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THE CANCER LETTER

Inside information on cancer
research and drug development

Vol.

46

No.

37

OCTOBER 2, 2020

www.cancerletter.com

SEXUAL HARASSMENT REPORTING STRUCTURES IN ONCOLOGY ARE BROKEN, THE CANCER LETTER SURVEY FINDS

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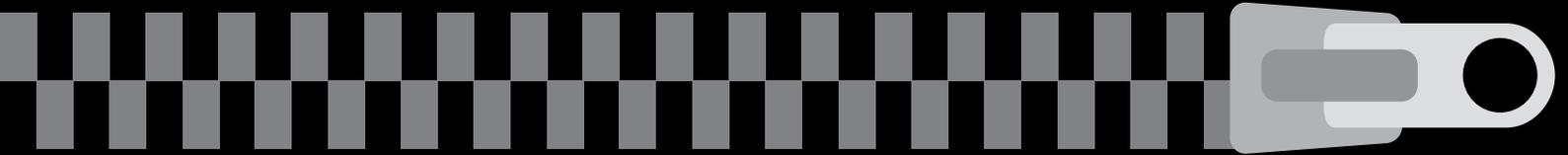
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SEXUAL HARASSMENT REPORTING STRUCTURES IN ONCOLOGY ARE BROKEN,



THE CANCER LETTER **SURVEY FINDS**

By Alexandria Carolan, Katie Goldberg, and Matthew Bin Han Ong

Women in oncology who face gender bias know what *not* to do: seek help from their institutions.

A survey by *The Cancer Letter* found that women in academic oncology who have encountered gender bias at work overwhelmingly accept the notion that their institutions will fail them, and those who do lodge complaints are, with no exception, disappointed.

In the survey, 62% (n=78) of women said they chose not to report such incidents. Tragically, it appears that they made the prudent choice, because all the women who did lodge complaints said their institution's response was inadequate or worse. Two said their institutions retaliated, leading up to termination and resignation. (This analysis excludes the six men who responded to the survey.)

Incidents reported in the survey fall into these categories:

- Disparity in treatment, including instances when men are addressed by title/honorific, but women are not,
- Disparity in pay or promotion,
- Inappropriate gender-related remarks,
- Sexual harassment,
- Inappropriate physical contact,
- Gender-related bullying,
- Gender-related shaming.

The survey is a follow-up to a news story that demonstrated that at scientific conferences and other professional settings, women are often referred to by first name while their male colleagues are referred to by titles and honorifics (*The Cancer Letter*, [Dec. 13, 2019](#)).

The survey was distributed via *The Cancer Letter's* mailing list and Twitter account, seeking respondents who have experienced gender bias or harassment. The survey was administered before the COVID-19 pandemic.

The survey isn't designed to measure the prevalence of gender bias and sexual harassment in oncology. The objective is to gather the data, anonymize them, and assess the aftermath in a systematic manner. The responses allowed us to compile a database of cases where the systems have failed—and to draw lessons from what we have learned.

When data on gender bias and sexual harassment are presented—particularly in the #MeToo era—attention must be paid.

Do reporting structures work? Do individuals feel empowered to speak up? Do they feel confident in their institution's leadership and work culture? What are the outcomes? Do such incidents impact science, productivity and professional standing?

We received 84 responses. Seventy-seven were from women, and some responses describe chilling accounts of misogyny:

There are numerous episodes through my surgical career of over 20 years. Rude and disrespectful jokes, references to my anatomy. Cornering me in an elevator by a senior attending when I was a medical student, unwelcome touching in front of my husband, salary disparity.

I have been consistently made to feel that I am unwelcome throughout my career. This included attempts to intimidate me using sexually suggestive comments and physical contact early in my career, to suggestions that I be less successful, because it was agitating my male colleagues later in my career.

Everyone just ignores any incidents of disrespect/harassment, because nothing

comes of reporting it to upper administration.

Upper administration members (all male) laughed at me in a meeting. Who do I report that to???

A compilation of anonymized responses is available on [page 20](#).

Misogyny—and futility

“These findings speak deeply to the culture of medicine and the very real fears that women have that if they complain about something like that, they will always be identified as a whiner, they will be marginalized, they will suddenly be labeled as someone who is not strong enough, it will be a distraction from their professional contributions, they will bear a stigma. And potentially, they will be further victimized as a result, and face retaliation,” Reshma Jagsi, deputy chair of radiation oncology, Newman Family Professor of Radiation Oncology, Residency Program director, and director of the Center for Bioethics and Social Sciences at the University of Michigan, said to *The Cancer Letter*.

Jagsi, one of the founders of TIME'S UP Healthcare, is one of a group of experts—directors of cancer centers and researchers of gender bias—who were asked to review the survey data for *The Cancer Letter*. To eliminate gender bias in oncology, the reporting systems must change, and diverse leadership is key to making the system work, these experts said.

As a result of gender bias, women say they were forced to reconsider their careers and made to doubt their self-worth. Many developed depression. Productivity tanked, scientific collaborations suffered.

“The study as a whole, the incidents of discrimination, harassment—are real-

ly shocking and disturbing,” said Leonidas Platanius, director of the Robert H. Lurie Comprehensive Cancer Center, Jesse, Sara, Andrew, Abigail, Benjamin and Elizabeth Lurie Professor of Oncology, professor of medicine (hematology and oncology), and biochemistry and molecular genetics at Northwestern University.

“This obviously needs to change, and it needs to happen fast. It’s totally unacceptable at all levels,” Platanius said to *The Cancer Letter*. “It negatively impacts cancer research. These situations can affect how teams function and, ultimately, have a negative impact in research.”

A conversation with Platanius appears on [page 37](#).

A toxic work culture is anathema to team science, said Caryn Lerman, H. Leslie and Elaine S. Hoffman Professor in cancer research and director of the University of Southern California Norris Comprehensive Cancer Center.

“When faculty members are uncomfortable among their colleagues, or do not feel safe, there is a disincentive to participate in team science. This not only may affect scientific productivity, but also could contribute to a sense of isolation and demoralization among women faculty,” Lerman said after reviewing *The Cancer Letter’s* data.

Institutional betrayal

“People who are targets of workplace discrimination or harassment often also experience institutional betrayal, a term developed by Dr. Jennifer Freyd and Dr. Carly Smith, to describe the failure of an institution to prevent or respond supportively to wrongdoings by individuals committed within that institution,” Ally Coll, president and co-founder of The Purple Campaign, said to *The Cancer Letter*.

In the era of #MeToo accountability, why do people avoid reporting gender bias?

Here is a selection from the answers we received:

- 👤 Boys’ club; no guarantee that things are kept confidential.
- 👤 There’s not a good culture for reporting this at my institution.
- 👤 Worried about retaliation.
- 👤 I didn’t want to make a fuss.
- 👤 It didn’t seem offensive, but the norm.
- 👤 Unresponsive in the past.
- 👤 Fear of retaliation from [the] chair.
- 👤 It was part of the overall culture due to lack of women as faculty.
- 👤 It would have made the situation worse.
- 👤 Satisfaction unlikely, bullshit likely.

“All of these are saying the same thing,” said Christina Chapman, assistant professor in the Department of Radiation Oncology at University of Michigan School of Medicine, Center for Clinical Management Research, VA Ann Arbor Healthcare System, “They’re saying the same thing in slightly different ways, which is that our reporting structures are inadequate, because the people who comprise them have bias. We know that this is harming. It’s harming our science, harming our patients.”

Many respondents suggest that gender bias is part of a workplace culture where harassment is the norm.

The data point to a pervasive sense of futility, said Narjust Duma, assistant professor of medicine in Thoracic Oncology at University of Wisconsin Car-

bone Cancer Center, the lead author of the path-breaking paper focused on disparity in the use of honorifics at a meeting of a professional society.

“A lot of people come to that conclusion, because some of these women have reported harassment, or have reported discrimination, and nothing has happened. The challenge is that once people have reported the effects, one, they’re downplayed. Two, no actions are taken, so you feel like, ‘Why are you going to put forth the effort?’” Duma said after reviewing *The Cancer Letter’s* data. “When a woman reports harassment, she is also put at risk that she will later be harassed for reporting on it.”

Writes one respondent:

The person who sexually harassed me was my mentor. When I didn’t give him what he wanted, he was furious, made my life a living hell at work, and dropped me as a mentee. He stifled my academic career. He has tried to tarnish my reputation among national and international leaders in my field by telling everyone I made up lies about sexual harassment so that I could take over his ‘empire.’

Of the 84 survey respondents, 75% said an incident negatively or very negatively impacted their productivity and morale. Personal well-being was also severely compromised: 73% of respondents ranked the impact of the incident as “negative” or “very negative.”

Pamela Kunz, a GI oncologist, is one of the few who spoke out.

Now leader of the Gastrointestinal Cancers Program and director of GI Medical Oncology at Yale Cancer Center, Kunz spoke with *The Cancer Letter* about years of gender-related microaggressions she experienced in her previous position at

Stanford School of Medicine. This history caused her to change jobs, she said.

“I think there’s often a reluctance to do anything to the perpetrators when they are full professors, or bring in a lot of philanthropic money, or have a lot of grants, or have longevity at an institution,” Kunz said to *The Cancer Letter*.

A conversation with Kunz and a response from Stanford appear on [page 29](#).

Respondents were asked to fill out the survey only if they experienced an incident of gender bias. Of the 84 respondents to *The Cancer Letter’s* survey, 66 identified as white, 14 as Asian, and four as Hispanic or Latino.

It may be noteworthy that *The Cancer Letter* did not receive any responses from Black women. Women of color can feel harm even more acutely, Jagsi said.

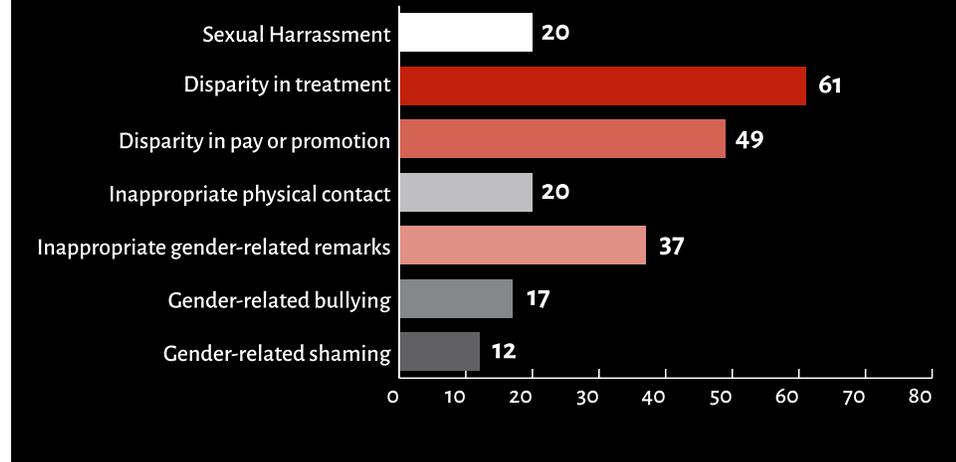
“The limitation of any small dataset is that we can’t even begin to imagine what the experiences are like of individuals who inhabit multiple minority identities,” Jagsi said. “And, quite conceivably, the systems might function even worse for individuals who are in multiple vulnerable subgroups. I think that’s important to call out.”

How can institutions do better?

“Culture change and transformation are absolutely necessary, and so, there need to be proactive initiatives,” Jagsi said. “Target the culture at the organization—make it clear that the organization no longer, if it did before or never did, tolerates this kind of behavior.”

Improving diversity at the top rungs of institutions is crucial to reducing gender and racial inequity. At this writing, nine of the 71 NCI-designated cancer centers are headed by women directors, and only one cancer center director is Black.

FIG. 1 - WHAT WAS THE NATURE OF YOUR EXPERIENCE?



Next week, *The Cancer Letter* will publish new data on diversity among leaders of top academic cancer centers in the U.S. and Canada. The survey was conducted in collaboration with the Association of American Cancer Institutes.

Failure rate: 89%

Eighty-nine people responded to *The Cancer Letter’s* survey. Eighty-four responses cite specific incidents of gender bias. Five responses were omitted: four because they cite no incident, and one because it contained abusive language and was not germane to the questions.

The average number of incidents per respondent is 2.6. (Fig. 1)

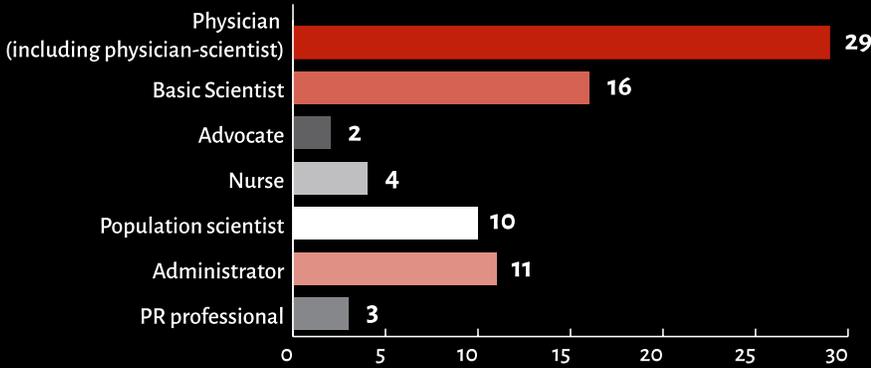
- 73% (61) report a disparity in treatment (i.e. your male colleagues were addressed by title/honorific, but you were not),
- 58% (49) report a disparity in pay or promotion,
- 44% (37) report inappropriate gender-related remarks,

- 24% (20) report sexual harassment,
- 24% (20) report inappropriate physical contact,
- 20% (17) report gender-related bullying,
- 14% (12) report gender-related shaming.

Writes one respondent:

I cannot believe that any woman could identify just one, or seven, or 10 incidents to discuss in this survey. You might hypothesize that those taking the time to respond to this survey are an isolated few who have had rare negative experiences. That is not the case. I’m a 60-year-old woman who is trusted as a good sounding board, a good friend. I don’t know one woman, who I have worked with, who has not experienced unwanted and uncomfortable sexual pressures. The design of this survey may be the equivalent of asking someone whose home was destroyed and family members killed and asking them if there has been “an impact on their personal well-being.”

FIG 2. - WHAT IS YOUR PROFESSION?



A majority of respondents—77%—work in academic medicine. Others are employed in the government (8.5%), advocacy (5%), community health (5%), industry (3.7%), and nonprofits (1.2%). (Fig. 2)

Fifty-three (63%) identify in an optional question that they work in oncology.

Respondents demographic and professional data is available on [page 10](#). (Fig 3, 4, 5)

Of all respondents, 61% did not report the incident through institutional reporting mechanisms. Only 34% of respondents reported the incident. (Fig. 6)

FIG. 6 - DID YOU REPORT THIS ISSUE?

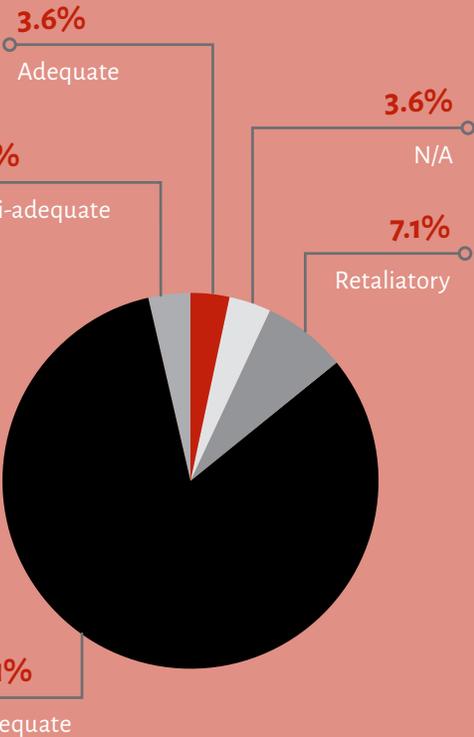
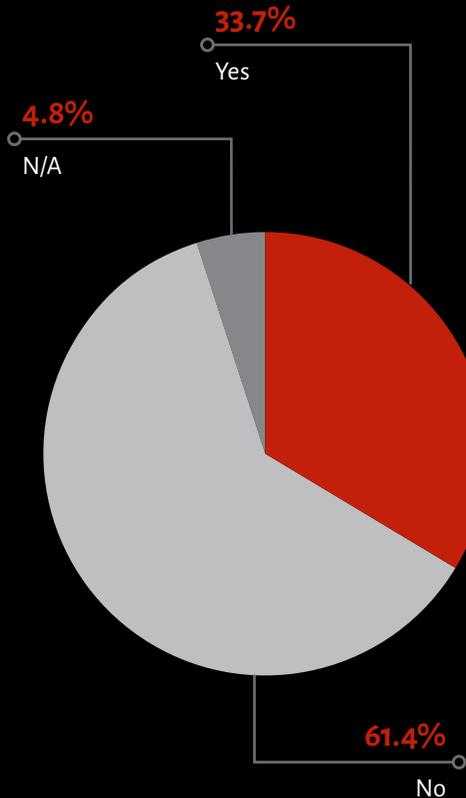


FIG. 7 - HOW WOULD YOU RATE THE INSTITUTION'S RESPONSE?

FIG. 3 - WHAT IS YOUR GENDER IDENTITY?

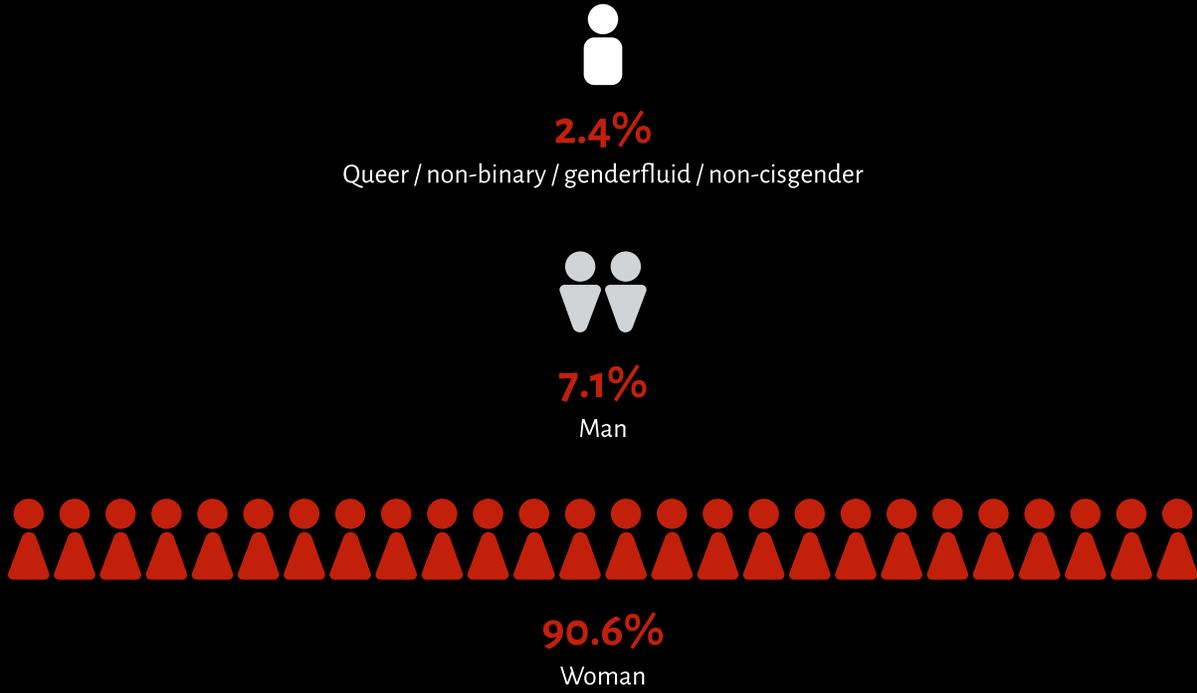


FIG. 4 - WHAT IS YOUR RACE/ETHNIC IDENTITY?

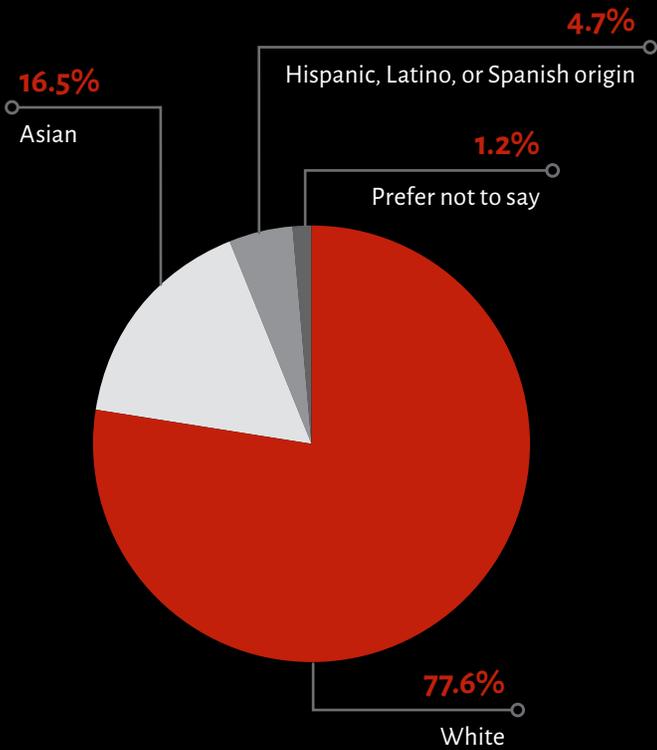
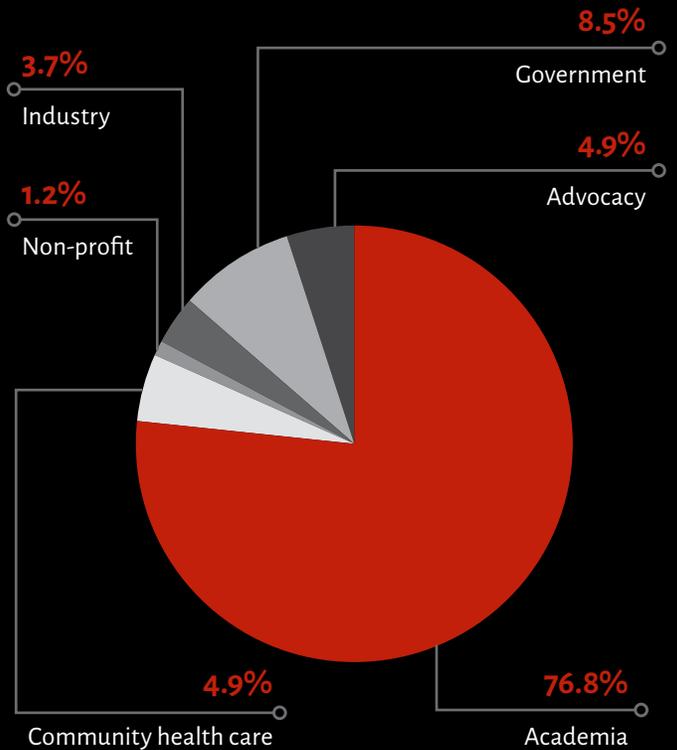


FIG. 5 - WHERE DO YOU WORK?



Of the 28 who chose to report an incident of gender-related bias, 82% said that their institutions' response was inadequate, and one said it was adequate on one count, but not another. Another two women said their institutions retaliated, leading up to termination and resignation. (Fig. 7)

Based on these self-reporting measures, this would amount to an 89% failure rate. Only one individual characterized the institution's response as adequate. That individual is a man. Among women, the failure rate is 100% (n=27).

Feelings of depression, isolation, doubt, and anger were noted again and again in response to the prompt, "describe the impact of this incident." In optional short answer questions, 13 respondents (15%) said they left their positions—and some, their profession—as a result.

Harassment can result in a feeling of being trapped, said Awad Ahmed, a radiation oncologist at Jackson Memorial Hospital and University of Miami, Sylvester Comprehensive Cancer Center, who conducts research on gender bias in radiation oncology.

"What a lot of people don't realize when it comes to medicine is that it's a completely different ball game. Lateral movement, or starting all over again isn't as easy as it is in other professions," Ahmed said. "To just up and switch is not easy. When you bring these issues forward, you're really risking a lot. I don't know if a lot of people realize that."

Respondents were asked to assess their institutions' ability to address gender bias:

- As a result of the incident, did you feel:
 - ▶ Empowered to speak up? (63% negative)
 - ▶ Confident in the ability of the leadership of your in-

stitution to address gender bias? (76% negative)

- ▶ Comfortable with your institution's work culture? (67.1% negative)
- ▶ Comfortable continuing to be a part of your institution? (48.1% negative)

The responses, graphed on [page 13](#), demonstrate a culture of toxicity. (Fig. 8)

In questions regarding their personal well-being and morale, respondents were given options to rank the impact from "very negatively" to "very positively":

- How did the incident impact your:
 - ▶ Productivity and morale? (75.1% negative)
 - ▶ Professional standing? (40.1% negative)
 - ▶ Personal well-being? (76% negative)

These responses are graphed on [page 13](#). (Fig. 9)

The Cancer Letter's survey results appear to be consistent with other studies across medicine.

A 2018 [report](#) from the National Academy of Sciences, Engineering, and Medicine demonstrated that female medical students were 220% more likely than students from non-STEM disciplines to experience sexual harassment—and that they were more likely to be harassed than students in other STEM disciplines as well.

Black and other minorities can be reticent to fill out surveys of this sort, experts say.

"A lot of times, when you are such a small number, even when people say it's going to be an anonymous survey, you

have doubts as to whether it ever truly be anonymous," Hopkins's Deville said. "It's not hard to figure out who you are the minute you say you are a Black female ENT surgeon respondent. There's probably a small enough number that one could start to think about and figure out who that person was.

"You may have some of those kinds of sentiments as well—I'm not even going to bother, I'm just gonna keep trying to do what I need to do or, my work or my job, or not take time for this survey, or not take time to try to speak up and address this issue. You're just trying to get through your day, or maybe navigate through the system in a different way."

The cost of failure

Asked to describe how the incidents made her feel, one respondent wrote: "Depressed; distraught; unable to focus or feel dedicated to my work."

Others wrote:

- 👤 I was burned out and clinically depressed. I am considering leaving the institution at which this happened, but have not a final decision.
- 👤 Being treated as less important undercuts confidence in speaking up, etc.,
- 👤 Created an atmosphere of anxiety whenever I had to be around the people responsible for the incidents.
- 👤 The constant drumbeat of a lack of respect has been fairly stressful and has made it difficult for me to advocate for resources and change.
- 👤 Emotional abuse, severe depression which took over a year to get back to "normal."

Professional standing is neutral because I am still worried about the impact of these incidents on my reputation. It also took a lot of time for me to even take the step of filling this survey.

I am not going to dredge up those thoughts and feelings.

“How can you truly be your best if you don’t feel like you are in an environment that values these kinds of issues, and has zero tolerance?” asked Deville. “That’s not really an environment where you’re going to be able to be successful and be your best self.”

Gender bias makes you question your own worth, said Tatiana Prowell, associate professor of oncology in the Breast Cancer Program at The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins and Under Armour Breast Health Innovation Center.

“It may cause them to question the value of their own contributions and thus disengage from the team. This impacts the individual first, but over time it also harms institutions as morale falls, and you begin to see difficulties with retention and recruitment,” Prowell said to *The Cancer Letter*. “In the best of cases, we find women leaving to more supportive institutions that will make better use of their talents. In the worst of cases, we lose them to the field of science and medicine entirely.”

The psychological toll of gender-related harassment ultimately affects research and patient care.

“Women are in positions and do important work that advances our field and that saves lives. If women are less productive, whether it’s because they are doing more cooking and cleaning, or whether it’s due to sexual harassment and sexual assault—strike one is the

fact that it occurs. That results in a lot of psychological distress,” Chapman said.

“The psychological distress removes women’s time away from the science, which impacts our patients, which impacts the field.”

The mechanisms of mistrust

Women who responded to the survey were particularly unhappy with reporting mechanisms at their institutions:

Institution was so unresponsive that I sought legal counsel and filed charges. Institution was so slow to react that it required a year of negotiations to settle the issue.

There has been little change, as the problem starts at the top.

The person that sexually harassed me was given the option to resign instead of being fired. This person has a position of leadership where he can continue to wield power over me and other individuals he harassed. I wrote a letter to [redacted] letting them know about his history and never got a response and this individual remains in the leadership position.

Though the behavior from this individual did get a little bit better, the overall toxic workplace environment did not. I was ostracized both socially and professionally from my colleagues. I was told that my performance on particular, difficult, laboratory procedures was not satisfactory, and I was essentially given an ultimatum: reach a certain success rate, or leave. I was given very few resources to improve these skills and had

to perform under immense pressure from my co-workers. I chose to leave this job because 1) I was in school at the time and knew I wanted to switch to a different field upon graduation, and 2) I was so stressed out all the time from the anxiety of this job that my mental health suffered greatly.

Was told my boss maintained an adequate professional standard because he said good morning regularly and was friendly.

Everyone just ignores any incidents of disrespect/harassment because nothing comes of reporting it to upper administration.

They did not acknowledge the notice issued by the human rights commission.

My boss (cc director) literally pretended to get a phone call and walked out of the room when I raised the issue of lack of promotion and differential treatment.

Change starts with calling out bad behavior, said Malika Siker, associate dean of student inclusion and diversity in the Office of Academic Affairs, associate professor in the Department of Radiation Oncology, student pillar faculty member, at the Robert D. and Patricia E. Kern Institute for the Transformation of Medical Education at the Medical College of Wisconsin.

“Every woman should take some time to consider the things that are happening to them. If they’re experiencing any type of harassment, bullying, or even just unprofessionalism—it can take courage to call it out,” Siker, also academic vice chair of the Community Advisory Board at MCW Cancer Center, Medical College

FIG. 8 - HOW DID YOU FEEL AS A RESULT OF THE INCIDENT?

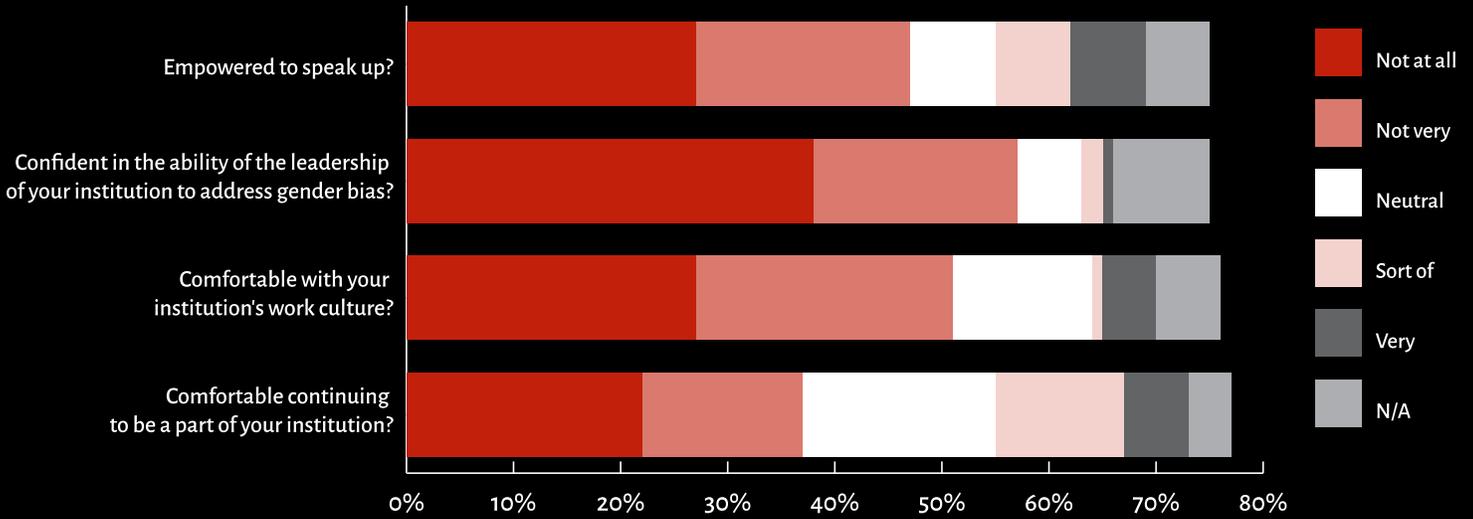
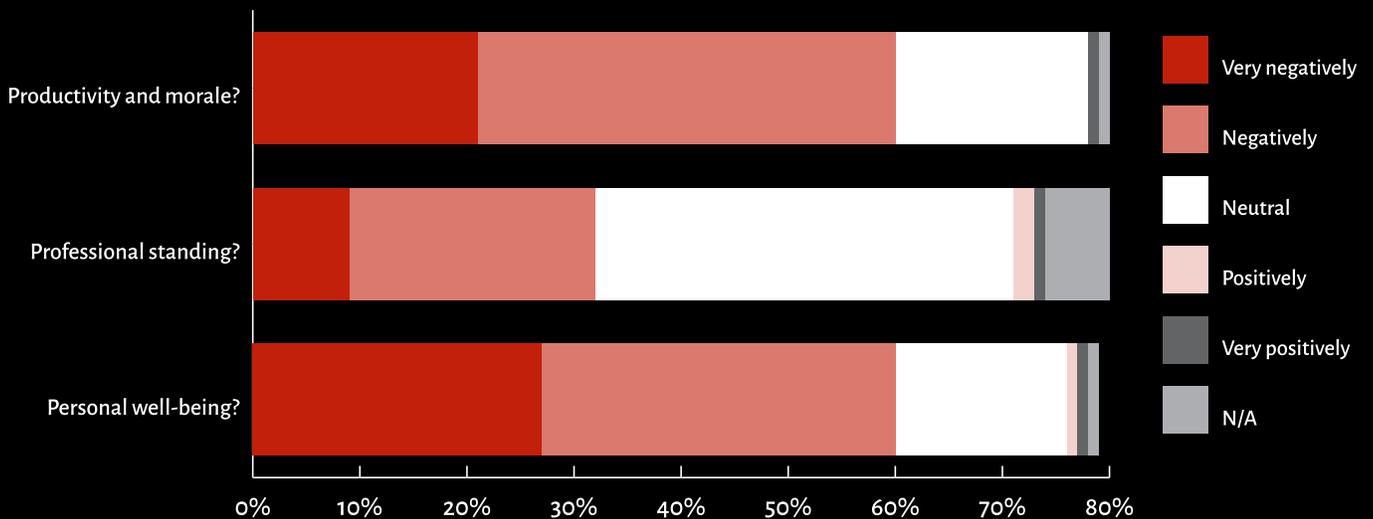


FIG. 9 - HOW DID THE INCIDENT IMPACT YOUR:



of Wisconsin, said to *The Cancer Letter*. “That’s a really hard thing to do, especially if someone doesn’t feel safe, or the institution is not in a position to support them, but it has to start somewhere.”

How would you know that your complaint has been taken seriously? That an investigation has been initiated? Or even that your harasser has been contacted as a result of your complaint?

“What often happens, in my experience, is that these kinds of complaints are actually taken very seriously—but the complainant doesn’t know that, and the complainant feels like nothing has been done,” Jagsi said. “Some of the dissatisfaction, or the sense that the process was inadequate—may reflect the fact that human resources and confidentiality concerns about protecting the identity and actions taken against the perpetrator limit the ability to inform the complainant about what exactly was done.”

“Reporting isn’t the ideal mechanism to address challenges like this because there are so many barriers, including fears of retaliation, marginalization, and stigmatization on the part of the target of the behavior, which often cannot be masked sufficiently to be reported anonymously.”

Four respondents cited “fear of retaliation” as a reason for not reporting to their institutions. Such fear is common, said The Purple Campaign’s Coll.

“Retaliation is a really common reason of why people are fearful of reporting harassment and discrimination. That study shows that they’re right to fear that, because it’s still so prevalent of a problem when people do report,” Coll said.

[Disclosure: Coll is a step-daughter of Paul Goldberg, editor and publisher of *The Cancer Letter*.]

The Equal Employment Commission in 2016 found that across all industries, 70% of people who experienced workplace harassment didn’t report it to a manager, supervisor or union representative. Worse, 75% of those who reported such incidents experienced some form of retaliation.

Retaliation is illegal—sure. But it exists.

“Companies always have anti-retaliation policies in place, but to what extent they’re enforced, is the question. And they’re not always enforced consistently,” Coll said. “Is somebody going to report retaliation when they’ve already reported an incident, and it’s resulted in that adverse consequences for them in the workplace?”

Perhaps a bureaucratic tendency to wish the problem away and hide the garbage is at play here, Chapman said. “I think what that tells us is that we need to stop, and we need to ask ourselves why,” she said. “The answer is that we haven’t made the progress. We need to, because the system is still run by individuals who continue to pass by it.”

Even the perfectly configured reporting system, if it existed, would get you only so far. “By the time we are talking about reporting mechanisms and responses to discrimination, the damage has already been done, so our focus long-term has to be upstream of this,” Prowell said.

The Vanderbilt Center for Patient and Professional Advocacy proposes one system, CORS—which is used at many institutions in academic oncology to promote conflict resolution.

The CORS program uses a tiered approach:

- “Recorded reports are reviewed to ensure allegations do not require mandated reviews or investigations (e.g., impairment, bias, inappropriate touch, fraud, harassment, etc.), but can simply be shared in a respectful, non-directive fashion during an informal conversation such as one might have with a colleague over a cup of coffee.”

ate touch, fraud, harassment, etc.), but can simply be shared in a respectful, non-directive fashion during an informal conversation such as one might have with a colleague over a cup of coffee.

- When patterns appear to emerge, CPPA supports peer-delivered Level 1 Awareness interventions with local and national peer comparisons as described above. Most clinicians respond to awareness interventions.
- Some, however, are unable or unwilling, and these clinicians are escalated to Guided Interventions by Authority (Level 2). Level 2 interventions include a written corrective plan developed by the individual’s authority figure (a department chair, chief medical officer, or other leader).
- A very small number may not respond to the plan and are elevated to Level 3 disciplinary action as defined by organizational policies, bylaws, contracts or other governing documents.”

“It’s their pyramid for what you do. You can provide routine feedback if there’s a single concern. You investigate whether there is merit. If it’s egregious, you escalate it to Level 3, which is disciplinary intervention—but you also can have mandated reviews and escalate it,” said Jagsi, whose institution, the University of Michigan, uses this approach.

The systems in place at Michigan haven’t prevented sexual misconduct allegations from slipping through the cracks in the past.

The second-highest administrator at the university, Martin Philbert, provost and executive vice president for academic affairs, resigned amid allegations of sexual misconduct earlier this year. Philip, who faced multiple formal complaints for years, left the university last June.

“Passing the trash”

Writes one respondent:

The #MeToo movement was great to raise awareness and empower women. But if institutions are just going to let people resign quietly, so that they can continue to harass other people and not actually be held accountable for their actions, then they are not really addressing the issue. This is similar to what happened in the Catholic Church, where priests were moved from parish to parish instead of actually facing consequences of their actions.

“When someone is dismissed for an allegation of this sort, they often get hired elsewhere, that phenomenon is so common as to have an actual name in the business, which is called ‘passing the trash,’” Jagsi said.

Jagsi addressed the phenomenon at a meeting of the Council of Deans earlier this year—the very people who “are passing the trash to one another,” she said.

“We have a real problem in medicine, and academic medicine, of individuals who are known perpetrators of really egregious behaviors getting passed around to several institutions before, finally, someone realizes that this has happened at several institutions—and it hopefully comes to public attention and it stops,” Jagsi said.

The practice is pervasive. “This is a common occurrence, in industries where people will leave—sometimes voluntarily, or sometimes they’re terminated, and seek employment elsewhere,” Coll said. “This is a common occurrence with sexual harassment, and with men harassing women, but it’s also something you see with other forms of harassment and discrimination—if you have some-

body who’s been making racially insensitive comments, for example.”

Joleen Hubbard, consultant, practice chair, and vice chair in the Division of Medical Oncology and Department of Oncology at Mayo Clinic, said she is familiar with situations where harassers have stayed in powerful positions, despite leadership knowing better.

“That person could retaliate against many, many people within that position. The fact that this person’s continued to be allowed to hold a position of leadership, even though many people know the underlying stories, is really disturbing,” she said.

Uncertainty prevails: a dean may pass one item of trash knowingly and unknowingly accept another. “They recognize that, yes, it seems like a good deal to hand off the trash to someone else—until they recognize that what’s happening is that someone else is handing them the trash, too,” Jagsi said.

A system of accountability would be good to have. “I don’t want a system in place so that this person never gets another job again. But I do think that other employers should probably be aware this person had a corrective action or had a serious harassment suit filed against them—or that they left under investigation, or under an unfinished claim,” Hubbard said. “There needs to be some sort of alerting system, otherwise this is going to perpetuate.”

If a harasser brings in funding, the department can be harmed financially if that person goes elsewhere. The trash stays put and the institution keeps the money. “This is a pattern where employers, rather than addressing the issue, choose to look the other way, particularly where it’s a very valuable employee involved,” Coll said.

One respondent offered an example:

The individual was moved out of their leadership role, but given another leadership role on campus with a multi-million retention so they didn’t lose their grant funding.

“[The institution] needs to recognize that they need to subsidize the good behavior,” Chapman said. “Essentially, they need to say to a chair, ‘You got rid of this very problematic person who broke the law, or violated our values, and was having a negative impact on our science and our field—and we recognize that, in many ways that is the right thing to do, but also a courageous thing to do.’”

Usually, a person with a history of harassment can continue to receive grants. NIH grantmaking policies leave it to institutions to regulate ethics of their employees and is therefore limited in what it can do.

Here is what NIH [says](#) about sexual harassment:

“While this communication does not constitute or substitute for a report of sexual harassment for legal action or investigation, NIH will follow up with the relevant applicant/grantee institution on all concerns related to NIH-funded research. NIH also strongly encourages people to report allegations of sexual harassment or assault to the appropriate authorities, which may include your local police department or your organization/institution equal employment opportunity or human resources offices.”

Parity is not enough

In an [analysis](#) of 6,030 faculty from 265 Accreditation Council for Graduate Medical Education oncology programs, women faculty represent 35.9% of the total faculty body in medical oncology, radiation oncology, and surgical oncology programs.

Representation of women in leadership positions is lower: 24.4% overall (medical oncology, 31.4%; radiation oncology, 17.4%; and surgical oncology, 11.1%).

Representation of women in chair positions is lower, with only 16.3% of departments chaired by a woman (medical oncology, 21.7%; radiation oncology, 11.7%; and surgical oncology, 3.8%).

In some subspecialties, the gender gap is unlikely to be closed anytime soon. Consider radiation oncology. A [study](#) by Holliday et al. notes that over the past 30 years, the percentage of women in the academic radiation oncology physician workforce has increased by approximately 0.3% per year for residents and faculty. (By way of comparison, the percentage of women fellows and faculty in medical oncology have increased by 1% per year during the same period.)

“We’re almost about at parity in medical oncology training, whereas in radiation, in that paper we found it would take 50 years for women to reach parity and representation in radiation oncology,” Deville said to *The Cancer Letter*.

The proportion of women among medical oncology trainees peaked near gender parity (48%) in 2013, but the proportion of women among radiation oncology trainees peaked in 2007 at 35%—and has declined since, the study shows.

“The exact causes for this ongoing gender disparity are unclear, but barriers that may contribute include unconscious bias, sexual harassment and overt discrimination, collisions between biological and professional clocks, and lack of radiation oncology exposure and mentorship for female medical students,” the study states.

How does this affect the culture within radiation oncology?

Another [study](#), a survey of women in radiation oncology residency programs 2017-2018 authored by Osborn et al., demonstrates that gender bias and an absence of mentorship may contribute to attrition of women from the radiation oncology workforce.

“Over half (51%) reported that lack of mentorship affected career ambitions. Over half (52%) agreed that gender-specific bias existed in their programs, and over a quarter (27%) reported they had experienced unwanted sexual comments, attention, or advances by a superior or colleague,” the study states.

“Whatever you find in terms of medical oncology, you have to multiply by a factor, because the diversity in radiation oncology is much less than you see in medical oncology,” Ahmed said to *The Cancer Letter*.

The culture of gynecologic oncology suggests another problem: that gender parity in the workforce doesn’t guarantee gender equity.

Women account for 51% of the Society of Gynecologic Oncology membership, but are underrepresented among leadership in gynecologic oncology. A [study](#) by Tempkin et al. demonstrates that women in gynecologic oncology are underrepresented in leadership roles.

“If you look at the folks we are training today in gynecologic oncology, there’s a ton of women that we are training, but if you look at the leadership, even among the cooperative groups—on who is actually leading these clinical trials, who is actually on the podium, it’s still overwhelmingly men,” said Don Dizon, director of Women’s Cancers at the Lifespan Cancer Institute, clinical director of Gynecologic Medical Oncology, and director of Medical Oncology at Rhode Island Hospital.

Another [study](#), which surveyed U.S.-based members of the SGO, found that

71% of female gynecologic oncologists reported sexual harassment in training or practice.

“The training environment is still not as nurturing as it could be. It’s forcing people to really reevaluate their ambitions. Some may choose to leave academia, and some may choose to just try their best. That group is probably most at risk for psychological demoralization,” Dizon said. “I know several folks who decided just to bug out and go into pharma, for example, because of it.”

Another problem: women in gynecologic oncology aren’t paid as much as men. A [study](#) presented early this year at SGO’s Annual Meeting on Women’s Cancer reported that “more than 75% of female providers in academic practice make below the median salary for gynecologic oncologists observed in this survey.”

According to the study, the median salary for men was \$500,000 a year, while women were earning \$380,000.

“The minority tax”

“There’s research that shows that women of color are not only more likely to be targets of harassment, but also less likely to be believed when they come forward to report. And I believe that is largely due to implicit bias,” Coll said.

“I think it’s really important for everybody, especially managers and supervisors, to undergo implicit bias training. We also really encourage organizations to have uniform and consistent policies and approaches to all forms of workplace harassment and discrimination,” she said.

Women in underrepresented minority groups face an additional obstacle known as the “minority tax.”

“First, you have to acknowledge that the problem is there, that intersectionality is real. For example, you have to pay two taxes,” Duma said. “If you’re in an intersection and you get hit by a car, that’s the gender bias tax. But if you get hit by a car, and then a bus, and then a bike all at the same time—that’s the intersectionality, when you have to pay so many taxes.”

Black women make up 13% of the U.S. population. In medicine, only 2.3% practicing oncologists self-identified as Black or African American, and 5.8% practicing oncologists self-identified as Hispanic, according to a 2017 [survey](#) by ASCO.

“Even just to do another survey is already more taxing for Black women, because there’s already the minority tax,” Chapman said. “They already have more societal barriers—have less time to spare—have less free psychological health. It’s already hard to bring people in, but I think it’s critical to do so.”

Change starts at the top

More than three-quarters of respondents (76%) to *The Cancer Letter* survey said they have little to no confidence in their institutions’ leadership to eliminate gender bias in oncology.

Leadership diverse in gender and race could help improve this metric, University of Miami’s Ahmed said.

“At the heart of it, having real leadership—not just titles—that reflect the diversity of the workforce, or the professional organization, is really integral,” he said.

Alas, leadership, too, can be tokenized. Writes one respondent:

Gender bias is a form of bullying, and extensive education is required to change the gender issues. As-

sertive women are experienced and very capable, not “bitches,” assertive men are often overrated and less capable than their female equivalents—especially the more they rise in leadership. Very high in leadership, women might not always be the best role models—they went through so much, they might have taken bad habits to survive.

Sometimes, women in leadership are used as cover for bias against other women, Chapman said.

“Women in leadership roles can similarly be pressured and manipulated into furthering these systems of gender-based discrimination,” she said. “The difficulty there is that there’s the appearance of objectivity. When you put women into leadership roles, there is the appearance of diversity, equity, and inclusion in that institution—when the woman may really be nothing else but a tool to further patriarchy and to further white supremacy.”

The phenomenon of women perpetuating sexism appears to figure in gynecologic and breast oncology, Lifespan’s Dizon said.

“What I have, unfortunately, found is that even women in power may be blinded to the inequities that are playing out in the way they might interact with female junior colleagues. They may not be as willing to take someone who’s going to be their competitor on as a mentee,” Dizon said. “I think that that just speaks towards the value that women feel they have within their divisions. You might be an assistant associate or even a full professor—there’s not this sense of security in your role. I don’t know how much that is subconsciously playing into the not-so-nurturing environment for women in medicine, even when it comes to women in power.”

How effective can reporting mechanisms be if the people in power aren’t committed to enforcing them?

“A policy or procedure may or may not be as impactful as just having women in leadership—you have to review what is actually happening in your immediate environment that either does or doesn’t foster diversity and inclusion from a gender perspective,” Deville said.

There are concrete steps to take when hiring for leadership positions, said Emma Holliday, assistant professor in the Gastrointestinal Radiation Oncology Section at MD Anderson Cancer Center, who studies gender bias in oncology.

“You can’t just say, hire some women of color. It’s got to be a process where the change starts from the top, where you give more people a seat at the table in selecting the candidates for leadership and in the interview and selection process,” Holliday said to *The Cancer Letter*.

Reporting can be optimized

Trash-passing can be prevented.

“Saying that someone lost their job for this type of behavior in the past year can be very powerful. You can’t necessarily say this person was let go because of this, especially because of these non-disclosure agreements,” Jagsi said. “But you absolutely can say, ‘In the past year, someone was let go because of a concern about professionalism and sexual harassment,’ if that’s the specific concern.”

Coll proposed a solution: employers would disclose the reason for someone’s termination, even if it’s done internally.

“That can go a long way toward creating more transparency,” Coll said. “If everybody in the workforce knows that they were terminated for a violation of this



These findings speak deeply to the culture of medicine and the very real fears that women have that if they complain about something like that, they will always be identified as a whiner, they will be marginalized, they will suddenly be labeled as someone who is not strong enough, it will be a distraction from their professional contributions, they will bear a stigma. And potentially, they will be further victimized as a result, and face retaliation.



— Reshma Jagsi

kind, it's more likely that it'll come up in a future reference check or a future job search."

Privacy issues are a concern, too, Coll said.

"One balanced approach that I like is to disclose that the person was terminated because of a code of conduct violation, without necessarily needing to get into all of the details of exactly what occurred," she said. "At least that way people are on notice that they were terminated because they violated the company values or specific policies that are in their code of conduct."

Often, reporting systems don't provide the option of anonymity. If there is no HR system in place, then the person who was harassed has only two options: staying quiet or letting their bosses know.

"We need both formal and informal reporting systems," Jagsi said. "There needs to be an option for anonymity. There needs to be inspiration drawn from things like campus sexual assault reporting processes, whereby someone can make a confidential report and say, 'I don't want to be contacted about this unless a certain number of other individuals also report this particular perpetrator. In which case I feel like there's sufficient strength in numbers that I will speak out about my experience.'"

Solutions

What would an appropriate institutional response look like?

Here is what the respondents wrote:

- 👤 Change their behavior, discuss it at a meeting, present the facts.
- 👤 More open and inclusive discussions of new initiatives and

a concerted effort to increase gender and racial diversity among senior leadership.

- 👤 To acknowledge the sexism in its approach to administrative leadership and try to equalize the balance of opportunities.
- 👤 Real training of the men to recognize their biases would be helpful but will never happen.
- 👤 To simply listen to me and not punish or retaliate against me for speaking out.
- 👤 Termination of the individual regardless of how much grant money they bring. Abuse should not be tolerated.
- 👤 Fire the offender instead of the victim.
- 👤 An investigation. The perpetrator should have been removed from their position.
- 👤 Providing parity in a more rigorous manner rather than waiting for individual complaints.
- 👤 Immediate action taken against the perpetrator (losing privileges, bonus money, his endowed chair, other).
- 👤 Very simple—acknowledgement, a simple apology and corrections of the many wrongs.
- 👤 Put women and minorities in leadership positions in proportion to the population.

What sort of policies and directives can institutions implement to eliminate gender bias?

Acknowledgement of incidents and consequences for the perpetrator would be a good start, some respondents said.

Others said leadership change would be an appropriate first step. Here are some of their suggestions:

- 👤 It has to be more than bias training.
- 👤 Each search committee should have a specific charge to increase diversity of applicants, and to more carefully consider gender and race in candidate selection. Implementation of meaningful unconscious bias training.
- 👤 For one thing, the university does not have an ombuds position. The institution seems to think that a monthly “women in cancer” funded lunch will placate the NCI for the support grant renewal, and I suspect they are correct.
- 👤 A zero-tolerance policy on sexual harassment and gender discrimination. Flexible reporting structures. Transparency in pay and promotion.
- 👤 I think that continued trainings in bias, with practical examples, would be helpful. I think it would be more impactful if stories within the institution or department were anonymized and used as teaching examples. Most people go to these types of training somewhat removed from the events or repercussions because the examples always seem to happen “elsewhere, but not here”.
- 👤 Harassers and discriminators need to be called out publicly; only then will it slow down. Getting away with it and being told to stop just doesn’t work.
- 👤 The institution lacked women in leadership. If more women

were there, I think this may not have happened.

- 👤 Include questions about mentorship and career advancement opportunities for junior faculty in supervising faculty’s annual review.
- 👤 Leadership at the very top should resign, or secure a professional service to assist in confronting their biases. The culture of retaliation needs to stop before gender bias can be addressed.

“We have to be intervening to stop discrimination before it happens. If the solution to discrimination is diverse leadership, then we have to devote energy to nurturing a deep pool of excellent candidates,” Prowell said. “That requires investing in the pipeline all the way down to high school, or even middle school, and doing the hard work of asking why, on an institutional and societal level, we see so much attrition of women and people of color.”

Dizon suggested a diversity quota that would ensure that the makeup of leadership in oncology better represents the entire workforce—similar to the goals NIH sets out for enrollment in clinical trials.

“When we open clinical trials, NIH requires us to fill an estimation of how the volunteers are going to fall in by race. We have to do these projections when we do our clinical trials, because this is going to give the NIH or the NCI some idea of how we’re going to attract a diverse group of volunteers, but also it’s going to hold our feet to the fire,” Dizon said. “We don’t do that in medicine. We don’t say, ‘Okay, you’re a chair. This is a composite of your faculty—where do you want it to be in five years?’ That’s

something that we as a field need to sort of start thinking about—real metrics to prove we’re making a difference.”

To eliminate gender bias, institutions must be proactive, experts say.

Bystander intervention is one such measure that encourages “ground-up change by empowering allies and creating ‘up-standers,’” said Jagsi, who published her findings on the subject in the *New England Journal of Medicine*. “And ultimately, it’s important to recognize that sexual harassment is not only a driver of gender inequity—but that gender inequity is the environment within which sexual harassment thrives, so, interventions to promote gender inequity more generally are extremely important.”

Ten-minute online videos and superficial trainings will not cut it.

“Having clear policies that are thoughtfully developed, and then disseminated to the audience of employees so that they realize that there’s no institutional tolerance—and really proactively enforced, so that they have real teeth, is so critically important,” Jagsi said. “That has to come from the top.

“Leadership really has to realize that this is an issue that is compromising the ability of the organization to deliver on its mission.”

In their own words: Responses to *The Cancer Letter* survey on gender bias

These harrowing responses to *The Cancer Letter's* survey on gender bias are best represented with no interpretation or analysis.

These excerpts have been anonymized and de-identified. To maintain anonymity, some excerpts containing multiple points have been separated. The average number of types of harassment and bias reported by respondents to this survey is 2.6 per person.

The excerpts respond to six questions:

1. What was the issue you experienced?
2. Why (or why not) did you report?
3. Describe the impact of this incident.
4. What would have been the appropriate response from your institution?
5. What policies or directives should your institution's leadership implement to address gender bias?
6. Is there anything else you'd like to add?

Please be aware that the first section about the harassment these respondents faced may be difficult to read. Later sections deal more specifically with policy issues. The respondents to this survey are in all levels of medicine, primarily academic oncology.

What was the issue you experienced?

(Did a colleague, professional acquaintance, peer, or senior coworker cause you to feel disrespected or unsafe because of your gender?)

👤 Every day.

👤 I work in an environment where diversity of opinion, among senior leadership, is not appreciated or encouraged. This situation is particularly true for women. The net result is a toxic work environment, which has led to a substantial de-

crease in the number of female leaders/chairs.

👤 Verbal abuse, screaming, ranting and raving, trapping me in my office. Grabbed my face on one occasion.

👤 During my fellowship, the other male fellow was given all the studies and I could not find anyone to allow me to participate. He was hired for a position he was not qualified for and two qualified women were not.

👤 I was alone in a hospital elevator when two surgeons stepped on. One proceeded to make comments to his colleague on my appearance and my presumed fellatio skills.

👤 The (female) senior leadership in my department and cancer center left, and the weaker male replacements did not protect

me from bullying by my facility head.

- 👤 I asked the editor-in-chief of a major cancer journal about submitting a paper that I thought might be right for the journal. We were in the midst of a large crowded poster session. He told me exactly what we were going to do together, in broad daylight, with a smile on his face, and no one was the wiser.
- 👤 When I made a suggestion in a meeting, upper administration (3 men) literally laughed at me for a good 20 seconds. They were laughing at the naivete (supposedly) of my suggestion. Myself and the other woman just looked at them as this occurred—I'm sure they didn't think it was out of the ordinary or problematic at all. I cannot imagine they would have laughed in a man's face that way, and the gender difference in behavior in the room was striking to the women at least.
- 👤 Repeated instances of “Dr. Man and First-name woman”—it is pervasive even when we are at the same level of full professor. More subtly, expecting the female faculty member to just pick up the care-taking and more menial tasks in a group effort. Scheduling meetings (and conferences) at off-hours/off-days when a person could be expected to be doing homework “because we're all free at that time” (and presumably because they have someone else doing the housework and grocery shopping and care-taking).
- 👤 As a med student (way back in the 1980s) an attending surgeon called all the male students on the rotation by their last names. He called me “honey.”

- 👤 Don't get me started on the number of times in my long career that I've been mistaken for a nurse, by doctors, by patients, but never by nurses!
- 👤 When I started my lab, I was one of the very few female PIs and I was one of the youngest as well. Due to this, whenever I wanted to have anything done, the administrators and even the cleaning people always asked for my boss, since I do not look like someone who can actually be a faculty.
- 👤 Inappropriate touching by a male peer at conferences.
- 👤 Having male residents reviewed as the team leader on rounds instead of me.
- 👤 The manager of a community cancer center calls me “little woman” or “little doctor” all the time but he calls my male colleagues by their last name with respect and fear.
- 👤 A senior president asked me to take me for dinner but when I immediately refused because I was shocked by his proposal he told me, “well then good luck with your career.”
- 👤 This is an issue that has been constant throughout my > 40 year career. There are so many that I can't possibly list them.
- 👤 I have been harassed for being gay, which while not sexual harassment per se, is related to gender.
- 👤 Gender bias in promotion. A senior coworker made unwelcome offers that felt suggestive and inappropriate.
- 👤 A co-worker often yelled and demeaned me in front of others,

and I believe that had I been male, he wouldn't have been so horrible to me. In general, this workplace was not very friendly to women: our ideas were not seen as worthy as men's in meetings, and male scientists often spoke poorly of women's contributions in the lab.

- 👤 One of my senior male mentors started to feel threatened by my success and retaliated by making disparaging comments about my leadership skills, making inappropriate comments that put me down in front of large groups, and talking to my personal research contacts in order to do separate research. During the course of this treatment he made me feel like it was my fault. I spoke with leadership at my institution, yet nothing was done. I ultimately had to leave my institution because of his behavior.
- 👤 Routinely addressed by first name or Ms. rather than “Doctor.”
- 👤 As junior faculty/PI (female), I assumed a leadership position vacated by a man who was at the same level (tenure/experience). I was paid 40K less than he was.
- 👤 While on a panel of experts at a conference, the male colleague seated next to me kept putting his hand on my knee. I was a young investigator.
- 👤 Overheard a senior male colleague refer to a female scientist who was junior with a sexist remark. This same senior male colleague had a reputation for never acknowledging women in meetings, even if they were seated next to him.

- 👤 New referrals preferentially given to male physicians. male physicians have a higher salary and are given several support staff—I have a part time nurse.
- 👤 When serving on a committee to review salary parity (across institutions, departments), it became apparent that male salaries were significantly greater than female salaries at the same rank and tenure. Although I repeatedly brought this up as an issue, this fact never made it into the final report.
- 👤 Called by my first name (including a demeaning nickname) when introduced for presentations.
- 👤 Funds were removed from my endowed chair and given to a male colleague. I was “chair in name only.” I was told that “math” was too difficult for me to understand, so my accounts were never provided to me—I taught partial differential equations to grad students.
- 👤 Disrespect in terms of maternity leave comments; comments about a female being ‘bossy/hormonal’ but a male being a ‘leader.’
- 👤 At my institution (a well known cancer center) women faculty are typically referred to by their first name but men are always “Dr.”
- 👤 Of the many examples, let’s describe a same-institution colleague at a meeting banquet, who probably had one too many glasses of wine, and told me that he was chairing a meeting in Greece. Asked if I knew how women went to the beach in Greece? If he invited me,

would I go to the topless beach with him...

- 👤 Grant and manuscript reviews that are not blinded often have dismissive tones in the review comments for females—less so for males and males are often ‘given a pass’ when details are not provided on certain aspects of grant applications.
- 👤 There are numerous episodes through my surgical career of over 20 years. Rude and disrespectful jokes, references to my anatomy, cornered in an elevator by a senior attending when I was a medical student, unwelcome touching in front of my husband, salary disparity several times.
- 👤 Ongoing and routine non-use of title/honorific when I am in certain clinical settings, salary disparity that took significant effort to discover and resolve, and, when I disclosed my pregnancy, a senior colleague thought it appropriate to respond, “I thought you were just eating too many Twinkies or something and getting fat.”
- 👤 Promotion/office space/lab space/resources bias towards male colleagues.
- 👤 I was not treated with respect: my title was not used (always referred to by my first name, not Dr). Pay was significantly lower than males of the same rank.
- 👤 Not part of the ‘good ole boys club’ due to gender, so I am left out/ignored.
- 👤 You do not have enough time: to summarize, I have been consistently made to feel that I am unwelcome throughout my

career. This included attempts to intimidate me using sexually suggestive comments and physical contact early in my career—to suggestions that I should be less successful, because it was agitating my male colleagues later in my career.

- 👤 Lack of opportunities or consideration for advancement based upon gender, treated differently and disrespected, not called by honorific (PhD), passed over for administrative promotion, treated as “de facto secretary” (assumed I’d take notes) because I was the lowest ranking woman in the room for a senior admin meeting.

Why did you report?

- 👤 I was hoping something could be done to make the situation better.
- 👤 It took two years to report the ongoing abuse. It wasn’t until a male faculty member intervened and encouraged me to report the abuse that I had the courage to do so.
- 👤 Because it impacted patient care.
- 👤 Because it was related to intellectual property and my federally-funded grant.
- 👤 He made it very difficult to do my job and made my life hell.
- 👤 The right thing to do.
- 👤 Non-use of professional titles and salary disparity I did report because it is important to correct these deficiencies—not just for myself, but for the women I mentor and train.

👤 I informed the HR team about the bullying but there is no change in the behavior of those staff members.

👤 I tried to report the salary differential, but was ignored. I was very junior when the other incidents occurred and didn't know what to do.

👤 Multiple conversations with chair and center leadership, eventually anonymously with the university ombudsman.

👤 Human rights.

Why didn't you report?

👤 This is academics, don't feel comfortable.

👤 Did not meet the standard of harassment or bias per institutional reporting. BUT, I have, in some cases, provided feedback to the speaker on their choice of words and action and assumptions.

👤 Did not feel it would be helpful. The women who were overlooked felt it would damage their careers.

👤 Ashamed to cause a scene. Also, he holds a superior position with many connections so I didn't want to cause any noise.

👤 Irritating but not really reportable—and who would I report it to? I certainly gossiped like crazy though to warn other women.

👤 There's not a good culture for reporting this at my institution.

👤 In the 1980s? In Virginia??

👤 Satisfaction unlikely, bullshit likely.

👤 No, it was part of the overall culture due to lack of women as faculty.

👤 Too much trouble/effort. You get used to this behavior/experience as a woman in the U.S.

👤 Instead, I left and am making 4x the salary somewhere else.

👤 It's endless. Sexual harassment has largely stopped (aging?) but the discrimination is always there, but better hidden for the most part. I take measures when I can to force more equality but reporting would take all my time.

👤 I am just a PhD, no one cares.

👤 Worried about retaliation.

👤 I felt that the institution would not support me and the process would be long and difficult. I left the institution a few months later. Untenable situation and I had to leave. One of the most difficult times of my life.

👤 Scared. Male colleagues circled wagons, management supported them.

👤 It was the mid-1990s, I was a medical student and the harasser was a professor.

👤 Did not feel it would make a difference.

👤 I reported the poor treatment to [my boss], but I did not report to HR. I was younger and relatively new to the workplace at this point in time, so I didn't stand up for myself like I would now. [My boss] handled this by having a conversation with the person who was harassing me in the break room—not in his

office with the door closed, like this should have been handled.

👤 Did not feel anything would be done.

👤 Who would I report it to?

👤 In the first instance, I was uncomfortable with the situation but I was early in my career and knew I needed to maintain a good working relationship with the people involved since I would interact with them every day for many years. In the second instance, I was comfortable speaking with the individual and since an apology was offered, I did not pursue it further although it still hurts me deeply to think about it.

👤 It didn't seem offensive, but the norm.

👤 Felt it would only hurt myself.

👤 It was minor.

👤 I addressed it myself with the individuals and named it as sexual harassment and it stopped.

👤 I didn't want to make a fuss.

👤

👤 No options for reporting. Would not have been seen by male leadership as significant issues.

👤 It would have made the situation worse.

👤 Prevalent attitudes are barriers and I didn't want to be seen as making trouble.

👤 I was young, inexperienced, and new to my role. Though it was not physical, the experience scared me enough to not report.

👤 Boy's club; no guarantee that things are kept confidential.

- 👤 HR unresponsive in the past. Fear of retaliation from chair.
- 👤 No mechanism for reporting.
- 👤 [He] was too powerful. It would have ruined my career. Never occurred to me to go to HR.
- 👤 Useless.
- 👤 Fear of retaliation.
- 👤 Upper administration members (all male) laughed at me in a meeting. Who do I report that to???
- 👤 Pointless.
- 👤 Fear of retaliation.
- 👤 Would sound like I am whining.
- 👤 Believed leadership would not take action.
- 👤 Seriously?

Describe the response or lack thereof.

- 👤 The individual was moved out of their leadership role, but given another leadership role on campus with a multi-million retention so they didn't lose their grant funding.
- 👤 Defensive, then retaliatory.
- 👤 There has been little change, as the problem starts at the top.
- 👤 Institution was so unresponsive that I sought legal counsel and filed charges. Institution was so slow to react, that it required a year of negotiations to settle the issue.
- 👤 Told me to "handle it."
- 👤 My department/school and the university faculty senate say

that I have no status as non-tenured faculty. A lawyer explained that as long as the people involved only slandered me within the institution I had no recourse. I haven't heard back from Title IX yet.

- 👤 Received a larger than usual raise but still did not match male equivalents.
- 👤 Was told my boss maintained an adequate professional standard because he said good morning regularly and was friendly.
- 👤 Manager [a woman] laughed and thought it was funny and that I was too sensitive.
- 👤 The person that sexually harassed me was given the option to resign instead of being fired. This person has a position of leadership where he can continue to wield power over me and other individuals he harassed.
- 👤 In faculty dinner meetings, I have been shamed publicly for using due process to complain about treatment.
- 👤 Salaries were adjusted for most women (15% pay gap).
- 👤 Though the behavior from this individual did get a little bit better, the overall toxic workplace environment did not. I was ostracized both socially and professionally from my colleagues. I chose to leave this job.
- 👤 The institution was initially going to conduct a formal legal investigation. I met with a lawyer, but learned many months later that they closed the investigation given that other women wouldn't talk.

- 👤 Despite bringing up the salary differential several times, it was ignored.
- 👤 The salary disparity issue was resolved adequately. I have yet to see whether the consistent non-use of professional titles has been resolved satisfactorily.
- 👤 As I was leaving, the head of the cancer center at the time told me I had a case for gender discrimination—I told him living well was the best revenge.
- 👤 They did not acknowledge the notice issued by the Human Rights Commission.
- 👤 Many of my colleagues (men and women) have complained on our annual employee surveys. The issue has never once been brought up when the results of the survey are being discussed.
- 👤 They said to let them know if it happened again.
- 👤 Blaming me.
- 👤 My boss literally pretended to get a phone call and walked out of the room when I raised the issue of lack of promotion differential treatment.

Describe the impact of this incident.

- 👤 I left my position and no longer work in academics. Gender equity now overshadows all of my academic work.
- 👤 Developed severe depression.
- 👤 It makes you doubt yourself. You are not regarded equal to or treated the same as the male counterparts or subordinates.

- 👤 The constant drumbeat of a lack of respect has been fairly stressful and has made it difficult for me to advocate for resources and change.
- 👤 Seriously considered leaving the program.
- 👤 Emotional abuse, severe depression which took over a year to get back to “normal.”
- 👤 It makes you wary of putting yourself in a situation where it can happen again.
- 👤 I am still at the institution where these incidents have taken place. I have an otherwise supportive team but I am cognizant that whether or not I make my personal life a topic of workplace discussion, it will still be speculated upon by others and also used to assign work and responsibilities. The only thing I can do is try to do for others what I wish had been done for me.
- 👤 Depressed; distraught; unable to focus or feel dedicated to my work.
- 👤 I am still worried about the impact of these incidents on my reputation. It also took a lot of time for me to even take the step of filling this survey.
- 👤 I’m way behind in advancement than my male colleagues.
- 👤 Moved to industry.
- 👤 Anger and depression at daily harassment—not directly at me, but a very hostile environment.
- 👤 The person who sexually harassed me was my mentor. When I didn’t give him what he wanted he was furious, made

- my life a living hell at work, and dropped me as a mentee. He stifled my academic career. He has tried to tarnish my reputation among national and international leaders in my field by telling everyone I made up lies about sexual harassment so that I could take over his “empire.”
- 👤 Lack of confidence in institutional culture.
- 👤 Isolated from my division.
- 👤 Well, I think I solved the problem when, one day in the OR when he said “honey hold the retractor” I responded “sweetie if you tell me where to place it I’ll do it,” and then pointed out to him that he called all the guys by their last name and called me honey. From that day forward all of us were called by our first names.
- 👤 I was burned out and clinically depressed. I am considering leaving the institution at which this happened, but have not made a final decision.
- 👤 I am currently in the process of leaving the profession.
- 👤 I left one institution, I now point out inequities and fight them out whenever possible. Lots of gender bias is subconscious, offending parties are completely unaware.
- 👤 I am leaving my current institution because of the toxic work environment.
- 👤 I ended up leaving the field and pursuing a new field of study. I learned from this experience and have subsequently promised to be an advocate for myself and others in the workplace.

- 👤 Being treated as less important undercuts confidence in speaking up, etc.,
- 👤 Increased my burnout.
- 👤 My resting heart rate was in the 90s, I gained 40lbs and developed a variety of skin conditions. All issues resolved after my boss was eventually removed.
- 👤 I stood up to my chairman and told him exactly what I thought when each situation occurred. He learned that I couldn’t be pushed around and that I was not going to tolerate his patronizing attitude. He did respect me for it and I had a very straight relationship thereafter with him when everyone around him lied to his face about everything.
- 👤 It pushed me. I learned that your fears follow you so you need to face them.
- 👤 It is difficult to always feel like the unwelcome outsider and to have only “perfect” interactions with everyone.
- 👤 Had to move to a new institution, start all over again.
- 👤 What would have been the appropriate response from your institution?
- 👤 A decent chair/leader would have stopped the [harasser], who was interfering with my ability to find additional funding.
- 👤 Providing parity in a more rigorous manner rather than waiting for individual complaints.
- 👤 Immediate action taken against the perpetrator (losing privilege-

es, bonus money, his endowed chair, other).

- 👤 More open and inclusive discussions of new initiatives and a concerted effort to increase gender and racial diversity among senior leadership.
- 👤 Very simple: acknowledgement. A simple apology and corrections of the many wrongs.
- 👤 Termination of the individual regardless of how much grant money they bring. Abuse should not be tolerated.
- 👤 Fire the offender instead of the victim.
- 👤 An investigation. The perpetrator should have been removed from their position.
- 👤 They should have been evaluated by HR.
- 👤 The HR team or administration should have taken steps to prevent the bullying.
- 👤 Looking at facts, identifying gaps, and responding to restore balance. However, the result is usually an excuse: “we can explain why, etc...” Or worse, lies.
- 👤 Re-assigning me to work with a different individual, and disciplinary action and remediation.
- 👤 For the persons in charge of meetings to correct those who refer to men as Dr. XX and women by their first names.
- 👤 Put women and minorities in leadership positions in proportion to the population.
- 👤 To simply listen to me and not punish or retaliate against me for speaking out.

- 👤 Any involvement of senior leadership.
- 👤 An apology.
- 👤 Equitable pay scale.
- 👤 Real training of the men to recognize their biases would be helpful, but will never happen.
- 👤 Direct response to the perpetrators, reform.

What policies or directives should your institution's leadership implement to address gender bias?

- 👤 They should have some!
- 👤 It has to be more than bias training.
- 👤 Each search committee should have a specific charge to increase diversity of applicants, and to more carefully consider gender and race in candidate selection. Implementation of meaningful unconscious bias training.
- 👤 My current institution does not seem to have issues, although slow to promote women to positions of authority. This is improving.
- 👤 We have all kinds of policies, they are just not enforced when it comes to individuals who bring in lots of money.
- 👤 For one thing, the university does not have an ombuds position. The institution seems to think that a monthly “women in cancer” funded lunch will placate the NCI for the support grant renewal, and I suspect they are correct.
- 👤 Leadership of more than the white good old boys.
- 👤 A zero tolerance policy on sexual harassment and gender discrimination. Flexible reporting structures. Transparency in pay and promotion.
- 👤 I think that continued training in bias, with practical examples, would be helpful. I think it would be more impactful if stories within the institution or department were anonymized and used as teaching examples. Most people go to these types of training somewhat removed from the events or repercussions because the examples always seem to happen “elsewhere, but not here.”
- 👤 I'm not sure what could fix this—I'm sure they don't think they behaved badly.
- 👤 Careful consideration of moral ethics when selecting Board Members and people in power, not only knowledge.
- 👤 Harassers and discriminators need to be called out publicly; only then will it slow down. Getting away with it and being told to stop just doesn't work.
- 👤 Policies are in place, they are not followed by leadership.
- 👤 The institution lacked women in leadership. If more women were there, I think this may not have happened.
- 👤 Include questions about mentorship and career advancement opportunities for junior faculty in supervising faculty's annual review.
- 👤 Have a safety net for affected individuals to voice concerns and actually do something about these concerns instead of ignoring them or blaming the victims

- 👤 Make bold statements like becoming a signatory member up for TimesUp Healthcare.
- 👤 Transparency and communication regarding gender discrimination and harassment (for example a faculty member in my Department was fired for overt sexual misconduct and there was no communication about this. I only heard about it via an external source).
- 👤 Be more open and up front about it!
- 👤 Implicit bias training, talking about ways in which women are spoken to differently than men.
- 👤 To better understand the entire gamut of gender bias—it's not just sexual assault.
- 👤 Put women and minorities in leadership positions in proportion to the population.
- 👤 Leadership at the very top should resign, or secure a professional service to assist in confronting their biases. The culture of retaliation needs to stop before gender bias can be addressed.
- 👤 Bringing it to the attention of the staff/employees. Once people are aware that it's happening, tools to correct the behavior would be helpful.
- 👤 Mandatory training, anonymous reporting, culture changes
- 👤 There should be directives from the top that all faculty are addressed with honorific titles or none are. This needs to be directed to all departments.
- 👤 Consistent use of professional titles should be required in a professional setting.

- 👤 Periodic department review of compensation and service assignments should be conducted to identify and correct disparities.
- 👤 Review salaries and remove gross disparities.
- 👤 Training of the men to recognize their biases. Committees to evaluate any leadership decisions to make sure they are not superimposing their expectations and biases. All women can't be 'difficult' or 'lightweight.'
- 👤 Maybe give the male leadership, specifically those over 65, training in "leaning out"—getting out of the way for the next generation of leaders.

Is there anything you'd like to add?

- 👤 Just look at our websites and you'll see differences in how men and women are portrayed.
- 👤 I do think that the role of the chair or chief cannot be understated. If the chair or chief pays lip service to these events or trainings, then no one else takes it seriously. The culture of the department starts at the top.
- 👤 The #MeToo movement was great to raise awareness and empower women. But if institutions are just going to let people resign quietly so that they can continue to harass other people and not actually be held accountable for their actions, then they are not really addressing the issue. This is similar to what happened in the Catholic Church where priests were moved from parish to parish instead of actually facing the consequences of their actions.

- 👤 I cannot believe that any woman could identify just one or 7 or 10 incidents to discuss in this survey. You might hypothesize that those taking the time to respond to this survey are an isolated few who have had rare negative experiences. That is not the case. I'm a 60 year old woman who is trusted as a good sounding board, a good friend. I don't know one woman, who I have worked with, who has not experienced unwanted and uncomfortable sexual pressures. The design of this survey may be the equivalent of asking someone whose home was destroyed and family members killed and asking them if there has been "an impact on their personal well-being."
- 👤 Our national standing in medicine and cancer research is impacted negatively when we accept the "norms" of various institutions. While I have done my part in fighting back, I predict that some catastrophic event (that I will not be part of) will force us as a society to reevaluate how we treat others who differ from us. I believe that a return to a meritocracy could result in diversity of our community.
- 👤 The problem in academics is that it is every man/woman/etc for him/herself. Salaries are not uniform or transparent, nor are bonuses, vacations, etc. So, it creates an atmosphere of animosity and distrust amongst colleagues and between chairs and their subordinate attending physicians. Stabbing in the back is common in medicine; it is just couched in different terms these days.
- 👤 Yes, this gender bias war will go on forever. We need to be given a safe place, room to grow, and set a precedent for the next generation.

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Kunz spoke with
Alexandria Carolan, a reporter
with The Cancer Letter.

A



CONVERSATION WITH
THE CANCER LETTER

Pamela Kunz: “In any other industry, if someone had behavior like that, they would be fired.”

“

In academic medicine we have division and departmental leadership, the dean’s office, and ombudspeople. But, I don’t think it’s the same as traditional HR in another industry who would normally be out to protect the employee. I feel like in medicine, those routes are really designed to protect the institution.

”



Pamela Kunz, MD

*Leader, Gastrointestinal Cancers Program,
Director, GI medical oncology,
Yale School of Medicine*

Pamela Kunz said she left Stanford School of Medicine because of years of gender-related microaggressions and verbal abuse she experienced there.

She wasn't holding back on letting the institution know what was going on every step of the way, she said.

"I let them know, for actually quite a while, that I was unhappy and that I felt that I was being discriminated against for my gender. I gave them examples of what I described as, pervasive microaggressions and verbal harassment," Kunz said.

Stanford officials declined to comment on Kunz's account.

"The School of Medicine does not provide public comment on confidential reports brought forward by individuals on behalf of themselves or others," the school said in a written response to questions from *The Cancer Letter*. "Stanford Medicine is dedicated to an environment that is free of sexual harassment and discrimination. We have robust policies in place to ensure the fair and respectful treatment of employees. When any violation of any of these policies occurs, our leadership, in collaboration with University leadership, takes immediate action to fully investigate and respond accordingly."

Stanford's full response appears on [page 34](#).

Kunz said she first contacted the office of the dean in 2018, and then just before she left her position in May 2020. Now, she is leader of the Gastrointestinal Cancers Program and director of GI Medical Oncology at Yale School of Medicine.

Kunz said she was verbally harassed over the years, especially when she became a mid-career physician. She often recalls an [article](#), "Is academic medicine making mid-career women physicians invisible?"

"It took me a while to really acknowledge what was happening to me. I think so many women in medicine normalize being mistreated and put down. I think that it was really when I entered the mid-career stage, and achieved a level of success, I recognized that I was perceived as a threat by some of my male colleagues," Kunz said. "I don't think I was treated that way my entire training and fellowship. I think really it peaked and became a problem when I was perceived as a threat."

The people she confided in were the same ones who make the policies. While Stanford School of Medicine has a human resource department, it does not serve as the central body for reporting harassment as in other industries. Kunz used many of the other reporting mechanisms available to her, however, she said no concrete actions were taken.

[Correction 10/3: An earlier version of this story stated that Stanford School of Medicine does not have an HR department. Stanford does have an HR department, however Kunz's said she could not turn to them.]

"In academic medicine we have division and departmental leadership, the dean's office, and ombudspersons. But, I don't think it's the same as traditional HR in another industry who would normally be out to protect the employee," she said. "I feel like in medicine, those routes are really designed to protect the institution."

She was called out for her looks rather than her intellect, she said to *The Cancer Letter*.

"Another example from a colleague, he said, 'Oh, your good looks helped get you on that panel'—really just undermining my intellect, and saying that I was selected for aesthetic reasons rather than for my knowledge," Kunz said.

Kunz, who has three children, was pregnant just before fellowship, as a fellow,

and as a junior faculty member. One colleague complained about her maternity leave—"really, just derogatory comments about being pregnant," she said.

"Oh, you're pregnant again. Oh, I have to cover your maternity leave again?" the colleague said to her.

Kunz was director of a continuing medical education course when a man second-guessed her expertise.

"While answering some questions at the end of the course, an audience member asked a question and then one of my colleagues said, 'Oh, I'm going to let Pam answer first so that I can correct her,'" she said.

These comments, while they may appear trivial on the surface, add up. They took a psychological toll on Kunz's mental health, and affected her work. Eventually, they became more pronounced. Some tried to take research opportunities away from her.

"The constant, repetitive nature of the comments just was too much. It became untenable for me to stay," she said.

At Yale, Kunz is able to breathe again, she said.

"I was talking, actually, with a colleague yesterday about this—and navigating these microaggressions and other forms of harassment takes so much time away from women being productive. I've only been at Yale a couple of months, but these concerns are off my plate, which has been great for my mental health and, frankly, adds so much time back to my day," she said.

Kunz spoke with Alexandria Carolan, a reporter with *The Cancer Letter*.

Alexandria Carolan: All of the women in our survey who experienced an instance of gender bias and reported it wrote that their institutions responded inadequately (100%, n=26). What does this tell us?

That's definitely what we've seen from this survey. People even said, it's like, "Who do I report to? The people I would report to are in leadership," the ones who control your paycheck. How do you go about that?

Pamela Kunz: First, I'm not surprised. Some of these things went through my mind as well when I was experiencing gender discrimination and harassment, and I've heard that same sentiment from many other women faculty at institutions across the U.S. I think there are multiple factors at play. I think that one, the fear of retaliation is completely real.

Even if women plan to leave their institution, I think they're fearful that retaliation could affect their reputation and ability to get future jobs. However, not every woman is looking to leave their institution. For them, they're fearful that speaking up is going to affect their current work environment. Fear of retaliation is one of the biggest deterrents in reporting.

Second, you mentioned the survey finding that institutional responses are not adequate. And I think a lot of it stems from women not knowing where to go.

I had the same experience. In fact, I had a friend outside of medicine ask, "Well, why don't you just go talk to HR?" And I responded, "Well, HR doesn't really exist in academic medicine."

In academic medicine we have division and departmental leadership, the dean's office, and ombudspeople. But, I don't think it's the same as traditional HR in another industry who would normally be out to protect the employee. I feel like in medicine, those routes are really designed to protect the institution.

PK: I made a conscious decision to be transparent with leadership about my experiences. I first spoke with division and departmental leadership and later the dean's office.

I let them know, for actually quite a while, that I was unhappy and that I felt that I was being discriminated against for my gender. I gave them examples of what I described as, pervasive microaggressions and verbal harassment. I was never physically harassed, but all the verbal harassment really added up and created a toxic work environment.

And I think that one of the other challenges with this particular issue is that some of these microaggressions are difficult to prove. And I will admit that. It's hard to provide objective evidence as the experiences are very subjective by definition.

But when it's the same person over and over, and there's a clear pattern of discrimination and harassment, that's when it becomes a problem and hopefully easier to prove.

I think there's a reluctance to discipline the perpetrators when they are full professors, bring in a lot of philanthropic money, have many grants, or have longevity at an institution.

I think it's really difficult to do anything with these people. Again, in any other industry, if someone had behavior like that, they would be fired. In academic medicine, unfortunately, there

is a culture of tolerating and enabling bad behavior.

In our survey we asked, "How do you think institutions could have responded better?" Have you considered solutions to the broken system? What might those look like?

PK: It's long been recognized that gender discrimination and harassment exist in academic medicine. So, moving and pivoting towards solutions is really important. And I personally have made that pivot in my mind and really want to try to help contribute in a positive way.

I think that there are a few ways of doing that. Number one is contributing to objective data around some of these gender disparities and discrimination in the professional workforce. And I think as we can generate some of that objective data, physicians are scientists and make decisions based on data, and so I think that can be helpful.

There are many physicians doing research in this area for example—Dr. Reshma Jagsi, a radiation oncologist at the University of Michigan, Dr. Julie Silver a physical medicine and rehabilitation specialist at Massachusetts General Hospital, and Dr. Shikha Jain a medical oncologist at the University of Chicago. Of note, both Drs. Silver and Jain have started successful leadership conferences for women to provide skills to navigate some of these challenges.

I'm personally trying to contribute to the objective data in this field by examining the gender of PIs on clinical trials in GI Oncology. I'm a clinical trialist, so I thought that would be an interesting way to examine if women are given the same leadership opportunities to

lead clinical trials as men. We're in the middle of that project. I don't have the answer to that yet.

Number two, I agree with the comment that you made about creating clear but trustworthy reporting mechanisms for those who experience harassment.

We've mostly talked about gender discrimination, but harassment can also occur due to sexual orientation, race and other protected characteristics. I think there need to be trustworthy places to go. Many of us who reported instances of harassment have felt that the existing mechanisms are not designed to help the people that are experiencing the harassment.

You mentioned there is often no HR in academia, you have deans and leadership. Respondents to the survey said that they wished that there was this ability to be anonymous in their reporting. Was that an option for you?

PK: I was not aware of an anonymous reporting option at the time. Had there been one, I might have used it. As we develop anonymous reporting mechanisms in the future, we should strive for ones that lead to concrete changes and remediation for harassers.

Gender discrimination and harassment is such a pervasive issue in medicine. I'm clearly not the first woman to have experienced it.

I was discouraged by the perceived lack of action and I think many women are discouraged from reporting for the same reason. If they feel that they're going to go through this effort, which requires being brave and courageous to report, and then nothing's done, that's one of the biggest deterrents to reporting. It indicates a broken system.

I was speaking with Reshma Jagsi, whom you mentioned briefly, about this a couple of weeks ago, and she described this phenomenon that I didn't even realize had a name, but it is called "passing the trash." Have you heard of that?

PK: I've not heard that phrase. But it makes sense.

I'm sure you can assume what it means. You have a harasser at this institution who has either resigned or was let go, but there is no accountability around the matter. There's no announcement about why this happened. This person can therefore go to another institution and have the same issues. From this, it sounds like the system is broken; right?

PK: Well, I think that there are a lot of factors at play. One, is the institution, and I think that there's this unwillingness to call people out, whether they're still at the institution or even after they leave.

I think there's also another interesting phenomenon about an unwillingness of bystanders to speak out. I think they have the same fears around risk of retaliation that we spoke about earlier.

If we can, I'd like to get back to discussing solutions. One of my motivators in speaking out was to normalize talking about gender discrimination and harassment. I had a really unique opportunity to speak out with a lower risk of retaliation because I already had a job lined up at a different institution.

I did not seek out the media. It sort of all just happened. I was a reluctant spokesperson in the beginning but have since embraced the role and feel very empowered.

Following the initial article in the Stanford undergraduate newspaper, the Stanford Daily, one of the San Francisco Bay area local newspapers, The Mercury News, picked up on that story and did a follow-up piece.

I really hope to inspire other women to speak out and encourage everyone, men and women, to have a conversation about this topic. If you are a leader in medicine, whether male or female ask your female team members, are they experiencing gender discrimination and harassment? If yes, ask what you can do.

Just acknowledging that it's there, I think, will start those conversations, and create an environment where it's okay to talk about and it's okay for bystanders to speak up.

I've had things said about me publicly that undermined my leadership. And just I wish someone, whether it had been a male ally, or another leader in the room, had said to the harasser, "Hey, that's not okay." And I think we just need to create an environment where it's okay to do that and call people out on bad behavior.

I'd like to take a step back to clarify some things really quickly. When you reported these microaggressions at Stanford, how exactly did you go about that? Was it an official report that you made, or was it more of a series of conversations?

PK: It was more of a series of conversations. It did get to the point when I spoke

to the dean's office and they launched an investigation on behalf of a series of women who had left Stanford or had also reported some similar things.

Ultimately, that investigation did not happen. I was told that other women were not willing to talk. I think, again, that speaks to this fear of retaliation. I also think that some women didn't want to relive talking about their painful experiences.

Another very common theme that I hear about is, if someone has experienced harassment at a given institution then left, many women, I'm sure, even though they want to help change culture are just like, "I can't relive that, it's like PTSD. I can't talk about it anymore."

On a personal note, I felt that I had brought my complaint up the ladder of reporting as far as I could. Despite that, and despite me saying, "Hey, just because they're not willing to talk doesn't mean things didn't happen," it just didn't go any further. I felt discouraged and demoralized.

Would you mind giving a few examples of what these microaggressions looked like for you?

PK: Yes, I'm happy to. Number one, it took me a while to really acknowledge what was happening to me. I think so many women in medicine normalize being mistreated and put down. I think that it was really when I entered the mid-career stage, and achieved a level of success, I recognized that I was perceived as a threat by some of my male colleagues.

I eventually had a realization that I did not like how I was being treated. In retrospect, I was able to look back on how I had been treated in the pre-

ceding years—an accumulation of microaggressions.

I don't think I was treated that way my entire training and fellowship. I think really it peaked and became a problem when I was perceived as a threat. That's also pretty common among the experiences of women in academic medicine and has been described in the literature.

I'll give you some specific examples. I'm a mom of three sons and had children at various stages in my career. First, I was pregnant at the end of my chief residency, second during fellowship, and third as a junior faculty member.

I remember one of my colleagues making repeated comments, "Oh, you're pregnant again." Or, "Oh, I have to cover your maternity leave again"—really, just derogatory comments about being pregnant. And another example from a colleague, he said, "Oh, your good looks helped get you on that panel"—really just undermining my intellect, and saying that I was selected for aesthetic reasons rather than for my knowledge.

Another example occurred when I served as a course director for a continuing medical education course. While answering some questions at the end of the course, an audience member asked a question and then one of my colleagues said, "Oh, I'm going to let Pam answer first so that I can correct her."

Lastly, I had colleagues try to usurp research opportunities and undermine my ability to lead a program.

For these examples, you might be able to overlook a single instance. However, the constant, repetitive nature of the comments just was too much. It became untenable for me to stay.

That sounds exhausting.

PK: Exhausting. I was talking, actually, with a colleague yesterday about this—and navigating these microaggressions and other forms of harassment takes so much time away from women being productive. I've only been at Yale a couple of months, but these concerns are off my plate, which has been great for my mental health and, frankly, adds so much time back to my day.

That's also something our survey touched on. We asked about the impact of this on professional well-being and on mental well-being. We got a few comments about developing depression.

PK: I think I was clinically depressed at a point, for sure. I was made to feel like I had brought on the harassment. Many harassers have a way of manipulating the situation to make you feel like it's your fault.

Harassment is really about power. And, medicine is especially prey to these power differentials because of the clear and longstanding hierarchy.

You mentioned earlier, but part of what makes it so difficult is that it's hard to document or report these microaggressions. How do you make people take it seriously?

PK: Well, because it's a he-said, she-said thing. And if you have a very senior faculty member who said, "No, I did not do that," it's really, really difficult to prove.

A lot of what we are talking about here is how these instances can really hinder science. You have women working working on teams, and if a harasser is working on these teams, it seems the science is at stake, as well as emotional wellbeing.

PK: You're absolutely right. It's sad that that's the case, but I think women are juggling a lot of responsibilities on top of childcare, and the second shift at home and all these other things, in addition to then having to deal with discrimination in the workplace.

And in your experience talking with leadership at your own institution, in terms of these microaggressions, what do you wish went right? In an ideal world, what do you think should have happened here?

PK: I've had a lot of time to reflect on this. Now that I'm in a leadership role, I really want to do it right and set a tone and a culture that promotes diversity, that really values diversity of opinion and promotes a culture of mutual respect.

I think it is critical to promote more diversity in leadership roles, in terms of race, gender, and other characteristics.

I really was disappointed with the lack of action by my prior institution. Nothing happened to my harassers. Nothing. I had really hoped that something concrete would be done including efforts at remediation. But sadly, I had to leave an institution instead of them having any corrective action towards them.

So, in your instance, was it that they were unresponsive or was it that you weren't even sure that they spoke with your harasser? Do you know what happened there?

PK: I think that there were some small efforts of speaking to the harassers. To my knowledge, there were no concrete actions taken that indicated the discrimination towards me mattered in a significant way.

Academic medicine is a unique industry and I acknowledge that. What could've been done in response to the reports of harassment? Well, I think there's probably a range of acceptable responses other than nothing.

Could there be executive coaching? Could there be disincentives tied to salary or bonuses? Could there be removal of leadership roles and responsibilities?

I think that clear expectations and guidelines need to be set by the institution, and, if violated, institutions need to respond with a zero tolerance policy. This is not discussed enough.

Is there anything else you'd like to add or discuss that you think is really important to this conversation?

PK: I'd like to give an example of one way to promote research in the field of workplace disparities. As I was leaving Stanford, the Department of Medicine developed more leadership roles for women and research seed grants for gender disparities research. This is one way to demonstrate that the institution values such work.

I encourage leaders to think of ways they can encourage that.

Of course. Thank you so much for speaking with me, Dr. Kunz, and kudos to you for coming forward and letting your voice be heard. I think that really does ultimately help others know that they can, too.

PK: Thank you so much. And thank you to the *The Cancer Letter* for conducting this survey. In doing so, you and your team are help to contribute to the objective data and will hopefully help enact change.

Stanford School of Medicine responds:

How did Stanford School of Medicine respond when first notified of Dr. Kunz experiences with gender bias?

Stanford School of Medicine:

The School of Medicine does not provide public comment on confidential reports brought forward by individuals on behalf of themselves or others.

If someone were to report an incident of gender bias now, how would it be different?

Stanford Medicine is dedicated to an environment that is free of sexual harassment and discrimination. We have robust policies in place to ensure the fair and respectful treatment of employees. When any violation of any of these policies occurs, our leadership, in collaboration with University leadership, takes immediate action to fully investigate and respond accordingly.

Could you describe the reporting mechanisms that Stanford has in place? (i.e., what steps are taken? What policies are there?)

Stanford Medicine's process for reporting complaints related to sexual mistreatment follows the process set by Stanford University. Individuals can report to the Sexual Harassment/Assault Response & Education-Title IX Office (SHARE-TIX), to a sexual harassment advisor in the School of Medicine or in any school at the university, to their department chair, to any faculty member, to the office of the vice dean of the School of Medicine, Linda Boxer, or the director of faculty relations, Ellen Waxman. There is no wrong way to report—everyone at the School of Medicine has a duty to take such complaints seriously, and to take appropriate action to advocate for anyone who may be experiencing sexual or gender mistreatment.

When a faculty member at Stanford School of Medicine experiences gender bias—how should they go about reporting this?

Please see the answer to question #3 above.

What steps did Stanford School of Medicine take to remediate the issue?

The School of Medicine does not provide public comment on confidential reports brought forward by individuals on behalf of themselves or others.

What steps has the School of Medicine taken to eliminate gender bias at the institution?

Equal opportunity and a commitment to diversity and inclusion are core to Stanford's mission. The School of Medicine has promoted

the importance of achieving gender diversity on any committee, in faculty searches in the applicant pool—actively reaching out to women in the field—and in leadership roles. Currently 40% of our department chairs are women, the highest ratio among our peer, research-intensive institutions and the third highest of any medical school in the United States. We recognize that more work needs to be done to improve gender diversity at the executive level and across the institution and we are firmly committed to this goal. For example, we've taken significant steps to improve gender pay equity, and engaged an external firm to provide department-wide training in the areas of diversity, inclusion, gender equity and unconscious bias. Sexual harassment prevention training is required every two years for all employees.

What actions have been taken since then?

The School of Medicine has focused on creating and developing systems of support that will achieve meaningful, lasting improvements and opportunities for women in medicine, especially at Stanford.

The 2019 Diversity dashboard, produced by the Office of Faculty Development and Diversity office, shows improvement in our numbers for both women and under-represented minorities over 2018.

As mentioned in the response to question #6 above, 40% of our department chairs currently are women, the highest ratio among our peer, research-intensive institutions and the third highest of any medical school in the United States.

Several of our departments monitor metrics about women and

under-represented minority participation, such as Department of Medicine Grand Rounds speakers (about 50% female in 2019 up from about 25% in 2017). The Department also routinely reports on all diversity metrics in the Annual State of the Department talk by the Chair each year.

We have a new faculty mentoring website with multiple programs that we are rolling out to support our faculty—not only women, of course: <http://med.stanford.edu/oa-mentoring.html>

Are there future steps the school is planning to take?

We continue to strengthen our existing programs mentioned in answer #7 and monitor and track results. We also recognize that discrimination and injustice do not happen in isolation—they intersect across race, gender, gender identity, and sexual orientation. Sexual harassment and gender discrimination, in particular, remain significant problems within the culture of academic medicine. We cannot accept this and must act swiftly to confront these systemic injustices.

In September, we appointed a Commission on Justice and Equity at Stanford Medicine. The Commission includes independent experts who can provide an objective perspective on our issues. It is charged with conducting a thorough review of our current practices and is responsible for recommending actions, which we will share with our community in full transparency.

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Platanias spoke with
Alexandria Carolan, a reporter
with The Cancer Letter.

A



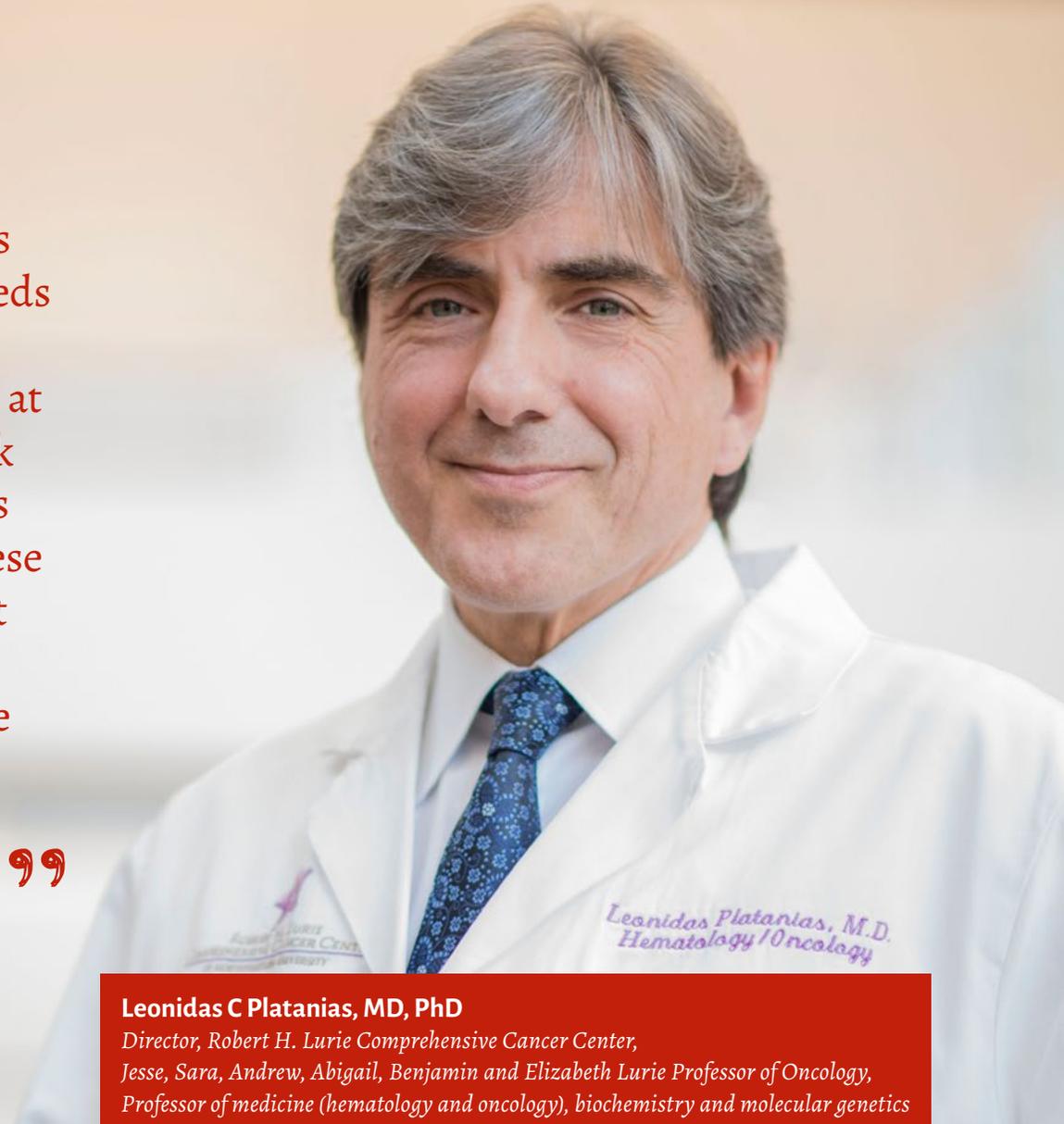
CONVERSATION WITH
THE CANCER LETTER

Leonidas Platanias: These incidents are “really shocking and disturbing”

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This obviously needs to change, and it needs to happen fast. It’s totally unacceptable at all levels. I also think it negatively impacts cancer research. These situations can affect how teams function and, ultimately, have a negative impact in research.

”



Leonidas C Platanias, MD, PhD

Director, Robert H. Lurie Comprehensive Cancer Center,

Jesse, Sara, Andrew, Abigail, Benjamin and Elizabeth Lurie Professor of Oncology,

Professor of medicine (hematology and oncology), biochemistry and molecular genetics

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Leonidas C. Platanias spoke with Alexandria Carolan, a reporter with *The Cancer Letter*:

Alexandria Carolan: With this survey, we compiled a database of cases of gender bias, cases where the system has failed. What is there to learn from this?

Leonidas Platanias: The study as a whole, the incidents of discrimination, harassment—are really shocking and disturbing. It's hard to believe that this type of gender inequity and related issues still exist in our century at the same time as medicine and science continue to advance.

This obviously needs to change, and it needs to happen fast. It's totally unacceptable at all levels. I also think it negatively impacts cancer research. These situations can affect how teams function and, ultimately, have a negative impact in research.

Essentially, this is a compilation of bad reviews. What is there to be learned by knowing how these systems have failed?

LP: I think it is important for all of us and all our institutions to be committed to create an inclusive environment free of bias. To do that, several things have to be in place. There is a lot of activity in that direction here at Northwestern.

People have to first recognize and understand both their conscious and unconscious biases. Then, there should be programs in place to provide information that would bring leaders in the

organization together, to address this important issue.

I think there should be an open dialogue and reflection. We have some examples here at the university, at the medical school level, with town hall meetings, a task force to address inclusion and bias—and other related efforts.

At the end of the day, people need to understand that these things are deeply offensive and wrong, and are clearly utterly unacceptable for any working environment.

What sort of reporting mechanisms for this does Northwestern have in place? How do you go about that?

LP: It's not a mechanism that goes through the cancer center. There is a detailed reporting process and a number of support mechanisms at the university level. There are response teams, websites, and other systems in place to report incidents in a confidential way via the Office of Equity or anonymously via an online portal.

One thing you might be interested to hear is that one respondent, who experienced no incident of gender bias, said Northwestern specifically was a good place to work.

LP: That's good to hear. There has been significant activity to address such issues. There has been a focused effort to proactively provide resources, and foster a supportive environment.

One other thing is that as a director, I have appointed more women to leader-

ship positions in recent years. We now have more women in leadership positions in the cancer center than before, including the deputy director of the cancer center and associate directors.

We also have many women program leaders. The point I'm trying to make is that we are intentional in addressing these very important issues across the cancer center.

And when you see data like these, it's shocking. I think that's the exact word you used.

LP: Yeah. And deeply disturbing, actually.

As a cancer center director, how do you begin to implement changes to improve the systems at work here? What is the first step?

LP: Well, again, one thing is that you have to remember that most cancer centers are matrix cancer centers—and work in cooperation with a medical school and a university. But I think the first thing is to create an inclusive environment, and to try to be free of bias.

This is something that, in order to be successful, has to be a deliberate effort. It has to target unconscious biases, too. We have developed some new programs, conversations with leadership, to get more information—so first of all, leaders understand that, and then they bring it to their faculty as leaders of different units.

The first step is to recognize the problem. The next step is to encourage open dialogue and reflection, and to create

an inclusive, respectful environment that will make it easier to confront attitudes and behaviors, with people at various levels.

Is there anything you'd like to add to the conversation?

LP: You mentioned that reporting can be optimized. That's exactly what needs to happen.

The problem needs to be confronted more aggressively, both at the local levels, at the different university centers, but also at the national level. There are already such efforts, but perhaps there should be a more comprehensive national conversation.

What would something national look like, in terms of NCI, or in terms of the government in general?

LP: In our field, it may be the NCI. Again, it will have to be something that will have a very specific pathway and a very specific purpose.

It shouldn't be something just to show that we are doing something. It should be something that really confronts the problem, to really make sure that there is no discrimination at any level.

Well thank you so much for taking the time to speak with me.

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The first step is to recognize the problem. The next step is to encourage open dialogue and reflection, and to create an inclusive, respectful environment that will make it easier to confront attitudes and behaviors, with people at various levels.

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IN BRIEF



C. Kent Osborne steps down as director of Dan L Duncan Comprehensive Cancer Center



After 15 years in the role, C. Kent Osborne has stepped down as director of the Dan L Duncan Comprehensive Cancer Center at Baylor College of Medicine, the institution said.

He will stay on at Baylor as founding director of the cancer center. Helen Heslop, director of the Center for Cell

and Gene Therapy, will serve as interim director while the search for a new director is underway.

“It has been my honor to serve the Duncan Cancer Center as its director for the last 15 years,” said Osborne, professor of medicine in hematology and oncology and Dudley and Tina Sharp Chair for Cancer Research at Baylor. “Our success is clearly a team effort, and I want to thank everyone from the leadership, cancer center members and staff for their help in getting the center off the ground and to comprehensive designation in record time. I especially want to thank the late Dan L Duncan and his extraordinary family for their transformational \$100 million gift, without which we would not have an NCI-designated Cancer Center today.”

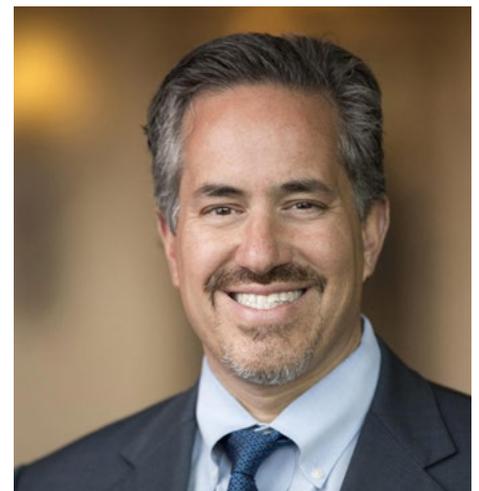
Osborne came to Baylor in 1999 from the University of Texas Health Science Center in San Antonio, starting what is now known as the Lester and Sue Smith Breast Center, a unit of the Dan L Duncan Comprehensive Cancer Center. He brought his expertise in breast cancer patient care and research and a Specialized Programs of Research Excellence (SPORE) NCI grant in breast cancer, now one of the longest running grants of its kind.

Under Osborne’s tenure, the Duncan Cancer Center was awarded the prestigious designation as a Comprehensive Cancer Center by the National Cancer Institute, which was renewed again this year. The comprehensive designation recognizes the center for its depth and breadth of clinical and basic science research, clinical research trials and service to cancer patients from diverse populations in the community. Since the initial NCI-designation in 2007, annual research grant funding at the Duncan Cancer Center has increased to \$170 million from \$99 million.

The Duncan Cancer Center has more than 450 members, including laboratory researchers, surgical, medical and

radiation oncologists, radiologists and pathologists providing comprehensive cancer care. Physicians provide patient care at multiple affiliated hospitals in Houston, including Baylor St. Luke’s Medical Center, Texas Children’s Hospital, Harris Health System and the Michael E. DeBakey Veteran’s Affairs Medical Center.

Ruben Mesa named executive director of the Mays Cancer Center



Ruben Mesa was named executive director of the Mays Cancer Center. His appointment includes academic and research programming, as well as leading the cancer center’s patient care and clinical programs of the UT Health San Antonio MD Anderson affiliation.

Mesa’s appointment broadens the scope of responsibility in coordinating and integrating all aspects of cancer prevention, screening, care and survivorship with practice, education and research across UT Health San Antonio.

Mesa will also lead the integration and development of the inpatient cancer services for the new UT Health San Antonio Multispecialty and Research

Hospital. This expanded appointment is part of the organization's longer-term strategy for the Mays Cancer Center to earn comprehensive status from NCI.

Mays is an NCI-designated Cancer Center. Earning comprehensive status signifies that additional rigorous NCI standards are met.

Stephen Gruber named head of City of Hope's Center for Precision Medicine



Stephen Gruber was named director of City of Hope's newly founded Center for Precision Medicine. He will lead a team of more than 14 researchers focused on personalized cancer prevention and treatment plans.

"City of Hope is at the forefront of precision medicine. We utilize our affiliate TGen's GEM ExTra test to assay all DNA-coding regions and to provide full RNA analysis of the human genome; as a result, we provide the most comprehensive genomic assessment available for clinical cancer testing," said Michael Caligiuri, president of City of Hope National Medical Center and the Deana and Steve Campbell Physician-in-Chief Distinguished Chair. "Dr. Stephen Gruber's previous experience as director of a comprehensive cancer center and international authority in genomic medicine leaves no doubt in my mind that he is the right person to lead our collaborative efforts to provide patients with the most appropriate personalized cancer care."

Gruber is a medical oncologist and an expert in the genetic epidemiology of cancer, and has focused much of his research on solid tumors. At City of Hope, he uses genetics and genomics to drive preventive medicine, population health, clinical medicine, health outcomes and translational innovation.

He will launch a Lynch Syndrome Center of Excellence, making City of Hope the only institution on the West Coast to have specialized focus in this underdiagnosed inherited condition.

"The goal is to diagnose disease earlier when it's more treatable and to treat patients with drugs that minimize or even cure their cancer rather than to prescribe ones that will have no effect on their specific tumor," Gruber said in a statement. "It's too early to disclose the details of our new program, but what I can say is that I'm excited and grateful to be part of the talented team at City of Hope that will usher in a new, personalized way to treat cancer."

City of Hope's precision medicine efforts have been given a boost through its affiliate, the Translational Genomics Research Institute (TGen), which provides access to Ashion and GEMExTra, both of which provide clinical genomic sequencing and analysis technology.

Gruber is a former director of the USC Norris Comprehensive Cancer Center and an attending physician at the cancer center and at Keck Hospital of USC. He was also a professor of preventive medicine at the Keck School of Medicine of USC.

Deirdre Cohen named director of Mount Sinai's Gastrointestinal Oncology Program



Deirdre J. Cohen, an expert in pancreatic and other gastrointestinal cancers, was named director of the Gastrointestinal Oncology Program and medical director of the Cancer Clinical Trials Office at The Tisch Cancer Institute at Mount Sinai Health System.

Cohen will also be an associate professor of medicine (hematology and medical oncology) at the Icahn School of Medicine at Mount Sinai. In these roles, she will conduct translational and clinical research, including studies that build upon scientific discoveries developed at Mount Sinai and collaborating institutions.

As director of the GI Oncology Program, Cohen will foster both clinical and research activities associated with GI cancers across the Mount Sinai cancer sites. She will also oversee the development of clinical trials in her role as medical director of the Cancer Clinical Trials Office.

Prior to joining Mount Sinai, Cohen was on the faculty in the Division of Medical Oncology at New York University for 13 years. Recently, she served as medical director for the Perlmutter Cancer Center Clinical Trials Office and acting director of NYU GI Medical Oncology.

James B. Yu named associate chief medical officer for radiation oncology at Smilow



James B. Yu, was named associate chief medical officer for radiation oncology for Smilow Cancer Hospital and Smilow Cancer Hospital Network.

A professor of therapeutic radiology at Yale School of Medicine and Smilow Cancer Hospital, Yu specializes in treating genitourinary cancers, including kidney, bladder, prostate, and central nervous system cancers and cases requiring Gamma Knife stereotactic radiosurgery.

Yu is a member of the Cancer Outcomes, Public Policy, and Effectiveness Research (COPPER) Center at Yale. Through his work in COPPER, Yu's research centers on the comparative effectiveness of new radiation technolo-

gies and how these new technologies are adopted nationally.

Yale awarded SPORE for head and neck cancer research

Yale Cancer Center researchers were awarded a five-year, \$11.7 million grant from NIH to fund the Yale Head and Neck Cancer Specialized Program of Research Excellence.

The goal of the Yale Head and Neck Cancer SPORE is to address critical barriers to treatment of head and neck squamous cell carcinoma due to resistance to immunotherapy, DNA damaging, and targeted therapy.

The YHN-SPORE is a collaboration with Fox Chase Cancer Center and the University of North Carolina Lineberger Cancer Center, and is one of three SPOREs awarded to YCC.

VICC receives "exceptional" score with renewal as an NCI-designated Comprehensive Cancer Center

Vanderbilt-Ingram Cancer Center received an overall "exceptional" score for its research impact and excellence in patient care.

The renewal of the NCI Cancer Center Support Grant provides Vanderbilt-Ingram more than \$36 million over the next five years to advance research discoveries, to sustain the work of its scientific leadership and administration, and to maintain its infrastructure, including shared resources for cancer investigators.

The grant renewal represents an increase in funding over the previous five-year grant award with new support for research education, training, career development, and community outreach and engagement

This is the fifth renewal of Vanderbilt-Ingram as an NCI-designated Comprehensive Cancer Center, three with Jennifer Pietenpol as director. It is the only Comprehensive Cancer Center in Tennessee providing treatment for adult and pediatric patients, and 1 of only 51 in the country to earn this highest distinction from the NCI. Vanderbilt-Ingram ranks in the top 10 matrix cancer centers nationwide for cancer research grant support, receiving \$141 million in annual cancer-related funding.

"Hundreds of people made this CCSG renewal possible, and I am so appreciative of their hard work," said Pietenpol, director of Vanderbilt-Ingram, executive vice president for research at VUMC, the B.F. Byrd Jr. Professor of Oncology and holder of the Brock Family Directorship in Career Development. "I am proud to work alongside highly talented and dedicated deputy directors, program leaders, associate directors, clinical teams, and researchers dedicated to lessening the cancer burden. The culture of collaboration at Vanderbilt-Ingram, combined with research excellence and high-quality patient care, are the distinctive capabilities with which we lead."

Currently, 283 faculty members are engaged in Vanderbilt-Ingram's research and clinical initiatives. Theresa Sberna, chief business officer for Vanderbilt-Ingram and deputy director for strategy and analytics, and Julie Schaum, director for research administration, lead essential administrative and operational functions for the cancer research enterprise and led the development of systems to orchestrate the collection and presentation of data for the renewal application and site visit.

For patients, an NCI Comprehensive Care Center provides promising new therapies, including clinical trials and a care program focused on excellence. Vanderbilt-Ingram was among the first cancer centers to offer new immunotherapies and targeted therapies, and during the past five years, has led or partnered in 31 FDA-registration clinical trials.

Working in partnership with Meharry Medical College, Tennessee State University, and Federally Qualified Health Centers, Vanderbilt-Ingram continues to identify and address racial disparities in cancer incidence and care. It houses multiple NCI-designated Specialized Programs of Research Excellence (SPORE), including breast and gastrointestinal cancers.

AACR convenes conference on health disparities

The American Association for Cancer Research, in association with the AACR Minorities in Cancer Research Council, will host a virtual meeting on cancer health disparities Oct. 2-4, 2020.

The Virtual 13th AACR Conference on the Science of Cancer Health Disparities in Racial/Ethnic Minorities and the Medically Underserved aims to advance the understanding of, and ultimately help to eliminate, the disparities that represent a major public health problem in the United States.

The meeting program will include discussion of diversity and inclusion in clinical trials; disparities in cancer risk and treatment among the LGBTQ population; cancer prevention and screening in adolescents and young adults; precision oncology in diverse populations; financial toxicity for cancer patients; the impact COVID-19 has had on patients with

cancer; diversifying the cancer research workforce; and more.

The full program is available [here](#). The meeting will build on the themes and data reported in the inaugural [AACR Cancer Disparities Progress Report](#), published Sept. 16, 2020. Read the full report.

Melanoma researchers at UCLA receive \$13M grant from NIH

UCLA researchers have received a \$13 million grant from NIH to find new ways to overcome melanoma resistance to some of the most promising targeted therapies and immunotherapies.

“While these therapies have transformed the way people with melanoma are treated, only about 40% to 50% of people respond to the therapies, and that is not good enough,” said Antoni Ribas, one of the principal investigators on the grant who is a professor of medicine at the David Geffen School of Medicine at UCLA and director of the Tumor Immunology Program at the UCLA Jonsson Comprehensive Cancer Center.

The five-year grant will allow researchers to focus on the biology of therapies and will fund clinical trials to develop new combination therapies to defeat melanoma resistance.

Along with Ribas, Roger Lo, a professor of medicine and director of the melanoma clinic in the UCLA Division of Dermatology, and Thomas Graeber, a professor of molecular and medical pharmacology and director of the UCLA Metabolomics Center, are leading the effort.

The interdisciplinary research team, whose members have been collaborat-

ing for over a decade, will be focusing on three translational research projects:

Understanding the resistance of NRAS-mutated melanomas: Lo is investigating ways to block multiple resistance routes in melanomas with the NRAS gene mutation and to combine and sequence targeted therapies and immunotherapies. By characterizing and co-targeting genomic, epigenomic, proteomic and immunologic alterations that resist therapies, the team will be able to reveal the landscape of resistance.

Targeting ferroptosis to block the de-differentiation resistance escape route: One way cancers escape targeted treatments is to de-differentiate, or change the type of cell they are into an earlier stage of development. This change of identity allows the cells to be less dependent on the pathway that was otherwise being effectively targeted. Graeber is investigating cell subtypes that de-differentiate and have shown sensitivity to a type of self-inflicted cell death called ferroptosis, which can potentially block melanoma cells attempting to take this escape route. Using ferroptosis-inducing drugs in combination with current standard treatments could potentially strengthen the response rate.

Studying resistance mechanisms in PD-1 blockade immunotherapy: This project, led by Ribas, is looking at how interferon-gamma, an immune response-stimulating signaling molecule that helps activate immune cells, guides the treatment response in people with advanced melanoma who are treated with one of the leading immunotherapies, called PD-1 blockade. Understanding how interferon-gamma genes work can potentially be used to predict a response to immunotherapy and for rationalizing new combination treatments that induce interferon signaling that can be used to treat more patients.

Ohio State receives \$10M NCI grant to study impact of COVID-19 in first responders

Researchers at The Ohio State University College of Medicine and The Ohio State University Wexner Medical Center have been awarded a five-year, \$10 million grant from NCI to study the long-term, longitudinal impact of COVID-19 on first responders, health care workers and the general population.

“This is one of the largest grants ever awarded to the College of Medicine,” said Peter Mohler, chief scientific officer for Ohio State Wexner Medical Center and vice dean for research for the Ohio State College of Medicine. It will fund the Center for Serological Testing to Improve Outcomes from Pandemic COVID-19 (STOP-COVID) at Ohio State, a new Serological Sciences Center of Excellence.

With this funding, researchers will learn more about the interactions among exposure risks, transmission, immune responses, disease severity, protection and barriers to testing/vaccination, with the goal of improving population health and clinical outcomes in the face of COVID-19.

“The Center to STOP-COVID will address some of the biggest questions in the field, such as ‘Can people be re-infected with COVID-19 once positive?’ ‘Why are some people more at risk for being infected and symptomatic?’ ‘Does infection with closely related viruses provide immunity or worsen COVID-19 disease outcomes?’ This whole scientific platform is based directly on the data our researchers collected during the earliest days of the pandemic, in March and early April,” Mohler said.

The Center to STOP-COVID will utilize state-of-the-art serological and molecular tests, developed at Ohio State, in a long-term study of first responders, a group at continual high risk of the specific coronavirus that causes COVID-19, as well as their household contacts. It is projected that nearly 2,000 participants will be followed over the five-year period.

“Stopping the spread of COVID-19 will require research that cross-cuts basic, translational and applied sciences,” said Eugene Oltz, chair of the Department of Microbial Infection and Immunity, and lead co-principal investigator for this study.

Joining Oltz as co-principal investigators of the center are Ashish R. Panchal, a professor of emergency medicine, who specializes in prehospital care at Ohio State Wexner Medical Center; Linda J. Saif, a world-renowned expert on coronaviruses at Ohio State’s College of Food, Agriculture and Environmental Sciences and College of Veterinary Medicine, and Ann Scheck McAlearney, a professor of family and community medicine at Ohio State with expertise in population health and applied health services research.

The center is partnering with the Columbus Police Department and Columbus Division of Fire, collaborations that were forged by Daniel Bachmann, associate professor of emergency medicine, and Gerard Lozanski, professor of pathology; Iris Velasco, industrial hygienist with Columbus Police; and Robert Lowe, medical director with Columbus Division of Fire. Center co-investigators include 46 interdisciplinary team members throughout five colleges across the university.

Researchers will learn more about critical aspects of transmission in both asymptomatic and symptomatic individuals; immune, host and viral determinants of disease outcome; and

factors associated with immune protection, including vaccines. They will also identify best practices for communication of test results and information about COVID-19 to improve understanding of risk, transmission and protection, while reducing access barriers to testing and future vaccination opportunities.

“We’re excited to establish this important STOP-COVID Center. We’ll also integrate our center with the broader SeroNet community, consisting of National Cancer Institute testing agencies and other recipients of these grants. This will be invaluable in keeping abreast of current COVID-19 research,” said Oltz, who is also a member of the cancer biology research program in Ohio State’s Comprehensive Cancer Center.

Ohio State receives \$9.1M NCI Grant renewal to support cancer retrovirus research

The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute and The Ohio State University College of Veterinary Medicine have been awarded a five-year, \$9.1 million grant Program Project Grant renewal from NCI.

The PPG grant has been continually funded since 2003 and will allow investigators from the OSUCCC—James, CVM and collaborators at the Washington University - St. Louis Siteman Cancer Center to continue studying retrovirus models of cancer.

The grant renewal extends through 2025 and is led by principal investigator Patrick Green, associate director for basic research at the OSUCCC – James and director of the Center for Retrovirus Research at the CVM.

The goal of this PPG is to use a human T-cell leukemia virus type 1 (HTLV-1) T-cell immortalization model to gain an understanding of the microenvironmental, cellular and viral factors that lead to adult T-cell (ATL) leukemia.

“This is a powerful area of basic research we expect to result in new targets for the treatment of HTLV-1 infection, ATL, and related leukemias and lymphomas,” says Green, who also serves as professor and associate dean for research and graduate studies in the CVM and holds the Robert H. Rainier Chair in Industrial Veterinary Medicine and Research.

“This grant has allowed our multidisciplinary team to advance understanding of how retrovirus proteins contribute to cell immortalization, how retroviruses cause cellular changes that position infected cells to progress to metastatic cancer, and how ATL cells contribute to paraneoplastic disease syndromes and can be targeted for anticancer therapy,” Green adds. “These are important discoveries, and this renewed funding will allow us to continue momentum in this area of cancer research.”

The collaborative research grant is organized around three research projects and three research cores.

Projects include:

- **Role of HTLV-1 HBZ in Transformation and Disease**

(Leader: Patrick Green; Co-I: Amanda Panfil, PhD)

This project will characterize the mechanism of *HBZ* gene products relating to HTLV-1 infection, viral latency and emergence of ATL. The major focus is on identifying and characterizing cellular binding partners that interact with *HBZ* messenger RNA (mRNA) and *HBZ* protein, and to determine the impact of those interactions on viral pathogenesis.

- **Effect of HTLV-1 Viral Oncogenes on the Bone Marrow Microenvironment in ATL**

(Leader: Katherine Weilbaecher; Co-I: Deborah Veis)

This project will define the molecular mechanisms that HTLV-1-transformed cells use to interact with cells in the bone microenvironment, which include osteoblasts, bone marrow stromal cells, macrophage lineage cells and osteoclasts. Researchers also will focus on the relationship between HTLV-1 *HBZ* gene expression and both the Wnt non-canonical pathway (involving *Wnt5a*) and the *HPSE* gene. This work will utilize mouse transgenic and humanized animal models to evaluate the relevance of these pathways on HTLV-1 bone pathology.

- **Role of CTCF in HTLV-1 Replication and Transformation**

(Leader: Lee Ratner)

Researchers will determine if and how the *CTCF* gene modulates the behavior of HTLV-1-infected T cells as it relates to virus expression, *HBZ* gene regulation, methylation of provirus elements, site of virus integration and effect on surrounding host genes.

The PPG also supports administrative/biostatistics, virus vector and animal research cores relating to this ongoing retrovirus research.

Co-investigators in the PPG include: Amanda Panfil, PhD, Stefan Niewiesk, DVM, PhD, and Krista La Perle, DVM, PhD, from the CVM; Kristine Yoder, PhD, Soledad Fernandez, and Lianbo Yu, PhD, from Ohio State’s College of Medicine; Amanda MacFarlane, PhD, from the OSUCCC – James; and Lee Ratner, MD, PhD, Katherine Weilbaecher, MD, and Deborah Veis, MD, PhD, from Washington University. Panfil, Niewiesk and La Perle are in the Leukemia Research Program at the OSUCCC – James, where Yoder is in the Molecular Carcinogenesis and Chemoprevention

Program, and Fernandez is in the Cancer Biology Program.

Cancer genomic screening program LC-SCRUM-Asia adopts latest Thermo Fisher Scientific NGS solutions

LC-SCRUM-Asia, a cancer genomic screening program, has selected Thermo Fisher Scientific’s [Ion Torrent Genexus System](#) and [Oncomine Precision Assay](#), a pan-cancer panel, to advance precision medicine in Asia.

The next-generation sequencing solutions will be used in two prospective, observational projects to support the development of future therapeutics and diagnostics for non-small cell lung cancer.

The Lung Cancer Genomic Screening Project for Individualized Medicine in Asia aims to overcome challenges in establishing precision medicine for patients with NSCLC through large-scale genetic screening and monitoring. The Lung Cancer Genomic Screening Project for Individualized Medicine—Molecular Testing for Resistant Tumors to Systemic Therapy (LC-SCRUM-TRY), launched on September 28, is designed to examine drug resistance in NSCLC.

“The studies will use the Genexus System and the Oncomine Precision Assay for rapid molecular profiling results,” said Dr. Koichi Goto, chief of the Department of Thoracic Oncology, National Cancer Center Hospital East, who is leading the cancer clinical trials. “The speed of NGS-based molecular profiling tests is becoming increasingly important. We believe these solutions, designed to deliver results

quickly, will transform the field of precision oncology.”

Thermo Fisher’s Ion Torrent Genexus System features an automated specimen-to-report workflow that delivers results economically in a single day. The Oncomine Precision Assay, which is designed to detect key biomarkers from formalin-fixed paraffin-embedded (FFPE) tissue and liquid biopsy specimens, contains more than 50 cancer-related biomarkers and has the lowest sample input requirements on the market for detection of both DNA and RNA variants.

The selection of the Genexus System and Oncomine Precision Assay represent an extension of Thermo Fisher’s ongoing collaborations with LC-SCRUM and Goto to make precision medicine solutions available in Japan. Since 2015, LC-SCRUM has adopted the [Oncomine Comprehensive Assay](#)* for use in the first three phases of clinical trials. In addition, Goto was instrumental in supporting Thermo Fisher’s efforts to gain approval in Japan for the [Oncomine Dx Target Test](#), the first NGS companion diagnostic test approved by the Ministry of Health, Labor and Welfare to simultaneously detect multiple biomarkers clinically associated with NSCLC.

ACS CAN: Executive order on pre-existing condition protections unlikely to help cancer patients and survivors

As part of a broader health care package, the Trump administration Sept. 24 issued an executive order to preserve health coverage protections for people with pre-existing conditions should the Supreme Court invalidate the Affordable Care Act.

A statement from Lisa Lacasse, president of the American Cancer Society Cancer Action Network follows:

“The executive order on pre-existing conditions falls far short of the protections already in place under the Affordable Care Act. The ACA’s rules against insurance denials or sky-high premiums based on someone’s health history have, for the last decade, been an essential lifeline to millions of American cancer patients and survivors.

“These patients cannot go back to a world wherein their ability to access life-saving treatment is tied to an insurance market that is again allowed to restrict, rescind or reject their care. Should the administration succeed in its case to throw out the law, the executive order will offer no guaranteed patient protections in its place.”

FUNDING OPPORTUNITIES



Lymphoma Research Foundation announces \$10M initiative for follicular lymphoma clinical research

The Lymphoma Research Foundation has announced the establishment of the Jaime Peykoff Follicular Lymphoma Initiative, named for follicular lymphoma survivor and wife of Andrew Peykoff II, owner of Niagara Bottling.

Established through the gift of the Peykoff Family and Niagara Cares, the \$10 million initiative is designed to convene experts in follicular lymphoma research and patient care, accelerate therapeutic development, and to drive direct investment in clinical research.

LRF assembled a steering committee comprising FL experts to provide thought leadership for the Initiative. This multidisciplinary, multi-institutional panel will ensure all key stakeholders are informed of the initiative’s goals and identify the most significant areas of unmet needs in clinical FL research. The initiative’s steering committee includes the following:

- Andrew D. Zelenetz, MD, PhD, Memorial Sloan Kettering Cancer Center, Chair
- Sonali M. Smith, MD, The University of Chicago Medical Center, Vice Chair
- Stephen Ansell, MD, PhD, Mayo Clinic, Rochester
- John P. Leonard, MD, Weill Cornell Medicine
- Brian Link, MD, University of Iowa, Holden Comprehensive Cancer Center
- Laura Pasqualucci, MD, Columbia University Medical Center
- John Timmerman, MD, UCLA Jonsson Comprehensive Cancer Center

LRF will develop an international scientific workshop to drive collaboration. Follicular lymphoma thought leaders would share early research findings,

discuss the results of pivotal clinical trials, and engage in planning exercises designed to advance FL research.

Under the leadership of the Jaime Peykoff Follicular Lymphoma Initiative Steering Committee and the LRF SAB, LRF will fund both Clinical Investigator Career Development Awards and Senior Investigator Grants to attract senior and early-career investigators and train them in the field of FL research.

For more information about the Jaime Peykoff Follicular Lymphoma Initiative or additional LRF research programs, visit www.lymphoma.org/research.

The Mark Foundation for Cancer Research launches drug discovery partnerships

The Mark Foundation for Cancer Research is announcing the launch of a funding program that supports the development of novel cancer therapeutics in areas with high unmet needs. These Drug Discovery Partnership awards are structured to support high-risk, high-reward research and bridge the substantial gap in advancing promising academic discoveries to novel therapies.

Two projects have been initially selected for funding:

- A team at the **Dana-Farber Cancer Institute led by Sara Buhrlage, PhD** is developing a best-in-class inhibitor of the USP7 enzyme for the treatment of Ewing sarcoma, a rare cancer of the bone and soft tissue that affects children and young adults. USP7 is a deubiquitinating enzyme or “DUB” a class of proteins that regulate cellular

protein homeostasis and play an important role in diseases including cancer. Over the past decade there has been much interest targeting DUBs with small molecule therapeutics, however progress has been slow due to issues with specificity and selectivity. Buhrlage’s lab has discovered a new series of potent and selective USP7 inhibitors that will be optimized preclinically and hopefully bring new therapeutic treatments to the clinic to help treat this devastating childhood cancer. More information on the [USP7 project](#) can be found on the MFCR website.

- A team at **MD Anderson Cancer Center’s Institute for Applied Cancer Science, part of the institution’s Therapeutics Discovery division, led by Philip Jones, PhD** is developing what could be the first inhibitor of the transcriptional co-activator CBP/p300 to be tested clinically in genetically defined leukemias. CBP and p300 proteins are both epigenetic regulators that can read and write certain epigenetic marks on histone proteins and have been linked to the development of cancer and other diseases. The IACS team at MD Anderson has discovered a highly selective series of CBP/p300 bromodomain inhibitors and will now focus on preclinical development. More information on the [CBP/p300 project](#) can be found on the MFCR website.

MFCR Drug Discovery Partnerships are focused on key milestones along the continuum from target identification to preclinical development and initial regulatory filings. Projects will typically be supported for 1–3 years with budgets aligned to detailed research plans and award payments made based on milestone achievements. For these initial two projects, up to \$4.6M total

is expected to be awarded over the next two years.

The scientists at MFCR will also take advantage of their experience working with contract research organizations and other industry partners to provide grantees access to state-of-the-art drug discovery and development capabilities.

Since 2017, MFCR has awarded over \$95 million in grants to enable innovative basic, translational, and clinical cancer research, including early-stage drug discovery. MFCR also has a growing investment portfolio that includes drug discovery companies Accent Therapeutics (focused on RNA-modifying proteins implicated in cancer) and Verseau Therapeutics (developing macrophage-targeting immunotherapies), as well as liquid biopsy diagnostics companies Czi Genomics and GRAIL.

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THE CLINICAL CANCER LETTER



TRIALS & TRIBULATIONS

The cancer detection rate—a public health approach to early detection



Joshua J. Ofman, MD, MSHS

*Chief medical officer and external affairs,
GRAIL Inc.*



Azra Raza, MD

*Chan Soon-Shiong Professor of Medicine,
Director of the Myelodysplastic Syndrome Center,
Columbia University;
Author, *The First Cell: And the Human Costs of Pursuing Cancer to the Last**

Back in the 1960s, the American Cancer Society first began promoting the Pap smear as an effective means of cervical cancer screening. A decade later, early detection of breast cancer through mammography became mainstream.

By the 1990s, colorectal cancer screening had been shown to be effective, and this decade, screening for lung cancer was found to reduce mortality. Despite this progress, that in each case has taken massive effort and excruciatingly long clinical studies, cancer is predicted to become the world's number one killer.

This is not a failing of the existing screening approaches as much as it is a product of the fact that most cancers that eventually claim people's lives are ones we do not screen for, and they are only detected when signs or symptoms are present, usually signifying advanced disease.

In reality, the various single cancer screening tests, combined with their respective rates of compliance and test performance, results in approximately 15% of the 1.3 million cancers diagnosed each year, being detected early among those aged 50-79. And finding those cancers is inefficient, with \$25 billion spent annually to identify approximately 206,000 cancers while spinning off nearly 8.7 million false positive results.

What, then, to do about all of the other cancers we still need to detect? There are some traditional medical approaches—when it comes to cancer screening, it is test sensitivity that should be maximized.

If someone has cancer, the screening test should find it. But when it comes to specificity, or its mirror image, the false positive rate, it is okay if screening tests fall far short of perfection. Managing “false positives” falls under the art of medicine, and doctors and patients can deal with them, the argument goes.

This high sensitivity and suboptimal specificity approach to cancer screening has worked until today, despite the high burden of false positives it produces, because cancer screening has been pursued tumor type by tumor type. But it has meant that each new screening approach has taken decades to be adopted into a reliable workflow. Infrastructure and care maps had to be created for this to occur, in particular, to mitigate harms from false positives for those screening tests.

But if we view the cancer morbidity and mortality as a public health problem rather than a clinical one, the paradigm shifts. In that respect, our problem is not unlike that of population management of the novel coronavirus, where it is widely agreed that we need to dramatically increase testing and detection, so that we can get control of this public health crisis.

To do this, we need to open the aperture from just looking at test characteristics (like sensitivity), and begin to look at infection detection rates in the population. The same approach needs to be taken with cancer. It is well recognized that improving early cancer detection may be the only way to really put a dent in the cancer mortality curve.

Some may assume that we aren't screening for these cancers because we don't have treatments. But that is not correct: nearly all cancers have effective surgical, radiation, or therapeutics available, even at early stages.

So, what if we developed a different approach? What if we could transition from screening for individual cancers and start screening individuals for all their cancers? What if we dramatically improved overall cancer detection? What if we tracked the Cancer Detection Rate (CDR) in the population?

First, let's define the CDR. It is the number of cancers detected divided by the

number of cancers expected in the population monitored. This could be applied to health systems, metropolitan statistical areas, states and countries. So, it is a population sensitivity measure normalized for cancer incidence.

Using the U.S. as an example, if the population is 107 million Americans between age 50-79, the CDR for mammography would be 9%, because it detects approximately 117,000 cancers of the 1.3 million expected. Similarly, with stool-based colorectal cancer screening, the CDR is about 6% (69,000 detected). So, even when all five single cancer screening tests are combined, the CDR is approximately 16% (206,000 detected), and it is clear that, while an enormous accomplishment, this alone will not bend the cancer mortality curve or address the public health crisis that is cancer.

With the genomic revolution and advances in machine learning, there are now several multi-cancer early detection (MCED) tests near commercial use, and the CDR may be the right way to assess our national progress.

The MCED test from GRAIL, with validation results recently published in the *Annals of Oncology*, has the ability to detect over 50 cancer types with good sensitivity, and with a false-positive rate less than 1%. And there are other tests in development as well that can detect from 8-10 cancers.

For the majority of cancers that have no currently recommended screening, they are only detected by happenstance, when they are not causing clinical symptoms. That means that even an average multi-cancer sensitivity of 30-50% for some early stage cancers is a step change improvement. Such a test would be used in concert with existing single cancer screening tests, using an annual blood draw, which approximately 70% of Americans aged 50-79 receive each year.



Some may assume that we aren't screening for these cancers because we don't have treatments. But that is not correct: nearly all cancers have effective surgical, radiation, or therapeutics available, even at early stages.



If everyone took the annual blood test that detects 50 cancers in addition to current screening, our calculations estimate that it could produce a CDR of 50% for all cancers and 75% for the deadliest cancers (e.g. those with 5-year survival less than 50%).

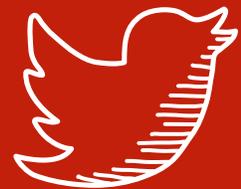
Why is MCED such a profound idea? Because developing and testing a new screening approach for each individual cancer, then building capacity to manage the downstream complications and false positives, is unworkable.

The new MCED tests take advantage of aggregate cancer prevalence and low false-positive rates to dramatically improve the predictive value of positive blood tests, nearly an order of magnitude better than many single cancer tests in terms of the cancer detection rate. Since these tests detect common cancer signals, they by nature may detect cancers for which there is low incidence and, thus, never have single cancer screening tests developed that would be cost-effective.

So, these tests may miss some cancers, thus they must be used in addition to existing single cancer screening. But today, there is no approach to early detection of most cancer killers, and so, from a population health perspective, even a 50% average sensitivity across cancers could lead to the discovery of many cancers prior to their clinical diagnosis, and potentially at earlier stages where treatments are more effective and potentially curable.

The advent of technological innovation provides an opportunity for us to evolve our approach. But we need to learn the lessons from decades of cancer research and the public health challenges posed by COVID-19. Just as we track COVID-19 infection rates, detection rates, and death rates by city, state, and nation, we need to embrace the CDR, and track our progress in early cancer detection.

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CLINICAL ROUNDUP



Corticosteroids improve survival in critically ill COVID-19 patients

An international team led by clinician-scientists at UPMC and the University of Pittsburgh School of Medicine have pooled data from 121 hospitals in eight countries to find that inexpensive, widely available steroids improve the odds that very sick COVID-19 patients will survive the illness.

The findings were made through the “Randomized Embedded Multifactorial Adaptive Platform-Community Acquired Pneumonia” (REMAP-CAP) trial and are reported in *JAMA* as part of a four-article package. The World Health Organization is updating its COVID-19 treatment guidance as a result.

REMAP-CAP includes the [UPMC-REMAP-COVID19 trial](#), the only U.S.-based trial to test corticosteroids — a class of drug that lowers inflammation and modulates immune system activity — for treating critically ill COVID-19 patients. [An analysis combining the REMAP-CAP data with that from six other randomized controlled trials](#) to test

corticosteroids reinforces [the results of the UK RECOVERY trial](#) reported in June, which found the steroid dexamethasone reduced deaths by 29% in ventilated COVID-19 patients.

“It is relatively rare in medicine that you find drugs where the evidence of their effectiveness in saving lives is so consistent,” lead author Derek Angus, chief health care innovation officer at UPMC and professor and chair of the Department of Critical Care Medicine at Pitt, said in a statement. “This is, in many respects, the single clearest answer we’ve had so far on how to manage terribly ill COVID-19 patients. People on ventilators or oxygen and under intensive care should definitely be given corticosteroids.”

Between March and June, the REMAP-CAP corticosteroid trial randomized 403 adult COVID-19 patients admitted to an intensive care unit to receive the steroid hydrocortisone or no steroids at all. The trial found a 93% probability that giving patients a seven-day intravenous course of hydrocortisone would result in better outcomes than not giving the steroid. The results were consistent across age, race and sex.

REMAP-CAP and the other corticosteroid trials did not test the drugs in non-hospitalized patients with COVID-19 who did not need respiratory support. Steroids currently are not recommended for these patients because they can dampen the immune system and have serious side effects. In addition, the REMAP-CAP corticosteroid trial was mostly conducted in resource-rich countries across Europe, North America and Australasia, so the findings may not translate to low- and middle-income countries.

Because it is designed to simultaneously test multiple combinations of potential therapies—as opposed to the traditional, slow clinical trial process that tests one therapy at a time—REMAP-CAP is particularly well-suited for

rapidly identifying effective treatments during the COVID-19 pandemic. It is currently testing thousands of different treatment regimens, including various doses and combinations of vitamin C, convalescent plasma, blood thinners, antivirals and immune modulators.

“REMAP-CAP and our findings on corticosteroids are possible because of a global community of clinicians and scientists coordinating and sharing data across different languages and countries,” said co-author Christopher Seymour, M.D., UPMC intensivist and director of the Translational and Clinical Science Program at the Clinical Research, Investigation and Systems Modeling of Acute Illness (CRISMA) Center in Pitt’s School of Medicine. “This is how we get definitive answers as fast as possible on how to best treat patients. Outcomes in Amsterdam are helping patients at UPMC Altoona.”

Timothy Girard, M.D., Christopher Horvat, M.D., David Huang, M.D., Kelsey Linstrum, M.S., and Stephanie Montgomery, M.S., all of Pitt’s CRISMA Center, also contributed to this research.

Additional authors on the JAMA publication are from the Raymond Poincaré Hospital – AP-HP (Greater Paris University Hospitals), University of Versailles and University Paris Saclay, all in France; King Saud Bin Abdulaziz University for Health Sciences in Saudi Arabia; Imperial College London, Imperial College Healthcare NHS Trust, University of Oxford, Bristol Royal Infirmary, University of Bristol, NHS Blood and Transplant, Queen’s University Belfast, and Intensive Care National Audit & Research Centre, all in the UK; Berry Consultants, LLC, the Global Coalition for Adaptive Research, University of California at Los Angeles and Harbor-UC-LA Medical Center, all in the U.S.; St. Michael’s Hospital of Unity Health Toronto, Université de Sherbrooke, University of Toronto, University Health Network, University of British Columbia

and University of Manitoba, all in Canada; Jena University Hospital in Germany; Monash University, Alfred Health, Princess Alexandra Hospital University of West Australia, The George Institute for Global Health and St. John of God Hospital, all in Australia; University Medical Center Utrecht, University of Amsterdam and Radboud University Medical Center, all in the Netherlands; Antwerp University Hospital in Belgium; Network for Improving Critical Care Systems and Training in Sri Lanka; Mahidol Oxford Tropical Medicine Research Unit in Thailand; Auckland City Hospital, The Health Research Council of New Zealand and University of Auckland, all in New Zealand; and St. Vincent's University Hospital and University College Dublin, both in Ireland.

This research was funded by The Platform for European Preparedness Against (Re-) emerging Epidemics (PREPARE) consortium FP7-HEALTH-2013-INNOVATION-1 (#602525), the Australian National Health and Medical Research Council (#APP1101719 and #1116530), the New Zealand Health Research Council (#16/631), the Canadian Institute of Health Research Strategy for Patient-Oriented Research Innovative Clinical Trials Program Grant (#158584), the UK National Institute for Health Research (NIHR) and the NIHR Imperial Biomedical Research Centre, the Health Research Board of Ireland (CTN 2014-012), the UPMC Office of Healthcare Innovation, the Breast Cancer Research Foundation, the French Ministry of Health (PHRC-20-0147), and the Minderoo Foundation.

Phase III trial shows Opdivo significantly improves DFS as adjuvant therapy for muscle-invasive urothelial carcinoma

Bristol Myers Squibb said CheckMate -274, a pivotal phase III trial evaluating Opdivo (nivolumab) after surgery in patients with high-risk, muscle-invasive urothelial carcinoma, met its primary endpoints of improving disease-free survival (DFS) versus placebo in both all randomized patients and in patients whose tumor cells express PD-L1 $\geq 1\%$ (programmed death-ligand 1).

CheckMate-274 is the first and only phase III trial in which immunotherapy has reduced the risk of relapse in the adjuvant setting for these patients.

“With currently available therapies, more than 50% of patients with bladder cancer will experience recurrence after surgery, and each year, the disease takes the lives of nearly 200,000 patients,” said Matthew Galsky, professor of medicine, director of genitourinary medical oncology, director of the novel therapeutics unit, and co-director of the Center of Excellence for Bladder Cancer at The Tisch Cancer Institute and the Icahn School of Medicine at Mount Sinai.

“Advances like immunotherapy have helped bring hope to patients across a growing number of cancer types, including previously treated advanced urothelial carcinoma. The positive results from CheckMate -274 point to the potential for nivolumab to become a new standard of care in the adjuvant setting, extending disease-free survival for post-surgery patients with muscle-invasive urothelial cancer without the use of chemotherapy.”

BMS plans to complete a full evaluation of the CheckMate -274 data, work with investigators to present the results at an upcoming medical conference, and submit the data to health authorities. The CheckMate -274 trial will continue as planned to allow for future analyses of secondary endpoints, including overall survival and disease-specific survival.

Yale study reinforces benefit of using targeted therapy for early-stage NSCLC

Treatment with the targeted therapy osimertinib following surgery continues to significantly improve disease-free survival in patients with early-stage, non-small cell lung cancer with epidermal growth factor receptor gene mutation, according to updated findings led by researchers at Yale Cancer Center.

The benefit of osimertinib treatment demonstrated earlier this year in the ADAURA trial was so substantial that the independent data monitoring committee recommended early unblinding of the multinational randomized controlled phase III trial. The latest findings are to be presented September 19 at 12:30 p.m., during the virtual science program at the annual meeting of the European Society for Medical Oncology. The results are also to be published online in the *New England Journal of Medicine* at the same time.

“These updated results from the ADAURA trial once again demonstrated a statistically significant and clinically meaningful improvement in disease-free survival in the adjuvant treatment of patients with early-stage EGFR mutations for NSCLC,” said Roy S. Herbst, chief of Medical Oncology at YCC and Smilow Cancer Hospital and senior author of the study. “It’s so critical to provide patients with this type of lung cancer a new treatment option.”

ADAURA is a phase III, randomized trial that looked at adjuvant therapy with osimertinib, a third-generation EGFR-TKI, versus placebo, in treating patients with Stage IB through IIIA EGFR-mutated non-small cell lung cancer. The trial results showed that osimertinib offered a two-year, 89% DFS for patients

with resected lung cancer (stage IB/II/IIIA) compared to a DFS rate of 52% in patients randomized to treatment with placebo, with manageable side effects.

Disease-free survival measures the time from randomization to first sign of cancer recurrence or death. In this trial, patients treated with osimertinib had a 79% reduction in the risk of their cancer returning or death. The study will continue to follow patients for overall survival outcomes.

“In the past, we haven’t had much success fighting recurrence in the liver, lung and brain of NSCLC in patients with EGFR mutations,” said Herbst. “These study results will hopefully be practice-changing and have a huge impact on patient care.”

This study was funded by AstraZeneca.

DRUGS & TARGETS



Innova Therapeutics receives Rare Pediatric Disease Designation from FDA for IVT-8086 for Osteosarcoma

FDA has granted Rare Pediatric Disease Designation for IVT-8086 for the treatment of Osteosarcoma.

IVT-8086 is a humanized monoclonal antibody with high affinity to a novel anticancer target, secreted frizzled-related protein 2.

The agent is sponsored by Innova Therapeutics Inc.

“IVT-8086 has the potential to become the first FDA-approved therapy for individuals with osteosarcoma in over 30 years,” Robert Ryan, CEO of Innova Therapeutics, said in a statement.

The underlying research was conducted in the laboratory at the Hollings Cancer Center at the Medical University of South Carolina (MUSC) by Nancy Klauber-DeMore, who is a co-founder and professor of surgery and BMW Endowed Chair of Cancer Research.

Celyad Oncology collaborates with MSD to evaluate CYAD-101 with Keytruda in microsatellite stable mCRC

Celyad Oncology SA, a clinical-stage biotechnology company focused on the discovery and development of chimeric antigen receptor T cell therapies for cancer, has entered into a clinical trial collaboration with Merck & Co., Inc., through a subsidiary.

Celyad Oncology will conduct the Phase 1b KEYNOTE-B79 clinical trial, which will evaluate Celyad Oncology’s investigational non-gene edited allogeneic CAR T candidate, CYAD-101, following FOLFIRI (combination of 5-fluorouracil, leucovorin and irinotecan) preconditioning chemotherapy, with MSD’s anti-PD-1

therapy, Keytruda (pembrolizumab) in refractory metastatic colorectal cancer (mCRC) patients with microsatellite stable (MSS) / mismatch-repair proficient (pMMR) disease.

“We are extremely pleased to enter into this clinical collaboration with MSD, as we believe the mechanism of actions of CYAD-101 and Keytruda are highly complementary and could help to drive meaningful clinical benefit in patients with advanced metastatic colorectal cancer, in particular with microsatellite stable disease where a high unmet medical need exists” said Filippo Petti, CEO of Celyad Oncology. “In addition, the collaboration with MSD adds an important dimension to our clinical program for CYAD-101 for the treatment of mCRC and provides us with the opportunity to build upon the encouraging clinical activity we’ve reported to date from the ongoing alloSHRINK trial.”

University of Illinois scientists enter licensing deal with Bayer, Systems Oncology

Researchers affiliated with the Cancer Center at Illinois discovered a novel small molecule compound that is now the subject of a new global licensing agreement between the pharmaceutical company Bayer AG and the cancer drug development company Systems Oncology LLC.

Systems Oncology originally licensed the IP related to the compound in 2018, and this new deal will now give Bayer the exclusive rights to develop the compound, currently called ERSO, as a cancer therapy. This compound was originally discovered by the laboratories of Paul Hergenrother, a professor of chemistry at the University of Illinois,

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Urbana Champaign, and U of I biochemistry professor David Shapiro.

Their research was the first to show that the compound can effectively target and kill certain cancer cells, especially breast cancer cells that express the estrogen receptor. An estimated 70% of women diagnosed with breast cancer have ER-positive breast cancer. According to Dr. Hergenrother, these types of breast cancer cells are very sensitive to ERSO, which rapidly and selectively kills these cancer cells.

In 2016, U of I first partnered with Systems Oncology to advance another small molecule invented by Dr. Hergenrother towards the clinic, so when it came to selecting an industry collaborator to drive the development for ERSO, the decision was made in 2018 to partner again with the Systems Oncology team.

CCIL member, Erik Nelson, a professor of molecular and integrative physiology, provided essential guidance to the scientists through their tumor studies. CCIL Research Program Leader, Timothy Fan, a professor of veterinary clinical medicine at Illinois, was their expert in toxicology and pharmacology.

Elevation Oncology and US Oncology Research collaborate to expand genomic testing of solid tumors

Elevation Oncology, a clinical stage biopharmaceutical company focused on the development of precision medicines for patients with genomically defined cancers, and US Oncology Research, one of the largest community-based oncology site management organizations in the U.S., announced a collaboration to utilize the US Oncology Research Selected Trials for Accelerated Rollout (STAR) program

for patient enrollment in the registration-enabling Phase 2 [CRESTONE](#) study for patients with solid tumors of any origin that have an NRG1 gene fusion.

“The ability to accurately detect rare genomic driver alterations in a patient’s tumor and subsequently open up a clinical study site in response, is paramount to bringing precision therapy opportunities to patients that may benefit from treatment,” said Shawn Leland, founder and chief business officer of Elevation Oncology. “US Oncology Research is ideally positioned to expand the reach of the CRESTONE study for patients with cancers harboring an NRG1 gene fusion for investigational treatment with seribantumab. A key component of this collaboration is the ability to quickly open CRESTONE clinical trial sites via the US Oncology Research STAR program, which minimizes patient travel and disruption in clinical care, a major advantage particularly given the current travel complexities due to COVID-19.”

The STAR program opens and activates clinical trials quickly across all cancer research sites managed by US Oncology Research. STAR is an operational model that allows for pre-screening of potentially eligible subjects upfront and only opens sites where subjects are identified. When a potential STAR trial patient is identified at a facility, the practice is trained in the details of the trial, and the study is opened within a two-week timeframe at the location where the patient will be treated.

US Oncology Research serves approximately 60 research sites and more than 165 locations, managing about 400 active trials at any given time.

Patients and physicians can learn more about the CRESTONE study at www.nrg1fusion.com or on www.ClinicalTrials.gov under the NCT number [NCT04383210](https://clinicaltrials.gov/ct2/show/study/NCT04383210).

NCI TRIALS



NCI Trials for Oct. 2020

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

For further information, contact the principal investigator listed.

Phase I - 10410

A Phase 1 Study of IPdR in Combination with Capecitabine and Radiotherapy in Rectal Cancer

University Health Network Princess Margaret Cancer Center LAO
Kinsella, Timothy James
(401) 444-6203

Phase II - 10398

A Phase 2 Study of Anti-PD-L1 Antibody (Atezolizumab) in Chondrosarcoma and Clear Cell Sarcoma

National Cancer Institute LAO
Chen, A P
(240) 781-3320

Phase II - S2000

A Randomized Phase 2 Trial of Encorafenib + Binimetinib + Nivolumab Vs Ipilimumab + Nivolumab in BRAF-V600 Mutant Melanoma with Brain Metastases

SWOG
Eroglu, Zeynep
(813) 745-8581

Phase II/III - EA2197

Optimal Perioperative Therapy for Incidental Gallbladder Cancer (OPT-IN): A Randomized Phase II/III Trial

ECOG-ACRIN Cancer Research Group
Maithel, Shishir Kumar
(404) 617-7936

Phase III - EA2176

A Randomized Phase III Study of Immune Checkpoint Inhibition with Chemotherapy in Treatment-Naïve Metastatic Anal Cancer Patients

ECOG-ACRIN Cancer Research Group
Eng, Cathy
615-936-0809

Phase III - EA5182

Randomized Phase III Study of Combination AZD9291 (Osimertinib) and Bevacizumab Versus AZD9291 (Osimertinib) Alone as First-Line Treatment for Patients with Metastatic EGFR-Mutant Non-Small Cell Lung Cancer (NSCLC)

ECOG-ACRIN Cancer Research Group
Yu, Helena A.
(646) 888-4274

Phase III - NRG-HN007

An Open-Label, Phase III Study of Platinum-Gemcitabine with or Without Nivolumab in the First-Line Treatment of Recurrent or Metastatic Nasopharyngeal Carcinoma

NRG Oncology
Ma, Brigitte Buig-Yue
852-35052118

Phase Other - 10323

Cancer Moonshot Biobank Research Protocol

Division of Cancer Treatment and Diagnosis
Moore, Helen M.
(240) 276-5713

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