Il valore del tempo per il medico

Roma, 15 novembre 2018

Gianpiero Fasola

Dipartimento di Oncologia
Azienda sanitaria universitaria integrata di Udine

Le dimensioni rilevanti

1. Alimentazione della cultura professionale
2. Le attività con il paziente
3. La comunicazione: pazienti, familiari, gruppo, azienda
4. Le attività per il paziente: organizzazione e gestione delle Strutture, del percorso clinico, “back office”
5. Riflessione e ristoro dei professionisti
6. Tempo guadagnato con buona qualità di vita

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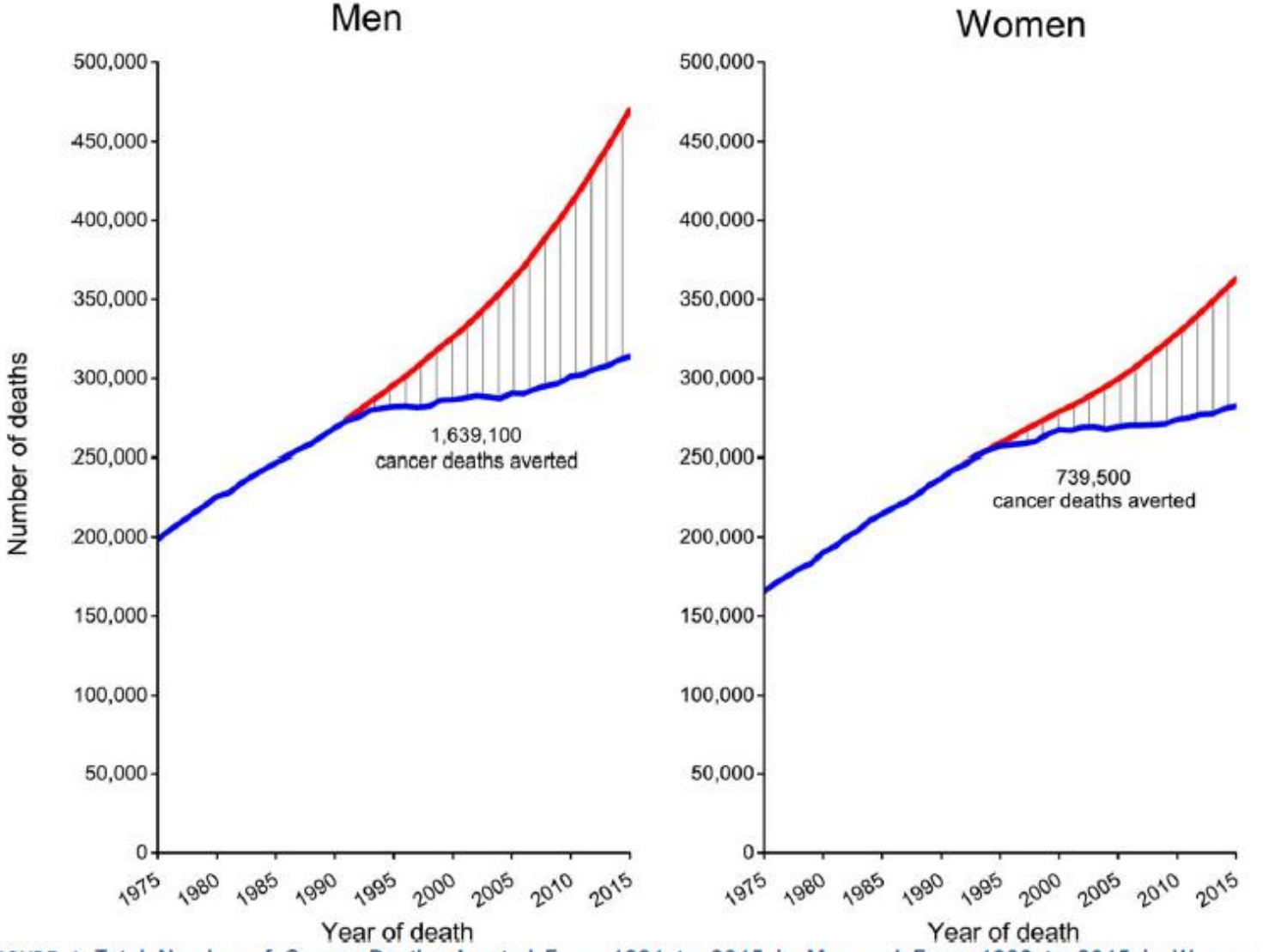

FIGURE 6. Total Number of Cancer Deaths Averted From 1991 to 2015 in Men and From 1992 to 2015 in Women, United States.

The blue line represents the actual number of cancer deaths recorded in each year, and the red line represents the number of cancer deaths that would have been expected if cancer death rates had remained at their peak.

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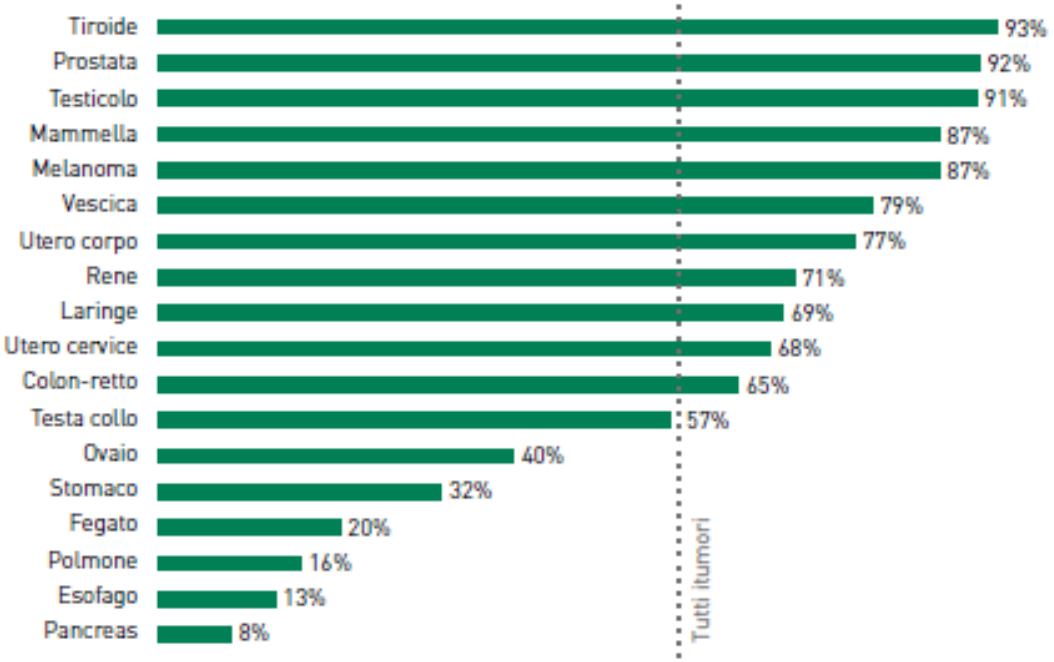
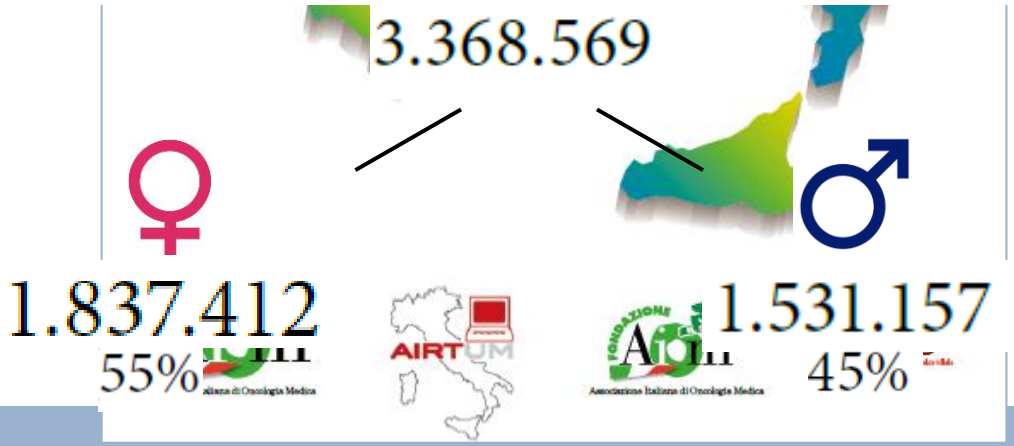


FIGURA 4. Sopravvivenza netta a 5 anni dalla diagnosi (standardizzata per età) per il periodo di incidenza 2005-2009 (pool AIRTUM), uomini e donne

Il numero di casi prevalenti aumenta, negli ultimi 15 anni, del 3% l'anno.



I numeri del cancro in Italia 2018

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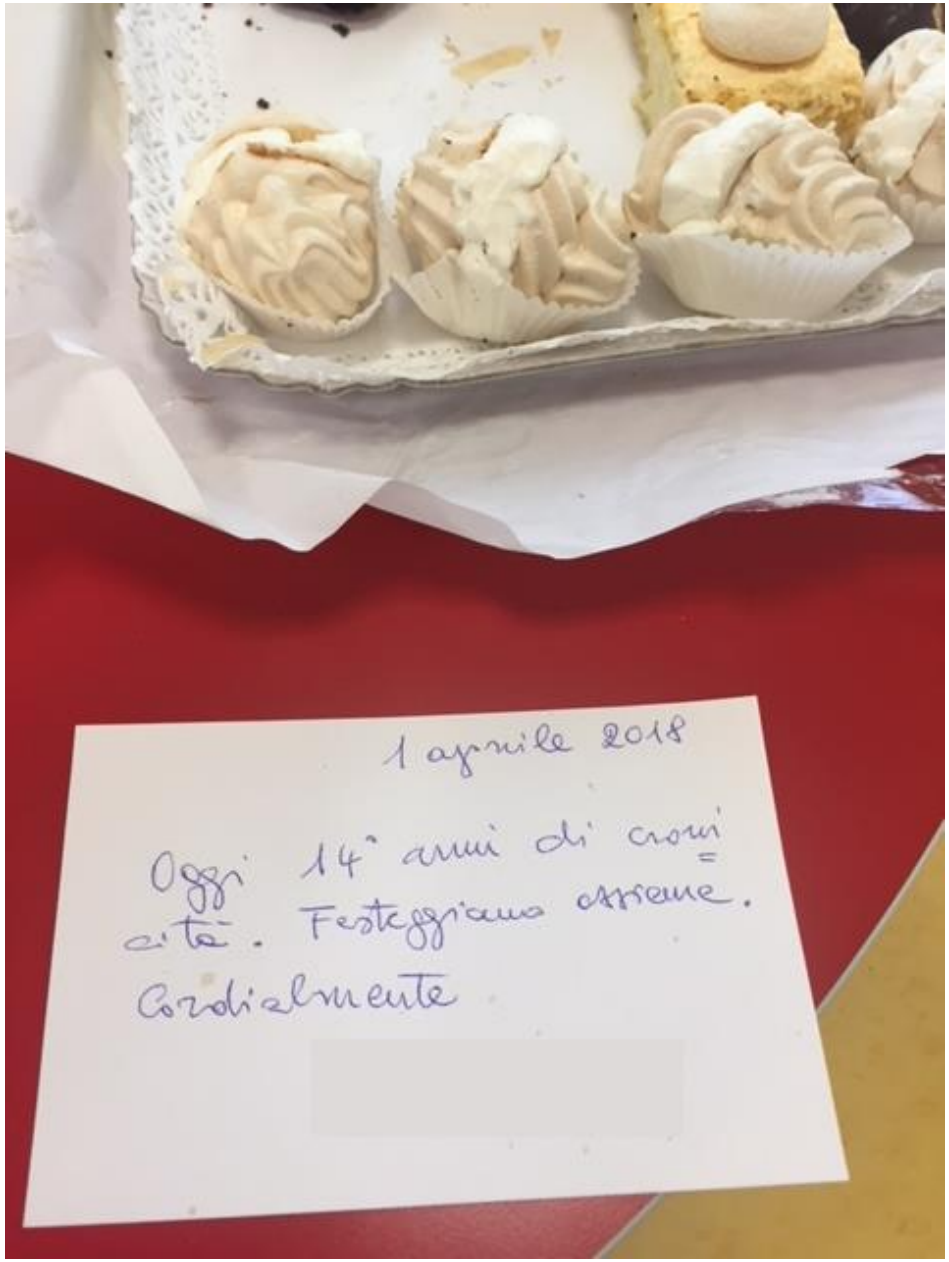

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Critical Practice Gaps in Oncology:

Implications for Development of Effective CME to Meet Accelerating Educational Needs

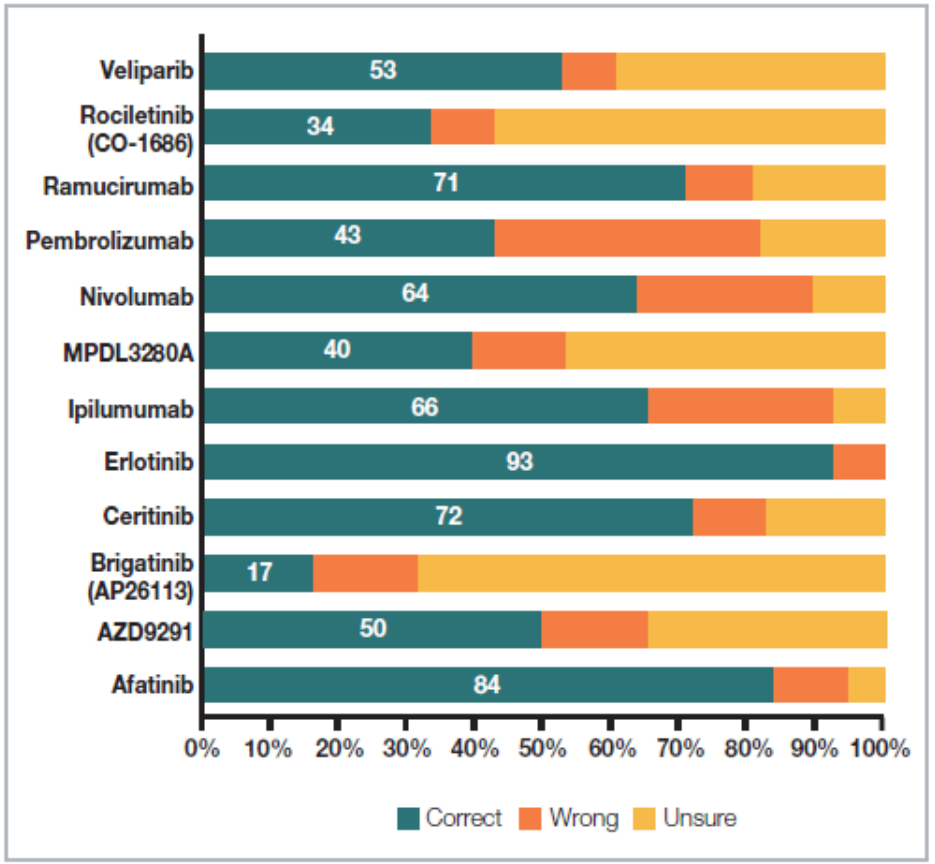
A CCO White Paper

The Looming Crisis in Oncology Knowledge

In a recent CCO survey, 48% of practicing physicians agreed or strongly agreed with the statement: "It is impossible for the practicing clinician to stay abreast of the high volume of relevant medical information/data currently available."[5] The overload is exacerbated by the proliferation of media sources covering oncology developments in assiduous detail and is further compounded by the ascendance of personal mobile technology that brings a real-time stream of information, right into every clinician's hand, at any moment of the day or night.

and potentially save lives.

Figure 6. Current knowledge of new agents for non-small-cell lung cancer.



VOLUME 36 · NUMBER 10 · APRIL 1, 2018

JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

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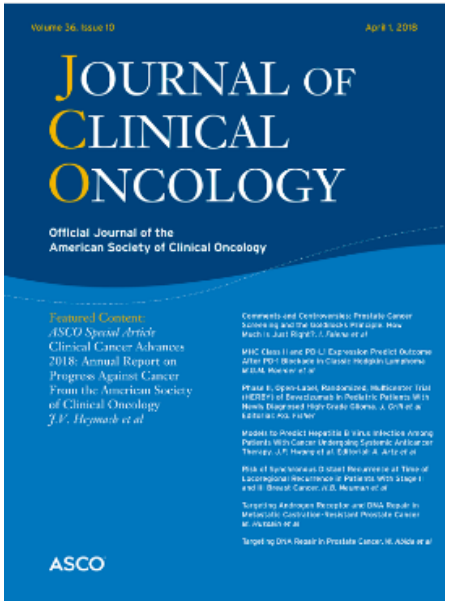

Clinical Cancer Advances 2018: Annual Report on Progress Against Cancer From the American Society of Clinical Oncology

John Heymach, Lada Krilov, Anthony Alberg,† Nancy Baxter,† Susan Marina Chang,† Ryan Corcoran,† William Dale,† Angela DeMichele,† Catherine S. Magid Diefenbach,† Robert Dreicer,† Andrew S. Epstein,† Maura L. Gillison,† David L. Graham,† Joshua Jones,† Andrew H. Ko,† Ana Maria Lopez,† Robert G. Maki,† Carlos Rodriguez-Galindo,† Richard L. Schilsky,‡ Mario Sznol,† Shannon Neville Westin,† and Harold Burstein**

A MESSAGE FROM ASCO'S PRESIDENT

I remember when ASCO first conceived of publishing an annual report on the most transformative research occurring in cancer care. Thirteen reports later, the progress we have chronicled is remarkable, and this year is no different. The research featured in ASCO's *Clinical Cancer Advances 2018* report underscores the impressive gains in our understanding of cancer and in our ability to tailor treatments to tumors' genetic makeup.

The ASCO 2018 Advance of the Year, adoptive cell immunotherapy, allows clinicians to genetically reprogram patients' own immune cells to find and attack cancer cells throughout the body. Chimeric antigen receptor (CAR) T-cell therapy—a type of adoptive cell immunotherapy—has led to remarkable results in young patients with acute lymphoblastic leukemia (ALL) and in adults with lymphoma and multiple myeloma. Researchers are also exploring this approach in other types of cancer.

This advance would not be possible without robust federal investment in cancer research. The first clinical trial of CAR T-cell therapy in children with ALL was funded, in part, by grants from the National Cancer Institute (NCI), and researchers at the NCI Center for Cancer Research were the first to report on possible CAR T-cell therapy for multiple myeloma. These discoveries follow decades of prior research on immunology and cancer biology, much of which was supported by federal dollars.

In fact, many advances that are highlighted in the *2018 Clinical Cancer Advances* report were made possible thanks to our nation's support for biomedical research. Funding from the US National Institutes of Health and the NCI helps researchers pursue critical patient care questions and addresses vital, unmet needs that private industry has little incentive to take on. Federally supported cancer research generates the biomedical innovations that fuel the development and availability of new and improved treatments for patients. We need sustained federal research investment to accelerate the discovery of the next generation of cancer treatments.

Another major trend in this year's report is progress in precision medicine approaches to treat cancer. Although precision medicine offers promise to people with cancer and their families, that promise is only as good as our ability to make these treatments available to all patients. My presidential theme, "Delivering Discoveries: Expanding the Reach of Precision Medicine," focuses on tackling this formidable challenge so that new targeted therapies are accessible to anyone who faces a cancer diagnosis. By improving access to high-quality care, harnessing big data on patient outcomes from across the globe, and pursuing innovative clinical trials, I am optimistic that we will speed the delivery of these most promising treatments to more patients.

Sincerely,

Bruce E. Johnson, FASCO

ASCO President, 2017 to 2018

Table 1. FDA Approvals of Cancer Therapies From November 1, 2016, to October 31, 2017

Drug	Indication	Approval Date
New use		
Daratumumab (Darzalex; Janssen, Beerse, Belgium)	In combination with lenalidomide and dexamethasone, or bortezomib and dexamethasone, for the treatment of patients with multiple myeloma who have received at least one prior therapy.	November 2016
Nivolumab (Opdivo; Bristol-Meyers Squibb, New York, NY)	Recurrent or metastatic squamous cell carcinoma of the head and neck with disease progression on or after a platinum-based therapy.	November 2016
Lenalidomide (Revlimid; Celgene)	Maintenance therapy for patients with multiple myeloma after autologous stem-cell transplantation.	February 2017
Nivolumab (Opdivo)	For treatment of patients with locally advanced or metastatic urothelial carcinoma who experience disease progression during or after platinum-containing chemotherapy or experience disease progression within 12 months of neoadjuvant or adjuvant treatment with a platinum-containing chemotherapy.	February 2017
Osimertinib (Tagrisso; AstraZeneca)	For treatment of patients with metastatic EGFR T790M mutation–positive NSCLC, as detected by an FDA-approved test, who experienced disease progression on or after EGFR tyrosine kinase inhibitor therapy.	March 2017

(continued on following page)

Table 1. FDA Approvals of Cancer Therapies From November 1, 2016, to October 31, 2017 (continued)

Drug	Indication	Approval Date
Palbociclib (Ibrance; Pfizer)	HR-positive, HER2-negative advanced or metastatic breast cancer in combination with an aromatase inhibitor as initial endocrine-based therapy in postmenopausal women.	March 2017
Pembrolizumab (Keytruda; Merck & Co, Kenilworth, NJ)	For treatment of adult and pediatric patients with refractory classic Hodgkin lymphoma or those who have experienced relapse after three or more prior lines of therapy.	March 2017
Regorafenib (Stivarga; Bayer HealthCare Pharmaceuticals)	For treatment of patients with HCC who have been previously treated with sorafenib.	April 2017
Avelumab (Bavencio)	For patients with locally advanced or metastatic urothelial carcinoma who experienced disease progression during or after platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy.	May 2017
Pembrolizumab (Keytruda)	In combination with pemetrexed and carboplatin for treatment of patients with previously untreated metastatic nonsquamous NSCLC.	May 2017
Pembrolizumab (Keytruda)	For patients with locally advanced or metastatic urothelial carcinoma who experience disease progression during or after platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.	May 2017
Nivolumab (Opdivo)	For treatment of HCC in patients who have been previously treated with sorafenib.	September 2017
Pembrolizumab (Keytruda)	For patients with recurrent locally advanced or metastatic, gastric, or gastroesophageal junction adenocarcinoma whose tumors express PD-L1 as determined by an FDA-approved test.	September 2017

Abbreviations: ALL, acute lymphoblastic leukemia; AML, acute myeloid leukemia; EGFR, epidermal growth factor receptor; FDA, US Food and Drug Administration; HCC, hepatocellular carcinoma; HER2, human epidermal growth factor receptor 2; HR, hormone receptor; NSCLC, non–small-cell lung cancer; PD-L1, programmed death-ligand 1.

Table 2. Notable Recent Advances With Immune Checkpoint Inhibitors

Cancer Type	Key Finding	First Author
Breast cancer	Addition of pembrolizumab to standard neoadjuvant therapy for high-risk, HER2-negative breast cancer increased rates of pathologic complete response, especially in women with triple-negative breast cancer—a 50% higher rate.	Nanda[36]
Head and neck cancer	Patients with recurrent or metastatic squamous cell head and neck cancer who received nivolumab lived a median of 2-3 months longer than did those who received standard therapy of investigator's choice.	Gillison[37]
Head and neck cancer	Compared with patients with recurrent or metastatic squamous cell head and neck cancer who received standard therapy of investigator's choice, those who received nivolumab had fewer symptoms and better quality of life for 15 weeks.	Harrington[38]
Kidney cancer	Response rate was higher in patients with advanced kidney cancer who received nivolumab as initial treatment than in those who received standard sunitinib (42% *v* 26%, respectively), and time until cancer worsening was longer (median, 11.6 months *v* 8.4 months, respectively).	Escudier[39]
Liver cancer	In an early clinical trial of patients with advanced liver cancer, response rate to nivolumab was 20%, and adverse effects were manageable.	El-Khoueiry[40]
Lung cancer	In a clinical trial of patients with advanced small-cell lung cancer, 1-year survival rate was 30% for those who received nivolumab and 42% for those who received nivolumab with ipililumab.	Hellmann[41]
Lung cancer	Treatment with checkpoint inhibitor durvalumab after standard chemotherapy and radiation delayed worsening of stage III NSCLC by 11 months.	Antonia[42]
Skin cancer	Compared with patients with advanced melanoma who received adjuvant ipililumab, those who received nivolumab had a higher rate of recurrence-free survival at 12 months (70% *v* 61%, respectively) and a lower rate of severe adverse effects (14% *v* 46%, respectively).	Weber[43]
Skin cancer	In patients with advanced melanoma, 3-year survival rate was higher with nivolumab and ipililumab combined (55%) than with either nivolulmab alone (52%) or ipililumab alone (32%).	Wolchok[44]
Skin cancer	In a clinical trial of patients with advanced Merkel cell carcinoma, response rate to PD-L1 inhibitor avelumab was 32% during a median follow-up of 10 months.	Kaufman[45]
Skin cancer	An early clinical trial suggests that a new PD-1 inhibitor, REGN2810, may be effective against a common skin cancer, cutaneous squamous cell carcinoma. Response rate in patients with advanced disease was 52%.	Papadopoulos[46]
Stomach cancer	A large clinical trial shows that nivolumab is effective as a salvage therapy for people with advanced gastric or gastroesophageal junction cancer that worsens despite chemotherapy. At 12 months, 27% of patients were alive compared with 11% of those who received placebo.	Kang[47]
Stomach cancer	Pembrolizumab showed promising efficacy in a clinical trial of patients with previously treated, advanced stomach or gastroesophageal junction cancer. Response rate was 11%, and 12-month survival rate was 23%.	Fuchs[48]

Abbreviations: HER2, human epidermal growth factor receptor 2; NSCLC, non–small-cell lung cancer; PD-L1, programmed death-ligand 1.

Heymach J. et al, J Clin Oncol, 2018 Apr 1;36 (10):1020-1044

Table 3. Recent US Food and Drug Administration Approvals of Immunotherapies for Bladder Cancer

Drug Name (trade name)	Indication	Date Approved
Atezolizumab (Tecentriq; Genentech Oncology, South San Francisco, CA)	For treatment of patients with locally advanced or metastatic urothelial carcinoma who experience progression during or after platinum-containing chemotherapy or within 12 months of treatment with platinum-containing chemotherapy.	May 2016
Nivolumab (Opdivo; Bristol-Myers Squibb, Sunnyvale, CA)	For treatment of patients with locally advanced or metastatic urothelial carcinoma who experience disease progression during or after platinum-containing chemotherapy or who experience disease progression within 12 months of neoadjuvant or adjuvant treatment with a platinum-containing chemotherapy.	February 2017
Avelumab (Bavencio; EMD Serono, Darmstadt, Germany)	For patients with locally advanced or metastatic urothelial carcinoma who experience disease progression during or after platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy.	May 2017
Durvalumab (Imfinzi; AstraZeneca, London, United Kingdom)	For treatment of patients with locally advanced or metastatic urothelial carcinoma who experience disease progression during or after platinum-containing chemotherapy or who experience disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.	May 2017
Pembrolizumab (Keytruda; Merck & Co, Kenilworth, NJ)	For patients with locally advanced or metastatic urothelial carcinoma who experience disease progression during or after platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.	May 2017

Heymach J. et al, J Clin Oncol, 2018 Apr 1;36 (10):1020-1044

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Table 4. ASCO Clinical Practice Guidelines, Updates, Endorsements, and Provisional Clinical Opinions from January to October 2017

Publication Date	Guideline
Guideline	
January 17	Management of Small Renal Masses: American Society of Clinical Oncology Clinical Practice Guideline Summary
January 30	Screening to Prevent Invasive Cervical Cancer: ASCO Resource-Stratified Clinical Practice Guideline
February 6	Molecular Biomarkers for the Evaluation of Colorectal Cancer: Guideline From the American Society for Clinical Pathology, College of American Pathologists, Association for Molecular Pathology, and the American Society of Clinical Oncology
March 6	Use of Adjuvant Bisphosphonates and Other Bone-Modifying Agents in Breast Cancer: A Cancer Care Ontario and American Society of Clinical Oncology Clinical Practice Guideline
March 17	Primary Prevention of Cervical Cancer: American Society of Clinical Oncology Resource-Stratified Guideline
August 10	Treatment of Nonmetastatic Muscle-Invasive Bladder Cancer: American Urological Association/American Society of Clinical Oncology/American Society for Radiation Oncology/Society of Urologic Oncology Clinical Practice Guideline
September 11	Patient-Clinician Communication: American Society of Clinical Oncology Consensus Guideline
Guideline Update	
March 27	Brachytherapy for Patients With Prostate Cancer: American Society of Clinical Oncology/Cancer Care Ontario Joint Guideline Update
April 11	Potentially Curable Pancreatic Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update
April 24	Adjuvant Systemic Therapy and Adjuvant Radiation Therapy for Stages I to IIIA Resectable Non–Small-Cell Lung Cancers: American Society of Clinical Oncology/Cancer Care Ontario Clinical Practice Guideline Update
July 10	Use of Biomarkers to Guide Decisions on Adjuvant Systemic Therapy for Women With Early-Stage Invasive Breast Cancer: American Society of Clinical Oncology Clinical Practice Guideline Focused Update
July 31	Antiemetics: American Society of Clinical Oncology Clinical Practice Guideline Update
August 14	Systemic Therapy for Stage IV Non–Small-Cell Lung Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update
Guideline Endorsement	
February 27	Head and Neck Cancer Survivorship Care Guideline: American Society of Clinical Oncology Clinical Practice Guideline Endorsement of the American Cancer Society Guideline
Provisional Clinical Opinion	
April 25	Second-Line Hormonal Therapy for Men With Chemotherapy-Naïve, Castration-Resistant Prostate Cancer: American Society of Clinical Oncology Provisional Clinical Opinion

Heymach J. et al, J Clin Oncol, 2018 Apr 1;36 (10):1020-1044

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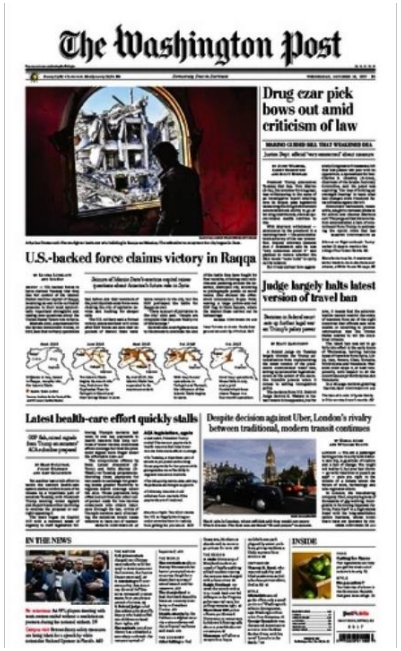
The Washington Post

Drug czar pick bows out amid criticism of law

U.S.-backed force claims victory in Raqqa

Judge largely halts latest version of travel ban

Latest health-care effort quickly stalls

Despite decision against Uber, London's rivalry between traditional, modern transit continues

IN THE NEWS

INSIDE

Health & Science

Ultra-personal therapy: Gene tumor boards guide cancer care

By Marilynn Marchione | AP October 18 at 2:09 AM

SAN DIEGO — Doctors were just guessing a decade ago when they gave Alison Cairnes' husband a new drug they hoped would shrink his lung tumors. Now she takes it too, but the choice was no guesswork. Sophisticated gene tests suggested it would fight her gastric cancer, and they were right.

Cancer patients increasingly are having their care guided by gene tumor boards, a new version of the hospital panels that traditionally decided whether surgery, radiation or chemotherapy would be best. These experts study the patient's cancer genes and match treatments to mutations that seem to drive the disease.

"We dissect the patient's tumor with what I call the molecular microscope," said Dr. Razelle Kurzrock, who started a board at the University of California, San Diego, where Cairnes is treated.

It's the kind of care many experts say we should aim for — precision medicine, the right drug for the right person at the right time, guided by genes. There are success stories, but also some failures and many questions:

Will gene-guided care improve survival? Does it save money or cost more? What kind of gene testing is best, and who should get it?

"I think every patient needs it," especially if cancer is advanced, said Kurzrock, who consults for some gene-medicine companies. "Most people don't agree with me — yet. In five years, it may be malpractice not to do genomics."

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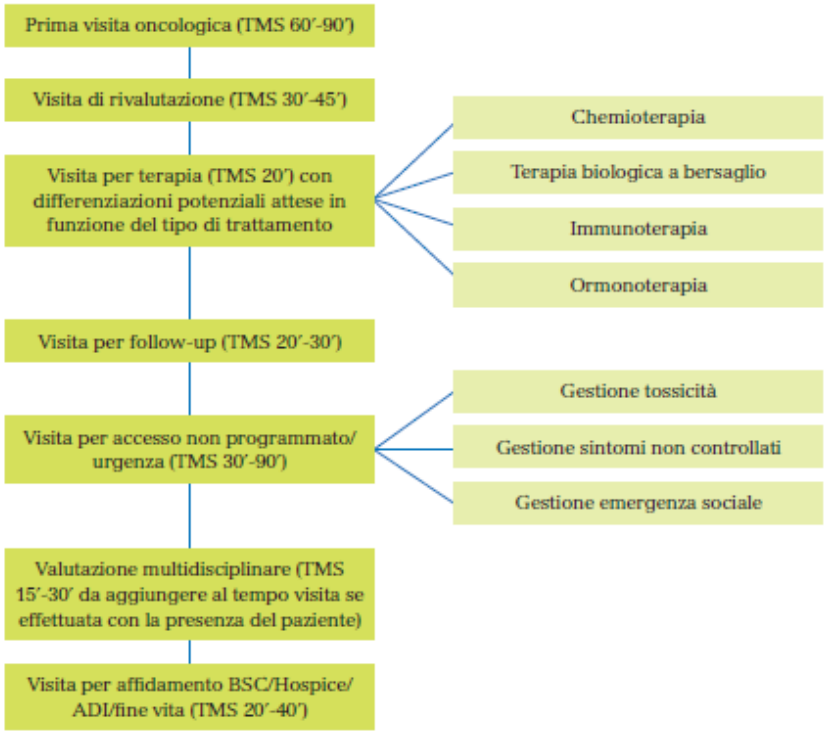
Processi organizzativi

1. Analisi e descrizione esplicita delle fasi del processo

La presa in carico di un paziente con diagnosi di tumore è un processo complesso, articolato in diverse fasi alcune delle quali uniche, altre che possono ripresentarsi con periodicità e diversa frequenza nell'unità di tempo. Una chiara declinazione delle varie fasi (diagnosi, terapia, follow-up, cure palliative) e del tempo medio stimato (TMS) per le prestazioni cruciali e per le attività clinico assistenziali nelle diverse fasi, può essere utile alle Direzioni aziendali e alla Direzione delle Unità Organizzative di Oncologia per la analisi e progettazione delle soluzioni organizzative. L'obiettivo è convergere su risultati di presa in carico e di outcome omogenei nelle diverse realtà.

Di seguito sono rappresentate le tappe fondamentali del processo:



Il TMS non può naturalmente essere considerato quale intervallo vincolante, posta la estrema variabilità del contesto (ad esempio: visita affidamento ad un Hospice in paziente informato e consapevole rispetto ad un paziente non informato).

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VOLUME 35 · NUMBER 31 · NOVEMBER 1, 2017

JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

Patient-Clinician Communication: American Society of Clinical Oncology Consensus Guideline

Timothy Gilligan, Nessa Coyle, Richard M. Frankel, Donna L. Berry, Kari Bohlke, Ronald M. Epstein, Esme Finlay, Vicki A. Jackson, Christopher S. Lathan, Charles L. Loprinzi, Lynne H. Nguyen, Carole Seigel, and Walter F. Baile

ABSTRACT

Purpose
To provide guidance to oncology clinicians on how to use effective communication to optimize the patient-clinician relationship, patient and clinician well-being, and family well-being.

Methods
ASCO convened a multidisciplinary panel of medical oncology, psychiatry, nursing, hospice and palliative medicine, communication skills, health disparities, and advocacy experts to produce recommendations. Guideline development involved a systematic review of the literature and a formal consensus process. The systematic review focused on guidelines, systematic reviews and meta-analyses, and randomized controlled trials published from 2006 through October 1, 2016.

Results
The systematic review included 47 publications. With the exception of clinician training in communication skills, evidence for many of the clinical questions was limited. Draft recommendations underwent two rounds of consensus voting before being finalized.

Recommendations
In addition to providing guidance regarding core communication skills and tasks that apply across the continuum of cancer care, recommendations address specific topics, such as discussion of goals of care and prognosis, treatment selection, end-of-life care, facilitating family involvement in care, and clinician training in communication skills. Recommendations are accompanied by suggested strategies for implementation. Additional information is available at www.asco.org/supportive-care-guidelines and www.asco.org/guidelineswiki.

Key Recommendations

4. Discussing end-of-life care

6. Communicating effectively when there are barriers to communication

(Type of recommendation: formal consensus; Strength of recommendation: strong)

6.1. For families who do not share a common language with the clinician, use a medical interpreter rather than a family interpreter.

6.2. For patients with low health literacy, focus on the most important points, use plain language, and check frequently for understanding.

6.3. For patients with low health numeracy, use pictographs or other visual aids when available, and describe absolute risk rather than relative risk.

7. Discussing cost of care

(Type of recommendation: formal consensus; Strength of recommendation: strong)

7. Clinicians should explore whether cost of care is a concern for patients with cancer.

transitioning to end-of-life care.

VOLUME 35 · NUMBER 31 · NOVEMBER 1, 2017
JOURNAL OF CLINICAL ONCOLOGY
ASCO SPECIAL ARTICLE

RECOMMENDATIONS

CLINICAL QUESTION 1

What core communication skills and tasks apply at every visit, across the cancer continuum?

Recommendation 1.1

Before each conversation, clinicians should review the patient's medical information, establish goals for the conversation, and anticipate the needs and responses of the patient and family (Type of recommendation: formal consensus; Strength of recommendation: strong).

Strategies for 1.1

a. Arrange for an appropriate location for the conversation and enough time to give the information and answer questions.
b. Have all the information necessary to conduct an effective encounter.
c. Know who should be present for the conversation.
d. Have one to three goals or take-home messages in mind for the conversation.
e. Anticipate the emotional responses of patients and family members.
f. Anticipate questions that might be asked.
g. Inquire if there are family members who are not able to attend meetings in person and ask whether they are informed about clinician/patient conversations. Consider offering a teleconference for people who are important to the patient but cannot be physically present.
h. Explore whether there are financial constraints.

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COMMENTARY

Clinical Pathways: Many Potential Benefits but 'More Work to Do'

Interview With Dr Robin Zon

Kathy D. Miller, MD; Robin Zon, MD

DISCLOSURES | June 20, 2018

Kathy D. Miller, MD: Hi. I'm Dr Kathy Miller, professor of medicine and associate director of clinical research at the Indiana University Simon Cancer Center. Welcome to Medscape Oncology Insights. Today I'm joined by Dr Robin Zon, one of my longtime friends. Robin is an oncologist at the Michiana Hematology and Oncology Group and chair of the American Society of Clinical Oncology (ASCO) task force on clinical pathways.[1] Thank you, Robin.

Robin Zon, MD: Thank you for inviting me to talk about something near and dear to my heart—pathways.

Why Pathways?

Zon: The explosion of new evidence is telling us and instructing us on how best to care for our patients. Keeping up with all of the precise information we need to know about our patients and applying that to their treatment care plans can be overwhelming.

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t two decades ago to serve as care management tools so that institutions could reduce variability and become more efficient operationally in

could help manage utilization of

Zon: We have not really addressed the administrative burden associated with pathway utilization,

Miller: Whenever care management is talked about, it sounds like code for "we want to reduce the cost and the amount we are paying for care."

Another challenge is the continued integration of new scientific knowledge. What may happen in the next few years are point-of-care decision support tools because of big data. I think of CancerLinQ®. How are we going to integrate that information when we are looking at pathways and making decisions about our patients? Somehow that needs to be reconciled.

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But we have a lot of patients who are not common. They are not usual. As a specialist, when I look at the breast cancer pathways, what I see are all of the things that are missing, the nuances that are not there. How do you, as a general oncologist, see pathways?

Zon: Those are great points—you're exactly right. Pathways as they are developed should not be intended to have 100% adherence rates. Patients vary not only by their disease type, stage, and molecular markings, but also by what they are able to tolerate in terms of therapies because of their comorbidities and by what they are able to access because of their geographic location. That being said, I agree that pathways need to take into account all of those variables. In pathway development and analysis, we would never recommend 100% adherence. In fact, I would challenge you to think that as precision medicine goes forward and care for patients becomes more granular, that pathways will need to keep up with that and be able to account for those variances.

Keeping Pathways Relevant

Miller: That has me thinking about one way that pathways could be really helpful to the practicing oncologist. We used to talk about first-line treatment for metastatic colon cancer. Now you need to know whether it is *RAS* mutated or *RAS* wild-

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Le dimensioni rilevanti

1. Alimentazione della cultura professionale
2. Le attività con il paziente
3. La comunicazione: paziente, familiari, gruppo, azienda,….
4. Le attività per il paziente: organizzazione e gestione delle Strutture, del percorso clinico, “back office”
5. Riflessione e ristoro dei professionisti

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Medscape Oncology

DRUGS & DISEASES CME & EDUCATION ACADEMY CONSULT VIDEO NEW

News > Medscape Medical News > Conference News > 18th World Conference on Lung Cancer (WCLC)

Oncology Most Stressful of Specialties: High Risk for Burnout

Zosia Chustecka
October 18, 2017

Four components help build resilience:

- Supportive relationships are important. It is essential to build relationships, both inside and outside work, and to spend time with people with whom the clinician is not obligated to be with and who improve one's quality of life. It is also important to take time to see friends who always make one laugh.
- It is important to look after one's own health, including emotional and spiritual health, and also to exercise.
- It is helpful to be aware of one's resources, to be realistic as to how much one can squeeze into a working day, and to learn to say no.
- It is important to find activities that are meaningful and to engage in them. This may involve spending time in nature, listening to music, or participating in adventure sports — doing the things that make one feel most alive.

"Often these are the things that we neglect when we are most stressed," Dr Flanou commented, but these are the things that we need to make time for, because they help with coping with that stress.

The stress in oncology stems from the nature of the disease that is being treated. The work involves repeatedly breaking bad news to patients, witnessing patient deaths as well as severe reactions to and adverse events from treatments, watching patients deteriorate session by session and seeing their physical suffering. In addition, "we often have to manage very ons," she added, which can include encounters with angry

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Lunedì 09 APRILE 2018

2018: fuga dagli ospedali

Le cronache raccontano di medici che abbandonano il posto di lavoro anche prima dell'acquisizione dell'anzianità contributiva utile ai fini della quiescenza, a causa del drammatico peggioramento delle condizioni di lavoro, grazie a mutate disposizioni legislative o alle sirene di un mercato privato rilanciato dal moltiplicarsi di fondi sanitari di fatto sostitutivi delle prestazioni del SSN

Oramai è una vera e propria valanga. Superato lo scalone previdenziale introdotto dalla legge "Fornero", le uscite di medici e dirigenti sanitari dal SSN stanno crescendo in modo esponenziale, senza distinzioni territoriali, al nord come al sud del nostro paese, dal Veneto alla Sicilia, solo per citare gli ultimi casi riportati dai media.

Il fenomeno del resto era atteso, come descritto dall'Anaao Assomed, nelle sue linee essenziali, già nel 2011. Le nostre, però, si stanno rilevando stime prudenziali con calcoli effettuati sul raggiungimento dei criteri previdenziali necessari per una pensione di anzianità secondo la legislazione vigente allora. Oggi le cronache raccontano di medici che abbandonano il posto di lavoro anche prima dell'acquisizione dell'anzianità contributiva utile ai fini della quiescenza, a causa del drammatico peggioramento delle condizioni di lavoro, grazie a mutate disposizioni legislative o alle sirene di un mercato privato rilanciato dal moltiplicarsi di fondi sanitari di fatto sostitutivi delle prestazioni del SSN.

Change is in the Air

- Profound changes afoot in care delivery models
- Increasing emphasis on value
  - Getting right treatment to right patient
  - Avoiding waste
  - Providing patient-centered care

PRESENTED AT: 2018 ASCO ANNUAL MEETING #ASCO18 PRESENTED BY: Ethan Basch, MD @EthanBasch1 2

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Cosa sta cambiando ?

- Nuovi fabbisogni formativi e di sistematizzazione delle conoscenze
- Nuovi fabbisogni organizzativi (ingegnerizzazione dei percorsi)
- Impatto dell'Oncologia sul numero di accessi non programmati e ai Pronto Soccorso, % di pazienti in ADI, nelle RSA, in Hospice
- Nuovi bisogni sociali
- Nuove relazioni interprofessionali negli ospedali (cardiologi, ortopedici, fisiatri, rianimatori) e con il territorio (assistenti sociali, psicologi, associazioni di volontariato, ……)
- Nuove modalità di comunicazione per temi emergenti (cure complementari, etica delle scelte, seconde opinioni, rapporto con il fine vita …)
- Valore dei costi e costo dei valori

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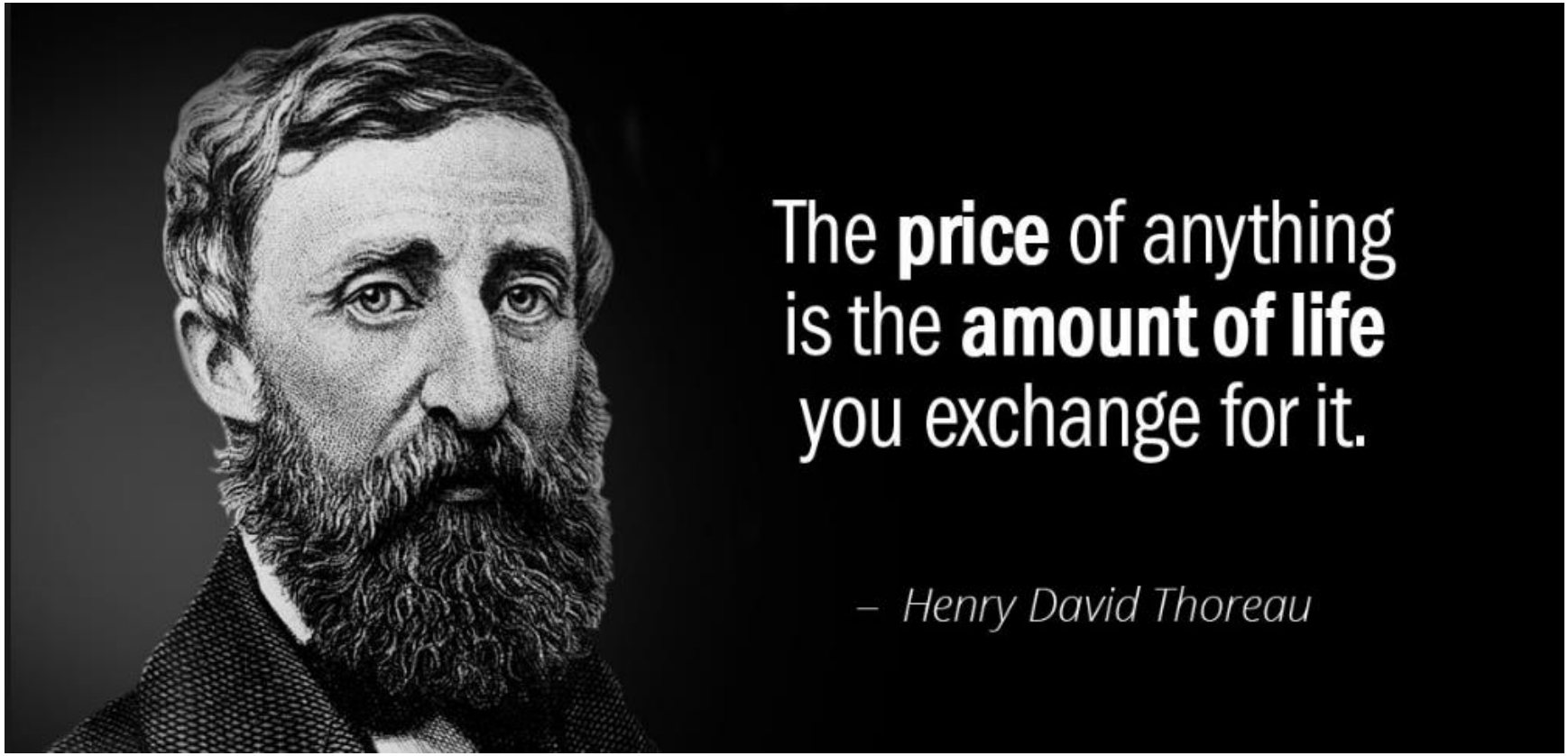
Alcune riflessioni (segue) ….

- Quale impatto sul Servizio Sanitario nel suo complesso ?
- Quale mix di cultura professionale (scientifica, clinica, manageriale, etica, ingegneristico gestionale) servirà?
- Come saranno composte le équipe del futuro?
- Come stanno cambiando le relazioni interprofessionali?
- Come continua a cambiare il ruolo del primario/direttore?
- Chi si sta (pre)occupando della formazione per queste sfide?



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Grazie per l'attenzione