THE CANCER LETTER

Vol. 36 No. 14
April 16, 2010

PO Box 9905 Washington DC 20016 Telephone 202-362-1809

IOM Panel: NCI Clinical Trials Groups At "Breaking Point," More Funds Needed

By Kirsten Boyd Goldberg

NCI should strengthen the Clinical Trials Cooperative Group program through an overhaul of organization, management, and funding, the Institute of Medicine concluded in a report released April 15.

A strong national clinical trials network is essential to making advances in cancer treatment, and the NCI program has been instrumental in establishing many therapies routinely used to treat cancer patients, the report said. However, the program faces many difficulties that compromise its ability to conduct the large, multi-institutional, late-stage trials that single institutions and the private sector can't or don't want to conduct.

"Cooperative group studies have steadily improved the care of cancer

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Research Funding:

FASEB Report On NIH Funding Urges Sustained Growth In Fiscal Year 2011

The Federation of American Societies for Experimental Biology released an updated compilation of data on research funding at NIH, as well as a statement about how current trends could affect biomedical research in FY2011.

"Based on projections from the President's budget summary, we will see a significant decline in the number of grants in FY2011 at the proposed funding level," said Howard Garrison, director of FASEB's Office of Public Affairs and author of the data resource. "This represents a reduction of research capacity and the potential delay or interruption of promising new efforts to find treatments and cures for life-threatening diseases."

"While it is clear the President recognized the importance of investing in biomedical research, based on the 3.2 percent increase he proposed in his FY2011 budget, the supplemental appropriations the agency received in FY2010 has created a wealth of emerging opportunities that cannot be ignored," said Mark Lively, FASEB president, "We want to ensure that policymakers understand that our progress against devastating conditions like cancer and Alzheimer's disease depends on sustaining the momentum of our current enterprise. This is more than just a trend in data; it is symbolic of a diminishment of hope."

FASEB officials said they hoped the series of graphs and analysis, which provides information on expenditures for research grants, grant

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NCI Clinical Trials Program Needs Reorganization, Funding

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patients for more than 50 years, but the program is at a breaking point," said committee chairman John Mendelsohn, president of the University of Texas M.D. Anderson Cancer Center. "Its effectiveness is being undermined at a time when the opportunity for improving cancer care has never been greater because of rapid advances in biomedical research.

"A few isolated or partial measures won't suffice," Mendelsohn said. "The program urgently needs changes across the board if it is going to continue producing the kind of studies necessary to answer crucial and fundamental questions about how to successfully treat and prevent cancer, which can't be answered through other means."

The IOM report, written at the request of NCI Director John Niederhuber, said the cooperative group program lacks an efficient process for developing new trials—the current process is "lengthy and redundant… typically requiring years to complete," the report said. The program also is hampered by complicated government oversight and lack of sufficient funding.

In response to the IOM report, the American Society of Clinical Oncology urged a doubling of funding for the cooperative groups.

"The Cooperative Clinical Research Program is the jewel of our nation's cancer research system, and is critical to advancing progress against the disease," said Richard Schilsky, ASCO immediate past president and chief of the Hematology-Oncology Section and deputy director of the Comprehensive Cancer Center at the University of Chicago. "In fact, the majority of what we know about treating cancer has come from this program. ASCO supports the recommendations in the IOM report and we urge NCI to increase the program's funding and make needed changes to the system.

"The report emphasizes that adequate investment is essential to the continued success of cooperative group trials," Schilsky said. "But today, the system is being starved of funding. In real dollars, the program receives less funding today than it did a decade ago. Considering the program's vital importance to the nation's fight against cancer, it is clearly not in the public interest that it receives such a small fraction of NCI's overall budget.

"ASCO calls on NCI to double its support for cooperative clinical research within five years," said Schilsky, who served on the IOM committee that wrote the report. "Congress had the vision to build this unique network, which includes institutions and community based practices, allowing access to clinical trials in virtually every community in the U.S. At a time of unparalleled opportunity, this collaborative system is a critical link between scientific discovery and improved treatments for cancer patients. Increased federal funding for cooperative clinical research would increase the number of cancer clinical trials, increase patient enrollment, speed translation of genetic discoveries into treatments for patients, and cover the real costs of participation."

Funding for the Cooperative Group Program is lower now in inflation-adjusted dollars than it was in 1999, and constitutes less than 3 percent of NCI's total budget of about $5 billion, the report said. Current funding is insufficient to support the number of trials the groups undertake, especially as trials are becoming more complex with a new focus on developing therapies tailored to the molecular and genetic characteristics of individual patients' cancers. NCI should allocate a larger portion of its research portfolio to the program, and if adequate funding is not available, cooperative groups should reduce the number of NCI-funded trials undertaken to a quantity that can be fully supported, the report said.

The report's goals and recommendations include:

Goal I. Improve the speed and efficiency of the design, launch, and conduct of clinical trials.

• Review and consolidate some front office

THE CANCER LETTER

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Editor & Publisher: Kirsten Boyd Goldberg
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Editorial, Subscriptions and Customer Service:
202-362-1809 Fax: 202-379-1787
PO Box 9905, Washington DC 20016
General Information: www.cancerletter.com

Subscription $375 per year worldwide. ISSN 0096-3917. Published 46 times a year by The Cancer Letter Inc.

operations of the cooperative groups on the basis of peer review.

• Consolidate back office operations of the cooperative groups and improve processes.

• Streamline and harmonize government oversight.

• Improve collaboration among stakeholders.

Goal II. Incorporate innovative science and trial design into cancer clinical trials.

• Support and use biorepositories.

• Develop and evaluate novel trial designs.

• Develop standards for new technologies.

Goal III. Improve the means of prioritization, selection, support, and completion of cancer clinical trials.

• Reevaluate the role of NCI in the clinical trials system.

• Increase the accrual volume, diversity, and speed of clinical trials.

• Increase funding for the Cooperative Group Program.

Goal IV. Incentivize the participation of patients and physicians in clinical trials.

• Support clinical investigators.

• Cover the cost of patient care in clinical trials.

The committee said the consolidation of group front office operations could be accomplished through the peer review process by ranking groups with defined metrics on a similar timetable and by linking funding to review scores.

Key planning and scientific evaluations should be at the disease site committee level, the report said. The focus should be on the quality and success of the clinical trial concepts developed and the committee's record of development of new investigators.

Committees that do well in review should be funded, and committees with low review scores should be eliminated. Committees should be organized with a multidisciplinary focus on disease sites, and group leaders should consolidate disease site committees from different groups to strengthen their productivity and review scores.

NCI should require and facilitate the consolidation of administration and data management operations across all of the Cooperative Groups (the back office operations) and, working with the extramural community, make process improvement in the operational and organizational management of clinical trials a priority, the report said.

For example, NCI should:

• facilitate the consolidation of offices and personnel for such activi-ties as data collection and management, data queries and reviews to ensure that the data collected are complete and accurate, patient registration, audit functions, submission of case report forms, train-ing of clinical research associates, image storage and retrieval, drug distribution, credentialing of sites, and funding and reimbursement for patient accrual;

• work with governmental and nongovernmental agencies with rel-evant expertise to facilitate the identification of best practices in the management of clinical research logistics and develop, publish, and use performance, process, and timing standards and metrics to assess the efficiency and operational quality of clinical trials;

• coordinate and streamline protocol development, as recommended by the Operational Efficiency Working Group; • devote more funds to drug distribution;

• provide resources and technical assistance to facilitate the rapid adoption of a common patient registration system as well as a common remote data capture system;

• facilitate more efficient and timely methods for ensuring that trial data are complete and accurate; and

• develop standardized case report forms that meet regulatory requirements.

The report also urges public and private health plans to fully cover the costs of study participants' health care during trials to eliminate financial disincentives that lead patients to decline enrollment or to drop out.

The Cooperative Group Program involves more than 3,100 institutions and 14,000 investigators who enroll more than 25,000 patients in clinical trials each year. Research by its 10 cooperative groups has contributed to the introduction of treatments and drug indications that have led to improved survival for cancer patients.

Successful trials depend on sufficient involvement by physicians and other health professionals. Cancer care providers devote significant amounts of time and effort to recruit patients into trials and manage their care during the studies. Inadequate reimbursement and recognition for their efforts are increasingly deterring their willingness to initiate or participate in trials, the report concluded.

The committee called on NCI to increase the amount it reimburses clinicians for the costs of managing each of their patients in trials, and to pay for their time and effort spent on designing and carrying out clinical trials. Medical centers should take into account health professionals' participation in clinical trials during

their consideration for tenure and promotions. NCI should establish a centralized credentialing system for investigators and sites that wish to participate in a national trials system to increase consistency across sites and eliminate the burden of recredentialing with different cooperative groups. This system also would provide a way to eliminate research sites with low levels of recruitment or inadequate data management capability.

Insurance providers' variable and uncertain coverage of patients' care during studies and overly restrictive eligibility criteria deter patient involvement in clinical trials. The committee called on public and private health plans to cover all nonexperimental costs of participation in clinical studies. Patient eligibility criteria should allow the broadest participation possible to facilitate more rapid recruitment and allow broader generalizations about study results to be made. Greater involvement by patient advocates could help facilitate this change, the committee added. Advocates can provide valuable input to study design and procedures, safety and confidentiality issues, and other factors important to potential research participants.

Before making its recommendations, the committee outlines what it thought would be an ideal cancer clinical trials program:

Rapid translation of scientific discoveries into public health benefits.

• Trials that address questions with significant implications for patient care.

• Collaboration among stakeholders, with effective and timely communication, in developing the most promising treatments.

• Streamlined procedures for the rapid planning, approval, and launch of trials, with accountability for meeting timelines and the provision of rewards for productivity.

• Efficient incorporation of new technologies and scientific questions, such as the identification and application of biomarkers and molecular imaging, into clinical trials.

A strong publicly supported clinical trials system in the United States that complements industry trials to develop drugs and devices.

• A highly efficient and flexible system for innovative, rigorously prioritized clinical trials.

• Adequate funding for well-designed, high-quality trials.

• Patient access to promising therapies as they develop.

• Addresses questions and collect data that are relevant and meaningful to the diverse U.S. patient population.

A robust, standardized, and accessible clinical trials infrastructure.

• A complete database of active and planned trials.

• Standardized electronic data capture.

• Publicly accessible tissue repositories with high-quality, fully annotated, and inventoried samples collected and stored in a standardized fashion.

• Broad use of those samples in retrospective studies as new hypotheses evolve.

• A consistent and dynamic process for rapidly setting national standards and unified procedures for new technologies, such as diagnostics, with reproducibility and effective incorporation into clinical trials.

Harmonized and synchronized rules and guidelines across federal regulatory agencies.

• Guidance grounded in an understanding of contemporary science as new paradigms in therapeutic approaches as well as in clinical trials methodology develop.

Support for clinical investigators.

• Training and retention of professionals to efficiently and swiftly carry out important clinical research.

• Adequate paid protected research time for active clinical investigators.

• Recognition and appropriate rewards for collaborative clinical research by providing advancement in academia and community practice careers.

• Adequate reimbursement of costs for actively participating institutions and physicians.

Broad patient involvement in clinical trials.

• Third-party payor coverage of the nonexperimental costs of care to ensure that patients do not forgo participation in trials because of financial hardship.

• Participation in the design, implementation, and conduct of trials and in the communication and dissemination of trial results.

Members of the IOM Committee on Cancer Clinical Trials and the NCI Cooperative Group Program were: John Mendelsohn (Chair), president, University of Texas M.D. Anderson Cancer Center; Harold Moses (Vice-Chair), Vanderbilt-Ingram Comprehensive Cancer Center; Susan Arbuck, consultant; Donald Berry, University of Texas M.D. Anderson Cancer Center; Michael Carducci, Johns Hopkins University School of Medicine; David Dilts, Oregon Health and Science University; Susan Ellenberg, University of Pennsylvania School of Medicine; Gwen Fyfe, consultant; Stephen

Grubbs, Delaware Christiana Care Community Clinical Oncology Program; Hedvig Hricak, Memorial Sloan-Kettering Cancer Center; Richard Kaplan, United Kingdom National Cancer Research Network and United Kingdom Clinical Research Network; Minetta Liu, Georgetown University Hospital; Lee Newcomer, United HealthCare; Edith Perez, Mayo Clinic Florida; Charles Sawyers, Memorial Sloan-Kettering Cancer Center; Richard Schilsky, University of Chicago Medical Center; and Ellen Sigal, Friends of Cancer Research.

The report was sponsored by the Centers for Disease Control and Prevention, FDA, NCI, ASCO, the Association of American Cancer Institutes, and C-Change.

Copies of the 314-page report, "A National Cancer Clinical Trials System for the 21st Century: Reinvigorating the NCI Cooperative Group Program," are available at www.nap.edu.

Sites Limiting Trial Participation

In a related development, ASCO released the results of a survey finding that one-third of the cooperative group sites plan to limit participation in federally funded clinical trials due to inadequate per-case reimbursement. Also, nearly 40 percent of sites planning to limit NCI cooperative group trials reported plans to increase industry trial participation, despite expressing a preference for conducting cooperative group trials.

Federally funded Cooperative Group clinical trials often examine questions that the private sector has little incentive to investigate, such as the comparative effectiveness of treatments made by different companies, therapies for rare diseases, and quality of life after treatment, ASCO said.

"This study indicates that far too many NCI cooperative group sites plan to reduce participation in federally funded clinical trials," said ASCO President Douglas Blarney. "Clinical trials are the essential link between laboratory discoveries and new treatments for patients. The outcomes of clinical trials help doctors improve patient care, and sometimes participation in a clinical trial is the patient's best option.

"Adequate NCI support for the Cooperative Group Program is critical to advancing progress against cancer and improving the lives of millions of cancer patients."

ASCO surveyed 509 U.S. and Canadian NCI-supported cooperative groups to identify the issues influencing enrollment in group trials. The sites planning to reduce participation will include limits on: the total number of patients accrued; the number of trials opened; and the number of cooperative group affiliations.

Sites planning to limit participation were asked to indicate the reason for their decision, including insufficient staffing, insufficient NCI per-case reimbursement, and other (which allowed a free-text response). Of the 168 sites planning to limit participation, 75 percent of the sites selected insufficient NCI per-case reimbursement as a reason for their decision.

Currently, NCI devotes approximately $145 million annually to the program, including $60 million to the $2,000 per-case reimbursement, representing only 1.2 percent of NCI's FY2009 budget of approximately $5 billion.

An ASCO study in 2003 and a C-Change study in 2005 determined that the actual cost of conducting NCI trials was $5,000 to $6,000 per case. If NCI reimburses at a more realistic rate of $6,000 per patient, tripling the current amount, this would require an additional $120 million, yet total funding would only account for 3.6 percent of the NCI budget.

The findings also suggest that 39 percent of respondents who indicated they are decreasing participation in cooperative group clinical trials plan to increase participation in industry-funded trials. This signifies that sites remain committed to clinical trials but are limiting participation in federally funded trials.

Anecdotal reports indicate that some sites see a necessity to increase industry trials in order to maintain infrastructure, staffing and equipment necessary to conduct trials and remain compliant with rules and regulations.

The shift away from federally funded trials could lead to fewer trials of diseases that affect small populations and fewer independent trials, which generate high-quality evidence to guide clinical practice.

As oncology treatments move into an era of highly characterized molecular subpopulations, the national reach of the NCI Cooperative Group Program provides the network critical to accrue sufficient numbers of patients on trials.

While funding is not the only factor impacting participation, the significant and growing disparity between actual research costs and the amount provided by NCI to cover those costs serves as a significant deterrent, ASCO said. Without increased funding from the NCI, cooperative groups and research sites cannot increase the number of trials, the number of participants enrolled or maintain current infrastructure to support and conduct clinical trials.

NCI News:

SWOG Wins NCI Renewal For Six Years, $120 Million

Noting that the organization's research "has touched the lives of virtually every adult cancer patient in this nation," NCI has renewed the Southwest Oncology Group's operating grants for six years, with a total funding package over that period expected to exceed $120 million.

The award was announced April 9 by Group Executive Officer Anne Schott, M.D., and Rep. John Dingell (D-Mich.).

The Southwest Oncology Group is a clinical research cooperative group that designs and conducts large-scale trials of new cancer treatments and prevention regimens. The Group is headquartered at the University of Michigan, but its network of almost 5,000 affiliated researchers and more than 500 institutions, including 19 of the NCI-designated cancer centers, extends across the U.S. and into several other countries.

"We're proud to be first among the 10 NCI cooperative groups to embrace—and to be funded for—comparative effectiveness research as part of our mission," said SWOG Group Chair Laurence Baker, referring to recent group initiatives to develop more formal methods of identifying which studies will have the greatest clinical benefit. Baker is professor of internal medicine and pharmacology at the University of Michigan Medical School.

The principal grant, more than $63 million, will be administered by the University of Michigan Medical School and is the largest single research award ever to that school. Most of the remainder of the NCI package will be distributed directly to the group's member institutions.

The NCI committee that reviewed the grant application praised the group's "outstanding record of productivity," citing the more than 300 peer-reviewed publications that document SWOG trial results during the previous five-year grant cycle.

The grant package supports the group's Ann Arbor headquarters, its operations office in San Antonio, and its statistical center in Seattle. The majority of the funds go to member institutions, helping them defray the cost of bringing patients into clinical trials and supporting investigators leading those trials.

The Southwest Oncology Group was founded in 1956. At any given time the group has roughly 100 clinical trials underway and is following more than 30,000 participating patients.

Cancer Trends Report Updated: NCI released the "Cancer Trends Progress Report: 2009/ 2010 Update."

The report, which spans the cancer control continuum from prevention through end of life and summarizes our nation's progress against cancer in relation to the Healthy People targets developed by the U.S. Department of Health and Human Services, has expanded its focus in this year's update.

Highlights of the update include nine new measures; a reporting of health differences and health inequalities across measures, where they exist; and a new summary measure of the most recent trends (average annual percent change).

This online report, first issued in 2001 as the "Cancer Progress Report," is updated every two years and when new data become available. The report, intended for policy makers, researchers, clinicians, and public health service providers, offers updated national trends data in a user-friendly format.

New measures:

- Medicaid coverage of tobacco dependence treatments
- Tobacco company marketing expenditures
- Treatment: Prostate, Kidney, Lung, Ovarian, Bladder
- Cost of cancer care (expanded)
- Cancer survivors and smoking

The report can be viewed online at http://progressreport.cancer.gov/.

NIH News:

NIH To Create Public Database Of Genetic Testing Information

NIH said it is creating a public database that researchers, consumers, health care providers, and others can search for information submitted voluntarily by genetic test providers.

The Genetic Testing Registry aims to enhance access to information about the availability, validity, and usefulness of genetic tests.

Currently, more than 1,600 genetic tests are available to patients and consumers, but there is no single public resource that provides detailed information about them. GTR is intended to fill that gap.

The goal of the GTR is to advance the public health and research into the genetic basis of health and disease. The registry will have several key functions:

• Encourage providers of genetic tests to enhance transparency by publicly sharing information about the

availability and utility of their tests.

• Provide an information resource for the public, including researchers, health care providers and patients, to locate laboratories that offer particular tests.

• Facilitate genomic data-sharing for research and new scientific discoveries

The GTR project will be overseen by the NIH Office of the Director. The National Center for Biotechnology Information, part of the National Library of Medicine at NIH, will be responsible for developing the registry, which is expected to be available in 2011.

GTR genetic test data will be integrated with information in other NIH/NCBI genetic, scientific, and medical databases to facilitate the research process. This integration will allow scientists to make, more easily and effectively, the kinds of connections that ultimately lead to discoveries and scientific advances.

During the development process, NIH will engage with stakeholders—such as genetic test developers, test kit manufacturers, health care providers, patients, and researchers—for their insights on the best way to collect and display test information. Other federal agencies, including FDA and the Centers for Medicare and Medicaid Services, will be consulted.

More information about the Genetic Testing Registry and NCBI is available at http://www.ncbi.nlm.nih.gov/gtr/.

National Human Genome Research Institute has named **Lawrence Brody** as chief of its Genome Technology Branch, the largest of seven branches in the NHGRI Division of Intramural Research. Brody has headed GTB's Molecular Pathogenesis Section, investigating genetic variants that lead to changes in normal metabolic pathways to cause cancer and birth defects. He has made key discoveries regarding the genetics of breast cancer and neural tube defects.

Research Funding:

FASEB Seeks $37 Billion From Congress For NIH

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numbers, success rates, and average award sizes, will help policymakers understand the case for sustained funding for biomedical research.

FASEB has recommended that Congress appropriate $37 billion for NIH in FY2011.

The FASEB NIH data resource is posted at http://www.faseb.org/Policy-and-Government-Affairs/Data-Compilations/NIH-Research-Funding-Trends.aspx.

In the Cancer Centers:

Ohio State Names Director For Medical Oncology Division

MIGUEL VILLALONA-CALERO was named director of the newly formed division of medical oncology at The Ohio State University Comprehensive Cancer Center–Arthur G. James Cancer Hospital and Richard J. Solove Research Institute. His position will become effective May 1.

Villalona directs Ohio State's solid tumors experimental therapeutics program. The OSUCCC-James' medical oncology unit was previously part of the department of internal medicine's division of hematology and medical oncology. The two sections will become independent divisions within the department of internal medicine.

"The establishment of two divisions allows each division to focus on and further develop their respective areas, which will help enhance our quality and recruitment initiatives, strengthen collaboration through our multimodality clinics and stimulate the translation of discoveries into clinical trials," said **Michael Caligiuri**, director of the OSUCCC and CEO of The James.

FRED HUTCHINSON CANCER RESEARCH CENTER pathologist and member **Peggy Porter** received a $5 million grant from Washington State Life Sciences Discovery Fund. The grant will allow Porter and colleagues at the University of Washington and Seattle Children's Hospital and Research Institute to establish a blood and tissue biospecimen collection program. The program will facilitate the development of molecular tests for early diagnosis of cancer and other diseases, as well as tests that enable treatments to be tailored to a patient's condition.

DANA-FARBER CANCER INSTITUTE physician-scientist **William Kaelin** received the 2010 Canada Gairdner Award. Kaelin and two other scientists working independently are sharing the award for identifying the molecular mechanisms that allow cells to detect a shortage of oxygen and respond by making new red blood cells and blood vessels. The research may pave the way for therapies that manipulate oxygen to treat diseases ranging from heart disease and anemia to cancer. The co-recipients, along with Kaelin, are **Gregg Semenza**, of Johns Hopkins University School of Medicine, and **Peter Ratcliffe**, of the University of Oxford.

RICHARD GOLDBERG has been appointed to a newly-created position with the Cancer and Leukemia Group B, an NCI-sponsored clinical trials cooperative

group. Goldberg, physician-in-chief of the N.C. Cancer Hospital and chief of the Division of Hematology and Oncology at UNC-Chapel Hill School of Medicine, will serve as associate group chair for intergroup affairs. In this role, he will help CALGB meet new NCI requirements designed to move cancer treatments from testing to approval more quickly and will serve as a primary liaison with the chairs of other cooperative clinical trials groups.

UNC Lineberger Comprehensive Cancer Center, where Goldberg is associate director of clinical research, is a member of CALGB, a network of 26 university medical centers, more than 200 community hospitals, and more than 3,000 oncology specialists who collaborate in clinical research studies. Goldberg was previously chairman of the CALGB Gastrointestinal Cancer Committee.

UNIVERSITY OF ILLINOIS AT CHICAGO Medical Center and Cancer Center named **Howard Ozer** chief of the Section of Hematology-Oncology and associate director of clinical research. He joined UIC from Oklahoma University where he specialized in lymphoma. AT UIC his goals include recruitment of new faculty into the Hematology-Oncology Section, expansion of efforts in therapeutic clinical trials and advancing the clinical trials infrastructure.

MEMORIAL UNIVERSITY MEDICAL CENTER appointed **Wayne Glasgow** director of laboratory oncology research at the Curtis and Elizabeth Anderson Cancer Institute. Glasgow will direct the translational cancer research program that includes researchers and physicians from both the ACI and Mercer University School of Medicine.

UNIVERSITY OF COLORADO CANCER CENTER will use a new $3.5 million grant to screen 2,000 advanced lung cancer patients for a cancer biomarker called epidermal growth factor receptor during the next two years. The patients will be enrolled in two international phase III trials of a new human EGFR antibody. Fred Kirsch, professor of medical oncology, is the grant leader. Others participating include **Wilbur Franklin**, **Marileila Varella-Garcia**, and **Paul Bunn Jr**.

ROSWELL PARK CANCER INSTITUTE signed a Memorandum of Understanding with King Fahad Specialty Hospital (KFSH) in Dammam, Saudi Arabia. This collaboration lays the groundwork for partnerships encompassing advanced oncology training for physicians, nurses, and technicians; collaborative scientific and clinical research based at RPCI and enrollment in the graduate education programs at RPCI through the University at Buffalo. Additional agreements with other centers in Saudi Arabia and Jordan are in development.

The KFSH agreement is the latest addition to RPCI's increasing portfolio of global collaborations. RPCI President and CEO Donald Trump appointed Youcef Rustum as director of global collaborations to create a more formalized support system to facilitate the development and implementation of those collaborations.

Rustum, a Distinguished Professor of Oncology, serves on the Board of Directors of the planned $300 million King Hussein Cancer Center and anticipates launching multiple joint initiatives when the facility opens in Amman, Jordan, in the next two or three years. KFSH faculty have begun specialized training at RPCI.

ROBERT H. LURIE COMPREHENSIVE CANCER CENTER of Northwestern University said **Malcolm DeCamp** joined Northwestern as chief of the Division of Thoracic Surgery at Northwestern Memorial Hospital, professor of surgery at the Feinberg School of Medicine, and as a member of the cancer center. DeCamp served as visiting associate professor of surgery at Harvard Medical School and chief of the Division of Cardiothoracic Surgery at Beth Israel Deaconess Medical Center in Boston. Previously, he directed the lung transplant program at the Cleveland Clinic.

MAYO CLINIC CANCER CENTER director **Robert Diasio** announced three transitions in the leadership team. **Edith Perez** succeeds **Robert Smallridge** as deputy director, Mayo Clinic in Florida. **Dan Billadeau** is the associated director, basic science, a leadership team role filled previously by **Ed Leof**. **Robert Smallridge** is the cancer center's first deputy director at large.

CITY OF HOPE National Medical Center professor and research scientist **Betty Ferrell** has been chosen to receive the 2010 American Cancer Society Trish Greene Quality of Life Award, honoring investigators in the field of quality of life research. Ferrell is being honored for her contribution to the science of cancer quality of life and her 30 years of innovative research in pain management, quality of life, and palliative end-of-life care. As the principal investigator of the End-of-Life Nursing Education Consortium, she oversees a program that has trained more than 2,600 nurses in palliative and end-of-life care in the past five years. Her research career includes three ACS grants totaling $1,480,000.