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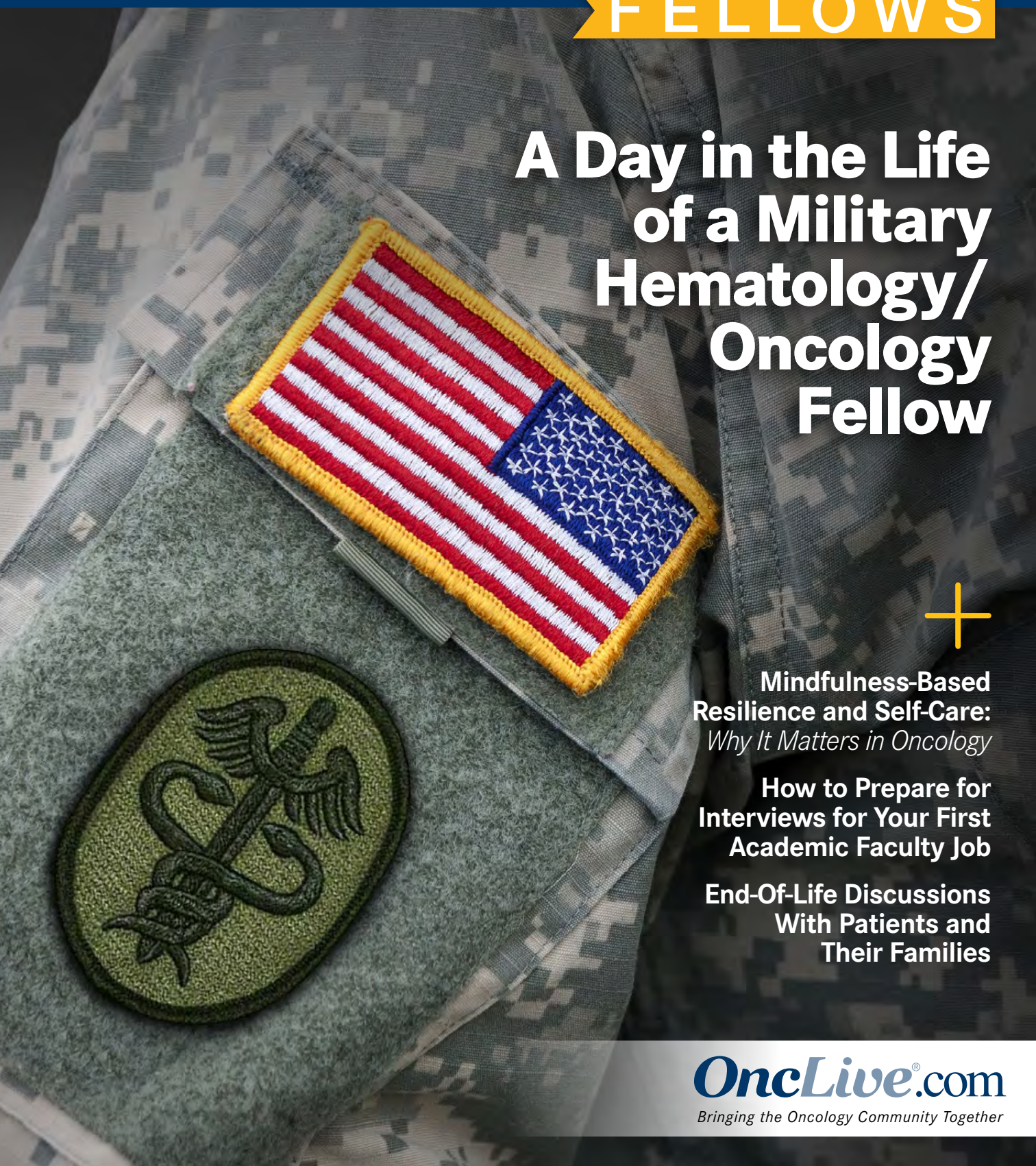

A Day in the Life of a Military Hematology/ Oncology Fellow

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A Day in the Life of a Military Hematology/Oncology Fellow

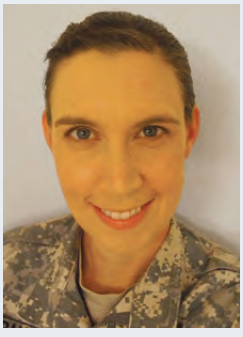
By Major Lindsey Graham, MD, MC, US Army

At 5:45 AM, the alarm on my phone goes off. I have 20 minutes until my 2 boys wake up, which is just enough time to get ready for work and fix myself a cup of coffee. I get out of bed and walk to my bathroom, stopping at my dresser drawer to pull out a sand-colored T-shirt and green wool socks. In the large master bathroom, I flip the light on and change into the T-shirt and a pair of cargo pants in a block-like camouflage print. Stepping up to the mirror, my hands methodically pull back my hair and begin a task that they have performed nearly every day for the past 7 years. A few minutes later, the straight brown hair that falls about 2 inches below my shoulders is neatly French-braided and tucked under at the nape of my neck and secured with 4 large hair pins. My bangs, which moments ago were falling over my right eye, are now twisted off to the side and secured with their own hairpin. I then apply a very light coat of makeup to my face with just a dusting of blush for color. Most days, I don't wear eye makeup because I do not feel as though the outfit demands it.

I walk out of my room into the kitchen at about 6:05 AM. I pour water into my single-cup coffee maker and load the single-serving coffee pod and press the start button. While I am waiting, I walk to the other side of the kitchen where a stack of hematology and oncology journals and other similar publications sit neatly stacked at the edge of the shiny black kitchen island. I pick up one of the journals and flip through the pages, ripping out articles of particular interest. As I am reading, I hear a door handle flip harshly and a door down the hall open. I then hear the familiar rapid thumping of 4 small bare feet on the hardwood floor coming toward me. A few minutes later, my husband is up. The next 50 minutes are spent in the living room wrangling a 2-year-old into his clothes and prompting my 4-year-old to dress himself, while taking breakfast orders and getting them out like a short order cook. I then sit down with them and drink my coffee while they eat their breakfast. My husband is shaving and putting on his own sand-colored T-shirt and camouflage cargo pants.

The last 10 minutes at home are spent as a family, all putting on our shoes. My husband and I pull on tan combat boots. I personally use the silky ties at the bottom of the pants to cinch them around the cuff of the boot, while my husband prefers to tuck his pants into his boots. I walk to the front door and pull a jacket-like shirt, or blouse, off the coat rack. The material and pattern match my cargo pants. I pull it on, pull up the front zipper, and secure the hook-and-loop closures over the zipper. In the middle of my chest is an embroidered gold oak leaf, symbolizing my rank, which is that of major.

ABOUT THE AUTHOR



Major Lindsey Graham, MD, MC, is a hematology and oncology fellow for the US Army

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I entered the Army as a second lieutenant, but never wore this rank much because I went to a civilian medical school, which is common for military doctors. Technically, I was in the Army Reserve, and spent the summer after my first year of medical school at a basic training course for medical officers. This is where I met my husband, who at the time was attending a medical school 500 miles away from mine. After graduating, I was commissioned on active duty as a captain. It is pretty standard that a doctor spends 6 years as a captain before being promoted to major. The first 3 of these years were spent in internal medicine residency at Walter Reed, which at that time was in Washington, DC. After that, I spent 2 years as an internal medicine staff physician stationed in San Antonio, Texas. I had always wanted to be an oncologist, but wanted to spend some time out of the training environment, so I didn't apply for a fellowship right away.

Over my right upper arm is an embroidered square patch with an ivy leaf inside each corner, meant to signify the Roman numeral IV. Their stems are connected in the center by a circle. This is the insignia of the 4th Infantry Division. Its position on my right arm indicates that this is the unit with which I deployed. Shortly after receiving orders to San Antonio, I was sent orders to deploy to Southern Iraq with the 3rd Brigade Combat Team, 4th Infantry Division. I was officially stationed in San Antonio, but was essentially "loaned out" to the unit as part of a Professional Filler System (PROFIS). It was an incredible experience–while in Iraq, I cared for the general medical needs of an Army unit. I returned to my job as a staff internist in San Antonio 10 months later. On my left upper arm is an oval patch displaying a modified caduceus with 2 snakes entwining a winged sword. This is the insignia of the Army Medical Command, worn by those serving at most hospitals, and its place on my left arm designates this as the command under which I currently serve.

My husband, my kids, and I step outside; on this September morning in San Antonio, it is already 88 degrees Fahrenheit. We then load into 2 cars, one headed directly to the hospital and the other stopping at a nursery school with the 2 boys before heading to the same hospital. My husband and I take turns with the kids depending on which one of us needs an earlier start to the workday. I exit the highway and turn onto a road leading up to a large gate with multiple lanes. At each lane is a guard checking identification. I wait my turn to enter the gate and then drive to the parking garage. I park and then put on my camouflage patrol cap, also known as my cover. I walk through the parking garage and over a walking bridge. As I walk, active duty personnel of junior ranks walking in the opposite direction will render a salute as a gesture of recognition that we are both proud members of the US Military. I, in turn, will render a salute to senior officers–lieutenant colonels and colonels, mostly.

Once I enter the building and remove my cover, I become more of a doctor than a soldier. Nonetheless, within the hospital many of the personnel are wearing military uniforms. I ascend the stairs to the third floor and walk down the hallway and through a door that unlocks when I swipe my badge over the detector. I walk down another hallway that contains almost all of the personal offices of both staff and fellows. The first staff office on the right is locked and will remain that way until its occupant returns from Afghanistan in January.

This morning, we have academic lectures, and I am hosting a journal club meeting. All of the fellows and staff are likely to attend. Everyone is wearing either an Army or an Air Force uniform except 1 senior staff member in a suit who spent 21 years in the Air Force before retiring and taking a job here, where he continues to be an excellent teacher and mentor.

Afterward, I head to the block of exam rooms to begin my half day of clinic. This morning's clinic contains a new patient with suspected polycythemia vera and 4 follow-up patients: 2 retired soldiers' wives with histories of breast cancer now taking aromatase inhibitors, 1 Air Force sergeant with Hodgkin's lymphoma who completed ABVD chemotherapy 6 months ago, and 1 Army captain with a glioblastoma multiforme here for a toxicity check and to pick up the next 28 days of his adjuvant temozolamide.

After clinic, I head back to the office that I share with a first-year fellow. She is currently on her first ward rotation

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and is busy writing notes and orders for the inpatients 2 floors above us. When she was an intern at this hospital, I was in my second year as a staff physician. I am now one of 2 third-year fellows. I sit down and log onto my secure computer and finish entering some of my notes. From across the narrow hallway, one of the second year fellows sitting at his desk asks, "Have you gotten food?" I reply that I haven't and log off my computer and walk out of my office. A few other fellows join us in the hallway from their adjacent offices and we go downstairs to buy lunch.

Today is Tuesday and there is a bone marrow transplant lecture in the conference room on the fifth floor BMT/inpatient oncology ward. One of our 5 transplant staff gives us a lecture on infectious complications of bone marrow transplant. At 1 PM, I walk back downstairs and read my e-mails, including one from the pathology resident stating that we are meeting at 2 PM. I am currently on a hematopathology rotation where I sit down with the hematopathology staff and resident and go over this week's cases. I finish my notes and work on some chemotherapy orders. At 2 PM, I walk out of our clinic and head to the middle of the hospital and walk up a flight of stairs to the labyrinth of hallways that makes up the pathology department. I briefly stop at my husband's office to say hello before walking over to the conference room. At about 4 PM, I return to my office. I spend the rest of the workday answering patients' telephone messages, preparing to present a patient case at a thoracic tumor board meeting on Thursday, and reviewing a few charts for a research project I'm working on.

My days as a military hematology and oncology fellow are very similar to those of my civilian colleagues. I attend lectures, see patients in clinic, spend a month at a time on the various oncology training rotations, work on research, and care for a family. The main difference is that every day occurs against the backdrop of the military.

After work, I drive through the light San Antonio work traffic to the daycare and pick up my kids. It is easily one of the best moments of my day, as it is for most working mothers, when my boys excitedly run up to me, throwing their arms around my waist. We drive home to one of the quaint neighborhoods just north of downtown where the houses are older and each one is filled with character.

I change into a T-shirt and yoga pants and simultaneously play Ninja Turtles with one boy and play trains with the other. My husband arrives a half an hour later with sandwiches from Jimmy John's and we all eat in the dining room together. After dinner, we wrangle the kids out of their clothes and into pajamas. I sit on the couch and read books to them. I then get them to brush their teeth and coax them into their beds in the room they share. I say goodnight, and then my husband comes in to read them the poem "The Highwayman" by Alfred Noyes.

A few minutes later, my husband emerges from their room and joins me on the couch where I am on my computer checking out houses for rent in El Paso, Texas, a place we may be moving to when I finish my fellowship. At about 7:30 PM, I head out to the detached garage where I will do sit-ups and push-ups and run on the treadmill as part of my constant preparation for a mandatory biannual physical fitness test. At around 8:30 PM I come back inside, shower, and dress for bed. At about 8:45 PM, I return to the detached garage carrying my computer and ascend the stairs to my study room above the garage. I study until about 10 PM and then return to the house. I spend about 5 minutes planning what to cook for dinner tomorrow and then my husband and I spend some time together watching an episode of a sitcom on Netflix before going to bed.

My days as a military hematology and oncology fellow are very similar to those of my civilian colleagues. I attend lectures, see patients in clinic, spend a month at a time on the various oncology training rotations, work on research, and care for a family. The main difference is that every day occurs against the backdrop of the military. I never need to worry about what to wear. After 2 pregnancies, I am in excellent physical shape from training to pass my physical fitness test. I am guaranteed a job after I graduate from my fellowship in June. Those I train with and those who train me will all continue to be my colleagues given that the military hires 100% of its graduates. Although I will not be deployed abroad during training, once I graduate, there is always the possibility that I will once again be given orders to tend to the medical needs of soldiers in a remote environment. Overall, I am proud of my job and the opportunity to serve my country. ■

**The ranks and genders of any patients mentioned above have been changed to respect their privacy.*

The views expressed herein are those of the author and do not reflect the official policy or position of Brooke Army Medical Center, the US Army Medical Department, the US Army Office of the Surgeon General, the Department of the Army and Department of Defense, or the US Government.

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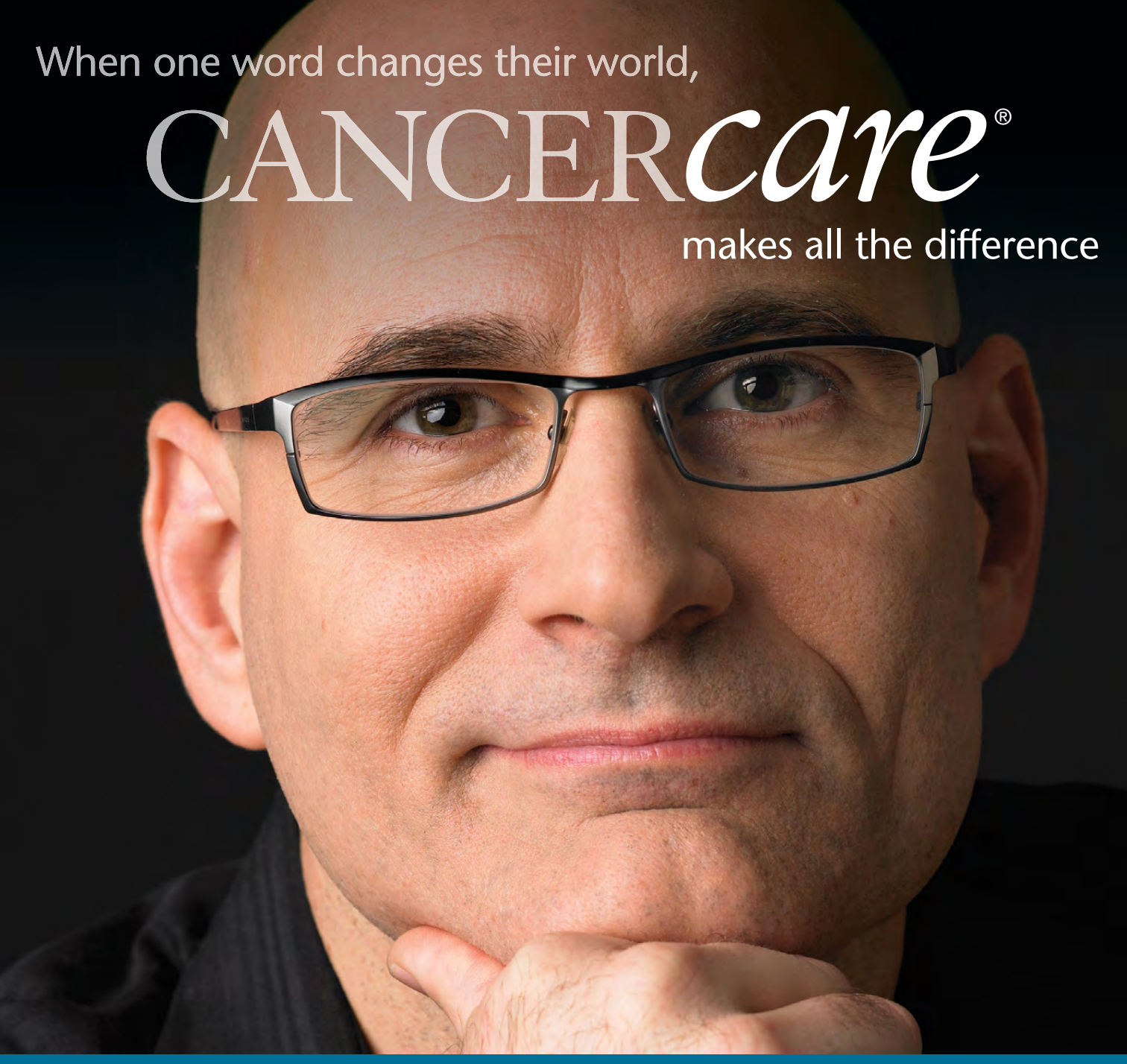

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Mindfulness Based Resilience and Self-care

Why it Matters in Oncology

By Brenda Ernst, MD

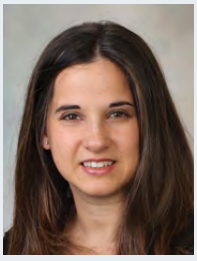
"Throw away all ambition beyond that of doing the day's work well. The travelers on the road to success live in the present, heedless of taking thought for the morrow. Live neither in the past nor in the future, but let each day's work absorb your entire energies, and satisfy your wildest ambition."[1]

-William Osler, Canadian physician

The Buddhist teaching that "Your true work is to discover your world and then with all your heart give yourself to it"[2] can certainly be applied to oncology. Medical practice is complex, and we may easily become perplexed and forget our own driving philosophies. The delivery of 21st century medicine is still, at its core, a science and an art. In successful practice, perhaps the application of mindfulness, resilience, and self-care provide the artist both the canvas and the art.

Mindfulness is an English translation of the Pali word "sati,"[3] meaning a simultaneous broad awareness of the present and a narrow focus of attention on the experience.[4] Mindfulness provides a way of dealing skillfully with what you're experiencing. Its practice is not about controlling experience but rather allowing space for the occurrences in your life. Some may mistake this concept as the act of focusing away from sadness toward happiness. However, more accurately, it is accepting the sadness, placing it in an appropriate compartment, and then choosing to open up the next door.

ABOUT THE AUTHOR



Brenda Ernst, MD, is a hematology and oncology fellow at the Mayo Clinic of Scottsdale, Arizona.

Resilience explores how we adapt to change and respond to difficult experiences.[4] In practice, this allows us to recover in a way that sustains our ability to be present in the future without fear of our past. Some methods of resilience incorporate positive engagement in the midst of the stress, while mindful understanding of the experience allows one to learn and grow from these experiences.

Stress is inevitable in medicine, and the practice of oncology brings with it a host of emotions. Mindfulness-based resilience acknowledges that it is normal to feel these emotions. Ideally, we receive training in the science and art of practicing medicine, but rarely do we learn to incorporate the skills that allow for adaptation to the stressors inherent in the doctor-patient relationship. It is then that resilience is born.

As individuals, team leaders, and patient advocates, a multitude of stressors arise from internal and external sources to challenge us. Over the course of a busy clinic day, many competing goals may lead us to feel overwhelmed and detached from the task at hand. Unexpected patient changes or emotions may arise in the context of a clinic visit and sap our energy. Family or interpersonal concerns may play a role in the day-to-day experience.

As we move from appointment to appointment, we can better serve our patients by allowing time to recognize the unique constructs in each relationship, patient visit, and role we play as physicians. There will be times when our

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patients merely need us to listen to the burdens of coupling a chronic illness with the business of daily life. As physicians, our challenge is to maintain compassion while standing steadfast in the gap between work and home, thereby garnering the strength and resolve to meet the next patient with the same novelty. To meet these challenges, techniques in self-care serve us well through the consideration of mind-body interventions, self-awareness, and preservation, as well as understanding the difficulties in coping with loss, burnout, and depersonalization. It is important to maintain work-life balance. Applying daily rituals allows pause for reflection and transition and functions to sustain our lifelong practice as caregivers.

Mind–body interventions

Mindfulness and meditation have been, and continue to be, studied in cancer, primarily to measure outcomes related to pain control, anxiety reduction, and an enhanced quality of life.[5-7] Perhaps the application of this broader science has, at its core, a place for the provider as well.

Canadian physician William Osler once implored physicians to "throw away all ambition beyond that of doing the day's work well. The travelers on the road to success live in the present, heedless of taking thought for the morrow. Live neither in the past nor in the future, but let each day's work absorb your entire energies, and satisfy your wildest ambition."[1] To truly focus on the task at hand is difficult, as it relies on tuning out the distractions that frequent the clinical day. The application of mindfulness, resilience, and self-care allow a means to learn our own tendencies so that we can better communicate with patients and ourselves.

Self-awareness and preservation

As we progress on this journey, it is helpful to understand what drives our reactions. These may be referred to as "hooks," and represent the things that trigger our emotions. It takes courage to be honest and understand why a particular event or experience might be so disheartening. Through identifying our hooks, we become more aware of our active reactions and learn how to analyze, grow, and adapt to be able to give full attention to the present situation.[8]

Everyone has a story, and as a physician you want to get to know those stories, including your own. Exploring what our triggers are, as well as what constitutes our sense of happiness, is a means of better understanding ourselves. Likewise, self-care is emerging as an important component of a healthy practice. For some, this may require introspection to understand what is required for one's own happiness or wholeness.

This understanding is gaining formal credence in major medical centers. Many programs have incorporated creative therapies such as visual arts, dance, and music to help individuals express their feelings and cope with the demands of the care continuum. A mindful communication program developed for physicians was studied and found to be associated with increased sense of well-being and attitudes associated with patient-centered care.[4] Self-care rounds, or Schwartz rounds as they have become known, provide a regular opportunity for providers to openly and honestly discuss social and emotional issues that arise in caring for patients.[9] In contrast with the science discussed during traditional medical rounds, the focus is on compassionate care through the human dimension of medicine.[10] This is particularly meaningful for cancer providers, caregivers, and physicians alike. Insomuch as we take care of ourselves, we are able to give more openly and freely to others, our patients, and our community.

Coping with difficult losses

While today's medical students are more schooled in communication than their forebears, there are still very few opportunities to learn about the death and dying process one is sure to encounter very early on in this field. To some, it may be seen as a rite of passage to learn how to talk to those who are dying and their caregivers (ie, the birthing of an oncologist).

Today, we understand that there is more of a science to this. A mindful practice and understanding of our own emotions can prepare us to be better communicators for our patients and their families. Few would deny that there is an element of fear in coming to the end of one's battle, whether it be the patient's, the caregiver's, or the physician's. And while we all strive to achieve different goals, we do each sheepishly desire the best of possible outcomes.

Caring for critically ill and terminally ill patients can elicit many emotions, including fear, grief, fatigue, and sense of failure, all of which may contribute to a sense of burnout.[11] These emotions can be particularly difficult in relational constructs, including instances where physicians develop close bonds with patients and their families. It is at this time that reflection becomes important. Ask yourself, "Why is this difficult?" Give yourself room to acknowledge the meaning before allowing yourself to come to "terms" with the passage of time that occurs in all of our patients' care timelines.

As physicians, we may experience an additional sense of grief due to our inability to control the situation and thereby prevent patients from experiencing physical or emotional suffering, which further portends an inner sorrow on the part of the physician.

The intentional application of techniques that recognize the active experience and provide adaptations and room for self-reflection benefits us both personally and as a medical community. In the case of patient loss, many physicians may feel it is unacceptable to talk about, much less experience or acknowledge, this difficulty in oneself. Oftentimes, there is a stigma around death and dying, viewed as the culmination of several failed attempts at competing with the cancer itself. Nevertheless, patients and families demand an ever-present physician capable of leading the experience even when the experience becomes extremely difficult. For young cancer physicians, this may feel like charting an unknown course, and in many respects it is best navigated personally with introspection and understanding.

Addressing burnout and depersonalization

There are ever-changing sets of interests in the delivery of modern medicine. More than ever, today's doctors are charged with delivering medicine with precision, in a cost-constrained environment, with a high level of patient satisfaction.[12] As oncologists, we recognize that for each victory there will be many defeats. Each of these aspects of training and practice in and of itself surely contributes to the burnout rate of physicians and oncologists alike. While we struggle to find new and better ways to deliver cancer care, the loss of many of our patients with advanced cancer, coupled with the constraints of more tightly regulated health systems, may lead to depersonalization.[11]

The frequent needs of a challenging patient require a progressive level of compassion and understanding. Clearly, even the most empathetic provider can easily fall to a level of compassion fatigue. Understanding what brings meaning and enjoyment to one's life and medical practice allows for interpretation of even a challenging experience within a positive construct. Moreover, this understanding of meaning, more so than the removal of the components of dissatisfaction within the work construct, has been linked with improved sense of fulfillment.[4]

Burnout is a commonly reported outcome among medical oncologists, with studies suggesting a prevalence of 25% to 35% among medical oncologists. There is growing evidence that physician distress can impact not only quality of care but also interpersonal relationships.[11] Furthermore, a recent article in the *Journal of Clinical Oncology* describes the work-life-balance satisfaction of oncologists as lower than their peers'. New fellows have reported a burnout rate as high as 43%, even with fellows underestimating the hours spent on patient care at work and at home.[13]

Maintaining a work-life balance

I'm sure we all can recall the first and the last time we divulged to anyone that we were, indeed, oncologists. Commonly we notice that shrug that says "I pity you," and the tone in their voice when someone comments "That's a tough job." No one needs to tell you it's a hard job. Most of us chose this job understanding its challenges and rewards. However, for me it was still an enigma yet to be realized: the everyday difficulty of turning off work and turning on home, of embracing the present, saying no to sadness, and saying yes to happiness.

For many of us, our support system is tied closely to our relationships outside of work (eg, spouses and other family members). Leaving work at work may prove difficult when such heavy decisions are weighing on your mind. Relationships are an important part of the medical experience. As physicians, our ability to feel connected is central to our professional and personal identity. However, our relationship partners may feel unprepared to cope with the enormity of emotions that develop through providing this type of care.

When I was a child, there was a proverb posted on a wall in my home that read "Change the things you can and accept the things you cannot change." Recently, I have come to a better understanding of this as a daily task.

Rituals are a hallmark of both mindful and resilience-based practice. One may consider hand washing between patients a ritual of sorts, and an opportunity to pause and reflect. This intentional use of rituals may offer a transition from one space to another; wholly allowing you to engage, adapt, and learn, while providing newness to the many important and changing relationships in your life. When I began my fellowship, I had a multitude of advice bestowed upon me, perhaps the strongest of which echoed the theme of providing a boundary between work life and home life. And while I still find this difficult, there is something to be said for the pause that occurs when you exit the building to go on to the enjoyable and calm environment we each call home.

As a vital element of our work, oncologists provide support and direction to others during a difficult time. As an imperative, we must fill our own pool so that we will be able to give to others. Mindfulness is about being present in the moment, acknowledging who you are, and accepting what's going on, while absolving yourself and the situation of judgment. Resilience incorporates an understanding of meaning, relationships, acceptance, compassion, and reflection. Intentionality drives us to deliberately seek connections with patients and people around us. Self-care reminds us to renew the strength that propels our journey. Coupled together, these entities make us present and purposed in our effort to provide wholly centered care that delivers the best for our patients and providers, therein building a community of care. ■

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How to Prepare for Interviews for Your First Academic Faculty Job

By Amer Zeidan, MBBS, MHS

The big moment has arrived. After many years of medical school, residency, and fellowship training, you have finally been invited to interview for your first academic faculty job at your top-choice institution. All your past hard work culminates into excitement about this great opportunity. You will finally have the chance to show potential future employers your true worth and what you are capable of achieving. However, this excitement is usually accompanied by significant anxiety and uncertainty about how to best prepare for the interview that will be extremely influential in landing your dream job.

Based on recent experience, I would like to share some helpful pointers with senior hematology/oncology fellows who are preparing for their first academic job interview. My article focuses on how to prepare for an interview after your mentors, faculty advisors, and program directors have hopefully helped you get invited to interview at your favorite institutions. These points are directed at first-time clinical-research faculty position interviews, as this is what I have just gone through. Nonetheless, the same general principles apply to interviews for basic science faculty, private practice, and industry jobs.

Be prepared to commit a significant amount of time to the interview process

Academic job interviews usually involve 2 or 3 separate visits to the inviting institution (assuming the first visit goes well). Each visit usually involves a day or two of interviews and an invitation to dinner the night before. Interview visits are usually separated over the course of a few months, and usually require 3 to 4 days of your time (including the days of arrival and departure).

Although you may be able to fly in the night prior to an interview and leave the following evening, it is usually difficult to schedule interviews with all "must-see" faculty and leadership in a single day. During your last year of fellowship, you should have the flexibility to dedicate at least 1 week each month to interviews.

Try not to commit to too many interviews with different institutions

Try not to interview with too many institutions at once. Unlike the residency and fellowship interview process, where many applicants interview with 10 to 15 different institutions, the ratio of invited candidates to open academic positions following fellowship is much lower; usually not more than 4 to 5 invitees per job. Interviewing with 3 to 5 institutions is usually sufficient (assuming that you are a good candidate).

Understand that the interview process can be logistically, mentally, and physically exhausting. Most institutions will conduct an extensive screening process. Expect institutions to review recommendation letters, contact your references, and conduct a phone interview with you before extending you an invitation for an in-person interview. If you are invited for an in-person interview (especially a second interview), chances are good that the institution has a genuine interest in you and would like to offer you the job.

Prepare to adapt to a variety of types of interviews

First, second, and third interview visits usually have different focuses. The first visit is generally intended to ensure that you would be a good fit for the institution's program as a person (in addition to your work/research). Most academic institutions will ask you to give a 30- to 45-minute presentation about your research during your first visit (or sometimes during the second visit) to assess your presentation skills in addition to the quality of your research. Make sure to practice your presentation a few times prior to the interview, know your slides well, and be prepared to field questions. Know who will be in the audience—you can ask the interview coordinator—as the degree of introductory material, complexity, and

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other aspects of your presentation should vary significantly based on who is attending (eg, medical students attending vs faculty experts only).

The first interview should also allow you to gain as much information about the institution as possible, in a courteous and respectful way, of course. Never show negative reactions to anything you learn during the interview (eg, clinical time commitment, salary) even if you don't like what you are hearing. Instead, be observant and collect as much information as you can. You will have plenty of time to process the information after your visit to decide if you are interested in a second look. If you decide not to return to the institution, be respectful in your response and inform them as early as possible so they may consider other candidates.

The focus of the second interview is usually to address any remaining questions; during the second visit, you will generally meet with several leaders from the institution (eg, department chief, cancer center director); learn additional details about the position (eg, salary, benefits, start-up funds), and go on a real estate tour of the area if you have not already done so. Most negotiations occur after the second interview, although this sometimes happens after the first interview. You should be able to distinguish what is negotiable (eg, start-up funds, research protected-time) from what is not (eg, salary and benefits) and make sure these line up with your expectations and your priorities. Take note of any deal-breakers.

There will rarely be a third interview; this is more common when applying for advanced positions. If there is a third interview, it is usually just to iron out final details after both parties have indicated preliminary approval. The second and third visits are usually good times to find housing in the area.

Know your CV by heart

This might seem like a no-brainer, but there is nothing worse during an interview than feeling or appearing clueless about a paper or a poster in your CV on which an interviewer asks you to elaborate, even if that work was done a long time ago. Be prepared to talk about anything on your CV–from a poster you presented in medical school, to charity work, to hobbies you have listed. I experienced interviews in which most of the 30 to 45 minutes were spent talking about the hobbies on my CV.

Be sure to review your CV the night before the interview to make sure your mind is fresh about any items you may have forgotten about over time. Be prepared to explain any gaps in your CV convincingly and address any concerns.

Do your homework

During each day of interviews, you could meet separately with as many as 12 to 15 different faculty members for 30 to 60 minutes each. This may include chatting over lunch or dinner. Be familiar with the research focus and work of each of your interviewers.

Make sure to obtain a list of persons you will interview with from the visit coordinator. If a final list or itinerary is unavailable, ask for the preliminary list so you can look each person up via Google, PubMed, etc.

Those you interview with will expect you to show interest in their work and they will be happy to discuss their work with you and explore opportunities for collaboration. Write down the major points for each interviewer on your itinerary, especially if you are scheduled to meet with many people.

Additionally, be prepared to ask questions. You will undoubtedly be asked if you have questions during the interview, and you should show interest by asking a question or two.

In addition to knowing your interviewers, you should know major highlights about the institution, city, etc. For example, during one of my interviews at a university with a major team in college football, the subject of their team came up several times in conversation. Unfortunately, I didn't know much about college football. I can tell you now that I should have been better prepared on this subject!

Go with the flow

Be prepared to stay on message in terms of showing why you are a good fit for the position you are interviewing for, but go with the natural flow of the interview. Don't force subjects that may not be of particular interest to the interviewer. There will be a significant amount of repetition involved during the many interviews you take part in, but you should always make sure to be, look, and act fresh and engaged.

Be sure to explain to the interviewers why you are a good fit for the institution and why you are a precious talent that they can't afford to let go.

Be courteous and respectful

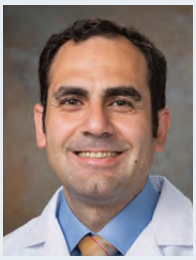
Finally, be courteous and respectful to everyone. This includes secretaries, coordinators, drivers, and anyone else that you meet during interviews. Say thank you, show appreciation, and be attentive to what non-faculty staff tell you. Word usually travels fast around the institution about how nice, or not so nice, of a person you are.

Don't be late

Never arrive late for an interview. Unless you have a really good reason, arriving late to an interview is rude and could reflect negatively on your chances of landing the position you are interviewing for.

Good luck, everyone! ■

ABOUT THE AUTHOR



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End-Of-Life Discussions With Patients and Their Families

Although it is important for healthcare professionals to discuss the goals of care and end-of-life plans with patients and their families, such discussions may not always take place. As a fellow who will soon be a full-fledged practicing oncologist, it is vital that you gain experience discussing these important topics. A recent study conducted in Canada explored how frequently these important discussions take place and what elements patients and their families would like to see addressed.

The study assessed the perspectives of 233 older adult patients with serious illnesses (mean age of 81.2 years) and 205 adult family members (mean age of 60.2 years) to determine which of the study-specified elements for goals-of-care discussions they found most important.[1] The elements were selected based on guidelines for goals-of-care discussions.[2-4] Additionally, the researchers examined whether participants agreed with the prescribed goals of care and whether they were satisfied with the end-of-life communication and decision-making process.[1]

Notably, the researchers reported that healthcare professionals had discussed the individual goals-of-care elements with patients and their families infrequently: between 1.4% and 31.7% of participants reported having discussed a particular element with a member of the care team. In addition, the results of the study showed that patients and their families ranked the same 5 discussion elements as most important, although the order of importance varied for patients and caregivers (**Table**).[1]

The results of this study provide insight into the preferences of patients and their families in terms of topics to be covered during end-of-life care discussions, and also highlight how infrequently these important discussions take place in current clinical practice. As a future oncologist, you have the opportunity to address this major gap in care and improve the quality of care provided to patients.

Table. Top 5 Elements as Ranked by Patients and Family Members[1]

Element	Rank Among Patients (n = 233)	Rank Among Family Members (n = 205)
Personal preferences for care	1	4
Personal values	2	5
Clear explanation of prognosis	3	1
Opportunity to share fears or concerns	4	2
Additional questions about goals of care	5	3

Adapted from You JJ, Dodek P, Lamontagne F, et al [published online November 3, 2014]. *CMAJ*.

Reference

1. You JJ, Dodek P, Lamontagne F, et al. What really matters in end-of-life discussions? perspectives of patients in hospital with serious illness and their families [published online November 3, 2014]. *CMAJ*.
2. Advance Care Planning: Concise Guidance to Good Practice Series, No 12. London (UK): Royal College of Physicians; National Council for Palliative Care; British Society of Rehabilitation Medicine; British Geriatrics Society; Alzheimer's Society; Royal College of Nursing; Royal College of Psychiatrists; Help the Aged; Royal College of General Practitioners; 2009.
3. Harle I, Johnston J, Mackay J, et al. Advance Care Planning With Cancer Patients: Evidentiary Base. Toronto, ONT: Program in Evidence-Based Care, Cancer Care Ontario; 2008.
4. Clayton JM, Hancock KM, Butow PN, et al. Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers. *Med J Aust*. 2007;186:S77,S79,S83-S108.

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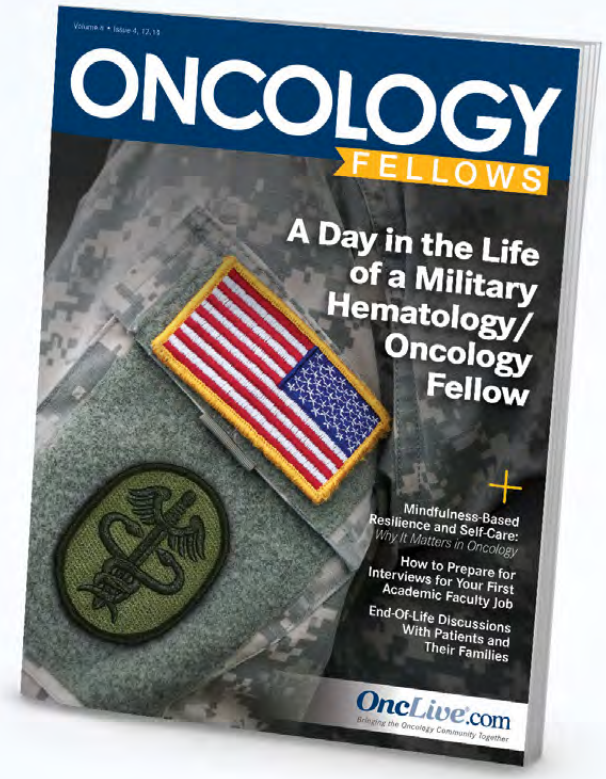

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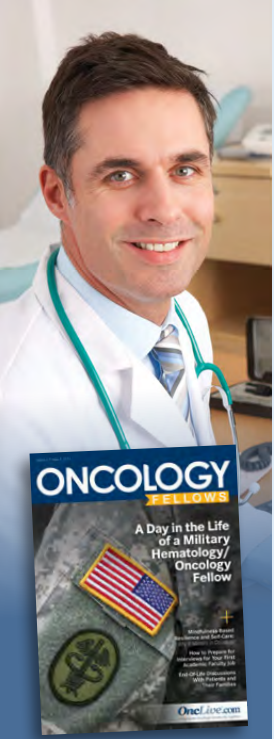

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