THE CANCER LETTER

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State of the Institution

MD Anderson's Balance Sheet is Issue No. 1 For DePinho's "Moon Shots Program"

By Paul Goldberg

MD Anderson President Ronald DePinho acknowledged "missteps" and "communications snafus that let misunderstandings gain traction" during his 45-minute State of the Institution address Oct. 9.

For the first time, DePinho focused on the money needed to finance his risky, multi-billion-dollar Moon Shots Program while living on the limited budget of the cancer center that costs $9 million a day to operate.

While the UT Board of Regents has shown tolerance, if not disregard, for DePinho's propensity to cause controversy, no one doubts that the regents are intensely following MD Anderson's bottom line.

DePinho's remarks make it clear that his moon shots will require continued belt-tightening and, more importantly, finding new sources of revenue.

(Continued to page 2)

CPRIT Reviewers Quit

Blistering Resignation Letters Declare CPRIT Outside Mainstream of Science

By Paul Goldberg

Sometimes people follow through on their warnings.

Scientists who review proposals for the Cancer Prevention and Research Institute of Texas said last spring that they would follow their chief scientific officer, Alfred Gilman, out the door.

And they did.

Seven of the eight members of the CPRIT scientific review council said they would leave, and the eighth is expected to quit as well, ending their association with the Texas state agency that dispenses $300 million a year for cancer research and commercialization.

(Continued to page 6)

In Brief

Sledge Named Oncology Chief at Stanford

GEORGE SLEDGE JR. will be the new chief of oncology in the **Stanford University Department of Medicine**, beginning Jan. 14, 2013.

Sledge, a former president of the American Society for Clinical Oncology, was recruited from the Indiana University Simon Cancer Center, where he is professor of medicine and the Ballvé-Lantero Professor of Oncology.

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DePinho: Moon Shots Require New Sources of Revenue

(Continued from page 1)

"For FY13, we have asked for and budgeted an average increase of 5 percent for key clinical activities metrics," DePinho told MD Anderson employees in his speech.

This is a significant increase for MD Anderson, an institution that operates on a margin of 4 percent. In the hospital business, a 4 percent margin is considered quite good, and going beyond it is difficult.

"Our financial performance has been strong but inconsistent from month to month across the course of the year," DePinho said. "We need to even out those peaks and valleys.

"The institutional margin contributes more than $275 million in research every year, $160 million in uncompensated care for Texans who cannot pay, and we invest nearly $90 million in medical, patient and community education," DePinho said.

Moreover, MD Anderson will commit $100 million for information technology projects this year, DePinho said.

"Faculty have asked for clinical expansion, such as the Pavilion Project, which would add another 11 state-of-the-art operating rooms and increased diagnostic imaging space," DePinho said. "That will cost $198 million. To justify that expenditure, we must generate the clinical volume in surgery that would continue to demonstrate the need for that facility in help pay for it."

DePinho's focus on surgery was painfully relevant, because two weeks earlier, on Sept. 26, highly respected surgeon Raphael Pollock was summoned to the office of Thomas Burke, the MD Anderson executive vice president and physician-in-chief, and was relieved of his duties as division head of surgery.

Pollock, who is Jewish, was fired on the Yom Kippur, the Day of Atonement.

Sources said Pollock was told he was fired because his division was inconsistent in meeting financial targets. Indeed, MD Anderson financial data show that surgery produced revenues that were $5 million below budgetary projections, underperforming by 33.2 percent—see the table on page 3.

This financial performance was caused in part by changes in CPT codes for surgery, which were published in November 2011, three months after MD Anderson finalized its budget, sources said.

Surgical facilities at the institution are running at full capacity—additional operating rooms would be required to add revenues.

"I'm grateful for Dr. Pollock's commitment to leading the division for the last 15 years, and I'm pleased that he will continue making contributions as a professor with joint appointments in the departments of Surgical Oncology and Molecular and Cellular Oncology," Burke wrote in an Oct. 1 email to the MD Anderson staff.

Pollock is the program director and principal investigator of an $11.5 million five-year Specialized Program of Research Excellence grant for translational research in sarcoma. The grant is held by the Sarcoma Alliance for Research Through Collaboration.

Pollock declined to comment on his dismissal.

The Meaning of the Increase

"What does the percent increase really mean?" said DePinho. "We recognize that this can place a strain on our faculty, who are already highly productive and maxed out.

"And I have asked the department chairs to take the responsibility of meeting their budget and working with their faculty to assure that the workload is distributed equitably in a transparent system.

"In addition to increasing the number of providers and distributing the workload, the institution is making enormous investments in IT and automation to enhance efficiencies, to capture more time for everyone."

In a recent internal communication available to MD Anderson employees, R. Dwain Morris, vice

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The University of Texas M. D. Anderson Cancer Center
Fiscal Year 2012 Institutional Financial Report
Executive Summary
For the Year to Date Ended August 31, 2012

	FY '12 as of 8/31/12	FY '11 as of 8/31/11	Increase (Decrease) From Prior Year	% Increase (Decrease) From Prior Year	FY '12 Budget as of 8/31/12	Variance From Budget Favorable (Unfavorable)	Variance % From Budget Favorable (Unfavorable)
Financials:							
Total Gross Patient Revenue	$ 6,144,132,636	$ 5,544,009,390	$ 600,123,246	10.8%	$ 5,992,540,848	$ 151,591,788	2.5%
Net Patient Revenue	2,958,786,294	2,730,178,747	228,607,547	8.4%	2,831,475,551	127,310,743	4.5%
Total Operating Revenue	3,400,687,047	3,167,835,466	232,851,581	7.4%	3,297,869,384	102,817,663	3.1%
Total Operating Expense	3,335,904,193	3,055,604,159	280,300,034	9.2%	3,283,004,021	(52,900,172)	-1.6%
Total Operating Income/(Loss)	64,782,854	112,231,308	(47,448,454)	-42.3%	14,865,363	49,917,491	335.8%
Operating Income/(Loss) %	1.9%	3.5%	(1.6) Points		0.5%	1.4 Points	
Total Non-Operating Revenue (Expense)	331,990,156	494,567,579	(162,577,423)	-32.9%	377,847,260	(45,857,104)	-12.1%
Net Income/(Loss)	396,773,010	606,798,887	(210,025,877)	-34.6%	392,712,623	4,060,387	1.0%
Net Income/(Loss) %	10.6%	16.6%	(6.0) Points		10.7%	(.1) Points	
PRS Net Income/(Loss)	5,392,451	16,058,586	(10,666,135)	-66.4%	4,725,930	666,521	14.1%
Statistics:							
Inpatient Admissions	26,726	25,230	1,496	5.9%	26,027	699	2.7%
Total Patient & Observation Days	196,180	184,114	12,066	6.6%	189,333	6,847	3.6%
Percent Occupancy	87.1%	85.0%	2.1 Points		85.2%	1.9 Points	
Average Length of Stay	7.17	7.15	0.02	0.2%	7.11	(0.06)	-0.7%
Outpatient Billable Visits	1,281,489	1,190,568	90,921	7.6%	1,250,950	30,539	2.4%
Total Surgeries (Patients)	18,937	18,221	716	3.9%	19,385	(448)	-2.3%
Billable Units:							
Pathology Lab Med Billable Units	11,619,591	10,937,213	682,378	6.2%	11,352,432	267,159	2.4%
Diagnostic Imaging Billable Units	497,660	515,999	(18,339)	-3.6%	523,834	(26,174)	-5.0%
Radiation Oncology Billable Units	283,503	267,513	15,990	6.0%	281,991	1,512	0.5%
Stem Cell Transplants	848	865	(17)	-2.0%	860	(12)	-1.4%
Hospital Revenue Categories:							
Consultations	72,811	63,016	9,795	15.5%	67,491	5,320	7.9%
Follow Ups	523,301	495,982	27,319	5.5%	524,230	(929)	-0.2%
New Patients	37,310	33,826	3,484	10.3%	37,697	(387)	-1.0%
Procedure Other	1,476,421	1,246,807	229,614	18.4%	1,075,274	401,147	37.3%
Full Time Equivalents (FTEs)	18,482	17,901	581	3.2%	18,386	(96)	-0.5%
Average Hourly Rate (AHR)	$ 39.77	$ 38.09	$ 1.68	4.4%	$ 39.42	$ (0.35)	-0.9%
Total Operating Income/(Loss) - Hospital and Clinic and PRS:							
Ambulatory Operations	$ 12,459,905	$ 3,499,336	$ 8,960,569	256.1%	$ 5,860,420	$ 6,599,485	112.6%
Anesthesiology & Critical Care	29,068,357	22,920,350	6,148,007	26.8%	26,499,332	2,569,025	9.7%
Cancer Medicine	6,746,547	3,905,665	2,840,882	72.7%	3,482,502	3,264,045	93.7%
Center for Global Oncology	44,949,311	29,127,383	15,821,928	54.3%	33,863,228	11,086,083	32.7%
Clinical Nutrition	(14,820,046)	(14,030,721)	(789,325)	-5.6%	(14,819,482)	(564)	0.0%
Diagnostic Imaging	373,731,276	334,875,464	38,855,812	11.6%	377,056,728	(3,325,452)	-0.9%
DoCP & PS - Clinical	(1,483,566)	(1,582,552)	98,986	6.3%	(1,645,226)	161,660	9.8%
Internal Medicine	4,928,472	4,254,184	674,288	15.8%	5,563,917	(635,445)	-11.4%
Materials Management Services	(11,788,523)	(11,047,548)	(740,975)	-6.7%	(12,206,151)	417,628	3.4%
Nursing Practice	27,728,021	10,377,484	17,350,537	167.2%	19,428,691	8,299,330	42.7%
Pathology/Lab Medicine	284,031,588	250,588,496	33,443,092	13.3%	276,579,201	7,452,387	2.69%
Pediatrics	(10,176,953)	(8,801,277)	(1,375,676)	-15.6%	(9,836,120)	(340,833)	-3.5%
Perioperative Enterprise	43,781,285	39,142,696	4,638,589	11.9%	45,997,550	(2,216,265)	-4.8%
Pharmacy	363,063,869	337,329,448	25,734,421	7.6%	329,732,514	33,331,355	10.1%
Radiation Oncology	76,003,954	65,299,015	10,704,939	16.4%	69,018,670	6,985,284	10.1%
Rehab Services	1,829,383	2,054,422	(225,039)	-11.0%	2,504,166	(674,783)	-26.9%
Surgery	(19,992,188)	(12,085,288)	(7,906,900)	-65.4%	(15,009,289)	(4,982,899)	-33.2%

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president of finance and accounting, offered a summary of the institution's performance in 2012.

The text of the Sept. 28 email follows:

New patient and consult visits were favorable to budget in most areas for the month of August, and inpatient metrics continued to perform well as compared to budget. [MD Anderson's fiscal year runs through the end of August.]

However, expenses were once again unfavorable to budget, driven primarily by purchased services. As a result, the operating income for the month of August was a negative $0.9 million (a loss). On a year to date basis, the operating income for FY 2012 was $64.8 million, well ahead of budget.

FY 2012 was a good financial year, and it's important to recognize and celebrate the institution's accomplishments. We continued to see healthy increases in our clinical activity and experienced a more favorable reimbursement environment than was expected. However, it is also important to note that much of the financial success of FY 2012 was a result of the activity generated in the first half of the year, while the results of the latter half of the year were not as robust.

The institution's ongoing financial success in FY 2013 will be dependent upon improving the key productivity metrics while controlling operating expense.

Revenue: Gross patient revenue for the month of August was $552.5 million and was favorable compared to budget by $35.2 million, or 6.8%.

Deductions to revenue were also favorable to budget for the month, resulting in net patient revenue of $261.9 million, which was favorable to budget by $17.5 million, or 7.1%.

On a year to date basis, gross patient revenue of $6.144 billion was favorable to budget by $151.6 million, or 2.5%. Net patient revenue of $2.959 billion was favorable to budget by $127.3 million, or 4.5%.

Total other operating revenue of $33.0 million for the month was unfavorable to budget by $6.3 million, or 15.9%. On a year to date basis, total other operating revenue was $441.9 million, which was unfavorable to budget by $24.5 million, or 5.3%. As noted earlier in the year, this unfavorable variance is due largely to a decline in the reimbursement associated with our blended indirect cost rate. While our indirect cost rate on federal grants is 58%, it is much lower from other sponsors, particularly for CPRIT awards. As the federal ARRA funding expires, we are seeing the revenue mix shift to sponsors with lower indirect cost rates.

Total operating revenue for the month of August was $294.9 million and was favorable to budget by $11.2 million, or 3.9%. On a year to date basis, total operating revenue of $3.401 billion was favorable to budget by $102.8 million, or 3.1%.

Expense: Personnel expense of $166.4 million was unfavorable to budget in August by $3.6 million, or 2.2%. On a year to date basis, personnel expense was $1.950 billion and was unfavorable to budget by $14.8 million, or 0.8%. The institution's net headcount decreased by 52 during the month, yielding a total headcount of 19,290.

Total operating expense for the month of August was $295.8 million and was unfavorable to budget by $17.8 million, or 6.4%. This variance was driven largely by an unfavorable variance in the purchased services line item. On a year to date basis, total operating expense of $3.336 billion was unfavorable to budget by $52.9 million, or 1.6%. All major operating expense categories were unfavorable to budget for the year, with the exception of other supplies, facilities and travel.

Total Operating Income: The total operating income for August was a negative $0.9 million (a loss) and was unfavorable compared to budget by $6.6 million.

Total operating income on a year to date basis was $64.8 million and was favorable compared to budget by $49.9 million.

Year to date, total operating revenue has grown 7.4% from prior year, and total operating expense has grown 9.2%.

Non-Operating Revenue: Non-operating revenue for the month of August was $63.7 million, which was favorable to budget by $26.9 million. On a year to date basis, non-operating revenue was $332.0 million, which was unfavorable to budget by $45.9 million.

Net Income: The net income for the month of August was $62.8 million, which was favorable to budget by $20.2 million. On a year to date basis, the net income was $396.8 million, which was favorable to budget by $4.1 million.

Morris's slides that accompany the memo are posted at http://www.cancerletter.com/categories/documents.

Beyond the 4 Percent Margin?

DePinho doesn't foresee improvement from clinical activities.

"We currently write off 48 cents of every dollar we bill in technical charges and 70 cents of every dollar we bill for professional fees," he said. These numbers can only deteriorate, and no payer is going to start increasing their reimbursement for patient care.

New revenue streams would be needed to fund the Moon Shots Program, DePinho said.

First, the institution will have to create a massive informatics program.

"Successful execution of the moon shots will require a big data analytics platform the likes of which have never been seen," DePinho said. "Early aspects of that platform include implementation of a clinical data warehouse and evaluation of novel approaches for storage and processing extraordinary amounts of genomic information."

"It's important to appreciate: one machine in the corner of a lab can now generate as much data in nine days as the entire sequencing capacity of the U.S. in all of the machines in the entire year 2007. You want to integrate that with the structured and unstructured clinical information as well as the world knowledge. That is the future."

New funds—billions of dollars—would have to come from expansion of the clinical network, philanthropy, cause marketing and commercialization of discoveries made by the faculty.

The institution is creating the MD Anderson Cancer Network, which will "engage community hospitals and healthcare systems with the goal of improving the quality of cancer care in those communities," he said. "These affiliations will be tailored to the needs of each network member, with services ranging from consulting support to specialized oncology programs and even to full clinical extensions."

DePinho's objective is to double the fundraising activities.

This will require finding new donors in Texas and worldwide. "It will also require a move to cause marketing.

"Cause marketing is when people support a cause, like ending cancer, while benefiting an organization like MD Anderson," DePinho said. "The possibilities are endless. Just think about the association of pink with breast cancer awareness and how that's grown since that seminal concept was envisioned by the Komen foundation in 1991.

"We want to capture that kind of idea and thinking in cause marketing."

Commercialization of intellectual property will involve forming partnerships with the pharmaceutical industry.

"We are improving business development to maximize return on our discoveries, designing platforms that create more mature assets, be it diagnostics or drugs," DePinho said. "Or make us more attractive to industry, through the development of co-clinical trial platform or a robust clinical genomic laboratory."

Collaboration with industry has been particularly controversial for DePinho. An $18 million project to create a biotechnology incubator led by his wife, Lynda Chin, has created a crisis at the Cancer Prevention and Research Institute of Texas. Chin is a scientist and senior administrator at MD Anderson (see story on page 1 and The Cancer Letter, Sept. 28).

Also, the UT System is reviewing DePinho's request for a waiver from conflict of interest regulations to enable him to preserve commercial ties with 12 entities (The Cancer Letter, Sept. 21).

"Our strong conflict of interest rules enable us to conduct these vital activities as we have proven in the past," DePinho said.

In the speech, DePinho attributed the controversy to misunderstanding, which education can correct.

"Lack of information in just a handful can fuel misunderstanding and limits our ability to ensure that the true facts are out there, to be evaluated objectively," he said.

MD Anderson plans to correct this by conducting courses on entrepreneurship, intellectual property, business development, creating new companies, ethics and managing conflicts of interest.

"We have to recognize that our community does not have as much experience in life sciences commercialization, and therefore there needs to be education," DePinho said.

"This includes trainees, faculty, administration, legislators, journalists, amongst others."

A recording of DePinho's speech, as well as MD Anderson's budget documents, are posted at: http://www.cancerletter.com/categories/documents.

CPRIT Reviewers Quit

All Eight Scientific Review Council Members To Resign

(Continued from page 1)

The scientists submitted blistering letters explaining their decisions to leave.

"This past spring, the peer review system of CPRIT was dishonored by actions of CPRIT's administration when a set of grants were delayed in funding because of suspicion of favoritism," writes Phillip Sharp, chair of the council. "Further, a proposal based on science similar to that previously reviewed by the CPRIT council was selected for funding using other criteria. These events ultimately led to the resignation of Dr. Gilman. The same events motivate my decision to resign now."

Both Gilman and Sharp are Nobel laureates.

The walkout—and, perhaps more so, the letters—send a powerful signal that CPRIT is now outside mainstream cancer science. The controversy—and the instance of "favoritism" alleged by Sharp—began when the state agency funded an $18 million project spearheaded by Lynda Chin, an MD Anderson scientist and the wife of that institution's president.

Documents obtained by The Cancer Letter show that the decision to fund the grants was the result of CPRIT's shift toward commercialization (The Cancer Letter, Sept. 28).

In his letter of resignation, William Kaelin, a member of the scientific review council, draws a connection between MD Anderson's Moon Shots Program and CPRIT's funding decisions.

"The recent posting on the CPRIT website (http://www.cprit.state.tx.us/news/cprit-applauds-md-anderson-moon-shots-initiative) lauding the MD Anderson 'moonshot' initiative also creates the impression that the future 'winners' have already been chosen and that there will be increased focus on perceived short-term deliverables," Kaelin writes.

"In this environment, I am not confident that scientific quality and rigor will triumph over grandiose promises and hucksterism."

Scientific review council members Charles Sherr and Tyler Jacks note that they continue to be troubled by the MD Anderson incubator.

"In my personal judgment, one of the most problematic events concerned the proposed funding of the Institute for Applied Cancer Science (IACS) at the MD Anderson Cancer Center," Sherr writes. "Their short proposal of less than seven pages was reviewed solely as a commercial 'incubator' project, but without rigorous scientific oversight by any of the more than 100 out-of-state experts already employed by CPRIT who could have offered informed opinions."

"These accusations, as well as the failure to mandate scientific review of so-called incubator grants during this period, served to undermine the careful work of my committee and the sanctity of the larger CPRIT scientific review process," writes Jacks. "Under the circumstances, I feel that I have no option than to resign my position."

Council member Sanjiv Gambhir praised Gilman for defending the peer review system: "I want to particularly thank Dr. Gilman for taking a firm stand against the CPRIT oversight committee for their actions that undermine the rigorous scientific review process that was championed by Dr. Gilman," writes Gambhir. "Politics and science at times must mix, but at other times such as this, they should clearly not."

The scientific review council members are being followed by the vast majority of rank-and-file reviewers, about 100 cancer researchers and clinicians, all from outside Texas. Sources say that the agency may have no scientific reviewers left.

MD Anderson officials withdrew the incubator grant, pledging to resubmit it for review later. Yet, scientists are leaving because they have no confidence in a post-Gilman CPRIT.

This walkout is an extraordinary act of solidarity on a scale never before observed in cancer science in the U.S. Even when former NCI director Andrew von Eschenbach was making patently absurd statements about eliminating suffering and death due to cancer by the year 2015, he encountered no open opposition from scientists.

CPRIT officials received their first warning six months ago (The Cancer Letter, May 25). Yet, they were unable—or unwilling—to avert the crisis.

Bill Gimson Explains

Last week, a group of outside advisors to CPRIT, called the Future Directions Group, urged the state agency to bring in a trusted third party to prevent further erosion of trust from scientists and the public.

Also last week, CPRIT Executive Director Bill Gimson recently faced a contentious hearing of a state legislative committee.

Rep. Dan Branch, chairman of the Texas House Higher Education Committee, appeared to be well informed about problems at CPRIT. The Houston Chronicle covered the hearing.

Though Texans approved a $3 billion expenditure

on CPRIT, the legislature has to sign off on the annual increments of $300 million to fund the institute.

Gimson didn't respond to questions from The Cancer Letter.

Instead, CPRIT issued a statement:

With the departure of Dr. Gilman, CPRIT is entering a new era. It is no surprise that some of the current reviewers have chosen to leave at this time. We have identified several exceptional candidates to succeed Dr. Gilman as Chief Scientific Officer, and this individual's first order of business will be to recruit outstanding cancer experts to serve as peer reviewers under his or her leadership. We have every confidence that CPRIT will have a full cadre of expert peer reviewers in place for the next scientific review cycle.

CPRIT stands by the integrity of our peer review process. Dr. Gilman was instrumental in establishing what is now considered the "gold standard" in the industry, and that process will remain intact. The process has in fact been improved over the last few years, as we have proactively seized opportunities to strengthen it.

Any assertions that the peer review process has been compromised or that CPRIT's staff or Oversight Committee members are trying to influence the peer reviewers are false and misinformed. Since CPRIT's inception, every single grant that has been recommended to the Oversight Committee by the reviewers has been approved.

It has been reported that CPRIT asks peer reviewers to reconsider their scores. When there are divergent scores among peer reviewers, in fairness to the applicants, the process allows for further review or discussion of the variances during panel discussions.

Unlike the prevention and research review process, the commercialization review process includes in-person presentations by the applicants, which the scientific reviewers do not attend. If new information comes up from the in-person question and answer period, it is shared with all reviewers – including those who were not in the presentation so all reviewers have the same information.

The final decision on whether to revise scores rests with the individual reviewer.

We are proud of our many accomplishments to date and many more to come. Through our Future Directions initiative, we have received a great deal of input from diverse stakeholders across the state.

This process is ongoing and no decisions have been made; this valuable feedback will inform the Oversight Committee's direction for CPRIT over the next seven years. Above all, we hold fast to our mission of reducing the burden of cancer in Texas.

Texans' lives are at stake, and in honor of those affected by this heinous disease, we won't back down.

Barrage of Blistering Letters

The members of the Scientific Review Council that submitted letters of resignation are:

• **Phillip Sharp**, a Nobel laureate and an institute professor at the Massachusetts Institute of Technology David H. Koch Institute for Integrative Cancer Research.

• **Tyler Jacks**, the David H. Koch Professor in the department of biology and director of MIT's Koch Institute for Integrative Cancer Research.

• **William Kaelin**, professor of medicine in the department of medical oncology at Harvard University and the Dana-Farber Cancer Institute.

• **Charles Sherr**, chair of tumor cell biology, co-director of the Molecular Oncology Program, and Herrick Foundation Chair at St. Jude Children's Research Hospital.

• **Sanjiv Sam Gambhir,** the Virginia and D.K. Ludwig Professor in the department of radiology and bioengineering, chair of the department of radiology, director of the Molecular Imaging Program, and director of the Canary Center for Cancer Early Detection at Stanford University.

• **Everett Vokes**, the John E. Ultmann Professor of Medicine and Radiation Oncology, and chair of the department of medicine at the University of Chicago Medical Center, informed other council members that he would be submitting a letter of resignation next week.

• **Clara Bloomfield**, the William G. Pace III Professor of Cancer Research at Ohio State University, submitted her resignation earlier.

• **Richard Kolodner**, professor of medicine and member of the Ludwig Institute for Cancer Research at the University of California, San Diego, could not be reached, but knowledgeable sources said he is expected to resign.

The letters of resignation follow:

Phillip Sharp

I write to submit my resignation as Chairman of the Council of CPRIT effective Oct. 12, which coincides with the effective date of the resignation of Dr. Al Gilman.

I agreed to chair the Council to advance cancer research and cancer care in Texas after the State's wonderful decision to commit $3 billion to this purpose.

A strong and objective peer review process is essential to achieve this end and the Council members

and panelists assembled by Dr. Gilman were the best in the country. They all shared the same objectives for CPRIT and executed their duties in an exemplary fashion and free of conflicts of interests.

It has been an honor to chair this group and work with Dr. Gilman.

However, this past Spring the peer review system of CPRIT was dishonored by actions of CPRIT's administration when a set of grants were delayed in funding because of suspicion of favoritism.

Further, a proposal based on science similar to that previously reviewed by the CPRIT council was selected for funding using other criteria. These events ultimately led to the resignation of Dr. Gilman. The same events motivate my decision to resign now.

The promise of CPRIT requires an unswerving commitment to peer review. I would be willing to help future CPRIT leaders if convinced that this commitment is central to selection of cancer research to be supported.

I believe that certain changes in CPRIT leadership would be essential to demonstrate such commitment. The past four years have greatly advanced cancer research in Texas and hopefully this record will continue.

Tyler Jacks

I am writing to inform you that I am resigning my position as the Chair of the BCRC-1A Review Panel of the Cancer Prevention and Research Institute of Texas (CPRIT) effective immediately.

I am grateful for the opportunity to have worked with Al Gilman, Phil Sharp, and my fellow panel chairs in helping to establish a system that set the highest standard for rigorous scientific review and deliberation.

Sadly, this system was tainted by baseless accusations by members of the CPRIT Oversight Committee that our review of a series of multi-investigator grants in the spring was influenced by regional or institutional bias and the consequent failure to advance these grants for funding consideration in that cycle.

These accusations, as well as the failure to mandate scientific review of so-called incubator grants during this period, served to undermine the careful work of my committee and the sanctity of the larger CPRIT scientific review process. Under the circumstances, I feel that I have no option than to resign my position.

Over the past three years, I have been privileged to lead a group of outstanding scientists on my panel. They have work diligently to evaluate the merits of hundreds of grant applications from Texas investigators.

Through their efforts, we approved the funding of many outstanding grants, which collectively hold the promise of important breakthroughs in our understanding of cancer development and new opportunities for treatment and prevention.

I believe that the CPRIT program—and current and future cancer patients— benefited significantly by the efforts of this group. To date, three of my panelists have indicated that they are stepping down. I will communicate my decision to the entire panel shortly.

They will decide for themselves as to whether to continue on, assuming they are welcome to do so.

The citizens of Texas deserve tremendous credit for choosing to fund the CPRIT program and doing their part to support the discoveries that will lead to improvements in cancer care and prevention in the future.

In turn, they should expect administrative and review systems that ensure that their tax dollars are used appropriately, without bias, political influence or conflict of interest.

I believe that the actions of the Oversight Committee over the past several months corrupted this process. For the sake of the program and for all of those cancer patients who stand to benefit from the proper use of these funds, I hope that CPRIT manages to regain what it has lost.

William Kaelin

As I indicated in my letter of May 14, I was willing to devote my time to CPRIT, despite having a wife who was recently diagnosed with a brain tumor, because I believed CPRIT could transform biomedical research in Texas and ultimately improve the diagnosis and treatment of cancer patients.

CPRIT was a brilliant idea and both the Texas legislature and the people of Texas are to be commended for it. In that same letter, however, I expressed my concerns regarding the events that eventually led to Al Gilman's resignation.

These events included the circumvention of the peer review process by the MD Anderson/Rice "commercialization" proposal and the suggestion that Dr. Gilman (and by extension, myself and the members of my study section) was giving preferential treatment to grants submitted by UTSW investigators.

I also indicated that the eyes of the scientific community were now on Texas to see which course CPRIT would take moving forward (as borne out by subsequent pieces in Nature, Science, and The Cancer Letter).

Neither you nor any member of your staff

responded to my letter to address my concerns. Moreover, it has become increasingly clear that the potential for "commercialization" is going to take on greater importance moving forward.

For example, I recently learned that at least two scientific reviewers who had given non-fundable scores to a commercialization project were asked by CPRIT to "reconsider" their scores so that they would be in harmony with those given by the commercial reviewers, who were far more favorable (both of the scientific reviewers are very sophisticated with respect to the needs of industry and correctly responded that trying to commercialize flawed science is a prescription for failure and waste).

The recent posting on the CPRIT website lauding the MD Anderson "moonshot" initiative also creates the impression that the future "winners" have already been chosen and that there will be increased focus on perceived short-term deliverables.

In this environment, I am not confident that scientific quality and rigor will triumph over grandiose promises and hucksterism.

For these reasons I have chosen to resign from CPRIT effective Oct. 12, 2012. I would be happy to discuss serving in the future but only if you succeed in replacing Dr. Al Gilman with a person who, like Dr. Gilman himself, embodies scientific excellence and personal integrity and I can be convinced, through structural changes at CPRIT, that my concerns have been adequately addressed.

Charles Sherr

The purpose of this letter is to tender my resignation as the Chair of the CPRIT Basic Science Cancer Research Committee-3 (BCRC-3) and as a member of the CPRIT review Council chaired by Dr. Sharp, effective immediately.

In a separate email addressed directly to you on May 3, to which you did not directly respond, I communicated my personal displeasure regarding events that would soon lead to Al Gilman's resignation.

Briefly stated, my previous letter concerned the manner by which Dr. Gilman had been inappropriately pressured to step down as CPRIT's Chief Scientific Officer and my dissatisfaction with the then emerging notion that a political agenda would subvert decisions about supporting only the very best medical science deemed most likely to accelerate prevention and effective treatment of cancer.

These matters were soon echoed in a separate joint letter from the CPRIT Council addressed to members of the Oversight Committee and widely quoted in the press.

Despite my unease, I thought it prudent to remain with CPRIT through the round of review just completed in September 2012, thereby allowing those investigators in Texas who had formulated new proposals in the last months to receive careful consideration of their scientific initiatives by the BCRC-3 group.

Having now completed these efforts, I feel free to step down. I had already alerted you to the fact that many other members of BCRC-3 were equally offended by the events of recent months, and I suspect that you may be hearing from others in this regard.

There have been a series of widely publicized incidents that have been visibly documented, in particular by reporters at the Houston Chronicle and in issues of The Cancer Letter broadly circulated to cancer centers throughout the country. In my personal judgment, one of the most problematic events concerned the proposed funding of the Institute for Applied Cancer Science (IACS) at the MD Anderson Cancer Center.

Their short proposal of less than seven pages was reviewed solely as a commercial "incubator" project, but without rigorous scientific oversight by any of the more than 100 out-of-state experts already employed by CPRIT who could have offered informed opinions.

The IACS proposal was approved within several weeks of its receipt, overriding Dr. Gilman's strong objections and even disregarding caveats offered by some of the persons who were asked to participate in its "commercial" review. The level of funding of the IACS greatly exceeded that of proposals that had been previously adjudicated by our Council and review groups, underscoring preferential treatment given to this one application.

As reported publicly, the IACS proposal's budget was not reviewed by the MDACC provost, Dr. DuBois, who recently resigned his post at MDACC. Despite your proclaimed enthusiasm and that of other CPRIT Overseers, but given widespread press coverage and criticism, the IACS proposal has been withdrawn pending re-review.

New guidelines for Requests for Applications (RFAs) for "incubators" which were to be drawn up have yet to appear, and I wonder whether some persons believe that forward movement in funding the IACS would be facilitated by Dr. Gilman's departure and the possible elimination of other naysayers, myself included.

When you [CPRIT executive director Gimson] phoned me last week, I reiterated that it has been an honor and a privilege to serve CPRIT under Dr. Gilman's aegis, to participate in the deliberations of the CPRIT Council in recruiting top quality investigators to institutions in Texas (including Drs. Chin, Allison, and others to the MDACC), and above all, in leading a committee of highly distinguished scientists from outside the state who have worked diligently and with keen collective insight in adjudicating applications referred to our review panel. Indeed, the opportunity to work with esteemed colleagues on the Council and the BCRC-3 Committee has been the best such panel review experience of my scientific career, bar none.

Our singular collective concern was that we would attempt to fund the very best transformative cancer science, whether clinical, translational, or basic. Investigators at different institutions throughout Texas were given a fair and balanced hearing by a coterie of national referees – our deliberations paid no attention to geography or political pressures within Texas, and we had no hidden agendas or conflicts of interest.

I fully accept that it is the purview of the Overseers and, ultimately, the citizens of Texas to decide how their funds should be best spent. Under current circumstances, however, I cannot lend my approbation to the changing of the guard.

Sanjiv Sam Gambhir

I am writing to inform you that I am resigning my position as the Chair of the Interfaces Review Committee (IRC) Review Panel of the Cancer Prevention and Research Institute of Texas (CPRIT) effective immediately. I will be available to help in the upcoming transition in any way that I can so that cancer researchers in the state of Texas as well as patients who have already been diagnosed and those yet to be diagnosed are not harmed due to my resignation.

It has been great to help in a small way by reviewing grants and to help the state of Texas attract the best minds from all over the country to the great Universities and medical centers throughout the state. I am highly thankful to my review committee of outstanding scientists and physician-scientists from all over the country who have carefully reviewed many grants over the last three years. Their hard work and dedication is matched only by that of the Texas cancer researchers. I only wish even more highly meritorious grants could have been funded. It is a highly challenging time for biomedical researchers everywhere, and I am so happy the Texas taxpayers have helped to support excellent biomedical research for such a deadly disease. The citizens of Texas are to be commended for their investments that will benefit cancer patients worldwide.

I am also very thankful for the opportunity to have learned from Drs. Al Gilman, Phil Sharp, and my fellow panel chairs. They have always worked with the highest principles to make decisions that are unbiased and at times quite difficult. I want to particularly thank Dr. Gilman for taking a firm stand against the CPRIT oversight committee for their actions that undermine the rigorous scientific review process that was championed by Dr. Gilman. Politics and science at times must mix, but at other times such as this, they should clearly not.

Correction: An earlier version of this story stated incorrectly that Clara Bloomfield resigned from CPRIT because of her plans to retire.

In Brief

George Sledge Jr. Appointed Chief of Oncology at Stanford

(Continued from page 1)

He will replace current chief Ron Levy. Linda Boxer, senior vice chair of medicine and chief of the Division of Hematology, will serve as the interim chief of oncology until Sledge's arrival.

Sledge plans to recruit new researchers to Stanford, and to integrate knowledge about breast cancer genomics with new technologies and treatments for patients.

NINA WENDLING was named executive director of **The National Coalition for Cancer Survivorship.**

Wendling has been with the organization for more than six years, previously serving as senior director of operations and development.

Under Wendling's leadership, the organization's policy efforts will focus on:

Advocating in Congress and federal agencies for reform of Medicare and other health care systems; representing cancer survivors in the implementation of the Affordable Care Act to guarantee that insurance

coverage meets the lifelong needs of cancer survivors; convening survivors, physicians, researchers and others to investigate solutions to problems related to cancer drug development; and articulating the concerns and interests of cancer survivors in policy efforts.

Prior to NCCS, Wendling was senior associate for Education Access Strategies Inc., where she assisted nationally-recognized nonprofits and independent educational institutions in strategic planning. She has also worked as development director and special assistant to the president for the National Park Trust.

THE UNIVERSITY OF NEW MEXICO CANCER CENTER is welcoming four new members: **David Lee**, **David Chafey**, as well as **Sarah Foster Adams** and husband **Andrew Cowen**.

Lee, assistant professor of radiation oncology, comes from William Beaumont Hospital. He trained at the University of Southern California Keck School of Medicine. Lee will conduct research in DNA repair and epigenetics.

David Chafey, assistant professor of orthopedic surgery, completed his training at the University of Texas MD Anderson Cancer Center and Baylor College of Medicine. He has two orthopaedic sub-specialties, trauma and reconstruction and musculoskeletal oncology.

Adams, assistant professor of obstetrics and gynecology, and Cowan, assistant professor of surgery, both studied at Harvard University, University of Chicago and University of Pennsylvania. Adams will perform gynecologic robotic surgery. Her research focuses on how the immune system affects the ability of ovarian cancer to metastasize in the peritoneal cavity.

Cowan is an otolaryngologist who specializes in head and neck cancer. He will perform trans-oral robotic surgery at the cancer center. Cowan also studies the role of human papillomavirus in cancers of the throat.

THE UNIVERSITY OF PITTSBURGH MEDICAL CENTER is making a five-year, $100 million investment in personalized medicine with technology partners **Oracle, IBM, Informatica** and **dbMotion**, to create a data warehouse that brings together clinical, financial, administrative and genomic information.

Advanced analytic and predictive modeling applications for clinical and financial decision-making are expected to produce better patient outcomes, and enhance research capabilities.

Over the next two years, UPMC will install the hardware and software needed to create a data warehouse that will bring together data from more than 200 sources across UPMC, UPMC Health Plan and outside entities, including labs and pharmacies. The amount of data at UPMC today totals over 3.2 petabytes. A petabyte is equal to one million gigabytes.

MARGARET FOTI, will receive the Founders Award for Excellence in Cancer Research from the **National Brain Tumor Society**. Foti is CEO of the American Association for Cancer Research.

The society is honoring Foti at its 2012 Summit, "Transforming tomorrow, today," in Boston. This event includes a scientific symposium and annual meeting to share research updates and recognize key individuals and organizations for their contributions to the field.

In June, Foti was recognized as a First Lady of the Intercultural Cancer Council and received the 2012 Biotech Humanitarian Award from the Biotechnology Industry Organization. Earlier this year, she was awarded Research!America's 2012 Raymond and Beverly Sackler Award for Sustained National Leadership.

Obituaries

Barton Aron Kamen, Pediatric Oncologist, Dies at Age 63

Barton Aron Kamen, pediatric oncologist and cancer pharmacologist, died Thursday, Sept. 27. He was 63.

His academic career consisted of three years at the Medical College of Wisconsin; 15 years at the University of Texas Southwestern Medical Center as professor of pediatrics and pharmacology and distinguished professor of pediatrics; followed by eight years as director of pediatric hematology-oncology and associate director of The Cancer Institute of New Jersey/Robert Wood Johnson Medical School.

From 2007 to 2009, Kamen served as chief medical officer of the Leukemia Lymphoma Society. He was a consultant to NIH and also bio-pharmaceutical and cancer therapeutic companies, including Morphotek and Metronomx Group.

Kamen was born in Brooklyn and grew up in Rockville Centre, N.Y. He received his M.D., Ph.D. from Case Western Reserve University and served his

internship, residency and fellowship in pediatrics and pediatric hematology-oncology and pharmacology at Yale University.

Kamen was the recipient of the Scholar Award from the Leukemia Lymphoma Society; The Damon Runyon Walter Winchell Fellowship; and the Burroughs Wellcome Clinical Pharmacology Award and was one of the few pediatric oncologists to be named to an American Cancer Society clinical research professorship. In addition, he was elected into the American Society of Clinical Investigation.

Kamen authored over 300 manuscripts and was the editor-in-chief of the Journal of Pediatric Hematology Oncology. He also served on numerous editorial and advisory boards of other cancer journals.

Barton served on the research and medical affairs committee of the American Cancer Society, as a commissioner of the New Jersey Commission for Cancer Research, and was on the board and treasurer of the National Coalition for Cancer Research. He was also a medical adviser for the Hole In The Wall Gang Camp, a consulting medical officer for the physical sciences oncology centers program of NCI and medical adviser for the Angiogenesis Foundation.

His major laboratory interests centered around folate biochemistry and anti-folate pharmacology. He was currently developing treatment to prevent both resistance and toxicity, especially neurotoxicity from therapy.

Kamen would earn his young patients' trust with magic tricks. He said a magician is someone who is able to produce startling and amazing effects. He is survived by his wife of 36 years, Ruth Saletsky Kamen and his daughter, Libby.

Robert Millikan, UNC Cancer Epidemiologist, Dies at 55

Robert Millikan, an epidemiologist, died Sunday, Oct. 7. He was 55.

Millikan was the Barbara Sorenson Hulka Distinguished Professor of Cancer Epidemiology at the UNC Gillings School of Global Public Health. He had been a faculty member of the school and the UNC Lineberger Comprehensive Cancer Center since 1993.

"Dr. Millikan had a major impact on the field of cancer and molecular epidemiology," said Andy Olshan, professor and chair of the epidemiology department and UNC Lineberger's associate director of population sciences.

"Dr. Millikan and his colleagues conducted three waves of this country's groundbreaking longitudinal study of breast cancer in African-American and Caucasian women," said Shelley Earp, director of UNC Lineberger. "Through the Carolina Breast Cancer Study, he sought to understand the complex reasons for poor breast cancer outcomes in African- American women."

In 2011, Millikan was awarded a $19.3 million grant from NCI for an ambitious study of breast cancer in young African-American women. He was also a lead investigator on the UNC Specialized Program of Research Excellence in Breast Cancer, which was just renewed by NCI for $10 million dollars over the next five years.

Data from the Carolina Breast Cancer Study, which Millikan directed for more than fifteen years, demonstrated that black women under the age of 45 are more likely to be diagnosed with aggressive types of breast cancer than are women of European ancestry. The phase III program, which he led, will collect information about more than 5,000 women to explore biological, environmental and epidemiologic reasons for the difference in cancer incidence.

Millikan's SPORE research combined traditional epidemiological measures of disease predisposition with molecular markers aimed at characterizing genetic susceptibility to cancers. He was also part of an international collaboration, called the Genes, Environment and Melanoma Study, to examine causes of malignant melanoma. He served for more than 15 years as a faculty member for the National Breast Cancer Coalition's Project LEAD, teaching breast cancer advocates about the science of breast cancer epidemiology and genomics.

Millikan earned undergraduate and doctoral degrees in veterinary medicine from University of California at Davis and a Master of Public Health and a PhD in epidemiology from University of California at Los Angeles. He was a postdoctoral fellow in molecular biology at Harvard Medical School and Dana-Farber Cancer Institute and completed internship in medicine and surgery at the University of Pennsylvania's School of Veterinary Medicine.

Millikan was director of the integrative health sciences facility core at the UNC Center for Environmental Health and Susceptibility. He held an adjunct professorship in the College of Veterinary medicine at North Carolina State University.