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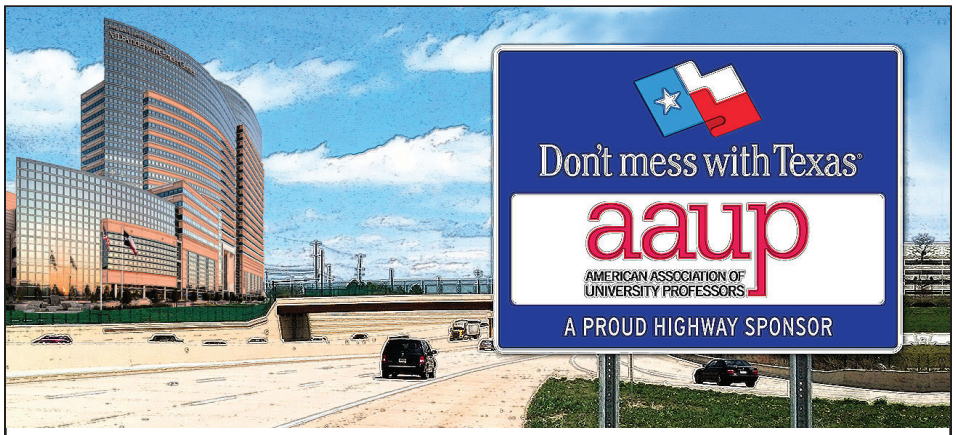

MD Anderson Violated Academic Freedom, Governance, Tenure Standards, AAUP Says

By Matthew Bin Han Ong

MD Anderson Cancer Center President Ronald DePinho's administration acted in disregard of academic standards and the institution's internal faculty appointment policy, according to a 23-page final report published April 8 by the American Association of University Professors.

The report is the outcome of a yearlong feud between the cancer center and AAUP, which defends academic freedom and shared governance.

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Congress Steps in to Examine FDA Device Regs As Insurers Restrict Coverage of Morcellation

By Matthew Bin Han Ong

Nearly a year and a half after a surgical tool routinely used by gynecologists disseminated her undiagnosed sarcoma, Amy Reed found herself back in the operating room—this time for removal of a second metastasis.

Reed's leiomyosarcoma, which had been in remission after a massive surgery and post-morcellation chemotherapy, has spread to her lumbar vertebrae.

A mother of six, Reed, 41, is an assistant professor of anesthesia and critical care medicine at the Hospital of the University of Pennsylvania.

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In Brief

Jensen Heads Oncology Care at Scripps Health

KAREN JENSEN joined **Scripps Health** as director of the oncology clinical care line for the health system's integrated cancer program.

For the past 21 years, Jensen held a variety of leadership roles in Mayo Clinic's southwest Minnesota region. Most recently, she was vice president of quality and director of clinical outcomes, where she was responsible

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Final Report Foreshadows AAUP's Next Move: Censure

(Continued from page 1)

The process was unusually contentious, even by the standards of tenure disputes, as MD Anderson officials—in an open challenge—released the confidential draft document that was sent to them for review. The administration's original response also included a statement that the report's description of conflicts of interest was "legally actionable" (The Cancer Letter, March 20).

Responding to the final report, MD Anderson officials said it was an effort on the part of a "labor union" to attract more members.

The report's negative findings increase the chances that the illustrious Houston hospital will be added to AAUP's censure list of over 50 institutions. Currently, there is no top-tier cancer center on that list.

According to AAUP, the censure list is closely watched by about 240 higher education and academic organizations that endorse AAUP principles. Job postings and other related media from censured institutions published in that network would be accompanied by a footnote that reads, "The administration of this institution is on the AAUP censure list."

The MD Anderson final report doesn't discuss censure—a decision that will be made at AAUP's annual meeting of several hundred members and delegates who vote on the association's recommendations.

Founded in 1915, AAUP has 47,000 individual members and 300 chapters.

The AAUP report summarizes the findings of an investigation triggered by refusal on the part of DePinho and his administration to provide justification for denying tenure renewals to Kapil Mehta and Zhengxin Wang. MD Anderson's Promotion and Tenure Committee had unanimously recommended both professors for renewal. (The Cancer Letter, April 25, 2014).

"The report finds that the cancer center administration violated commonly accepted academic standards when it terminated the appointments of two professors," Henry Reichman, chair of the AAUP Committee A on Academic Freedom and Tenure, said in an email to the association's members. "Neither of the two professors at MD Anderson received the due process recommended by the AAUP for full-time faculty members with more than seven years of service: an opportunity for a faculty hearing, in which the burden of demonstrating adequate cause for dismissal rests with the administration.

"Instead, after being notified that their appointments would not be renewed, the professors were limited to appealing the decision to the same administrative officers who made it.

"If no steps are taken to remediate the MD Anderson policies, it is likely that the AAUP membership will consider imposing censure on the MD Anderson administration at our annual meeting on June 13," Reichman wrote.

In advance of the AAUP annual meeting, held in Washington, D.C., Committee A will make a recommendation to censure, not to censure, or to hold it over pending negotiations. The committee will convene end of May.

It seems unlikely that DePinho and his administration would be open to negotiations.

"As with the draft report released in March, The University of Texas MD Anderson Cancer Center continues to disagree with the conclusions made in American Association of University Professors' final report issued [April 8]," MD Anderson officials wrote in a statement to The Cancer Letter. "MD Anderson is secure in the knowledge that the review process for the individuals involved was transparent, documented and justified as well as compliant with both policy and fairness.

"Several significant factual errors and inappropriate statements have been removed from the final document, but the objectivity of the report still is obviously deficient.

"As a labor union, the AAUP will reach whatever conclusions it deems favorable to its purposes. However, to draw broad conclusions that denigrate the dedication of MD Anderson faculty to advancing the

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science of curing cancer in order to save lives, through the AAUP's narrowly-informed editorializing on MD Anderson's strategic course crafted through extensive faculty participation, does an injustice to our scholarly physicians and researchers and their commitment to our mission."

MD Anderson can avoid censure by reforming its policies and resolving the situations of the professors in question, said Gregory Scholtz, AAUP associate secretary and director of the Department of Academic Freedom, Tenure and Governance

"It would be nice if they got rid of that obnoxious oxymoron, 'term tenure,'" Scholtz said, referring to MD Anderson's seven-year renewable faculty contracts.

The AAUP report slammed MD Anderson for its lack of "indefinite" tenure—a system practiced by nearly 90 percent—111 out of 126—of medical colleges and institutions, according to a 2008 study by the American Association of Medical Colleges (The Cancer Letter, May 30, 2014).

DePinho: We Will Enhance The Tenure Process

MD Anderson will not abandon its seven-year appointments.

Nonetheless, in an email to the faculty March 13, DePinho promised "enhancements" to the renewal process.

"We're enhancing MD Anderson's term tenure renewal process in response to faculty concerns about nonrenewal of term appointments when the Promotion and Tenure Committee (PTC) unanimously recommends renewal for another seven-year term.

"Beginning immediately, in the rare instance when the president is considering nonrenewal of a seven-year term tenure appointment following a unanimous PTC recommendation for renewal, the following steps will be taken:

"1. Before a final decision is made, the president will consult with two former PTC chairs and the UT System Executive Vice Chancellor for Health Affairs.

"2. Written recommendations from those consultations will be obtained, and the Executive Vice Chancellor's comments will be available for the faculty member's review.

"After three years, this newly expanded process will be reviewed by a committee of former PTC chairs. They'll consider whether to extend the use of these additional steps or modify/expand them to improve the system."

DePinho also promised to invest $10.8 million in clinical resources, which will, among other things, be used to recruit 84.5 new full-time employees.

Report Links DePinho, Chin to Faculty Morale Decline

The AAUP report devotes over two pages to a section titled "The Administration of President Ronald DePinho," where the investigation committee describes in detail events that negatively impacted morale at MD Anderson, based on faculty feedback to the committee.

"After Dr. DePinho assumed the presidency, the cancer center became embroiled in controversies, and the specific issues of academic due process and shared governance to be discussed in this report are interwoven with those controversies," the report reads.

"Faculty members, proud of MD Anderson's reputation for both superb patient care and contributions to basic science, told the investigating committee that they were stung by missteps and improprieties reported in the press—particularly in The Cancer Letter, a trade publication—that tarnished the image of their institution.

"Members of the faculty complained that demands on them were being ratcheted up and their employment was being made less secure at a time when funding was less accessible nationally and when the administration was dedicating additional institutional funds to a unique drug-development initiative."

The report goes on to list alleged conflicts of interest involving Lynda Chin, DePinho's wife, who recently stepped down as founding chair of Genomic Medicine and scientific director of the Institute for Applied Cancer Science at MD Anderson to join the UT System as an associate vice chancellor for health transformation and chief innovation officer for health affairs (The Cancer Letter, April 3).

"In May 2012, Dr. Chin attracted faculty criticism and unfavorable press coverage when it came to light that the IACS she codirected had bypassed the grant-application portal monitored by MD Anderson's then provost, Dr. DuBois, with an email application to the Cancer Prevention and Research Institute of Texas (CPRIT), which then bypassed its standard scientific peer-review process in awarding an $18 million incubator grant, prompting several resignations from CPRIT, including the Nobel laureate who was it chief scientific officer.

"Controversy also erupted over ties that Dr. DePinho and Dr. Chin maintained with Aveo Pharmaceuticals, a company they cofounded.

"President DePinho was meanwhile seeking a sweeping waiver from conflict-of-interest regulations from the University of Texas system so that he could continue his collaborations with twelve entities and so

that MD Anderson would be allowed to run trials on drugs and biological of the companies in which he had a stake.

"Ultimately, the board of regents declined to approve the full list, directing nine to a blind trust, but the board allowed President DePinho to retain his interest in three, including Aveo which was developing a drug that he especially wanted MD Anderson to test.

"Dr. Shine, who authored the waiver, stressed to The Cancer Letter the potential benefits of having a commercialization-oriented leader over the potential harms related to conflict-of-interest considerations. The unusual arrangement ran into principled objections from critics on MD Anderson's faculty."

The Report's Conclusions

After lengthy discussion of the individual tenure dispute cases, MD Anderson's contractual appointments and academic due processes, as well as its climate for academic freedom, the AAUP investigating committee concludes that:

1. The administration of the University of Texas MD Anderson Cancer Center acted in disregard of the joint 1940 Statement of Principles on Academic Freedom and Tenure, which calls for the protections of tenure to full-time faculty members after seven years of service, when it failed to retain Professors Kapil Mehta and Zhengxin Wang following thirty and twelve years of service, respectively, without having afforded them requisite academic due process.

2. In both the Mehta and Wang cases, the administration acted in disregard of the Association's Recommended Institutional Regulations on Academic Freedom and Tenure and of its own "Non-Renewal of Faculty Appointment Policy" when it failed to provide a written statement of reasons to the two professors for their nonreappointment.

3. In both cases and in others where nonrenewals and deferrals belied the positive recommendations of the faculty committee with primary responsibility for ensuring faculty excellence, the administration acted in disregard of the Association's Recommended Institutional Regulations on Academic Freedom and Tenure and the Statement on Government of Colleges and Universities when it failed to provide compelling reasons, stated in detail, to the Promotion and Tenure Committee for rejecting its recommendations.

4. In Professor Mehta's case, the administration additionally ignored the findings of a faculty appeal panel that had sustained his appeal of the adverse action and misrepresented the panel's findings to Professor Mehta.

5. The administration acted in disregard of the Association's Recommended Institutional Regulations on Academic Freedom and Tenure and in disregard of its own "Faculty Appointments Policy" in failing to provide accurate licensure information in Professor Gouhui Lu's initial letter of offer and in subsequent appraisals and reviews—information later used to remove him from faculty status and place him in a classified position.

6. The University of Texas MD Anderson Cancer Center administration shows its disregard of principles of shared governance articulated in the Statement on Government of Colleges and Universities in its procedures for appointing department chairs and in its general failure to involve faculty meaningfully in academic decisions.

"Reputable Institutions" Prefer to Avoid Censure

Universities and colleges "of a certain pedigree" usually care about not making the AAUP censure list, said Matthew Finkin, director of the Program in Comparative Labor and Employment Law & Policy at the University of Illinois.

"They draw their faculty from PhD programs in reputable places. Their faculty attends conferences; they want to sponsor conferences. They're in what I would call, 'The orbit of comparison,'" said Finkin, who is also the university's Albert J. Harno and Edward W. Cleary Chair in Law. Finkin has participated in four AAUP investigations, chairing two of them.

"Highly selective liberal arts colleges, heavyweight regional or state universities tend not to get on the censure list," Finkin said to The Cancer Letter. "If on occasion that happens, for whatever alignment of the stars, they tend not to stay on it for very long because they care.

"The faculty will usually say, 'This is hurting us. We don't want to be on the same list as Frank Phillips College of Borger, Texas. I mean, come on!'

"So they tend to take AAUP seriously, they tend to solve cases, and when they end up on the censure list, you'll see that they get off pretty quickly. For the institutions that don't get off quickly, what you usually have is an entrenched administration or board of trustees or both that really thinks that they did nothing wrong, that the AAUP is at fault, not they.

Finkin is the author of two definitive books on tenure in the U.S., The Case for Tenure, and For the Common Good: Principles of American Academic Freedom. He is also an author of Labor Law, a leading casebook in American legal education.

Finkin said he is not surprised that DePinho and

his administration appear unfazed.

"The question is the shame quotient: Is this a place that is subject to any notion of shame?" Finkin said. "And the answer is, apparently not much, as it appears.

"What happens is you have to await a change of president," Finkin said. "Very often, you'll see a removal of censure that coincides with a new president, who comes in and says, 'One of the conditions of my presidency is I want to get this institution off the censure list. It's embarrassing.'

"All the AAUP can do is name and shame. If the MD Anderson administration has no sense of shame, then all AAUP can do is announce to the world that they should be ashamed of themselves, and that they should behave even better.

"It's up to the thinking public to act on whatever manner they see fit."

AAUP: Censure is for Fringe Institutions

MD Anderson's response to the AAUP report isn't encouraging, said AAUP's Scholtz.

"Given that MD Anderson, as the report itself said, is more hospital than university, I wonder to what extent they care, if they do, about being considered an institution of higher education," Scholtz said to The Cancer Letter.

"The whole purpose of a censure is to send a message that says, 'This is not a place that's friendly to academic freedom and tenure. If you're concerned about academic freedom and if you're seeking the protections of tenure for academic freedom, this is not a place to work.'"

Other "reputable" universities typically offer full cooperation, Scholtz said.

"The University of Virginia was subject to a governance investigation a few years ago and the University of Illinois right now is probably heading towards censure, but they've bent over backwards to accommodate us," Scholtz said. "There have been investigations that I was part of where the institutions avoided censure by fixing things before the annual meeting.

"In those cases, these institutions were very concerned about the adverse publicity and very concerned about their academic bona fide. But it may be that MD Anderson is not concerned about its academic bona fides. I hope it is, because we'd like to see the possibility of censure removed.

"What matters the most are the ones that are conscious of their image as being among the more reputable institutions in higher education. We don't want that censure list to get too long, because it's a list of institutions that don't take academic principles as seriously—we have the hardest time getting institutions off the censure list who are more on the fringes of higher education.

"They're not terribly concerned about the opinions of what one might consider to be core academic institutions about their status and standing."

The full text of DePinho's March 13 email to the MD Anderson faculty follows:

Dear colleagues,

Thank you to everyone who attended Wednesday's faculty townhall. We hope the information shared, the questions and comments addressed, and our planned path forward will allow all of us to jointly push the reset button and continue our collaborative efforts to end cancer.

For those unable to attend, following is a high-level overview of what was discussed. You also can watch the session in its entirety.

Expansion of the Institutional Executive Committee

In the spirit of welcoming and engaging additional viewpoints to help guide our strategic goals and efforts, we're expanding MD Anderson's Executive Committee. Included now will be representatives, selected by their peers, from the division heads, clinical department chairs and basic science department chairs.

The chair of the Executive Committee of the Faculty Senate also will serve on the committee. These key people will provide valuable perspectives that will ensure we continue on a nimble and proactive path in the near term, as well as a strategic path in the long term.

$10.8 million investment in clinical resources

After committing $10 million to implement creative solutions designed to have an immediate impact on the working environment of our faculty in their labs and clinics, we empowered divisional and departmental leaders to solicit ideas from their faculty and determine how we should invest those funds.

Not only did we approve their plans, we increased the available funds to $10.8 million to accommodate the very real needs of our faculty. This additional support is needed now.

As quickly as possible, we'll add 84.5 full-time employees – mostly mid-level providers, nurses and other clinical professionals, as well as additional faculty.

Additionally, based on feedback gathered by our research chairs, plans are being finalized to help

students and postdocs with parking and enhanced videoconferencing capabilities. We also will expand our support of bridge funding.

Enhancements of our promotion and tenure process

We're enhancing MD Anderson's term tenure renewal process in response to faculty concerns about nonrenewal of term appointments when the Promotion and Tenure Committee (PTC) unanimously recommends renewal for another seven-year term.

Beginning immediately, in the rare instance when the president is considering nonrenewal of a seven-year term tenure appointment following a unanimous PTC recommendation for renewal, the following steps will be taken:

1. Before a final decision is made, the president will consult with two former PTC chairs and the UT System Executive Vice Chancellor for Health Affairs.

2. Written recommendations from those consultations will be obtained, and the Executive Vice Chancellor's comments will be available for the faculty member's review.

After three years, this newly expanded process will be reviewed by a committee of former PTC chairs. They'll consider whether to extend the use of these additional steps or modify/expand them to improve the system.

Improving systems and transparent reporting of financial information

Progress has been made to improve the usability of Resource One/PeopleSoft. Leaders in Finance and Information Technology have reached out to division and department leaders to answer questions and offer additional training.

Dedicated teams have been assembled to offer unified system access and training materials across all components of PeopleSoft. And Grants and Contracts accounting managers are staffing hotlines: Ext. 3-1122 or PSGrant_Support@mdanderson.org for PeopleSoft; Ext. 5-6065 or Grants_And_Contracts@mdanderson.org for the Help Desk.

A group of faculty and administrative representatives has been tasked with ensuring all necessary resources are applied to keep PeopleSoft enhancements on target.

As of Dec. 22, ad hoc reporting capabilities for FTE and income statement analysis was released for extended testing in production. Training continues and end-user feedback has been positive.

Additionally, the Grants Portal is on target for release April 30. User acceptance testing is complete with positive end-user feedback. Enhancements are being prioritized and incorporated. Data reconciliation between PeopleSoft's subsystems continues and is estimated to be complete this month.

A work group also will be established to receive and evaluate requests from faculty for detailed financial information on topics such as our Moon Shots Program, major capital projects, investments through UTIMCO and days of cash on hand.

A number of questions already have been submitted, and work is underway to consolidate these requests and collaborate with faculty leadership to identify the most appropriate mechanism to provide responses and ongoing education.

Thanks again to everyone for participating in our ongoing process to further our excellence. Joining forces will be crucial to our ongoing success. We must remember our primary responsibilities are to our patients who entrust their care to us and the public who supports our research.

Through ongoing dialogue, a willingness to learn and grow together, as well as a commitment to our core values, we can work together and achieve much more.

Thank you for all you do for our patients and their families, your colleagues and MD Anderson.

Ron DePinho, M.D.
President

Tom Buchholz, M.D.
Executive Vice President and Physician-in-Chief

Ethan Dmitrovsky, M.D.
Provost and Executive Vice President

Leon Leach, Ph.D.
Executive Vice President and Chief Business Officer

Tom Burke, M.D.
Executive Vice President,
MD Anderson Cancer Network

Dan Fontaine, J.D.
Executive Chief of Staff, President's Office

Decision Analysis Paper Irks Critics of Morcellation

(Continued from page 1)

Reed and husband Hooman Noorchashm led a national campaign against the gynecological procedure.

"Amy had a big operation, and is undergoing radiation therapy," said Noorchashm, formerly a cardiothoracic surgeon at Brigham & Women's Hospital who now practices at Thomas Jefferson University Hospital. "She had to sacrifice an L2 sensory nerve and fuse two vertebrae in that operation."

The couple's travails began on Oct. 17, 2013, when Reed's uterus was removed via power morcellation at Brigham & Women's. Spread by the spinning blades of the device, within days, Reed's undetected sarcoma metastasized in her abdominal cavity (The Cancer Letter, July 4, 2014).

When Reed first went into surgery, she and Noorchashm had no idea that power morcellation was the standard method for removal of fibroids and hysterectomies.

It was performed on an estimated 100,000 women in the U.S. each year.

The media campaign Reed and Noorchashm conducted in the aftermath of their personal ordeal brought urgency to what ordinarily would have been an obscure debate among subspecialists. Hospitals, physicians, and minimally invasive gynecological societies scrambled to address the controversy.

Within a year, FDA decreed that power morcellators are contraindicated for hysterectomies or fibroid removal in the vast majority of women getting these procedures—essentially ending power morcellation as a standard practice (The Cancer Letter, Nov. 26, 2014).

"We have come a very long way," Noorchashm said. "For the most part, however, I think the morcellation fight has been quelled."

"We're going back down to the FDA on April 21 to talk about device regulation," said Reed, formerly an anesthesiologist at Beth Israel Deaconess Medical Center. "Other than that, we've been keeping busy with the six kids—soccer, basketball, gymnastics, lacrosse, and school."

Climbing Numbers

Clinical practice and payment policy changed rapidly as a result of the couple's advocacy.

FDA estimated that Reed's is not an isolated case. About one in 350 women who are undergoing hysterectomy or myomectomy for fibroids is found to have an unsuspected uterine sarcoma, the agency says.

The American Association of Gynecologic Laparoscopists disagrees with the estimate, citing international data reporting lower prevalence rates.

However, a study published last December indicates that the risk may be twice as high as the FDA estimate.

A retrospective review of medical records for 3,523 women by Jasmine Tan-Kim and colleagues from Kaiser Permanente San Diego found that about one in 156 women who underwent laparoscopic hysterectomy with power morcellation were diagnosed with uterine sarcoma. The paper was published in the American Journal of Obstetrics and Gynecology.

A more recent study puts the incidence of unexpected gynecologic malignancy—uterine sarcoma and endometrial cancer—at 2.7 percent. Nichole Mahnert, a clinical lecturer of obstetrics and gynecology at the University of Michigan, led the study, which reviewed records for 7, 499 women who underwent a hysterectomy in 2013.

Other studies support FDA's estimate: a study by Andrew Brohl et al. at the Icahn School of Medicine at Mount Sinai found that the overall aggregate risk of unsuspected uterine sarcoma was 1 in 340. Published in The Oncologist March 12, the retrospective study pooled data from eight studies conducted between 1980 and 2014, with a total sample of 10,120 patients.

A large study of 36,470 women by Columbia University physicians, published in JAMA July 2014, found that the risk was one in 368 women.

"Several studies have come out that—beyond a shadow of a doubt—demonstrate that the rate is somewhere in the one to 200 to one in 500 range," Noorchashm said. "That's not disputed any longer."

The Question of Cost

A study published April 10 in the Journal of Minimally Invasive Gynecology argues that power morcellation is more cost-effective than other procedures.

"Eliminating morcellation hysterectomy as a treatment for fibroids is not cost-effective under a wide variety of probability and cost assumptions," the authors concluded. "Performing laparotomy for all patients who might otherwise be candidates for morcellation hysterectomy is a costly policy from a societal perspective."

Led by Pietro Bortoletto, a senior advisor for the Chicago Life Science Consortium, the study compared the cost for preventing disseminated cancer to the overall savings from using power morcellators for the removal

of fibroids—on a societal scale.

Bortoletto's decision analysis model provoked swift outrage from Reed and Noorchashm.

"I'm really struggling with the whole ethics of what the OBGYN community has been publishing lately," Reed said. "They're completely missing the point, over and over and over again.

"That is actually shameful. What do you mean by cost effective? Cost effectiveness in this context is shooting everyone over the age of 80, because they cost the health care system a lot. That's not medicine.

"There is no cost effectiveness to killing a small subset of people to preserve the health of others. That's atrocious. If the OBGYN community stands behind that, they should be stripped of their medical licenses."

Added Noorchashm: "Am I hearing this right? These minimally invasive gynecologists are actually justifying the sacrifice of a minority subset of lives from cancer upstaging to save costs?

"America went to war to stop fascism, perhaps its time for Congress to step up and eliminate this kind of perverse ideology from the American corporate ethos."

Congressional Pressure

FDA categorizes the power morcellator as a Class II moderate-risk surgical device, which means that it was cleared for the market based on comparability to predicate devices already in use, according to the 510(k) process.

Only Class III high-risk devices are subjected to a rigorous FDA premarket approval application process.

The couple's lobbying efforts have been productive as well.

Two members of Congress—Sen. Robert Casey (D-Penn.) and Rep. Michael Fitzpatrick (R-Penn.)—have begun an inquiry into FDA's processes for clearing devices such as the power morcellator.

In a five-page letter dated Feb. 19 and addressed to the FDA Commissioner, Fitzpatrick put forward 23 questions about the 510(k) process and consumer protection mechanisms at the Center for Devices and Radiological Health, which is responsible for the premarket approval of all medical devices, as well as overseeing the manufacturing, performance and safety of these devices.

"I write to seek clarification of your agency's regulation of medical devices," Fitzpatrick wrote. "I am specifically looking to obtain answers about the 510(k) process, and hoping to gather information about whether the FDA has plans to alter this process in light of recommendations from the Institution [sic] of Medicine."

FDA and Congress asked the Institute of Medicine to review the 510(k) process in 2009. The committee unanimously concurred that the process was defective, and that it should be replaced.

In a similar push, Sen. Casey inquired about FDA's response to the concerns that have been raised about the safety of power morcellators. FDA has not responded to the Fitzpatrick and Casey at the time of writing.

The letters can be downloaded here.

FDA's CDRH is responsible for safeguarding the public from potentially harmful devices, Noorchashm said.

"It's the 510(k) process, but it's also more than that," Noorchashm said to The Cancer Letter. "The mission of the CDRH is to streamline entry of lifesaving devices into the marketplace. That's a very different mission than insuring public health, and in the public health equation, that's a mistake. The industry is not the public. The public is the primary and foremost stakeholder."

Noorchashm takes pains to explain that neither he nor Reed are anti-business.

"I'm pro-industry and pro-business, but the argument here is very clear-cut," he said. "Here's the thing about the public—the public who isn't affected is usually not informed enough to fight, so they're not going to really engage in the democratic process with respect to this particular topic.

"The part of the public that's harmed is usually very hurt, very bankrupt or very dead, which effectively dissociates them from the democratic process.

"That leaves the lobbyists, and that leaves the industry. When the CDRH, instead of focusing on the public's interest as the primary and only stakeholder, focuses on the interests of industry or the lobbyists as an equal stakeholder, industry and lobbyists win.

"So it's not because our federal government is failing. It's because specific individuals within CDRH and FDA leadership have forgotten what their mission is."

Insurance Providers Limit Coverage

Two insurers—Health Care Service Corp., and UnitedHealth Group Inc.—have placed limitations on their coverage for power morcellation.

In a policy that went into effect April 6, UnitedHealth, the nation's largest insurer with 40 million customers, requires doctors to obtain authorization from the insurer for all hysterectomies except outpatient vaginal procedures, which do not use power morcellators.

Recently, Health Care Service Corp., the fourth largest at almost 15 million customers, proposed labeling power morcellation as "not medically necessary." This typically means that the procedure would not be eligible for coverage. The draft policy is open to public comments before a decision June 1.

Aetna Inc. is considering changes in its coverage and will complete its review end of April, according to a spokesperson. At 23 million customers, Aetna ranks third.

Other insurers, including Blue Shield of California, UPMC Health Plan, Blue Cross Blue Shield of Massachusetts, HighMark Inc. and AmeriHealth Caritas, ceased or limited coverage by the end of 2014.

"As far as we are concerned, we have raised an alarm, and we've let the public know," Noorchashm said. "Whether our Congressional and corporate leaders, and citizens of this country are capable of looking at it and recognizing this, it is the question.

"It's up to them to decide."

Upcoming Litigation?

Reed and Noorchashm, who both have doctorate degrees in immunology, are studying the disease.

"The recurrence gave us an opportunity to look a little more carefully in the lab," Reed said to The Cancer Letter. "If I continue to feel better, I'll be able to get back in there and study the immune response to my tumor, or lack thereof."

Added Noorchashm: "If you will, we're basically on an island that's on fire. And we're trying to use whatever information we have to build a raft and get away as fast as we can, or we will be engulfed by the flames."

Noorchashm said he has informed the Department of Justice and the Federal Bureau of Investigation about the power morcellator.

His argument: manufacturers of the device and hospitals that use it have violated federal law—specifically, Section 803 of Title 21—by neglecting to report adverse events.

This argument is reflected in a letter from Rep. Fitzpatrick to FDA.

"Does FDA have a legal and prosecutable 'positive mandate to self-report adverse outcomes in the medical device space' for individual practitioners, [hospitals, and device manufacturers]? If so, have there been any prosecutions for failure to report?" Fitzpatrick inquired in the letter.

In the course of his campaign against power morcellation, Noorchashm has fired off thousands of emails to regulators, academics, hospitals, legislators and journalists.

In a recent email to his former colleagues at Brigham & Women's, Noorchashm said DOJ and FBI are getting involved.

"I will look forward to your federal subpoenas," Noorchashm wrote March 13, as Reed was recuperating from her lumbar surgery. "Very certainly after the first fatality at the Brigham from this complication, you should have stopped. You did not."

Brigham had seen adverse events related to power morcellation before Reed's surgery.

At the time Reed was recuperating from her hysterectomy, another patient, Erica Kaitz, was dying from metastatic disease. Kaitz died on Dec. 7, 2013, nearly two months after Reed received her diagnosis (The Cancer Letter, Nov. 21, 2014).

Patients across the U.S. were subjected to power morcellation without being informed of the cancer risk. The risk had been described in medical literature, but was often underestimated.

"So I will only assure you, that not only will the civil court system query your negligence in practice, but the FBI and the U.S. attorney's office are now looking with eyes wide open," Noorchashm said in the email.

"Do not mistake me for a 'distraught patient family member.' Remember, I am one of you, and I know what you have done and why you did it."

DOJ and FBI didn't respond to questions from The Cancer Letter. Brigham & Women's Hospital declined to comment.

The next battle in the ground war on power morcellation will be fought in the courts, Noorchashm said.

"I think that negligence will be demonstrated," Noorchashm said to The Cancer Letter. "Once that's done, and once several millions of dollars are lost, I think most institutions will think twice about doing this."

Medical device safety is a national health and economic security issue, Noorchashm said.

"We're very good at talking about threats to the security of our nation, we're very good at going 5,000 miles away and saying, 'ISIS does this, ISIS does that,' but when something clear-cut like this comes out in our own system, we are virtually paralyzed at solving it. That's not right," Noorchashm said.

"Amy alone—one patient, one device—she had a $30,000 operation, which has, up to date, cost about half a million dollars in follow-up care. You take that,

and you integrate that over all the people that have been hurt over 20 years—the cost to the insurance infrastructure will be in the billions of dollars. And this is just one device.

"There is no real safety testing to make medical devices in this country safe, and the morcellation example is the bellwether case for that."

False-Positive Mammograms, Overdiagnosis Cost $4 Billion

The costs of false-positive mammograms and breast cancer overdiagnoses add up to $4 billion a year, according to a paper in the April edition of the journal Health Affairs.

The issue contains a cluster of papers focusing on the cost and quality of cancer care.

"This is imprecision medicine, where we are precisely treating the wrong patients a certain fraction of the time," said Kenneth Mandl, professor at Harvard Medical School and the Boston Children's Hospital Chair in Biomedical Informatics and Population Health.

One alternative approach is "personalized screening, which is based on a risk factor or a set of risk factors," Mandl said at a press conference April 7.

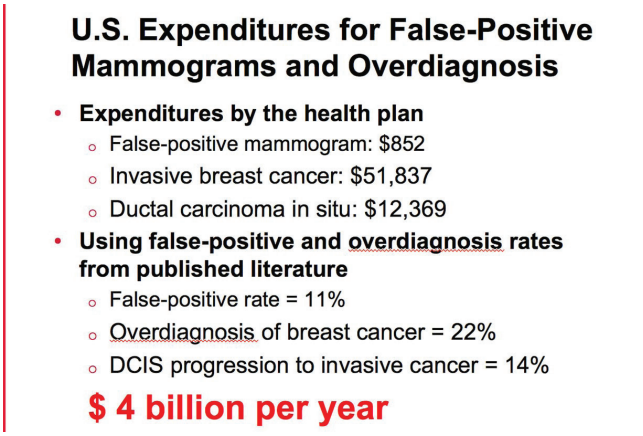
The paper, co-authored by Mandl with Mei-Sing Ong, of the Boston Children's Hospital Informatics Program, assessed the costs as the result of false-positive mammograms and breast cancer overdiagnoses among more than 700,000 women ages 40–59 between 2011 and 2013.

Average expenditures for each false-positive mammogram, invasive breast cancer, and ductal carcinoma in situ in the twelve months following diagnosis were $852, $51,837 and $12,369, respectively.

"We have to recognize that with $4 billion of revenue supporting a certain mode of operation, if we are going to change the guidelines, it would be remiss for us not to understand that there may be a revenue shift and that there may be resistance on that point," Mandl said.

It's not easy to explain false positives and overdiagnoses to patients, Mandl said.

"If you said 'There is a chance that we will get a false positive, we will get through it, its going to be stressful but there is a big benefit at the end,' versus 'It turns out the most likely thing that will happen to you is a false-positive, a very likely thing is an overdiagnosis, and there is actually a very small percentage that can be treated, so if you did nothing,' then a woman and her family will have a different take."



Other papers in the cancer issue of Health Affairs include:

• Does increased spending on breast cancer treatment result in improved outcomes?

Aaron Feinstein of Yale University School of Medicine's Cancer Outcomes, Public Policy, and Effectiveness Research Center and coauthors compared care costs and survival rates among women ages 67–94 diagnosed with stage II or III breast cancer during two time periods, 1994–96 and 2004–06.

They found that over the course of a decade, median cancer-related costs increased from $12,335 to $17,396 among women with stage II disease, and their five-year survival rate improved from 67.8 to 72.5 percent. For those women with stage III disease, costs increased from $18,107 to $32,598 with an accompanying five-year survival improvement from 38.5 to 51.9 percent.

The cost increase was largely attributable to a substantial increase in the cost of chemotherapy and radiation therapy. The authors note that the price society is willing to pay for an additional year of life remains controversial in the United States and suggest that more research is needed to determine how to best contain costs while continuing to advance patient care.

• For Uninsured Cancer Patients, Outpatient Charges Can Be Costly, Putting Treatments Out of Reach; Stacie Dusetzina of the University of Carolina at Chapel Hill and coauthors.

• Cancer Mortality Reductions Were Greatest Among Countries Where Cancer Care Spending Rose The Most, 1995–2007; Warren Stevens of Precision Health Economics, Dana Goldman of the Schaeffer Center for HealthPolicy and Economics at the University of Southern California, and coauthors.

• One of the nation's largest fee-for-value initiatives among the first to show promise;

Christy Harris Lemak of the University of Alabama at Birmingham and coauthors analyzed Blue Cross Blue Shield of Michigan's Physician Group Incentive Program's impact on quality and spending for more than three million beneficiaries across 11,000 primary care practices from 2008 to 2011. They found practice participation in the fee-for-value program was associated with approximately 1.1 percent lower total spending for adults and a 5.1 percent reduction in total spending for children. At the same time, the practices maintained or improved performance on eleven of fourteen quality measures—including screenings for patients with diabetes, breast and cervical cancer screenings, and well-child visits. The authors note that the findings contribute to the growing body of evidence in favor of models that align physician payment with cost and quality performance.

Publication of the cancer studies in the April issue was supported by Precision Health Economics and Celgene Corp.

In Brief

Portteus Named President, CEO of LIVESTRONG Foundation

(Continued from page 1)

for improving quality and safety across patient care, including the implementation of a regional medical staff quality program.

Previously at Mayo Clinic, she served as vice president of organizational performance, learning and innovation; vice president of operations; chief financial officer; and director of patient flow.

CHANDINI PORTTEUS was named president and CEO of **LIVESTRONG Foundation**.

Portteus most recently served as chief mission officer at Susan G. Komen For The Cure, where she was instrumental in creating initiatives involving more than 30 countries. Her global programming work included fundraising with major donors and partnerships Fortune 100 companies.

In addition, she was the architect and relationship manager for the scientific advisory bodies of Susan G. Komen, which included the Scientific Advisory Board and the Komen Scholars.

Previously, she worked in sales for Knoll Pharmaceutical, as well as conducting clinical research at UT Southwestern Medical School, Children's Medical Center, UT Houston School of Public Health and Parkland Hospital.

MARGARET HAMBURG, former commissioner of FDA, was appointed foreign secretary of the **Institute of Medicine**.

In this part-time position, Hamburg will serve as a senior advisor on international matters to the IOM president and council and as liaison to foreign academies of medicine and science. Her term is effective through June 30, 2019.

She succeeds Jo Ivey Boufford, president of the New York Academy of Medicine, who served in the position for eight-and-a-half years.

Hamburg was appointed commissioner of the FDA in May 2009, the second woman to serve in this position. Her past roles have also included senior scientist at the Nuclear Threat Initiative; assistant secretary for policy and evaluation in the Department of Health and Human Services; and commissioner of the New York City Department of Health and Mental Hygiene.

Hamburg is the daughter of David Hamburg, who served as president of the IOM from 1975 to 1980. Since her election to the IOM membership in 1994, she has actively contributed to the mission of the IOM as chair of the Board on Global Health (2005-2009) and as a member of the IOM Council (2005-2009) and various consensus and convening activities.

THE NCCN FOUNDATION awarded its fifth series of Young Investigator Awards to six oncology researchers from NCCN Member Institutions.

The awards provide grants of $150,000 over a two-year period for research initiatives focused on assessing and improving outcomes in cancer care, beginning in July. The studies will be managed and overseen by the NCCN Oncology Research Program.

The awards were made possible through support from AbbVie, Amgen, Genentech, Gilead, Merck, Millennium, Pfizer and Sigma-Tau.

The award recipients and their studies are:

James Blachly, of The Ohio State University Comprehensive Cancer Center – James Cancer Hospital and Solove Research Institute, for "Genomic Stratification and Prognostication of Adult Acute Myeloid Leukemia by Combination Mutation Status."

Roisin Connolly, of the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, for "Harnessing the Immune System to Treat Breast Cancer: Novel Mechanisms of Resistance and Treatment Strategies."

Areej El-Jawahri, of Massachusetts General Hospital Cancer Center, for "A Multimodal Intervention

to Address Sexual Dysfunction in Hematopoietic Stem Cell Transplant Survivors."

Douglas Johnson, of Vanderbilt-Ingram Cancer Center, for "Survivorship in Patients Receiving Immune Checkpoint Inhibitors."

Todd Morgan, of the University of Michigan Comprehensive Cancer Center, for "Tissue-Based Genomics for Risk Stratification in Localized Renal Cell Carcinoma."

Alpa Nick, of MD Anderson Cancer Center, for "Matched Pair Pharmacodynamics and Feasibility Study of Pembrolizumab in Combination with Chemotherapy in Frontline Ovarian Cancer."

CHRISTINA COUGHLIN was named chief medical officer of **Immunocore Ltd.**

Most recently, Coughlin was leading two early development programs at Novartis in checkpoint inhibition and PI3 kinase inhibition. She led the overall program early development teams, including preclinical pharmacology, toxicology, clinical pharmacology, clinical development, biomarker development and regulatory work.

Before that, she served as international project team leader at Morphotek Inc., where she led the early clinical development team responsible for monoclonal antibody development against novel targets.

GERRIT LOS was named vice president of pharmacology at **AnaptysBio Inc**.

Los will lead translational biology across the company's antibody pipeline, including programs focused in immuno-oncology. Los will report to Macro Londei, AnaptysBio's chief development officer.

Los joins AnaptysBio from Five Prime Therapeutics, where he led translational medicine across several immuno-oncology related biologics. Prior to Five Prime, Los was head of cancer biology at Pfizer, where he directed teams responsible for the development of several targeted cancer therapeutics, including crizotinib, axitinib and palbociclib.

Prior to Pfizer, Los was an adjunct professor at the University of California San Diego where his work focused on identifying response markers in cancer.

Draft Guideline on Colorectal Cancer Biomarker Published

The American Society for Clinical Pathology, the College of American Pathologists, the Association for Molecular Pathology, and the American Society of Clinical Oncology released a draft of a clinical practice guideline on the use of molecular marker testing for patients with primary or metastatic colorectal carcinoma.

This evidence-based guideline will help establish standard molecular marker testing, guide targeted therapies, and advance personalized care for these patients.

The draft guidance document, "Guideline on the Evaluation of Molecular Markers for Colorectal Cancer Workgroup Draft Recommendations Summary," (#CRCOCP) is now available online for public comment through April 22, 2015.

The draft guidance is designed to identify opportunities for improving patient outcomes.

The co-chairs, one from each of the four organizations, utilized the expertise of more than 25 specialists in a variety of disciplines, including pathologists and oncologists as well as patient advocates, to draft the guidance document.

The multi-disciplinary perspective has resulted in a thorough set of draft recommendations that streamline processes and contribute to improving patient outcomes.

"While other colorectal cancer biomarker guidelines have been published, they tend to focus on one marker or a small panel of markers for one specific clinical use, unlike the collaborative multidisciplinary approach for this guideline," said Stanley R. Hamilton, of MD Anderson Cancer Center, project co-chair on behalf of CAP. "This guideline addresses all current molecular markers that can impact treatment decisions for patients with colorectal cancer. To date, there isn't an evidence-based guideline that's quite as all-encompassing and patient-centered as this one."

Input from stakeholders, including scientists, clinicians, government agencies, other non-profit organizations, patients, patient advocates, and members of the public is critical to the release of a final set of recommendations for the care of patients with colorectal cancer.

The final guidance document is targeted for publication later this year.

"Given the rapid evolution of the field, we have 'future proofed' the document with a research section that acknowledges molecular markers and tests on the horizon," said Carmen Allegra, od the University of Florida Health Cancer Center, project co-chair on behalf of ASCO."

Drugs & Targets

Vectibix Gets European Approval for Wild-Type RAS Colon Cancer

The European Commission approved a new use of Vectibix (panitumumab) as first-line treatment in combination with FOLFIRI chemotherapy for the treatment of adult patients with wild-type RAS metastatic colorectal cancer.

The new indication is based upon studies that evaluated Vectibix plus FOLFIRI in the first-line setting. Vectibix is now approved in the European Union for the treatment of adult patients with WT RAS mCRC: in first-line in combination with FOLFOX or FOLFIRI; in second-line in combination with FOLFIRI for patients who have received first-line fluoropyrimidine-based chemotherapy (excluding irinotecan); and as monotherapy after failure of fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy regimens.

In the U.S., Vectibix is indicated for the treatment of patients with wild-type KRAS (exon 2 in codons 12 or 13) metastatic colorectal cancer as determined by an FDA-approved test for this use: as first-line therapy in combination with FOLFOX; or as a monotherapy following disease progression after prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy.

Intrexon Corp. signed a cooperative research and development agreement with NCI for the development of adoptive T cell therapies utilizing the RheoSwitch Therapeutic System platform for the treatment of solid tumor malignancies.

The CRADA's principal goal is to develop adoptive cell transfer-based immunotherapies using NCI proprietary methods for the identification of autologous peripheral blood lymphocytes possessing naturally occurring anti-tumor activity combined with Intrexon's RTS gene switch for introducing spatially and temporally controlled interleukin-12 expression.

RTS enables transcriptional regulation of a wide variety of therapeutic genes upon dosing of an oral activator ligand veledimex, including in vivo modulation of IL-12 gene expression with a broad dynamic range.

As the first gene switch employed in the clinic to enable dose-dependent cytokine expression and offer the ability to administer or withdraw veledimex for continued treatment cycles, the RheoSwitch platform provides the opportunity to tailor solutions for patient-specific therapeutic effects. Lead anti-tumor ACT/PBL/IL-12 cell therapy candidates will then be clinically evaluated by NCI in patients with metastatic cancer.

Under the CRADA, Steven Rosenberg, chief of the surgery branch in the Center for Cancer Research at the NCI, will be the principal investigator for the study, and Gregory Frost, senior vice president and head of Intrexon's Health Sector, will serve as co-investigator.

Rubicon Genomics Inc. extended its clinical supply agreement with Agendia for use of its TransPLEX whole genome RNA amplification technology.

Agendia uses the TransPLEX C-WTA kits for the analysis of patient samples for its MammaPrint 70-Gene breast cancer recurrence assay, which recently received 510(k) clearance from FDA. This new three-year agreement follows an earlier contract between the two companies.

Financial details of the agreement were not disclosed. TransPLEX C-WTA kits are manufactured under cGMP and are available for clinical use.

Merck and Pfizer will begin co-promoting Xalkori in the U.S., Canada, Japan and five European Union countries: France, Germany, Italy, Spain and the U.K.

In the U.S. and Canada, Xalkori will be co-promoted by EMD Serono, the US and Canadian biopharmaceutical businesses of Merck.

Xalkori will be co-promoted in two waves, the first of which will begin in the second and third quarters of 2015 in the U.S., Canada, Japan and five European Union countries. The second wave will begin in 2016, and includes China and Turkey.

In 2015, Merck will receive a reimbursement associated with its promotion of Xalkori, followed by an 80 percent (Pfizer), 20 percent (Merck) profit sharing on the product starting in 2016. The co-promotion term will last through 2020 for the first wave and from Jan. 1, 2016 through Dec. 31, 2021 in China and Turkey. Pfizer will report the sales of Xalkori in countries where it is co-promoted with Merck.

This co-promotion relationship is related to the announcement in November 2014 of a global strategic alliance between Merck and Pfizer to jointly develop and commercialize avelumab, an investigational anti-PD-L1 monoclonal antibody, to accelerate the development of immuno-oncology medicines for patients with cancer. The immuno-oncology alliance will also advance Pfizer's PD-1 antibody.