

THE DO'S AND DON'TS

OF COMMUNICATION
ON ADVANCED/
METASTATIC
BREAST CANCER

Metastatic Breast Cancer

MBCalliance>

ABC
GlobAlliance



Agenda

> Welcome and Introduction

- Dr. Fatima Cardoso, President, ABC Global Alliance (Portugal)

> Effective Communication from a Patient Perspective

- Dr. Ellen Landsberger, Patient Advocate, MBC Alliance (United States)

> How to Communicate a Diagnosis of Advanced/Metastatic Disease

- Dr. Reshma Jagsi, Chair, Department of Radiation Oncology, Emory University School of Medicine (United States)

> How to Communicate Disease Progression and Prognosis

- Dr. Belinda Kiely, Sr. Research Fellow, NHMRC Clinical Trials Centre (Australia)

> How to Communicate About Clinical Trials

- Dr. AnaMaría López, Chief of Cancer Services, Jefferson Health New Jersey – Sidney Kimmel Cancer Center (United States)

Agenda (continued)

> Interactive Breakout Discussions

- Moderators will include Health Care Providers (HCP) and patient advocates

> Report Back from Groups

> Closing Remarks

- Beth Burnett, Chair, MBC Alliance (United States)

Welcome and Introduction

Dr. Fatima Cardoso, President, ABC Global Alliance

- Dr. Cardoso is the Director of the Breast Unit of the Champalimaud Clinical Center (CCC) in Lisbon, Portugal. She is board certified in medical oncology and internal medicine.
- She earned her medical degree at the University of Porto in Portugal and completed fellowships in the Translational Research Unit of the Jules Bordet Institute (IJB) in Brussels, Belgium, and the Department of Molecular and Cellular Oncology at MD Anderson Cancer Center in Houston, Texas.
- Dr. Cardoso has authored about 350 publications and has presented her work nationally and internationally. She is editor-in-chief of The Breast Journal, associate editor of the European Journal of Cancer, and is an editorial board member of several other journals.



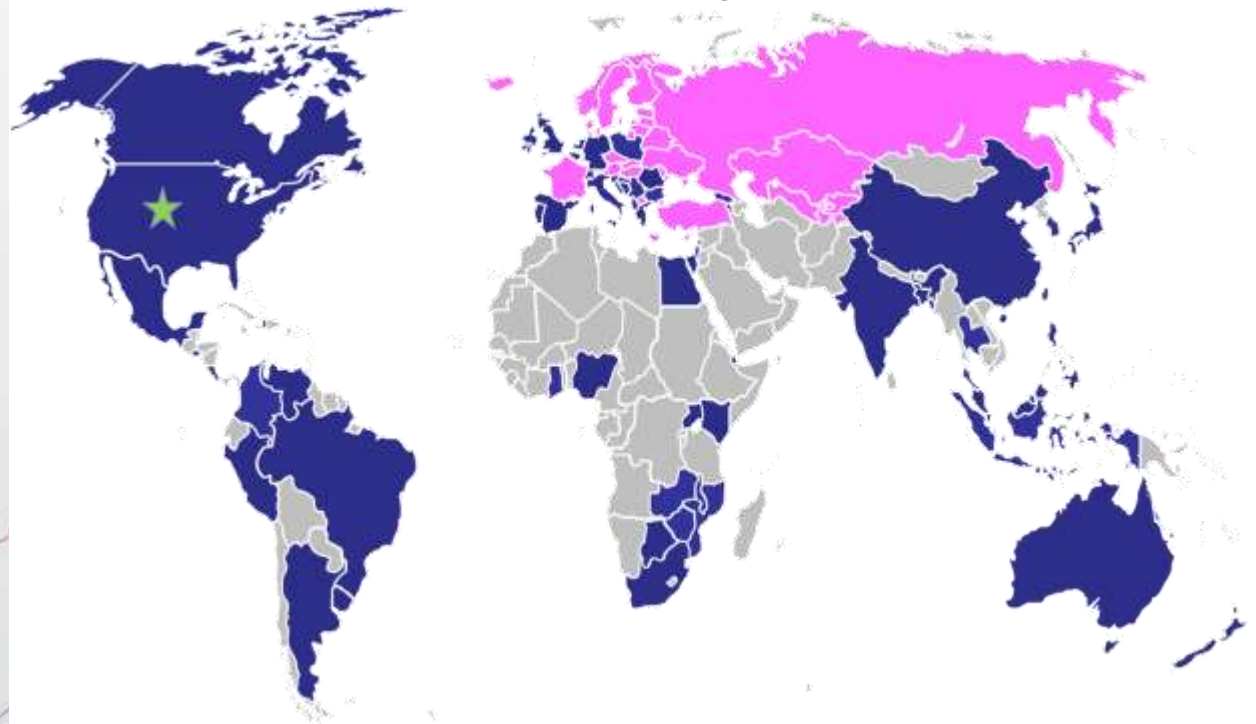


The ABC Global Alliance

Continuing the work of the ABC Consensus Conference and Guidelines

275 Members from 103 Countries

As of Sep 2024



- ABC Global Alliance members
- Members represented through Europa Donna - The European Breast Cancer Coalition
- ★ MBC Alliance represents all its members in the ABC Global Alliance

Full list of members available at www.abcglobalalliance.org

**GET TOGETHER!
COLLABORATE!**

SHARE RESOURCES AND KNOWLEDGE!

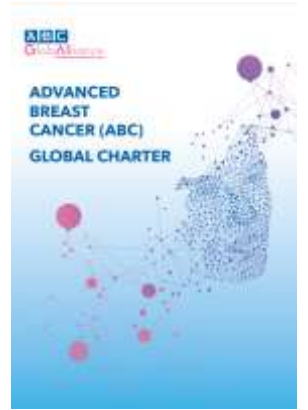
Website: www.abcglobalalliance.org

Email: info@abcglobalalliance.org

Social media: [@ABCGlobalAll](https://www.instagram.com/ABCGlobalAll)

ABC Global Charter

10 goals for 10 years
(2015-2025)



COMPREHENSIVE NEEDS ASSESSMENT DEFINES MOST URGENT AND ACTIONABLE GOALS

Developed with members of the ABC Global Alliance, including (almost) all different stakeholders involved in ABC

- 1 HELP PATIENTS WITH ABC LIVE LONGER BY DOUBLING ABC MEDIAN OVERALL SURVIVAL BY 2025
- 2 ENHANCE OUR UNDERSTANDING ABOUT ABC BY INCREASING THE COLLECTION OF HIGH QUALITY DATA
- 3 IMPROVE THE QUALITY OF LIFE (QOL) OF PATIENTS WITH ABC
- 4 ENSURE THAT ALL PATIENTS WITH ABC RECEIVE THE BEST POSSIBLE TREATMENT AND CARE BY INCREASING AVAILABILITY OF ACCESS TO CARE FROM A MULTIDISCIPLINARY TEAM
- 5 IMPROVE COMMUNICATION BETWEEN HEALTHCARE PROFESSIONALS (HCP) AND PATIENTS WITH ABC THROUGH THE PROVISION OF COMMUNICATION SKILLS TRAINING FOR HCPS
- 6 MEET THE INFORMATIONAL NEEDS OF PATIENTS WITH ABC BY USING EASY TO UNDERSTAND, ACCURATE AND UP-TO-DATE INFORMATION MATERIALS AND RESOURCES
- 7 ENSURE THAT PATIENTS WITH ABC ARE MADE AWARE OF AND ARE REFERRED TO NON-CLINICAL SUPPORT SERVICES
- 8 COUNTERACT THE STIGMA AND ISOLATION ASSOCIATED WITH LIVING WITH ABC BY INCREASING PUBLIC UNDERSTANDING OF THE CONDITION
- 9 ENSURE THAT PATIENTS WITH ABC HAVE ACCESS TO TREATMENT REGARDLESS OF THEIR ABILITY TO PAY
- 10 HELP PATIENTS WITH ABC CONTINUE TO WORK BY IMPLEMENTING LEGISLATION THAT PROTECTS THEIR RIGHTS TO WORK AND ENSURE FLEXIBLE AND ACCOMMODATING WORKPLACE ENVIRONMENTS



Metastatic breast cancer: a forgotten group

The number of people living with metastatic breast cancer is currently unknown. This is largely because many cancer registries fail to record relapse. Many patients with metastatic breast cancer feel abandoned, isolated, and alone, and might not receive appropriate care. With adequate evidence-based resources and a shift in attitudes, it might be possible to cure some patients, treat most, alleviate the suffering of all, and forget or abandon no one.

The Lancet Breast Cancer Commission

*Charlotte E Coles, Helena Earl, Benjamin O Anderson, Carlos H Barrios, Maya Bienz, Judith M Bliss, David A Cameron, Fatima Cardoso, Wanda Cui, Prudence A Francis, Reshma Jagsi, Felicia Marie Knaul, Stuart A McIntosh, Kelly-Anne Phillips, Lukas Radbruch, Mareike K Thompson, Fabrice André, Jean E Abraham, Indrani S Bhattacharya, Maria Alice Franzoi, Lynsey Drewett, Alexander Fulton, Farasat Kazmi, Dharmesha Inbah Rajah, Miriam Mutebi, Dianna Ng, Szeyi Ng, Olufunmilayo I Olopade, William E Rosa, Jeffrey Rubasingham, Dingle Spence, Hilary Stobart, Valentina Vargas Enciso, Ines Vaz-Luis, Cynthia Villarreal-Garza on behalf of the Lancet Breast Cancer Commission**

Lancet 2024; [https://doi.org/10.1016/S0140-6736\(24\)00747-5](https://doi.org/10.1016/S0140-6736(24)00747-5)

**It is time for a deep CHANGE IN
MENTALITY and PERSPECTIVE towards
ABC/MBC!**



Bridging the Gap

Advanced Breast Cancer

Eighth International Consensus Conference

6-8 November 2025
Lisbon, Portugal

Chair: F. Cardoso, PT

Co-Chair: R. Kaur, MY

Honorary Chairs: EP. Winer, US

L. Norton, US - A. Costa, CH/IT

Scientific Committee: C.H. Barrios, BR – L. Biganzoli, IT

L. Carey, US – P.A. Francis, AU – S. Paluch-Shimon, IL



Receive updates on
www.abc-lisbon.org

Effective Communication from a Patient Perspective

Dr. Ellen Landsberger, Patient Advocate, MBC Alliance

- Ellen Landsberger is a retired Obstetrician-Gynecologist who specialized in Maternal-Fetal Medicine. She was active in the American College of Obstetricians and Gynecologist (ACOG) and retired from practice in 2016.
- She developed Breast Cancer, Stage 1 ER+/PR+/Her2-disease at age 43 and treated it aggressively. Ten years later she was found to have serous carcinoma of the uterus and again, treated it aggressively. Shortly after retiring from her busy academic practice, she was shocked to be diagnosed with metastatic breast cancer 22 years after her early breast cancer.
- She volunteers as a Breast Cancer Patient and Research Advocate with several organizations, primarily at Memorial Sloan Kettering Cancer Center where she is treated. She is a member of the Patient and Family Advisory Council for Quality (PFACQ) at MSK.
- No financial disclosures



My Background

- 1995 ObGyn/ Maternal-Fetal Medicine Specialist
 - Stage I ER+PR+HER2- Invasive Ductal Carcinoma

- 2017 22 years later, retired
 - MBC bone only, spine and pelvis

Reminders for Health Care Professionals

- LISTEN !
- Don't interrupt
- Look at patient, not computer
- Written material

Reminders

- Patients don't fail the drugs - The drug or trial fails the patient
- Avoid militaristic language
- Be truthful

Do's and Don'ts for Patients

- Speak up
- Be prepared
- Compliant patient \neq better outcomes
- Be proactive

How to Communicate a Diagnosis of Advanced/Metastatic Disease

Dr. Reshma Jagsi, Chair, Department of Radiation Oncology, Emory University School of Medicine

- Reshma Jagsi, M.D., D.Phil., is the Lawrence W. Davis Professor and Chair of the Department of Radiation Oncology and a Senior Faculty Fellow in the Center for Ethics at Emory University in Atlanta, Georgia.
- A graduate of Harvard College, Harvard Medical School, and the University of Oxford, where she earned her DPhil in Social Policy as a Marshall Scholar, she is the author of over 450 publications regarding both breast cancer and bioethics.
- She is the PI of multiple grants from the US National Institutes of Health, the Susan G. Komen Foundation, and other philanthropic foundations. Both a clinical trialist and health services researcher, she is known for research to strengthen autonomy in breast cancer patients and to individualize breast cancer care.



The Lancet Breast Cancer Commission



Metastatic breast cancer: a forgotten group

The number of people living with metastatic breast cancer is currently unknown. This is largely because many cancer registries fail to record relapse. Many patients with metastatic breast cancer feel abandoned, isolated, and alone, and might not receive appropriate care. With adequate evidence-based resources and a shift in attitudes, it might be possible to cure some patients, treat most, alleviate the suffering of all, and forget or abandon no one.

Communication is key

Many patients describe breast cancer as robbing them of power. Improving patient communication and facilitating patient autonomy in decision making can:

- » Improve patient quality of life
- » Improve patient body image
- » Improve adherence to therapy, which can lead to...
- » Positive effects on survival



Patient Empowerment

- Patient empowerment should be defined as being fully informed and supported to confidently participate in decisions about personal health and wellbeing to the desired extent
- Patient-centered communication must acknowledge the unique background and need for information of each individual, consider their situation holistically, and work with the patient to define and achieve shared goals in their care

Patients Don't Fail: But We Do Fail to Prevent the Development of Metastatic Disease for Many

- Outcomes of metastatic breast cancer have improved considerably in the past decade
 - median overall survival of metastatic breast cancer has remained at around 2–3 years for decades
 - but within the past 5 years, median overall survival has reached 5 years for 2/3 main subtypes (HER2-positive and ER-positive/HER2-negative), which account for approximately 85% of people with MBC
- Some patients can now live 10 years or longer with metastatic disease
 - and some subgroups are beginning to be considered as having a chronic disease
- Metastatic breast cancer is a spectrum of disease, both at a molecular level and in terms of disease burden
 - including potentially curable oligometastatic disease, long-term remissions or stabilizations, and more rapidly progressive disease (often the triple-negative subtype)
- Therefore, both the management of metastatic breast cancer and communication about the meaning of a diagnosis of metastatic disease must be individualized
 - not just on the basis of tumour biology, but also on patient characteristics

Challenging Conversations

- The balance between efficacy and toxicity of treatments and between the focus on survival, quality of life, and relief of serious health-related suffering is delicate and very personal for each individual in the metastatic setting
- Supportive care and palliative care are crucial parts of the management of metastatic breast cancer and should be incorporated from diagnosis
 - In a survey of 240 US oncologists, only 17% said that they refer patients to palliative care upon diagnosis of metastatic disease, despite two-thirds of respondents agreeing that earlier introduction of palliative care leads to better outcomes
 - Resistance from patients and their families is also a problem, often due to stigma and the perception that palliative care only means end-of-life care

The Concept of MBC & Goals of Treatment: What Providers Must Accomplish

- Explain that although MBC is usually incurable, it is treatable & can often be controlled for years
- Explain that treatment aims to slow cancer progression, reduce symptoms, improve quality of life, and prolong survival
- Understand how a patient prioritizes longevity, comfort, and independence
- Help patients make the treatment decisions that are best for them
 - requires the patient to understand the goals, logistics, and side-effects of treatment
 - requires the clinician to understand the patient's individual preferences, values, and life goals
 - (e.g., wanting to attend a loved one's wedding, travel, meet a grandchild, or avoid any change in appearance)
- Give realistic hopes and expectations: extremely challenging but also essential
 - Patients who want prognostic information might not always ask for it, so it is recommended that doctors ask explicitly if, when, and how patients want to talk about prognosis
 - It is best not to confront patients with information they do not want
 - Many patients still find it helpful to know the truth, and there is no evidence that increased information about prognosis with sensitive communication is harmful to patients, or that it increases anxiety or distress

Principles & Best Practices of Communication for Providers

- Build rapport
- Convey respect for the patient and understand their preferences regarding decision-making
 - Set the agenda for the visit in collaboration with the patient
 - Specifically ask about the patient's priorities for the consultation and their preferences for information and decision involvement (both their own and that of others)
- Share information
- Check understanding
- Empathize
- Review and make recommendations
- Come to mutual understanding about next steps

Examples of Language

- With these recent tests, we now have some new information about the disease that I would like to discuss with you.
- Unfortunately, the cancer has spread to...
- We can talk through what this means and what options there are.
- I know this is hard to hear. I am here to support you and will work with you and your other doctors to get a plan in place that works best for you and your priorities.
- Here's what we know about this cancer so far....
- Sometimes, the hardest thing is knowing you have metastatic cancer and not yet knowing what your next steps are going to be. Once you have a plan, and you understand how to put that plan into action with your team, I really do think it will feel so much better. Here are the options for how we might treat this.
- What is your understanding of what we've discussed so far?
- Is there anything else I should know about you that will help me take the best possible care of you?
- Based on everything we've discussed, I think this would be the best option for you. Does that sound like the right path to you?


Complicating Factors

- 21st Century Cures Act prohibits EMR information blocking
- This means that many health systems provide immediate release of results (including radiology and pathology) to patients, who may receive the news of new metastatic disease late at night, when no one is available to convey this information
- This is pretty clearly not patient-centered or ethical but is also viewed by most hospital lawyers as legally mandatory

Future Work



- Developing an accessible tool to provide information and support for individuals diagnosed with metastatic breast cancer with the goal of mitigating worry and facilitating choices that align with individuals' values and preferences
 - Modeled on the SharES tool developed with the support of NCI P01 and R01 grants and the Alliance A231901CD trial
- Collaborators:
 - Sarah Hawley, Director, Center for Health Communications Research, University of Michigan
 - Rohini Bhatia, Radiation Oncologist, Emory University School of Medicine
 - Jane Meisel, Medical Oncologist, Emory University School of Medicine; Chair, ASCO Communication Committee



*Above all what matters
is not to lose
the joy of living
in the fear of dying*

--Maggie Jencks, founder of Maggie's centres in the UK

Acknowledgements

- 30 commissioners, including 5 with lived experience of breast cancer, from 6 continents
- 40 collaborators, 8 early career researchers, 3 administrative leads



THE LANCET

Breast Cancer Commission Summer Meeting
The Moller Institute, 28 – 30 June 2022

**BREAST
CANCER
NOW** The research
& care charity

How to Communicate Disease Progression and Prognosis

Dr. Belinda Kiely, Sr. Research Fellow, NHMRC Clinical Trials Centre

- Dr. Belinda Kiely is a medical oncologist who specializes in breast cancer. She is a Staff Specialist at Concord and Campbelltown hospitals in Sydney, Australia and a Senior Clinical Research Fellow and Oncology Prognostication Program Lead at the NHMRC Clinical Trials Centre, University of Sydney.
- Her research interests include breast cancer treatment, prognostication and survivorship. Dr. Kiely led the development and evaluation of a web-based tool to help oncologists estimate and explain scenarios for survival time to patients with advanced cancer and contributed to the development of CancerSurvivalRates.com, a website helping patients with cancer and their doctors find prognostic information.



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— How to Communicate Disease Progression and Prognosis

Dr. Belinda Kiely

Medical Oncologist
Concord and Campbelltown Hospitals Sydney Australia
NHMRC Clinical Trials Centre, University of Sydney

What to expect when living with advanced breast cancer

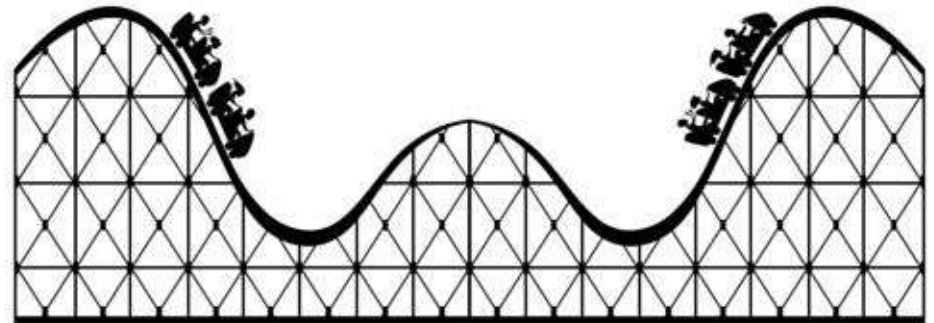
- Many people live many years
- Nearly always on treatment
- But treatment won't work forever
- Scans every few months
- Stepping from one treatment to the next
- For most people cure is not possible



Ups and downs like a roller coaster

Disease trajectory is individualized

- varies with subtype of breast cancer, extent of disease, treatment response,...
- Helpful to prepare patients for the likely ups and downs as they move through different treatments
 - Periods of feeling well while treatment is working
 - Periods where cancer progresses and symptoms increase



“Unexpected” deterioration

- Many have a prolonged response to first-line therapy
 - first progression can be a shock
 - often a long time from initial conversations about diagnosis, prognosis
 - patients and doctors can “forget” the cancer is incurable
 - false sense of security
- How should we remind people that treatment will not work forever, the cancer cannot be cured, ...

Forecasting

- “Right now I am hoping that treatment will go well for you.....
.... there usually comes a time when
treatment is no longer effective,
and I will let you know when that time comes ...”

Importance of prognostic information

- Prognostic information helps people with advanced cancer plan for the future and make informed decisions
- Communicating about prognosis is a fundamental skill for oncologists but there is limited guidance
- Prognostication is daunting
- Patients may receive little or no prognostic information

Barriers to discussing prognosis with patients

- Survey of 206 medical oncologists from Australia and New Zealand
 - family members requesting that prognostic information not be discussed (56%)
 - not knowing expected survival time (46%)
 - time limitations in the clinic (35%)
 - fear of causing stress to the patient and their family (35%)
 - fear of getting the survival estimate wrong (23%)

When and how to discuss prognosis?

- Start conversations early
- Don't wait for the patient to ask
 - Would you like me to talk about what the future might look like?
 - Is there **something** else you want to discuss?
- Ongoing process - often several conversations
 - values, priorities, preferences, wishes...
 - palliative care services
 - end-of-life care
 - understanding how a person ranks longevity, comfort and independence



Systematic Review: Timing of prognostic discussions

58 studies, guidelines and expert recommendations

Timepoint	Guidelines/ expert recommendations	Studies of doctors	Studies of people with advanced cancer
At first consultation	√	√	√
Prior to commencing treatment	√		
When a patient directly asks	√	√	√
→ At important transitions (disease progression , stopping treatment, hospitalisation, ...)	√		√
When patient expectations don't align with expected prognosis	√	√	√
When no further anti-cancer treatments	√	√	√
When recommending palliative care	√	√	√
→ When a patient's life expectancy < 12 months	√	√	

Scans to evaluate treatment response

- Important to explain
 - the reason for the scan
 - possible results
 - the plan for good news and for bad news
- Acknowledge scanxiety
 - common, transient, peaks before scan and waiting for results¹
- Discuss delivery of results
 - avoid delays
 - face to face preferable
 - challenge when patients access own scan results online

When the scan shows disease progression

- Be prepared – check result before speaking to patient
- Give the result straight away
 - *“I have the results of the CT scans you had done yesterday and I wanted to go over the results with you if that’s ok.”*
- Express solidarity (eg, *“I wish I had better news.”*)
- Give the bad news clearly and succinctly in plain, nontechnical language
 - *“Unfortunately, your cancer has spread to your liver.”*
- Pause for the patient to absorb what has been said
- Avoid trying to minimise the bad news or changing the subject
- Reassure that you will help them figure out the next steps

When the scan shows disease progression

- Tendency for oncologists to focus on discussing the next treatment
 - Treatment-talk occupied 50% of bad news scan result encounters in one study¹
 - Only 4 instances of frank prognosis discussion in 33 encounters (3 patient initiated)
- Opportunity to
 - discuss prognostic implications of scan results
 - reassess a patient's goals, priorities, and desire for information
- ***Would you like to talk about what this means?***

Forecasting

- Introducing Advanced care planning

“Your cancer has progressed, but we still have a treatment option.

Have you considered what you want if this treatment does not work?

If there is an emergency situation, have you thought about what you want to be done?”

Preferences for prognostic information vary

Type and amount of information sought varies
between individuals
within an individual at different times

Some just want the big picture

is this cancer curable?
will this cancer shorten my life?

Others want all the details

numbers and percentages
best-case scenario and worst-case scenario

Some people don't want to discuss
prognosis at all

Understanding why may help finding a way to
discuss it

Best not to confront a patient with information
they do not want unless a compelling reason to

Decision making does not always require patient
to understand detailed prognostic information



Preferred format for receiving information about life expectancy

Survey of 505 Australians with cancer (breast primary 64%)

- 2 formats to explain life expectancy to a hypothetical patient with an estimated survival of 12 months

1. Three scenarios

“If we imagine 100 people in exactly the same situation, then we'd expect:

- *5 to 10 would live 3 years or longer*
- *5 to 10 would die within 3 months*
- *the middle 50 would live 6 months to 2 years”*

2. Median survival

“The median survival time in this situation is about 12 months.

This means half of the people will live longer than 12 months and half will die within 12 months.”

**88% preferred
three scenarios**

**5% preferred
median survival**

<https://www.ctc.usyd.edu.au/3scenarios/>

- Website to help doctors estimate and explain 3 scenarios for survival
- Input: estimate of “median survival in a group of similar patients”

NHMRC Clinical Trials Centre

3 SCENARIOS FOR SURVIVAL

HOW TO USE THIS TOOL (-)

This website converts median survival times into ranges representing 3 scenarios for survival: a best case, a worst case, and a typical range. These ranges are based on studies of groups with known median survival times, and of individuals with estimated median survival times.

Please enter the estimated **MEDIAN SURVIVAL TIME** for a group of similar patients (people with the same condition and similar characteristics). Click on the arrow to view scenarios.

All items on this screen are entered and shown in months.

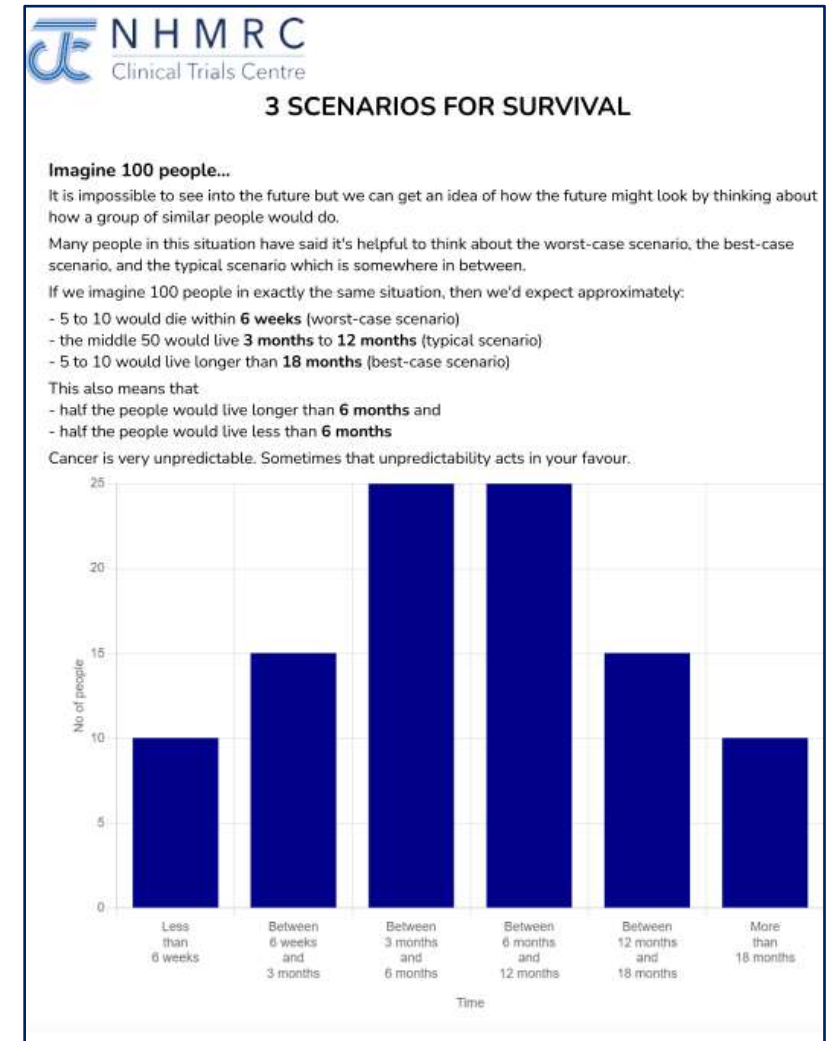
Worst-case scenario

Lower-typical scenario

***MEDIAN SURVIVAL TIME**

Upper-typical scenario

Best-case scenario



Attitudes of people with advanced cancer to receiving their own expected survival time formatted as 3 scenarios

33 oncologists estimated & explained expected survival to 222 patients with advanced cancer

	(%)* n=146
Having survival time explained this way:	
was helpful	91
makes sense	96
helped me make plans	88
improved my understanding	88
was reassuring	64
gave hope	56
was upsetting	41
Receiving a printed summary was helpful	91

* agree and strongly agree (vs. unsure, disagree, strongly disagree)

Patient attitudes to 3 scenarios

Hearing each scenario was helpful*	%	
Best-case scenario	92	} Majority wanted to know the worst-case scenario
Worst-case scenario	81	
Most likely scenario	86	
How scenarios compared with expectations		
Same as expected	46	} 77% found the survival scenarios the same or better than expected
Better than expected	31	
Worse than expected	23	

* agree and strongly agree (vs. unsure, disagree, strongly disagree)

<https://cancersurvivalrates.com>

website for people affected by cancer and clinicians

Breast Cancer

21% 5 Year Survival Rate

sex: male | female

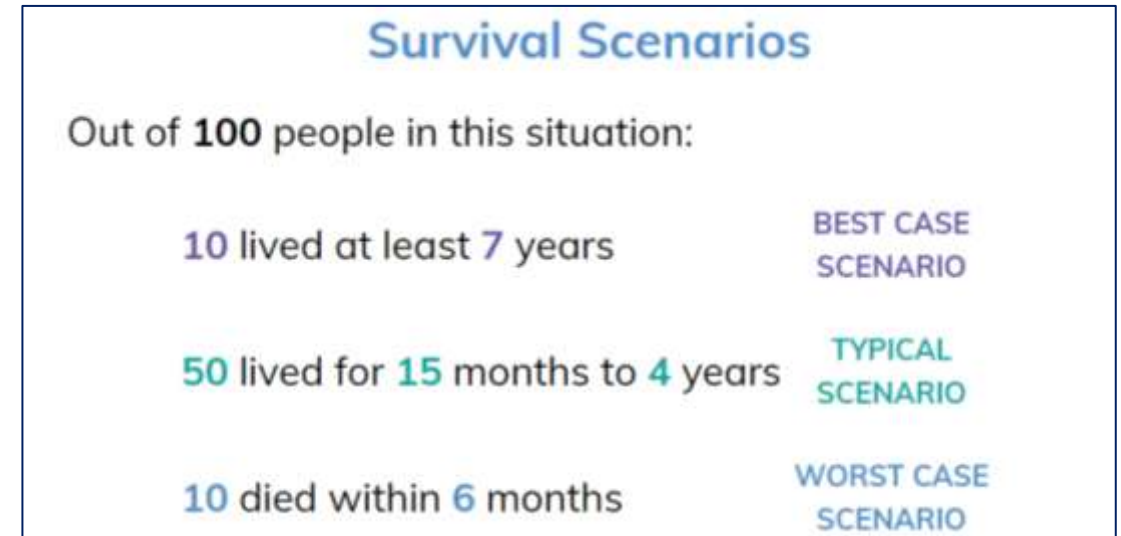
age: 18 | 55 years old | 90

stage: 1 | 2 | 3 | 4

grade: well | moderately | poorly

diagnosed: within past month | 2 years ago

subtype: her2+/HR+ | her2+/HR- | her2-/HR+ | triple negative



Survival information for all types and stages of cancer

- More reliable information for people googling “how long have I got?”
- >3 million patients, cancer diagnoses from 2000 to 2016, followed until 2017
- Cox proportional-hazards models using NCI SEER data; 1, 2, 3, 5, 10 yr survival models

Conclusion

- Help patients understand the likely trajectory of metastatic breast cancer
- Conversations about prognosis, values, priorities and end of life wishes, are important and need to be part of routine care
- Absence of questions does not equate with unwillingness to know
- Key timepoints (disease progression or expected survival < 12 months) can serve as 'triggers' for doctors to start a conversation
- Acknowledge patients as individuals with unique information needs
 - type, timing and amount of prognostic information

THANK YOU FOR JOINING US!

How to Communicate About Clinical Trials

Dr. AnaMaría López, Chief of Cancer Services, Jefferson Health New Jersey – Sidney Kimmel Cancer Center

- Dr. Ana Maria Lopez, MD, MPH, MACP, FASCO, is a medical oncologist and integrative oncologist at the Sidney Kimmel Cancer Center at Thomas Jefferson University, where she serves as Professor of Medical Oncology and Integrative Medicine and Nutritional Science.
- Dr. Lopez has dedicated her career to addressing healthcare inequities and supporting the development and advancement of a diverse healthcare workforce. By working with communities, by listening to needs and priorities, and by considering innovations in technology, digital health, and wearables, Dr. Lopez has committed herself to improving health outcomes. She has authored more than 130 peer-reviewed journal articles and multiple book chapters.



Interactive Breakout Discussions

Report Back from Groups

Closing Remarks

Beth Burnett, Chair, MBC Alliance

- Beth Burnett is the chair at Metastatic Breast Cancer Alliance, leading the coalition of allies to meet the needs of those living with or impacted by MBC.
- With over 30 years of experience in Oncology primarily in the pharmaceutical industry, Beth retired from Pfizer three years ago and joined the Alliance as an Individual Member/Advocate.
- Beth has a proven track record of working collaboratively with non-profits and patient advocates. She is passionate about improving the experience for people with cancer. Outside of work, Beth enjoys reading, hiking, cooking and traveling.



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