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WALTER LAWRENCE, 95, REFLECTS ON THE NATIONAL CANCER ACT, MEDICINE, SOCIAL JUSTICE, COVID-19, AND RICHMOND'S VANISHING MONUMENTS

In 1971, when the National Cancer Act was signed, Walter Lawrence, Jr., was one of the surgeons eager for a push forward, driven by rigorous science reviewed and funded by the federal government.

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Director of Administration – Wake Forest Baptist Comprehensive Cancer Center

The Wake Forest Baptist Comprehensive Cancer Center (WFBCCC), located in Winston-Salem, North Carolina, is seeking a Director of Administration who serves as the WFBCCC Associate Director for Administration for the NCI Cancer Center Support Grant. This position reports to the Comprehensive Cancer Center Director and is a member of the leadership team of the WFBCCC. This position has broad responsibilities which unite faculty and staff members from within WFBCCC and from various other Centers, Departments, and Institutes within Wake Forest and collaborating institutions around a common strategic vision. The Director of Administration helps facilitate the vision of the Director and other senior WFBCCC faculty leaders by creating an environment of collaboration and interaction for the membership across departmental, school, and institutional boundaries. S/he is also responsible for ensuring that all WFBCCC activities meet National Cancer Institute Cancer Center Support Grant (CCSG) guidelines and essential characteristics.

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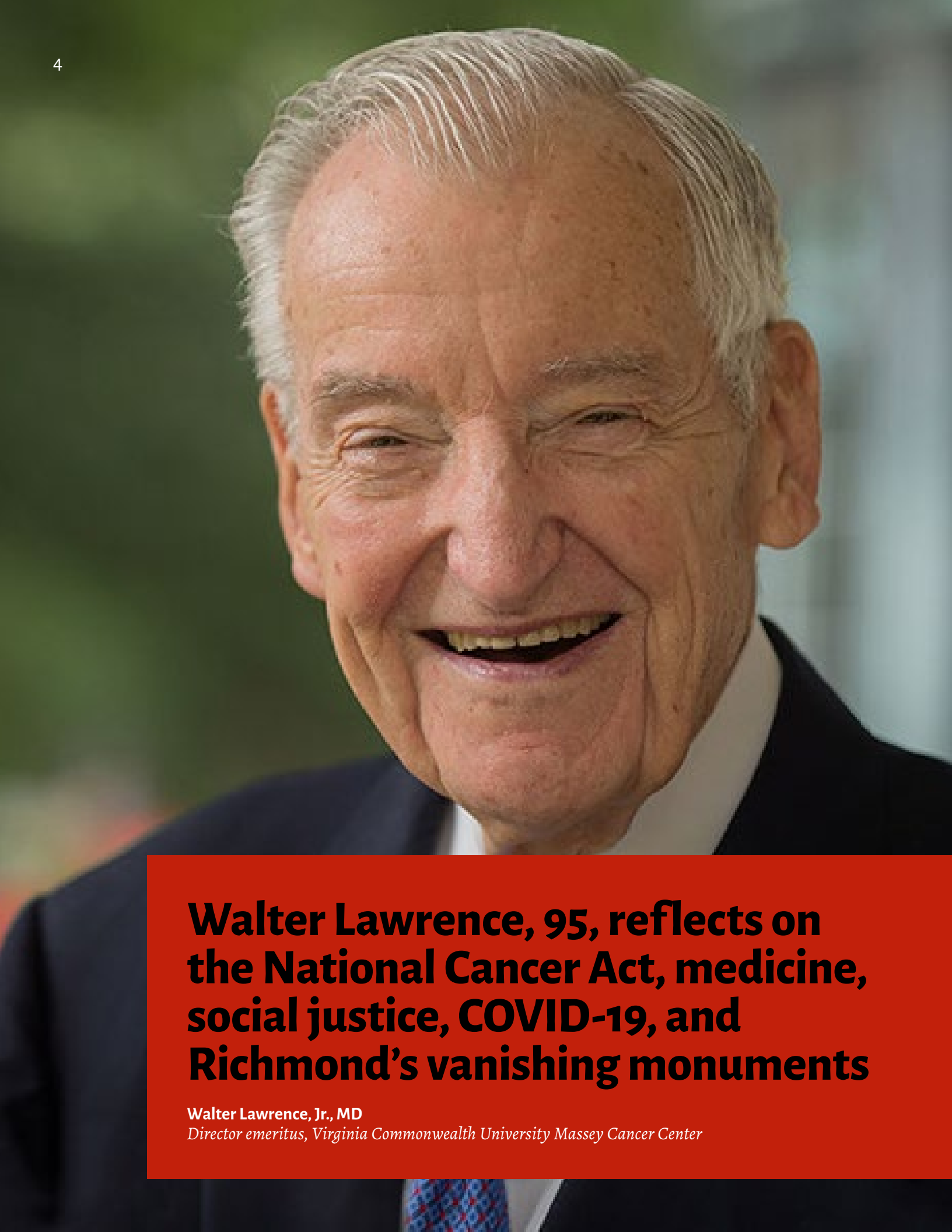
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Walter Lawrence, 95, reflects on the National Cancer Act, medicine, social justice, COVID-19, and Richmond's vanishing monuments

Walter Lawrence, Jr., MD

Director emeritus, Virginia Commonwealth University Massey Cancer Center

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Lawrence spoke with
Paul Goldberg, editor and
publisher of The Cancer Letter,
and Robert Winn, director of the
VCU Massey Cancer Center

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CONVERSATION WITH
THE CANCER LETTER

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I knew him as a man of great intellect, who could be counted on to do what's right and just, and whenever he made a comment, you knew it would be well-thought-out, and relevant, and often funny, reflecting his unique sense of humor. People like Walter Lawrence don't come along very often.

—Norman Wolmark

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In 1971, when the National Cancer Act was signed, Walter Lawrence, Jr., was one of the surgeons eager for a push forward, driven by rigorous science reviewed and funded by the federal government.

The entire field of scientific inquiry needed to evolve, and his colleagues—the surgeons—needed to be educated in cancer biology, and methodology of clinical trials.

Today, at 95, Lawrence continues to teach medical students at Virginia Commonwealth University and advise the new director of the VCU Massey Cancer Center, the place where, in 1966, Lawrence set up the first-ever university-based division of surgical oncology.

Were it not for his disarming smile and a gift for cracking a knee-slapper of a joke, the towering, lanky Lawrence might be an intimidating presence. He is, after all, one of the giants from the time when giants walked the earth.

More than that, Lawrence has combined scientific vision with walking the walk for social justice, advocating for enrolling minority patients in clinical trials, mentoring young Black oncologists, and—at a time when the American Medical Association refused to take a stand against racism—attending the Society of Black Academic Surgeons, a group of distinguished surgeons that made him an honorary member.

In fact, Lawrence had resigned from the Southern Surgical Association in protest against that organization's refusal to admit LaSalle Leffall, Jr., a Black surgeon. Lawrence rejoined the association years later, only after Leffall was admitted.

The 50th anniversary of the National Cancer Act—a document signed on Dec. 23, 1971—comes at a time when science and health equity have become inseparable. Walter Lawrence was ahead of his time, and now, with the world catching up, *The Cancer Letter* invited Lawrence to

reflect on the past half-century of pursuit of truth and justice.

Lawrence saw promise in the National Cancer Act, and earning the Cancer Center designation from NCI in 1975 allowed VCU, then called the Medical College of Virginia, to become systematically involved in clinical trials.

“Randomized clinical trials were the only way we had of really improving patient cancer care—things like the one that Bernie Fisher in Pittsburgh started, the National Surgical Adjuvant Breast and Bowel Project,” Lawrence said in an interview.

“I was a good friend of Bernie's, so we were a big producer in his program.

“Starting that clinical trials program here, as part of the cancer center, benefited patients quite a bit. And, actually, our grant from the NIH at that time was for introducing minority patients.

“Because, as my head of radiotherapy at that time pointed out, 50% of Richmond were African American, we were an ideal place to bring in more minorities into the trials, because the trials up to that point were somewhat in question, because they didn't include the balance of people who live here in America.”

Lawrence spoke with Paul Goldberg, editor and publisher of *The Cancer Letter*, and Robert Winn, director of the VCU Massey Cancer Center, the only Black director of an NCI-designated cancer center.

“The thing that was exciting about the National Cancer Act, which I think was one of the best things President Nixon did, among things that weren't so good, was that it did bring the federal government into the funding of various kinds of research,” Lawrence said.

In recent weeks, the statues of leaders of the Confederacy came down on



A video recording of the conversation is posted here and appears in transcript below.

Richmond's Monument Avenue. Only two statues remain on the wide, leafy street—Robert E. Lee, whose horsed likeness sits on federal land, and Arthur Ashe, a Richmond-born Black tennis star.

Our conversation meandered from history of oncology, to America's reappraisal of its past, to the COVID-19 pandemic, to the killing of George Floyd, to the problem of health disparities.

"It's amazing how so many of us were totally insensitive to the harm and the injury that those monuments did give to certain parts of our population. We looked at them as nice historic artistic things that dolled up the avenue," Lawrence said.

"But I think all the recent demonstrations, mainly peaceful, have really awakened a lot of us to how much those things did hurt. So, even though we've lost some of the beauty temporarily by losing some artistic monuments, I think

we've got real progress already in that dimension, by having them removed.

"I have confidence that we are going to have other things to doll up the street and make us just as proud as before, but it'll take a little time. Of course, I, again, want to emphasize, I think we aren't going to solve this racism problem by just getting rid of monuments, but it really is a first step that I think is important in this whole procedure of improving the relationship with certain parts of our population in every way."

A video recording of the conversation is posted [here](#) and appears in transcript below.

"Walter Lawrence is a pioneer in so many ways, and he never became an anachronism," said Norman Wolmark, chairman of the National Surgical Adjuvant Breast and Bowel Project, a component of NRG Oncology, a clinical trials group. "He was always on the leading

edge. MCV was always the incubator for surgical oncology in so many ways.

"He believed that the field of surgical oncology was more than cloistering in the operating room and churning out cases."

In the 1970s, at a time when it was said that lesser surgeons did lesser mastectomies, Lawrence and Fisher questioned whether "heroic" surgeries benefited patients. Such heresy meant being ostracized by the profession.

"He saw surgery as an integral part of the evolving paradigm in solid tumors, and he saw surgeons as more than just gatherers of tissue," Wolmark said to *The Cancer Letter*. "He had perfect credentials. He was at UChicago, he was at Hopkins, he was at MSK, he could have been churning cases. Instead, he was willing to study biology and behavior, becoming—deservedly—the first surgeon to head a cancer center.

“I knew him as a man of great intellect, who could be counted on to do what’s right and just, and whenever he made a comment, you knew it would be well-thought-out, and relevant, and often funny, reflecting his unique sense of humor. People like Walter Lawrence don’t come along very often.”

Otis W. Brawley, Bloomberg Distinguished Professor of Oncology and Epidemiology at Johns Hopkins University, met Lawrence in the late 1980s.

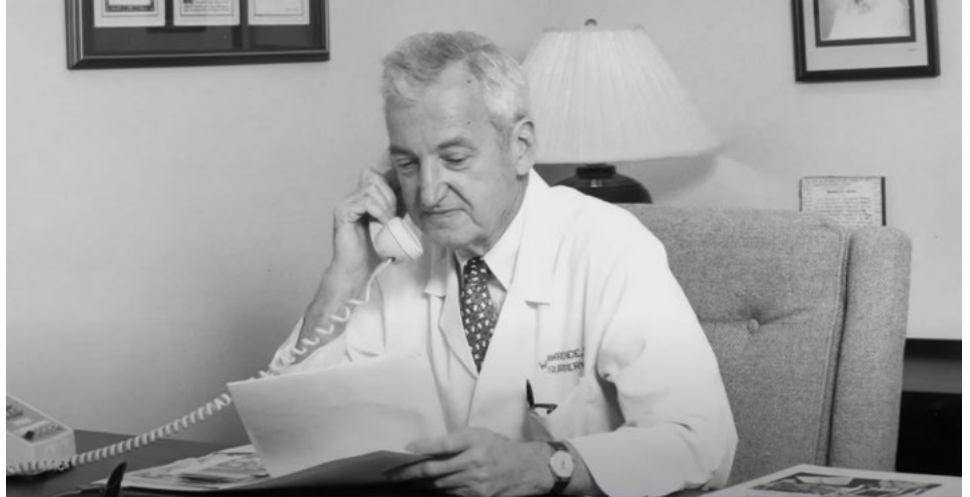
“Medicine, like all scientific disciplines evolves over time. Those who are most successful in medicine do not just evolve with it, they drive the evolution,” Brawley said to *The Cancer Letter*. “Walter Lawrence the physician/scientist/civil rights advocate has been in the forefront driving the evolution of medicine for decades. He is the consummate physician and gentleman.”

Friends speculate that Lawrence, who was a surgeon at the 46th Army Surgical Hospital during the Korean War, was a prototype for the surgeon Hawkeye Pierce in the novel, movie, and television series *M*A*S*H*.

There are other surgeons who are purported to be the prototypes for Hawkeye, and an argument can be made that surgeon Hiester Richard Hornberger, Jr., a co-author, with the writer W.C. Heinz, of the autobiographical novel, had a wealth of his own material—and his own cast of characters from 8055th M.A.S.H., where he served.

Lawrence doesn’t recall having met Hornberger, but he does love the television show his work inspired. “I had the same job as Hawkeye Pierce—chief of surgery,” he said to *The Cancer Letter*. “I think all of us would like to claim we were the model for him, but I don’t know.”

That said, Lawrence’s drive, his advocacy for patients, his lack of tolerance for



Lawrence, as director of the VCU Massey Cancer Center, which he founded and ran from NCI designation in 1975 through 1988.

nonsense of any sort, and his sense of humor invite one to think of Hawkeye.

Consider a Lawrence teaching moment captured in a 30-year-old issue of *The Cancer Letter*:

Lawrence, then a member of the NCI Board of Scientific Counselors, was presenting a report of a BSC subcommittee recommending instituting a special grant program aimed at educating surgeons to systematize staging of disease—and bring them into the fold of the institute’s cooperative groups.

Asked whether surgeons could be expected to apply for standard grants, Lawrence responded with a simple No.

“Pitifully few surgical oncologists are trained as researchers,” he declared (*The Cancer Letter*, April 11, 1980).

Having Lawrence as a mentor was life-changing.

“He’s very much responsible for my career,” said Harry D. Bear, the Walter Lawrence, Jr., Distinguished Professor of Oncology and chair of the Division of Surgical Oncology at the Department of Surgery, and associate director of clinical research at VCU Massey. “He

encouraged me to get involved with the NSABP, and that certainly has been a big part of my career.

“He was an example to follow in terms of getting involved, understanding the importance of clinical trials and cancer research from somebody who was a busy clinician and a leader and an administrator. He got the NCI designation, and he ran the cancer center from 1975 to 1988, and he was a very effective administrator—some people called him ‘the velvet hook.’

“He got things done.”

In 1971, a young woman named Edith Mitchell, a native of Brownsville, Tenn., came to MCV and enrolled in the more rigorous three-year program. A year later, Mitchell was placed on Lawrence’s service in surgical oncology.

“Only select students could do surgery on Dr. Lawrence’s service,” said Mitchell, a clinical professor, director of the Center to Eliminate Cancer Disparities, program leader for gastrointestinal oncology at Thomas Jefferson University, and a member of the President’s Cancer Panel.

At the time, Black patients at MCV were treated at the E.G. Williams Hospital, “He

and patients were seen in different areas based on race.

“But when it came to surgery and taking care of patients, I never saw Dr. Lawrence make a difference in what he did for the Black patients, compared to the white patients,” Mitchell said to *The Cancer Letter*. “And he never taught us to make a difference.”

Mitchell performed physical examinations and took histories on all patients, regardless of race.

“It was the situation where the Black patients were in one hospital, the whites were in another, and if a patient requested that this little Black girl not be a part of their medical team, Dr. Lawrence never went along with it.

“I never saw him make a difference in what he recommended to patients, or his management of patients based on race; and his insistence, that I be included in the patient’s care,” Mitchell said. “And the patients could not elect to have me omitted from their care because of my skin. So, I can understand why he walked out of the Southern Surgical Association because they did not accept LaSalle Leffall.”

Mitchell was the first Black student to graduate from MCV’s three-year program. Before graduation, Lawrence gave her helpful advice.

“He said to me, ‘Edith, don’t ever put anything on a form in the next few years that you graduated in three years.’ And I said, ‘Why not?’ He said, ‘There are some state statutes that state that you must have four years of medical school. You will not have four years of medical school. In fact, you won’t even have three. So, you don’t ever put that on a form, because you never know in what state you will apply for a license.’ We knew that racial things could be stumbling blocks. Somebody could use that against me.”

Mitchell said she didn’t recall thinking deeply about the Confederate statues on Monument Avenue while she was at MCV.

“One of the things that I learned early on in the South was when to choose battles. The statues were not among the battles that I chose, but now, in 2020, when we are recognizing all of the things in the past, I think it is very much important that we give due honor to the United States of America,” said Mitchell, a retired brigadier general of the U. S. Air Force.

“These were people who fought against the United States of America. Therefore, I am very much a proponent of bringing to light the actual history. And that’s what Dr. Lawrence did for me—making sure I knew what was real, and that cancer patients had real needs, and that cancer research needed to be put at the forefront, and that we needed to engage,” Mitchell said.

Lawrence remains active in the VCU medical school and at Massey.

“We have our teaching conferences for fellows and residents on Zoom on Tuesdays and Thursday mornings and Thursday afternoons,” Bear said. “Walter comes, he pays attention, he asks questions, he provides a historical perspective when it’s needed. I am, actually, getting to the point where I’m providing historical perspective, but he has a much longer view of history in medicine and surgery. So, it’s always good to have him there. And he comments on the articles and the presentation—he’s still quite engaged.”

Five years ago, at 90, Lawrence gave up skiing and tennis.

However, his buddies still gather regularly at the tennis court in his backyard.

“He stopped playing about five years ago; I’m in charge of organizing the

games,” Bear said. “But we still play at his house, and he comes out, and sits in the chair, and gives us advice or comments on our shots.”

Paul Goldberg: Dr. Lawrence, thank you for sitting down and talking with us. We deputized Dr. Winn to be an interviewer for *The Cancer Letter*—it’s an adjunct position. Let’s go back to 1971. What were your thoughts about the National Cancer Act, and why did you decide to seek NCI Cancer Center designation for MCV?

Walter Lawrence: Well, thank you for having me. I would say that back in 1971, most of the support, in terms of research, support and emotional support, in a way, for cancer programs at universities, really, was organizations like the American Cancer Society.

Although here in Richmond, we had the Virginia Federation of Women’s Clubs and the local Masons outfit, and other organizations were very supportive, but none of these could provide the kind of support that our friendly government could do.

The thing that was exciting about the National Cancer Act, which I think was one of the best things President Nixon did, among things that weren’t so good, was that it did bring the federal government into the funding of various kinds of research.

We were pretty excited here when we had a lot of people at the basic science level and at the clinical level who all wanted to work together and collaborate. But having a cancer center funded by the government would really be helpful in that regard.



Lawrence as an army surgeon in Korea in 1952.

The National Cancer Act really gave us a lot of enthusiasm about the future, getting more things done in terms of improving the whole problem of cancer overall, patient wise and in the laboratory.

PG: What does it take to make it happen, to make the NCI designation happen in Richmond?

WL: Well, in '71, it's different than now, I could tell you. Because then the government group working with the idea of cancer centers really were hung up on the fact that you had to have authority that made you more or less independent of a lot of the other administrative people at the school.

Many schools, the deans or the departmental chairmen had their noses out of joint by having another new or-

ganization that was taking over some authority. But the advantages here in Richmond were that the deans, and at that time the departmental chairman and everything, were gung ho about having this new coordinating entity.

Now, it wasn't suddenly going to give us a lot of money for our research and other activity. What it was going to do was to give us those kinds of support funds that would help coordinate what was already funded on its own merit.

We did have a number of basic investigators and clinical investigators here at the time, all of whom had various kinds of research grants, sometimes through the American Cancer Society, some through the federal government, and various parts of the NIH.

Having this additional funding source of a coordinating entity really was exciting for both the basic scientists we were collaborating with, I say we—those who were clinical people dealing with

cancer—and the basic science people who suddenly felt they were going to have some clinical advantage come from the work they were doing in the research labs.

PG: When did you get the designation?

WL: We had a planning grant that helped us. I must admit, they were very helpful in getting our heads straight on how to go about it. We put in our core grant in '74, and it was approved in 1975. In that time, we became an NCI grantee.

Now, I'm glad you mentioned that, because the other thing that happened at that time, a lot of little commercial outfits, if they did a little cancer work and they would call themselves a cancer center. Being called an NCI Cancer Center was a big-deal difference, because you could just go down the street and

call yourself a cancer center if you treated a few patients.

And, of course, the NCI Cancer Center in those days was primarily research, both basic and clinical. It didn't really cover clinical treatment programs. We just had to have those as a background for having this wonderful coordinated cancer center.

But the main thing was to get funded, and to be named a Cancer Center, like we were, required us having grants. And we did have a number of grants, some from the NIH and some from the American Cancer Society.

I think we measured up, because we also had administrative support at the vice president and dean level, and departmental chairman level—everybody saying it was a good idea. I think that emotional support we had was also very helpful.

PG: This happened at the same time as Alabama, really the first batch of cancer centers, right?

WL: Yeah.

PG: Maybe we should just go back—your coming to Richmond. You're from the Midwest, you've been in New York a long time, what brought you to Richmond?

WL: Well, actually, it's really not the cancer deal at all.

I spent 15 years, my first career, at Memorial Sloan Kettering, and I was really excited about working there in both research and in clinical work. Ran one

of the services there. But in those days, the only dialysis unit for kidney dialysis was Memorial, none of the other universities.

So, it turned out that when kidney transplantation was started here in Richmond, by Dr. [David M.] Hume, he couldn't take our patients very well who had renal failure. So, I ended up, by being a young surgeon, they said, well, why don't you start doing transplants here? So, I did all the first kidney transplants as a side issue of my cancer work at the cancer center and got to know Dr. Hume.

And Dr. Hume needed a vice chairman to answer the phone and to run things, because he was on the run [all over] the country all the time, selling kidney transplantation. So, I came down here as a transplanter, but I quickly shifted, because my big deal was really cancer work.

So, I told Dr. Hume I could be his vice chairman if he would let me start an entirely different, a separate cancer service, called the Division of Surgical Oncology. And he said, "Whatever you want, whatever you want."

So, I really came here interested in getting cancer surgery going, and I had no idea when I came of wanting to start a cancer center.

Robert Winn: That's really great. You've talked a little bit about the National Cancer Act and its founding in 1971. What did the National Cancer Act accomplish for cancer patients in Richmond, in the country, and worldwide?

WL: Well, actually, I think the National Cancer Act was really mainly benefiting those people who were doing research, and there was much less concentration on patients.

On the other hand, you had to have a substantial relationship with the management of cancer patients for you to get funded. In a way, I think the way the cancer patients actually benefited, besides us possibly getting much more knowledgeable about how to manage their care, was the fact that it did allow us to really get going on clinical trials.

Randomized clinical trials were the only way we had of really improving patient cancer care—things like the one that Bernie Fisher in Pittsburgh started, the National Surgical Adjuvant Breast and Bowel Project.

Lawrence performing surgery at a M.A.S.H. unit in Korea.



I was a good friend of Bernie's, so we were a big producer in his program.

Starting that clinical trials program here, as part of the cancer center, benefited patients quite a bit. And, actually, our grant from the NIH at that time was for introducing minority patients.

Because, as my head of radiotherapy at that time pointed out, 50% of Richmond were African American, we were an ideal place to bring in more minorities into the trials, because the trials up to that point were somewhat in question, because they didn't include the balance of people who live here in America.

RW: You have a lot of distinctions. Any number of them.

WL: You're just going on.

RW: But one of them has been really something that has motivated me from when I was a medical student and, certainly, a resident. You were one of the few white surgeons who were active in the Black Academic Surgical Association. Could you talk about that just a little?

WL: Well, actually, I snuck in. There is a very distinguished group of surgeons called the Black Academic Surgical Society.

It's a national organization with lots of surgical leaders in it, and one of the major leaders then was LaSalle Leffall, who recently died. He was in Washington, and he was at Howard, and he was chairman of surgery there, but he was also a nationally known cancer surgeon.

LaSalle happened to get his training at Memorial when I was a junior doctor, so I started training him, sort of, but we became mainly friends over the years, and due to LaSalle, and a number of other members of that organization that I was friends with, to be nice to me, they made me an honorary member.

Naturally, if you get to be an honorary member, you better go to the meeting every year, and it was very worthwhile, because they're a wonderful group of people, and continue to be, and it's quite a national organization that I'm proud of being an honorary member of.

RW: Well, thank you. This question, there has been a change at VCU Massey recently, they had a new appointed cancer center director, I think the guy's name is Dr. Winn. Are there any reflections you have on being in this position and any advice that you would give to this new cancer center director?

WL: Well, that's a tough one. That's a tough question.

Well, first of all, I must state here, I'm excited that you're the new director, but not because you're a minority or anything else. It's because of what you've done and what you bring to the cancer center. Dr. Winn is very well known for his work in pulmonary work.

Everybody in the world knows that our leading cancer—that's our biggest problem still—is lung cancer, so, having somebody who has a special research interest in pulmonology is especially good.

The second thing that is especially good, is since you came here, you've got so much energy and zip that I'm sure you're going to rev things up even further. We

are looking forward to great, great things from you.

Lastly, the fact that you are African American means that we are going to be guaranteed to have diversity in our workforce, so we are winning on all levels on this thing. So, thank you for coming.

And, incidentally, he's from the same hometown that I came from. He didn't really grow up there. He came from somewhere in the East, but both of us are from Chicago, so we are straightening out these Southerners a little bit.

PG: You certainly have seen polio in your career. You have gone through the HIV era. And now there's COVID. What has the COVID pandemic told us about the U.S. healthcare system?

WL: Well, first of all, I might say that this COVID epidemic is so much more overwhelming than all those previous problems, at least from the standpoint of public perception.

The polio hit us when I was mainly a kid, and the main thing I noticed was that we couldn't go to the movies, and it did worry us, but we still went to school.

Since then, we've learned a lot, and, of course, we benefited a lot from the work on polio, but this epidemic is so much more overwhelming. When you say, what did we learn, I'm really impressed with how well our medical facilities nationwide have anted up and come through and dealt with a disease for which we have no real treatment.

We have things that help, the dexamethasone and so forth, but still it's really impressive how nurses and physicians and other healthcare workers have really anted up when it was needed.



Lawrence, third from the right, at a 1986 dedication of North Hospital which today houses VCU Massey Cancer Center's Dalton Oncology Clinic, Radiation Oncology Department, BMT inpatient and outpatient clinics, and Thomas Palliative Care Unit. NCI Director Vincent T. DeVita is second from the right.

What's really worried me is how our culture has really not responded as well as they might. I'm afraid it has something to do with leadership, but I'm not going to get into politics. But I think we needed a little more leadership than we seem to be getting at the present time.

PG: What about disparities that you see in cancer and that we saw in HIV, and what we are seeing in COVID? They seem to be working very similarly.

WL: Actually, I bet this business of the disparities in both the incidence and in the severity of all these things is, it's a mixed bag. Some of it may well have genetic aspects, but most of it is more in the social realm.

A lot of it probably has to do with underrepresented minorities having less satisfactory social systems. It's bringing to our attention, the fact that we have

to do a lot about that. I'm hoping now, with some of the recent activity that's gone on, that we will get improvement.

RW: It seems that almost after every big event, after polio, after HIV, and, certainly, after COVID, that people get fatigued, people have the protest, people have the energy, and then all of a sudden it goes away. Do you think that there'll be any difference after this COVID crisis is over?

WL: Of course, we all say we hope so. But I honestly think so. It's another similar situation as that little young girl that sailed across the Atlantic on climate change.

I think the younger generation may have a lot more pizzazz in response to seeing some of the awful things that are hap-

pening, and that the younger generation may have more impact on how we do things than our elderly one and your middle-aged ones.

The other thing is with the cell phones and that, a lot of us really had some of these things brought to our attention much more dramatically than before.

Watching the killing of somebody on your phone is just pretty earthshaking. I think some of these things may have a lot more impact than things in the past. We certainly deserve to get more benefits, because this epidemic is so much worse than all the other ones.

PG: What are your thoughts, as you navigate Monument Avenue in Richmond these days? I hear Jeff Davis is not there anymore, and a few others might be coming down.

WL: When you go there, it's really impressive. It's amazing how so many of us were totally insensitive to the harm and the injury that those monuments did give to certain parts of our population. We looked at them as nice historic artistic things that dolled up the avenue.

But I think all the recent demonstrations, mainly peaceful, have really awakened a lot of us to how much those things did hurt.

So, even though we've lost some of the beauty temporarily by losing some artistic monuments, I think we've got real progress already in that dimension, by having them removed.

I have confidence that we are going to have other things to doll up the street and make us just as proud as before, but it'll take a little time.

Of course, I, again, want to emphasize, I think we aren't going to solve this racism problem by just getting rid of monuments, but it really is a first step that I think is important in this whole procedure of improving the relationship with certain parts of our population in every way.

PG: Let me just disagree with you on one point, which is that I don't think you're giving yourself enough credit, because you really were seeing, were very sensitive to these matters all along, as your career shows and, certainly, a lot of people regard you—and I'm one of them—as a civil rights hero. Given that, maybe I should ask you if you ever expected that in your lifetime you will see an African American director of Massey Cancer Center.



Circa 1980; from left: Alan Kaplan, Walter Lawrence, S. Elmer Bear (then chair of oral surgery at MCV) and Jose Terz (fellow surgical oncologist who came from MSKCC with Lawrence)

WL: It's an interesting question, but it never occurred to me one way or another, but now that it's happened, I'm just as excited about it.

But it just wasn't one of those things. One of the reasons I never really thought about it too much is that even in my retirement, I was head of admissions for the medical school for a while, and we were always trying to encourage minority groups admission to the school, but we never really accomplished as much as we wanted to, because there weren't enough applicants.

And the reason there weren't enough applicants is, if we are going to develop somebody like Dr. Winn, we got to start improving things at the kindergarten level and not wait until they go to medical school or wait until they go into the faculty of medical school.

Solving this whole problem of racism in this country is going to require repairing a lot of our systems.

RW: Going back to science and the impact of the NCI Cancer Centers, what's been the thing for you, the one either miracle drug or the one surgery, or maybe the combination of the surgical approaches or the medical approaches? I think when I began my career, for example, I know that we were not really enthusiastic, or there wasn't any real hope in curing lung cancer, really treating lung cancer. What were some of the big wow moments when you were a sitting director? What are the big wow moments since?

WL: Well, I have to admit when I was in surgical training, one of the things that led me to being interested in cancer was that I thought the operations that we did for cancer were the most interesting operations we did.

66

As my head of radiotherapy at that time pointed out, 50% of Richmond were African American, we were an ideal place to bring in more minorities into the trials, because the trials up to that point were somewhat in question, because they didn't include the balance of people who live here in America.

99

—Walter Lawrence, Jr.

As a young surgeon, they were thrilling, because they were some of the bigger ones. Of course at the time I entered into this cancer field, which is in the early fifties, I'll have to admit the only good treatment for most cancers was surgery.

As I go along here, what excites me about the future? What's exciting me about the future is the fact that we finally began to see where there are some—this happened right along, of course—but we now begin to see that there's some real excitement about things like immunotherapy.

And this is only the last 10 years that we see what we always wanted to have happen is happening, so the thing that's exciting is that the non-surgical, or at least non-destructive methods of treating cancer, have a big hope now for the first time.

We were really looking forward to immunotherapy when I started in the fifties, but it never seemed to work out. It was a good idea, too bad it didn't work.

There've been breakthroughs in cancer research in this last decade that are now being profited from, in terms of development. It's not developed yet, but is in the process of development at the cancer center. I think the work there is exciting for the future, and I think you're going to do it.

RW: I was thinking about from where you started to where we are now about the impact of technology in the field of cancer. Do you have any reflections about that, because there's always this battle about too much technology. Is it really working? Is it just snake oil? But it's clear that the technology all along, whether we are talking about robotic surgeries, whether we are talking about... How has technology added?

WL: When technology hit surgery, that's when laparoscopic surgery, robotic surgery, and those things came along.

Of course, those of us who had been doing something another way all along resisted a little bit, but it became clear that there were tremendous advantages.

There had been some disadvantages. Part of the disadvantages is the increase in technology has increased subspecialization, so many of the people treating patients have shifted from being, in a sense, physicians to technologists, and they only do one kind of treatment, and they suddenly lose sight of the disease and all its aspects and focus more on the mechanics of treatment.

But it's one of those things that goes with the territory. I think that, all in all, the technology of some of these improvements in surgery, for example, have really made this less damaging treatment and one that's better tolerated, and so it is progress overall, it just has a few of those things that make me worried.

That's part of the reason I still teach medical students, because I don't spend time teaching them how to treat cancer now. I teach them how to take care of people. That's still something that's very necessary in cancer management, and I'm sure you do that well.

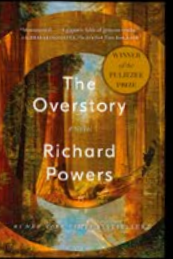
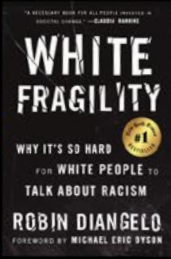
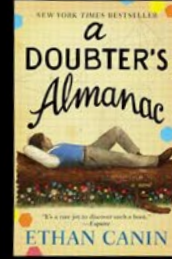
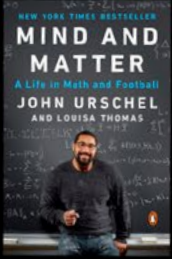
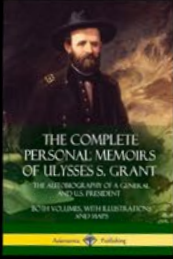
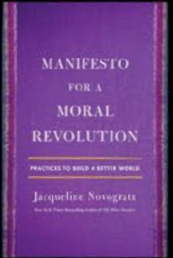
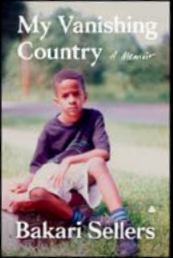
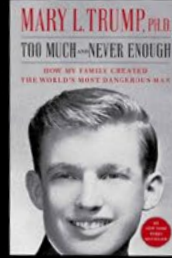
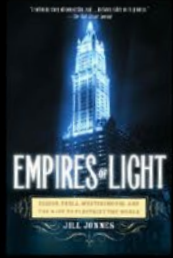
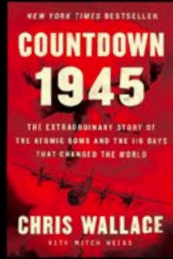
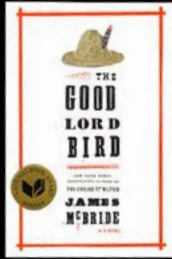
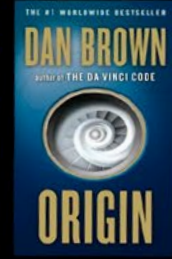
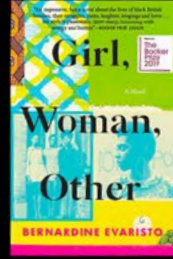
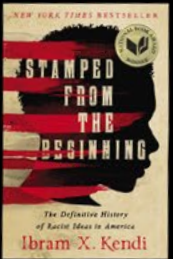
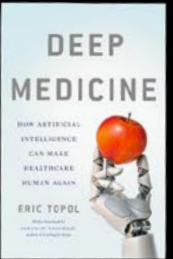
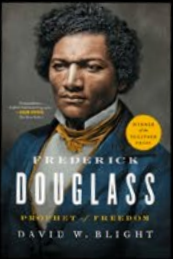
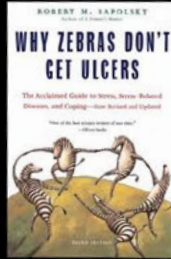
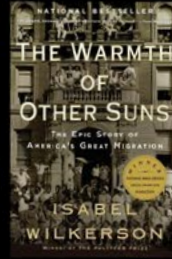
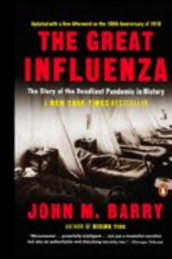
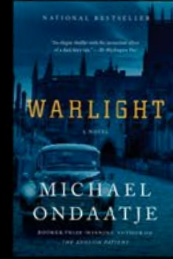
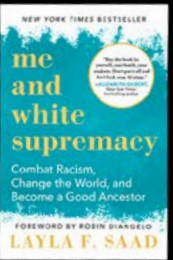
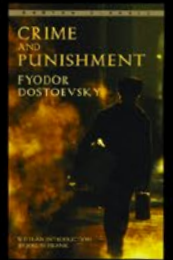
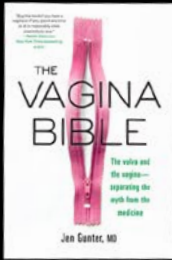
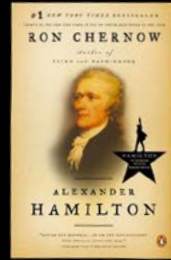
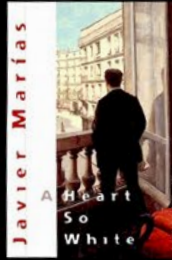
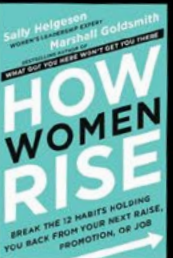
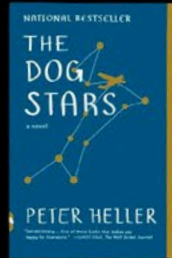
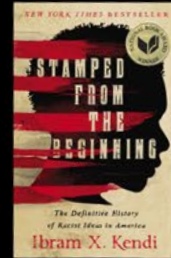
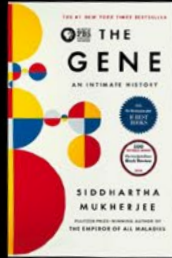
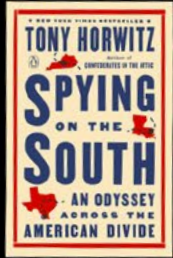
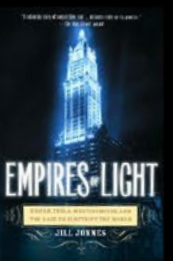
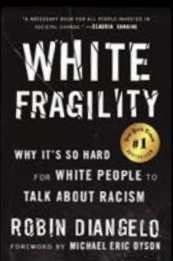
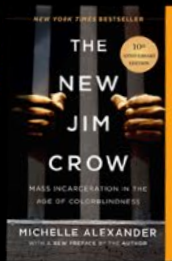
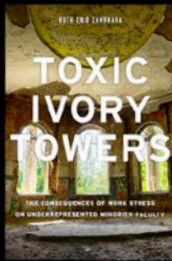
RW: Paul, any other questions from you?

PG: Thank you so much.

WL: Well, thank you. I'm flattered that you would think I know anything at the age of 95. Thank you very much.

Walter Lawrence (right, seated), with Harry Bear (left, seated) and friends in a recent photo





What are you reading?

A reading list is a glimpse into the soul of a community. A reading list is also a reflection of a time. And a projection of visions of the future.

We asked our readers: “What have you read this year that has made an impression on you?”

There was nothing scientific about our sample. There were no guidelines, no boundaries for genre, topic, or contemporary relevance.

We wanted a reading list and we got one: 67 recommendations, the books your colleagues—clinicians, basic scientists, drug developers, regulators, advocates, senior scientists, early-career researchers—have turned to as the pandemic exposed America’s deepest flaws.

Here are some admittedly unscientific observations about the list:

- Fiction and nonfiction are equally represented.
- At least fourteen books are explicitly about racism and race in America.
- At least four books are about infectious diseases.

Here is the list, arranged by reader, in alphabetical order:

Monica M. Bertagnoli



*Professor of surgery,
Harvard Medical School;
Chief, Division of Surgical Oncology,
Brigham and Women’s Hospital and
Dana-Farber Cancer Institute*

- **Splendid Solution: Jonas Salk and the Conquest of Polio**, by Jeffrey Kluger

I just finished reading *Splendid Solution*, and found it to be fascinating to consider both the similarities and differences between the search for a polio vaccine and our current struggles to overcome COVID-19.

Bruce A. Chabner



*Professor of medicine,
Harvard Medical School;
Director emeritus, clinical research,
Massachusetts General
Hospital Cancer Center*

- **Frederick Douglass: Prophet of Freedom**, by David Blight,
- **Tennessee Williams: Mad Pilgrimage of the Flesh**, by John Lahr

I have read two remarkable biographies.

Frederick Douglass: Prophet of Freedom is an extraordinary story of a remark-

ably talented orator and writer whose escape for slavery led to his critical role as the most influential thinker in the post civil war period. His life experience teaches much about the failure of the war to change the racist culture that continues to surface in our country.

The second book I would highly recommend is the profoundly insightful and analytical biography of Tennessee Williams (*Tennessee Williams: Mad Pilgrimage of the Flesh*), the dominant playwright of the post World War II era, by John Lahr, the son of Burt Lahr, and for many years the primary theater critic of the New Yorker.

The book is long but worth the effort as it reveals the thought and emotion behind Williams' extraordinary plays. The vignettes about the actors (Marlon Brando, Elizabeth Taylor, Bette Davis, and Geraldine Page) and directors (Elia Kazan) are priceless. Coincidentally, I first appreciated Lahr's talent as a critic and author when he was taken on as a freshman apprentice reporter (a healer) at the Yale Daily News, where I was a sports writer and mentor.

Nancy E. Davidson



President and executive director,
Seattle Cancer Care Alliance;
Senior vice president, director and
member, Clinical Research Division,
Fred Hutchinson Cancer Research Center;
Professor and head of medical oncology,
University of Washington

- [*The Good Lord Bird*](#), by James McBride,
- [*The Splendid and the Vile: A Saga of Churchill, Family, and Defiance During the Blitz*](#), by Erik Larson

The Good Lord Bird by James McBride—story of a young slave boy who passes as a girl when he is taken up by John Brown in his antislavery crusade, which started in the Kansas Territory and ended at Harper's Ferry. I bought the book early in the year and read it during our current period of demonstrations against racial injustice.

The Splendid and the Vile by Erik Larsen—the story of Winston Churchill's first year as Prime Minister of Great Britain at the beginning of World War II and the Battle of Britain and is told from personal papers and diaries of his family, friends and colleagues. It is an inspirational story about leadership during an unfathomable crisis. Another book that I bought early in the year before I understood what we would all be facing this year with COVID-19, economic decline, and public demonstration about racial injustice.

Narjust Duma



Assistant professor of medicine,
Thoracic Oncology,
University of Wisconsin
Carbone Cancer Center

- [*The Vagina Bible: The Vulva and the Vagina: Separating the Myth from the Medicine*](#), by Jennifer Gunter,
- [*Between Grit and Grace: The Art of Being Feminine and Formidable*](#), Sasha K. Shillcutt,
- [*Why Zebras Don't Get Ulcers: The Acclaimed Guide to Stress, Stress-Related Diseases, and Coping*](#), by Robert Sapolsky

The Vagina Bible: So many important questions, so much convincing, confusing, contradictory misinformation! In this age of click bait, pseudoscience, it's easy to be overwhelmed—whether it's websites, advice from well-meaning friends, uneducated partners.

This book provides excellent contact about women's health, a history behind the stigma associated with women's sexual health, and other aspects that all women should know. The audiobook is available and is a must!

Between Grit and Grace: The Art of Being Feminine and Formidable: This is the book of female professionals who are feeling stuck or disempowered in the workplace.

The book provides exercises, realistic situations, and a wonderful sense of humor. The book breaks down the "too" bossy, colorful, and energetic issues associated with gender bias—a quick read for the weekend after a busy clinic.

Why Zebras Don't Get Ulcers by Robert Sapolsky: Let's get real, it is not such a big deal. Be a zebra, and enjoy your life. This book provides data about stress and the consequences of our stressful behaviors.

Robert Peter Gale



Visiting professor of hematology,
Imperial College London

- ***Crime and Punishment***, by Fyodor Dostoevsky,
- ***The Death of Ivan Ilyich***, Leo Tolstoy

The lockdown in California and no travel gave me time to re-read two books I think are relevant to us as oncologists: *Crime and Punishment* by Fyodor Dostoevsky and *The Death of Ivan Ilyich* by Leo Tolstoy.

Why *Crime and Punishment*? Rodion Romanovich Raskolnikov (Rodya) is a university law student in Petersburg. His sister Dounia is to enter a loveless marriage to an older wealthy official to rescue him and their mother from poverty. He rebels against the notion. His plan: kill Alyona Ivanova, an elderly pawnbroker and steal her money and pawned items. In a frenzied state he barges into her flat killing her with several axe blows to the head.

Alyona's sister, Lizaveta, enters the flat because Raskolnikov has accidentally left the entry door ajar and he is obliged to kill her as well. He flees. The uncertainties in the scene Dostoevsky

describes, Rodya's impulsiveness, the unplanned entry of Lizaveta remind me of the stochastic nature of cancer, especially the randomness of mutations that underlie it. Had Raskolnikov met someone on the stairwell to the flat, had Alyona Ivanova not opened the door (she hesitated several minutes), had Lizaveta not entered (she was meant to be elsewhere) *Crime and Punishment* would be a very different story—or perhaps no story at all. But these events happened and we are left with two murders, or perhaps a cancer of a different sort.

Why *The Death of Ivan Ilyich*? Ivan Ilyich Golovin is an unhappily married magistrate in Petersburg. One day he falls from a ladder hurting his side. His condition worsens, no one knows what it is, but everyone agrees he will die a painful death. (My diagnosis is plasma cell myeloma. Today he might be cured by high-dose chemotherapy, an auto-transplant and new drugs—but then we wouldn't have a novel.)

Initially, he is visited by colleagues who come out of a sense of duty. However, as Ivan lingers, they become resentful of his disrupting their lives. He is dying too slowly. During the long, painful process of dying Ivan realizes he doesn't deserve his fate, concluding pain and death must be arbitrary and senseless—and he begins to hate his family for avoiding the subject of his death. In his last days he realizes he has led a superficial life, which is why he fears death. He is overwhelmed with compassion and sympathy, forgives his family, his fear of death leaves him, and he dies peacefully.

Having finished both novels the choice is clear: Vodka, caviar and blini or *War and Peace*, depending on how the SARS-CoV-2 lockdown plays out.

Берегитесь коронавируса.

Bobby Green



Chief medical officer,
Flatiron Health

- ***Alexander Hamilton***, by Ron Chernow

I bought Ron Chernow's *Alexander Hamilton* right after I was lucky enough to see the Broadway show in early 2016. Given the amount of time I spend on airplanes, I thought I'd get some reading done in my travels. Unfortunately, I actually bought the book, not an electronic version, and it's huge... so it wasn't really amenable to taking on airplanes.

When my travel stopped abruptly back in March, I finally started reading it and I'm about halfway through. It's a wonderful window into the world of our founding fathers, and obviously gives insight into the founding father most of us knew little about before Lin Manuel-Miranda.

What I've really been struck with however is how relevant so much of it is today, specifically the debate around the role of the federal government versus the states. Hamilton, as now most of us know, was an advocate for a strong federal government and executive leadership. And as we have seen in the past four months with the current pandemic—we need this now more than ever.

Fred R. Hirsch



Executive director, Center for Thoracic Oncology, Mount Sinai Cancer, Mount Sinai Health System; Professor of medicine and pathology, Icahn School of Medicine; Joe Lowe and Louis Price Professor of Medicine; associate director, Tisch Cancer Institute

- **Countdown 1945: The Extraordinary Story of the Atomic Bomb and the 116 Days That Changed the World**, by Chris Wallace and Mitch Weiss,
- **Rise and Kill First: The Secret History of Israel's Targeted Assassinations**, by Ronen Bergman

My most recent reading was Chris Wallace's (with Mitch Weiss), *Countdown 1945*. Chris Wallace, who is the anchor of Fox News Sunday, is telling an extraordinary story about the atomic bomb and the 116 days that changed the world. He describes the global political situation, which necessitated the use of an atomic bomb, but the book describes all the internal considerations leading to President Truman's sanction to use the bomb. There were certainly good arguments for and against the use of such a destructive weapon, which the

world never had seen, and which would change the world within a moment.

It is also a story about an untested new President Harry Truman, who as Vice President, was kept out of war planning and knew nothing about the top-secret Manhattan Project and the development of the world's first atomic bomb, and shockingly learned about the project after the death of President Franklin D. Roosevelt.

He also got very conflicting advice from generals like Dwight D. Eisenhower and George Marshall. The book takes us through details in the planning, both from a scientific perspective and from a national and international political perspective, and leads us through all the last detailed preparations for getting the bomb ready for use. Very fascinating read about a U.S. and global historical landmark, which changed the world and the future perspectives.

I have read a few other books, too, among them the *Rise and Kill First* about the secret history of the Israeli intelligence community and the history of Israel's targeted assassinations, its successes and failures.

Jonathan Hirsch



Founder and president, Syapse

- **The Splendid and the Vile: A Saga of Churchill, Family, and Defiance During the Blitz**, by Erik Larson

I've been a big fan of Erik Larson's works since reading *The Devil in the White City* while sitting in Jackson Park when I was an undergraduate at University of Chicago.

Larson's new book, *The Splendid and the Vile*, is a perfectly-timed lesson in leadership during a time of acute, and potentially catastrophic, crisis.

Larson focuses on the pivotal time period of May 1940 through May 1941, and describes how Churchill successfully rallied Britain against the Axis powers through an exploration of his interactions with his family and colleagues. Larson adds novel and important dimensions to this well-studied time in history by weaving together deeply personal and private accounts from the diaries of those closest to Churchill. His relationship with Lord Beaverbrook highlights his merging of the personal and the political.

Churchill appoints a trusted friend, highly successful businessman, and a bit of a gadfly with no manufacturing experience as the Minister of Aircraft Production, charged with solving the key problem facing Britain: a lack of fighter planes. Churchill and Beaverbrook constantly debate with and antagonize one another, and it is through this process that Churchill is able to receive honest assessments of the state of British defenses, and determine how to rally the government and people to take action. Churchill, in private and public, showed that transparently acknowledging problems is not a sign of weakness, but of strength. I was struck by the deep empathy that Churchill had for the plight of the British people impact-

ed by the Blitz, and how he channeled this empathy into symbolic actions that boosted the morale of the public, and their willingness to make sacrifices to defeat their enemy.

Clifford A. Hudis



Chief executive officer,
American Society of Clinical Oncology

- ***The Nickel Boys***, by Colson Whitehead,
- ***The Warmth of Other Suns: The Epic Story of America's Great Migration***, by Isabel Wilkerson,
- ***The Dog Stars***, by Peter Heller,
- ***Blindness***, by Jose Saramago

I read three books in the past six months that turned out to be of-the-moment for different reasons. Two that address racism in America through different perspectives, and one that I read late in 2019 that imagines a dystopian post-pandemic America.

I just this past week re-read Colson Whitehead's *The Nickel Boys* for my book club, having read it initially about a year ago. I'm not always so ahead of

the curve—but since I read it it has won a slew of awards including the Pulitzer for its simple and engrossing description of a fictionalized version of a real place of horror. Everything you might imagine when picturing a racist, evil reform school happened here—both in reality and in this fictionalized telling.

I had heard of the great migration but never really dove in. *The Warmth of Other Suns* was recommended to me because it tells the story through the lives of several people and families over decades. In the process it also illuminates the transforming impact of the railroad on America, although that is far from the main point!

It illustrates that upward mobility may be an aspiration and even a possibility for everyone in America, but both the starting line and the obstacles are not evenly distributed.

Years ago I loved Peter Heller's account of a year spent learning to surf (***Kook: What Surfing Taught Me About Love, Life and Catching the Perfect Wave***). *The Dog Stars* is so-called postapocalit—a story of a few survivors of a global pandemic. When I read it I found it to be ultimately a moving exploration of the need for human connection (both emotional and physical) and the will to survive. But now, looking back after 120 days of COVID-19 lockdown, it is even more moving and real.

You didn't ask, but for fun I will share that I am now re-reading Jose Saramago's *Blindness*. It was a fantastic novel when first translated from Portuguese around 1995 (I think) but the story of a society's response to a transmitted form of sudden vision loss is of course scary and relevant.

Reshma Jagsi



Newman Family Professor,
Deputy chair, Department
of Radiation Oncology,
Director, Center for Bioethics and
Social Sciences in Medicine,
University of Michigan

- ***Cutting for Stone***, by Abraham Verghese

Lately, I have been seeking refuge from reality in novels that immerse me in a completely different time and place.

One favorite I pulled out recently is *Cutting for Stone*. There are ties to medicine, but the primary focus of the story is on the bonds and relationships that form between human beings. I recommend it to anyone who wishes to be transported completely to another world and to recognize what is beautiful about what we do in our lives.

Karen E. Knudsen



Executive vice president of oncology services, Jefferson Health; Enterprise director, Sidney Kimmel Cancer Center; Hillary Koprowski Professor and Chair, Department of Cancer Biology, Chair, cancer biology, Thomas Jefferson University

- **Deep Medicine: How Artificial Intelligence Can Make Healthcare Human Again**, by Eric Topol,
- **Robert Frost: Collected Poems, Prose, & Plays**, by Robert Frost,
- **Cold Comfort Farm**, by Stella Gibbons

Over the last month I've been digging into three different genres. You can take your pick:

I finished Eric Topol's *Deep Medicine*, which inspired new thinking on my part with regard to opportunities for refining cancer care in the post-pandemic world.

I've also been reading more deeply into a collection of later year poetry from Robert Frost, which I find mentally soothing.

Finally, I have a great love of using timeless British comedy for escapism and

will re-read favorites. While I often turn to PG Wodehouse, I am in the midst of re-enjoying *Cold Comfort Farm* from Stella Gibbons, which I frankly find laugh-out-loud hilarious even on the fifth or sixth read.

Our heroine, Flora Poste, is creative, witty, and a woman before her time. I love this character, but let's also not forget the unforgettable character of Ada Doom, who famously coined the phrase "I saw something nasty in the woodshed!" as the response to any situation in which she finds herself in a pickle. I'm laughing even as I write this....and that's good medicine.

Danielle N. Krol



Medical officer, breast oncology, Center of Drug Evaluation and Research, Office of Oncologic Diseases, Division of Oncology 1, FDA

- **How Women Rise: Break the 12 Habits Holding You Back from Your Next Raise, Promotion, or Job**, by Sally Helgeson and Marshall Goldstein,
- **Stamped from the Beginning, the Definitive History of Racist Ideas in America**, by Ibram X. Kendi

I was the social butterfly of my medical school class, which continued through residency and fellowship. I was some-

one who needed continuous stimulation from people, so I became class president of my med school class and put my high energy to use. After going through four years of med school, three years of residency and another three years of hematology oncology fellowship, I found myself ready to enter that next phase: attending life.

I've been fortunate to be mentored by amazing women physician mentors, however I've also witnessed women physicians being held back from leadership positions. I decided to start a Book Club at FDA with women physicians, and our first book would be *How Women Rise*.

One day in the mail I received a package, with a book inside called *How Women Rise*. It was mailed to be by my longtime mentor, Dr. Darilyn Moyer, CEO of the American College of Physicians, with a little note inside saying—"Start a book club." Darilyn was a mother figure to me, and never stopped mentoring and inspiring me to be the best I could be after I lost my mother to breast cancer many years ago. I took her advice yet again, because Darilyn was never wrong, and I started a book club in February 2020.

How Women Rise is a masterclass in personal development. The authors did a paramount job of identifying the roadblocks that women face as they advance in the workplace, and explaining various habits that hold women back as they seek to advance. Instead of focusing on external corporate cultures, the authors focused on the personal thought processes and behaviors women can control, adjust and even replace as they move up in their careers. For men and women alike, who want to take the next step in your career, this book is for you.

After the success from the inaugural book club where we read *How Women Rise*, I decided that there was no better

time than during a Pandemic to hold book club number 2. At the same time of deciding my new read, *Stamped from the Beginning: The Definitive History of Racial Ideas in America*, the video of George Floyd's death at the hands of the police in Minneapolis triggered protest around the world and brought renewed attention to the ongoing concerns about racism in the criminal justice system.

Because Americans like to insist they are living in a post-racial society, seeing the news broke my heart that racist ideas have a long and lingering history. *Stamped from the Beginning* would soon become my new book club read. It provides one of the most thought provoking accounts of American racial history. Kendi uses five influential characters in American history from the colonial era to the present age as tour guides to explore the landscapes of the evolution of racial ideas. To improve conversations about race, racism and racial justice, this book ambitiously taught so much on American history and also served as an opportunity to have an open discussion about race.

Michelle M. Le Beau



Director,
University of Chicago Medicine
Comprehensive Cancer Center

• *My Vanishing Country*, by Bakari Sellers

Sellers' engaging memoir is timely, and sheds light on the critical issues of the day. His honest and moving portrayal of the systemic racism that represses the black population is both eye-opening, and a testimony to the courage and strength of individuals, families, and communities. One cannot help but reflect upon the contemporary issues of social justice, and the toll of current and impending legislation on people of color, without developing the conviction that we must do better.

Jed Manocherian



Founder and chair,
ACT for NIH

• *Better Angels*, by Sadie Keller

Better Angels was written by 12 year old Sadie Keller, who was diagnosed with acute lymphoblastic leukemia when she was 7 years old. In the last five years while battling cancer, she has become a YouTube sensation with her instructional video diary about her treatments, has created a foundation for cancer research, and another foundation called Sadie's Sleigh which has donated 58,000 toys to children with cancer, and she worked with Rep. Michael McCaul (R-

TX) to help pass the most important childhood cancer legislation in history.

Better Angels is the story of Sadie's personal two and a half year battle with cancer, including emergency room visits, surgeries and side effects, such as experiencing stroke-like symptoms and losing her hair eight times. It is also a story of hope, inspiration, and how a selfless little girl has brought meaning to her life by helping others.

I asked Sadie if she wishes she never had cancer, and why she wrote *Better Angels*, and this was her response: "My life has changed, it's totally different, and I love helping kids and spreading awareness. It was meant to happen so I could help other kids like me. Help them to get through a hard time, provide hope, and that angels are all around you and you just have to open your eyes—some are here and some are in heaven." Sadie has lost five of her closest friends to cancer.

Better Angels was written to help other children with cancer, and all profits are directed to charities for childhood research. Sixteen thousand children are diagnosed with cancer each year, and Sadie's hope is to provide a free copy of her book to all of them.

Sadie's legislative agenda is to increase the NCI budget allocation for childhood cancer research which is at 4%. It is not just the number of lives lost, it is the number of years lost. An adult who dies from cancer may have lost 10 years from their lifespan, a child 60-70 years. Childhood cancer survivors have over a 65% chance of having long term side effects during their life. In Sadie's case, she is susceptible to heart ailments, bone density, neuropathy, and learning disabilities. Sadie is a positive energy and force for good on a mission to improve humanity. She is an angel, and I know you will enjoy *Better Angels*!

Shelley Fuld Nasso



Chief executive officer,
National Coalition for
Cancer Survivorship

- **Rodham: A Novel**, by Curtis Sittenfeld,
- **So You Want to Talk About Race**, by Ijeoma Oluo,
- **A Long Petal of the Sea**, by Isabel Allende,
- **Daisy Jones & The Six**, by Taylor Jenkins Reid (**audiobook**)

I tend to read fiction, rather than cancer-related books, in my spare time. A few recent reads:

Rodham, by Curtis Sittenfeld, re-imagines Hillary Clinton's life if she had chosen NOT to marry Bill Clinton in the early 1970s. I previously read and enjoyed Sittenfeld's *American Wife*, a thinly veiled fictionalization of Laura Bush's life, so I was eager to read *Rodham*.

Rodham is a portrait of the Clintons' early relationship and intense connection. Early on, Hillary learns of Bill's infidelities. When faced with the decision whether to accept his womanizing and

give up her own career ambitions in exchange for their deep love, she walks away. The thought experiment about how their lives and political careers would have been different continues through the 2016 election. The portrait of the powerful woman behind the scenes, including the indignities and double standards she faces, is interesting. And the twists and turns on historical events are entertaining.

So You Want to Talk About Race, by Ijeoma Oluo. This summer, as the Black Lives Matter protests have captured the attention of the country and heightened understanding of systemic racism, I, like many others, wanted to learn more about what I could do. Oluo offers straight talk about white privilege, implicit biases, microaggressions, intersectionality, and more, as well as real instruction about how to talk about race and really listen to others' lived experiences with racism. Talking is only a starting point, but we have to start somewhere. She also offers plenty of suggestions for action.

A Long Petal of the Sea, by Isabel Allende, tells the story of two people who fled Spain under Franco in the 1930s to Chile, where they built a new life for themselves. It's a story of love and honor, changing relationships over time, refugees and immigrants, and what home really means.

I have to throw in one more, this time an audiobook. Before the pandemic, I listened to many audiobooks during my commute time, but I still make some time for audiobooks. *Daisy Jones & The Six*, by Taylor Jenkins Reid, is a delicious and fun story of sex, drugs, and rock and roll in the 1970s, and how an iconic band came together and fell apart. The story is told in a documentary style, and so I highly recommend the audio

version, with a host of actors, Jennifer Beals and Benjamin Bratt, playing the roles of band members, journalists, and family/friends of the band.

Lori J. Pierce



President, American Society
of Clinical Oncology;
Vice provost,
Academic and Faculty Affairs,
Professor of radiation oncology,
University of Michigan

- **Stamped from the Beginning, the Definitive History of Racist Ideas in America**, by Ibram X. Kendi

I am currently reading *Stamped from the Beginning, the Definitive History of Racist Ideas in America*. It is a *New York Times* bestseller written by Ibram X. Kendi, a professor of history and international relations who I believe just recently went to Boston University to become the director of their Center of Antiracist Research. Kendi looks at the evolution of racism in this country through the eyes of five influential individuals spanning the period of colonialism through recent years.

The range allows the reader to contrast segregationist, assimilationist, and

antiracist ideologies, their impact on their respective societies at the time, and their subsequent collective impact on race relations in this country. My hope, after I finish reading the book, is to have a greater understanding of the background behind the racial divisions within our country right now and to reflect upon some of my own experiences and feelings as a person of color.

Peter WT Pisters



President, The University of Texas
MD Anderson Cancer Center

- **Me and White Supremacy: Combat Racism, Change the World, and Become a Good Ancestor**, by Layla F. Saad,
- **The Ride of a Lifetime: Lessons Learned from 15 Years as CEO of the Walt Disney Company**, by Bob Iger

Me and White Supremacy provides a thoughtful and engaging approach to an important issue for society and for all leaders. I consider it an imperative for all leaders to explore this topic, to learn about their own prejudices and to expand their thinking in order to create the greatest impact possible during their tenure. The practical tools to enable self-change that are shared

in the book are extremely valuable and provide a useful first step in this exploration.

Reading this book quite possibly was the most useful thing I have ever done to examine my own prejudices and relationship to race. It was uncomfortable to confront the impact of white skin and how that affords me certain privilege and how I may have inadvertently used that privilege at different phases of my career, but it gave me the tools to fully examine myself and to move forward in the most positive and inclusive way possible.

I highly recommend this book and the process you undergo to anyone interested in combating racism and wanting to understand what they can do to make society more equal and socially just from an individual level. I learned about myself and about the ways in which white supremacy makes the world toxic for all of us.

We all know Disney based on our own personal experiences with its movies, amusement parks and more, but *The Ride of a Lifetime* truly takes you inside of The Walt Disney Company—a massive media company—from the perspective of Bob Iger, executive chairman and former CEO.

Iger does a terrific job of outlining how he thought through building on the company's strengths and confronting its weaknesses. He also does an excellent job of explaining what it is like to be a CEO and the fact that you always are thinking about and reflecting on this question: "Which thing am I not spending enough time on?"

As Iger writes, "You go from plotting growth strategy with investors, to looking at the design of a giant new theme-park attraction with Imagineers, to giv-

ing notes on the rough cut of a film, to discussing security measures and board governance and ticket pricing and pay scale...there are also, always, crises and failures for which you can never be fully prepared."

Based on my own experiences, the overall picture he creates of the challenges of being a CEO is quite accurate.

When I last met Iger, we had a detailed conversation on the topic of brand protection, something that is a top priority for me at MD Anderson and, interestingly, also for him at Disney. Many of the topics we discussed—including his insights on how to approach the rigor around brand protection—are outlined in detail in this book.

Tatiana M. Prowell



Associate professor of oncology,
Breast Cancer Program,
The Sidney Kimmel Comprehensive
Cancer Center at Johns Hopkins,
Under Armour Breast Health
Innovation Center

- **The Plague**, by Albert Camus,
- **And Every Morning the Way Home Gets Longer and Longer**, by Fredrik Backman,

- **[The Vanishing Half](#)**, by Brit Bennett,
- **[American Dirt](#)**, by Jeanine Cummins,
- **[Manifesto for a Moral Revolution: Practices to Build a Better World](#)**, Jacqueline Novogratz,
- **[Just Mercy](#)**, Bryan Stevenson,
- **[The Great Influenza: The Story of the Deadliest Pandemic in History](#)**, by John Barry

The Plague by Albert Camus is a well-known novel from the 1940s about a mysterious plague in the French Algerian town of Oran that feels remarkably modern and relevant. My favorite quote of the book: "There's no question of heroism in all this. It's a matter of common decency. That's an idea which may make some people smile, but the only means of fighting a plague is common decency." So, please wear a mask, ok?

And Every Morning the Way Home Gets Longer and Longer, by Fredrik Backman is a novella written from the perspective of a grandfather with progressive dementia. This will be a familiar and cathartic work of fiction for anyone who has ever witnessed a loved one's memory unravel.

The Vanishing Half, by Brit Bennett, is a novel about Black identical twin sisters who run away from home at age 16, one ultimately living her life as a Black woman back in the south where she grew up and one passing for a white woman, with very different experiences. Their divergent, but interconnected, lives hold the mirror up to American society.

It's a beautifully told story about the construct of race, who defines it, and how it shapes individual and collective destiny over generations.

American Dirt, by Jeanine Cummins, is a novel about a woman and her son who are unexpectedly and suddenly forced out of their ordinary life to become migrants. The story speaks to me at a moment when the world has been upended by the pandemic and we realize that all of the things we took for granted were never guaranteed to us.

Manifesto for a Moral Revolution: Practices to Build a Better World, by Jacqueline Novogratz, is a non-fiction book about leadership that relies on storytelling. Its central thesis is that ordinary people empowered to believe in their own personal agency change the world, and I am here for that message!

Just Mercy is a true story by Bryan Stevenson, a defense attorney, about his work as the founder of Equal Justice Initiative. The heart of the book is his defense of Walter McMillian, a Black man from Alabama who was sentenced to die for a murder he did not commit. It's a book about forgiveness, justice, and our shared humanity. My favorite quote from the book: "We can embrace our humanness, which means embracing our broken natures and the compassion that remains our best hope for healing. Or we can deny our brokenness, forswear compassion, and, as a result, deny our own humanity...Each of us is more than the worst thing we've ever done."

The Great Influenza: The Story of the Deadliest Pandemic in History, by John Barry, is a brilliant and comprehensive book about the 1918 Spanish Flu pandemic. Anyone who is a fan of the history of medicine genre will love it. From it, I've concluded that humans are hard-wired to make a limited number of predictable mistakes over and over across centuries. How we identify and correct our own poor decisions in real time to alter our fate is one of my current obsessions.

Antoni Ribas



President, AACR;
Professor of medicine, professor of surgery, professor of molecular and medical pharmacology, University of California Los Angeles;
Director, Tumor Immunology Program, Jonsson Comprehensive Cancer Center;
Chair, Melanoma Committee, SWOG

- **[A Heart so White](#)**, by Javier Marías,
- **[The Man of Feeling](#)**, by Javier Marías,
- **[Origin](#)**, by Dan Brown,
- **[The Gene: An Intimate History](#)**, by Siddhartha Mukherjee,
- **[The New Jim Crow: Mass Incarceration in the Age of Colorblindness](#)**, Michelle Alexander

Indeed, I have been catching up on reading in the past months. In other times, I found myself reading research articles as opposed to books, so the pandemic allowed me to go back to enjoy reading books.

There is a thread on my Spanish background, as I read two of Javier Marías novels (*A Heart so White*, *The Man of Feeling*) and Dan Brown's *Origin*, which mostly happens in my hometown, Barcelona.

Now I am on the last chapter of *The Gene: An Intimate Story*, by Siddhartha Mukherjee, bringing me back to the biomedicine field—and next, I will be starting *The New Jim Crow* by Michelle Alexander.

Mace L. Rothenberg



Chief medical officer,
Pfizer

- **Too Much and Never Enough: How My Family Created the World's Most Dangerous Man**, by Mary Trump,
- **The Last Flight**, by Julie Clark,
- **The Splendid and the Vile: A Saga of Churchill, Family, and Defiance During the Blitz**, by Erik Larson

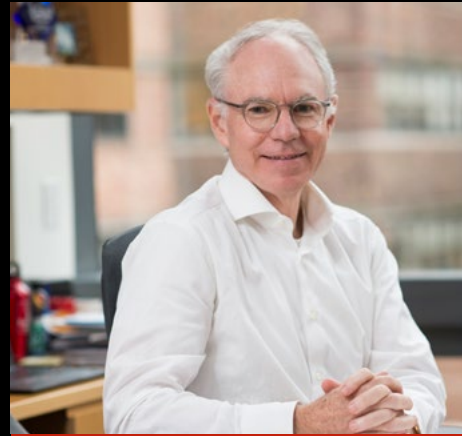
I'm reading *Too Much and Never Enough* by Mary Trump. Curious to know more about the back-story of our 45th president.

The book I just finished was *The Last Flight* by Julie Clark. A well written tale about 2 women who switch airline tickets at the airport ... and what happens when one of their flights crashes.

The book before that was *The Splendid and the Vile*—A detailed account of

Winston Churchill's courage, leadership, sprinkled with eccentricities during the Nazi Blitz of London in 1940-1941.

Charles L. Sawyers



Investigator,
Howard Hughes Medical Institute;
Marie-Josée and Henry R. Kravis Chair
in Human Oncology and Pathogenesis,
Chair, Human Oncology and
Pathogenesis Program,
Memorial Sloan Kettering Cancer Center

- **Spying on the South: An Odyssey Across the American Divide**, by Tony Horwitz,
- **Code Blue: Inside America's Medical Industrial Complex**, by Mike Magee,
- **A Passage to India**, by E. M. Forster,
- **White Fragility: Why It's So Hard for White People to Talk About Racism**, by Robin DiAngelo

Spying on the South is a timely perspective on the US North/South divide by retracing the late 1850s journey of Fredrick Olmsted (later famous for designing NYC's Central Park) through the American south and southwest pre-Civil War, now in modern times. Enormous implications vis a vis the current political

climate and anti-racism. (I also highly recommend his earlier book *Confederates in the Attic*). Full disclosure: I grew up in Nashville.

Code Blue is a fascinating account of the current medical industrial complex—how it has developed and evolved after WWII and why the current ecosystem is a barrier to universal health care in the United States. The author has a compelling perspective—as a practicing urologist, then vice president of medical affairs at Pfizer, and now medical historian.

A Passage to India is a classic novel on racial tension and prejudice in India during the British colonial period, centered around the trial of an Indian doctor falsely accused of assault by a British school mistress. Published in 1924, but the themes remain highly relevant today

I assume everyone knows about this important book, *White Fragility*, on racism, from the perspective of a white woman who facilitates racial and social justice conversations in the workplace. If you have not already read it, you should.

Ellen V. Sigal



Chair and founder,
Friends of Cancer Research

These are truly terrific books that I loved:

- **Warlight**, by Michael Ondaatje,
- **The Dutch House**, by Ann Patchett,
- **Girl, Woman, Other**, by Bernardine Evaristo,
- **Night Boat to Tangier**, by Kevin Barry,
- **Death in Venice**, by Thomas Mann

Steven R. Singer



Senior vice president,
Chief communications officer,
Dana-Farber Cancer Institute

- **A Doubter's Almanac**, by Ethan Canin,
- **The Overstory**, by Richard Powers,
- **Dept. of Speculation**, By Jenny Offill,
- **Empires of Light: Edison, Tesla, Westinghouse, and the Race to Electrify the World**, by Jill Jonnes

I'm surely not the only person who'll say that working insane hours during our first COVID-19 surge this spring really put a damper on available time and energy. That said, I've resolved to cut back on doom scrolling and Netflix and just this weekend started the latest (OK, it was published a few years ago) by a favorite writer—Ethan Canin, who also was a physician earlier in his career. *A Doubter's Almanac* tells the story of a truly gifted mathematician who emerges from the backwoods of Michigan to heights of the profession, even as we watch the dissolution of his life and character.

Earlier this year, I was truly absorbed by Richard Powers' *The Overstory*, a big, deep and affecting novel that has stayed with me far more than most. Powers weaves the generational stories of several characters together across decades to a climax in the ecological movement in the Pacific Northwest. It's one of the rare books that works both as a polemic and as high art. No one who reads it will ever think of a forest the same way.

Dept. of Speculation is also powerful but quite different in style and scope...extremely economical and concise, it tells the story of the life and death of a marriage through an accumulation of short observations, musings, and memories.

Lastly, I greatly enjoyed *Empires of Light*, which tells of the great competition between these geniuses. Jonnes does a wonderful job setting the development of the electric age in the context of the times, and the relevance to the huge tech battles of the internet age are both unsaid and clear.

Charles R. Thomas Jr.



Professor and chair, radiation medicine,
School of Medicine, Biomedical
Informatics Graduate Program,
Oregon Health & Science University

- **Toxic Ivory Towers: The Consequences of Work Stress on Underrepresented Minority Faculty**, by Ruth Enid Zambrana,
- **Mind and Matter: A Life in Math and Football**, by John Urschel and Louisa Thomas

Toxic Ivory Towers is of interest since it attempts to describe experiences of URM faculty throughout academia. Most importantly, there are tools that may partially mitigate work-related stress. The author has studied this topic and seems to be speaking to me directly, during certain portions of the book.

Mind and Matter is of interest since it serves as an autobiography of a student-athlete who continues to excel in the classroom. I'm always keen to learn

more about focused student-athletes, accent on student; especially those from the Black diaspora. I wonder how many more John Urschel's there are out there.

Robert A. Winn



Director,
Virginia Commonwealth University
Massey Cancer Center

- ***The Complete Personal Memoirs of Ulysses S. Grant***, by Ulysses S. Grant,
- ***Begin Again: James Baldwin's America and Its Urgent Lessons for Our Own***, by Eddie S. Glaude,
- ***The Plot Against America***, by Philip Roth

The Complete Personal Memoirs of Ulysses S. Grant is a must read for all Americans. His impact on the U.S. has been equal to that of President Abraham Lincoln, and yet his accomplishments have been frequently overlooked in the canon of American history. It is worth getting reconnected to one of the U.S. greatest unsung heroes.

Begin Again is a wonderful book that reminds us of the importance of the body of work created by James Baldwin. Glaude's book deals directly with the hope and wonderful aspirations of the promise of America and the stark reality of how it often falls short.

The Plot Against America is a powerful book and warning to America of the cost of being overly complacent about our freedom of speech. The book drives home the need for all of us to be vigilant in protecting the sanctity of the vote and actively ensuring that the freedoms in the U.S. are enjoyed by all of its citizens. It's a book that demands your full attention.

Jedd D. Wolchok



Lloyd J. Old/Virginia and
Daniel K. Ludwig Chair,
clinical investigation,
Chief, Immuno-Oncology Service,
Director, Parker Institute for
Cancer Immunotherapy,
Memorial Sloan Kettering Cancer Center;
Associate director,
Ludwig Center for Cancer Immunotherapy

- ***White Fragility: Why It's So Hard for White People to Talk About Racism***, by Robin DiAngelo

I must admit that the past three months have been an arid period for reading anything except grant applications and manuscripts (oh yeah, and *The Cancer Letter*). Once I complete our U54 COVID serology grant submission at the end of this week, I hope to pick up *White Fragility* by Robin DiAngelo as my next reading assignment.

Here's what I know in advance.

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– Richard L. Schilsky, MD, FSCT, FACP, FASCO
ASCO Chief Medical Officer and Executive Vice President

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GUEST EDITORIAL

Living as an ethnic minority in a nation laden with discrimination



Coral Olazagasti, MD

*Hematology/oncology fellow,
Zucker School of Medicine at Hofstra/Northwell Health*



Diana Martins-Welch, MD,

*Assistant professor,
Donald and Barbara Zucker School of Medicine at Hofstra/Northwell*

As a Latina, I feel deeply impacted when I see reports of hate crimes against ethnic and racial minorities in the news. The recent string of news reports highlighting police brutality and the victimization of black people has caused a great deal of pain in my heart, prompting me to reflect on my own experiences.

Being born and raised in Puerto Rico, I received my Bachelor of Science from the University of Puerto Rico followed by a Medical Degree in Universidad Central del Caribe in Bayamon, Puerto Rico. After much deliberation, I took a leap of faith to widen my horizons, leave behind the only place I knew as home and move to the mainland to pursue a

residency in internal medicine in New York City. One would think that because Puerto Rico is a United States colony, the transition would be a rather smooth one. This was not quite the case.

My first block as an intern was in the Medical Intensive Care Unit. I remember that in my first week, a pulmonary and critical care fellow decided it was acceptable behavior to use an extremely derogatory term and tone to describe a Hispanic patient, despite being aware of my background. Not understanding what prompted my colleague to say such a thing, and at the time being somewhat naïve to a culture of discrimination, I ran and locked myself in the bathroom to

cry desperately. Even now, I can close my eyes and remember the pain I felt in that moment. Since then, I have grown much thicker skin, but, unfortunately, the encounters did not stop there.

Throughout my six years living in the U.S., I can recount many instances of macro- and micro- aggressions, many more than I would like to remember. I have been subjected to many discriminatory experiences because of my race/ethnicity, culture, upbringing, skin color, and accent. For instance, I once had a white male patient fire me and the African American nurse working alongside me during a night shift—because of our race/ethnicity.

I have been questioned more times than I can count where I went to medical school because of the way I look, or asked apprehensively where I come from because of my accent. I have been made fun of for my heavy accent, or when I have made occasional mispronunciations. In one instance, I, along with other minority friends, was harassed by a group of white men at a restaurant/bar for speaking in Spanish while dining.

In an attempt to minimize the hurt caused by such scarring experiences, I have created walls and defense mechanisms that, in hindsight, were not the appropriate path to take. Early on I learned that if I start making fun of my own accent, the feeling of alienation would be lessened since I would not be the subject of someone else's joke made at my expense. I have changed the pronunciation of my name to make it easier and more "American-like" even though I deeply dislike it. I have even taught myself to "tone my Latina down," after being called "too eager or excited," to try to fit better into what I believe is more socially and professionally accepted.

Even without clear intent, I've been made to feel less-than, which at times has had a great impact on my self-esteem as a physician. I often find myself comparing my abilities to others' and doubting my potential. That is, until I remind myself that I have the same medical training as my counterparts that surround me and I should never put down my own sacrifices and hard work that have led me to where I am today.

As an expectant mother with a son on the way, I fear about the repercussions of bringing a mixed race child into this world and the impact it will have on his life. I will never want my son to experience firsthand the hate of others for something that is out of his control, or to be made to feel less deserving. I also realize that discrimination is an issue that has to be confronted head on. Speaking about it and educating others is the

only way to overcome it. Throughout these times of self-reflection I learned that minimizing myself in the hopes of fitting to others' impression of ideal is not only detrimental to me and my future child, but to other minorities that are made to feel like being themselves is not worthy or enough.

My career goals are the same that they were when I first decided to trust my gut and expand my horizons. Today, more than ever, I am convinced that I am where I'm supposed to be. This experience has taught me that I should use my journey as an opportunity to lead by example for other minorities who aspire to be physicians and achieve greatness, but do not have the mentorship or guidance.

Data from 2015 U.S. medical graduates showed that only 4.6% were Hispanic/LatinX, and 5.7% were Black or African American.¹ Although there have been attempts to implement changes and increase diversity and inclusion, not much has changed throughout the years. As of 2018, only 5.0% of all active physicians in the U.S. identified as Black or African American, and 5.8% identified as Hispanic/LatinX.² Similar statistics are seen in the field of hematology-medical oncology, where racial and ethnic minorities are largely underrepresented. A census by the American Society of Clinical Oncology has shown that only 2.3% of practicing oncologists self-identify as Black or African American, and 5.8% self-identify as Hispanic, despite accounting for 13% and 18% of the total U.S. population.³

I want to be an example to others—that the sky is the limit when you work hard and believe in yourself. Additionally, I want to be a voice for my Spanish-speaking patients who express such gratitude for having a doctor who speaks their native language, and whose lives and medical care are positively impacted by having physicians who look and speak like them. Ultimately, I must not forget that over the past six years, the amount of positive experiences I have had along

with the supportive colleagues, faculty and mentors encountered far outweigh the negative instances I have faced.

I believe there is a lot of improvement that has yet to be done, but I also know in my heart that we are on the right path. The good far outweighs the bad. By acknowledging that the U.S. has a discrimination problem, we can then make strides to effect necessary change. This nation was built by immigrants, and there is beauty in inclusivity and justice. In inclusivity we find union and power, and essentially, that is our nation's goal.

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Robert Winn,

Otis Brawley:

**“I could have been
George Floyd”**

Like a laser, COVID-19 traced the shocking contours of inequality in America's health system—demonstrating that science and health equity have always been inseparable.

The police killing of George Floyd in Minneapolis upped the stakes, catalyzing a global movement for racial equality (*The Cancer Letter*, [June 12, 2020](#)).

In June, two powerful voices in oncology rose above others, relying on their own experiences to demonstrate that injustice and racism do not vanish after you earn academic honorifics. Such things don't matter to marauding cops.

In editorials widely shared and acknowledged across oncology, Robert Winn, director of Virginia Commonwealth University Massey Cancer Center, and Otis Brawley, Bloomberg Distinguished Professor of Oncology and Epidemiology

at Johns Hopkins University—writing as Black men in America—shared their stories of chilling encounters with police.

Their iconic twin editorials were discussed during the second virtual meeting of the American Association for Cancer Research on June 26. At a July 17 virtual town hall hosted by NRG Oncology, NCI Director Ned Sharpless emphasized the importance of Brawley and Winn's words.

"These sorts of conversations, having them more frequently and having them on a continuing basis is an important part of our plans going forward to make sure that we are in a good place for all of our employees," Sharpless said.

66

In my experience, our endemic institutional racism is, and has always been, a public health issue. In fact—as a result of the COVID-19 disaster—we are all now finally recognizing that racism is a contributing factor to chronic diseases, including cancer.

— Robert Winn

99

I could have been George Floyd—many times

Reflecting on the cancer of racism



Robert A. Winn, MD

Director, Virginia Commonwealth University Massey Cancer Center

I am almost certain that no other director of an NCI-designated cancer center can claim the distinction of having had a gun pulled on them by police.

I've had that experience not once, but twice.

I struggled a great deal in deciding whether to put something together this week in response to the senseless killing of Mr. George Floyd. His untimely death has stirred up a number of complex issues, which I thought I had wrestled under control.

If there is anything we've learned from the COVID-19 crisis, it's that the boundaries between cancer and non-cancer can be porous. And health disparities come in bunches, bouquets of injustice. And, as a pulmonologist, I hear Floyd's last words—"I can't breathe." Don't tell me that chokeholds, literal and figurative, are anything other than a public health issue.

And let's not forget that George Floyd, before being killed by rogue cops, had survived COVID-19.

I am proud of being a director of an outstanding NCI-designated cancer center. I am also proud to have the distinction of being the only African American currently in that position. But as a black male I cannot forget that when I step out from behind my desk, hang up my white coat and get out into the street, I am just a black male—just like George Floyd.

[Read more](#)

I could have been George Floyd, too



**Otis W. Brawley, MD,
MACP, FASCO, FACE**

*Bloomberg Distinguished Professor
of Oncology and Epidemiology,
Johns Hopkins University*

The past ten days have seen an outpouring of emotions as American society, devastated by the tragic murder of George Floyd by four Minneapolis police officers, plunges into a crisis of conscience.

Suspicious deaths of blacks at the hands of police have been in the news for years. Floyd's death wasn't even the first to be seen on video. Rarely is a policeman held accountable for one of these deaths. Colin Kaepernick conducted a peaceful protest to bring light to this problem. It led to this talented professional football player losing his career and being viciously criticized and called a "son of a bitch" by the President of the United States.

Still, many well-meaning Americans are now shocked and surprised learning of the pervasiveness of mistreatment of blacks by police.

“

Police harassment and mistreatment is a form of oppression. It exists to remind blacks of their social position. Other things exist to remind us of our social position, such as Confederate Civil War monuments and flags.

”

– Otis Brawley

Police mistreatment of blacks—especially black men—is widespread. It is especially bad for young blacks, but no black is exempt.

Even a 40-plus-year-old military officer and physician can get thrown to the ground, handcuffed and questioned at gunpoint for looking suspicious in a nice part of Montgomery County. That would be yours truly a few years ago.

My real offense: standing in the garage of my own home.

[Read more](#)

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Gauging the effects of COVID-19 on cancer mortality

For cancer epidemiologists, the COVID-19 pandemic is a natural experiment in the importance of screening, early detection, and diagnosis.

In January, the American Cancer Society announced that long-term efforts in lung cancer prevention and treatment are paying off: A significant decrease in lung cancer-specific mortality is mostly responsible for the biggest drop in overall cancer mortality—continuing the gradual decline observed since 1990.

Now, that 30-year downward trend may be interrupted by the virus.

In June, NCI projected that SARS-CoV-2 will lead to 10,000 additional deaths, on top of the expected one million deaths resulting from breast cancer and colorectal cancer.

The estimated excess deaths for other cancer types are currently not known.

In many cities, the pandemic has severely exacerbated health and racial disparities—which became immediately apparent when the death toll began climbing. For example, by May, 80% of those who died from COVID-19 in Washington, D.C., were African American. According to the 2018 U.S. Census, 45.5% of the District's population is Black.

The recent development of more sophisticated real-world data capabilities in oncology is timely, enabling re-

searchers to rapidly pull data and study patient outcomes.

A [study](#), conducted through the COVID-19 and Cancer Consortium and published in *The Lancet*, found that “among patients with cancer and COVID-19, 30-day all-cause mortality was high and associated with general risk factors and risk factors unique to patients with cancer.”

Results from another [study](#) conducted by Syapse and FDA, announced July 22, found that cancer patients who had

COVID-19 are more likely to have a 16-fold increased mortality risk.

“The clinical experience of people with cancer who have contracted COVID-19 is an essential resource that can help the medical community better understand the impact of the disease in this population,” said Harpreet Singh, associate director of cancer in older adults and special populations at FDA’s Oncology Center of Excellence, and director of Division of Oncology 2 within FDA’s Center for Drug Evaluation and Research.

“The data we analyzed in collaboration with Syapse revealed a stark reality that people with cancer are at an increased risk of more serious outcomes from COVID-19 but also that there are inequities for Black Americans and those of lower socioeconomic means,” Singh said in a statement. “It’s imperative that we continue to rapidly examine real-world data to address the urgent health care challenges brought on by this pandemic.”

The *Cancer Letter*’s comprehensive coverage of the pandemic is available [here](#).

Following is our 2020 coverage of data on cancer mortality:

Feb. 7

Are drugs really driving the latest drop in lung cancer mortality? Looks like treatment is playing a role, experts say

On Jan. 8, the American Cancer Society published its annual estimates of new cancer cases and deaths, declaring that the latest data—from 2016 to 2017—show the “largest ever single-year drop in overall cancer mortality of 2.2%.”

[Read more](#)

March 20

Sifting through fatality data and projections on COVID-19: People with cancer, other comorbidities face highest risk

Early data from China and Italy confirm that cancer patients are at higher risk for developing severe adverse events and dying after testing positive for the novel coronavirus.

[Read more](#)

May 1

AACR data from China and Europe amount to “two different messages” for cancer patients with COVID-19

Are COVID-19 patients with cancer at a greater risk of dying than non-cancer patients? Depends on whom you ask.

[Read more](#)

May 8

COVID-19 slams into the nation’s capital region; Here is the damage assessment at six institutions

In the first effort of its sort, The Cancer Letter has compiled a damage assessment, gauging the severity of the COVID-19 outbreak in the District of Columbia, Maryland and Virginia, gathering information on populations that were struck hardest, and quantifying impact on academic cancer centers and large hospital systems.

[Read more](#)

May 15

Sharpless: COVID-19 threatens to reverse long-running trend of decreasing cancer mortality

Delayed cancer diagnoses, deferred care, and postponed surgeries amid the COVID-19 pandemic will adversely impact cancer outcomes, which may show up as an increase in cancer mortality in the next few years, said NCI Director Ned Sharpless.

[Read more](#)


June 19

Sharpless: COVID-19 expected to increase mortality by at least 10,000 deaths from breast and colorectal cancers over 10 years

The COVID-19 pandemic will likely cause at least 10,000 excess deaths from breast cancer and colorectal cancer over the next 10 years in the United States.

[Read more](#)

***The Cancer Letter* invites oncology leaders to share insight, strategize on COVID-19**



At The Cancer Letter, we watched with growing alarm as early warnings of the virulence of SARS-CoV-2 started pouring in from Wuhan, and later, from Lombardy.

We quickly decided to chart a course for intensive coverage of the pandemic as it reached our shores—oncologists are well-poised to take the lead in shaping research on COVID-19, and exposure mitigation strategies for high-risk patients. This coverage is collected [here](#).

Everyone we talked to—in the U.S. and abroad—rallied, uniting oncology against a common threat. *The Cancer Letter* became a convener, as we opened the weekly issues to opinion leaders amid this most devastating public health crisis in living memory.

As leaders in academic and community oncology implemented tier upon tier of contingency measures, we received an unprecedented number of commentaries and guest editorials. We also published numerous conversations that reflected how cancer center directors, federal officials, private practitioners, and health IT experts were coping and responding to the pandemic in real-time.

Combined with our coverage, the result is a panoramic view of the evolution of a pandemic—meeting cancellations, emerging mortality data, the role of geopolitical forces in shaping exposure reduction strategies, dropping patient volumes, looming financial threat, and worsening racial disparities.

As we focus on the reopening of clinics and labs, and on the resurgence of the virus, here is a compendium of commentaries that look toward the future. What can we learn from COVID-19? How can leaders in oncology work to eliminate health disparities, fix telehealth, and become frontrunners in the race to develop vaccines and treatments?

The Cancer Letter is on the story.

March 13

COVID-19 and the cancer patient: A call to action for balancing cancer care and viral risk

By Karen E. Knudsen and Roy Jensen

As COVID-19 has now officially been declared a source of the pandemic, with increasing incidence across the nation, it is without question that the needs of patients with particular vulnerabilities should garner particular attention.

Given the specialized needs of cancer patients, it is imperative to consider how we, as the major cancer centers, may address and communicate how the impact of COVID-19 could impact the timing and delivery of cancer care, and to communicate this information to cancer patients.

[Read more](#)

March 20

The COVID-19 pandemic gives us the urgency—and one more chance—to address health disparities

By Robert Winn

As the crisis triggered by the COVID-19 pandemic deepens, the two separate, unequal societies that make up the United States of America are equally frightened, bewildered, and unsure of what comes next.

[Read more](#)

What community cancer centers need to know about COVID-19

By Jeff Patton & Lee Schwartzberg

Community cancer centers play an important role in this conversation and in the fabric of caring for those with cancer across the United States. As two oncologists in the community setting and as leaders of a national oncology practice partnership, we've spent the last few weeks with our practices and leaders in our communities, to set in place strategies to flatten the curve of the virus' exponential spread, care for our vulnerable patients, and mitigate exposure to those providing lifesaving care.

[Read more](#)

March 27

Hollander: Fix telehealth infrastructure—or America will be just as unprepared for the next pandemic

Conversation with Judd Hollander

As U.S. health systems switch to telehealth to connect with patients—via phone calls and online video conferencing—during the COVID-19 pandemic, providers are quickly learning that the lack of a national infrastructure for telehealth is making it difficult to reach patients.

[Read more](#)

Knudsen, Flomenberg: Eliminate digital health disparities; we don't want telemedicine to be for the one-percenters

Conversation with Karen Knudsen and Neal Flomenberg

The Sidney Kimmel Cancer Center at Thomas Jefferson University has been developing a scalable telehealth program long before the spread of SARS-CoV-2 in the United States.

[Read more](#)

April 3

Friending viral foes: The Zika story and (perhaps) lessons for COVID-19

By Scott M. Lippman

While viral epidemics pose severe challenges to society, there are instances where thoughtful efforts can turn these foes into potential friends in the fight against cancer. This is also a case study in thinking deeply, following scientific leads, breaking silos—and just sheer luck.

I believe that in the midst of COVID-19, and based on this conceptual background, it may be informative to consider the 2015-2016 viral outbreak—the case of Zika virus.

[Read more](#)

What cancer immunologists are doing about COVID-19

By Rachel Humphrey

To read the pulse from the front lines, I connected with a ready-made community of world-class physicians and scientists who assembled in 2007 because of their mutual love of immunology and also because of their mutual love, of all things, music.

The group, a blues-rock band called The Checkpoints, is composed of global leaders who are leveraging their deep knowledge of the immune system to assist in the battle against COVID-19. They include multiple heads of cancer or immunotherapy departments in major American institutions, former and current presidents of the Society for Immunotherapy of Cancer (SITC), and a Nobel Prize-winning scientist.

[Read more](#)

COVID-19 and cancer: Ethical dilemmas in immune checkpoint blockade

By Allison Betof Warner

As oncologists, we are all too familiar with making treatment recommendations and advising on end-of-life care in the absence of robust data. In ethical conundrums, we rely on guidance from our colleagues in the field, institutions, and national/international leadership bodies.

The COVID-19 pandemic has magnified many of these ethical dilemmas and

raised new and unexpected challenges. I will focus here on what I consider some of the key challenges during the COVID pandemic surrounding the use of immune checkpoint inhibitors, the fastest growing option for systemic therapy for a variety of malignancies.

[Read more](#)

April 10

NCTN group chairs: Cancer trials take backseat to clinical care amid COVID-19 pandemic

By NCTN group chairs

While the National Clinical Trials Network (NCTN) groups remain open for business during the pandemic, it's not business as usual. For good reason, clinical trials are taking a backseat to clinical care. Leadership and members themselves face significant challenges treating oncology patients, as attention and resources are diverted to minister to those with COVID-19.

[Read more](#)

Chernobyl doctor's view of COVID-19: Trump threatens 267 years of progress in biomedical research

By Robert Peter Gale

Governments respond differently to crises which threaten the health of their citizens. For example, during the current

SARS-CoV-2 pandemic, some countries instituted an immediate lockdown whilst others have not restricted social activities, or have done so too late to be maximally effective.

The question is: What prompts these different policies?

[Read more](#)

April 17

Amid COVID-19 pandemic, cancer community responds to fill data gap

By Richard L. Schilsky

As clinicians in a medical specialty that relies on evidence to guide treatment plans for individuals with cancer, we face an unfortunate dearth of data to help steer us during the coronavirus pandemic.

For our part, the American Society of Clinical Oncology has launched the [ASCO Survey on COVID-19 in Oncology Registry](#) to help the entire cancer community learn about how the pandemic is impacting the delivery of cancer care as well as the treatment and outcomes of our patients.

[Read more](#)

Lichtenfeld: COVID-19 exposed weaknesses in the U.S. health care system

Conversation with J. Leonard Lichtenfeld

“The virus will expose the weaknesses of our system at many, many levels. And research is one. And health care is another. And outcomes are going to be another still,” said J. Leonard Lichtenfeld, deputy chief medical officer of the American Cancer Society.

[Read more](#)

April 24

Berry: “Designing clinical trials doesn’t have high priority when there’s no pandemic. And then, when there’s a pandemic, there’s panic”

Conversation with Donald A. Berry

After a series of global epidemics, Don Berry has spent the past several years preparing for a serious pandemic that would be caused by yet another viral pathogen.

“People have long said that we’re not prepared for the next pandemic. We get a pandemic and then it goes away,” Berry, a professor in the Department of Biostatistics and founding chair of that department at MD Anderson Cancer Center, said to The Cancer Letter. “And so everybody says, ‘Well, okay, the next pandemic is way in the future, and so let’s not worry about it.’”

[Read more](#)

When disparities widen: COVID-19 in minority patients with cancer

By Coral Olazagasti and Narjust Duma

Recently, troubling trends and data from across the country started to suggest that minority populations, especially Hispanic and black, are experiencing higher risk for COVID-19 infections and mortality that outpace the different state’s population.

[Read more](#)

May 1

COVID-19 vs. community oncology: Flatiron’s data provides first damage assessment

Conversation with Bobby Green

Community oncology practices in the United States are reeling from a sharp decrease in business—whether you look at new patients, chemotherapy visits, or non-chemo visits—the result of reduced activity and stay-at-home orders across the country to mitigate the spread of SARS-CoV-2.

[Read more](#)

Skip Burris: These few months are going to shape health care in the coming years

Conversation with Howard A. "Skip" Burris III

The COVID-19 pandemic will change the structure and economics of clinical care and clinical trials in cancer, said Howard "Skip" Burris, president of clinical operations and chief medical officer of Sarah Cannon, the Cancer Institute of HCA Healthcare.

"The pandemic is going to create an opportunity to look at how oncology should be reimbursed and how a practice is not disadvantaged when they're able to function electronically in some areas," said Burris, who is this year's president of the American Society of Clinical Oncology. "And then I think bigger picture, this pandemic will help us set some health care priorities for the population."

[Read more](#)

May 8

COVID-19 and community cancer care: A panorama of a catastrophe

By Debra Patt and Michael Kolodziej

Much has been written about the impact on hospitals and on the health care professionals enduring horrific stress to support the acutely ill. These providers are heroes, and we are all indebted to them. But less attention has been paid

to the indirect effects of the pandemic on health care, particularly the care delivered to those with chronic medical illnesses.

What does cancer care look like now? And how will it be changed forever?

[Read more](#)

Embracing the increasing value of eHealth in patient-centered cancer care during the COVID-19 pandemic and beyond

By Frank J. Penedo and Joshua Kronenfeld

With the widespread use of computers, tablets and smartphones, delivery of cancer care via eHealth platforms continues to expand. This trend has accelerated dramatically this spring, as the COVID-19 pandemic has changed the landscape of clinical care in the U.S. and around the world.

[Read more](#)

With the COVID-19 pandemic, the cancer clinical trials—they are a-changing

By Gregory Masters, Nicholas Petrelli and Kandie Dempsey

Prior to the COVID-19 pandemic, NCI estimated that about 3% to 5% of adult cancer patients participated in clinical trials.

But what can we do now with new barriers to enrollment imposed by the COVID-19 pandemic?

[Read more](#)

May 15

SARS-CoV-2 and oncology drugs. What do we mean when we talk about value?

By Garth Strohbehn, Daniel Goldstein and Mark Ratain

It is a humbling moment to reflect on not only the current situation, but also on whether drug reimbursement policy changes might help to encourage nimbler global responses to public health threats in the future.

[Read more](#)

May 22

Let's not form blue ribbon panels to study disparities in COVID-19 deaths. Instead, let's find the will to act

By Robert Winn and Katherine Tossas

On a chaotic COVID weekend two months ago, a friend's child (a young, talented black and Latino student athlete) came home from college not feeling well. The young man's mother, an executive administrative assistant, called off work to stay home with him

because of his, as she described, “full-blown flu-like symptoms.”

Concerned for her son, she called her doctor to ask if she could bring him to the ER and get him COVID-19 tested, but was discouraged from doing so. When he began experiencing respiratory distress, his mother rushed him to the ER, where they ruled out strep, and flu, but not COVID-19; he apparently at the time did not meet the “requirements” set by the CDC algorithm.

[Read more](#)

May 29

CCC19 data point to extensive use of hydroxychloroquine, azithromycin, or both, by patients with cancer and COVID-19

By Otis Brawley

Nicole Kuderer and colleagues are to be congratulated for their report—in [The Lancet](#) and at the ASCO 2020 Annual Meeting—on the impact of COVID-19 on a cohort of patients with cancer.

In a very short time, these researchers used social media and novel ways of communicating to bring together healthcare providers from over 100 institutions in the US, Canada, and Europe to form the [COVID-19 and Cancer Consortium](#) (CCC19) database.

[Read more](#)

June 12

Working to end cancer in the time of COVID-19

By Peter Pisters

MD Anderson has one of the largest and densest concentrations of immunocompromised patients in the world. We consider it our responsibility to protect the health and safety of all of our patients at all times, including during a global pandemic. As we started seeing data coming from impacted countries that showed that cancer patients who contracted the SARS-CoV-2 virus are at increased risk for hospitalization and death from the infection, we knew the months ahead would require swift, significant action to ensure we could fulfill our commitment to patients.

[Read more](#)

Impact of COVID-19 on Georgia’s community providers: a snapshot from Georgia NCORP

By Guilherme Cantuaria

We surveyed our GA NCORP partners and affiliates to ascertain the impact of the COVID-19 pandemic and the shelter in place orders on daily practice and trial participation. Areas addressed in the survey included the use of telemedicine, surgery, ambulatory cancer care and testing, personal protective equipment, the impact on clinical research, and staffing.

[Read more](#)

June 19

Conquest of COVID-19: Publish it to death?

By Robert Peter Gale

Early in the War Against Cancer, when huge amounts of federal funds were suddenly funneled into cancer research, many scientists and clinicians working in other fields suddenly found it convenient—if not essential—to incorporate cancer into the title of their grant applications.

The hope was the application would be directed to a National Cancer Institute review panel, instead of a less-funded institute. The situation became so acute, some cynics commented more people were living from than dying from cancer. Fortunately, some of these re-directed research efforts were productive in unpredictable ways and helped us make substantial progress against cancer, even if total victory is not yet ours.

[Read more](#)

June 26

To expedite progress against COVID-19, a public-private “accelerator” taps into real-world data

By Jeff Allen and Susan Winckler

Real-world data is everywhere. During the COVID-19 global pandemic, we are literally generating, and collecting, real-world data every single day—from electronic health records, insurance claims, patient registries, and a myriad of other sources. But the question

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remains: how do we use this data to better understand, prevent, and treat this disease?

[Read more](#)

July 2

(Social + geographic) distance = Ongoing challenges in disparities for rural cancer patients

By Jennifer Dill, Marsha Kutter and Peggy Wisher

Approximately two-thirds of the NCI Community Oncology Research Programs, serve states in which the rural population exceeds 30%.

Besides the existential challenges of battling cancer, rural cancer patients have the additional issues associated with obtaining increasingly complex cancer diagnostic tests and treatment.

Heartland Cancer Research, our NCORP, is among those programs striving to provide rural patients access to outstanding care through the vehicle of NCTN treatment, cancer control, and cancer care delivery trials.

[Read more](#)

July 17

Giuseppe Curigliano: The COVID-19 curve in the U.S. will never decrease, like in Italy

Conversation with Giuseppe Curigliano

In early March, when Giuseppe Curigliano, an oncologist in Milan, first spoke with The Cancer Letter about COVID-19, the situation in Italy was “like being in a war zone” (*The Cancer Letter*, [March 11, 2020](#)).

At the time, it seemed unfathomable that the U.S. could face a catastrophic event of a similar magnitude.

Today, the tables have turned.

[Read more](#)

July 24

Insurers' moves to limit telehealth amid COVID-19 are inhumane and must be stopped

Letter to the editor by Christina Cone, William T. Dod, and Henry S. Friedman

It is obvious to virtually everyone in the United States that the numbers of patients affected with COVID-19 are continuing to escalate. The impact of this is obvious, with many patients dying or permanently damaged from this dangerous virus.

However, an additional problem is the impact on patients with other medical illnesses including, of course, cancer. *The Cancer Letter* has reported on this several times and all of the national cancer organizations are making the same observations in trying desperately to continue to provide care hindered by the constraints imposed by the current pandemic.

[Read more](#)

Gary Reedy to retire from top job at ACS

By Paul Goldberg

Gary Reedy announced that he will retire from his job as CEO of the American Cancer Society when his contract expires next April.

“I came to this decision after very thoughtful consideration, and, as I told the Board, I believe the time is right for both my family and the Society,” Reedy wrote in an Aug. 4 letter addressed to “friends and colleagues.”

Describing his nearly five years at ACS, Reedy wrote that the charity has become “more nimble, less risk-averse, more courageous, and not afraid to innovate for greater impact.” Also, “we are delivering on our key initiatives through cutting-edge research, increasing screening rates, improving access to health care, deepening corporate engagement with our partners, and launching the BrightEdge philanthropic impact fund.

“I am confident that by April, we will emerge on the other side of the COVID-19 pandemic and global economic crisis and be well positioned for a new leader to come in and hit the ground running,” Reedy wrote.

Reedy’s departure was widely predicted well before the pandemic gutted the charity’s fundraising. In February, weeks before the first cases of COVID-19 were reported in the U.S., Reedy ceded day-to-day operations of the society to a chief operating officer.



At the time, Reedy described the transfer of power to COO Kris Kim as motivated by an effort “to dedicate more of my time to reach new audiences and accelerate our mission and revenue priorities.”

However, knowledgeable sources at the time said that conflicts among members of the society’s “senior leadership team” have on several occasions reached the board level (*The Cancer Letter*, [Feb. 7, 2020](#)).

The charity’s revenues have been sliding since 2008, when it reported total public support of over \$1 billion. In 2015, the year Reedy accepted the CEO’s job, total public support was at \$810 million.

After COVID-19 struck, the Atlanta charity found itself facing catastrophic revenue losses. According to information widely shared with the staff, the charity was hoping to raise \$512 million this year, a target that represents the best-case scenario (*The Cancer Letter*, [June 19, 2020](#)).

On July 22, ACS staff members working at the Atlanta headquarters received notice to remove their personal belongings from the headquarters by July 30 as the society prepared to vacate the high-rise building overlooking the Centennial Olympic Park (*The Cancer Letter*, [July 24, 2020](#)).

The text of Reedy’s announcement follows:

Aug. 4, 2020

Dear friends and colleagues,

I am writing to share the news that I recently informed the Board of Directors that I plan to retire as the chief executive officer of the American Cancer Society and ACS CAN when my contract expires in April 2021.

I came to this decision after very thoughtful consideration, and, as I told the Board, I believe the time is right for both my family and the Society. When I reflect on my tenure as CEO, I feel humbled and grateful for each of you.

We have been through both wonderful and challenging times together. When I stepped into the role of CEO in April of 2015, the newly organized single corporate entity of the American Cancer Society required us to rebuild together.

You, our volunteers and staff, never wavered and I could not be prouder of our joint accomplishments. We have a new mission statement and a clear path with 2035 goals for the nation through our Blueprint for Cancer Control in the 21st Century and the Society’s refreshed first-ever enterprise-wide strategic plan.

We have reinvigorated our volunteer-staff partnership and returned to our roots as a volunteer-led and driven organization. Together we developed new customer promises, core values, cultural beliefs, and a stronger commitment to diversity, inclusion, and equity than ever before.

We are more nimble, less risk-averse, more courageous, and not afraid to innovate for greater impact. And we are delivering on our key initiatives through cutting edge research, increasing screening rates, improving access to health care, deepening corporate engagement with our partners, and launching the Bright-Edge philanthropic impact fund.

While the ACS and ACS CAN Boards and I provided leadership, you – the volunteers and staff – continue to do the hard work to make every innovation and success possible. Our shared success in these areas and so many

others made this decision all the more difficult.

I am confident that by April, we will emerge on the other side of the COVID-19 pandemic and global economic crisis and be well positioned for a new leader to come in and hit the ground running.

The Board will soon begin a rigorous CEO search and you will be hearing directly from our Board Chair about the process they will undertake to identify and transition to a new chief executive.

Thank you for the honor of serving as your CEO of the American Cancer Society and ACS CAN. I consider it one of the greatest privileges of my life. As I reflect on my time here, I can say unequivocally that what I will miss most are the amazing volunteers and staff I have come to know as colleagues and friends.

The spirit of volunteerism and the mission of this organization will forever be a part of who I am. Before I was your CEO, I was a volunteer for the American Cancer Society, and I will continue to volunteer after my departure.

We still have a great deal of work to do in the coming months and I remain as committed to moving our mission forward as my first day on the job. With great optimism I look to the future of the American Cancer Society and to seeing how we will continue to save lives, celebrate lives, and lead the fight for a world without cancer.

Warm regards,

Gary M. Reedy

Matthew Ong named to the Poynter, Washington Post Leadership Academy for Diversity in Digital Media

Matthew Bin Han Ong, associate editor of *The Cancer Letter*, was named by the Poynter Institute and The Washington Post to the Leadership Academy for Diversity in Digital Media.

Ong is part of a class of 32 journalists who were selected from over 130 applicants, who “are pioneers in digital media who have demonstrated an aptitude for leadership through current projects and references.”

They were selected by a committee that included graduates of the program, with an emphasis on ensuring diversity across race and ethnicity, geography, technology platforms, organization size and skill sets.

“The need for diversity in newsroom leadership isn’t new, but the urgency is greater than ever as we have seen from the racial reckoning happening across our industry. This academy not only better equips participants to lead through times of uncertainty, but it provides them with an essential network of fellow managers to support them as they grow in their careers,” Doris Truong, Poynter’s director of training and diversity, said in a statement Aug. 5. “Together, they are going to be extremely powerful in their work to ensure inclu-



sion and equity—not only from fellow staff members but also in the types of news and the communities they cover.”

Ong will join a network of over 100 inductees.

“The Washington Post is committed to deepening the national conversation on issues of race and identity,” Carla Broyles, senior editor at The Post, said in a statement. “Partnering with Poynter

further that commitment by providing a leadership training platform where journalists of color can find community and strengthen their skills for the critical work ahead.”

The Academy is also sponsored by CNN, Craig Newmark Philanthropies, the Scripps Howard Foundation, TEGNA Foundation, and the Ethics and Excellence Journalism Foundation.

NCI TRIALS



NCI Trials for August 2020

The National Cancer Institute approved the following clinical research studies last month.

For further information, contact the principal investigator listed.

Phase I - 10346

Pilot Study of DS-8201a Pharmacodynamics in Patients with HER2-Expressing Advanced Solid Tumors

National Cancer Institute LAO
O'Sullivan Coyne, Geraldine
(301) 402-9122

Phase I - 10367

A Phase 1b Study with Expansion Cohort of Escalating Doses of KRT-232 (AMG 232) Administered in Combination with Standard Induction Chemotherapy (Cytarabine and Idarubicin) in Newly Diagnosed Acute Myelogenous Leukemia (AML)

City of Hope Comprehensive Cancer Center LAO
Kelly, Kevin R.
(323) 865 3828 MTD

Phase I/II - 10366

A Phase 1/2 Study of M3814 (Peposertib) in Combination with Hypofractionated Radiotherapy for the Treatment of Locally Advanced Pancreatic Adenocarcinoma

JHU Sidney Kimmel Comprehensive Cancer Center LAO
Davis, Sarah Lindsey
(303) 724-8681

Phase II - 10330

A Phase 2 Study of Belinostat and SGI-110 (Guadecitabine) for the Treatment of Unresectable and Metastatic Conventional Chondrosarcoma

Yale University Cancer Center LAO
Ingham, Matthew
(202) 285-4944

Phase II - 10334

Blockade of PD-1 Added to Standard Therapy to Target Measurable Residual Disease in Acute Myeloid Leukemia 2 (BLAST MRD AML-2): A Randomized Phase 2 Study of the Venetoclax, Azacitadine, and Pembrolizumab (VAP) Versus Venetoclax and Azacitadine as First Line Therapy in Older Patients with Acute Myeloid Leukemia (AML) Who Are Ineligible or Who Refuse Intensive Chemotherapy

Yale University Cancer Center LAO
Zeidan, Amer M.
(203) 737-2572

Phase II - A091902

A Multicenter Phase II Trial of Paclitaxel with and Without Nivolumab in Taxane Naïve, and Nivolumab and Cabozantinib in Taxane Pretreated Subjects with Angiosarcoma

Alliance for Clinical Trials in Oncology
Grilley-Olson, Juneko E.
(919) 843-5497

Phase II - AREN1921

Treatment of Newly Diagnosed Diffuse Anaplastic Wilms Tumors (DAWT) and Relapsed Favorable Histology Wilms Tumors (FHWT)

Children's Oncology Group
Geller, James Ian
(513) 636-6312 X 6312

Phase II - EA6192

A Phase II Study of Biomarker Driven Early Discontinuation of Anti-PD-1 Therapy in Patients with Advanced Melanoma (PET-Stop)

ECOG-ACRIN Cancer Research Group
Gibney, Geoffrey Thomas
(202) 444-2223

Phase II - EA8185

Phase 2 Study of Bladder-Sparing Chemoradiation with MEDI4736 (Durvalumab) in Clinical Stage 3, Node Positive Bladder Cancer (INSPIRE)

ECOG-ACRIN Cancer Research Group
Joshi, Monika
(717) 798-8678

Phase II/III - NRG-HN006

Randomized Phase II/III Trial of Sentinel Lymph Node Biopsy Versus Elective Neck Dissection for Early-Stage Oral Cavity Cancer

NRG Oncology
Lai, Stephen Yenzen
(713) 792-6528

Phase III - A031902

CASPAR - A Phase III Trial of Enzalutamide and Rucaparib as a Novel Therapy in First-Line Metastatic Castration-Resistant Prostate Cancer

Alliance for Clinical Trials in Oncology
Rao, Arpit
(612) 625-9604