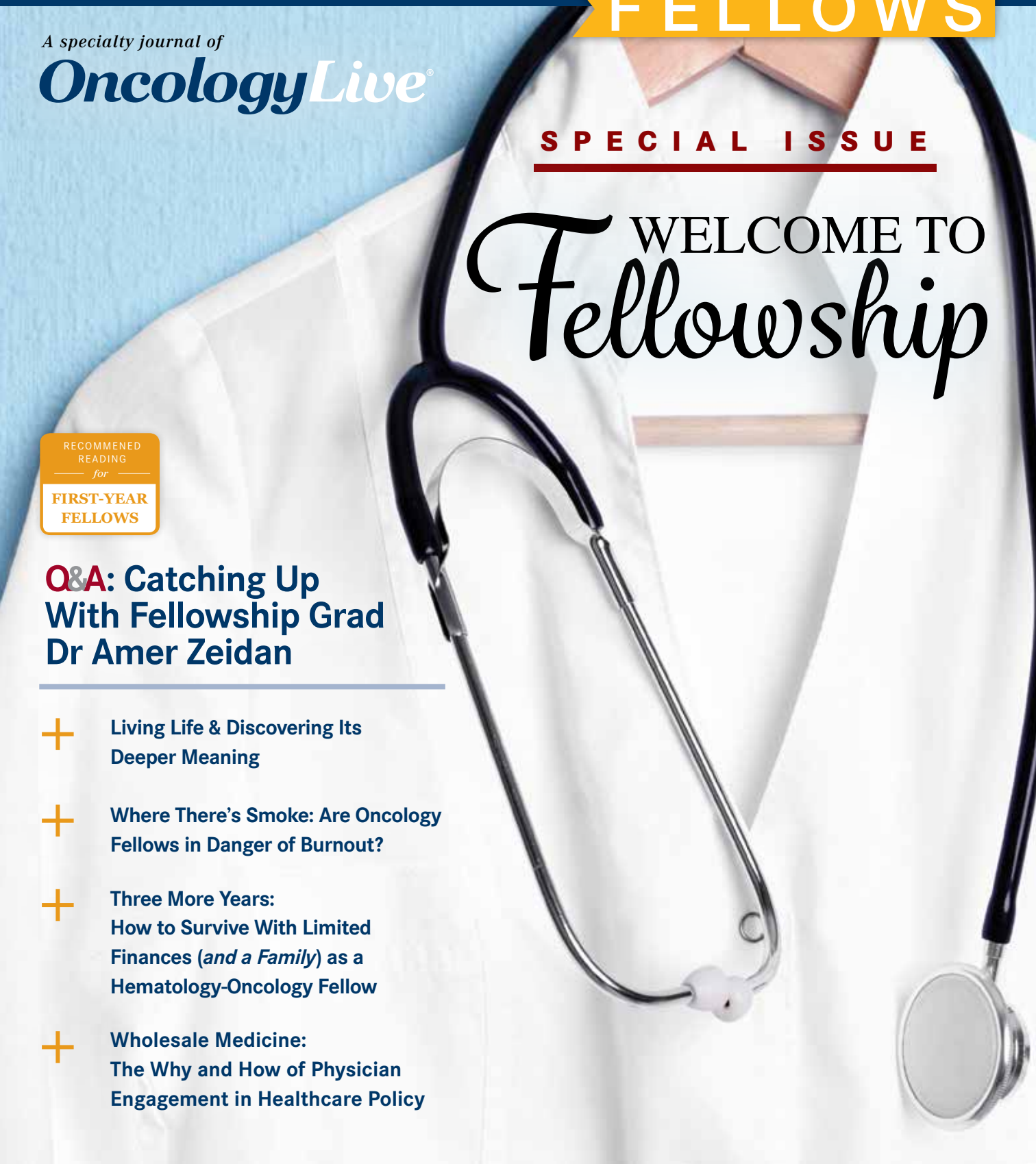
Volume 8 • Issue 3, 09.16

ONCOLOGY

FELLOWS

A specialty journal of OncologyLive®



SPECIAL ISSUE

WELCOME TO Fellowship

RECOMMENED READING *for* FIRST-YEAR FELLOWS

Q&A: Catching Up With Fellowship Grad Dr Amer Zeidan

- Living Life & Discovering Its Deeper Meaning
- Where There's Smoke: Are Oncology Fellows in Danger of Burnout?
- Three More Years: How to Survive With Limited Finances (*and a Family*) as a Hematology-Oncology Fellow
- Wholesale Medicine: The Why and How of Physician Engagement in Healthcare Policy

MyLifeLine.org
connect. inspire. heal.

FREE, personal websites for cancer patients, survivors, and their caregivers.

www.MyLifeLine.org

Get started with just a few clicks!

"MyLifeLine.org gave me a place to share with my friends and family the ups and downs of my journey. It simplified the telling of my experience by making it possible to share with everybody without having to repeat myself."

–Susan Boyes
Stage 3C Ovarian Cancer

"I am so grateful to have the support of my family and friends, and MyLifeLine.org allows me to gain that support 24/7."

–Kelley Gleason
Pancreatic Neuroendocrine Tumor

Intellisphere®
Oncology Specialty Group

Editorial & Production

Senior Vice President of Operations and Clinical Affairs
Jeff D. Prescott, PharmD, RPh

Senior Clinical Projects Manager
Ida Delmendo

Project Coordinator
Jen Douglass

Associate Editor
Jeanne Linke

Proofreaders
Maggie Shaw
Griselda Demassey

Designer
Wassana Techadilok

Sales & Marketing

Vice President & Executive Producer of MJH Productions
David Lepping

Vice President of Oncology Specialty Group
Robert Goldsmith

National Accounts Manager
Albert Tierney

National Accounts Associate
Phil Conover

Sales & Marketing Coordinator
Jessica Smith

Strategic Partnership Coordinator
Nicholas D. Santoro

Operations & Finance

Vice President of Operations
Michael Pico

Group Director of Circulation and Production
John Burke

Vice President of Finance
Leah Babitz, CPA

Accountant
Kim Rotunno

Corporate

Chairman and CEO
Mike Hennessy, Sr

Vice Chairman
Jack Lepping

President
Mike Hennessy, Jr

Chief Financial Officer
Neil Glasser, CPA/CFE

Chief Marketing Officer
Warren Dardine

Executive Vice President and General Manager
John Maglione

Vice President of Editorial Services and Production
Kerrie Keegan

Chief Digital Strategy Officer
Steve Ennen

Vice President of Digital Media
Jung Kim

Chief Creative Officer
Jeff Brown

Director of Human Resources
Shari Lundenberg

Scan with a QR code reader to visit OncLive .com, the online home of *Oncology Fellows*.

Michael J. Hennessy Associates, Inc.

Office Center at Princeton Meadows
Bldg. 300 • Plainsboro, NJ 08536
(609) 716-7777

ONCOLOGY FELLOWS

Table of Contents

Volume 8 • Issue 3, 09.16

Q&A

2 **Catching Up With Fellowship Grad Dr Amer Zeidan**
Amer Zeidan, MBBS, MHS, an assistant professor of medicine (hematology) at Yale University, shares his story about his journey through training with *Oncology Fellows*, and talks about landing his dream career.

Feature

6 **Living Life & Discovering Its Deeper Meaning**
Jasmine Kamboj, MD, discusses her decision to pursue oncology/hematology and provides personal advice on how to navigate through fellowship.

Departments

A Word From Your Fellows

12 **Where There's Smoke: Are Oncology Fellows in Danger of Burnout?**
Morganna Freeman, DO, FACP, explains the risk of physician burnout in oncology/hematology and highlights resources and techniques that can improve outcomes for physicians in practice.

18 **Three More Years: How to Survive With Limited Finances (*and a Family*) as a Hematology-Oncology Fellow**
Pursuing a career in medicine comes with a price. In this article, **Christopher Dittus, DO, MPH**, discusses how he has combated student debt throughout training and recommends financial support resources for others who are in a similar situation.

22 **Wholesale Medicine: The Why and How of Physician Engagement in Healthcare Policy**
C.J. Stimson, MD, JD, defines healthcare policy and reinforces the value of physician involvement in federal and state legislation.

Conference Center

30 **2016-2017 Oncology & Hematology Meetings**

Online Oncologist

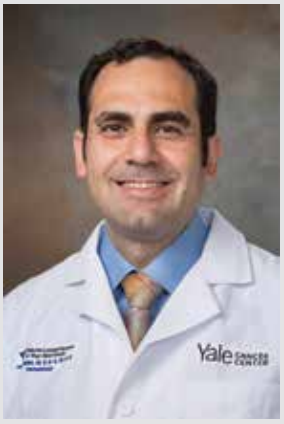
31 **Mobile Medicine**
Apps for the healthcare professional

By the Numbers

32 **Oncology Career Outlook**

Interested in contributing to *Oncology Fellows*? If you'd like to submit an article for consideration in an upcoming issue, please e-mail Jeanne Linke at jlinke@clinicalcomm.com.

Catching Up With FELLOWSHIP GRAD *Dr Amer Zeidan*



Dr Zeidan's journey to landing his dream career in hematology

To help inspire new fellows to pursue their dreams and to reinforce how training will make a huge impact in the future care of patients with cancer, *Oncology Fellows* recently had the opportunity to speak with Amer Zeidan, MBBS, MHS, an assistant professor of medicine (hematology) at Yale University, to hear his story about his path to landing his dream career.

Dr Zeidan just completed a hematology/oncology fellowship and a clinical research fellowship in myelodysplastic syndromes (MDS) at Johns Hopkins University, where he also earned a master of health science degree in clinical investigation. Prior to fellowship, Dr Zeidan completed an internal medicine residency program in Rochester, NY.

Before moving to the United States, Dr Zeidan graduated with honors (in 2001) from the Faculty of Medicine at the University of Jordan, the country's oldest and most prestigious medical school. Dr Zeidan's clinical interest is in the management of myeloid malignancies.

What triggered your interest in pursuing a career in hematology?

Dr Zeidan: As a medical student, my first patient in my first ever hospital rotation was a young kid with a refractory leukemia. I saw him daily for several weeks before he died from his advanced disease. This experience had a major influence on my life direction. Not only did it make me decide to pursue hematologic oncology as a career, but it also played a huge role in my decision to work in clinical research to help find a cure for patients with refractory leukemia.

The best place to pursue these academic interests was the United States. I came to the United States in 2004 from my country, Jordan, to gain the necessary knowledge and expertise to become a clinical investigator in the field of refractory hematologic malignancies. I completed my internal medicine internship and residency at Rochester General Hospital, in Rochester, NY, before moving to Johns Hopkins University for my hematology/oncology fellowship.

For more articles, go to
www.OncLive.com/publications/oncology-fellows

Now that you have finished fellowship, what are you working on?

Dr Zeidan: The focus of my clinical/translational research is the development of novel therapies for MDS, acute myeloid leukemia (AML), and other refractory myeloid malignancies. I have been working on designing and conducting early-phase clinical trials with a special focus on immunotherapeutic and epigenetic approaches. After joining Yale University, I have become the principal investigator in several National Cancer Institute, Cooperative Group, pharma-sponsored, and investigator-initiated early-phase clinical trials. Additionally, I have an ongoing interest in effectiveness research and population-level outcomes research in myeloid malignancies, which I conduct within the Cancer Outcomes, Public Policy, and Effectiveness Research Group at the Yale Cancer Center.

During your training, who has influenced your decision to pursue the career that you have chosen?

Dr Zeidan: I was lucky enough to be guided and mentored at important junctures in my life by several world-renowned scientists and researchers. My first endeavors in clinical research started under the mentorship of Dr Meir Wetzler and Dr Peter Kouides, in Rochester, NY. I subsequently moved to Johns Hopkins University to pursue hematology/oncology clinical research under the mentorship of Dr Steven Gore and Dr B. Douglas Smith, in the areas of MDS and refractory hematologic malignancies.

Aside from finally landing your dream job, what are some of your biggest accomplishments, thus far?

Dr Zeidan: I have been lucky to be a part of several important projects. I have authored more than 75 peer-reviewed publications, including more than 25 original research papers and several book chapters. I have also presented many abstracts at national and international hematology meetings and have delivered invited presentations at several prestigious institutions both in the United States and abroad.

We are currently in the final steps of analyzing the data of my first investigator-initiated trial using the immune-checkpoint inhibitor, ipilimumab, in refractory MDS/AML. This trial has a special spot in my heart, as it was the first protocol I encountered when I was at Johns Hopkins University before moving to Yale University and opening the trial there, as well.

During this process, I have acquired a valuable combination of research skills, including protocol writing, data collection and analysis, and manuscript preparation and presentation. These efforts have resulted in being awarded the "Edward P. Evans Fellow" grant for clinical research by the MDS Clinical Research Consortium and the Aplastic Anemia and MDS International Foundation, and a "Young Investigator Award" by the American Society of Clinical Oncology. I was also able to obtain an institutional "Molecular Targets for Cancer Detection and Treatment Grant (T32) Research Fellowship" grant.

I feel that my supportive world-renowned mentors, my strong work ethic, determination, solid training, and successful track record in multiple research endeavors render me very well-prepared to effectively replicate, at Yale, the success I enjoyed at Hopkins.

What are you looking forward to in the near future at Yale?

Dr Zeidan: My goals, in the next few years, center on ensuring the successful completion of my transition into an independent clinical/translational investigator in the field of hematologic malignancies, especially MDS. This process involves the conduction of several important investigator-initiated projects as a way of achieving this goal.

Reflecting back to fellowship, what factors or experiences were most beneficial in establishing your career?

Dr Zeidan: Connecting with the right mentor was the most important factor in making my career choice. Dr Steven Gore has taken me under his wings and has fostered a great environment for me to explore my full potential in conducting both clinical trials and effectiveness and outcomes research in MDS, which subsequently became the focus of my academic career.

What was one of the most challenging aspects of fellowship? How did you get through it?

Dr Zeidan: Trying to balance my personal and professional lives has always been quite challenging, as it is for many of my peers. This was particularly difficult during fellowship; it was one of the busiest periods of my life. Having a supportive family and great group of friends and mentors has been crucial for me in figuring out how to achieve that balance.

What is your advice to those who are just beginning fellowship?

Dr Zeidan: To think, from day one, about where they want to be at the end of their fellowship and to work hard during fellowship to achieve that. This is particularly important for those interested in research careers, as it requires thoughtful planning and identifying mentors who can help you find your way early in your fellowship. During a busy fellowship, it is quite easy to get distracted by day-to-day events and find yourself halfway through the fellowship without having thought about your career goals.

What deciding factors played in a role in your decision to pursue fellowship at Johns Hopkins University?

Dr Zeidan: The reputation of Johns Hopkins as a top-notch science institution and a leader in cancer research, especially in hematologic malignancies, was the most important factor in making my choice to pursue fellowship there. Meeting established and well-known investigators and scientists during the interviews, whom I could foresee being my potential mentors and collaborators, was crucial in making my decision. ●

BEST HOSPITALS
U.S.News & WORLD REPORT
NATIONAL CANCER
2013–14

#1 IN NEW JERSEY
TOP 50 IN THE NATION

John Theurer Cancer Center
at Hackensack University Medical Center
Your Best Option

HackensackUMC
Where medicine meets innovation

AS JOHN THEURER CANCER CENTER'S NATIONAL RANKING GROWS, OUR GOAL REMAINS THE SAME – PROVIDE THE BEST CARE IN THE COUNTRY. RIGHT HERE, IN NEW JERSEY.

- The only ranked New Jersey cancer center in U.S. News & World Report
- The most nationally acclaimed cancer doctors in New Jersey
- The largest facility dedicated to innovative, personalized care
- The greatest access to breakthrough technologies

Cancer is Hard Enough. Every Patient Deserves Extraordinary Care. We are Committed to Delivering It.

Learn more at jtcancercenter.org

For more articles, go to
www.OncLive.com/publications/
oncology-fellows

Living Life & Discovering Its Deeper Meaning

By Jasmine Kamboj, MD

How It All Started

After attending a family event in California, I was landing in Chicago, the city I did my residency in, when my cell phone gained a signal and messages and e-mails started to pour in. It is amazing how technology captures our attention and plays a large role in day-to-day life. I had already been feeling anxious and restless during the flight, being disconnected from my phone. As I opened up my mailbox, there it was, an acceptance into one of the country's best hematology/oncology programs at Baylor College of Medicine. Despite having just landed on the ground, I felt as if I had taken off into the air, much higher than the actual flight's altitude. There was a sense of exhilaration as tears gathered in my eyes with deep satisfaction welling up my heart. My first thought was that "Dreams do come true."

Deciding on a subspecialty during my medicine residency was not easy. In fact, my brother was the first one to prompt me to opt for hematology/oncology, as he himself was practicing surgical oncology and felt this would be a great option for me. A few close friends, however, disliked the idea because of my jubilant and perky, yet very emotional, personality. Everyone who even faintly knew me felt that I would become depressed when I would see my patients dying because of this ghastly disease, often regarded as, "The Emperor of All Maladies." Nonetheless, I weighed my options and after putting much thought into it, I did finally make a decision to pursue hematology/oncology.

There It Comes

As I started my fellowship in January of 2013, every passing day and every single patient that I met with, strengthened my determination to master this subject. Fortunately, I had the privilege of connecting with indomitable faculty at Baylor and ever inspiring seniors and friends who helped me learn the fine details of the topic material and the art of managing patients with cancer.

Patients Are Your Biggest Teachers and We Must Learn to Befriend Them

At the end of the day, however, I must say that the most important teachers in this field are your patients. Beginning with their first scan, when a mass "concerning for malignancy" shows up, patients experience profound anxiety and curiosity. Physicians disclose the scan findings to patients, who then undergo pathologic diagnosis and are referred to medical oncology for consideration of systemic therapy. The first visit with a medical oncologist is the most crucial. The appointment can last anywhere from 45 minutes to an hour and a half. The patient will have a million relevant questions to ask about the exact diagnosis, staging, and their treatment options. And, of course, the patient will ask the worst and most difficult question, "Doc, how much time do I have?"

ABOUT THE AUTHOR

Jasmine Kamboj, MD, is a hematology/oncology fellow at Baylor College of Medicine.

As a physician in training, I found responding to patients' questions very difficult in the beginning. Beyond questions on diagnosis and stage, I struggled with how to answer questions related to prognosis or questions on the category-1 treatment options recommended for their cancer type. Slowly, however, I found that you do get a grip on how to handle these situations. It took me around 6 months to become comfortable establishing myself as a confidante and a friend to my patients.

When patients with cancer are waiting inside a clinic room, they are normally filled with a swirling storm of thoughts and emotions related to their diagnosis and prognosis. If they are an established patient, they are more concerned about treatment response and the possibility of disease progression. Therefore, it is of tremendous importance that we are not only good physicians, but also good friends with our patients.

One of my attendings taught the fellows not to introduce ourselves as "doctors." "They already know you are a doctor, you don't have to reiterate that fact," he would say. Now, when I enter the room and introduce myself, I tell them, "Hi, I'm Dr Kamboj." Almost 100% of the time they ask me how to pronounce my last name. I normally respond with, "You can call me Jasmine, and I absolutely don't mind that." There is a sense of relief and comfort as I say this. Most of the patients start calling me "Dr Jasmine." I feel I have won a battle when my patients come comfortably into my zone or territory and offer me their trust. As patients with cancer, they are literally placing their lives into your hands. Gaining their trust is vital, as we are starting this voyage together.

Cancer Treatment Is Not a Destination, It is a Journey!

Once the diagnosis has been revealed to the patient, and prognosis and treatment options have been discussed, I feel the most significant next step is to "give them some space." Not pressing on patients during the same clinic visit for their final decision, allowing them time to discuss their situation with their loved ones, and offering them all of their available options are critical points in care. When I say "available options," I not only discuss the treatment for cancer, but also insurance coverage, drug assistance programs, social work help for sorting out a tough family situation, and transportation issues. For those of us who are in private practice, insurance approvals form a dominant

part of such issues while for those who are in county settings, social assistance can be very taxing.

Most of the time when you throw the ball in a patient's court they ask YOU to make the final decision on their behalf. They often say, "You are the doctor, and you know what is the best for me, so you decide what I should opt for." At this point, we need to jump in as their shepherd and escort them along their path.

When a patient is about to begin this frightful expedition, the key is to lay out the plan in 2 ways. First, explain the overall plan (eg, for locally advanced rectal cancer, chemotherapy and radiation to start, followed by surgery, followed by more chemotherapy). Second, we must tell the patient what to expect over the next few days to weeks. This may include discussing side-effect profiles of chemotherapy or common side effects from radiation (although radiation oncologists would go over these details in their clinic, as well). Patients should be aware of what to expect, as surprises are not pleasant for patients who are already going through a lot of turmoil. Often, when we are not clear enough in outlining the overall plan, a patient may be taken aback when they visit us after surgery only to have us reveal the plan for 4 more months of chemotherapy (again, following the example of locally advanced rectal cancer).

> **"The key is to use the right supportive and prophylactic medications at the right time. Pain, nausea, diarrhea, malnutrition, anxiety, and depression are commonly experienced by patients with cancer, and there are excellent guidelines for the management of all of these conditions."**

We usually follow up with our patients every 3 weeks, or sometimes more frequently, to monitor their adverse effects and tolerance of chemotherapy. We should never shy away from adjusting the dose of chemotherapy based on their tolerance. Again, supportive care is critical. In this day and age, many chemotherapy treatments are not as harsh as they used to be. The key is to use the right supportive and prophylactic medications at the right time. Pain, nausea, diarrhea, malnutrition, anxiety, and depression are commonly experienced by patients with cancer, and there are excellent guidelines for the management of all of these conditions. Studies have shown that practicing good palliative care from the start of cancer treatment improves survival. Any oncologist can recommend chemotherapy, but what makes you distinct from the rest is how comfortably your patients sail through their treatments.

Remember That Both the Patient and the Doctor (YOU) Are Human Beings

I feel that one very common mistake is maintaining a very serious environment in the clinic 24/7. Despite the fact that the patients who enter an oncology clinic are overwhelmed with apprehension, I feel it is essential that we don't forget the basic etiquette of "being human." Laughing with them, initiating a conversation with their accompanying family members, narrating your own experiences, letting them know the simplest things like, "It is not your fault that you have cancer," asking them toward the end of encounter, "Is there anything else I can help you with?", will go a long way in calming down the trepidation. Of course, you have to make a judgement call regarding what to say and when. We cannot laugh during end-of-life discussions; rather, these conversations require a great deal of compassion and empathy.

Don't Overtreat

As cancers doctors, we are in the habit of overexpecting and overestimating in certain circumstances. Most of us have type A personalities and always seek to achieve better in our personal or professional lives.

That principle also holds true for us when it comes to our patients. It is important, however, to us and to them to be able to identify where to put a full stop or a comma in the cancer treatment. Advising your patients to take a chemotherapy holiday to be able to make a trip to meet family and friends is most often well appreciated and does not adversely affect outcomes. To make a call to stop treatment after progression on multiple lines of chemotherapy or if a patient's performance status rapidly deteriorates, is crucial. We must recognize that our job is to make things easier and better for them. Buying a few weeks extra at the cost of poor quality of life may not serve that purpose.

End-of-Life Discussions

Like many others, I believe that medicine is an art. This is an area where having knowledge is only one part of the whole game. You must have attributes such as compassion, empathy, and humanness to be able to be a successful doctor. In oncology, these attributes are especially important as we often perform the task of giving bad news.

After our most powerful chemotherapeutic agents or targeted therapies fail, and surgery or radiation are not options due to widespread metastases, we need to inform patients about the futility of any further interventions. Not only must we acknowledge our limitations as a physician and the frailty of Western medicine, we must also suggest comfort care or hospice. By definition, this means that the patient has a life expectancy of 6 months or less. In actuality, in cancer medicine, it is often much less than that.

We must ensure that we explain to patients and their families the philosophy of supporting their emotional, social, and spiritual needs while addressing their symptoms. This helps care for them as a whole, as you are respecting their needs as a human being and their family members' beliefs and wishes. Letting them know they are "not being abandoned" is of paramount importance to this extremely challenging discussion. Making yourself available, even when patients are in hospice, will do wonders. As I mentioned previously, cancer treatment is a journey, and we form a bond with our patients and their families. We should not abruptly break that bond.

Establish a Work-Life Balance

I have led a bachelorette lifestyle throughout my fellowship. My 5-year-old son has been in India with my wonderful parents, who have always tried to make my life easier and more comfortable. For those of us who have families, I think it is essential to take time off and spend time with our families on a regular basis. Hematology/oncology is a rapidly changing subspecialty and demands persistence in updating ourselves with the latest developments.

Needless to say, the emotional aspect of the field can sometimes impact us significantly. Once we are seeing a patient every few weeks, over a long period of time, we develop a relationship not just at a professional level, but also at a spiritual level. The losses are inevitable. To be able to accept those losses with dignity and not get affected negatively by the fragility of human life is a must, in order to cater properly to our other patients. A doctor's family and friends, therefore, are as important on this journey as the doctor, patient and patient's family.

My Gratitude

In the end, I would like to express my gratitude to God, who has offered me this opportunity to be able to take care of patients affected by cancer; my family (my mother, father, brother, and my little son who means the world to me), who have always stood by me and been a constant source of strength during some really testing times; my teachers, seniors, friends, and staff at Baylor, who have taught me some very important lessons in the subject and in life; and last, but not least, all of my patients, who have made me the person and physician that I am today. ●

Strategic Alliance Partnership

Every month, our editors collaborate with renowned cancer centers across the country to bring you reports on cutting-edge developments in oncology research and treatment.

CANCER CENTERS

Yale CANCER CENTER
A Comprehensive Cancer Center Designated by the National Cancer Institute

UNC LINEBERGER

UT Medicine CTRC
Health Science Center San Antonio

Rutgers Cancer Institute of New Jersey

HUNTSMAN CANCER INSTITUTE
UNIVERSITY OF UTAH

City of Hope
RESEARCH · TREATMENT · CURES

MOFFITT CANCER CENTER

Memorial Sloan Kettering Cancer Center

MAYO CLINIC
Cancer Center

DANA-FARBER CANCER INSTITUTE

UAB COMPREHENSIVE CANCER CENTER

Seattle Cancer Care Alliance
Fred Hutch · Seattle Children's · UW Medicine

The Angeles Clinic
AND RESEARCH INSTITUTE
A CEDARS-SINAI AFFILIATE

Wake Forest Baptist Medical Center
Comprehensive Cancer Center

LSU Health
NEW ORLEANS
School of Medicine
Stanley S. Scott Cancer Center

Carbone Cancer Center
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

UC DAVIS
COMPREHENSIVE CANCER CENTER

UNIVERSITY OF IOWA
HOLDEN COMPREHENSIVE CANCER CENTER
University of Iowa Health Care

UK HealthCare
Markey Cancer Center
An NCI-Designated Cancer Center

THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

NYU Langone
MEDICAL CENTER

Sidney Kimmel Cancer Center
at Jefferson
NCI – designated

THE UNIVERSITY OF CHICAGO MEDICINE
Comprehensive Cancer Center

The James
THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

John Theurer Cancer Center
at Hackensack University Medical Center

FOX CHASE CANCER CENTER
TEMPLE HEALTH

Weill Cornell Medicine
Meyer Cancer Center

SARAH CANNON
Fighting Cancer Together.

Georgetown | Lombardi
COMPREHENSIVE CANCER CENTER

INDIANA UNIVERSITY
MELVIN AND BREN SIMON CANCER CENTER

Cleveland Clinic

Stephenson CANCER CENTER
THE UNIVERSITY of OKLAHOMA

UTSouthwestern
Harold C. Simmons Comprehensive Cancer Center

UCLA Jonsson Comprehensive Cancer Center

THE WISTAR INSTITUTE

Mount Sinai
The Tisch Cancer Institute

THE University of Vermont CANCER CENTER

Tulane University
SCHOOL OF MEDICINE
Tulane Cancer Center

SYLVESTER
COMPREHENSIVE CANCER CENTER
UNIVERSITY OF MIAMI HEALTH SYSTEM

Baylor College of Medicine
DAN L. DUNCAN CANCER CENTER

USC Norris Comprehensive Cancer Center
Part of Keck Medicine of USC

UPMC CancerCenter
Partner with University of Pittsburgh Cancer Institute

SITEMAN CANCER CENTER
BARNES-JEWISH Hospital
Washington University in St. Louis
SCHOOL OF MEDICINE

EMORY WINSHIP CANCER INSTITUTE
A Cancer Center Designated by the National Cancer Institute

CEDARS-SINAI
SAMUEL OSCHIN COMPREHENSIVE CANCER INSTITUTE

University of Virginia Health System
UVA Cancer Center
An NCI-Designated Cancer Center

BAYLOR
Charles A. Sammons Cancer Center at Dallas

tgen

JOHNS HOPKINS
MEDICINE
THE SIDNEY KIMMEL COMPREHENSIVE CANCER CENTER

MUSC
HOLLINGS CANCER CENTER
A National Cancer Institute Designated Cancer Center

ROSWELL PARK CANCER INSTITUTE

COMPREHENSIVE CANCER CENTER
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

MASSEY CANCER CENTER
VCU

COLUMBIA UNIVERSITY MEDICAL CENTER
Herbert Irving Comprehensive Cancer Center

ONCOLOGY NETWORKS

21st Century Oncology

The US Oncology Network

RCCA
REGIONAL CANCER CARE ASSOCIATES LLC

OncLive®.com

Where There's Smoke: Are Oncology Fellows IN DANGER of Burnout?

By Morganna Freeman, DO, FACP

The pager beeped for what felt like the 100th time that day—I had just sat down to dinner, hopeful for a quiet break during my 24-hour outpatient call, and was already aggravated and tired. The hospital operator informed me there was a patient with breast cancer on the line calling about back pain. I groaned inwardly, hoping this would not be a long conversation. "What can I do for you this evening, ma'am?" I asked. The patient launched into a long description of multiple symptoms, none of which I could clearly identify as the reason for the call. Finally I broke in and asked, "Ma'am, is there something I can actually do for you tonight?" After a pause, she replied, "Yes, I am in pain, can't you tell? I can't believe this. You are one of the least sympathetic physicians I have ever talked to."

This exchange left me stunned. Had I sounded unsympathetic? Normally, I prided myself on my ability to speak softly, demonstrate a caring attitude, and appear willing to serve my patients' needs. Yet, it was late in the evening, I had spoken to multiple patients and families throughout the day, and I felt that my emotional bank account was overdrawn. This moment occurred during the middle of my first year of fellowship, and I felt overwhelmed by clinical responsibilities and a seemingly insurmountable learning curve. The question dawned on me: was I suffering from burnout?

Recognizing the Signs

As medical professionals, we know that this is a phenomenon to which few of us are immune. Physician burnout results in, and from, communication difficulties, mental overload, a shortage of time, and perceived loss of control. It has elsewhere been described as a "prolonged stress reaction," characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment.[1] Given the demands of patient care, documentation, personal life, and finances, it is no wonder that burnout happens to a lot of us. A recent Accreditation Council on Graduate Medical Education survey of residents' assessment of wellness showed lower overall rates of well-being compared with the general population. A total of 24.5% of residents reported feeling "down, depressed, or hopeless" an average of 1 to 2 days during a 2-week period compared with 15.9% of the general population.[2]

ABOUT THE AUTHOR

Morganna Freeman, DO, FACP, is a chief oncology fellow at H. Lee Moffitt Cancer Center.

As oncology fellows, we encounter the daily struggle of life and death, leaving us susceptible to emotional exhaustion. We often use depersonalization as a coping mechanism when our patients are dying. The overwhelming amount of knowledge we must master over the course of 3 years of training could certainly lead to feelings of reduced personal accomplishment. This all makes burnout seem bound to happen. Thus, in our endless drive to quantify medicine, the inevitable question is: what do the data show? And does this impact our practice?

Burnout Among Oncology Trainees

What contributes to burnout in oncology? There are a number of factors. On a daily basis, we are faced with life-and-death decisions, rely on toxic therapies with narrow therapeutic windows, and balance clinical judgement with patient preference (these may not always align). But despite our best advances, we may not be able to prolong life for many patients.[3] Frequent exposure to death and suffering has the potential to lead to depression, cynicism, a sense of futility, and nihilism,[4] which impacts both our perceptions of skill and our ability to emotionally connect with patients. Time in training, too, may be a factor; even at the medical school level, significant erosion of empathy occurs between the first and final years of education,[5] a concerning trend given the time point at which both burnout and frequency of patient encounters intersect. Burnout and emotional exhaustion have been seen in every branch of oncology: various studies have demonstrated a prevalence of 25% to 35% among medical oncologists, 38% among radiation oncologists, and 28% to 36% among surgical oncologists.[6]

So, how often is burnout happening at the trainee level? The results of a 2010 French survey of over 200 oncology residents showed that 44% of trainees reported emotional exhaustion and depersonalization, with 18% reporting abnormally high levels of each. The authors also found that burnout had a statistically significant association with the desire to either leave healthcare altogether or to change specialties,[7] which may be related to the emotional toll that oncology practice can take.

A 2014 US study published by Shanafelt et al in the *Journal of Clinical Oncology* included 1345 fellows who previously participated in an American Society of Clinical Oncology In-Training Exam survey, referred to as the MedOnc ITE, which assessed fellows' level of knowledge feedback on issues related to training. The study revealed a burnout frequency as high as 43.3% among first-year fellows. The frequency decreased as training advanced (31.7% in second-year fellows, 28.1% among third-years). A similar trend was seen with emotional exhaustion (42.7%, 29.4%, and 25.4%, respectively) and depersonalization (18.5%, 16.1%, and 13.6%, respectively). These improvements in burnout occurred in parallel with improvements in fatigue, satisfaction with work-life balance, and overall quality of life, which may reflect diminution of knowledge gaps and call responsibilities as oncology fellowship advances.[8]

For more articles, go to
www.OncLive.com/publications/oncology-fellows

What do we know about how burnout affects our practice? Studies have shown that depression is associated with medical errors[9] and burnout contributes to impaired results on standardized testing. One study of internal medicine residents showed the effect size was roughly equivalent to an entire year of residency training (ie, median scores for burned out second-year residents were equivalent to intern scores). Pointedly, longitudinal follow-up showed that residents who started with lower scores did not recover to the level of their colleagues during the course of training.[10] Another study of burnout on internal medicine resident performance showed a correlation between emotional distress and medical errors. Each 1-point change on the 30- to 54-point burnout scales was associated with a 6% to 10% increase in the likelihood of reporting an error over a 3-month period,[11] and burnout remained independently associated with errors after adjusting for fatigue and sleep deprivation.[12]

> **"Participating in peer support groups, receiving training on end-of-life care, or learning about medical humanities during fellowship training may alleviate the emotional exhaustion that cancer care entails."**

Given the prevalence of burnout and the impact on our practice, what can fellowship programs do to address this problem? Clearly, there is a need to address the stresses of caring for acutely ill or terminal patients as we learn the technical aspects of cancer care. Some studies have suggested that participating in peer support groups, receiving training on end-of-life (EOL) care, or learning about medical humanities during fellowship training may alleviate the emotional exhaustion that cancer care entails.

Peer Support Groups

We are expected to perform as strong, untroubled professionals even in our darkest and most self-doubting moments. This can make it difficult to identify colleagues in trouble or admit that we may need help ourselves. Data reported at the European Society of Medical Oncology Congress in 2014 showed a troubling trend among young oncologists: burnout survey data revealed that 73.4% of trainees and 82.6% of post-trainees never ask for support. Even more troubling was the news that 74% of respondents reported having no access to support services. Burnout was suggested as a possible contributing factor,[13] which may have an influence on emotional exhaustion, as trainees fear either discovery or being perceived as less clinically competent.[14]

One method of creating support and destigmatizing burnout is by using group therapy. Balint training, an interventional method developed in the 1950s, is a form of group discussion aimed at helping physicians improve communication skills and overall doctor–patient relationships. During meetings, participants discuss cases, focus on clinical interactions, and practice interaction with a focus on empathy.[15]

The *Journal of Clinical Oncology* detailed a study of a 2-year program in which 84 oncology fellows participated in Balint-like discussion groups. Participants reported improvements in their perspectives of themselves as physicians, their ability to deal with emotional clinical situations, and their comfort when discussing the stress of home at work.[16] A second study in the *Journal of Cancer Education* outlined a bimonthly fellows' luncheon where oncology and psychiatry attendings moderated discussions on topics such as breaking bad news, managing the depressed or angry patient, and complex family and cultural issues. Again, participating fellows reported high satisfaction with the sessions and improvements in their emotional well-being,[17] suggesting that participating in group sessions can improve empathy and reduce symptoms of depersonalization and emotional exhaustion.

Training on End of Life

For the most part, the formal oncology curriculum focuses primarily on disease processes and therapeutics, not on clinical experiences, such as dealing with dying patients. Special effort is needed to openly discuss death, bereavement, maintaining empathy, and the inherent difficulty of EOL discussions. This effort is challenged, however, by our tendency to maintain a culture of resilience and toughness in "the war on cancer." Often, acknowledging such issues comes only at the very end of life (if at all).

A study examining the relationship between fellow burnout and perceived preparedness for EOL care found that whereas 24.2% of fellow respondents reported high emotional exhaustion, lower emotional exhaustion scores were associated with explicit teaching about certain EOL topics. Fellows also reported less depersonalization and a higher sense of personal accomplishment if they had training on specific components of EOL care, such as explicit teaching on opioid rotation, instruction on when to refer a patient to hospice, and observations by an attending oncologist while leading a goals-of-care discussion. The authors concluded that although good EOL training may be associated with less burnout, additional focus on EOL aspects is needed.[18]

Medical Humanities

The study of the field of medical humanities in its various forms may help oncology trainees and other physicians to rekindle empathy and cope with burnout. The use of narrative medicine to help tell, listen to, and reflect on personal stories has been shown to improve clinicians' understanding of their patients not merely as objects of care, but as unique and fellow humans.[19] This was demonstrated through an educational mindful communication program that included narratives of meaningful clinical experiences, significantly increased empathy, and reduced symptoms of burnout among physician participants.[20]

Nevertheless, the majority of humanities-based medical education has focused on medical students and residents,[21] and only rarely on specialty fellows.[22] A pilot program focused on physician and patient narratives, which included medical, radiation, pediatric, and neuro-oncology trainees at the University of Rochester, resulted in high levels of attendance, positive qualitative feedback, and an eagerness among participants to continue the program. The authors encouraged further development of such programs to allow rekindling of the empathy that oncology trainees already bring with them and thus re-humanize the relationships between physicians and their patients.[23]

Physician, Heal Thyself

Of paramount importance, of course, is the concept of self-care. Individuals who pursue hobbies and engage in life outside of medicine are less likely to develop burnout and more likely to report a better quality of life. Taking just 1 day a week to do so can decrease the risk of emotional exhaustion and depersonalization. Other daily practices of self-care may include rewarding yourself with an early coffee break, taking a walk or a "time out" after a particularly challenging event, stopping at a window to take in nature, connecting with loved ones throughout the day, or practicing meditative breathing.[24] Self-care is essential and has been shown to enable physicians to care for their patients in a sustainable way with greater compassion, sensitivity, effectiveness, and empathy.[25]

Ultimately, there are a variety of reasons why, at some point in our training and subsequent careers, our spirits and hearts will be challenged by the very work we chose to do. Recognizing contributing factors and engaging in thoughtful ways of processing them (whether through group discussion, reflective writing, or personal habits) can combat the attendant risks of an emotionally challenging career. Doing so will help each of us continue to serve in one of the most noble of professions; most importantly, we will continue to do that work well, in the interests of the people who need us the most. ●

REFERENCES

1. Bar-Sela G, Lulav-Grinwald D, Mitnik I. "Balint group" meetings for oncology residents as a tool to improve therapeutic communication skills and reduce burnout level. *J Cancer Educ*. 2012;27(4):786-789. doi: 10.1007/s13187-012-0407-3.

For more articles, go to
www.OncLive.com/publications/oncology-fellows

2. ACGME survey reveals concerning data on resident wellness. AMA Wire website. www.ama-assn.org/ama/ama-wire/post/acgme-survey-reveals-concerning-data-resident-wellness-1. Published June 8, 2015. Accessed October 14, 2015.
3. Ramirez AJ, Graham J, Richards MA, et al. Burnout and psychiatric disorder among cancer clinicians. *Br J Cancer*. 1995;71(6):1263-1269.
4. Shanafelt T, Adjei A, Meyskens FL. When your favorite patient relapses: physician grief and well-being in the practice of oncology. *J Clin Oncol*. 2003;21(13):2616-2619.
5. Hojat M, Vergare MJ, Maxwell K, et al. The devil is in the third year: a longitudinal study of erosion of empathy in medical school. *Acad Med*. 2009;84(9):1182-1191. doi: 10.1097/ACM.0b013e3181b17e55.
6. Shanafelt T, Dyrbye L. Oncologist burnout: causes, consequences, and responses. *J Clin Oncol*. 2012;30(11):1235-1241. doi: 10.1200/JCO.2011.39.7380.
7. Blanchard P, Truchot D, Albiges-Sauvin L, et al. Prevalence and causes of burnout amongst oncology residents: a comprehensive nationwide cross-sectional study. *Eur J Cancer*. 2010;46(15):2708-2715. doi: 10.1016/j.ejca.2010.05.014.
8. Shanafelt TD, Raymond M, Horn L, et al. Oncology fellows' career plans, expectations, and well-being: do fellows know what they are getting into? *J Clin Oncol*. 2014;32(27):2991-2997.
9. Garrouste-Orgeas M, Perrin M, Soufir L, et al. The Iatroref study: medical errors are associated with symptoms of depression in ICU staff but not burnout or safety culture. *Intensive Care Med*. 2015;41(2):273-284. doi: 10.1007/s00134-014-3601-4.
10. West CP, Shanafelt TD, Kolars JC. Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. *JAMA*. 2011;306(9):952-960. doi: 10.1001/jama.2011.1247.
11. West CP, Huschka MM, Novotny PJ, et al. Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. *JAMA*. 2006;296(9):1071-1078.
12. West CP, Tan AD, Habermann TM, Sloan JA, Shanafelt TD. Association of resident fatigue and distress with perceived medical errors. *JAMA*. 2009;302(12):1294-1300. doi: 10.1001/jama.2009.1389.
13. Burnout in young oncologists: results of pan-European survey on the work conditions of young oncologists presented at the ESMO 2014 Congress. ESMO website. www.esmo.org/Career-Development/Young-Oncologists-Corner/Initiatives/Burnout-Project. Accessed October 14, 2015.
14. Moutier C, Cornette M, Lehrmann J, et al. When residents need health care: stigma of the patient role. *Acad Psychiatry.* 2009;33(6):431-441. doi: 10.1176/appi.ap.33.6.431.
15. Cataldo KP, Peeden K, Geesey ME, Dickerson L. Association between Balint training and physician empathy and work satisfaction. *Fam Med*. 2005;37(5):328-331.
16. Sekeres MA, Chernoff M, Lynch TJ Jr, Kasendorf EI, Lasser DH, Greenberg DB. The impact of a physician awareness group and the first year of training on hematology-oncology fellows. *J Clin Oncol*. 2003;21(19):3676-3682.
17. Armstrong J, Lederberg M, Holland J. Fellows' forum: a workshop on the stresses of being an oncologist. *J Cancer Educ*. 2004;19(2):88-90.
18. Mougalian SS, Lessen DS, Levine RL, et al. Palliative care training and associations with burnout in oncology fellows. *J Support Oncol*. 2013;11(2):95-102.
19. Dunn PM, Arnetz BB, Christensen JF, Homer L. Meeting the imperative to improve physician well-being: assessment of an innovative program. *J Gen Intern Med*. 2007;22(11):1544-1552.
20. Krasner MS, Epstein RM, Beckman H, et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA*. 2009;302(12):1284-1293. doi: 10.1001/jama.2009.1384.
21. Shapiro J, Friedman M, Lie D. The resident as teacher of medical humanities. *Med Educ*. 2002;36(11):1099-1100.
22. Gilewski T. The art of medicine: teaching oncology fellows about the end of life. *Crit Rev Oncol Hematol*. 2001;40(2):105-113.
23. Khorana AA, Shayne M, Korones DN. Can literature enhance oncology training? A pilot humanities curriculum. *J Clin Oncol*. 2011;29(4):468-471. doi: 101200/JCO.2010.33.3617.
24. Quill TE, Williamson PR. Healthy approaches to physician stress. *Arch Intern Med*. 1990;150(9):1857-1861.
25. Shanafelt TD, West C, Zhao X, et al. Relationship between increased personal well-being and enhanced empathy among internal medicine residents. *J Gen Intern Med*. 2005;20(7):559-564.

THREE MORE YEARS

For more articles, go to
www.OncLive.com/publications/oncology-fellows

How to Survive With Limited Finances (*and a Family*) as a Hematology-Oncology Fellow

By Christopher Dittus, DO, MPH

If you are anything like me, you are sitting on the couch staring at your laptop with Disney Junior on the television and a rambunctious toddler running from his room to the couch banging on a tambourine. You know that you have an article to write, or a chapter in your ASCO-SEP to read, but you realize that these will probably have to wait until you get back to work on Monday. Unfortunately, if you are similar to me, you are also the proud owner of an ever-increasing collection of student debt. You likely have an array of different types of debt (unsubsidized, subsidized, private, consolidated), each processed by a different company, and these debts may even be transferred to other companies yearly just to complicate things. Additionally, you have probably felt a certain amount of guilt about possessing debt. However, despite the difficulties of managing and dealing with debt, there is hope.

My particularly large amount of debt has accrued through a series of events. First, I attended a private medical college. Second, I did so in the Northeast, where everything costs more, including tuition, rent, utilities, food, and other day-to-day items. With little outside financial support, and a wife in law school, I first had to take out private loans, then Grad PLUS loans, in order to have enough money for living expenses.

Once I completed medical school and started my residency, I quickly realized that living in Manhattan on an intern's salary did not leave me a lot of income to put toward repaying my debt. To avoid making payments, I put my student loans into forbearance, meaning that I could avoid paying any interest or fees. The downside was that interest would continue to accrue and compound. Near the end of my second year, my daughter was born. This meant that we needed a nanny and a bigger apartment—and there was absolutely no way I could begin to pay off my debt.

After completing a year as chief resident, I started fellowship. Shortly thereafter, my son was born. Fellowship in Boston again meant a high cost of living (now with 2 children), with only a nominal increase in salary. I continued to put my loans into forbearance and primarily focused on providing supplemental income to pay for the rising costs associated with child rearing. Although it is still demanding, fellowship offers more elective time, particularly in the second and third years. I began moonlighting at the Boston Veterans Administration (VA) in the emergency department midway through my second year of fellowship. At this point, I had finished the majority of my inpatient rotations and had fewer weekend calls and tumor board presentations than I had during my first year of fellowship. By working two, 9-hour shifts per month at the VA, I was able to increase my income by roughly 25%. Additionally, modest honoraria provided for writing magazine articles helped fill the gaps from time to time.

ABOUT THE AUTHOR

Christopher Dittus, DO, MPH, is an assistant professor of medicine in the Division of Hematology/Oncology Lymphoma Program at the Lineberger Comprehensive Cancer Center, at the University of North Carolina at Chapel Hill.

As I started to look forward to my career as an oncologist, I was confronted by how I would repay my student debt, yet still provide for a comfortable lifestyle for my family. Initially, I planned to go into private practice, which was primarily a financial decision since my passion was for academic medicine. As my fellowship progressed, I realized that I did not want to hedge on my career goals. I decided that I would pursue academic malignant hematology and, if need be, make other concessions in order to achieve this endpoint.

First, I knew I would have to relocate. According to the 2016 version of the *Medscape* Oncologist Compensation Report,[1] the Northeast has the lowest compensation rates compared with the rest of the country. Additionally, the cost of living is greater in the Northeast than in most other regions, particularly if you live near one of the larger cities. Consequently, and after a great deal of research, I accepted a position at the University of North Carolina at Chapel Hill. This allowed me to pursue my interest in academic malignant hematology while living in a lower-cost region with improved physician compensation. Importantly, if you are interested in buying a home, you should be aware that many banks offer a Physician Mortgage Loan, which has the benefit of giving physicians with extensive debt and limited funds the opportunity to obtain a mortgage with 100% financing and favorable terms. Pursuing this type of mortgage has allowed me to purchase my first home with relatively little money in my savings account. Most banks also require a very good credit score, so you should ensure that you pay your credit card bills promptly and maintain a reasonable balance throughout training.

“If you are interested in buying a home, you should be aware that many banks offer a Physician Mortgage Loan, which has the benefit of giving physicians with extensive debt and limited funds the opportunity to obtain a mortgage with 100% financing and favorable terms.”

Second, I had to address my debt directly. Since my income:debt ratio was not favorable, I looked into income-based repayment. The first, and most important, website I reviewed was the Federal Student Aid website, which is administered by the US Department

For more articles, go to
www.OncLive.com/publications/oncology-fellows

of Education (www.studentloans.gov/myDirectLoan/index.action#). They offer several repayment plans with payments that are calculated based on income; if you qualify for these plans, they can substantially decrease your monthly payments. This allows you to pay down your debt slowly and still maintain a comfortable lifestyle. The interest rate is generally favorable, so it would be prudent to pay off nongovernment debt (private loans, credit cards) more aggressively. It should also be noted that federal government loans are forgiven after 20 or 25 years of regular payments (depending on the payment plan),[2] so choosing to pay down your federal student debt slowly will not necessarily mean you will pay more in the long run. Additionally, the fact that 12 of my 13 loans can be consolidated into one monthly payment makes this a convenient option.

Finally, if you are interested in either basic or clinical research, you should be aware of the Loan Repayment Programs offered by the National Institutes of Health (NIH) (www.lrp.nih.gov/eligibility-programs#programs). These programs are aimed at decreasing the loan burden of physicians who choose to pursue a research career.[3] If you apply and are accepted, you can have up to $35,000 of your qualified educational debt paid annually by the NIH. For new physicians who are concerned that a career in academics is associated with lower compensation, this may help offset some of the financial burden of a lower-paying position.

If you are anything like me, despite working incredibly hard, not getting paid adequately for many years, and accumulating an incredible amount of debt, you could not imagine any other career. You should remember to pursue your exact medical career goals and not allow your finances and debt to dictate your level of happiness. By taking certain measures (see **Sidebar**), you can have a great job, spend time with your family, and live comfortably, despite having substantial student debt. ●

REFERENCES

1. Peckham C. *Medscape* oncologist compensation report 2016. Medscape website. www.medscape.com/features/slideshow/compensation/2016/. Published April 1, 2016. Accessed August 1, 2016.
2. Federal student aid website. https://studentloans.gov/myDirectLoan/index.action#. Accessed August 1, 2016.
3. Eligibility & programs. National Institutes of Health Division of Loan Repayment website. www.lrp.nih.gov/eligibility-programs#programs. Accessed August 1, 2016.

Sidebar. Considerations When Strategizing and Managing Student Loan Debt

Factor	Suggestion
Medical school tuition	Consider public (state) medical school
Geographic location	Cities in the Northeast tend to be associated with higher costs of living and lower compensations. The Midwestern and Southern regions generally are lower-cost and have greater compensation.
Home mortgage	Consider a Physician Mortgage Loan
Loan repayment	Review the Federal Student Aid (FSA) website for repayment options based on income (www.studentloans.gov/myDirectLoan/index.action)
Loan consolidation	Federal loans can be consolidated via the FSA website to simplify payments
Debt relief for researchers	Apply for a National Institutes of Health (NIH) Loan Repayment Program (www.lrp.nih.gov/eligibility-programs#programs)

Wholesale Medicine: The Why and How of

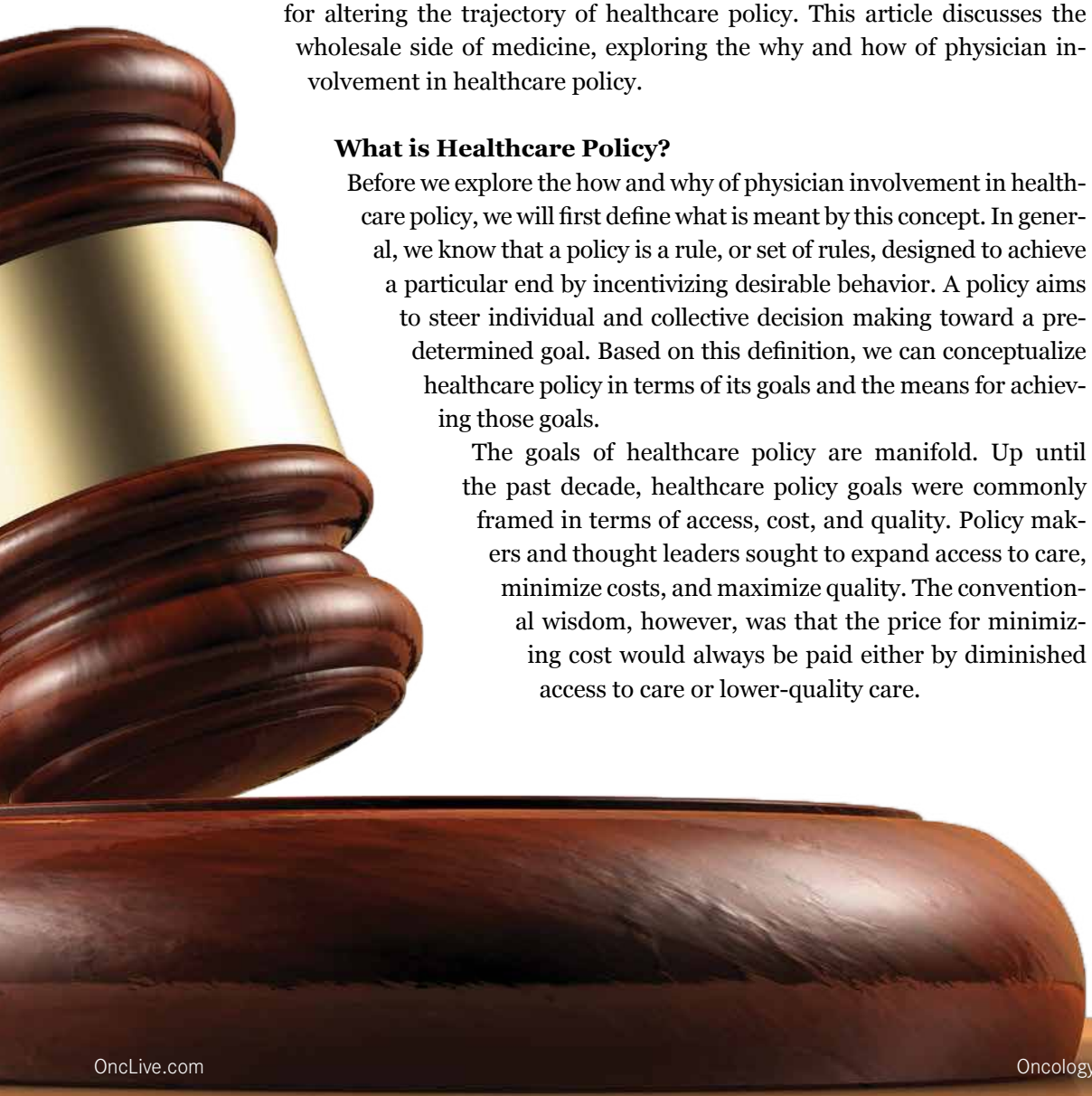
Physician Engagement in Healthcare Policy

By C.J. Stimson, MD, JD

For more articles, go to
www.OncLive.com/publications/
oncology-fellows

There are 2 types of medical practice: retail and wholesale. Retail medicine occurs at the individual patient level in clinics, operating rooms, and hospital wards where physicians and patients work together to prevent and cure disease. Wholesale medicine, in contrast, occurs at the population and healthcare system levels, where policy makers set the rules that govern the retail practice of medicine.

Physician engagement in the political process is an important mechanism for altering the trajectory of healthcare policy. This article discusses the wholesale side of medicine, exploring the why and how of physician involvement in healthcare policy.



What is Healthcare Policy?

Before we explore the how and why of physician involvement in healthcare policy, we will first define what is meant by this concept. In general, we know that a policy is a rule, or set of rules, designed to achieve a particular end by incentivizing desirable behavior. A policy aims to steer individual and collective decision making toward a predetermined goal. Based on this definition, we can conceptualize healthcare policy in terms of its goals and the means for achieving those goals.

The goals of healthcare policy are manifold. Up until the past decade, healthcare policy goals were commonly framed in terms of access, cost, and quality. Policy makers and thought leaders sought to expand access to care, minimize costs, and maximize quality. The conventional wisdom, however, was that the price for minimizing cost would always be paid either by diminished access to care or lower-quality care.

The past decade has seen an evolution in the framing of these healthcare policy goals. Borrowing from longstanding principles in management science, "value" has become the focus of healthcare policy. Defined by a direct relationship with quality and an inverse relationship with cost (value ≈ quality/cost), this new value era in healthcare has combined the aforementioned policy goals of minimizing cost and maximizing quality into a single policy target. Framed in this way, the goal of healthcare policy is to maximize the value of healthcare such that it is worth expanding access to healthcare.

ABOUT THE AUTHOR

C.J. Stimson, MD, JD, is the Warburton-Jewett fellow in Urologic Oncology at the James Buchanan Brady Urological Institute of Johns Hopkins Hospital.

But if the goal of healthcare policy is to maximize value, the next question is, "Value for whom?" The constituents of healthcare policy makers include patients, providers, payers, and purchasers, and these highly integrated and related groups can have highly disparate perceptions of value. For example, for patients—the majority of whom are responsible for only a fraction of the total cost of their healthcare consumption—the value proposition is largely centered on maximizing quality. In contrast, payers (eg, private insurance companies) and purchasers (eg, employers that purchase healthcare services or health insurance on behalf of their employees) are more cost-sensitive.

Some providers, particularly physicians, have professional obligations to healthcare quality and patient welfare that must be balanced against the financial realities of managing a practice; however, other providers, such as hospitals, are not bound by professional obligations, but must deliver care in a manner that preserves operating margins. And while it may be appealing, often appropriate, and always politically expedient to elevate patient notions of value above all others, the answer to the question, "Value for whom?" must be an inclusive one. With this understanding of value, its multiple dimensions, and its place in the goals of healthcare policy, we now have an outstanding opportunity to explore how the next generation of physicians can engage and influence the value conversation in healthcare policy.

The means by which policy achieves its ends are rules that can influence the behavior of both individuals and the systems of which they are a part. For a rule to effectively influence behavior, it must be enforceable, and to be enforceable, it must be backed by the force of the law. This can occur in the setting of legally enforceable contracts between private parties, judicial rulings, legislative statutes, or administrative regulations. Legislation and regulation can occur at both the federal and state levels.

The opportunity for physicians to influence healthcare policy—both in its goals and the rules to achieve those goals—is greatest at the federal and state levels, where legislatures enact healthcare legislation and administrative agencies (ie, regulators) execute the legislation through a process called rulemaking. This is, in large part, due to federal and state government programs that provide health insurance coverage under Medicare, Medicaid, and the State Children's Health Insurance Program. In administering these programs, federal and state policy makers not only influence the policies that govern the delivery of care for more than 40% of the US population (more than 130 million beneficiaries are enrolled in these programs),[1-3] but they also influence the behavior of private healthcare entities, such as insurance companies, hospital systems, and physician group practices.

To illustrate the lifecycle of the legislative and regulatory process that culminates in healthcare policy, consider the following example: In 2010, President Obama signed the Affordable Care Act (ACA), which had been passed by Congress. The ACA, a broad and

There Can Only Be One Best.

We're proud to announce that

cure Connections®

has been selected as the
2016 min Magazine Media Awards'

Best Video Series

Real people expressing their feelings, fears and hopes.

An opportunity to hear cancer patients, along with their families and loved ones, speaking openly about their experiences is a click away. These discussions will address many of your patients' questions, helping them prepare for the journey ahead.

curetoday.com

A patient video series brought to you by cure® magazine, the premiere BPA-audited, direct-to-patient oncology publication.

BPA WORLDWIDE CONSUMER

Visit **curetoday.com** and subscribe to receive the latest video updates.

sweeping piece of legislation, directed the executive branch to promulgate a variety of regulations. One of the directives from the legislation was to create an "innovation center" within Medicare that would be responsible for developing and testing new policies for paying physicians, hospitals, and other care providers.[4] Based on this legislative mandate, and with a $10-billion appropriation over 10 years, the Center for Medicare and Medicaid Innovation (CMMI) was established in 2011. To date, CMMI has implemented dozens of payment models. One of the most recently proposed payment models includes the Medicare Part B Drugs Payment Model, published in the Federal Register in March 2016, which directly impacts how medical oncologists and other physicians are paid for delivering medications, including chemotherapy, in their offices or hospital outpatient settings.[5]

> **"Although it is impossible to know what the final policy would have been without an organized response from orthopedic surgeons, it is highly unlikely that CMMI would have modified the proposed rule without input from providers."**

Why Does This Matter to Physicians?

Physicians need to engage in healthcare policy because it has altered, and will continue to fundamentally alter, the practice of medicine. Seminal moments in the history of healthcare policy, including the creation of Medicare and Medicaid in 1965,[6] the Medicare transition to a hospital inpatient prospective payment system in 1983,[7] the development of the New York state clinical registry for cardiac surgery in 1989,[8] and many others, continue to have a significant impact today. Without real-world input from the physician community, we risk letting policy development occur in a vacuum, almost certainly resulting in disruptive and detrimental downstream consequences in healthcare delivery.

To illustrate the impact of involvement in the healthcare policy process, consider the Comprehensive Care for Joint Replacement (CJR) model.[9] This bundled payment model was proposed by CMMI, in July 2015 and finalized in November of the same year. The payment model is a mandatory 5-year program that bundles the hospital, physician, and post–acute care provider costs over a 90-day period for total hip and knee replacements. Hospitals in the model that perform a hip or knee replacement will be financially responsible for all related Medicare spending in the 90 days following discharge. If 90-day episode spending exceeds prospective target prices, then these hospitals may owe Medicare a repayment amount. However, if this spending is less than the prospectively set target prices, these hospitals may receive a portion of that savings.[10]

The proposed CJR rule did not incorporate any clinical risk stratification in the bundled payment policies. As a result, hospitals performing hip and knee arthroplasty would receive the same prospective target for patients regardless of the clinical indication for the operation. The response of the orthopedic surgery community to this proposal during the comment period was robust. Hundreds of comments were received by CMMI, particularly regarding the lack of any clinical risk-stratification. In response to this physician engagement during the regulatory notice and comment period, the final CJR rule was published with a risk-stratified payment methodology based on the presence of hip fracture. CMMI listened to the response from the physician community, confirmed that the need for adjusting target prices based on the presence of absence of hip fracture was sup-

For more articles, go to
www.OncLive.com/publications/oncology-fellows

ported by claims data, and then changed the final policy in response.[11]

Although it is impossible to know what the final policy would have been without an organized response from orthopedic surgeons, it is highly unlikely that CMMI would have modified the proposed rule without input from providers.

The CJR rulemaking experience proves that physician involvement in the healthcare policy process matters and that such engagement can result in better policy making.

How Can We Get Involved?

Given this understanding of what healthcare policy means and why it matters, I close with a series of recommendations on how physicians can get involved in shaping future policies. The basic principle is to make your voice heard. So, the question is, how do we do this? There are 3 general approaches that all physicians can take to influence the trajectory of healthcare policy (see **Sidebar**).

First, get involved in the advocacy efforts of your professional society. Professional societies are uniquely positioned to advocate effectively on behalf of physicians and their patients. These organizations are typically well funded and staffed with skilled personnel who are dedicated to monitoring and responding to healthcare policy developments. This staff expertise translates into more effective and efficient advocacy strategies than can be achieved by individual physicians alone augmenting the policy impact of these efforts. In the CJR discussion above, for example, the organized response of orthopedic specialty societies allowed for a more rapid and appropriately messaged response than could be achieved by individual surgeons. The advocacy arms of these organizations are typically located in proximity to the federal legislative offices and executive agencies such that they can respond to urgent policy concerns in a timely and face-to-face fashion.

> **"The consequences of elections and the political milieus that follow are going to play an increasingly larger role in how we deliver care to our patients. If we choose to ignore this reality, the process will move forward without considering us or our interests."**

Having argued for increased involvement in professional society advocacy efforts, it is important to address a common physician concern: that the policy priorities of physicians and the organizations that represent them are not in alignment. Some physicians believe that the policy platforms promoted by their professional societies do not address the policy burdens borne by physicians in daily practice in the clinic and the operating room. Although it is reasonable to object to the policy priorities being advanced by professional societies, the appropriate response should be further engagement—not less. The policy platforms of specialty societies are built by individuals, not by organizations. As a result, these platforms can be restructured, a process that can only result from member engagement, not disengagement.

Cultivating relationships with elected officials and their staff is another important avenue for physician engagement in healthcare policy. Members of Congress have significant authority over healthcare policy through both the passage of legislation and oversight of the administrative agencies that execute legislation. These legislators, however, must be responsive to the full spectrum of public policy and are, therefore, rarely experts in the issues faced by physicians. This presents an opportunity

for physicians, a highly respected voting block of constituents, to step in as subject matter experts who can support the healthcare policy efforts of their elected officials. Additionally, connecting with a legislator's staff can facilitate ongoing communication with those members of the legislative team specifically tasked with healthcare policy issues.

Finally, physician engagement in the political process is an important mechanism for altering the trajectory of healthcare policy. Politics is a messy game, and physicians are justifiably reticent to engage in this space. The merit-based system of medicine that starts with competitive admission to medical school continues with matching in residency and fellowship and culminates in a successful practice at odds with the retail politicking and glad-handing that define the political process. Wanting to remain unsullied, many physicians simply refuse to participate. Although there is merit in this position, there is a practical reality that we, as physicians, must confront. The consequences of elections and the political milieus that follow are going to play an increasingly larger role in how we deliver care to our patients. If we choose to ignore this reality, the process will move forward without considering us or our interests. However, if we choose to participate in the political process, we can shape the political landscape and clear a viable path for effectuating our healthcare policy goals.

Sidebar. How Physicians Can Get Involved in Shaping Future Policies

- ☑ Participate in the advocacy efforts of professional societies
- ☑ Cultivate relationships to ensure that policy makers will listen to what you have to say
- ☑ Engage in the political process and support representatives who are sympathetic to your positions

Closing Thoughts

Physicians need to engage in healthcare policy, and there are several ways to become involved. Whether through engaging with professional societies, cultivating relationships with legislators, or becoming active in the political process, physicians can influence the rules that govern how we practice. We know that wholesale medicine matters, now we just have to own it. •

REFERENCES

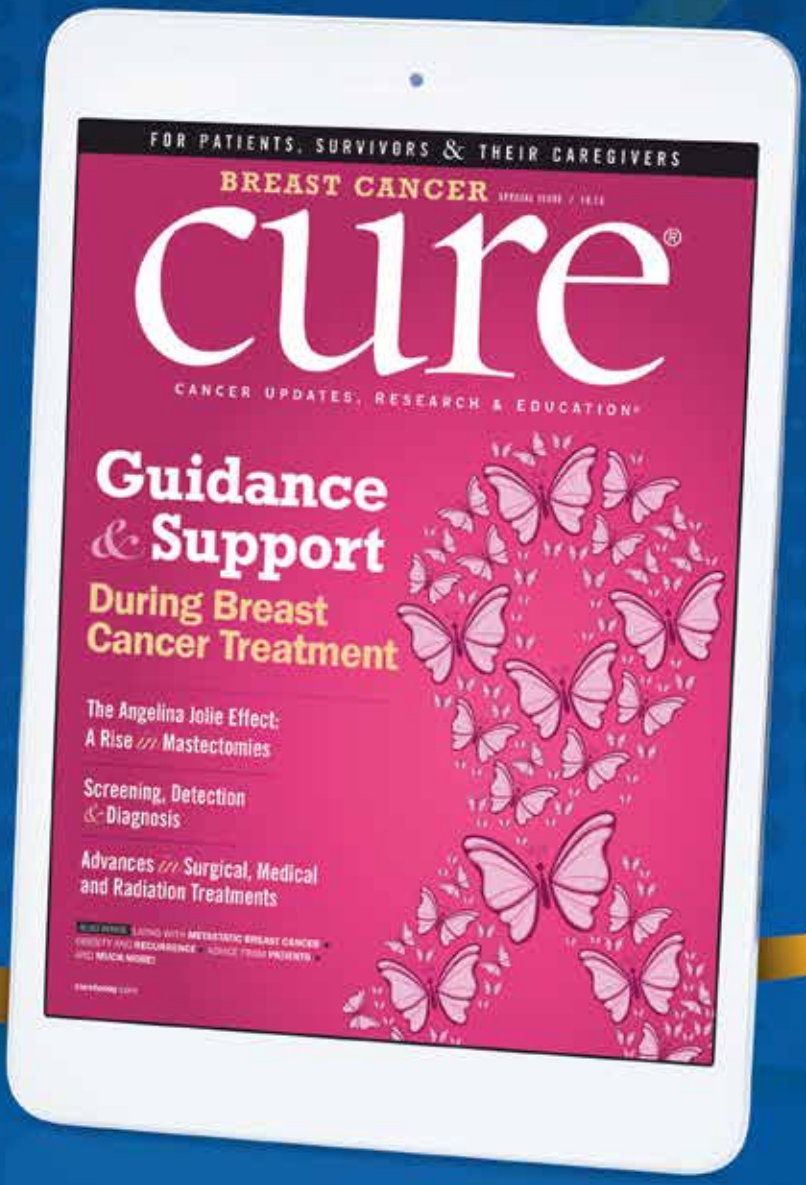
1. Total number of Medicare beneficiaries: timeframe: 2015. The Henry J. Kaiser Family Foundation website. http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/. Accessed August 15, 2016.
2. Medicaid enrollment by age: timeframe: FY2011. The Henry J. Kaiser Family Foundation website. http://kff.org/medicaid/state-indicator/medicaid-enrollment-by-age/. Accessed August 15, 2016.
3. Total number of children ever enrolled in CHIP annually: timeframe: FY2014. The Henry J. Kaiser Family Foundation website. http://kff.org/other/state-indicator/annual-chip-enrollment/. Accessed August 15, 2016.
4. Berenson RA, Cafarella N. The Center for Medicare and Medicaid Innovation: activity on many fronts. Robert Wood Johnson Foundation website. www.rwjf.org/en/library/research/2012/02/the-center-for-medicare-and-medicaid-innovation.html. Published February 12, 2016. Accessed August 15, 2016.
5. Medicare Part B drugs payment Model. CMS.gov website. https://innovation.cms.gov/initiatives/part-b-drugs. Accessed August 15, 2016.
6. Starr P. The health-care legacy of the great society. In: Glickman NJ. *Reshaping the Federal Government: The Policy and Management Legacies of the Johnson Years*. Princeton, NJ: Princeton Unviersity. Princeton University website. www.princeton.edu/~starr/articles/articles14/Starr_LBJ_HC_Legacy_1-2014.pdf. Accessed August 15, 2016.
7. A framework for evaluation: predicted effects of Medicare's prospective payment system. Princeton University website. www.princeton.edu/~ota/disk2/1985/8516/851604.PDF. Accessed August 15, 2016.
8. Hannan EL, Cozzens K, King SB 3rd, Walford G, Shah NR. The New York State cardiac registries: history, contributions, limitations, and lessons for future efforts to assess and publicly report healthcare outcomes. *J Am Coll Cardiol*. 2012;59(25):2309-2316. doi: 10.1016/j.jacc.2011.12.051.
9. Mechanic RE. Mandatory Medicare bundled payment–is it ready for prime time? *N Engl J Med*. 2015;373(14):1291-1293. doi: 10.1056/NEJMp1509155.
10. Comprehensive Care for Joint Replacement model. CMS website. https://innovation.cms.gov/initiatives/CJR. Accessed August 15, 2016.
11. Medicare program: Comprehensive Care for Joint Replacement Payment model for acute care hospitals furnishing lower extremity joint replacement services: a rule by the Centers for Medicare & Medicaid Services on 11/24/2015. Federal Register website. www.federalregister.gov/articles/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals. Published November 24, 2015. Accessed August 15, 2016.

Win a FREE iPad!

Sign up someone you know to receive a free *CURE*® Magazine subscription, and you could win an iPad!

Now that you have discovered the benefit of reading *CURE* for yourself, don't you wish someone had shared it with you at the time you were diagnosed with cancer?

Four times a year, *CURE* magazine will select one of its readers who has referred a friend to receive a free Apple iPad. The more friends referred, the more chances to win! Visit **GetCureNow.com/Refer** to refer a friend and enter a chance to win.



cure®

GetCureNow.com/Refer

2016-2017 Oncology & Hematology Meetings

September 30-October 1, 2016
National Comprehensive Cancer Network (NCCN) 11th Annual Congress: Hematologic Malignancies™
New York, NY
http://bit.ly/1UVkTpO

October 19-22, 2016
48th Congress of the International Society of Paediatric Oncology
Dublin, Ireland
http://bit.ly/1YmLWgW

November 3-5, 2016
14th Annual School of Breast Oncology®
Atlanta, GA
http://bit.ly/1LLY7BS

November 9-11, 2016
34th Annual Chemotherapy Foundation Symposium: Innovative Cancer Therapy for Tomorrow®
New York, NY
http://bit.ly/21VWGoL

November 12, 2016
11th Annual New York Lung Cancer Symposium®
New York, NY
http://bit.ly/1W3edaY

December 4-7, 2016
17th International Association for the Study of Lung Cancer (IASLC) World Conference on Lung Cancer
Vienna, Austria
http://bit.ly/1U7eytU

December 6-10, 2016
2016 San Antonio Breast Cancer Symposium
San Antonio, TX
http://bit.ly/1HtTtRH

December 10, 2016
1st Annual International Congress on Immunotherapies in Cancer™: Focus on Practice-Changing Application
New York, NY
http://bit.ly/21h1Yc3

January 19-21, 2017
2017 Gastrointestinal Cancers Symposium
San Francisco, CA
http://bit.ly/1tYJsJv

January 27-28, 2017
Cancer Survivorship Symposium: Advancing Care and Research
San Diego, CA
http://bit.ly/1Kimr8C

February 11, 2017
13th Annual International Symposium on Melanoma and Other Cutaneous Malignancies
Sunny Isles Beach, FL
http://bit.ly/2bBR2sB

February 16-18, 2017
2017 Genitourinary Cancers Symposium
Orlando, FL
http://bit.ly/1a9KmFf

ON THE WEB

OncLive®

For coverage from the latest oncology/hematology conferences, visit **onclive.com/conference-coverage**

ON THE WEB

PER® Physicians' Education Resource, LLC

For information on upcoming CME-accredited conferences, visit **gotoper.com**

MOBILE MEDICINE: APPS FOR THE HEALTHCARE PROFESSIONAL

e-ESO: European School Oncology
PRICE: Free
PLATFORMS: Android, iPhone, iPad, and iPod touch

The e-ESO mobile app, offered by the European School of Oncology in cooperation with Nature Reviews in Clinical Oncology and Critical Reviews in Oncology Hematology, provides a series of distance-learning programs on the Internet called "e-sessions." The e-sessions, many of which are CME-accredited, offer students and practicing professionals comprehensive overviews on specific topics relevant to diagnosing and treating patients with cancer.
http://bit.ly/2bjWjQv

WM Hematology Subspecialty
PRICE: $49.99
PLATFORMS: Android

Based on information from the Washington Manual *Hematology and Oncology Subspecialty Consult*, 3rd edition, the WM Hematology Subspecialty mobile app is suggested as a practical reference for fellows, residents, and medical students rotating on hematology and oncology subspecialty services. The app provides quick access to the essential data needed to evaluate a patient on a hematology and oncology subspecialty consult service, and the content is authored by hematology-oncology fellows or internal medicine residents who have recent experience with the issues and questions that arise throughout the course of training.
http://bit.ly/2aXVGgg

ASCO Flashcards: Drug Toxicities
PRICE: Free
PLATFORMS: Android, Blackberry, iPhone, iPad, iPod touch, Windows

The American Society of Clinical Oncology (ASCO) Flashcards: Drug Toxicities app provides users with more than 50 digital flashcards related to chemotherapy toxicities. Six classes of chemotherapy agents are covered. Designed to help fellows and advanced practice providers master concepts related to improving the treatment and management of patients with cancer, the flashcards are organized by chapter (deck), and users receive a personalized score following completion of each deck.
http://bit.ly/2aVTOJ7

Lab Values Reference
PRICE: $3.99
PLATFORMS: Android, iPhone, iPad, and iPod touch

The Lab Values Reference app is useful in both academic and clinical settings, as it provides concise information on more than 370 commonly performed laboratory tests. The app provides suggestions on conditions related to abnormal lab values, explanations of tests, links to outside references, an overview of order of draw, and a user-friendly notes section.
http://bit.ly/2aVQr4y

EventPilot Conference App
PRICE: Free
PLATFORMS: Android, iPhone, iPad, and iPod touch

The EventPilot Conference app is a universal resource that gives professionals access to an entire meeting or event program. Users can use the app to construct a personal daily agenda, stay informed about program changes or information on an upcoming session, connect with other attendees, take notes on exhibitors, and download available presentations. No WiFi connection is required to access a conference program, schedule, or animated map.
http://bit.ly/1yNzFUe or http://apple.co/2bIgQHe

For more articles, go to www.OncLive.com/publications/oncology-fellows

Oncology Career Outlook

According to *Medscape*'s Oncologist Compensation Report 2016, salaries for healthcare professionals practicing in oncology have increased by 8%, placing oncology as the fourth highest paying medical field among those listed in the report. Suggested reasons for the increase in pay include a rise in patient volume, longer hours worked, salary raises, and changes in career paths.[1]

The report, which is based on a survey of 19,183 physicians practicing in 26 specialties conducted between November 2015 and February 2016, further revealed that professionals currently working in an outpatient clinic setting reported the highest salaries ($453,000). Other high-earning oncology settings include office-based, single-specialty group practices, and healthcare organizations (see **Table**).[1]

For those pursuing a career in oncology, this latest report demonstrates a promising future in the profession. It's never too early to begin planning your career path. Try to make decisions about where you'll end up in the field as early in fellowship training as possible. •

"An aging population and better treatments will lead to greater demands on the oncology workforce."

- Peter Yu, MD, American Society of Clinical Oncology[2]

Table. Oncology Compensations By Setting[1]

Oncology Setting	Salary
Outpatient clinic	$453,000
Office-based, single-specialty group practice	$391,000
Healthcare organization	$357,000
Office-based, multispecialty group practice	$357,000
Hospital	$305,000
Office-based, private practice	$305,000
Academic, research, military, government	$211,000

REFERENCES

1. Peckham C. *Medscape* oncologist compensation report 2016. *Medscape* website. www.medscape.com/features/slideshow/compensation/2016/oncology. Published April 1, 2016. Accessed August 18, 2016.
2. Stern V. Does oncology have a recruitment problem? *Medscape* website. www.medscape.com/viewarticle/836555. Published December 16, 2014. Accessed August 18, 2016.

ONCOLOGY FELLOWS

CALL *for* PAPERS

We welcome submissions to ***Oncology Fellows***, a publication that speaks directly to the issues that matter most to hematology/oncology fellows at all stages of training. ***Oncology Fellows*** aims to provide timely and practical information that is geared toward fellows from a professional and lifestyle standpoint—from opportunities that await them after the conclusion of their fellowship training to information on what their colleagues and peers are doing and thinking right now.

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

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

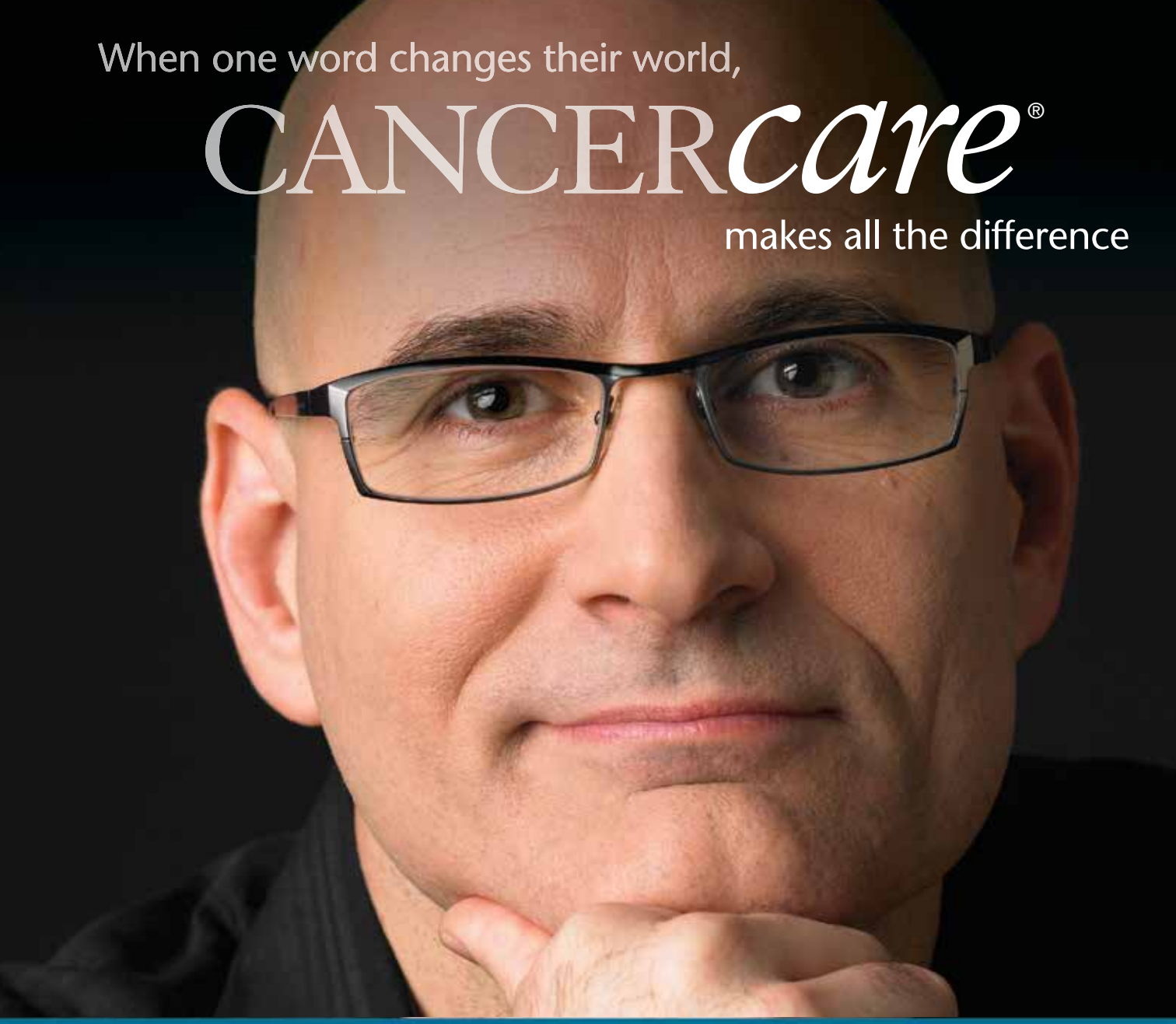
- **Lifestyle and general interest** articles pertaining to fellows at all stages of training.
- **A Word From Your Fellows:** articles written by current fellows describing their thoughts and opinions on various topics.
- **Transitions:** articles written by oncology professionals that provide career-related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

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

Learn more about Oncology Fellows at:
www.onclive.com/publications/oncology-fellows

If you are interested in contributing an article to ***Oncology Fellows*** or would like more information, please e-mail Jeanne Linke at **jlinke@clinicalcomm.com**.

OncLive®.com



With Cancer*Care*, the difference comes from:

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

For needs that go beyond medical care, refer your patients and their loved ones to Cancer*Care*.

Cancer*Care*'s free services help people cope with the emotional and practical concerns arising from a cancer diagnosis and are integral to the standard of care for all cancer patients, as recommended by the **Institute of Medicine**.

CANCERcare®
Help and Hope

1-800-813-HOPE (4673)

www.cancercare.org