Oncologists’ Treatment Responses to Mental Health Distress in Their Cancer Patients

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Abstract
The objectives of this study were to identify how oncologists respond to mental health distress in their patients, what specific strategies they use in treating this distress, and what barriers they report responding to their patients’ emotional distress. Twenty-three oncologists at two cancer centers were interviewed. The grounded theory method of data collection and analysis was used. Oncologists varied in their response to patients’ emotional distress. Strategies used in responding to patients’ distress included creating supportive relationships and prescribing medications, while barriers included patient reluctance, a lack of protocol on how to respond to patients, limited psychosocial resources, and a lack of time. Developing and adopting clear guidelines to addressing mental health distress among cancer patients is critical in assuring quality care for the whole patient and reduce the risk for poor quality of life and potential disease-related morbidity and mortality.

Keywords
oncologists; cancer; mental health distress; qualitative methods; Israel; Grounded Theory

Introduction
It is well established in the literature that cancer patients often suffer from mental health distress, including depression and anxiety, as a result of their diagnosis (Blow et al., 2011; McLoone et al., 2012; Mitchell et al., 2011; Nakash, Barchana, Liphshitz, Keinan-Boker, & Levav, 2013; Nakash et al., 2014; Nakash, Liphshitz, Keinan-Boker, & Levav, 2013; Roth & Massie, 2007; Singer, Das-Munshi, & Brähler, 2009). These findings prompted the development of several international guidelines to increase awareness among oncologists about identification of mental health distress and suicidality in their cancer patients (Andersen et al., 2014; Holland et al., 2013; National Breast Cancer Center & National Cancer Control Initiative, 2003; National Comprehensive Cancer Network [NCCN], 2007; Zebrack et al., 2015). Despite this awareness, however, consistent evidence shows that oncologists often fail to identify distress in patients and that there is a large gap between patients’ need for psychosocial support and the treatment they receive (Gouveia et al., 2015; Holland & Alici, 2010; Jacobsen & Wagner, 2012; Keller et al., 2004; Lampic & Sjödén, 2000; Nakash et al., 2014; Söllner et al., 2001; Werner, Sterner, & Schüz, 2012). Barriers to identifying mental health distress in patients include lack of screening tools, time constraints, lack of support services, and insufficient referral guidelines (Absolom et al., 2011; Biddle et al., 2016).

What has been far less researched is how oncologists respond to mental health distress when they do identify it in their patients. In one study of nearly 450 oncologists, 47% reported that they initiate a referral for psychosocial services, while 48% reported making both a referral and starting the patient on psychiatric medications such as an antidepressant (Muriel et al., 2009). In another retrospective study that looked at electronic medical records over a 12-week period to examine whether oncologists adhered to the NCCN guidelines for responding to cancer patients, approximately half of patients who indicated clinically significant distress received a referral to a mental health...
that had extensive experience doing one-on-one interviews. The study PI trained the interviewer who conducted the interviews face to face with participants. The interviewer was a graduate student in clinical psychology who had extensive experience doing one-on-one interviews in clinical and research contexts. The interviewer wrote memos during the process of data collection that were discussed with the study PI and were later used to inform the data analysis.

Data Analysis

Data collection and analysis took place concurrently, and line-by-line coding of the transcripts was used (Charmaz, 2006; Glaser & Strauss, 1967). The study PI and a research assistant separately coded the first five transcripts, followed by team discussions on the developing coding scheme to ensure consistency between coders and validity of the emerging findings. Analysis was inductive with codes and categories emerging from participants’ narratives and not from preconceived codes or categories. Constant comparison was used to examine relationships within and across codes and categories. Throughout the process of data collection and analysis, the study team met
frequently to discuss emerging findings and to ensure consistency in the emerging coding scheme. We employed a constructivist inquiry that consistently focuses on the data and the possibilities for meaning that can be constructed from them. Data collection stopped when we reached data saturation and no new codes were created. NVivo 10 computer software was used to store and organize the data.

Findings

Oncologists Treatment Responses to Mental Health Distress in Cancer Patients

Twenty-three oncologists were interviewed about their treatment responses to mental health distress and suicidality in their cancer patients (participant demographics are presented in Table 1).

Oncologists reported that once they identify mental health distress (Granek et al., 2017; Granek, Nakash, Ben-David, Shapira, & Ariad, 2018), they utilized a number of approaches to addressing their patient’s concerns. These included several strategies to treat their patients’ emotional distress with the following subthemes: creating a supportive relationship with the patient, tailoring their responses to patient cues, maintaining continuity of care, calming patients, focusing on the positive, normalizing the patient’s distress, encouraging hope, and finally, prescribing medications. An additional theme representing a different approach to address their patients’ concerns involved referring patients to other health care professionals (HCPs), with the following subthemes: psychiatrist, psychologist, social worker, pain clinic, supportive care clinic, and family doctor. These findings are summarized in Table 2 and each theme and subtheme is explained in more detail below.

Treating Mental Health Distress

Strategies in treating mental health distress. Oncologists reported that if they felt they had the ability to respond to the patient’s mental health distress themselves, particularly during the initial meetings where they were just starting to get to know the patient, they tried to address the patient’s concerns on their own without referring to a mental health professional. For example, one oncologist explained,

If it’s my first meeting with the patient, many times I’ll try to respond to her mental health distress myself. If it’s not an emergency in which she is telling me: “I want to die and want to commit suicide.” If at our next meeting she doesn’t improve, then I’ll refer her.

Oncologists reported using a number of strategies when attempting to treat their patients’ emotional distress as follows:

Creating a supportive relationship with patient. Oncologists reported that one way in which they treated the patient’s mental health distress was to try to build a supportive, caring relationship with their patients based on trust, availability, and a sense of “togetherness” in fighting the disease. On this, one oncologist noted,

I do a series of things: I create a relationship of trust with the patient, I coordinate expectations, I support them emotionally when needed, and I relieve concerns. I give them the feeling that when they’re in distress, they always have a place to turn to.

Another similarly explained, “I build trust between us. Sometimes it’s enough that they know there’s someone who wants to help them, and they already feel better.”

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**Table 1.** Participant Demographics (N = 23).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Male</th>
<th>Female</th>
<th>Age, M (SD)</th>
<th>Israel</th>
<th>Former Soviet Union</th>
<th>Other</th>
</tr>
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<tbody>
<tr>
<td>Gender, % (n)</td>
<td>30.4 (7)</td>
<td>69.6 (16)</td>
<td>45.7 (11.3)</td>
<td>47.8 (11)</td>
<td>30.4 (7)</td>
<td>21.7 (5)</td>
</tr>
<tr>
<td>Country of birth, % (n)</td>
<td>65.2 (15)</td>
<td>34.8 (8)</td>
<td>21.7 (5)</td>
<td>30.4 (7)</td>
<td>4.3 (1)</td>
<td>4.3 (1)</td>
</tr>
<tr>
<td>Family status, % (n)</td>
<td>9.1 (2)</td>
<td>90.9 (21)</td>
<td>13 (3)</td>
<td>26 (6)</td>
<td>56.5 (13)</td>
<td></td>
</tr>
<tr>
<td>Years in practice, % (n)</td>
<td>30.4 (7)</td>
<td>69.6 (16)</td>
<td>21.7 (5)</td>
<td>30.4 (7)</td>
<td>47.8 (11)</td>
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<tr>
<td>Oncology unit, % (n)</td>
<td>Clinics</td>
<td>Day hospital</td>
<td>Ward</td>
<td>Radiation</td>
<td>Palliative care</td>
<td>Oncology Emergency Room (ER)</td>
</tr>
<tr>
<td>No. of patients seen per week, % (n)</td>
<td>5–15</td>
<td>16–25</td>
<td>26–40</td>
<td>More than 40</td>
<td></td>
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</tr>
</tbody>
</table>

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*Only 18 participants answered.
*Some oncologists work in several departments.
Tailoring responses to patient cues. Oncologists reported that they tailored their response to the patient’s mental health distress according to the patient’s cues about what they need. This could range from a conversation, to a hug, to prescription for a medication depending on what the patient appeared to need at the moment. On tailoring communication, for example, one oncologist explained,

I talk with them in accordance with their level of distress and their coping style: if the patient is a “fighter,” or if someone’s in denial, or if someone is into being a victim.

On taking cues about what response to provide, another oncologist explained,

The decision on how to respond to patients’ mental health distress depends on who is sitting in front of me. Is it a woman or a man, a young person or an old person, is it an educated person, of which ethnic origin and so on. I try to find out what is bothering them—is it the fact they have to come here every day? Or the future? Or the family. Then I see what I need to do. One gets a hug, the other gets medication, another gets a joke. Sometimes patients are invited to see me frequently.

Maintaining continuity of care. Another strategy in reducing and/or treating mental health distress involved maintaining a continuity of care with the patients. Oncologists reported that they often scheduled additional appointments for patients experiencing distress even when it was not medically necessary so that the patients felt they were being supported. For example, an oncologist remarked,

What I always do with people with mental health distress is I schedule them another appointment with me, so that they know they aren’t leaving here without anyone looking after them, and it is important for me to see them.

Calming patients. Oncologists reported that when they identify mental health distress, they calm their patients by talking to them, listening to them, and reassuring them about their fears. On this, one oncologist explained that they “try to calm them down, to encourage them to live despite the disease, to cope and to go on,” while another noted, “when identifying mental health distress in a patient, I try to calm them down and tell them, even if it’s not accurate, that their prognosis is better than they think.”

Focusing on the positive. In addition to calming patients, oncologists also tried to distract patients from their negative thoughts and assuage their mental health distress by pointing out the positive aspects of the patients’ lives. One oncologist remarked,

I try to teach them to put aside the negative thoughts, and to think about something positive. To mothers I say: remember the feeling of holding the child, the warmth, the love. I try to alter their point of view, so that they’ll appreciate every moment they have left.

Another similarly explained,

Sometimes I remind patients what are the potential sources of satisfaction in life. I always point them out when I see them. I can also highlight the good things in patients’ lives, so they’ll notice they happen or happened.

Normalizing the patient’s distress. Oncologist’s reported that they normalized their patients distress by reassuring them that their emotional reactions were normal part of having a cancer diagnosis and that this distress would pass with time. One oncologist explained,

I reflect back to her the fact that she’s in distress, and the fact that this distress is reactive to the diagnosis. I explain it’s all right. I legitimize her feelings.
Giving patient’s hope. Oncologist’s explained that one way to help relieve and/or prevent mental health distress in their patients was by trying to give the patient’s hope, even in instances where there was no hope for cure, or treatment success. For example, one oncologist said,

When you say at this stage we won’t give treatment, and I’ll see you in three or four weeks, and we’ll decide what to do next, it somehow gives them hope. It could be hypocrisy on my part—but it could give hope to the patient who is afraid to hear the truth.

Prescribing medications. A large number of oncologists (83% of the sample) prescribed medications to help with mental health distress. Antidepressants, anti-anxiety drugs, sleep-aids, and, in some cases, cannabis were prescribed to patients in cases where the oncologist felt the wait for a psychologist or a psychiatrist was too long; the patient did not want to seek help from a mental health professional; the oncologist felt that treating the patient in another way would be too time-consuming; the oncologist felt that the patient was too emotionally labile to have a conversation about end of life that was causing the patient’s distress, and it was easier to treat with medications; the patient was too anxious to continue with treatments; or the patient was resistant to talking about mental health distress and a sedative was offered instead. These themes are illustrated in a series of quotations below from different oncologists on the topic of prescribing medications.

Sometimes I prescribe pharmacological treatments, antidepressants, if I feel it’s not an urgent case of mental health distress, and if we don’t want to wait till they reach an elective appointment at a psychologist.

We talked about end of life decisions with patients with whom we could talk. With patients who are psychologically labile, we didn’t even try. We preferred taking care of them with medications, to calm them down, and not to talk. Because the anticipation is that there won’t be a dialogue, and it will only worsen the depression, or state of fear and anxiety of the patient.

Many of them don’t sleep well because of the anxiety. It’s easier for me to persuade them to take sedative medication before going to sleep, which can help with the sleep but it also has a relaxing effect. That way I manage to ‘slip’ them a treatment for mental health distress through the back door.

Referring patients to other HCPs. When oncologists did not think they had the capacity, time, or skills to respond adequately to the patient’s mental health distress, they referred them to other HCPs who they thought could support the patients. These included psychiatrists, psychologists, social workers, family doctors, the pain clinic, and the supportive care clinic. On this, one oncologist noted,

In more acute cases, when a patient is in a deep depression and we tried to treat them but with no results, or with patients for whom our conversations didn’t help—we call a psychiatrist for a pharmacological treatment.

On the issue of referrals, oncologists noted that they preferred to refer to psychologists; however, they were often unavailable due to the shortages of staff and few number of shifts leading to long wait-times and difficulties in patients getting appointments. For example, at one study site we recruited at that gets 1,100 new patients each year, there was one part-time psychologist. At the other study site where there are 2,500 new patients every year, there is one full-time psychologist, four part-time psychologists, and three psychologists who work 1 day a week or less. Nonetheless, oncologists preferred to offer psychological services first when possible. On this, an oncologist remarked,

If a person says they have some mental health distress, I think they should consult with a psychologist in a therapy. I ask the patient right away: do you want a pill? Or a psychologist? They usually choose the psychologist, but for the others I prescribe pills.

While social workers were reported as being helpful when psychologists were not available to treat mental health distress, some oncologists noted that social workers focused more on accessing resources for patients and were less trained in dealing with the patient’s emotional distress. One oncologist explained,

There is a problem that there aren’t enough psychologists. The psychologist can only see a patient in a week or two at the earliest. In urgent cases there are social workers. Some of them are not trained well.

On the contrary, other oncologists remarked that they turned to social workers frequently and that they were invaluable in responding to patients’ mental health distress. On this, an oncologist said,

I think the social worker is an important resource here. She can address mental health distress. She has more time to talk to patients, to ask about it.

Oncologists referred to the pain clinic when they felt that the patient’s mental health distress was being manifested by somatic symptoms and/or the distress was being caused by physical pain. Moreover, they noted that the pain clinic doctors had more time to sit and listen to the patient’s concerns and was a good place for the patient to receive additional support. On this, an oncologist explained,

There, the doctors deal with pain and symptoms management, but they also have more time in each session, to really listen, which is something I don’t have time for.
Finally, within the hospitals, the supportive care unit was reported as being useful in helping the patient’s and their families cope with the emotional difficulties associated with the disease and its treatment. For example, one oncologist explained, 

There is a new supportive service for families. It’s great, because many times the mental health distress is in the family. They’re not my patients, but it makes the patient’s coping and my coping more difficult, and it’s definitely hard on the family. I already referred a few families there. Once a week they have a group conversation for the primary caregivers. I’m sure it will help them.

This unit houses psychiatry, social work, and pain management health care providers who work together to control symptoms of the disease. In addition, there is a complementary medicine unit that provides acupuncture, shiatsu, reflexology, homeopathy, and massage for a fee. Finally, sometimes oncologists preferred to refer out of the hospital completely and send the patients to their family doctors for supportive care. On this, one oncologist noted, 

I refer them to another doctor who is helping us with supportive care, and he is sometimes helping us with starting the treatment in SSRIs, SNRIs and all these. I prefer not to be the one who starts this treatment, because it has its own side effects, so I would rather not prescribe myself. I write a letter to the family physician, saying I think this patient needs to be treated with SSRI, SNRI.

Challenges in Responding to Mental Health Distress in Cancer Patients

When asked about challenges they face in responding to distress in their patients, oncologists reported two themes. The first had to do with patient reluctance to receive help. The second had to do with having a lack of resources, with the subthemes of lack of protocol, limited psychosocial resources, and a lack of time. Each is discussed in more detail below and supporting quotations are presented in Table 3.

Patient reluctance. Oncologists reported that some patients did not want help for their distress. In these cases, oncologists identified distress but were not able to offer help in the form of a mental health professional or a prescription for an antidepressant. While oncologists identified these cases as being a challenge, they tended to retreat when a patient indicated that they did not want assistance. For example, one oncologist explained, 

There are those who don’t want help with their problems and mental health distress. For these patients, I leave them their “space.”

Another similarly noted, 

Sometimes I see that a person is depressed, and I offer them to start on pills. Some people aren’t very receptive to this idea. They say, “What am I, a nutcase?”

Lack of protocol. Oncologists reported that there was no set protocol or guidelines on how to respond to patient distress. Each oncologist was left on their own to identify and to respond to patient distress without having set guidelines on what to do, or how to help their patients. Oncologists had a variety of responses to this lack of protocol. Some indicated that it may be problematic; however, because there was also a lack of resources in which to respond to patients, a lack of protocol was inevitable. A protocol would require that there be someone to refer out to in the cases where distress was identified. On this, one oncologist said, 

We don’t have a protocol [for responding to mental health distress of patients], because you need resources to have a protocol. The support system we have as caregivers is very limited. So you don’t have anyone to help you, you don’t have a system you can count on.

Other oncologists did not perceive this lack of protocol to be a problem, although it was identified as a challenge to responding to patient distress. On this matter, another oncologist reported,
We don’t have protocols. Each of us builds their own protocol in their mind. I’m not sure a protocol can really be useful. What is a protocol? We are talking about humans, not robots. Each person is different. You can’t have one standard for [responding to] everybody.

**Limited psychosocial resources.** Related to the challenge identified above, oncologists reported that there were severely limited psychosocial resources at their institutions. Both institutions had only one or two psychologists working half-time to address patient needs and social workers that had long waiting lists to see patients. On this problem, one oncologist remarked,

We need way more psychologists so that the patient could feel they are being heard, that the time is being devoted only to them, that someone is here to help them. For this, you need time and human power. What we can currently do is too little for all these patients.

**Lack of time.** Finally, and importantly, oncologists noted that they were limited in time to respond to patient distress. On this, one oncologist remarked,

You can’t do it all alone. In the 20—minutes—per—patient you are given, you can’t prescribe medications, explain test results, do physical examinations, and hear all the side effects and complaints they have—and still have time to help the patient calm down.

**Discussion**

While there have been numerous studies about identification of mental health distress in cancer patients by oncologists (Gouveia et al., 2015; Jacobsen & Wagner, 2012; Werner et al., 2012), to our knowledge, our study is one of the first to examine how oncologists respond to distress in their patients, including what strategies they use to respond to patients’ emotional distress, who they refer out to, and what challenges they face in responding to their patient’s needs. We found that oncologists, on the whole, attempt to address their patient’s emotional distress on their own. When this is not possible, they refer out to colleagues such as a mental health professional, a family doctor, a pain doctor, or to a complementary medicine clinic. The strategies they use in treating patients include creating supportive relationships with patients, tailoring their response to patient cues, maintaining a continuity of care with patients, calming patients, focusing on the positive with patients, normalizing the patients distress, giving patients hope, and finally, prescribing medications. Oncologists reported on a number of barriers to responding to distress in their patients including the patient’s reluctance to receive care, a lack of systematic protocol on how to respond to patients, limited psychosocial resources, and lack of time.

Some of these findings are corroborated by other studies in the field. For example, the issue of having no readily available psychosocial resources to refer out has been reported in other publications (Absolom et al., 2011; Fagerlind, Kettis, Glimelius, & Ring, 2013; Muriel et al., 2009). Time constraints in responding to patient’s distress have also been reported by oncologists around the globe (Biddle et al., 2016; Fagerlind et al., 2013; Wein, Sulkes, & Stemmer, 2010).

Our study findings are nuanced and provide a unique window into where oncologists excel when it comes to responding to their patients’ distress and where they face difficulties. Oncologists, for example, reported that they try to provide support and remain accessible and attentive to their patients by both providing an empathic ear and, when deemed necessary, providing a prescription for an antidepressant. These strategies mimic critical elements in providing good emotional support including building rapport and an alliance based on trust with patients (see also Fuertes et al., 2007; Trevino, Fasciano, & Prigerson, 2013), and emphasizing accessibility. On the contrary, while oncologists reported that being available to patients and referring out to psychosocial resources was important, they also noted they often had a lack of time to do so, and that there were limited psychosocial resources to access. These findings point to a gap in how oncologists would like to consistently respond to patients’ emotional distress and structural barriers to do so. In addition, oncologists reported that having a lack of protocol on how to respond to patients was a barrier to responding to their patient’s distress. Each oncologist responded to their patients in their own way without any systemic training and this can result in poor care and/or overburden the individual oncologist to find ways to respond adequately to the tremendous needs of their patients.

Thus, one important clinical implication from this study is providing a protocol, or at least guidelines on how to respond to emotional distress in patients. The guidelines for managing psychosocial distress published by the NCCN can serve a basis for developing and adapting a protocol that is evidence based and culturally responsive (Holland et al., 2013). These guidelines emphasize the role of oncologists in identifying and treating the psychosocial needs of patients (including, among others, recognizing patients’ distress, educating patients about treatment options, and prescribing medications to alleviate distress) and when needed referring them to mental health professionals.

Recommendations to respond to patients’ emotional distress can include, for example, (but is not limited to) training in providing cognitive behavior therapy (CBT) for oncologists. CBT teaches patients how to cope with stressors by challenging cognitions and focusing on behavior modification. One meta-analysis that looked at
and behavioral sequelae (Andersen et al., 2014). Similar positive effects have been documented for CBT interventions for anxiety and depression among cancer patients. Given the limited resources for specialized mental health care and the possible demands that CBT training can impose on oncologists, a stepped care approach should also be considered (Davison, 2000). In stepped care, a majority of patients are first treated with low-intensity psychological interventions (Bennet-Levy, Richards, & Farrand, 2010), which are generally based on cognitive behavioral therapy and delivered via written materials or information technology with limited professional guidance. Low-intensity interventions have been proven effective for anxiety and depressive disorders in the general population, and studies in primary care context have shown that within a stepped care model, physicians can be trained to deliver the initial care for common mental disorders (Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010; Araya et al., 2003; Cuijpers, Donker, van Straten, Li, & Andersson, 2010; Osborn, Demonstrada, & Feuerstein, 2006; Tatrow & Montgomery, 2006). Indeed, the American Society of Clinical Oncology has recommended that depending on levels of symptoms and supplementary information, differing treatment pathways are recommended, while emphasizing that clinicians have a vital role in mitigating the negative emotional and behavioral sequelae (Andersen et al., 2014).

Limitations

The study included a convenience sample of HCPs, and it is possible that findings cannot be generalized to everyone. However, it is likely that HCPs who participated in the study represent those who are more willing to discuss issues related to mental health (potentially representing those who are more equipped to deal with mental health in cancer patients). Thus, the challenge of management of mental health concerns among cancer patients may be even more pronounced among the general oncology HCP community. Another limitation concerns the participation of the study collaborators as participants since they were aware of the study goals. Despite this limitation, they were able to provide rich and valuable information on the research questions.

Conclusion

HCPs tend to provide emotional support and empathic listening to their patients who struggle with emotional distress, while highlighting accessibility and continuity of care—all are important elements in the establishment of good physician–patient alliance that is considered key common factor for effective mental health interventions. Developing and adopting clear guidelines to addressing mental health distress among cancer patients is critical in assuring quality care for the whole patient and reduce the risk for poor quality of life and potential disease-related morbidity and mortality. Training oncologists to deliver evidence-based interventions such as low-intensity cognitive behavioral therapy within a stepped care model has potential to offer a cost-effective approach to ameliorate the mental health treatment gap among cancer patients.

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