Pressing the Restart Button as a New Postgraduate From Fellowship: Year No. 1

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After 10 years of medical education, I had finally done it! I had finished my medical oncology and hematology fellowship at Duke University and started as a new attending physician at the Gibbs Cancer Center in Spartanburg, South Carolina. I had left behind the difficulties of being a subordinate, not in control of my time, and was now taking on the difficulties of being a leader, still not in control of my time. (I almost feel like a surgeon, given how many times I have to be at work at 7:00 AM for tumor boards.) This transition is different for everyone, and I want to share my thoughts on a few challenges that I have faced from the perspective of a new oncologist working at a large community hospital–based practice with numerous other oncologists.

Challenge No. 1: Growing Your Practice

Some oncologists who join a group practice are taking the place of someone who has just left, so they have a large population of patients immediately. I fell into the other category, starting with a fresh, new, empty panel. As I stared at my patient census each day, which oscillated from zero to two, I wondered what the future would bring.

How did I finally get enough patients? In short, by focusing on three things. First and foremost, I cared for my patients. Unlike my fellowship, my new position left me with hours and hours of fairly open time at first. As a result, I was able to devote as much time to my patients as they wanted. I was able to answer all their questions and get to know them. Everyone naturally becomes busier over time, but good habits that you set up early will last, which is why I recommend that all physicians follow this example. The main benefit of extra attention to patients, frankly, is better medical care. To quote Dr William J. Mayo, "The best interest of the patient is the only interest to be considered." Patients who have a great experience will tell their referring physicians and their friends and family about it, and more referrals will follow. Building up referrals is a slow process, but a reputation for being short, rude, and inaccessible spreads fast and can quickly destroy a career. (Take note, this applies to your treatment of ancillary staff as well.)

This leads to the next point—the importance of developing relationships with referring physicians. Patients do not walk into your clinic because they underwent imaging and biopsies at home. Referrals come from people who were practicing in the community long before you were and already have people they call on frequently. You must make the effort to reach out to referring physicians after they send patients your way, and with more than just an e-mail or a routed note. Actually pick up the phone. Walk up to and talk to referring physicians at tumor boards, lunch, etc. The electronic world is extremely beneficial, but it does not replace human contact.

My last point combines the two prior ones: be a subspecialist. I am a community physician, but I treat only a few diseases—namely, genitourinary, thoracic, and skin cancers. Oncology is changing extremely quickly, and experts can present abstracts at meetings and incorporate new developments into practice long before they are published in a journal. A few key ways to stay up-to-date include focusing on and scouring as many annual meeting abstracts as possible, and also keeping up a dialogue with colleagues at academic centers who are on the cutting edge. This approach entails being humble and willing to send patients for second opinions. The eventual win-win result is that community patients get more expert care locally, and you can make a name for yourself. This model works for larger practices, but I would suggest that you make every effort to subspecialize even if you work in a smaller group.

A parting shot is to dress to impress. Look professional, and put on your best every day. For me, this

includes wearing a tie when it is at all appropriate. Patients may not know about your training or intelligence, but they know how you look. A precise outside conveys a precise intelligence.

Challenge No. 2: Getting Involved With Research

As I said before, I am at a community hospital–based practice and essentially unable to do bench research or start my own phase 1 or phase 2 trials. Our practice is part of the Alliance for Clinical Trials in Oncology, however, as well as a few other trial groups. Get involved with these trial groups if possible, or just with drug company trials if those are all you have access to. Go to professional meetings, meet colleagues at other centers, and try to bring trials to your institution. Even better, get on the committees of trials that are about to start. Clinical trials can be opened only at a limited number of sites, and opening trials puts your site on the map as a location for new trials. Everyone agrees that patients should be enrolled in clinical trials whenever possible; these can provide participants with better care and advance the field to benefit others. Many of my patients are unable to travel to academic centers, so the more we do to bring trials to our community site, the better.

Getting involved with research also is important because, as mentioned earlier, it allows you to interact with experts in the field. During such interaction, you will naturally share patient cases and learn more about the best options in nuanced situations. Learning about active and planned trials helps you look forward to the future of your field rather than backward to the past.

Challenge No. 3: Knowing When Enough Is Enough

The first two challenges I have discussed here require long-term planning, whereas my next point relates to daily practice. Unlike those of my colleagues who see patients with nonfatal or easily treated conditions, I see a specific population of patients with a high mortality rate—most of them have recurrent or metastatic disease by the time I see them, and their disease is often not curable.

As a result, physicians like me must help to decide when chemotherapy and other interventions should end, and when hospice should start. While I was in training, I always had the attending around to support my recommendation that a patient was ready for hospice. Now I am the only medical oncologist seeing my patients. I find it easier to recommend hospice when a patient is elderly and extremely ill in the hospital, quickly nearing death. However, I find it difficult to make this recommendation to those patients in my clinic who have a performance status of 3 and for whom approved lines of care are still left, especially if they have not received any therapy. Delivering a new diagnosis of advanced lung adenocarcinoma to a patient who is awake and sentient, and explaining that no effective therapy is available, crushes my soul. I want to pull out the miracle story I saw during fellowship in which the "Hail Mary" therapy did indeed work for an otherwise terminal patient. Because I am still very early in my career, I unfortunately cannot offer much wisdom, but what I can say is that deciding when to stop oncologic treatment gets easier with time and experience. I also have learned that many patients know they are dying long before you have that conversation with them, and inwardly they are begging you to confirm that there is no more therapy, that they are dying, and that it is okay to stop treatment and go home to be with their loved ones. I encourage you to continue to wrestle with these decisions and let them affect you to some degree. I continually learn from the times when more treatment clearly was too much. Talking to colleagues and friends about these cases is helpful, which is why I like having frequent conversations with my attendings, especially those in palliative care. I always want to do more, even when a patient is obviously dying, but in some cases less really is more.

Finally, underlying everything and carrying me though the many valleys of the shadow of death around me is my religious faith. I personally believe that Christ is the ultimate physician and healer, and I encourage you to examine your spiritual health to help you understand this broken world. But in the moment, sometimes the most tangible and visceral relief comes when I call my father, also a physician, and run my patient cases by him just to hear him say, "Yes, that was a terrible situation."

Summary

- Spend time with your patients and get to know their lives. Also get to know your referring physicians. Subspecialize and make a name for yourself in narrower fields.
- Participate in research and clinical trials, and whenever possible, try to be a part of trial leadership. It will benefit your patients and force you to grow and be challenged.
- Don't be afraid to tell your patients that they are dying and that no more therapy is available. Learn from the times you did give too much, and talk about it with those who will understand.