THE CANCER LETTER

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News Analysis

Zaltrap Economics 101: The Pricing And Repricing of an Expensive Drug

By Rena Conti

Last week, pharmaceutical companies Sanofi and Regeneron Pharmaceuticals Inc., the manufacturers of the colorectal cancer drug Zaltrap (ziv-aflibercept), said they would cut the drug's "list price" by 50 percent, in effect extending discounts to purchasers.

Soon after Zaltrap's August launch into the U.S. market, its price triggered an unprecedented act of defiance on the part of U.S. oncologists: doctors from Memorial Sloan-Kettering Cancer Center wrote in a New York Times editorial that they wouldn't prescribe the drug because it costs twice as much as Genentech's Avastin (bevacizumab), a competing drug with similar expected outcomes (The Cancer Letter, Nov. 2, Nov. 8).

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Capitol Hill

Recalcitrant Cancer Bill Heading To Senate May Face Hold in the Lame Duck Session

By Paul Goldberg

The controversial legislation that aims to step up the NCI efforts in "recalcitrant" cancers is running into opposition in the Senate.

The measure, which has gone through two iterations and has been passed by the House, now targets pancreatic and lung cancers. In the Senate, it is likely to face a hold from Sen. Tom Coburn (R-Okla.), sources said.

The original version of the bill—which was an authorization measure—limited the NCI authority in charting the course on research in pancreatic cancer (The Cancer Letter, Aug. 3, Aug. 10, and Sept. 14)

"It would basically have taken away from the NCI the responsibility of deciding what grants that address pancreatic cancer would be funded," NCI Director Harold Varmus said to the NCI Board of Scientific Advisors Nov. 5

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In Brief

Pres. Bill Clinton to Serve as Honorary Chair Of NBCC's Breast Cancer Deadline 2020

PRESIDENT BILL CLINTON will serve as honorary chair of the **National Breast Cancer Coalition's Breast Cancer Deadline 2020**—the coalition's strategic plan to end breast cancer by January 1, 2020.

"It's time to give breast cancer a deadline," said Clinton. "That's why I applaud the National Breast Cancer Coalition's ambitious campaign to end

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The Cancer Letter will take a short break from publication until Nov. 30.

Sanofi's Rebate Will Not Affect Patients' Co-Pay For Zaltrap

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The manufacturers' dramatic response raises fundamental questions about price-setting for cancer drugs in the U.S. market, inviting scrutiny of the plethora of "prices" that determine—or, more precisely obscure—how much these drugs cost.

To understand what happened with Zaltrap, we have to first consider how Zaltrap's manufacturers and other pharmaceutical companies set the above-mentioned list prices. We have to look deeper, tracing how the newly discounted price of Zaltrap will reverberate through the system, and how it will affect purchasers, insurers, doctors—and patients.

Which of these players stand to benefit from the discount?

To illustrate the panorama of answers, I will trace the purchase of Zaltrap through the U.S. "buy and bill" system for parenteral cancer drugs. Branded pharmaceutical manufacturers set the list price of a novel drug to reflect:

• The sunk costs of research and development, the variable costs of production and meeting regulatory manufacturing requirements, and

• The likely willingness to pay by potential consumers.

The manufacturer's profits reflect the sales of these drugs (quantity multiplied by price), minus all the costs of production, research and development.

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In a competitive market, the profits enjoyed by a manufacturer of novel drugs would quickly erode to cover only the incremental costs of production.

This will happen because other manufacturers would enter the market to produce the drug and undercut the pioneering manufacturer's price in order to gain market share.

However, the U.S. market for branded pharmaceutical drugs has been protected from such downward pressures. Branded manufacturers own temporary rights—conferred by patent protection—to be the sole supplier during the drug's period of exclusivity, usually seven to 12 years.

Manufacturers are able to set their initial list price to reflect the highest willingness to pay. In the case of Zaltrap, interviews with Sanofi officials revealed that they had set the price to match a dose of Avastin that they thought was routinely used to treat colorectal cancer. They set the list price at $11,000.

They were wrong. Only half of that dose was used and Zaltrap's initial list price overshot the Avastin price by a factor of two.

Recognizing the error, the manufacturers offered discounts on Zaltrap's price to purchasers. The original list price remains the same.

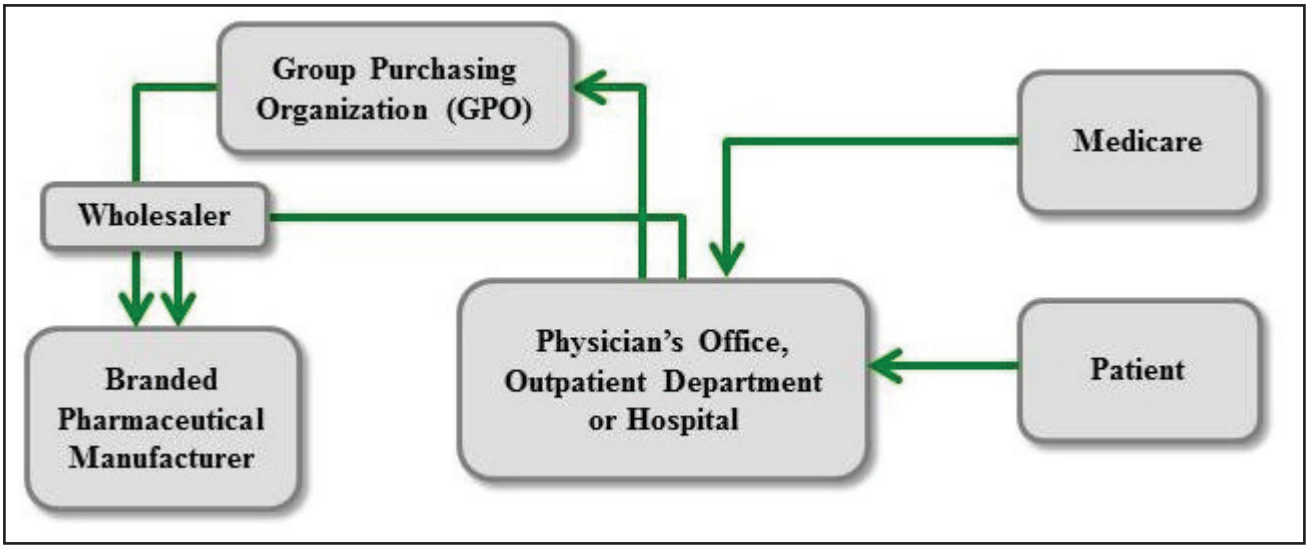
In the past, patients, physicians and insurers have been willing to pay a lot for parenteral cancer drugs, regardless of their expected efficacy. This is because a patient's survival upon diagnosis is often low, and there are few alternative treatment options.

In addition, patients are largely shielded from trading off a drug's benefits relative to its acquisition price because of the presence of insurance. In the case of Zaltrap, a fully insured patient is spared having to weigh a 1.4 month survival gain versus $11,000 versus the efficacy and costs of competing treatments.

Negotiated discounts off list price by the direct purchasers are common practice in the two largest markets for these drugs: the U.S. and the E.U. So much so that manufacturers are obligated to anticipate discounts when they set the list price.

The U.S. has a complicated system for purchasing parenteral cancer drugs, commonly called "buy and bill."

In the E.U., many governments (including France, Italy, and Germany) negotiate prices directly with the manufacturer on behalf of their citizens—and obtain deep discounts off the list price in exchange for offering the drug on the national formulary.



The flow of money through the "buy and bill" system of purchasing branded pharmaceuticals.

The Price We Pay

The U.S. government does not negotiate prices with branded drug manufacturers directly on behalf of citizens.

Rather, oncologists and hospitals purchase drugs like Zaltrap from manufacturers or wholesalers with direct relationships to manufacturers, and are reimbursed by Medicare or private insurers when these drugs are administered to patients.

I can enumerate at least four "prices," which will figure in the U.S. market for Zaltrap:

• The manufacturer-determined list price for Zaltrap.

• The wholesale price for Zaltrap, which oncologists and hospitals pay to manufacturers or wholesalers.

• The "reimbursement price," which insurers pay to oncologists and hospitals for administration of Zaltrap to patients, and

• The coinsurance or copayment prices, which patients pay to insurers for treatment with Zaltrap.

The majority of physicians and hospitals get discounted prices for these drugs.

Physician groups, such as US Oncology, and hospitals can negotiate directly with manufacturers or wholesalers for discounts off the list price.

Purchasers' ability to obtain discounts from the manufacturer or wholesaler is directly related to their purchase volume.

Group purchasing organizations consolidate demand for many different drug products over many physicians and hospitals.

GPOs are able to negotiate higher rebates and discounts off list prices on behalf of their members. Some, but not all, of these price concessions are passed through to providers.

Since 1990, some federally-qualified health centers, children's hospitals, and specialized public health clinics have qualified for discounts off the purchase of parenteral cancer drugs to be used in the outpatient setting through the 340B program.

Under the Patient Protection and Affordable Care Act, the 340B price for branded drugs like Zaltrap must be at least 23.1 percent discounted off of the Average Manufacturer Price. The AMP is simply a quantity-weighted average of a firm's wholesale prices for a given drug across all purchasers.

In practice, 340B discounts amount to 30-50 percent off of average wholesale prices for branded drugs.

In 2010, under the Affordable Care Act and related legislation, the 340B program was significantly expanded to include critical access hospitals, free standing cancer hospitals, and some community hospitals.

Since 2005, the number of providers that purchase drugs through the 340B program has quadrupled. A third of all hospitals in the U.S. now qualify for 340B discounts.

Finally, if patients are insured by Medicaid, manufacturers are required to provide "best price" rebates for the purchase of these drugs to treating physicians and hospitals.

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Medicare Reimbursement

Medicare is the largest insurer of cancer-related treatment in the U.S., including colorectal cancer, Zaltrap's primary indication.

If a patient is insured under Medicare, the use of Zaltrap is reimbursed to physicians or hospitals under the Medicare Part B benefit covering outpatient services. Private insurers commonly follow Medicare's reimbursement policy for these drugs.

In the first six months after launching a new branded drug, the manufacturer's list price determines the reimbursement physicians and hospitals receive for prescribing it.

After six months, reimbursement for Part B drugs is set to 106 percent of the Average Sales Price (referred to as "ASP+6"). ASP represents the price all purchasers pay for a given drug including discounts and rebates.

Revenues of outpatient oncology practices and hospitals have been traditionally tied to the difference between insurer reimbursement for parenteral cancer drugs and their wholesale acquisition price, sometimes called "cost recovery."

Medicare's coinsurance rate for parenteral cancer drugs is commonly set at 20 percent of Medicare reimbursement price; list price for the six months following launch and ASP+6 thereafter.

For patients covered by Medicare and without supplemental insurance, the coinsurance amount for Zaltrap is approximately $2,200 a month (20 percent of $11,000).

Patients currently on Zaltrap and patients who will be treated with the drug for the next four months shouldn't expect to have their out-of-pocket spending on Zaltrap decline. There will be no rebate check—from Sanofi, Medicare, or anyone else.

In the near future—over the four months that remain before ASP-based reimbursement kicks in—some outpatient oncology practices and hospitals may have an opportunity to make additional revenue off the use of Zaltrap for Medicare patients, because of the lag in ASP setting. Zaltrap's 50 percent discount off list price will increase the spread between these practices' actual acquisition cost and Medicare reimbursement.

The insurers' reimbursement to physicians and hospitals should decline as ASP takes over from the list price as the basis for reimbursement. Again, insurers who previously reimbursed physicians and hospitals for Zaltrap's use shouldn't expect a rebate. The discounts off list price offered by Zaltrap's manufacturers will not impact physicians and hospitals who have already purchased Zaltrap.

Discounts off Zaltrap's list price in the future may not be an equally good deal for all purchasers.

The deal will help out physicians and hospitals who, for whatever reason, were unable to obtain deep discounts off list price.

It remains to be seen whether physicians and hospitals will decide to purchase Zaltrap to treat their patients' colorectal cancer and whether insurers will agree to reimburse for its use.

One thing is clear: the kerfuffle over the pricing of Zaltrap suggests that the threat of exclusion from hospitals' and insurers' formularies is a potent tool for challenging the price of a cancer drug.

Will doctors continue to exert their newly-found leverage?

Will manufacturers listen?

The author is an assistant professor of health policy and economics at the University of Chicago.

Capitol Hill

Coburn's Letter on Recalcitrant Cancers Opposes Earmarking

(Continued from page 1)

The version of the bill passed by the House has been largely stripped of the features Varmus and other scientists found objectionable. Varmus described the new version as "something I can live with, but it's not a bill that I'm particularly happy about, because it tells us to do what we can be told to do in a much simpler way through report language in the appropriations bill."

"If we are told by members of Congress in the appropriations bill that we should do a report on some topic—a certain cancer, a certain problem in oncology—we do it," Varmus said. "We are very responsive to our appropriators, for very good reason—actually multiple reasons."

Varmus said he doesn't like the definitions of "recalcitrant."

"In my view, the bill can be tolerated, but it's not a particularly useful bill," he said. "Members of Congress should be paying attention to more important legislation. As it is currently written, we'd be required to do studies of pancreatic cancer and something that's called 'lung cancer,' but my own view is that we need to pay more attention to categories of cancer that conform to the cell of origin and the nature of the genotype. Lung cancer is certainly not one disease, just as pancreatic cancer is not one disease.

"When we talk about pancreatic cancer, we really don't mean the islet cell carcinomas, we are talking

about ductal adenocarcinoma of the pancreas which accounts for over 95 percent of pancreatic cancer. In lung cancer, we have four major types, and lumping them together for simplification is, in my mind, not particularly useful.

"Nor is the term non-small cell lung cancer a useful term anymore. And I urge all of you in this field to refer to squamous cell carcinoma of the lung, adenocarcinoma, and large cell carcinoma, because that's a much better depiction of a category of cancer.

"Eventually, of course, we are going to be thinking of sub-labels of immense significance."

Recently, NCI conducted a 'horizon-scanning' workshop on pancreatic cancer. The workshop was chaired by James Abbruzzese, chair of the Department of Gastrointestinal Medical Oncology and Digestive Diseases at MD Anderson Cancer Center. At the BSA meeting, Varmus said the workshop pointed to "some new possibilities for assessing risks and developing better studies of pathophysiology and perhaps developing new therapeutic opportunities."

Abbruzzese is scheduled to discuss the workshop at the upcoming meetings of the National Cancer Advisory Board and the NCI Clinical Trials and Translational Research Advisory Committee.

The recalcitrant cancers bill, HR 733, was passed by the House by voice vote, and its Senate version, S. 3566, has been referred to the Senate Committee on Health, Education, Labor, and Pensions.

Coburn's letter to the NIH director Francis Collins basically invites him to spell out why he would oppose the bill.

The text of the Coburn's letter follows:

I appreciate your excellent work as director of the National Institutes of Health (NIH). We are at the forefront of exciting discoveries in biomedical research, and you have led our nation's efforts well. Patients around the world benefit from your hard work and dedication.

I seek your input on the recalcitrant cancers bills—originally specific to pancreatic cancer—that have been making their way through both houses of Congress. Newer versions of the bill call for the creation of "scientific frameworks" and working groups to identify the directions that research should take. Even with these changes, I believe these bills are still unnecessary to your work and lead us in a harmful direction to micromanage NIH. Scientists I have heard from are skeptical of these bills.

While my colleagues and advocacy groups have laudable desires to spur on research of these cancers that are difficult to fight, I believe these types of bills may hinder the goals of fighting recalcitrant and other cancers. NIH should certainly have research plans and strategic initiatives to address many specific diseases, such as Alzheimer's disease. Those plans, however, should arise, in most cases, when your agency determines they are necessary.

Every time Congress passes legislation directing NIH in these endeavors, we further restrict the agency's freedom to respond to groundbreaking discoveries and to allocate resources as the science requires. What is more, medical research today is often not distinguishable by disease or cancer, but rather it is highly interdisciplinary. Congressional mandates typically maintain an unhelpful framework of approaching research on a disease-by-disease basis. Yet, patients will benefit most when NIH officials and the research community are free to make plans in response to emerging science, not to comply with Congress.

In your view,

1. Does NIH already have the ability to create strategic plans and working groups without a legislative mandate to do so? When does the agency utilize them? Please provide an example.

2. Is legislation that directs NIH to address a specific disease, or a group of diseases, necessary for the agency to achieve groundbreaking discoveries?

3. When NIH is legislatively directed to focus on a specific disease—or a group of diseases—to what extent is the agency's ability to freely study basic biology and mechanisms and to best allocate resources hindered?

4. With the recent advancements in genetics over the last decade, how has research moved away from a disease-specific focus to one that focuses more broadly on underlying mechanisms?

Sincerely,
Tom A. Coburn, M.D.
U.S. Senator

MD Anderson

Vice Chancellor Kenneth Shine To Retire From UT System

By Paul Goldberg

Kenneth Shine will retire from his post as the University of Texas System executive vice chancellor for health affairs in early 2013.

Shine, a cardiologist and physiologist, joined the UT System in November 2003. During his tenure, the Office of Health Affairs has completed six presidential searches. Prior to joining the UT System, Shine served as president of the Institute of Medicine.

Shine's hires included the president of MD Anderson Cancer Center, Ronald DePinho, who was hired with the understanding that he would continue to serve in his roles at several companies he co-founded while running the state institution.

This condition of employment was recently finalized when Shine issued a waiver allowing DePinho to continue his association with these companies (The Cancer Letter, Oct. 26).

DePinho has structured his term at MD Anderson around his "Moon Shots" program, aimed at elimination of seven cancers. The program's future hinges on DePinho's ability to attract billions of dollars in new funds and, more importantly, to continue to meet the institution's budgetary targets.

Last month, Shine met with the MD Anderson faculty senate to explain the rationale for his decision for granting the waiver. DePinho's waiver request and the recommendations of a group of experts who advised Shine in this decision were not made public.

The DePinho hiring coincides with the state's moving away from reliance on peer review science to a new emphasis on commercialization. This move affects the Cancer Prevention and Research Institute of Texas, a state-funded initiative that distributes $300 million a year to cancer-related enterprises.

After the state agency bypassed its standard peer review procedures to fund an $18 million technology incubator co-directed by DePinho's wife and MD Anderson scientist Lynda Chin, nearly all of its peer reviewers resigned in protest. CPRIT's chief scientific officer, Nobel laureate Alfred Gilman, was among those who left.

Shine advocated a delay in making a $18 million grant to Chin's technology incubator (The Cancer Letter, Sept. 28).

Drug Shortages

84% of Surveyed Practices Had To Modify Treatments

The Community Oncology Alliance announced the results of a drug shortage survey of 200 member practices across the U.S.

Representing approximately 525 physicians, 98.5 percent of the respondents reported experiencing a drug shortage in the last year.

Survey participants indicated that the cancer progressed more quickly in more than 60 percent of patients as a result of the drug shortages, and more than 70 percent of patients had more severe side effects as a result of drug shortages.

Almost half of those surveyed reported seeing more than one patient per day affected by a drug shortage, and 58.2 percent indicate the shortage in cancer care drugs is increasing. Over 80 percent of the patients and over 90 percent of the practices affected by a cancer drug shortage also experienced a more severe financial burden.

In addition to issues of optimal treatment, drug substitutions made because of a shortage often result in patients facing significantly higher costs.

When asked if, at any time, did the practice temporarily or permanently suspend, modify, or provide a less effective drug within the prescribed chemotherapy regimen due to the then-current drug shortage, 84.5 percent of respondents said yes, and were offered the opportunity to provide examples.

"FOLFOX, FOLFIRI were switched to leucovorin IVP 40mg instead of an infusion," said one respondent. "All leucovorin infusion doses are currently being modified to 40mg IVP. This has been going on for a year."

"We are 1) unable to treat acute leukemia without cytarabine—this is clearly a disgrace in a country with our resources," said another. "And 2) relapsed lymphoma is treatable without cytarabine, but not with drugs that would be my first choice."

A third respondent described: "We were a few doses away from treatment changes and were able to borrow from other facilities. We stockpiled at-risk medications. These issues continue today with taxol and costs the facility increased dollars to procure the medications."

"We have delayed by days or even a week, but it will get worse if the shortages continue," said yet another. "I have spent as long as four hours on the phone with vendors/distributors and other offices in order to

obtain enough of a single drug for one patient for one treatment."

COA Past-President Patrick Cobb: "When treating ovarian cancer, a commonly used drug is leucovorin. The cost to Medicare is $35 per dose; the patient co-payment is $9. But leucovorin is a generic drug and in short supply." Cobb is an oncologist at the Frontier Cancer Centers and Blood Institute in Billings, Mont.

"The substitute is a branded drug that is readily available. The cost to Medicare for a dose of the branded drug is $2,000 and the cost to the patient is $520. This is an unacceptable consequence of the drug shortage crisis."

The complete survey results and comments from respondents are available at http://www.communityoncology.org/site/coa-studies.htm.

Cancer Disparities

Black Women More Likely to Die From Breast Cancer, CDC Says

Although breast cancer death rates have declined in the past two decades, black women are more likely to die of breast cancer than any other racial or ethnic group, according to a report published by the Centers for Disease Control and Prevention, Vital Signs: Racial Disparities in Breast Cancer Severity—United States, 2005–2009.

Researchers analyzed data on new cases of invasive breast cancer reported during 2005 through 2009 from the CDC's National Program of Cancer Registries and NCI's Surveillance, Epidemiology and End Results program. Breast cancer deaths were based on death certificates submitted to the National Vital Statistics System.

The researchers found that black women had lower breast cancer incidence rates (116.9 cases per 100,000) compared to white women (122.1). Black women had higher numbers of advanced-stage breast cancer (45 percent) compared with white women (35 percent).

For every 100 breast cancers diagnosed, black women had 9 more deaths than white women (27 deaths per 100 breast cancers diagnosed among black women compared with 18 per 100 deaths for white women).

Also, among 40 states and the District of Columbia with enough data to analyze, the number of deaths per 100 breast cancers was higher for black women in almost all states. The range was 14 to 33 for black women and 16 to 21 for white women.

In terms of cancer screening, the report says that "although similar rates of mammography use among white and black women have been described using national self-reported data, studies verifying self-report have shown that mammography use might actually be lower among black women.

"One study found that after accounting for over-reporting, the prevalence of mammography use decreased from 77 percent to 65 percent among white women and from 78 percent to 59 percent among black women. Black women are more likely to have longer intervals between screening mammograms which might lead to an increase in diagnosis of cancer at a later stage."

The report concludes there are proven and effective strategies to address these disparities, and that the full benefit of breast cancer screening can only be achieved when we ensure that all women are receiving timely follow up and high-quality treatment.

In Brief

President Clinton To Chair Breast Cancer Deadline 2020

(Continued from page 1)

breast cancer by 2020. The stakes are too high; the losses have been too great to let another decade go by without ending breast cancer."

"As we convene and coordinate stakeholders from around the world to focus on a deadline and plan of action to end breast cancer, President Clinton's understanding of the issues and extraordinary ability to bring people together to work toward a common vision will be vital to our success," said Fran Visco, president of the National Breast Cancer Coalition.

The plan calls for resources and efforts to be spent in the areas that it says will end breast cancer: primary prevention of the disease, and researching the causes of metastasis. The coalition will pursue four strategies: targeted research; a public policy approach, including federal legislation; grassroots advocacy and education of a large number of community activists; and media outreach.

In 1993, the coalition urged Clinton's administration to create a National Action Plan on Breast Cancer, a collaboration of government, science, private industry and consumers. Clinton established the group and asked Fran Visco, president of NBCC, to co-chair the plan's implementation.

Clinton later worked with NBCC on the Department of Defense Breast Cancer Research Program and key legislation such as the Centers for Disease Control Breast and Cervical Cancer Treatment Act.

In 2005, President Clinton and NBCC launched

the Virginia Clinton Kelley Fund to honor the memory of President Clinton's mother. The fund supports the coalition's programs that train breast cancer survivors to influence research and public policy, foster innovation in research and healthcare, and expand access.

KAREN KNUDSEN was named editor-in-chief of **Molecular Cancer Research**, one of the major journals of the **American Association for Cancer Research**.

Knudsen is professor and Hilary Koprowski chair in the departments of cancer biology, urology and radiation oncology at Thomas Jefferson University, and deputy director for basic science of the Kimmel Cancer Center.

Knudsen succeeds **Michael Kastan**, executive director of the Duke Cancer Institute. She will officially begin her term in January 2013, and will serve as editor-in-chief for five years.

Knudsen is an author of more than 80 peer-reviewed publications in cancer and biomedical science journals. In addition, she has authored numerous book chapters focusing on transcription and cell cycle regulation in hormone-dependent cancers. Knudsen's research interest is predominantly prostate cancer and the molecular mechanisms that underlie tumor progression.

She recently received the Excellence in Mentoring Award from Thomas Jefferson University, the Richard E. Weitzman Laureate Award from the Endocrine Society and the Ron Ross Award from the Pacific Rim Breast and Prostate Cancer Foundation.

Knudsen served as assistant professor in the department of cell and cancer biology at the University of Cincinnati College of Medicine for five years and was promoted to associate professor with tenure in 2005. Two years later she joined Thomas Jefferson University as an associate professor in the departments of cancer biology and urology.

STEVEN ROSEN was named chair of the **Leukemia & Lymphoma Society**'s medical and scientific advisory board.

Rosen is director of the Robert H. Lurie Comprehensive Cancer Center of Northwestern University and Genevieve E. Teuton Professor of Medicine at the Feinberg School of Medicine. He is also director of cancer programs at Northwestern Memorial Hospital.

Members of the board advise the society's board of directors on a wide range of issues, including periodically reviewing the society's medical affairs and recommending funding for research grant awards.

THE VAN ANDEL INSTITUTE, **Saint Mary's Health Care** and **Mercy Health Partners** have signed an agreement to expand a world-class biorepository utilizing the infrastructure of the VAI Program for Biospecimen Science.

The institute's program became one of only seven biorepositories in the nation to be accredited by the College of American Pathologists in September. The program serves as the coordinating facility for the prospective collection of biological specimens in western Michigan and as a clearinghouse for the processing, storage and isolation of specimens to fuel biomedical discovery at VAI and partnering institutions.

Under the agreements, with patient consent, Saint Mary's Health Care and Mercy Health Partners will collect biospecimens and approved data and transfer them to the Van Andel Institute Program for Biospecimen Science. The Institute will store the biospecimens and data using sophisticated processes and equipment and will make the specimens available to physicians and researchers.

VANDERBILT UNIVERSITY MEDICAL CENTER and the **Baptist Memorial Healthcare Corp.** agreed to an academic affiliation agreement, paving the way for new clinical research and academic education opportunities.

The new affiliation establishes a framework for collaborative oncology initiatives between Baptist Cancer Center and Vanderbilt-Ingram Cancer Center. Baptist cancer patients will have increased access to VICC clinical research trials and genetic diagnostic tools. Many of these services will be available in local communities through Baptist's 14-hospital system across Mississippi, Tennessee and Arkansas.

Specific goals of the academic affiliation include: joint clinical trials; sharing of clinical pathways; sharing of cancer tissue to help advance personalized, genomic-based therapy; jointly held disease-specific conferences for physicians and staff; research-based fellowship training programs in oncology subspecialties; joint public education programs in cancer prevention, treatment and control; Baptist Cancer Center's participation in National Comprehensive Cancer Network activities as a VICC sub-site; and partnership in grant applications for cancer research funding.

Baptist and VUMC will continue to maintain additional relationships with other health care institutions throughout the region.

THE AMERICAN CANCER SOCIETY conferred its highest honor—the Medal of Honor—to four individuals at its Nationwide Volunteer and Staff Leadership Summit. They are: **Diane Meier**, for cancer control; **Waun Ki Hong**, for clinical research; **Kenneth Anderson**, for basic research; and **Janet Mordecai**, for philanthropy.

The society also honored five other individuals with national awards, and installed 11 volunteers into its board of directors for the next year.

Meier was recognized for her efforts to bring non-hospice palliative care into mainstream medicine.

Meier is director of the Center to Advance Palliative Care. She also serves as director of the Lillian and Benjamin Hertzberg Palliative Care Institute; professor of geriatrics and internal medicine in the Brookdale Department of Geriatrics and Palliative Medicine; and Catherine Gaisman Professor of Medical Ethics at Mount Sinai School of Medicine.

She edited the first textbook on geriatric palliative care, and has contributed to more than 20 books. Her book, Palliative Care: Transforming the Care of Serious Illness, was published in 2010.

Hong was the main architect of the Veterans Administration Cooperative laryngeal preservation trial, which changed the way the disease is managed and served as a model for organ preservation for many other cancers.

Hong is head of the Division of Cancer Medicine and professor and vice provost of clinical research at MD Anderson Cancer Center, where he also serves as American Cancer Society Professor and the Samsung Distinguished University Chair in Cancer Medicine. He is a past recipient of the Society's Distinguished Achievement in Cancer Award.

In addition to his research and clinical work, Hong has played a major role in through his service on the NCI Translational Research Working Group; the FDA Oncologic Drug Advisory Committee; the Prevention, Clinical and Therapeutic Subcommittee for the NCI External Board of Scientific Advisors; and as chair of the Subcommittee of Clinical Investigations for the National Cancer Advisory Board. He also has served both the American Association for Cancer Research and the American Society of Clinical Oncology in leadership roles.

Anderson was honored for his contributions to the understanding of the cause and treatment of multiple myeloma.

Anderson is currently the Kraft Family Professor of Medicine and associate medical director of the Brigham and Women's Hospital Blood Bank; vice chair of the Joint Program in Transfusion Medicine at Harvard Medical School; director of the Jerome Lipper Multiple Myeloma Center; and chief of the Division of Hematologic Neoplasia and director of the Lebow Institute for Myeloma Therapeutics at Dana-Farber Cancer Institute.

Anderson identified the varying growth mechanisms of myeloma cell at the cellular and molecular level, and found mechanisms of resistance to apoptosis, which may lead to new cancer therapies.

Mordecai was honored for her outstanding philanthropic contribution to further the American Cancer Society.

A retired nurse, Mordecai is well known for her many contributions to her local community of Denver. In 2008, she made one of the largest individual scientific research gifts in the society's history in order to establish the Multiple Endocrine Neoplasia type 2 Thyroid Cancer Consortium.

The individual projects made possible by this gift cover a wide spectrum of MEN2 research, including epidemiology, drug development and fundamental genetic studies.

Among her many philanthropic commitments, Mordecai created the Daniel and Janet Mordecai Rural Health Nursing Endowed Chair, as well as four Rural Health Nursing Endowed Fellowships at her alma mater, the University of Colorado College of Nursing.

Past recipients of the society's Medal of Honor include President George H.W. Bush and First Lady Barbara Bush; the late Edward Kennedy, senator from Massachusetts; George Papanicolau, inventor of the Pap test; Robert Gallo, for his achievements in the field of human retrovirology; the late Judah Folkman, a researcher in the field of antiangiogenesis; C. Everett Koop, former surgeon general; and advice columnists Ann Landers and Abigail Van Buren.

The society also honored **Barbara Berkman** and **David Rosenthal** with Distinguished Achievement in Cancer Awards; **Sigurd Normann** with the National Volunteer Leadership Award; as well as **Laurence Baker**, who received the Distinguished Achievement in Cancer Award in 2011, but was unable to attend the ceremony last November. The society also honored **Charles von Gunten** with the Pathfinder in Palliative Care Award.

Berkman is responsible for advancements in the assessment instruments oncology social workers use to identify patients and families who are at risk for poor psychosocial adjustment to changes in health status.

Berkman is the Helen Rehr /Ruth Fizdale Professor of Health and Mental Health at Columbia University School of Social Work, and adjunct professor in the Department of Community and Preventive Medicine at Mount Sinai School of Medicine. She is a fellow of the Gerontological Society of America, the New York Academy of Medicine, and the American Academy of Social Work and Social Welfare.

Rosenthal is a past president of both the former Massachusetts Division and the American Cancer Society. Among his most enduring contributions has been his leadership of the effort to bring an American Cancer Society Hope Lodge to Boston. The Lodge opened in 2008, and has helped thousands of cancer patients and their caregivers save millions of dollars in lodging costs when they must receive treatment far from home.

Rosenthal is director of Harvard University Health Services, and professor of medicine at Harvard Medical School. He also serves as a senior physician at Brigham and Women's Hospital, Beth Israel Deaconess Medical Center, and the Dana-Farber Cancer Institute, where he is also medical director of the Zakim Center for Integrated Therapies.

Normann has been a volunteer with the American Cancer Society since 1976. He has served in numerous capacities, including a term as president of the Florida Division Board of Directors and national service as a delegate to the former national assembly, and as a member of the Peer Reviewers Advisory Group, the Colorectal Cancer Operations Committee, the Research Evaluation Advisory Group and the Research and Medical Affairs Committee.

Normann is professor emeritus at the University of Florida's Department of Pathology.

Baker became chairman of SWOG in April 2005. Baker is also executive director of SARC, a not-for-profit consortium which advocates for sarcoma medical research and for the conduct of clinical trials studying new treatment for sarcoma. Baker is professor of internal medicine and pharmacology in the Division of Hematology/Oncology at the University of Michigan Medical School.

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Von Gunten is the founder of one of the earliest academic hospital palliative care programs at Northwestern University Medical School and Hospitals. He now leads the largest palliative medicine fellowship training program in the nation at San Diego Hospice and University of California San Diego.

His national effort helped bring about the American Board of Medical Specialties' endorsement of palliative medicine as a formal new subspecialty of ten participating parent Boards in 2006, among them internal medicine, surgery, pediatrics, neurology, and anesthesiology.

The society also installed 11 new officers to its volunteer board of directors.

Leading the board will be Chair **Gary Reedy** and President **Vincent DeVita, Jr**.

The other officers named were: **Pamela Meyerhoffer**, chair-elect; **Tim Byers**, president-elect; **Robert Youle**, vice chair; **Douglas Kelsey**, first vice president; **Enrique Hernandez**, second vice president; **Daniel Heist**, treasurer; **Robert Kugler**, secretary; **W. Phil Evans**, immediate past president; and **Cynthia LeBlanc**, immediate past chair.

Reedy is worldwide vice president of government affairs and policy at Johnson & Johnson. Reedy began his volunteer career with the society in 2000 as a member of the former ACS Foundation board of directors, where he served first as a trustee, and then as the ACS Foundation liaison to the ACS board. In 2007, Reedy became a director-at-large member of the ACS board of directors before becoming an officer.

He currently serves as chair of two board committees, and has also served on the board of directors of the American Cancer Society Cancer Action Network. He is immediate past chair of the ACS CAN board, and currently serves as the chair of the ACS CAN governance committee.

DeVita is the Amy and Joseph Perella Professor of Medicine at Yale Cancer Center and Smilow Cancer Hospital, and a professor of epidemiology and public health at the Yale School of Medicine.

DeVita spent the early part of his career at NCI where, in 1980, he was appointed by President Jimmy Carter as director of NCI and the National Cancer Program. At NCI, he was instrumental in developing combination chemotherapy programs that ultimately led to an effective regimen of curative chemotherapy for Hodgkin's disease and diffuse large cell lymphomas.

Meyerhoffer has been an active American Cancer Society volunteer for more than 40 years. She currently

serves as a member of a number of board committees, and previously served two years as Board chair of the former Great West Division affiliate. Meyerhoffer is president and CEO of PKM Consulting.

Byers is the associate director for cancer prevention and control at the University of Colorado Cancer Center and the associate dean for the Public Health Practice at the Colorado School for Public Health.

Youle has been a member of the board of directors for five years, and a member of the former Great West Division Board since 2003. He is an attorney and partner at Sherman & Howard.

Kelsey is a Medical Fellow at Eli Lilly and Company, where he specializes in clinical research, especially in the area of ADHD in children, adolescents, and adults. His other areas of expertise include pediatrics, infectious diseases, immunology, and microbiology.

Hernandez is professor and chairman of obstetrics, gynecology, and reproductive sciences at Temple University School of Medicine. Hernandez has been a member of the Board of Directors since 2009. He was president of the former Pennsylvania Division from 2008 to 2010.

Heist will continue to serve in his role as treasurer. He is director of internal audit at Pennsylvania State University.

Kugler has served on the society's board of directors since 2002, and served as chair, secretary, treasurer, and member of several workgroups and committees at the ACS CAN since 2007. Kugler served as chair of the former New Jersey Division from 1985 to 1987, and as president of the former Eastern Division from 2000 to 2002.

Evans remains on the board as immediate past president. Evans is director of the Center for Breast Care and professor of radiology at the University of Texas Southwestern Medical Center. He is a fellow of both the American College of Radiology and the Society of Breast Imaging.

LeBlanc will remain on the board as immediate past chair. LeBlanc is a Road to Recovery volunteer, legislative ambassador, and ACS National Leadership Development Program coach.