THE CANCER LETTER

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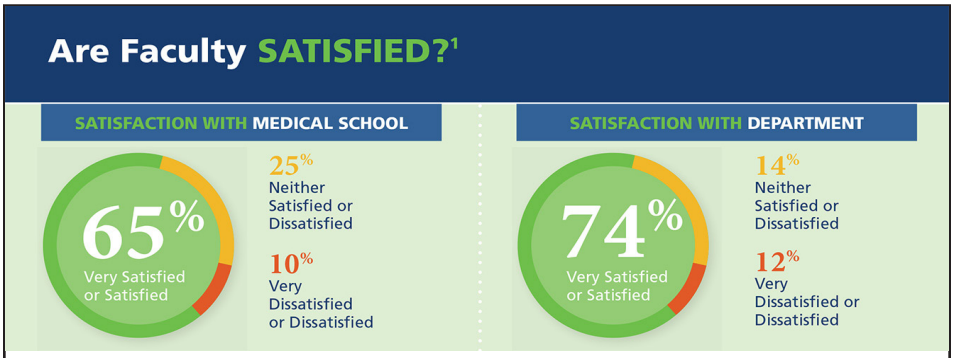

Is Everyone in Academic Medicine Unhappy? Or is it Just MD Anderson?

By Paul Goldberg

Faculty members at MD Anderson Cancer Center are arguably the most intensely watched cohort in academic medicine. Their angst has been measured four times by three administrative entities over two years.

Now, the institution's president, Ronald DePinho, is under a mandate from his bosses to improve faculty morale (The Cancer Letter, Nov. 7).

Are these folks an anomaly, or is everyone in academic medicine unhappy these days?

There is a place to obtain comparison data: the Faculty Forward Engagement Survey conducted by the Association of American Medical Colleges.

(Continued to page 2)

Government Funding

Senate Debates $1.1 Trillion "Cromnibus" Bill That Includes a $150 Million Increase for NIH

By Matthew Bin Han Ong

Early Friday morning, President Barack Obama signed a two-day funding resolution averting a government shutdown and giving the Senate time to debate a $1.1 trillion funding package passed by the House of Representatives late Thursday night.

The year-long "cromnibus" bill—a Washington-speak portmanteau of continuing resolution and omnibus—passed by a 219-to-206 vote three hours before government funding expired.

(Continued to page 9)

Daniel Hayes Elected President of ASCO

DANIEL HAYES was elected president of the **American Society of Clinical Oncology**.

The three-year appointment begins with Hayes becoming president-elect on June 1, 2015. He will serve as president from June 1, 2016, to May 31, 2017, and will serve as immediate past-president for the year after.

(Continued to page 14)

MD Anderson Faculty Surveys Show 12 Point Drop in Satisfaction

(Continued from page 1)

That survey was last administered in 2011 to 15,570 faculty from 14 academic medical centers. MD Anderson wasn't a part of that survey, and the questionnaire isn't identical with those used at the Houston-based cancer center.

In the AAMC survey, 65 percent of faculty members said they were either satisfied or very satisfied with their institutions.

This is similar to the results seen in the MD Anderson administration's 2014 BIG Survey, which gauged overall faculty satisfaction at 64 percent (The Cancer Letter, May 23).

If MD Anderson's data is roughly the same as those in the AAMC survey, what's the problem?

MD Anderson faculty satisfaction has incontrovertibly slipped from a higher level. In 2012, the same survey measured satisfaction that was 12 percentage points higher—76 percent.

The 2012 BIG Survey was taken soon after AAMC collected its primary data. Today, the faculty's satisfaction with MD Anderson may be no worse than it is on other medical campuses—but, certainly, MD Anderson's faculty is used to feeling better about the place.

A more recent survey, administered by the UT System, posed the question differently, asking faculty to rate agreement with this statement "I support the changes being implemented by executive leadership."

One in four faculty members said they agreed with the statement. The same proportion—25 percent—agreed with the statement "Executive leadership has shown appropriate recognition of my contribution to the institution."

Now, how do these faculty members intend to cure their disaffection? Will they stay put or will they go elsewhere?

The surveys aren't identical in addressing this question:

• In the AAMC survey, 10 percent said they plan to leave their institution in the next one to two years. Another three percent said they plan to retire in the same period.

• In the BIG Survey, 57 percent of faculty members agreed with the statement "If I were offered a comparable position with similar pay and benefits, I would stay at MD Anderson."

• In an earlier survey by the Faculty Senate, 9.3 percent of the 500 faculty members who responded said they would likely leave within a year, another 22 percent said they would likely leave within three years, and 20.5 percent said they would leave within five years (The Cancer Letter, Jan. 18, 2013).

"The faculty scores used to gauge satisfaction in MD Anderson's 2014 employee survey data are actually higher in many areas when compared to the AAMC's survey scores across several U.S. medical schools," MD Anderson officials said in a statement to The Cancer Letter.

"At MD Anderson, 83 percent of faculty said their work provides a sense of personal accomplishment, 70 percent feel energized by their jobs and 70 percent would recommend MD Anderson as a great place to work. In addition, 79 percent of our faculty see a clear link between their work and MD Anderson's mission."

However, a large number of faculty stars have left MD Anderson.

The cancer center's administrators say that, statistically, attrition was never out of the ordinary, and it may have slowed down in recent months (The Cancer Letter, Jan. 17).

In the 2014 fiscal year, 90 percent of the faculty considering competing offers from other institutions were retained, according to MD Anderson. The center also has the highest five-year retention rate among tenured/term-appointed faculty members across all UT health institutions and the second-highest five-year retention rate among tenured/term-appointed faculty members across all UT System institutions.

Meanwhile, the cancer center's NCI funding has dropped below the 2003 level, even before adjusting for inflation (The Cancer Letter, Oct. 31). The center's officials say that this change is explained in part by the fact that many MD Anderson researchers pursue

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Are Faculty SATISFIED?[1]

SATISFACTION WITH MEDICAL SCHOOL

65% Very Satisfied or Satisfied

25% Neither Satisfied or Dissatisfied

10% Very Dissatisfied or Dissatisfied

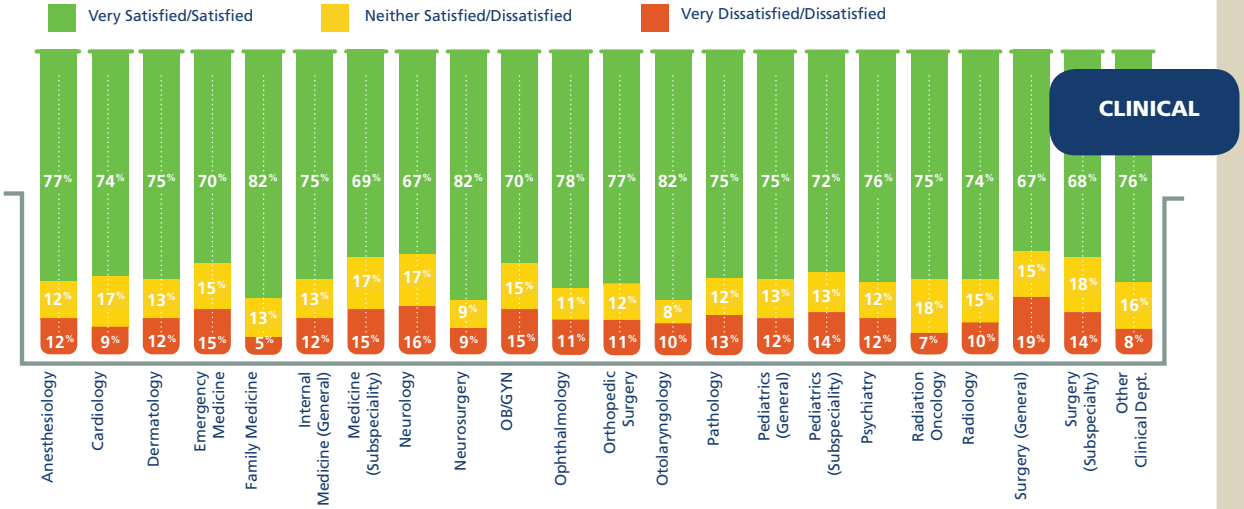
SATISFACTION WITH DEPARTMENT

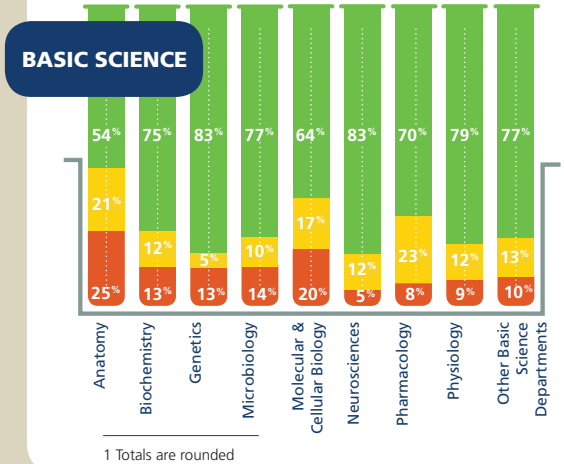
74% Very Satisfied or Satisfied

14% Neither Satisfied or Dissatisfied

12% Very Dissatisfied or Dissatisfied

Overall Satisfaction with Department: A look at Satisfaction by Specialty





1 Totals are rounded

Who Stays and Who Leaves?

Respondent Characteristic	YES	NO	UNSURE
Plan to retire in the next 1–2 years	3%	91%	7%
Plan to leave this medical school in the next 1–2 years	10%	71%	19%
Plan to retire, leave the medical school, or leave academic medicine in the next 1–2 years	13%	67%	20%

Source: AAMC's Faculty Forward Engagement Survey

grants from the Cancer Prevention and Research Institute of Texas (The Cancer Letter, Nov. 7).

In an effort to explain the findings of the latest UT System survey, MD Anderson administrators said that academic medicine in general isn't a happy place.

"While some concerns raised by faculty are unique to MD Anderson, tension between faculty and leadership is unfortunately common at most academic health institutions in the United States," officials said in a statement explaining the latest survey results.

"Faculty members at American health institutions are facing unprecedented pressures derived from the reduced availability of federal funding for research and the greater reliance on clinical operations funding to help fill this void; the greater need for clinical productivity in the face of declining reimbursement from all payors; and a mounting regulatory burden that restricts the time devoted to actual patient care, research and education."

The UT System survey of MD Anderson faculty focused mainly on the role of the administration.

Here are the highlights:

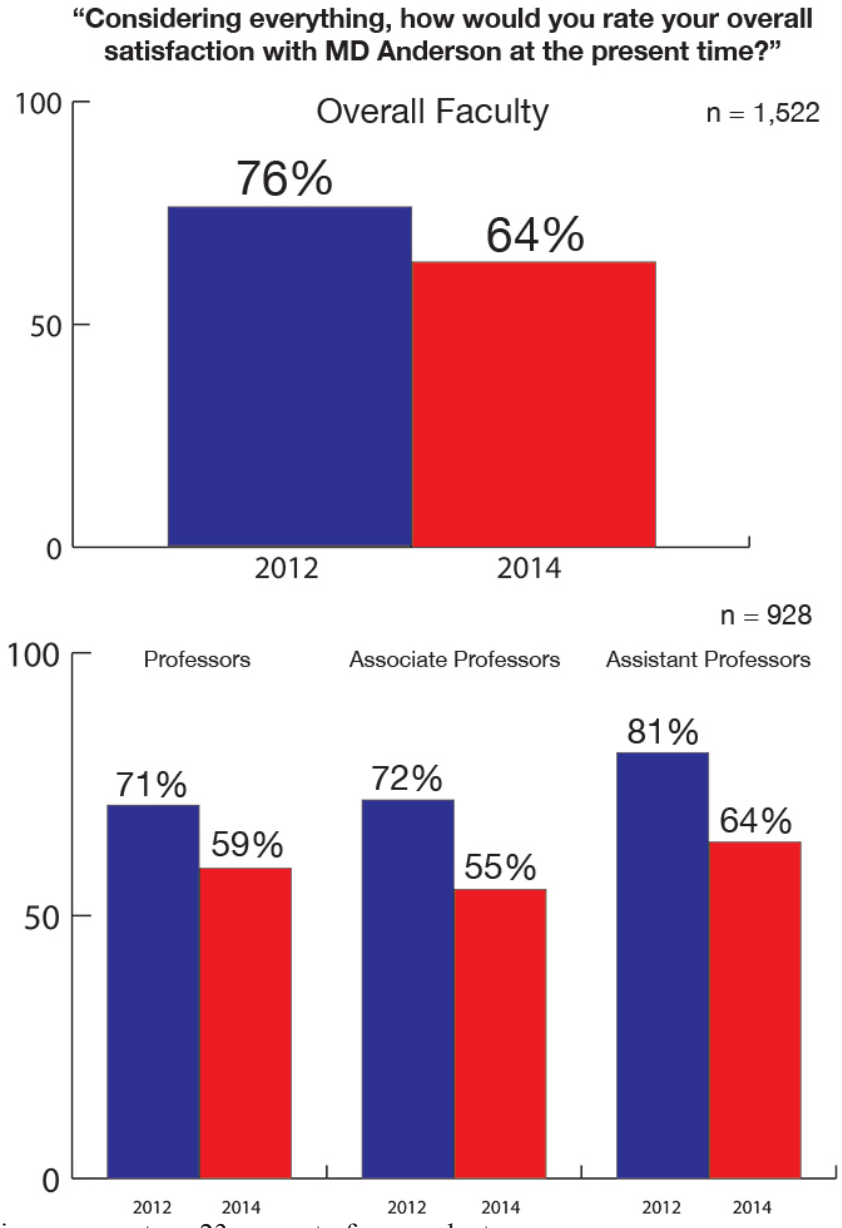
Clinicians were split on the question of patient safety, with 39 percent saying they were satisfied with patient safety, and 34 percent saying they were dissatisfied. This assessment of patient safety is consistent with the results from a 2013 Faculty Senate survey, where clinicians said that the administration's demands to increase workloads have eroded patient safety (The Cancer Letter, Sept. 20, 2013).

One in four faculty members said they agreed with the statement "I support the changes being implemented by executive leadership."

The same proportion, 25 percent, agreed with the statement "Executive leadership has shown appropriate recognition of my contribution to the institution."

Only 14 percent agreed with the assertion that "overall morale has improved as a result of recent changes made by the executive leadership."

The statement "Executive leadership is open to faculty ideas and recommendations," was supported by 23 percent of respondents.



Among clinicians, 19 percent said they were satisfied with clinical expectations, 15 percent said they had sufficient time for academic responsibilities.

Among non-clinicians, 45 percent were dissatisfied with institutional support for their research, while 31 percent expressed satisfaction.

The latest MD Anderson survey results are available here.

The UT System's brief survey, which contained six questions, was sent to 1,578 faculty members at MD Anderson in September. Responses were received from 966 faculty members, which included 640 clinicians and 326 non-clinicians. The faculty members were asked to focus on their experience over the last six months.

In response to the survey, the institution's management has asked department heads to directly

MD Anderson Faculty Surveys

May 2014

The BIG Survey | Faculty By Rank | ITEM DETAIL

KEY ■ Favorable ■ Neutral ■ Unfavorable ~ No Data Available

★ **Strengths:** Indicate that the 2014 results are significantly higher than the 2012 results.

⚑ **Concerns:** Indicate that the 2014 results are significantly lower than the 2012 results.

ORGANIZATIONAL COMMITMENT	2014 External Benchmark	2010 Results	2012 Results	Strengths/ Concerns	2014 Results
ORGANIZATIONAL COMMITMENT	~	67%	69%		62% 22% 16%
14. I feel valued as an employee of MD Anderson.	64%	68%	74%		68% 18% 15%
26. I would sacrifice a great deal if I were to leave MD Anderson.	~	62%	64%		59% 26% 15%
37. If I were offered a comparable position with similar pay and benefits at another organization, I would stay with MD Anderson.*	68%	63%	62%		57% 25% 18%
38. Considering everything, how would you rate your overall satisfaction with MD Anderson at the present time? *	72%	75%	76%	⚑	64% 20% 16%

November 2014

Question 1:	CLINICAL FACULTY Strongly Agree or Agree	Neutral	Strongly Disagree or Disagree	Response Count	NON-CLINICAL FACULTY Strongly Agree or Agree	Neutral	Strongly Disagree or Disagree	Response Count
Executive Leadership has made changes which are positive	31%	29%	40%	639	29%	29%	42%	326
Executive Leadership is appropriately responding to important internal issues	25%	25%	50%	639	22%	24%	53%	326
I support the changes being implemented by Executive Leadership	25%	35%	40%	636	26%	31%	43%	325
			answered question	639			*answered question*	326
			skipped question	1			*skipped question*	0

gather additional information from faculty, and has pushed leaders to spend more time in clinics, labs, staff meetings, and feedback sessions, according to MD Anderson officials. The leadership is also addressing the previously voiced frustrations related to the institution's computer technology, and is increasing the regularity and the depth of communications regarding MD Anderson's finances.

AAMC Survey

AAMC's Faculty Forward Engagement Survey measures faculty engagement and retention intentions at any given point in time.

AAMC has measured the levels of satisfaction by specialty. In the category called "Medicine (subspecialty)," which includes oncology, satisfaction with the medical school runs at 69 percent and dissatisfaction at 15 percent.

These results were published last year.

The metrics of satisfaction have improved slightly since the previous survey, published in 2010.

Clinicians are less satisfied with the way their institutions communicate financial information. Only 28 percent of respondents in the AAMC survey agreed with the statement: "Senior leadership does a good job explaining medical school finances to the faculty." Similarly, 39 percent said they were satisfied with communication to physicians about their practice

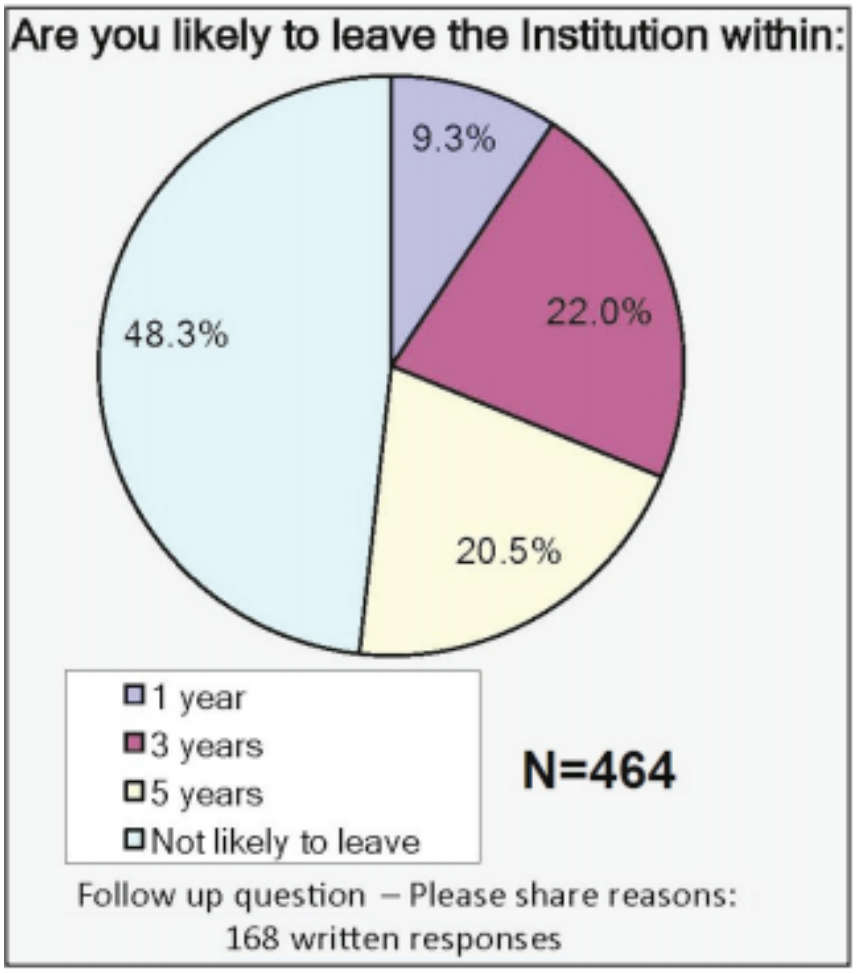
location's financial status.

MD Anderson officials said comparing their surveys with AAMC's is "a case of comparing apples to oranges," as the data does not align, and both sets of surveys asked different questions.

But overall, faculty members don't like to move: only 13 percent said they planned to leave their medical school. This includes retirement (3 percent) and other reasons (10 percent).

When faculty members decamp for other institutions, replacing them is expensive. Other AAMC data state that the mean cost of replacing a surgeon in 2009 was $587,123. Replacing a subspecialist cost $286,503, and replacing a generalist cost $115,554. The average medical school loses $1.7 to $2.3 million in turnover costs per year, AAMC estimates.

Satisfaction with organization, governance and transparency drives overall satisfaction. "Our results show that the survey dimensions predicted the global satisfaction measures well and illustrate several dimensions that were consistent predictors across models." said the AAMC.



"First, organization, governance, and transparency, within the department and the medical school, predicted faculty satisfaction with their department and medical school, respectively. Organization, governance and transparency were the top predictors of global satisfaction with the faculty members' departments and medical schools.

"This finding is notable because, despite significant environmental challenges like the evolving health care system, leaders still can have a strong, positive influence on their faculty. We posit that a culture characterized by open communication, consistency in decision making, and opportunities for faculty input contributes to faculty perceptions of their worth to their institution and of institutional equity, all of which foster satisfaction."

The AAMC published their results in an article titled "Predictors of Workplace Satisfaction for U.S. Medical School Faculty in an Era of Change and Challenge."

"Our philosophy is for schools to survey every three years, a period during which results can be analyzed, actions from these results can be identified, and changes can be implemented to improve the faculty workplace," said Valerie Dandar, senior research specialist for Faculty Forward at AAMC. "Workplace change generally will take this long to take effect. Many schools that have used the survey have seen improvements in faculty satisfaction over time."

Nearly one-in-three medical schools have administered the Faculty Forward Engagement Survey since 2009. The survey continues to be administered at any time a medical school requests and is offered to all full- and part-time faculty. Some of the institutions that participated in 2009 are now preparing to administer a third survey in order to continue measuring faculty perceptions of their departments and institution.

"Some of the institutions that participated in the 2009 survey also surveyed again between 2011 and 2014, thus it is not surprising that we see an improvement amongst some of the department level data," Dandar said. "However, it should be considered that in addition to the new policies and practices an institution might implement based on their survey data, leadership changes and new faculty participants may affect changes in results as well."

MD Anderson's Response

The following is the full text of the response from MD Anderson officials to questions submitted by The Cancer Letter:

1. It appears the 2014 BIG Survey faculty satisfaction scores are rather similar to the average score (in the 65% range) in the AAMC survey, but it should be noted that MDA's 2014 score is also significantly lower than in previous years. How is overall faculty morale at MD Anderson?

The faculty scores used to gauge satisfaction in MD Anderson's 2014 employee survey data are actually higher in many areas when compared to the AAMC's survey scores across several U.S. medical schools. At MD Anderson, 83 percent of faculty said their work provides a sense of personal accomplishment, 70 percent feel energized by their jobs and 70 percent would recommend MD Anderson as a great place to work. In addition, 79 percent of our faculty see a clear link between their work and MD Anderson's mission.

That being said, comparing two different types of surveys to try and extract meaningful conclusions is difficult. You're never certain if the comparison is accurate or if the different types of data you're comparing truly aligns. It's likely best to separate the two.

With that in mind, MD Anderson's survey that focuses specifically on our faculty and staff opinions provides helpful information about what we can do to improve the working environment and areas where we're on the right track. Our latest data shows there's work to be done in establishing improved relationships and communications between leadership and faculty. That work is ongoing and expanding as we move forward.

As for your questions where you compare the most recent MD Anderson survey results to past MD Anderson survey results, the Cancer Letter covered the 2014 MD Anderson faculty survey at length, including a comparison to previous surveys this year. We invite you to revisit our comments for that story where you posed the same kinds of questions to us.

2. What is the administration doing to address this drop?

That work is extensive, ongoing and expanding. Here are a few examples.

• We've launched extensive efforts to get our leaders out of the office and into our clinics, labs and other work settings to talk with faculty. They attend staff meetings and feedback sessions to listen to concerns and take those thoughts and ideas back to the rest of the administrative team.

• Engagement efforts were extensive throughout our recent strategic planning process. Communications took place face-to-face, through email and online.

• We have expanded the extent of our communications, especially in areas where faculty and staff have requested more information.

• In response to the most recent faculty survey data, we've asked department heads to gather additional information to help us react and respond.

• We're addressing some of the logistical frustrations voiced by faculty related to computer technology used as part of our business.

• In response to our faculty's request to receive more information about MD Anderson's finances, we're increasing the regularity and depth of detail of these communications.

• We're investigating what we can do to help staff manage the expanding regulatory requirements we face. We want to ensure we're operating efficiently, safely and effectively, while reducing as much time burden for staff as possible.

3. What is the status of the admin's dialogues with the faculty?

See above answer which also addresses this question.

4. In an abstract comparison of the following data, it would appear that a significant number of MDA faculty would leave if comparable positions are available, and that a higher-than-AAMC number would leave between one to three years. What do these data mean to MDA, and its retention of quality faculty members?

• In the AAMC survey, 10 percent said they plan to leave their institution in the one to two years. Another three percent said they plan to retire in the same period.

• In the BIG Survey, 57 percent of faculty members agreed with the statement "If I were offered a comparable position with similar pay and benefits, I would stay at MD Anderson."

• In an earlier survey by the Faculty Senate, 9.3 percent of the 500 faculty members who responded said they would likely leave within a year, another 22 percent said they would likely leave within three

years, and 20.5 percent said they would leave within five years.

As we said earlier, comparing the results of two separate surveys conducted for two separate populations at two different times and locations will not likely result in meaningful data. It's impossible for us to respond to these comparisons because the data doesn't align. It's a case of comparing apples to oranges. For example, as you're likely aware, variations in the way survey questions are posed generate varying responses. MD Anderson's survey question about staff mobility includes the phrase "If I were offered a comparable position with similar pay and benefits," where AAMC's survey does not. Certainly these types of variations impact responses. Furthermore, AAMC's survey measured faculty attitudes across several institutions through asking general questions. MD Anderson's survey focused on the employees of one organization with much more focused questions with the goal of advancing that organization. Because those surveys are focused on two very different populations responding to surveys with very different goals, the data does not translate from one to the other. We don't believe the Cancer Letter, MD Anderson or another can likely derive meaningful comparisons because of the differences between questions, survey populations and goals of the two instruments.

What we can say is that MD Anderson values faculty and staff, and there's plenty of data to show this. Our faculty retention success is exceptional. In FY14, 90 percent of the faculty considering competing offers from other institutions were retained at MD Anderson. The institution has one of the highest faculty retention rates among all UT System institutions. MD Anderson has the highest five-year retention rate among tenured/term-appointed faculty members across all UT health institutions and the second-highest five-year retention rate among tenured/term-appointed faculty members across all UT System institutions. In the past 18 months, faculty-led search committees have successfully assisted recruiting three clinical division heads — Surgery, Internal Medicine and Radiation Oncology — and three new department chairs. In addition, we were pleased to announce the successful recruitment of Dr. Craig Jordan earlier this year, a world-renowned cancer researcher who played a crucial role in the development of Tamoxifen, a groundbreaking therapeutic drug that has saved countless lives.

When it comes to employees, MD Anderson's success is due in great part to our efforts to hire and retain people who share our passion for our mission. The dedication to them is reflected in many ways, including our regular attempts to obtain their input and reactions so that we can continue to ensure the best for our patients and those who serve them.

Government Funding

NCI Slated for $27 Million Boost In FY2015 "Cromnibus" Bill

(Continued from page 1)

NIH is slated to receive a half-percent increase in the 1,603-page spending bill.

"The NIH total in the Labor-HHS portion of the bill is $30.084 billion and NCI is $4.95 billion," NIH officials said to The Cancer Letter. "That's an increase of $150 million and $27 million, respectively, over the FY 2014 enacted levels."

NCI's increase comes to 0.54 percent.

The legislation would also double the funds—from $25 million to $50 million—for melanoma and other cancer research at the Department of Defense's Peer Reviewed Cancer Research Program.

The House, having completed its last day of legislating for the year, leaves the Senate little choice but to approve the funding bill before midnight on Saturday to keep the government funded through September 2015.

Obama and other White House officials lobbied for the bill, leading dozens of House Democrats to break with Minority Leader Nancy Pelosi (D-Calif.) and back the legislation.

The administration said the bill is worth supporting because it would provide $5.4 billion to fight Ebola and $5 billion for military operations to combat the Islamic State in Iraq and Syria. The measure also provides uninterrupted funding for the Affordable Care Act and the president's immigration executive action.

"The president on a number of occasions has expressed his concern about economic headwinds emanating from Congress and that there is a significant benefit associated with Congress acting responsibly to pass a budget without the threat of a shutdown, and to do so over an extended period of time, over a full year, because it provides the kind of certainty that's important to our economy," said White House Press Secretary Josh Earnest, adding that the president would sign the bill.

Biomedical research advocates called the half-percent increase for NIH "underwhelming."

"The tiny increases included in the 'cromnibus' bill for the National Institutes of Health and our nation's other health research agencies are just that," said Mary Woolley, president and CEO of Research!America. "The underwhelming support for the NIH, the Centers for Disease Control and Prevention, the National Science Foundation and the Food and Drug Administration following years of stagnant funding and budget cuts begs the question—how low can we go, given health threats the likes of which stand to bankrupt the nation?

"And the decision to flat-fund the Agency for Healthcare Research and Quality does not provide what it takes to reduce the much-complained of inefficiencies in our health care system. The pain and economic drain of one disease alone—Alzheimer's—is not going to be effectively confronted without stronger investments in research.

"Every American who wants to see our nation overcome health threats, create jobs and shore up our economy for sustained prosperity must make it clear to the next Congress that it can and must do more, making research and innovation a strategic national priority."

Sustained federal investment in biomedical research is necessary, said Carrie Wolinetz, president of United for Medical Research and deputy vice president for federal relations at the Association of American Universities.

"Congress has missed a major opportunity to fund advances in science and medicine that improve our nation's health and economic outlook, with nearly flat funding for the National Institutes of Health in its FY15 omnibus bill," Wolinetz said.

"With millions of deaths annually from disease, millions more receiving devastating diagnoses every day and a decade of declining funding slowing the progress of scientists in research labs across the country, we call on Congress to renew its effort to fund vital medical research supported by NIH.

"Sustained increases to the NIH budget are necessary to close our nation's innovation deficit— the widening gap between the current medical research funding levels and the investment required to ensure the U.S. remains the world's innovation leader."

Varmus Discusses Grant Policy, Changes in Congress, & Ebola

NCI Director Harold Varmus addressed a joint meeting of the NCI Board of Scientific Advisors and the National Cancer Advisory Board Dec. 2, updating them on his proposed bypass budget for the institute, changes in Congressional leadership, and NCI and NIH grant policy.

He also took the time to congratulate NCI Deputy Director Douglas Lowy—who, along with colleague John Schiller, was honored by President Barack Obama with a National Medal of Technology and Innovation for their work on the HPV vaccine. The full story is available on p. 15.

Varmus also played a short video of President Franklin Delano Roosevelt dedicating Building One on the NIH campus in 1940, in an homage to Obama's NIH visit that day regarding Ebola clinical trials and

research funding.

His remarks to the joint BSA and NCAB meeting follow:

We only have 12 members of the NCAB; there is a slate that has not yet been endorsed by the White House. This is a serious problem to correct. And hopefully we'll get the appointments through.

Today's agenda is long and complicated, in ways I'll mention later, by the presidential visit. But there is a theme here today about presidents and the NIH and you will see more in just a moment.

Today's agenda is in four parts, roughly. We will have some promised follow-ups on the Center for Cancer Genomics and follow-up to our conversation a few meetings ago on e-cigarettes. We'll talk about some grant policies, including K awards and modular grants.

We have three RFAs for approval, shouldn't take too much time. Then we'll have a unified discussion of a very important topic, prevention and early detection. I will point out in advance that we have had many discussions about BSA and NCAB about topics tobacco, aspirin, HPV vaccine and biomarkers and other things that pertain to these topics. But I'm concerned with the excitement about immunotherapy and precision medicine that people get the impression that we're only about therapy; that we're not about early detection and prevention.

I strongly believe though we don't have huge advocacy groups for prevention or people for who the disease was prevented and want us to do more; they don't know their disease was prevented. This is an important part of our effort and we're having this discussion today reviewing some things you heard about before and thinking more broadly about the entire NCI portfolio, to get your impressions whether we're missing things we need to be doing.

I also point out this meeting in a sense continues tomorrow for a few of you, because in response to what happened the last time we had a joint meeting of the NCAB and the BSA, we're going to launch a review of the SPORE program which many of you think needs a deeper evaluation.

I usually say a couple of things about personnel at the NCI. You heard in the past about Lynn Austin becoming our executive officer, deputy director for management. Lynn Austin is here, and has gotten up to speed quickly. She has no specific role in this meeting, but stand up anyway.

Many of you have got to know Linda Weiss over many years, she's been running the Office for Cancer Centers well over a decade, done a remarkable job in that role dealing with both irate and happy cancer center directors, and helping us to reformulate the way we award the cancer centers.

She let me know month or so ago that she's going to retire in March—this might be an appropriate time to give her a round of applause. There will be a national search, or international, for someone to replace her.

I don't have many changes in staff, that's a happy thing, I do have at least couple of staff members of the NCI whose reputation has been elevated by a presidential action, if I can have the next slide.

This is a picture taken a week and a half ago of Doug Lowy and John Schiller in the White House in the East Room about to receive their Medals of Technology and Innovation. I have to add that innovation now is a word that has to be appear in virtually every religious and political ceremony.

I want to say something about what Obama had to say. He gave a wonderful opening to the whole ceremony, but with respect to John and Doug, he said, and I quote, "Douglas Lowy and John Schiller collaborated nearly 30 years and together they developed a technology that led to the vaccine to prevent the cancer-causing HPV virus.

"When they presented their research to drug companies, many told them while their data looked good a vaccine against sexually transmitted disease just wasn't going to work.

"With the help of NIH research funding they can created one of the most successful preventive treatments in decades, potentially saving the lives of millions of young women and girls."

Now a presidential statement of that kind is very helpful to all of us, from the point of view of just enhancing the reputation of the NIH and the NCI, to making a better case for the vaccine.

And many of you recall the report of the President's Cancer Panel. This is the report Barbara Rimer and her colleagues put together, which lays out a very important set of recommendations for improving uptake of the vaccine. And hopefully we can make some use of this presidential statement.

I have permission from the head of the Foundation for National Medals to show a short video that displays some of the characteristics of our honorees. I have pledged to say the following video was produced by the National Science and Technology Medals Foundation through support by Genentech. It's possibly no coincidence that my pal and former post-doc Art Levinson was also one of the winners.

[The video and full story can be found here.]

That was shown at the dinner following the ceremony, and, for those of you noticing Doug's appearance, I can testify having known Doug for over 50 years—we were in college together—that his appearance has not changed in all that time. Pretty notable. Little flecks of gray in the beard maybe, but that's about it.

The importance of statements about NIH from the presidential level is pretty important.

I want to pay homage to that, in part because of Doug and John's prize, but also in part because of today's visit by President Obama, to show you a film put together by the Library of Medicine that commemorates and illustrates the visit that Franklin Roosevelt paid to the NIH campus near the end of his third campaign for the presidency.

He had taken the train from Boston to Washington, and motorcaded out to NIH in the morning of October 31 to acknowledge a gift from the Wilson family, which owned a farm on this property. Now in that time there was much less security; there were no gates around the campus. The campus was quite simple at that time. He's standing on the front porch of Building One.

I want point out a couple of things. This is not the whole speech, it's the segment, and you will see three things. First of all some discussion of the process of getting prepared for World War II, indeed World War II had begun at that point, we just weren't in it.

Secondly, you will hear him say 1937, that was the year he signed the National Cancer Act and established the National Cancer Institute.

At that time if you look carefully at what is emblazoned across the top of the National Institute of Health, and the NCI was also there. The third thing you will hear about is infectious disease, which ties this appearance to today's appearance on behalf of the effort against Ebola.

[The video of FDR is available here.]

The last thing in the movie is a picture of "a national cancer institute." I found that interesting.

I thank the NLM putting this together. The complete talk is easy to get from a variety of sources online if you want to look, it's really pretty remarkable. I hope Obama is up to the—I think he's presently up to that level today, but that's a hard act to match.

I never walk up the steps of building one without thinking about the fact that FDR was on that podium, giving that speech.

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NIH Grant Policy

So let me return to the mundane. A few things about NIH grant policy: we posted the number as we have every year of the success rate for people with different percentile scores to show we do not have a simple pay line. We do review grants that get percentile scores between the range of 10 to 25.

And the score profiles you will see on the website are very much like they were in previous years: overall success rate of 13 to 14 percent depending on what category you look at; R21s versus R01s.

At present, as you know, we're under a continuing resolution, same level as last year, in previous years always under a CR this time of year, we're paying our grants at 90 percent of expected levels with the intention to top those numbers up once we have a full-year appropriation.

One thing that will be of interest is we have one important new grant mechanism, outstanding investigator awards, and we have received 221 applications. We expect, as I said before, to pay roughly 50, plus or minus. So it will be a modest success rate, but it's for people who are used to having a high success rate; these are outstanding people. There will be of course another cohort next year.

Many of you are being asked to be reviewers. It will be a very interesting review exercise, and I hope all of you were asked to participate do because we have a shortage of people who are distinguished in cancer research who would be great reviewers for these programs and who are not themselves applicants—so we urge you, if you're asked, to serve.

Changes in Congress

As you all, I hope, know, we had an election in November that changed the composition of Congress.

The House, which was Republican, is now more Republican. The Senate has become Republican by a modest margin. Absolute numbers are to be determined because a there is a runoff to be played out in Louisiana. [Republican Bill Cassidy won the Dec. 6 runoff election, ousting Democratic incumbent Mary Landrieu.]

There is already some knowledge about our committee chairs. Those experienced in this business know the chairs of our critical committees play a huge role. The appropriations committees in the House and Senate will have some changes, because of change in the Senate.

In the House, however, Hal Rogers (R-Ky.) will still be the chair, and Nita Lowey (D-N.Y.) will be the ranking member for the Democrats.

On the Senate side, Thad Cochran (R-Miss.), who has always been a strong supporter of NIH will be the new chair taking [Barbara] Mikulski's place (D-Md.). She will be extremely supportive of our efforts as ranking member.

On the labor-health subcommittee, which is a critical subcommittee that writes our bills, we will have some substantial changes. We're not sure what is going to happen on the Senate side, but there are rumors that Jerry Moran (R-Kan.), who's a stalwart friend of ours and helped get the cancer center in Kansas up and running, is likely to be the chair. We don't know that for sure.

And it's likely that Patty Murray (D) of Washington will be the ranking member now that Tom Harkin (D-Iowa), one of our great champions, is regrettably retiring from the Senate.

On the House side there's going to be a distinct change because Jack Kingston (R-Ga.) was voted out of Congress when he tried to run for the Senate.

The new chair of the House subcommittee on appropriations Tom Cole (R-Okla.), who is not well-known to us, he's been in our committee, but he's now risen to the chairmanship. He seems to be a very reasonable person with strong interests in the NIH, he's also a graduate of Cornell College, which has nurtured the education of number of important people in biomedical research.

The ranking member will remain Rosa DeLauro (D-Conn.), also a good friend of ours.

Other committees include Energy and Commerce in the House. Fred Upton (R) from Michigan will remain the chair, and he is, as you may recall from a previous meeting here, is running an effort to try to address some of NIH's problems, that's a healthy thing.

The ranking member will be Frank Pallone (D), from New Jersey, after the departure of our good friend Henry Waxman (D-Calif.).

The Health and Education committee, the so-called HELP committee in the Senate, which was previously chaired by Tom Harkin, will likely now, with the Republican takeover, be chaired by Lamar Alexander (R-Tenn.). We don't know for sure. And Patty Murray will probably be the ranking member.

Let me say a couple of things about what you have in front of you, which is the bypass budget and narrative. It's a document that we're pleased with.

It's somewhat different character from previous ones issued under the current realm. It has an account of very broad themes, and not so many specific projects, and very few people mentioned. It compiles our important programs, but doesn't address progress made in specific cancers, as we did in our previous bypass narratives.

It emphasizes large number of changes that remains at the NCI over the last several years despite budgetary shortages and we're obviously proud of that.

Doug [Lowy] who wrote the rough draft we all worked on, points out it's a good account of how our team changed the NCI.

The focus is on elements of the infrastructure, such as new grant mechanisms like the Outstanding Investigator Award or Provocative Questions on other parts of the infrastructure like cancer centers, the clinical trials systems, training mechanisms, the intramural research program, our informatics infrastructure and the Frederick National Lab.

It also says a number of things about some specific broad advances in new scientific programs in basic science, genomics, clinical trial design, immunotherapies, pediatric cancer, the RAS oncogene, cancer prevention and cancer health disparities.

There is a strong budget rationale in my view which is founded on the precept that even the proposed 15 percent increase that we're asking for, one that I do not expect to see achieved in the current Congress, that increase would only partially compensate for the money we have lost over the past decade because of attrition.

In fact, it's more than a billion dollars less than where we should be if we just had the Biomedical Research Price Index increase.

Forty percent of that loss would be recovered by the budget we're proposing, and of course it seems like an outrageous proposal to ask for a 15 percent increase—it's not going to happen, but it is a useful way to put things in perspective. And I thank Pat McGarey for making that argument, Doug for writing a very effective rough draft, and Peter Garrett and his colleagues for getting this all pulled together in time for today's meeting.

NIH, Ebola and NCI Precision Medicine Trials

I want to say a couple of things about some campus-wide issues.

At NIH these days we hear Ebola every day. We have taken care of patient with Ebola on this campus. We are part of the request for supplemental funding which the president will discuss today.

I point out to you that this is not all NIAID. The Frederick National Lab has played a vital role here in doing contract work for NIAID to develop reagents for testing and vaccine production, and that's an important aspect of things.

Let me just say a couple of things about the president's visit today. We learned about this over the weekend, so we weren't able to hire additional people to work in the security center, or hire extra bus drivers.

The president is going to visit the vaccine research center where some of the relevant work has been done and made many of you probably heard on the radio or read in the New England Journal of Medicine about early results in the phase I trial that recently conducted at the Clinical Center with a vaccine that was initiated by Gary Nable when he was director of the VRC.

The vaccine, not taken up by industry ten years ago when it was first tested, now looks like it's maybe on its way to clinical trials in Liberia and other West African countries.

The president will spend a half-hour at the Vaccine Research Center, then will go to the Clinical Center, then the auditorium, and he will speak beginning at 4:50. We hope to have our business out of the way by then, and the speech itself will be streamed into this room at that time, if all goes well.

You are free to try to leave. I don't know what it will be like to get off the campus. It will be as hard as getting on to the campus. It will be easy after the president finishes his remarks and leaves himself; he will be gone by 5:30. So my advice to you, if you can, is to stay and watch the speech, then make your merry way along the freed-up biways. It's also possible to walk to the metro without too much impediment.

In any event we will be moving along as quickly as we can. I have to apologize, as a presidential appointee it's expected that I be over there, so I will leave the prevention discussion around 4:00. I'm sorry about that, but I trust that good minutes will be taken, and maybe I'll be able to stream our meeting on my iPhone sitting there waiting for the president. We'll have to see whether that can be arranged.

Couple of other things.

We talked here in the past about sending a message to the scientific community, that we expect all grant holders to serve on peer review. We have our own way of trying to do this, the NIH embraced this concept, and there will be an expectation of service notification that goes to all institutions, that says we expect your investigators who receive NIH grants to be willing to serve if asked. So that's now going to be an NIH policy as well as NCI's.

Secondly we discussed here before about being sure all trials have their results communicated to the public, either through clinicaltrials.gov or some other mechanism. We have launched our notification of all grant recipients who are doing clinical trials of any kind with NCI money, that they're expected to find a way to make that happen.

The NIH could be doing the same thing, and they're putting a proposal out for comment. And I think we'll have a harmonized policy before long.

I also want to draw your attention to a meeting of the advisory committee to the NIH director that will occur next Thursday and Friday. This meeting addresses a number of topics of great interest to us.

Reports on the Children's Health Study, a large cohort study that's been in difficulty, and a group is asked to comment on how the Children's Health Study should be conducted in the future. Or if it should be conducted.

Secondly, there's going to be a report on the Office of AIDS Research and how it allocates its money to institutes for research and what topics constitute valid topics for use of AIDS funds.

And third, there will be the report we discussed last time on the intramural research program, from a group of folks whose were assembled to evaluate the work of the intramural program. That will bear special attention from many of you. That meeting is streamed and the agenda is available if you're interested in those topics.

A few things about NCI-related themes. Precision medicine is still a dominant factor in our daily lives from many perspectives. For example, we now have quite a number of precision medicine trials as we call them, either just initiated or up and running. Those up and running include the MPACT trial, you'll hear more about that from the presentation of RFA in a couple of hours.

The so-called LUNG MAP trial, which addresses treatment-refractory squamous cell cancer of the lung, is conducted with Foundation for the NIH, NCI and industry money.

A trial called ALCHEMIST that is a test of adjuvant therapies for patients with resectable tumors with EGF receptor mutations and ALK translocations. There are other trials that are opening soon including the exceptional responders investigations, the NCI MATCH trial and a master protocol to test new drugs, second- and third-line drugs against ALK translocations in lung cancer.

There's been a campus-wide discussion on how we usher in an era of precision medicine, not just in cancer, but throughout the repertoire of diseases that NIH addresses, and I think you will hear more about that in the public domain fairly shortly.

To conduct all these trials of course we make use of the new National Clinical Trials Network. We had a

discussion at the last NCAB meeting about how that is working. A discussion was organized by Mack Roach and Jim Doroshow, and Jim will comment briefly about a letter we published on the topic of how we're organizing the new NCTN.

There's been a lot of activity in relation to pediatric cancer and precision medicine. This summer, I spoke at a White House event on this topic and Francis Collins talked to a congressional caucus on pediatric cancer.

There was a discussion at our last joint meeting with Malcolm Smith discussing many results, as well as Daniel Gerhart. They've been charged to make better use of the genomic data coming out of the target program, as well as other genomic data coming from other efforts around the country to design new trials and so forth. We have had further meetings with activists from the pediatric advocacy community, and have told them that many things are happening—a variety of publications are being prepared that describe findings of the various target projects.

There's going to be a workshop, probably in February, that brings together pediatric cancer genome scientists with clinical trialists and a pediatric MATCH trial that sorts patients by molecular lesion into a variety of trial subsets. It is being planned already and hopefully will be launched sometime early next year.

Informatics plays as huge role in precision medicine and many other aspects of what we do, but there are genomic cloud pilots, contracts awarded to three institutions a couple of months ago and the genome data commons that was awarded a few months ago by the Center for Cancer Genomics.

One thing that pleases me is these awardees, the PIs from the Cancer Genome Atlas Project have been getting together; they met in October and will meet again in January to discuss how we're trying to integrate the new proposed informatics infrastructure with the continuing exploration of cancer genomes, and how scientific questions will be approached through these various entities using cloud computing and bringing together all cancer genomic information into one large database.

Another aspect of precision medicine, important to point out, is what's happening in cancer immunotherapy, not initially considered part of precision medicine, but as we learn more about the kinds of tools that are available to enhance the immune response and look at genomic profile of cancers that have responded to immunotherapy, we're learning a lot about the relationship between high mutation rates, tobacco's mutation signature, the nature of the mutated monomers that are created by in cancer cells, the presence of PDL-1 on the surface of cancer cells as well as invading lymphocytes. Successes with not just melanomas, but with kidney and bladder and lung cancers and others; many described in an issue of Nature that appeared last week.

To get off the topic of precision medicine for a moment, we are continuing to look for new projects at the Frederick National Lab and we will evaluate a proposal to create a center for cryo-EM, a form of imaging that has dramatic success the last two years down to roughly a three-angstrom resolution.

Joe Gray and others have been involved in creating a workshop that will bring in 30 people next week to talk about whether it's appropriate to have such a center at the Frederick National Lab for training, carrying out the important projects and collaboration with extramural scientists and serving as a center for following the development of this technology.

Hayes Named ASCO President

(Continued from page 1)

Hayes is the clinical director of the breast oncology program at the University of Michigan Comprehensive Cancer Center.

"I'm honored to be elected incoming president of ASCO, which has had such a major influence on my professional career," says Hayes, the Stuart B. Padnos Professor of Breast Cancer Research at the University of Michigan Comprehensive Cancer Center.

Prior to joining the faculty at the University of Michigan, he held academic appointments at Harvard Medical School and Georgetown University Medical Center.

Hayes has previously served on the ASCO board of directors and has chaired several ASCO guideline committees and its scientific program committee. He has also served as a charter member and co-chair of ASCO's Tumor Marker Guideline Expert Panel.

Hayes serves as chair of the Breast Cancer Intergroup of North America's Correlative Sciences Committee, chair of the Southwest Oncology Group's Breast Cancer Translational Medicine Committee, and is on the Union for International Cancer Control TNM Expert Advisory Panel on Breast Tumours and the Early Breast Cancer Clinical Trials Collaborative Group Executive Committee.

According to ASCO, his term will focus on including new strategies for health care reform; the development of ASCO's CancerLinQ and other efforts; personalized cancer care; and reducing disparities.

NCI's Lowy and Schiller Honored with National Medal

NCI's Douglas Lowy and John Schiller were honored by President Barack Obama with a National Medal of Technology and Innovation, the nation's highest honor for technological achievement, for their work in developing a vaccine for human papilloma virus.

Lowy, deputy director of NCI, and Schiller, of the Laboratory of Cellular Oncology in the NCI Center for Cancer Research, received their awards at a White House Ceremony Nov. 20.

"Douglas Lowy and John Schiller have collaborated for nearly 30 years," said Obama.

"When they presented their research to drug companies, many told them that while their data looked good, a vaccine against this sexually transmitted disease just wasn't going to work. But with the help of NIH research funding, they helped create one of the most successful preventive treatments in decades, potentially saving the lives of millions of young women and girls."

Lowy's and Schiller's research directly led to vaccines that protect against infection with the HPV types that cause most cervical cancers in women and anal and oral cancers in both sexes, as well as HPV types that cause genital warts in both sexes, according to NCI.

During the joint meeting of the NCI Board of Scientific Advisors and the National Cancer Advisory Board Dec. 2, NCI Director Harold Varmus again honored Lowy and Schiller, and said that the statements made by the president are "very helpful to all of us—from the point of view of enhancing the reputation of the NIH and the NCI, to making a better case for the vaccine."

Varmus also presented a video produced by the National Science and Technology Medals Foundation, with support from Genentech, highlighting Lowy and Schiller's work in developing the HPV vaccine.

"Those of you noticing Doug's appearance, I can testify having known Doug for over 50 years—we were in college together—that his appearance has not changed in all that time," said Varmus. "Pretty notable—little flecks of gray in the beard maybe, but that's about it."

Regulatory Approvals

Gardasil 9 Vaccine Covers Five Additional HPV Types

FDA approved Gardasil 9 (Human Papillomavirus 9-valent Vaccine, Recombinant) for the prevention of certain diseases caused by nine types of Human Papillomavirus.

Covering five more HPV types than the version of Gardasil previously approved by the FDA, Gardasil 9 has the potential to prevent approximately 90 percent of cervical, vulvar, vaginal and anal cancers.

Gardasil 9 is approved for use in females ages 9 through 26 and males ages 9 through 15. It is approved for the prevention of cervical, vulvar, vaginal and anal cancers caused by HPV types 16, 18, 31, 33, 45, 52 and 58, and for the prevention of genital warts caused by HPV types 6 or 11.

The five additional HPV types—31, 33, 45, 52 and 58—cause approximately 20 percent of cervical cancers and are not covered by previously FDA-approved HPV vaccines.

A randomized, controlled clinical study was conducted in the U.S. and internationally in approximately 14,000 females ages 16 through 26 who tested negative for vaccine HPV types at the start of the study. Study participants received either Gardasil or Gardasil 9. Gardasil 9 was determined to be 97 percent effective in preventing cervical, vulvar and vaginal cancers caused by the five additional HPV types (31, 33, 45, 52, and 58).

In addition, Gardasil 9 is as effective as Gardasil for the prevention of diseases caused by the four shared HPV types (6, 11, 16, and 18) based on similar antibody responses in participants in clinical studies.

Due to the low incidence of anal cancer caused by the five additional HPV types, the prevention of anal cancer is based on Gardasil's demonstrated effectiveness of 78 percent and additional data on antibodies in males and females who received Gardasil 9.

The effectiveness of Gardasil 9 in females and males ages 9 through 15 was determined in studies that measured antibody responses to the vaccine in approximately 1,200 males and 2,800 females in this age group. Their antibody responses were similar to those in females 16 through 26 years of age. Based on these results, the vaccine is expected to have similar effectiveness when used in this younger age group.

Gardasil 9 is administered as three separate shots, with the initial dose followed by additional shots given two and six months later. For all of the indications for

use approved by the FDA, Gardasil 9's full potential for benefit is obtained by those who are vaccinated prior to becoming infected with the HPV strains covered by the vaccine.

Gardasil 9 is manufactured by Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc.

FDA granted Fast Track designation to DPX-Survivac, a cancer vaccine candidate developed by Immunovaccine, as a maintenance therapy in advanced ovarian, fallopian tube, and peritoneal cancer who have no measureable disease following surgery and front-line platinum/taxane chemotherapy to improve their progression-free survival.

DPX-Survivac is designed to activate immune system T cells expected to recognize and eliminate cancer cells.

Immunovaccine has previously reported positive clinical data for DPX-Survivac in ovarian cancer patients, showing robust and durable CD8 T cell responses for nearly all patients receiving a specified regimen of the vaccine.

The company is finalizing the design of a large randomized phase II trial in ovarian cancer to be sponsored and conducted by Canada's NCIC Clinical Trials Group.

FDA approved a new indication for Xgeva (denosumab) for the treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy. Xgeva was also granted Orphan Drug Designation by the FDA.

HCM is a complication in patients with advanced cancer, including those with hematologic malignancies, resulting from cancer-driven increases in bone resorption, and if untreated, can lead to renal failure, progressive mental impairment, coma and death.

The approval is based on positive results from an open-label, single-arm study, which enrolled patients with advanced cancer and persistent hypercalcemia after recent bisphosphonate treatment.

The primary endpoint was the proportion of patients with a response, defined as albumin-corrected serum calcium <11.5 mg/dL (2.9 mmol/L) within 10 days after the first dose of Xgeva.

Secondary endpoints included the proportion of patients who experienced a complete response (defined as CSC <10.8 mg/dL [2.7 mmol/L]) by day 10, time to response and response duration (defined as the number of days from the first occurrence of CSC <11.5 mg/dL).

The study achieved its primary endpoint with a response rate at day 10 of 63.6 percent in the 33 patients evaluated. The overall complete response rate was 63.6 percent. The estimated median time to response (CSC <11.5 mg/dL) was nine days, and the median duration of response was 104 days.

Xgeva is administered as a 120 mg subcutaneous injection every four weeks with additional doses of 120 mg on days eight and 15 of the first month of therapy.

Xgeva binds to RANK Ligand, a protein essential for the formation, function and survival of osteoclasts, thereby modulating calcium release from bone. Xgeva prevents RANKL from activating its receptor, RANK, on the surface of osteoclasts, thereby decreasing bone destruction and calcium release, according to the drug's sponsor, Amgen.

FDA approved MP Diagnostics HTLV Blot 2.4, the first FDA-licensed supplemental test for human T-cell lymphotropic virus-I/II.

This test is intended for use as an additional, more specific test for human serum or plasma specimens that have previously tested positive on an FDA-licensed HTLV-I/II blood donor screening test. The MP Diagnostics HTLV Blot 2.4 is a qualitative enzyme immunoassay test intended to confirm infection with HTLV and to differentiate between HTLV-I and HTLV-II.

The viruses are a group of human retroviruses known to cause diseases such as adult T-cell leukemia/lymphoma and inflammation of the nerves in the spinal cord, as well as other conditions. HTLV can be transmitted from person to person through breastfeeding, unprotected sexual contact, or transfusion of blood from an infected donor.

Because HTLV can be transmitted through blood, the FDA requires that donated blood be tested for HTLV-I/II antibodies. Currently there are two FDA-licensed screening tests for HTLV-I/II. If the test is positive, the donation is discarded and the donor is notified of his or her deferral. The test, developed by MP Biomedicals, provides blood establishments with additional information to convey to the donor; specifically, the test can confirm infection and determine which virus type is causing the infection, HTLV-I or HTLV-II.

FDA granted clearance for the SAVI SCOUT surgical guidance system, which uses real-time audible and visual indicators to give surgeons a precise way to target tissue during lumpectomy and excisional biopsy procedures. The system is developed by Cianna Medical Inc.

The surgical guidance system uses electromagnetic waves to detect a reflector that can be placed in the target tissue up to seven days prior to surgery. During the procedure, the surgeon then uses a handpiece that emits infrared light and electromagnetic waves, to locate the reflector and plan the incision. The surgeon then removes the reflector and the target tissue.

Results from an ongoing pilot study evaluating successful placement, localization and retrieval were presented at the San Antonio Breast Cancer Symposium. The study included 24 patients, and resulted in 100 percent surgical success. In all cases, the target tissue and reflector were successfully removed; there were no incidents of reflector migration or adverse events. Pathology reports showed clear margins in comparable numbers to radioactive seed location.

In Brief

Weldon Gage Named CFO Of MD Anderson Cancer Center

WELDON GAGE was named vice president and chief financial officer of **MD Anderson Cancer Center**, effective Jan. 12, 2015.

Gage began as a financial analyst at MD Anderson in 1999 and rose to associate director of strategic finance before becoming vice president for finance at Texas Children's Hospital, where he served from 2005 to 2012.

In 2012, Gage joined Children's Hospital of Wisconsin as the organization's chief financial officer, where he connected financial planning with the organization's strategic plan, and launched a transformation of the hospital's financial reporting and analytics program.

Both Texas Children's Hospital and Children's Hospital of Wisconsin implemented the Epic electronic medical records system during Gage's tenure, and he will help MD Anderson continue to implement its new electronic health record system.

MARCELO BENTO SOARES was named senior associate dean for research at the **University of Illinois College of Medicine at Peoria**.

Soares is currently director of the Cancer Biology and Epigenomics Program at the Stanley Manne Children's Research Institute, and the scientific director of the Falk Brain Tumor Center at the Ann and Robert H. Lurie Children's Hospital.

He is known for his contributions to the Human Genome Project, and in particular for his work for the development of publicly available databases of Expressed Sequence Tags. Over the last 15 years, Soares has focused on cancer research, including chondrosarcoma, osteosarcoma, breast cancer, prostate cancer, and most especially pediatric brain tumors.

Soares will provide direct research and academic leadership, oversee recruitment of new researchers to Peoria and develop existing investigators to strengthen the basic science research at UICOMP as well as engage with the local community on collaborative translational research programs. He also will serve as UICOMP's head of cancer biology and pharmacology.

He will officially begin in February, relocating his own research laboratory to UICOMP's Cancer Research Center. His current work is aimed at identifying the molecular mechanisms underlying development of pediatric brain tumors, the study of a mouse model of pediatric neuroectodermal tumors, and the impact of diet on prostate cancer development.

BORIS KUVSHINOFF II was named chief medical quality officer and interim chief medical officer at **Roswell Park Cancer Institute**.

Kuvshinoff will oversee initiatives involving organizational performance improvement, infection control, occupational and environmental safety, radiation safety, medical staff credentialing, ongoing professional practice evaluation and development of clinical pathways and guidelines.

He will continue as an associate professor in the Division of Gastrointestinal/Endocrine Surgery within the Department of Surgical Oncology; as director of RPCI's Liver and Pancreas Tumor Center; and as clinical associate professor of surgery at the University at Buffalo.

An RPCI staff physician since 2002, Kuvshinoff has led various quality and outcome-optimization initiatives, and recently concluded a term as president of the Roswell Park medical staff.

DAVID CURROW was named director of palliative medicine and hospice care at the **Dartmouth-Hitchcock health system**.

Currow will lead Dartmouth-Hitchcock's new Center for Palliative and Hospice Care, currently in the planning stages. He will also join the Geisel School of

Medicine as a professor of medicine in January 2015.

Currow is chief cancer officer in New South Wales, Australia, and chief executive officer of the state's cancer control agency, the Cancer Institute, New South Wales. He also serves as professor of palliative and supportive services at Flinders University.

He is the principal investigator for the Palliative Care Clinical Studies Collaborative, and is a foundation partner in the Australian Palliative Care Outcomes Collaborative.

JOANNA WEISS was named vice president of revenue cycle management at **Moffitt Cancer Center**.

Weiss has been with Moffitt since 2006. During that time she has worked to develop the cancer center's internal audit department and managed and coordinated the financial statement audit. Weiss will be responsible for Patient Access, Health Information Management and Patient Financial Services for Moffitt and the Moffitt Medical Group.

Previously, Weiss worked as an internal control manager for PSCU Financial Services and as an auditor with Ernst & Young, LLP, both in Florida.

THE AMERICAN CANCER SOCIETY published the second edition of **The Cancer Atlas** at the World Cancer Congress, in partnership with the International Agency for Research on Cancer within the World Health Organization, and the Union for International Cancer Control. The data featured in the book and website highlight strategies that governments can use to reduce their cancer burden.

The annual number of new cancer cases worldwide is predicted to increase from 14 million in 2012 to almost 22 million in 2030 due to population growth and aging alone. But each country has different challenges according to their level of development, demographics, risk factors and lifestyle patterns. Economically developing countries such as India, China, and other East and Central Asian countries account for nearly half of the world's new cancer cases and deaths.

The atlas consolidates research from 184 countries, including the IARC GLOBOCAN database, into a comprehensive guide to the global cancer landscape, highlighting country-by-country strengths and weaknesses worldwide, and allowing policymakers, researchers and academics to fully assess differences in risk, burden and prevention, and emphasizes the potential for improvement.

"Perhaps the most striking message from The Cancer Atlas is the inequality in access to the very interventions that can either prevent or effectively treat and manage the disease," said IARC Director Christopher Wild. "In relation to cancer, where you live affects your risk of developing the disease, how you live with the disease, and ultimately whether you survive the disease. One of the great cancer control challenges of the 21st century is to bring the benefits of effective interventions to as many people as possible, including in low- and middle-income countries."

Findings from The Cancer Atlas include: smoking causes more than 16 different types of cancer and accounts for 20 percent of all global cancer deaths; indoor air pollution caused by solid fuel use is estimated to cause about 2.5 million deaths each year in developing countries, or about 4.5 percent of global deaths each year; and 129 countries have not yet introduced the HPV vaccine, nearly triple the 45 countries that have introduced the vaccine.

The atlas is authored by more than 60 medical and subject matter experts from six continents. Together, the contributors have published more than a thousand papers, articles and books. Translated editions of the book, available in Spanish, French, Chinese, Arabic, and Russian, will be launched in 2015.

RXTRIALS and **Clinical Oncology Research Excellence** entered into a collaboration that will offer a centralized clinical research infrastructure.

CORE was created in 2013 to provide assistance to private medical oncology practices managing their clinical research programs. RxTrials will expand into oncology with this partnership.

Sites involved in this network will be part of the RxTrials Partner Site program and be supported by RxTrials' and CORE's standardized management services, but will be encouraged to maintain autonomy in certain areas and direct interaction with study sponsors during the course of their trials.

RxTrials and CORE will provide essential development and operating support for the sites, while allowing the sponsor to maintain an investigator-centric relationship. The collaboration will provide a central trial management service for the sites that includes contract/budget negotiations, accounts receivable management, pipeline/program development, recruitment strategies. The companies plan to add at least 10 sites to the network by mid-2015.

YALE UNIVERSITY and **Organovo Holdings Inc**. formed a collaboration to develop 3D bioprinted organ tissues for surgical transplantation research, made possible by a gift from the Methuselah Foundation.

Methuselah is donating at least $500,000 in direct funding to be divided among several institutions for Organovo bioprinter research projects. This funding will cover budgeted bioprinter costs, as well as other aspects of project execution.

At Yale's School of Engineering & Applied Science and Yale's Department of Surgery clinicians and basic scientists are working to combine tissue engineering technologies with medical therapies.

"We are excited to begin this collaboration with Organovo and are honored to be part of Methuselah's University 3D Bioprinter Program, which gives our key researchers access to cutting-edge 3D bioprinting technology," said John Geibel, vice chairman, director of surgical research, and professor of surgery and cellular and molecular physiology at Yale. "This collaboration is a great way to bring the best minds of both worlds to solve a major research and medical goal—using bioprinting to produce transplantable tissues."

PHARMACYCLICS Inc. was awarded the 2014 Society for Medicines Research Award for Drug Discovery for its discovery of **Imbruvica (ibrutinib)**. The award was presented by **The Society of Medicines Research** at its biennial award lecture in London.

The award recognizes development in the field of drug discovery and honors compounds which demonstrate a novel mechanism of action, a novel molecular interaction principle, a high degree of clinical benefit, and a significant ability to address an unmet medical need.

Imbruvica acts as a covalent inhibitor of the protein BTK, a key signaling molecule in the B-cell receptor signaling complex. Imbruvica blocks signals that tell malignant B cells to multiply and spread uncontrollably.

Betty Chang, vice president of research at Pharmacyclics, accepted the award on behalf of the company and provided the SMR Award Guest Lecture, entitled "Bench to Bedside: From PCI-32765 to ibrutinib to Imbruvica." Chang leads the company's research on BTK inhibitors.

Imbruvica is jointly developed and commercialized by Pharmacyclics and Janssen Biotech Inc.

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THE CROWDCARE FOUNDATION announced the first crowdfunding initiative for myeloma research at the 2014 conference of the American Society of Hematology.

The Myeloma Crowd Research Initiative is a new approach to funding cancer research; combining the skill and knowledge of myeloma specialists with the patient perspective and supportive patient social communities to select and fund promising research projects in myeloma.

Research proposals will be accepted on the www.myelomacrowd.org website beginning February 1, 2015. As an initial phase of the MCRI project, both a scientific advisory board and patient advisory board will work together with various research communities to source the most promising research projects in myeloma.

The MCRI panel will filter the various projects and initially select two new projects to receive funding. Once chosen, the Myeloma Crowd will launch a crowdfunding campaign for each project in April 2015. All proceeds for each campaign will be donated to the two final projects.

SEATTLE CHILDREN'S HOSPITAL and Research Foundation launched a $100 million, multi-year fundraising initiative to support patient access to clinical trials as well as immunotherapy research.

The program, Strong Against Cancer, is sponsored by Seattle Seahawks quarterback Russell Wilson.

Seattle Children's recently announced that it has begun recruiting patients for immunotherapy research for neuroblastoma, and plans to create a nationwide network of corporate sponsors and individual donors to fund Strong Against Cancer. The funding will help pediatric cancer patients who qualify for the immunotherapy research trial to be treated at Seattle Children's Hospital.

MARLO THOMAS was presented with the Presidential Medal of Freedom, the nation's highest civilian honor, during a special ceremony at the White House. Thomas is the national outreach director of St. Jude Children's research hospital.

The medal is bestowed upon individuals who have made significant contributions to the security or national interests of the United States, to world peace, or to cultural or other significant public or private endeavors. In its release about the 2014 medal recipients, the White House wrote of Thomas: "For giving voice to the less fortunate, breaking barriers by portraying television's first single

working woman on That Girl, teaching children to be Free to Be...You and Me, and for her tireless efforts on behalf of the children of St Jude Children's Research Hospital, Thomas inspires us all to dream bigger and reach higher."

An award-winning actress, producer, best-selling author and social activist, Thomas has worked for St. Jude to raise awareness and funds for the research and treatment of childhood cancer.

She has appeared in public service announcements, on national television programs and at hundreds of fundraising events across the country to advance St. Jude's mission. Along with siblings Terre and Tony Thomas, she helped create the St. Jude Thanks and Giving campaign, which encourages holiday shoppers to support cancer research. Over the past decade, it has raised more than $487 million.

Ms. Thomas is one of 19 honorees this year; full details are available in the formal announcement made by the White House.

Obituary

Lee Wattenberg, 92, "Father of Chemoprevention"

Lee Wattenberg, emeritus professor of laboratory medicine and pathology at the University of Minnesota Masonic Cancer Center, died Dec. 9 at the age of 92.

His research established the discipline of chemoprevention. Wattenberg first recognized that some compounds could effectively block the development of carcinogens in animals. In 1966, he published a paper in the journal Cancer Research that reviewed 36 years of animal studies on the effects of certain compounds on carcinogenesis and laid the framework for our understanding of how these compounds work. It was in this paper that he introduced the term chemoprophylaxis.

He later investigated two categories of chemopreventive agents: synthetic compounds that might prevent carcinogen-induced lung cancer, and dietary constituents, such as the cruciferous plants cabbage and broccoli. He studied the processes that cause irreversibility in carcinogenesis and sought to determine whether and how these processes could be targeted for intervention. Also, most recently, Wattenberg pioneered the use of aerosols to deliver drugs in lung cancer.

He traced his lifelong dedication to cancer prevention to his work from 1944 to 1946 as a junior biologist with the Medical Research Group of the Manhattan Project, whose mission in relation to the development of the atomic bomb was to study the effects of radiation. This early work was inspired by his brother, Albert Wattenberg, a renowned physicist who worked with Enrico Fermi on the development of the atomic bomb.

A native of New York, Wattenberg received his B.S. from City College of New York in 1941. He then received his medical degree from the University of Minnesota School of Medicine and was a distinguished faculty member at the university for more than 60 years.

Wattenberg served as president of the American Association for Cancer Research from 1992 to 1993 and was an elected fellow of the AACR Academy in 2013. He became an active AACR member in 1961.

He served terms as associate editor for two AACR journals, Cancer Research and Cancer Epidemiology, Biomarkers & Prevention, as well as on every major standing committee of the organization, most notably as chairperson of the first AACR Task Force on the topic of Cancer Prevention.

He chaired the first cancer prevention symposium at the 1979 AACR Annual Meeting, served as chair of the Annual Meeting Program Committee in 1982, and was a featured speaker at the AACR conferences on Frontiers in Cancer Prevention Research.

During his AACR presidency, he launched the Associate Member Council in 1992 to represent the interests of associate members in the association's governance. He was later honored for his commitment to the professional advancement of young investigators as the first recipient of the Associate Member Council Award of Excellence, which recognizes AACR members "whose insight, courage, and actions have resulted in significant benefits for associate members."

He was also president of the American Histochemical Society in 1996. His work was recognized by his colleagues with the Naylor Dana Award of the American Health Foundation in 1991, the AACR-American Cancer Society Award for Outstanding Contributions to Cancer Prevention in 1996, and the AACR Award for Lifetime Achievement in Cancer Prevention Research in 2010.

Preceded in death by his son Richard and daughter Lynn, Wattenberg is survived by his wife of 70 years, Esther; his children, Mark, Anne, Binks, and Elizabeth; eight grandchildren; and a great-granddaughter.

In lieu of flowers, the family asks that memorial donations be made to the AACR.