

Making the Most of Your Vitreoretinal Fellowship: Part 1

Advice from senior attendings.

BY ADAM GERSTENBLITH, MD; CHAR DECROOS, MD; AND RAJIV SHAH, MD



Ten years is a long time. As you well know, that's the minimum amount of time it takes from graduating college to starting your career as a vitreoretinal surgeon if you pursue a 2-year vitreoretinal fellowship. By the time you reach your fellowship, you are so close to the end of your training that you can taste it! You're beginning to feel ready to be finished, to get out there on your own. The prospect of finding a job is exciting,

and the idea of being in training is becoming less and less appealing. There is, however, some degree of anxiety about actually being out there on your own. Many former vitreoretinal fellows will tell you that they learned much more in their first year in practice than they ever anticipated. For the first time, patients are yours alone, and you alone are accountable for their outcomes, good or bad. You are no longer being spoon-fed the data from the latest studies. You no longer have a doctor with 20 years of experience sitting next to you in the OR for when things go awry. You may not have access to the latest technology in medical or surgical vitreoretinal practice and you may no longer have instant access to colleagues across all specialties of ophthalmology and medicine. For all of these reasons, it is essential that we not lose sight of the value of our final years of training.

For part 1 of this 2-part column on getting the most out of your fellowship, we interviewed some of our senior attendings to get some words of advice. In part 2, we will interview some recent graduates of fellowship.

-Adam Gerstenblith, MD; Char DeCroos, MD; and Rajiv Shah, MD

What are some things fellows can do, in your opinion, to make the most out of their fellowships?

Arunan Sivalingam, MD: Come prepared.

Developing a strong foundation of medical retina during residency prior to the start of fellowship will allow you to take full advantage of the learning opportunities that are available to you. Reading textbooks, such as Gass' *Atlas of Macular Diseases*, among others, will provide you with a basic understanding of the anatomy and pathophysiology of retinal, vitreous, and macular diseases. This will help you both in clinic and scientific conferences in taking the next step and learning advanced concepts.

David H. Fischer, MD: See a lot of patients. Clinical exposure is one of the best ways to learn. The more patients you see during fellowship, the more valuable the experience. Fellowship can be tiring, but those who make an extra effort are the best prepared once they start practice.

Carl D. Regillo, MD, FACS: Most fellowships are a part of busy private practices and academic centers. Clinic can move quickly, and there is often not enough time for fellows to ask questions of their attendings after each patient encounter. When I was a fellow, I used to keep a list of questions regard-

(Continued on page 80)

(Continued from page 29)

ing patients' diagnoses and treatment plans. At the end of the day, I would pull the charts and ask to go over some cases with the attending. I encourage our fellows to do the same thing. If you do not take the time to learn the decision-making process that your attendings go through, both in the clinic and the OR, you will not be prepared to start practice on your own. Additionally, following up on patients to see how these decisions affected their clinical outcome is an essential part of the learning process.

In your opinion, what attributes in a fellow best correlate with future success in practice?

Dr. Fischer: I have found that those fellows who work well in a team environment tend to have the greatest success in practice. Regardless of where you land after fellowship, taking care of patients is a team effort. Those who have learned teamwork are usually successful.

Dr. Regillo: Most retina practices have a high clinical volume, and to be successful one must learn how to efficiently examine and diagnose patients. Learning what parts of the chief complaint, exam, and discussion with the patient are important and relevant to their care is essential. Fellows who can learn to effectively triage patients tend to have the easiest transition to clinical practice.

What do you find attendings struggle with the most?

Dr. Sivalingam: All new attendings struggle with a variety of aspects in practice. The point of struggle often depends on where someone did his or her fellowship. Coming from a program that does not have large surgical volumes, a new attending might find the OR to be particularly challenging. Another aspect that a doctor just out of fellowship may struggle with is practice management. The business side of medicine, including billing and staff management, is often a new concept for doctors just out of training. Those coming from fellowships based in busy private practices may be better prepared for this than those coming from academic centers, but regardless of where one trains, learning the business of retina is very important.

Dr. Fischer: Back when I started in practice, vitreoretinal surgery took many years to master. The surgical learning process continued long after fellowship. Today, with advances in small-gauge vitrectomy and the myriad surgical tools we have available, the time it

takes to become proficient in surgery has decreased. Most of our fellows leave this program essentially as technically proficient as the attendings. However, the "thinking" aspect behind the surgery, the intraoperative surgical decision making, this is what is often underdeveloped in new attendings. This part of vitreoretinal surgery is important and, despite advances in technology, takes many years to perfect.

Dr. Regillo: One of the most challenging aspects of starting in practice after fellowship is patient communication and managing patient expectations. Fellows often perform the patient workup before the attending sees the patient, moving on to the next patient without hearing the ensuing conversation that occurs with that initial patient and the attending. Despite advances in medical and surgical therapies, many patients still end up with poor vision as the result of serious retinal disease, so managing patient expectations prior to initiating and during ongoing medical and surgical treatments is essential. This can be challenging as patients often have unrealistic expectations. The ability to ensure that patients truly understand their prognosis and continue to have confidence and trust in you as the physician can be a delicate balance in some situations. Therefore, I recommend that fellows spend time observing how experienced attendings talk to their patients. ■

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