The second woman ever to hold the ESMO presidency, Solange Peters brings to the role impressive clinical and research experience in lung cancer, one of the most challenging and fast-moving areas of oncology.* Cancer World *asked her about how ESMO is adapting to meet the needs of oncologists in today's complex and rapidly changing clinical landscape, and about her vision for ESMO, and its role in the world.

Cancer World: *New treatments are coming to market much faster than the evidence doctors and patients need to make informed choices about how best to use them. What issues does this raise for ESMO's task of developing evidence-based guidelines?*

Solange Peters: Evidence-based guidelines are increasingly important as treatments are becoming more expensive and healthcare resources are more restricted. It is very important to offer evidence-based medicine to the maximum number of patients, so spending money on therapies that are not of benefit has to stop.
In response to current challenges, we are working to improve our guidelines in a number of ways. Firstly, our statement of benefits of each intervention is always qualified to indicate the level of evidence and grade of recommendation. Secondly, as the number of options expand, and as biological subgroups of cancers are identified, guidelines have been getting increasingly lengthy and complex to read and apply. We are therefore looking to adopt a more schematic approach to presenting the evidence, for instance by making greater use of algorithms.
Thirdly, with the clinical landscape changing so fast, we need to ensure our guidelines are always up-to-date. We have now started publishing online so-called 'living guidelines', which incorporate new evidence in real time, as it emerges from the literature.
The fourth thing is the ESMO Magnitude of Clinical Benefit Scale (ESMO-MCBS). With so many treatment options now available for many cancers, you need to make a choice. The ESMO-MCBS qualifies the extent of clinical benefit in terms of various dimensions including overall survival, progression-free survival, toxicity, long-term survival, quality of life and so on, which means you can use it to prioritise the strategies to use in patients.
So in the ESMO Clinical Practice Guidelines you now have the level of evidence, the clinical grade of recommendation and the ESMO-MCBS score.

CW: *The ESMO Guidelines Committee can only work with the evidence that is available. How do we ensure the right studies are done to answer unresolved questions about which treatment strategies work best for which patients?*

SP: There are many outstanding questions: the usual examples are about duration of immunotherapy as well as the optimal frequency of administration and doses of these drugs. These questions that the community is asking will in general only be answered by academic research. ESMO is committed to doing as much as we can to support the academic and collaborative groups doing research, so whenever a request comes for any operational or policy support we always try to respond.
But there are also ways to incentivise the pharma industry to ask the right questions. The ESMO-MCBS has an important role here. As the scale includes mandatory measures of aspects such as toxicity, quality of life, and long-term benefits, then if industry trials do not evaluate those data, they won't qualify to reach the maximum score. So that could be one incentive for industry to generate the evidence doctors and patients need.

CW: *You are only the second woman president of ESMO, and you've been instrumental in significantly boosting the profile of women in senior ESMO roles. How did you do that, and what advice do you have for others trying to address gender bias in oncology?*

SP: Martine Piccart, ESMO's first woman president, started ESMO's Women for Oncology initiative,

I picked that up from her. When I first joined the ESMO Executive Board, it was composed of more than 10 men, and me. I was the only one who really saw this as a problem. The attitude was that, more and more women are entering the profession, so the gender gap will resolve 'spontaneously'. So I asked for funding to do a study to better define the magnitude of the problem. When we looked at the numbers it turned out that less than 30% of ESMO committee members, less than 25% of invited speakers at ESMO meetings, and less than 15% of ESMO Board members were women. Importantly, this picture had not changed at all over the previous 10 years, despite the marked increase in the proportion of women working in the profession over that time.
Once the ESMO Board realised there was a problem, we saw rapid change. Today the Executive Board is composed of 50% men and 50% women, and at the last ESMO Congress (2019), women accounted for 45% of speakers. So the advice I can give to anyone wanting to start challenging gender inequalities is that you first have to prove and describe that the problem exists.
Challenging the gender balance has been important for equality within ESMO, but it also helps challenge some of the bias and barriers that women members say hold them back in their careers, by offering role models, building confidence and changing negative perceptions about women's capabilities in leadership positions.
We are now also encouraging the industry to address the entrenched gender gap when choosing their principal investigators, first authors and members of their advisory boards, as it is almost impossible now to build a career in oncology without some involvement in industry trials.

CW: *ESMO has undergone a significant change in identity in recent years. Is it still a medical oncology society and is it still European?*

SP: In everything we do now, we are not just medical oncology, we are multi-professional. All our guidelines, all our faculties across diseases, encompass all the treating subspecialties, the cancer caregivers.
Our roots are European, our membership is international – 25% of ESMO members are in Asia. Our approach is to deliver education according to our members' needs and consequently this includes organising activities in countries outside Europe. We have the capabilities, we have the energy, we are happy to do that. But we are always very respectful of the local knowledge in cancer, what is in place and what is needed.
One of the aims of my presidency is to move ESMO towards philanthropy, to fund travel costs, for instance, for doctors in under-resourced countries to learn about how a new radiation machine is working, or education about how to optimally manage patients in different settings. I expect we will offer such support primarily to countries in Asia, Africa, South America, but also in Europe when necessary.
I think that when an organisation such as ESMO has become so reliable in developing resources and services for patient care, it must ensure appropriate resources are accessible to its members and patients in countries with more fragile situations. This is one of the most important things for me. We will also provide funding for new types of fellowships, which will be more closely tailored to national needs. If I have to think of any legacy at the end of my presidency I hope it will be this.