

ONCOLOGY

FELLOWS



What I Have Learned Since Fellowship

Tips for professional success and happiness

Learning to Deliver Bad News

Help Prevent Costly Malpractice Suits

Finding Hope Amid Cancer's Destruction

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What I Have Learned Since Fellowship

Tips for Professional Success and Happiness

By Lawrence B. Afrin, MD

I have just finished my 15th year on faculty and my 13th year directing the hematology/oncology fellowship program at the Medical University of South Carolina. Although none of what I have learned along the way is truly novel, I hope that a few observations born of experience in my professional life will help you achieve success and happiness in yours.

Board Exams

Take 'em, Take 'em Early, and Keep On Taking 'em Until You Pass 'em

Take whatever boards you are eligible for as early as possible. A board exam covers the specialty's full breadth, yet odds are good that once in practice you will quickly come to focus in some subset of the specialty. Do not be surprised if you quickly lose much of your knowledge, skills, and currency in any area in which you do not regularly practice. So take your exams at the earliest opportunity. For those training in combined hematology/oncology, do not wait to take the hematology exam until the year after taking the oncology exam. And if you feel you need extra study time, ask for it (ideally when negotiating your employment arrangements). Your employer wants you to obtain and maintain certification for all boards for which you are eligible, so a wise employer should grant you a reasonable amount of study time if you think you need it.

Experience Always Trumps Reading, but if Reading Is All You Can Do....

Unless you are convinced your knowledge in a particular area is deficient, do not bother studying much for your first attempt at the boards, with 1 exception: hematology/oncology fellows should not forget that gynecologic oncology is on the oncology boards. In many adult medical oncology and hematology/oncology programs there is little opportunity to attend didactics in—let alone practice—gynecologic oncology, so this area of the boards can

“The best advice I can give you is to know yourself and then do what makes you happy.”

hurt you if you have not even read in this area. Remember that board questions are written carefully, and it has been my consistent observation across multiple exams that if you have seen a case of X within the last year or so, you will quickly know the right answer. Conversely, if you have never seen a case of X, you may be able to narrow it down to a couple of choices, but mere preparatory reading likely will not help you any more than a coin flip would. So if you fail an exam, actively seek opportunities to practice (and read) more in the areas in which you were deficient. (You will always learn far more from practice with reading than reading without practice.) Then take that exam again as soon as possible.

Do Not Waste a Year of Your Life

If you are in a combined adult hematology/oncology program and facing the prospect of not 1 but 2 (expensive) exams, just suck it up and take them both until you pass them both. It is silly to have spent an unrecoverable year of your life in exchange for a modest fellow’s salary and the right to take the hematology boards—and then end up not getting certified in hematology. (At that rate, you would have been far better off doing just 2 years of oncology training and going right out into practice.) So take ‘em both until you pass ‘em both. It makes an important statement to yourself, your colleagues, your institution, and, most importantly, your patients. And if you flunk the hematology boards on your first attempt but then are so focused on your oncology practice that you realize you need to take a hematology review course prior to retaking the hematology boards, then by all means take a hematology review course.

Your Next Board Exam Is Sooner Than You Think

Maintenance of certification (MoC) processes are far from perfect, but they are the best methods we have for assuring those around us of our continuing competency. You should keep abreast of the seemingly ever-changing MoC requirements and develop a plan to meet the requirements starting at the earliest possible point. Your practice and perhaps other work will quickly grow to consume your professional life, so if you have not developed and followed your MoC plan, you will find it needlessly challenging and anxiety-provoking to rush at the end to finish everything that must be done before you can once again sit for the boards.

Career Direction

Don’t Worry, Be Happy

Barring the grossest lapses of competence and professionalism on your part, you will always be highly employable—likely in the setting of your choice, too. Furthermore, as you age, you’ll increasingly appreciate how short life is, particularly the truly healthy portion. Therefore, the best advice I can give you is to know yourself and then, whenever possible, do what makes you happy. And, if your interests change in time—especially if you reach a point where, day after unending day, you get up in the morning not looking forward to what awaits you—be willing to change your work.

Loans? My Happiness Doesn’t Need No Stinking Loans

When you finish fellowship and enter practice, you will quickly earn enough to provide you and your family a good quality of life and still be able to pay back your student loans far faster than you might be able to believe right now. Therefore, I recommend you try to not let the size of your loan portfolio drive your choice of initial job. Select the position you feel you will enjoy the most rather than the one that will compensate you the most.

Making the Transition

I’m Really in Charge Now?

As recently discussed by William Wood,^{1,2} a regular contributor to *HemOnc Today*, the initial post-training stage of your professional life may be the most unnerving you will ever face, quite unlike the beginning of your internship or fellowship.

Late in fellowship you will be pretty comfortable in your work due more to a growing base of experience than a growing base of knowledge. But another invisible factor contributes substantially to your comfort in training: you still are not *responsible* for what happens to your patients, at least not nearly to the extent that your faculty are. But as noted by Dr. Wood, suddenly one morning—and for the rest of your career—no one is more responsible for the consequences of your actions than you.

My recommendation: do not worry so much about being smart, and instead just be willing to work hard—and

be humble. Quietly do what you are confident in doing, but when you realize you know less than would best serve the situation, admit it and seek help. Tell the patient you need time to review the latest literature. Step outside the exam room and ask your colleagues for advice. Present the case at tumor board. If there is not a tumor board where you practice, start one. Your peers and patients will be more impressed with you for your self-recognition of your deficiencies and your quest for self-improvement.

A Few Points for Success in Practice

The Toughest Decision: Doing Nothing

Advancements in medical science and in the evolving medicolegal and healthcare financing landscapes have created an often inappropriate sense of obligation, even a terrible temptation, to *do* things to patients. Early in your career, when your experience base is still relatively light, there can be insufficient appreciation of the potential for harm—medical, financial, and otherwise—posed by many interventions, both diagnostic and therapeutic. In 2011 cancer remains a bad disease, and though a

majority now survive their disease,³ about a third still do not. Therefore, “first, do no harm” remains a terrific guiding principle.

Patient History: The Hematologist’s Best Friend

Typically, different types of satisfaction are gained from addressing oncologic problems versus hematologic problems. In malignancy (solid or liquid), the diagnosis is rarely in question. (Do not be misled by the disproportionate share of unusual cases of diagnostic question that funnel into an academic center.) Thus, your satisfaction as an oncologist is largely derived from (1) identifying which treatment likely will offer the greatest benefit/cost ratio and (2) using your knowledge and skills to guide the patient through the treatment as effectively and comfortably as possible. After that, aside from further surveillance and prevention efforts, there is not much more for you to do than what your patient has been doing all along: hope for the best.

In nonmalignant hematology, though, the diagnosis is often the primary question. Toward that end, I will opine that the diagnostic hematologist’s best friend is almost always the patient’s history. The modern pressures impeding the physician’s ability to take a full history are apparent, but you will have a pretty good idea by the end of the evaluation

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“It fundamentally remains your choice in every encounter how much you will succumb to the ever-present pressures to minimize your time with the patient.”

what the correct diagnosis is if you (1) take a *complete* history and (2) always give preference to diagnoses that unify as many of the case findings as possible. The quickest route to erroneous diagnosis, futile (even harmful) diagnostic and therapeutic interventions, and dissatisfaction of all parties is skimping on history-taking and focusing exclusively on the patient’s hematologic issue.

Most nonmalignant hematologic aberrancies are reactive, not primary. Make a point of figuring out the true root of the problem if you want the best outcomes. If you cannot figure it out at first (for lack of time or whatever other reason), do not give up. Revisit the situation soon and again think about the best unifying diagnosis. And if a few at-bats still do not yield the right answer, be humble and ask for help. Truly new, never-before-seen diseases are extremely rare, so it is far more likely that the situation indeed is diagnosable and just needs a fresh look—and the persistent use of readily available knowledge sources.

Normal Is Not Always Normal and Abnormal Is Not Always Abnormal

Look at every test result (there is a reason that a complete blood count includes more than just hemoglobin, leukocyte, and platelet counts) and try to at least briefly ignore the presence or absence of the High/Low flags, asking instead whether the result is Expected/Unexpected. (Oh, for a computer that could show “E/U” instead of “H/L”!) For example, try to train yourself not to reflexively think—let alone reflexively work up or treat—“iron deficiency” upon seeing microcytosis. Take a moment to trend the parameter and put it in context. For example, chronic stable mild microcytosis in a black person is far more likely to be alpha thalassemia than iron deficiency. Conversely, a newly “normal” mean corpuscular volume in a known thalassemic may bear as much significance as frank macrocytosis in a nonthalassemic.

What Patients Really Want From Their Physicians

Sure, your patients would like you to cure them, but they understand this often is not possible, so what they want even more is for you to allay as much as possible their physical pain and then the psychological pain that comes from the uncertainty about their future (and their family’s future) that is inherent with any serious illness.

Allaying a patient’s uncertainty takes a physician’s time; there is just no way around it. But it fundamentally remains your choice in every encounter how much you will succumb to the ever-present pressures to minimize your time

with the patient. Furthermore, though you may enjoy the artifice of duty hour limits while in training, once in practice you should never forget that in becoming a physician, you *chose* to always place your patients’ interests before yours, so always try to give your patients whatever time of yours they need. As a rule to live by, “do unto others as you would have them do unto you” will not be going out of style anytime soon.

Final Words

Odds are you will be competent upon finishing your training, but competence is merely necessary, not sufficient, for happiness. If you got into medicine for the reason most of us did, every day you spend serving your patients and colleagues the *best* you can will go a long way toward furthering your own happiness. Good luck!

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Feature

Simple Communication Can Help Prevent Costly Malpractice Suits

By Ed Rabinowitz



Each year the healthcare industry weathers a heavy financial burden: the cost of medical malpractice claims. In the article “10 Ways to Reduce Medical Malpractice Exposure—Doctors, Lawyers, and Lawsuits,” which was published in the March 2002 issue of *Physician Executive*, Dr V. Franklin Colon reported that the annual dollar costs were well into the billions. The solution to the problem, however, is not to pay out exorbitant premiums to ensure adequate malpractice insurance coverage. It is much simpler than that.

“I think oftentimes the simplest things are the most effective,” said Gerald Chambers, a medical malpractice defense attorney at the law firm of Turner Padgett Graham & Laney P.A., based in Columbia, South Carolina. “Communication is one of the major factors in avoiding litigation and assisting in the defense of a lawsuit, as well.”

And it takes only a few minutes.

Building Rapport

Peter Hoffman is an attorney and chair of the Professional Liability Group at Eckert Seamans, a law firm in Philadelphia, Pennsylvania. He said that people go into medicine because they want to help others. They work hard in college and medical school, and then at some point between their second year in medical school and when they become an attending physician the situation changes. For many physicians, several factors—such as the sheer amount of work and responsibility—can cause them to treat patients as cases, not as people.

“The people and families that they’re dealing with...are under a tremendous amount of stress [and] uncertainty, and they know their life is changing—and certainly not changing for the better,” Hoffman explained. “I think that the most important thing for [oncology fellows] to realize is that they’re dealing with people, not 3 x 5 index cards. And they owe to their patients and to themselves, the time that it takes—maybe time that they don’t think they have—to develop a relationship and rapport with these people and with their families.”

Chambers echoed those thoughts. He said that numerous lawsuits are brought by patients or their family

members simply because they got angry with the physicians. They feel that the physicians have not spent enough time talking with the patients and helping them to understand their cases.

“Sometimes it’s just that the patient is upset with their doctor because they feel like they’re not being given the time and the attention that they deserve,” Chambers said. “Often this is avoided by simply spending a couple of extra minutes with them.”

He also pointed out that discussions between physicians are equally important, especially in an oncology practice, where various consultations with the patient are necessary and sophisticated lab tests need to be

ordered. It is also critical to communicate with the lab to ensure that the results of an ordered test do not slip through the cracks.

“And make sure the results are being communicated between the various physicians who may be taking care of a patient,” Chambers added. “Because often it’s not just 1 doctor who’s taking care of a patient, it’s a team of doctors. And you need to make sure that everyone understands what the game plan is and who’s responsible for what.”

Detailed Documentation

Along with communication, documentation is critical for helping to avoid malpractice claims. Even effective, thorough communication should be documented. Dr Barry Lang was an orthopedic surgeon for 23 years and has worked for the past 15 years at Law Doctors, a medical malpractice agency based in Boston, Massachusetts. He claimed that he was able to effectively link communication and documentation during his years as a practicing physician.

“I had a Dictaphone in every examining room, and the purpose was several-fold,” Lang explained. “Number 1, when you speak with a patient—when you take their history and describe what their treatment program is going to be—it helps to have the patient hear it a second time. And since you have to make

“Gerald Chambers said that numerous lawsuits are brought by patients or their family members simply because they got angry with the physicians.”

notes of the encounter anyway, you might as well give the patient the opportunity to hear it a second time.”

Lang continued, “So after I had completed taking the information from the patient after the examination, instead of waiting until the end of the day to try to recall what may have gone on with 20 or more patients—or just scribbling a few notes where I might leave something important out, and then leaving the patient with just 1 conversation between the two of us—I would pick up the Dictaphone and I would dictate a complete note of what just transpired.”

Lang said the Dictaphone not only saved him time and effort, it gave the patient the opportunity to hear the exchange a second time and opened the door to an additional opportunity for discussion.

“Then you ask the patient, ‘Did I forget anything and do you completely understand?’” said Lang. “If there are any questions at that time, you can go over them. So not only does that help the doctor, it also helps the patient. In addition, it may help avoid litigation—or if there is litigation, you have a set of notes that outline everything you did for your own defense.”

Chambers agreed. He says it is critical for oncology fellows to ensure that patients understand, to the best of their ability, the recommendations and treatment options they are being presented with. And in the field of oncology, it may be difficult for a layperson to understand the concepts and terminology that physicians often take for granted.

“It’s a lot easier to put an X-ray up on a screen and say, ‘Okay, here’s where you broke your arm’ than to put up an MRI and say, ‘There’s where your cancer is,’” Chambers said. “I think with oncology more so than other fields, you just have to take more time to explain to the patient what their situation is and what the treatment options might be. You don’t want to over-document, which

“Just because the document states that the form covers everything, including death, does not completely protect the doctor.”

can become problematic as well, but you need to communicate, and you need to document your communication, as well.”

Informed Consent

Lang noted that a very important part of communication is informed consent. Too often the informed consent form is just a printed sheet from the hospital that is very generalized. “And I would say that in my practice, about 9 out of 10 times, nothing is filled in by the doctor,” he claimed. “There’s just a signature on the bottom of the page by the patient and the doctor.” Lang explained that informed consent does not relieve the doctor of negligent care. Just because the document states that the form covers everything, including death, does not completely protect the doctor. Instead, the physician needs to write in certain common complications that he or she has spoken about with the patient.

“A doctor isn’t responsible for writing down every possible complication of every procedure,” Lang said. “His writing would have to be encyclopedic. He doesn’t have to include extremely rare complications. The law protects him with that.” Lang continued, “But if the doctor knows that there are certain complications that can occur with a surgical procedure...he should write that down so the patient understands, and so the

patient can’t later say the physician didn’t discuss that.”

Lang also stressed that there is a time and place to obtain a patient’s informed consent. He said that the form should be signed during an office visit before the patient is admitted to the hospital. That indicates that the doctor has spent time talking to the patient and that the patient did not sign a bunch of papers without reading them while stressed and/or medicated.

“You’re talking about the expenditure of a few minutes to save 4 years of litigation,” Lang said. “It’s well worth the investment. A lot of doctors are rushed, they’re overworked, and these things slip through the cracks, and then they get into trouble. And it’s really so easy to take those couple of extra minutes just to avoid the litigation.”

A Matter of Trust

Hoffman explained that the bond between patients and physicians is very important. He urged physicians to look their patients in the eye and talk to them as if they matter—as though they were speaking with their own aunt or uncle. Hoffman said, “Put them at ease and develop a trust.”

And when things go wrong? Hoffman said, “[With something] as simple as an IV injection that’s not done the right way, or [with] an IV that’s hard to establish and the patient

is in pain, the physician has to say, 'I understand this happened and I apologize for that. This is what we're going to do to try to make it better.' That's a skill that's not taught."

Hoffman pointed out that cancer is often referred to as The Big C, but that "C" also stands for "communication." He said, "You only have so much time with the patient, but you want to make them feel that they're the only thing on your mind at that time."

If You Suspect Litigation

Despite all your precautions, malpractice claims are going to occur. Chambers said that if there is even the slightest hint of litigation on the horizon, you should contact your malpractice insurance company.

"Typically, most [malpractice] carriers will go ahead and investigate the claim and even retain an attorney

to investigate it," Chambers said. "For instance, if you get a request for a medical record saying something to the effect [of] 'We are requesting the medical record of this patient to determine whether or not the treatment you provided was appropriate'...you need to immediately put your carrier on notice, and more likely than not they will get an attorney involved in investigating that claim early on."

Chambers pointed out that in most states the statute of limitations is somewhere around 2 to 3 years, and it is typical that a plaintiff's attorneys will wait until the very end of that time to file a lawsuit.

"All of a sudden you're trying to remember back to what happened 2 years ago, and people may have moved on," he said. "There may have been a key nurse involved who is no longer there, or a

partner [has] moved on. It's just not as fresh in your memory. So it's always best to start investigating those [malpractice] claims at the earliest opportunity."

Ultimately, there are no guaranteed, surefire ways to make you immune from malpractice charges. But if you show your patients that you are not arrogant, you care about them, and you will take the time to allay their fears, you have made a crucial first step toward potentially preventing a costly lawsuit.

Ed Rabinowitz is a veteran healthcare journalist based in Upper Mt. Bethel Township, PA.

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Learning to Deliver Bad News

By Sheetal M. Kircher, MD



How do you tell a 45-year-old mother of 2 that not only has her breast cancer returned but it is now incurable? Or how do you explain to a 22-year-old student that despite intensive chemotherapy and a 6-week hospitalization, he still has acute leukemia and is not eligible for a bone marrow transplant? Even for an experienced oncologist, walking into a room and initiating a conversation that will change the life of someone who sought your help can be a daunting challenge.

Early in your oncology training, learning the biology and treatment of a dozen malignancies was a task that seemed overwhelming. For many oncologists, knowing how to compassionately deliver bad news—something that is often learned through trial and error—is less important than absorbing and understanding an avalanche of cancer-related information. But just as you need to know how to discuss the efficacy and side effects of a chemotherapeutic agent whose name at first you could barely pronounce, you must learn to disclose the truth with sensitivity for patients' concerns. This is a vital skill that all oncologists must hone.

The Importance of Compassionate Communication

Difficult conversations between oncologists and patients about prognosis, disease progression, and death are a crucial part of the treatment process. Whereas physicians may not recall all the difficult conversations they have had, despite how painful they seemed at the time, patients and their families will remember them word for word. They will remember whether you approached this juncture with truth and compassion, or whether it was awkward, rushed, and filled with medical terms they could not understand. They will remember if they left this life-changing visit with a sense of clarity and understanding or with fear and hopelessness.

Good communication can help clarify patients' understanding of their disease, ease adjustment, and lessen physical and emotional pain. It can also leave them more satisfied with their care.

Learning Communication Skills

Many people believe that effective

communication skills are not something that can be taught or learned and that some physicians are just better or more natural at it. Though it may be true that some may have an innate facility for conversation, you can develop the necessary tools to communicate clearly, effectively, and compassionately.

Fellowship is an excellent time to begin developing your skills. Just as you study the algorithms of the National Comprehensive Cancer Network to treat lung cancer, you can learn a framework for how to approach a difficult conversation that will make the task less daunting while offering deeper value to your patients.

The literature has proposed a number of models for effective communication, but the most widely accepted is "SPIKES," a 6-step protocol developed by Dr Walter Baile and colleagues at The University of Texas MD Anderson Cancer Center.¹ The individual letters represent the following: (1) setting up the interview, (2) addressing the patient's perception, (3) obtaining the patient's

invitation, (4) giving knowledge and information to the patient, (5) addressing the patient's emotion with empathic responses, and (6) strategy and summary.

According to Baile and his team, the goal of SPIKES is to allow you to fulfill the following 4 important objectives of the interview in which you deliver bad news¹:

1. Gather information from the patient.
2. Provide intelligible information in accordance with the patient's needs and desires.
3. Support the patient by employing skills to reduce the emotional impact and isolation experienced by the recipient of bad news.
4. With the patient's input and cooperation, develop a strategy in the form of a treatment plan.

The SPIKES Protocol

Meeting these 4 goals can be accomplished by completing the steps of the SPIKES protocol. Although all 6 steps are not always needed, when they are it is important that you follow them in order:

“You will ultimately develop your own style of delivering bad news to patients.”

Step 1: Setting up the interview. You should be sensitive to the patient's surroundings as she receives life-changing news. Be sure that you are in a private room and that she is accompanied by a family member, if desired. One of the most challenging aspects of having difficult conversations is the time involved. But even if you feel rushed, you should sit down and maintain eye contact with the patient to help her relax and show her that she is your priority. You should tell her in advance of any time constraints or expected interruptions.

Step 2: Addressing the patient's perception. Before launching into a detailed conversation, ask open-ended questions to get an accurate picture of how the patient perceives her medical situation. This not only gives you a glimpse into whether she is experiencing denial, wishful thinking, or unrealistic expectations, but it allows you to tailor your discussion based on what she already knows.

Step 3: Obtaining the patient's invitation. To you as an oncologist, it may seem obvious that the patient is in your office and therefore is prepared to hear full information about her diagnosis, prognosis, and treatment. But some patients do not want all this information. Asking a patient, “Would it be okay to go over the details of your test results?” or “Shall we spend more time discussing the treatment plan?” will let you know how she wants to receive the information.

Step 4: Giving knowledge and information to the patient. This is the part of

the conversation we tend to focus on and likely have the most experience with. When giving medical facts, start at the level of comprehension and vocabulary of the patient. If necessary, use words such as “spread” instead of “metastasized” and “sample of tissue” instead of “biopsy.” Do not forget to repeatedly check in with the patient to ensure that she understands what you are saying.

Step 5: Addressing the patient's emotion with empathic responses. Responding to strong emotions is one of the most difficult challenges in breaking bad news. Patients' emotions may vary from silence to disbelief, crying, anger, or denial. Physicians often feel uncomfortable addressing these strong emotions and may compensate by providing more information about the disease or treatment. An empathic response is one in which you not only recognize the emotion that the patient is experiencing (such as anger, sadness, or denial) but directly name it back to her. For example, after hearing that her metastatic colon cancer has progressed, the patient is surprised and angry. An empathic comment would be, “I can tell that this news is not the news you expected and that it makes you very angry. I also wish that the news were better.” A comment like this lets the patient know that you understand how she feels and validates that such thoughts are normal and expected.

Step 6: Strategy and summary. Before discussing the treatment plan, it is important to determine whether the patient is ready. If she is still experiencing strong emotion, it is unlikely

that she will be able to move on to discuss a treatment plan or prognosis. Isolation, fear, and uncertainty are common feelings that patients may have, and letting them know that you will be with them on this journey is reassuring. Once you determine that the patient is ready to discuss the treatment plan, you must understand her treatment goals, such as symptom control. You can then frame hope in terms of what is possible to accomplish.

Final Thoughts

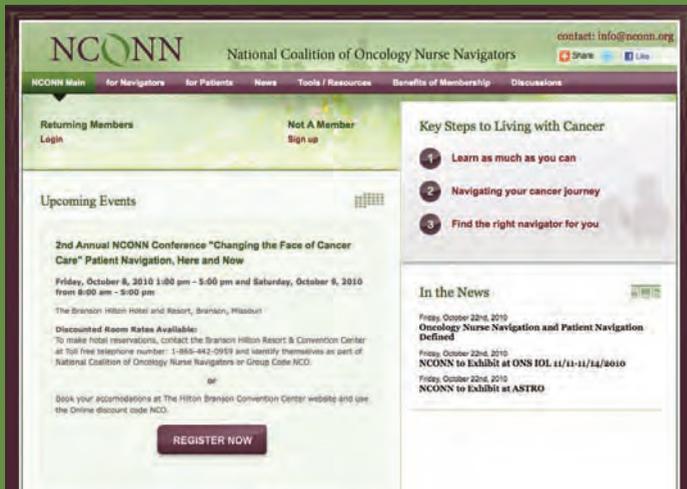
You will ultimately develop your own style of delivering bad news to patients, and this model is just 1 tool that can be used as a beginning framework for enhancing your communication abilities. The patient benefits, plus you are rewarded by learning skills that transform the dreaded task of delivering bad news into a skill that can be mastered with practice. Also, you will probably find that your self-confidence increases over time. Armed with this knowledge, you will soon find that the words will flow easier, your connections to your patients will become stronger and more meaningful, and you will become better able to understand their disappointments, fears, and hopes for the future. ■

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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@onlive.com.



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All Roads Lead to Vail:

Preparing for a Career in Clinical Research By Sam J. Lubner, MD

Clinical investigation is a vital part of an academic career in medical oncology. Gaining experience in clinical investigation, however, requires enthusiasm, opportunism, and a little bit of luck. Residency and fellowship can teach you about the clinical care of patients, but it takes an extra bit of effort and opportunity to learn how to be a clinical investigator.

The annual Methods in Clinical Cancer Research Workshop, sponsored by the American Association for Cancer Research/American Society of Clinical Oncology (AACR/ASCO) in Vail, Colorado, provides a unique opportunity to meet and work with expert investigators and to network with other fellows or new faculty who are interested in developing a career that includes clinical research. The workshop helps you to hone your research skills, understand trial design, and read and comprehend the literature.

This article will outline some of the steps required in the process of getting accepted to the workshop and developing an excellent protocol. It begins with mentorship, continues through the application/preparation stages, and even extends to after the meeting.

Generating an Idea

Coming up with an original idea that merits further study

is intellectually the most difficult part of the process. Having good mentorship is critical to getting an idea started, whether it is a mentor from prior research experience in medical school, your residency, or your fellowship. Having a point person—such as your program director, a research mentor, or someone with whom you have already collaborated—review your idea is absolutely essential in the early stages of developing a protocol.

Before applying to the workshop, ask your mentor to review your idea and determine whether it can be developed into a viable protocol. A good idea is simple, has a measurable end point, and asks a question that can be answered by a relatively straightforward design. Broad questions such as “Does agent X work in breast cancer?” are much too general. A focused way of formulating the question would be more like, “Does agent X, when given with standard neoadjuvant therapy in breast cancer, phosphorylate target Y in the tumor when the excised tissue is examined?”

Once you have developed an idea, start looking for funding mechanisms, whether it is an institutional grant, National Cancer Institute (NCI) grant, ASCO fellowship grant, or some other resource. In your application, you will need to demonstrate that the trial you are planning has a chance of reaching completion.

Applying to the Workshop

The application itself will test your ability to distill your idea into a concise application, and closely mirrors the structure of an NCI-sponsored grant application. Applications are due in March and can be downloaded from www.vailworkshop.org. (Check the site for the actual deadline date.)

The requirements are fairly straightforward. You will need to submit an online application form, a brief description of your trial, your CV, a statement explaining why you wish to participate in the workshop, and a letter of recommendation from your program supervisor or department head. If individuals from your institution have attended in the past, soliciting their feedback during this process would be very helpful. If they still have their proposal, it is worth a read to get an idea for the structure of the application.

As you write your application, ask yourself, “If this concept gets approved, could I accomplish this in the next couple of years?” You will be judged on your trial design, so keep it simple and straightforward and be sure your objectives are achievable. If you design a multi-institution trial that enrolls 3000 left-handed patients with atypical carcinoid, your application will probably be turned down because it is simply not feasible. A small, biomarker-driven, proof-of-principle, early-phase study is much more likely to be accepted.

The review of your application takes a couple of months. If you get accepted to the workshop, congratulations! If not, use the experience to make next year’s application better. (And do not lose heart: applicants are encouraged to reapply.)

You will have about 3 months to prepare for the workshop. Do not use the time to write the protocol; the whole point of the week in Vail is supposed to be for crafting the protocol itself. If you have a prewritten protocol, you will end up being disappointed, because what you thought was a perfectly elaborated idea will likely be radically changed. Instead, use the time to solidify your thinking and to learn everything you can about the disease you are studying, the treatment you are proposing, or the experiment you are conducting.

Attending the Workshop

If you planned on doing a lot of hiking, biking, canoeing, or sightseeing while in Colorado, you will be disappointed. Most of your time at the workshop will be spent indoors. Remember, Vail is at 8000 feet, so if you feel dyspneic, you are not alone. You will also be reminded to drink a lot of water.

The lectures are broad and not too in-depth, so they will be applicable to most attendees. Most of the lecture slides are available on a flash drive that you will receive when you arrive, so you will not have to scribble notes the whole time. Bring your own laptop. Although there is a computer lab, having your own hardware is helpful.

The essence of the workshop is in the small-group sessions. You will be asked to defend your idea to about 8 or 9 other

“If you planned on doing a lot of hiking, biking, canoeing, or sightseeing while in Colorado, you will be disappointed.”

workshop attendees, a statistician, 2 faculty members, and a patient advocate. Many times, the trial concept will be radically altered by the group or the faculty. Be willing to be flexible. This is the time where you will be sorely disappointed if you had a randomized phase II design already written and it gets critiqued into a single-arm phase I study.

If you need extra assistance, every faculty member has “office hours” for one-on-one time. Take advantage of the opportunity to meet opinion leaders and key members of the research community. Not only can they improve your protocol, they can help provide you with career advice or some direction on future trial concepts.

When you are not in lectures, small-group sessions, or office hours meetings, you will be writing. You will need to turn in a protocol development sheet (ie, a brief summary of the trial after its initial revision), a statistical design, rough draft, informed consent, and final copy. In total, it will end up being more than 50 pages of text. It seems like a lot, but the templates are incredibly helpful for keeping your protocol in proper order. By the time you complete the workshop, the document you produce will be nearly ready for a review committee back home.

Taking the Lessons Home

While the workshop cannot teach every nuance of clinical research in the span of a week, it will certainly illuminate some of the critical steps required for turning a hypothesis into a study with maximal potential for achieving its objectives. Applying the tools learned in terms of statistical methods, correlative end points, or useful biomarkers will help you in any future research endeavor. Spread the lessons around to your co-fellows and be a helpful reviewer of your colleagues’ ideas. Stay in touch. Your faculty members from Vail will want to hear how your protocol went and how your career is going. Their feedback can be helpful well beyond the week you spend in the mountains.

My time at the Methods in Clinical Cancer Research Workshop was one of the most challenging—but fun—experiences of my fellowship in oncology. I hope these reflections will encourage you to submit your own application!

Sam J. Lubner, MD, is assistant professor at the University of Wisconsin Carbone Cancer Center in Madison.

Medical Professionals and Social Networking: *The Opportunities, Challenges, and Risks*

By Maurie Markman, MD

Due to the remarkable expansion of the Internet over the past decade, the world of medicine has undergone a revolution in the realm of communication. Today, many hospitals and physician practices have their own Web sites, which advertise their services and ultimately make the patient's experience more favorable. For example, online registration is increasingly common, thereby reducing the administrative burdens encountered by patients when they arrive at a new facility or healthcare provider's office.

Physicians and their staffs frequently use e-mail rather than the telephone to communicate test results or instructions, and patients can use it to inform their doctors about any new symptoms or treatment-related side effects. With e-mail, it is now possible for patients to send inquiries 24 hours a day and potentially receive a response outside of normal business hours. This strategy is particularly attractive for busy clinicians who can use their non-office hours to respond to patient concerns and questions.

Perhaps even more dramatic than how electronic communication has changed the traditional interactions between physicians and their patients is the ever-expanding quantity of medical information that is accessed directly by patients. The Web sites established by existing health-related organizations, patient advocacy initiatives, and private companies currently provide millions of pages of informational content dealing with individual conditions and patient experiences. Of course, to be complete, it is essential to note that the interpretation of what is being stated on a particular site, its usefulness, and its validity are very different issues from mere availability.

Social Networking and Organized Medicine

Recently added to this explosion of Internet-based communication between healthcare providers and their patients is the complex and evolving world of social networking. With sites such as Facebook and Twitter, the expansion of strategies to rapidly and easily communicate with 1 or many "friends" in cyberspace has been nothing short of spectacular.

Important questions need to be asked in regard to social networking. For instance, how has social networking impacted medicine, and how might this evolve in the future? Are there particular concerns associated with this unique form of communication that healthcare providers, including students and those in training, should fully understand before they elect to participate in 1 or more of these forms of social networking? How can the potential risks be mitigated to help ensure safe and appropriate communication?

Opportunities for Social Networking

Social networking can benefit physicians, patients, professional groups, and medical students/trainees. The following are a few examples.

Physician-to-physician communication

Physicians can quickly and easily share opinions with peers regarding a specific medical topic. For example, a new paper on a novel treatment of an uncommon cancer may be published in a peer-reviewed journal or an abstract presented at a national or regional scientific meeting. Is the information truly important? Are there serious flaws in the study design? What are the implications for patients currently under the physician's care or those who will become patients in the near future?

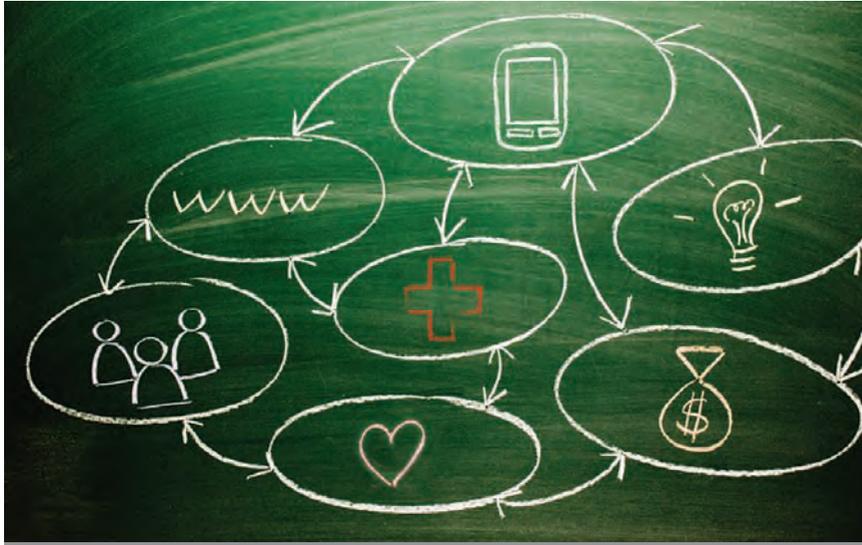
Add to these issues the fact that the media may publish information (that may or may not be accurate) on the study results, and patient-associated Internet sites may similarly announce the findings (which, again, may not be accurate). How should physicians respond if asked by patients how the study results will affect their own care? Rapid communication between a community of interested and knowledgeable physicians may help an individual physician to effectively interpret and subsequently discuss with others (including patients) the implications of this new report. Physicians may use social networking to discuss practice management and other issues not directly related to individual patient care, including healthcare reform or payment for covered Medicare services.

Physician-to-patient communication

Physicians may elect to use social networking to directly communicate with their patients regarding how they personally interpret study results. This ensures that the information quickly reaches the patients. In addition, helpful patient education resources can be shared via the social networking sites.

Professional groups

A growing network of people living with cancer and their families are using social networking for information, support, lobbying, and fund-raising.¹ In one Facebook search in 2008, more than 500 such groups were found. Cancer organizations could band together to provide a type of central clearinghouse for up-to-the-minute information about cancer prevention and control, and to communicate effectively and efficiently with their own members and other organizations.¹



impact on an individual's life associated with such pronouncements cannot be overstated, regardless of their accuracy.

One report about this sort of situation in medical schools noted a disturbing number of instances in which disciplinary action had been required against medical students due to inappropriate and unprofessional online content that included sexually suggestive material, discriminatory language, and scenes of intoxication.⁴ While the essential principle of freedom of expression must not be forgotten in this discussion, it is critical to acknowledge the fundamental responsibility to society of a medical professional, including students and those in training positions.

This concern also relates to patient privacy. It is one thing to discuss "friends" (hopefully, with their consent) on a Facebook page or during a Twitter exchange, but it is something very different (and unacceptable) to discuss a patient encounter, even if it is believed that the patient will not be able to be identified. Again, the issue here is professional responsibility. Once something is posted on a social networking site, it is simply and permanently in the public domain, a place where private patient-related information does not belong.

“While the essential principle of freedom of expression must not be forgotten in this discussion, it is critical to acknowledge the fundamental responsibility to society of a medical professional, including students and those in training positions.”

Trainees/students

Trainees or students in professional schools may effectively use social networking strategies to share common events or to suggest strategies to survive the rigors of particular experiences (eg, specialty or subspecialty boards, internship year).

Potential Dangers of Social Networking

Unfortunately, it is not difficult to provide examples of the dangers associated with social networking that are relevant to everyone, including all members of the healthcare team (ie, physicians, nurses, and other support staff), trainees, and students in health-related professional schools.

Two such examples, while not medically related, could just as easily involve medical professionals. In 2009, a 12-year-old boy in California was assaulted by as many as 14 of his middle-school classmates after a Facebook group urged students to beat up redheads.² Anonymous gossip sites on college campuses have targeted individuals with claims (true or not) regarding sexual orientation, detailed descriptions of sexual encounters, and the presence of a sexually transmitted disease.³ The horrific

Mitigating the Risks of Social Networking

There are ways to guard against the pitfalls of social networking. The following are some methods to consider.

The medical school curriculum

Teaching how to lessen the risks associated with social networking can become part of the curriculum in medical schools. These lessons could include information about such risks, the proper way to use networks, setting privacy controls, and employing patient data.⁵

Regular monitoring

Always be aware of what others can find out about you through Internet searches. In addition, physicians should regularly monitor their own sites or pages to ensure that they do not miss important messages. Those who use their sites to communicate with patients run the risk of missing important information sent from a patient. This could then make them the target of a malpractice suit for not responding.⁶

“Remember that you should never be anonymous in your postings.”

The line between patients and ‘friends’

Physicians should avoid accepting Facebook “friend” requests from patients and they should also maintain strict privacy settings. Their personal pages should be separate from pages representing their practices so as to not blur the line between patients and friends.⁶

Discussion boards/forums

Be wary of taking advice from physicians on discussion boards, forums, and other such open—and often casual—vehicles of communication. Their suggestions may be outside the standard of care, and it is often difficult to verify that users are who they say they are.⁶

Lack of anonymity

Remember that you should never be anonymous in your postings. And never write negative things about your facility, other physicians, patients, or anyone else who could possibly be identified. Copyright, slander, and libel laws very definitely apply to the Internet.⁶

Conclusion

Social networking has the potential to be a valuable component of medical communication, both from physician to physician and between physicians and their patients. However, it is critical to appreciate the very public nature of such communication strategies, and the fact that being a medical professional requires one to understand the essential obligations of both confidentiality and propriety. ■

Maurie Markman, MD, is vice president for clinical research at the University of Texas MD Anderson Cancer Center in Houston.

Resources for the Healthcare Professional

Social Networking Sites for Medical Professionals

<http://bit.ly/c5xqzL>

Top 25 Social Networking Sites for Healthcare & Medical Professionals

<http://bit.ly/f7WKwt>

Sermo

www.sermo.com

A rapidly growing physicians’ social network that now has more than 60,000 subscribers. It is open to all licensed physicians in the United States. The site draws in members with features like free access to news from medical journals.



Physician Connect

www.medscape.com/connect

Recently launched from Medscape/WebMD.

Within3

www.within3.com

A site designed to foster collaboration between physicians and researchers.

MedTrust Online

www.oncoentric.com

A social networking site for oncologists and others who treat cancer. It provides easy access to pertinent medical literature, clinical trial information, treatment options, and a wealth of other data.

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LIFE PERSISTS

One Fellow Finds Hope Amid Cancer's Destruction

By Jason H. Mendler, MD, PhD

It was midnight and I had just been jarred out of a sound sleep by the startlingly repetitive beeping of my pager. I fumbled for it on my nightstand and glanced at the display. It was the hospital's emergency department. "Damn," I thought.

Half asleep, I wandered downstairs. I tried not to trip on the stairs as I prepared my foggy brain for the medical conversation I was about to have. I successfully navigated the steps and sat down at my desk. My home "office" is actually in my kids' playroom, though it doubles as my workspace. (Ah, the oncology fellow's life of luxury...)

I picked up the phone and dialed. "Hello?" said the

emergency department physician on the other end. "Yes, this is Dr Mendler, the oncology fellow who is returning your page," I replied. (I was relieved that I was waking up enough to put a full sentence together.)

The physician said, "Dr Mendler, I was hoping to run a case by you that we have here in the ED. The patient is a 35-year-old man who had a bone marrow transplant about 2 months ago and is now presenting with a low-grade fever. He's had some sinus congestion but no other localized signs of infection. Do you think it's okay if we send him home with close follow-up, or should we admit him?"

At this point I was fully awake. I had been on the inpatient transplant service 2 months ago and had spent 1 day each week in one of the transplant clinics. I knew many of the transplant patients very well.

“Who’s the patient?” I asked.

The physician responded, “His name is Jonathan, a guy with a history of acute lymphoblastic....Wait a minute, his labs just came back. His white blood cell count is 100 and his platelets are 15. His counts were normal 5 days ago.”

I was hit by a wave of nausea. I could not believe that Jonathan was potentially relapsing. It happened too fast. Please, God, don’t let this be a relapse, I prayed.

A Lone Wolverine Among Buckeyes

My mind wandered back to everything I knew about Jonathan. He was a young man whom I had first met a few months previously, toward the latter stages of his myeloablative, allogeneic stem cell transplant for acute lymphoblastic leukemia. In the transplantation ward he would often bang away on his laptop, preparing lesson plans for when he would return to his job as a high school English teacher.

Jonathan also had moxie. He took an unabashed, unapologetic stance as a Michigan Wolverines fan among a sea of Ohio State Buckeyes fans on the ward. (For those of you who have never spent time in Columbus, Ohio, there is no mercy for Michigan fans, even for those in the midst of a bone marrow transplant.) His wife was often there with him, and they spoke frequently of their 1-year-old daughter and how much he missed her during the weeks of his transplant. I remembered his exuberance on his day of discharge, when he was going back home to see her, having survived another stage of his battle against leukemia. I also recalled the day in the transplant clinic, a few weeks after his discharge, when he brought the attending physician 2 model race cars, each of which was personalized with the name of the attending’s 2 children. I remembered thinking, “What a hell of a nice guy. Not only is he appreciative of everything we’ve done for him, but he’s taken the time to get to know the names of his doctors’ kids and give them gifts.”

And now, after all that Jonathan’s been through, could he really be relapsing? After speaking with the ED physician, I paged the hospital’s attending transplant physician, who is a mentor, and filled him in on everything. He said to me, “You know, Jason, we’ll give him salvage therapy, but he’s almost certainly going to die from this. It just sucks.” I paused for a moment to digest this. After receiving his life-altering diagnosis, Jonathan had had to deal with months of intensive chemotherapy treatments, brutal side effects, bone marrow biopsies, remissions, and uncertainties. But through it all, he had retained hope for the future.

Now it was all being blown to hell by one blood draw

in the emergency department. The transplant attending physician and I philosophized for a few moments about the nastiness of a disease that relapses after total body irradiation, myeloablative doses of chemotherapy, and an allograft. There would be no silver lining in this cloud.

Pushing On

I hung up the phone and all was quiet. I climbed back upstairs and lay in my bed. I wanted someone to tell me that everything would be okay and that this had all been a bad dream. That voice never came. I ached for Jonathan, for his wife, and especially for his daughter, who would never really get to know her dad. “How will his family go on?” I thought. “How will I go on?”

How will I go on? I pondered this question as the clock struck 4 AM. I was drained, not simply because of tonight’s news but from a year of experiencing a multitude of young, vibrant people fighting losing battles against cancer. I wondered how I would provide optimism to my patients the next day with the hurt of Jonathan’s relapse still drenching my soul. I wondered how I could spend a career doing this. How could I continue to bear witness to the worst of what cancer does to people and still push on? Was I resilient enough? Was I courageous enough? Was I selfless enough?

My body and mind finally succumbed, and I fell asleep. My alarm woke me a couple of hours later, and I groggily got up after a few thumps on the snooze button. My insides felt like a sour brew of exhaustion and despair. I desperately needed a dose of perspective. I flipped through the pages of a book of quotations that I keep beside my bed and came across one from Mahatma Gandhi:

I have found that life persists in the midst of destruction, and, therefore, there must be a higher law than that of destruction.

I thought about this for a moment and felt a twinge of hope. Despite all the cancer-induced destruction I see every day, there must be a way to see the persistence of life. I was not sure how I would find it, but it seemed well worth a try. I resolved to look for this life force in each patient I saw that day. I realized that these signs would appear differently in each person, and would be hard to find in some, but I felt confident that it was there in everyone. A sense of well-being came over me and I began to mop up the hurt. I felt hope take hold more fully in my body. “I can do this. My patients need me to do this. I need me to do this,” I thought. I straightened my tie, grabbed my coffee, clipped on my pager, and walked out the door, on a mission to find life. ■

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Platforms: iPod Touch, iPhone, iPad (requires iOS 2.1 or later; 0.3 MB)

This ReachMD app, developed by MedicinePhone, is a fully accredited CME tool that gives healthcare practitioners a convenient way to earn free CME credits. It allows users to search for CME programs by keyword, listen to all ReachMD CME content, get regular updates on new CME content, and take CME tests for credit. Also, if your exam is interrupted for any reason (such as a phone call), you can easily resume working on it afterward.

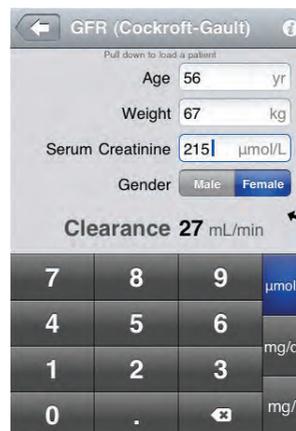
<http://bit.ly/gz5b8i>



MedCalc Pro

Price: \$7.99 iTunes (MedCalc basic is free)

Platforms: iPod Touch, iPhone, iPad (requires iOS 3.0 or later; 7.2 MB)



MedCalc Pro, developed by Dr. Pascal Pfiffner and Dr. Mathias Tschopp, is a medical calculator that gives healthcare professionals access to complicated medical formulas, scores, scales, and classifications. The Pro version offers a patient management system that allows you to save and access results. You can search for equations by name or keywords and customize a list of fa-

vorite equations. MedCalc Pro supports 3 languages: English, French, and German.

<http://bit.ly/dFISfL>



Skyscape Medical Resources

Price: Free

Platform: BlackBerry (requires software version 4.2.0 or later; 1102 KB)

This app from Skyscape includes a useful collection of free medical information and decision support resources for healthcare professionals. The free information includes Rx Drug Information, Outlines in Clinical Medicine, Archimedes medical calculator, MedWatch (current medical information from the FDA and other public sources), and CME STAT.

<http://bit.ly/hCc1pe>

Planning and Execution Are the Keys in Salary Negotiation

BY ED RABINOWITZ

Though it may seem that the job interview itself is the most daunting aspect of your job search, in reality it is what looms at the end that makes even the most confident fellow anxious: the dreaded salary-negotiation process. But you can conquer your fear. Whether you are negotiating an \$80K or \$580K salary, the strategies for success are the same.

“It’s about finding the right job and making sure they want to hire you before you start negotiating salary,” said Lee E. Miller, author of *Get More Money on Your Next Job... in Any Economy* and co-author of *A Woman’s Guide to Successful Negotiating: How to Convince, Collaborate, & Create Your Way to Agreement*. And the entire process starts with being properly prepared.

What Are You Worth?

Eric Dickerson, managing director at Kaye/Bassman International in Dallas, Texas, is a top recruiter for the medical field. He said that well before going on a job interview, it is essential that you clearly understand your value in different regions of the country. That is important for fellows, because they often want to live and work in a certain geographical area. Recruiters can tell you the median compensation for a medical oncologist, but unless they do some research they cannot tell you what it will pay in the South, West, North, or East. And even within those regions there are variances. Certain markets have salary caps due to reimbursement constraints that have developed over the last 5 to 10 years. Other areas will pay more based on the demands of the marketplace and according to the needs of a particular hospital or physician practice.

“Doing the research is not just looking at a national salary survey,” Dickerson explained. “It’s truly understanding the geography of where you are or where you want to be.”

So, where can you find that data? Miller said that there is a lot of general information available on the Internet. But for a specialized area like oncology, it is best to talk with people in the field, including members of trade associations. This is not unlike first researching the selling prices of comparable neighborhood homes while house hunting.

“You want to learn what other people in similar positions are earning,” Miller said.

At this stage, you may wonder whether you should work with a recruiter. Dickerson cautioned, however, that not all physician recruiters are well versed in the oncology field, so you should determine their particular strengths and weaknesses. If you tackle the job search process on your own, you will certainly save money. Recruiters earn their commissions by taking a percentage of your future salary, making your actual take-home amount smaller. But if you choose to use a recruiter, be sure you understand the level of physicians they have worked with as well as their knowledge of the oncology market.

Dickerson added, “It never hurts physicians to interview various [recruitment] firms to decide with whom they want to work.”

Broaching the Subject

Experts agree that salary is the very last thing that should be discussed in the job interview process. According to Miller, it is all about timing.

“Think of it in terms of when you buy a car,” he suggested. “What’s the first thing a car salesman does? He gets you to drive the car. Because once you drive the car and you fall in

love with [it], all of a sudden it’s not the price that matters.” Miller said the buyer will then try to figure out how to afford the vehicle, because he just has to have it.

“The same is true with a candidate,” claimed Miller. “Once they fall in love with you and you’re the one they want, then it’s ‘How do we make this happen?’” They won’t “buy” the lower-priced oncologist if he or she is less qualified than you are. Using a vehicle analogy, Miller said, “If you want to buy a Mercedes, you don’t go out and buy a Hyundai just because it’s cheaper.”

Raising the salary issue too early during the interview process can also harm your chances of landing the position you desire. For example, if you float a figure and it is too high, you have just priced yourself out of the position. If you come in too low, the interviewer may think you do not consider yourself qualified enough. Or, they may eagerly hire you because they realize they have found a bargain.

“The basic rules in life are, you don’t get what you deserve—you get what you negotiate,” Miller said.

Dickerson echoed those thoughts. “Negotiation 101 says that when your initial offer is accepted immediately, that indicates they know it’s a good deal and you could have gotten a whole lot more,” he explained. “You’re shooting yourself in the foot.”

Rather than discuss dollars, Dickerson suggested you demonstrate your value to the hospital or medical practice. For example, he encouraged fellows to talk about the job and about the

facilities. Who are your peers? What does the practice group look like? Tell the interviewer you would like to speak with others at the hospital or practice. Salary is important, but there are a lot of other deeper, long-lasting factors beyond the money.

“By taking that approach, what you’re doing is really demonstrating a focus on the value you could bring,” Dickerson said. “Therefore, when it gets to the point at the end of the game that it’s time to talk about money, you have taken the time to demonstrate that value. And therefore your perceived value would deservedly be closer to the best possible market price you could have, versus raising the [salary] question at the very beginning.”

Proven Negotiating System

Jim Camp is the president and CEO of Camp Negotiation Systems, and an accomplished negotiator who has developed a negotiation system that is taught in MBA programs worldwide. He is also the author of *NO: The Only Negotiating System You Need for Work and Home*.

Camp said that the first step in the negotiation process is

“Lee E. Miller said, ‘If you want to buy a Mercedes, you don’t go out and buy a Hyundai just because it’s cheaper.’”

to understand the concept of mission and purpose. In other words, be clear about what you are trying to deliver. For an oncology fellow, that means understanding what you will deliver not only to the patient, but also to the hospital or healthcare organization. Too often that is not clearly thought out.

“How can you help someone else see what you’re bringing, what you’re delivering, if you can’t see it yourself?” asked Camp.

The second step is to recognize the problems inherent in your particular negotiation. For example, although an oncologist and a urologist are both specialists, an oncologist brings a different value to an organization. But if the healthcare organization is trying to establish pay equity across the spectrum of physicians, that is a problem that must be dealt with. Negotiate it out of the negotiations by creating the value that separates you from others in your field or profession.

You will also need to contain your emotions. Camp claimed that decisions “are made 100% emotionally [and] not intellectually, with facts.” He continued, “We all have to deal with what we call baggage: the emotions we bring to the game. The key is to lower that emotion until it’s almost nonexistent and create a vision so that decisions can be made comfortably.”

Those emotions could be tied to someone other than the fellow who is engaged in the salary negotiation process. Dickerson pointed out that personal factors, especially family and the desire to live within a particular geographic location, can significantly reduce an individual’s leverage when it comes to salary negotiation. “There’s a wide variety of comfort levels that people have with that,” said Dickerson. “It’s important to evaluate where that falls among your priorities.”

The next step, said Camp, is to know exactly what you want. Then have a vision of what you want to happen next, after the negotiation. That vision can be viewed in small steps, not big ones. You may just want the person you are negotiating with to take all of the information you have provided, digest it, and then schedule a follow-up meeting. Whatever it is, make sure you carefully think through what you want because, Camp noted, you just might get it.

Perks and Competition

It is often said that competition brings out the best in people. And according to Miller, there is nothing better for a job-seeking fellow than a hospital or practice competing for you. For example, suppose 2 hospitals have expressed an interest in having you join their staff. Hospital A has offered a higher salary, but hospital B is where you would truly rather work. Miller suggested the following approach.

“Tell hospital B that they’re your first choice [and] that you would really love to work there because it’s a great fit,” he said. “But, you have an offer from hospital A. Is there anything hospital B can do to sweeten the offer? Just put it on the table and leave it open.”

And remember, Miller added, it is not always about the money. The reality is that sometimes the compensation at one facil-



Women (Unfortunately) Don’t Negotiate

The differences between men and women in the business and medical worlds have been debated for ages. One difference that appears undeniable, however, is that women tend to shy away from the negotiation process. According to Lee E. Miller, women tend to negotiate less often than men and accept the initial salary offer.

“Very rarely is the first offer the best offer,” Miller explained. “There’s usually something to negotiate. And when women do negotiate, they tend to ask for too little.”

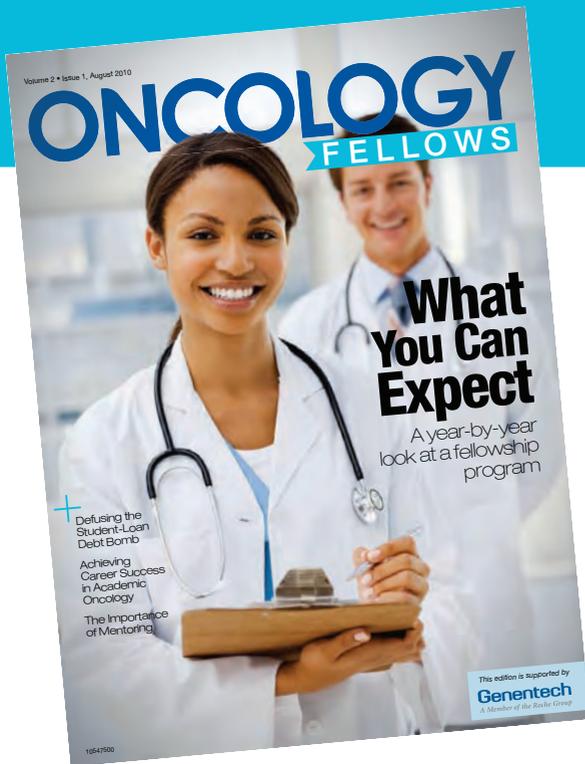
Miller’s point is echoed in a wide range of studies, many of which are published in *Women Don’t Ask: Negotiation and the Gender Divide* by Linda Babcock and Sara Laschever. In their book, the authors note the following:

- In surveys, 2.5 times more women than men said they feel “a great deal of apprehension” about negotiating.
- Men initiate negotiations about 4 times as often as women.
- Asked to pick metaphors for the process of negotiating, men selected “winning a wrestling match” while women said “going to the dentist.”
- Twenty percent of adult women (22 million) say they never negotiate at all, even though they often recognize negotiation as appropriate and even necessary.

In addition, failure to negotiate can have a long-lasting impact. By not negotiating a first salary, an individual stands to lose more than \$500,000 by age 60. According to studies, men are 4 times as likely as women to negotiate their first salary.

ity is high because the job is terrible. Sometimes the facility offering the lower salary, combined with perks such as health benefits and vacation leave, might just be the better package. ■

Ed Rabinowitz is a veteran financial journalist based in Upper Mt. Bethel Township, Pennsylvania.



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.

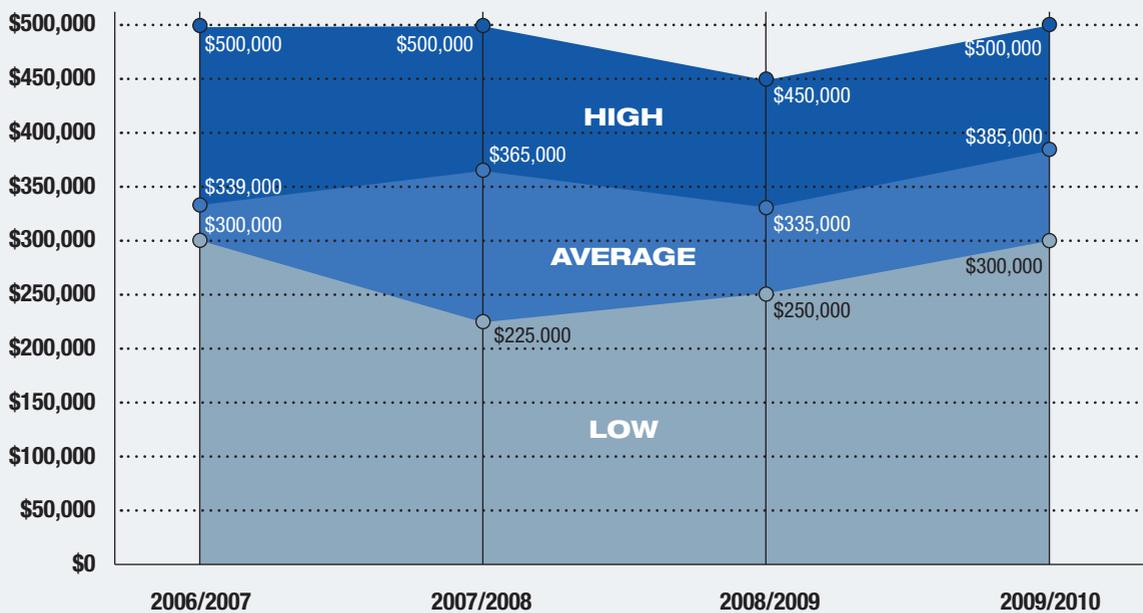
By the Numbers

Average Income for Oncologists and Hematologists Increases

Merritt Hawkins, an AMN Healthcare company, is a national search and consulting firm that specializes in the recruitment of physicians. The following data were published in the 2010 version of Merritt Hawkins' annual report, *Review of Physician Recruiting Incentives*. (The 2011 version of the report will come out sometime in late March or early April, according to a company spokesman.) The data referenced below are taken from the 2813 permanent physician and advanced allied health professional search assignments that were conducted by Merritt Hawkins/AMN Healthcare from April 1, 2009, to March 31, 2010.

The good news for oncology and hematology fellows is that, on average, you will eventually earn more than many other physicians. Of all the physician specialties, the pay for oncologists/hematologists increased by a significantly greater percentage over the other specialties between 2008/2009 and 2009/2010.

Income Offered to Oncologists/Hematologists*



Specialties Showing Highest Gain in Income Offers from 2008/2009 to 2009/2010

	2008/2009	2009/2010	% Increase
Oncology/Hematology	\$335,000	\$385,000	14.9%
Neurology	\$258,000	\$281,000	8.9%
Orthopedic Surgery	\$481,000	\$519,000	7.9%
Radiology	\$391,000	\$417,000	6.6%
Dermatology	\$297,000	\$314,000	5.7%

Source: Merritt Hawkins. 2010 review of physician recruiting incentives. www.merrithawkins.com/.../mha2010incentivesurvPDF.pdf. Published 2010. Accessed January 14, 2011.

Conference Center

2011 Oncology & Hematology Meetings

March 3–6

Stem Cells, Development, and Cancer

Vancouver, BC, Canada
<http://bit.ly/9r42hB>

March 6–11

Keystone Symposia: Stem Cells, Cancer, and Metastasis

Keystone, CO
<http://bit.ly/fiVHhV>

March 9–11

Breakthrough Breast Cancer: Triple Negative Breast Cancer Conference 2011

London, England, UK
<http://bit.ly/fLskF2>

March 9–13

NCCN Annual Conference: Clinical Practice Guidelines & Quality Cancer Care

Hollywood, FL
<http://bit.ly/ezsktT>

March 17–19

International Symposium on Advances in Cancer Prevention

New York, NY
<http://bit.ly/eYkDN5>

April 2–6

AACR 102nd Annual Meeting 2011

Orlando, FL
<http://bit.ly/dzpkBJ>

April 8–9

Eighth International Symposium on Melanoma and Other Cutaneous Malignancies

New York, NY
<http://bit.ly/dzGI14>

April 8–10

Asian Oncology Summit 2011

Hong Kong, China
www.asianoncologysummit.com

April 13–16

Southwest Oncology Group Spring 2011 Group Meeting

San Francisco, CA
<https://swog.org/Visitors/GpMeeting.asp>

April 29–May 1

Cancer Pain Conference: Integrating Interventional Pain Management and Supportive Care in Patients Diagnosed with Cancer

Scottsdale, AZ
<http://bit.ly/dN40XO>

June 3–7

47th ASCO Annual Meeting

Chicago, IL
<http://chicago2011.asco.org>

June 19–24

Cancer Research Imaging Camp

St. Louis, MO
<http://bit.ly/g20ayD>

June 23–25

Accelerating Anticancer Agent Development and Validation Workshop

Bethesda, MD
www.acceleratingworkshop.org

July 16–22

20th Annual AACR Aspen Workshop: Molecular Biology in Clinical Oncology

Snowmass, CO
<http://bit.ly/fcf4nk>

July 21–24

12th International Lung Cancer Congress

Carlsbad, CA
<http://bit.ly/dYPIsZ>

July 25–28

Workshop on Systems Biology of Tumor Dormancy

Boston, MA
<http://bit.ly/hU8zol>

August 15–17

International Conference and Exhibition on Cancer Science and Therapy

Las Vegas, NV
<http://omicsonline.org/cancerscience2011>

September 14–18

Second AACR Conference on Frontiers in Basic Cancer Research

San Francisco, CA
<http://bit.ly/eJXFqv>

September 23–27

European Multidisciplinary Cancer Congress

Stockholm, Switzerland
<http://bit.ly/fWBbf>





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