Volume 3 • Issue 2, July 2011

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Healthcare Reform and the Future of Oncology

By Sheetal Kircher, MD

The healthcare system in the United States has become increasingly unsustainable. We hear frequent reports in the media and within our hospitals about the inability to improve health outcomes despite spiraling healthcare costs. The financial burden of cancer care is monumental. In 2008, overall costs were estimated at $228 billion, which included $93 billion in direct medical expenditures, $18.8 billion in lost productivity, and $116.1 billion in indirect costs.[1]

One example of this economic burden is seen in an analysis of patients with metastatic breast cancer. In this analysis, direct costs averaged $35,164 per year. New targeted-therapy drugs costs range from $20,000 to $50,000 per year per patient, and these costs continue to increase. Another example is seen in colorectal cancer therapy, which increased an incredible 340-fold between 1994 and 2004.[2] The drugs we prescribe as oncologists account for 40% of all Medicare prescription costs. This is in contrast to only 4% of federal dollars that are directed toward cancer prevention.[3] This article will discuss the impact that the Patient Protection and Affordable Care Act (PPACA) will have on our patients with cancer, on our hospital systems, and on us, the physicians.

Impact of Health Reform on a Patient With Cancer

When you combine the costs of tests, imaging, physician services, chemotherapy, surgery, and radiation therapy, the price tag on cancer treatment may range anywhere from $40,000 to more than $100,000 per patient. There are provisions within the PPACA that may offer modest advantages for our patients, including greater scrutiny when raising insurance premiums. Because of the increased requirements for employers to provide insurance coverage, individual states will form health insurance exchanges or cooperatives that offer low-cost options for workers as well as create competition in the marketplace. It is unclear how this will be federally regulated; many of these exchanges may operate differently because they will be created at the state level. Federally, the government will provide subsidies to low-income individuals so they can obtain

"Historically, Americans have low rates of adherence to recommended screenings for breast, cervical, and colorectal cancers."

insurance. With these changes, it has been estimated that 32 million additional individuals may be covered by 2019.[4]

One of the biggest concerns of patients is whether PPACA will cover preexisting conditions. Under the current plan, children with preexisting conditions such as cancer are protected from being excluded from insurance and will also be covered until the age of 26 under a parent's insurance plan. For those patients who fall into the category of non–Medicare-eligible retirees older than age 55, there will be access to subsidized high-risk pools and insurers will not be allowed to set annual or lifetime limits on coverage. These changes will likely have a significant impact on patients with cancer who may fall into the age range that is not yet eligible for Medicare benefits.

A major challenge for our patients is finding coverage for their skyrocketing prescription drug costs. This will become especially important in cancer treatment as we increasingly develop targeted agents, many of which are in oral form. Currently, there is a large gap in Medicare Part D coverage. Many patients find themselves in the "donut hole," causing them to struggle financially because their coverage is lacking. As the PPACA reforms take effect, there will be a $250 subsidy for those affected by the donut hole. By 2020, however, it is projected that 75% of oral medications will be covered by Medicare—a significant improvement over today's Medicare coverage.

Historically, Americans have low rates of adherence to recommended screenings for breast, cervical, and colorectal cancers. Recent Centers for Disease Control data reveal that 38% of Americans older than age 50 have not had their recommended colonoscopy and sigmoidoscopy screening, and 24% of women aged 40 to 50 years and 21% of women over age 50 have not had recommended mammogram screening in the last 2 years.[5] Preventive, quality-focused, cost-effective care will be the major PPACA initiatives, with preventive services coverage being federally mandated. Medicare will cover 100% of actual charges and fees for preventive care, such as cancer-screening exams. Incentives to Medicare beneficiaries may increase compliance with screening recommendations; this might ultimately save thousands of lives while cutting healthcare costs.

The expanded healthcare access will affect those covered under Medicare, private insurance, and PPACA. Unfortunately, of the 32 million people with newfound coverage, up to 50% will be covered under Medicaid and may not benefit from the expanded coverage. It is unclear if those with Medicaid will face the same challenges they currently do. In addition, it is possible that hospitals and private practice will continue to suffer financially by caring for Medicaid patients.

Impact of Health Reform on Private Practice and Hospital Systems

PPACA will have both positive and negative impacts on hospital finances. Under the expanded care, up to 95% of the US population will be insured. On the positive side, this will dramatically decrease the number of completely uninsured people, reducing hospitals' bad debt. Currently, approximately 15.3% of the population is uninsured and 35% is underinsured. For the most part, hospitals are burdened with uncompensated medical care costs that one 2001 report estimated to be $35 billion.[6]

These financial benefits, however, will be offset by a $14 billion reduction in Medicaid's disproportionate share hospital (DSH) payments, which will begin in 2014.[4] DSH payments provide financial assistance to hospitals that serve a large number of low-income patients, such as the uninsured and those with Medicaid. Medicaid DSH payments are the largest source of federal funding for uncompensated hospital care. For the hospitals that depend on DSH, this will add additional burden to an already stressed system; this may ultimately result in hospital consolidations, additional hospital services bring cut, and hospital closures. Medicare will provide expanded coverage by making cuts using the following strategies: not paying for hospital-acquired conditions, which will save $1.4 billion over 10 years; not paying for excessive readmissions, saving $7.1 billion over 10 years; and additional Medicare/Medicaid efforts to reduce fraud, saving $2.9 billion over 10 years.

In order to raise the quality of care delivered and provide incentives to hospital systems that are able to cut costs, accountable care organizations (ACOs) are an integral aspect of provisions set to go into effect next

> **"Medical oncologists have felt significant financial pressures even prior to the passing of PPACA."**

year. According to the Centers for Medicare & Medicaid Services (CMS), an ACO is defined as "an organization of healthcare providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it [sic]."[7] The pillars of ACO are care coordination, care effectiveness, population health management, safety, and efficiency.[8] In this system, if an ACO is able to meet performance standards and achieve a specified level of savings for an "episode of care," then the ACO would share in some of the cost savings. The expected effect of ACO implementation on cancer care remains unknown at this time.

Impact of Health Reform on Physicians

Medical oncologists have felt significant financial pressures even prior to the passing of PPACA. The American Society of Clinical Oncology estimates that 80% of patients in this country receive their care in a community setting. Under this model, patients typically visit their physician in a private-practice office where they receive their infusional chemotherapy. Under this system, the private practice has purchased the drug and will bill the payer for both drug and administration. PPACA is expected to drastically alter this model by changing reimbursement for chemotherapy, supportive drugs, and professional services, and by attempting to move all practices toward ACOs.

Prior to 2005, the CMS reimbursed practices at 95% of average wholesale price for chemotherapy and associated drugs, and this rate was quite profitable for oncologists. With the Medicare Modernization Act of 2005, the oncologists' profits plummeted after drug reimbursement became based on average sales price (ASP) rather than average wholesale price (AWP). (*Editor's note: Before we went to press, the Senate introduced S. 733, a bill designed to correct this reimbursement issue.*) ASP provides approximately 49% less in value than AWP. These changes have already increased the number of referrals to hospital infusion centers and have created partnerships between hospitals and private groups in order to shift financial risk to larger hospital systems. In addition to decreased margins in delivering pharmaceuticals, reimbursements for professional services will also decrease. The combination of these financial threats poses a major risk to small private practice groups because they will likely struggle to meet ACO regulations.

Preparing for Change

In the future, the stresses on the healthcare system will magnify. By 2030, the US population will expand to 365 million people, with 72 million adults over the age of 65. As the baby boomer population ages, the incidence of cancer is predicted to increase more than 45% from 2010 to 2030. There were 1.6 million patients with cancer in 2010; this number will swell to 2.3 million in 2030.[9] This increase will occur as the oncologist workforce continues to shrink. In preparation, it is essential that our disjointed system of care be restructured to be more efficient, nonduplicative, cost-effective, evidence-based, and safe. As these cancer care delivery models evolve, it will be essential that physicians take an active role in policy changes in order to protect their livelihood as well as continue to provide high-quality patient care. ■

Sheetal Kircher, MD, is a second-year fellow at Northwestern University Feinberg School of Medicine in Chicago, Illinois.

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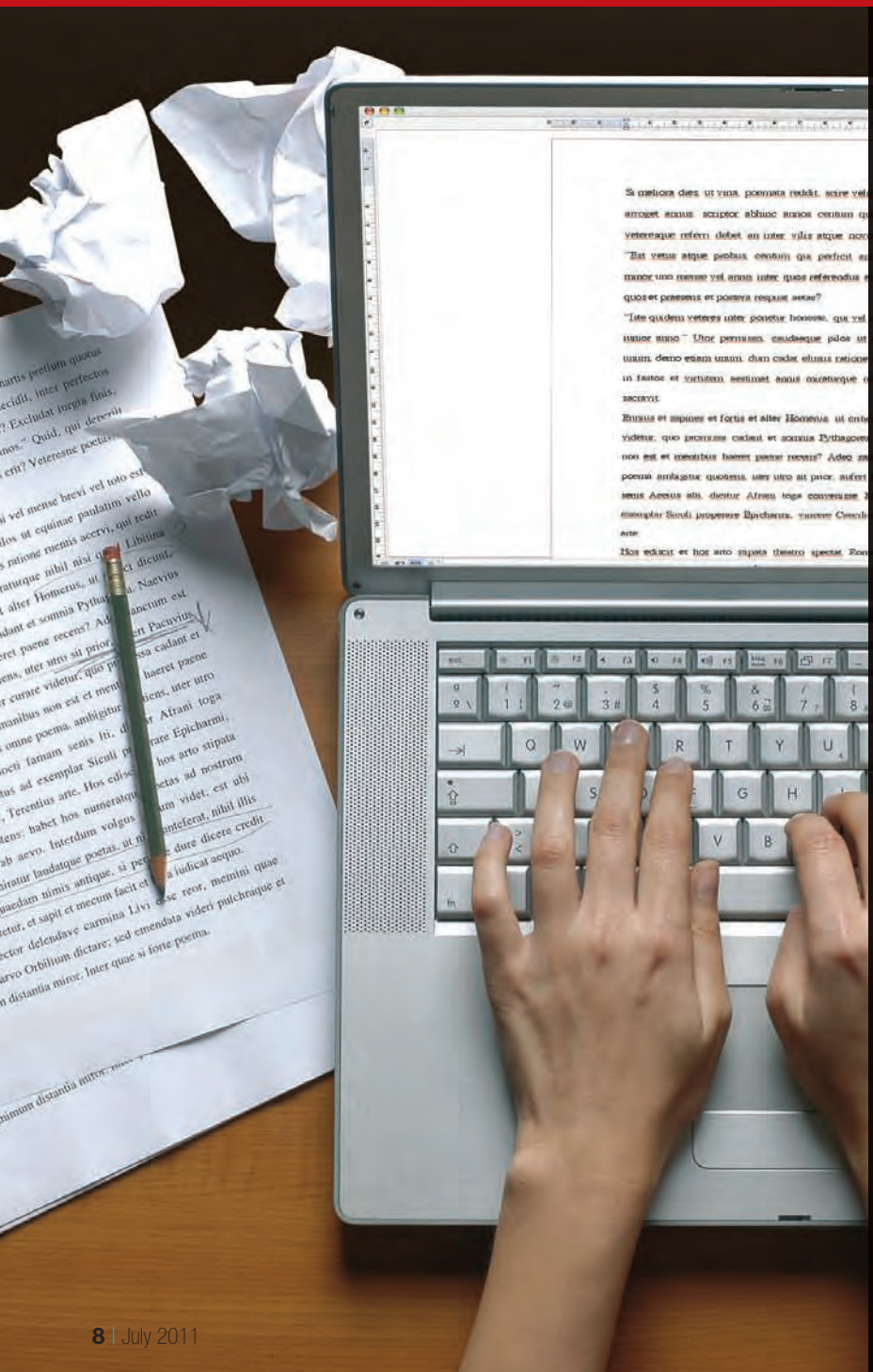
CANCER IS HARD ENOUGH. EVERY PATIENT DESERVES EXTRAORDINARY CARE, WE'RE COMMITTED TO DELIVERING IT.

Publish or Perish

Insider Tips for Publishing in Peer-Reviewed Journals

By Laura Bruck



As an oncology fellow you have chosen what is arguably the most research-driven field in all of medicine. Indeed, the lives of your patients depend, in large part, upon the expeditious flow of novel and increasingly safe and more effective therapies from the lab to clinical practice. This seemingly lofty goal is now more attainable than ever, but requires that knowledge be shared and information exchanged in reputable peer-reviewed journals.

Patients are clearly the primary stakeholders in this endeavor, but the list of those who rely on a solid track record of publications as a means to a critical end is a lengthy one. To varying extents, the ability to publish impacts everything from research funding to clinicians' reputations to the good standing or very existence of programs and entire institutions—and the competition is stiff.

While researchers and clinicians are not necessarily expected to be world-class writers, a well-written article that effectively communicates the topic at hand and adheres to the journal's standards, style, and guidelines is, indeed, more likely to be published than one that doesn't live up to these standards.

But can an article really be rejected based solely on an author's inability to produce a well-written manuscript? "Absolutely," said Kelly Brooks, managing editor of *Journal of Oncology Practice*. "The content might be appropriate for our journal, but all manuscripts are peer-reviewed. If the editors think the writing quality isn't worthy of inclusion in the *Journal*, they may certainly reject it for that reason," she cautioned.

Luckily for you, few, if any, would-be authors ever bother to read an article about the ins and outs of getting published, and instead move blindly through this unfamiliar and often confusing territory. For this reason, any effort you make to inform yourself about this process will give you a proverbial leg up.

Behind the Scenes

Understanding the process that leads to a paper's acceptance or rejection is the first step toward attaining the above-mentioned advantage. Much like going to a job interview, preparing an article for submission to a peer-reviewed journal would be somewhat of a fool's errand if you did not first get a sense of what the decision-makers are looking for.

While the process varies somewhat from journal to journal, newly submitted manuscripts generally get their first perusal at the hands of the editor-in-chief, who is usually a renowned expert clinician who evaluates the submissions less for the quality of their writing than for their timeliness, relevance, and potential interest to readers.

Once accepted by the editor-in-chief, the paper must pass muster with the editorial review board, a group of clinicians and academicians—all experts in their fields—who are charged with the task of evaluating the submission for content, scientific accuracy, appropriateness for their journal, and relevance to the journal's readers. Based on these criteria, review board members can accept or reject a manuscript outright, but can also return the paper to the author(s) with a request for clarification, revisions, or even a complete rewrite. At that point, acceptance for publication becomes contingent upon the author's ability to make the requested revisions to the satisfaction of the board.

"We have, indeed, rejected papers after asking for revisions," said Brooks, "because the author(s) ultimately couldn't produce a well-written paper."

It is only after these requested revisions have been made and approved that the paper moves on to the journal's editorial staff, whose job is to ensure that the article is as clear, concise, and error-free as possible. Ideally, the editing process serves as a series of checks and balances, with an initial edit performed for content and scientific accuracy (by the managing or senior clinical editor), followed by a second edit for features such as flow, organization, and proper style (by the copy editor) and, finally, a proofreader's line-by-line inspection for typos and errors in spelling and grammar. In this way, the paper is seen by multiple individuals, each of whom contributes a fresh perspective and pair of eyes, hopefully catching errors and inconsistencies not seen by the previous editor.

While most editors prefer this system of checks and balances, it is not unusual for a single person to perform all these steps, depending on the size of the journal and its staff. Even the best editor will acknowledge that errors are more likely when a single person performs all of the needed editing steps, underscoring the need for authors to submit papers that are as "clean" as possible. In fact, the more changes a paper requires, the greater the risk not only of introducing errors but also of changing the author's intended meaning, even if subtly. An author who submits a paper in need of a "heavy edit" also runs another risk; namely, that the author's "voice" will be lost, and the article will ultimately reflect the writing style of the editor rather than that of the author.

At some point during the editing process the author(s) might again be asked for clarification or additional information, this time by the editors. Once the editing and revisions are complete, some (but not all) journals will send the author a PDF of the typeset proof, providing one last chance to make sure the article reads the way the author intends.

Despite the possible bumps in the road, this process can and should go smoothly. To that end, the following tips are intended to give you the aforementioned leg up in getting your paper published, and in making the process as painless as possible, from submission, to acceptance, to publication. (See "Tricks of the Trade: Getting Ready to Publish.")

Know Your Readers

Medical writing is not a one-size-fits-all proposition. On the contrary, writing for journals requires that the same content be presented differently, depending on the needs and knowledge of your readers. Knowing your readers should, in fact, be considered the first commandment of any type of writing, and requires not only that you identify your readers, but also that you determine their levels of comprehension as well as what they do and don't need to know.

Let's assume, for example, that your area of expertise is gynecologic oncology and your article deals with a specific surgical technique. An article written for a journal whose readers are largely nononcologists will be read more with academic interest than with the intent to learn the ins and outs of the technique. In other words, the readers will need sufficient background information to bring them up to speed on a topic that's not within their area of expertise, but will not want or

require the amount of detail needed by someone who intends to employ the technique you're describing. If you intend to submit your article to a general oncology journal, keep in mind that some of your readers will be those from your subspecialty but the majority will not. In this case, less background information is required but the description of the technique might focus more on potential candidates, benefits, and outcomes, all of which would be of interest to oncologists who might refer their patients for such treatment. Finally, if the article will appear in a journal read primarily by those in your subspecialty, any background information should be summarized and the technique in question might be described in more of a step-by-step fashion for readers who might, themselves, ultimately consider performing such a procedure. The trick is to strike a delicate balance between providing your readers with the information they want and need and not insulting them with lengthy explanations of information considered to be common knowledge.

Along these same lines, *Journal of Oncology Practice* copy editor Wayson Jones provided some words of advice from "down in the trenches," noting that jargon and phrases coined within your discipline should be avoided, especially when writing for clinicians outside your area of expertise.

"A good copy editor who's confronted with such language will do his or her best to 'translate' it into more commonly understood verbiage, and doing so introduces the possibility of changing the author's intended meaning," he said.

Heed the Guidelines

Once you have effectively tailored your article's content to the needs of your readers, the task becomes one of "styling" the article to conform to the journal's standards. The vast majority of medical journals apply the standards put forth in the *AMA Manual of Style*, an indispensable resource for anyone and everyone who writes or edits for medical publications. While it is generally a very safe bet to use the *AMA Manual of Style* as a guide, the information in your target journal's guidelines for authors/manuscript submission should supersede that in the AMA *Manual of Style* when inconsistencies exist.

Even so, if you were to ask a room full of copyeditors about their biggest pet peeve, you'd probably hear something along the lines of, "Everything they need is right there in the author guidelines. Isn't anyone reading them?" Copy editors come by their frustration honestly. Despite the fact that peer-reviewed journals offer relatively specific guidelines for manuscript submission and style (in print, online, or both), a surprising number of authors either don't bother to read them or only scan them and basically choose to ignore the information they provide. And that information is invaluable. It includes the formats in which to submit text, tables, and figures; preferred spacing and font style/size; styling of references and footnotes; information required for author biographies; and statements of potential conflict.

A good copy editor will usually have a relatively sound working knowledge of the topics covered in his or her journal, but an author should never assume that the knowledge of any member of the editorial staff approaches the level of a physician's expertise. Jones provides some words of caution along these lines, citing failure to properly structure tables and figures as an example of an oversight that can lead to big problems.

He said, "Some authors try to cram too much information into a table, or ignore the guidelines and send a table that's formatted improperly or not at all, leading to misaligned rows and columns that force editors to guess."

This, warns Jones, leaves the copy editor with the task of attempting to line up headings and subheadings with corresponding data, inviting potential errors. Similar problems can arise from figures not designed according to the journal's standards, forcing the copy editor to try, for example, to make sense of unintelligible symbols superimposed on clinical art. The

Tricks of the Trade: Getting Ready to Publish

The following tips will help to give you a leg up when you consider submitting an article for publication.

- Purchase a copy of the latest version (10th edition) of the *AMA Manual of Style* or access it online (www.amamanualofstyle.com/oso/public/index.html).
- To identify the readers of a particular journal, check the masthead and contact a staff member from the sales and marketing team. These are the people in the best position to give you an accurate breakdown of the journal's readership.
- Never submit an article without first reading a number of articles from your target journal. If you don't have a copy handy, check the journal's Web site for current and past issues.
- Give your first and subsequent drafts to a colleague whose knowledge and experience are similar to those of your intended readers. Ask for and accept constructive criticism.
- When preparing original research for publication, clarify your target journal's policy about news stories appearing in medical trade publications. While, in theory, publication of a *summary* of your findings in such a trade magazine shouldn't affect your chances of being published in a peer-reviewed journal, different editors have very different views on this topic. As with most things in life, it's better to be safe than sorry.

same issues can arise from improperly expressed statistics, medication dosages, and units of measure.

Admittedly, all author guidelines are not created equal; some are more specific than others and some are in need of updating. Even so, these instructions are your best resource for properly preparing a manuscript for submission. And because the guidelines are written by those who will be editing your article, it only makes sense to adhere to them as closely as possible.

If you read the guidelines but still have questions, 2 excellent options remain. The first of these options is to contact the editor named in the guidelines or in the journal's "call for papers." That editor would, no doubt, much rather take a phone call or respond to an e-mail than have to chase down an author in mid-edit to clarify matters of style. Your second option is to use the journal itself as a guide; in it you can find 1 or 2 articles similar to yours (eg, original research, case studies) and use those articles as models. Doing so also will give you a sense of the preferred tone of the journal's articles (ie, formal vs more conversational).

Revise and Respond

The last bit of advice relates to the need to respond to any and all requests for clarification, and to do so in a timely fashion. A good editor will insert queries that leave no doubt about the information being requested, and will also tell authors exactly how to respond to those queries and by what date. Journals live and breathe by deadlines, and failure to respond to all queries or to do so by the specified date will likely jeopardize your article's slot in the upcoming issue. To avoid such a situation, it's also important to ensure that you or the author designated the primary contact for the journal is easily accessible during the review and editing process.

The Bottom Line

Whether you are the first or last author on your article, the time and effort invested in the process will determine whether your insights and knowledge will ultimately be shared with their intended recipients. The task is at once rewarding and challenging. It requires patience, care, and attention to detail—qualities already well known to oncologists. ■

Laura Bruck is a Cleveland, Ohio–based freelance medical writer and editor who has served as a copy editor, senior clinical editor, and managing editor for a variety of peer-reviewed journals and medical trade publications since 1987.

Introducing Humanities Into the Oncology Curriculum

*By David N. Korones, MD; Michelle Shayne, MD; and Alok A. Khorana, MD**

It seems that every year, the list of Accreditation Council for Graduate Medical Education (ACGME) requirements grows longer and more bewildering. That's no surprise in oncology. Our patients are increasingly complex, our therapies are more numerous and more sophisticated, and the ACGME's reach extends beyond medicine into patient safety, quality improvements, and understanding medical systems. In addition, there is the burgeoning list of required conferences, institutional demands, and the dawning of the electronic age, complete with electronic medical records, electronic admission, electronic discharge, electronic sign-in and sign-out, and electronic communication, all of which conspire to keep us at our laptops far longer than at the bedsides of our patients.

Add to this the stress of our clinical work. We try to satisfy the needs of our patients and their families, many of whom are facing life's biggest crisis. They deserve more attention than our crowded and fragmented schedules will allow; this only heightens our stress. For the fellow, this stress can be still greater. There are the additional burdens of being less experienced, being less appreciated by families, struggling with difficult decision-making and poor outcomes, and managing the competing demands of patients, faculty, the fellowship program, and the fellow's own family life.

Given the stresses and demands of our field, it is not surprising that the prevalence of burnout is high. Burnout is defined as emotional exhaustion, depersonalization (ie, treating patients as objects), and a low sense of accomplishment. However, there are many ways to maintain the deep satisfaction that comes with working with patients with cancer and their families and with our colleagues. Incorporating medical humanities into one's medical practice and the fellowship curriculum is one such way. Medical humanities is simply application of history, literature, art, music, and other fine arts to the practice of medicine and the care of the patient.[1]

There is not much literature on this approach, particularly in oncology. Gilewski describes a forum for fellows at Memorial Sloan-Kettering Cancer Center that focuses on end-of-life care and the stresses of such care on fellows and other caregivers.[2] Sands et al reported on a narrative training course, in which members of a pediatric oncology team wrote about their own personal experiences with their patients.[3] The 19 participants in this course displayed improved perspective on their patients' problems, higher empathy scores, and better teamwork.

'Narratives in Oncology' Seminar

In 2009, we introduced a seminar at the James P. Wilmot Cancer Center in Rochester, New York, titled "Narratives in Oncology," which was designed for medical and pediatric oncology fellows and radiation oncology residents. Our goal was to introduce our trainees to literature, poetry, and essays in the lay press as well as in the medical literature that focus on the human side of patient care. We hoped that such literature would open the eyes of our fellows to a rich source of thought-provoking material on patient and physician perspectives on life, death, and medical care. We also hoped that discussion of these essays would stimulate dialogue among us about subjects we seldom discuss: what to tell (or not to tell) our patients, the challenges of communicating bad news, how to deal with difficult families, coping with loss, and our own personal stresses caring for so many medically and emotionally needy patients.

The seminar was designed so that we would meet in a 1-hour session once a month for 6 months. The faculty preceptors and the fellowship director chose articles to review, and 1 week prior to each session 1 or 2 essays/articles were distributed to the fellows. We chose articles that provided the patient's perspective and that highlighted common clinical dilemmas. For example, for our first session we read an essay by Stephen Jay Gould called "The Median Isn't the Message," which discusses how a patient might look at odds of survival very differently than would a physician.[4] In another session, we read a *Glamour* magazine excerpt, "I Want My Life Back," by Andrea Coller, a young patient with multiply recurrent Hodgkin lymphoma, and learned what it feels like to be 27 years old and go through intensive chemotherapy and how we physicians look from the perspective of a young adult. (It wasn't pretty!)[5] We read a painful essay called "Facing Our Mistakes" by David Hilfiker[6] and watched Casey's Legacy, a video of a physician who tearfully describes a mistake he made in caring for a child.[7] For the last session, fellows were asked to write an essay about

a moving interaction with a patient, and selected essays were read at that session.

The seminar was quite successful. Attendance ranged from 11 to 18 fellows and it was clear they had read the assigned material. Discussion was lively and almost all the fellows actively participated. Faculty preceptors guided the discussion, but little stimulation was needed to provoke conversation. Fellows frequently cited their own patient scenarios that related to articles we reviewed. They frequently brought up the unique aspects of being a fellow and dealing with stressful patient encounters. They cited such examples as not feeling comfortable with the attending physician's communication skills, their own lack of experience when patients ask difficult questions, their discomfort when delivering bad news, and their unhappiness about knowing that, as a trainee, they cannot always speak freely. As the word spread about the seminar, we were joined by other faculty members, nurses, and nurse practitioners.

For the final session, fellows and faculty were asked to write a brief essay. One fellow wrote a moving piece about running into a very grateful couple in the grocery store and how he just could not remember who they were. He explained how embarrassed he was to have no memory of them. Was one a former patient? Were they bereaved family members? But at the same time, it made him realize that through his actions he can have a real impact on his patients' lives. Another fellow wrote about her interactions with a demanding daughter, a hospital executive who tested the limits of the fellow's patience. The fellow described how, tough as the executive in her power suit seemed, deep down she was scared of losing her mom, who eventually died of cancer. The fellow said that she knows how this feels because she, too, lost her mother.[8]

At the conclusion of the seminar series, we formally surveyed the fellows for feedback on the course. Ten of the 11 fellows who returned the survey felt that the course was a useful part of their curriculum. The fellows "repeatedly cited the openness to discussion of issues that typically are not part of the traditional oncology curriculum, as well as the relevance of the specific articles chosen."[8] As one of the fellows said, the course "provided a forum in which we could discuss our experiences and explore difficult issues with others who have shared similar experiences."[8] Ten of the 11 fellows said the course had a positive impact on their interaction with patients, enabling them to have a more "humanistic approach," be "more aware of patients' feelings," and hang on to empathy when it might otherwise have been lost. The majority of fellows felt that the writing exercise was useful, albeit difficult. It should be noted that 1 respondent did not find the course helpful at all; hence, a reminder that this is not an approach that is useful for everyone, and that we need to be sensitive to the needs of individuals who may choose to deal with patient care dilemmas more privately.

Overall, there was consensus among the fellows and faculty that the "Narratives in Oncology" seminar is a valuable part of the fellowship curriculum, and that the principles and practices we discuss can be incorporated into patient care, help to improve patient-physician communication, and make care of the patient with cancer more gratifying. As we move into year 2 of the seminar, we hope to expand to include other forms of artistic expression, such as art, music, and video, and perhaps expand our audience to other healthcare providers and other subspecialists. ■

**This article is adapted by the authors from: Khorana AA, Shayne M, Korones DN. Can literature enhance oncology training? A pilot humanities curriculum.* J Clin Oncol. *2011;29:468-471.*

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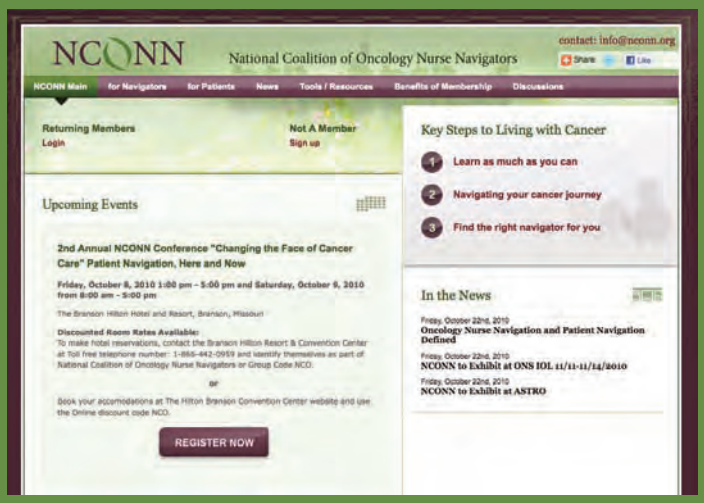

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How Fellows Can Establish a Smoking Cessation Clinic

By Cyrus Khan, MD; and Alice Ulhoa-Cintra, MD

In this country, an estimated 46 million people—20.6% of all adults—smoke cigarettes. Cigarette smoking also happens to be the leading cause of preventable death in the United States, accounting for approximately 443,000 deaths, or 1 of every 5 deaths each year. Approximately 40% of these deaths are from cancer, of which lung cancer is the most prevalent.

In addition to the disastrous impact that tobacco use has on our collective health as a nation, it wreaks havoc on our economy. Cigarette smoking is estimated to be responsible for $193 billion in annual health-related economic losses in the United States—that's $96 billion in direct medical costs and approximately $97 billion in lost productivity. Cigarette smoking results in 5.1 million years of potential life lost in the United States annually.

It is estimated that 70% of smokers want to quit completely and that 45% of smokers have tried to quit. Yet we realize from our interactions with patients that this is often a losing battle. Patients, even those with lung cancer, at some point in time will return to smoking. Compared with the billions of dollars that cigarette companies pour into marketing their products, the healthcare system is ill-equipped to respond. Smokers who want to quit often have limited resources available to them. As fellows and residents, we often know how important it is to counsel, yet have limited time with each patient to do so.

There are many smoking cessation interventions available, group sessions being one of them. As effective as they are, they are often an option only for those who can pay for them. As fellows and residents, we not only have a responsibility to help fight this major public health hazard, but we are also in an excellent position to do so. Most training programs are affiliated with community health centers. Approximately 20 million Americans are served by such centers, with 40% of these affiliated with residency programs. The majority of patients that visit such centers are poor—the very people who

smoke the most and who therefore need the most help. In the following sections, we provide an overview of how fellows/residents can set up and successfully run a smoking cessation clinic.

Starting Out

Planning is of paramount importance. You will need to speak with the health center director and ensure that resources are available to run such a clinic, which is held in a group meeting format in 2-hour-long sessions once a week for 4 weeks. The following are needed:

- A large conference room that can hold 10 to 15 people and that is available for a 2-hour slot on a specified day every week for 4 consecutive weeks
- 2 patient exam rooms
- A nurse and a medical assistant (MA) who are available each week for that 2-hour time period
- An attending physician who can be available for 30 minutes per session
- A whiteboard and pens and paper for the patients

Patient Enrollment

Once you have selected a day and a 2-hour time slot, begin by advertising the clinic. Print out flyers, hang them up in the clinic, and give them out to patients. Have a system in place where the MAs ask each patient coming through the clinic about his or her smoking status. If the patients smoke, at checkout have the staff offer to enroll them in your free smoking cessation clinic. Many will take you up on the offer. Once you have 10 to 15 patients enrolled, you are ready to start your very own smoking cessation clinic!

Next, we will describe how you should conduct each of the 4 sessions. Note that the group sessions will last for approximately 1 hour, with the remaining 1 hour used for individual patient counseling in exam rooms. This counseling allows the clinic to bill for the sessions.

Session 1: Committing to Quit

Start off by congratulating the patients for joining. Introduce them to the notion of smoking cessation through behavior modification and group therapy along with pharmacotherapy, if necessary. Stress the importance of follow-up through subsequent sessions. Hand out printed smoking cessation material, if available.

Next, talk about the harmful effects of smoking. Involve the group and ask them how much they know about the dangers associated with smoking. Discuss the heightened risk of cancer and chronic obstructive pulmonary disease (COPD). A useful exercise is to give out straws and ask the patients to pinch their noses and only breathe through the straws in their mouths; explain that if they do not stop smoking, this is how it will feel when they have emphysema.

Discuss in detail the benefits of quitting smoking. Specifically mention the health benefits, such as having more energy and a reduced risk of cancer and heart and lung diseases. Emphasize the psychological benefits, such as increased self-esteem and self-respect and a sense of accomplishment in quitting. Next, talk about the financial benefits, such as reduced insurance premiums, decreased future healthcare costs, and an almost $2000 savings per year from not buying cigarettes.

Wrap up by preparing patients for session 2. Prior to the next session, ask patients to think about what triggers their smoking. They should consider the reasons why they smoke as well as their desire to quit. Have them reflect on their past attempts to quit and why they failed and to start thinking about a quit date. Answer any questions that they may have. At the end of this and each subsequent session will be individualized patient sessions. (These are described at the end of the article.)

Session 2: Exploring the Smoking Habit

This session will help patients understand the psychological aspects of smoking. It is designed to explore in detail the patients' reasons for smoking and why they want to quit, and to reflect on past experiences with quit attempts.

Start off by asking patients to discuss the reasons they smoke. Write them down on the whiteboard. Ask them if they think smoking is a psychological need or truly a physical addiction to nicotine. Ask them when they have their first cigarette in the morning. Then ask each patient why he or she likes or dislikes smoking. This exercise will start a discussion among the participants and help them realize the reasons they smoke so that they can plan to gradually eliminate those reasons.

Discuss the circumstances in which they smoke each cigarette. Are they happy, sad, angry, frustrated, nervous, or something else? Make a list on the whiteboard of all the triggers for the different patients. They will soon realize that everyone has fairly similar triggers.

Next, talk about the true desire of the patient to quit. Discuss why it is so important to do so. Make sure they understand that they may have to undergo many months—if not years—of self-reflection and attempts at quitting before finally being successful.

Now, discuss in more detail the patients' past quit attempts. Discuss the methods used. Ask them how long their quit periods lasted and whether the attempts were successful. Talk about the reasons why the patients feel that specific past interventions did not work.

Toward the end of this session, you will discuss some strategies to cope with urges to smoke. Ask them to remember the "4 Ds" when they feel the need to smoke: delay, deep breath, drink water, and do something else. Ask each patient to come up with 3 situations that made him or her really want to smoke again. Write those on the whiteboard. Then ask them what they could do instead.

Session 3: Arming Patients With the Tools to Quit

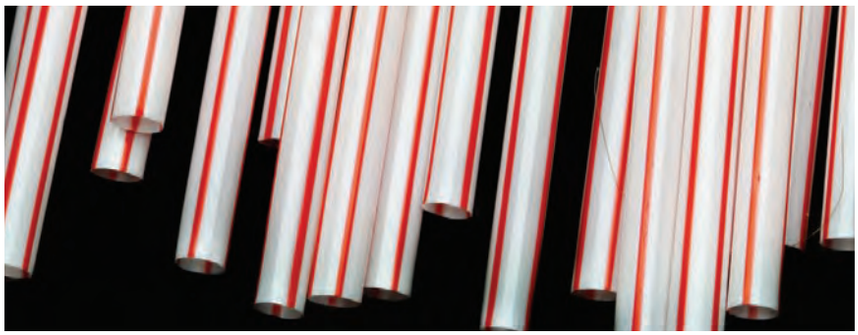
Hopefully, by now the patients will have a clear idea of what makes them smoke and what strategies they can use to quit. This

session is about dealing with recovery symptoms (ie, nicotine withdrawal) and the correct use and side effects of different smoking cessation products. At the end of this session the product of choice should be prescribed, if appropriate for the patient.

It is important to teach patients how to deal with withdrawal. Explain that after quitting smoking, the body experiences both physical and psychological "recovery symptoms." These symptoms decrease after the first few days and usually pass within 2 to 4 weeks. Specific interventions that can help are taking fluids for a dry mouth, sipping warm water for a cough, and having low-calorie snacks to combat hunger pangs. Other symptoms that are expected are insomnia, fatigue, headache, irritability, and constipation.

Next, you will review products that can be used for smoking cessation. These include nicotine replacement (eg, patch, gum, lozenge, inhaler), bupropion, and varenicline (Chantix). Based on patient preference, any product or combination can be chosen. If nicotine replacement is chosen, it is best to prescribe the patch plus a short-acting nicotine product (eg, gum, lozenge) to deal with the cravings.

You will need to describe in detail how to correctly use each product, their advantages and disadvantages, and their side effects. This sort of material is easily found on Web sites such as Uptodate.com.



"A useful exercise is to give out straws and ask the patients to pinch their noses and only breathe through the straws in their mouths; explain that if they do not stop smoking, this is how it will feel when they have emphysema."

Session 4: Preventing Relapse

At this point, you hope that the patients have quit smoking and are perhaps also on a smoking cessation aid. This is the last session of the series and will mainly focus on relapse prevention and answering any questions that the patients might have about the program and the previous sessions.

First off, discuss relapse-prevention techniques. Relapse prevention requires that patients develop a program that suits them and that they will follow if they begin to slip back to smoking. Talk about avoiding situations that serve as triggers to smoke. Exercising and taking up new hobbies often help. At the end, provide a short recap of all the sessions. If patients are using any of the smoking cessation aids, ensure that they are using them correctly. Answer any questions. Also be sure that you book follow-up visits with the patient's primary care provider specifically for smoking cessation consultation.

Individual Patient Sessions

These sessions are required for billing purposes. The patients would already have had their vital signs taken by an MA when they registered for the course. The staff will bring them to the exam rooms and each meeting with the fellow or resident should not take more than 3 minutes. Briefly go over the specific reasons that the patient should quit. If the patient has a disease, such as coronary heart disease, the physician should tailor the smoking cessation plan accordingly. Briefly document your discussion and then precept with an attending physician. If needed, other patient complaints or concerns should be addressed on a separate visit. This meeting is only for smoking cessation.

This program serves as a basic outline and can be tailored to your own specific needs and patient population. If you would like more details about running a smoking cessation clinic, please contact Dr Khan at cyruskhan@gmail.com. ■

Cyrus Khan, MD, is a second-year hematology/oncology fellow at the Western Pennsylvania and Allegheny General Hospital in Pittsburgh. Realizing that the lack of smoking cessation services was a major drawback to the efforts of patients who wanted to quit smoking, he helped start his community health center's very first smoking cessation program.

Alice Ulhoa-Cintra, MD, is a second-year hematology/oncology fellow at the Western Pennsylvania and Allegheny General Hospital in Pittsburgh. Her primary interests encompass all aspects of solid tumor oncology, including cancer-preventive strategies with the potential for a significant public health impact, such as smoking cessation initiatives.

Using Smartphones to Access Medical Reference Information

By Swapna Goday, MD, MPH

Smartphones are becoming the most transformational IT solution to ever impact healthcare. In developed countries they are in the process of changing the practice of medicine due to their ease of use and inherent portability. However, fellows face some challenges due to the learning curve involved in adapting to the smartphone's digital delivery options. In fact, patients seem more adept at learning how to receive digital healthcare information than most physicians are at figuring out how to provide it.

The practice of healthcare lends itself well to smartphones, which provide a wide range of conveniences and workflow efficiencies that cannot be achieved with traditional tools such as notepads and pocket medical references. Smartphones allow physicians access to most updated information in the form of podcasts, smartphone apps, and more. They don't need to carry tons of books or subscribe to dozens of hard copy journals. Podcasts are audio files that you broadcast or listen to on demand, and they usually have subscription options that allow updates to be automatically downloaded to smartphones. As for apps, for the iPhone alone there are currently almost 6000 medical-related apps in Apple's App Store. Apps targeted to physicians include alerts, medical reference tools, diagnostic tools, and continuing medical education. Podcasts and apps give you the option of accessing only what you need, when you need it.

In the oncology world, protocols, interventions, and research change at a rapid pace, causing day-to-day variations in the ways that patients are treated. It is very important for an oncologist to have the most up-to-date information as soon as it is available. Smartphones are always connected to the information source and are capable of providing instant updates. For oncologists, the smartphone is able to access drug reference guides on the go, monitor a patient's health conditions, and securely share electronic health records. Consequently, there is tremendous improvement in the time taken to make decisions. Healthcare is now a team effort, and using voice over IP (VoIP), unified communication tools, and instant messaging allow for effective clinical collaboration. If an oncologist receives an alert about a patient, he or she can call 2 colleagues instantly on a smartphone for a second opinion.

Oncologists are using their smartphones to hasten access to the most updated information and also to expedite the decision-making process. And you no longer see this pattern only among young oncologists; senior physicians are doing it as well. With advancing technology, more and more clinical data can be accessed, including NCCN guidelines and clinical articles from numerous medical journals. Not only are there apps for calculating prognostic scores to give survival estimates, but also apps to access the most recent clinical trials in progress. With such rapidly changing clinical practices and ongoing research, it is difficult for oncologists to stay up to speed on all the latest advances. But the apps that give access to the chemotherapy protocols, drug regimens, and the most updated research are an enormous information resource for oncologists.

The access to online oncology communities such as Sermo.com and QuantiaMD has been made even easier with smartphones. You can post clinical questions and discuss them online with your colleagues and seek their expertise. Mobile technology, which includes iPads, is a revolutionary change for access to medical information. We can access these devices to show lab trends and imaging studies, as well as explain to patients—in a pictorial format—their diagnosis and its implications. The ease of access to this kind of information can save a lot of time and ensure faster delivery of quality care to the patients. The accessibility to the healthcare information at the point of care makes a huge difference in decision making, both for the patient and the oncologist. It can reduce the burdens of apprehension and anxiety associated with the diagnosis, treatment options, and prognosis for the patient and his or her family.

Epocrates is another popular app that is used by oncologists. Epocrates not only provides drug information but also dosages, adverse reactions, interactions with other medications, pricing, brand names, body surface area calculations, chemotherapy dosage calculations, and more.

In the past, such apps were used primarily on PDAs. However, with the advent of smartphones and other mobile devices, the apps can be easily installed and accessed on the phone at any time. Over the past few years, there has been an increasing trend of using smartphones and other mobile devices as sources for reference information. This is a big step forward from the days of PDAs and, further back, hard copy books and journals. With the rapidly changing clinical advances in oncology, the trend toward accessing resources via smartphone will only increase. ■

Swapna Goday, MD, MPH, is a second-year hematology/oncology fellow at Western Pennsylvania Hospital/Allegheny General Hospital in Pittsburgh. She finished her residency in internal medicine and graduated in June 2009. Her areas of interest include but are not limited to solid tumors, stem cell transplant, and the use of mobile technology for patient care.

Are You Thinking About Starting a Medical Practice?

By Ed Rabinowitz

After fellowship training, you—the oncology or hematology fellow—need to make some important decisions. Do you sign on with an academic institution, join a hospital or existing practice, or start your own oncology or hematology practice? If you decide to do the latter, there are many options to consider. And as with almost every business, it *is* all about location—but confidence in your abilities is important too.

"There are little markets all over the country," said Dirk Davidson, MD, who heads up Tennessee Plateau Oncology in Crossville. "And probably the main reason nobody is in them is because [the physicians] … don't think they can start and manage such an operation."

But with the right game plan, you can open your own lucrative practice in an area previously thought to be unprofitable.

Location, Location, Location

Alan Hill is a certified public accountant and a principal and director of medical services at Rea & Associates, an Ohio-based public accounting firm. Hill said that when considering the location of a new oncology practice, you must determine whether there is a need in the area being served. In other words, if you start your practice in a place that contains other oncologists, it will be more difficult to acquire your own patients.

"Talking with [local] hospitals is a good way to go,"

advised Hill. "Hospitals know where there is a need in their area, and you might be able to approach them for assistance in starting up your practice, because that's where you are going to be referring your patients. They might be able to tell you about the population in that area. Location—knowing what your market ecosystem looks like—is definitely an issue."

Population is another key consideration. Last November, John Jones, MD, opened the doors to his Simplicity Urgent Care facility in Arlington, Virginia. He and his partner, John Maguire, MD, were looking for an area with a population density of 40,000 to 50,000 people within a 2-mile radius of their practice. They researched population demographics, including the number of young families in the area, and the average local income. They also checked out their competition.

"It's important to know who's located near you, as far as other oncologists or any other practice," Jones said. "A lot of that is simply going through a physician directory and finding out where they are. We did not want [any other physicians] within a 3-mile radius of us."

As proprietors of an urgent care facility, Jones and Maguire wanted to be on a well-traveled road. It was imperative that they were easily accessible via public transportation. In a departure from the norm, Jones and Maguire looked at retail space, which is likely the opposite of what an oncology practice ought to consider.

"An oncology practice would probably go into a medical office building," said Jones. "And while medical office buildings don't [always] have the prime real estate location, such as being on a major road, they're also less expensive. An oncology practice doesn't need to be on a major highway because it's more referral-based and establishes relationships with a lot of local doctors."

Financing the Deal

Unless you have a rich uncle who will lend you the funds necessary to get your oncology practice up and running, you will likely need to secure a loan through a local bank. But in today's tight economy, are banks lending? Hill confirmed that they are, but the loan terms are more restrictive than they used to be.

Hill said he is starting to see more banks targeting loans to the healthcare field. "Within the bank you'll want to seek out the healthcare department—those who do the financing in that area," he said. "Because it is a little different; it's not a machine shop. There isn't inventory attached. There's machinery, but not like a large widget manufacturer employing 100 people. So…you need to make sure you align yourself with a banker who works in healthcare."

Nevertheless, Jones said, be prepared to make a presentation that includes a spreadsheet with predicted expenses and a cash flow forecast. It can be challenging for an oncologist coming straight out of a fellowship who is starting a medical practice for the first time because there is much you don't know. For example, how much will you earn per patient? How many patients will you see? How much do you plan to spend per square foot on build-out (ie, the process of finishing a raw space)? What is the average salary of a receptionist? How many receptionists will you need?

"There are a lot of variables in the equation," Jones said. "And the bank is going to want to see all of these numbers so they know that you've thought through the entire process…before you go to them." He pointed out that it might be helpful to hire an accountant or attorney who understands this process. Jones said, "We used an urgent care consultant who helped set up other urgent care practices and she was very helpful."

Staffing the Practice

Davidson is also the co-founder of Crossville, Tennessee–based Oncology Partners, which helps oncology practices maximize their efficiency. He cautioned that an oncology practice just starting up should consider doing so with minimal employees: perhaps just a receptionist and a nurse, in addition to the physician.

"That's always an issue: how many people do you really need?" said Davidson. "A lot of people think they need to project an image of strength and size, so they automatically hire more people than they need. If you think you are going to administer chemotherapy soon, then hire a good chemotherapy nurse who can also draw blood and run an IV. But remember that as you grow, you can always add people appropriately."

Hill advised that when it comes to running the practice, physicians need to determine how hands-on they want to be in managing the day-to-day tasks as opposed to hiring someone else to do it for them.

"I'm a big fan of getting somebody who can manage your office for you." he said. "Look for someone with credentials, such as MGMA [Medical Group Management Association]. They stay on top of office issues and what's going on in the practice of medical office management. That way you can spend more time seeing patients and less time on office matters."

Jones agreed with that advice. He and Maguire brought in a business manager a couple of months before the center opened its doors, and Jones believes that it was one of their best decisions. Jones said, "She had run a practice before, she knew what questions to ask, and we…let her manage most of that." It is a strategy he suggested that oncology fellows employ. Jones said that when oncology fellows leave their fellowship, "they're going to be moonlighting or working for other groups. They're going to be working in order to maintain an income, so setting up a new practice is something they will be doing in their off time."

Jones acknowledged that there are "a million" pitfalls to avoid when starting a practice. He said one lesson that he and his partner were surprised to learn is that things end up costing more than they expected. When they initially spoke with their banker, they asked for a set loan amount. But the banker said, "Let me give you 20% extra, because no matter how you cut this project, it's going to cost more than you think it will." Jones said, "And you know what? He was right."

Covering the Bases

Hill outlined the importance of relationship building. Before starting the practice, he said you should make some phone calls to an accountant, an attorney who practices healthcare law, a banker who handles healthcare finance, and a malpractice carrier. You will also want to consider whether you should open a practice on your own or with a partner. Davidson said that's a decision a physician has to feel comfortable with. "If you go into a partnership and you're at odds with your partner, that's chaos," he said. "When you go [into your own practice] you want career satisfaction. Do you feel like you're in charge or that you can practice medicine the way you feel is right? Those are important considerations."

Jones said that he has known his partner for 10 years and they have worked together in a hospital. For him, it has been crucial to have someone with whom he can bounce ideas around.

"Picking the right partner is critical," Jones said. "And you also have to figure out how many partners you want. The more partners you have, it becomes more of a committee decision rather than you and another guy just getting it done."

Ultimately, deciding to start your own practice requires careful consideration of all of the variables involved. (See "Should You Start Your Own Practice?") Doing the legwork to research and evaluate locations, the competition, financing, staffing, potential partnerships, and other key factors will help you launch a successful medical practice. ■

Ed Rabinowitz is a veteran healthcare journalist based in Upper Mount Bethel Township, Pennsylvania.

Should You Start Your Own Practice?

If you are contemplating starting an oncology or hematology practice upon completion of your fellowship but you're not certain if it's the right move for you, consider this decision-making tool from *Starting a Medical Practice, Second Edition*, published by the American Medical Association. Simply circle the answers that are most true for you, then see which column contains the highest score.

	Sole Proprietor	Partnership or Group Practice—Part Owner	Employed
1. Do you prefer to make your own decisions?	Yes	Somewhat	No
2. Are you comfortable with making difficult decisions?	Yes	Somewhat	No
3. Are you organized and detail oriented?	Yes	Somewhat	No
4. Do you perform well under productivity incentives to see X number of patients?	No	Somewhat	Yes
5. Do you perform well when having your clinical utilization monitored?	No	Somewhat	Yes
6. Do you enjoy marketing and networking?	Yes	Somewhat	No
7. Are you willing to compromise on your objectives or settle on an issue?	No	Somewhat	Yes
8. Are you a competent record keeper?	Yes	Somewhat	No
9. Do you enjoy managing and leadership?	Yes	Somewhat	No
10. Are you good at containing expenses?	Yes	Somewhat	No
11. Do you have the mindset of a business owner who can focus on profits, in addition to patient care?	Yes	Somewhat	No
Total:			

Source: Daigrepont JP, Mink L. *Starting a Medical Practice.* 2nd ed. Chicago, IL: American Medical Association; 2003:2.

Komen Tissue Bank volunteer and Purdue University graduate student, Rebecca Fega, helps process breast tissue samples November 2009 in West Lafayette, Ind.

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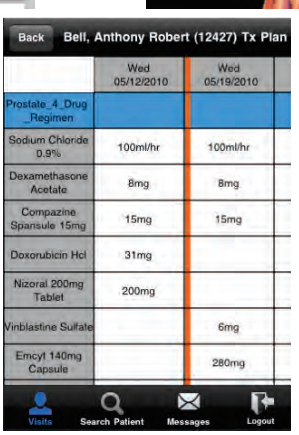
Created by Altos Solutions Inc, this is an iPhone/Android front end to OncoEMR, an oncology-specific electronic medical record.

http://bit.ly/ff5FYB

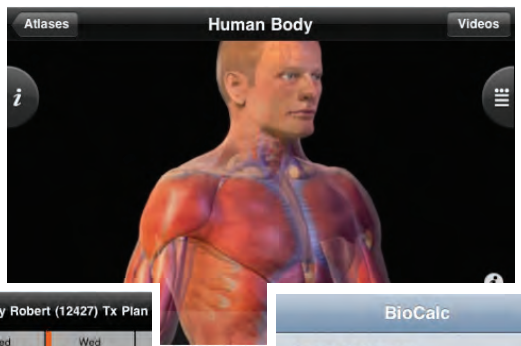


Blausen Human Atlas

Price: $19.99 for iPhone, iPad, iPod Touch, and Android; $29.99 for BlackBerry
Platforms: iPhone, iPad, iPod Touch; Android; BlackBerry

This app, developed by Blausen Medical Communications Inc, allows healthcare providers to easily communicate core medical concepts to their patients.

http://blausen.com/mobile

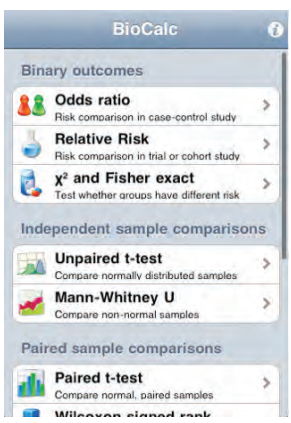


Biostats Calculator App

Price: $9.99
Platforms: iPhone, iPad, iPod Touch

Created by Sam McCall, this app provides a collection of biostatistical calculations that allows access to common tests without requiring a complicated desktop statistics package. It also includes a sample-size calculator for epidemiological studies.

http://bit.ly/kkZ2MW

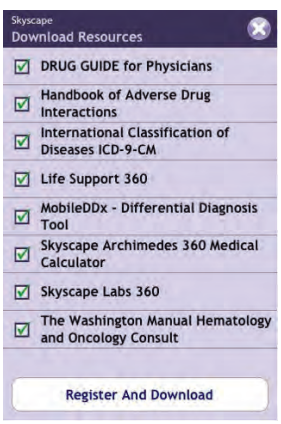


Hematology Oncology Constellation: All-in-One Hematology & Oncology Solution App

Price: $94.99
Platforms: iPhone, iPad, iPod Touch; Android; BlackBerry

This app, created by Skyscape, provides a core set of resources in 1 package. Information can be tailored to your needs and you can cross-index with Skyscape's 500-plus medical references.

http://bit.ly/imlURA



5 Steps to Financial Security for Fellows

BY TERRI CULLEN

The first few years after medical school can seem financially suffocating for young physicians. Who can think about saving for long-term goals, such as buying your first home or planning for retirement, when you're struggling with day-to-day bills and the equivalent of a mortgage in student loan debt? The good news is that fellows are earning more. The 2010 Postgraduate Fellowship Compensation Survey, produced by the American College of Healthcare Executives in Chicago, found that nearly 75% of fellows surveyed earned between $45,000 and $60,000 per year. Just 4% of those polled said they earned less than $40,000 a year, while 15% said they were paid $60,000 or more. (See "What Do Fellows Earn?" on page 29.)

Indeed, fellowship compensation has increased over the last 5 years; median base compensation rose 14% to $49,800 in 2010, from $43,604 in a similar survey conducted in 2006. "[T]here also has been a noticeable improvement in fringe benefits that are fully paid versus those [that are] partially paid. The improvements are most noticeable for medical, dental, and disability insurance," according to the study's authors. "For example, 43% of fellows in 2010 received fully paid disability insurance when in 2006 only 29% received this benefit."

Still, even students at the high end of the fellowship pay scale must find the means to service enormous debt. The average educational debt for the Class of 2010 was $157,944, according to the Association of American Medical Colleges in Washington, D.C. (That's just an average—students in certain medical specialties graduate with debt of $200,000 or more.)

"In the coming years, a lot of people will still be paying off their student loans when it's time for their kids to go to college," said Mark Kantrowitz, the publisher of financial aid information Web site finaid.org, in an interview with *The New York Times*.

On top of 6-figure education loans, many graduates have substantial high-interest credit card debt. On average, older graduate students (aged 30 to 59 years) had outstanding credit card balances of $12,593, according to a 2007 Nellie Mae survey, the most recent data available. That's almost twice as much as their younger counterparts aged 22 to 29 years, who carried average credit card debt of $6479.

So what's a struggling fellow to do? Don't panic. By taking a methodical approach to managing your spending and your debt, you can get on the road to financial security. Just follow these 5 steps.

"In the coming years, a lot of people will still be paying off their student loans when it's time for their kids to go to college."

Choose the Right Repayment Plan

If you're one of the lucky few young physicians with enough income to cover your monthly expenses and your debt payments, with money to spare for saving, choose a student loan repayment program with the shortest term. The standard federal loan repayment program extends payments out for 10 years. (Extended and graduate repayment programs allow graduates to expand payments up to 30 years.) If you have higher-interest private loans, pay the minimum owed on your federal loans and concentrate on making larger payments to pay down the higher-interest debt first.

But if you're neck-deep in debt, including high-interest credit card debt, and you expect your current meager salary to increase steadily over the next decade, consider enrolling in an income-based repayment (IBR) program. Graduates pay 15% of their income over 25 years, and after that the remaining balance (if any) is forgiven. (You can cut that down to 10 years if you work in public service, including jobs in government and nonprofit 501(c)(3) organizations, under the Public Service Loan Forgiveness plan.)

In 2010, the federal rules were changed to make the IBR rules more equitable for married couples. Previously, the formula that lenders used to calculate IBR payments did not combine a couple's total student loan debt, leading to monthly payments that were up to twice the amount 2 single borrowers would have to pay, particularly if both spouses had advanced degrees. For married couples who file jointly, lenders now use a formula that factors in the couple's total outstanding federal student loan debt and adjusted gross income to come up with the minimum monthly payment. Find out if you're eligible for the IBR program by using this calculator: http://www.ibrinfo.org/calculator.php.

Can't Afford Your Lifestyle? Change It

Many graduates in their late 20s have enjoyed living on their own for many years. When the time comes to finally start repaying those big monthly education bills, however, some may find themselves unable to make ends meet and be forced to make hard decisions about their living arrangements.

Moving back home with one or both of your parents can seem like a drastic—and humiliating—step for a young physician to take, but eliminating monthly housing costs can allow you to concentrate all your disposable income on repaying your high-interest debts. But don't just show up on your parents' front porch, laundry in hand. Instead, create a "rapid debt-reduction plan" that plots out how long it will take you to whittle down your debt to a manageable level, and sets a goal for when you plan to get back out on your own. (Vertex2.com, a site devoted to Microsoft Excel spreadsheets, has an excellent debt-reduction worksheet—based on the "snowball method" of paying the highest debts first—that can help you track your progress at http://bit.ly/15FuL.)

If moving home with your parents is not an option (or at least, not a palatable one), consider taking on a roommate to share your monthly household expenses, and perhaps even your commuting costs.

Save for a Rainy Day, Even When It's Pouring

Once you've got the right loan repayment plan in place and you feel comfortable that you can afford your monthly household expenses, it's time to focus on emergency savings. Yes, emergency savings is even more important than saving for retirement at this point. The fact is, small and even big financial crises—such as a major car repair or being unable to work because of accident or injury—do happen to people your age, and you need to plan for it.

Conventional wisdom calls for saving between 3 to 6 months of monthly expenses in an emergency account, but even this amount can seem daunting when there are so many other pressing bills to pay. So start small—and stick with it. Open a high-interest online savings account and start socking away,

say, $25 to $50 a paycheck, by having the funds automatically deposited each pay period. Then once a year, or sooner if your cash flow improves, increase that amount steadily until your savings would cover at least 3 months of expenses. Using an online account and cutting up your debit card to avoid easy access to the funds will help you avoid the urge to splurge.

Not Saving for Retirement Yet? Start

With your short-term financial cushion in place, it's time to think about long-term savings. Younger workers are notorious for putting off saving for retirement early in their careers. In fact, a full one-third of workers aged 25 years and under do not contribute to employer-sponsored retirement plans, and only 4% of young workers are maxing out their workplace retirement plans, according to a recent survey by the tax-information publisher CCH Inc.

This is especially true for younger physicians and couples struggling to repay enormous student loan debt. Most do not realize, however, that even meager retirement savings in the first few years after medical school can contribute substantially to their retirement nest egg down the road. By the time retirement rolls around, they will have missed out on a lifetime of compounding.

The retirement age for those born after 1960 is 67, so a 27-year-old fellow has 40 years to build a nest egg before he or she is eligible for full Social Security benefits. For example, socking away $5000 a year over 40 years, with a relatively conservative 6% return, will generate savings of $871,667. But if you postpone retirement savings in just that first year alone, your account would end up with $51,429 less.

Again, if you're struggling financially and even saving $5000 a year pre-tax seems too steep, try at the very least to contribute enough to get your employer's 401(k) matching contribution. It doubles your return on savings before you even begin investing.

Thinking About Raiding Your Next Egg? Stop

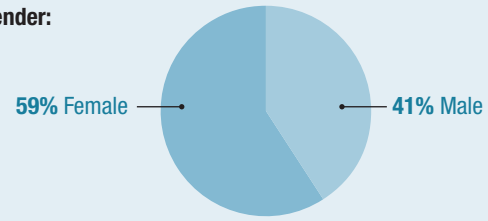
If you have already begun contributing to a retirement savings account—on your own with an individual retirement account (IRA) or a Roth IRA, or through your workplace's defined contribution plan, such as a 401(k)—the temptation to tap into the savings to make ends meet may be strong. Nearly 1 in 5 Americans admitted raiding their retirement accounts during the past 12 months to cover household expenses, according to a recent report by consumer finance site Bankrate.com. Even worse, 60% of young workers cash out their 401(k) when changing jobs.

If you are considering tapping your retirement savings, don't! After getting hit with taxes and penalties, you'll end up with roughly 70 cents on the dollar. And as with the example above, spending even a few thousand dollars in savings early in your career can have dire consequences when you're ready to retire. In fact, some may find themselves unable to retire because their savings fall short of their goals. Instead, search for other ways to cut back on spending and leave your tax-deferred retirement account alone.

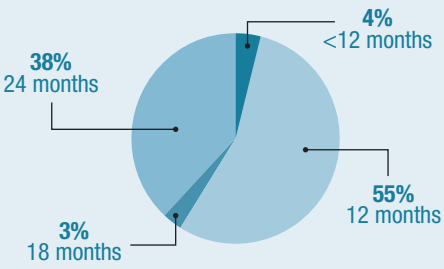
What Do Fellows Earn?

Median age: 26.9 years

Gender:



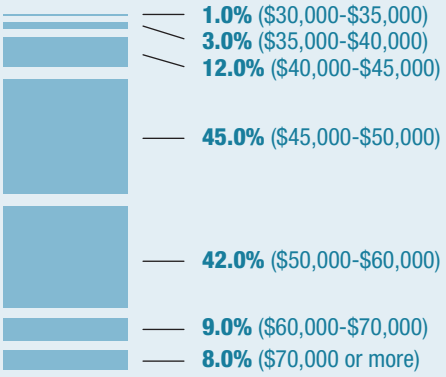
Term of Fellowship:



Hours Worked Per Week (mean): 54

Median Compensation: $49,800

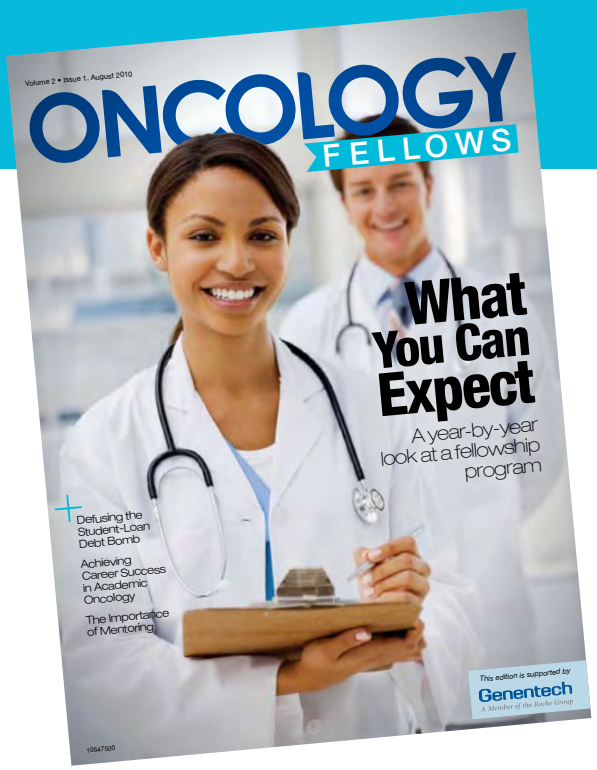
Compensation Breakdown:



Source: 2010 Postgraduate Fellowship Compensation Survey, the American College of Healthcare Executives.

By following these steps, and sticking with them—no matter how tough the going gets—you will shore up your finances, pay down your debt more quickly, and potentially save yourself thousands in interest costs. ■

Terri Cullen is managing editor of Physician's Money Digest, *a personal finance, financial news, and practice management resource exclusively for physicians. She has covered personal finance and financial planning topics for more than 15 years as an author and former writer and columnist for* The Wall Street Journal.



CALL FOR PAPERS

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. ***Oncology Fellows*** aims to provide timely and practical information that is geared toward fellows from a professional and lifestyle standpoint—from opportunities that await them after the conclusion of their fellowship training, to information on what their colleagues and peers are doing and thinking right now.

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 invite current fellows and oncology professionals to submit articles on a variety of topics, including, but not limited to:

- **Lifestyle and general interest** articles pertaining to fellows at all stages of training.
- **A Word from Your Fellows:** articles written by current fellows describing their thoughts and opinions on various topics.
- **Transitions:** articles written by oncology professionals that provide career-related insight and advice to fellows on life post-training.
- **"A Day in the Life":** articles describing a typical workday for a fellow or an oncology professional post-training.

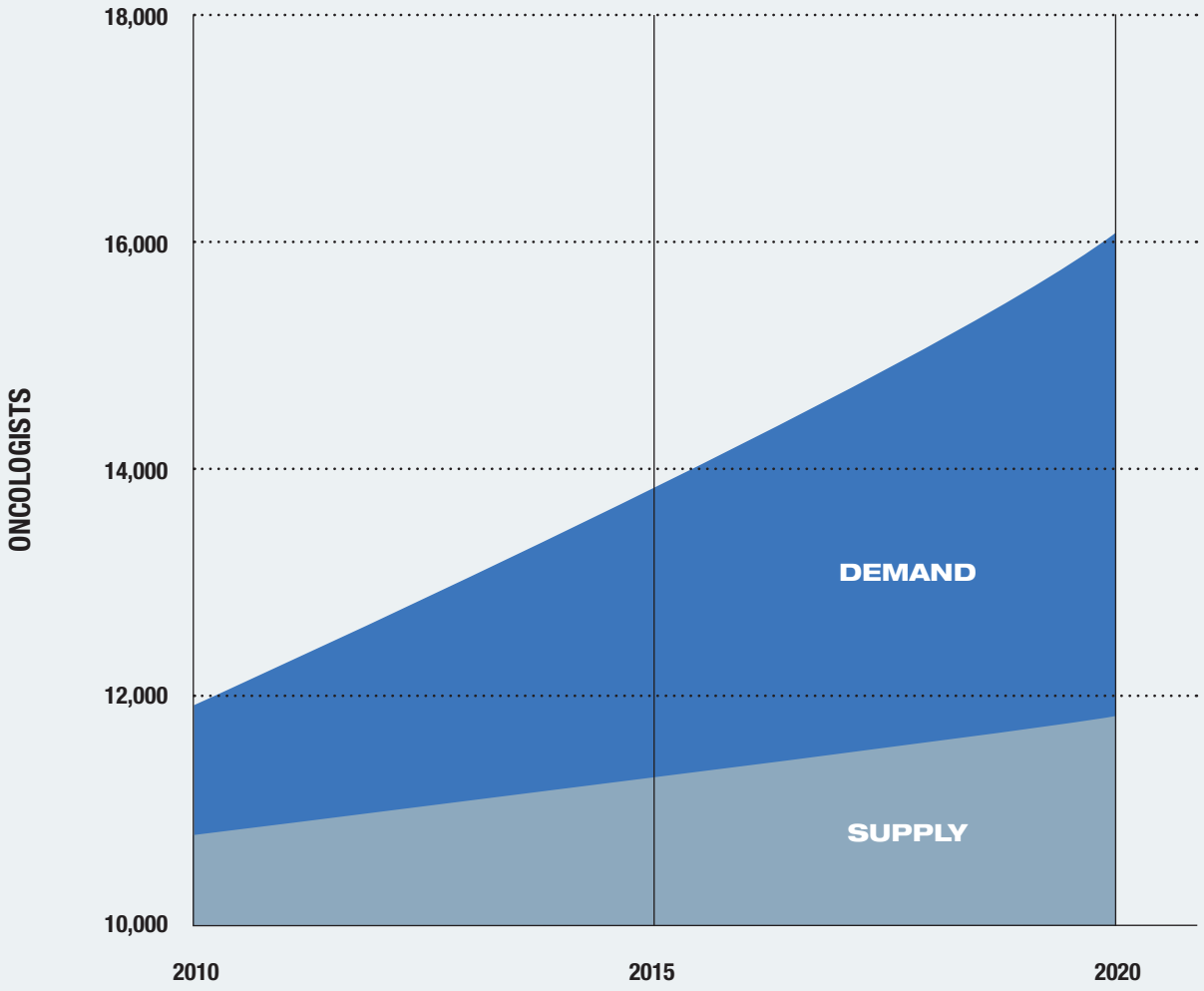
The list above is not comprehensive, and suggestions for future topics are welcome. Please note that we have the ability to edit and proofread submitted articles, and all manuscripts will be sent to the author for final approval prior to publication.

If you are interested in contributing an article to ***Oncology Fellows***, or would like more information, please e-mail John Eichorn, Senior Editor, at jeichorn@onclive.com.

Demand for Oncologists Increases As the Supply Decreases

As you are undoubtedly aware, the demand for oncologists is increasing, right along with the US population and cancer care expenditures. Although this provides a good deal of job security for the oncology fellow, it will almost certainly affect your workload. By 2020, the United States is expected to face a significant shortage of medical and gynecologic oncologists, and it is estimated that there will be 2550 to 4080 fewer oncologists than are needed. Overall, by 2020 it is projected that there will be a 36% deficit in the supply of oncologists compared with the requests for care. Some of this shortfall will be made up by physician assistants, nurse practitioners, and oncology nurses, but the overriding problem of not enough oncologists to fill upcoming vacancies is not easily remedied.

Oncologist Supply and Demand, 2010-2020



Adapted from: Cooper RA. The medical oncology workforce: an economic and demographic assessment of the demand for medical oncologists and hematologist-oncologists to serve the adult population to the year 2020. http://www.asco.org/ASCO/Downloads/Cancer%20Research/Medical%20Oncology%20Workforce-Cooper%20Study.pdf. Accessed May 13, 2011.

2011 Oncology & Hematology Meetings

July 12–13
NCCN Academy for Excellence & Leadership in Oncology
Philadelphia, PA
www.nccn.org/academy/philadelphia.asp

July 14–17
Gynecologic Oncology Group: 83rd Semiannual Meeting
Philadelphia, PA
http://bit.ly/lHjKzL

July 16–22
20th Annual AACR Aspen Workshop: Molecular Biology in Clinical Oncology
Snowmass Village, CO
http://bit.ly/fcf4nk

July 21–24
12th International Lung Cancer Congress
Carlsbad, CA
http://bit.ly/dYPIsZ

July 25–28
Workshop on Systems Biology of Tumor Dormancy
Boston, MA
http://bit.ly/hU8zol

July 30–August 5
2011 ASCO/AACR Workshop: Methods in Clinical Cancer Research
Vail, CO
www.vailworkshop.org

August 1–3
IBC's Drug Discovery & Diagnostic Development Week
San Francisco, CA
http://bit.ly/igq2Zg

August 4–7
10th International Congress on the Future of Breast Cancer
Coronado, CA
http://bit.ly/f3QwRs

August 11–14
12th International Lung Cancer Congress
Carlsbad, CA
http://bit.ly/dYPIsZ

August 15–17
International Conference and Exhibition on Cancer Science and Therapy
Las Vegas, NV
http://omicsonline.org/cancerscience2011

August 26–27, 2011
Eighth Annual Oncology & Hematology Review Symposium
Nashville, TN
www.vicc.org/2011/onchemrev

September 8–10
Breast Cancer Symposium 2011
San Francisco, CA
http://breastcasymposium.org/Home.aspx

September 9–10
NCCN 6th Annual Congress: Hematologic Malignancies
New York, NY
http://bit.ly/mFBhJ4

September 14–18
Second AACR Conference on Frontiers in Basic Cancer Research
San Francisco, CA
http://bit.ly/eJXFqv

September 18–21
Fourth AACR Conference on the Science of Cancer Health Disparities in Racial/Ethnic Minorities and the Medically Underserved
Washington, DC
http://bit.ly/at54yV

September 23–24
2011 American Society of Hematology State-of-the-Art Symposium
Chicago, IL
www.hematology.org/Meetings/State-of-the-Art-Symposium

September 23–27
European Multidisciplinary Cancer Congress
Stockholm, Switzerland
www.esmo.org/events/stockholm-2011-congress.html

November 10–11
ESMO Symposium on Metastases
Zurich, Switzerland
http://bit.ly/kJD58W

November 10–12
Society of Integrative Oncology's Eighth International Conference
Cleveland, OH
www.integrativeonc.org

December 10–13
2011 ASH Annual Meeting and Exposition
San Diego, CA
www.hematology.org/Meetings/Annual-Meeting

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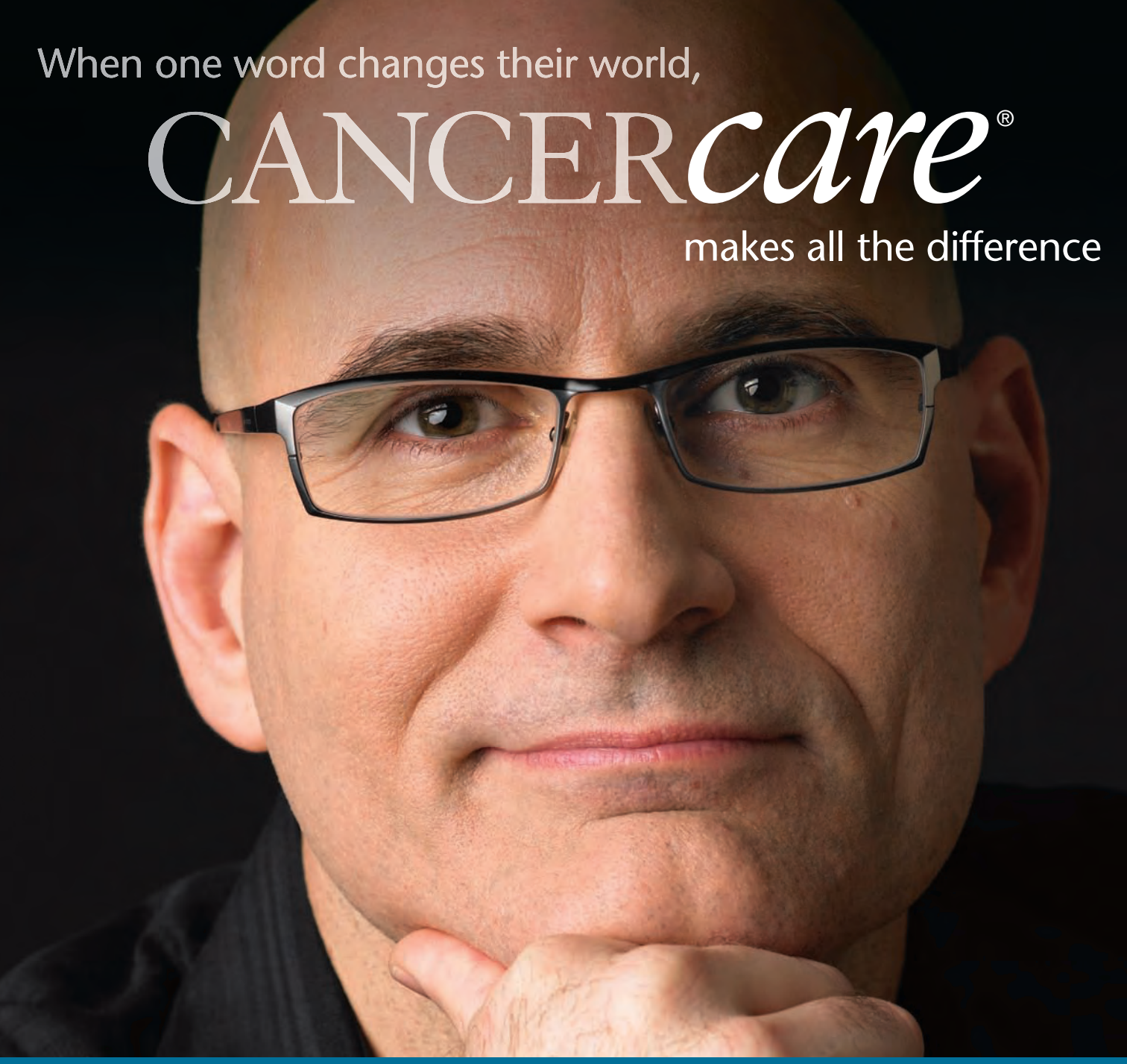

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