

## Editorial

# “I’m in a New York State of Mind”

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It is an honor for me to present to you today.

First, let me set the record straight. My priorities in life have been very simple. They have been God, family, country, the New York Yankees, and the University of Notre Dame. Nothing else in my life has mattered. Certainly, my friends are in the category of family. Notice that medicine is not on this list, nor will it ever be on this list. However, a subgroup of individuals in medicine is part of my family, and I will talk about them at the end of this presentation.

It has been an honor and privilege to be your President over the past year. It is traditional to start presidential addresses by thanking individuals, and, as I have stated before, I have never been traditional, but I am breaking my rule this morning. I would not be standing before you if it wasn't for several individuals that I need to thank. First and foremost, I would like to thank my family. I'd like to thank my wife, Cathy, and my two daughters for tolerating a lot of my antics over the years. They indeed are the love of my life, although at times I know it didn't seem that way.

My academic career would not be what it is if it wasn't for my 23 years at the Roswell Park Cancer Institute. There are many individuals to thank, but I would like to especially mention four. Arnold Mittelman who was my mentor for 28 years and my father away from home. I miss him. Harold Douglass, former Chief of the GI Surgical Service at Roswell Park, and Hector Nava, Associate Chief of GI and probably one of the best endoscopists in the country. I have one story that I would like to share with you concerning Dr. Harold Douglass. Soon

after I was appointed Chief of Surgical Oncology at Roswell Park, an anesthesiologist had been diagnosed with liver metastases from colon cancer. The anesthesiologist asked me, Harold Douglass, and Hector Nava to scrub on the case. Keep in mind that both Harold Douglass and Hector Nava were teachers of mine during my fellowship. Of course, the morning of the surgery, I prepped and draped the patient and then took my position as the second assistant at the table. The scrub nurse passed the scalpel to Harold Douglass, Chief of GI. Without saying a word, he pointed to me. I assumed my position as surgeon at the OR table. As Dr. Nava was moving toward the second assistant position, Harold Douglass told him to stay at the first position, and then Harold Douglass himself moved to the second assistant position. This case was one of the most satisfying in my career, and it demonstrated to me the ultimate mentorship which was exemplified by Harold Douglass.

The fourth individual is Constantine Karakousis, surgeon and poet, an individual who despite a tremendous volume of surgical experience with melanoma and sarcoma, would always pull out an anatomy book in the locker room prior to each surgical procedure to review the anatomic relationships that he and the surgical team would face. It was an example set for everyone from the level of medical student to attending staff, and I thank him for that and the many other experiences that we shared.

Last year, Dr. Pollock started his Presidential Address by relating to you the struggles that he had with a topic for presentation. I had the same. I went through a list of topics which included the treatment of colorectal cancer and clinical trials in view of my experience in the NCI Cooperative Groups. Frankly, those were boring to me. Let's face it, we have gone from a median survival of 9 months to 20 months for

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patients with stage IV unresectable colorectal cancer with the new systemic agents so I am happy for patients. I am not happy for us as clinicians and researchers because it has taken us 40 years, with the same drug, and we are still only palliating and not curing patients. Lastly, there was the topic of vision for the Society. As far seeing a vision, my track record consists of predicting the Yankees would win the World Series last year and the Irish would have a winning football season. You don't want to hear my vision for the Society.

As I was going through a list of topics, I noticed many of the diplomas and Society memberships that were hanging in my study. An important question came to mind that I had never asked myself before, and that was, "What contributions have I made to society outside of the field of medicine?" Think about that question yourself. Don't get me wrong, caring for patients is one, if not the best and most satisfying profession in the world. But we all do that. It reminded me of what my wife has asked me numerous times throughout my career—"Do you want your epitaph to say here lies a good surgical oncologist or here lies a good husband and father?" Now there are numerous examples of contributions to society that I'm sure many of you have contributed outside the field of medicine, but I would like to share one.

Lieutenant Colonel Alan Beitler, Lieutenant Colonel Jim North, and Lieutenant Colonel Brad Waddle, please stand. Like other individuals who are in the armed forces and are sitting in this audience, these three individuals have put their lives on the line in order for us to sit here over the next three days at this meeting without the worry of a suicide bomber hitting this hotel. These gentlemen have had numerous publications and presentations, but to me, this contribution of protecting our country is their greatest. Gentlemen, thank you for fighting for our freedom, please sit down.

As a side note, I showed a gift from these three gentlemen to my Dad who was a World War II veteran and one of the most patriotic individuals I have known. This is an individual who made me salute the American flag on TV when the National Anthem would play prior to the Yankee games. When I showed him this gift which has sat on our living room coffee table since 2000, tears welled to his eyes. My dad was born and raised in New York City and loved the City and always thought of it as the center of the universe. He died August 5, 2001, four days after I started my job in Delaware. This was slightly before 9/11.

So what topic did I decide upon, because you can't tell by the title of my talk, which is from the piano

man from Hicksville, Long Island? Although it does signify "attitude." My presentation centers on the core of these individuals (Fig. 1). This Presidential presentation is not about me, it's about these individuals and what has been accomplished in a community-based teaching hospital/cancer center in a state that had until recently the highest cancer incidence and mortality in the United States. I don't know why it took us so long to recognize the importance of the community surgeon as being a member of our Society. I congratulate Dr. Pollock and the Executive Council and the overwhelming majority of the membership for realizing that there are community surgeons performing outstanding cancer care in this country that should be given the privilege of joining our Society.

Importantly, as the Coalition of Cooperative Groups under Bob Comis, PI of ECOG, has shown, the majority of accrual to clinical trials comes from community-based practices. The community physicians are the key to NCI trial accrual. Those quality physicians, many of whom are surgeons, need to become members of SSO.

I would also recommend to Drs. Balch and Roh that they add an editorial section to the *Annals of Surgical Oncology* entitled "Community Cancer Center Outcomes" or at least add community surgeons who are members of our Society to be on that editorial board or minimally have Rick Green the section editor of Health Care Policy and Outcomes add community surgeons to his Editorial Section. They will do an outstanding job of manuscript review, and perhaps it will stimulate community cancer centers to publish their outcomes.

So I'd like to spend a little bit of time in demonstrating to you what a core of high-quality individuals can accomplish in a short period of time in a community-based teaching hospital/cancer center. Our physicians and others have been committed to a statewide program of cancer care. Despite busy practices, they indeed have found the time to build programs, buy into a vision, receive peer review funding, participate in translational cancer research, and publish in quality journals resulting in quality cancer care in Delaware.

John Wooden, the Wizard of Westwood, an icon among basketball coaches, described a leader as one who has to accomplish the difficult task of getting those on the team to believe that "we" supersedes "me." Frankly, I prefer my own definition of a leader: "To be successful as a leader, surround yourself with individuals who are smarter than you, but just don't let them know that." Walt Disney was a lousy



**FIG. 1.** Individuals responsible for contributing to cancer program development at the Helen F. Graham Cancer Center and throughout the state of Delaware.

artist and failed many times in his early career until he was convinced to succeed he needed to surround himself with great artists and hire his brother to handle the finances. With these two moves he was free to do what he did best: use his imagination. Leaders also need to think outside the box. It is important to leave the established road map behind to explore new territories.

The Helen F. Graham Cancer Center is just one part of Christiana Care, which is a matrix system that includes the only Level I trauma between Philadelphia and Baltimore. We see over 3000 new cancer cases per year, and it is a very busy surgical campus with over 40,000 surgical procedures per year. Delaware does not have a physical presence of a medical school; the chartered medical school is Jefferson Medical College. Aside from the Jefferson medical students who rotate through the campus, Christiana has its own residency and fellowship programs, including an excellent general surgery residency program represented by Dr. Michael Rhodes, Chief of the Department of Surgery, who is in this audience today. Clinical research abounds not only in cancer, but also in other areas. So the vision for this Cancer Program since 2002 has been

to raise the standard of oncology care in the state. This has occurred through four major clinical programs: educational programs such as DOCS or the Delaware Oncology Conferences, which is a statewide program of videoconferencing—the DOCS Program is being presented by Dr. Diana Dickson-Witmer at our meeting this week; increasing accrual to NCI clinical trials and early detection and prevention programs, especially in a state that used to be number one in cancer incidence and mortality; and lastly, an integrated statewide health care system. The strategic plan (Fig. 2) has been built around developing and implementing the multidisciplinary care of the cancer patient in the state. This started at the local level at the Helen F. Graham Cancer Center, and the plan has been and continues to expand across the state with resources that include the spectrum of peer-reviewed grants and state government funding. We are a small state, which poses major challenges, but also opportunities. The state has seven hospitals that are just about evenly distributed throughout the three counties in the state. At the present time, four of the seven hospitals are involved in NCI clinical trials and part of the state cancer control plan for 2007–2010 is to have

## Helen F. Graham Cancer Center

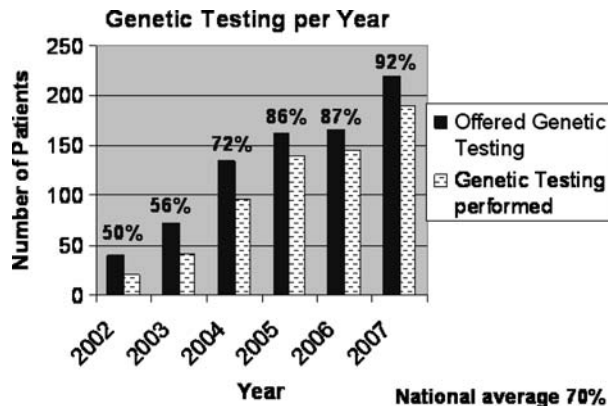
### Strategic Plan

- **Develop and Implement the Multidisciplinary care of the Cancer Patient in Delaware**
  - **Start at Local-Regional level - HFGCC**
  - **Expand across the State**
  - **Resources:**
    - **Peer reviewed Grants**
    - **Pharmaceutical Programs/Projects**
    - **Corporate Support**
    - **Public Fund Raising**
    - **State Government**

**FIG. 2.** A strategic plan for the multidisciplinary care of the cancer patient in Delaware.

all hospitals involved in NCI clinical trials with a 10% accrual. There are interesting dynamics in the state. North of the Delaware Chesapeake Canal is what I like to call “corporate America,” and south of the canal are beautiful beaches and farmlands and a large population of medically underserved. Collaborative efforts with Beebe Hospital and Dr. Jim Spellman, also a member of our society, in the most southern county has allowed us to bridge the gap of cancer care in the state.

The strategic plan and vision has been built around developing an infrastructure of high-quality physicians with support staff and the multidisciplinary team approach to cancer care. These two components have allowed academic productivity, a strong NCI clinical trials and pharmaceutical trials program, early detection and prevention program development, and, believe it or not, translational cancer research with the goal of being recognized by the National Cancer Institute. So we were at the right place at the right time, and in May of 2007 we were selected by the NCI as one of only 14 community cancer centers in the U.S. to participate in the new NCI Community Cancer Center Program, or NCCCP. Now, this NCI program was not only put together to increase access to NCI-sponsored clinical trials but with an emphasis on minority recruitment, but also reducing *cancer* health care disparities, collecting materials for translational cancer research, utilizing the NCI Cancer Biomedical Informatics Grid, ca-BIG, to develop a national database of electronic medical records, and quality-of-life best practice outcomes and survivorship programs starting with colorectal and breast carcinoma. All of this to bring more Americans into a system of high-quality cancer care. What’s wrong with that?



**FIG. 3.** Percent of individuals undergoing gene testing following genetic counseling from 2002–2007. The national average is 70%.

Nothing! Some of the reasons for developing the NCCCP program included the fact that 85% of cancer patients in the United States are diagnosed at hospitals in their communities. The other 15% are diagnosed at NCI-designated cancer centers, which are 63 academic institutions mainly in urban areas. Many patients are not treated at major cancer centers because of distance from home, personal, or economic reasons.

With that backdrop, I’d like to briefly discuss four programs, which have been successful because of the high-quality physicians that I showed you just several minutes ago. These programs deal with our statewide high-risk family cancer registry, our NCI clinical trials CCOP program, our multidisciplinary disease site centers, and translational cancer research. Prior to August 2002, there was not one *full-time* adult genetic counselor in the state of Delaware. Following recruitment, we now have three full-time adult genetic counselors at the Graham Cancer Center. Over the last 5 years, this high-risk family cancer registry named after the governor of the state has collected 900 families with over 30,000 individuals. This is a genetic counseling and gene-testing program that has spanned across the state. It involves a collaborative effort between surgeons, family practice physicians, and medical oncologists. One of the reasons it has been effective is that on a weekly basis, the genetic counselors travel to the most southern part of the state to see patients so that they don’t have to travel to the Helen F. Graham Cancer Center. The high-risk family cancer registry has required a tremendous educational effort. As you can see (Fig. 3) in 2002, approximately 50% of individuals who were offered genetic testing actually underwent gene testing. However, in 2007, 92% of individuals offered genetic testing actually had the



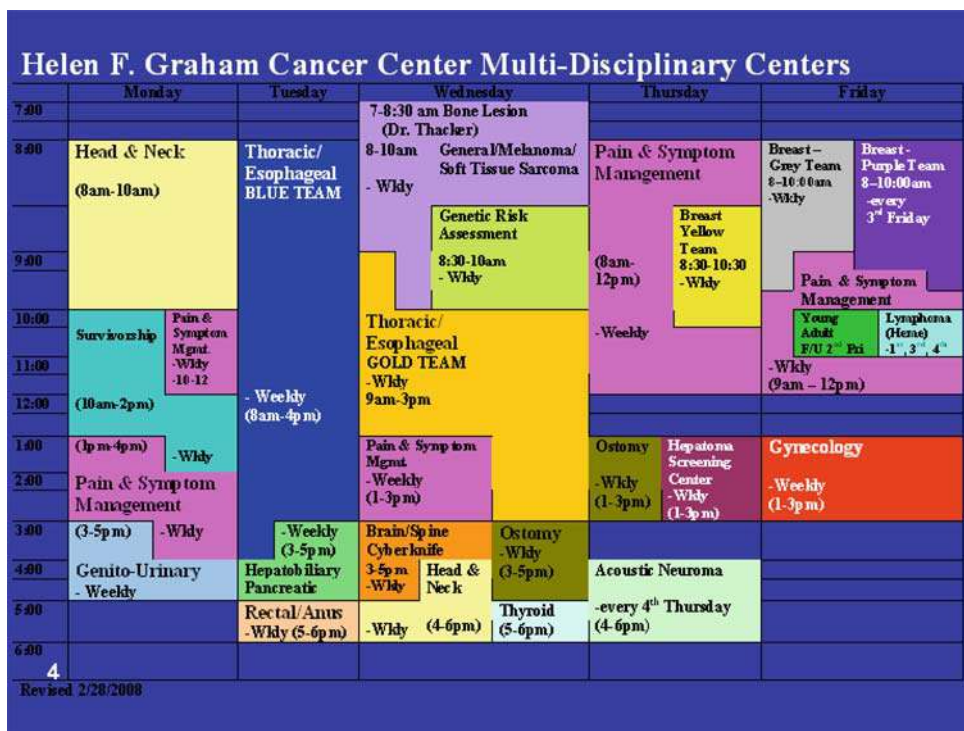


FIG. 4. The 16 multidisciplinary disease site centers at the Helen F. Graham Cancer Center where a medical oncologist, surgeon, and radiation oncologist are physically present along with all support services, such as genetic counselors, nutritionists, psychologists, and subspecialists, such as interventional radiologists and physiatrists.

gene testing performed. The national average is 70%. Well, what has been the impact of genetic testing on individuals where gene alterations have been discovered? Ninety to 95% have had an impact on their health care management either with prophylactic surgery, increased cancer surveillance, participation in NCI clinical trials, or chemoprevention. Medical oncologists often spend a great deal of effort trying to squeeze in an extra few months of a cancer patient's life, but no matter how effective our treatments become, they will never be as effective as avoidance of the cancer in the first place. The greatest opportunity to save lives lies in the appropriate counseling and testing of at-risk family members of patients with genetic mutations.

Now I would like to turn our attention to the second program, which was the development of the multidisciplinary disease site centers. These were established in 2002. We started with only three centers: thoracic, head and neck, and a general oncology center to handle all other cancers. However, through the hard work of our physicians and support personnel, we now have 16 multidisciplinary disease site centers (Fig. 4). In each of these centers, a medical oncologist, surgeon, and radiation oncologist are

physically present to discuss patient treatment and diagnostic procedures. However, aside from the three major disciplines, these disease site centers also have participation by support staff such as nurse navigators, clinical trials nurses, genetic counselors, nutritionists, psychologists, and subspecialists such as interventional radiologists and physiatrists. These multidisciplinary disease site centers have decreased the fragmentation of cancer care which existed prior to their establishment. Patients no longer have to wait several weeks or months to see a medical, surgical, and radiation oncologist. The treatment plan can be established in one visit with a centralized follow-up plan and measures of outcomes (Fig. 5).

Believe me, starting these multidisciplinary centers was no easy task. The key was identifying high-quality physicians, obtaining their support as leaders, developing a formal participation agreement between the hospital and physicians, and finally, a leadership committee to design and review performance criteria (Fig. 6).

Figure 7 demonstrates the 11 performance criteria for physicians who want to participate in the multidisciplinary centers. They include criteria such as a track record of placing patients on NCI clinical trials

## Benefit of the MDC

- **Centralization of care; no fragmentation**
- **Reduce wait between diagnosis & treatment**
  - > PET Scan 2- 3 weeks to 1 week
  - > CT Scan/General X-ray 1 week to 1 day
- **Centralized followup plan & measurement of outcomes**
  - > Reduced average length of hospital stay 0.67 days
  - > Increased Stage III colon cancer patient referrals from 47% to 95%.

FIG. 5. Multidisciplinary disease site center outcomes demonstrating some of the benefits of this type of cancer care.

## Checklist for starting a multidisciplinary clinic

- Identify "less competitive" disease sites
- Identify lead physicians ◀
- Obtain their support as leaders ◀
- Meet with doctor-leaders to develop processes
- Design and review a billing plan with hospital and legal counsel
- Formally invite prospective physician-members
- Develop a formal participation agreement between hospital and physicians ◀
- Develop a leadership committee to design and review performance criteria ◀

FIG. 6. The elements necessary to develop a multidisciplinary disease site clinic/center.

each year, attending 66% of the multidisciplinary tumor conferences in the cancer center, and participating in quality-of-care outcome programs. So one example of the success of these MDCs is demonstrated by our sarcoma multidisciplinary center where after recruiting high-quality physicians on campus and from outside recruitment, patients think twice before leaving the state for their sarcoma care. These multidisciplinary disease site centers have allowed immediate access for patients to clinical trials, especially in the adjuvant and prevention trial environment. They have also allowed access to genetic counselors for detailed family history and gene testing followed by recommendations for prophylactic surgery, chemoprevention, or increased surveillance in individuals who are part of the high-risk family cancer registry.

The next program that I would like to briefly discuss is the NCI Delaware Christiana CCOP. This is

under the direction of Dr. Stephen Grubbs, PI of the CCOP, a medical oncologist who is also in the audience today. I have been asked numerous times how we were able to get our patient accrual rate to NCI clinical trials above 20%. Drs. Grubbs, Grusenmeyer, and I know it's a simple formula for success. Resources  $\times$  personnel = high accrual. Of course, the hard part and caveat is that resources means one thing: money. And, of course, personnel equals high-quality physicians and clinical research associates who are willing to commit time in an *efficiently* run system. I can't emphasize enough that the system has to run efficiently. We have been very fortunate because of our leadership and hardworking nurses and physicians to have an increase in our CCOP funding since 2002. Our NCI accrual to clinical trials is just over 20%; however, when you add our other clinical trial programs, (pharmaceutical, translational research), it is 30% (Fig. 8). However, our goal for the Helen F. Graham Cancer Center in the next 3 years is to reach the 30% accrual rate for NCI trials *alone*. Here's one way we plan to do it. In January 2008, we established criteria for becoming an NCI Clinical Trials Investigator. Why not?—you must earn that status and give it credibility. The criteria are a minimum of four patients accrued to NCI trials in 1 year, attend one NCI Cooperative or CCOP research base meeting every other year, and have your medical records undergo an internal and external audit on a regular schedule in preparation for NCI Cooperative group audits. Failure to meet these criteria results in your investigator status being revoked. If you want to be reinstated you need to wait 1 year, attend an NCI Group meeting, and pay \$500.<sup>1</sup>

I mentioned at the beginning of this talk that translational cancer research was a goal of our cancer center. How could this be possible in a community cancer center? Well, I hope I've already demonstrated to you the strong infrastructure that we have with a strong multidisciplinary approach to cancer care. When you add on to that a major university, such as the University of Delaware (UD), 6 miles from the Helen F. Graham Cancer Center, and other colleges in the state inclusive of a strong department of Biologic Sciences at UD, it seemed to me that a second strong infrastructure could evolve for translational cancer research. Hence, a \$16 million NIH Idea Network of Biomedical Research Excellence Award (INBRE Grant) allowed the University of Delaware and Helen F. Graham Cancer Center to establish in February 2006 a Center for Translational Cancer Research. These NIH grants allowed us to establish a

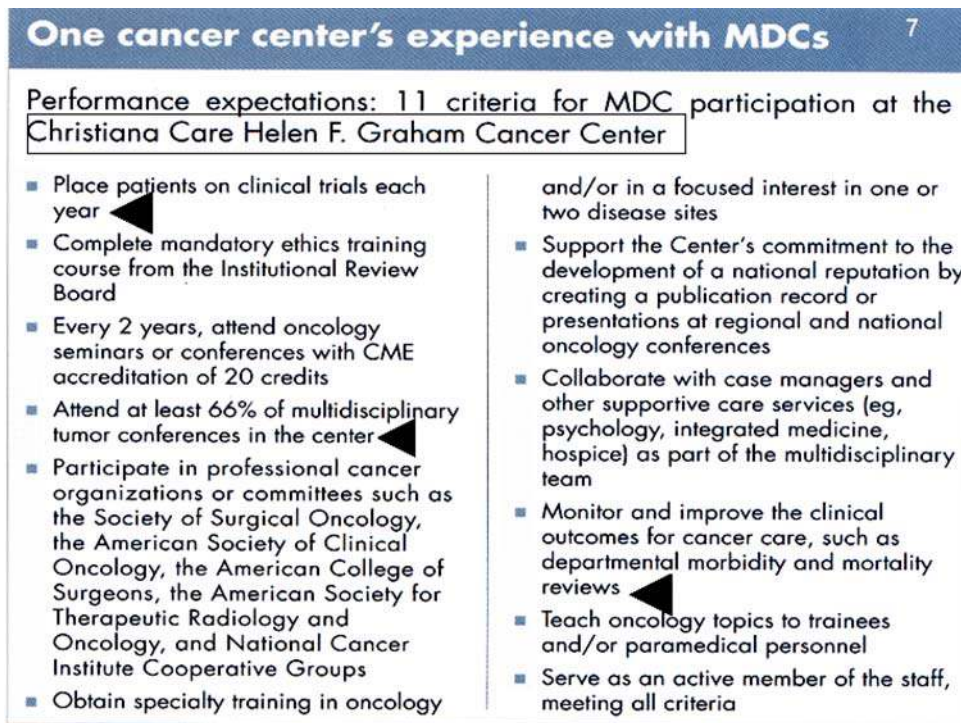


FIG. 7. The 11 performance criteria needed for physicians who want to participate in the Helen F. Graham Cancer Center multidisciplinary disease site centers.

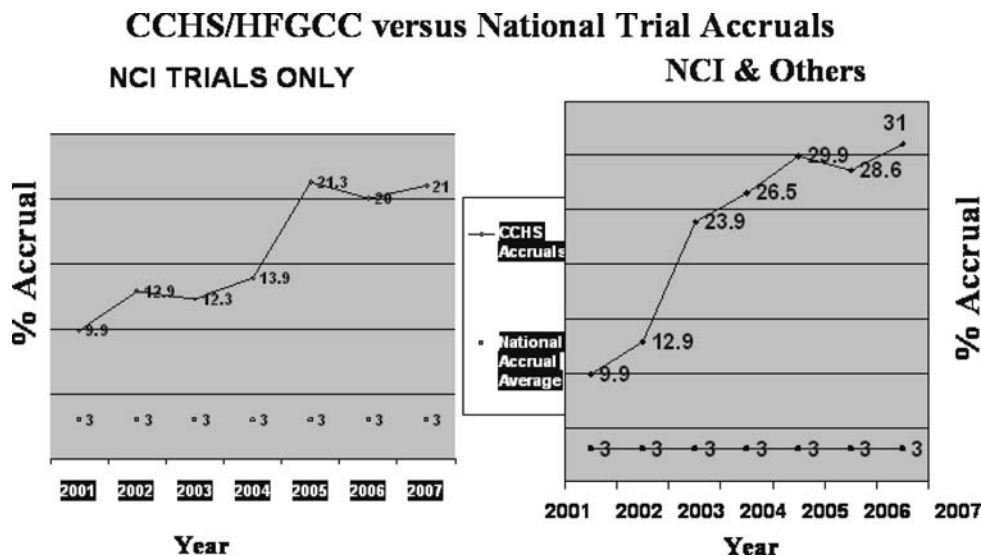


FIG. 8. The National Cancer Institute accrual to clinical trials at the Helen F. Graham Cancer Center at Christiana Care is just over 20%. It is 30% when the NCI trials are added to other clinical trials programs, such as translational cancer research and pharmaceutical trials.

Tissue Procurement Center which in 2.5 years has over 200 specimens inclusive of a database for patient demographics and treatment status. This obviously serves as a strong resource for translational research.

Figure 9 is a list of many of the translational cancer research projects that are now ongoing. The individuals underlined are clinicians at the Helen F. Graham Cancer Center who are collaborating with



### Matching HFGCC Clinicians with Scientists to Foster Better Cancer Care

- **Hydrogels for liver surgery** (Bennett, Schneider, Pochan, Farach-Carson)
- **Brain/Breast cancer growth :chick brain embryo model** (Galileo, Boulos, Dickson Witmer, Kanzer)
- **3-D Organ Imaging** (Bauer, Steiner)
- **Oligonucleotide directed gene repair esophageal cancer** (Bauer, Kmiec)
- **Vocal cord repair** (Witt, Jia, Duncan)
- **Salivary gland tissue engineering for xerostomia** (Witt, Carson, Jia)
- **Micro RNA's & Stem Cell Development in Colorectal Cancer** (Boman)

**FIG. 9.** Translational cancer research projects ongoing between clinicians at the Helen F. Graham Cancer Center in collaboration with scientists at the University of Delaware. These research projects are part of the Center for Translational Cancer Research, which is a joint venture between the Helen F. Graham Cancer Center, the Department of Biologic Sciences at the University of Delaware and the Nemours Research Institute at the A.I. DuPont Children's Hospital in Delaware.

scientists at the University of Delaware in many aspects of cancer research. The Center for Translational Cancer Research has also had monetary support from state government. Again, in a small state, programs can be successful in an extremely short period of time.

So these programs and others have allowed the state of Delaware to make tremendous progress over the last 6 years in cancer incidence and mortality. In 2006, the Centers for Disease Control (CDC) reported that cancer deaths decreased in 16 states. They declined by more than 12 deaths per 100,000 in Delaware. As a matter of fact as you all sit here in this audience today, Delaware has the most rapid decline in cancer mortality in the United States. Twice as fast as the United States rate. For the first time since the American Cancer Society has kept statistics on cancer incidence and death rates, Delaware is no longer in the top 10 in both incidence and deaths. Keep in mind that we used to be number 1 on both of these lists. This is not one top 10 list you want to be on.

Of course, state government has played a major role in helping to decrease the cancer incidence and mortality in the state. In November of 2002, the state passed the strictest clean indoor air act in this country. It has a statewide program to screen all Delawareans over the age of 50 with colonoscopy. Early results show a narrowing in disparity of African Americans for colorectal cancer screening (Fig. 10).

### State Government Programs

- **The Clean Indoor Air Act of Nov 2002**
- **Colorectal Screening Program (≥ 50 yrs age)**
  - Narrow disparity of AA CRC screening- 2002=47% 2007=69%
- **Delaware Cancer Treatment Program** (family of 4; \$120,000; uninsured)
- **Screening for Life (breast, cervical, colorectal cancer)**
- **HPV Vaccine Education Program - 2007**
  - AA-African American, CRC –Colorectal cancer, HPV- human papilloma virus

**FIG. 10.** Government programs that have played a major role in helping to decrease the cancer incidence and mortality in the state of Delaware. In 2002, 47% of African Americans underwent colonoscopy in the state, whereas in 2007, 69% underwent colonoscopy due to the statewide program to screen all Delawareans over the age of 50 with colonoscopy.

Unprecedented in this country, the Delaware Cancer Treatment Program will pay for 2 years of cancer care in an uninsured family of four where their family income is up to \$120,000 a year. Aside from the Screening for Life Programs funded by the CDC, there is a major HPV vaccine educational program for cervical cancer through the immunization registry. All of these programs are the reason Lieutenant Governor John Carney is receiving the James Ewing Layman's Award Saturday evening. However, in my mind, these state programs would not be as successful without the Helen F. Graham Cancer Center, which serves as the focus for cancer program development and especially leadership. I'm sure Lieutenant Governor Carney would agree.

So in 2002, we started with 60,000 square feet, and, because of the success of our programs, by the spring of 2009 we will have added an additional 124,000 square feet to our cancer center. This will allow us to encompass all resources for cancer care under one roof. Indeed, Delaware has come a long way, and, for me personally, this whole process over the last 6 years has truly been a labor of love.

As a semifinal thought, and as my colleagues at Christiana know, we constantly talk about trying to change culture. In my mind, we need to begin to change the culture in oncology. We need stronger working relationships between oncologists in academia and those in community hospitals across this country. I believe the new NCI initiative of the community cancer programs (NCCCP) will help that process. The SSO has and must continue to play a



role in this relationship. In this way, the problems in cancer care and the solutions to these problems will be useful for investigators, practitioners, and patients with their advocates.

Now let me turn to the last part of my talk: The other members of my family. Individuals who I have played a small role in their lives and surgical oncology education. They all lived under three trainee rules. First, don't tell me how hard you have worked, but rather what you have accomplished. Second, if it was easy, anybody could do it. Third, repetition is the key to education. There was a fourth rule that *fortunately* only a few have heard. That is "There is no crying or whining in surgery, so suck it up."

I have spent more time with my fellows than with my children. Why is that? It's because of a commitment I made to play a small role in the education of these young men and women throughout their lives not just in training, to watch them grow and mature into talented physicians and adults. It all starts out with many of us being mentors.

To me, mentorship has four phases. The first is serving as a teacher and guiding individuals to become the best physician they can be. The second is being an advisor for appropriate job positions and career aspirations. The third is becoming a colleague where patient problems are discussed, and the last is becoming a friend with discussions of family, life, good wine, beer, and food, but only after their training is complete. You can't be their friend during training. You are their mentor. There is a big difference.

Frankly, trainees keep one young. They also keep us on the cutting edge of knowledge and sometimes life with the hope that one won't fall off that edge. They believe T.S. Elliot, who said "only those who risk going too far can possibly find out how far to go."

Yes, they work very hard, but they can also play hard. They can develop long-lasting friendships even if they didn't graduate in the same class or as part of a graduating class. They are indeed remarkable young men and women.

However, when all is said and done, they do become family. In the end, the bottom line is that all of



**FIG. 11.** Some of the graduates of the Roswell Park Cancer Institute Surgical Oncology Fellowship Program during the tenure of Nicholas Petrelli, MD.

the hard work, all of the late nights, all of the badgering by their mentor is done for the next generation of young men and women. They do indeed understand that it isn't how hard you work in life, but what you have accomplished. It has been my honor to serve them, to play a small part in their lives, and to be proud of what they have accomplished (Fig. 11).

As a final thought, my advice through all of this for young investigators in the audience is to dream. Dream about what your careers can be, dream about what your family life can be because if you are lucky like me, many of those dreams will become a reality. Electric Light Orchestra said it the best: "When you get so down that you can't get up, when you want so much but you're all out of luck, when you're so downhearted and misunderstood, just hold on tight to your dreams."

Thank you and just keep rockin' on!!

## REFERENCE

1. Petrelli N, Grubbs S, Price K. Clinical trial investigator status: you need to earn it. *J Clin Oncol* 2008; 26:2440-1.