Why one got in

Nephrologist Becky Dahlberg, M.D., decided primary care is where she’d rather be.

BY SUZY FRISCH

After finishing up her residency and fellowship in nephrology in 2010, Becky Dahlberg, M.D., was finally ready to put her years of training to work helping patients with kidney-related disorders. She and her husband, an allergist, moved that June from Madison, Wisconsin, to Pennsylvania to launch their careers. There, she began working in a small private practice. But it wasn’t long before Dahlberg realized nephrology wasn’t a good fit. Although she had concerns during her fellowship, she kept hearing that her feelings would change once she got into practice. They didn’t. “I found I wasn’t terribly happy with the types of patients I was taking care of,” she says. She knew that about 50 percent of dialysis patients die in about five years. “At times I was questioning, ‘Why am I doing this? Why are we doing dialysis on an 84-year-old with pneumonia or a lady with multiple amputations who lives in a nursing home and has dementia? Why are we providing her with this life-saving modality?’”

In addition, the stress of working with chronically and terminally ill people—and often having to rush to the hospital in the middle of the night to deal with a crisis—made her truly dislike her job. She started questioning her decision to go into nephrology and even considered quitting medicine altogether.

Instead, she thought about what she liked best about being a physician and realized it was helping patients avoid becoming ill in the first place. So Dahlberg decided to move into primary care, which she had enjoyed during the early years of her internal medicine residency. She also welcomed the opportunity for a more stable and consistent work life.

Just how rare it is for a subspecialist to make the switch back to general medicine is not known. But it’s clear that Dahlberg was bucking an overall trend in internal medicine. According to the American College of Physicians, only about 20 to 25 percent of internal medicine residents eventually practice general internal medicine now compared with 54 percent in 1998.
and one got out

Cory Ingram, M.D., left family medicine for palliative medicine.

BY CARMEN PEOTA

For years before he went to medical school, Cory Ingram knew he wanted to be the kind of physician he'd seen growing up in Iowa. He'd take care of people of all ages, whatever their problems, and he'd come to know his patients as individuals. So after medical school and an internship in the Netherlands, he traveled to the University of Nebraska to do a residency in family medicine. He especially liked that program's focus on rural practice.

Ingram spent most of his residency working in a community health center frequented primarily by young families. When he completed the program, he was concerned that he really didn't know much about taking care of older patients. So he decided to do a fellowship in geriatrics at Maine Dartmouth. By the time he took a job at Mayo Clinic Health System in Mankato in 2006, he thought he was finally well-equipped to deal with any patient who walked through his door.

For three years, his family medicine practice went smoothly—with his geriatrics expertise, he saw a fair number of older patients with dementia—and his practice grew. That trajectory might have continued had he not been approached by a middle-aged woman with stage 4 ovarian cancer who asked if he would care for her until she died. She didn't want him to treat her cancer; other doctors were doing that. She wanted support through the final stage of her life.

Ingram agreed, not knowing what to expect, and did his best to help the woman control her pain and manage her symptoms. He tried to answer the hard questions she asked and provide supportive counsel. But after the woman died and he reflected on the experience, he concluded his attempts had been inadequate. “I thought we could do better.”

Surprising discovery

As Ingram thought further about what caring for her had required of him—extra visits squeezed in at lunchtime or calls made late at night—he realized that not only did he not know as much as he should about caring for a dying patient, but also his family
Dahlberg couldn’t be happier with her shift to primary care. “I can focus more on taking care of people before they have end-stage disease, and I have found that very rewarding,” she says.

That’s not to say the transition from nephrology was seamless. It took about four months for Dahlberg to fully reconnect with the knowledge she gained during the early years of her internal medicine residency. During that time, she did copious amounts of reading and attended a medical conference on current issues.

Although she was taking an unusual step, most physicians she spoke to were supportive of her move back to primary care, and she had little trouble finding a new job in the Twin Cities. “Other than one provider at our clinic who seriously questioned my desire to go back to primary care, everyone was pretty eager,” adds Dahlberg. “I think docs like to have someone around to ask specialist questions of.”

Now Dahlberg, the mother of an infant son, works four-and-a-half days a week, doesn’t go the hospital at all, and answers call questions over the phone as needed. She enjoys the regular hours and not having to wonder whether she will get called in the middle of the night to set up dialysis.

She says she has had to make some adjustments to the way she practices. For example, she’s had to relearn how to step back and look at the big picture rather than home in on kidney problems. And she has needed to get used to answering questions about all kinds of issues instead of only renal-related ones. To that end, she has shifted away from basing conversations with patients on information in their charts and instead takes a more flexible and relaxed approach to discussing their concerns and answering their questions.

“It’s different. The pay is less, and there’s not the glamour of being able to swoop in

Becky Dahlberg

(continued from page 12)

Specialty start

Dahlberg, a native of Mission, Kansas, attended the University of Kansas for undergraduate and medical school. She completed her residency and fellowship at the University of Wisconsin–Madison, gravitating toward nephrology because she enjoyed the physiology and being able to base decisions on objective markers such as creatinine or protein levels.

But while practicing in Pennsylvania, Dahlberg was one of three doctors who every third week would round in the hospital from 7 a.m. to 2 or 3 p.m. seven days in a row, often returning for consults later in the day and evening. She spent most of the week on call, too. Other weeks she would be in the clinic all day or handle rounding with the dialysis patients. Over time, caring for a large population of chronically or terminally ill people took its toll. She felt worn down, constantly on edge waiting for that next emergency call in the middle of the night. Never being able to make plans or having to change them at a moment’s notice started chipping away at Dahlberg’s zest for medicine.

Other physicians sympathized. Several even told her that they wouldn’t want her job, either. Although she had never met another specialist who moved from a focused practice to general medicine, Dahlberg was willing to give it a shot.

Making the change

When she and her husband, Paul, decided to relocate to the Twin Cities in October 2011, Dahlberg decided to make a career switch to internal medicine. After taking a few months off and interviewing at three clinics, she started working in November at the Allina Medical Clinic–Woodlake in Richfield, where she sees patients who are 18 and older.

Dahlberg now spends four-and-a-half days a week in the clinic and answers call questions over the phone.
and save the day when someone is having a crisis,” Dahlberg says. “But now my well-being is significantly improved by not always having to carry a pager every three weeks and thinking that when it goes off I’ll have to go to the hospital. To me, that was hard.”

Dahlberg doesn’t regret her time in nephrology. In fact she uses much of her training in her current practice. If someone has high levels of creatinine, kidney stones or hypertension, she can counsel them about what to do and what to expect, then direct them more quickly to a urologist or nephrologist. “I think my training and brief stint as a nephrologist makes me a better primary care doctor,” she says. “I can see people who have kidney disease and do some of the same work-ups I did before.”

But when the crisis hits, it’s in the specialists’ hands. And she’s just fine with that. MM

Suzy Frisch is a freelance writer from Apple Valley.

Cory Ingram
(continued from page 13)

medicine practice didn’t allow a him to properly care for such a seriously ill person. “As I thought about it, I asked, ‘Don’t people who have serious illness deserve a more dedicated approach than just relying on the exceptional efforts of somebody? Shouldn’t it just be regular medical care and do some of the same work-ups I did before?’”

The experience prompted Ingram to once again head back East, this time to do a fellowship in hospice and palliative care medicine at Dartmouth-Hitchcock. As he worked alongside experienced palliative care physicians, he began to see that they had skills and knowledge he lacked, even after all his training. He appreciated their explicit lessons about such things as prescribing medications for pain and talking about difficult subjects, recalling how attention to symptom management and communication with the patient often had been treated as secondary concerns in his previous training. “It was a very professional approach to caring well for seriously ill people,” he says.

When he returned to Mankato, it was to practice palliative medicine. Today, he sees patients in the clinic at the Andreas Cancer Center and in the Mankato hospital.

Knowledge deficits and systems problems

Over the years, Ingram has continued to develop his ideas about what’s needed in order for physicians to be able to care for truly sick patients. And he’s distilled them into three main concepts: 1) Doctors need special skills to properly treat them; 2) they need to be able to devote their attention to those patients rather than “fit them in” with other daily demands; and 3) they need the time to do this, as discussions about death or dealing with agonizing pain can’t be done in a 10-minute visit.

He says the health care system doesn’t allow the average primary care physician to do this well. And he thinks family physicians, in particular, are hamstrung not only by the system but also by their specialty. “In 1969, when family medicine was conceived in the United States, it was designed to take care of everybody—cradle to grave. Then the time from serious illness to dying was short. But serious illness has changed,” he says, adding that family medicine training and practice have not. He points out that family physicians are taught to do procedures such as endoscopies or C-sections but aren’t trained to see their patients through their toughest days. “For the 94 percent who don’t practice in really rural areas, who needs those skills?”

“As I thought about it, I asked, ‘Don’t people who have serious illness deserve a more dedicated approach than just relying on the exceptional efforts of somebody?’”

Cory Ingram

Ingram wants all physicians to understand that caring for the very sick requires having enough time and the specialized skills to do the work well. He thinks his ideas resonate with family physicians. “They might say, ‘My patient’s got a serious illness, and I haven’t seen them for two years because they’re in the oncology center.’” They want things to be different, he says. “Family physicians are hungry for this.” MM

Carmen Peota is managing editor of Minnesota Medicine.