THE CANCER LETTER

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The Moon Shot

DePinho Seeks Broad Waiver From COI Policy To Cover Financial Ties With 12 Entities

By Paul Goldberg

As MD Anderson President Ronald DePinho announces what he calls the "Moon Shots Program" to eventually cure cancer, his efforts to send science soaring to unexplored heights continue to be plagued by the terrestrial challenges of managing conflicts of interest with a dozen different entities.

Days before the announcement, MD Anderson's hometown newspaper, the Houston Chronicle, reported that DePinho was seeking a broad waiver from conflict of interest policies.

DePinho had said in an interview with The Cancer Letter that he is seeking a broad waiver covering many entities (The Cancer Letter, Sept. 7).

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As MD Anderson Targets Eight Cancers, Detailed War Plan Remains Under Wraps

By Paul Goldberg

MD Anderson President Ronald DePinho rolled out his long awaited Moon Shots Program at a ceremony Sept. 21.

DePinho, who in the past had vowed to "kick cancer's butt," was more measured as he introduced projects targeting eight specific cancers.

The cure for cancer wasn't promised during the hour-long conference, which was pegged to the 50th anniversary of President John F. Kennedy's speech that began the American effort to send a manned spacecraft to the moon.

MD Anderson materials described the moon shots as efforts "to dramatically accelerate the pace of converting scientific discoveries into clinical advances that reduce cancer deaths."

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In Brief

José Baselga Named Physician-in-Chief Of Memorial Sloan-Kettering Hospital

JOSÉ BASELGA was named physician-in-chief of **Memorial Sloan-Kettering Cancer Center's Memorial Hospital**. He will begin Jan. 1, 2013.

Baselga is chief of the Division of Hematology/Oncology at Massachusetts General Hospital and is associate director of the MGH Cancer Center. He succeeds Robert Wittes, who will step down at the end of this year after serving a decade as physician-in-chief.

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Events

NCI Director Harold Varmus to discuss impediments to progress against cancer: The **National Press Club,** Washington, D.C., **Tuesday, Sept. 25, at 10 a.m.**

Chin Reports To Officials Who Report To DePinho

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The waiver leaked to the Chronicle would cover the ownership interest, ongoing compensation and future compensation from 12 entities.

• **Ownership interest in seven companies:** Agios Pharmaceuticals, Aveo Pharmaceuticals, Karyopharm Therapeutics, Metamark Genetics, Eden Therapeutics, Elan Corp., and Epizyme.

• **Compensation of $10,000 or more from 12 entities:** Agios Pharmaceuticals, Aveo Pharmaceuticals, Boehringer Ingelheim Pharmaceuticals, Dana Farber, Eden Therapeutics, Enzon Pharmaceuticals, Epizyme, GlaxoSmithKline, Karyopharm Therapeutics, Metamark Genetics, Plutus Holdings 2 Limited, and the Sidney Kimmel Foundation.

• **Future ties with ten entities:** Agios Pharmaceuticals, Aveo Pharmaceuticals, Karyopharm Therapeutics, Eden Therapeutics, Epizyme, Metamark Genetics, Merck, Sanofi, the Sidney Kimmel Foundation, and the Dana-Farber Cancer Institute.

Obtaining a waiver from COI policies—usually an obscure process—has now become front-page news.

If the UT System declines, this would constitute a highly visible setback for the scientist who leads one of the world's largest and most prestigious cancer research institutions.

Documents obtained by The Cancer Letter show that granting of the waiver would constitute a direct departure from the COI regulation mechanism outlined in the letter in which DePinho was offered his job.

The same batch of internal documents, obtained under the Texas Public Information Act, points to additional difficulties in managing conflicts that can arise from the continuing employment of DePinho's wife, Lynda Chin, by MD Anderson.

Documents show that in matters that don't require presidential action, Chin reports to the MD Anderson provost and the head of the Division of Cancer Medicine, who in turn report to DePinho.

These materials, posted at http://www.cancerletter.com/categories/documents, offer a glimpse at the process that led to DePinho's hiring and spell out the terms of his employment. Also, they offer insight into the difficulties the MD Anderson senior officials may face in overseeing Chin.

Last month, MD Anderson's Provost Raymond DuBois announced that he would step down. Although DuBois declined to comment, knowledgeable sources have said that he refused several requests from Chin. DuBois was also not asked to review Chin's application for an $18 million grant to establish a technology incubator. (The Cancer Letter; May 25, June 1, Sept. 7.)

MD Anderson officials declined to comment on the waiver.

"We prefer not to comment on the Chronicle story, because we are prohibited from sharing confidential and privileged information under consideration by the UT System special Conflict of Interest Committee, which was the subject of the story," said DeDe DeStefano, director of external communications. "We are unable to provide clarifications, other than to advise you that the waiver request 'version' obtained by the Chronicle was not the same as the actual request submitted to System for review, was not printed on letterhead, and was not signed."

In an interview with the Chronicle, Sen. Chuck Grassley (R-Iowa), said that the waiver shouldn't be granted. As long as conflicts described in the waiver request exist, "any type of plan to manage them seems likely to be inadequate," Grassley said.

The Chronicle has not posted the leaked document on its website.

Decade-Old Policy Prompted By Erbitux

If granted, the waiver would exempt DePinho and Chin from the provisions of a policy that grew out of the business involvement of MD Anderson's former president in ImClone Inc., a company that was developing his drug Erbitux (cetuximab).

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"The 2002 conflict of interest policy was written by a group of faculty of which I was one," said Leonard Zwelling, former MD Anderson vice president for research administration who now serves as professor of medicine and pharmacology.

"This was done in response to a request from President [John] Mendelsohn to re-examine and rewrite the policy in place at the time. This policy revision followed a report in the Washington Post that almost 200 patients at MD Anderson had received an experimental therapy through participation in an IRB-approved company-sponsored trial with the drug invented by Dr. Mendelsohn without the participants' knowing the President's involvement with the drug's development or with the sponsor."

The 2002 Washington Post story has since been reposted at http://www.commondreams.org/headlines02/0630-03.htm.

The waiver request also appears to seek change in the conditions of employment spelled out in the letter offering DePinho the job of MD Anderson president, which come with a $1.8 million salary. The June 15 offer letter, from Kenneth Shine, the UT System vice chancellor for health affairs, reads:

"You have provided a schedule for resigning from a number of companies with which you are associated. Your knowledge and experience with technology transfer and commercialization is valuable in your role as President.

"You will continue with positions at Karyopharm and Metamark, which will involve no cash compensation, and will be limited to founder shares. You will continue on the Board of Directors of AVEO, from which you are likely to resign once FDA decision is rendered on the approval of its first Phase III drug.

"Any cash you receive for this service will be donated to the MD Anderson Cancer Center graduate programs. Identification of your role with any of these companies will be part of any consent forms signed by a patient enrolled in clinical trials at MD Anderson Cancer Center involving drugs or biological produced by them.

"Your activities in these areas will be monitored by the MD Anderson Cancer Center Conflict of Interest Committee in the course of its usual responsibilities. Any concerns of that committee will be brought to the attention of the Executive Vice Chancellor for Health Affairs."

In a recent interview with this reporter, DePinho discussed his commercial interests and his intent to seek the waiver. In the interview, he said he eliminated his involvement with several of the companies that nonetheless appear on the waiver document leaked to the Chronicle.

An excerpt from the Q & A follows:

PG: What were some of the business interests which you have that—investments and equity stakes in companies—that you had to give up or sell? How were those decisions made, about what stays and what goes?

RD: I eliminated my role in a number of companies that I was advising them in, due to the limitations of time and the need for intensive focus in the job that I now have the privilege of having.

The only companies that I elected to remain on were companies that I felt I was playing a special role that was essential for the success of the company, and by extension, where my role would help the companies succeed so that they could help patients.

The three companies were AVEO Pharmaceuticals, which is a company that Lynda and I co-founded over ten years ago. It's focused on the development of drugs using sophisticated genetics and cancer biology as well as mouse model systems.

The other one was Metamark Genetics. Again, we were co-founders of that company and that company is focused on diagnostics to develop diagnostics for individuals with prostate cancer, to identify which men are at risk for the development of lethal disease in that context as well as in other cancers such as melanoma.

The third is another company that I was a co-founder is Karyopharm Therapeutics, which is focused on targeting nuclear export machinery as a novel therapeutic approach for cancer.

PG: And you got rid of?

RD: To name a few, I eliminated my role as an advisor for GSK, for Epizyme, for Agios, for Enzon, amongst others, although I still have some equity from my service in Agios and Enzyme.

PG: And the reason is that they could do well without you, they didn't need...

RD: That's right. I was not a founder of those companies. I was merely playing a role as an advisor, and the question that I ask myself with anything that I eliminate or retain is, would it impact adversely on the ability of those companies to impact human health.

PG: So it was basically your own decisions, I suppose, with no feedback from the UT System?

RD: That's correct.

PG: You were able to make the proposals—this is how you're going to deal with the conflicts and they said, fine?

RD: Yes. And they have very strong conflict management procedures that are in place and we could give those procedures to you.

PG: I would love to see them. Recently there was some press coverage of AVEO trial that was proposed for MD Anderson [http://www.chron.com/news/houston-texas/article/M-D-Anderson-involved-in-trial-of-drug-marketed-3711441.php**]. Do you think, in retrospect, that it would have been better not to go forward with that study, which of course required you to seek a waiver for it to continue? Are you still seeking a waiver?**

RD: First of all, there has been a recent story in the press and we've been successful in correcting some of the misinformation in that story. We have not gone forward with the proposed AVEO study and it will not go forward until we receive guidance from UT System on the conflict issues.

Also, no waiver has been requested with respect to this specific proposed AVEO study. A general waiver of certain provisions of MD Anderson's Conflict of Interest Policies as they pertained to a number of companies, including AVEO, was submitted to UT System. Hand in hand with the waiver request was a detailed proposed plan to monitor and manage conflicts of interest if the waivers were granted.

Shortly after we became aware that AVEO issued a news release incorrectly implying that the study was open at MD Anderson and that a member of MD Anderson's faculty was the lead investigator, we asked AVEO to clarify the release, as it would not be possible for the lead Principal Investigator to be at MD Anderson even if UT System granted the pending waiver, because of other rules that we have that manage conflicts of interest. It's important to understand that those discussions between AVEO and MD Anderson started, I believe, in 2009.

This was a number of years before the job for MD Anderson president even emerged. But at this point, the trial will not open at MD Anderson unless the waiver is approved by UT System.

PG: So you are still seeking the waiver?

RD: Yes. Absent a waiver, AVEO is unable to sponsor any research if the principal investigator is at MD Anderson.

PG: Right. With waiver requests, or one single waiver?

RD: One single request has been sent to UT System, but it includes multiple waiver requests and is not exclusive to this trial or to AVEO, and it includes a comprehensive conflict management plan, depending on the company and type of trial involved. For instance, there are different rules, depending upon whether the trial involves patients or not.

Complex Reporting Chain for Lynda Chin

Documents released to The Cancer Letter by the UT System lay out the unusual schema for managing conflicts that could arise from Chin's employment at MD Anderson.

Chin, whose total compensation package is $812,990, reports to the provost—at the time, Raymond DuBois—and the head of the Division of Cancer Medicine, Waun Ki Hong.

On matters where the president's action is required, the decisions will be made by Kenneth Shine instead of her husband, DePinho.

This schema means that the individuals who supervise Chin, evaluate her performance and decide whether she would receive the resources she requests report to her husband DePinho.

Shine describes this unusual arrangement in an email dated Aug. 11, 2011, addressed to Chin and DePinho, as well as Provost DuBois, Hong, Executive Vice President Leon Leach, and Senior Vice President for Business Affairs Dan Fontaine.

The email follows:

Dear Ron and Lynda,

These are guidelines, which have [been] provided to colleagues at MDACC, including Ray DuBois, Ki Hong, Leon Leach and Dan Fontaine. They are designed to provide clarity and to answer any outside questions about our arrangements. The statement has been reviewed by General Counsel and has been found appropriate. Let me know if you have any questions. There is great excitement on the campus about your future contributions and we look forward to your arrival with great excitement.

Dear Colleagues:

As you know, we have completed the recruitment of Dr. Ronald DePinho as the President of the MD Anderson Cancer Center (MDACC) effective Sept. 1, 2011.

President Designate DePinho's wife, Dr. Lynda Chin, is a very accomplished physician and scientist who will be joining the faculty at MDACC. She will serve as Chair of a new Department of Genomic Medicine and as Scientific Director of a newly constituted Institute of Applied Cancer Science,

In view of her relationship to the President designate, I have conducted, in consultation with faculty and staff at MDACC, the recruitment of Dr. Chin, including her salary, the resources required for her personal laboratory and for the Department of Genomic

Medicine.

I have also approved the organization, business plan and budget for the Institute of Applied Cancer Science.

As Chair of the Department of Genomic Medicine, Dr. Chin will report to Dr. Waun Ki Hong, Head of the Division of Cancer Medicine. As Scientific Director of the Institute, Dr. Chin, with the Administrative Director of the Institute, Dr. Giulio Draetta, will report to Provost Raymond DuBois.

Drs. Hong and DuBois will have direct responsibility for supervising Dr. Chin, evaluating her performance, identifying resources needed for her programs, assisting in recruitment efforts by her, and otherwise functioning in the usual manner required by their responsibilities.

However, so long as Dr. DePinho is President he will not participate in any of these functions so far as his wife is concerned. At any time when a presidential action is required in regard to any of these activities, or any other activities of Dr. Chin's employment, the Executive Vice Chancellor (EVC) for Health Affairs will be consulted, and EVC for Health Affairs approval will be required in place of any Presidential action.

This includes setting Dr. Chin's salary, promotion, or any other substantial change in her status. It also includes any additional provision of institutional resources which would ordinarily require Presidential approval.

Any committee report concerning Dr. Chin, such as those of the Conflict of Interest Committee, which would ordinarily be made to the President of MDACC will be sent to the EVC for Health Affairs.

These arrangements are consistent with the Regents' rule 30106 regarding nepotism. We are very excited for the future impacts of Dr. Chin and President DePinho upon MDACC and upon cancer discoveries and treatment. Let me know if you have any questions about these arrangements.

—Ken

Home/Office Arrangement

In his recent Q&A with The Cancer Letter, DePinho described the home and office interplay in his family.

RD: First of all, Dr. Chin plays a very important role, just as all of our department chairs do. She is chair of a new department of genomic medicine, and her focus is on genomics at a precise moment when technology and scientific thought, concepts, are coming together to cause major disruptive change in the way that cancer is viewed and treated.

She'll sink or swim on her own scientific merit and accomplishment here. I have great confidence in her ability to succeed, as evidenced by her track record, her stature in the field and her publications, including her recent Cell paper that just came out.

In the institute, she is the scientific director and she is one of the leadership group under Giulio Draetta, along with Phil Jones, Jannik Andersen [senior associate director of drug discovery], Joe Marszalek [senior associate director of target validation] and others that are in the leadership group that help manage the myriad activities that occur in the institute.

PG: It must be really challenging to work closely with one's spouse. How is that working out for you?

RD: We have always been bound together by our common interests, not just in our family lives, but in our scientific lives and it's been a tremendous source of, what's the right word...Well, it has just been a very gratifying experience to share a common passion.

So, we have always been able to work very effectively together, because while we work in the same area, we emphasize different things. I'm more of a cancer biologist and geneticist, whereas Lynda is more focused on genomics. And I also work on aging and she doesn't work in that area.

PG: At this point, it's just a potential for, basically, side conversations—and just the difficulty of managing the potential conflicts and appearances of conflicts.

RD: Anybody that's in the room for a few minutes with each of us recognizes that we actually spend very little time talking about science.

With three young children, we tend to focus most of our energies on raising our kids whenever we do have time together. We had, over the years, joint lab meetings—that's where most of the professional interaction is.

Just to give you an example of how little we do communicate on the scientific level, it came as a surprise (to me) that Lynda had a paper published in Cell. And the way I found out about it is that MD Anderson had a press release today and I read the press release and I saw Lynda's name in it and I'm reading on it, and I thought maybe she was commenting on another group's paper, and it turns out that it was her paper in Cell.

So we are independent, we are colleagues, and we do have a lot of common interests scientifically—but we don't spend a lot of free time together on our jobs. In the time that we do spend together, we tend to focus on family, our children and each other.

The Moon Shot

MD Anderson Has No Plans To Release Details of Strategy

(Continued from page 1)

The rollout didn't include a public release of the actual plans to speed up progress against eight cancers. Cancer center officials said the actual plans are "being developed and projects prioritized now." It is unclear when this process will be completed and whether the plans would be released.

For now, MD Anderson has released six brief "backgrounders" on the projects. Those materials are posted at http://www.cancerletter.com/categories/documents.

"Generations [after the Kennedy speech], the Moon Shots Program signals our confidence that the path to curing cancer is in clearer sight than at any other time in history," DePinho said in a statement. "Humanity urgently needs bold action to defeat cancer. I believe that we have many of the tools we need to pick the fight of the 21st century. Let's focus our energies on approaching cancer comprehensively and systematically, with the precision of an engineer, always asking, 'What can we do to directly impact patients?'"

The program initially targets eight cancers:

• acute myeloid leukemia and myelodysplastic syndrome;

• chronic lymphocytic leukemia;

• melanoma;

• lung cancer;

• prostate cancer;

• and triple-negative breast and ovarian cancers—two cancers linked at the molecular level.

MD Anderson officials said it would rely on "technical platforms" to provide key infrastructure for the moon shots.

"In the past, each investigator or group of investigators has developed their own infrastructure to support their research programs," stated MD Anderson's press release. "Frequently they were under-funded and lacked the high level management and leadership required to ensure that they were of the highest caliber and in particular that they were able to adapt to the rapidly changing scientific and technological environment.

"The moon shot platforms will be designed and resourced to provide expertise that will support the efforts of all of moon shots teams. The platforms will provide a critical component to the success of each moon shot and of the overall Moon Shots Program. In particular, they will leverage the investment across the moon shots."

The platforms, as described by the institution, will include:

• **Adaptive Learning in Genomic Medicine:** A work flow that enables clinicians and researchers to integrate real-time patient clinical information and research genomic data, allowing understanding of the cancer genome and ultimately improving outcome.

• **Big Data**: The capture, storage and processing of huge amounts of information, much of it coming from Next Generation Sequencing machines (genome sequencing).

• **Cancer Control and Prevention**: Community-based efforts in cancer prevention, screening, and early detection and survivorship to educate and achieve a measureable reduction in the cancer burden. Interventions in the areas of public policy, public education, professional education and evidence-based service delivery can make a measurable and lasting difference in our community, especially among those most vulnerable - the underserved.

• **Center for Co-Clinical Trials**: Uses mouse or cell models of human cancers to test new drugs or drug combinations and discover the subset of patients most likely to respond to the therapy.

• **Clinical Genomics**: An infrastructure designed to bank and process tumor specimens for clinical tests that can guide medical decisions.

• **Diagnostics Development**: The development of diagnostic tests for use in the clinic to guide targeted therapy.

• **Early Detection**: Using imaging and proteomic technologies to discover markers that can identify patients with early-staged cancers.

• **Institute for Applied Cancer Science**: Developing effective targeted cancer drugs.

• **Institute for Personalized Cancer Therapy**: An extensive infrastructure that analyzes genomic abnormalities in patient tumors to direct them to the best treatments and clinical trials.

• **Massive Data Analytics**: A computer infrastructure that develops or uses computational algorithms to analyze large-scale patient and public data.

• **Patient Omics:** Centralizing collection of patient biospecimens (tumor samples, blood, etc.) to profile genes and proteins (genomics, proteomics) and identify mutations that can guide personalized treatment decisions and predict therapy-related toxicity to improve overall patient outcomes.

• **Translational Research Continuum:** A

framework to facilitate efficient transition of a candidate drug from preclinical studies to early stages of human clinical trial testing so effective drugs can be developed in a shorter time and clinical trials can be quicker and cheaper with higher success rates.

Frank McCormick, director of the University of California, San Francisco Cancer Center and president of the American Association for Cancer Research, led the review panel of 25 internal and external experts that narrowed the field to the inaugural six moon shots.

"Nothing on the magnitude of the Moon Shots Program has been attempted by a single academic medical institution," McCormick said in a statement. "Moon shots take MD Anderson's deep bench of multidisciplinary research and patient care resources and offer a collective vision on moving cancer research forward. The process of bringing this amount of horsepower together in such a focused manner is not normally seen in academic medicine and is valuable in and of itself."

In the first 10 years, the cost of the Moon Shots Program may reach an estimated $3 billion, MD Anderson officials said. Implementation of the program will begin in February 2013, and is expected to reach full stride by mid-2013.

Asked to describe the resources the moon shots required, DePinho said MD Anderson had millions of dollars to spend on the projects, but would need to raise a great deal more.

"It's an integrated effort that will involve philanthropic support, we have very generous support from the community and many individuals that really believe in MD Anderson," he said. "We ask for your support, and so we currently have tens of millions of dollars that we can deploy, in hand, thanks to those sources. We can actually get started immediately.

"In addition, we believe that these activities will generate data that will make us more competitive for grants from foundations, from [the Cancer Prevention and Research Institute of Texas] and the state, and from federal sources, which are diminishing. So we want to become more competitive for those scarce resources.

"And, in addition, because these platforms will create assets that are more mature—diagnostics and drugs—as we license those drugs into the private sector, the return that we get from licensing revenues will plough back into the system and bring that program forward.

"It's a diversified portfolio of activities. In addition to institutional support, because we will have more patients now that we will be seeing, all of those activities will put the wind in our sails and go forward. But, clearly, one of the greatest risks that we have with this program is that we will fail to receive sufficient support.

"So we ask for your support and your confidence."

Sequestration

OMB Estimates 8.2 Percent Cut To NIH, NCI and FDA Budgets

By Conor Hale

The White House Office of Management and Budget released a report detailing the full effect of automatic budget cuts planned for the federal government, scheduled for January 2013.

The report, released Sept. 14, estimates an 8.2 percent cut across the budgets of NIH, NCI and FDA.

NIH would lose $2.5 billion, lowering its budget to $28.3 million. The FDA's discretionary budget would drop $318 million. NCI's budget would decrease by an estimate of $400 million.

"Sequestration would undermine investments vital to economic growth, threaten the safety and security of the American people, and cause severe harm," said the OMB report. "The National Institutes of Health would have to halt or curtail scientific research, including needed research into cancer and childhood diseases."

"Cancer patients face a triple threat from the specter of these budget reductions," said Sandra Swain, president of the American Society of Clinical Oncology. "Not only will life-extending cancer research sustain a devastating hit, but providers of cancer care who are already struggling will be faced with significant cuts that will impede access to care. Sequestration will also hinder the federal review and oversight of new oncology treatments."

Legislators made a pact through the Budget Control Act of 2011—allowing them to raise the debt ceiling and avoid default—but it required Congress to enact a $1.2 trillion deficit reduction plan by the end of this year, under the threat of automatic, instant, and across-the-board budget cuts should they fail.

Meanwhile, the 2012 Cancer Progress Report, published by the American Association for Cancer Research Sept. 12, highlighted the benefits brought about by cancer research—and demanded that Congress secure cancer research as a national funding priority and work to avoid the automatic cuts planned for NCI and NIH.

"Members of Congress do not have the option of turning away from funding what is going to help the health of this nation," said Margaret Foti, CEO

of AACR, during the presentation of the report in Washington, D.C. "It is a responsibility to invest the health of our citizens."

The report, published in the AACR journal Clinical Cancer Research, estimates that automatic cuts would reduce NIH grants by at least 2,300 and NCI grants by at least 300—resulting in losses of over 38,500 U.S. jobs.

The report listed several achievements of the past 12 months: eight new drugs to treat a variety of cancers, including two new classes of drugs; a new drug to treat precancerous lesions of the skin; and four new uses for previously approved cancer drugs.

"Unfortunately, continued progress against cancer is in jeopardy due to the current crisis in funding for cancer research and biomedical science at the federal level," said the report. "Without action to avert further cuts, our nation's ability to seize today's scientific momentum and capitalize on prior investments in cancer research, spur innovation, and most importantly, save lives is at risk."

The report describes how NIH and NCI's budgets have essentially remained flat over the past decade—and inflation in the biomedical sector has resulted in a 20 percent erosion of the agencies' purchasing power, or nearly $6 billion.

"We do recognize that Congress is in a bad situation right now," said Foti. "But there are priorities. We want the health of this nation to be a priority. These demanding times require that our leaders set these funding priorities and make important decisions that benefit every American and their families. Failing to do so will stall the future advances and risk the economic health and wellbeing of our nation."

The Federation of American Societies for Experimental Biology has projected that NIH extramural research funding will decline by $2.8 billion if sequestration goes into effect.

"The loss of funds due to sequestration will curtail vital research projects at universities and institutions in all 50 states and result in layoffs of thousands of Americans," said FASEB President Judith Bond.

Eight states face funding reductions exceeding $100 million—California, Maryland, Massachusetts, New York, North Carolina, Pennsylvania, Texas, and Washington. Those states account for 28,740 NIH awards alone, out of a total of 50,591, for the 2011 fiscal year.

"Administering a reduction of this scale in a short timeframe will be calamitous," said the FASEB report. "[Sequestration] will require arbitrary funding cuts that will prevent critical research projects from reaching completion.

"Since at least 75 percent of the grant budgets are for salaries, the impact on employment and local economies will be immediate and severe. The negative impact on our nation's health, security, and international competitiveness will be impossible to estimate, and it may take us generations to recover the lost talent, as highly trained researchers and dedicated young scientists and engineers will be driven from science by the disruption of their training and their work."

At this writing, the House and Senate are working to pass House Joint Resolution 117, a fiscal Band-Aid that seeks to maintain the current budget levels through March 27, 2013, to avoid a government shutdown due to the lack of a comprehensive budget bill. The 2012 fiscal year ends Sept. 30.

The measure has been approved in the House, and the Senate is expected to approve the measure before it takes its recess through the November elections. The continuing resolution does nothing to address sequestration.

In Brief

Baselga Named Chief Physician At MSKCC's Memorial Hospital

Baselga will direct the clinical component of Memorial Sloan-Kettering, leading a staff of approximately 834 attending physicians. His responsibilities will include the management of patient care delivery in the hospital as well as at clinics and regional sites. He will also focus on clinical strategic planning and will oversee clinical and translational research.

His laboratory investigations have focused primarily on breast cancer, particularly in the area of growth factor receptors and signaling pathways. He has also been involved in the preclinical and clinical development of several molecularly targeted agents including trastuzumab and lapatinib, and insulin-like growth factor receptor inhibitors.

Baselga led the early clinical development and clinical studies that resulted in the FDA approval of two drugs for the treatment of breast cancer—pertuzumab (Perjeta) and everolimus (Afinitor). His current work focuses on the development of PI3K inhibitors.

Baselga is a past president of the European Society for Medical Oncology, has served on the board of directors of the American Society of Clinical

Oncology and the American Association for Cancer Research.

LISA CAREY was appointed chief of the Division of Hematology and Oncology at the **University of North Carolina** School of Medicine and physician-in-chief of the **N.C. Cancer Hospital**.

Carey is the Richardson and Marilyn Jacobs Preyer Distinguished Professor in breast cancer research, professor of medicine, medical director of the UNC Breast Center, and associate director for clinical research at UNC Lineberger Comprehensive Cancer Center.

In her role as division chief, Carey will be responsible for the overall administration of the division, including clinical practice, educational activities, research programs, fiscal management, and meeting the missions of patient care, research, and education. As physician-in-chief, Carey will be responsible for the clinical operations of the N.C. Cancer Hospital and will help coordinate care throughout the UNC Health Care System.

Carey co-leads the UNC Breast Cancer SPORE grant and is a nationally respected breast cancer expert who has been appointed to the NCI committee that reviews and approves all of the NCI breast cancer trials.

PAUL MISCHEL joined the **Ludwig Institute for Cancer Research** to lead the newly created Laboratory of Molecular Pathology. He will also hold a professorship in the UC San Diego Department of Pathology.

Mischel's research focuses on analyzing tumors for their molecular patterns to better understand glioblastoma. These patterns can then be used to develop personalized treatments for cancer patients.

Mischel comes to Ludwig after nearly 15 years at UCLA, most recently as a professor of pathology and laboratory medicine and molecular and medical pharmacology and also as a member of UCLA's Jonsson Comprehensive Cancer Center and Broad Stem Cell Research Center. Currently, he is a member and past-president of the American Society for Clinical Investigation.

STEVEN ROSENBERG and **HIROYUKI MANO** were awarded the **Keio Medical Science Prize** by **Keio University**. The award recognizes outstanding contributions to the fields of medicine or the life sciences.

Rosenberg is chief of surgery at NCI. Mano is a professor at Jichi Medical University in Shimotsuke, Japan, and is a project professor at The University of Tokyo.

Laureates receive a certificate, a medal and an award of 10 million yen (approximately $128,000). The ceremony and lectures will be held at Keio University in Tokyo Nov. 29. Six laureates of this prize have later won the Nobel Prize.

Rosenberg will present "Development of Effective Immunotherapies for Patients with Cancer" and Mano will present "Discovery of a lung cancer oncogene EML4-ALK and development of molecular targeted therapy."

WENDELL YARBROUGH was named section chief of otolaryngology at **Yale-New Haven Hospital** and **Yale School of Medicine**. He will also be director of the head and neck cancer program in Smilow Cancer Hospital at Yale-New Haven and co-director of the molecular virology research program for Yale Cancer Center.

Yarbrough joins Yale-New Haven from Vanderbilt University, where he was professor of otolaryngology and of cancer biology. Yarbrough was the Ingram Professor of Cancer Research and co-leader of the thoracic and head and neck program at the Vanderbilt Ingram Cancer Center.

His research concentrates on the identification of tumor suppressors in head and neck cancers.

GARY DUNNINGTON was named chair of the **Indiana University School of Medicine** Department of Surgery.

Dunnington took the position following 15 years at the University of Southern Illinois, where he had served since 2000 as professor and chair of surgery. Previously, he was an associate professor of surgery and senior associate dean for academic affairs at the University of Southern California School of Medicine.

His clinical focus is in breast and endocrine disease. He has been the founding medical director of two multidisciplinary breast centers, first at the USC Norris Cancer Center and at Southern Illinois University. He also has a particular interest in medical education and has received 19 institutional teaching awards.