Volume 2 • Issue 2, December 2010

ONCOLOGY FELLOWS

City Oncologist, *Country Oncologist*

What to consider when choosing to practice in a rural setting

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Interested in contributing to *Oncology Fellows?* If you'd like to submit an article for consideration in an upcoming issue, please e-mail John Eichorn at jeichorn@onclive.com.

Cover Story

City Oncologist, Country Oncologist

By Robert Warner, MD

The story of the city mouse and the country mouse is a popular Aesop's fable for children that concludes, "A modest life of peace and quiet is better than a richly one with danger and strife." Is that the choice an oncologist makes when he chooses where to practice? Is the life of a country oncologist quieter and less intense, while the city oncologist's life is noisier and more stressful?

First, it's important to note that few oncologists have practiced in both an urban and a rural practice, so it is difficult to find one physician who can tell both sides of the story. I have practiced in Council Bluffs, Iowa, (population 60,000) for almost 25 years, and my office is about 20 feet from where I was born, so I can tell you what it is like to be a country oncologist.

The view from my "porch"

I practice in a five-physician group. We are not the only practice in town, but we are the largest. Sadly, oncologists rarely suffer from lack of patients, so it is probably just as easy to have a full patient roster in a small town as it is in New York City. Additionally, we have 10 satellite offices in the communities surrounding Council Bluffs.

Even in Corning, Iowa, the site of our farthest satellite, where the town population is about 2000, we have a local oncology-trained nurse who works with us and a local hospital to support our patients. The community is grateful for the care we provide, so treating those patients is especially rewarding. The other small communities we serve are similar in their support of the practice and the services available for patients. And for the patients who would never make the drive to Council Bluffs (a big city by their standards), providing local care is an ideal solution.

I regularly see my patients outside of the office. Almost once a day I run into a patient—at the gas station, post office, or a high school football game. If I am in the smaller communities, I'm almost guaranteed to cross paths with a patient. My life as a rural physician is not an anonymous one.

My longest commute is the three-hour drive to and from our farthest satellite office. I could have a driver and use the time for paperwork (though my nature would be to talk rather than work), but most often I drive myself and listen to books on tape. When I arrive home, I am rested; I no longer need to "decompress," and the remainder of my day is mine. When my children, who are now in college, were younger, I did not miss a concert, sports event, or parent-teacher conference. I even have the option of flying my small plane to an outlying office, which likely would be a financial and logistical impossibility in an urban practice.

"When I arrive home, I am rested; I no longer need to 'decompress,' and the remainder of my day is mine."

I consult with my partners when developing a treatment plan for a patient or when a patient is not responding as I had expected. With the advent of the Internet, imaging results online, and electronic medical records, I can also easily consult with a colleague hundreds or thousands of miles away.

My rotation on call is less frequent now, but it was not unreasonable even in the early days. I spoke recently with a colleague who is a solo practitioner in Wyoming. He has been on call for 8 years because he is the only oncologist in his town. When asked how disruptive it was to his family life, he remarked that it was a problem when he wanted a vacation. Beyond that, there were calls that came at inopportune times and calls that were no disruption at all.

Some patients in rural communities will travel to the large, famous cancer treatment facilities around the country, often for a confirming diagnosis. My experience has been that when a patient receives a confirmation of the diagnosis I have made, he or she is reassured, and our relationship improves. I have never felt minimized.

Lifestyle differences

So then, if being an oncologist in the country or city is similar once the examination room door closes, what is the difference? The difference is lifestyle. In Council Bluffs, for example, a $250,000 house is a big house. Dinner for four at one of the better restaurants is under $100. The numbers may be smaller, but the life is not smaller. If you want to live on an acre or more of land but do not want the longer daily commute that it would require in Chicago or Denver, a rural practice may be for you.

However, I would be remiss if I didn't mention that there are trade-offs. While on the popular culture front, books and magazines are as available in a small town as they are anywhere else, movies may open in the theater a week or two later, and finding legitimate theater may be a challenge. Regarding practical issues, worries about traffic, parking space availability, and long commutes are not daily concerns.

As mentioned, a physician practicing in a remote corner of America has easy access to the medical community far beyond his or her town via modern technology. The days of a rural physician being isolated are long gone.

A family decision

A professor once told me, "When you are deciding on where to practice, bring your spouse. You will close the door and could be anywhere, but your spouse will have to live each day in the community you choose." That may be one of the more important lessons I learned in medical school. The choice of where to practice is a family decision, not an individual one.

Local education is a big consideration. It's important to investigate the schools in a town that you're considering relocating to if you have a family or plan to have one in the future. However, the days of small-town education being small or inadequate are gone. Medical schools are full of the sons and daughters of rural physicians who received a quality education at small-town high schools, attended first-class universities, and went on to some of the best medical schools in the country. My daughters are both at a nationally ranked university with plans to attend medical school; I have no doubt that they will get in. (I have not asked where they intend to practice, but I can guess.)

A bigger issue may be employment for a physician's spouse. Depending on his or her field of expertise, this may present the most significant logistical issue. Fortunately, many universities are in smaller cities and towns, telecommuting has made working from a remote office a viable option, and opportunities are more plentiful than they once were. It was not the case for me, but I suspect that for some, asking one's spouse to give up a career is a lot to ask. Perhaps *too* much to ask. I doubt that there are any hard data on the subject, but the high incidence of a spouse working as practice managers, at least in the early days, may represent a common solution to the career question.

Just as visibility for a physician in a small town is greater, so is visibility for a physician's spouse and family. For my family, it's simply been a fact of life that hasn't had a negative impact on their daily lives. At least, not any that I've heard about!

Factors to consider

As you complete your fellowship, you'll begin the process of determining where to practice. What factors should you consider?

Economics can play a role. Many rural practices, especially oncology practices, are experiencing

difficulties because of under-reimbursement and patients' inability to pay deductibles and copays. These issues are compounded for an oncology practice because of the high cost of cancer drugs and can often be so severe as to threaten the financial survival of the practice. When finances interfere with the ability to deliver care or with a patient's ability to pay for care, physicians can find themselves dealing with issues beyond that of a clinical nature. Recent healthcare reform legislation does not provide any relief to this problem.

I don't need to tell you about interviewing the physician practice you may be considering; that is an obvious and important part of your decision. The culture of a practice is a product of the people and personalities within it, so you will need to project how you may see yourself interacting with them. Ultimately, your satisfaction and happiness will come as much from the practice environment itself as from the geographical location.

An important factor to consider is pace—the pace of your practice and the pace of your life. If you view rural/small-city oncology and rural/small-city living as slow, dull, and lacking more than it offers, it's not for you. However, if city life leaves you feeling breathless and stressed, the nonurban option may be a good fit.

Get to know a town close up

Spend some time in the community you are considering beyond the time you would spend in the practice. Go to the schools, grocery store, hardware store, and department store. Check out the local movie theaters and libraries. Eat in the best restaurant in town and in the local diner. Read the local newspaper; better yet, subscribe for several months prior to visiting the community to see what's going on around town. Find out how far it is to the nearest airport or Amtrak station. Check flight availability to the places you'll likely want to travel. For example, Greenville, South Carolina, is a lovely rural community with a temperate climate and easy access to the Smoky Mountains. It is probably a great place to live. It is also one of the most expensive cities to fly to and from because of its limited air service.

This last suggestion is decidedly low-tech but still one of the most practical: Make a list of the pros and cons of each option. Make lists of what you will gain and what you will give up in small-town living. Make lists of what you want—shopping, nightlife, open land, or blue skies—and what you feel you cannot live without. Soon the choice will become obvious.

If you choose rural oncology, good for you. And welcome!

Robert Warner, MD, is a practicing oncologist in Council Bluffs, Iowa.

Federal and State Incentive Programs for Rural Physicians

The United States Department of Health and Human Services estimates that 50 million Americans lack ready access to primary health care, and that number is expected to increase in coming years.[1] To help address this critical shortage, both federal and state incentive programs offer full or partial repayment of student loans to physicians agreeing to work for specified periods of time in underserved locations, known as health professional shortage areas (HPSAs). Most programs are open to physicians who serve patients in both rural and urban HPSAs.

Programs vary by the amounts awarded, the number of hours and weeks a physician must practice to earn the award, and may require employment with a nonprofit healthcare facility, establishment of a sliding scale fee schedule, or acceptance of specific insurance coverage options, such as Medicare or Medicaid, in order to be eligible.

Below are some of the major repayment and incentive programs available to physicians through federal or state agencies. Individual states or healthcare agencies may offer additional incentive programs, as well.

National Health Service Corps (NHSC) Loan Repayment Program
The NHSC program offers $50,000 in exchange for a 2-year, full-time service commitment or a 4-year, part-time commitment. Physicians must be employed by, or have applied to, a site that has been approved by the NHSC.
http://nhsc.bhpr.hrsa.gov/loanrepayment

Arizona
Arizona Rural Private Primary Care Provider Loan Repayment Program offers up to $25,000 each year for up to 4 years to allopathic or osteopathic physicians, as well as dentists.
www.azdhs.gov/hsd/az_rural_private_loan_repayment.htm

Arkansas
The Community Match Rural Physician Recruitment Program offers $80,000 to physicians who are Arkansas residents and who agree to practice in designated communities for 4 years. The funds are paid by both the state and the community in which the physician practices.
www.uams.edu/com/ruralprograms/communityrecruitment.asp

California
The Steven M. Thompson Physician Corps Loan Repayment Program offers up to $105,000 for a 3-year practice commitment.
www.oshpd.ca.gov/HPEF/STLRP.html

Colorado
The Colorado Health Foundation's Physician Loan Repayment Program offers up to $50,000 annually for a 3-year commitment.
www.coruralhealth.org/programs/loanrepayment/tchf-plrp.htm

The State Health Care Professional Loan Repayment Program offers $35,000 annually for a 2- to 3-year practice commitment.
www.cdphe.state.co.us/pp/primarycare/chsc

Delaware
The State Loan Repayment Program offers up to $70,000 for physicians agreeing to practice for 2 years; optional extensions are available to qualified physicians as funds allow, up to a 4-year maximum.
http://dhss.delaware.gov/dhss/dhcc/slrp.html

Georgia
The Georgia Physician Loan Repayment Program offers $25,000 per year to physicians who agree to practice in designated communities for at least 2 years.
www.mcg.edu/students/finaid/PDF/LPR.pdf

Illinois
The Illinois National Health Service Corps State Loan Repayment Program offers up to $25,000 annually for a minimum 2-year commitment, and up to $35,000 annually for a third and fourth year.
http://services.aamc.org/fed_loan_pub/index.cfm?fuseaction=public.program&program_id=16

Iowa
The state's Primary Care Recruitment and Retention Endeavor offers up to $30,000 per year to physicians agreeing to a 2-year service contract.
www.idph.state.ia.us/hpcdp/primecarre.asp

The Osteopathic Physician Recruitment Program offers up to $100,000 in loan repayment funds in return for a 4-year commitment to practice in a designated area in Iowa.
www.dmu.edu/fa/scholarship_info/do/oprp

Kansas
The Kansas State Loan Repayment Program offers up to $30,000 each year to both physicians and dentists who agree to practice for a minimum of 2 years.
www.kdheks.gov/olrh/download/SLRP_Overview.pdf

Kentucky
The Kentucky State Loan Repayment Program offers up to $35,000 each year to physicians agreeing to practice in their area for at least 2 years.
www.mc.uky.edu/RuralHealth/slrp.asp

The Rural Kentucky Medical Scholarship Fund Establish Practice Grant Program offers $110,000 payable over 7 years to physicians practicing in designated areas.
www.kyma.org/content.asp?q_areaprimaryid=5&q_areasecondaryid=4&q_areatertiaryid=6

Louisiana
The State Loan Repayment Program offers up to $18,000 each year for a 2-year commitment, and up to $20,000 per year for a 3-year commitment.
www.dhh.louisiana.gov/offices/page.asp?ID=88&Detail=4986

Maine
The State Loan Repayment Program offers up to $25,000 per year for loan repayment to physicians agreeing to serve for at least 2 years; when available to qualified applicants, the funding may be extended for additional third and fourth years.
www.maine.gov/dhhs/boh/orhpc/SLRPSUMM.htm

Maryland
The state's Loan Assistance Repayment Program offers up to $30,000 each year for up to 4 years.
www.mhec.state.md.us/financialAid/ProgramDescriptions/prog_larppcs.asp

Michigan
The Michigan State Loan Repayment Program offers up to $25,000 per year for physicians agreeing to practice in their areas for 2 years.
www.michigan.gov/mdch/0,1607,7-132-2945_40012-135399--,00.html

Minnesota
The Minnesota Rural Physician Loan Forgiveness Program offers up to $25,000 each year up to a maximum of $100,000 total, and requires an initial commitment of three years. Recipients must agree to work at least 30 hours per week for 45 weeks each year during the funding period.
www.health.state.mn.us/divs/orhpc/funding/loans/ruralphys.html

The Minnesota State Loan repayment Program offers up to $20,000 annually for loan repayment to physicians who agree to practice for at least 2 years.
www.health.state.mn.us/divs/orhpc/funding/loans/state.html

Missouri
The Health Professional Loan Repayment program offers physicians up to $25,000 per year for a minimum 2-year commitment.
www.dhss.mo.gov/LoanRepayment/

Montana
The Montana Rural Physician Incentive Program offers up to $100,000 in loan repayment to physicians who agree to practice full-time for up to 5 years. Funds are awarded incrementally every 6 months.
www.mus.edu/mrpip/MRPIP-benefits-obligations.asp

Nebraska
Under the state Loan Repayment Program, physicians may receive up to $40,000 per year for a 3-year practice obligation.
www.hhss.ne.gov/hew/orh/LoansState.htm

Nevada
The Nevada Health Service Corps offers varied funding depending upon available monies, with variable minimum contract requirements generally equaling 2 years.
www.medicine.nevada.edu/cehso/nhsc.html

New Hampshire
The State Loan Repayment Program offers up to $75,000 for a 3-year commitment and up to $27,500 for a 2-year commitment. Both awards may be extended.
www.dhhs.state.nh.us/DHHS/RHPC/slrp.htm

New Jersey
The Primary Care Loan Redemption Program of New Jersey offers up to $120,000 over a 4-year period, with a 2-year minimum contract.
www.umdnj.edu/lrpweb

New Mexico
The Health Professional Loan Repayment Program offers physicians up to $25,000 per year for a minimum 2-year commitment; up to $35,000 may be available to those who practice in a federally designated HPSA.
http://fin.hed.state.nm.us/content.asp?CustComKey=200291&CategoryKey=216320&WebFileKey=216321&pn=webfilesview&DomName=fin.hed.state.nm.us

New York
Doctors Across New York offers loan repayment up to $150,000 during a 5-year commitment period.
www.hanys.org/workforce/dany

North Carolina
The State Loan Repayment Program offers up to $70,000 to physicians who make a 4-year commitment to practice.
www.ncruralhealth.org/services.html#inc1

North Dakota
The State Community Matching Physician Loan Repayment Program offers up to $90,000 for a 2-year practice commitment.
www.ndhealth.gov/OCA/State%20Loan%20Repayment%20Program.pdf

Ohio
The Physician Loan Repayment Program offers up to $25,000 annually for a 2-year commitment, and up to $35,000 annually for third- and fourth-year extensions.
www.odh.ohio.gov/odhprograms/chss/pcrh_programs/recruitment/slrp.aspx

Oklahoma
The Physician Community Match Loan Program offers up to $40,000 for a 3-year practice commitment and up to $20,000 for a 2-year commitment.
www.pmtc.state.ok.us/match1.htm

Oregon
The Oregon Partnership State Loan Repayment Program offers the lesser of up to $30,000 or 25% of total loan debt annually to physicians who make a 2-year practice commitment.
www.ohsu.edu/ohsuedu/outreach/oregonruralhealth/providers/loan_repayment.cfm

Pennsylvania
The Loan Repayment Program offers up to $64,000 for a 3-year commitment.
www.portal.state.pa.us/portal/server.pt/community/primary_care_resources/14194

South Dakota
The State Loan Repayment Program offers physicians up to $35,000 for a 2-year commitment and up to $100,000 total for a commitment of 4 years.
http://doh.sd.gov/RuralHealth/StateLoan.aspx

Tennessee
The Tennessee Rural Health Access Incentive Program offers practice incentive grants of up to $50,000 for physicians serving in specific areas for a period of 3 years. Monies can be used for loan repayment, practice set-up fees, and other approved costs.
http://health.state.tn.us/rural/haip.html

Texas
The Physician Education Loan Repayment Program offers loan repayment of up to $160,000 for physicians agreeing to a 4-year commitment. Prorated awards are available for part-time practitioners.
www.dshs.state.tx.us/chpr/tpco_info.shtm

The Children's Medicaid Loan Repayment Program offers up to $140,000 for physicians providing services to children covered by Medicaid and requires a 4-year commitment.
www.dshs.state.tx.us/chpr/tpco_info.shtm

Vermont
The Vermont Educational Loan Repayment Program for Primary Care Practitioners offers physicians up to $20,000 per year for a maximum of 6 years. Physicians must practice an average of 20 hours minimum per week during the funding period.
www.med.uvm.edu/ahec/downloads/2011_Primary_Care_ELR_Overview.pdf

Virginia
The State Loan Repayment Program offers up to $50,000 for a 2-year practice commitment; up to $85,000 for a 3-year commitment; and up to $120,000 for a 4-year commitment.
www.vdh.state.va.us/healthpolicy/primarycare/incentives/loanrepayment/vlrp-overview.htm

Washington
The State Health Professional Loan repayment Program offers up to $30,000 annually for a minimum contract of 2 years.
www.hecb.wa.gov/paying/waaidprgm/documents/RevGUIDELINESTERMSOFAGREEMENT2011.pdf

Wisconsin
Under the Health Professions Loan Assistance Program, physicians may receive up to $50,000 for a 3-year commitment.
www.worh.org/hplap_info

1. U.S Department of Health and Human Services. National Health Service Corps. Why We Are Here. Available at: http://nhsc.hrsa.gov/about/reports/reauthorization/why.htm. Accessed October 13, 2010.

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Being Your Own Advocate

Patrick W. Cobb, MD

I had never thought of myself as a political operative. I've been an oncologist in Billings, Montana, since 1995. When I was younger, there wasn't much concern about getting reimbursed; you billed and you were paid. As far as my political involvement, it was nearly nonexistent. I never expected to walk the halls of Congress, meet with more than 50 members, and talk to my colleagues about the importance of traveling to Washington, DC, to make sure that our voices were heard. (I remember once bumping into Sen. Max Baucus [D-MT], now chairman of the Senate Finance Committee, in a cafeteria when he was running for re-election in 1996. I had to ask someone, "Isn't that Senator Baucus?")

However, as the current chairman of the Policy Committee and 2008-2010 past-president of the Community Oncology Alliance (COA), which represents more than 2500 oncologists at community cancer clinics, I am now an expert on the advocacy process, and I travel each month to the nation's capital to advocate on behalf of oncologists and our cancer patients.

Why do I do this? Seven years ago, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which changed how doctors are reimbursed by the Centers for Medicare & Medicaid Services (CMS). When payments for chemotherapy administration were reduced, it forced oncologists to take on a new active role. We then established COA to mobilize the oncology community, including physicians, patients, administrators, nurses, and other healthcare providers, to increase awareness on Capitol Hill about how the law was affecting the cancer care delivery system. This has become an increasingly critical role now as oncologists are fighting for the lives of their patients *and* their practices—community cancer clinics, which treat 84% of Americans with cancer.

As the World Health Organization predicted, this year cancer overtook heart disease as the leading cause of death. About 7.6 million people died of cancer in 2008, and about 12.4 million new cases are diagnosed each year, according to a report by the American Cancer Society.[1] The report further states that cancer costs more in productivity and loss of life than AIDS, malaria, the flu, and other diseases that are spread from person to person. Cancer's economic toll was $895 billion in 2008, which is equivalent to 1.5% of the world's gross domestic product.[1]

Although cancer is the number one killer of Americans under age 85, the good news is that cancer survival rates in the U.S. continue to improve. The number of Americans living with cancer is likely to increase with the aging population, more screenings leading to earlier detection, and current treatments allowing patients to live longer. As a result, more oncologists will be needed in the future to administer the treatments to the growing population of patients. It is estimated that by 2020, the country will be 4800 oncologists short.[2] Unfortunately, the state of physician reimbursement has disillusioned many practicing oncologists today about the Medicare system.

Physician reimbursement penalized

Congress has failed to address the Sustainable Growth Rate (SGR), the formula used to calculate payments to physicians annually based on the economy. The intended purpose of this formula was to place constraints on the growth of Medicare. However, it appears that physicians alone are being punished for the increases in Medicare spending, despite the fact that physician reimbursement is a very small part of overall spending. Congress has blocked the cuts each year, and, in December, the seven-month patch will end again.

For the past 6 years, the SGR has reduced Medicare reimbursement for some of the most expensive drugs and services used to care for cancer patients. The CMS Physician Fee Schedule for 2010 cuts even deeper, reducing payment for chemotherapy administration services an additional 5% annually, and up to 20% by 2013. There are additional cuts for cancer diagnostic imaging and physician consultation services. Medical practices cannot continue to provide care when they lose money.

Many community oncology clinics treat patients who cannot afford supplementary insurance and are solely dependent on Medicare. This alone causes financial pressure for oncologists who are already losing money from inadequate reimbursements for drugs and chemotherapy administration, as well as other overhead expenses.

Before the MMA was passed there wasn't as much concern with access to chemotherapy treatments as there is now. That law radically changed how

"For the past 6 years, the SGR has reduced Medicare reimbursement for some of the most expensive drugs and services used to care for cancer patients. The CMS Physician Fee Schedule for 2010 cuts even deeper, reducing payment for chemotherapy administration services an additional 5% annually, and up to 20% by 2013."

we were paid for delivering cancer care. Now we're seeing the full impact of the law, with practices decreasing services and the flight of community oncology clinics to merge with hospitals and larger groups. For some practices, the situation has become even more dire. In the past 3 years, 166 clinics have closed. Since January 2010, 39 community cancer clinics in 15 states across the United States have closed or are in the process of closing because of financial pressures from severe cuts in Medicare reimbursement for cancer care. By the end of the year, the number of clinic closings could double. A cancer clinic serving Selma, Alabama, for nearly 25 years was forced to shut its doors. Now those patients must travel an hour to obtain treatment at a community oncology center in Montgomery.

Practices depend on payments from private insurers to support their business. The COA conducted a study that showed that Medicare reimburses less than half of the cost of providing cancer treatment for patients. Practices take a financial loss every time they give a Medicare patient chemotherapy because of this poor reimbursement. This is not a sustainable business model. We need advocates to help convey to Congress that the cancer delivery system that has been built over the past two decades is quickly falling apart.

"In the past 3 years, 166 clinics have closed. Since January 2010, 39 community cancer clinics in 15 states across the United States have closed or are in the process of closing because of financial pressures from severe cuts in Medicare reimbursement for cancer care. By the end of the year, the number of clinic closings could double."

The mission of the Community Oncology Alliance

Meanwhile, there are a lot of conflicting and competing pressures. There is pressure from the government to hold down costs, and in the private sector, more pressure from insurance companies to contain costs. Oncologists, like other physicians, are frustrated by the entire process. Therefore, we must become our own biggest advocates. Someone has to stand up for patients' access to chemotherapy drugs and the state of cancer care. The best ones to do that are physicians. In the last 7 years since COA was founded to advocate for patients and providers in community oncology clinics, there is a growing number of us who are doing just that.

This brings us to the core of COA's mission. While it is true that oncologists first, and foremost, are responsible for diagnosing and caring for patients with cancer and hematologic disorders, and second, for continuing to increase our knowledge about the disease through clinical and laboratory research, we now have another obligation that is equally as important: We must educate medical students, residents, fellows, and other trainees about how to advocate on behalf of our cause. This includes not only advocating for patients and their families, but advocating for our practices so that we can continue to save the lives of our patients.

COA's mission is to protect patients' access to quality, affordable cancer care across the country. We want to ensure that the nation's cancer care delivery system remains the best in the world. Since COA was established, we have rallied the cancer community—physicians, staff, and patients—to take our message to Capitol Hill. Through political advocacy, we have made an impact.

It is vital that physicians take a leadership role when Medicare or Congress comes out with new rules that affect patient care. We must meet with our local officials and members of Congress. Elected officials, from the U.S. Congress to the state capitals, have a lot on their plates. They cannot be experts on every topic, particularly when it comes to healthcare concerns such as Medicare. They are looking to their constituents for advice, and who better to advise them on healthcare issues than physicians. We must speak up for our patients; if we don't, no one else will.

Of course, here in Montana, it's a lot easier to gain access to members of Congress because they have far fewer constituents than the more heavily populated states. We have senators who are willing to sit down over coffee and talk about the issues. But now I go to Washington, DC, practically every month to meet with members of Congress about issues that impact COA members across the country. I walk the halls of Congress to bring attention to COA's causes.

Get involved in your community

To be an advocate, you don't have to travel to the nation's capital every month. There are many ways that an oncologist can help. COA has a petition, "Stop Cancer Care Cuts," that was distributed to all of the offices of COA members for their patients, administrators, and staff to sign. Then they were to encourage their friends and families to sign. Another COA initiative, "Sit

in My Chair," has been embraced by oncologists. Oncologists invite their members of Congress to come to their clinics and observe patients being treated in an outpatient setting while actually sitting in the doctor's chair. It is a very powerful tool. No single act drives home the importance of community cancer care than being there and seeing firsthand how patients are cared for.

To quote Bush Foundation vice president Pamela Wheelock as she spoke of the mission of their leadership program for medical fellows in October 2009, "Physicians have always been at the forefront of confronting community problems, whether it was by keeping its residents healthy through their daily work of seeing patients or by instituting new community programs—both related to health and with a broader emphasis... [fellows] "must put their courageous leadership skills to work on the questions that face our communities today and in the future."[3]

It is easy to become politically involved in your own community, ranging from attending meetings with congressional staffers and political fundraisers to talking with your patients, family, friends, and neighbors about how the law is affecting Medicare reimbursement. We must spread the word about the negative impact that the MMA is having on cancer patients and their doctors. We must be our own best advocates.

Patrick W. Cobb, MD, is chairman of the Policy Committee of the Community Oncology Alliance and managing partner at Hematology-Oncology Centers of the Northern Rockies in Billings, Montana.

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The Heart of Collaboration:
Oncologists and Nurses Working Together

Melissa Andres, BSN, RN, OCN, CBPN-C

Scenario 1

An inexperienced nurse receives an order that she believes was intended for a different patient. Rather than asking the oncologist directly, she goes to her nurse coworkers for direction. She "polls" the nurses and receives feedback on their interpretation of the order. She chooses to proceed without discussing the issue with the oncologist, and a medical error occurs.

The Institute of Medicine stated in its report, *To Err Is Human*, that medical errors account for between 44,000 and 98,000 hospital deaths per year in the United States.[1] This information should not be new to anyone, as this report was released more than 10 years ago. What you may not know is why these errors occur. The Joint Commission suggests that organizational culture, availability of resources, staffing ratios, and education and training are top contributors to errors.[2] It also identifies lack of communication or miscommunication as the number one root cause of sentinel events.

I have been a nurse for 15 years and have progressed from a novice new graduate nurse who did what I was told, to an experienced oncology nurse who thinks critically and asks questions. I have worked with oncologists who have discounted my knowledge, some who have yelled at me, and many who have collaborated with me as a peer to care for our patients. I have worked in healthcare facilities where the executive leadership team ignored unprofessional behavior from physicians, and I have worked in facilities where skilled communication and true collaboration have not only been encouraged, but expected and fully supported from the executive team.

I can personally reflect on these experiences and identify which were healthy and satisfying and which were not. I can also remember experiences that resulted in medical errors and those that were potential errors that did not reach the patient. I do not believe that it was coincidental that potential errors were caught when professional communication occurred within the interdisciplinary team—and when all roles were respected and valued.

The Danger of Not Communicating

In 2005, the American Association of Critical-Care Nurses (AACN) partnered with VitalSmarts, a corporate training organization, to conduct a study titled, *Silence Kills: The Seven Crucial Conversations for Healthcare Professionals*.[3] The study found that healthcare professionals fail to have crucial conversations when there are broken rules, mistakes, lack of support, incompetence, poor teamwork, disrespect, and micromanagement. Other barriers to having crucial conversations were identified as lack of ability, belief of "it's not my job," lack of time, and fear of retaliation.[3]

Not having these conversations, or having the wrong conversations, can have an impact on medical errors, patient safety, quality of care, staff commitment, employee satisfaction, discretionary effort, and turnover. Improvement in communication could not only contribute to a significant reduction in errors, but also improve the quality of care.

It seems simple: if we communicate effectively, we can improve patient safety and patient outcomes. So why are we not doing it? Why did the

nurse in the first scenario not speak with the oncologist directly and question the order? There were several reasons, or "barriers": the nurse was inexperienced, the oncologist had a reputation of yelling at nurses for "being stupid," the oncologist was busy, the nurse did not want to bother him, and the organization did not support nurses questioning physicians.

Overcoming Barriers to Communication

As a result of those findings, the AACN made a commitment to actively promote the creation of healthy work environments that support and foster excellence in patient care wherever acute and critical care nurses practice. They identified six standards for establishing and sustaining healthy work environments[4]:

- Skilled communication
- True collaboration
- Effective decision making
- Appropriate staffing
- Meaningful recognition
- Authentic leadership

Regarding the first two, skilled communication requires that nurses be as proficient in communication skills as they are in clinical skills. In order to have true collaboration, nurses must be relentless in pursuing and fostering true collaboration, and nurse managers and medical directors must be equal partners in modeling and fostering true collaboration.[4]

Scenario 2 reflects an effective oncologist-nurse relationship in which communication is clear, uninhibited, and encouraged—and directly affects the quality of patient care.

Scenario 2

An inexperienced nurse receives an order that she believes was intended for a different patient. She speaks to the oncologist and says, "I was looking over Mrs. Jones's orders and noticed that she is scheduled for a head CT, but I wasn't sure why. Also, when we rounded together this morning, you mentioned that Mrs. Smith needed a head CT today, but I didn't see that ordered for her. Was this ordered on the wrong patient?" The oncologist responds, "No, both patients need a head CT. I must have missed ordering that on Mrs. Smith. Thank you for bringing that to my attention. Great catch. Now let's talk about Mrs. Jones. You said you weren't sure why it was ordered on her. Tell me what you see with her and why you think a head CT would or would not be important…"

The culture of the nurse-physician relationship has changed dramatically over the past years and is one of the most important drivers of a healthy work environment. Magnet research has demonstrated the importance of healthy nurse-physician relationships on outcomes for nurses, physicians, and patients.[5] It is much easier to have a crucial conversation with someone with whom you have an established, respectful working relationship.

Policies, procedures, and workflow are essential in healthcare facilities to provide safe care of our patients. However, shortcuts will be taken, resources will be stretched, and emotions will run high. We will all make mistakes, and we will all see mistakes about to be made. How we respond to those situations will make or break our safety mechanisms and directly impact our patients.

My advice to both nurses and oncologists is: Treat each other with dignity and respect, get to know your coworkers' professional strengths and weaknesses, build off one another's strengths to further your own professional development, and mentor others to increase their knowledge and expertise. ■

Melissa Andres, BSN, RN, OCN, CBPN-C, is a nurse navigator in Indianapolis, Indiana, and a member of NCONN, the National Coalition of Nurse Navigators.

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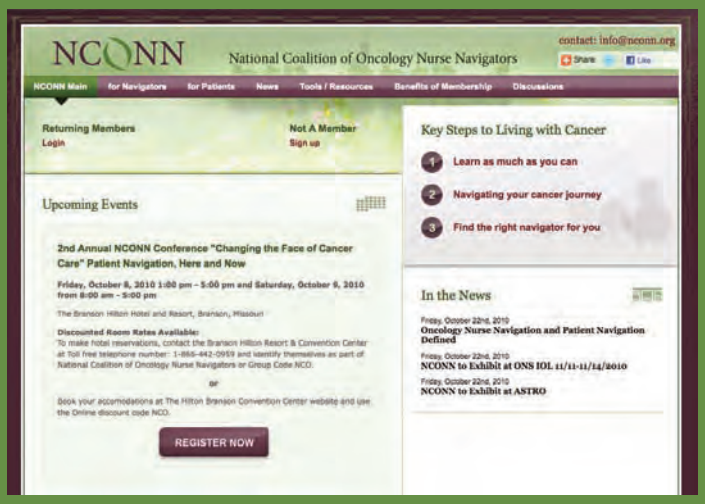

GET NCONNected!

The National Coalition of Oncology Nurse Navigators (NCONN) has launched its new Website, www.nconn.org. With easier navigability, discussion boards, a patient resource page, and other new features, NCONN's updated site offers a wealth of support and guidance for nurse navigators. NCONN members receive enhanced site access, so be sure to sign up today for the organization that is truly "Changing the Face of Cancer Care."

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A WORD FROM YOUR FELLOWS

The New Medical Oncology/Palliative Medicine Fellowship Track

Max Vergo, MD

I was drawn to medical oncology because it combines science and humanism. I am witness to my patients' most vulnerable, challenging, and genuine moments. That said, the most lasting memories I have from internship involve the fear, shock, and failure that I felt as I cared for ill or dying oncology inpatients. I decided that if I was to become a medical oncologist and be entrusted to care for patients with a life-threatening illness, it was my responsibility to be as well trained as possible in physical symptom management, communication, and nonphysical distress. I would follow them from diagnosis to either cure or death and never abandon them. Training in palliative medicine as well as medical oncology felt like honoring the saying: "To cure sometimes, to relieve often, to comfort always."

I am just finishing up a 2-year medical oncology fellowship after completing a hospice and palliative medicine fellowship and will be starting as an attending in both GI oncology and palliative medicine this summer. This dual training is becoming a much more frequent occurrence with medical oncologists,[1] and some oncology training programs across the country have integrated medical oncology/palliative medicine into a 3-year ACGME-accredited fellowship similar to hematology/oncology. This article aims to recount my experience in this dual training, including the challenges I faced and the benefits I reaped. Hopefully, this will help better inform oncology fellows regarding whether or not this training suits them.

Benefits

I will never forget visiting a hospice patient as a palliative medicine fellow and talking with his wife. She felt their oncologist was wonderful, knowledgeable, and connected with them, but he had abandoned them since hospice enrollment. He didn't call and was no longer involved in decision making. And believe me, there were decisions to be made. Should they continue tube feeds? What were the benefits and risks? What should they do about his secretions that were severely impacting his quality of life? When and how should they tell other family members? Most likely the oncologist "abandoned" his patient because he just didn't know or have experience in caring for patients while they were dying. Just as I can advise the right chemotherapy regimen for treating metastatic cancer, I can also assure symptoms are managed right up until death or assure a patient is sedated if all other conventional methods fail.

This continuity of care is vital to helping patients transition as their cancer progesses. I have known them for months to years and have learned and elicited their values and goals throughout their course of cancer. They trust me because I know them intimately, what they have been through, and have fought beside them during their battle with cancer. Therefore, when I tell them we have come to a point where their life would be "better" (based on their own definition) without further chemotherapy, they believe me. They can accept their fate and begin to find other sources of hope to sustain them for the time they have left.

As oncologists, we gather to discuss challenging clinical quandaries in conferences, but we do not discuss how emotionally draining it is to care for certain patients or families and grieve their loss. In hospice and palliative care, emotional coping and strategizing is a crucial piece of the multidisciplinary meeting time with chaplains, social workers, psychologists, nurses, and physicians. Oncologists are prone to burnout[2] and having the experience of a true multidisciplinary support network in cancer care and learning emotional resilience[3], such as that learned in hospice and palliative medicine, can help improve job satisfaction and prevent this burnout.

Solid malignancy services can be heavily burdened with patients who have suffered complications from chemotherapy or their cancer. A palliative medicine training can assure that I can always make an impact on the patient's care and on the residents' and fellows' education whether I am titrating medications to relieve refractory nausea or pain, navigating tricky goals of care issues with challenging families or young patients, or helping coworkers and residents grieve their dying patients.

Lastly, improved end-of-life care, including decreased spending and better symptom management, are hot button topics. In an era when research money is tight and innovation is valued, having insight into strategies that could reduce aggressive care at the end of life while respecting patients' values and goals could allow for a successful, independently funded research niche.

Challenges

One potential issue is the worry that oncologists trained in palliative medicine may not be as aggressive and would encourage patients to seek comfort care despite there being further therapy available. Interestingly, after my palliative care training, a mentor has joked that I am far more aggressive

"I feel lucky that I have been formally palliative medicine-trained, so those emotions don't keep me from being there for my patients and their families at the end.."

in some situations than she would be. For example, after getting a sense of the value a patient places on quality of life and extension of life, I explain how potential therapies may impact each of these points. If a patient chooses an aggressive therapy in order to reach a goal that I think is possibly achievable despite significant potential toxicity, then I will likely treat. It is one thing to treat aggressively as a rule and another to tailor your aggressive therapy based on a patient's prognosis, values, and goals.

A second challenge is whether a physician can wear both an "oncologist hat" as well as a "palliative medicine hat." The answer varies depending on the situation. Many of my oncology patients are thrilled that I am trained in palliative medicine because they feel assured that no matter what happens with their cancer, they will not be left to suffer and will have guidance if they have to face the dying process. On the other hand, patients who view palliative medicine as equivalent to hospice may not trust me to make aggressive decisions for them. In addition, I need another practitioner to "share the load" when caring for patients who have extreme and/or refractory symptoms.

Lastly, I had not anticipated just how difficult it would be for me to watch a patient progress from diagnosis to death. A 50-year-old man with metastatic pancreatic cancer was admitted to the inpatient hospice unit for pain and delirium management 8-9 months after I had met him, a healthy-looking man. It had been a few months since I had last seen him, but when I walked into his hospital room I had to leave and check that I had entered the right room. He was no more than skin and bones. I felt like a proxy family member watching from beginning to end as the cancer consumed him. In that moment I realized, at least in part, why medical oncologists may not be fully present during a patient's death… it is very, very hard to bear witness to. I feel lucky that I have been formally palliative medicine-trained, so those emotions don't keep me from being there for my patients and their families at the end.

On a practical note, a hospice and palliative medicine fellowship after oncology training will break up your oncology experience by a year and may make restarting this oncology career more challenging. This must be weighed against the depth this training adds to your experience.

Conclusions

Medical oncology is a complex field, rich in basic science, mechanism of actions, and cutting-edge clinical investigation but also physical, emotional, social, and existential distress for the patient. The field of hospice and palliative medicine is well suited for training oncologists in the science of compassion and communication, which can significantly improve the experience of cancer patients. A push for some palliative medicine training in all oncology fellowships would be extremely appropriate, but for individuals who feel this aspect of oncologic care is what gives them job satisfaction and is an essential part of their practice, I would strongly recommend a yearlong ACGME accredited hospice and palliative medicine fellowship. I sleep well at night. ■

Max Vergo, MD, recently completed his oncology/hematology fellowship at Northwestern University Feinberg School of Medicine in Chicago, Illinois.

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Evolving Treatment Options for Older Patients with AML

George Ansstas, MD

About 13,300 new cases of acute myeloid leukemia (AML) are diagnosed yearly, and nearly 9,000 deaths occur in the United States. It is a rapidly progressive disease that results in the accumulation of immature, functionless cells in the marrow and blood, leaving the body unable to fight infections or produce enough normal red blood cells, white blood cells, and platelets. The disease primarily affects people age 60 and older and is the second most common form of leukemia in adults.

Almost two-thirds of AML patients over age 65 do not receive treatment for the disease because standard therapy can be risky. The traditional, harsh chemotherapy approach is difficult for anybody, but particularly so for older patients who don't tolerate the "thunderbolt" of intensive chemotherapy well. Many patients are judged not to be candidates for any treatment at all because they likely would not survive the traditional, harsh chemotherapy approach. Furthermore, the AML seen in elderly patients is also more likely to have evolved from a prior hematologic disorder, and the leukemic blasts are more likely to have poor-risk structural and numeric cytogenetic abnormalities and expression of multidrug resistance protein (MRP1). These blast features have been associated with greater resistance to therapy, which makes the response rate lower, the risk of relapse higher, and the cure rates lower. On average, such patients survive only 1.7 months after diagnosis.

The development of a less toxic therapy has enabled such patients who would have never received treatment for their disease to actually benefit from prolonged remissions with improved quality and length of life, without paying the price exacted by intensive therapy regimens.

Researchers at Washington University School of Medicine in St. Louis and collaborating institutions found that decitabine might benefit older AML patients by reactivating genes that cancer cells turn off. It works by reducing the amount of DNA that is marked with a chemical tag called a *methyl group*. Scientists think that the excess methylation found in cancer cells inactivates genes that normally suppress tumor development.

The study published in the *Journal of Clinical Oncology* by Cashen et al was conducted at three sites: Washington University School of Medicine; the University of California, Los Angeles; and the City of Hope National Medical Center in Duarte, California. The researchers tested decitabine in 55 AML patients with an average age of 74 years. All patients received the same decitabine dose for five consecutive days every 4 weeks until their disease stopped responding to the drug and began progressing or until an adverse event occurred to prevent further participation. By comparison to standard chemotherapy and stem cell transplantation, the treatment was considered a low-intensity treatment and was more tolerable for elderly patients, especially those with accompanying medical problems. In 24% of the study participants, blood counts and bone marrow returned to normal, which is considered a complete response. It took 4.5 cycles of decitabine treatment on average to achieve a complete response. In those with a complete response, average survival time was 14 months. For all study participants, average survival time was 7.7 months. Treatment-related adverse events included low blood counts (red cells, white cells, and platelets), infection, fever, and fatigue. Almost half of the study participants had at least one serious adverse event. Seven patients discontinued treatment, and three patients died as the result of adverse events.

In a different study, we looked back at our institution experience with decitabine as initial treatment for older patients with de novo AML and MDS-related AML and found that 45 patients met the criteria. About one-third of patients achieved complete response (CR/CRi) with maximum of 5 cycles of therapy and durable response of 13 months. The median overall survival for the whole cohort was about 9 months and for CR/CRi group was 19 months. Day 100 mortality was about 20%. The length of hospital stay averaged 20 days. Cytogenetics had no impact on response. No documented invasive infections were found, and only fatal bleed was reported.

Decitabine seems to have acceptable response rate, side-effect profile, and short hospital stay duration. At the same time, we have to wait for the results of further trials of decitabine to have a better estimate of the response rate and survival outcome compared to other low-intensity options for older adults. ■

"The traditional, harsh chemotherapy approach is difficult for anybody, but particularly so for older patients who don't tolerate the 'thunderbolt' of intensive chemotherapy well."

George Ansstas, MD, is a third-year oncology/hematology fellow at Washington University School of Medicine in St. Louis, Missouri.

A Day In the Life of a Pediatric Oncologist

By Aarati Rao, MD

As a practicing pediatric oncologist at an academic institute, every morning begins with optimism and a quest to win the day. As I walk into my office, I see my nurse flagging me down to sign a bunch of papers including procedure orders, chemotherapy orders, and home-health laboratory test orders. I get a hot cup of coffee and take time to catch up on emails, communications from consultants, referrals, and patient reports. Next, I review the children admitted through the inpatient service and their blood test results from overnight. Often, this is also the ideal time to review updates on new clinical developments in oncology, or to read up and educate myself on clinical dilemmas and ongoing research. This helps to prepare me for my resident education on clinical bedside rounds.

Children admitted to our facility, a pediatric specialty service, are cared for by resident staff at night, in consultation with practicing oncologists. In the morning, I attend the inpatient service bedside rounds and discuss the children's care with the resident staff. Academicians at most institutions have teaching responsibilities that may occasionally include additional lectures for residents or medical students. Investing time in teaching

the residents often rewards me with fewer tortuous night calls, since the residents are usually better prepared to handle anticipated complications as a result.

Pediatric oncology is a stimulating field with a multitude of research opportunities and discoveries every day. The prognosis in several childhood cancers has improved tremendously thanks to novel drug therapies, drug delivery systems, and protocol-driven treatments that have helped standardize therapy across the U.S. and improve results. It is intellectually stimulating to discuss ideas and diagnoses with other consulting services or experienced colleagues in my field across the country. Doing so enhances the quality of care I provide and helps broaden my perspective and differential on a given case. Be prepared to be humbled, however, as discussing clinical experiences with other physicians makes you vigilant and allows for fewer errors. Also, while consulting services can add to the quality of care you provide, remember to advocate for your patients and keep possible diagnoses in perspective before heading down the path of ordering multiple tests or scans.

For example, I once saw a 6-year-old girl with Cushing's syndrome and a hepatic mass suspected to be hepatoblastoma. The mass showed calcification on scans and her alpha-fetoprotein level was normal. The child had severe hypertension consequent to paraneoplastic syndrome, preventing us from taking her to surgery. We insisted on a biopsy before proceeding with any chemotherapy, although the majority of the consultants were convinced it was a hepatoblastoma. Ultimately, when the mass was excised, it was a rare "nested stromal tumor" of the liver.

Following up on your patients when they are admitted to another service, such as surgery or intensive care, helps you stay abreast of events and changes in their status. Being familiar with a child's long-term medical illness also helps protect him or her when you advocate for their care. It is key to follow up on the children and their several tests as the day progresses, as each update has the potential to alter treatment plans that were made earlier in the day based on certain assumptions.

I head to the hospital in-service as I begin the day. My resident team, pharmacist, and nurse practitioner are waiting and ready. We spend the morning seeing and discussing our inpatients. A simple case of scheduled chemotherapy, a sick child with fever and neutropenia, or a more involved case of a newly diagnosed child with acute leukemia or a new solid tumor keeps us engaged. The morning passes in a flash as we manage each issue and care plan. Some of the most enjoyable moments involve the exchange of knowledge between myself, residents, pharmacists, nursing staff, child life services, and social services because it helps me render comprehensive care for my patients. Unfortunately, not every day is a breeze. We have challenging days where we spend considerable time discussing and resolving more complicated issues such as end-of-life care, palliative therapy, pain control, and optimal quality of life for our less fortunate children with terminal disease.

Communicating with parents and children is a skill. It is also a predominant part of my job description and of my professional day. Training in how to communicate bad news and discuss end-of-life care or options such as pain relief, hospice care, and resuscitation choices with parents is often initiated during fellowship and fully mastered in practice when you are responsible for the care of each child whom you manage. Prudency is in realizing that each situation is unique, showing true empathy to the needs of children and parents, and being prepared to listen. As much as you would like to be outlining plans, taking the time to listen to the concern of a child or parent can help get you through difficult situations. Remember to include the children in decisions and discussions.

Next, I head to the outpatient clinic and infusion center. The aura is lighter and less somber. Scheduled outpatient chemotherapy follow-up, outpatient procedures like spinal tap with instillation of medications, bone marrow procedures, postchemotherapy follow-up, and health surveillance for our cancer survivors, fill the afternoon. Seeing a cancer survivor cheerfully return to the clinic with tales of school or summer vacation, or witnessing young teens recount their camp experience or academic success brings true satisfaction. Those days, I succeed in my quest to win the day.

I end the day with some more paperwork, including billing for services rendered. Coding and billing is an integral part of practicing medicine. Detailed and time-intensive care planning is often accompanied by paperwork, and an efficient team of personnel including nurse, patient liaison, social worker, and home-health services is an invaluable asset. I check back on issues pending for the day and make sure my hospital patients are well cared for before I head home for the night. While every day is not a winning day as an academic oncologist, optimism can provide hope for winning every day! ■

Aarati Rao, MD, is a professor in the department of pediatrics at the University of South Alabama in Mobile.

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Medical Spanish

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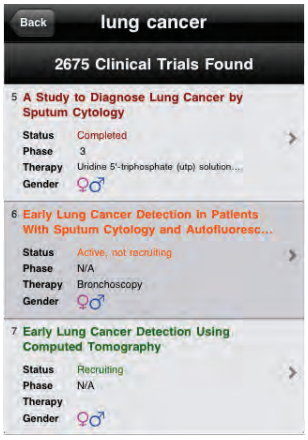

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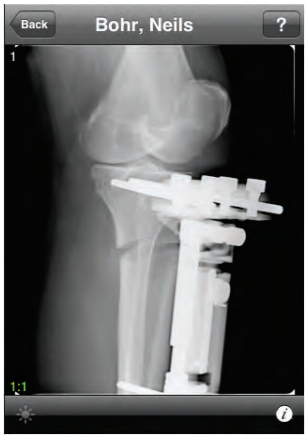

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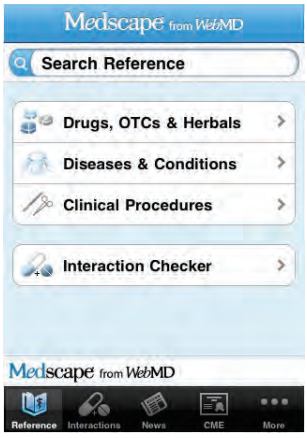

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How to Choose the Best Credit/Rewards Card for You

BY ED RABINOWITZ

Like most Americans, you've probably noticed a significant increase in the amount of credit card and rewards card offers you've received lately. That's because the number of offers dispersed through the mail during the second quarter of 2010 exceeded 1 billion, more than double the 419 million for the same period in 2009, according to a report from Mintel Comperemedia, which tracks direct marketing.[1] As a physician, you're likely receiving more than your fair share.

Credit cards and rewards cards are a staple in today's society, and have been for many years. According to "The Survey of Consumer Payment Choice," published by the Federal Reserve Bank of Boston in January 2010, there were 176.8 million credit cardholders in the U.S. in 2008, with the average credit cardholder having 3.5 credit cards. About 60% of all consumers had a rewards credit card.[2]

What's challenging, however, is wading through the sea of offers to select the credit card or rewards card that is right for you. The card you end up with should be a reflection of your needs, lifestyle, and purchasing habits—and that's going to be different for every individual. But the process of card selection holds true no matter what your purchasing profile looks like.

Names and interest rates

There were 270 million Visa credit cards and 203 million MasterCard credit cards in circulation in 2009.[3,4] The numbers for American Express and Discover credit cards pale by comparison, and stand at 48.9 million and 54.4 million, respectively.[5,6] Those numbers, says Joel Ohman, CFP, founder of the Website CreditCardChaser.com, are an important consideration in the credit card selection process.

"A good rule of thumb is to have at least a Visa or a MasterCard, because they're accepted in more places," says Ohman, who admits that his favorite is an American Express cash back card. "But some places just don't take it." He explains that some merchants may not want to pay additional and/or potentially higher fee schedules for Discover or American Express, and rationalize that, given the lower number of consumers holding either of those two cards, they won't be losing a lot of business by declining them.

As for interest rates, Christine Moriarty, CFP, president of Vermont-based MoneyPeace, Inc., says that should be less of a concern in your decision-making process, especially if you don't plan on carrying any balances forward from month to month—a practice she strongly advocates.

"The only time it makes sense to carry the balance from month to month is for someone who gets reimbursed for business expenses," Moriarty says. That's because individuals who need to use their credit card for travel may receive their monthly statement prior to being reimbursed. "If they pay the bill in full, most will have to dip into savings or wreak havoc on their household financial system."

Of greater importance, she says, is to remember that many credit cards, and quite a few rewards cards, carry annual fees, such as the American Express Premier Rewards Card, which comes with a $175 annual fee—another practice Moriarty frowns on. "I may be old-fashioned, but I'm also living in today's world. And I say an annual fee is not necessary."

Don't Be Afraid of Debit Cards

While you're wrangling over the decision of which credit or rewards card to apply for, it's important to remember that you don't have to use credit cards for everything. According to Christine Moriarty, CFP, president of Vermont-based MoneyPeace, Inc., consumers using credit cards spend, on average, 20% more than they might otherwise have spent.

"One of my clients told me that they recently went into the grocery store to purchase a gallon of milk," Moriarty explains. "However, they didn't want to use their credit card just to purchase a gallon of milk. So, they bought a bottle of wine as well. Using the credit card, you end up spending much more. Don't be afraid of debit cards."

Of course, most debit cards do not offer any type of rewards or cash back program. The exception, says Joel Ohman, CFP, founder of the website CreditCardChaser.com, is PerkStreet Financial, an online bank that offers a Visa debit rewards card. The program offers 2% cash back rewards if you maintain a balance of at least $5,000 in a checking account.

Information on PerkStreet Financial's debit rewards card is available at www.perkstreet.com.

Travel points or cash back?

Are you a frequent traveler, either for business or pleasure? If so, Ohman says it makes more sense to obtain a card that helps you earn points or cash back toward airline tickets, or an affinity type program that offers higher average rewards if you travel on a select airline or stay at a specific hotel chain (TABLE 1). Two of the more popular travel rewards cards are the PenFed Premium Travel Rewards American Express card, and the Simmons First Visa Platinum Travel Rewards card. The former awards five points for every dollar spent on airline tickets, and three points for every dollar spent on hotels and dining. The latter awards one point for every dollar spent, with 22,000 points needed to quality for an airline ticket.

For many, however, a basic cash back rewards card will suffice (TABLE 2).

"I'm fairly average and I don't travel a lot," Ohman says. "If I had to pick, I'm very happy with my plain cash back card. I don't have to worry about different formulas for calculating ratios and points. I know that if I spend X-amount, I'm going to get 1% or 2% back. People tend to like the cash back cards because of their simplicity."

Speaking of keeping things simple, Moriarty cautions those shopping around for a credit or rewards card to be aware of credit card roulette, a practice whereby the rewards categories rotate periodically, sometimes quarterly, making it a little more challenging to keep track of which purchases are earning you the maximum amount of cash back. Moriarty tells her clients to steer clear of those types of cards.

"Take that same energy [used to keep track of changing categories] and put it into devising a payment plan to pay off your credit card," she suggests.

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Capital One® VentureOne℠ Rewards	13.90% Var.	25 Days	None
Miles by Discover® Card	10.99-16.99%	25 Days	None
Capital One® No Hassle Miles℠ Rewards	16.90% Var.	25 Days	None
Simmons First Visa® Platinum Rewards	9.25% Var.	25 Days	None
Chase® Sapphire℠ Preferred Card	12.24% Var.	21 Days	$85
Starwood Preferred Guest® from American Express®	15.24% Var.	20 Days	$45
American Express® Gold Card	NA*	N/A*	$125
Platinum Delta SkyMiles® from American Express®	14.5% Var.	20 Days	$150

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Source: LowCards.com. Airline Miles Credit Cards. Available at: www.lowcards.com/airline-miles-credit-cards.aspx. Accessed October 13, 2010.

TABLE 2. **Best Cash Back Credit Cards**

Card Name	Cash Back Overview
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Discover® More Card - $75 Cash back Bonus	Earn 5% cash back bonus in gas, restaurants, movies and travel. Earn $75 cash back bonus after $500 in purchases during first three months of opening account.
Chase® Sapphire℠	A rewards card with many options. Earn 10,000 bonus points after first purchase. Cash back rewards start at 5,000 points for $50. Points do not expire.
Blue Cash® from American Express	Earn 1% rebate for everyday purchases for the first $6,500 of eligible purchases. Purchases of $6,501 or more earn rebate of 5% for everyday purchases.
Discover® More Card	Earn 5% cash back bonus in rotating categories (categories rotate every quarter). Cardholders must "sign up" for each 5% program, and each program has a bonus limit.

Source: LowCards.com. Cash Back Credit Cards. Available at: www.lowcards.com/cash-back-credit-cards.aspx. Accessed October 13, 2010.

Ohman agrees. He points out that there are two different types of people when it comes to rewards cards. There are certain people who like to be extremely frugal. They like to clip out coupons, they'll comparison shop, and are the type of people who get the flyer brochures from their credit card company every quarter with the different cash back categories and they'll schedule purchases, knowing they'll use one credit card during one quarter for this type of purchase, and another card for another type of purchase the following quarter. But Ohman's thought process, perhaps similar to that of many physicians, is different.

"For me, my time is money, so I'd prefer not to have to think about all these different categories, and get confused by different formulas and have to remember what to spend during what quarter," he explains. "It's hard to keep track of."

Side-by-side comparisons

There are a wide range of websites that not only rate different credit and rewards cards, but also enable consumers to compare them side by side, in categories ranging from Introductory Period APR to earnings and rewards potential. These sites include Ohman's CreditCardChaser.com, as well as LowCards.com, Credit.com, and CreditCards.com. Moriarty says the website she is most familiar with is BankRate.com, and points out that while these sites contain a lot of valuable information, it's important to know that the source of that information is unbiased.

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One category to be aware of when comparing credit and rewards cards is Credit Needed, or the minimum threshold of credit that's required for obtaining that particular card. Some cards list that threshold as "Good," while others carry a "Fair" or "Poor" indication. The reason for the low threshold is that some credit cards are specifically designed and marketed toward people with poor credit, giving them an opportunity to rebuild their credit. As such, unless you have less than good credit, it's advisable to steer clear of those types of cards.

In addition, says Moriarty, the "Poor" rating under the Credit Needed heading could say a great deal about the company offering the credit or rewards card. "You want to stick with a big name company that's going to be reliable for handling your debt and your money, and for reporting to the credit bureau. Know who you're dealing with."

Avoid the pitfalls

One of the biggest mistakes consumers make when they obtain a rewards card, says Ohman, is becoming so focused on the fact that they're earning 2% cash back on their purchases that they forget to pay their balance in full each month. If your card carries an interest rate of 10% or 12%, failing to pay off the balance each month can negate your cash back rewards for several months. Some credit and rewards cards, however, offer a way to avoid that dilemma.

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One very important element in selecting a credit or rewards card, says Moriarty, is to know oneself. "And knowing yourself may include *not* getting a rewards card. If you know you're the impulsive type who will buy a lot of things just to get the rewards, you might actually end up spending more money in the long run." ■

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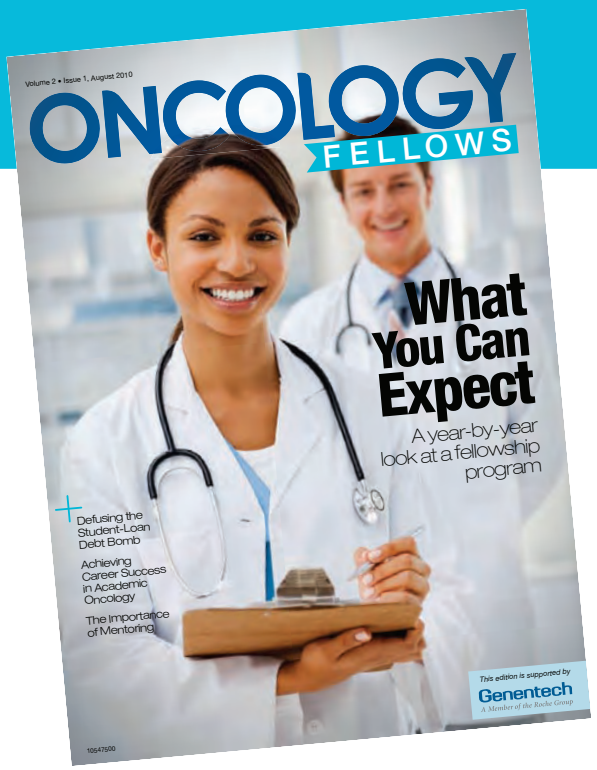

CALL FOR PAPERS

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

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

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

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

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

If you are interested in contributing an article to ***Oncology Fellows***, or would like more information, please e-mail Jennifer Santiago, Director of Oncology Projects, at jsantiago@onclive.com.

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

But scientific minds cannot solve breast cancer alone. Susan G. Komen for the Cure®, the leader of the global breast cancer movement, is leading in science again. We've just tapped 50 of the world's top cancer experts to Komen's new Scientific Advisory Council, to drive innovation and breakthroughs in cancer research. We think of it as the Ultimate Cancer Think Tank.

We're also supplying the tools that will help global researchers unlock the secrets of breast cancer. How it begins and grows. How we can stop it in its tracks. The answers may lie in the Susan G. Komen for the Cure Tissue Bank at the Indiana University Melvin and Bren Simon Cancer Center -- the largest source of healthy breast tissue in the world, soon to be available digitally to researchers around the world over the Internet.

Make an impact and donate today. Visit komen.org/donations.

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By the Numbers

Mobile Apps & Oncology

Mobile applications have revolutionized medicine by enhancing information access at the point of care. The applications reduce treatment errors and improve productivity, which leads to improved patient care. Epocrates, Inc recently surveyed 200 US oncologists who use Epocrates about mobile application use and general oncology issues. The graphs below summarize what Epocrates' 2010 Oncology Specialty Survey reveals about oncologists' current mindset. For more information, go to www.epocrates.com.

In Your Professional Opinion…

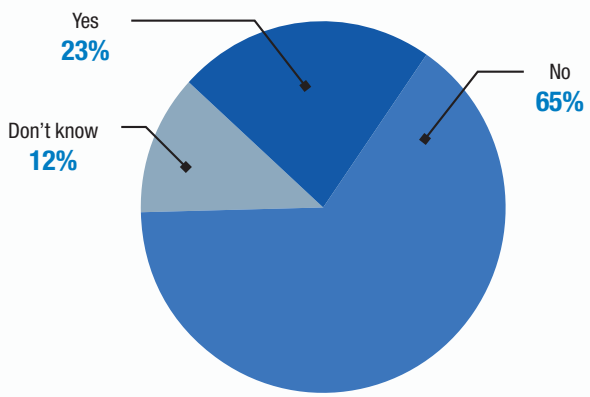
Job Satisfaction

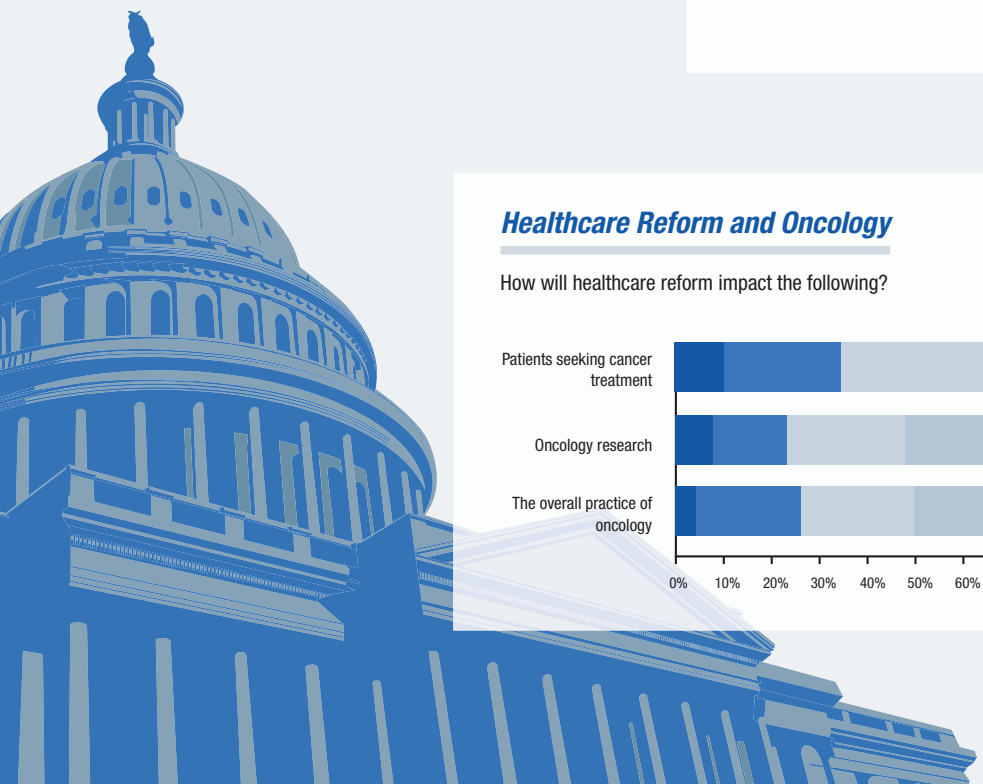
84% of oncologists are satisfied with their career choice.

78% would recommend the specialty to a medical student.

Impending Oncology Service Shortage?

Are there adequate oncology services in place to accommodate the rising number of cancer survivors?

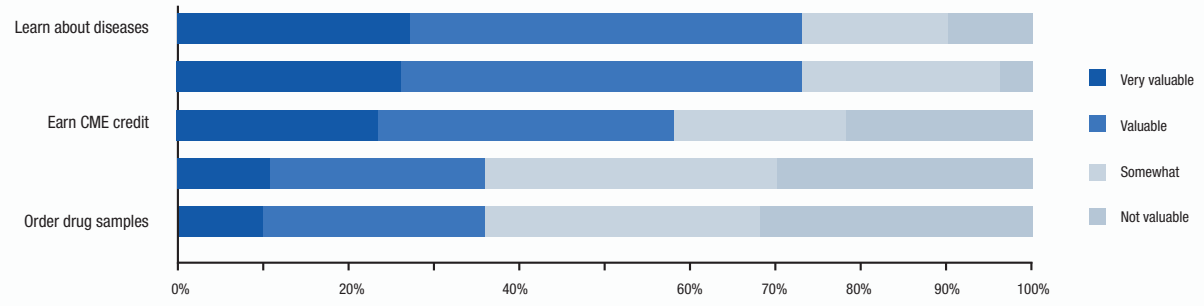




Healthcare Reform and Oncology

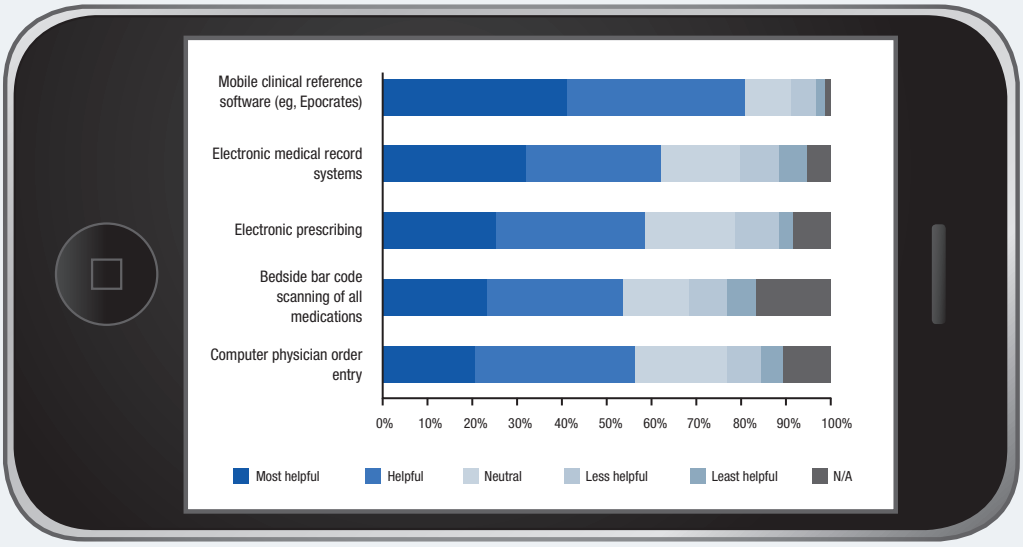
How will healthcare reform impact the following?

Rate the value of conducting the following activities on a mobile device:



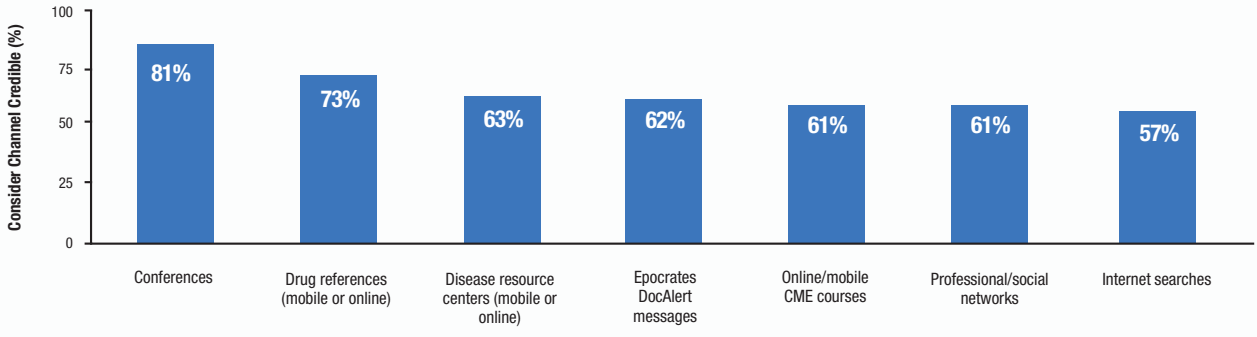
Mobile App Impact

How do the following technologies help you avoid medical errors and improve patient safety?



Mobile Apps Considered Credible

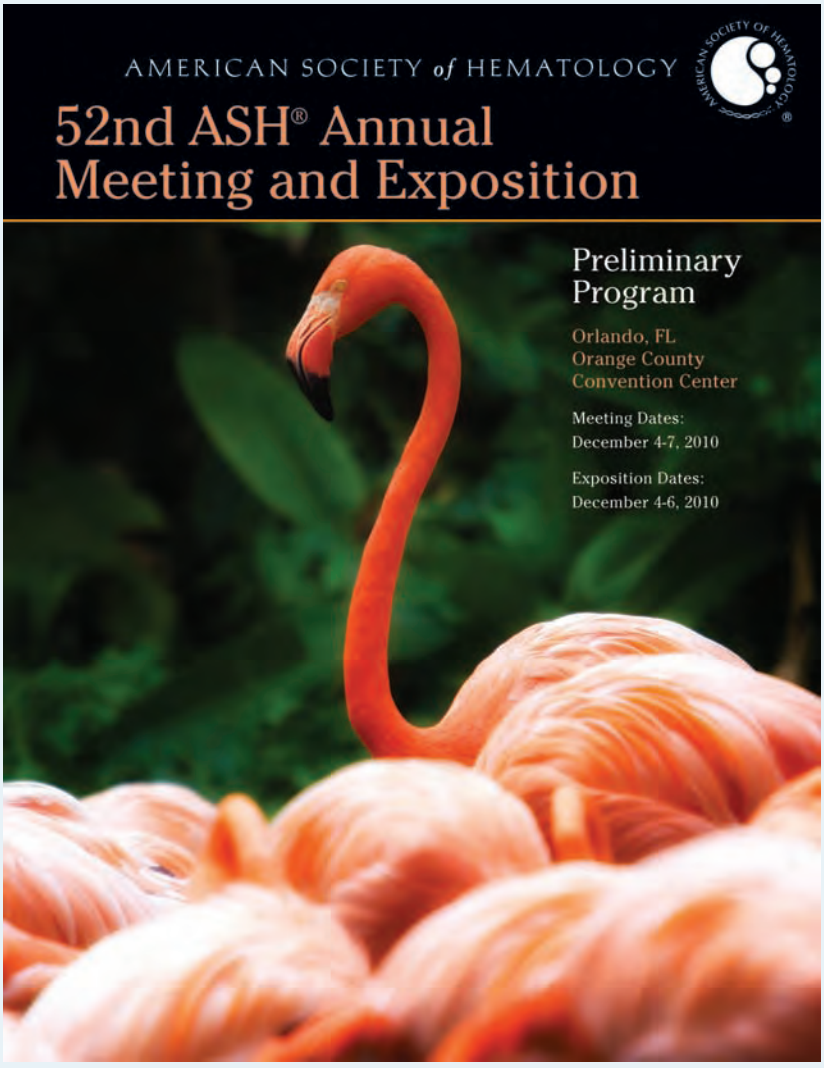
Please rate the credibility of the clinical information and news you receive from the following channels:



Reference:
Epocrates. "2010 Oncology Specialty Survey." San Mateo, California; 2010.

2010/2011 Oncology & Hematology Meetings

2010



December 4 – 7
52nd American Society of Hematology Annual Meeting
Orlando, FL
www.hematology.org/Meetings/Annual-Meeting

December 8 – 12
33rd Annual San Antonio Breast Cancer Symposium
San Antonio, TX
www.sabcs.org

December 9 – 11
2010 Chicago Multidisciplinary Symposium in Thoracic Oncology
Chicago, IL
www.thoracicsymposium.org

2011

January 20 – 22
2011 Gastrointestinal Cancers Symposium
San Francisco, CA
www.gicasymposium.org

January 30 – February 2
AACR-ACS Joint Meeting on Chemistry in Cancer Research: The Biological Chemistry of Inflammation as a Cause of Cancer
San Diego, CA
http://bit.ly/bLW1YN

February 17 – 19
2011 Genitourinary Cancers Symposium
Orlando, FL
http://gucasymposium.org

February 27 – March 2
AACR-NCI Conference on Systems Biology: Confronting the Complexity of Cancer
San Diego, CA
http://bit.ly/bPszfb

March 9 – 13
NCCN 16th Annual Conference: Clinical Practice Guidelines & Quality Cancer Care
Hollywood, FL
www.nccn.org/professionals/meetings/annual_conference.asp

April 2 – 6
AACR 102nd Annual Meeting 2011
Orlando, FL
http://bit.ly/dzpKBJ

April 13 – 16
Southwest Oncology Group Spring 2011 Group Meeting
San Francisco, CA
https://swog.org/Visitors/GpMeeting.asp

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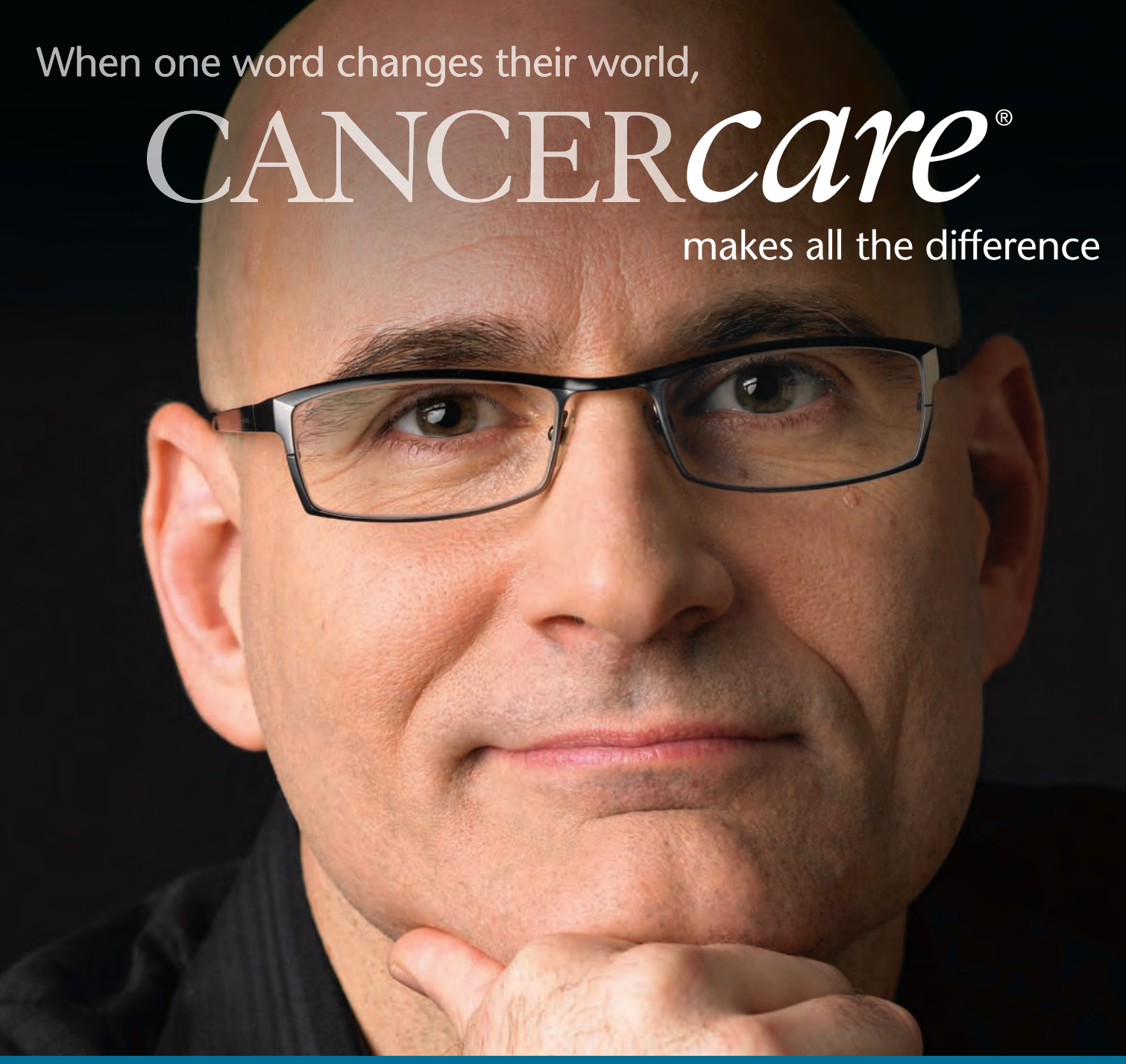

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- Free counseling
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