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# *Fellows*

## As the Global Burden of Cancer Rises, **Can Fellowship Training Adapt?**

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# As the Global Burden of Cancer Rises, Can Fellowship Training Adapt?

*Mary Chamberlin, MD  
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**AS A MEDICAL ONCOLOGIST** who has long been interested in global health, I felt it was a privilege to be able to attend my first African Organization for Research & Training in Cancer (AORTIC) Conference last November in Kigali, Rwanda, and I look forward to many more. As I reflect on the excitement of the release of the National Comprehensive Cancer Network Harmonization Guidelines and the recent announcement by Pfizer and Cipla to increase access to 16 essential cancer treatments,<sup>1</sup> I was a little amused but also rather shocked during rounds last week at Dartmouth Medical Center in Lebanon, New Hampshire. A patient with newly diagnosed rapidly progressive, poorly differentiated, metastatic lung cancer was being examined by 1 of our second-year hematology-oncology fellows. As I will explain, it was a reminder of how quickly we all have to adapt our teaching and training programs to keep up with the changing pace of care around the world.

The fellow and I were discussing a previously healthy 66-year-old white American male. Pathology showed poorly differentiated carcinoma, not otherwise characterized, and immunohistochemistry results were equivocal as to the primary site, but radiographically it appeared to be a lung primary. Molecular tests had been ordered several days prior, and results were pending. The patient had responded well to palliative radiation to an orbital metastasis but his pulmonary status was worsening because of a steadily growing left lung mass. When I asked the fellow what his treatment plan was, he said, "There's nothing that can be done until we get the molecular pathology results back. Chemotherapy won't work and will only make things worse." »



Addressing the global cancer crisis in medically underserved communities is a key objective of the Global Health elective at Dartmouth.

Understandably, he is “growing up” as an oncologist in a very different era from even a few years ago. He honestly had never seen a patient with advanced lung cancer receive carboplatin and paclitaxel. We then discussed the data behind platinum doublets in advanced cancer and the proven modest but significant improvement in quality of life compared with best supportive care, as well as the potential risks and benefits of radiation to the lung. We made a plan to proceed with radiation and, if no molecular targets were identified, or if the patient worsened further before results were available, to include chemotherapy.

For me, as his fellowship director, it was yet another eye-opener to the pace of change in high-income countries, while the majority of patients with cancer globally are lucky to have access to any chemotherapy, much less molecular profiling and targeted therapies. In just a few short years, we run the risk of producing oncologists who may not have sufficient experience with the very drugs that are just now barely becoming available to many parts of the world. Furthermore, as we work to expand opportunities for doctors caring for patients with cancer in low-income countries to come to the United States, we have to make sure the experience is appropriate to the setting to which they are going to return.

Hematology-oncology fellowship programs in the United States can adapt in several ways. One way is to create a Global Oncology track that would provide more exposure to a broader range of subspecialties, such as radiation oncology, gynecologic oncology, and pediatric hematology-oncology, and spend significantly less time in the hematology

bone marrow or stem cell transplant ward, for example, which currently occupies almost 50% of their training. A Global Oncology track could be in parallel to traditional fellowships and could have a separate applicant pool to allow for international and domestic fellows interested in careers in global health to apply and train together with multiple options for continuity clinics in low-resource settings. To make international sites a feasible setting for Accreditation Council for Graduate Medical Education (ACGME) board certification, we need to increase the number of US faculty from ACGME-approved programs to be onsite as well. By attracting fellowship-trained oncologists to supervise fellows in low-resource settings, they would also be available to directly teach the local staff and doctors. These adaptations will require funding and organization, so it is with great anticipation that I await the results of the ASCO Global Oncology Task Force recommendations due to be released at the end of this year. Here at Dartmouth, we have had great success with a pilot program of a Global Oncology elective in Rwanda over the past 2 years,<sup>2</sup> and we look forward to continuing our work as we strategize and brainstorm together on how to create more opportunities and larger programs to address the global cancer crisis.

There are also myriad opportunities for oncologists to get involved at the very beginning of cancer care in many parts of the world, and this will hopefully attract many fellows into this field. As an academic oncologist, I find it fascinating to try to articulate the “art of oncology” to a nononcologist and to winnow down over 15 years of experience into where the most benefit lies. What works the best and for what cost? As a new member of AORTIC, I applaud the efforts of the African Cancer Coalition as they organize and build on the momentum of the November meeting, expanding the guidelines to include additional disease types and raising money for the ChemoSafe Project as chemotherapy access begins to rapidly improve in countries such as Ethiopia, Kenya, Uganda, Tanzania, and Rwanda. The objectives of this program are commendable and include the following:

1. Training of nurses and pharmacists in safe handling and administration of chemotherapy
2. Strengthening of facilities that deliver cancer treatment to reduce risk of exposure to hazardous drugs
3. Improving access to personal protective equipment
4. Pathology strengthening

Since the Harmonization Guidelines are intended for use by oncologists, and oncologists are still a very rare commodity in East Africa, and based on my own observations as a consultant in Rwanda over the past 2 years, I propose 2 additional objectives for the ChemoSafe project:

5. Training of physicians in assessing response and tolerance to chemotherapy to ensure safe and ethical use
6. Training all providers in the art of difficult conversations

These are challenging topics in any setting, yet they are critical to maximize the benefit of limited resources and, more importantly, to avoid harm.

Once we agree on these additional objectives, the question



Fellows from low-income countries who train in the United States face a serious adjustment when returning home. Fellowship directors need to adapt their teaching methods to make sure the experience appropriately reflects the state of the science in their home country.

then becomes how to teach these important skills.

There are many ways to evaluate benefit to treatment, and requires constant assessment, history, and physical examination as well as radiographic measurements. Patients for whom we have been caring during many lines of therapy, with long histories of metastatic disease, often will tell us when they have had enough. Patients who have been waiting months for treatment and have sacrificed the time and resources from many members of their family to get to a place where they can be treated may have a very different perspective on what they are willing to tolerate, leaving it to us as physicians to determine whether a treatment will help or harm. If someone presents with a large breast mass that is unresectable and the goal is to make it resectable and there is doxorubicin, cyclophosphamide, and paclitaxel available, it is appropriate to treat but also to watch closely for evidence of response. If the disease is not responding or is getting worse after 2 cycles, it is difficult to explain to someone that it is not helpful to continue and that it may harm them, but sometimes that is the most ethical choice. As chemotherapy becomes more accessible, there is an understandable sense of obligation to treat from all parties, yet it may not always be the right thing to do.

Expanding cancer care to places in the world where options are limited and resources are scarce will require education and research to assist us in predictive and prognostic methods that will undoubtedly be different from those



Mary Chamberlin, MD

in high-resource settings. We need to give our colleagues in low-resource countries the tools to assess who will benefit from treatment and teach them how to have difficult conversations with patients and families, to give them the words and support they need to say when there is nothing else that should be done, even if there may be more that could be done.

As senior oncologists, we need to train more of our fellows for careers in global health, or at least prepare them to be advisers. As the global burden of cancer accumulates, it is today's fellows who will be called on to help. Cytotoxic chemotherapy is not perfect, but it will continue to have a role in treating many cancers and managing symptoms of advanced cancer for many decades to come. ■

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# PERSPECTIVES ON THE FELLOWSHIP JOURNEY

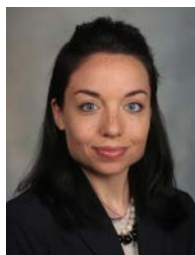
*Candace Haddox, MD, and Narjust Duma, MD*

*Both authors are affiliated with Mayo Clinic, Rochester, Minnesota.*

*The hematology-oncology fellowship is a daunting experience. Here we provide insights into the journey from 2 perspectives: the first from the view of a third-year resident about to enter a hematology–oncology fellowship program, the second from a second-year fellow, soon to be starting her last year of training.*

## **I Matched! Excitement Versus Fear**

Candace Haddox, MD (Postgraduate Year 3)



Candace Haddox, MD

**I AM WRITING THIS** as a recently matched postgraduate year 3 internal medicine resident about to start a hematology-oncology fellowship in T minus 3 months. I hope my musings are relatable to rising fellows or reminiscent to those who felt similarly at the start of their hematology-oncology training.

As I look back, the hematology–oncology fellowship interview trail was both exhausting and exhilarating. Meeting future colleagues and hearing about the exciting advancements that medical oncology will see in the coming years gave me a sense of pride for my chosen field. I felt as if I was joining a movement that had already seen decades of momentum in research and development of novel therapeutics and care models. Needless to say, cancer therapy has changed dramatically over time. I imagined the innovations and milestones that I would see during my career and felt excited to complete internal medicine training and start my next adventure.

Soon after Match Day, my excitement was tempered by all the practical tasks ahead of me: a new state medical license, another new driver's license, and to-do lists embedded in to-do lists. Moving across the country to a new place has punctuated every training step for me thus far. Although I enjoy exploring new cities and

meeting people, it has been difficult to move away from close friends, colleagues, and the rhythm that my life had become. I also wondered about the transition to a new academic center. During residency training, you truly feel integrated in your institution, which affords familiarity with everything from where to find the stairwells to the reputations of specialists and other trainees to the culture of the place. Here I have learned how to get work done effectively and efficiently. I can only hope that I quickly establish the same familiarity at my new institution.

Ahead of all the practicalities of moving and adjusting, I know that my new role as a hematology–oncology fellow will be the most formidable and satisfying challenge to overcome. My class of fellows and I will have to quickly rise to higher expectations for specialized knowledge and polished skills, a situation that feels reminiscent, yet more complicated, than in my early intern years. Today, I may ask for clinical advice from a fellow whose role I will be filling in a few short months. How strange and intimidating! But I remember how neat it was to transform into an autonomous, confident resident during intern year, and I can only imagine that this next transformation will be even more rewarding. This is the time when I will finally be doing what I wanted to do at the start of this journey. This time will likely shape my career trajectory more than any other segment of my training. As monstrous as it all seems, soon enough I will be reflecting on how quickly fellowship has passed as I look ahead to another transition.





## The Full Fellowship Experience Involves Doubts, Fears, and Understanding

Narjust Duma, MD (Second-Year Fellow)



Narjust Duma, MD

**I AM WRITING AS** a second-year hematology–oncology fellow about to start the journey of finding that “dream” faculty position for which many of us have trained for the past 14 years. I am sharing some of my experiences during fellowship and hoping a hungry and tired fellow somewhere will know she or he is not alone.

During the interview trail, I always heard “the learning curve is steep,” but I didn’t realize it until the first day of my oncology continuity clinic. My first patient had a pleomorphic sarcoma. After I did some reading for 5 minutes, a sense of doom invaded my body. The fear of sounding “stupid” or losing my first oncology patient’s trust was overwhelming. After a long night trying to seize some basic knowledge about sarcoma, I met with 1 of our sarcoma faculty to discuss the case. He said, “There are more than 100 types of sarcoma,” and my heart skipped a beat. He took a piece of paper and kindly explained the basics about pleomorphic sarcomas. That was the moment when I realized that I was not alone, that our faculty was there to support us. Trainees’ relationships with faculty change as you advance in training. You are no longer one of the residents—you are now one of them.

Another unforgettable moment during my fellowship was the first time one of my patients passed away. We all have encountered death during our training (eg, intensive care unit rotations), but when you care for patients during their cancer journey, you develop a strong bond with them and

their families. I remember receiving a message saying that “Mr M has passed away,” and immediately an incredible sense of sorrow pervaded my day. I asked myself, “Is this the right job for me?” and I questioned my decision to pursue a career in oncology. At the end of that day, I mustered the courage to call my patient’s family to offer my condolences. His wife picked up the phone and with a warm voice said, “Dr Duma, thank you for taking care of him. You two had a special connection.” A few tears rolled down my cheek, and all the fear disappeared—I had chosen the right field. After my 2 years of training in hematology–oncology, losing patients has not gotten easier, but I will always carry their memories and will continue fighting for them through my everyday clinical practice and research.

As you start your fellowship, you may feel lonely. You started with a class of 20-plus residents, and eventually you end up with a few fellows. That friend with whom you always had rotations together is no longer around. Going through a hematology–oncology fellowship is a life-changing experience that you share with only a few individuals. Over time, you will develop strong friendships with your co-fellows. They will become your confidantes, advisers, and even the future godparents of your children. James Cash Penney, founder of the retail store JCPenney, said, “Growth is never by mere chance; it is the result of forces working together.”

Lastly, ups and downs are common. One day your patient has a complete response and another day disease progression. Learning how to celebrate little victories has helped me to cope with the battles I have lost. Fellowship training has not only helped me grow as a physician but has also helped me become a better wife, daughter, friend, and teacher. I know the journey will not end after I secure a faculty position, but my experiences have taught me a lesson: We are lifelong learners, and we are not alone during this journey. ■



# SURVIVING THE MARATHON

James Gerson, MD  
Fellow, Hematology Oncology  
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Philadelphia, PA

**FOURTEEN MILES INTO A** recent 50-mile trail ultramarathon, I found myself running next to Gregory.\* We began to chat and go through the usual—where are you from, what do you do—but when I told him that I was a fellow in hematology and oncology, he stopped me.

“Eighteen months ago,” he said, as we crested a hill and caught a glimpse of a lush valley erupting with golden flowers, “I had a feeding tube and weighed 85 pounds.”

He went on to tell me about his recent battle with human papillomavirus-positive tonsillar cancer—how he lost 75 pounds just 2 weeks into his treatment that consisted of radiation therapy with high-dose cisplatin. He couldn’t eat and, despite a strong aversion to it, acquiesced to placement of a feeding tube. A lifelong runner who had completed countless marathons and ultramarathons, he was forced to stop running for the first time in his life due to intractable fatigue and weakness. He felt lost and struggled to find meaning. He even considered giving up and stopping the treatments altogether.

But then, he told me, he realized that the only way through was to approach therapy just like he did the countless running races he had already finished. The daily radiation treatments became mile markers. Each cycle of cisplatin was a steep climb to the top of a 10,000-foot mountain. If he saw food, it was like an aid station—eat or drink even if you don’t feel like it. Soon he found himself at his last treatment. That finish was more joyous than completing any running race he had ever done.

Just a few weeks after his therapy ended, he went for his first run. It was 1 mile at a snail’s pace. Every step was agony, but he kept going. At 6 weeks, he ran a 5K sponsored by the Head and Neck Cancer Alliance, which was raising money for cancer research. Three months after that, in celebration of the negative posttreatment positron emission tomography/computed tomography scan, he signed up for his first marathon as a cancer survivor. And now, just 18 months later, we were running 50 miles together in the mountains, with the glowing sun rising behind us over San Francisco.

Our patients come from all over the world and all walks of life. Some are parents, some are police officers or teachers, and some are plumbers and veterans. They have hobbies just like my co-fellows and me, be it music or running, playing chase with their dogs, or staying up late watching bad TV. But the common thread of a cancer diagnosis ties them together as the disease shakes the foundations of their lives, threatening to pluck the things they love from their grasp. It defines a struggle that we as providers cannot truly know.



James Gerson, MD

Each day in clinic, I find myself inspired by their stories. Our patients defy cancer by persevering through unimaginable toxicity, sometimes even completing marathons during treatment.<sup>1</sup> They astound us by remaining positive and warmhearted even when all seems lost. Those who transition to end-of-life care awe us with their grace and composure through the journey.

With every visit, I am reminded of the reason I pursued oncology in the first place: to care for these astonishing individuals during what will likely be the most difficult time in their life and help give them back the life that cancer tried to take away.

Gregory and I chatted for a few more miles, and then he bade me farewell and sped up, finishing the race almost an hour before me. When I finally arrived at the finish line, he was waiting there for me.

“Doc,” he said, “I want to thank you for doing what you do.” My mind instinctively went to the pile of paperwork I had left behind in my office, the unfinished clinic notes from last week, a few unanswered phone calls, and an upcoming presentation I’d been too busy to finish. And yet I smiled. I couldn’t wait to meet my first patient on Monday morning.

“No,” I said, shaking his hand, “thank you.” ■

\*NAME CHANGED TO PROTECT PRIVACY.

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## BY THE NUMBERS

# Younger Patients Face Higher Net Costs for 4 Common Cancers

Tony Berberabe, MPH

**PATIENTS YOUNGER THAN 65** years experienced net cancer costs that were higher for breast, colorectal, lung, and prostate cancer compared with patients who were 65 years and older, according to results from a study by the Center for Health Research at Kaiser Permanente Northwest in Portland, Oregon.<sup>1</sup> Lead investigator Matthew P. Banegas, PhD, MPH, said the findings help to fill in the gaps in the literature about cancer care costs, especially in younger populations. Much of the historical research that has been conducted uses data from the Surveillance, Epidemiology, and End Results (SEER)-Medicare linked database.

“Although the SEER-Medicare database is an incredibly valuable source of data, it is limited to Medicare fee-for-service beneficiaries,” said Banegas, an investigator with Kaiser Permanente Northwest. “That excludes people without Medicare and individuals who receive Medicare through private insurance, like Medicare Advantage,” he said.

About 31% of all Medicare enrollees receive their care through Medicare Advantage plans, said Banegas. “Because cancer is not just a disease of the aged, my colleagues and I thought it was important to improve our understanding and estimates of cancer care costs across all ages in the United States,” he said. “We want to highlight the high cost of cancer care in that under 65 population.”

The findings can serve to provide important inputs for economic analyses, comparative effectiveness studies, and tools such as the National Cancer Institute’s Cancer Intervention and Surveillance Modeling Network (CISNET) that aim to guide public health research and priorities, leading to the development of optimal cancer control strategies. “We hope our findings are used in cost-effectiveness or comparative analyses, so researchers and policy makers can improve the quality of the cost inputs,” said Banegas.

Patients were members of 4 health plans that are part of the Cancer Research Network, which consists of Kaiser Permanente Washington (formerly Group Health Cooperative), Henry Ford Health System, Kaiser Permanente Colorado, and Kaiser Permanente Northwest. A total of 45,522 adults served as cases, compared with 314,887 frequency-matched controls who did not have a

cancer history. The patients were stratified by 5-year age group, sex, and health plan eligibility. Eligible patients were diagnosed between January 1, 1988, and December 31, 2007, and had at least 30 days of continuous health plan eligibility during the study period (January 1, 2000, through December 31, 2008).

Each plan has a tumor registry and an integrated electronic health record database. These plans provide both private and public health insurance coverage, including Medicare Advantage and Medicaid risk contracts.

The findings are important to healthcare systems, providers, and employers, said Banegas. “The younger age group and investments in early detection and prevention programs for employers can be impacted by the findings,” he said. “If we can identify those younger individuals through early diagnosis and provide routine preventive care, employers and health plans can avoid those future cancer costs at later stages of disease.”

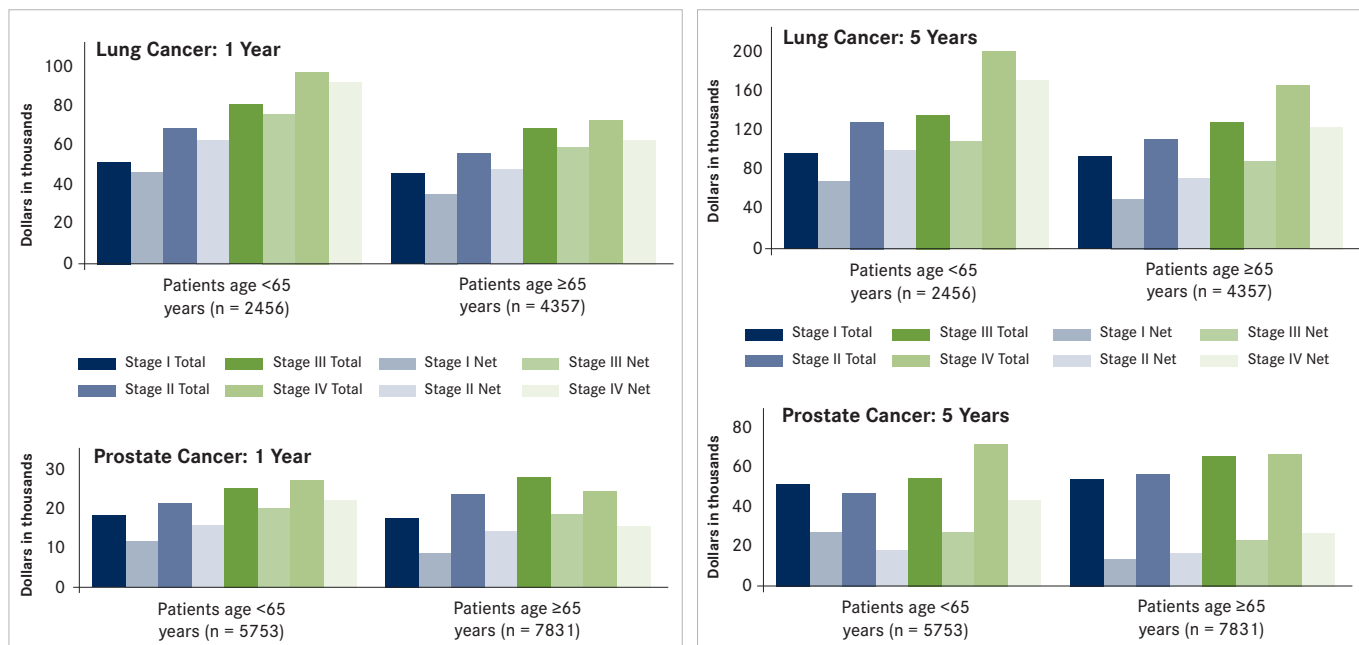
Among the 4 cancer types, patients with prostate cancer had the lowest costs, with patients who had lung cancer at the other end of the cost spectrum, according to the study (**Figure**). “A lot of lung cancer treatment and late-stage colorectal treatment costs dwarf the costs of care for prostate cancer,” Banegas said.

To estimate the cost of cancer care, the researchers used a phase-of-care approach, which breaks down the continuum of cancer care into 3 time periods: initial phase (first 12 months following diagnosis), end-of-life (EOL) phase (final 12 months of life), and continuing phase (all months between the initial and EOL phases). “The approach helps researchers compartmentalize the costs of cancer over a long period of time. Also, it is an efficient use of data,” said Banegas.

From previous research, the year after initial diagnosis involves high intensity healthcare resource use, resulting in high costs. The costs for that one year were stratified following the diagnosis, said Banegas. “Alternatively, at the last 12 months of life we see super high-intensity healthcare use and high costs. Using this approach allows us to breakdown the costs into clinically relevant periods.”

“The continuing phase is that time when people have completed their treatments and they’re trying to get back

Figure. Mean Total and Net Costs of Medical Care for Lung and Prostate Cancer



to normalcy. They are returning to work. It’s a period that they may see late or long-term effects of cancer treatment,” he said. “As a whole, if we look at patients with a history of cancer, as compared with those without a history, those folks in the continuing phase still have a greater cost compared with the person with no history.”

Banegas recommends that “oncology fellows continue to consider the cost of care in their practice, especially those

who are going to be physician scientists. It will be important for them to keep an eye on costs so they can achieve the highest value of care for their patients.” ■

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# ONCOLOGY Fellows CALL for ARTICLES

**Oncology Fellows** features articles written by practicing physicians, clinical instructors, researchers, and current fellows who share their knowledge, advice, and insights on a range of issues.

We welcome submissions to **Oncology Fellows**, a publication that speaks directly to the issues that matter most to hematology–oncology fellows at all stages of training.

If you are interested in contributing an article to **Oncology Fellows** or would like more information, please email Tony Berberabe at [aberberabe@onclive.com](mailto:aberberabe@onclive.com).

For more information, visit: [bit.ly/2Jbkhhk](http://bit.ly/2Jbkhhk).



# HIGHER LEVELS OF RESILIENCE AND FLOURISHING CORRELATES WITH LOWER BURNOUT

Tony Berberabe, MPH

**SYMPTOMS OF BURNOUT CONTINUE** to plague the physician community overall, but a recent survey suggests that factors such as resiliency and the ability to flourish can diminish its detrimental effects. Members of the Society of Gynecologic Oncology (SGO) reported a 23% rate of burnout, scoring highest on measures of emotional exhaustion (16.9%) and depersonalization (14.8%). However, the survey also revealed several possible factors that protect against burnout. Married participants reported higher flourishing ( $P = .026$ ) than nonmarried members, and parents reported higher resilience scores ( $P = .023$ ). Religious affiliation and age were not associated with scores on any inventories.

Lead author Monica Hagan Vetter, MD, a fellow in gynecologic oncology at The Ohio State University in Columbus presented her findings at the *OncLive*® National Fellows Forum: Gynecologic Oncology meeting in Miami, Florida.

Members of SGO received a cross-sectional electronic survey consisting of 82 questions that measured both burnout and well-being. The investigators distributed the questionnaire via email and reported a 21% (373 of 1745 members) response rate.

Her research is part of an emerging field called positive psychology, a scientific approach to studying human thoughts, feelings, and behavior that focuses on strengths instead of weakness. The goal is to build on the positive in the lives of all people—not just those who struggle with depression—rather than just repair problems.<sup>1</sup>

Vetter and her colleagues applied measures used in positive psychology to determine their use in future studies.

Low personal achievement scores were reported by 15% of respondents, compared with 11% in a 2013 survey. Respondents who reported high levels of burnout scored significantly lower on both the resilience and flourishing questions compared with those who did not meet the criteria for burnout ( $P < .0001$ ).

The 2013 survey was only sent to physician members of the SGO with 32% of them reported experiencing signs of burnout. Vetter pointed

out that their survey was sent to all healthcare providers of the SGO.

Although the rates for burnout have improved, Vetter said, findings involving the rates of depression and of alcohol and substance abuse were concerning. “About 50% of respondents reported a positive depression screening,” she said. “We found the rate of alcohol abuse was 17%, and the rate of substance abuse was 12%. It was surprising that the secondary measures of burnout and distress were as prevalent as they were.”

From the positive psychology standpoint, the researchers found what they expected—higher levels of flourishing and resilience seemed to correlate with less burnout. “It suggests that these tools can serve as surrogate markers to indicate how we are addressing burnout,” Vetter said.

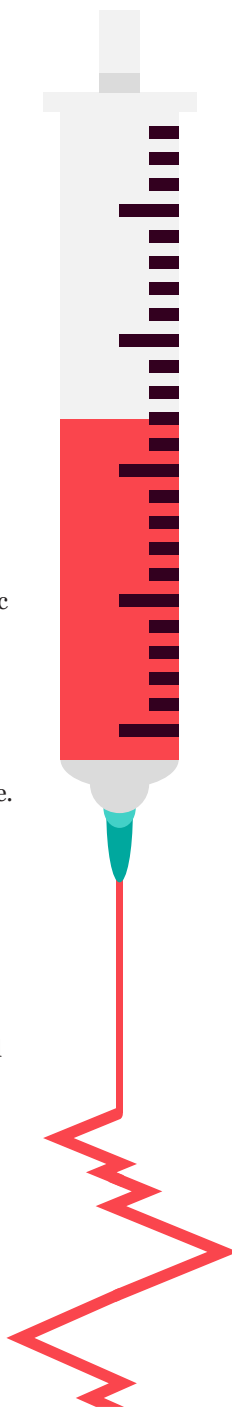
In response to this and other research, SGO formed the Gynecologic Oncology Wellness Task Force. Its goal is to enhance members’ wellness through focused presentations and courses at the American Society of Clinical Oncology annual meeting.

“I’m advocating for the inclusion of some of the factors identified in our survey, like substance abuse and alcohol abuse, in the curriculum to address the availability of mental health resources,” Vetter said. “People need to know that it’s OK to admit that you’re experiencing distress.” Earlier intervention might prevent substance or alcohol abuse or even suicide, she said.

Although the signs of a downward trend for burnout are encouraging, Vetter said, much work remains to ensure not just SGO members receive help or counseling but also that all physicians are aware of the resources afforded to them. “We know what burnout can do to healthcare professionals, so we want to prevent that from happening in the first place,” she said. ■

## REFERENCE

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# THE COMMUNITY OPTION— THE ROAD LESS TRAVELED

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**WITH THE PLETHORA OF** new targeted agents, immunologic therapeutics, and next-generation sequencing, there has never been a better time to be a hematologist/oncologist, as the armament is rich. That said, the army of physicians needed to do battle with cancer in the community setting is becoming a scarce commodity. Policy makers, healthcare organizations, providers, and payers are failing to recognize the value of the delivery of that care in the cancer patient's community, close to home and a support system of family and friends.

In the not too distant past, almost 85% of cancer care was delivered in the private practice, community oncology setting. Fast forward to 2018, and that percentage dwindles to a little more than 50% of patients being treated in their own communities. A number of factors account for the shift from community to hospital outpatient setting, including important issues that fellows should learn about, such as the 340B Drug Discount Program, site payment parity, and the sequester cut to drug payments. But the message coming out of Washington, DC, and from policy makers is that the era of corporate hospital-based cancer centers monopolizing the healthcare system is on its way out. Fellows would be wise to look to the future and consider the community practice option.

As we advance toward producing an integrated cancer model, the value of the practicing community oncologist has revealed itself to be an integral piece of the puzzle. Medicare's health reform think tank, the Center for Medicare & Medicaid Innovation, has invested significant resources in the Oncology Care Model (OCM), which aims to both provide higher-quality, more highly coordinated oncology care and achieve cost efficiencies for Medicare and beneficiaries. Close to 200 oncology practices and 16 payers across the country treating more than 150,000 Medicare beneficiaries currently participate in this oncology-specific payment-and-delivery reform model.

The Community Oncology Alliance (COA) is focused on helping practices succeed and thrive in the OCM. The alliance also has invested significant resources to its proposed OCM 2.0 model, addressing several issues identified by participants and charting a path for incorporating value-based payments. Among all specialties, community oncology is much further along with producing an integrated care model that exemplifies high-quality, well-coordinated cancer care to patients that also reduces costs for Medicare and beneficiaries.

It is precisely for those reasons that the COA launched

its COA Fellows Initiative, seeking to engage and educate hematology-oncology fellows about the value of practicing in the community setting. The program is designed to explore all practice setting options, inclusive of research, academia, government agency, and hospital- and community-based care, showcasing the array of choices post fellowship.

Current research shows that in just 2 short years, this country will experience a shortage of as many as 3800 oncologists. At the same time, an aging population, coupled with increased survivorship, will accelerate the need for even more hematology/oncology subspecialists.



Mary Kruczynski

Thriving community oncology practices exist throughout the United States, as evidenced by the COA job board and chatter among practices. The need for new physicians is real, and practices are eager to welcome new faces into the community.

COA looks forward to meeting with fellows across the country during 2018 to discuss the benefits of community practice, as well as connect them with employment opportunities that fit their specific needs. There are a number of opportunities for first-, second-, and third-year fellows to join COA and for our members to attend national conferences, meetings, Capitol Hill lobbying days, and more to learn about the value of community oncology and its importance in the US cancer care system.

At a recent joint meeting of the North Carolina and South Carolina Oncology Associations, several fellows from nearby schools joined practicing oncologists at a relaxed dinner program discussing both the risks and benefits of joining a private community oncology practice. It became immediately evident just how much is not taught about real world oncology, which was readily acknowledged by program directors at other COA fellows programs. The Fellows Educational Initiative addresses precisely that problem, offering an opportunity to learn about the differences in practice, whether it be academia, hospital, or private practice community oncology. Only then can a fellow be armed to choose wisely the best personal fit. ■

You can learn more about COA and our Fellows Initiative at [communityoncology.org/fellows](http://communityoncology.org/fellows).

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