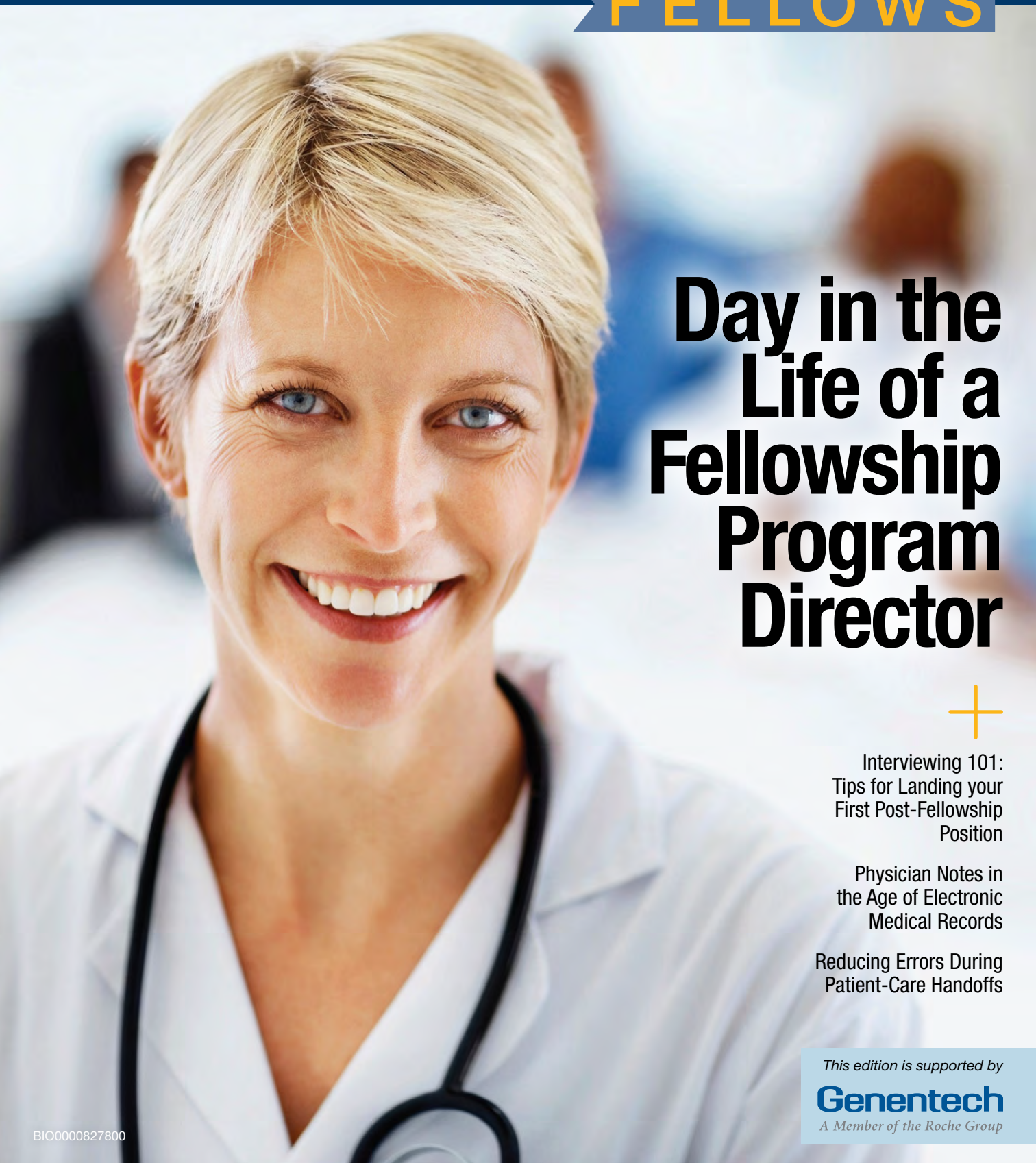
Volume 3 • Issue 4, December/January 2012

ONCOLOGY FELLOWS



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Day in the Life of an Oncology/Hematology Fellowship Program Director

By Joanne E. Filicko-O'Hara, MD

It is Friday morning and my workday starts at 7:30 AM with a conference. Fellows and attendings straggle in with coffee and sleepy eyes, wondering who will be on the "hot seat" today.

Trainees have sat in this hot seat at the front of the room for decades. It's not really warm, of course. This is where the fellow sits who is asked to review the findings, come up with a differential diagnosis, and devise a plan for the case in question. A peripheral smear appears on the big screen and John, a first-year fellow, starts to tell us what he sees. He points out red cells, then platelets, then white cells. We ask him the history and physical. John then develops a differential diagnosis, makes the diagnosis, and discusses the treatment plan. Twenty to 30 minutes later, we're on to a second case and another fellow takes John's place. At then end of the hour, we've reviewed 3 cases and we're all a little wiser. Now it's time to see the patients.

Is There a Typical Day?

After the conference at 7:30, the rest of the day generally goes as follows, more or less:

- ***8:30 AM*** — Office hours
- ***12:00 PM*** — Oncology conference with fellows and attendings
- ***1:00 PM*** — Desk time
- ***3:30 PM*** — Sign-out conference with the hematologic malignancies and stem cell transplantation team

But is there a typical day for a fellowship director? Not really. The days are crammed full of activities and responsibilities that vary based on the time of the year and the clinical

"On a good day, the afternoon will include time spent at my desk. This time is valuable (and difficult to protect) and usually includes some fellowship-related activities."

responsibilities for the day. There are often changes in the schedules due to new issues that come up. Flexibility is very important. Half the time, I have clinical responsibilities. These may be inpatient or outpatient activities, and may or may not include the fellows or other trainees.

Following our conference on this particular Friday morning, I start to see outpatients with hematologic malignancies. As part of her training, Amy, one of the fellows, is doing an outpatient hematologic malignancies block and is working with me. Together with Lisa, one of a team of great nurse practitioners, we divide up the schedule and start to see our patients in the outpatient offices. Most of the patients with follow-up visits are doing well. Together with Amy and Lisa, I make plans to restage lymphoma in 2 patients, evaluate anemia and a monoclonal protein in another, sign a consent for salvage chemotherapy for another, do some long-term follow-up for a few more, and end the morning with a new patient who would like to discuss options for an allogeneic stem cell transplant for relapsed acute myeloid leukemia. It's been a busy morning, but we got through it without any emergencies or admissions and finish with just enough time to get to our noon conference.

Our noon conference focuses on solid tumor didactics. Fellows and attendings are present, along with a student and resident on elective rotations. Today Dr Zibelli discusses adjuvant therapy for breast cancer. Although I am part of Thomas Jefferson University's Division of Hematologic Malignancies and Hematopoietic Stem Cell Transplantation and do not provide care for these patients, I try to attend as many of the fellows' conferences as possible. Our fellows have 6 required conferences each week, usually held at noon. The responsibilities on specific services often include attending the conferences specific to that discipline (eg, multidisciplinary breast conference while doing a breast cancer rotation, hematologic malignancies sign-out while on the hematologic malignancies rotation). There are multiple other optional conferences that the fellows and faculty can also attend if time permits. While I cannot attend all of the conferences myself, I feel responsible for ensuring

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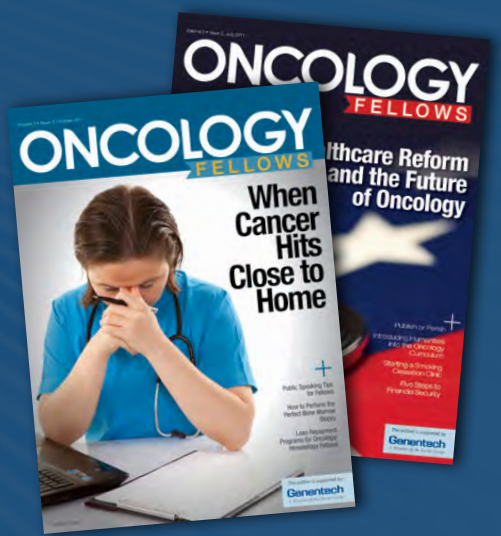

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"My fellows are a family. They need guidance and mentoring as they go through the training program. "

that the fellows' didactic conferences are up to par, so I try to attend as many as possible. Most program directors would agree that keeping tabs on the quality of the lectures and the attendance by faculty and fellows is best done if you or the associate program director regularly attend.

On a good day, the afternoon will include time spent at my desk. This time is valuable (and difficult to protect) and usually includes some fellowship-related activities. My program coordinator has a folder of e-mails about elective requests and vacation coverage for the fellows, off-campus conferences a fellow would like to attend, research plans that need to be reviewed, and other papers that need signatures. Fellows' schedules need to be revised. Online and paper evaluations must be reviewed to ensure all fellows are progressing in the right direction. Goals and objectives are updated. Process-improvement projects and plans for research projects must be reviewed and approved. I frequently visit the Web sites of the Accreditation Council for Graduate Medical Education (ACGME), American Board of Internal Medicine (ABIM), and Electronic Residency Application Service (ERAS). The ACGME page is particularly useful right now, as I prepare for a site visit. The ABIM site is visited more frequently as annual reports become due. This year, with the change in the schedule for fellowship matches, I probably won't need to visit ERAS for awhile, but once that starts up in the fall, I'll be reviewing applications for what will seem like weeks.

Halfway through the afternoon there's a page. An issue has come up. Today, one of the fellows has to leave early because her 6 year old got sick at school. We call the backup fellow, arrange a quick sign-out, and 30 minutes later everything is under control. On another day, the afternoon call will be one of the fellows who needs clarification about a policy. A week later, one of the faculty members pages me with concerns about one of the fellow's ability to manage a rapidly growing service. Sometimes, it's a simple call to clarify the rotation or call schedule. Whether a big problem or a small one, however, everything else gets put on hold to deal with the current crisis.

Then there are meetings; these range from individual discussions with 1 fellow to full-blown conferences that include all of the fellows. There are also semiannual reviews with individual fellows, fellowship committee meetings, and meetings with faculty to review and revise rotations.

The afternoon draws to a close and it's time to go home. But then an hour later my beeper goes off. When I call back Maria (a third-year fellow), she says, "Sorry to bother you, but I thought you should know…." So even though I'm home, I still have to deal with this next problem, clarifying how we deal with growing services at a time when service caps on the internal medicine services are changing the landscape for all of us.

A Good Fit

Five years ago, 6 months after my second child was born, my division chief walked into my office and said "We need a new fellowship program director. Motherhood seems to agree with you—I bet this would be a good fit." We laughed, but he wasn't completely wrong. My fellows are a family. Although no longer children, they need guidance and mentoring as they go through the training program. They need support and someone who will be available as an advocate. Being a program director is a full-time job. As program directors for fellowship programs in hematology and medical oncology, we are teachers, administrators, and counselors—not to mention physician role models. At times we are mentors and at times disciplinarians. We are advocates for our fellows; we liaise between the fellows and the faculty and administration. The most rewarding aspects of the job come from the fellows themselves. As I watch them become confident and mature hematologists and oncologists, ready to go out into practice, I commend them on their progress and share a sense of accomplishment. ■

Joanne Filicko-O'Hara, MD, is associate professor of medicine and medical oncology for the Division of Hematologic Malignancies and Hematopoietic Stem Cell Transplantation in the Department of Medical Oncology at Kimmel Cancer Center and program director of the Combined Fellowship Program in Hematology and Medical Oncology at Thomas Jefferson University Hospital in Philadelphia, Pennsylvania.

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Interviewing 101:
Tips for Landing Your First Post-Fellowship Position

By Laura Bruck

Been to your college reunion? If so, you probably spent some time basking in the admiration of your classmates, all of whom were, no doubt, quite impressed (and maybe a bit envious) that you've become an oncologist. And while that admiration is certainly well earned, it's quite likely that your nonphysician classmates have something you probably do not: interviewing experience.

Think about it. While you were slaving away in medical school, your classmates were interviewing for, and securing, their first "real" jobs. And as you embarked on your internship, residency, and fellowship, many of those same classmates probably changed jobs, or even careers, all the while racking up even more interviewing experience.

There is, however, some good news. Like all the other skills you've honed so finely over the years, interviewing can be mastered with the help of some solid tips, ample preparation, and a good dose of practice.

What to Expect

Your interviewing experience will depend upon a number of factors, including the type of position you're seeking and the type and size of facility or practice with which you're interviewing. In general, however, plan for a busy, all-day affair. In an academic center, for example, be prepared to interview with several individuals, such as the division director, medical director, and facility administrator, as well as the department head and other faculty members from your subspecialty.

Once you've survived day 1 of the interviewing process, be prepared to wait. Most academic centers have selection committees, the members of which meet with several candidates over a specified time period, and then decide which of those candidates to bring back for a "second look." Depending on the number of candidates being interviewed and the schedules of those doing the interviewing, it could be weeks or even months before you're called back for a second (and, hopefully, final) round of interviews. In most cases, that second session will involve additional meetings with individuals higher up the chain of command (such as the cancer center director) and might also include beginning negotiations and initial discussions about laying out a proposal.

What Your Interviewers Look For

There's no better way to prepare for an interview than to find out what your interviewers will be looking for during those all-important face-to-face meetings. To that end, *Oncology Fellows* spoke with Marc Stewart, MD, medical director of Seattle Cancer Care Alliance, and Steven J. Cohen, MD, fellowship director for the Fox Chase/Temple University Hematology-Oncology Fellowship Program, about how they separate the wheat from the chaff while interviewing candidates for positions at their facilities.

Question: *How do you decide which candidates to bring in for interviews?*

Dr. Stewart: This is usually based on our personal experience (if, for example, a fellow has trained in our program). Otherwise, the decision is based largely on the candidate's CV, along with later discussion with the program directors at the applicant's training site.

Dr. Cohen: We start by looking at where the fellows trained, mentors who can vouch for them, and what they've accomplished in their area of interest, such as clinical trials and projects of their own that could potentially translate into successful careers and meaningful research findings.

Question: *What are the must-haves that you look for in potential candidates?*

Dr. Stewart: We look for candidates who have a focused area of interest and a solid vision about the direction and future of their career and potential contributions. We also look for academic productivity and excellent clinical reviews. Good interpersonal and communication skills also are important.

Dr. Cohen: The most important quality we look for is a true commitment to the candidate's chosen career path, along with solid ideas about how to move that commitment forward and build upon what's already been accomplished. We also look for individuals who will work well with others. Stated differently, we're looking for people whose egos won't get in the way of their willingness to be mentored and work as part of a team.

Question: *What, in your past interviewing experiences, have been some of the qualities that have set candidates apart and made you want to hire them?*

Dr. Stewart: Two such qualities would be publications in outstanding journals and funding.

Dr. Cohen: Nothing strikes a better chord than a candidate who knows about the center at which he or she is interviewing, and can articulate what it is that attracted him or

her to that particular center. But what truly impresses us is a fellow's ability to demonstrate and discuss his own work and his unique role in generating the data from his research.

Question: *What are some common mistakes made during interviews that might result in a candidate losing an opportunity for a position?*

Dr. Stewart: Failure to show a focused interest in research would definitely be considered a negative attribute.

Dr. Cohen: As alluded to previously, simply describing research conducted by a mentor rather than being able to discuss the details of a candidate's unique role in his or her research is disappointing. We're not looking for a literature review or a summary of the field. Instead, a candidate needs to be able to discuss the details of any research and articulate a vision for the direction that research might take in the future.

Interviewing Basics

If all of this still sounds a bit daunting, the following tips will help to position you for success during that all-important "face-to-face."

Get your materials in order. Most larger facilities will have very specific instructions about what materials to send prior to your interview and which materials to bring with you. When in doubt, it's always better to ask than to guess. While a curriculum vitae, letters of recommendation, and all material related to research and funding are must-haves, different centers will likely request different types of materials.

Do your research. This is no time for a cold call. Well before your interview, take some time to research not only the practice or center but also those with whom you'll be interviewing. Doing so will allow you to ask relevant questions and demonstrate your interest in the facility to which you're applying. The center's Web site is a good place to start, but keep in mind that the site's information is written by media specialists rather than medical staff members and may not have been recently updated. For this reason, a search for publications about the facility and by the physicians with whom you'll be interviewing is a must. Whenever possible, talk to physicians who have already interviewed at the facility or, better yet, have already been hired.

Be prepared to discuss your strengths and even your perceived limitations—and to do so with candor.

Anticipate questions and ask your own. Be prepared to discuss your strengths and even your perceived limitations (described as areas you'd like to improve)—and to do so with candor. And, as stressed by Dr. Cohen, anticipate detailed questions about your role in research and the direction you'd like that research to take. Just as important as your ability to answer the basic "What would you bring to our facility?" questions is your ability to ask questions about the center or practice and your role as a staff physician or scientist. Failure to ask questions conveys a lack of preparedness or, even worse, a lack of interest.

Ask your friends, ask your mentors. Don't be afraid to pick the brains of friends and colleagues who have already been through the interviewing process. Who better to tell you what to expect than someone who has already "been there, done that"? And while you're picking brains, be sure to include your mentors, who can tell you first-hand what they, and their colleagues, look for in potential candidates.

Conduct a mock interview. More likely than not, your fellow fellows are dealing with their own interview-induced anxieties. Talk to your colleagues about getting together for an evening of mock interviews, in which each of you has an opportunity to play the role of both candidate and interviewer, and then ask for and accept constructive criticism. This little exercise will, at the very least, give you a sense of what to expect before the big day and, even better, likely provide you with some pointers from those who will judge your interviewing skills with objectivity.

Dress for success. The rule of thumb for dressing for an interview is to wear what you'd normally wear to work once the job is yours. This, however, doesn't mean you should go to your interview in scrubs or a lab coat. Instead, choose attire that conveys a sense of professionalism.

Be genuine. Impressive people don't need to *try* to impress. Keep in mind that a successful candidate conveys confidence and an eagerness to learn. Keep your ego in check and let your work speak for itself. ■

Laura Bruck is a Cleveland, Ohio–based freelance writer and editor who has specialized in healthcare since 1987.

Physician Notes in the Age of Electronic Medical Records

By Alok A. Khorana, MD

With the adoption of electronic medical records (EMRs), healthcare systems in the United States are moving rapidly toward digitization. This movement is being driven by a variety of influences, including regulatory and governmental authorities, with the aim to increase accessibility to information, reduce errors, and improve compliance with quality and performance measures. The overarching objective is to allow physicians to gain control over the ever-increasing complexity of the current healthcare system. Indeed, the American Recovery and Reinvestment Act provides for both financial incentives and punitive measures that are designed to accelerate the adoption of EMRs.[1]

"I find note-writing to be the EMR's major shortcoming, as it tends to disrupt many of the intended uses of the traditional patient-progress note."

I personally welcome the introduction of EMRs into healthcare. My own research program has benefited from the advent of information technology. Our group has utilized large healthcare data sets to conduct analyses that would not be possible with clinical trials alone and has used electronic order entry alerts to improve patient outcomes.[2,3] From a clinical oncology perspective, writing chemotherapy orders is perceived to be safer and easier in EMRs, and most of us appreciate not having to hunt down paper charts for writing orders or for finding patient heights and weights.

Note-Writing in the EMR

Having transitioned to an EMR at my institution earlier this year, however, I find note-writing to be the EMR's major shortcoming, as it tends to disrupt many of the intended uses of the traditional patient-progress note. The progress note has a long and storied tradition in healthcare, and it serves many purposes. The first is documentation, as it captures essentials of the visit and reminds physicians of their discussions with the patient. A second purpose is communication, with versions of progress notes ("letters") sent to other providers for either information or to request input. A third—and more recent—purpose is compliance, with notes documenting mandatory preventive measures (for example, thromboprophylaxis in the inpatient setting or influenza vaccination in the outpatient setting) that can later be queried for quality-of-care audits.

The EMR first causes disruption outside of the progress note itself. Patients do not feel as engaged with their physicians, who are looking at the computer screen rather than the live patient in front of them. While many of my patients are forgiving of my focus on the screen, I find it difficult to practice mindfulness when multiple items on the screen (eg, laboratory results, flagged messages, imaging results) are all vying for my attention and competing with the actual patient.

One can accept disruptions if this leads to improvement over current capabilities. However, the primary uses of the progress note—documentation and communication—are disrupted as well, because EMR notes rely heavily on templates and point-and-click software applications. Although convenient for note-writing, such choices made by software designers (and not physicians) force us to reduce our patients to the "boxes" that have been provided by the software designer. For instance, if I wanted to document that the patient at a recent visit was anxious, but the choices offered by the program are "sleeping," "active," "cooperative," or "distressed," it might be easier to pick "distressed" even though it doesn't accurately convey the situation. This is not the physician failing to write a good note; it is a software program deficiency that narrows available choices for physicians and leads to an inaccurate capture of reality.

My concerns about this issue are affirmed by a recent critique of current software design by one of Silicon Valley's own pioneers. In *You Are Not a Gadget*, computer scientist Jaron Lanier states that information underrepresents reality and that current software does not have the capability to capture the nuances of human interactions (let alone the complexities of physician-patient interactions).[4] Even worse for future EMR development, Lanier describes the process known as software lock-in, where software choices made early in program development become entrenched for all future iterations of the program.[4] In other words, the choices made in currently existing programs, if accepted by end-users (physicians) as a sacrifice necessary for transitioning to EMR, will be kept for the next several generations of medical software. As Lanier points out, software lock-in "removes design options based on what is easiest to program, what is politically feasible, what is fashionable, or what is created by chance…[and] narrows the ideas that it immortalizes, by cutting away the unfathomable penumbra of meaning that distinguishes a word in natural language from a command in a computer program."[4]

Take Ownership of the Note

The genie, of course, cannot be put back in the bottle. EMRs are here to stay. What, then, can physicians do to optimize note-writing in the age of EMRs? The first step is to take ownership of the note: develop EMR "etiquette" based on consensus within your own group

of physicians. When you open the record on the desktop, explain to the patient exactly what you are doing. For those who are new to EMRs, apologize in advance for having your back turned. Many of my patients find it useful if I tilt the screen toward them, so they can view what I'm viewing and I can run through vitals, medications, and test results with them. This empowers the patient to be part of the record-keeping process and reduces the mysteriousness of the screen that you keep looking at as an alternate source of information. Avoid the temptation of cutting and pasting the enormous amount of data that are freely available through the EMR and are merely repeated in the note. Keep only what is essential (with a nod to the gods of billing compliance) and capture the heart of that specific interaction with the patient, so that the primary purpose—communication—is preserved. Avoid point-and-click boxes if they do not sufficiently capture the interaction; use free text instead.

All of this is, of course, harder to practice than preach. I am still learning, and my notes do not always achieve the ideal. But if we as physicians do not take ownership of the physician-patient interaction, who will? ■

Alok A. Khorana, MD, is associate professor of medicine and oncology and vice-chief for the Division of Hematology/Oncology at the James P. Wilmot Cancer Center and the Department of Medicine at the University of Rochester in New York.

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Reducing Errors During Patient-Care Handoffs

By Mateusz Opyrchal, MD, PhD

Providing medical care to patients in the hospital setting has become increasingly complicated. Large amounts of clinical data need to be processed, and new rules governing resident and fellow hours have resulted in fragmented care. There have been many initiatives to improve hospital care, and it is a process that needs continuous reevaluation and updating.

Communication between physicians has been identified as an area in which many mistakes happen. These can lead to potentially negative outcomes for our patients, such as prolonged hospital stay or death.[1] In 2003, the Accreditation Council for Graduate Medical Education instituted limits on the number of hours that residents can work in the hospital per 24-hour period. Although the goal was to improve patient safety by decreasing fatigue among residents, it had unintended consequences. The rules led to the increased need for multiple handoffs of patient care among residents, fellows, and attending physicians in the inpatient setting. Unfortunately, these communications are often not standardized and may lead to disastrous results.

Change-of-Care Perils

The change of physician on duty can be a perilous time for the patients, because the majority of medical errors resulting in liability have been traced to miscommunications.[2,3] The errors resulting from poor handoffs can include incomplete or incorrect lists of medications, incorrect code statuses, and inaccurate laboratory results. But the most serious mistakes are errors of omission, when the events of the last 12 to 24 hours are not relayed and the new physician does not have an accurate picture of the patient's health.

In the studies that examined liability claims, 26% to 31% of events were due to errors in communication.[2,3] There are not many data that directly evaluate physician-to-physician communication at the time of patient-care handoff. Specifically, there is a lack of data about teams caring for patients on internal medicine hospital services, although

a few studies report an alarmingly high rate of errors and omissions during change-of-care times.[4]

Over the past 5 years, the Joint Commission has made standardized communications a priority among physicians performing patient-care handoffs. However, there is no concerted effort to evaluate and recommend the most efficient and reliable methods. Individual institutions have designed their own solutions, although there are no high-quality data on which approaches lead to better outcomes in patient care and safety. Most institutions now use some form of electronic board that can be updated by various members of the team.[5]

"Unfortunately, there is great variation among different institutions and their approach to patient-care handoffs."

Unfortunately, there is great variation among different institutions and their approach to patient-care handoffs.[6] Some of the differences stem from the fact that there are many solutions to the resident-hour rules, ranging from the night-float system to residents staying overnight in the hospital and leaving early in the morning. It is disturbing to learn that the process was not standardized across institutions nor within specific programs.[6] These observations call attention to the lack of high-quality data needed to help institutions implement solutions that would assure patient safety, and to the lack of education for physicians and residents on how to efficiently and thoroughly communicate patient information to other physicians.

The uniform standardization of patient handoffs across all institutions might not be possible or even desirable due to the differences between academic institutions and private institutions. Also, hospital services caring for certain patient populations have their own requirements and points of emphasis specific to their specialties. Internal medicine services and especially hematology and oncology inpatient services have increasingly complex patients with multiple medical problems. It is imperative that physicians caring for these patients have up-to-date and accurate information.

Several existing studies offer recommendations to make the process safer. Face-to-face interactions between the 2 parties is essential in limiting errors.[7] This allows the physicians to ask questions and clarify information, resulting in more accurate patient data being transferred. Interruption-free time was also important in ensuring an error-free transfer of care. Computerized systems that automatically pull information from patients' charts help to reduce errors and make the process more efficient.[8]

Consistency in Communication

It is clear that the process of patient-care handoffs must be made safer and more efficient. The increasing implementation of sophisticated software programs will most likely improve the accuracy of the information as well as the efficiency of the process. Unfortunately, these ancillary products will not be able to replace a physician's necessary clinical acumen. One of the most important parts of the change of care is anticipation of potential problems and designing appropriate responses. All doctors do this to some degree while caring for their patients—often subconsciously. The challenge lies in communicating this information to others. No software program will be able to replace this interaction. Medical schools and residency programs will need to introduce or expand existing programs in teaching physicians the necessary methods to effectively and concisely hand off the care of their patients to new care teams. Likewise, institutions must continually reevaluate the process to decrease the number of poor patient-care handoffs, leading directly to improved patient safety. ■

Mateusz Opyrchal, MD, PhD, is a second-year oncology fellow with Mayo Clinic in Rochester, MN.

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Day in the Life of an Oncology Fellow

By Sheetal M. Kircher, MD

When my alarm goes off at 5:30 AM, I wake up prepared to play many roles. Juggling family life with 2 young children, caring for my patients as a fellow, and pursuing scholarly activities leaves little free time. One of the joys of being a fellow at an academic institution is that I really do not have a "typical" day. Each workday brings a different combination of patient care and research, both of which can be challenging and exciting.

By 7 AM, there has already been a lot of activity in my home. Changing diapers, feeding bottles, and searching for my elder daughter's favorite pink dress consume my early morning. Afterward, I rush to work so that I arrive on time for rounds.

If I'm on an inpatient service, by 7:30 AM my rounds are starting. The residents and interns are busy gathering patients' vital signs and orders, and I am preparing chemotherapy orders. As a fellow on rounds, I enjoy leaving issues such as uncomplicated diabetes and hypertension to the internal medicine residents while I focus on the oncologic care of the patient. After our attending hurries off the wards to clinic, I am in charge of the service and our patients. Most days on service I spend much of the morning going over plans with the residents and—most importantly—teaching the students what they must know about our oncology patients. I try to focus less on specific chemotherapeutics, which I am still learning myself, and more on treatment of complications and communication with patients. Even though I am still acquiring these skills, one of the most useful things I can teach the students is how to deliver difficult news to our patients. Medical schools and residency programs do an excellent job of teaching facts, treatment algorithms, and disease management, but the oncology ward is the ideal place for students to learn the art of communication.

If I am the hematology or oncology consult fellow during a given month, by 7:30 AM my pager has already gone off a couple of times. In my experience, the busiest

times in fellowship are consult services, when you never seem to be in enough places at once. On the positive side, however, this fast-paced work helps me learn the most about a wide variety of cases.

If I am not on service, which is typical now that I am a senior fellow, my morning is somewhat more relaxing. After many months of busy service as a first-year fellow, when I became a senior fellow I welcomed the opportunity to do clinical research in the comfort of my office. I can now spend my time reading and focusing on GI research. More specifically, I am working on a review article about pancreatic cancer and a clinical protocol for neuroendocrine cancers. I'm always working on multiple projects at once in hopes that at least some get published, or funded in the case of a grant. Even as a senior fellow, it is easy to be caught up in patient care at the hospital because there is always a need for a bone marrow biopsy, intrathecal chemotherapy, or orders to be written. It's very important, though, that I make enough time to pursue scholarly activities that will help me in my career and to become a better oncologist.

By noon, I have left the residents to manage the oncology service and I squeeze in a lecture. As a fellow, finding time to attend a lecture is a daily struggle. Between clinical work and research, it is very tempting to skip it so that I can catch up on work. Most days I do try to avoid this temptation, as the lectures are essential to my learning as a fellow.

After a quick bite to eat, it's off to clinic for the remainder of the afternoon. Now that I've been in clinic for a couple of years, the patients are familiar to me because I've had the opportunity to follow many of them as they progress through their treatment. Although my attending is in clinic with me, many of my patients now view me as their oncologist. Each afternoon in clinic is usually a mix of emotions as I share both good and bad news with them. It is not uncommon that in 1 hour of clinic I have rejoiced with one patient at the completion of her chemotherapy course and in the next visit have consoled another after learning that his malignancy has recurred. For me, each of these encounters is equally fulfilling, and I always leave clinic feeling privileged to have shared in these experiences with my patients, whether joyful or sad.

"Each afternoon in clinic is usually a mix of emotions as I share both good and bad news with my patients."

By 5 PM, although I am tired, I am excited about one of the best parts of my day. After finishing at least some of my clinic notes, I hurry down the street to pick up my kids from day care. The look on their faces when they see me is always reenergizing and is a much-needed break from the hospital. Although sometimes it is impossible, I try not to do any more work when I am at home. During fellowship, the time with my husband, kids, and friends is a precious thing. My evenings consist of tea parties with my daughter, rocking my son to sleep, and catching up with my husband. I have to admit that it is not always easy balancing my family with fellowship. It is difficult to completely keep family life and work separate in oncology because many of our patients depend on us even when it is not between the hours of 8 AM and 5 PM. Although I value keeping my family life the highest priority, I also hope that the dedication and time commitment I have shown to my patients and research will be a good example for my children.

By the end of the evening, fatigue has set in and I begin to prepare for the next day. There is always a recent article or textbook chapter to be read that oftentimes needs to wait until the next day. My clinic notes need to be finished too, but they will also need to wait until the next day. The beauty of oncology training is that tomorrow will offer new challenges to find enough time in the day as well as opportunities to learn more about how best to help our patients. ■

Sheetal M. Kircher, MD, has completed her oncology fellowship at Northwestern University in Chicago, IL, and is now an attending at the Ann Arbor Veterans Administration and University of Michigan in Ann Arbor, MI.

The Importance of Mentorship for Oncology and Hematology Fellows

By Josephine Feliciano, MD

What is mentorship? The term "mentor" originates with the mythological character Mentor, with whom Odysseus entrusted his son, Telemachus. Mentor was responsible for educating and instilling values in Telemachus when Odysseus departed for the Trojan War. Nowadays, mentorship is a partnership or relationship focused on education, inspiration, and support between a mentor and a mentee. This type of relationship forms part of the central structure of medical education, including hematology and oncology training. Mentorship can help drive your education, whether or not you choose to pursue a traditional academic career.

What Makes a Good Mentor?

Medical education is anything but a straight line. Different forks in the path may require guidance and counsel from individuals with unique perspectives. Thus, it is common, even ideal, for someone to identify multiple mentors as their career progresses. Though one can have multiple mentors, there are several tasks often required of a mentor or mentors. These include the establishment of trust, and the provision of logistical assistance, subjective advice, and feedback.[1] Overarching these tasks is the ability and willingness to inspire, support, and to invest in a mentee.[2]

During my training as a resident and fellow, various physicians have acted as mentors to inspire, support, and invest in *my* career. As a medical student and resident, I established an important relationship with a pulmonologist with whom I met periodically for career advice and general counsel. He inspired me with both his actions and his words. I learned that medicine is a lifelong education (though the tests slowly go away, you are never done learning) and part of that education is to question the status quo, to never stop asking "Why?" It was his bedside manner with patients, however, that was most inspirational to me as a young physician. His example of placing a hand on patients' shoulders while sitting down to listen to them, explaining their x-rays, and learning more about their life outside of the hospital was invaluable to me. Patients would open up completely to this physician and trust him immensely. He inspired me to simplify the complexities of medicine by putting the doctor-patient relationship above all else.

As a hematology/oncology fellow, 2 oncologists in particular were excellent mentors and supported me on an academic and personal level. As a new mother starting a fellowship, it was very difficult learning how to balance family life with a demanding academic schedule. Both physicians had developed successful academic careers, yet, as mothers and wives themselves, had navigated these same issues throughout their training. Their support and encouragement helped me learn to balance my time at work and at home, to be more efficient, and to understand that a successful academic career need not come at the expense of a happy family life. During my most challenging moments as a physician and as a mother, their support as empathetic mentors encouraged me to continue to work toward my goals.

I have had faculty mentors who, on a daily basis, helped me to build the foundation of my academic career. Common among them was their regular availability, constant logistical feedback, and tenacity with establishing goals and meeting them. They helped open doors for me, such as those that involved educational and research opportunities. They identified areas of my training that needed enhancement. They contacted and introduced me to colleagues, wrote letters of recommendation during my job hunt, and invited me to meetings. In short, the mentors in my medical career have demonstrated that they believe in me and are invested in my success.

Why Is It Important to Have a Mentor?

Medicine is not a career meant to be staked out alone. I would argue that it is difficult to be successful if you are not in a mentoring relationship. To avoid stasis and regression, we need examples to inspire us and we need the objective feedback that an invested mentor can provide. This continuous pursuit of improvement is vital in the field of medicine, where change is constant.

The mentorship relationship is surely not a one-way street. It is vital that you take the role of being the mentee just as seriously as finding the right mentor(s). You need to be open to criticism and understand that challenges provide opportunities for growth. Instead of viewing challenges as a nuisance, you should use these opportunities to prove to yourself that you are capable of more than you may have imagined. Furthermore, you as the mentee must be just as invested in the relationship as the mentor, by being available, working hard, and spending the time to improve yourself. You should also provide regular feedback to your mentor, because there is no cookie-cutter approach to the mentoring relationship.

How Do You Choose Your Mentors?

Most of the mentors in my life have been physicians with whom I got along well on a personal level. They were physicians who inspired me and after whom I hoped to pattern my own career. From a clinician's standpoint, I chose people to emulate who I believed were excellent clinicians, had a wonderful bedside manner, and always placed the best interests of the patient above anything else.

Finally, from an academic standpoint I looked for mentors who were successful in their field, even if they were in one that was different from mine. I knew I could learn skills such as clinical trial design or grant writing, for example, that were necessary for a successful academic career and apply them to oncology and hematology. I also looked for mentors who would take the time to meet with me on a regular basis so I could be sure I stayed on the right career path. I looked to find those who were as invested in my success as I was. I also sought out individuals who had successfully mentored others in the past. ■

Josephine Feliciano, MD, is a junior faculty member at the University of Maryland's Marlene and Stewart Greenebaum Cancer Center in Baltimore.

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MOBILE MEDICINE: APPS FOR THE HEALTHCARE PROFESSIONAL

Genentech BioOncology HD App

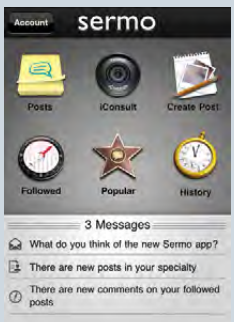
PRICE: Free
PLATFORMS: iPhone, iPad

This app provides all healthcare professionals with free access to the most recent oncology news and resources. Some of these resources include information about Genentech's research as well as Genentech and non-Genentech clinical trials.
http://bit.ly/sNPJyv

Sermo Mobile App for Physicians

PRICE: Free
PLATFORMS: iPhone, iPad, iPod Touch

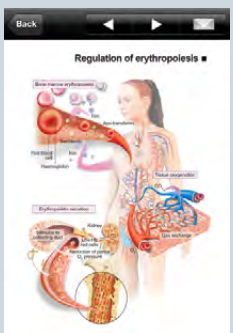
Enables physicians to access 120,000 other medical professionals for real-time opinions and expertise on any number of medical topics. One key new feature is iConsult, which in 3 touches allows a user to take a photo of an x-ray, physical finding, or lab result and send it to specialists in the Sermo network for consultation.
http://bit.ly/ujXjtc



Miniatlas Hematology

PRICE: $9.99
PLATFORMS: iPhone, iPad, iPod Touch

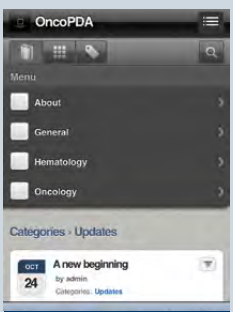
Physicians can use this app to show their patients the anatomy, physiology, and pathology of their blood disorder. According to the company, all images are of high quality and are accompanied by detailed explanations.
http://bit.ly/t2lXzK



OncoPDA Apps

PRICE: Free
PLATFORMS: iPhone, iPad, iPod Touch; Android; BlackBerry; HP Web OS

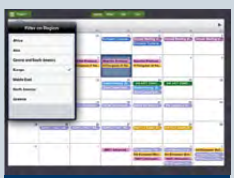
This site allows oncologists and hematologists to download a number of different apps that include common hematology/oncology algorithms.
http://oncopda.com



TRM OncoCalendar App

PRICE: Free
PLATFORMS: iPad

This app provides access to information about worldwide oncology congresses and events, as well as the details that accompany them.
www.trmoncology.com



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

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What Oncology and Hematology Fellows Can Do to Reduce Their Loan Debt

BY MATTHEW T. CORSO

While debt from medical school loans is inevitable for most oncology and hematology fellows, there are strategies they can consider to lessen that burden. Moreover, recent announcements from the Obama administration would cut loan debt for some medical school borrowers.

Nevertheless, many fellows and young physicians still face substantial debt when they complete their schooling. Matthew Shick, senior legislative analyst for the Association of American Medical Colleges (AAMC), told *Oncology Fellows*, "Medical school tuition and fees continue to rise. The amount medical students borrow to pay for medical school has averaged around $160,000 for the past 3 years (as reported by medical students graduating in 2009, 2010, and 2011)."

Similarly, the American Medical Association (AMA) estimated the average educational debt of indebted graduates of the class of 2010 at $157,944.

However, some good news has emerged to brighten the financial outlook for borrowing students. The Obama administration announced in late October that it will reduce the maximum required payment on student loans from 15% of discretionary income annually to 10%. Obama said the plan would go into effect in 2012, instead of 2014. In addition, the White House says the remaining debt would be forgiven after 20 years, instead of 25. The proposal is expected to affect some 1.6 million borrowers starting in 2012.

In other good news, AAMC's Shick said that recent statistics indicate that "Since 2008 we've started to see a recent trend of medical education debt leveling off."

Finally, the economic stimulus bill that President Obama got through Congress includes an additional $300 million for students who agree to take public service jobs, including those in medicine.

Still, many observers of healthcare trends contend that the spiraling debt burden has serious consequences for American medicine. For example, Catherine Spina, MD, a PhD candidate at Boston University School of Medicine, and immediate past chair of the Organization of Student Representatives (OSR) of the AAMC, wrote in a newsletter in February 2011: "The grim financial outlook of state-funded schools has translated to an increased burden on the learner. As a result, many matriculating medical students arrive with more debt from their undergraduate educations and are forced into deeper debt as they shoulder the expense of soaring medical school tuition."[1]

One possible consequence of the crushing weight of debt, according to some observers, is to steer young physicians into the higher-earning specialties rather than lower-paying primary care medicine. S. Ryan Greysen, MD, assistant clinical professor of medicine for the Division of Hospital Medicine at University of California San Francisco, who has written on the subject for *The New York Times*, said that "My sense is that the rising cost of medical education may be part of a cultural shift where the practice of medicine is more of an investment than a calling. I make the argument in my [*New York Times*] article that medical education is seen now as a personal investment and I hear colleagues refer to their debt as a 'mortgage,'" especially since "obtaining medical education in the United States has become a loan-dependent, individual investment."

Greysen is quick to point out that the data on how school loans affect the kind of medicine young physicians choose to take up are ambiguous, with some studies showing that it has minimal effect.

"The studies here are often conflicting—some show that students with higher debt are less likely to practice primary care or work with underserved populations but others show there is no relationship with debt," Greysen said. "Several recent studies have shown correlations between debt and stress or burnout—and these may affect students' decisions about which specialty they enter," he added.

Shick said of this issue: "In the 2011 AAMC Graduate Questionnaire, students reported personality fit, specialty content, work/life balance, role model influence, future family plans, fellowship training options, income expectations, length of residency, competitiveness of specialty, and expectations of family as having a higher influence on specialty choice than student debt."

However, he added: "That being said, the cost of medical education weighs more heavily on certain

"The amount medical students borrow to pay for medical school has averaged around $160,000 for the past 3 years."

cohorts of students. With the high price tag and expected debt burden, the decision to attend medical school can be daunting for socioeconomically disadvantaged and minority students who are typically more averse to taking out high loan volumes."

Nonetheless, oncology and hematology fellows do have choices that can substantially reduce their debt.

Public Service

One of those choices is public service medicine that makes young physicians eligible to receive loan repayment programs (LRPs). Applicants for these programs must agree to commit to practicing for a specified time in a medically underserved region of the United States or in research at an approved institution.

The National Institutes of Health (NIH) is the largest provider of LRPs, recruiting physicians to practice in areas designated by the US Health Resources and Services Administration either as a Health Professional Shortage Area or a Medically Underserved Area. To qualify for this program, applicants must be willing to work full-time serving patients in the designated areas.

For example, the American Society of Clinical Oncology LRP, funded by Susan G. Komen for the Cure, provides repayment of qualifying educational debt to oncologists or oncology fellows who, after completing their training, commit to practicing oncology in a medically underserved region of the United States. The LRP will repay up to $35,000 per year for 2 years (up to $70,000 total) of qualifying education loans. For questions, contact grants@asco.org or call 571-483-1662. [*Editor's note:* For more on loan repayment programs, see Finance for Fellows in the October 2011 issue of *Oncology Fellows*.]

Increased Funding for Public Service Medicine

The LRPs get funding through the National Health Service Corps (NHSC), which has been given a financial boost from Congress and the Obama Administration. The American Recovery and Reinvestment Act of 2009 (the so-called stimulus package) provides an additional $300 million in funding for NHSC, including $168 million for LRPs, to increase the physician workforce in medically underserved areas.

According to AAMC's Shick, the expanded funding means that NHSC practice locations will increase significantly, to include urban and rural areas not previously designated as health professional shortage areas. He predicted that the program, which is already strong, is going to be even stronger, providing many more opportunities in urban areas than there were in the past.

An option for oncology and hematology fellows is military service. The Armed Forces, through the Health Professionals Loan Repayment Program (HPLRP), offer up to $40,000 per year to physicians who commit either to active duty service or to service in the National Guard or Reserves, or to the Veterans Health Administration. [*Editor's note:* For more on HPLRP, see Finance for Fellows in the October 2011 issue of *Oncology Fellows*.]

"Expanded funding means that NHSC practice locations will increase significantly, to include urban and rural areas not previously designated as health professional shortage areas."

Ideas for Reducing Student Debt

The AAMC, Shick said, has advocated strongly for the following proposals:

- Reduce the amount of interest paid on federal Stafford loans through the Department of Education. At the current 6.8% rate for graduate and professional students, medical students can expect to repay between $300,000 and $450,000 on the average $160,000 medical education debt (between $140,000 and $290,000 in interest).

- Increase funding for the NHSC, the federal program that provides scholarships and loan forgiveness in exchange for primary care practice in underserved areas.

Additionally, Shick said, the AAMC sponsors Financial Information Resources Services and Tools (FIRST) for medical education. He said this program "offers a full range of resources for medical school applicants, students, and residents to help expand their financial literacy, make smart decisions about student loans, and manage their student debt wisely." Students and fellows can learn more about this program online at www.aamc.org/first. ■

Matthew T. Corso is a veteran editor and writer who has worked in medical publishing for more than 25 years.

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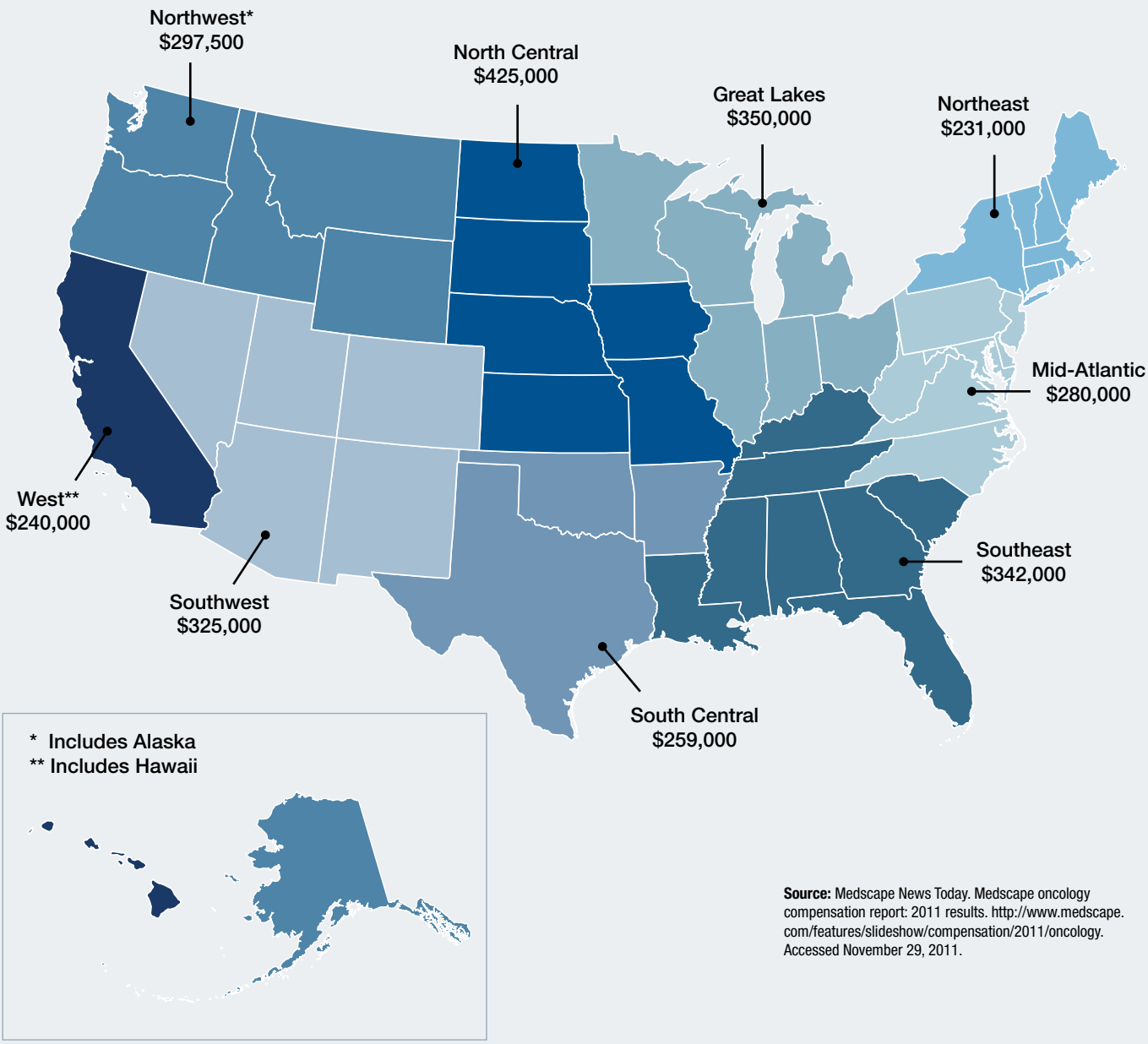
What US Oncologists Are Earning: Medscape's 2011 Report

At first glance, you might be struck by the seemingly odd distribution of oncology salaries in the United States. For example, why would oncologists in the Mid-Atlantic region, where the cost of living is relatively high, have lower median salaries than the North Central region, where the cost of living is lower?

According to Medscape's 2011 report, it is due to the higher concentration of research hospitals and community oncology practices in the Northeast, Mid-Atlantic, and West. These institutions increase the competition for oncology positions and thus lower the median salaries.

FIGURE. *Oncologist Compensation by Geographic Area*



Source: Medscape News Today. Medscape oncology compensation report: 2011 results. http://www.medscape.com/features/slideshow/compensation/2011/oncology. Accessed November 29, 2011.

2012 Oncology & Hematology Meetings

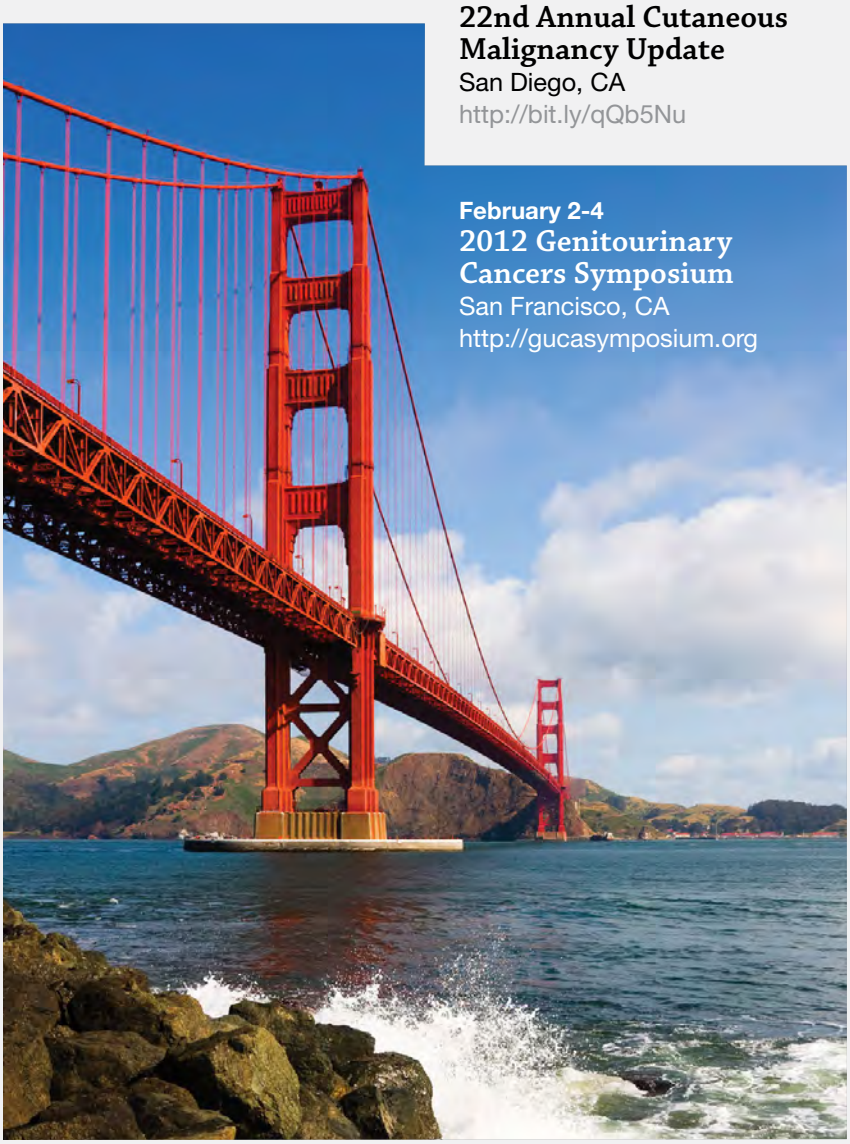
January 12-14
Clinical Hematology and Oncology 2012: 9th Annual Mayo Review
Scottsdale, AZ
http://bit.ly/nEuyKI

January 14-15
4th Annual Symposium on Clinical Interventional Oncology
Miami Beach, FL
http://bit.ly/trQJ5r

January 19-22
9th Annual GI Cancers Symposium
San Francisco, CA
http://bit.ly/uthiww

January 19-22
Radiation Therapy Oncology Group Meeting
Atlanta, GA
http://bit.ly/qTw2F4

January 21-22
Melanoma 2012: 22nd Annual Cutaneous Malignancy Update
San Diego, CA
http://bit.ly/qQb5Nu



February 2-4
2012 Genitourinary Cancers Symposium
San Francisco, CA
http://gucasymposium.org

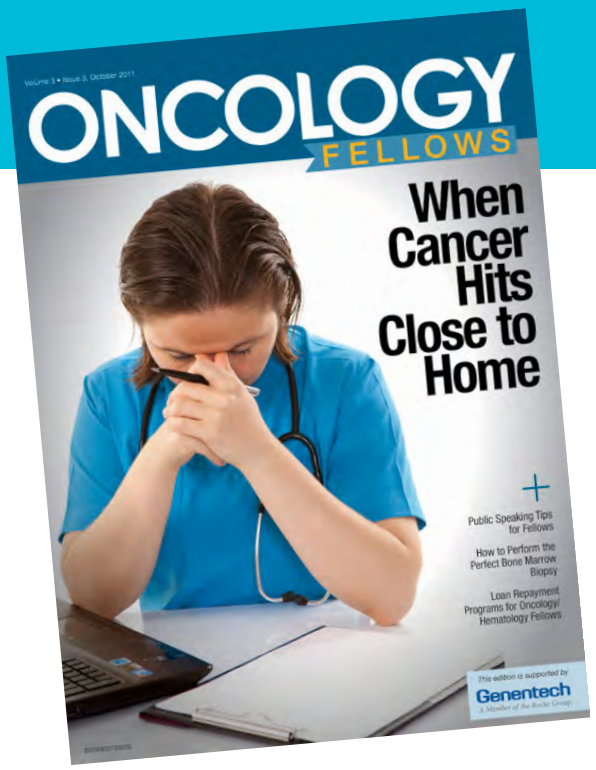
February 23-26
15th Annual International Congress on Hematologic Malignancies: Focus on Leukemias, Lymphomas, and Myeloma
Snowbird, UT
http://bit.ly/qD3aox

March 14-17
29th Annual Miami Breast Cancer Conference
Miami, FL
http://bit.ly/nkDSmS

March 21-24
SSO 65th Annual Cancer Symposium
Orlando, FL
www.surgonc.org/meetings--events/annual-cancer-symposium.aspx

March 25-28
2012 Annual Meeting on Women's Cancer
Austin, TX
www.sgo.org

May 3-6
37th Annual ONS Congress
New Orleans, LA
www.ons.org/CNECentral/Conferences/Congress



CALL FOR PAPERS

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

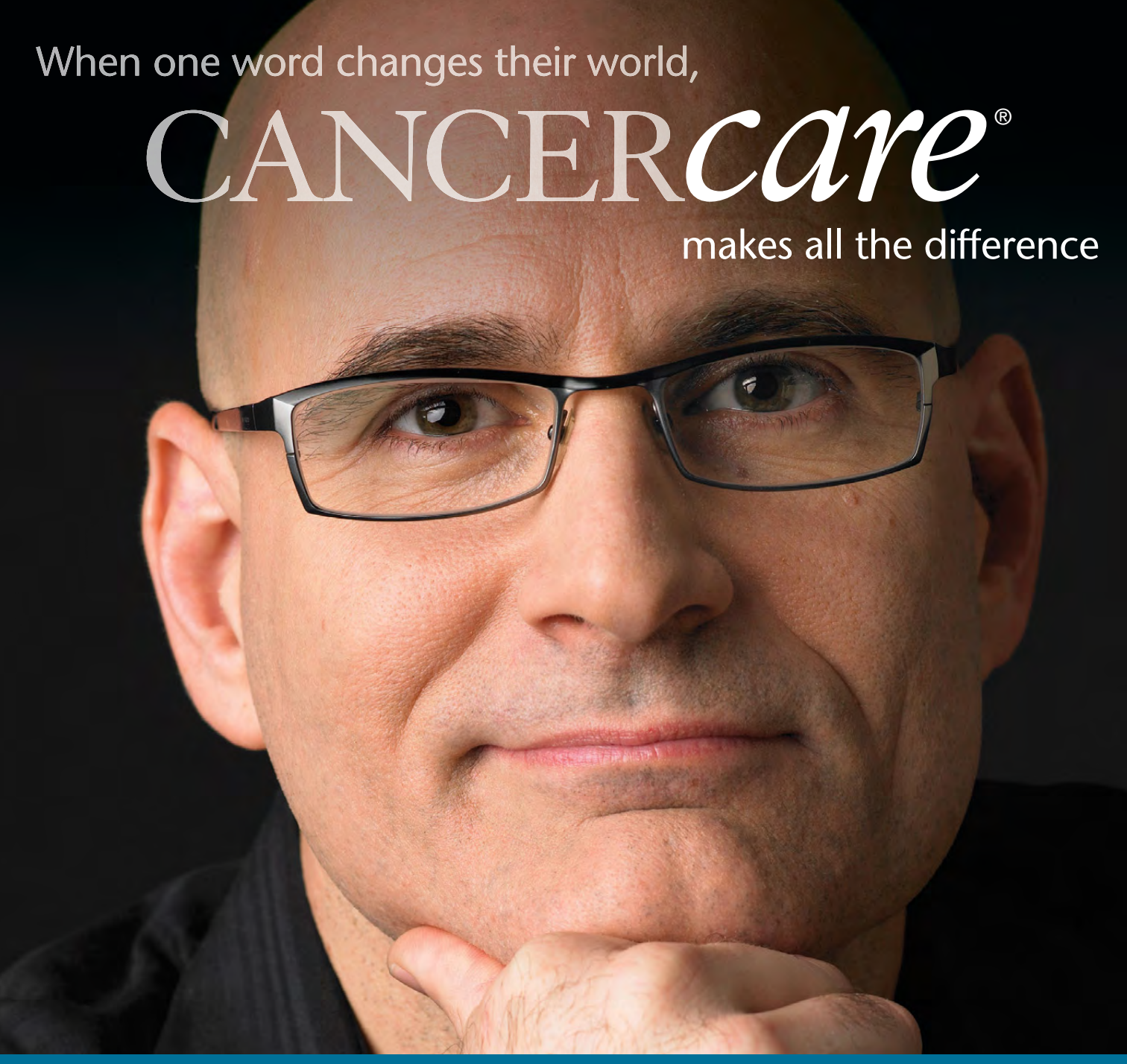
Oncology Fellows features articles written by practicing physicians, clinical instructors, researchers, and current fellows who share their knowledge, advice, and insights on a range of issues.

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

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

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

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



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We would like your feedback on *Oncology Fellows*. Please complete the survey below and drop this postage-paid postcard in the mail!

1. Overall, how would you rate the information and resources found in *Oncology Fellows*? (5 = very useful, 1 = not useful at all)

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

2. Which topics would you most like to see addressed in future issues?

❑ Personal finance and money management
❑ New developments in medical technology
❑ Subspecialty-specific clinical and research updates
❑ Career advice
❑ Other (please specify) _____

3. In my opinion, the number-one topic that oncology fellows need more information on is: _____

_____

4. How important do you think it will be to effectively use information technology in your clinical career, if applicable? (5 = very important, 1 = not important at all)

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

5. How often do you go online to research clinical information?

❑ 5 or more times a day
❑ 2-4 times a day
❑ Once a day
❑ A few times each week
❑ Once a week
❑ Hardly ever

❑ Please contact me—I am interested in contributing an article for an upcoming issue.

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