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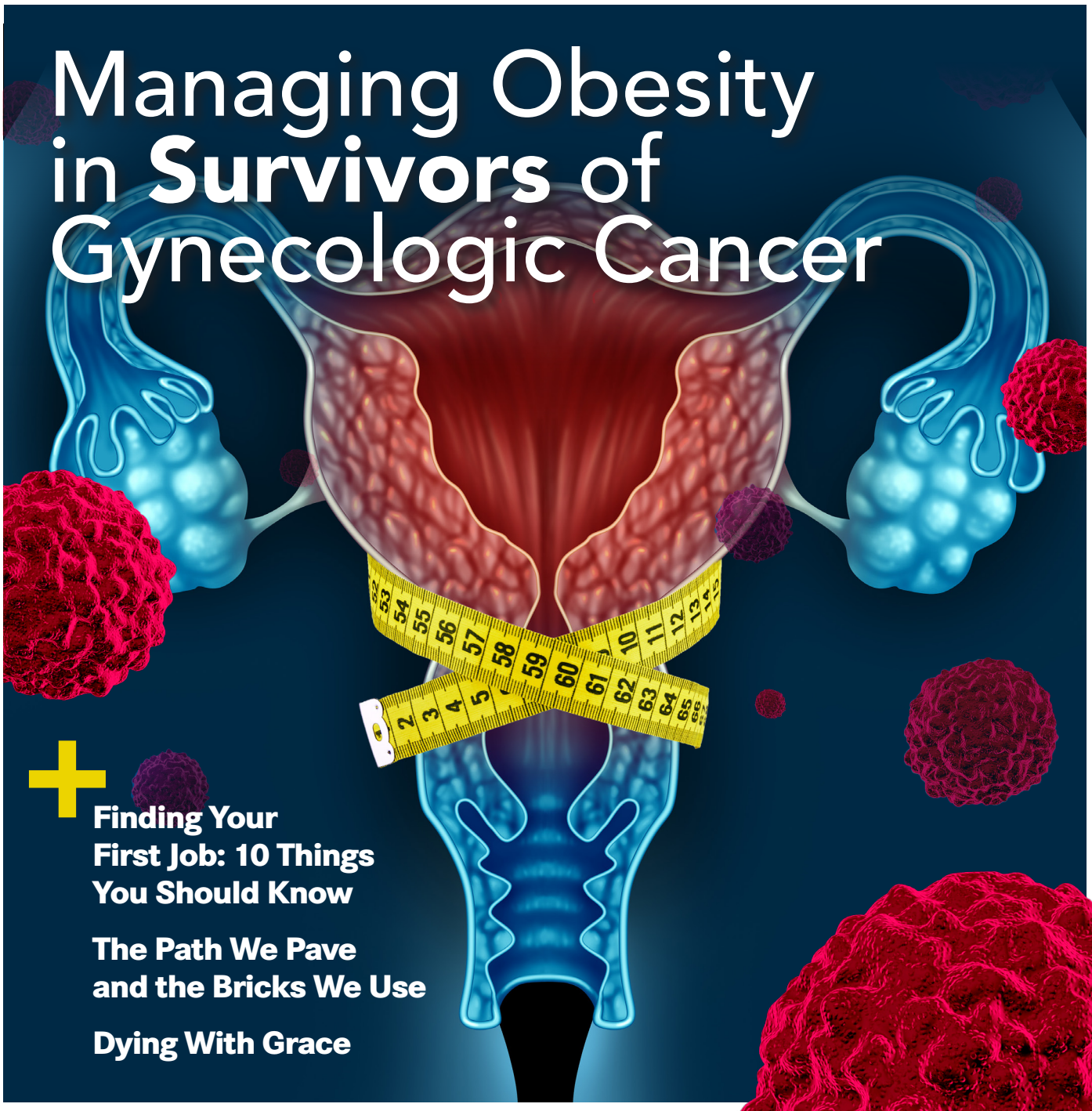

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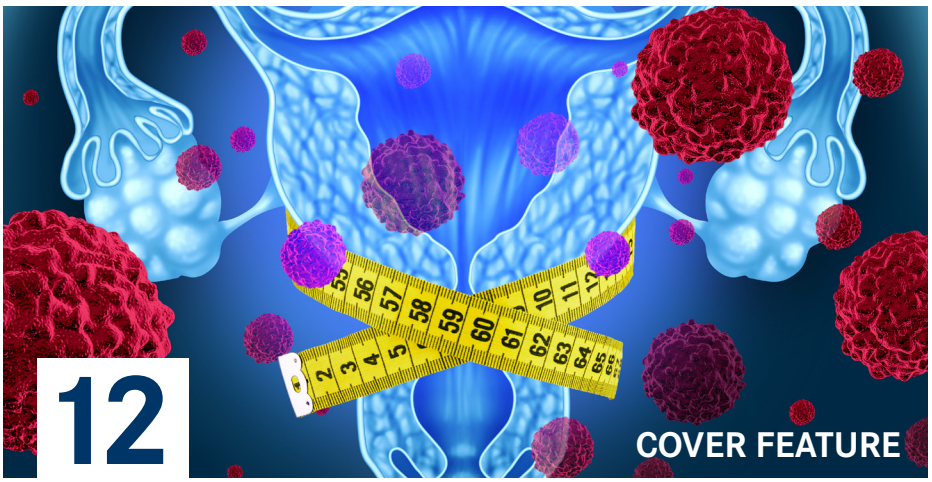

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Habits of Young Adults Threaten to Reverse Cancer Progress

Tony Hagen

SMOKING AND OBESITY RATES are rising rapidly among middle school and high school students, and these trends may undo the progress made against tobacco- and obesity-related cancers in adults, according to reports from the Centers for Disease Control & Prevention (CDC) and the Trust for America's Health in collaboration with the Robert Wood Johnson Foundation.[1,2]

The CDC's National Youth Tobacco Survey results indicated that in 2018, 27.1% of high school students (4.04 million) and 7.2% of middle school students (840,000) used tobacco products (**FIGURES 1 AND 2**). Electronic cigarettes (e-cigarettes) topped the list—they were used by 20.8% of high schoolers (3.05 million) and 4.9% of middle schoolers (570,000). Increasing use of e-cigarettes among US youths, coupled with no change in use of other tobacco products from 2017 to 2018, eclipsed recent progress in reducing overall tobacco product use in this population, the CDC reported, describing the growing attachment to e-cigarettes as an "epidemic"[1] (**FIGURE 3**). "Approximately 1.5 million more youths... used e-cigarettes in 2018 (3.6 million) compared with 2017 (2.1 million)," the report stated.

Findings from the annual survey showed that from 2017 to 2018 e-cigarette use among high school and middle school students increased 38.5%.[1] The results indicated that 42.0% of high schoolers and 42.7% of middle schoolers who used tobacco products in 2018 used e-cigarettes exclusively.

FIGURE 1. ESTIMATED PREVALENCE OF TOBACCO PRODUCTS USED BY HIGH SCHOOL STUDENTS BY DEMOGRAPHIC GROUP—2018

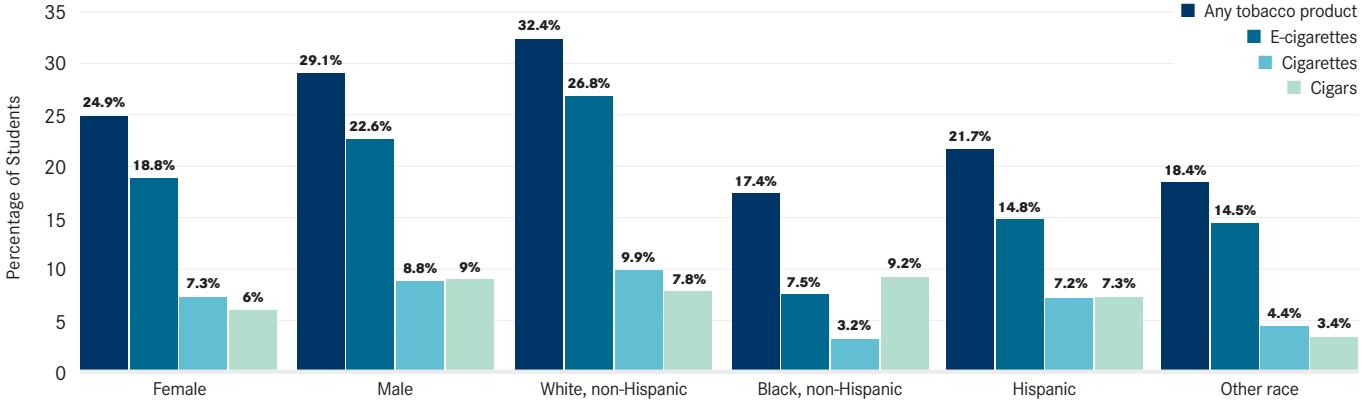

FIGURE 2. ESTIMATED PREVALENCE OF TOBACCO PRODUCTS USED BY MIDDLE SCHOOL STUDENTS BY DEMOGRAPHIC GROUP—2018

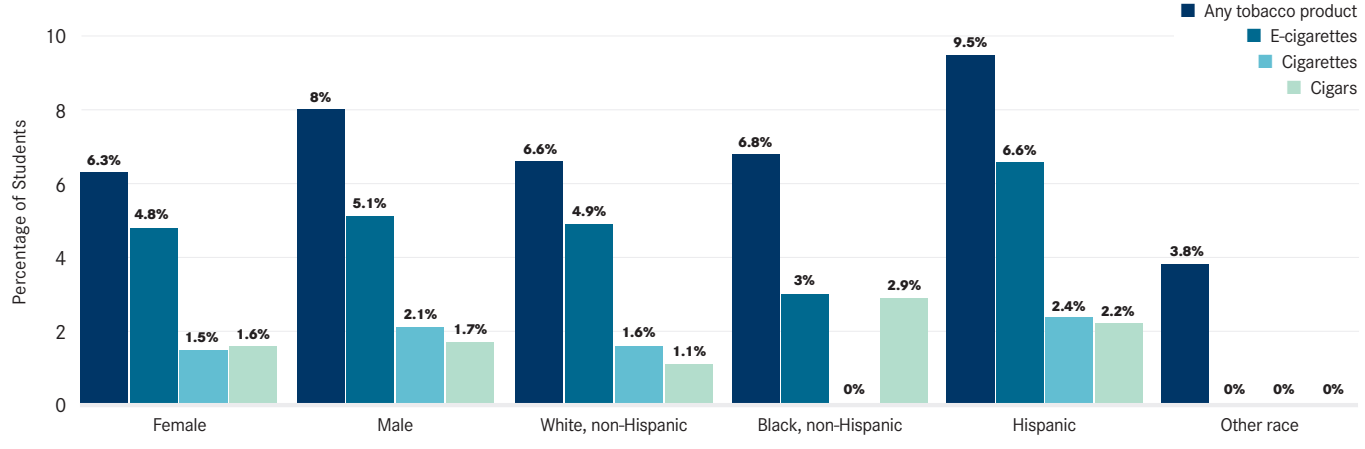

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FIGURE 3. OVERALL TOBACCO PRODUCT USE AMONG HIGH SCHOOL STUDENTS—2018

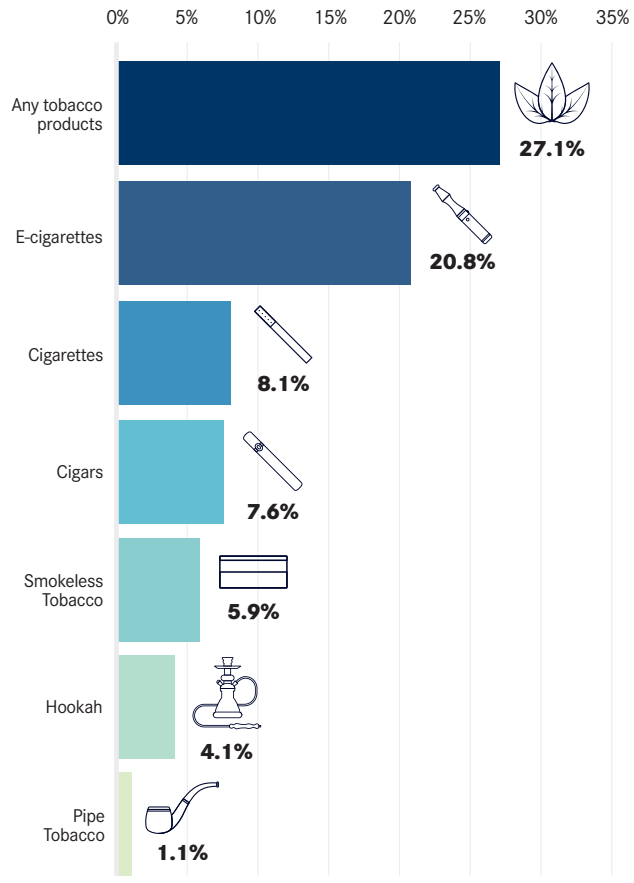


FIGURE 4. PERCENTAGE OF HIGH SCHOOL STUDENTS WITH OBESITY—1970-2016

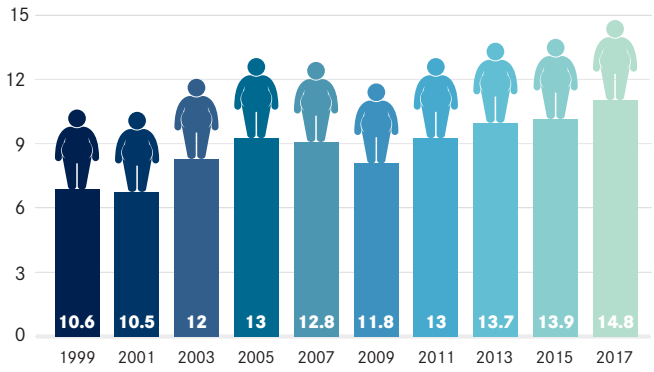
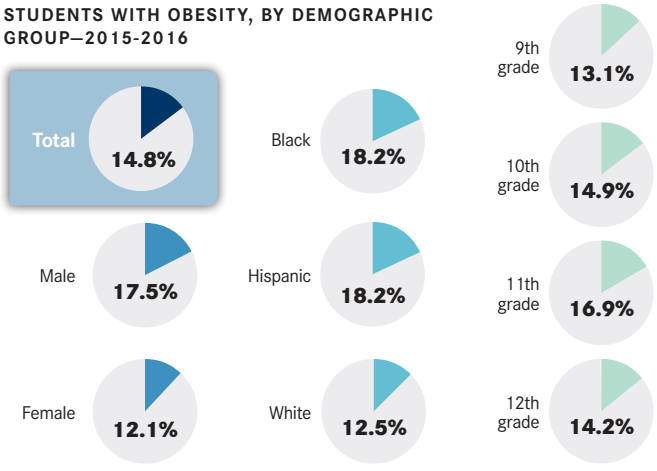


FIGURE 5. PERCENTAGE OF HIGH SCHOOL STUDENTS WITH OBESITY, BY DEMOGRAPHIC GROUP—2015-2016



The report said that e-cigarettes are on the rise due to an increase in the sales of Juul, a USB-shaped device with a high nicotine content that can be used discreetly and is available in flavors such as mint and mango that appeal to youths. Introduced in 2015, Juul was the most commonly used e-cigarette product by December 2017. A single prefilled liquid nicotine pod contains as much nicotine as a pack of cigarettes.[1]

In March 2019, the FDA released a draft compliance policy aimed at limiting the distribution of flavored e-cigarette and cigar products, with a special focus on preventing youth access. "We cannot allow a generation of children to become addicted to nicotine through e-cigarettes," said Scott Gottlieb, MD, former commissioner of the FDA, in a statement. "If the 2019 National Youth Tobacco Survey continues to show sharp increases in youth use of tobacco products, the FDA will consider additional measures to address this crisis."[3]

Similar concerns regarding trends in youth arose in obesity trends of high school aged students in the United States. Between 1980 and 2016, obesity rates among teenagers aged 12 to 19 years quadrupled, going from 5% to 20.6%, according to the National Health and Nutrition Examination Survey, which was cited in the 2018 State of Obesity Report compiled by the Trust for America's Health and Robert Wood Johnson Foundation. Authors collected data from the most recently available surveys to provide a fuller picture of the historical impact and trend of obesity among the United States' youth (**FIGURES 4 AND 5**).[2]

The Youth Risk Behavior Survey results indicated that in 2017, 14.8% of high school students nationwide had obesity and 15.6% were reported overweight—a contrast from 2015, when the respective rates were 13.9% and 16.0%. Among children aged 10 to 17 years, 16.1% were obese and 15.0% were overweight, according to the 2016 National Survey of Children's Health.[2]

The prevalence of obesity and severe obesity increases with age, which affects the prevalence of obesity-related diseases. Without intervention, more than half of today's children will be obese by age 35, according to "The State of Obesity", an annual report.[2]

A 2019 study reported that from 1995 to 2014, the incidence of 6 of 12 obesity-related cancers (including multiple myeloma, colorectal, uterine corpus, gallbladder, kidney, and pancreatic) rose significantly among adults aged 25 to 49.[4] Younger generations are experiencing longer-lasting exposure to excess fat and obesity-related health conditions, according to Ahmedin Jemal, DVM, PhD, a co-author of the study. ■

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NEWS

OncLive® Launches Online Community for Oncology Professionals

Kristi Rosa

THIS MONTH, *OncLive*® officially launched the *OncLive*® Community, a social network designed specifically for healthcare professionals working in the field of oncology. This special forum will serve as an exclusive outlet for experts to collaborate, network, and debate key topics and issues within the cancer space.

"The *OncLive*® Community provides a new and easy avenue for communication for the global oncology community," said Michael J. Hennessy, Jr., president of Michael J. Hennessy Associates (MJH), Inc., the parent company of *OncLive*®. "We are excited to have launched this platform, and we believe the open forum for communication will help improve patient care for all who participate."

MJH developed the verified forum in partnership with Medstro®, a leading software developer. The *OncLive*® Community is a service platform for online communities and online contests—known as challenges—which will serve as a social channel exclusive to oncology healthcare professionals. Members of the global network will range from community, academic, and clinical oncologists, to nurse practitioners, physician assistants, case managers, and allied health professionals. This new resource will allow professionals to communicate with one another in real-time in an effort to ultimately improve cancer care.

On the forum, members are encouraged to share and debate their thoughts and real-world experiences, all while building their own social network. In order to keep up with the rapidly changing landscapes across tumor types, oncologists must not only stay informed of the latest data presented in the field, but also how such data are being applied in the real-world setting. With the help of the network, they can discuss key care challenges with their colleagues and contribute to meaningful, eye-opening discussions.

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The first discussion topic to go live on the platform is focused on expanding on recent successes seen in advanced ovarian cancer and will feature insights from some of the panelists from a recent *OncLive*® *Peer Exchange*® on Shifting Paradigms in Ovarian Cancer. Panelists of this series includes Bradley J. Monk, MD, FACOG, FACS, of the University of Arizona and Creighton University School of Medicine; Kathleen N. Moore, MD, of Stephenson Cancer Center at the University of Oklahoma; Elena S. Ratner, MD, of Yale University School of Medicine; and Brian M. Slomovitz, MD, of the Sylvester Comprehensive Cancer Center, University of Miami Health System.

"The community allows us to best share information on the latest treatment options based on the most recent studies," Slomovitz told *OncLive*®. "This improved information sharing platform will help all of our patients." ■

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Voice Recognition Systems Save Time, Money

Istvan Pataki, MD, and Kenneth Manning, MD
Drs Pataki and Manning are practicing oncologists at Cape Fear Valley Health in Fayetteville, NC

TODAY'S ONCOLOGISTS FACE MULTIPLE challenges in collecting, managing, and sharing their patients' health data. Just the sheer volume of information generated in routine oncology care makes it difficult to manage patient data, including an increasing number of diagnostic, prognostic, and monitoring tests that physicians administer to plan, monitor, and adapt treatment to optimize safety and efficacy.


Istvan Pataki, MD

Additionally, the growing use of multimodal therapy creates an increasingly complex treatment environment that may involve care providers across multiple disciplines and departments, such as medical oncology, radiation oncology, and surgery. Moreover, many patients may receive supportive care, such as nutrition counseling and mental health services, which must also be incorporated into their medical records.

The data deluge does not end when the patient completes treatment. Patients with cancer typically face years of follow-up care, which can be as frequent as every few months in the years immediately following treatment. For patients with relapsed cancer, accurate recording of prior therapy is essential for guiding additional treatment planning, because response to earlier therapy can be prognostic for the potential efficacy of second- or third-line treatment. Additionally, use of certain cancer agents may contraindicate patients for repeat use of those drugs or other therapies. Finally, with a growing emphasis on learning from each patient's experience, many care providers and institutions also collect outcomes data that can be used to understand the interactions among demographic, diagnostic, and prognostic factors and how they influence response to different therapies.

Although the amount of patient data itself can be overwhelming, the challenge to effective and efficient data collection is exacerbated when the data collection platforms vary among departments or facilities and applications, such as the devices used to plan and deliver radiation therapy. The collection and sharing of data between institutions is still largely manual and paper based. This typically means that test results, patient histories, and information about prior or concurrent treatment performed outside a provider's institution must be collected via fax and scanned before being added to the patient's electronic health record (EHR) as a PDF file. Finally, physicians must also navigate an increasingly complex regulatory landscape related to the collection, retention, and security of patient data.

As a result of these factors, oncologists are spending an increasing percentage of their time managing patient data and generating documentation to complete a comprehensive treatment record. This leaves less time to spend with patients and can lead to burnout. The growing demands of collecting and managing patient data increase the need for additional administrative staff to support patient data management, which can increase costs for care centers and providers.

Fortunately, a growing number of electronic and software solutions help mitigate the challenges of patient data overload. New EHR platforms can seamlessly integrate data from multiple sources, such as treatment planning software, treatment delivery devices, scheduling, and billing.


Kenneth Manning, MD

Moreover, healthcare information technology innovators are capitalizing on advances in automation and artificial intelligence to reduce the amount of manual effort needed to capture, enter, and share patient data. Such advances include voice recognition technology that enables automated, real-time dictation and facilitates data sharing and follow-up actions.

CASE STUDY: NORTH CAROLINA CENTER

Cape Fear Valley Cancer Center is one of the largest cancer facilities in North Carolina. The institution is committed to improving the quality of life of all its patients, and the cancer care providers strive to achieve this goal through a patient-centered approach that emphasizes innovation, teamwork, and accountability.

Until recently, its ability to realize this vision was hindered by a slow and expensive approach to EHR data entry, which entailed a cumbersome, multistep process that comprised dictation, transcription, and editing. Completing an entry took up to a week, making it difficult to achieve real-time tracking of patients who might have multiple appointments, tests, or procedures within that time frame. This slow and inefficient process was also very costly, requiring 3.5 full-time transcriptionists and an outside agency to support 14 providers. Moreover, the effort to generate accurate and timely patient notes reduced the time physicians had available for patient care, creating time and cost inefficiencies for the cancer center's staff and leading to physician burnout.

Recognizing that this approach to oncology patient data management was neither optimal nor sustainable, the cancer center sought transformative technologies that would increase efficiencies, reduce cost, and allow oncologists to spend more time engaged with their patients and less time bogged down in note-taking. After evaluating several options, the cancer center implemented a cutting-edge speech-to-text technology solution, Palabra, that works with the center's EHR, MOSAIQ Oncology Information System.

Electronic and software solutions can help mitigate the challenges of patient data overload, allowing physicians to spend more time with patients.

MOSAIQ enables efficient management across radiation and medical oncology programs because it uses a common database for radiation and chemotherapy records. This provides a single point of access for patient data, which is especially critical for the many patients who receive multimodal therapy. It simplifies the management of complex treatment regimens with automated and customizable workflows while facilitating personalized treatments through decision support that enables more informed clinical decision making. The use of automation to pull data from treatment planning and delivery systems reduces errors and patient wait time by eliminating data entry errors and unnecessary procedures.

Palabra is a clinical documentation system that integrates speech recognition engines, such as Dragon Medical and M*Modal, deep into MOSAIQ and includes sophisticated voice-driven dictation for ease and efficiency. Palabra fully automates the document creation process and reduces physician workload through a powerful combination of voice, automation, and highly personalized templates. Because of its deep integration with MOSAIQ, Palabra enters data into the EHR in real time without the need to review transcripts later. Physicians can make changes or adjustments using voice commands before approving the note at the end of the patient's visit. This has created tremendous time savings of 30 to 60 minutes per day, which physicians can now devote to patient care.

Palabra also allows the document to be transferred to the referring physician upon approval. This capability enables providers to create comprehensive and accurate patient notes instantly compared with the 5 to 7 business days required for the legacy process. Additionally, the ability to use voice-enabled dictation has eliminated more than $200,000 in annual transcription costs for the cancer center—further streamlining documentation for the entire patient population, which includes approximately 2000 new hematology and oncology patients and 1500 analytic cancer cases every year.

The use of Palabra Favorites also simplifies the dictation process and reduces the pitfalls that the center experienced using Dragon alone by enabling improved accuracy and profile management, especially with respect to medical terminology, which may not be recognized by other voice-recognition applications. Another key feature that attracted the cancer center to Palabra is its use of individualized templates that allow physicians to merge fields and import data according to their preferences while maintaining the cancer center's standards. This includes automated entry of discrete data sets, such as for Centers for Medicare & Medicaid value-based program reporting into MOSAIQ, without any human intervention. This is a very powerful functionality, because all the data for orders, charges, schedules, quality checklists, and assessments populate within MOSAIQ as soon as the note is approved.

It's also important to mention that these notes are readily available through the cancer center's informa- »

tion system to help improve visibility into the patient's treatment. This helps eliminate information silos that interfere with effective data sharing among multiple care team members and facilitates collaborative decision making based on a shared understanding of the patient's history, current status, and treatment goals.

A COMPLEX TECHNOLOGY LANDSCAPE

Today's oncology care ecosystem is complex and streamlining the processes for patient data collection and management is essential for providing optimized, timely, and cost-effective care. Based on the Cape Fear Valley Cancer Center experience, other cancer care centers seeking new data management approaches should work to identify platforms that offer maximum flexibility with respect to interoperability and data sharing. Automated solutions that seamlessly integrate treatment planning, treatment delivery, scheduling, and document management are also recommended, because these platforms can reduce the time and errors associated with manual data entry.

Care centers must ensure that any new system will be compliant with the increasingly stringent requirements for patient data collection, retention, and security. Additionally, any new technology solution for the challenges of oncology patient data management should allow effective communication among caregivers—within a single institution and with external providers.

Finally, it is important to ensure that any system or solution adopted today is future-proof. Just as oncology care evolves to incorporate new understandings and therapies, healthcare information technology is highly dynamic. Any system adopted today should have the flexibility to evolve over time, ensuring that cancer care centers can continue to offer patients the best care possible. ■

DISCLOSURE STATEMENT

The authors and Cape Fear Valley Cancer Center have no financial interest in Palabra or Elekta, developer of MOSAIQ, or in the success of any of these companies' products, nor have they received any promotional or other fees associated with writing this article.

Process Gets Overlooked in the Obsession With Outcomes

Maurie Markman, MD

IT IS NOT DIFFICULT to identify multiple examples of the success of precision cancer medicine. One can begin with the decades-old observation that patients with breast cancer whose malignancies overexpress the estrogen receptor are appropriate candidates for antiestrogen therapy, followed by the knowledge that a mutation in the catalytic domain of *EGFR* is a biomarker for patients with lung cancer who should receive an EGFR inhibitor. Further, *BRAF* mutations are key to determining who among those with metastatic melanoma may benefit from an inhibitor of this target.

However, these and numerous other success stories have had the unfortunate effect of emphasizing outcomes rather than the important processes through which results can be obtained.

An example of this phenomenon is a randomized phase II trial in France that compared standard chemotherapy of physician's choice with matched molecularly targeted agents in patients with refractory cancer across tumor types.[1] When the study results revealed no difference in outcomes between the 2 study arms, the investigators stunningly and inappropriately declared this was evidence that "off-label use of molecularly targeted agents should be discouraged." In fact, the study revealed the exact opposite.

It is essential to appreciate that precision cancer medicine is a process, not an event, and this study directly illustrates the importance of this process in cancer medicine. The trial tested the hypothesis that these specific drugs (11 in the experimental arm) could effectively target and subsequently favorably interfere with the negative consequences of defined molecular abnormalities considered to be drivers for cancer progression in this patient population.

The appropriate conclusion for this study should have been one of the following: (a) these agents or the selected dose/schedules tested do not meaningfully diminish the negative influence of the molecular targets; (b) affecting the molecular target itself does not alter the progression of the cancer (it is not a driver abnormality); (c) the design of the study, which included multiple antineoplastic drugs »

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and several hypothesized molecular targets or pathways, was simply inadequate to objectively evaluate the utility of individual drugs against their molecular targets; or (d) a combination of these factors.

In the future, investigators may elect to explore the potential that an alternative trial design may yield a different result, but it is the search for an approach to favorably impact a valid molecular target that needs to be highlighted rather than the failure of this specific effort to reach a positive outcome.

It is not difficult to find other meaningful examples where a negative conclusion in the evaluation of the utility of a specific molecular biomarker underscores the relevance of the process of precision cancer medicine.

Investigators examining the clinical utility of adding atezolizumab (Tecentriq) to standard-of-care cytotoxic chemotherapy (carboplatin plus etoposide) in the treatment of extensive-stage small cell lung cancer explored the potential that the "number of mutations per megabase of tumor" would be predictive of the patients most likely to benefit from the inclusion of the checkpoint inhibitor in the therapeutic regimen.[2] The addition of atezolizumab improved both overall and progression-free survival (PFS), and in this study, the prespecified level of measured tumor mutations was not predictive of benefit with atezolizumab.

Is this a failure of "precision cancer medicine"? The answer is, unquestionably, no. Again, what this provides is another relevant example of the utility of this paradigm-changing exploratory process.

Will future investigation ultimately discover a relevant biomarker that will meaningfully predict for the benefits of employing atezolizumab or other immunotherapeutic strategies in the management of small cell lung cancer? The answer to this question depends on the outcome of studies addressing this critically relevant point; however, it is virtually certain that efforts to be more precise in the delivery of therapy in this setting will become an essential component of clinical research.

For a final example of the value of negative outcomes in the precision cancer medicine process, we turn to the utility of antineoplastic agents developed to interfere with the biological activity of PARP in the management of epithelial ovarian cancer. Although both clinical and preclinical data have strongly supported the value of this class of agents in women with known germline or somatic mutations in *BRCA*, it has been hypothesized that other molecularly relevant defects within certain ovarian cancers might also predict for a patient population with a normal *BRCA* network who could benefit from delivery of this class of drugs.

As widely anticipated, in a phase III randomized trial examining the utility of the PARP inhibitor, niraparib (Zejula), employed as a second-line or later maintenance strategy following a response to platinum-based chemotherapy, patients with a documented *BRCA* mutation exhibited the greatest benefit, measured by improved PFS, from delivery of this agent.[3] Further, cancers that did not have such a mutation but were scored as being positive for the presence of a proprietary molecular biomarker measuring other mechanisms of deficient DNA repair exhibited a reduced but statistically significant improvement in this relevant survival outcome.

However, returning to the main point, in this study cancers without a *BRCA* mutation that were classified as being negative for the proposed biomarker were also shown to exhibit a statistically significant favorable PFS outcome following niraparib delivery. As a result, when niraparib was ultimately approved for routine commercial use in this clinical setting, there was no requirement that therapy be directed by the presence or absence of any biomarker. Although some might quite inappropriately conclude this outcome is an example of the failure of precision medicine, the reality is that the result focuses attention on the critical value of the process itself. ■

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"It empowers subject-experts by providing them with a platform to share knowledge unique to their experience as a HCP, patient, or caregiver", said Ryan Pitcherello, Quantitative Operations Associate at HRA. "This gives them the opportunity to make a difference on a larger scale than would be possible in their day-to-day duties," said Pitcherello.

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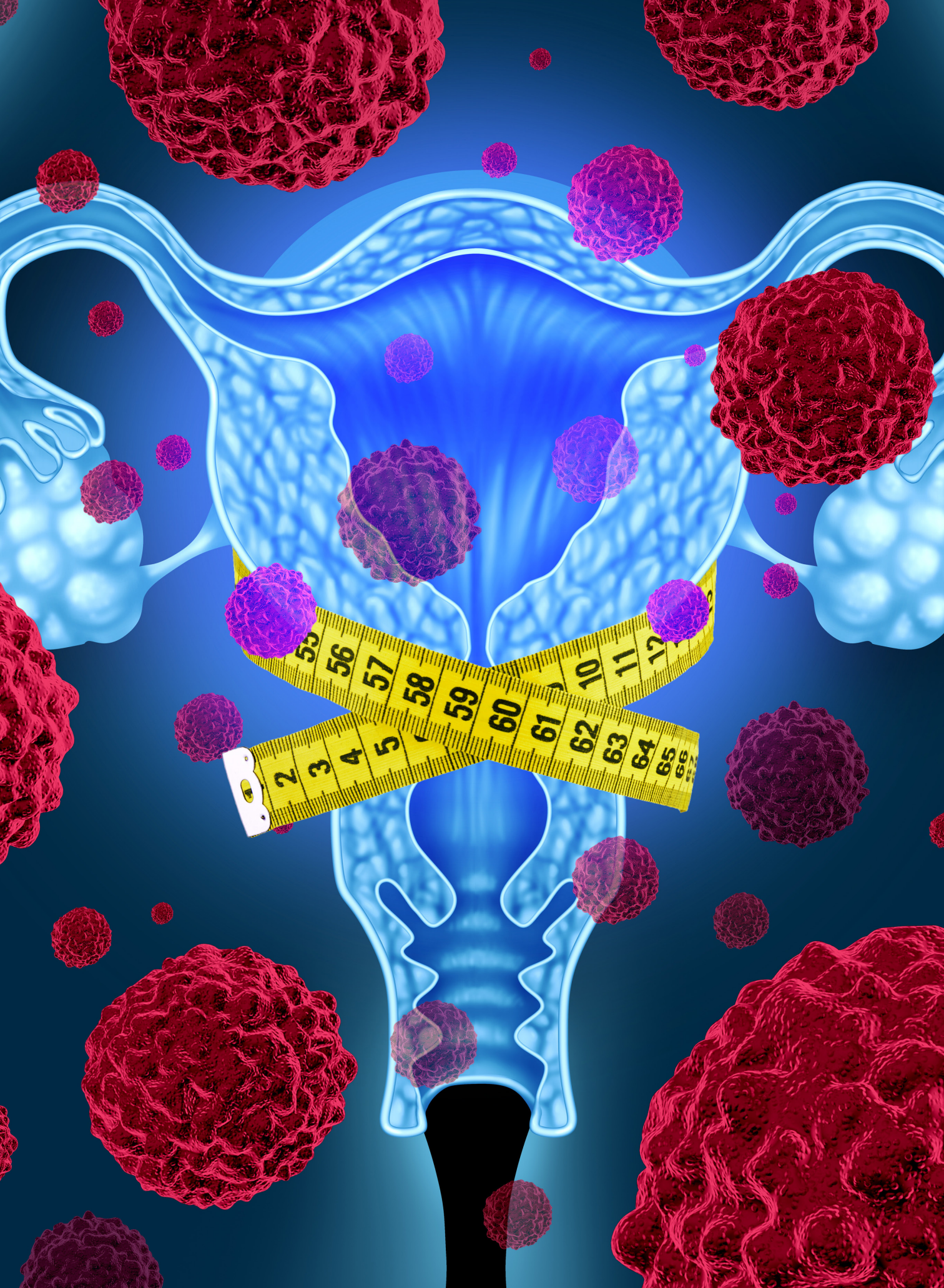

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Managing Obesity in Survivors of Gynecologic Cancer

Allison Staley, MD, MPH
Fellow, Gynecological Oncology
University of North Carolina School of Medicine

OBESITY INFLUENCES THE DEVELOPMENT and management of gynecologic cancer through several mechanisms, including hormonal, inflammatory, and metabolic pathways. Prospective data demonstrate a significantly increased risk of mortality from cancers of the breast, uterus, cervix, and ovary in women who are considered obese.[1] With nearly 40% of the adult population in the Unites States classified as obese (body mass index [BMI] ≥30kg/m^2), gynecologic oncologists must be ready to address the specific needs and considerations for this population, including for patients who have entered survivorship.

Addressing modifiable risk factors for recurrence is the crux of survivorship goals following primary cancer treatment. Patients must be counseled regarding the known risks of obesity in the setting of a malignancy diagnosis. Nonobese women with endometrial cancer have better survival rates than obese women.[2] Therefore, interventions aimed at addressing risk factors for cardiovascular disease will likely have greatest potential to improve survival in women with endometrial cancer, particularly low-grade and early-stage disease.[3]

Patient education is key to successful survivorship. In a survey of 1500 healthy women, nearly 60% were not aware that obesity increased the risk of developing endometrial cancer.[4] In another survey, only 53.5% of women with endometrial cancer were aware that obesity was a factor in the development of their disease.[5]

Further, only 37% of patients report that their healthcare provider discussed the relationship between their obesity and development of gynecologic malignancy.[6] In a survey of 450 gynecologic oncology providers, 40% reported feeling that they had adequate preparation to counsel patients on weight loss strategies, but only 11% of responders reported receiving formal training in obesity management, most often from conference lectures or self-directed reading.[7] Women's health providers must be poised to advise and support women on obesity's relationship to cancer development and recurrence. Within this dialogue must be a discussion of tangible strategies to attain sustainable weight loss, including lifestyle changes, pharmacologic interventions, and bariatric surgery.


Allison Staley, MD, MPH

The Physician's Role in Patient Counseling

Clinical evidence consistently shows that patients who receive directed counseling from physicians are more likely to lose weight and use appropriate methods to do so.[8] Many national cancer organizations promote obesity education and weight loss as a priority for effective cancer care. The American Society of Clinical Oncology has recommended the Assess, Advise, and Refer framework as an approach for providers to

address obesity with their patients. Providers should take the following steps:

Assess the patient's BMI at each office visit. Any BMI that is not within normal limits must be qualified and discussed with the patient.

Advise a patient considered obese on the associated reproductive health risks, such as malignancy, infertility, surgical complications, and high-risk pregnancy and preterm birth. Acknowledging these events as potential downstream effects of obesity can be a productive first step in increasing patient motivation and engagement in strategies for weight loss.

In one survey, only 53.5% of women with endometrial cancer knew that obesity played a role in the development of their disease.

Refer the patient to weight loss management centers, community programs, or bariatric surgery consultation, particularly for the population classified as morbidly obese.[9]

Lifestyle Changes and Weight Loss Programs

Providing even a small amount of directed nutrition and lifestyle counseling leads to significant changes in patient diet and weight loss. Williams et al reported that 5 physician-directed counseling sessions over 1 year can successfully result in weight loss for women.[10] Additionally, community-based programs offer the required consistency and affordability for patients who are uninsured, underinsured, or who lack financial support. YMCA organizations, for instance, provide nutrition consultations in addition to fitness education across the country. For cancer survivors, Livestrong provides 12-week, small-group programming to increase healthy nutrition and physical activity through the YMCA. More novel payment structures are required to support these community-based programs, but such structures may offer more financial availability to patients needing to meet out-of-pocket costs.[8,11]

For patients who need pharmacologic intervention, there are 2 categories of anti-obesity drugs: central acting appetite suppressants, or satiety enhancers, and peripherally acting agents. The FDA has approved 5 pharmacologic agents for weight-loss management: orlistat, lorcaserin (Belviq), phentermine/topiramate, naltrexone/bupropion (Contrave), and liraglutide. These agents have been approved for use in patients with a BMI ≥30 or in patients with a BMI ≥27 with 1 obesity-related comorbidity. These medications are available as prescriptions, and orlistat can be purchased over the counter.

Common adverse effects of these drugs include nausea, vomiting, and constipation, and education regarding drug-specific effects is required for safe medication management. For providers, these agents may be used as safe adjuncts to lifestyle modifications and close counseling to achieve demonstrable weight loss.

Bariatric surgery, which commonly includes Roux-en-Y gastric bypass, adjustable gastric banding, and sleeve gastrectomy, has been shown effective in both short-term and long-term patient outcomes. This surgery lowers all-cause mortality and reduces the cardiovascular and diabetic effects of obesity.[12] A US retrospective cohort demonstrated a 60% decrease in cancer-related deaths following bariatric surgery, providing evidence of the correlation between obesity and cancer.[13] Depending on the procedure type, weight loss typically ranges from 15% to 32% within the first 2 years following surgery and stable loss of 15% to 25% at 10 years.[14]

Patients may qualify for bariatric surgery if they have BMI ≥40 without comorbidity or BMI ≥35 with one or more severe obesity-related diseases.[15] In spite of these well-documented benefits to health and quality of life, fewer than 1% of qualified patients undergo bariatric surgery. For patients with gynecologic cancer, systematic reviews show that patients favorably view a weight loss discussion with their cancer care provider, and patients are more likely to consider or receive bariatric surgery if a physician referred them for consultation.[16,17]

A coordinated multidisciplinary and systematic effort is required to address the prevention and treatment of obesity, as the sequela of this disease is a clear risk factor for the development of gynecologic malignancy and other comorbidities. Support for weight loss interventions and transparent patient education are paramount. This worldwide health problem is ever growing, and women's healthcare providers must be ready to address the specific needs and considerations for this population. ■

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Finding Your First Job:

10 Things You Should Know

Narjust Duma, MD
Chief Hematology-Medical Oncology Fellow
Mayo Clinic Rochester

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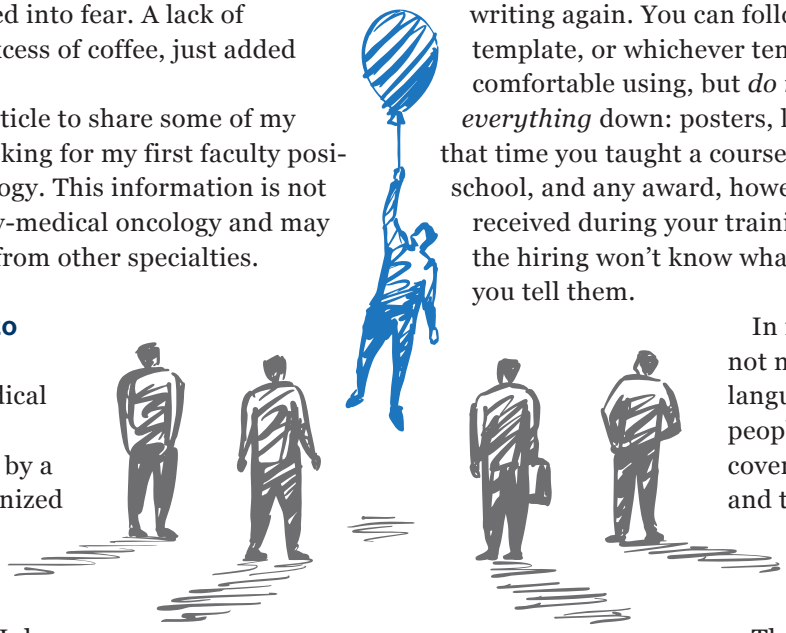
AFTER COMPLETING MEDICAL SCHOOL, surviving residency, and finally getting to study your disease of choice during fellowship, your program coordinator sends you an email titled, "Job opportunities." Minutes after I received that email, anxiety started building up. Is it time to start looking for my first faculty job? How does this work? Where do I start?

Those questions followed me for days. Then I heard some of my co-fellows had already found their first jobs and were close to signing their contracts. And my anxiety turned into fear. A lack of knowledge, and an excess of coffee, just added fuel to the fire.

I am writing this article to share some of my experiences while looking for my first faculty position in medical oncology. This information is not unique to hematology-medical oncology and may be helpful to fellows from other specialties.



1 Say Goodbye to The Match

Starting with the medical school application, medical students live by a time line and an organized system. One perfect example of this is The Match: The application opens in July, you complete an application, the interviews go on for a few months, you create a ranking list, and at the end you receive an email with your new destination.

Finding your first job is quite different. A few job openings can be found on society websites, such as the American Society of Clinical Oncology or the American Society of Hematology, or career sites, but the most common style is word of mouth—and there is no official posting for many jobs. You can work with recruiters, and if you're interested in working with the pharmaceutical industry, each company has a medical liaison that works with your institution developing and opening clinical trials. Ask your mentor or program director for the liasion's contact information and email them about your interest and curriculum vitae (CV).

2 Private Practice Versus Academia Versus Industry

Oncology practice has evolved over the years, and it no longer involves only the options described above; you can also pursue a career in government or with a consulting firm, among other options. All of them have their pros and cons, from salary to research time to the opportunity to wear jeans on Friday. It's important that you define what type of environment best fits your professional and personal goals before you start looking for that first job.

3 CV and Cover Letter

It's time to put all your accomplishments in writing again. You can follow your institution's template, or whichever template you feel most comfortable using, but *do not* forget to write *everything* down: posters, local oral presentations, that time you taught a course in the medical school, and any award, however small or big, you received during your training. The people doing the hiring won't know what you've done unless you tell them.

In my case, English is not my first or even second language, so I had a few people review my CV and cover letter for grammar and to make sure I didn't accidently drop a Spanish word here or there.

The cover letter is more specific to the job and institution to which you are applying. Try to explain why you think this role and this place would be a good fit for you and how you can help the institution achieve its goals.

4 Reaching Out

There are several ways of contacting potential employers: emailing the contact person listed in the job posting, cold emailing the division chair or disease-specific chair to see what positions might be available, asking your mentor to make inquiries for you, and contacting a recruiter who can help you establish those connections. In addition, you can connect with future employers at conferences and career fairs.

In my case, I emailed many people, many times, and had a decent success rate. The times when jobseekers were told "Do not contact program directors" are over; it's your duty to seek an answer. »

5 Phone Interview

Before your visit is scheduled, your potential employer will contact you for a brief screening interview, a 10- to 15-minute conversation about your interests and what they are looking for. Research the person you'll be speaking with ahead of time and try to reduce interruptions. In the case of video interviews, wear business causal.

6 The In-Person Interview (first and second looks)

Congratulations! They want to bring you in for face-to-face meetings. This time around, your potential employer will cover the cost of your travel, such as airfare and hotel. Work closely with your fellowship program coordinator to plan time away and coverage if needed. Remember, we are still fellows.

Narjust Duma, MD

The interview will vary depending on the type of practice you decide to pursue, but general concepts will apply. You will likely have a dinner with some people from the institution the night prior, and the following day you will meet with key people (eg, division chair, future colleagues, etc).

What to wear? For the interview day, full business attire is appropriate, so get that interview suit out of the closet! For the dinner prior, and perhaps after the interview, business causal is fine.

In academia, a second look is almost mandatory. The goal of this second visit is to see if the institution and city are a good fit for you. Second looks are a great opportunity to meet with future mentors and tour the city; in most cases, you can bring your partner/spouse for a real estate tour. On this visit, you'll discuss salary and benefits, and you can meet with human resources to discuss vacation time, sick leave, and other benefits.

7 The Job Talk

In many settings, you will be asked to give a "job talk," or a summary of your research. Many people recommended against discussing a review topic, such as immunotherapy in lung cancer or CAR T-cell therapy in lymphoma, because you want to demonstrate that you are capable of starting and completing a project, and no one will know more about your research topic than you (hopefully).

The talk should last about 45 minutes. Avoid delivering excessive amounts of text in your PowerPoint, credit all your collaborators, and try to focus on only a few topics. Finally, tell a story that the attendees can follow.

8 Contract Negotiations

You've been offered a job. Congratulations! This is a huge moment, so let yourself enjoy your success. That said, you still have work to do.

Remember, *everything* is negotiable. Consider their first offer to be a draft, and do not be afraid to ask for what you want—the worst they can say is no. You can negotiate clinical versus research time, salary, bonuses, conference attendance, participation on boards, access to support staff, in-patient time, and more.

Ask your mentors, friends, and co-fellows what they have negotiated. As someone once told me, "Nothing is off limits."

> "Remember, *everything* is negotiable."
>
> — NARJUST DUMA, MD

9 Legal Advice

This applies more for private practice where you negotiate partnerships. Many of my co-fellows had an attorney review their contract. A legal professional can help you navigate the noncompete agreement and other legal language that can be difficult to understand.

10 Your First Job Is Not Your Last Job

We all want to find the "perfect" faculty job with the plenty of clinical time, available start-up funds, and amazing coworkers. In reality, that perfect job may not exist. Understand the difference between your must-haves and your nice-to-haves, decide where you're willing to compromise, and pick the job that best fits your personal and professional goals.

Additionally, your first job is just that, *your first job*. Important names in oncology have changed institutions and you can, too. Your goals and needs will likely change over time and more opportunities will come.

One final recommendation: Be honest and be you. You want to be hired for who you are and not for who you pretend to be.

Good luck! ■

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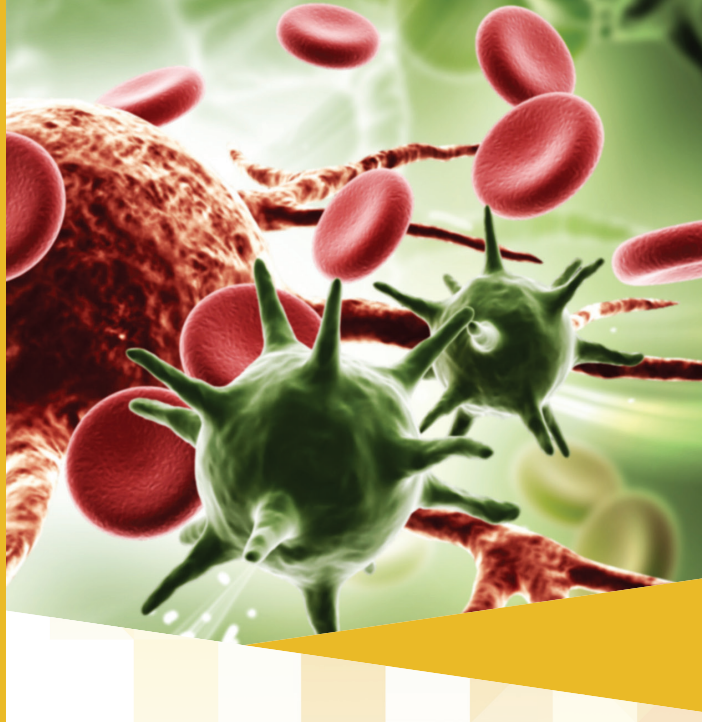

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THE PATH WE PAVE AND THE BRICKS WE USE

Casey Cosgrove, MD
Gynecologic Oncology Fellow
The Ohio State University Wexner Medical Center

THE PATH TO BECOMING a physician is a long and often surprising one. There is, of course, the actual process of applications, tests, and learning the mechanics of taking care of patients. But I would argue that identifying a specialty that allows for personal and professional happiness should be a major point of discussion starting early in a physician's career.

Entering medical school, we all have a general concept of what we want to do, whether it's practicing in the community or conducting research in an academic setting. But life, as they say, happens when you're making other plans. Despite the blueprint, things often change, and with every decision, the changes can be quite significant. We may go from dreaming of surgery to pediatrics or from picturing an illustrious career in academia to working in a rural private practice.

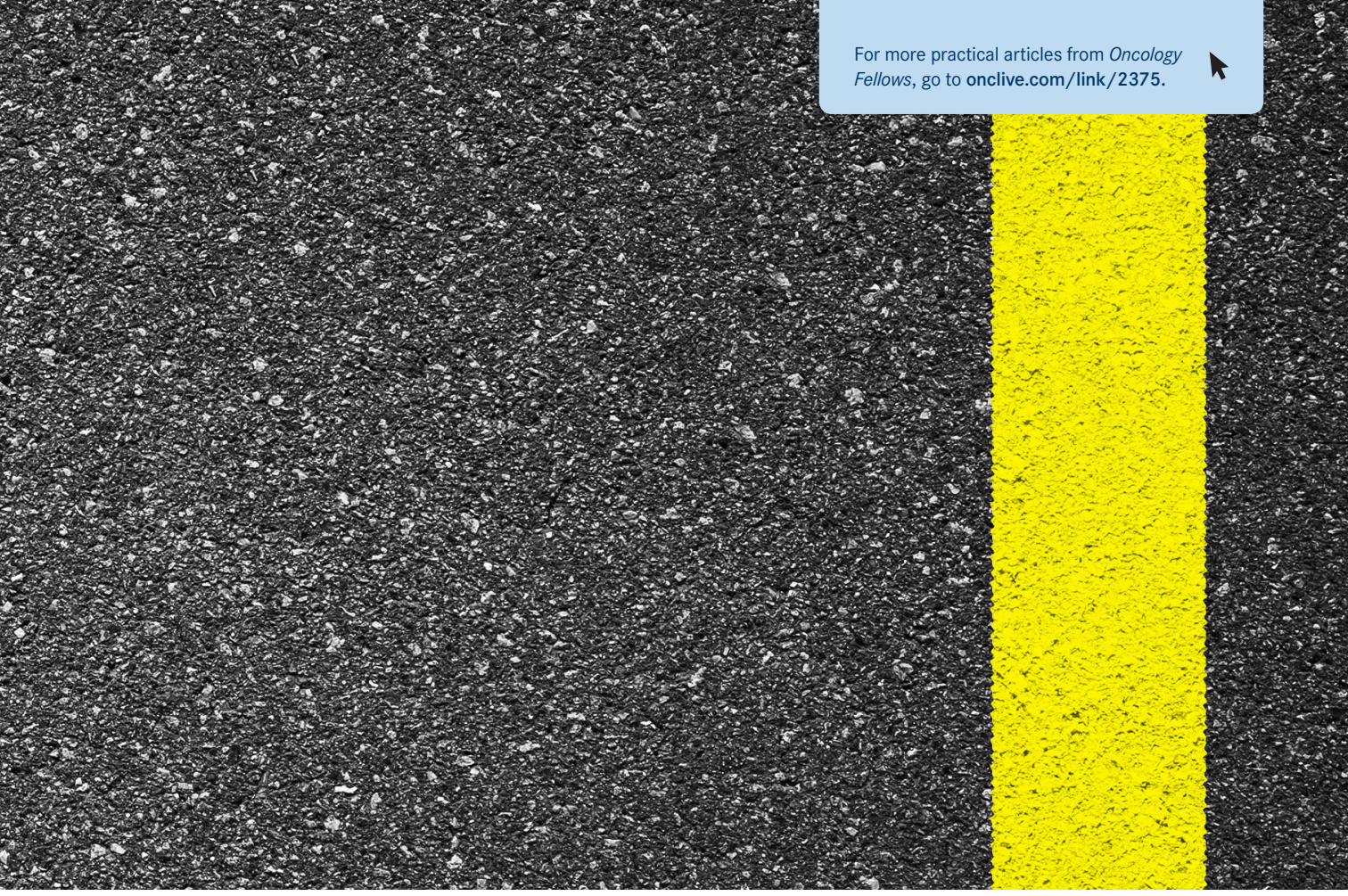
Why? Because each step on the long path of medical training impacts the next step. We change our priorities. We unexpectedly fall in love with a specialty. We recognize surgery isn't for us. We have life-changing events. We don't score as high as we would like on a test, and on and on.

Some of the "whys" are beyond our control. Other things we do not recognize as important until later. In my opinion, there are 2 major ways to combat the loss of opportunities or to respond to a unplanned twist in your career path: First, identify strong mentors. Mentors are exceptionally important as we home in on our ultimate goals, but they also provide guidance and sage advice. A mentor can help you think through big picture decisions or, at the completion of your fellowship, provide crucial insight for contract negotiations and help you identify the nuances that separate a job that is the right fit from one where you will struggle to have success.

Casey Cosgrove, MD

The second way to respond to life's surprises is through preparation. Identifying training opportunities that provide the exposure and training to fulfill your goals is exceptionally important. This is true not only if you have your heart set on a certain specialty or subspecialty, but also if you are unsure about the path of your life and career.

I didn't always picture myself as a physician. Growing up, I thought I would be a sports broadcaster. As I got older, however, I realized that being a doctor would be an unbelievable honor. Working with patients and providers, building relationships, and pursuing scientific knowledge make being a doctor an amazing career.



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Entering medical school, I could rattle off the handful of specialties I had interest in. I was exposed to anatomy, and surgical specialties took priority. I experienced training as an OB/GYN and found I could easily visualize a career rushing to a delivery at lunch time or being in the clinic one day and the operating room the next. I could see myself taking care of patients throughout their lives. I was fortunate to match into obstetrics/gynecology at The Ohio State University, which exposed me to subspecialties of that field, and provided amazing generalist training.

This is where I found my true calling: taking care of women with cancer, with performing complex surgeries, and providing comprehensive medical care. This was not the path I had expected, but the opportunity was there and the experience made me realize this was the career for me. I identified mentors who provided the guidance required to make these complicated decisions and to assist in positioning myself for a career.

> **"Growing up, I thought I would be a sports broadcaster. As I got older, I realized that being a doctor would be an unbelievable honor."**
>
> — CASEY COSGROVE, MD

After matching into my gynecologic oncology fellowship, I recognized along the way that I wanted to pursue an academic career. My future as a generalist community OB/GYN in Florida, where I grew up, was no longer the plan. I threw out that blueprint and drew a new one. Soon, I will be starting an academic gynecologic oncology position in Ohio, a situation I never would have imagined, even through medical school.

I am so fortunate that the pieces have fallen into place to allow me to have the career that I could never have envisioned. I wonder how any small step in a different direction could have changed everything; acceptance into a different OB/GYN clerkship or working with different residency faculty could have sent me in a different direction. These pieces came together, though, because each individual step not only shaped what my goals and desires were, but also provided the resources to fulfill them. ■

DYING WITH GRACE

Jennifer Y. Sheng, MD
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MOST PATIENTS WITH CANCER fear the word "hospice." It marks the "end of the road" and is to be avoided at all costs. Because of this misconception, which also affects physicians, many patients with cancer use excess hospital care and intensive care services at the end of life. Acute hospitalization accounts for nearly half of Medicare spending for patients with advanced cancer.[1]

Introduced in the United States more than 40 years ago and added as a Medicare entitlement in 1982, hospice is the model for compassionate care for people in the last 6 months of life.[2,3] Providing expert medical care, pain management, and emotional support, the goals for hospice care include promoting comfort and dignity, rather than prolonging life, and providing support for the patient's family.[3]

Although more than 1.4 million individuals in the United States received hospice care in 2016, patients with cancer made up only 27% of this group. Patients spend just a median of 19 days in hospice care.[4]

Physicians will recommend hospice countless times while caring for patients with cancer. As much as patients are alarmed by this topic, we also dread these conversations. Although some of my patients receiving chemotherapy accept palliative care and have heard about hospice multiple times, it is still heartbreaking for both of us when I can no longer recommend therapeutic agents and instead recommend hospice care.

When I started my fellowship, my mentors told me I would become more comfortable with death and dying as I observed experienced providers and worked with my own patients. However, it was not until my second year of fellowship when I got the experience I needed all along: I visited my patient and her family in a hospice facility.

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Doctors Don't Know Much About Hospice

LS was a lovely middle-aged woman with stable pancreatic cancer and on her third line of chemotherapy when she was diagnosed with pneumonia in July 2017. She was treated with antibiotics and supportive measures at her local hospital. I assumed she would beat the infection, but her condition sounded worse every time I talked with her husband.

The antibiotics didn't work, and she developed a blood stream infection. She became so confused that she could no longer communicate with us. Ultimately, her in-patient team and I recommended hospice. Her husband chose a facility close to their home.

As residents and fellows, we might have some experience with hospice. However, oncology trainees rarely, if ever, visit an off-site hospice facility, even though that is often what we recommend for our terminally ill patients. I had never been to a hospice facility, but I felt compelled to see LS. I was not at peace over her imminent and unexpected death.

It's OK to Cry

On my Saturday off, I drove 30 minutes to visit LS. As I pulled up to the hospice facility, I was surprised by its homey appearance. Nonetheless, I still expected to walk into a bleak environment full of devastated patients. Inside, LS's husband rushed toward me. He gave me a hug and whispered, "Dr Jenni, thank you so much for coming."

He directed me to the communal space and introduced me to several close family members. Each person embraced me, told me that they had heard so much about me, and thanked me for caring for LS.

Sitting around a large table, they told me about their long travels to be there. They shared food and stories about LS. I discovered her quirks and her accomplishments, and I saw how deeply she was loved. As our conversations came to a close, her husband and I separated from them so that I could see LS.

As I walked into her room, I noticed the warm color of the walls. The wood panels were a pleasant contrast to the sometimes-bland hospital. She even had a sliding door leading to a small garden.

Immediately upon seeing LS lying in bed, I felt my eyes well up with tears. I was disappointed with myself and wondered how I could have prevented her current situation. The what-ifs built up quickly, but I never voiced them.

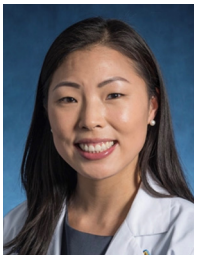
My heart felt heavy knowing that I would never again be greeted with her kind smile or hear her sweet laugh and gentle voice. Although she did not respond to words, her husband placed his head next to hers and said, "Dr Jenni's here to see you."

Sitting at her bedside and holding her hand, I told her how much I loved meeting her loved ones and seeing them gathered together. I recounted our year-long treatment journey and told her how blessed I was to know and care for her. I gave her one last hug.

Outside the room, her husband squeezed me a bear hug and thanked me again. As he started crying, the tears that I had held back rolled down my face. After some silence, I wanted to address our unspoken guilt and emptiness.

"I'm glad *we* chose hospice care for her and gave her the opportunity for family to come together in a beautiful and peaceful place to honor her life," I said.

She died 2 days later.



Jennifer Y. Sheng, MD

I shared this experience with my co-fellows, as it enriched my understanding of hospice and reshaped my conceptions of end-of-life care. For all my subsequent patients, my experience helped me better address their anxieties and uncertainties. Knowing what hospice is, is one thing; experiencing it is another.

I do not know many doctors have visited their own patients in hospice, but I'm grateful I was able to have this experience early in my career—the countless patients I'll care for in the future will benefit. Oncologists develop an intimate trust with our patients that is forged through countless clinic visits over months or years. We owe it to them to be as informed as possible about each option we recommend. I am thankful to LS for teaching me to celebrate little victories, cope when our treatments fail, fill a life with loved ones, and die in peace. ■

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July 26-27, 2018
***18th Annual* International Congress on the Future of Breast Cancer® West**
The Westin San Diego Gaslamp Quarter
San Diego, CA
onclive.com/link/5623

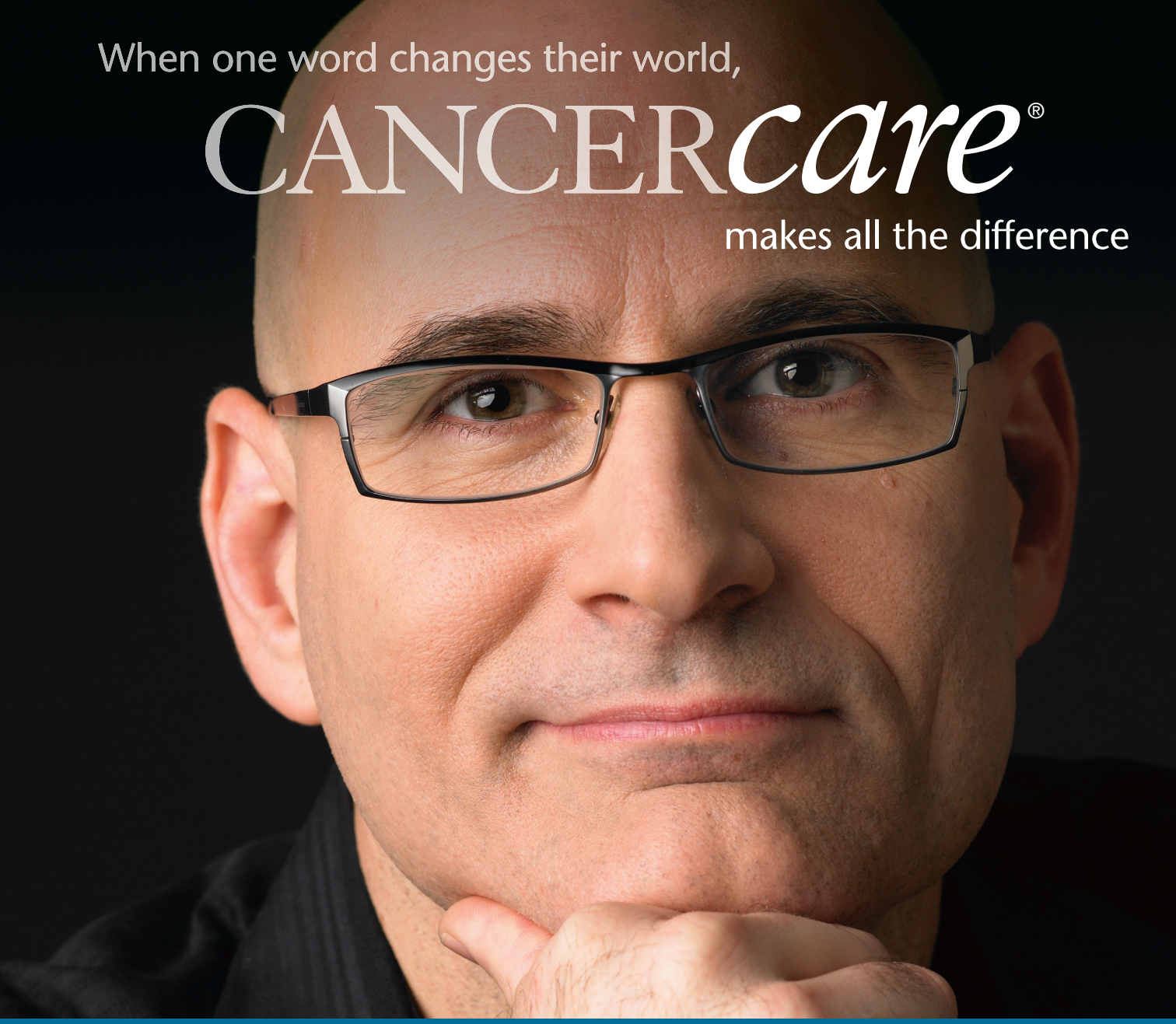
July 30, 2019
State of the Science Summit™: Genitourinary Cancers
Jacksonville, FL
onclive.com/meetings/soss

August 2-3, 2019
***3rd Annual* School of Nursing Oncology™**
Sheraton San Diego Hotel & Marina
San Diego, CA
onclive.com/link/5624

September 5, 2019
ASCO Oncology Practice Conference
Hilton San Diego Bayfront Hotel
San Diego, CA
meetings.asco.org/opc/register

September 7, 2019
New York Advanced Practice Collaborative Overview
InterContinental New York Barclay
New York, NY
onclive.com/link/5626

September 12-14, 2019
ECCO2019: European Cancer Summit
Brussels Marriott Hotel Grand Place
Brussels, Belgium
eccosummit.eu



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- Professional oncology social workers
- Free counseling
- Education and practical help
- Up-to-date information
- Cancer*Care* for Kids®

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