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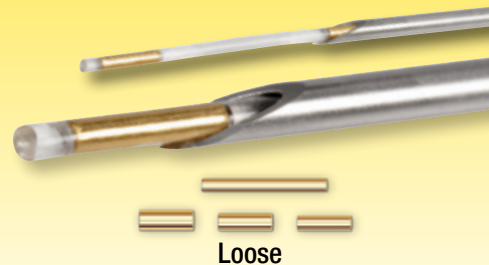
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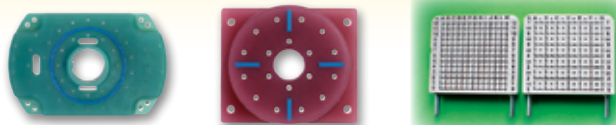
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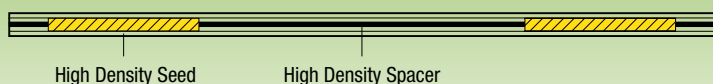
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# ASTRO news

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## EDITOR'S *notes*

BY BRIAN KAVANAGH, MD, MPH, FASTRO, ASTRONEWS

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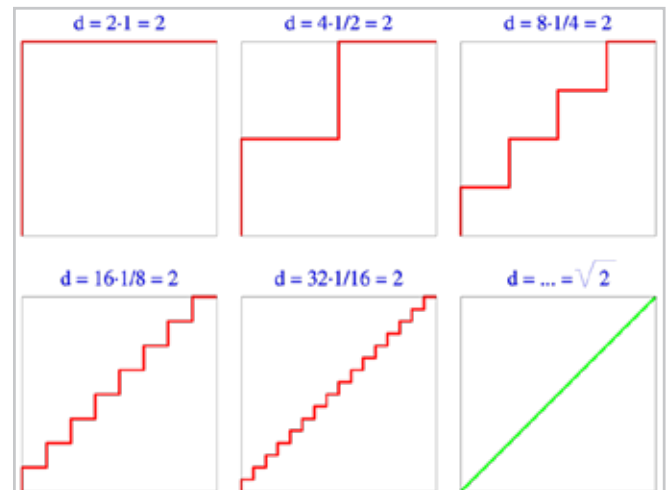
### THE STAIRCASE PARADOX IS BEAUTIFULLY

counterintuitive. As illustrated in the figure, the basic idea is that as the number of right-angled steps taken to cross a square of side length 1 diagonally approaches infinity, the sum total of line segment distances remains a stubborn 2. And yet the length of a straight-line segment from corner to corner is always the square root of 2, a lesser value.

The application of popular business strategies to the world of medicine presents a similar conundrum. As much as we might like to think that a classic like Jim Collins' "Good to Great" might offer a blueprint for success for health care enterprises, the problem is that those entities do not operate in a free market system in the same way that a company selling groceries or razors or any other type of widget does. For example, there are variable government subsidies and rules impacting the business of medicine, not to mention patient behavior that, at least historically, has not exactly always been that of a rational consumer maximizing their personal utility. And so, a plan intended to lead from now to a future imagined state might end up being less a straight line and more a zig-zagging journey.

The current issue theme is a nod to the argument that small- and large-scale programs require both a strategy and a successful plan of execution to be successful, which is the essential premise of "The 4 Disciplines of Execution," another best-selling business advice book by McChesny, Covey and Huling. We wanted to tell some stories about how a few innovative individuals and groups strategized and executed ambitious aspirational goals either within the domain of radiation oncology or in a closely adjacent sphere of influence. We had no preconceived notion of how those narratives should sound, and we invite readers to draw their own conclusions of how things played out.

We did, however, feel that three of the stories in particular stood apart from others based on their extra-large dimensions along financial, metaphysical or professional scales. It also seemed that Tobacco Free Portfolios, Life's Door, and Targeting Cancer have all



*For a square with unit side length,  $d$  represents the length of line segments from one corner to the opposite corner. Red line segments are perpendicular steps, whereas the green line segment is straight from corner to corner. Drawing by Wikipedia user RokerHRO, in the public domain.*

thrived in large part due to an alignment of stars and the passionate commitment of key individuals leading the charge. With apologies to anyone tired of dad-joke-level rhyming word play or astronomical references, please do have a look at "Syzygy and Resolution" anyway, because Drs. Bronwyn King, Ben Corn, Sandra Turner, and Lucinda Morris are all amazing people.

Equally extraordinary is this issue's guest editor, Nikhil Thaker, MD. Dr. Thaker is arguably the most business strategy-aware person in the field. During his residency at MD Anderson Cancer Center, he completed a fellowship in health care management, where he worked with national leaders at MD Anderson and the Harvard Business School, including Michael Porter and Robert Kaplan at the Institute for Strategy and Competitiveness. He is double board certified in radiation oncology and clinical informatics, holds Master's degrees in health care, information technology, and business administration, has served as a Chair of Radiation Oncology and Chief Medical Information Officer, and has also founded multiple companies that integrate artificial intelligence and management principles in oncology to drive digital transformation.

It takes about five minutes of conversation with Nikhil to realize that he is truly one of the brightest bulbs in the chandelier, with high energy and keen intellect — and as



a bonus, he is a very nice young man. He was charged with organizing a systematic way to tell all the other stories so that maybe, just maybe there might be overarching themes to extract or common lessons to learn or even, dare we venture, inspiration to be drawn.



## GUEST EDITOR

Nikhil Thaker, MD, MBA, MHA

✉ @NGThaker\_XRT

Capital Health Medical Center

### Bridging the Strategy-Execution Gap in Oncology

Strategy without execution is merely a dream. Execution without strategy is chaos. Those of us working in oncology — whether in clinical practice, research, industry or policy — live at the intersection of these two realities. We develop ambitious plans to improve cancer care, adopt cutting-edge technologies, or transform our institutions, but how often do we see these ideas falter in execution?

During my time at MD Anderson Cancer Center, I had the opportunity to participate in an extensive strategic planning initiative. It was a master class in high-level visioning, systems thinking, and innovation. But what struck me just as powerfully was witnessing how real-world challenges force pivots, how execution can often fall short, and how the best strategies evolve through constant iteration. It was this experience that helped me refine strategy and execution as I transitioned to other organizations, encompassing academic, community, private practice and even start-up initiatives. It led me to dive deeper into business principles rarely taught in medicine, namely health care leadership, strategic planning, informatics, and digital transformation, which shaped my approach to this issue of *ASTROnews*.

When Brian and I began discussing this edition, we wanted to move beyond abstract concepts and showcase real-world examples of strategy and execution in oncology. I crafted the interview questions with a simple goal: to uncover how leaders across different domains — clinical practice, startups, industry, and academia — bridge the gap between vision and reality. How do they set priorities amid competing demands? How do they navigate unexpected obstacles? And critically, what lessons can we extract from their successes and failures?

We grounded our approach in the oft cited “4 Disciplines of Execution” framework, which emphasizes:

- Prioritizing the few objectives that truly move the needle
- Identifying the key actions that drive success rather than merely tracking outcomes
- Making progress visible to sustain engagement and accountability
- Establishing structured follow-ups to ensure sustained momentum

These principles are universal, yet their application in radiation oncology is uniquely challenging due to regulatory constraints, reimbursement complexities, and the high stakes of patient care.


### Lessons from Our Contributors

To explore these ideas, we spoke with some of the most innovative minds in oncology, from academia, to industry, to the startup world, and beyond. These interviews reveal that transformative change in health care hinges on a blend of personal conviction and strategic clarity. These leaders demonstrate that by embracing agile execution — through iterative development, clear metrics, and continuous feedback — ambitious ideas can be turned into marketable products and impactful initiatives. Whether it's rethinking investment strategies, harnessing the power of narrative and hope, or fostering decentralized, accountable teams, the common thread is that adaptive, collaborative decision making is key to translating visionary concepts into measurable, lasting outcomes.

### Where Do We Go from Here?

As radiation oncologists, we are increasingly called upon to think beyond the clinic — whether integrating new technologies into workflows, leading multi-institutional initiatives or shaping policy. But grand ideas are not enough. The difference between a stalled initiative and a game-changing innovation often lies in execution.

My hope is that this issue of *ASTROnews* serves as more than just an interesting read. I hope it prompts reflection: How do we, in our own work, translate strategy into action? How do we measure progress, pivot when needed, and sustain momentum over time?

The individuals featured in this issue don't just have great ideas — they are actively transforming vision into reality, building something lasting. And that, ultimately, is the true measure of strategy. 



Dr. Kavanagh welcomes letters to the editor at [ASTROnews@astro.org](mailto:ASTROnews@astro.org).



## CHAIR'S *Update*

BY HOWARD SANDLER, MD, MS, FASTRO

### Serving the Society


#### IT'S AN HONOR TO REPRESENT ASTRO AS CHAIR

of the Board of Directors. We have a large and broad array of members — including large numbers of domestic and international members — and it is with pleasure to note that during Board of Directors meetings we consider all of our members as we respond to events and take forward-looking actions consistent with our mission and our strategic goals. The Board of Directors, which has fiduciary responsibility for the health of the organization, meets monthly with nine video calls and three in-person meetings including one at the Annual Meeting and other in-person meetings in the winter and summer seasons. The board primarily consists of members who represent our various councils such as Government Relations, Science, and so on but the board members are not provincial and represent the entire society when working on budgets, board business and other essential board activities. Having served for a number of years on the ASTRO Board of Directors, first as a council member and then as president-elect, I've been impressed with the commitment, dedication and talent of the volunteers who serve our society through board membership.

A wise erstwhile ASTRO person once told me that every person who serves as board chair will have some type of crisis to deal with during their year as chair. One of my sincere goals is to break with that tradition and see if we can indeed have a crisis-free year. That said we will always have challenges that need attention. For example, this year we are attempting to address a long building crisis situation of sorts related to decreases in reimbursement for radiation oncology

services, somewhat accentuated by the move toward hypofractionation with shorter courses of treatment becoming the norm, a move certainly welcomed by our patients. When my moderate hypofractionation prostate patients are unhappy to learn that their treatment course is four or five weeks long, I shake my head and explain how “back in the day” we routinely treated prostate cancer with courses lasting eight or nine weeks. One day nearly all prostate cases might be addressable with five fraction approaches and four to five weeks will seem to patients like an eternity. A move to an episode-based reimbursement approach has been reintroduced and enactment will certainly be a stabilizing element for radiation oncology services. Please pay attention to updates regarding the ROCR Act and provide support if possible.

Continuing my overt effort to avoid or prevent a crisis issue in the next year, we can attempt to preempt developing situations by maintaining open lines of communication. Speaking mostly for myself but likely for all board members and ASTRO staff, please note that we would like to hear from members regarding issues that fall under ASTRO's umbrella.

The organization is a membership organization and exists for the radiation oncology community. Quoting Dr. Edward Halperin from this issue of *ASTROnews*: “The most critical element that contributes to success is an institution's ability to remain true to its core values while adapting to changing times.” ASTRO remains true to its core values and is ready to adapt to changes ahead. 

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"I've been impressed with the commitment, dedication and talent of the volunteers who serve our society through board membership."

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— HOWARD SANDLER, MD, MS, FASTRO

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# SOCIETY NEWS

## CEO's Report: Reflections from my first 90 days

BY VIVEK S. KAVADI, MD, MBA, FASTRO

### I HAVE SPENT MY FIRST FEW MONTHS AS CEO

of ASTRO learning more about the inner workings of the organization that I have been so proud to be a part of for more than 30 years. In my new role, I found it important to do a great deal of observation to gain a deeper understanding about the organization, its structure, its people and history. With these observations, I implemented small tweaks to the organizational structure to better position ASTRO for the future, including creating a new role of Vice President for Business Development and Marketing. We are actively recruiting for this executive level position that will oversee enhancing revenue generation and strengthening ASTRO's reputation.

- As I have shared before, one of my top initiatives early on was and is member outreach. From day one, I set out to make a concerted effort to recruit and retain members and reclaim those who previously dropped their ASTRO membership and understand why they did so. Individual conversations with these members have been quite informative, and their comments will be taken to heart as we navigate the future. I have enjoyed what I call my roadshows, visiting members in Chicago and San Diego with trips planned for Phoenix, Salt Lake City, Seattle and Houston over the next couple of months. I seek to grow personal connections with members, and hope that all — whether academic, community hospital or freestanding centers — understand how important they are to the Society. Private practice and community-based physicians make up half of ASTRO's membership, yet there is a perception that ASTRO primarily represents academic-based practices. To help overcome this perception

and better support the needs of freestanding and community practice physicians, the Board approved the creation of a community practice task force. The task force is charged with strategizing how to more fully engage our community practice members in ASTRO activities and is already hard at work.

- Another top priority of focus these past few months has been to grow ASTRO's international membership. Currently, 22% of ASTRO members are international, and there is room for growth to enhance programs for this large cohort of our membership. I also am working to broaden ASTRO's influence in international organizations and look forward to continued partnerships with peer international societies such as ESTRO, JASTRO, RANZCR and AROI and others. In addition, we are looking to grow our collaboration with IAEA and UICC. Together, we can move the field forward to improve outcomes for our patients and broaden access to care worldwide.
- As CEO, I am responsible for ensuring that ASTRO remains financially sound. We have a strong asset base that is doing well thanks to market conditions, and I am working with the leadership team to bring our operating budget in line with long-term spending guidelines within the next two budgeting cycles. We always need to invest in our future to keep the specialty and the Society healthy and growing, and I am working to establish a new structure for ASTRO investment deployment.
- The Radiation Oncology Institute (ROI) – ASTRO's foundation – has done many good things since its


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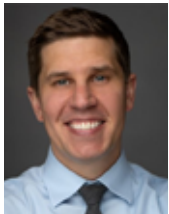


inception, including funding \$3.7 million in research to improve outcomes for patients and advance the field. Primary among this is its support of young investigators. I am looking at how to position ROI for the future and optimize the relationship between ASTRO and its foundation.

- ASTRO's relationships with industry partners have always been strong, and we are enhancing those relationships to bring more collaboration on important programs. I am working on a robust project to show value in oncology care, and I will share more details as this develops in the months to come.
- Our advocacy efforts continue at full speed with the reintroduction of the Radiation Oncology Case Rate (ROCR) Value Based Program Act. We are also working actively in the CPT RUC process as radiation oncology codes are currently being evaluated.
- In looking at new programs and scope, the field is well positioned to grow radiopharmaceutical therapies in our practices. ASTRO is supporting these efforts in many ways, including bi-annual meetings with industry partners. We are going into

year two of the RPT Roundtables, which are hosted at ASTRO headquarters and engage members and industry partners to discuss how to best prepare radiation oncologists to increase utilization of this therapy. We are exploring radiopharmaceutical training centers to assist our members who voiced a need for more training in this area as well as exploring the expansion of the Annual Meeting RPT Workshop session into a standalone meeting. I look forward to sharing more as these initiatives develop. Another area of growth, while not necessarily new to the field itself, is regaining the spotlight. Historically, many nonmalignant diseases have been treated with radiation therapy but a renewed focus on the use of radiation therapy for benign diseases is gaining traction. This topic is part of the theme for this year's Annual Meeting as well as a recent *ASTROnews* and webinar series.

This is an exciting time to work in radiation oncology. I am beyond honored to serve as CEO of ASTRO. There is much to do, but my team and I are rolling up our sleeves and are hard at work to see the Society continue to thrive and grow. This is a great job, and I am having a lot of fun doing it! 



## Implementing a Radiopharmaceutical Therapy Program: One Practice's Experience and Helpful Tips

BY DUSTIN BOOTHE, MD, AND NIKKI MAUGHAN, PHD, INTERMOUNTAIN HEALTH AND UTAH VALLEY HOSPITAL

Radiopharmaceutical therapy (RPT) is a growing modality within oncology care. To improve patient access to this treatment option, it is imperative to build RPT programs in all radiation oncology practice types. Our practice covers a wide geographic reach in both a community hospital system, Intermountain Health, and a private practice, Utah Cancer Specialists. Regardless of the setting, some uniting principles have emerged from building a successful RPT program.

### Address Regulatory Requirements Early

Radiopharmaceuticals, under the category of unsealed byproduct materials “for which a written directive is

required” (NRC CFR 35.300), requires an Authorized User (AU) for legal delivery. If your practice does not have an available AU to lead your RPT program, then one of your physicians will need to go through the necessary training and documentation to obtain AU status, which can be found in 10 CFR 35.390. When identifying a potential AU, look to those in your practice who are less than seven years from training, as the process to obtain AU status for these physicians is relatively straightforward. Those beyond seven years of training may need additional training and experience to become AUs. It is advised to speak to your regulator about the necessary requirements.<sup>1,2</sup> Even if only



considering developing a program, it is never too early to assess what is needed to obtain AU status for one or more physicians on your team.

## Be Strategic in Your RAM License Application

A radioactive material (RAM) license will be required for your practice. When you do so, make the language as broad as possible. NURREG 1556 vol. 9 rev. 3 suggests that “The chemical/physical form may be ‘Any’ unsealed byproduct material permitted by 10 CFR 35.300.” In one of our locations, it took almost two years to get an amended RAM license, partly due to limiting language in the license. So, if permitted, use broad language. For example, instead of applying for “Lutetium-PSMA 617,” consider applying for “Lutetium-based radiopharmaceuticals.” Additionally, when specifying the amount of on-site radioactivity in your application, consider the half-life of contaminants. This can facilitate in-house storage and help minimize costs associated with using an external broker for waste decay.

## Partner with Industry

We have found partnerships with industry helpful in building our program. Many new AUs and their staff have received limited training with RPTs. Industry partners can help prepare administration, revenue cycle teams, treatment delivery staff (nurses, nuclear medicine technicians) and physicians for some of the challenges faced when starting a new program. Establishing research partnerships with industry can also lead to early access to novel drugs and imaging agents. As you build your clinical trial program your practice can be a hub for patients seeking innovative trials and therapies that are often limited by supply and logistics. With the biannual roundtable with industry, ASTRO is actively seeking to build these partnerships and communicate the value that radiation oncologists can provide in the field both in research and standard-of-care therapy.

## Embrace Multidisciplinary Care


Delivering RPTs is inherently multidisciplinary. By the time a patient has been referred for RPT, they have been managed for years by their medical oncologist and/or other specialists. You’ll work closely with these referring physicians regarding treatment eligibility, concurrent medication administration, lab evaluation and treatment decision making. Many of these relationships are preexisting; if they aren’t, you’ll need to create ways to facilitate multidisciplinary care. Consider organizing an

RPT tumor board where patients can be discussed with the involved stakeholders or making a habit of having regular discussions with referring providers. Implement a routine decision point to evaluate patient progress and collaborate with the referring doctor. For some agents, this can center around interval imaging with post-treatment SPECT/CT or PSMA PET after cycle two or three.

Patient navigation is key to facilitating your multidisciplinary program. Our patient navigators help with scheduling patient visits, communication with referring offices, insurance authorizations and providing assessments on the day of treatment. Although usually a nurse, we have seen programs use other support staff for this role such as medical assistants, advanced practice providers and nuclear medicine technicians.

## Be a “Champion”

Every practice needs enthusiastic advocates for the RPT program. At our practice, medical oncologists and nuclear medicine partners share our enthusiasm for the current and future landscape of RPT. However, in some situations, you may be the only one in your region who knows the current applications and the potential of the field. Familiarize yourself with the current data and the ongoing trials. Be willing to speak up at tumor boards and administration meetings and share your successes.

Implementing RPT requires careful planning, interdisciplinary collaboration and adherence to regulatory and safety standards. As RPT evolves, embracing these advanced treatment options will not only improve clinical outcomes but also position the practice at the forefront of precision oncology. With a well-structured approach, radiation oncology teams can successfully implement an RPT program that meets both clinical and operational goals while delivering cutting-edge therapies to patients in need. 

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## Beyond the Beam

Learn more about RPTs in this nine-part series available on ASTRO Academy.

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# SYZYGY & RESOLUTION

## PART I: TOBACCO GETS SMOKED

BY BRIAN KAVANAGH, MD, MPH, FASTRO

**EIGHTEEN. TRILLION. DOLLARS.** That's trillion with a T followed by a lot of zeros. This outrageous sum is the amount of money now held in the dozens of large funds that, in the last decade and a half, have divested themselves of tobacco-related securities after thoughtful stewardship from Tobacco Free Portfolios. And it all started with a mortgage application.

### Other Options

In the spring of 2010, Bronwyn King, MBBS, and her husband were hoping to buy a house, and as is routine for such an adulting endeavor, they gathered the requisite financial data required for a loan application. To fill in the blank about how much money she had in her pension plan, she had a pleasantly uneventful meeting over a latte with the pension plan representative. Papers with numbers shuffled across the table. Box checked.

But then a quick afterthought and a question to the pension plan rep. Didn't he want her input on how her assets were invested? No, no, it's all taken care of. You're on the default option. Does that mean there are other options? [a quick sigh, an eye roll] Oh, there is this one special option for people who have a problem with investing in mining, alcohol or tobacco.

There was, for the young Dr. King, at that precise moment, in that coffee shop, with the faint hiss of a milk steamer in the background, an epiphany.

Flashing through her mind were her years of training to be a radiation oncologist, her daily practice of caring for patients whose lives were broken by smoking-related cancers, the frightened and weary looks on the faces of their family members, and the unsettling realization that she and others were unwittingly underwriting products with devastating health effects.

As Dr. King describes her thoughts at the time, "That is just a circuit that needs to be broken because it makes absolutely no sense....I'm gonna have a crack at fixing that."



### Enter the Mentor

Did she know anything about finance? Nope. Did she have a strategy? Negative. Did she have a list of deliverables to accomplish on a path toward fulfilling the strategy? Oh, wait, we just said that she didn't have a strategy.

Did she have any idea where to start? Not really. But she knew she had to start talking about the

*Continued on the following page*

issue with colleagues, at least. And so, when it was her turn to present an interesting lung cancer case for the weekly Friday afternoon departmental conference, she instead shared what she had learned about their faculty pension plan, the plan endorsed by the renowned Peter MacCallum Cancer Centre, the one that supports companies that distribute the most indisputable carcinogen ever sold. There was unanimous outrage and a call to action. She needed to go straight to the CEO of the organization and let him know that this was a big problem.



**Professor David Ball**

Among the attendees of that assembly-turned-rally was Professor David Ball, the head of the Peter Mac lung cancer unit. Yes, that David Ball, internationally known clinical researcher, principal investigator of the CHISEL study, leader in many influential cancer-related organizations, key mentor for Dr. King, and all-around good guy. Professor Ball helped to prep Dr. King for that initial meeting with the CEO and came along for moral support. Reassuringly, the CEO was completely supportive of the idea of constructing a pension plan portfolio sans tobacco investment. And this is where the real work began.

### Forming the Path

Years from now, when Zendaya is playing Bronwyn King in the biopic “Kicking Ash,” based on the NY Times best-selling memoir, there will be a scene set in a hotel lobby somewhere in Europe, circa 2017, where Bronwyn is rehearsing and tweaking her presentation for the 500th time in preparation for yet another meeting to convince a group of financiers to eschew the chew. She sees in the Venetian mirror that her attorney/friend/confidante Clare Payne (played by Florence Pugh) is seated in a Barcelona Chair, scrolling through emails on her phone.

In a moment of existential anxiety and self-reflection (note to cinematographer: that’s why you need the mirror), Bronwyn turns to Clare and asks, “Where’s my life going? Where is all this going?”

By this time Tobacco Free Portfolios had been gaining substantial momentum. Although they could not guarantee windfall returns from a tobacco-free investment approach, what they could do was leverage good will that would be amplified. The mantra *Name and Fame* captured their promise to financial executives that in exchange for a commitment to divest, Tobacco Free Portfolios would do everything they could to generate favorable publicity and respect for any institution that joined the crusade. In fact, never had they encountered an investor who staunchly opposed their ideas on principle. Nevertheless, their success rate was not nearly 100%, and the effort was taking a toll. Time away from family, emotional energy drain, wearying travel.

The Zen response from Clare in that hotel lobby resonated with Bronwyn then and remains a soothing meditation to this day. “Just keep stepping forward, the path is forming under your feet.”

### Banning a Word

In her teens, Dr. King trained hard for years as a competitive swimmer, reaching an elite junior level of competition though falling shy of making it to the Olympics. Still, she loved the people she met along the way and thoroughly enjoyed the environment, so much so that she jumped at the chance after graduating from medical school to serve several years as a doctor for the Australian national team. Tobacco Free Portfolios was not even a concept at that time, but lessons she learned as swim team doctor have continued to inspire her and inform the advice she would give to anyone who wishes to emulate her and chase a crazy big dream.

Epitomizing her experience from that time is an instance she recalls one year at The Commonwealth Games. An ordinary start to the day, a casual breakfast with some of the athletes, who are all engaging in small talk and typical young person conversations, just regular human beings hanging out together. And then a little while later in the day, during a race one of them breaks a world record and thus shatters Dr. King’s preconceived notion of what is possible for a normal person to accomplish.

Citizen King is not campaigning to win an election. Not yet, at least. But if she ever does take a shot at politics, part of her policy platform might already be set. “If I was the Prime Minister of Australia, I’d ban the word impossible.” 





# SYZYGY & RESOLUTION

## PART II: OPENING THE DOOR TO HOPE

### CONSTANTLY PLAYING INSIDE THE MIND OF BEN

Corn, MD, FASTRO, is a symphony of Big Ideas. And so, in conversation, after the initial pleasantries about family/weather/seen-any-good-movies-recently/last-night's-NBA-games, he can flip a switch and riff rhythmically on science and philosophy and religion and the meaning of life. His voice is a mellifluous baritone. Crescendos, decrescendos. He speaks with the polished diction of a lexicomane. But there is an unmistakable reverb of a Brooklyn childhood in the background, which he would never want to abandon.

Ben shared his origin story as an oncologist with attendees of the 2017 ASTRO Presidential Symposium. In his elegiac eight-minute tale, "An Appointment to Keep," an 11-year-old boy is jolted into the cruel world of malignancy and mortality after the shocking revelation of his father's imminent demise from metastatic prostate cancer. I hope there is a recording of that talk still floating around the internet, because the narrative and the performance were sublime.

### More Sublimation

I first met the young Dr. Corn, currently a Professor of Oncology at The Hebrew University, early in his meteoric rise through the academic ranks. It was my second time flubbing an interview in the City of Brotherly Love, the first a bungled try for a residency at University of Pennsylvania and the next an equally ineffectual audition for a faculty position there. Ben was already working in a grownup job as Assistant

Professor and had been entrusted with leadership roles from the minute he finished his residency. Although chronologically only a few years older, he was decades ahead professionally.

Ben could have treated our 30-minute meeting as an utter waste of time with an inconsequential Southern gentile PGY-5 and listened to music through Walkman<sup>1</sup> headphones the whole time. He chose graciousness instead. He waxed poetic on topics ranging from ongoing RTOG studies to the psychology behind his reasons for selecting a particular color palette for the patient chart folders<sup>2</sup> at the Medical College of Pennsylvania Hospital, where he was clinical director. Unbeknownst to him, when I returned to Durham after my futile Philly foray, I anointed myself founding president of the Mid-Atlantic Chapter of the Ben Corn Fan Club, a secretive organization whose membership rolls remain confidential.

The Fan Club was completely confused a few years later when news of Ben's move to Israel drifted our way. To me it was mind-boggling that someone on a fast track toward Chair of Radiation Oncology at [insert your favorite top five U.S. institution] would give up all of that and move a million miles away to a perennially war-torn region. Years later, with a broader lens and an awareness of Ben's backstory, I see now that he had not only sublimated his childhood family cancer trauma into a career choice but was further channeling respect for his heritage into meaningful self-sacrifice.

*Continued on the following page*

Most of us would feel that that was enough to justify coasting along the rest of our lives with a clear conscience. But most of us are not Ben Corn.

### Presidents and Prisoners

Soon after relocating to Tel Aviv, Ben and his wife, Dvora, a family therapist, established Life's Door, a charity organization whose primary mission is to help terminally ill patients and their families cope with angst and prepare for grief in a way that allows everyone to maximize the joy and love that can be shared when time together is limited. From humble beginnings about 25 years ago, Life's Door has expanded internationally to involve hundreds of staff and volunteers supporting thousands of people each year through their journey. The Corns have launched programs in multiple countries (Greece, Japan, South Africa, and the UK, to name a few) and received numerous accolades for their selfless work embodied in the diverse activities of Life's Door.

There are many praiseworthy support groups around the world that gather patients and family members in the local community center, dishing out lamb stew and hugs, lending a sympathetic ear, and maybe occasionally leading a chorus of Hallelujah.<sup>3</sup> What sets Life's Door apart? It is a thinking person's movement, and its founders were quick to realize early on that they had to pivot and document rigorously their successes as well as their failures.

Ben recalls those first few years, when the emphasis was, in retrospect, too narrowly thanatological: "We did all sorts of things. We conducted retreats with patients and caregivers at a time that there was not even a Hebrew word for a retreat...The thing about that was whether we were talking to patients, caregivers or physicians, nobody really wanted to discuss death."

At some point after hosting such an event at a beautiful resort located, with unintentional irony, near the Dead Sea, it suddenly clicked. Ben realized that Life's Door needed a course correction. As he puts it, what people really wanted, what they really needed, "...

was something else, which was the other side of that coin of life's end, and that was hope."

The leading pioneer in what is now known as Hope Theory was a psychologist at the University of Kansas named Rick Snyder, PhD.<sup>4</sup> Dr. Snyder was a prolific author and highly regarded academic, internationally known for work in the domain of positive psychology, which involves the cultivation of happiness and fulfillment. According to Ben, Dr. Snyder's definition of hope boils down to three elements: (a) having a goal, (b) devising a pathway to reach that goal, and (c) marshaling the agency or motivation to set out on that pathway. A proper treatment of the topic is beyond the

range of this article, but the basics and certain nuances, such as how to measure a person's level of hopefulness and how to try to elevate it, are discussed in one of Ben's many publications on the topic.<sup>5</sup>

The question emerges, though, of not only whether it is possible to enhance a person's level of hope but also whether such enhancement leads to a desired physical

and/or mental health outcome. The answer might be contextual. In Dr. Snyder's most famous experiment, individuals with a higher level of hope demonstrated a higher level of pain tolerance.<sup>6</sup> In most of Life's Door's ongoing collaborative initiatives with an assortment of medical research entities, the common hypothesis to be tested is whether enhancing hope in patients with a particular medical disorder (dialysis-dependent renal failure, Parkinson's disease, fibromyalgia, early dementia, or one of an assortment of malignancies) can lead to reduced perception of symptoms, improved desire to adhere to treatment recommendations, and/or a similar quality of life benefit. Future study results will inform where meaningful gains can be made. To weave together the varied research efforts — Life's Door has over a dozen academic partners around the globe — Ben will soon inaugurate an Institute for the Study of Hope, Dignity, and Wellbeing with the dean of his medical school.

But why stop at just the traditional boundaries of the field of medicine? Is hope enhancement a good



*Dr. Corn receiving the Presidential Award for Volunteerism from Israeli President Shimon Peres in 2011.*



Israeli and Palestinian breast cancer patients at a Life's Door hope enhancement workshop

thing outside the confines of hospitals and clinics? Ben and his team were contacted by the director of the Israeli Prison Society a while back. In Israel, approximately 7,000 incarcerated individuals are released from the jails every year, but at two years, the recidivism rate, i.e., the frequency of re-incarceration — akin to a local failure in cancer treatment — is 40%. Life's Door is going to try to reduce that rate by coaching ex-prisoners to have more hope in order to be re-integrated into society (e.g., by finding jobs and rekindling relationships).


About a month ago, Ben received a call from another VIP, the current president of Israel, Isaac Herzog. President Herzog's wildly ambitious idea is for Life's Door to roll out something on a national scale for hope enhancement. Stay tuned — more to follow on how that project evolves across an ecosystem with strata ranging from the public school systems to minoritized populations. In the meantime, though, anyone anywhere in the world who thinks they could use a little hope booster shot can download the Life's Door Hopetemize app, which will guide you along a personalized hope improvement pathway.

### Simpatico

In recent years, Life's Door's hope-augmentation workshops have incorporated a dash of narrative medicine.<sup>7</sup> A winner of the 2012 Lancet Oncology essay contest,<sup>8</sup> Ben was the logical choice to be the founding editor of the Narrative Oncology section of *Practical Radiation Oncology* 10 years ago. Franziska Eckert, MD, used the *PRO* narrative canvas to paint the dark dehumanization of radiation-related experiments in Nazi Germany; Norman Coleman, MD, FASTRO, reflected on being a bone-marrow donor for a cousin with leukemia; and Ritsuko Komaki, MD, FASTRO, traced her career as a radiation scientist to her youth in Japan, where outside Hiroshima her family and friends were exposed to

the nightmare of nuclear apocalypse. Many now turn to that arts-centric forum before reading the science-centric articles. Ben attributes this behavior to our common human quest for meaning. Given a vehicle to offer tales of challenges and how to overcome them, physicians and patients and caregivers alike somehow almost always find a path leading to hope.

The Life's Door workshops have also been determined to transcend barriers. There have been events where Jewish women from Israel suffering from breast cancer spent time together with Muslim Palestinian women with the same illness. Participants shared stories across a cultural chasm of their common anxieties and fears. As Ben explains in a video about the beautiful scene in the picture, "They see in the other a reflection of themselves. And that creates the desire to help the other person."

Imagine that. 

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# SYZYGY & RESOLUTION

## PART III: A DECADE OF UPSIDE DOWN UNDER

**THE INDEFATIGABLE, IRREPRESSIBLE**, indomitable Julie McCrossin is one of radiation oncology's all-time best allies. By the early 2000s, she was a nationally famous Australian journalist/comedian/media personality/social activist, best known for her role on the popular TV comedy quiz show *Good News Week*. Her star was still rising in 2005, when she was tapped to co-host the popular Australian Broadcast Corporation Radio Sydney morning show. Alas, it was then that she was diagnosed with a head and neck cancer. That cancer didn't



*Julie McCrossin speaks at a Targeting Cancer event.*

know what it was up against.

Julie's livelihood and identity were built on her wit and voice. Radiotherapy as primary treatment allowed her not only a chance for cure but also an excellent prospect for preserving her capacity to speak clearly. She has shown her gratitude in many ways, including years of unselfish service as an ambassador for the Targeting Cancer campaign.

This portrait of Targeting Cancer thus begins with an individual patient's story, because Targeting Cancer was and always will be patient-centric.

### Serendipity

For those who don't know, Targeting Cancer (<https://www.targetingcancer.com.au/>) is a large-scale educational/public-relations initiative sponsored by the Royal Australian and New Zealand College of Radiologists, aka RANZCR. As Sandra Turner, PhD, MBBS, summarized in an article from 2015 celebrating its first anniversary, "The Radiation Oncology: Targeting Cancer campaign aims to dispel myths and provide information for both patients and doctors on radiation therapy and where it can be effectively used."<sup>1</sup>

Dr. Turner recalls how it all started after one too many RANZCR committee meetings in which a buzz<sup>2</sup> of radiation oncologists were sitting around, lamenting the public's lack of awareness and fellow doctors' ignorance of the valuable role of radiotherapy in the treatment of so many cancers. "And so we just decided to stop complaining and do something about it."

It was a departure from tradition for RANZCR to sponsor a program like Targeting Cancer, but the

organization had a new CEO and a refreshed culture with appetite for novel challenges. The initial financial commitment was modest but adequate to move things forward, allowing for the hiring of an outside public relations consultant, for example. Dr. Turner, by virtue of her keen insight into the problem and potential solutions as well as her passion to tackle it, emerged as the obvious choice to lead the project. She was soon joined as de facto co-leader by Lucinda Morris, MBBS, a recent residency graduate who would be an invaluable liaison to the younger crowd. As Dr. Morris reflects, "In retrospect, there was a serendipitous nexus at that time of clinician groundswell and organizational motivation."

Here I must set the record straight. True, RANZCR leadership were more open-minded in 2014 than previously. True, many radiation oncologists were frustrated with the status quo. But to say that those two conditions were sufficient is an infinite monkey theorem trap.<sup>3,4</sup> Sure, eventually something productive would have probably emerged, but the real serendipity was the accidental flame-accelerant teaming of Drs. Turner and Morris. Dr. Turner the sagacious mentor to Dr. Morris' limitless vibrancy, both with charisma and people skills in superabundance. Attend one of their ESTRO leadership courses if you don't believe me.



*Sandra Turner, PhD, MBBS*



*Lucinda Morris, MBBS*

### Target Practice

Targeting Cancer quickly gained momentum due to its infectious popularity. Dr. Morris recalls her own entrée: "If you work in radiation oncology, you understand how poorly appreciated and understood our profession is, and patients die or suffer because of that. So I caught the bug immediately. And lots of others did, radiation therapists, physicists, colleagues across all levels."

One lesson in communication learned early was that doctorspeak was not going to work if the goal was to connect with patients. Radiation oncologists often quote clinical outcomes in jargon and statistical gobbledygook.

“Symptomatic pneumonitis happens 9.3% of the time,” instead of “One in 10 patients will need medicine for shortness of breath.” As Dr. Turner put it, “We had to untrain ourselves and some of the other volunteers to not be scientifically pedantic, because that’s what we’re all trained to do normally.”

Dr. Morris adds that the lessons went beyond semantics. “We learned a lot about how to have humility... as clinicians in the workplace, we are used to people listening to what we say, but in the broader community and on social media and traditional media, the patient’s voice and story matter most.”

After a few years of honing the campaign’s content to resonate with the lay public target audience, RANZCR made a key strategic adjustment, narrowing the messaging emphasis from a broad “radiotherapy is great” to a more focused approach highlighting the value proposition of radiotherapy as the primary curative modality for prostate cancer patients in particular — a visionary decision, as we will see.

### Fair Dinkum KPIs

Sadly, the Legend of Targeting Cancer does not include a boxing kangaroo,<sup>5</sup> a crazed Tasmanian devil,<sup>6</sup> or even an edgy platypus.<sup>7</sup> It would be charming to have a magical creature as fabular hero, but the reality is that Targeting Cancer’s success resulted from lots of hard work by lots of people. There was some fun along the way, but there was also a structured business plan full of legitimate key performance indicators (KPIs). Targeting Cancer was accountable to RANZCR for continued support, and progress had to be demonstrated.

A few KPIs: about 60 Targeting Cancer-initiated print, radio and traditional media stories have been shared across Australia and New Zealand focusing on positive radiotherapy-related patient stories, innovations and funding needs. Educational programs for general practitioners (GPs) have achieved measurable improvements in their understanding and willingness to refer patients to radiation oncologists.<sup>8</sup> Workshops to expose medical students to radiation oncology have likewise paid dividends.<sup>9</sup>

Targeting Cancer’s public service announcement has aired on Australian television since 2016, but the campaign extends worldwide through multiple channels. The videos have attracted over 60,000 views on YouTube, and the cumulative website traffic is approaching 1 million visits. In sum, across these and various other social media platforms, the global audience reach of the Targeting Cancer program is estimated to be over 150



**Drs. Morris and Turner hold up the left and right corners of the Targeting Cancer banner with a jubilant crowd following a fundraiser 5k run at the 2022 RANZCR meeting in Adelaide, Australia.**

million people. And then there is the biggest metric of all to date.

Periodically Australian Medicare, the country’s universal health service, offers a chance for public input into its coverage policies. In one of those windows of opportunity, the Targeting Cancer team mobilized in force to ensure patients’ access to radiotherapy for prostate cancer. The barrage included advocating to patient support groups, gathering signatures on petitions, producing videos to be seen in GPs’ office waiting rooms, and publishing policy statements about the benefits to patients. Ultimately, a few years ago, Targeting Cancer accomplished their goal. It is now written into the Australian Medicare regulations that urologists must refer patients with prostate cancer to a radiation oncologist or document a clear reason why such a referral is not needed, or else they risk fiscal repercussions.

Dr. Turner remembers that, as expected, they had encountered heavy opposition: “It attracted a lot of backlash, even though it was absolutely doing the right thing.” Bullseye. 🎯

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It was a distinct pleasure to interview the esteemed group of individuals whose insights are shared in the following pages. We aspired to capture opinions from a wide spectrum of leaders whose influence and experiences span the gamut from venturing into entrepreneurial endeavors to leading a large community-based practice to creating educational programs to steering gigantic health care institutions. Enjoy!

BY NIKHIL THAKER, MD, MHA, MBA

## Minding Their Own Businesses

Radiationoncologyville wasn't quite big enough for Tim Showalter, MD, MPH, and Ben Frank, each of whom left town for a trip to Industryburg.

Dr. Showalter is the founder of Advaray, the maker of BrachyGel™, and is currently the Chief Medical Officer at Artera, with a side hustle as Professor of Radiation Oncology at the University of Virginia. Mr. Frank completed his Fellowship in Healthcare Administration at MD Anderson Cancer Center, where he served as a Program Manager and then Administrative Director in Radiation Oncology. He has served as President of Provision Healthcare, founder and CEO of Wheelhouse and Apollo Healthcare, and founder and advisor for Unity HealthTech.

Dr. Showalter and Mr. Frank graciously agreed to share insights on strategy and execution in the business world based on their years of experience.

**ASTRONews: Every great product starts with an idea. Where did the concept for BrachyGel™ originate, and what problem were you hoping to solve?**

**Dr. Tim Showalter:** With a busy cervical cancer practice, I started to become frustrated with the vaginal packing options available to me. The initial inspiration for BrachyGel™ came while buying spray foam insulation at a home improvement store one Saturday morning. I wondered if I could find a material that would expand in position to provide packing during cervical cancer brachytherapy.

**AN: Many academics have great ideas, but few turn them into products. What was the moment when you decided to go beyond research and build a tangible product?**



**TS:** I initiated the project by seeking grant funding for the research and finding a polymer chemist collaborator. At that stage, I was under the impression — which I know now was naïve — that I could address this need by simply finding a collaborator who could identify the right polyurethane foam or hydrogel. I thought that it would be a quick project. I soon learned that I needed to develop a full product, including an integrated delivery system combined with a bag to contain the gel. There was no specific moment where I committed to building a tangible product, but I became more deeply committed step-by-step as I went from pilot grants to Phase I and II Small Business Technology Transfer (STTR) grants from the National Cancer Institute (NCI).

**AN: What advice would you give to someone in academia who wants to turn an idea into a product?**

**TS:** I would encourage academic researchers with an interest in building new products to give it a shot. Industry needs contributions from experienced clinicians and researchers. If it suits your interests, there are many ways to make a positive impact on patient care as a physician in industry. The best approach is to just take the first step.

**AN: Execution is where things can get tricky. What were the biggest challenges in the early stages of developing BrachyGel™, and how did you navigate them?**

**TS:** Although I had a lot of clinical expertise, I knew nothing about polymer chemistry or biomedical engineering. It was challenging to get connected to the right consultants and collaborators. At the start, I focused on the resources available to me at the University of Virginia and the local biotech ecosystem. It was not until I started looking into the broader world of medical device design and manufacturing that I began to find consultants with the capability I needed to work efficiently and effectively.



**AN: Startups and research projects rarely follow a straight line. Did you ever have to pivot your strategy?**

**TS:** It wasn't until around the time of our Phase I STTR award that we came to the messy conclusion that, based on testing of a prototype system on cadavers, it was not feasible to instill hydrogel directly as vaginal packing. This realization compelled me to rethink the strategy to envision a more complex device. I scrambled to find a medical device design consultant with experience in complex catheters and was able to include this change in our subsequent Phase II STTR application to fund some of the expanded scope of device development. The timing of this change was key to our success, as we were able to pull in a great team that was able to carry us through our FDA submission and even initial manufacturing.

**AN: You took BrachyGel™ from concept to commercialization, and eventually through an acquisition. What were the key factors in successfully scaling the product?**

**TS:** My initial plan was for Advaray, the company that I founded to develop BrachyGel™, to develop its own sales force, to produce the product through manufacturing partners, and to develop a broader portfolio of products for radiation therapy. My primary motivation was to provide brachytherapists with an easy-to-use packing option that improves patient comfort. I wanted to be sure that was available broadly. I initially pitched to CQ Medical to see if they'd invest in Advaray.

My experience in partnering with CQ Medical has provided a lesson in going farther through partnership with others than what is possible on my own. Advaray was acquired soon after FDA clearance of the product and before any commercial sales. Our small team navigated device design and testing, establishing a quality management system, sponsoring a clinical trial, getting BrachyGel through FDA clearance in a de novo pathway, and establishing our initial manufacturing processes. We were able to accomplish this through federal and state grant funding, without raising private investment dollars.

Key factors to successfully navigating the process include 1) keeping an eye on the key milestones, like

FDA submission, and systematically checking the highest priority boxes along the way, 2) engaging expert consultants early to be sure that duplicative or unnecessary work is avoided, 3) continuously reminding consultants of the clinician's perspective and patient impact to be sure that the project stays on the right track, and 4) always focusing on scientific integrity and patient outcomes.

**AN: What do you wish you had known about strategy and execution before starting the company?**

**TS:** I wish I knew to fully embrace the saying, "greatness is in the agency of others," which I learned from business professor/podcaster Scott Galloway. During the early days of Advaray, I spent countless hours working to learn a wide range of topics spanning quality management, manufacturing and commercialization strategies. Now I know that I could have saved many hours by engaging advisors and consultants earlier in the process. As a physician founder, it's significant enough to contribute the clinical perspective and leadership – and there are plenty of expert advisors available to fill in the missing pieces for your plan.

**AN: While you were in the process of building Advaray, you were also moving into a new role at Flatiron Health and now Artera. What motivated you to transition from academic practice to the industry side? What are some cultural insights you've observed that might be useful for others in the field?**

**TS:** I started to realize that it was possible for me as an individual physician to potentially make a greater impact by working with multidisciplinary teams in industry to move innovation forward. Flatiron had a compelling set of core values that I continue to think about today. One of my favorite values was "Be willing to sit on the floor," which encourages experts and leaders to take on direct projects, rolling up their sleeves to play well with others and focus on complex work. Another is "Seek feedback at 30%."

While in academia, my tendency was to hold onto a manuscript or proposal until it was a solid final draft. Unfortunately, this often results in missing the

*Continued on page 20*

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"If you're doing something innovative, there will generally not be a predefined optimal path to success for any given project."

– TIM SHOWALTER, MD, MPH

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## 8L2A Linear Array

APPLICATIONS: Arterial, Carotid, Vascular Access, Venous



## 12L5A Linear Array

APPLICATIONS: Arterial, Breast, Carotid, Dialysis Access, Lung, Neonatal Hip, Nerve Block, Ophthalmic, Testes, Thyroid, Vascular Access, Venous



## 14L3 Linear Array

APPLICATIONS: Arterial, Breast, Carotid, Dialysis Access, Lung, MSK, Neonatal Hip, Nerve Block, Ophthalmic, Testes, Thyroid, Vascular Access, Venous



## 15LW4 Linear Array

APPLICATIONS: Arterial, Breast, Carotid, Dialysis Access, Lung, MSK, Neonatal Hip, Nerve Block, Ophthalmic, Testes, Thyroid, Vascular Access, Venous  
VET Biopsy Kit Available



## 15LA Linear Array

APPLICATIONS: Arterial, Breast, Carotid, Dialysis Access, Lung, MSK, Neonatal Hip, Nerve Block, Ophthalmic, Testes, Thyroid, Vascular Access, Venous  
VET Biopsy Kit Available



## 15L4A Linear Array

APPLICATIONS: Arterial, Breast, Carotid, Dialysis Access, Lung, MSK, Neonatal Hip, Nerve Block, Ophthalmic, Thyroid, Vascular Access, Venous



## 16L5 Linear Array

APPLICATIONS: Breast, Lung, MSK, Nerve Block, Vascular Access  
VET Biopsy Kit Available



## 8V3 Phased Array

APPLICATIONS: Cardiac



## 4V2A Phased Array

APPLICATIONS: Cardiac, FAST, TCD



## 5C2A Curved Array

APPLICATIONS: Abdominal, FAST, Fetal Cardiac, MSK, OB/GYN, Renal, Thyroid, Visceral  
VET Biopsy Kit Available



## 9MC3 Curved Array

APPLICATIONS: Abdominal, Cardiac, Neonatal Head, Small Parts, Thyroid, Vascular Access



## 8EC4A Endocavity

APPLICATIONS: OB/GYN, Prostate  
VET Biopsy Kit Available



## XY-BI-Plane Phased Array

APPLICATIONS: Cardiac, Vascular, Lung



## 10EC4A Endocavity

APPLICATIONS: OB/GYN, Prostate  
VET Biopsy Kit Available



## 10BP4 Bi-Plane

APPLICATIONS: Prostate



## 8BP4 Bi-Plane

APPLICATIONS: Prostate



## 8TE3 Trans-esophageal

APPLICATIONS: Motorized Adult Multiplane TEE Probe



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opportunity to seek meaningful feedback from others. I think it's a useful practice to seek input early before committing to a final concept, which can often result in a better final result. At Flatiron I learned how powerful a basic practice of setting quarterly and annual team goals can be to foster team alignment and accountability. This is something that I did not see executed well in academia, and it can be a simple, powerful force.

**AN: Based on your experience across academia, startups and industry, what do you think people most often get wrong about execution?**

**TS:** Many people assume that execution requires a pre-trained expert who seamlessly performs a series of well-established steps, following a clear playbook. That couldn't be farther from reality, in my experience. Execution is essential to innovation, and it's best to just get started. If you're doing something innovative, there will generally not be a predefined optimal path to success for any given project. Generally, the best path forward is one well-intentioned step at a time, asking a lot of questions and learning along the way.

**AN: Can you walk me through how you got started in prior authorizations and EMR software, and what drives your passion for this space?**

**Mr. Ben Frank:** Early on in my work at MD Anderson, I saw how frustrating the letter of medical necessity and prior authorization processes were for physicians. As I moved up in radiation oncology at MD Anderson, I saw how these administrative hurdles impacted care across the board. Later, when I left for Provision Healthcare, I experienced it from an operator's perspective. Ultimately my frustration turned into motivation to start Apollo Healthcare, where we built an outsourced prior authorization service. At the core, my passion comes from wanting to remove unnecessary obstacles so providers can focus on patient care instead of paperwork.



**AN: Your work is so impactful in streamlining administrative burdens for providers. What's the big-picture vision you're working toward, and how do you ensure your team stays aligned with that?**

**BF:** The big-picture goal is to turn prior authorization from a bottleneck into a seamless, data-driven process that empowers providers rather than burdens them. We want to get to a point where approvals are predictable, denials are minimized and appeals are almost automatic.

To keep the team aligned, we emphasize impact over activity. Everything we do must contribute to making prior authorization faster and more efficient for our clients. We track real-world outcomes — approval rates, turnaround times and revenue cycle impact — to ensure we're moving in the right direction. We also maintain a culture of adaptability, encouraging our team to continuously refine and challenge our approach to make sure we're solving the right problems in the most effective way.

**AN: Building businesses in health care can be unpredictable. Can you share an example of a moment where you had to pivot?**

**BF:** After Apollo, I started Wheelhouse with some of the same investors who had backed us before. The idea was born from what we had seen firsthand — patients navigating complex cancer treatment decisions were often overwhelmed, and employer-sponsored health plans weren't structured to provide the support they truly needed. We believed there was an opportunity to bridge that gap by helping patients access the right care while reducing costs for employers.

At first, it seemed like we were on the right track. We signed multiple enterprise-level employers and built a strong operational framework. But, we kept running into a fundamental challenge: while employers liked the idea, and patients found value in the service, the tangible return — whether financial or clinical — wasn't strong enough to justify long-term investment at scale.

We pivoted multiple times: adjusting the service offering, refining how we engaged with patients and testing different employer models. But no matter how we tweaked it, we always came back to the same core question: does this create enough impact to be a sustainable business? Ultimately, the market wasn't ready. Shutting down Wheelhouse wasn't a failure — it was a learning experience in market timing, business model validation and staying disciplined about when to push forward and when to pivot.



**AN:** How do you ensure your team is focusing on the most impactful actions? Are there specific metrics or systems you rely on to track progress and ensure accountability?

**BF:** We prioritize metrics that directly impact patient access: approval rates, turnaround times and appeal success rates. If a change doesn't move those numbers, it's not a priority. Beyond that, we emphasize ownership. Everyone on the team understands how their work contributes to making providers' lives easier. We use real-time dashboards for transparency, but the real key is ensuring that people feel empowered to solve problems rather than just complete tasks.

**AN:** Motivating teams in high-pressure environments is tough. What's your approach to keeping your team energized and focused, especially when facing challenges like scaling or external pressures?


**BF:** Clarity and transparency. People stay motivated when they understand the bigger picture and feel like they have a stake in the outcome. We keep an open dialogue, especially when challenges arise, and focus on solutions rather than just problems.

I also believe momentum is key. Prior authorization and growing a startup can feel like an uphill battle, so we celebrate progress, whether an operational improvement or a success story from a client. Keeping the team connected to the impact of their work is the best way to maintain energy and focus.

**AN:** If you could go back to your fellowship days with the knowledge you have now, what advice would you give yourself about strategy and execution in entrepreneurship?

**BF:** First, execution beats ideas. Back then, I thought success came from having the right vision. But the best

ideas in the world mean nothing without execution. You have to test, iterate and move fast. Getting something 80% right and improving it is better than waiting for perfection. That said, "good" has to actually be good. Too many people ship half-baked products or sell complete vaporware. Functional, effective and real will always win over hype.

Second, timing is everything. The best opportunities come from matching a great idea with the right moment. Lastly, I'd tell myself to get comfortable with uncertainty. The best moves in my career weren't the ones I planned — they were the ones that emerged when I was willing to adapt. You can't force a market to be ready, but you can build something solid so that when the time is right, you're already ahead. 

"The best moves in my career weren't the ones I planned — they were the ones that emerged when I was willing to adapt."

— BEN FRANK

## Nouveau Teaching Ventures in the Digital Era

Nadine Housri, MD, and Erin Gillespie, MD, share a passion for sharing knowledge. Each has produced an educational instrument used by tens of thousands of physicians around the United States and beyond.

Dr. Gillespie founded eContour in 2015 as a free, online, case-based interactive contouring atlas of value to trainees and seasoned practitioners of radiation oncology. Usage skyrocketed in the first five years of its existence and has continued to grow steadily since, with literally hundreds of thousands of case views annually. Founded by Dr. Housri in 2014, theMednet is an online question-and-answer forum where experts from a wide assortment of medical specialties answer clinical questions, filling the gap between textbooks and real world experience. Its database is easily searchable, and to date nearly 40,000 physicians have sought advice via theMednet. We caught up with Drs. Gillespie and Housri to learn how those initiatives came into being and became so successful.

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## ASTROnews: Could you share the journey that led to the creation of eContour? What specific challenges in radiation oncology education and practice were you aiming to address?

**Dr. Erin Gillespie:** As a resident, if I had a question about how to contour a new case, my senior residents would point me to published guideline or a prior case contoured by my attending. Similarly, my mentor Jim Murphy, MD, MS, had received at residency graduation a CD (yes, a physical one!) of anonymized H&N cases contoured by his attending for future reference. Around this same time, our research group was identifying increasing differences in patient outcomes based on radiation oncologist case volume in the IMRT era.<sup>1</sup> We also were observing that contouring guidelines were becoming increasingly available, but they were often complex and not particularly easy to access at the point of care. We therefore asked if generating a database of high quality, guideline-informed cases that could provide quick reference for residents and less specialized practicing physicians, could potentially address a gap in knowledge and skills underlying differences in patient outcomes.



## AN: What overarching goals have driven the development of eContour, and how do you determine which features or content to prioritize to best serve the radiation oncology community?

**EG:** eContour has always been driven to serve the needs of busy radiation oncologists trying to deliver the best quality of care to their patients. We have surveyed our userbase every few years which has further informed prioritizing expansion of high yield case content, as well as website speed and ease of use. We have been asked many times to add full sagittal and coronal images but have declined to do this without technology to make image loading acceptably fast. We did just this

past year establish a collaboration with researchers at Massachusetts General Hospital to leverage Open Health Imaging Foundation (OHIF) technology to address this image viewer challenge, which is funded through an NIH U24 grant. So more to come on that!

## AN: What business models did you consider to make eContour self-sustaining? Are there future business strategies you're contemplating?

**EG:** Early on we considered establishing eContour as a company. When we approached UC San Diego's Office of Innovation and Commercialization in 2016, they thought it best represented scholarly work of an educational nature, akin to a book or journal. This combined with a fairly limited market for rad onc education made it an easy decision to keep the site's goal of open access education, which aligned best with our personal priorities and interests. We have been fortunate to receive educational innovation grants, especially from the Radiologic Society of North America, and to establish a partnership with the American College of Radiation Oncology to award 10 travel grants per year for case contributions, with funding provided by MIM Software. This is our current approach, though we have filed as a 501c3 non-profit to keep open the possibility of soliciting donations like Wikipedia, or implementing a fee-based model based on ability to pay. We are, though, still a couple years from needing to go in this direction.

## AN: Throughout eContour's evolution, what significant challenges have you encountered, and how have you adapted your strategies to overcome them?

**EG:** Figuring out how to motivate physicians to participate in activities like education and quality improvement that extend outside their busy jobs has been an ongoing challenge. Early content development and review fell mostly on me and the dedicated attendings at UCSD, led by Parag Sanghvi, MD, MSPH (who was critical in facilitating our robust set of H&N cases at the start). This became unsustainable, so in line with the approach of running the website more like a journal, we developed an editorial board structure. The board enabled us to highlight the work of the dedicated few, provide professional opportunities for growth and managing others, and establish a platform for social accountability by meeting and getting to know each other. With a few early dedicated members like Mike Sherer, MD, and Jeremy Price, MD, PhD, we have been fortunate







to build up a robust and committed team that curates submitted cases, seeks expert peer review, etc. And on the case submission side, we partnered with a few different professional organizations, but ultimately ACRO was the most successful and sustainable. Their funding supports travel to their conference, which serves as an educational and networking opportunity for residents. I think this speaks to the importance of professional development and interpersonal relationship building as a motivator as much if not more than the money itself.

**AN: What strategies have been most effective in translating your vision for eContour into a practical tool that enhances clinical practice? Are there specific metrics or feedback mechanisms you use to assess its impact?**

**EG:** Remaining responsive to our userbase has made it easy to feel we are achieving the vision. Our main metric to monitor progress has been website analytics (number of users and especially number of case views per day) as evidence of utility. Creating something that people actually use is hard, so as long as we continue to grow our usage, we know we are on the right track. In our initial randomized study, we asked participants to rate the website using the System Usability Scale, which enabled us to compare usability to a contouring textbook and show superiority.<sup>2</sup>

**AN: Given the need to integrate clinicians and computer scientists at eContour, how do you foster collaboration among the eContour team and contributors, and what approaches have you found effective in maintaining motivation and alignment with your strategic goals?**

**EG:** It has definitely helped to develop an editorial board, which has a standing weekly meeting. Our programmer, Scott Lundy, sometimes attends this meeting. We are very lucky to have found Scott — I was a new attending in NYC, and he was a Cornell graduate whom I found through the Cornell computer science department. Scott is an independent contractor, and one thing that has helped maintain his commitment to the project is that we almost never ask for things done urgently, which helps accommodate his other jobs and life. He also appreciates the mission and visible impact.

**AN: With rapid advancements in technology, such as AI and machine learning, how do you envision these tools integrating into platforms like eContour to further support radiation oncology professionals?**

**EG:** There are certainly increasing opportunities here, particularly for partnerships with industry to develop and pilot test solutions. One angle I've been thinking about for a while is how to test a physician's ability to detect an inaccurate contour, as our role moves from active contouring to contour editing/approval.

**AN: Reflecting on your experience with eContour, what key lessons have you learned about bridging the gap between strategic planning and effective execution?**

**EG:** A wise mentor, Dave Fuller, MD, PhD, once told me it was not worth worrying about what the website would be more than five years in the future, because everything can change in that time. But Dave is also one of the biggest proponents of goal-setting. I think the balance is to establish a vision and set short-intermediate-term goals that will encourage focused efforts to accomplish that vision but still allow yourself to take risks. I think as physicians we are trained to think so long-term, for example how our specialty choice will impact our life in 30 years, which can end up being somewhat counterproductive.

**AN: Can you tell us how theMednet came to be?**

**Dr. Nadine Housri:** After I started my internship, my dad was diagnosed with cancer. To be sure he was getting the best care,



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I started reaching out to experts at top cancer centers around the country. I sent some emails and spoke on the phone with experts, and their advice was incredibly helpful. He received excellent treatment and is doing very well years later. I would have left it at that, because this is something we do all the time as physicians: we ask experts our questions. But I happen to have an older brother whose background is in technology, and he started asking about how experts share knowledge. He pointed out two things that I had taken for granted. The first is how much expertise is simply stored in a few people's brains! The know-how of what to do when there are no clear guidelines is trapped in their heads, because there's only so much that's published or presented at conferences. Second, when this type of knowledge is shared, it's often shared privately, not in a way that helps people who are not in the middle of this expert-to-clinician conversation. And so, we thought, let's put all this online. Ask experts questions and share answers in a private physician platform, so that previously one-on-one conversations become part of a searchable repository of answers for physicians who might not have expert access otherwise.<sup>3</sup>

**AN: What is the overarching vision driving theMednet, and how do you ensure that your team stays focused on the most critical priorities amidst competing demands?**

**NH:** Our vision is to answer every doctor's question. The way that the team really stays focused is that the Mednet's first value is "Doctors first." And it's not just a platitude, it's not just something put up on the wall for people to think, "oh, that sounds nice." We live by this value. Every decision that we make goes back to this question: Are we helping physicians make better decisions and take better care of their patients?

**AN: Can you share an example of a significant strategic pivot you've made during the history of theMednet?**

"Every decision that we make goes back to this question: Are we helping physicians make better decisions and take better care of their patients?"


— NADINE HOUSRI, MD



**NH:** We'd been working since 2018 to raise awareness to oncology clinical trials through theMednet with grant support through SWOG and the National Science Foundation. Then, two things happened in 2020. First, we applied for the second part of a National Science Foundation grant, which would have given us resources to build machine learning technology to match clinical trials to a clinician's questions. Unfortunately, we didn't get the grant — and at the same time, COVID-19 happened. To me, COVID was a wake-up call and showed how much of a need there was for theMednet outside of oncology. And so with this clarity, we started expanding to include more and more specialties within internal medicine and beyond into dermatology, neurology, psychiatry, and even a few pediatric specialties. Today theMednet exists in 15 specialties across medicine.

**AN: It seems that you were thinking of some AI ideas before ChatGPT became a household word. Do you see a role for this or another emerging technology in your short- or long-term planning?**

**NH:** Yes, the vision has always been to answer every physician's question. We started with the most difficult questions — those that are not answered by textbooks, guidelines, or UpToDate. The idea that a clinical trial would be suggested as an answer to a clinical question came about before the emergence of large language models (LLMs) and required older machine learning technologies. With LLMs, this is not only easier, but the results are better. We were recently awarded a \$2M contract from the NCI to build this technology, and we

already have a prototype that matches patient cases to appropriate clinical trials. We will also be integrating traditional sources of knowledge into the Mednet like guidelines and papers. So stay tuned! 

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## A Picaresque Leadership Journey



Chris Rose, MD, FASTRO, played a key role in significantly growing a large private practice and held leadership roles within ASTRO, including serving as ASTRO's president during Society's shift to stand up as an independent society from ACR. We sat down with Dr. Rose to

hear his unique perspectives on strategy and execution from the lens of private practice and society leadership.

**ASTROnews:** You've played a key role in growing a large private practice. How did you approach strategic decision making during that experience?

**Dr. Chris Rose:** I had no formal training in implementation science. Over my career, I guess I learned to be flexible and retain a certain cynicism about strategic plans and top-down management. When Valley Radiotherapy Associates (VRA) was small, it was easy: Les Botnick and I had no strategy other than attempting to provide our patients care as good or better than they could receive at any other institution in Los Angeles. As VRA grew, we hired a managerial psychologist to take the temperature of all the docs and to keep the hierarchy

flatter than what we had experienced in academics. We also regionalized management at VRA with a centralized professional manager, medical directors for the various regions, and a council for the medical directors. None of us had gone to business school so this was on the job training.

The framework was a yearly two-day strategic planning retreat for all the docs. We were quite intentional to keep the number of goals small (I recall we had four or five every year). At each of the meetings of the regional council, the practice manager summarized our progress toward meeting the goals. The outcomes were financial and non-clinical (reputation in the community, patient satisfaction, our docs' satisfaction, our referrers' satisfaction).

**AN:** What were your observations of the strategic planning process in ASTRO when you were president?

**CR:** When I was elected to the leadership track, ASTRO had just undertaken an important strategic planning effort. There was dissatisfaction with how the ACR had managed ASTRO, and there was a new plan that set ASTRO on the path to self-governance. In retrospect the process was naïve. In those days, the volunteer leadership was spread thin. After five rather chaotic years, Laura Thevenot was hired as CEO. She brought in her own team, which allowed the volunteers to focus on larger strategic goals to be implemented by the staff. Strategic planning occurred with retreats every three to five years.

My main concern was that the size of the organization and the governance did not allow for agility. Society, economics and science were changing at a very fast pace, and the three-to-five-year strategic plan sometimes did not accommodate new and pressing changes. For example, during the end of my time at ASTRO, radiation safety and the need for QA for IMRT at smaller institutions was not recognized. The New York Times famously excoriated radiation therapy as unsafe.<sup>1</sup> ASTRO, the medical device manufacturers and the medical physicists needed to provide a response. This eventually happened but none of this was on the "strategic plan dashboard."

**AN:** What are the key differences in executing strategy in a private practice versus when you took on a leadership role within a large corporation like McKesson?

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**CR:** In private practice I had only one master: my docs. At McKesson I had two masters: my employer and their clients, the US Oncology Network. I would like to think that McKesson leadership and the physician practices were always aligned but sometimes this was not the case.

**AN: Given competing demands, how did you ensure your teams focused on what truly matters?**

**CR:** What truly mattered for my team at US Oncology was what mattered for the physicians. We surveyed them, had focus groups, and gathered the senior radiation oncology leadership to listen to their concerns. Then we prioritized the concerns and modified them with respect to what we could accomplish in the short and medium term. We limited the focus to five items that we could achieve. When enthusiastic staff members suggested additional items, we reminded them that we could not “boil the ocean” and that adding items outside of the implementation cycle would detract from successful accomplishment of the prioritized items.


**AN: What approach have you found most effective in translating high-level strategic plans into real, measurable outcomes? Are there metrics you rely on to track progress and ensure accountability?**

**CR:** This was a method that Rehman Meghani, MBAS, my business partner at McKesson/US Oncology, formulated and taught me. After the yearly strategic plans were formulated, he and I would create quantitative commitments to each other. Every other month, we were responsible for assessing our individual and joint progress. We asked other individuals to also provide a list of commitments in their lanes that would afford achievement of the strategic plans, and each of us would jointly assess their efforts six times a year. These check-ins would take at most 30 minutes to document the progress, or the lack thereof.

**AN: Based on your experience, what are the biggest pitfalls leaders face when trying to close the strategy-execution gap?**

**CR:** First is resistance to change: “Why do we have to do things differently?” Second, lack of incentives (mainly financial, but also lack of understanding) to change, closely followed by rapidity of change/burnout and the unwillingness of institution to recognize the need to change.

**AN: If you could go back to the beginning and give yourself advice about strategy and execution in health care, what would it be?**

**CR:** I would tell myself that being an excellent clinician is necessary but not sufficient in service to the patient. I’d tell myself that medicine is not an individual effort but it is a team practice. That one needed the cooperation and understanding of all the team members within the practice (i.e., therapists, nurses, dosimetrists, physicists) and administrators whose views and priorities might be different than mine but who probably chose this vocation for similar reasons — to be of service. 

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## Views from the Top

To gain the perspectives of leaders at the very top administrative stratum of large health care organizations, *ASTROnews* interviewed Edward Halperin, MD, MA, and Mohan Suntha, MD, MBA.

Dr. Suntha is President and CEO of the University of Maryland Medical System (UMMS), a private, university-based regional health system comprised of more than 29,000 employees and 4,600 affiliated providers, offering primary and specialty care at 11 hospitals, in more than 150 locations. Dr. Halperin is the Chancellor and CEO of New York Medical College (NYMC), a health sciences university with over 1,900 faculty members, approximately 2,200 students, and 600 residents and fellows practicing and learning in a network of more than 700 affiliated practice sites.

The missions and strategic plans of each of these organizations are available online,<sup>1,2</sup> but we wanted to

hear a bit more about how those aspirational goals are achieved directly from the individuals at the tops of those pyramids. We posed a very similar series of open-ended questions to each leader, hoping to catch a glimpse of how they frame the issues.

**ASTRONews: What do you see as the key factors for UMMS to fulfill its missions?**

**Dr. Mohan Suntha:** We try to be very purposeful in viewing issues through our four galvanizing theme lenses. First, we are relentless in our focus of providing objectively measured, compassionate, high-quality health care, as seen through the lens of our patients and objective data relative to our performance. Second, we own the responsibilities of being anchor institutions in the communities that we're blessed to live and serve in. As the state's largest private employer, we have economic responsibilities when it comes to serving our mission. Third, we try to leverage the size and scale of our health system by acting like an integrated health care delivery system. Finally, we invest in our differentiation as an academic health system.

**AN: Is there a particular business philosophy or framework that you find most effective in guiding a complex health system like UMMS?**

**MS:** I start with a lens as physician first, and with that, apply our foundational philosophy, which is rooted in being a high-reliability organization (HRO). The principles that are part of an HRO include preoccupation with failure, commitment to expertise, sensitivity to operations, deference to expertise and reluctance to simplify. HROs exist in many industries. In health care there are few examples where a system of our scale have taken this journey. We're an incredibly diverse health system. We encompass everything: a complex tertiary/quaternary academic medical center, urban safety net health care, rural health care, and familiar suburban health care. To maintain our high reliability as a system, we have a clear and purposeful approach to how we think about this philosophy.

**AN: How do you monitor whether strategic goals are translated into actionable plans across the system?**

**MS:** It starts at the highest levels of our organization. We're a private not-for-profit health system with a board of directors that I'm accountable to, so we start with the



strategic direction of the system, aligning governance and management, driven by clarity of strategy.

With the challenges of the external world evolving at times faster than health care has historically evolved, we have a responsibility as leaders to have clear priorities and, within each of those priorities, defined operational tactics. The tactics require organizations to have what I'll call a progressive and modern organizational design and structure.

Our system has grown up as a confederation of states, given the diversity of our communities, our assets, with everyone living on their own bottom line. But if we're going to be a leading-edge academic health system, we've got to evolve into a more integrated health system. We're doing that work now. And let me be clear, it's at times painful. It is moving a lot of people's cheese,<sup>3</sup> changing job titles, moving accountabilities.

**AN: What obstacles, expected and unexpected, have you come across?**

**MS:** Having leaders from different contexts — physician leaders, administrative leaders, nursing leaders — develop what we call a systems-thinking mindset is often challenging. We're asking them to evolve from the traditions of how they've thought about the responsibilities they've had in whatever roles they've served. Given the historic siloed mentality, building up trust requires disproportionate skillsets in communication.

And so here's my radiation oncology pitch: we're blessed as radiation oncologists because we've professionally grown up within a multidisciplinary world of care delivery. We are used to being in a room with people with different perspectives, whether medical oncology, surgical oncology, radiation oncology, pathology, etc. We have to apply systems thinking that is patient centered. And, well, we can all have our opinions but only one set of facts.

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We break down silos with storytelling. We communicate the why, which is how we create the mission, not just connect to the problem. The number one skillset is emotional intelligence. At the end of the day if you don't have that, it'll be a real challenge to thrive in a complex organization.

**AN: What metrics do you prioritize to assess the effectiveness of your approach?**

**MS:** You have to measure the objective performance. We can all subjectively describe the reason we exist and our mission and value proposition. But if you can't stand behind the subjective description with objective measures, then when you go to stakeholders who don't live our reality every day, your message will fall flat. Objectively measuring quality, safety, clinical outcomes, patient experience, financial performance, return on investment, economic vibrancy, community impact is critical. As leaders we must communicate that the objective performance of our organizations supports the aspirational way we describe our missions.

**AN: What are the most critical elements that will contribute to NYMC's success in fulfilling its missions?**

**Dr. Edward Halperin:** An article in the "Bulletin of the History of Medicine" addressed the history of physician speeches about the future of medicine.<sup>4</sup> For 200 years these speeches follow a predictable pattern. Whatever is the most recent technological innovation, the speaker asserts, will transform medicine...Therefore, the entirely predictable and facile way I could answer your question is to say that "our ability to adapt to artificial intelligence will be the key to New York Medical College's success." That would be both a predictable response and wrong.

The most critical element that contributes to success is an institution's ability to remain true to its core values while adapting to changing times. True wisdom only is found at the confluence of knowledge and values. A health science university is a community of scholars that exists for the generation, conservation and dissemination of knowledge about the causes, prevention and treatment of human disease. If we stay true to that vision, then we not only succeed, we must prevail because our mission is too crucial to society for us not to prevail.



**AN: Is there a particular business philosophy that you find most effective in guiding a complex health system like NYMC? How do NYMC's core values inform this approach?**

**EH:** "The main thing is keeping the main thing the main thing."<sup>5</sup> A common mistake in leadership is to have too many "priorities" and to whipsaw from one to another. We were founded in 1860. Our founder, William Cullen Bryant, thought that the great impediments to the success of the American experiment were racism, sexism, unbridled capitalism and alcoholism. This point-of-view led New York Medical College to begin admitting women and Black students to medical school by the 1860s, appointing women as department chairs by 1900, offering scholarships specifically designated for Black women and men by 1929, and disregarding the antisemitic admissions quotas of the 1920s-1950s.

NYMC is a health sciences university under Orthodox Jewish auspices. In the Jewish tradition the practice of medicine is as close to holy work as can be undertaken in our secular lives. When it comes to "core values informing an approach," I don't think it gets any better than that.

**AN: How do you monitor whether NYMC's strategic goals are translated into actionable plans across the institution?**

**EH:** Among the most wasteful things colleges and universities do is hire high-priced strategic planning consultants...I have always had a different attitude. It is based on a story attributed to Pablo Picasso. It is claimed that he said, "When art critics get together, they discuss truth, beauty, line, form, and whither art is going in the next half century. In contrast, when practicing artists get together, they discuss where to buy really high quality turpentine."

I believe in strategic planning based on acquiring high quality turpentine: Pick a goal, make a list of action steps to get to that goal, identify who is responsible for each step, check off the steps as you move toward the goal until you either reach it or circumstances change, and you have to modify the goal.

**AN: What is the most common challenge you encounter in executing strategic initiatives?**

It is the faculty member who states, "I had no idea this was going on. Nobody discussed it with me." As an academic leader you can conduct faculty meetings, host campus wide "Town Halls," send out newsletters, and make speeches





– and none of it is ever enough. There will always be resistance that derives from “But you didn’t notify me!”


About 12 years ago, I attended a meeting of the American Council on Education where I was paired with an experienced college President/Chancellor who asked me what troubled me most in my first six months on the job. I explained what I just articulated...the gentleman replied, “That comes with the territory with your job. Get over it.”

The moral of the story, I believe, is that communication is not about one person speaking; it is about when the other person receives and processes the information. Often that requires multiple repetitions in multiple formats.

#### AN: What metrics do you prioritize to assess NYMC's performance?

**EH:** My most important measure of effectiveness is how good I am in meeting the first responsibility of a schoolteacher. My mother, who was an eighth grade English teacher, taught me that the first responsibility of a schoolteacher is to maintain a safe learning environment. No one can learn if they do not feel physically and emotionally safe. The treatment of the students must create an environment where they feel emotionally safe and ready to learn.



I believe there are objective measures of success. They are: (a) Are all education programs fully accredited by the best standard practice accrediting bodies with no adverse actions? (b) Is there full enrollment in all of our degree-granting programs, and do objective measures show that the entering students are of high quality? (c) Is the faculty’s research output of the highest quality as measured by external grant funding, publications and citations, and selection for membership in national and international organizations? (d) Upon graduation, are our graduates getting the kinds of job offers they want, at the places they want; and are these job offers comparable or better than peer institutions? 

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## RADIATION THERAPY IN FOCUS: ASTRO'S NEW PUBLIC AWARENESS CAMPAIGN

BY JEFF WHITE, DIRECTOR OF PUBLIC RELATIONS AND STRATEGIC COMMUNICATIONS, ASTRO

### ONE OF ASTRO'S STRATEGIC PLAN GOALS

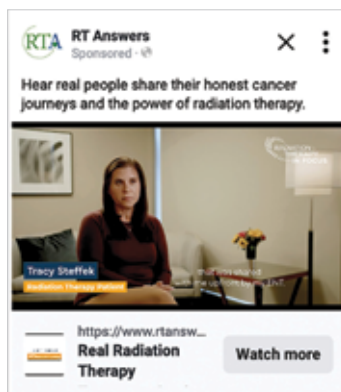
is to showcase the patient benefits of radiation therapy. We offer patients several ways to learn what radiation therapy is and how it can treat or cure their cancer. Patient education offerings include the RTAnswers website which features treatment videos and downloadable brochures. All these materials are produced with oversight from the Communications Committee.

The ASTRO Board is committed to ensuring that patients have the most current information about radiation therapy, and thus, requested the development of a public awareness initiative. To first gauge the public's understanding, we fielded survey questions to assess people's knowledge about radiation therapy. The findings included that people felt less informed about radiation therapy than other cancer treatment modalities and more than a third said they were unaware that radiation therapy can cure certain types of cancer.

Today's media landscape and the myriad ways people access information has evolved with most people researching health information online. Another challenge is that not all information found online is credible or factual. These realities highlighted the need for clear, accessible education about radiation therapy, and shaped the initiative's design to focus on educating people with easy-to-digest facts about radiation therapy while dispelling common and outdated misconceptions.

The new initiative, Radiation Therapy in Focus, is a multi-pronged online effort to inform people who receive a diagnosis of cancer about what radiation therapy is, who radiation oncologists are and how they help people with cancer better understand the treatment. It also answers an array of common questions and concerns people have about radiation therapy.


The Radiation Therapy in Focus materials added to the RTAnswers website demystify radiation therapy and emphasize its value as an essential, effective and often life-saving option for people with cancer.



Radiation Therapy in Focus has new materials for patients including:

- Short video interviews with ASTRO member radiation oncologists who discuss the science behind radiation therapy, what patients can expect from the treatment and address a top concern for people — possible side effects
- Interviews with patients who share their radiation therapy treatment experiences
- Answers to Frequently Asked Questions (FAQs) about radiation therapy that are downloadable so patients can bring them to their appointments
- Fact vs. fiction quiz about radiation therapy which works to dispel common myths

The campaign is being promoted via advertisements on Google, on social media channels, including Instagram and Facebook, and ASTRO's and RTAnswers' social media channels. We encourage you to bookmark the RTAnswers.org website as you discuss treatments with your patients and share the website with them so they can learn from the information.

Since the campaign launched in November, traffic to the RTAnswers website tripled. Hundreds of people downloaded the FAQs document and spent time exploring the content. The vision is to expand the campaign to produce more videos, including radiation oncologist interviews done in Spanish, increased engagement with cancer patient advocacy groups, media outreach and more. 

Encourage your patients to explore RT in Focus at [www.RTAnswers.org/RTinFocus](http://www.RTAnswers.org/RTinFocus) and the other patient education resources on RTAnswers, including videos, brochures and our "Ask a Radiation Oncologist" series.



## Giants of Radiation Oncology: Biographical sketches from the ASTRO History Committee

**JUAN ANGEL DEL REGATO, MD**  
(March 1, 1909 – June 12, 1999)

Growing up in Cuba, Juan del Regato's father ran the movie projector at a local cinema and was an avid photographer. His familiarity with camera equipment meant he was often called to service the X-ray machines at local physician's offices. It was on these trips that his young son developed an interest in medicine.

In 1926, Dr. del Regato enrolled at the University of Havana. A few years later, student protests closed the school. He had been working as an X-ray technician and the Cuban League of Cancer offered to send him abroad to finish his medical training at the University of Paris. Although he did not speak French, he jumped at the chance.

In Paris, Dr. del Regato attended school and worked in radiology, developing X-rays and assisting with radium treatments at night. The job was exciting but not always safe. On one occasion, a physicist came to Dr. del Regato saying that some radium sources he had been using were not properly sealed. Dr. del Regato, patients and staff had been exposed to massive amounts of radon. Two nurses later developed leukemia and died. "For half a

century," Dr. del Regato told an interviewer in 1984, "I have been expecting to develop bleeding or some other sign of leukemia."

Dr. del Regato never developed leukemia and finished medical school in 1937. He then accepted a position at the Institut de Curie as assistant to the prominent French radiotherapist Henri Coutard. Coutard was internationally known for his work on fractionated treatments and for curing laryngeal cancer with external radiation when others were still using radium implants. While assisting Coutard, Dr. del Regato was called to X-ray Marie Curie's arm which she broke after a fall in her laboratory.

The open tubes of the treatment machines at Institut de Curie allowed doctors to use reflected light to draw treatment fields on the skin of patients. A British physician approached Dr. del Regato after she learned that her hospital had bought a machine with enclosed shockproof tubes that did not emit light. Dr. del Regato designed an add-on localizer capable of reproducing the shape of the beam for the physician which she sent back to a British manufacturer. The

"del Regato Localizer" was born and quickly incorporated into treatment machines in the United States. The light field remains a standard feature of linear accelerators today.

Gold ultimately led Dr. del Regato to Colorado where he accomplished his most important work. Wealthy businessman Spencer Penrose had amassed a fortune mining for gold outside Colorado Springs. When he developed larynx cancer, he traveled to Paris to consult with Coutard. He was so pleased with the results that a few years later, when he developed esophageal cancer, he once again sought Coutard's opinion. By this time, Coutard and Dr. del Regato had immigrated from France to Chicago.

Mr. Penrose began his treatment in Chicago but hated the oppressive Midwestern heat. He paid General Electric Co. to install a treatment machine at his home in Colorado Springs and insisted that Coutard come out to supervise his care. After his treatments were completed, Mr. Penrose and his wife donated the machine and significant funds to a local facility, the Glockner

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## "ASTRO owes its being to Juan del Regato."

– MORTON KLIGERMAN, MD, FASTRO, ASTRO GOLD MEDAL WINNER

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Tuberculosis Hospital, which in 1939 was renamed the Penrose Tumor Institute, and later, the Penrose Cancer Hospital.

Despite a population of less than 50,000, the Penrose Cancer Hospital in Colorado Springs had an “excessive amount of equipment” including 3–200 kV units, 1–400 kV unit and a substantial amount of radium. Patients came from all over the country to be treated at Penrose and in 1949, Dr. del Regato became the center’s director.

Hoping to permanently establish therapy as an independent specialty, Dr. del Regato created one of the first and largest training programs in the U.S. for radiotherapists (the operative nomenclature at that time). At a time when radiation therapy was a subset of General Radiology, Dr. del Regato petitioned the American Board of Radiology to separate the training, exam and certification processes. Penrose graduates include James Cox, Larry Kun, Robert Bogardus, J. Frank Wilson, Jerome Vaeth, Robert Lindberg, and many others from around the world. While at Penrose, Dr. del Regato debunked the widely held belief that adenocarcinomas were “radioresistant.” He treated men with “inoperable” prostate cancer and proved for the first time that prostate cancer could be cured with radiation. In 1947, with Lauren Ackerman, MD, a renowned pathologist at Washington University School of Medicine, he co-authored the first edition of *Cancer*, which for decades served as


the authoritative textbook of cancer biology, diagnosis and management.

In 1955, the first meeting of the American Club of Therapeutic Radiologists was held at the Palmer House in Chicago. Organized by Dr. del Regato, the few dozen radiotherapists continued to meet twice a year to exchange ideas and compare notes. Like Dr. del Regato, most were immigrants or had trained overseas. Dr. del Regato memorably interrupted a presenter at one of the meetings who, like himself, spoke with a strong accent. He asked the man what language he was speaking. I am speaking the international language of radiotherapy, the man replied, Broken English. As the number of radiotherapists grew, the organization name was changed to the American Society of Therapeutic Radiology (ASTR) in 1965, a precursor to today’s ASTRO. In 1977, ASTR awarded its first Gold Medals to Dr. del Regato, Gilbert Fletcher, MD, and Henry Kaplan, MD.

At the end of his career, Dr. del Regato retired to Tampa, Florida, where he continued to teach and care for patients at the Veteran’s Administration Hospital. He also published biographies in the *Red Journal* on significant physicists including Wilhelm Roentgen, Max Planck, Niels Bohr, and others. Dr. Juan del Regato died in 1999 at the age of 90, his wife, Inez, having predeceased him. He was survived by two daughters, a son, and five grandchildren.



*Juan del Regato working in a lab at the Institut de Curie, circa 1937.*

Dr. del Regato’s dedication to our field lives on in the Radiation Oncology Institute’s Juan A. del Regato Fund. Like its namesake, the fund, administered through the ROI, supports efforts to foster innovation, education and community amongst young radiation oncologists as well as preserve the history of our specialty. The life of Juan del Regato reminds us to never stop looking for better ways to deliver safe treatment, commit to educating a new generation of leaders in our field and welcome diverse voices to our table. 

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## **THIS ISSUE OF ASTRONEWS IS FOCUSED ON**

business strategy and implementation in a health care setting. Advancements in technology, techniques and patient care processes are constant in radiation oncology and practices need more than willingness and technical knowledge to successfully manage change; true change requires teamwork. Collaborative efforts ensure that new ideas and workflows are adopted efficiently and translate into improved patient care.

Radiation oncology inherently involves collaboration through the multidisciplinary team, and each discipline plays a crucial role in patient care. For example, integrating a new treatment modality requires coordination between physicists for calibration, therapists for operational use, oncologists for clinical application and dosimetrists for implementation. Without teamwork, the transition to such advanced workflows can lead to inefficiencies, errors or suboptimal outcomes. This concept is widely understood, but what are the practical elements to achieving this or strengthening your team?

**Leadership and Shared Vision** – Strong leaders foster a shared vision, which is critical for successful teamwork. Leadership must inspire and guide their teams toward common goals. When implementing a new workflow, such as adaptive radiation therapy, leaders should confirm that all team members understand the objectives for having a successful adaptive program and the potential benefits to patients. By aligning everyone's efforts, leaders create a cohesive unit capable of overcoming resistance to change and achieving innovation.

**Effective Communication** – Clear communication is fundamental in implementing new ideas and workflows. Regular meetings, detailed process documents, and open channels for feedback create a culture of collaboration. For example, when adopting artificial intelligence (AI) tools for treatment planning, team members must understand how technology impacts roles and contributions. Physicians need to articulate clinical goals, physicists must explain AI integration and dosimetrists should provide insights into practical execution. Encouraging open dialogue and respecting diverse viewpoints lead to more innovative solutions. For instance, a

therapist's observation about patient comfort during immobilization could inspire modifications to treatment protocols, enhancing both patient experience and clinical outcomes. A well-informed team can anticipate challenges and address them proactively through trust and cooperation.


**Training and Education** – Introducing new workflows often requires comprehensive training. Teamwork is essential in creating an environment where members can learn from one another and operate at the highest level. For instance, when transitioning to a new treatment planning system, senior dosimetrists can mentor junior staff, while physicists provide technical insights. This collaborative approach not only builds confidence but also strengthens professional relationships within the team.

**Building Trust and Morale** – Beyond technical and clinical expertise, teamwork relies on trust and morale. A team that supports and trusts one another can weather challenges and maintain focus on patient care. Celebrating milestones, acknowledging individual contributions and fostering a positive work environment contribute to a cohesive team dynamic. Tools like ASTRO's RO-ILS: Radiation Oncology Incident Learning System® and APEX – Accreditation Program for Excellence®, are examples of programs that promote analyzing processes and learning from errors, ultimately improving quality and safety. The ability to learn from each other is also based on a foundation of trust. For example, when a physicist identifies a discrepancy in treatment planning, prompt reporting and collaborative problem solving can prevent recurrence and improve protocols. Regular team discussions on incident learning findings foster a culture of accountability and continuous improvement. Accreditation emphasizes the importance of teamwork in maintaining high standards of care and promotes a shared commitment to excellence, ensuring that all team members are aligned in their dedication to patient safety and quality care.

**Measuring Success and Continuous Improvement** – The implementation of new ideas should include mechanisms for evaluating success and identifying

*Continued on the following page*

areas for improvement. Teamwork plays a pivotal role in this process. Regular debriefings, outcome analyses and peer reviews encourage a culture of continuous learning. For example, after introducing a new patient education program, feedback from nurses and therapists can help refine the approach, confirming it meets patient needs effectively.

In radiation oncology, the implementation of new ideas and workflows must be a collaborative effort. Teamwork means that innovations are not only adopted but are optimized for patient care. By fostering effective communication, strong leadership, mutual respect and a culture of continuous improvement, radiation oncology teams can navigate the complexities of change and advance the field. Ultimately, it is the collective effort of the team that transforms challenges into opportunities and ensures the delivery of cutting-edge care. 

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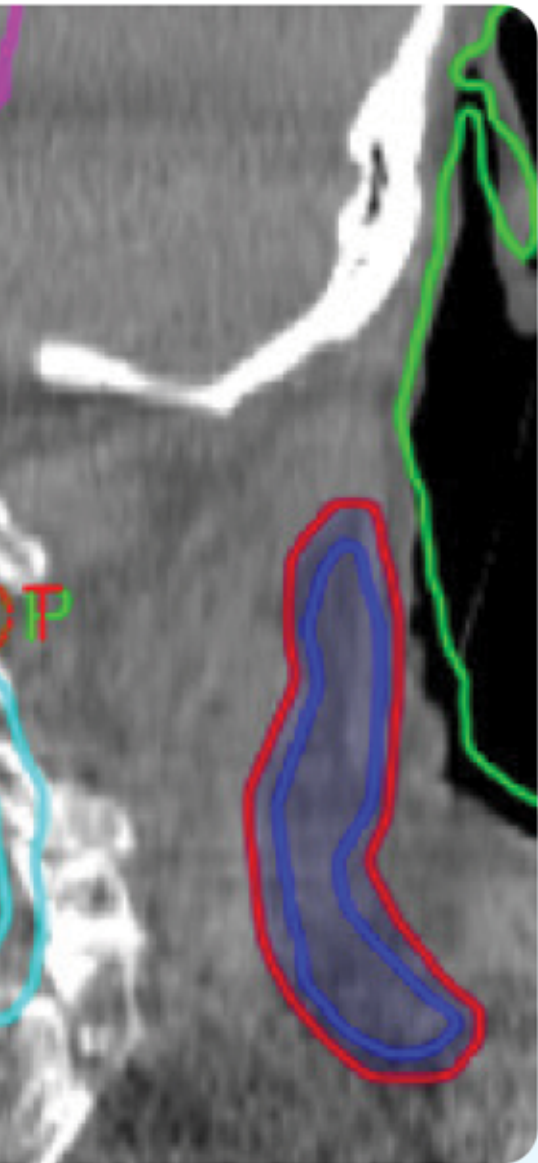


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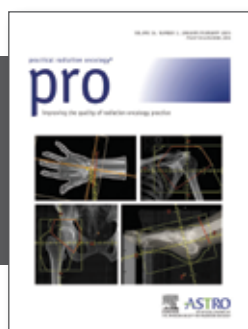


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## Radiotherapy in the Management of Hidradenitis Suppurativa: *An Interview with Chirag Shah, MD, Division Chair, Radiation Oncology, AHN Cancer Institute*

This project was conducted at Allegheny Health Network and Taussig Cancer Institute.

### Could you please give a brief overview of your study and its findings?

Radiation therapy (RT) has been used to treat nonmalignant conditions for more than 100 years. However, over the past few years there has been a resurgence in the interest in using RT to treat nonmalignant conditions ranging from osteoarthritis to keloids (See *ASTROnews* 2024 Spring Issue, Volume 27 Number 2). One disease where RT can be considered is hidradenitis suppurativa (HS), a chronic autoinflammatory condition that can lead to abscesses, fistulas and significantly impact patient quality of life. Treatments range from steroids and antibiotics to systemic immunomodulators and surgical procedures.

At our institutions, we have seen an increase in patients diagnosed with HS as part of multidisciplinary collaboration. Our dermatologists have reached out to us to consider the role of RT, particularly for patients with recalcitrant disease or those unable to receive systemic therapy approaches. In creating institutional policies for indications, dose/fractionation and treatment techniques, we realized that while data were available, it was limited by small numbers, short follow-up and variable treatment techniques.

### Why did you engage in this project?


We engaged in this project to provide clinicians a manuscript that not only reviewed the data surrounding the role of RT in the management of HS but also informed clinical practice by providing indications, dose ranges, target delineation and treatment technique approaches. We found a range of dose/fractionation regimens available, though prospective data was limited.

### What did you find surprising about your research/ results?

What was most surprising was the consistent benefit and limited toxicity that RT has demonstrated for HS patients, which is juxtaposed with its limited clinical utilization at this time.

### How can this article be used to inform clinical practice?

It suggests that radiation therapy should increasingly be considered in the management of HS and that larger prospective studies are needed. Given the low RT doses needed, the excellent side effect profile, and ease with which treatments can be delivered (as compared to surgical procedures for example), with increasing data, RT may be increasingly considered earlier on in the management of HS.

This *PRO* article is available at [https://www.practicalradonc.org/article/S1879-8500\(25\)00012-8/fulltext](https://www.practicalradonc.org/article/S1879-8500(25)00012-8/fulltext). Author disclosures are available in the article. 



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## ASTRO offers a variety of educational resources for patients!

**RTanswers.org** is ASTRO's patient-focused website that helps patients and their caregivers understand radiation therapy as a safe and effective treatment option.

Available **patient resources** include:

- A collection of 17 general and disease site-specific patient brochures with the most up-to-date information on radiation therapy, side effects charts, and questions to ask the radiation oncology team (Many available in Spanish).
- Patient education videos, also available with Spanish voiceover.
- Information about how radiation therapy, radiopharmaceuticals and immunotherapy are used together to treat cancer.
- "Find a Radiation Oncologist" search tool with simple and advanced search options.

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