

If I Could Do It All Over Again

Experienced retina specialists recall transitioning from trainee to attending.

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"Although I feel like I am working more than anyone else, I think in actuality I am working the least of anyone here ..."

-A new attending at his first job after training.

As spring warms to summer, another cohort of senior retina fellows prepares to complete training and begin practice at varied locales across the nation. After more than a decade of preparation, these trainees will finally employ skills developed over years while simultaneously traversing a steep learning curve. As with all substantial transitions, the change from retina fellow to attending is exciting as well as a bit daunting. We interviewed several attendings, some more close to fellowship than others, for helpful advice on how to make the best of the upcoming transitions.

If you had the opportunity to do it all over again, what 1 thing would you do differently when transitioning from fellow to attending?

Sunir J. Garg, MD: Both from a clinical and surgical perspective, I remember several "strange" things that happened to me early during practice. Although I think I have a pretty good sense of what I'm good at and what I'm not, I don't think I fully appreciated how much my attendings were helping me surgically, most of the time in small ways that I didn't appreciate at the time. There were many seemingly trivial comments that they would make during the course of the surgery that I think I took for granted, and when I no longer had these attendings at my disposal, "paranormal" activities occurred.

I remember 1 of my first cases was a straightforward macular hole. I was operating in a new facility, with different staff and different equipment. The patient had a small superotemporal horseshoe tear. During my training, I had primarily used illuminated, curved laser probes, but in my new facility, all that was available was a straight, nonilluminated laser probe. The assistant

was uncomfortable with scleral depression, and I found it tough to laser the sclerotomy. Eventually, I thought I had done a fairly good job sealing the break. That is, until the patient developed a retinal detachment as soon as the gas bubble dissipated. This was, of course, caused by an inadequately treated break. Thinking about the case afterwards, I realized that I should have spent time going over the available equipment with the OR personnel and asked them to order a few things that I felt were necessary for me to do the case. I could also have performed cryotherapy. Neither of those things had entered my consciousness prior to this case because I never had to deal with that situation before.

In the clinic, I wish I had spent more time personally meeting referring doctors. When I started out, all I wanted to do was see patients and operate. At the start, my entire schedule was open, and, because I wasn't very busy, I would end up seeing one patient at 8:00, another one at 9:30, another one at 11:00, and then patients at 1:00 and 3:00. Although this allowed me to spend incredible chair time with the patients, it wasn't an effective use of time. It would've been smarter for me to block half a day once or twice a week to go and meet doctors because being able to put a face to a name really does help. It takes more time than you think to show up at a doctor's office and spend a few minutes speaking with him or her and the staff, so even during a half day it can be a challenge to meet more than 2 or 3 doctors during that time. In a large metropolitan area, it can take a long time to meet everyone, so plan appropriately.

Omesh P. Gupta, MD, MBA: During fellowship, most of my focus was on being a better retinal clinician and surgeon. I paid a lot of attention the nuts and bolts of retina—seeing patients, performing office procedures, and operating on patients. I wish I had paid more attention to the style in which different attendings managed patients. Once I left fellowship, I had to develop my own

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-Omesh P. Gupta, MD, MBA

style of talking to patients about their conditions, knowing when to operate, and accurately informing patients about their office procedure or surgery. One philosophy I found helpful to adhere to was to under-promise and over-deliver.

I similarly wish I had paid more attention to the style in which attendings interacted with staff. Once you are an attending, you are now perceived as “The Doctor.” You are also part of the management team of employees. Motivating staff, managing the clinical flow, and resolving office conflicts are incredibly important skills once you are out in the real world.

Andre J. Witkin, MD: I would have tried to videotape and edit more of my surgical cases, even those that were straightforward. As a fellow, you don’t realize how useful videos are for teaching and discussion purposes. Fortunately, I saved a number of surgical and clinical cases from fellowship, some of which I’ve already used for presentations or to informally show to fellows and residents.

I also would have tried to figure out how to bill properly, and perhaps attended a billing course. There are many nuances regarding when to use surgical or clinical modifiers and the elements needed to bill for a specific level of clinic visit or complex surgical case.

What steps did you personally take to ease your transition from fellow to attending?

Dr. Garg: I was fortunate to train in a fellowship program where I had a number of excellent faculty mentors. In the last few months of my fellowship, I paid more attention to how the attendings interacted with their patients and, just as important, interacted with the referring doctors and staff. I also spent some time gaining an understanding of billing, which is an area that all fellows would be well-served by learning early in their training. Just as with surgery, it takes many cases to become proficient; one has to bill a lot of visits before being comfortable that he or she is billing appropriately.

Dr. Gupta: Taking time off is a nice luxury if your

potential employer agrees. Another way to help ease the transition is to enjoy the relatively lower volume of patients early in your career. All of us who graduate from fellowship are anxious to get busy, but it is important to take time to get to know your staff and to learn the other aspects of practicing medicine that you may not have learned enough about during fellowship, such as medical and surgical billing.

Dr. Witkin: I think the most important thing for me was to take some time off after fellowship. It’s the only time you have to take a few weeks off and go somewhere you wouldn’t otherwise go.

How did you balance your academic interests and your clinical responsibilities when starting as a new attending?

Dr. Garg: In the beginning, I was so interested in developing a busy schedule in clinic that I didn’t develop a strong strategic research plan. If you are joining an academic center, it is worthwhile to speak with the chairman and other senior faculty members who are active in research to learn about research opportunities. Developing a collaborative research plan is helpful, and aggressively pursuing this from day 1 will help tremendously. Prospective, grant-funded research takes a long time to get off the ground, and the earlier you can start, the better.

In a private practice setting, there are also multiple research opportunities available. Of course, becoming involved in large multicenter clinical research trials is an excellent step to take. However, there are a number of research projects that one can successfully conduct in a private practice setting. It can be challenging to design prospective trials in a private practice simply because, as the principal investigator, you may not have enough patients to make the project worthwhile, but it is worth discussing projects that several members of the group may be interested in.

Dr. Gupta: This is always a challenge. During residency, fellowship, and now as an attending you are going to be pulled in different directions. I think the key is to decide if academia is something that you are interested in. It is not for everyone. If you decide that you want to become involved, then I think the key is not to overextend yourself. During residency or fellowship, you may have felt obligated to say yes to everything but it is OK for you to say no now.

Dr. Witkin: I am trying to ensure that I build time into my schedule for academic pursuits, which can be a chal-

lenge as my schedule becomes busier.

Teaching is possibly the trickiest academic interest to incorporate early in your career because everything is new and it takes time to become comfortable with the fellows, residents, staff, surroundings, and equipment.

When operating as a new attending for the first time, what steps did you take to optimize your surgical outcomes?

Dr. Garg: I would encourage every fellow to make a checklist of the equipment to which he or she is accustomed and find out what is available before starting a case. Being a new attending is nerve-racking enough—there are differences in microscopes, foot pedal design, foot pedal controls, personnel, and equipment, all of which can make surgery more challenging. The more things you have to think about during the surgery, the less brain power you have left to think about what you are doing inside the eye. Successful businesses standardize their operating procedures so that they can focus on efficiency and good customer service. I look at performing surgery the same way. I want to standardize as many variables that are in my control as I can so that I can be better prepared to deal with variables that are outside of my control, such as intraoperative circumstances. If using equipment with which you are not familiar, I recommend having the equipment representative come in for your first few cases.

I would also encourage fellows to simply do what they know how to do and not to try fancy maneuvers early on. Your job in the first 3 years of practice is simply to provide your patients with excellent outcomes and to establish and enhance your reputation in the referring and at-large community.

Finally, for cases like retinal detachment repair, if you are considering a scleral buckle, do the buckle. I have never regretted putting on an encircling band during a retinal detachment repair. I have only regretted not putting 1 on later.

Dr. Gupta: In the same way that preoperative planning is imperative for complex cases, for the new attending, planning is imperative for every case. In addition to discussing with other attendings, make sure you visit the OR, maybe even sit in on a senior attending to see how the OR staff functions. Don't assume that all OR staff skill sets are the same in every facility or that the equipment that you had available during fellowship will be available in your new facility.

In addition, preoperative counseling for patients is important. When I was a fellow, I didn't appreciate the need to discuss the benefits and risks of a procedure

with patients as much as I do as an attending. Managing patient expectations is central to maximizing patient outcomes.

Dr. Witkin: The first thing I did was to watch a few surgeries in the OR I was going to work in primarily. Although much of the equipment was the same as during fellowship, there were some subtle differences. I also made sure the OR staff knew my preferences, and they even ordered lighted laser probes for me, which they didn't have prior to my arrival. It's also very helpful to have with you in the OR a surgical representative from the particular company whose equipment you're using for the first few cases.

I also think it's helpful to think about exactly how you will approach each surgery after you see the patient in the clinic, and then discuss any questions you think of with colleagues. I am fortunate to have excellent colleagues at my current position, as well as having trained with great mentors and co-fellows during fellowship. There are therefore always people available for me to ask questions of when planning surgery. If it's a particularly difficult case, senior colleagues are often willing to come to the OR and assist. For example, during 1 particularly difficult case that I had early on, in which an unforeseen complication occurred, I called 1 of the senior attendings, who then came to the OR and helped discuss how to proceed. Many practices actually require that a senior partner attend the first few surgeries a new associate performs.

How did you seek out assistance when you may not have known the solution to a clinical (or surgical) scenario?

Dr. Garg: Developing good working relationships both with your attendings and with your senior fellows will be of great help during practice. I was fortunate to have a few attendings I could call on in a pinch. Now I'm fortunate to be in a position in which some of our former fellows will call me in the middle of their clinic, or sometimes even while they are in the middle of operating, to ask advice about how to deal with something. I once called 1 of my former attendings (and current partner) James Vander, MD, about a surgical case, and I asked him if he minded that I called him now that I was no longer a fellow. He said, "It's no bother at all. In fact, it helps me understand things that we need to emphasize more during training." I think if you can find an attending with that attitude, he or she will be a lifelong teacher to you.

Some people seem to think that, because they have completed their training, they should know everything that there is to know. For me, being an attending who

trains fellows is a constant reminder of how much more I have to learn. Even to this day, I will bounce complicated cases, both medical and surgical, off my more senior colleagues. Most of the time all I need is affirmation that my thinking is correct. Sometimes, however, I honestly don't know what to do in a certain situation, and the experience and knowledge that I gain from my colleagues continues to help me become a better doctor.

Dr. Gupta: When you leave fellowship, I hope there is someone you can call to discuss a case with. You may have someone who was really good with medical cases and another who was good with surgical principles. Your former co-fellows are also invaluable resources. They can not only be helpful with directing management, but also be supportive of your struggle to find an answer for a patient.

Dr. Witkin: In the field of retina, we are fortunate to have a wide array of imaging at our disposal. It's easy to send images to colleagues and seek various opinions. If something appears unusual, photograph it. I often will bring patients back frequently if I'm not sure what is going on with them, and I've called patients back sooner if I think about something I've missed after the patient has left. ■

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