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Bush Budget Proposal A $511 Million Cut For NIH, $11 Million Decrease For NCI

By Kirsten Boyd Goldberg

On a recent visit to NIH, President George W. Bush expressed what optimists construed as a commitment to biomedical research.

"I truly believe the NIH is one of America's greatest assets," he said Jan. 17. "And it needs to be nourished."

His remarks notwithstanding, Bush's budget proposal for fiscal 2008 places NIH on severe calorie restriction, biomedical researchers said after the document was released Feb. 5.

NIH would receive $28.9 billion, a $511 million cut compared to the FY 2007 continuing resolution the House approved on Jan. 31. NCI would receive $4.782 billion, a decrease of $11 million from the House-approved $4.793 billion.

The Senate has yet to approve the FY 2007 spending measure, but is

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In the Cancer Centers:

Armstrong Foundation Awards Ohio State $1.25 Million Survivorship Center Grant

OHIO STATE UNIVERSITY Comprehensive Cancer Center and the Ohio State University Medical Center James Cancer Hospital and Solove Research Institute received a five-year $1.25 million grant from the Lance Armstrong Foundation for a cancer survivorship center, including research and educational and support services. Ohio State is one of seven cancer centers in the Livestrong Survivorship Center of Excellence Network. **Charles Shapiro**, director of breast medical oncology, is director of the survivorship center. **Electra Paskett**, associate director for population sciences, is co-director. The grant will expand the educational and support services at The James and strengthen partnerships with OSU East Hospital and the Holzer Center for Cancer Care, which serves a region of Appalachia. . . . **KARMANOS** Cancer Center and ProMedica Health System, of Ohio, have formed a partnership for cancer care and research. As an affiliate of Karmanos, ProMedica Health System patients will have access to advanced clinical trials and diagnostic advances, said **John Ruckdeschel**, Karmanos president and CEO. ProMedica physicians will be a part of the Karmanos Multidisciplinary Team structure. ProMedica cancer patients will receive treatment plan review by Karmanos Cancer Center physicians. Also, ProMedica will commit $42 million to building a cancer institute with advanced equipment and care options. . . . **PAUL HARARI** was named chairman of the Department of Human Oncology

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President's Budget Represents "Deprivation," Scientists Say

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expected to do so, and the President is likely to sign it. At the time the President's budget request was released, the White House could accurately state that the proposal for NIH represented an increase of $232 million, or 0.8 percent, compared to the stopgap spending measure that is keeping the government running until Feb. 15.

"The President's proposal stands to cause grievous harm to our ability to combat debilitating diseases… as well as leaving us woefully unprepared to deal with emerging illnesses or pandemic influenza," Leo Furcht, president of the Federation of American Societies for Experimental Biology, said in a statement. "Far from nourishing NIH, the FY2008 budget represents further deprivation and attrition of this invaluable agency…. Flat funding in recent years combined with the force of biomedical research inflation has eroded NIH's ability to maintain the momentum of discovery that has resulted in dramatic declines in death from heart disease and cancer."

Scientists and their advocates will need to turn once again to Congress for support. "It is essential that Congress accomplish what this budget fails to, and not only sustain but increase the nation's investment in NIH research," Robert Berdahl, president of the Association of American Universities, said in a statement.

Using the White House budget comparisons, NCI was one of four institutes that would see a decrease under the President's request. The National Institute of Allergy & Infectious Diseases would receive the largest increase—$210 million—bringing that institute's budget to $4.59 billion, further closing the gap between this second-largest institute and NCI. Funding for the NIH Roadmap initiatives would increase by $3 million, compared to the House version of the continuing resolution, to $486 million.

"Cancer Research Is Not A Priority"

Cancer researchers said the President's budget request, released three weeks after his visit to NIH to announce a decrease in U.S. cancer deaths (The Cancer Letter, Jan. 19), sends the wrong message to scientists and clinicians working to reduce the burden of cancer.

"There is a message that has been given consistently that for some reason cancer research is not a priority," said Geoffrey Wahl, president of the American Association for Cancer Research and professor of gene expression at the Salk Institute of Biological Sciences. "[Scientists] are fearful they are losing the next generation, despite their best efforts…which have resulted in the first reductions in cancer mortality that we have seen in 70 years.

"We are expecting an increased incidence of cancer in the near future…because we are living longer, and cancer is a disease of age," Wahl said at a Feb. 6 meeting of the National Cancer Advisory Board. "We are going to have to confront this increased risk. If that isn't the best advertisement for increased funding for cancer, I'm not sure what will be."

NCI's budget has declined by about $72 million from fiscal 2005 to 2007.

"If your paycheck is down four or five times in a row and someone else's paycheck is up, I don't care if it's a dollar and a half, it sends a message," said Donald Coffey, the Smith Distinguished Professor of Urology at Johns Hopkins University and a member of the Presidentially-appointed NCAB. "The NCI is not being treated the same as everyone else, and we need to find out why."

Using the old version of the continuing resolution as a benchmark, NIH officials presented the President's budget as a small increase.

NCI Director John Niederhuber said he lost a bet to NIH Director Elias Zerhouni. "[The 0.8 increase to NIH] cost me a good bottle of cabernet to Dr. Zerhouni, because I bet him that he couldn't pull that off, and he did," Niederhuber said to the NCAB.

"For NCI, it was not as good news," Niederhuber said. "We didn't seem to share in this, which I reminded

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him when I gave him the bottle of wine. He said to me, 'Well, it could have been worse.' So, that was my gift. He said, 'You're down only $9 million—that's nothing.'"

NCI advisors weren't celebrating. "Maybe we as a board need to send a letter," said NCAB Chairman Carolyn Runowicz, director of the Neag Comprehensive Cancer Center at University of Connecticut. "Cooperative groups may have to delay or close 95 trials this year. This brings home the point that as an institute, we are a little different from the other institutes… We have to keep the pressure on. As a board we certainly could be helpful to [NCI] in continuing to advocate for not only a flat budget, but an increase."

"It's your NCI," Niederhuber said. "Your success in building resources for NCI will mean that we will move quicker down the road."

Asked whether the White House or the Department of Health and Human Services had provided any reasoning behind the decrease for NCI, Niederhuber said that no explanation was offered. "That's the reality of the discretionary budget at the department and the White House," he said. "This is the part of the budget that takes the hit when there are other demands."

When Bush visited NIH, "he was really a kid in a candy store," Niederhuber said. "He loved being here."

The visit "wasn't set up as an opportunity for us to connect about the budget," but to discuss the decline in cancer deaths and meet with staff and patients, Niederhuber said. "He really enjoyed himself and was very natural in his interactions with patients as well as with the staff."

The American Cancer Society moved the embargo date for the release of the statistics back by two days for the event. "I owe a word of thanks to [ACS CEO] John Seffrin and ACS for allowing us to move the embargo date on the mortality data that they were going to present so that the President could present it," Niederhuber said.

"Believe me, the White House was extremely grateful for this."

Many news stories on the event included comments by ACS spokesmen and cancer specialists on the "urgent need for federal funding of cancer research and programs that will accelerate the gains we've made against cancer," according to a summary by Rebecca Kirch of ACS. "We were pleased to see that message addressed by several news organizations," Kirch wrote in an email to Runowicz that was distributed to the NCAB. "This largely science-based story had policy implications that were intensified by President Bush's visit to NIH."

Fiscal 2007: NCI R01 Payline At 12th Percentile

The Senate needs to act by Feb. 15 to approve the continuing resolution that would fund government agencies through the remainder of fiscal 2007, or face a government shutdown. Under the spending measure passed by the House, NIH would receive $28.9 billion, an increase of $620 million over FY 2006.

The bill mandates that $483 million be put into the Common Fund, which includes the NIH Roadmap. It allows the institutes to retain funds that were previously transferred to the Center for Medicare and Medicaid Services or earmarked for the Roadmap. That will add $46 million to the NCI budget.

Under NIH-wide guidelines for FY 2007, there will be no inflationary adjustments on non-competing grants. That means about a 3 percent decrease from commitments of record for all grants. NIH will award the same number of competing RPGs as awarded in FY 2005, with a particular emphasis on new investigators. The average cost of competing RPGs same as in FY 2006.

The continuing resolution mandates that NIH fund 500 more RPGs than during the previous year, and provide 1,500 awards to new investigators, an increase from 1,363 in FY 2006. The bill provides $91 million to fund new investigators.

NCI's budget for FY 2007 would be $4.793 billion, the same amount the institute received the previous year when the Roadmap funds are included.

"Dr. Zerhouni has taken the message to the Hill that we don't want to lose the next generation of scientists," Niederhuber said. "That's a good message and that's been a wise decision. We could have taken nanotechnology, we could take a lot of things, but their eyes would glaze over."

While NCI will get to keep the money that would have gone to the Roadmap, Congress specified that half of it must fund RPGs.

"If you are an R01 investigator, that's good news," Niederhuber said. "If you are the director of the NCI and you are trying to manage the SPORE program, and the cancer centers program, you put up your hand and say, 'Wait a minute, what about me? We have this centers program that none of the other institutes have, and we have the SPOREs program, we have cooperative groups.'"

For FY 2007, NCI plans to spend $2.022 billion on RPGs:

—$1.45 billion on 3,878 non-competing grants, 14 fewer than the previous year.

—$424.7 million on 1,310 competing grants, an

increase of 30 grants.

—$49.8 million on administrative supplements to grants.

The R01 payline would remain at the 12th percentile, and the payline for new investigators would remain at the 18th percentile. The RPG success rate will drop from 19.4 percent to 18.9 percent. The success rate reflects the still-increasing number of grant applications being submitted to NCI, Niederhuber said. In FY 2004, the success rate was 24 percent. In FY 2005, the success rate was 20 percent.

"Those are numbers that are very influenced by the denominator," Niederhuber said. "I don't think we are losing ground, but we are not growing much."

At a budget retreat last month with extramural advisors, Niederhuber was asked how many grants NCI isn't able to fund, he said. "We said that maybe in a perfect world, one funds about a fifth of all the grants that come in; that we would expect in the research community across the U.S. that 20 percent of the grants that come in ought to be of the quality that deserves funding," Niederhuber said. "That's a guess on our part. We calculated that we probably didn't fund in '06 about 180 grants that would have been funded in a perfect world. That gives you an idea of what we aren't doing."

Besides not funding 180 grants, NCI may have to cancel or postpone 95 new clinical trials—about 60 percent of the new trials that open each year—in the cooperative group system due to a proposed 10 percent cut to the budgets of the groups. That would limit the availability of trials for about 3,000 cancer patients (The Cancer Letter, Jan. 12).

The proposed cuts have prompted the cooperative groups to stop studying some cancers. The Southwest Oncology Group eliminated its sarcoma and head-and-neck committees, and will no longer plan clinical trials in those areas. The Eastern Cooperative Oncology Group said it will eliminate its brain cancer and sarcoma trials.

"We have a significant clinical trials infrastructure across this country," Niederhuber said to the NCAB. "I try to remind Dr. Zerhouni of the importance of this. It is in place; it is distinctive among all the institutes. There is no other institute on the NIH campus that has this type of infrastructure across the country. We don't have to build a resource to start trials. We can take an idea and put it into place and begin to acquire patients for that trial.

"It has been a huge part of the success story of the National Cancer Institute."

In the Courts:

Court Could Determine Future Of Clinical Trials In FDA Case

By Paul Goldberg

When the judges of the U.S. Court of Appeals for the District of Columbia meet to hear arguments in *Abigail Alliance v. Andrew von Eschenbach*, they will be examining the fundamentals of cancer drug development, and the ultimate outcome of the case could shape the future of drug regulation and experimental medicine.

On March 1, the court will reconsider an earlier ruling by a panel of three judges that the Constitution guarantees terminally ill patients access to experimental drugs. The case was filed by Abigail Alliance, a patient group in an effort to redraw the drug approval process, making it possible for drug sponsors to charge for drugs after they clear phase I testing.

"The integrity of the clinical trials process is at stake in this case," said Allen Lichter, executive vice president and CEO of the American Society of Clinical Oncology, one of the groups that have filed *amici curiae,* friends of the court, briefs in the case. "We have the utmost respect for the Abigail Alliance, for their passion in this area. We just happen to believe that their position is one that should not prevail, and if it prevails, it will do great harm to the system, which will in turn do great harm to thousands of patients."

ASCO filed its brief in conjunction with the Association of American Medical Colleges and the National Coalition for Cancer Survivorship.

Taking the opposite side, oncologist Emil Freireich, one ASCO's past presidents, and Oregon oncologist Stephen Strum, who also advises a group that sells dietary supplements, filed a brief that challenges the fundamental ethics of the clinical trials process.

Drug developers seek "to sacrifice the lives of terminally ill patients in the interest of compelling participation in clinical trials by denying any other option for those who lack approved treatments," Freireich and Strum wrote in their brief. "At a minimum such a position deserves scrutiny to determine whether the lives of these patients should be sacrificed on the alter [*sic*] of science."

Freireich is the director of the Adult Leukemia Research Program at M.D. Anderson Cancer Center. Strum is an Ashland, Ore., board-certified oncologist who treats prostate cancer and is a member of the scientific advisory board and the medical advisory board of Life Extension Foundation, a Hollywood, Fla., a non-

profit. On its website, the foundation, which is based in a retail store, claims that it "often uncovers potential therapies to treat the degenerative diseases of aging such as Alzheimer's and Parkinson's disease, cancer, stroke, macular degeneration."

The Freirech and Strum brief states that "the clinical trial industry is big business with strong influence over FDA and its amici at ASCO" and that its supporters "have a significant interest in preserving the status quo, even when it leaves many terminally ill patients with no hope."

ASCO's Lichter said the association is defending science, not some vested interests. "I can't imagine how our trying to preserve a clinical trials process could be interpreted in that fashion," he said in an interview. "We are supporting the FDA here. I don't think it's a relevant comment."

Over decades, Freireich has questioned the ethics of randomization and criticized the FDA requirements that physicians obtain Investigational New Drug licenses even when they are treating one patient. "The FDA doesn't publish statistics for single-patient IND applications, but there is widespread perception in the medical and patient communities that this process is administratively burdensome, untimely and unfairly administered," Freireich and Strum write in their brief.

Freireich and Strum argue that the controversy is about the thousands of terminally ill patients who run out of treatment options. "Although their treating physician believes that a drug currently in phase II or phase III trials might save or extend their lives, they cannot get into a trial, so they have no hope to live" unless the existing system is changed, the two oncologists write.

"The highest risk to the safety of terminally ill patients is not getting any treatment," they write. "By the time a drug is in advanced clinical trials, the FDA has already certified that a clinical trial, perhaps involving hundreds or thousands people, is sufficiently safe to conduct. Thus the real issue is whether terminally ill patients not fortunate enough to participate in clinical trials will have the same chance for lifesaving drugs as those in the trials."

These statements are founded in belief that patients would stand to benefit from further relaxing access to early-stage drugs, mainstream oncologists say.

"Overall, statistics show that only about 5 percent of drugs that get through phase I eventually end up being commercialized products," Lichter said. "We believe that the Abigail Alliance and others have mistakenly assumed that a drug that has been through phase I has been proven safe. That's just not so. A dose has been selected that can be further tested, but that doesn't mean the drug is safe. And it certainly doesn't mean the drug is effective."

The agency hasn't been restrictive in granting expanded access to drugs, Lichter said. "Their new proposed regulations make that even more accessible," said Lichter, referring to the agency's new proposed guidance, which were published late last year. "Under appropriate circumstances, patients can get drugs that are showing promise and still in the testing phase. Supporting that doesn't mean that we should put the entire structure of FDA at risk."

Moreover, the brief filed by ASCO, NCCS, and AAMC points out that it's up to sponsors to decide whether to grant expanded access to drugs.

"The Abigail Alliance is seriously misguided in its failure to recognize the role of pharmaceutical sponsors in determining whether patients may receive access to unapproved drugs outside of clinical trials," the brief states. "FDA regulations are extremely open to such access, even though it is theoretically true that FDA retains the authority—almost never exercised—to make the decision not to grant individual access."

Changing regulations to allow sponsors to charge could lead to harm to patients, the brief states. "Most major manufacturers have expressed little or no interest in the Abigail Alliance proposal, as they appreciate that a rigorous and orderly product review and approval process is best for all concerned," the document states. "Companies with a pressing need for revenue or for demonstrable product results, however, may find it a more attractive option, and once a drug is approved, even on the basis of no more than phase I data, there is no mechanism for restraining the price of the product."

Another brief was filed by a group of five free-market economists. The economists wrote:

"The legal question at the heart of this case is not whether due process requires the FDA to provide terminally-ill patients with access to unsafe drugs—by definition, the post-phase I drugs at issue here have already achieved a preliminary safety definition. Rather, the question is whether the court should permit the FDA to erect an administrative obstacle that, through delay, prevents useful drugs from reaching patients with no remaining treatment option."

Last May, a panel of three judges ruled that the right to obtain phase I drugs was covered in the Due Process Clause of the Fifth Amendment, which provides that no one shall be "deprived of life, liberty, or property, without due process of law" (The Cancer

Letter, May 5, 2006). In November, the court vacated that ruling and decided that the case should be heard by all 10 judges who sit on the court (The Cancer Letter, Dec. 1, 2006).

Later that month, FDA published a proposed rule that systematizes the obscure practices and traditions that govern the granting of access to experimental therapies, often allowing companies to recover cost of producing drugs given outside clinical trials (The Cancer Letter, Dec. 22, 2006).

FDA News:

Weight-Loss Drug Approved Despite Safety Concerns

By Paul Goldberg

FDA Feb. 7 approved over-the-counter sales of the anti-obesity drug orlistat, disregarding concerns about its link to what may be a precancerous condition.

The over-the-counter version of the drug is sponsored by GlaxoSmithKine, and will be sold under the name Alli. The prescription version, sponsored by Roche AG, was approved in 1999 and is sold under the trade name Xenical.

Even before the drug's initial approval almost eight years ago, the agency's toxicology review of Roche animal data found that the drug is associated with aberrant crypt foci, or ACF.

Though data on ACF have been accumulating, the advisory committee that voted to make orlistat available for over-the-counter sale last year wasn't asked to review this suspected link (The Cancer Letter, June 2, 2006).

ACF is far from being a validated biomarker. However, its appearance as a potential toxicity raises questions about feasibility of FDA's plans to start approving drugs based on biomarkers. Observers wonder whether the agency would treat the biomarkers for toxicity with the same level of interest as the biomarkers for efficacy.

"We know that being overweight has many adverse consequences, including an increase in the risk of heart disease and type 2 diabetes," Douglas Throckmorton, deputy director of FDA's Center for Drug Evaluation and Research, said in a statement. "Orlistat, along with diet and exercise, may aid overweight adults who seek to lose excess weight to improve their health."

Sidney Wolfe, director of Public Citizen's Health Research Group, who filed a citizen's petition to ban the prescription version of the drug, said that the agency's action earlier this week demonstrates unprecedented "recklessness."

"At a time when colon cancer is a leading cause of death and disease in the U.S., FDA's decision to approve, for over-the-counter use, a drug that clearly causes pre-cancerous lesions of the colon is the height of recklessness and shows a profound lack of concern for the public's health," Wolf said in a statement.

"This marks the first time, to my knowledge, that the FDA has approved a drug for over-the-counter use despite knowing in advance that the drug causes either cancer or pre-cancerous lesions," Wolf said. "This decision raises very serious questions about the competence of former NCI Director Dr. Andrew von Eschenbach in allowing the approval of a drug that may well increase the incidence of colon cancer in this country."

Orlistat blocks dietary fat from being absorbed and disgested.

Obituary:

CHRISTOPHER E. DESCH, 51, national medical director of the National Comprehensive Cancer Network, who was as passionate about quality cancer care as he was about flying, died Dec. 10 when a private plane he was piloting crashed due to engine failure near Charlottesville, Va.

Desch joined the faculty of the Virginia Commonwealth University Massey Cancer Center in 1988, and founded the center's Rural Cancer Outreach Program. He joined NCCN in January 2006, but continued to serve as a leader of clinical trials for breast cancer prevention at the center.

He was a partner in the Virginia Cancer Institute for the past eight years and director of Quality Assurance and Education. Desch's patients and co-workers appreciated his calm and caring demeanor, as well as his colorful ties and socks. He once returned to the cancer center in the evening, wearing a tuxedo, to dance with a leukemia patient who couldn't attend her senior prom.

Desch was one of the founders of the Quality Oncology Practice Initiative of the American Society of Clinical Oncology.

"He was smart, kind, funny, and perceptive," Joseph Simone, QOPI founder and clinical director emeritus of the Huntsman Cancer Institute, wrote in an appreciation of Desch in the Jan. 25 issue of Oncology Times. "He inspired us to press on when things were rocky; he provided the unique perspective of one who was both an academic and community oncologist."

Desch had been a member of the Wingnuts Flying Club of Chesterfield County for the past three years. He was flying alone for practice in a 30-year-old Piper Lance, one of four planes owned by the club, when he

reported engine trouble after having been cleared to land at the Charlottesville airport. An emergency medical helicopter heard the distress call and followed the plane, witnessing as it crashed into a tree and immediately burst into flames, according to news reports.

Desch earned his undergraduate degree in 1977 and MD degree in 1981 from Ohio State University. He was a resident in internal medicine at the University of Rochester from 1981 to 1984, and Medical Chief Resident from 1984 to 1985. He completed a fellowship in hematology and oncology at the University of Washington from 1985 to 1988.

He is survived by his wife, Roxanne Cherry, and their son Toby; his mother, Geraldine Desch; a sister and four brothers.

In the Cancer Centers:

Sartor Replaces Tepper As Dept. Chairman At UNC

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at the University of Wisconsin School of Medicine and Public Health. He also was appointed associate director of the UW Paul P. Carbone Comprehensive Cancer Center. Harari, a radiation oncologist, has been a faculty member at the school for 16 years. . . . **CAROLYN SARTOR** was appointed chairman of the department of radiation oncology at University of North Carolina at Chapel Hill School of Medicine. Sartor, a project co-principal investigator of the UNC breast SPORE, will enhance the research activities of the UNC Lineberger Comprehensive Cancer Center and the UNC School of Medicine, said **Shelton Earp**, director. She succeeds **Joel Tepper**, Hector MacLean Distinguished Professor of Cancer Research and professor of radiation oncology, who is stepping down as department chairman after 20 years. . . . **FREDERICK RACKE** was named director, Division of Hematopathology, Department of Pathology, at Ohio State University Medical Center. He is a member of the OSU Comprehensive Cancer Center. Racke was recently named pathology cadre leader for the Cancer and Leukemia Group B.

In Brief:

Komen Gets A New Name

SUSAN G. KOMEN for the Cure is the new name of the Susan G. Komen Breast Cancer Foundation. The foundation marks its 25th anniversary this year. The organization was founded in 1982 by **Nancy Brinker,** who started it as a promise to her sister Susan who died of breast cancer. "'For the Cure' reaffirms our vision of a world without the disease," the foundation said in a statement. The foundation said it has raised $1 billion for research, education, and health services. . . . **SANYA SPRINGFIELD** was appointed director of the NCI Center to Reduce Cancer Health Disparities. She has served as acting director of the center since 2005. She was chief of the NCI Comprehensive Minority Biomedical Branch. . . . **ALAN KRENSKY** was named NIH deputy director for the Office of Portfolio Analysis and Strategic Initiatives. He is professor of pediatrics and associate chairman for research in the Department of Pediatrics at Stanford University, chief of the Division of Immunology and Transplantation Biology, and associate dean for children's health. . . . **KING & SPALDING** Washington, D.C., office added staff to its FDA health practice: **Pamela Furman**, partner, and consultants **Ann Graham** and **Anne Kelly**. Furman was a principal at Olsson, Frank and Weeda, P.C. Graham was a branch chief in the FDA Office of Device Evaluation. Kelly was senior vice president for Andrx Pharmaceuticals Inc. . . . **NATIONAL LIBRARY of Medicine** added a selection from the papers of **Rosalind Franklin** (1920-1958) to its Profiles in Science Web site at http://www.profiles.nlm.nih.gov. Franklin was a chemist and crystallographer who worked on the structure of DNA. Her X-ray diffraction photos and analysis gave Francis Crick and James Watson clues to the DNA helical structure in early 1953. Franklin never knew they had access to her then-unpublished data. Crick and Watson received the Nobel Prize for their DNA model in 1962, four years after her death. The online exhibit features correspondence, published articles, photos, lab notebooks, and reports from her files. . . . **NIH** named seven members to its advisory committee to the director: **Catherine DeAngelis**, editor-in-chief of the Journal of the American Medical Association and professor of pediatrics at the Johns Hopkins University School of Medicine. **Karen Holbrook**, president of Ohio State University. **Ralph Horwitz**, the Arthur Bloomfield Professor and chairman, Department of Medicine at Stanford University. **Mary-Claire King**, the American Cancer Society Professor, Departments of Medicine and Genome Sciences, University of Washington. **Alan Leshner**, CEO of the American Association for the Advancement of Science and executive publisher of its journal, Science. **John Nelson**, medical director for HealthInsight, the Quality Improvement Organization for Utah and Nevada. **Barbara Wolfe**, professor of economics, population health sciences, and public affairs and faculty affiliate, Institute for Research on Poverty, University of Wisconsin-Madison.

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