THE CANCER LETTER

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ACS Prostate Cancer Screening Guideline Urges Doctor-Patient Informed Decision

By Paul Goldberg

The American Cancer Society has updated its prostate cancer screening guideline to emphasize informed decisions by patients within the doctor-patient relationship.

The society abandoned its campaigns for mass screening in 1997, but its guidelines have been widely misunderstood to endorse screening all men at average risk starting at age 50.

Released on March 3, the latest version of the document tries to clear up confusion by stating repeatedly that it does not recommend screening uniformly.

The guidelines now present the topics that should be covered in

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Professional Societies:

Obama's Virtual Colonoscopy Sets Off Real-World Turf War Of Specialty Groups

By Paul Goldberg

President Barack Obama's decision to undergo a virtual colonoscopy has triggered an explosion of indignation from two professional societies that represent physicians who perform colorectal cancer screening.

On March 1, the day after the details of Obama's medical exam were released, the American College of Gastroenterology fired off a letter to the White House objecting to the president's decision to forego the modality that, the society maintains, represents the gold standard in screening.

An uninitiated observer might have thought that radiologists would rejoice over the President's decision to go with the CT procedure. They did not.

The American College of Radiology issued a statement pointing out that the procedure Obama selected would be unavailable to the elderly receiving Medicare benefits and many people whose commercial insurance doesn't cover the CT procedure.

The turf war is illustrative of incongruity of guidelines and the role professional societies play in promulgating them, observers say.

"It should not be a surprise that professional organizations are enthusiastic about procedures that they do," said David Ransohoff, a screening researcher at the University of North Carolina. However, Ransohoff noted that "it's fascinating when guidelines—that are supposed to be based on

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ACS: New Guideline Leaves Less Room For Misreading

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discussion between the doctor and patient, endorsing the use of decision aids, including one that it now posted on the society's website.

"We are trying to make informed decision-making so explicit in out guideline that you can't miss it," said Andrew Wolf, associate professor of medicine at the University of Virginia and chairman of the panel that formulated the 29-page guideline.

"My concern is that men—and then doctors—may misinterpret this guideline the other way—that we are recommending against early detection efforts altogether," said Wolf, a primary care physician. "And we are not. We are recommending that men be made aware of the issues and be allowed to decide."

The guideline now states that ACS "recommends that asymptomatic men who have at least a 10-year life expectancy should have an opportunity to make an informed decision with their health care provider about whether to be screened for prostate cancer, after receiving information about the uncertainties, risks, and potential benefits associated with prostate cancer screening."

The previous version stated that screening should be "offered."

Further, the new document states:

"Prostate cancer screening shouldnot occur without an informed decision-making process. Men at average risk should receive this information beginning at age 50 years. Men at higher risk, including African American men and men who have a first-degree relative (father or brother) diagnosed with prostate cancer before age 65 years, should receive this information beginning at age 45 years. Men at appreciably higher risk (multiple family members diagnosed with prostate cancer before age 65 years) should receive this information beginning at age 40 years… Patient decision aids are helpful in preparing men to make a decision whether to be tested."

In other changes:

• The guideline deemphasizes the role of digital rectal exams. "Although the value of adding a periodic DRE to periodic PSA testing is unknown, it will depend in part on the PSA biopsy threshold and the individual who performs the DRE," the guideline states. "Even under optimal performance and with a high biopsy threshold, the added value of performing a periodic DRE is likely to be quite low, increasing the cancer detection rate by 17% at most, and few of these cancers detected exclusively by DRE are likely to be high grade. Thus, for men who choose to be screened for prostate cancer, testing is recommended with PSA with or without DRE. To assist in individualized decision making, health care providers should consider performing a DRE for PSA levels between 2.5 ng/mL and 4.0 ng/mL if it has not already been done."

• The guideline "discourages participation in community-based prostate cancer screening programs unless they can provide adequately for an informed decision-making process and appropriate follow-up care.

"These programs have a special obligation to provide high-quality, objective, informed decision making either through interaction with trained personnel or through the use of validated, high-quality decision aids appropriate to the target population. Moreover, it is incumbent on such programs to assure that participants with abnormal screening results receive appropriate counseling and follow-up care.

"Because virtually all men age 65 years and older have health insurance through Medicare, they should be discouraged from participating in community-based screening programs and should be referred to a primary care provider."

The society last updated its guideline in 2001. The latest review was triggered in part by publication of two large randomized trials: the U.S.-based PLCO study, which demonstrated no benefit to screening, and the European ERSPC, which demonstrated a 20% reduction in prostate cancer mortality (risk ratio, 0.80;

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95% CI, 0.67–0.98; P = .01). The European study found that for one man to benefit, 48 had to be treated for screen-detected disease.

"Rope 'em and Poke 'em"

Many screening outreach campaigns have stated incorrectly that ACS guidelines call for screening of men starting at 50, implying that the society recommends mass screening.

Skip Lockwood, CEO of Zero; The Project to End Prostate Cancer, a Washington-based group that operates two screening vans, said his group would make no changes as a result of the ACS guideline. Zero is the former National Prostate Cancer Coalition.

Lockwood said his group has not engaged in a practice he describes as "rope 'em and poke 'em," a reference to inducing men to show up and be subjected to a blood test.

"We do what we consider man-centric health care, which is health care that's put together in such a way that makes men comfortable," Lockwood said. "We make it perfectly clear that there are risks as well as benefits of this testing.

"I don't know who ACS thinks is doing all of this community screening," Lockwood said. "Last time I checked, 99.5 percent of ones getting done were done by doctors in hospitals. I don't know what kind of clandestine black market screening system they think exists, where guys are just running up, getting poked and running away."

Wolf says that if his experience is an indication, health promotion campaign attract men who are likely to get harmed by the intervention.

"I can tell you from personal experience, the men who get screened, who come back to my practice, are almost exclusively in their eighties," Wolf said. "Retirees spend a lot of time going from health fair to health fair. And these are not the men that anyone would be targeting for prostate cancer screening. It creates a very uncomfortable situation when they bring back the PSA results that are often borderline or modestly elevated. It opens up a can of worms that we would not have normally wanted to open up."

Get the Test, Then Decide

Arguing against the ACS guideline, several groups said that men should not be urged to focus on deciding whether to opt for screening.

Instead, they should focus on deciding whether to perform follow-up tests, watch the tumor or treat it if the disease is found.

Responding to the ACS guideline, the American Urological Association said it concurs that informed consent, "including a discussion between physician and patient about the risks and benefits of testing, is a key part of one's decision to be tested for prostate cancer."

Indeed, informed decision-making is mentioned in the AUA's most recent guideline (The Cancer Letter, May 1, 2009).

However, the urology group offered a detailed recommendation on what needs to be done:

"The AUA believes that all men, with a life expectancy of 10 years or more, should have a baseline PSA test at the age of 40.

"Physicians should determine re-screening intervals for each patient based on PSA (and, on occasion on its change over time). Likewise, the decision to proceed to prostate biopsy should be based not only on elevated PSA and/or abnormal DRE results, but should take into account multiple factors including free and total PSA, patient age, PSA velocity, PSA density, family history, ethnicity, prior biopsy history and co-morbidities. Although prostate cancer risk correlates with serum PSA, there is no PSA value below which a man may be reassured that he does not have biopsy detectable prostate cancer."

The Prostate Cancer Foundation, a group founded by the financier Michael Milken, took a similar stance.

"Every man has the right to know if he has cancer and to make informed decisions with his urologist," Jonathan Simons, president and CEO of the foundation, said in a statement responding to the ACS guideline. "Unfortunately, public debate has focused mostly on the limitations of the PSA blood test rather than improving processes for informing patients. We should not throw this proverbial baby out with the bath water. Until new diagnostics are available, we need to guard against telling patients not to be screened. Discussions of early detection of prostate cancers, when they are best treated, are imperative."

ACS guideline committee chairman Wolf says he has heard this idea expressed with increasing frequency in recent months.

"On the face of it, it's a very understandable approach," Wolf said. "The problem is, you have changed this man's life, potentially significantly, by giving him this number. There is now good evidence that men who have an elevated PSA and have a normal biopsy continue to think they are at higher risk.

"You change men's lives with false positives, but what about true positives? What is increasingly clear

since the last guideline is that we have a very large problem with overdiagnosis and overtreatment," Wolf said. "If you are a survivor and have made the decision to get treated, it's hard to internalize that you may be one of the perhaps 48 who are being treated unnecessarily rather than one of the 49 whose life is being prolonged by it.

"You don't know whether you are doing this for nothing—and you never will."

Choice of Guidelines

On March 4, a day after the ACS guideline was published, the society's Chief Medical Officer Otis Brawley testified before the House Committee on Oversight and Government Reform.

The guideline has been rewritten to eliminate any possibility of misunderstanding, Brawley said at the hearing.

"The American Cancer Society has been in favor of informed decision-making since 1997," Brawley said at the hearing. "It's just that people would read what we said and then say that ACS says men should get screened. The ACS says men should be informed and make a decision. So that's why we changed our guideline. Within the physician-patient relationship, the physician and the patient should have a conversation, talk about the known risk and the possible benefits and make a decision as to what's right for the patient."

Screening for prostate cancer presents a greater uncertainty than screening for breast cancer, he said. "Nine studies show that mammography screening decreases the mortality rate," Brawley said. "Two of the nine focused on women in their forties. We have four randomized trials in prostate cancer that have ever been attempted. One, actually, was DRE. Three of those four trials actually showed a slight increase risk of mortality in the screened arm vs. the unscreened arm.

"One of them—the European study—showed a decrease in mortality. The reason there is uncertainty is we've got three studies that say that this screening stuff could be like lung cancer screening back in the 1960s and we have one study that says, no it does save lives."

This uncertainty was in part caused by physicians and patient activists who declared that screening saves lives and "only a fool would not get screened," Brawley said.

"Unfortunately, we lost a lot of time, because we started advocating the screening in the early nineties," Brawley said. "Saying everybody should get screened dissuaded men from going in the studies to figure out if screening worked. Things like the American study that just reported was five years late because of slow accrual. Why would you go into this study when all these advertisements are saying everybody should get screened, screening saves lives? Once we get people to understand that this is a huge problem, it's probably going to be ten or 15 years before we can get a good answer."

James Mohler, chairman of the Department of Urology at Roswell Park Cancer Institute, disagreed.

Men don't have the luxury to wait for "Dr. Brawley's 15 year studies," he said at the hearing.

"What happens in the 15 years since the American and European studies were designed is medicine advances and then the results 15 to 20 years into the future become obsolete," Mohler said at the hearing. "And so men are being faced with this difficult problem of what to do now.

"The [National Comprehensive Cancer Network] guidelines emphasize aggressively finding prostate cancer in young men," said Mohler, who headed the committee that wrote the NCCN guidelines. "You need to relax as men get older. PSA and treatment are being justifiably criticized right now because there has been overzealous use of both PSA for early detection and treatment. We need more science to separate autopsy cancer from the lethal cancer and then we will not need to be having so many of these discussions."

The new ACS guideline is posted at http://caonline.amcancersoc.org/cgi/content/full/caac.20066v1.

The NCCN guidelines, which were published in January, are posted at http://www.nccn.org/professionals/physician_gls/f_guidelines.asp#detection.

Professional Societies:

Groups In Turf War Over Colorectal Cancer Screening

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evidence—correlate with who made the guidelines."

The U.S. Preventive Services Task Force guidelines, written by generalists and methodologists, doesn't recommend the CT procedure. Also, USPSTF recommends that screening start at age 50, which in the president's case is a year-and-a-half away. The task force, which relies on rigorous analysis of several screening strategies, recommends three modalities: colonoscopy, sigmoidoscopy, or fecal occult blood testing. The CT procedure chosen by Obama is not on the lists.

However, both colonoscopy and colonography are on the list of recommended screening modalities

published by the American Cancer Society-led Multisociety Task Force. Those guidelines, written with buy-in from gastroenterologists and radiologists, discussed the pros and cons of screening methods that have an over-50 percent chance of detecting colon cancer (The Cancer Letter, Oct. 10, 2008).

ACG was not among GI societies that signed on to the ACS-led guideline, and it continues to stand by its own guideline that refers to colonoscopy as the "preferred" procedure. And, the group didn't pass up the opportunity to tell the president that he was wrong to take his business across the street.

"Colonoscopy represents the best option for colorectal cancer detection and prevention for the largest number of people, and is the best, most effective test for our nation's health care system," Philip Katz, ACG president, wrote in a letter dated March 1.

"At a time when your administration and Congress are looking to reform the health care system by increasing the quality of health care delivered to patients, colorectal cancer screening by colonoscopy is a prime example of a preventive service that truly saves lives and saves money, as you mentioned in your first address to a joint session of Congress in September 2009," Katz wrote.

ACG recommends that African Americans start screening at age 45, five years earlier than other groups.

"We are particularly concerned about screening in the African American community, because evidence reveals that African Americans are diagnosed with colorectal cancer at a younger age, and African-Americans with colorectal cancer have decreased survival compared with other racial groups," Katz wrote.

Katz's letter also takes several swipes at CT colonography, pointing to potential radiation risk and undetermined benefits.

"CT colonography might be an option to consider for patients who, because of infirmity or the presence of significant co-morbid diseases, would be at an increased risk for complications related to colonoscopy," Katz wrote. "However, the vast majority of patients would benefit from the lifesaving potential of screening for colon cancer using colonoscopy."

On March 2, radiologists fired off this letter to the White House:

"We would like to congratulate you on your recent physical exam and your 'clean bill of health,'" said the letter signed by James Thrall, chairman of the ACR board of chancellors. "We would also like to commend you on recognizing the importance and benefits of the latest colorectal cancer screening technology, CT colonography.

"Advantages include that it is much less invasive, and does not require sedation. Patients can go back to normal daily activity immediately following the procedure. In your case, this was particularly important, as you did not have to nominate a designee for office during the study.

"However, Medicare patients continue to be denied coverage of CT colonography. Medicare's denial of coverage, in effect, creates a two-tier coverage approach to screening coverage for this deadly disease: one for those who have private insurance and lesser coverage for Medicare beneficiaries. You have yourself publicly addressed the importance of screening for colorectal cancer and have also stated that every American should have access to the same level of care that you receive. The Centers for Medicare and Medicaid Services (CMS) should cover CT colonography for Medicare patients so that our nation's seniors have the same level of access as yourself."

The Cancer Letter asked Bernard Levin, professor emeritus at M.D. Anderson Cancer Center and chairman of the ACS panel that produced a joint guideline on colon cancer screening, and panel member David Lieberman, chief of the Division of Gastroenterology and Hepatology at Oregon Health and Science University, to comment on the politics and science of Obama's screening decision.

Their comments follow:

Colorectal cancer (CRC) screening is effective in reducing morbidity and mortality from CRC. The "best" form of CRC screening is not clear based on the evidence. Each type of test has advantages and limitations. Although different professional organizations may prefer one test over another, there is currently no evidence that any of the recommended tests results in better outcomes.

Several effective methods for screening exist. Fecal tests can detect blood in stool samples. Patients should understand that if the test is positive, the risk of cancer is increased and colonoscopy should be performed. If fecal tests are negative, the test should be repeated annually.

Structural exams of the colon such as colonoscopy and computed tomographic colonography can detect both cancer and significant adenomas. There is evidence that detection and removal of adenomas may prevent many cancers. In expert hands, CTC and colonoscopy are equally sensitive for the detection of colorectal

cancer and adenomas 1 cm and over in diameter.

Patients who receive CTC require a bowel prep, and should understand that if significant polyps are detected, they will be offered colonoscopy. Colonoscopy requires a bowel prep, is usually performed with sedation, and is associated with a small risk of complications. It is important for patients to engage in informed decision-making with their health care provider so as to arrive at the best personal choice.

There is strong evidence that black Americans have a higher risk of death from CRC than whites; they also have a higher risk of developing advanced polyps compared to whites. However, there is no evidence for a reduction in CRC deaths if blacks initiate screening at a younger age than whites. Given the increased risk of CRC in blacks, they should be targeted for screening beginning at age 50 years.

We are pleased to learn that President Obama discussed CRC screening with his physicians. We hope that the president's example will encourage all Americans to discuss effective screening with their physicians or other health professionals.

ASCO Says FDA Plan For ESAs Creates Administrative Burden

By Paul Goldberg

In a recent letter to members, the American Society of Clinical Oncology said the FDA-mandated Risk Evaluation and Mitigation Strategy for erythropoiesis-stimulating agents creates an unnecessary administrative burden on oncologists.

The program requires physicians to consent patients every time they receive ESAs and to preserve record of having administered consent.

The society said it should have been consulted before REMS was enacted and that it was at work on a formal letter to the agency.

Since the society's objections revolve around a relatively new administrative mechanism for managing risks, The Cancer Letter asked FDA officials to comment on ASCO's letter.

The agency said that the Oncologic Drugs Advisory Committee, which includes ASCO members, had discussed the issues that form the foundation of the risk-mitigation measures and that the staff saw no need to seek guidance of outside advisors on the specific features of REMS.

"Questions regarding the extent and scope of the outreach efforts that were conducted by the sponsor during the development of the ESA REMS should be directed to Amgen," the agency said.

Amgen Inc. produces both Aranesp (darbepoetin alfa) and Procrit (epoetin alfa), which is marketed by Johnson & Johnson.

ASCO Letter To Members

The text of ASCO's letter to members follows:

Oncologists are trained to treat patients with potent drugs and to manage potentially severe side effects of cancer treatment. We agree that it is critical for oncologists and other physicians to understand the risks and benefits of the drugs they prescribe, and to share this information with patients in a manner that is meaningful in the context of their individual treatment plans.

A REMS program should build upon existing processes of informed consent, continuing education, and the use of practice guidelines, and should not be duplicative of them. Oncologists continually struggle to provide high quality cancer care in the face of dwindling resources and growing administrative burdens. While ASCO supports efforts to raise risk awareness and promote patient safety, we strenuously object to duplicative requirements that further diminish time and resources available for patient care.

ASCO has noted with growing concern the process by which REMS are imposed without input from the physician community. ASCO and its members were not part of the development of this latest REMS, and yet the resulting system will have a significant impact on the day-to-day practice of hematology and oncology. There is a precedent for the FDA seeking stakeholder input as they consider a REMS program.

When the FDA was initially considering a class wide REMS for opioid drugs, the agency held open meetings and solicited public comment on the proposed program. ASCO attended these meetings, submitted comments, and presented public testimony. In our comments we expressed physicians' concerns, proposed practical solutions, and pledged to work with FDA on a program that would protect patient safety without impeding access to quality medical care. When oncologists will be asked to employ a REMS in the clinic, ASCO feels strongly that our members should be represented during the development or review process.

While we vigorously advance our comments and concerns to the FDA, please note that enrollment for this program will begin on March 24, 2010, and providers who do not enroll will no longer be able to prescribe ESAs.

We appreciate all of the comments we have

received to date and will keep you informed of any new developments.

FDA Statement

Responding to an inquiry from The Cancer Letter, FDA officials issued the following statement:

ASCO, other medical societies, organizations, stakeholders, and special government employees (consultants) participated in the discussion of safety findings associated with use of ESAs, and these discussions informed the agency's development of the REMS.

In addition, advice on ESA safety issues was provided to the Agency during three Oncology Drug Advisory Committee meetings that contained ASCO members that were voting members of the ODAC. REMS are developed through discussions between FDA and drug sponsors; public meetings and additional input are not customary or required parts of the process.

However, FDA does take its understanding of stakeholder views into account. Although FDA did not specifically obtain direct input from the leadership of ASCO during review of the REMS, the extensive input received from prior discussions with stakeholders and advice provided at the March 13, 2008, ODAC meeting in particular on key elements that should be included to ensure safe use were taken into consideration.

FDA has only held public meetings in the development of one REMS; for long-acting and sustained release opioids. In contrast to the development of that REMS, which involves many different products and sponsors, the ESA REMS involved two products and one sponsor. Therefore, FDA did not identify a need to have public meetings similar to those that have been conducted as the FDA works to develop a class REMS for the long-acting and sustained-release opioids.

Questions regarding the extent and scope of the outreach efforts that were conducted by the sponsor during the development of the ESA REMS should be directed to Amgen.

The approved REMS included consideration of the views that Amgen shared with FDA. The final ESA REMS was designed so as not to be unduly burdensome on patient access to ESAs and to the extent practical, to minimize the burden on the health care delivery system.

Amgen is required to submit periodic assessments of the REMS. After Amgen submits its assessment, FDA will consider the effectiveness of the REMS in meeting its goals and determine whether the REMS needs to be modified.

In the Cancer Centers:

Patrick Loehrer Named Director Of IU's Simon Cancer Center

INDIANA UNIVERSITY said **Patrick Loehrer Sr**. was named director of the Melvin and Bren Simon Cancer Center. He also will serve as associate dean for cancer research and hold the title HH Gregg Professor of Oncology, pending approval by the board of trustees at the Indiana University School of Medicine.

Loehrer is the second director of the cancer center since its founding in 1992. He has served as interim director since February 2009, following the death of **Stephen Williams**, the founding director. Loehrer, who joined the IU faculty in 1990, is a specialist in testicular cancer, gastrointestinal cancer, and thymoma. He was one of the original four medical oncologists at the IU School of Medicine, where he was the Kenneth Wiseman Professor of Medicine and director of the Division of Hematology-Oncology.

He was associate director of clinical research at the medical school from 2002 to 2006, and deputy director of the cancer center from 2006 to 2009. For two decades, he was founding chair of the Hoosier Oncology Group, a statewide collaboration to conduct clinical trials. He is principal investigator at IU for the Eastern Cooperative Oncology Group and was recently appointed to the FDA Oncology Drug Advisory Committee.

"BETTER YOU THAN ME," said The Donald—**Donald J. Trump**, real estate mogul of The Trump Organization—as **Donald L. Trump**, president and CEO of Roswell Park Cancer Institute, had his head and mustache shaved by **Kathleen Hogan**, a Buffalo cancer patient, to honor Roswell Park's 26,292 patients, and to encourage others to participate in the "Goin' Bald for Bucks" program.

The Donald shared his admiration via videotape for the institute's work, while gibing his namesake about the haircut. The two Donalds spoke by phone earlier this year for the first time, when the developer called the doctor to discuss treatment for a friend's son. Trump, who has had the mustache since medical school, challenged RPCI staff to raise over $15,000 in order for him to take the bald plunge. Twenty other RPCI staff members took part in the event and raised (with a $5,000 donation from The Donald) over $40,000 for cancer research. A video is posted at http://staging.roswellpark.org/media/video/dr-donald-trump-goes-bald-bucks-special-appearance-donald. The developer appears at about 17 minutes into the video and the doctor's shearing begins after about 22 minutes.

LURIE COMPREHENSIVE CANCER CENTER member **Warren Tourtellotte**, associate professor of pathology, neurology and neuroscience at Northwestern University Feinberg School of Medicine, was recently named associate director of the Medical Scientist Training Program, which has trained more than 220 MD/PhD physician-scientists for careers in academic medicine, government and the biotechnology-pharmaceutical industry.

Tourtellotte has served in other leadership roles at the medical school, including director of the Northwestern Transgenic and Targeted Mutagenesis Laboratory and director of the Northwestern Research Histology and Phenotyping Laboratory. Tourtellotte has also been active in the MSTP, having served as director of admissions, class advisor to current second-year students, and research advisor to two MD/PhD graduates as well as a current student. His research focuses on transcriptional regulation in central and peripheral nervous system development. **David Engman**, **Sandra Lee**, and **Hossein Ardehali** will continue as MSTP director, administrative director, and director of admissions, respectively.

CANCER INSTITUTE OF NEW JERSEY announced that Cooper University Hospital will be the fourth affiliate hospital within its network to receive the Major Clinical Research Affiliate designation. Cooper University Hospital joins the Carol G. Simon Cancer Centers at Morristown Memorial Hospital and Overlook Hospital as well as Jersey Shore University Medical Center. Through this affiliation, Cooper University Hospital is able to provide its patients with access to clinical trials only available at NCI-designated cancer centers and their networks.

As an MCRA, Cooper University Hospital also will receive professional education, community education and outreach, and other services from CINJ. To achieve MRCA status, affiliates commit to upholding stringent programmatic standards as outlined by the designation mandates. One of these requirements is that an MCRA must house at least one nationally-funded cancer-related program in the areas of basic science, clinical care or research, prevention, screening or outreach and education.

WINSHIP CANCER INSTITUTE of Emory University received a $100,000 grant to create tools for analyzing proteins from brain tumors. The leader of the project is **Erwin Van Meir**, professor of neurosurgery and hematology and medical oncology. The tools are slides that allow small amounts of cerebrospinal fluid from patients to be detected and measured. This information can give doctors insight into the biology of the patient's tumor, and possibly help them build personalized treatment plans for each patient. The funding comes from the Brain Tumor Funders Collaborative, a partnership including eight private philanthropic foundations in the U.S. and Canada.

NIH News:

AAU's Patrick White To Head NIH Legislative Policy Office

PATRICK WHITE has been appointed NIH associate director for legislative policy and analysis. White has been vice president for federal relations at the Association of American Universities, where he developed advocacy strategies.

Before working at AAU, he was director of legislative relations for the Federation of American Societies for Experimental Biology from 2000 to 2003, and director of public affairs for the American Association of Immunologists from 1993 to 2000. White also has experience in the White House Office of Science and Technology Policy and as chief of staff for a Michigan Congressman, the late Robert Davis. **Roz Gray** served as acting director of the NIH Office of Legislative Policy and Analysis for the past 10 months.

NIH DIRECTOR FRANCIS COLLINS contends in a new book that "faith and reason are not, as many seem to be arguing today, mutually exclusive. They never have been."

His latest work on the subject, "Belief: Readings on the Reason for Faith," is due out this month, published by HarperOne, an imprint of Harper Collins (hardcover, $19.99). According to the publisher's press release, the book is a "provocative collection of essays which reinforce the longstanding intellectual tradition on the side of faith. Including the writings of many of the world's greatest thinkers from past to present—philosophers, preachers, poets, and scientists—'Belief' features the work of C.S. Lewis, Martin Luther King Jr., Madeleine L'Engle, Elie Wiesel, Desmond Tutu, Mother Teresa, Mahatma Gandhi, and many others. An essential companion for anyone seeking clarity on the ongoing debate between reason and faith, 'Belief' proves once and for all, despite the doubts of a cynical world, the rationality of faith."

Collins is the author of "The Language of God: A Scientist Presents Evidence for Belief" and "The Language of Life: DNA and the Revolution in Personalized Medicine."