Episode 1 : Internal Medicine Journey Pathway with Dr. Pendharkar #podcast #medicine #heal Transcript

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Introduction and Episode Overview

Hello and welcome to the Clinical Canvas, stories from seasoned doctors. >> This is a podcast series where we share our physician journeys in healthcare.

I'm Dr. Seema Pendar a practicing internal medicine physician. >> And I'm Dr. Jenica Steel a practicing emergency medicine physician. What we share here today are limited to our own opinions and do not reflect those of an employer or any other institutions.

So welcome. Today being our episode number one, our first episode of this series, we'd like to talk about what it means to be an internal medicine physician and I'd like to find out about your journey and pathway of being an internal medicine doctor. >> Yeah, so just to go back to the beginning of my career pathway, I did finish a dual residency in internal medicine and pediatrics and from there at the time I thought I wanted to get into academic medicine.

Early Career and Choosing Internal Medicine

So I first joined UCSF as a hospital medicine physician where I was doing a little bit of teaching and I was also seeing patients as a hospitalist physician.

>> So question, when was this? How long ago was this? >> So this was back in 2012 that was my first job and I stayed in that position for probably about two years and >> What made you decide to choose internal medicine? >> I really love writing, I like reading, I like thinking. So I think that it's really fun to come up with a detailed assessment and plan for medically complicated patients. I really enjoyed that. And is >> there was there another option for you in terms of what specialty you would use?

>> Yeah, in terms of I mean I did complete a residency in pediatrics as well and I enjoyed that as well. I thought about sub specializing in infectious diseases because there was a time when I really enjoyed traveling and sort of global health and and that sort of thing, but I decided to just kind of go with hospital medicine ultimately. >> So instead of doing like a private practice for internal medicine, you decided to focus more hospital. Was that the the options? >> Yeah, and I had a special interest you know in patient safety and quality and research on those topics and so that was another reason why the academic setting made a lot of sense for me. I was really drawn to that. >> Did you know ahead of time what it meant to be an academic medicine you know physician?

>> Yeah, I mean I think I completed my residency in an academic setting and so I think in some ways I thought that was probably the only option. I think that I did do some rotations in private practice, but I'd say that in the place where I did my residency which was at Duke, private practice in a way was almost frowned upon like it was a little more prestigious to pursue academic positions. So in that sense I was probably influenced a little bit by my peers and and things like that. >> Oh, I see. Okay. So you went from Duke to the West Coast?

>> Um yes, to UCSF on the West Coast. >> And why did you decide to make such a big change?

Academic Medicine at UCSF and Early Challenges

>> Uh well, my sister actually had lived on the West Coast for several years and I would visit her and I really thought I could just explore the climate and a different setting and and I had to. >> And so what did you what was kind of like your career journey or your learning within that first say five years of your of being an internal medicine physician?

>> Yeah, I would say that you know I really loved the actual clinical medicine like the patient diagnosis. I loved looking at different studies and research and literature. I did try applying for several grants to um head up different quality patient safety projects. And I found all of that really appealing, but um I do think that um at times it was a little more um difficult to sort of break into those areas, if that makes sense. I felt like I had to work really hard to sort of get the acceptance, if that makes sense.

>> So, going into this first job, you had to learn the clinical skills. You know, though you know, residency you're learning a lot, but being an attending is kind of taking it to the next level in terms of your clinical skills. So, in addition to clinical skills, you were also trying to almost do like a research aspect of it by doing applying for grants. You know, that has That's a lot. So, how did that all fit together?

>> Yeah, I would say that, you know, like luckily my residency training, I feel like they gave us a lot of practice independence, you know, so I think that it allowed me to be really secure with my clinical skills. Um so, that the clinical piece and the teaching was something that I don't think I had to worry about too much. I mean, I think every new physician is a little stressed out. So, um definitely I had that piece going on. I think the hardest thing that I probably had to navigate was the political piece in terms of um navigating any hospital system. Um there's a very, very large political piece that I think probably to this day that um I would say I've probably haven't um mastered that, and it's really not something that I enjoy. And I think that if I had known that that wasn't going to be a really significant component, I probably >> [clears throat] >> would have explored private practice a lot earlier. >> Okay.

What about, you know, was there a huge learning curve in terms of your clinical work? And how did that come about? Did you, you know, did you feel comfortable being an attending or did you have to adjust some things in order to to to get to where you wanted to be or felt you needed to be? >> Yeah, I think I would say the hardest part was trying to do sort of the clinical part and then on top of that grant writing, joining the right committees, connecting with the right people and especially since I went to the West Coast on my own without any connections. I had to do all that and sort of from scratch. So networking is something that I still really enjoy to this day and I think even back then I enjoyed it, but I think building those new connections and relationships it definitely takes time. So >> Did you have any mentoring at that time or did you kind of not realize that that was as important as it was potentially been?

>> Yeah, actually it's funny that you mentioned that the strongest mentor that I had actually was somebody who was in health tech IT. So he wasn't a physician and I actually recently saw him 3 weeks ago when he visited in New York and I'm still in touch with him, but he was definitely very generous with his time and trying to connect me and I did I I got like a $20,000 grant to build an app and do some interesting things in health IT.

I don't think it was as easy for me to find other physicians that were sort of mentoring me and I would say I like the word sponsoring actually. I think that's kind of an important distinguishing factor between mentorship versus sponsorship. I think that you have to find a person that really is going to feel like they're investing in you and they want to see you advance and grow.

If that makes sense. >> As opposed to what would you say a mentor would be as a >> Yeah, I mean I would say like a mentor is somebody that like maybe you could check in with, you get lunch with. A sponsor I'd say is somebody that's actively and it has your interest in mind and they're actually maybe even seeking opportunities and things for you when you're not even thinking about it, you know?

Mentorship, Sponsorship, and Networking

>> So ideally it would be someone a mentor and sponsor would be the same person. >> Yeah, exactly. >> In theory. >> Yeah, yeah. >> But uh you know Was it hard to find um say specifically a a woman who has already gotten grants and already gotten funding in a academic setting to try to help you along or was that even >> Hostility or >> Yeah, I mean I would say that in my experience personally in academic institutions with women mentors and this is just my personal experience. I know that a lot of women had to like really struggle to get into those higher positions and um so I think that they were harder to come by. Uh that was my experience. I did >> Harder to approach or harder it just if there was fewer fewer of them or >> probably fewer of them and they were spread thin so they probably already had like, you know, groups of people that they were already sponsored sponsoring and

mentoring so um it was harder to say.

>> So how long did you stay uh on the West Coast then? >> Um I ended up staying for um a total of 2 years. >> Mhm. And then after that, where did you go?

>> At the end of my time in San Francisco, um I decided that I wanted to be in New York and I actually came to New York without a job, without a plan, without anything in concrete. I just knew that I wanted to be in New York. Um and luckily as a hospitalist, um I think generally it's been easy to find um locums positions and so that was sort of my next move is that I got into locums a little bit. >> And so can you describe locums and how that works? >> Yeah, yeah. So um locums I'd say I mean it's still you need a good network, you need the connections and contacts and I think uh at the time it wasn't something that I knew a lot about. I just kind of put my feet in the water. There were hospitals that had a need for internal medicine doctors, and so I found a few places, and I just tried it out, and I didn't really um in terms of navigating contracts and that sort of thing, I didn't know what I was doing. And then in terms of the patient care, that always came to me um pretty easily, and I enjoyed it.

>> So, how did you figure out the contract part? Like, that seems very kind of overwhelming. >> Yeah. Yeah, I mean, I would say that probably for a few years, I would say that I I probably really did um sell myself short, so to speak, and >> Tell me uh more about that. What do you mean by that?

Locums Work and Evaluating Hospital Safety

>> Yeah, I mean, so I think that when you're navigating um a locum's contract, there's a lot of different things that um you have to sort of consider, including, you know, like what's the patient load, how many patients are you going to be rounding on, are you going to go round on patients in the ICU, are you going to be doing admissions, what's the structure of that hospital, is there support, and then of course, the thing that people think about the most is the pay rate, but I would say that that's probably the least of your concerns. Um I would say the top thing is you want to put yourself in settings where um you're not going to get sued. It's safe to do patient care in a high-quality way, and I would say that you have to [clears throat] trust your contacts and talk with people to get that information. >> How would you know that it'd be safer like in in one hospital as opposed to another?

>> Yeah, and I think asking a lot of those key questions is really important, like how many patients am I going to be rounding on, do I see ICU patients? And I think that like once you get an idea of the structure of a particular hospital, it really gives you an idea if you're savvy as to whether that's a place where you're going to be safe. >> Safe so as in like you have backup in case you need help, or if you are just going to be kind of left to be the only doctor of >> Yeah.

>> hospital, is that what you mean by say >> Exactly, exactly. And I'll just give a a brief example without naming any names, of course. But a recent hospital that I was at, the staffing was I'd say very minimal.

They had specialists on their roster who would never really come into the hospital when you needed them. They had ICU care that was only done by video visits. And of course an ICU level patient is somebody that needs to be seen in person by the ICU doctor. So those are the types of hospitals that I would not go to because you can't keep the patients safe. You know, if my own family was going to a hospital like that, I would take them out right away and send them somewhere where they could have access to the specialists and everything that they needed. >> So is that a Like I would think that it's only a rural a rural area that the hospital would be. >> I wish I could say that, but no, that the bad hospital was in you know, a city that we're currently in right now. So >> Oh wow, so big as >> Big city that >> Yeah. >> that has options.

>> Yes. >> Yeah, have people. It's not in a rural >> Absolutely. A very rural place. >> Yeah, mid Midwest or something. >> Yeah, unfortunately. I mean, I think a lot of hospitals these days are being acquired by large venture capitalist companies and so unfortunately a lot of those organizations are very invested in their profit. And so that's the way that they save money. And so again, I think that I encourage physicians to be astute and to be savvy to talk with the people that are already in that hospital. Again, you could be in situations where you could be the best and brightest physician.

However, if the safeguards and things are not in place in that hospital, you're setting yourself up for failure. But I'll >> So how long did you do locums then? >> I've done it on and off actually for the I'd say the last um several years, you know. I had Initially, I was more attached to like a W-2 type of setup because that's what I knew. I was familiar with that, but I think as the years went by, I realized I would have a little more flexibility and a better lifestyle.

>> So, you went from um the West Coast to locums in New York, and then did you get Brigette like decide to work specifically in a place in New York? >> Yeah, I did actually go back to a W-2 position, and I was at Mount Sinai for a couple of years where I learned a lot. I was the in a leadership role there for hospital medicine. So, um again, I did learn a lot, and it was an interesting experience.

>> So, how was the leadership role different, or how did you combine that into your clinical work? Like, how did that work? >> In a lot of these academic institutions, when you do the leadership piece, it's almost like a um side note in the sense that you're still expected to do the patient care, and that responsibility is still there. So, I did find over the years that in these clinical leadership positions, often times it didn't feel safe because, you know, you have to focus on the patients, but then you're being asked to attend a lot of meetings and this and that, and it's a little bit unrealistic, this is what I found.

>> So, did you ever get any like your time amount of clinical work decrease because of your administrative duties?

Leadership at Mount Sinai and Burnout

>> Yeah, I mean, in a lot of those positions, they will tell you that you're getting, you know, say 60% clinical, 30% admin, but at the end of the day, I found myself in a lot of positions where I was the chief of hospital medicine, and then the rounding doctors, they would get stressed out, and they would say, "Oh, I have 25 patients today. Will you take five of my patients?" You know, and then you get pressured like that, and um even the higher administration will sort of um encourage you to just go ahead and keep taking keep taking keep working keep working you know until you feel that you know it's just not feasible and and you get frustrated.

>> So how long did you do that? >> So again I did I would say that I've never really lasted in a clinical role for than two years in adult acute position because like my frustration level would just skyrocket they don't want feedback they just want to tell you sort of what to do and again if if you're not up for working around the clock day and night then a lot of times the only option is to transition into something different.

>> So what did you then transition to from there? >> So basically you know I think when I hit my I'd say I hit sort of rock bottom in the sense that I realized that you know I don't want to work for these types of employers that you know are forcing me to do these positions that are unsafe they're not thinking about my wellness they don't care about how I feel and I sort of hit that point and I started exploring you know how could I you know still continue to do clinical work in a way that feels safe and comfortable for me so I'd say that sometime after the pandemic you know in 2020 / 2021 that's when I started exploring the idea of a private practice a little more and then having locums on the side so I can kind of build up the private practice piece a little more. >> And so what is building up a private practice what does that even look like? >> Yeah yeah I think there's a lot of different versions actually and so I think the standard model is having like you know your own clinic where you see the patients they come to you they're sort of like your own patients and that's actually sort of the vision that I had but then I think somewhere along the way there were other opportunities that came up for me and so one aspect of my current practice is that I have sort of like a locums model where I have three or four physicians that will go and do care in other facilities where they have a demand, yeah. And that's not really sort of what I was planning on, but it was like sometimes the opportunities will just come to you.

Transition to Private Practice and Post-Acute Care

>> And so you're doing that, and then what settings were is that hospital settings or is that like >> So um that's a post-acute care facility, so like nursing homes and sort of sometimes um it could be LTACH facilities as well, so >> So how do you find that different than say hospital medicine? >> So I actually never envisioned myself um working in that type of a setting, but it's been really rewarding actually, you know, I think that a lot of the patients they have um yeah, then they can be medically complex, they have need, and doing basic things like adjusting their

medications for diabetes, blood pressure can make a tremendous impact, you know, and even as my own dad ages and I help him uh you know, you just realize how much care people need in their um older years. >> And so do you do you feel like you are having that longevity uh that internal medicine physicians like uh with patients in this setting or is it you you're kind of coming and going?

>> Um actually it's nice because there is a continuity and you see some of the same patients and you really get to know them and you get to know their story and yeah, it's it's really fun. I have a particular memory of sitting at a table with um some older ladies with dementia and they had like a robotic cat they were playing with and their eyes just um like sort of like lit up, you know, and they were very grateful that I sat down with them. Some times they'll ask you to play bingo or just other games with them, you know, and that's it's really nice because sometimes as a hospitalist, you know, you can get pulled into more stressful situations where people are, you know, they're feeling stressed and angry, and and so this is a different type of experience.

>> So, how how is this different for you personally? Like, you're in your life, your everyday life, how does it work? Is this a better situation for you? Is this >> Yeah.

>> Uh like, but financially is it concerning to you? You know, questions like that. >> Yeah, I would say that it's it's a it's a better fit because I think when you're managing your own sort of practice at the end of the day, you get to control your own schedule, you know, so I have a scheduler that helps me, and for example, I told her that, you know, I don't want to work on these certain days, or these are the limitations, and you can really um kind of adhere to that. But then on the other hand, when you're sort of business owner, I guess, you are working around the clock, you know, and having to do things like um accounting, bookkeeping, scheduling.

Those are things that um I actually do enjoy them, and I've learned how to do them, but it's not something that I was doing when I had a W-2 position.

>> Right. Yes. I I I know that entrepreneur part of me is I don't have it. So, I like other people to do that for me. Yeah. So, um but I can understand that that would be something that would be really empowering as well.

>> It is, yeah. It's definitely something I have invested time into um in terms of learning from other people that are experts that have taught me and are teaching me, so. >> So, you're like financially fine. Like, you're you're living, you're you're even though you don't have like a a set job with, you know, 401k, and, you know, health care benefits and all that, you are you are fine. >> Yeah, I mean, I would say that I'm even much better off than I was when I was doing a W-2 because again, this is sort of a situation where you get to control it, right? I mean, I can work 7 days a week, 24/7, around the clock if I wanted to, but uh I don't want to do that, you know? And uh so, it's my choice, and again, you can kind of do it based on what your financial goals are. And I think these days I do try to be have more uh do more of like a a minimalist. Um they call I think they call it um like low consumption or something. I like that.

Career Reflections and Advice for Physicians

I mean, I think there's a term for it on social media, but I think it's better to live a simple life, work less. I I like that concept. >> Got it. And so, out of your how many years have you been in internal medicine? >> So, I have been practicing for 14 years now. >> So, for the 14 years of your career, any big take-home points, any big, you know, suggestions for someone who might be interested in going into internal medicine?

>> Yeah, well, what >> kind of things have you learned that you would like to pass on to others? >> Yeah, um I would say like the top thing would be don't be discouraged, cuz I think a lot of times these days we hear about how people are so burned out, and they're so miserable in their clinical roles. And I do think that that can definitely happen if you're in the wrong situation, but you can turn your situation around much quicker than you might imagine, you know? And I would say my top tips would be number one, um surround yourself with people that are thriving, they're in um positions that they're um enjoying, because I think at the end of the day, what we do, which is caring for people, helping them with their health, it is like very rewarding, and we don't have to abuse yourself to do that. You really don't have to, even though I think that that's kind of the constant message that we get. Like even in residency, they had a certain mantra, which was the Duke Lorraine's, I think, which meant just put your head down and keep working and working and working and I I don't think that's really like a healthy mantra.

>> Excellent. Well, thank you so much for sharing all that information and your journey in trauma medicine and we'll see you next time. >> See you next time. Take care.