THE CANCER LETTER

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# Breaking With Tradition, NIH Director Heads Obama's Search For NCI Director

*By Kirsten Boyd Goldberg*

In a significant break with tradition, NIH Director Francis Collins is leading the Obama administration's search for an NCI director, The Cancer Letter has learned.

For nearly three decades after the signing of the 1971 National Cancer Act, a law that gave NCI special authorities and made the institute director a presidential appointee, prominent players in the cancer field formed committees that selected NCI directors.

This tradition was first broken when former President George W. Bush handed NCI to a family friend, the urologist Andrew von Eschenbach, who,

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*In the Cancer Centers:*

## Maha Hussain To Lead Clinical Research At Michigan Comprehensive Cancer Center

**UNIVERSITY OF MICHIGAN** Comprehensive Cancer Center appointed **Maha Hussain** as the center's new associate director of clinical research.

Hussain will oversee the development of clinical research within each of the cancer center research programs, and will oversee all of the shared resources that support clinical research at the center, including the Clinical Trials Office, Protocol Review Committee, and Data Safety and Monitoring Committee.

"Our cancer center has a wonderful opportunity to develop innovative clinical research that is drawn from, and in turn, informs more basic research at the center," said Max Wicha, distinguished professor of oncology and director of the cancer center. "We are delighted to have someone with Dr. Hussain's demonstrated leadership abilities, as well as her extensive background in clinical research to head these efforts."

Hussain is a professor of internal medicine and urology at the U-M Medical School, and currently serves as co-leader of the cancer center's urologic oncology program. She is an expert in the management of genitourinary malignancies. Her research is focused on the development of novel treatment approaches for prostate and bladder cancer.

Hussain served as an FDA adviser and chairman of the FDA's Oncologic Drugs Advisory Committee, a leader in the Southwest Oncology Group genitourinary committee and immediate past chair of the American Society

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## "No Formal Search Committee" For NCI Director, NIH Says

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upon departing for a job as the head of FDA, picked his successor, John Niederhuber, the current director.

Now, President Barack Obama has not taken the opportunity to reinstate the tradition of delegating selection of his NCI director to a group with even nominal independence, and for the first time, handed control over the selection to the NIH director. This is important because in the past, NIH and NCI have had conflicting priorities, and their directors sometimes clashed over issues big and small.

Collins declined to comment on the search.

"He is involved in the search," NIH spokesman John Burklow confirmed in an email to The Cancer Letter. "There is no formal search committee."

Collins is leading what appears to be an ad hoc group that includes Harold Varmus, president of Memorial Sloan-Kettering Cancer Center, and Eric Lander, founding director of the Broad Institute of MIT and Harvard, sources said.

Collins' role in the search for the next director "will be a source of consternation in the cancer community," a candidate who turned down the job said to The Cancer Letter. "There is a sense that the next NCI director will have to fall into line more, acting in a way that doesn't play up the presidential appointment card. There is a sense that the next NCI director is stepping into a situation where the position will have less clout than it once did. Funding is going to remain relatively flat for the foreseeable future."

There is precedent for Collins' role, NIH spokesman Burklow said.

"Harold Varmus, then NIH director, led the search for the NCI director in 1994 that led to the appointment of Rick Klausner," Burklow said. "Dr. Collins' involvement signals the importance of the selection being based on scientific credentials. It makes sense that he is working on it. If you flipped it around, wouldn't it look odd if he weren't involved?"

This account of the 1994 search differs from the recollection of a source who was on the committee. Klausner was recommended by a formal committee comprised of members selected by the Clinton administration and chaired by Paul Marks, then president of MSKCC.

"The [Marks] committee certainly felt they were supposed to be leading the search," the source said. "Varmus wasn't on the committee and didn't participate in meetings, but he certainly influenced the process. There was some unease with the extent to which Varmus was involved in the process.

"I don't think the director of NIH should have a direct role over the selection of the NCI director," the source said. "This should be led by people in the cancer field."

The NCI director is appointed by the president, but unlike the NIH director, the appointment doesn't require Senate confirmation. In recent years, when control of the White House changed parties, NIH directors resigned, usually before the end of presidential term, but NCI directors stayed on for about a year. Niederhuber's stay has now exceeded that period.

Obama appointed Collins as NIH director in August 2009, but the search for an NCI director began in July, sources said.

"They are setting the bar appropriately high, but as a result, it's taking a long time," one candidate familiar with the process said.

In addition to concerns over the leadership of the search process, cancer activists and academic leaders say they are concerned about rumors that three top physician-scientists have turned the job down.

Those who are said to have turned it down include Charles Sawyers, chairman of the Human Oncology and Pathogenesis Program at MSKCC, William Kaelin Jr., professor of medicine at Harvard, and Brian Druker, chairman of leukemia research and professor of medicine at Oregon Health & Science University Cancer Institute.

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"Everyone in the community is frustrated," said an academic oncologist familiar with the selection process. "The cancer center directors are frustrated. There's nobody leading NCI who gets it. We need a vigorous well-funded program of investigator-initiated research, and somebody's got to pay attention to raising the next generation of investigators."

The low success rate for grants is a major source of frustration. With a $5 billion budget, NCI should be using more resources to increase the research project grant payline from the current 15th percentile, the source said.

Under the President's budget proposal released last week, NCI plans to spend $2.2 billion on research project grants, just under half its budget.

Besides the frustration over research funding, the next NCI director will have to contend with the institute's intramural program and the NIH Clinical Center. The center now deals mainly with rare cancers, and no longer is seen as the premier place for a young person to receive training, oncology professionals in academia and within NCI said.

The institute has had seven directors since the signing of the National Cancer Act. Of them, three came from inside NCI and one from inside NIH, while three came from outside the institute.

However, the "best and the brightest" who used to flock to NIH in the 1970s and even into the 1980s are no longer attracted to government service, since the academic cancer centers have become robust. As a result, it appears that there are no viable internal candidates for the top job.

Anyone contemplating government service has to contend with a lower salary than what could be found in academia or the private sector, as well as ethics rules requiring divesture of stocks and holdings.

Niederhuber's adjusted base salary for 2008 was $247,500, making him 57th in a list of the highest-paid NIH officials, according to a U.S. Office of Personnel Management database (http://php.app.com/fed_employees/search.php). This is more consistent with the salary of a professor of medicine, as opposed to the salary of a cancer center director or a dean.

It's unclear whether the NCI director receives other pay on top of the base salary. Full salary information for NIH officials isn't publicly available.

The highest-paid NIH official in 2008 was Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, with a base salary of $335,000, according to the OPM database.

NIH conflict of interest restrictions might make the job difficult for a mid-career physician-scientist, said one cancer center director. Many people involved in translational research have ties to small biotech spin-offs from their academic research and would be reluctant to break those ties before seeing their research come to fruition.

Despite the difficulties, the NCI director's position could be a good opportunity for a physician-scientist in mid-career, an academic oncologist said.

"You've got a $5 billion budget. The scientific community needs leadership. The advocates look to NCI for leadership. The solutions to the cancer problem are going to come from research.

"In the grand scheme of things, there's nothing like running a war."

**Top 100 NIH Salaries for 2008**

According to a database linked to the Office of Personnel Management, base salaries for 100 highest-paid NIH officials ranged from $230,000 to $335,000 in 2008.

No information was available indicating whether the base salary represented the entire salary received by the employee.

Following is a list of the 100 highest-paid NIH officials, by base salary:

1. Fauci, Anthony $335,000
2. Bluemke, David $325,000
3. Quezado, Zenaide $325,000
4. Nabel, Elizabeth $310,000
5. Sieving, Paul $310,000
6. Rosenberg, Steven $305,000
7. Gallin, John $300,000
8. Katz, Stephen $300,000
9. Pettigrew, Roderic $300,000
10. Tabak, Lawrence $300,000
11. Schrump, David $295,000
12. Hodes, Richard $290,000
13. Insel, Thomas $285,000
14. Rodgers, Griffin $285,000
15. Yang, James $285,000
16. Volkow, Nora $280,000
17. Alexander, Duane $270,000
18. Kington, Raynard $270,000
19. Gottesman, Michael $265,000
20. Battey, James $260,000
21. Helman, Lee $260,000
22. Landis, Story $260,000 (+$3,000 bonus)
23. Li, Ting Kai $260,000
24. Lipman, David $260,000
25. Nabel, Gary $260,000

26. Alving, Barbara $255,000
27. Berg, Jeremy $255,000 (+$3,000 bonus)
28. Green, Eric $255,000
29. Guttmacher, Alan $255,000
30. Alter, Harvey $250,000
31. Auchincloss, Hugh $250,000
32. Balaban, Robert $250,000
33. Balis, Frank $250,000
34. Bax, Ad $250,000
35. Camphausen, Kevin $250,000
36. Chan, Leighton $250,000
37. Fraumeni, Joseph $250,000
38. Giaccone, Giuseppe $250,000
39. Heilig, Markus $250,000
40. Kastner, Daniel $250,000
41. Krensky, Alan $250,000
42. Kwong, King $250,000
43. Lane, Henry $250,000
44. Levy, Elliot $250,000
45. Linehan, W M $250,000
46. Lonser, Russell $250,000
47. Macdonald, Ian $250,000
48. Mcgowan, John $250,000 (+$3,000 bonus)
49. Noel, Pierre $250,000
50. Oshea, John $250,000
51. Park, John $250,000 (+$10,000 bonus)
52. Pinto, Peter $250,000
53. Sherry, Richard $250,000
54. Van Waes, Carter $250,000
55. Wiltrout, Robert $250,000
56. Zoon, Kathryn $250,000
57. **Niederhuber, John $247,500**
58. Decherney, Alan $245,000
59. Gershengorn, Marvin $245,000
60. Henderson, David $245,000
61. Koroshetz, Walter $245,000
62. Shurin, Susan Blakely $245,000
63. Gottesman, Susan $243,800
64. Lowy, Douglas $243,800
65. Pastan, Ira $243,800
66. Waldmann, Thomas $243,800
67. Wu, Carl $243,800
68. Rapoport, Judith $241,501
69. Heiss, John $240,000
70. Hoffer, Barry $240,000
71. Libutti, Steven $240,000
72. Tatum, James $240,000
73. Cannon, Richard $238,029
74. Chang, Richard $238,029
75. Jaffe, Elaine $238,029
76. Kramer, Barnett $238,029
77. Barker, Anna $235,000
78. Briggs, Josephine $235,000
79. Finkel, Toren $235,000
80. Lederman, Robert $235,000
81. Oberholtzer, John $235,000
82. Young, Neal $235,000
83. Davies, David $234,601
84. Eaton, William $234,601
85. Felsenfeld, Gary $234,601
86. Moss, Bernard $234,601
87. Paul, William $234,601
88. Purcell, Robert $234,601
89. Ungerleider, Leslie $234,601
90. Wickner, Reed $234,601
91. Wurtz, Robert $234,601
92. Quinn, Thomas $233,030 (+$5,000 bonus)
93. Patterson, Amy $230,132 (+$5,000 bonus)
94. Leonard, Warren $230,001
95. Martin, Malcolm $230,001
96. Miller, Louis $230,001
97. Abrams, Jeffrey $230,000
98. Choyke, Peter $230,000
99. Cimino, James $230,000
100. Germain, Ronald $230,000

*FDA News:*

## FDA To Limit Radiation Doses From Imaging Procedures

FDA plans to institute regulations that would limit radiation doses from medical imaging procedures, including computed tomography, nuclear medicine studies, and fluoroscopy.

The agency said these regulations could include requirements that such devices display, record, and report equipment settings and radiation dose, an alert for users when the dose exceeds a diagnostic reference level, training for users, and a requirement that devices be able to capture and transmit radiation dose information to a patient's electronic medical record and to national dose registries.

This could be accomplished by requiring equipment to incorporate safeguards into the design and to provide appropriate training to medical practitioners.

The agency plans to hold a public meeting on March 30-31 to solicit input on potential requirements.

"The amount of radiation Americans are exposed to from medical imaging has dramatically increased over the past 20 years," Jeffrey Shuren, director of the FDA's Center for Devices and Radiological Health,

said in a statement. "The goal of FDA's initiative is to support the benefits associated with medical imaging while minimizing the risks."

Moreover, FDA and the Centers for Medicare and Medicaid Services are collaborating to incorporate quality assurance practices into the mandatory accreditation and conditions of participation survey processes for imaging facilities and hospitals.

According to a white paper published by FDA, the agency is considering a three-pronged approach to regulating diagnostic devices:

1. Promote Safe Use of Medical Imaging Devices

—FDA may require, for example, that CT and fluoroscopic devices display, record, and report radiation dose and alert users when the dose exceeds a diagnostic reference level, a peak skin-dose threshold for injury, or some other established value. FDA may also require that manufacturers provide additional data in their premarket submissions to support specific clinical uses, and incorporate that information into product labeling and training to enhance safe use of these devices.

—Under the Medicare Improvements for Patients and Providers Act (MIPPA), CMS oversees accreditation of stand-alone medical imaging facilities. Additionally, CMS has established conditions of participation for hospitals and accompanying interpretive guidelines for Medicare surveyors.

FDA is working with CMS and its designated accreditation organizations to support the inclusion of key quality assurance practices in MIPPA accreditation criteria for stand-alone imaging facilities. FDA and CMS are also exploring options to enhance the existing interpretive guidelines for hospitals related to their radiologic and nuclear medicine services. FDA traditionally builds quality assurance instructions into product-specific labeling and training in order to promote safe use. Collaborating with CMS will help improve quality assurance at user facilities and further support safe use of medical imaging equipment.

—Building on the efforts of various professional organizations, such as ACR and NCRP, FDA recommends that healthcare professional organizations continue to develop nationally recognized diagnostic reference levels for medical imaging procedures that use radiation, including pediatric procedures. FDA will increase our participation in these efforts.

For procedures for which such norms have not yet been developed on a national level, FDA recommends that each user facility, to the extent feasible, develop its own locally-based diagnostic reference levels, for use until more broadly recognized levels are available.

A radiation dose registry is a collection of de-identified patient radiation dose data from individual medical imaging exams. By pooling dose data across imaging facilities nationwide, a national radiation dose registry will help support the development of diagnostic reference levels where they do not yet exist, and allow for broad validation of those levels that have been developed to date.

Such a registry will also help facilities benchmark their radiation doses relative to those of others, and could be a key source of information about trends in doses over time. Raff, Chinnaiyan, Share, et al. recently used a statewide dose registry for cardiac CT angiography in Michigan to measure the effectiveness of implementing selected dose-reduction best practices.

2. Support Informed Clinical Decision Making

—FDA may require, for example, that CT and fluoroscopic devices be capable of specific functions, such as capturing the radiation dose value from each exam and linking it with the study image to facilitate the storage of dose information in a patient's paper or electronic medical record. FDA may also require that devices be capable of automatically recording radiation dose information in a standardized Digital Imaging and Communications in Medicine (DICOM) structured report, and transmitting this information to a patient's electronic medical record or a dose registry. Such steps will provide ordering physicians with more comprehensive information about a patient's imaging and radiation dose history, to support their decisions about the most appropriate clinical course of action for each patient.

—Recommend that the healthcare professional community continue to develop and adopt criteria for appropriate use of CT, fluoroscopy, and nuclear medicine procedures, or other procedures that use these techniques.

Building on the efforts of various professional organizations, including ACR and ACC, FDA recommends that the healthcare professional community continue to develop and adopt appropriate use criteria for CT, fluoroscopy, and nuclear medicine procedures. Electronic decision support tools for ordering imaging procedures could incorporate these criteria to improve quality and consistency in clinical decision making.

3. Increase Patient Awareness

—FDA is collaborating with the ACR and RSNA joint task force currently coordinating Image Wisely, to develop and disseminate a patient medical imaging record card. FDA will make this card available on our

website. While ultimately the best way of tracking a patient's history of radiation exposure will be to incorporate it into that patient's paper or electronic medical record, a personal record card will give patients and their caregivers a means, in the short term, of tracking their own medical imaging histories and sharing this information with their physicians. This will help facilitate critical discussions between patients and providers about the best available clinical options.

Additional information is posted at: http://www.fda.gov/Radiation-EmittingProducts/RadiationSafety/RadiationDoseReduction/UCM199904.htm

*In the Cooperative Groups:*

## Southwest Oncology Group Moves Operations Office

The Southwest Oncology Group has transferred its operations office out of the University of Texas and placed it under administrative control of the group's philanthropic arm, The Hope Foundation.

"The move lets SWOG operate more efficiently," group chair Laurence Baker, of the University of Michigan Medical School, said in a statement. "In an era when NCI funding is flat at best, we're doing what we can to squeeze the best research out of every dollar."

SWOG was running its operations out of the Cancer Therapy and Research Center at the University of Texas Health Science Center at San Antonio. The group had moved to the CTRC in 1981, when the group came under the chairmanship of Charles Coltman Jr.

When Coltman stepped down as group chair in 2005, the organization relocated its headquarters to the University of Michigan, but some of its staff remained at CTRC. Now, these staff members have moved to new San Antonio facilities and have become employees of the Ann Arbor-based Hope Foundation.

*Patient Advocacy:*

## Survivorship Coalition Joins Commission On Cancer

The National Coalition for Cancer Survivorship has accepted an invitation to join the Commission on Cancer, a multidisciplinary organization administered by the American College of Surgeons dedicated to reducing the morbidity and mortality of cancer through education, standards setting, and the monitoring of quality of care.

The CoC invited NCCS, a key patient advocacy organization, to join with its members' efforts to improve the quality of care and services received by cancer patients.

"We are very pleased that NCCS has been invited to join the Commission on Cancer," said Thomas Sellers, president and CEO of NCCS. "We believe the evolution of the Commission on Cancer's mission aligns well with our mission to ensure that all Americans have access to high quality cancer care that is comprehensive, coordinated, and patient-centered. We look forward to advancing this important work together."

By joining the Commission, NCCS has the opportunity to ensure patients' voices are heard as CoC accredits cancer programs at over 1,400 hospitals and health care organizations nationwide and collects information for over 70 percent of all cancer patients treated in the United States.

NCCS will collaborate with the CoC on efforts including using the Commission's National Cancer Data Base and hospital registries to produce patient care summaries and care plans. NCCS has long advocated for the widespread use of cancer treatment plans and summaries and post-treatment care plans as an essential part of quality cancer care.

Through its public policy and grassroots outreach, NCCS educates cancer survivors and decision makers about the need for cancer care planning, which coordinates care among multiple specialists and settings, eliminates duplicative testing, and eases patients' anxiety about the difficult transitions before, during and after cancer treatment. NCCS also collaborates in programs such as Journey Forward (www.JourneyForward.org), which provides free tools that help doctors and patients work together to create a treatment summary and post-treatment care plan.

*EPA News:*

## Independent Report Backs EPA Classification Of PERC As Likely Human Carcinogen

The U.S. Environmental Protection Agency's classification of the environmental contaminant tetrachloroethylene as "likely to be a human carcinogen" is appropriately supported in EPA's draft assessment of adverse human health effects for the chemical, according to a report by the National Research Council, which also recommends improvements for EPA's final assessment.

The report suggests using better designed studies

than those EPA had chosen in estimating the adverse health effects of tetrachloroethylene. Also, the report proposes ways to strengthen the scientific basis for estimating the potential to cause cancer, as well as safe inhalation and oral exposures to tetrachloroethylene.

Tetrachloroethylene, also known as perchloroethylene, PCE, or PERC, is a dry-cleaning solvent that is found as a contaminant in the air, groundwater, surface waters, and soil. In humans it can damage the nervous and reproductive systems, liver, and kidneys and is a likely carcinogen. People are mostly exposed to PERC by breathing it in the air, but exposure can also occur by ingestion or skin contact. EPA's assessment aims to provide estimates of potential noncancerous and cancerous health effects following exposure to PERC and will be used to establish air- and water-quality standards and set cleanup standards for hazardous-waste sites. EPA asked the National Research Council to review the draft health assessment for PERC independently before EPA finalizes it.

For the cancer assessment, EPA's classification of PERC as "likely to be a human carcinogen" is supported by data that meets the relevant criteria in EPA's 2005 Guidelines for Carcinogen Risk Assessment, concluded the committee that wrote the report. The scientific community agrees in general that PERC is carcinogenic in laboratory animals, but debate continues about how to interpret and use those findings to predict human cancer risks, the report states. This debate is reflected in the committee's examination of which possible PERC-related cancer—leukemia, liver tumors, or kidney cancer—provides the strongest data for EPA to estimate its cancer potential.

The majority of the committee members judged that the leukemia data EPA chose to estimate cancer potential contained too many uncertainties to make the data useful. These members said that a more scientifically defensible approach would be to employ the dataset that has the least uncertainty rather than the cancer dataset that yields the highest estimates of adverse health effects. Following this approach, the committee members suggested EPA use the liver-cancer data, followed by the data based upon kidney cancer and leukemia.

However, other committee members judged that the leukemia dataset should be used for estimating cancer potential. Their opinions were based on the observation that reproducible, statistically significant increases in leukemia were found in male and female rats above the background incidence of leukemia and that leukemia was the type of cancer with the highest sensitivity to PERC exposure.

For the potential noncancerous health effects attributed to PERC, such as impairments to the nervous system, EPA estimated the inhalation and oral exposures allowed per day that will likely not cause harm. As the basis for its inhalation "reference concentration" calculation, EPA selected one study that observed adverse neurotoxic effects in people who lived near dry-cleaning facilities. Based on this study, EPA derived a value of 2 parts per billion (ppb) per day. The committee recommended instead that EPA use four other human studies and one animal study that applied stronger methods and provided more reliable findings. When the committee used these five studies and applied EPA's same estimation methods, it produced a range of daily allowable inhalation of 6 to 50 ppb.

The report was sponsored by EPA.

Copies of "Review of EPA's Draft IRIS Assessment of Tetrachloroethylene" are available from the National Academies Press; tel. 202-334-3313 or 1-800-624-6242 or www.nap.edu.

*In the Cancer Centers:*

## DFCI, Sanford-Burnham Sign License With Genentech

(Continued from page 1)

of Clinical Oncology education committee. She also chaired the University of Michigan Medical School's Dean's Advisory Council on Clinical Research.

Hussain began her appointment Feb. 1. The position had previously been vacant for several years.

**DANA-FARBER CANCER INSTITUTE** and the Sanford-Burnham Medical Research Institute have signed a license agreement with Genentech, a wholly owned member of the Roche group, and Roche, that grants the companies exclusive rights to manufacture, develop and market human monoclonal antibodies to treat and protect against group 1 influenza viruses. These viruses include the strains for the current seasonal and H1N1 influenzas. Genentech and Roche also have a non-exclusive right to manufacture, develop and market diagnostic tests for group 1 influenza.

The discovery of the antibodies was first reported by **Wayne Marasco**, associate professor of medicine at Dana-Farber and Harvard Medical School; **Robert Liddington**, professor and director, Infectious and Inflammatory Disease Center at Sanford-Burnham; and **Ruben Donis**, chief of the Molecular Virology and Vaccines Branch at the Centers for Disease Control and

Prevention, in Nature Structural and Molecular Biology in February 2009.

They demonstrated that the newly identified antibodies attach to the stem region of the viral proteins (hemagglutinin), rather than to the head region, the standard target of current influenza vaccines. Binding to the highly conserved stem region prevents changes in the protein that are necessary for viral entry into the host cell, thereby inhibiting further infection of host cells and the rise of escape mutants. Standard influenza vaccines that consist of an attenuated, or killed, virus typically stimulate antibodies against the protein's head. These vaccines are less effective as the head region is prone to change, leading to the rise of forms of the virus that can evade neutralizing antibodies.

Complete terms of the agreement are not public, but Dana-Farber and Sanford-Burnham will receive license fees and may receive milestone payments and royalties.

**ROSWELL PARK CANCER INSTITUTE** said its president and CEO, **Donald Trump**, will have his head shaved by a Roswell Park cancer patient on March 3, to honor the institute's 26,292 patients, and to encourage others to participate in the "Goin' Bald for Bucks" program.

His mustache, a fixture since medical school, will also be shaved.

"On the surface, my challenge is based in fun. But the cause behind it means so much more," said Trump. "I am doing this to honor the memory of my parents, who both died from cancer; to recognize the many students and others across our community and country who are setting a positive example through their Goin' Bald for Bucks participation; and to pay tribute to every patient Roswell Park has the privilege of caring for."

Trump has significant experience with the clinical aspects of vitamin D in the treatment of solid tumors and has performed more cancer clinical trials with vitamin D than anyone else in the world. He also holds both U.S. and European patents for the use of vitamin D in cancer treatment.

Since 2002, "Goin' Bald for Bucks" has raised more than $700,000 for RPCI.

RPCI also announced that **Yashodhara Satchidanand** has joined the Anesthesiology and Pain Medicine department as a physician and assistant professor in oncology, with a specialty in palliative care. Satchidanand came to RPCI from St. Joseph's Hospital in Cheektowaga, NY, where she served as director of palliative care.

**UNIVERSITY OF WISCONSIN** Carbone Cancer Center said **James Shull** was appointed associate director of laboratory research and chair of the Department of Oncology/McArdle Laboratory for Cancer Research. Shull succeeds **Norman Drinkwater,** who served as oncology chair for more than 16 years. Shull's research focuses on the basic mechanisms of breast cancer.

University of Wisconsin Carbone Cancer Center members, **Perry Pickhardt**, professor in radiology, and **Maureen Smith**, associate professor in population health sciences and family medicine, received a $2.7 million grant from the NIH entitled "Virtual Colonoscopy and Colorectal Cancer Screening."

This grant represents a unique collaboration between the Department of Radiology and the Health Innovation Program to understand the impact of virtual colonoscopy availability on colorectal cancer screening and to identify factors affecting the adoption of virtual colonoscopy by primary care physicians.

The University of Wisconsin is the only center in the U.S. with large numbers of patients who have commercial insurance coverage for both virtual colonoscopy and traditional optical colonoscopy screening and thus is uniquely positioned to address these issues.

Three Carbone Cancer Center members have been selected to be on the Morgridge Institute for Research leadership team. **James Thomson**, professor of anatomy, **Paul Ahlquist**, professor of oncology and **Thomas "Rock" Mackie**, professor of medical physics, will join four other top scientists on the team.

The Morgridge Institute for Research is the private side of the new interdisciplinary Wisconsin Institutes for Discovery at the University of Wisconsin-Madison. It's mission is to accelerate the ability to treat, cure or eradicate such devastating diseases as cancer, hepatitis C, diabetes and heart disease.