Choosing and Managing a Career as a Community Practitioner

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The Community Practice Choice

In the latter half of my fellowship training at Washington University in St Louis, Missouri, I had the opportunity to choose between an academic post and community practice. My decision to join a community practice was based, like so many decisions, on a combination of introspection and family considerations. During my fellowship, I looked to my own experience as well as supervisor evaluations to assess my personal strengths and weaknesses. Although many of my colleagues and mentors have the gift of excelling at both clinical research and patient care, I recognized that I was happiest and at my best when managing patients.

Ultimately, I joined a hospital-employed group of physicians affiliated with the University of Michigan in my wife's hometown of Midland. With my wife practicing law and both of us caring for two young children, we valued being closer to family. Another important factor was practicing in a place where my services were needed. There are only four other medical oncologists in my city, some of whom are nearing retirement. My clinic volume rapidly increased to a full but manageable level within three months of starting. Setting aside for a moment the objective metrics that hospital administrators focus on, this gave me the feeling of usefulness within the community.

During my investigation of community practices, I did not anticipate having many opportunities for teaching or research. It was therefore a welcome surprise to have both readily available. I have always enjoyed teaching, so the opportunity to continue instructing medical students and family practice residents has become a gratifying aspect of my practice. Offering clinical trial enrollment to patients is important in our field, and I was pleased to see our organization join a National Cancer Institute research program designed to ease the process of opening trials in community cancer centers. Given the low number of adult cancer patients enrolling in clinical trials, the American Society of Clinical Oncology and other national cancer organizations support the goal of expanding the availability of trials beyond the auspices of major institutions. I have found that many patients are willing to participate as long as they do not need to travel long distances. Providing novel and exciting trials in the community is a goal to be prioritized.

Managing My Practice

During fellowship, I was encouraged to observe how different attendings manage their staff with respect to task delegation, communication, and clinic preparation. Thankfully, I picked up a few pearls of wisdom that helped me in my first year of practice. My nurse handles most of the telephone communications with patients. For this to be successful, I provide decisive and clear information and am readily available to answer questions. This creates efficiency by limiting my time on the telephone, so I can devote more time to the patients in clinic or in the hospital. Another great practice is to review patient charts with the clinic team periodically. My nurse and I meet at least monthly to review each patient seen since our last meeting. In some cases, it may only be a quick peek into the chart to ensure that appropriate follow-up is scheduled; other charts may harbor unresolved issues requiring more time to address. Each meeting feels productive and like time well spent. I believe that sharing information and educating those working with me is the key to building a great team. It is important to me that my clinic staff feel like they are contributing to patient care. Altogether, I am fortunate to work with an excellent clinic staff.

My goal has long been to embody the three *A*'s of medical practice: availability, affability, and ability. Communication is an important component of these characteristics as well. I took time to meet and make myself available to primary care doctors and other specialists in town. I also strove to earn these doctors' trust and build

collaborative relationships as I saw their patients. Keeping these goals in mind certainly helped me navigate my first year in practice.

Community Practice Challenges

At times during my first year in medical oncology practice, I found myself going back and reviewing the principles of oncology and internal medicine I had learned years ago. Although keeping abreast of current expert opinions and trial data is of primary importance, opening textbooks and reviewing physical examination techniques, information on a class of chemotherapeutics, or even anatomy was sometimes necessary and felt unexpectedly refreshing. Perhaps the familiarity was comforting.

Getting to know radiation and surgical oncologists, learn from them, and collaborate with them was an important part of my first year of practice. For example, I once gave specific recommendations to a rural-based patient with stage I diffuse large B-cell lymphoma of the neck, stating that he should receive involved-site radiation after his short course of chemotherapy. The patient soon called my office, distraught that he had been started on whole-neck irradiation with a plan lasting much longer than I had told him to expect. I placed a call to the outside radiation oncologist, whom I had not met, and explained my advice based on current recommendations for treatment fields and doses. To his credit, he appreciated my phone call and altered the plan accordingly. Knowledge of current radiation and surgical oncology best practices is particularly important in the community.

During my training, I fell under the admittedly biased assumption that all complicated oncology problems are managed at university centers with specialized oncologists. Early in my current practice, when I encountered complicated or rare cases I would refer them to the regional tertiary center for consultation. Some patients are not interested in traveling to an academic institution, however, or do not have the means to do so. Because of this, I found myself managing complicated or less-common cancers, such as refractory Hodgkin lymphoma and metastatic Ewing sarcoma. This was an exciting but unexpected challenge, and I consulted my colleagues as well as experts I knew from fellowship or at the regional tertiary center. I found that building these relationships during my fellowship paid dividends when I found myself in a challenging situation in practice. Such relationships may fade with time, however, and cannot be taken for granted. Networking with regional experts was an important early step for me toward developing contacts I could rely upon in such challenging situations.

Although I am someone who generally does not seek to be the center of attention, I have taken part in some efforts to market myself to the community. I provided a few words about myself and my practice style for a marketing video that was posted online, and I even took part in a television interview regarding ovarian cancer. Mercifully, the local television station did not air my portion, instead using the few minutes to focus on their interview with the charismatic Olympian who is an ovarian cancer survivor. If you ever come across my marketing video, you may judge whether I should consider a career change to broadcast journalism (hint: I won't quit my day job). Community outreach is, however, an important part of community oncology. Providing education in forums such as public lectures and cancer support groups gives one an opportunity to reach out and share your excitement at the progress as well as acknowledge the challenges which remain.

Just as I managed developing relationships with referring providers and the community, I also needed to manage relationships with the oncologists I was joining. It became apparent to me that by attempting to exceed everyone's expectations, I was potentially alienating my new colleagues. After having recently completed my training at Washington University, I was excited to share cutting-edge ideas and practices. There were times when I presented an alternate opinion at our tumor board that led to lively debate, for example. However, I came to understand that in many cases it was I who had more to learn from those with experience. Disagreements will invariably come up in a collaborative setting, and settling them in the most professional manner is critical to maintaining working relationships.

The first year of practice was a rewarding and challenging experience. Now that I am in my second year of practice, some challenges remain, but the nuance and progress in the practice of hematology and oncology keep each day fresh and interesting. I am reminded how much we all grow both personally and professionally with each passing year of practice, and how privileged we are to treat patients with cancer.

Summary

- Consider the benefits of community practice, where a single oncologist can have a large impact.
- Focus on communication and the three A's of medical practice: availability, affability, and ability.
- Maintain existing relationships with other oncologists, and build relationships with physicians in your community and those in your current practice.