer mortality rates and, thus, decreases in cancer disparities in outcomes among these underserved populations.

The research hypotheses are that navigated patients will: (1) receive timelier, definitive diagnosis following screening and abnormal finding; (2) receive more timely treatment following positive diagnosis; (3) improve their satisfaction with the health care system experience. Some examples of relevant research questions include:

--What impact does type of patient navigators have on navigation success--e.g., professional health care provider (nurse, social worker, other allied health care professional) versus indigenous nonprofessional (cancer survivor, community layperson)?

--What impact does patient navigator status have on navigation success--e.g., paid patient navigators versus volunteer patient navigators?

---What impact does type of services/extent of services provided to patients--e.g., overcoming access barriers, cancer information/education assistance, emotional and psychological support assistance, successful completion of care-have on treatment outcome?

--Does the primary location of the patient navigator have an impact on navigation success--e.g., community-based organization, primary care screening/diagnosis clinic/center, or hospital/center?

--Do race/ethnicity matching of patient and navigator, or having a patient navigator who is fluent in the primary language of the patient affect standard-of-care adherence and perceived satisfaction with the health care system?

--Does a patient navigator assisting patients in coordinating care among multiple physicians affect standard-of-care adherence and perceived satisfaction with the health care system?

--Does a patient navigator assisting patients through the cancer care continuum increase patients' and their families' identification and use of a usual source of care, for both cancer follow-up and other medical conditions?

Successful implementation of a range of patient navigator interventions to address these research questions in. diverse underserved communities will provide a variety of community-based patient navigator interventions that can be implemented in other communities across the nation.

The objective of this RF A is to invite research applications for Cooperative Agreements to develop and implement structured patient navigation in communities that serve racial/ethnic minorities, people of lower socioeconomic status, residents of rural

areas, and other underserved populations. Applicants must develop effective approaches to developing and implementing formal referral and care arrangements between community outpatient settings and a hospital that offers quality, standard cancer treatment. Applicants must present methodologies and techniques for overcoming barriers--such as primary language other than English-to timely access to cancer diagnosis and treatment services by encouraging participation from the underserved community facilitated by a trained patient navigator. Applicants must demonstrate that targeted communities have cancer screening rates to ensure that a sufficient sample (i.e., based on power analysis) of patients with abnormal findings are referred to the patient navigator to statistically analyze and report on primary outcome measures. Applications must address plans for: conducting a needs assessment, selecting and training navigators, tracking patients, conducting program evaluation, and disseminating findings.

The Applicant's research design must include baseline historical data and plans for a continuous comparison group throughout the study period in order to address history effects, system biases, community activities that may impact changes in cancer disparities (e.g., other organizations' efforts to increase cancer screening rates), and other confounding factors. Community cross-sectional surveys should be considered to interpret changes over time. Thus, a comparison group will be critical to interpreting PNRP findings and developing conclusions regarding causal relationships and degree-of-success factors. All research designs will be reviewed for ethical concerns and human subjects issues within vulnerable populations.

Rigorous evaluation of effectiveness is a critical component of the patient navigator program. In collaboration with Program Administrators of the NCI CRCHD, grantees will establish evaluation criteria for their research, using qualitative and quantitative indicators collected at the start of the project and regularly updated throughout the grant period of performance. This Program evaluation process and associated outcome metrics will be developed to address the three research hypotheses and other outcome measures. Metrics will also provide insight into community changes possibly related to the project, such as increases in cancer screening rates; observed short-term reductions in stage at diagnosis; and increases in cancer prevention, screening, and treatment knowledge and cancer-preventive behaviors. Documentation should be maintained on aspects of the Program that may be implemented for other cancers and diseases.

Each patient navigation project should be funded at a maximum of $800,000 per year; estimated at $500,000 per year for direct costs.

BSA Discussion: Unclear Research Question?

"Anybody who has tried to navigate the health-care system either for themselves or for their family knows that it is complex, confusing, irritating, inefficient, and sometimes downright dangerous," said BSA member Robert Young, president of Fox Chase Cancer Center, who was assigned to review the proposal. "The issue of how one navigates the health-care system is of enormous importance. The whole area of delivery is one that has been under-addressed by NCI over the years. There is no question about the laudatory nature of the goal, and the amount of money carved out is reasonable.

"I struggled as I read this to get a handle around what the research questions could be," Young said. "The more I tried to get a handle on it, the more elusive it became. There are a variety of models with regard to personnel. There are five different cancer settings that have been proposed. There are multiple environmental settings… It's so broad that almost anybody could respond with anything. One of the problems with evaluating this kind of thing, for sure, if you take a nurse and attach that nurse to a patient, they will get better navigation. In order to make an impact with any of these programs, you are going to need a mechanism for leverage. Nowhere in this proposal is that mentioned, the idea of creating mechanisms by which multiple people can impact from the patient navigation provided by a limited number of individuals.

"It seems to me that until we get a system in which leverage is possible, there are never going to be enough people in the world to navigate all of the 1.3 million people per year who go through the health-care system with a diagnosis of cancer," Young said. "I have real concern about whether or not this can succeed. I don't believe we have a research question sufficiently defined to make it viable."

Several other BSA members spoke in concurrence with Young's comments.

"I would love to respond to this from our own cancer center, but I don't know where to start," said BSA member David Alberts, director of cancer prevention and control at the Arizona Cancer Center. "A half a million dollars is not going to be able to build this program. I would like to see the RFA lay out the hypotheses that are going to be pre-eminent in answering these questions. What you are going to get is a hodge-podge of applications that may not accomplish very much,

even in a cooperative agreement setting."

"There has to be a scalable model, or I don't think it's a good investment," said BSA member William Wood, chairman of surgery, Emory University Hospital.

Roland Garcia, the NCI program director who presented the concept, said the proposal would allow investigators to come forward with ideas. "This is broad intentionally so that we can encourage and solicit the best possible approaches to these models and best practices in various community settings," he said. "With the RFA and pre-application meetings, we can narrow and guide principal investigators. We are looking to creative PIs to establish models and best practices."

"It doesn't make sense to have the health-care system that we have in this country if the research community isn't going to invest in research on how to fix it," Freeman said in support of the concept.

Von Eschenbach urged the board to approve the concept. "If discovery and development truly come to fruition as rapidly as I expect they will in the next five years, the health-care delivery system is going to be even more complex, very heavily technology dependent, and very much faced with challenges having to do with the potential widening of disparities between those who can navigate the system and those who cannot," he said.

"Although I have listened and we are very attentive to the concerns and issues, I would ask the board to consider allowing the process to go forward with those caveats, with the recognition that we need to steer this process, and for you to know that the leadership not only of the Center to Reduce Cancer Health Disparities, but also the commitment of the NCI itself and the resources that are available to us," von Eschenbach said.

BSA member Hoda Anton-Culver, chief of epidemiology, University of California, Irvine, made a motion proposing that the board approve the concept and work with NCI staff to revise it for greater focus.

SBIR Concept

The board also approved a concept by the Division of Cancer Prevention to fund Small Business Innovation Research grants in developing new technologies for capturingand preserving exfoliated abnormal cells for use in biomarker studies. The concept statement follows:

Circulating Cells in Cancer Detection (Small Business Innovation Research). Concept for a new RFA using SBIR funds, estimated cost $1 million for two to three phase I or phase II applications. Program director: Mukesh Verma and Sudhir Srivastava, Cancer Biomarkers Research Group, Division of Cancer Prevention.

The purpose of this concept is to develop novel technologies for capturing, enriching, and preserving exfoliated abnormal cells in body fluids or effusions and to develop methods for concentrating the enriched cells for biomarker studies. In body fluids, such as sputum, the number of exfoliated tumor cells is often small compared to the number of non-neoplastic cells. Therefore, the detection of exfoliated abnormal cells by routine cytopathology is often limited because few atypical cells may be present in the specimen. Furthermore, there may be difficulty in separating dysplastic cells from non-specific reactive changes and degenerating cells or variation in diagnostic criteria. Furthermore, exfoliated cells are frequently contaminated with normal cells, bacteria, and other cellular debris, which makes molecular analysis difficult without physical separation of the neoplastic cells. Thus, the development of enrichment methods is a prerequisite for the routine detection of small numbers of exfoliated cells and small amounts of sub-cellular materials in biological fluids for molecular analysis.

The primary purpose of this initiative is to encourage the development of high-throughput technologies to facilitate the isolation and enrichment of exfoliated cells. In pursuit of these goals, the NCI invites applications which address the following areas:

1. Development of high-throughput technologies for identifying abnormal exfoliated cells in body fluids.

2. Development of sampling technologies for capturing and preserving exfoliated tumor cells in body fluids.

3. Development of enrichment methods for the isolation of tumor cells and tumor cell-associated macromolecules, such as circulating DNA.

4. Development of sensitive, high-throughput molecular, cytomorphometric, immunologic, and other relevant technologies to isolate tumor cells in malignant effusions for detection of low tumor burden and to help distinguish reactive cells from tumor cells.

The long-term goal, to which this initiative will eventually lead, is to assemble a panel of well-characterized biomarkers derived from exfoliated cells that can be sampled in a clinical setting. These methodologies will be tested and validated in future population-based clinical trials, and integrated into a comprehensive information system that will be developed under the Early Detection Research Network.

Only eleven applications were received against the

three receipt cycles in response to a previous program announcement (PA-02-086). Two were funded from the first cycle. This poor response is believed to result in part from no funds being set aside to fund these applications. When the original concept was approved by the NCI Executive Committee, we were asked to see the response from the research community and if the response is poor, the concept should be brought back for consideration to include some set-aside funds.

This initiative will continue to utilize an RFA under the Small Business Innovation Research and Small Business Technology Transfer mechanisms, along with a parallel Program Announcement of identical scientific scope under the R21 PAR mechanism. No set aside funds are requested because the SBIR/STTR is a set aside mechanism.

FDA News:

Product Development Slowed By Lack of Predictability, Report Finds; McClellan Confirmed To Head CMS

The process of development of medical products is obstructing innovation, FDA said in a white paper released last week.

"A new product development toolkit—containing powerful new scientific and technical methods, such as animal or computer-based predictive models, biomarkers for safety and effectiveness, and new clinical evaluation techniques—is urgently needed to improve predictability and efficiency along the critical path from laboratory concept to commercial product," the agency said in a paper titled "Innovation or Stagnation: Challenge and Opportunity on the Critical Path to New Medical Products."

FDA Commissioner Mark McClellan has noted on numerous occasions that the pace of medical innovation has slowed down in recent years. The report attempts to find out why, and to develop methodology for eliminating roadblocks for new treatments.

Last week, Senate confirmed McClellan's move to Centers for Medicare and Medicaid Services, an agency whose mandate was expanded with the addition of Medicare prescription drug benefits earlier this year.

"Today, as never before, we face a tremendous potential for new medicines to prevent and cure diseases, but fewer new products are actually reaching the FDA," McClellan said in a statement.

"With so much promising technology in development in the clinical labs, ranging from engineered tissues to new kinds of biologicals and genomics-based treatments, we need to turn the process of bringing these technologies to patients from a costly and time-consuming art form to a well-understood science," he said.

McClellan said FDA is uniquely positioned to "to turn the critical path of product development into a fast, certain, and more affordable process, to improve access to better treatments for all Americans." FDA has "a unique vantage point on scientific challenges that cause delays and failures in product testing and manufacture," he said.

According to the agency, the report was requested by McClellan and Deputy Commissioner Lester Crawford, who will head the agency after McClellan departs for CMS.

The question of cost figures in the FDA report. "With rising health care costs, there is no concern about how the nation can continue to pay even for existing therapies, the report states. "If the costs and difficulties of medical product development continue to climb, innovation will continue to stagnate or decline, and the biomedical revolution may not deliver on its promise of better health."

According to the report, FDA plans to initiate "an aggressive, collaborative effort to create a new generation of performance standards and predictive tools." The agency would spearhead development of the following methodologies:

--Assessment of safety. These would include predictors of human immune responses to foreign antigens, methods to enhance the safety of human tissues, techniques for assessment of drug liver toxicity, methods for identifying gene therapy risks.

--Assessment of medical utility. "As health care costs rise, patients, medical professionals and health care purchasers are all demanding from the medical treatments they use," the report states. Researchers and regulators need to find better ways to demonstrate effectiveness of these treatments for particular patients.

--Tools for characterization and manufacturing of new therapies.

"It is critical that we enlist all stakeholders in this effort," the report states.

The document is available at **www.fda.gov/oc/initiatives/criticalpath/whitepaper.pdf**

The report addresses problems in development across all indications. However, in a lecture at NCI last month, McClellan described his view of these problems as they affect development of cancer therapies (**The Cancer Letter**, Feb. 6).

NCI Budget:

NCI "Redeployed" $54.5 Million To Fund Strategic Initiatives

By reducing NCI division budgets by 5 percent in fiscal 2004, the Institute created a pool of $75 million to fund "strategic initiatives," Institute Director Andrew von Eschenbach said last week.

The funds will be "redeployed" to support the Institute's highest priority projects, von Eschenbach said to the NCI Board of Scientific Advisors and Board of Scientific Counselors on March 15.

So far, a total of $54.5 million of the funds have been committed "to address the strategic initiatives that we as an entire institute—division heads, center directors, the deputies, the senior leadership—had all agreed were the highest priorities for the year," von Eschenbach said.

These include:

--$11 million for the Integrative Cancer Biology Consortium RFA.

--$15 million for bioinformatics, including the Cancer Bioinformatics Grid.

--$4 million to scale-up several programs, including the Rapid Access to Intervention Development (RAID) and Rapid Access to Prevention Intervention Development (RAPID) programs.

--$10 million for clinical trials programs.

--$7.5 million for biomarkers.

--$4 million for imaging.

--$3 million for health disparities.

Von Eschenbach said $15 million will be held in reserve for unexpected funding needs until the end of the fiscal year, and $5.5 million was "reallocated to operational units" to fund division-specific initiatives.

NCI also was able to "recover" about $28 million from other projects, including contracts, von Eschenbach said.

"We have redeployed all the dollars, and now we are at a point where we are still about $7.5 million short—we have more commitments that dollars," von Eschenbach said. The reserve funds could be used to support the shortfall, but there may be some savings later in the year from projects that will be delayed, he said.

"Resources have been a significant challenge for us, not because resources have shrunk, in fact, just the opposite is true," von Eschenbach said. "There has never been as much invested in cancer research as there is today. The problem is, the opportunities are great, and so the challenge is to address those opportunities, and to do that in a way that enables us to redeploy resources, which requires us to be as strategic about the things we say 'No' to as we are strategic about the things we say 'Yes' to."

Funding Opportunities:

Program Announcement

PAR-04-077: Research Partnerships for Improving Functional Outcomes

Application Receipt Dates: Oct. 13, 2004, Oct. 13, 2005, Oct. 13, 2006

Participating Institutes and Centers of NIH, including NCI, invite applications for R01 awards for basic, applied, and translational multi-disciplinary research that addresses biological, behavioral, medical, and/or psychosocial research problems related to rehabilitation or health maintenance for acute or chronic disease. The partnership must include individuals with clinical expertise related to rehabilitation in combination with biomedical, psychosocial-behavioral, engineering, epidemiological, and/or health services researchers. An RPIFO may propose outcomes-directed, developmental, discovery-driven, translational or hypothesis-driven research at universities, national laboratories, medical or nursing schools, large or small businesses, or other public and private entities or combinations of these entities. The PA will use the NIH Research Project Grant R01 award mechanism. The PA is available at http://grants.nih.gov/grants/guide/pa-files/PAR-04-077.html.

Inquiries: For NCI--Noreen Aziz, program director, Office of Cancer Survivorship, Division of Cancer Control & Population Sciences, phone 301-496-0598; fax 301-594-5070; e-mail na45f@nih.gov.

NCI Seeks CRADA Partner

Identification, Characterization and Development of Inhibitors That Act on Proteins Involved in Modulating Pro-oncogenic Processes.

Response Due Date: April 30, 2004

NCI is seeking a collaborator for a CRADA to work with investigators in the Center for Cancer Research, the Medical Oncology Clinical Research Unit, to select protein binding sites on targets involved in modulating pro-oncogenic processes, discover novel small molecules to meet these binding site requirements, then synthesize and test these small molecule inhibitors for their efficacy in modulating pro-oncogenic processes.

The collaborator will use its proteomics and bio- and chemiinformatics capabilities to assess, analyze mutually agreed upon crystal structures of target proteins, generate

a drug design report and provide conceptual, representative structures of small molecule inhibitors that are recommended for synthesis. Upon synthesis and confirmation of activity of members of a novel series by NCI, collaborator may undertake co-crystallization of compounds and further apply proteomics and bio- and chemiinformatics for lead optimization. The collaborator's contribution may include submission of an IND to the FDA.

NCI (or collaborator) may synthesize and NCI will test mutually agreed upon compounds and identify leads with suitable biological activity and acceptable ADME properties. NCI will conduct necessary preclinical and clinical studies to advance optimized molecules to IND status, and perform appropriate clinical trials required for product registration. The NCI contribution may include submission of the IND to the FDA. NCI and the Collaborator will jointly design a CRADA research plan, will jointly interpret the data generated, and mutually agree on which compounds should enter clinical trials.

Inquiries: Michelle Booden, phone 301-451-2185 or 301-496-0477; fax 301-402-2117; e-mail: boodenm@mail.nih.gov.

HHS News:

Obesity Poised To Become Leading Preventable Cause Of Death In U.S., Study Finds

A study released by the Centers for Disease Control and Prevention shows that deaths due to poor diet and physical inactivity rose by 33 percent over the past decade and may soon overtake tobacco as the leading preventable cause of death.

HHS Secretary Tommy Thompson said the department and the Ad Council would begin a new advertising campaign to encourage people to eat healthier food and become more active.

Also, NIH has drafted a strategic plan for obesity research. The plan is available for public comment until April 2 and is posted at http://obesityresearch.nih.gov.

Current NIH funding for obesity research is $400.1 million. The budget request for fiscal 2005 is $440.3 million, a 10 percent increase.

"Americans need to understand that overweight and obesity are literally killing us," Thompson said. "To know that poor eating habits and inactivity are on the verge of surpassing tobacco use as the leading cause of preventable death in America should motivate all Americans to take action to protect their health. We need to tackle America's weight issues as aggressively as we are addressing smoking and tobacco."

The CDC study published in the Journal of the American Medical Association, "Actual Causes of Death in the United States, 2000," finds that 400,000 deaths in the U.S. in 2000 (17 percent of all deaths) were related to poor diet and physical inactivity. Only tobacco use caused more deaths (435,000).

In Brief:

Putnam Named Chairman, Thoracic Surgery, at Vanderbilt

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anniversary. The circle is comprised of benefactors who have donated $25,000 each to support the mission of the foundation toward research and public education. The foundation was established in 1979 by **Perry Robins**. . . . **JOE PUTNAM Jr**. has been named chairman of the new Department of Thoracic Surgery at Vanderbilt University Medical Center. Putnam was deputy chairman of thoracic and cardiovascular surgery at M.D. Anderson Cancer Center. He joined Vanderbilt in January as Ingram Professor of Cancer Research in the Vanderbilt-Ingram Cancer Center. He also serves as program director for the residency education program in thoracic surgery with a secondary appointment as professor of biomedical informatics. The newly created department includes clinical and academic programs of thoracic surgical oncology including lung cancer and esophageal cancer; lung failure surgery for emphysema and other lung diseases; and lung transplantation. Putnam was a surgical oncology fellow at NCI. He is chairman of the Workforce on Clinical Trials of the Society of Thoracic Surgery, and participates in other NCI cooperative trials. . . . **UNIVERSITY OF PITTSBURGH** Schools of the Health Sciences faculty members have been elected to the American Society for Clinical Investigation for their achievements in biomedical research. Known as "young turks," the UP researchers include **Yuan Chang**, professor, department of pathology and **Raphael Hirsch,** professor, department of pediatrics, said **Arthur Levine**, senior vice chancellor, health sciences, and dean of the University of Pittsburgh School of Medicine. . . . **BRADLEY GEORGE** has been named medical director at Children's at Scottish Rite by the AFLAC Cancer Center and Blood Disorders Service of Children's Healthcare of Atlanta. George, a pediatric oncologist specializing in high-risk solid tumors, was associate of pediatric hematology/oncology with Geisinger Medical Center of Danville, Pa. He was also clinical assistant professor at Jefferson Medical College, medical director of VITALine Home Infusion Service and director of pediatric medical student education at Geisinger Medical Center.

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