THE CANCER LETTER

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Doubling Of Cancer Research Budget To Take Eight Years Under Obama Plan

By Kirsten Boyd Goldberg

The Obama administration last week said the plan to double the cancer research budget will take eight years, not five as candidate Barack Obama proposed last year.

The longer time frame was revealed in NIH budget documents released May 7 as part of the detailed rollout of the President's budget request for fiscal 2010. The White House had submitted the budget request to Congress in February, but didn't release detailed agency funding plans (The Cancer Letter, Feb. 27).

The budget proposal includes $6 billion for "cancer research across NIH," and would be the first year of an eight-year effort to double cancer

(Continued to page 2)

In the Courts:

ACLU Sues Myriad, U.S. Patent Office Over Patents For BRCA Gene Mutations

By Paul Goldberg

The American Civil Liberties Union last week filed a lawsuit arguing that patents on the BRCA1 and BRCA2 genes responsible for breast and ovarian cancers are unconstitutional.

The patents in question are held by Myriad Genetics, a biotech company based in Salt Lake City, which charges $3,120 for its most extensive test. Though the plaintiffs seeks to invalidate selected claims in seven of the company's patents, their ultimate goal is to throw out all patented human genes, said Daniel Ravicher, of the Public Patent Foundation at the Benjamin N. Cardozo School of Law.

"Every person's body contains human genes, passed down to each individual from his or her parents," states the complaint filed May 12 at the U.S. District Court for the Southern District of New York. "These genes determine, in part, the structure and function of every human body. This case challenges the legality and constitutionality of granting patents over this most basic element of every person's individuality."

In addition to Myriad, the case names the U.S. Patent and Trademark Office, which issued the patents, as well as the directors of the University of Utah Research Foundation, which holds an interest in Myriad.

Plaintiffs include ACLU, the Public Patent Foundation as well as the Association for Molecular Pathology, the American College of Medical Genetics, the American Society for Clinical Pathology, College of American

(Continued to page 5)

FY 2010 Request For NCI $5.15 Billion, A 3.6% Increase

(Continued from page 1)

research by FY 2017, according to an NIH document (http://officeofbudget.od.nih.gov/ui/HomePage.htm).

The FY 2010 request for cancer research represents an increase of $268 million or 5 percent over the estimated FY 2009 level.

The NCI request is $5.15 billion, a $181 million or 3.6 percent increase over the FY 2009 appropriation. NCI also would receive $8 million from the NIH buildings and facilities budget for repairs and improvements at the NCI Frederick campus.

For NIH overall, the President's request is $30.838 billion, an increase of $443 million, or 1.4 percent above the FY 2009 level. Of this amount, $30,759 million is requested through the Labor/HHS/Education appropriation bill, and $79 million for Superfund Research activities through the Interior bill.

The FY 2010 request increases the AIDS research program by $45 million or 1.5 percent to $3.055 billion. NIH will transfer $300 million to the Global Fund for HIV/AIDS, Tuberculosis and Malaria.

In addition to the emphasis on cancer research, the budget request for NIH includes the following strategic priorities:

Autism Research: NIH plans to provide $141 million of the $211 million HHS-wide initiative that also encompasses the Centers for Disease Control and Prevention and the Health Resources Services Administration in FY 2010 for research into the causes of and treatments for autism spectrum disorders. For NIH, this represents an increase of $19 million, or 16 percent above estimated FY 2009 level.

Nanotechnology-related Environment, Health and Safety Research: The FY 2010 request includes a $9 million increase to the National Institute for Environmental Health Sciences for a new initiative to support nanotechnology safety research.

NIH Common Fund: The request provides $549 million for the CF, an increase of $8 million or 1.5 percent over the FY 2009 level. The CF remains at 1.8 percent of the total NIH budget. Within the CF, some of the original Roadmap five-year projects will end the incubator phase in FY 2009. Further, FY 2010 will have major decreases in several projects as they transition to the institutes and centers as planned.

Bioethics: A total of $5 million from the Office of the Director will be used to launch a new effort in bioethics, which will be funded in coordination with the ICs. "A renewed commitment to bioethics research and training is necessary to maintain and enhance public trust and confidence as we explore new frontiers in science, bioinformatics, and biomedical and behavioral medicine," the NIH budget document states.

Oversight: The Office of the Director increases by $5 million to support and expand on-going trans-NIH stewardship and oversight activities.

The budget proposal for NIH would fund a total of 9,849 new and competing renewal research project grants, an increase of seven RPGs over the estimated FY 2009 level. Competing RPGs total $3.935 billion, an increase of $79 million or 2 percent over the FY 2009 level. Due to the receipt of Recovery Act funds in FY 2009, NIH will temporarily suspend the NIH Director's Bridge Award program in FY 2010; the vast majority of these funds are redistributed to the ICs.

For noncompeting continuation awards, the President's budget provides inflationary increases of 2 percent. The average cost of competing RPGs increases by 2 percent over the FY 2009 level.

NIH proposes to increase support for research centers to $3.056 billion, an increase of $40 million or 1.3 percent increase above the FY 2009 level. This request level will continue to provide program growth for the Clinical and Translational Science Awards.

NIH will support 17,742 Full-Time Training Positions, an increase of 101 FTTPs over the FY 2009 level. National Research Service Award funding increases by $8 million or 1 percent over the FY 2009 level.

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NIH will not provide stipend or other training-related expense increases in FY 2010.

R&D contracts would increase by $33 million or 1 percent compared to the FY 2009 level, for a total of $3.412 billion.

NIH would continue to fund the newly created Therapeutic Rare and Neglected Diseases Initiative at $24 million, as well as the Undiagnosed Diseases program. Each IC will support the Undiagnosed Diseases program with a proportional level of support totaling $1.75 million in FY 2010, with an additional $1.75 million allocated to the Office of the Director.

Support for the NIH intramural research program increases by 1.5 percent above the FY 2009 level, for a total of $3.219 billion. This increase maintains the intramural program at approximately 10 percent of NIH's overall budget.

For FY 2010, Research Management Support would be funded at $1.43 billion, an increase of $25 million or 1.8 percent above the FY 2009 level, in order "to improve stewardship of all funds."

The NIH Office of the Director would decreases by $64 million or -5 percent. The FY 2010 request does not include funds for the NIH Director's Bridge Award program, because Recovery Act funds enabled NIH to support additional awards just missing the nominal payline.

White House Seeks 19% Increase for FDA

The President's budget requests $3.2 billion for FDA, a 19 percent increase over the agency's current budget.

The FY 2010 request includes increases of $295.2 million in budget authority and $215.4 million in industry user fees. FDA is proposing four new user fees to facilitate review of generic drugs, register and inspect food manufacturing and processing facilities, reinspect facilities that fail to meet Good Manufacturing Practices and other safety requirements, and issue export certifications for food and feed.

"This historic increase in the FDA's budget is a great investment in public health," said Joshua Sharfstein, acting FDA commissioner.

Following are the FDA's key proposed budget increases:

Protecting America's Food Supply ($259.3 million): The goal of this effort is to protect American consumers by preventing intentional and unintentional contamination. This effort invests in priorities that strengthen the safety and security of the supply chain for foods. Supply chain safety and security relies on the principle of risk-based prevention with verification. Under this principle, the FDA holds all segments of industry accountable for ensuring that their products meet U.S. safety standards. The Protecting America's Food Supply initiative focuses on foreign and domestic sources of ingredients, components, and finished products at all points in the supply chain, including their eventual use by the American public. Within this initiative, the FDA proposes to collect a total of $94.4 million in new user fees to register food facilities and increase food inspections, issue food and feed export certifications, and reinspect food facilities that fail to meet the FDA's safety standards.

Safer Medical Products ($166.4 million): This effort provides targeted resources to improve the safety of human and animal drugs, medical devices, vaccines, blood, and other medical products. It will allow the FDA to strengthen safety and security of the supply chain for medical products. The initiative also includes $46.6 million in new user fees for generic drug review and new fees to reinspect medical product facilities that fail to meet safety standards.

Current Law User Fees ($74.4 million): In addition to the new user fees proposed for FY 2010, the FDA request also includes inflationary and other authorized increases for fees that support FDA review of applications for new human drugs (+$67.5 million), animal drugs (+$2.3 million), and medical devices (+$4.5 million).

Follow-on Biologics & Drug Importation ($5 million): Within the Safer Medical Products initiative, the budget proposes a new authority for the FDA to approve follow-on biologics through a regulatory pathway that protects patient safety and promotes innovation, and includes $5 million for the FDA to develop policies to allow Americans to buy drugs approved in other countries.

Further information on the President's FY 2010 budget for the FDA: http://www.fda.gov/oc/oms/ofm/budget/documentation.htm.

The Alliance for a Stronger FDA praised the budget proposal. "There is now tangible evidence of Presidential commitment to FDA," said Wayne Pines, president of the Alliance. "With these added funds, the incoming FDA commissioner can move forward on restoring confidence in FDA's ability to protect and advance the public health."

According to the Alliance, the President's request for 9,166 full-time equivalent employees finally brings the agency up to the staffing level of 9,167 FTEs that it had in 1994. These numbers exclude user fee staffing.

Advocacy:

Groups Offer Revisions To Kennedy-Hutchison Cancer Bill

By Kirsten Boyd Goldberg

Cancer patients advocacy groups and professional societies have recommended that the bill intended to replace the National Cancer Act be revised to provide wider access to clinical trials and establish a cancer care planning service within Medicare.

The bill, introduced by Sens. Kay Bailey Hutchison (R-Tex.) and Edward Kennedy (D-Mass.) last month, is called the 21st Century Cancer Access to Life-Saving Early Detection, Research, and Treatment (ALERT) Act (S.717) (The Cancer Letter, April 3).

Since its introduction, the bill has gained several co-sponsors, including Sens. Robert Casey (D-Penn.), Diane Feinstein (D-Calif.), Tim Johnson (D-S.D.), Robert Menendez (D-N.J.), Jeff Merkley (D-Ore.), Barbara Mikulski (D-Md.), Bernie Sanders (I-Vt.), Charles Schumer (D-N.Y.), and Debbie Stabenow (D-Mich.).

In a letter sent to Kennedy and Hutchison, the Cancer Leadership Council recommended substituting the wording of two other bills for that contained in the ALERT act. The text of the April 28 letter follows:

Dear Senators Kennedy and Hutchison:

The undersigned cancer patient, research, and provider organizations appreciate your commitment to legislation to revitalize the nation's cancer research effon and enhance access to quality cancer care. We look forward to working with you to ensure that the 21st Century Cancer Access to Life-Saving Early Detection, Research, and Treatment (ALERT) Act meets the pressing needs of those living with cancer and those who will be diagnosed this year and in the future.

We offer the following recommendations for modifications, additions, and deletions to the ALERT Act.

• *Ensure access to care in clinical trials without regard to type of insurance plan of the cancer patient.*

The ALERT Act provisions on clinical trial coverage would apply only to a portion of private health insurance plans and as a result would prevent many with cancer from considering care in a clinical trial. Access to care in a clinical trial should not depend on the nature of insurance coverage; instead, such coverage should be an integral component of any health care system. We urge substitution of the language of the Access to Cancer Clinical Trials Act (S. 488/H.R. 716), which applies to all private insurance plans, for the clinical trials language in the ALERT Act.

Substitution of the language of S. 488/H.R 716 would address the potential problems created by the ALERT Act's prohibition of coverage of costs that are "necessitated solely because of the trial." This language will create uncertainty about third party coverage of routine care costs and as a result will discourage patients from trial enrollment. In contrast, S. 488 and H.R. 716 define covered costs with admirable clarity.

• *Encourage care planning for all cancer patients.*

We propose that the language of the Comprehensive Cancer Care Improvement Act (H.R. 1844) establishing a Medicare cancer care planning service replace the cancer care planning demonstration currently included in the ALERT Act. Providing all Medicare beneficiaries access to cancer care and survivorship planning honors the recommendations of the Institute of Medicine (IOM) for better coordination of cancer care. The demonstration project included in the ALERT Act would be implemented in only six sites and would take a number of years to implement and evaluate, a period of time during which most Medicare beneficiaries would be denied access to a standard of care repeatedly endorsed by the IOM.

• *Guarantee that those diagnosed with cancer through federally supported screening programs have access to cancer care.*

We commend your decision to provide access to care for those who are diagnosed through the colorectal cancer screening program. The experience with the National Breast and Cervical Cancer Early Detection Program underscored the serious problems that are created when individuals are diagnosed with cancer through a public screening program and are then unable to receive appropriate care. We urge you to resist efforts to remove from the ALERT Act the provisions that would help those diagnosed in the screening program obtain necessary care.

We recommend two changes in the language authorizing the colorectal cancer screening program. We propose that grantees be permitted some flexibility regarding the utilization of funds for outreach and education, at least in the early years of the program and subject to a justification that additional funds are needed for those purposes. The authorization should also permit adjustment in payment rates for screening services, if technological changes justify such modifications. These issues can be addressed by incorporating the language of H.R. 1189, the Colorectal Cancer Prevention, Early Detection, and Treatment Act.

• *Ensure that the cancer research program reflects the diversity of cancer and cancer research.*

Although important strides have been made in me treatment of some types of cancer. for many others the pace of discovery and therapeutic development is slow and improvements in survival are limited. In addition, many survivors suffer serious late and long-term effects of their treatment. There remains a pressing need to improve treatments for all cancers, including by minimizing the side effects of treatment.

The research and development provisions of the ALERT Act should reflect the realities and difficulties of cancer research and the diversity of the scientific and clinical challenges of cancer research. The provisions of the bill requiring reports about grants for high-mortality cancers and low-incidence cancers will provide valuable information for assessing the cancer research program. We recommend greater accountability and transparency regarding all National Cancer Institute (NCI) investments.

• *Eliminate the reference to "complete recovery care."*

We applaud the inclusion of provisions that acknowledge me psychosocial needs of cancer patients and that authorize programs to improve the delivery of such services. We recommend. however, that the phrase "complete recovery care" be replaced by the phrase "coordinated cancer care." Although many cancer patients enjoy a long period of survivorship, few achieve "complete recovery," which would seem to mean either cure or treatment without late and long-term effects.

We recommend the wording change so the legislation and this provision more accurately reflect the current experience of most cancer survivors and the benefits of coordinated cancer care, including appropriate symptom management.

• *Invest in clinical research to ensure optimal translation of basic research findings into new and better therapies.*

We recommend that the ALERT Act be amended by the addition of provisions to strengthen the existing clinical trials infrastructure. This could be accomplished by authorizing payments to clinical researchers that are adequate to match the costs associated with enrolling patients in trials and by strengthening programs that encourage active participation of community oncologists in clinical research.

• *Achieve a Cancer Human Biorepository Network by utilizing new technologies.*

The language of the ALERT Act should clarify that the Cancer Human Biorepository Network will be a virtual network that would link existing biospecimen repositories into an interoperable system that would facilitate research. We believe that maximum collaboration of institutions and investigators could be achieved by structuring the network as a virtual one and utilizing technology to achieve interoperability in collection, storage, and sharing of biospecimens and data.

• *Develop the oncology workforce of the future.*

One of the most serious issues confronting the cancer community in the 21st century will be the inadequacy of the oncology workforce. It is projected that the workforce will be woefully inadequate to meet the needs of an aging population that already accounts for 60 percent of cancer diagnoses and will account for a larger portion in the future. The ALERT Act is silent on this issue, save a modest nurse education provision. Additional legislation will be necessary in the near future to address the supply, education, and distribution of oncology providers, including physicians and nurses.

We appreciate the opportunity to offer these recommendations regarding the ALERT Act and look forward to working with you on this legislation.

The letter was signed by: American Society of Clinical Oncology, American Society for Radiation Oncology, Bladder Cancer Advocacy Network, Breast Cancer Network of Strength, C3: Colorectal Cancer Coalition, Cancer Care, Coalition of Cancer Cooperative Groups, International Myeloma Foundation, Kidney Cancer Association, The Leukemia & Lymphoma Society, Lymphoma Research Foundation, Multiple Myeloma Research Foundation, National Coalition for Cancer Survivorship, National Lung Cancer Partnership, North American Brain Tumor Coalition, Ovarian Cancer National Alliance, Prevent Cancer Foundation, Sarcoma Foundation of America, and The Well ness Community.

In the Courts:

ACLU Lawsuit Could Impact All U.S. Patents On Genes

(Continued from page 1)

Pathologists, as well as individual researchers, patients and patient groups.

The controversy over BRCA genes is nearly 20 years old, and it has revolved around intellectual property after the filing of the first of Myriad's nine BRCA1 and BRCA2 patents in August 1994. Though the controversy has raged in a variety of venues, until now no one has challenged the practice head-on in U.S.

courts, Ravicher said.

"No court case has ever questioned whether genes can be patented," Ravicher said. Many other gene patents are at stake in all areas of medicine. In colorectal cancer alone, these could include three patents covering the MLH1 gene, the MSH2 protein, and the APC gene.

"There are tons of other patents we could have chosen, but we didn't," Ravicher said. "We chose these because these are offensive patents, and they have a large impact. We had to choose one set of gene patents to sue, and when we win and the court says these gene patents are invalid because human genes cannot be patented, that decision will render invalid all the other gene patents in the U.S."

Myriad didn't return calls from a reporter.

The patents granted to Myriad give the company the exclusive right to perform diagnostic tests on the BRCA1 and BRCA2 genes and to prevent any researcher from even looking at the genes without first getting permission from Myriad, ACLU argues. This control over genes hampers clinical diagnosis and serves as a disincentive for research, because Myriad not only has the right to enforce its patents against other entities but also has the rights to future mutations discovered on the BRCA2 gene.

NCI confronted that issue a decade ago, after the patents were first issued. In December 1999, then-NCI Director Richard Klausner and Myriad officials signed a "memorandum of understanding" that provided discounts on testing for all NCI-funded studies. Under the agreement, researchers could perform research testing within their institutions without seeking Myriad's permission, but were unable to patent additional discoveries.

Plaintiffs in the suit include two University of Pennsylvania researchers who received cease and desist letters from Myriad in connection with their work with the genes, as well as other researchers who would be able to perform testing or use other labs, perhaps at reduced costs, the complaint states.

Myriad requires that testing be carried out at its $30-million facility in Salt Lake City. No other commercial entity can validate the findings of that lab, the complaint states. A recent case study prepared by the Duke University Center for Genome Ethics, Law & Policy states that Myriad hasn't prospectively specified when it would seek to enforce its intellectual property claims against researchers.

"While Myriad maintains it has not enforced its patents against researchers, neither has it publicly stated that it would not do so in a written, actionable form except in the NCI MOU," the case study states. "This ambiguity may itself be a factor in stifling further research to the extent that this has occurred." The document is posted at http://oba.od.nih.gov/oba/SACGHS/Appendix%201%20SACGHS%20Patents%20Consultation%20Draft%20Compendium%20of%20Case%20Studies.pdf.

A case study of the Myriad controversy by the International Expert Group on Biotechnology, Innovation and Intellectual Property at McGill University disputed the argument that human genes aren't patentable because they are not inventions.

This argument is a "mischaracterizations of patent law," the case study states.

"Patents on genes have been issue for years in the United States, Europe, Canada, Japan, Australia and other jurisdictions.

"Human genes are patentable subject matter in all countries in which disputes over Myriad's genes arose," the document states. "According to the patent laws of these countries, human genes purified and isolated, or put in a non-natural state (for example, isolated in a test-tube or inserted into a species different from its natural host) as well as artificial genes can be patented. Patent law considers an 'invention' to be anything this is in an altered form (from its natural state) due to human intervention.

This technical definition of invention differs from the more common definition of invention that focuses on originality.

"For the purposes of patent law, an invention need not be original in the sense that the thing owes its existence solely to the inventor. Instead, an inventor need only show that the thing did not exist in the exact way the inventor described it (that is, it is placed in a different context), that the inventor exercised a degree of creativity and that the invention as described is useful. On this understanding, while a human gene in an isolated state may not be an invention in ordinary parlance, it is an invention under the accepted principles of patent law."

The case study is posted at www.theinnovationpartnership.org/data/ieg/documents/cases/TIP_Myriad_Report.pdf.

"The ACLU cares about scientific freedom, we care about women's health, and we care about bodily integrity," said Tania Simoncelli, science advisor to ACLU, describing the organization's rationale for filing the suit.

The complaint is posted at www.aclu.org/brca.

Medicare:

CMS Withholds Coverage For CT Colonography

The Centers for Medicare and Medicaid Services May 12 issued a final determination to withhold coverage for computed tomography colonography.

"The evidence is inadequate to conclude that CT colonography is an appropriate colorectal cancer screening," states the determination published May 12.

Screening with CT colonography is controversial. While the American Cancer Society recently included the procedure in its guidelines, the U. S. Preventive Services Task Force has not (The Cancer Letter, Oct. 10, 2008).

A recent study by NCI and the American College of Radiology Imaging Network Trial demonstrated that CT colonography is comparable in effectiveness to standard colonoscopy as a screening tool for the detection of cancer and precancerous polyps. The paper was published in the New England Journal of Medicine last year.

The USPSTF guideline didn't recommend the procedure largely because the impact of radiation and incidental findings couldn't be evaluated. However, some private insurers are covering CT colonography. These include CIGNA and United Healthcare nationwide. Anthem Blue Cross Blue Shield provides coverage in some states.

In several recent decisions, CMS chose to provide coverage through pilot projects under the Coverage with Evidence Development program. Recently, CMS broadened coverage of positron emission tomography. While in the past the test was covered for initial diagnosis, now coverage include subsequent treatment strategies.

The American College of Radiology said it plans to lobby Congress to prevail on CMS to reverse its stance on CT colonography.

"Make no mistake: If let stand, this CMS decision not to pay for CT colonography will cost lives," James Thrall, chair of the American College of Radiology Board of Chancellors, said in a statement. "More than 140,000 Americans are diagnosed with colorectal cancer each year. Nearly 50,000 of them die due to late detection. How can CMS ignore the fact that people are dying because they do not want to have the tests that are currently covered? For CMS to turn its back to a technology that can attract more patents to be screened and save countless lives is deeply concerning. CMS should reverse this determination immediately or Congress should step in and vote to mandate coverage of CTC."

The American Cancer Society was similarly disappointed with the result.

"I am disappointed in this decision, as randomized clinical trials clearly show CT colonography is as effective as optical colonoscopy for the early detection of early cancers and premalignant lesions. Medicare coverage for CTC, also known as virtual colonoscopy, would have provided an additional option for colorectal cancer screening," said Otis Brawley, ACS chief medical officer. "Additional options are absolutely necessary as the supply of gastroenterologists is currently inadequate to supply optical colonoscopy to all of those who need it. It is our belief that by increasing the proportion of Americans 50 and over who get colorectal cancer screening, we could increase the number of lives saved from this devastating disease and decrease long term medical costs. The American Cancer Society still believes that a battery of different tests for colorectal cancer screening should be available to the American people. This includes optical colonoscopy, virtual colonoscopy, stool blood testing, as well as sigmoidoscopy."

The text of the CMS determination is posted at www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=220.

HHS News:

COI Rules May Require More Disclosure By Investigators

HHS is revising conflict of interest rules that apply to extramural investigators. Changes may require greater disclosure from investigators and may raise the threshold of "significant financial interest" above the current level of $10,000.

Under current rules, which were adopted in 1995, conflict regulations applied to grantee institutions, which were obligated to regulate conflicts of interest on the part of investigators.

According to a notice of proposed rulemaking published in the Federal Register, conflict rules need to be tightened because researchers now frequently work in multi-institutional groups and collaborating with commercial entities. These collaborations increase the potential of conflicts introducing bias into research.

Excerpted text of the document follows:

Expanding the Scope of Regulations and Disclosure

—Should the regulations be expanded so that they also apply to Phase I Small Business Innovation Research and Small Business Technology Transfer Research applications and proposals for PHS funding? Currently, the small business programs are excluded from confluct regulatons.

—One recommendation was that investigators conducting human subjects research should be required to report all of their outside financial interests directly or indirectly related to their professional responsibilities to their Institution, regardless of dollar amount and regardless of whether or not the investigator believes that the reported financial interests might reasonably appear to be affected by his or her current or anticipated research. In light of the above, should Investigators be required to disclose to their Institutions all Significant Financial Interests that are related to their Institutional responsibilities? Would this expanded disclosure allow the Institution to better determine which of these Significant Financial Interests constitute a FCOI?

Defining "Significant Financial Interest"

—The rules would revisit the "significant financial interest" threshold for applicability of conflict regulations.

—Are the current de minimis thresholds ($10,000 and 5 percent ownership interest in any single entity) reasonable? If not, how should the de minimis thresholds be changed? Should these thresholds be the same for all types of research? Should certain Significant Financial Interests (i.e. Significant Financial Interests received from specific sources or related to certain types of research) automatically be considered a FCOI under the regulations?

Identification and Management of Conflicts by Institutions

—Should large Institutions (defined as greater than 50 employees) be required to establish an independent committee to review financial disclosures, and require that committee to report to an organizational level within the Institution that is not conflicted by the short-term financial interests of the Investigator or Institution? Would a 50 employee threshold reasonably balance the risk of a more relaxed requirement for smaller Institutions against the burden imposed by requiring an independent panel for these evaluations?

—For certain types of research, should the Institution be required to develop a conflict management plan when the Institution decides to manage or reduce, rather than eliminate, the conflict? If so, for which types of research? Should there be prescribed standards for the conflict management plans? Should the Institution be required to submit this plan to the PHS funding component when it reports the existence of a conflict to the component?

—Should Investigators who are involved in participant selection, the informed consent process, and clinical management of a trial, be prohibited from having a Significant Financial Interest in any company whose interests could be affected by their research or clinical trial? If so, what special circumstances would justify waiving this condition, if any?

—Should the regulations prescribe specific approaches for the management, reduction, or elimination of particular types of FCOI? If so, for which types of FCOI? Which approaches?

—Should specific requirements related to the identification, management, and reporting of FCOI be established for subrecipients (i.e., subgrantees, contractors, subcontractors, collaborators)?

—Should amounts received by Investigators from certain kinds of organizations be limited to certain maximum thresholds if an Investigator is supported with PHS research funds? If so, which kinds of organizations? At what thresholds?

Assuring Institutional Compliance

—Should the regulations enhance existing enforcement options in the event of noncompliance?

—Should Investigators be required under the regulations to complete routine FCOI training?

—Should independent confirmation of an Institution's compliance with the regulation be required? If so, what should this confirmation look like (e.g., accreditation by an outside body, an independent audit)?

Requiring Institutions to Provide Additional Information to the PHS

—Should Institutions be required to submit to the PHS funding component additional information on any identified conflict? If they should not be required to submit additional information for all identified conflicts, should they be required to submit additional information for identified conflicts involving certain types of research? If so, for which types of research? What kind of information would provide valuable data to the PHS funding component in evaluating these reports and the potential risk of bias in conduct of research?

Institutional Conflict of Interest

—How would Institutional conflict of interest be defined?

—What would an Institutional conflict of Interest policy address in order to assure the PHS of objectivity in research?

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