**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**PUBLIC HEALTH SERVICE**
**NATIONAL INSTITUTES OF HEALTH**
**NATIONAL CANCER INSTITUTE**
**23rd Virtual NATIONAL CANCER ADVISORY BOARD MEETING**

# Summary of NCAB Meeting
**2 December 2025**

**Virtual Meeting**
**National Cancer Institute**
**National Institutes of Health**
**Bethesda, Maryland**

**NATIONAL CANCER ADVISORY BOARD**
**BETHESDA, MARYLAND**
**Summary of Meeting**
**2 December 2025**

The National Cancer Advisory Board (NCAB) convened its 23rd virtual meeting on 2 December 2025. The meeting was open to the public on Tuesday, 2 December 2025, from 1:30 p.m. to 4:00 p.m. and closed to the public from 4:15 p.m. to 5:00 p.m. The NCAB Chair, Dr. John D. Carpten, Director, Comprehensive Cancer Center, Director and Chief Science Officer, Beckman Research Institute of City of Hope, presided during both the open and closed sessions.

**NCAB Members**

NCAB Members Dr. John D. Carpten (Chair)
Ms. Margaret Anne Anderson
Dr. Nilofer S. Azad
Dr. Richard J. Boxer (Absent)
Dr. Callisia N. Clarke
Ms. Ysabel Duron
Dr. Karen M. Emmons
Ms. Tamika Felder
Dr. Christopher R. Friese
Ms. Julie Papanek Grant
Dr. Amy B. Heimberger
Dr. Ana Navas-Acien
Dr. Edjah K. Nduom
Dr. Kimberly Stegmaier
Dr. Fred K. Tabung
Dr. Ashani T. Weeraratna
Dr. Karen M. Winkfield

**President's Cancer Panel**

Dr. Samantha L. Finstad (Executive Secretary) (absent)
Dr. Mitchel S. Berger (absent)
Dr. Carol L. Brown

**Alternative Ex-Officio NCAB members**

Dr. John Gordon, CPSC (absent)
Dr. Craig Shriver - DoD
Dr. Boris Wawrik – DoE
Dr. Rebekah Zinn-FDA
Dr. Michelle Heacock-NIEHS
Dr. Michael Kelley, VA (absent)
Dr. Richard Pazdur, FDA (absent)
Dr. Kerry Souza, NIOSH (absent)
Dr. Matthew Mamoli, NIH (absent)

**Members, Scientific Program Leaders, National Cancer Institute, NIH**

Dr. Anthony Letai, Director, National Cancer Institute
Dr. Randiak Alaro, Program Director, Center for Global Health
Ms. Shayla Beckham, Program Specialist, Committee Management Office
Dr. Philip Castle, Director, Division of Cancer Prevention
Dr. James Doroshow, Director of Division of Cancer Treatment and Diagnosis
Dr. Gary Ellison, Deputy Director, Division of Cancer Control and Population Sciences
Dr. Satish Gopal, Director, Center for Global Health
Dr. Toby Hecht, Deputy Director, Division of Cancer Treatment and Diagnosis
Mr. David Higgins, NIH/OD/ORS
Dr. Lori Henderson, Chief, Clinical Grants and Contracts Branch, DCTD
Dr. Warren Kibbe, Deputy Director for Data Science and Strategy
Dr. Douglas Lowy, Principal Deputy Director, National Cancer Institute
Ms. Anne Lubenow, Chief of Staff, Director, NCI
Dr. Kristin Komschlies McConville, Director, Office of Scientific Operations, FNLCR
Dr. Lori Minasian, Deputy Director, Division of Cancer Prevention
Ms. Erika Moshtahadian, OD, NCI
Ms. Thu Nguyen, Program Analyst, Division of Extramural Activities
Dr. Krzysztof Ptak, Director, Office of Cancer Centers
Mr. Weston Ricks, Director, Office of Budget and Finance
Mr. Ricardo Rawle, Program Analyst, Division of Extramural Activities
Dr. George Sigounas, Chief Science Advisor
Dr. Ashley Smith, Chief, Outcomes Research Branch, DCP
Dr. Malcolm Smith, Associate Branch Chief, Clinical Investigations Branch, DCTD
Dr. Shamala Srinivas, Associate Director, Division of Extramural Activities
Dr. Carol Thiele, Acting Co-Director, Center for Cancer Research
Dr. Neli Ulrich, Director, Huntsman Cancer Center, University of Utah
Dr. Brigitte Widemann, Chief, Pediatric Oncology Branch
Dr. Keren Witkin, Program Director, Division of Cancer Biology

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## I. CALL TO ORDER AND OPENING REMARKS—DR. JOHN D. CARPTEN

Dr. John D. Carpten called to order the 23rd National Cancer Advisory Board (NACB) virtual meeting. He congratulated and welcomed Dr. Anthony Letai, Director, National Cancer Institute to his first NCAB meeting, members of the Board, ex-officio members, liaison representatives, staff, and guests. Members of the public were welcomed and invited to submit in writing any comments regarding items discussed during the meeting to Dr. Shamala Srinivas, Associate Director, Scientific Review and Policy, Division of Extramural Activities (DEA), National Cancer Institute (NCI), within 10 days. Dr. Carpten reviewed the confidentiality and conflict-of interest practices required by Board members in their deliberations. He also called Board members' attention to the future meeting dates listed on the agenda will be moved to a later date due to delays in the peer review and that members will be informed about the new date as soon as it is determined.

**Motion**. A motion to accept the minutes of the 4 September 2025 NCAB meetings was approved unanimously.

## II. THE NCI DIRECTOR's REMARKS—DR. ANTHONY LETAI

Dr. Anthony Letai, Director, NCI welcomed the National Cancer Advisory Board members and attendees to the 23rd virtual meeting and did a brief introduction, and provided updates key areas of focus, budget outlook, and grant funding approach.

Dr. Letai shared his personal background. He was raised outside Philadelphia, PA, started as a Physics major (Princeton University) and transitioned to medicine through the Medical Scientist Training Program (MSTP) at the University of Chicago (PhD thesis in the laboratory of Dr. Elaine Fuchs). Dr. Letai completed MD in Internal Medicine at the Brigham and Women's Hospital followed by fellowship in Hematology Oncology at the Dana Farber Cancer Institute (DFCI). He led a laboratory at the DFCI for 20 years focused on apoptosis and BCL-2 biology and pre-clinical and clinical progression of venetoclax in chronic lymphocytic leukemia and acute myelogenous leukemia. He is married with three children, including a daughter in the MSTP program, another who is an Olympic short-track speed skater, and a son who is an audio engineer and tour guide. Dr. Letai's hobbies include playing violin and rose gardening.

Dr. Letai began his role as the Director of National Cancer Institute on 29 September 2025 followed by the government shut down for 43 days, which gave him time to study NCI operations and admire the dedication of NCI employees.

Dr. Letai expressed his enthusiasm about the work ahead and was optimistic about where NCI cancer research programs will lead in the future. He emphasized his desire to communicate and engage American public for a better understanding of the impact that NCI has on their lives. He wants to rebuild public trust in health institutions and

highlight the value of taxpayer investment. Dr. Letai mentioned the statistics that since 1990, there has been a 30% reduction in cancer mortality in the United States, that currently there are probably twenty million survivors of cancer. When there is a new drug commercial by pharmaceutical companies such as Lily or Pfizer that has a great impact on a specific cancer, an important message to communicate to American public is that most of the work started at NCI, either from intramural or extramural research. He plans a series of short patient vignettes involving interaction with patients to link major advances in cancer care to NCI-funded research to give the public a better understanding of the impact that NCI has on their lives. In addition, Dr. Letai also intends to listen to stakeholders' needs. He aims to engage extramural researchers, early-stage investigators, and the broader cancer research ecosystem. The outreach will convey a message of stability about funding. Dr. Letai emphasized that production and maintenance of a continuing crop of young investigators is extremely important to the NCI, and NCI understands that the extramural community and extramural partners are essential for progress in the United States in terms of cancer.

Dr. Letai emphasized the ongoing focus on improving cancer prevention, screening, and addressing health disparities. He highlighted a major opportunity for functional precision medicine (testing drugs directly on patient tumor samples). Dr. Letai noted that genomics alone may not be adequate; many patients lack actionable mutations. He plans to convene an expert panel to guide the use of functional precision medicine for therapy with a goal to drive discovery and development of companion diagnostics. Dr. Letai's vision is for the resources to be accessible to both intramural and extramural researchers both for standard clinical care as well as for clinical trial support and basic research support. Because of the exciting advances in immunotherapy, Dr. Letai wanted NCI to apply resources to expand capacity to accelerate promising immunotherapy hypotheses through preclinical testing, clinical trial support, GMP manufacturing (vectors, vaccines), and smoother regulatory pathways toward first-in-human trials by leveraging and potentially expanding Frederick National Lab resources.

**Budget Outlook**: Dr. Letai mentioned that NCI currently is operating under a continuing resolution expiring January 30. Although FY26 budget is uncertain, the assumptions are based on flat funding compared to recent years. Even flat funding means loss of buying power due to inflation, requiring careful planning. Roughly 25% of the budget will be for intramural research and 75% for extramural research will remain.

Grant Funding Approach: Maintaining the Research Project Grants (RPG) at about 1000 is high priority as is funding early-stage researchers. Contrary to the public speculation, NCI is not reducing extramural grant funding. Some of the R01 grants will be fully funded upfront. A minority of R01 will receive two-year funding followed by administrative review for potential extension to a full 5-year grant. This structure will support high-risk, high reward science. Merit will be the number one priority in identifying fundable research. The NCI will use a wider 'gray zone' for programmatic decisions; instead of ~15%, up to ~50% may be considered for discretionary awards.

Strong scores from the peer review conducted by Center for Scientific Review (CSR) will remain essential for consideration. Political appointee involvement in final decisions is not new and has always been true for NCI directors. Dr. Letai acknowledged that he will be guided by the NCI program directors and by the deputies.

## Questions and Answers

In response to Dr. Carpten's request to comment on what Dr. Letai's vision is for NCI and about the National Cancer Plan, Dr. Letai refrained from making detailed comments due to his brief tenure. He noted the importance of reviewing the working group reports before making statements about the NCI mission.

Dr. Karen M. Emmons appreciated Dr. Letai's focus on cancer prevention and control and inquiries about the institute's commitment to equity and disparities, especially in underserved geographic areas. Dr. Letai acknowledged the need to address both racial and geographic disparities in cancer care, emphasizing the delivery of prevention, screening, and care to underserved communities.

In response to Dr. Christopher Friese's question about how NCI would ramp up communication plan because of the reduction in NCI's communication team, Dr. Letai emphasized the importance of communication programs. He assured the Board that more communication efforts would be visible in the coming weeks, making the best use of available resources. Dr. Letai indicated that the process is ongoing and involves personnel shifts, leading to more prioritization and redistribution of communication functions within NCI, particularly those related to outreach and interaction with cancer care communities.

Dr. Amy Heimberger expressed her interest in gathering researchers specializing in spacial biology to ensure success of assays. This would offer valuable opportunity to consider partnerships with commercial and industry stakeholders. Dr. Heimberger highlighted the success of research partnerships between junior and senior investigators, as evidenced in many successful CVs, including those of meeting attendees. There was a suggestion to create grants specifically tailored for senior investigators collaborating with innovative junior researchers to nurture groundbreaking research initiatives. Dr. Letai acknowledged the merit of this proposal but noted that their current focus has been more urgent and broader. Despite the current broad scope, the suggested model aligning investigators in such a manner is intriguing and worth considering for future planning.

Dr. Kimberly Stegmaier highlighted the collective dedication of the group to support and refine the strategies for effective communication to public, emphasizing how best to convey the importance of research funded by the NCI, leveraging the expertise and commitment of the group members. Dr. Letai expressed the intention to utilize the resources of cancer centers to disseminate the message broadly. He emphasized that

some cancer centers have excellent communication departments. These departments could play a pivotal role in amplifying the message and ensuring it reaches a wide audience.

In response to Dr. Neli Ulrich's question about how cancer centers can help through their community outreach and engagement efforts, and how important it will be going forward, Dr. Letai responded that NCI intends to continue encouraging outreach efforts and hoped to expand clinical trials to rural and non-academic communities. He also added that these efforts often rely on nearby cancer centers and hoped that this will continue.

In response to Dr. Nilofer Azad's concern about the education of public considering reports of a potential change in recommendations for hepatitis B vaccination for infants, Dr. Letai acknowledged that although issues with vaccination do impinge upon cancer, it also important that the NCI speaks to its core mission of reduction of cancer mortality.

## III. CHILDHOOD CANCER DATA INITIATIVE—DR. WARREN KIBBE

Warren A. Kibbe, Ph.D., Deputy Director for Data Science and Strategy, NCI presented an update on the Childhood Cancer Data Initiative (CCDI). He started with the background of CCDI that began in 2019 after the State of the Union address by the President of the United States followed by Board of Scientific Advisors (BSA) working group that made 24 recommendations in eight categories identifying gaps, needs, and research priorities. The working group consisted of patient advocates, industry partners, and individuals from academia and government who participated in identifying priority activities. The goals and objectives are to collect, analyze, and share data; maximize NCI's investment in pediatric and adolescents and young adults (AYA) cancer survivorship, build processes to transform data into knowledge that moves the field forward in meaningful ways, and learn from every child and AYA patients to improve long-term health outcomes.

The idea is to learn from and use data to support research and discovery using data from more than 60 research grants (several funded by CCDI), intramural research programs (developed a Rare Pediatric Tumor Cell Atlas, to provide single cell sequencing of pediatric tumors), cohorts, 12 cancer center data supplements (NCI funded Data Supplements to Cancer Centers to provide in-depth, harmonized clinical (C3DC) and genomic data which now resides in the CCDI Ecosystem), and 10 CCDI funded training grants focused largely on data harmonization and sharing; generate and aggregate novel data from clinical, pre-clinical models (The Pediatric Preclinical In Vivo Testing (PIVOT) Consortium collaborates with industry partners on preclinical testing of novel agent development (PDX sequencing)), molecular characterization, survivorship data, 30+ data supplements, and rare cancer initiative; and build a foundational data infrastructure using data portal, CCDI participant index, National Childhood Cancer

Registry (NCCR), data modeling, clinical data commons, federated infrastructure, visualization and analytical tools, and molecular targets platform. CCDI has built a federated data ecosystem that provides access to data and analytics across basic, clinical, public health, and epidemiologic data.

The components of the eco-system include the primary databases–Cancer Research Data Commons, NCCR, National Clinical Trials Network archive/Clinical trials data commons, and CCDI Data Federation. The knowledge bases and reference data include CCDI Data Catalog and Molecular Targets Platform; Data access includes the CCDI Data Hub – https://ccdi.cancer.gov, NCCR PedsExplorer - https://nccrexplorer.ccdi.cancer.gov/ , and the dbGaP/CRDC portals. The Data Processing and Harmonization includes a Data Coordination Center to assist with data submission and harmonization.

To develop a national strategy around biospecimen collection and genomic testing, including types of molecular profiling should be performed at diagnosis in different pediatric/AYA cancers to guide care and enhance discovery, in 2021, in partnership with Children's Oncology Group (COG), Project: EveryChild was launched with current enrollment of more than 7500 patients from 47 states, Canada, Australia, and New Zealand have been consented. Specimens include CNS, soft-tissue sarcomas, rare tumors, high-risk neuroblastoma, Ewing sarcoma with state-of-the-art molecular characterization at diagnosis, results returned to participants and treating physicians within 14 days, with identification of molecular tumor subtypes.

## IV. FREDERICK NATIONAL LABORATORY—DR. KRISTIN KOMSCHLIES MCCONVILLE

Kristin Komschlies Mcconville, Ph.D. Associate Director for Frederick National Laboratory for Cancer Research presented an overview of the NCI Frederick laboratory for Cancer Research (FLNCR). The NCI's FNLCR is at the forefront of developing and adapting new technologies and translating basic scientific discoveries into novel agents/approaches/devices for the prevention, diagnosis and treatment of cancer and other diseases. It was established as part of the National Cancer Act of 1971 by President Nixon - converting some of Fort Detrick's biodefense laboratories into "a leading center for cancer research and focuses on human cancer and other diseases. It was designated as a Federally Funded Research and Development Center (FFRDC means activities that are sponsored under a broad charter by a Government Agency (or agencies) for the purpose of performing, analyzing, integrating, supporting, and/or managing basic or applied research and/or development, and that receive 70% or more of their financial support from the Government). In 2012, the FNLCR was designated as a National Laboratory, and this is the only FFRDC in the nation dedicated solely to biomedical research. As an FFRDC, the FNLCR provides NCI and NIH, other agencies, and the extramural research community a unique resource to achieve flexibility, rapid response, and increased efficiency. The FFRDC can take on projects or activities within NCI's statement of work that cannot be done as effectively by other

government mechanisms, and that is an important aspect to this private sector piece of the not competing.

There are flexibility and a broad latitude in how the work is performed. Experienced and capable staff on site can pivot on starting projects for rapid response, in case of emergency situations or high priority research. The project could either be performed by the primary contractor, the primary contractor could bring in subcontractors or consultants.

The FFRDC is undergoing recompetition and the tentative award date is November 2026. The new contract will allow for 10-year base ordering period with three options, each to extend the ordering period for up to five years. Minimum government obligation is $5 million and ordering ceiling, for 25 years, is up to $89 billion.

The FNLCR goals and operating principles are to pursue high risk/high reward projects, build relational bridges and work as a team with partners for shared success, maintain full intellectual scientific partnership with the government, operate in a flexible, transparent, accountable, and effective manner, and demonstrate boldness and creativity in ideas and execution. The FNLCR Operates the NCI at Frederick as a government-owned, contractor-operated (GO-CO) facility includes government facilities and facilities leased by the contractor (currently Leidos Biomedical Research, Inc. (LBR)).

The Frederick campus is 68 acres with 97 buildings of which 850,000 sq ft are laboratory space, 210,000 sq ft of administration space, 120,000 sq ft is for vivarium, 110,000 sq ft for infrastructure, and 25,000 sq ft for repository. There are leased facilities on the 68 acres and six off-site buildings, most of which are either laboratories or CGMP facilities. Currently, there are 2200 contract staff members who perform and manage all the work that is brought onto the contract including required licenses certifications, and accreditations.

Specific examples of scientific research performed in support of NCI include Experimental Therapeutics Program (NExT), NCI-Molecular Analysis for Therapy Choice (NCI-MATCH), NCI's Anti-CD22 CAR T Cell Trial, NCI's Patient-Derived Models Repository (PDMR), RAS Initiative – National mission, Cryo EM Program – National mission, and Technical Service Agreements – Unique Assays.

## QUESTIONS AND ANSWERS

In response to Dr. Amy Heimberger's query to clarify the affiliation and infrastructure alignments with hospitals to carry out the functional assays for functional precision medicine project at the FNLCR, Dr. Komschlies McConville responded that FLNCR has capability and would certainly have to work through the specifics. She also highlighted that such projects have been carried out in the past.

In response to Dr. Christopher Friese's comment about the need for an advisory body due to sunsetting of advisory committee for the FNLCR, Dr. Komschlies McConville responded that there are conversations within NCI to work through NCAB to have advice for the FNLCR.

In response to Dr. Ashi Weeraratna about how the gap in the number of contractors will be filled due to reduction, Dr. Komschlies McConville responded that staffing is based on the need at FLNCR; the staff numbers go higher or lower depending on the requirements.

## V. ONGOING AND NEW BUSINESS—DR. JOHN D. CARPTEN

**NCAB Subcommittee on Planning and Budget.** Dr. Weeraratna, Chair of the NCAB Subcommittee on Planning and Budget, presented the report of the 2 December 2025 meeting. Dr. Weeraratna noted that Mr. Weston Ricks gave an overview at the subcommittee meeting. Between 2016 and 2025 the National Institutes of Health (NIH) experienced an annual change totaling $227.4 million, reflecting an annual change of $118 million from the previous decade. Currently, the budget is in the midst significant deliberations, where the House has proposed $48 million increase for the NIH and the Senate has proposed $150 million. These figures come amidst a substantial proposed budget cut of $2.7B (40% cut) by the President.

One of the more distressing statistics is that NIH has lost approximately $3 billion in purchasing power, with the National Cancer Institute (NCI) alone accounting for 50% of this loss. This reduction in real budgetary resources has serious implications for research funding and operational capacities.

The proposed budget from the senate includes a restriction on the restructuring of institutes, and on fully forward- funding research project grants (RPGs). A critical note is that upfront funding will have a more pronounced impact in the initial couple of years, with impacts lessening over time. Questions surrounding accountability for multi-year funding arose, with Dr. Winkfield noting that disbursements will continue to be monitored but retain the right not to disburse funds if necessary. The payline for funding remains a guideline, suggesting some level of flexibility in addressing allocations based on performance metrics and research needs.

There is a desire for institution-specific guidance to help navigate the funding landscape. A concerning shift towards favoring R03 (small research grants) and R21 (exploratory/developmental grants) over R01s and P01s (traditional research project grants) raises alarms regarding the potential fragmentation of research initiatives and priorities. Dr. Friese raised the need for better communication and guidance to combat eroding morale. Dr. Letai made the point that the reality is that things are not as bad as they are perceived to be, that even with the upfront funding model, the grant success rate is expected to hold around 10% rather than the dreaded 4%.

Drs. Grant and Nduom both raised the fact that there are escalating concerns regarding the "efflux" of talent from academia to private industry, as well as the emigration of skilled professionals from the United States to other countries, which could have long-term repercussions for NIH's research capabilities and influence. There are also deep concerns and eroding morale among early-stage investigators.

One of the most striking data points from Mr. Ricks' presentation was the considerable loss of FTEs, fellows and contractors within the NIH, further affecting the organization's ability to meet its research objectives. Dr. Grant pointed out that among his many other duties, Dr. Letai will have the responsibility of identifying and bridging gaps created by the loss of staff at the NCI. This initiative is crucial for maintaining the stability and efficacy of ongoing research projects.

Overall, the NIH faces multiple challenges in funding, staffing, and research capacity over the next decade. The interplay of legislative support, budget constraints, and market dynamics in biomedical research necessitates strategic adaptations to ensure continued progress in national health initiatives. As the landscape evolves, maintaining open communication and clear guidelines will be integral to navigating these changes effectively.

**Motion**. A motion to accept the report of the 2 December 2025 NCAB Subcommittee on Planning and Budget meeting was approved unanimously.

**NCAB Ad Hoc Subcommittee on Population Science, Epidemiology, and Disparities.** Dr. Winkfield, Chair of the NCAB Ad Hoc Subcommittee on Population Science, Epidemiology, and Disparities reminded the role and purpose of the subcommittee is to advise the NCI director and the NCAB on strategic approaches and opportunities to enhance contribution to population science, epidemiology, and health disparities and identify opportunities to address populations facing health disparities through multidisciplinary programs and research surveillance, patient care, primary prevention, education, and cancer control. Dr. Winkfield discussed the establishment of an *ad hoc* working group focused on systems and multi-level interventions in cancer control. She acknowledged the presentation by Dr. Karen Emmons who provided an overview and rationale for the working group emphasizing a systems-based approach.

Traditionally, cancer control interventions operate at one or two levels, such as patient education or provider tools. However, many risk factors are influenced by complex environmental, structural, policy, and social systems. To reduce disparities effectively, cancer control research must integrate approaches that span individual, interpersonal, community, organizational, and policy systems. Examples provided by Dr. Emmons is the Chicago Breast Cancer Mortality study where she discussed historical disparities in breast cancer mortality in Chicago, illustrating how system-level factors can create population-level changes. Obesity contributes to 16-22% of cancers.

Effective intervention requires environmental and social factors, not just clinical or behavioral treatments. The NCI has initiated pilot programs focused on multi-level interventions for obesity control. While promising, these efforts are relatively small compared to the magnitude of the problem.

**Establish NCAB Ad Hoc Working Group on multi-level and systems approaches in Cancer Control.** Dr. Carpten explained that the Board will need to approve establishing an NCAB *Ad Hoc* Working Group on multi-level and systems approaches in cancer control. The proposed working group aims to conduct a landscape analysis of existing research grants and evidence; review existing NCI and NIH-funded research on systems and multi-level interventions; identify gaps, opportunities, and priorities for future investments and recommend strategies for selecting which systems or levels to target. Dr. Winkfield emphasized the importance of whole-system interventions and the need for intentional examination of interactions among different levels.

Dr. Ellison outlined what was needed to move this working group forward. He outlined the functional statement after further discussion, the subcommittee voted to approve the charge and to move forward to the NCAB.

**Motion**. A motion to approve the establishment of Working group on multi-level and systems approaches in cancer control was unanimously approved.

**Motion**. A motion to accept the report of the 2 December 2025 NCAB *Ad Hoc* Subcommittee on Population Science, Epidemiology, and Disparities meeting was approved unanimously.

**Consideration of public comments**. Dr. Carpten informed the Board that there was a letter received from the Science Advancement and Outreach, Division of PETA, to urge NCAB to align research and training priorities with NIH's commitment to prioritize non-animal methods (NAM) and this will be taken under advisement. Dr. Letai mentioned his support for human models but emphasized the continued value of mouse models. He highlighted the importance of balancing human benefit against animal suffering and aligning with NIH priorities. Dr. Letai also proposed prioritizing direct study of human tissues and models. Dr. Kibbe highlighted the importance of the canine clinical trials where dogs with cancer are not treated as experimental animals but treated like human clinical trials. As such, he acknowledged that not all animal research is the same.

**Future Agenda Items**. Members suggested (1) an update on NCI training initiatives recognizing the loss of diversity supplements and bringing the best minds from all communities into science; (2) an update on Cancer Centers especially how the centers are engaged with community and how they are engaging community-based organizations; and (3) long-term strategy for a clear scientific oversight of FNLCR recognizing its importance, scope, and complexity. NCAB members were asked to forward any further suggestions for future agenda items to Drs. Carpten and Srinivas.

Dr. Anderson asked a question regarding how NCAB could assist in some of the initiatives mentioned, particularly related to patient engagement and enhancing connectivity with community. In response, Dr. Letai asserted that NCI is in planning stages and has not yet finalized programs that aim to directly engage patients. Once these programs are organized, NCAB's support would be immensely helpful. One way the NCAB could assist is through the dissemination of NCI's message via various channels such as social media and electronic media. Effective promulgation is crucial because the message needs to extend beyond the NCAB and generate widespread discussion. NCI also hopes to create enough interest to gain free media coverage. Dr. Letai added that if anyone has ideas on how to achieve this to please contact him.

**IV. ADJOURNMENT OF OPEN SESSION—DR. JOHN D. CARPTEN**

Dr. Carpten adjourned the open session. Only Board members, Ex Officio members, and designated NCI staff remained for the closed session.

**VI. NCAB CLOSED SESSION— DR. JOHN D. CARPTEN**

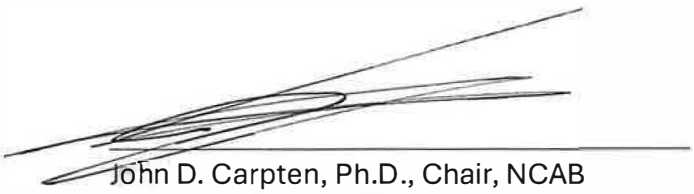
This portion of the meeting is being closed to the public in accordance with the Provisions set forth in Section 552b(c) (6). Title 5 U.S. Code and 10(d) of The Federal Advisory Committee Act, as amended (5 U.S.C. appendix 2).

There was a discussion of personnel and proprietary issues. Members were absent from the meeting during discussions for which there was potential conflict of interest, real or apparent.

**XI. ADJOURNMENT—DR. JOHN D. CARPTEN**

Dr. Carpten thanked all the Board members, as well as the observers, for attending. There being no further business, the 23rd virtual meeting of the NCAB was adjourned at 5:00 p.m. on Tuesday, 2 December 2025.

03/17/2026
Date



John D. Carpten, Ph.D., Chair, NCAB

3/17/2026
Date

Shamala K. Srinivas, Ph.D. Executive Secretary