

How a surgeon in the boonies becomes a researcher and regional expert

by Gary Unzeitig, MD, FACS

After a few decades in practice, many surgeons feel secure in their skills and calm under pressure but may question if the pinnacle has been reached and if the next wave of medical advances will render their clinical experience obsolete. We also have witnessed sub-optimal care given to patients and their subsequent flight to distant medical centers, and it makes us want to improve what we have to offer. For me, involvement in clinical trials has been the means to stay on the cutting edge academically; to give the community access to services that individuals previously had to travel great distances to receive; and, in the process, to become acknowledged as a regional expert in my field—and it was not that hard to do.

The use of clinical trials as the means to achieve a standard for evidence-based medicine was in its infancy in the 1970s. Trials that compare time-honored surgical techniques with novel techniques have rapidly changed how all physicians practice, including surgeons. In my case, research during general surgery residency, on surgical options for breast masses, sparked an interest in the field that now is my specialty. My solo practice

began in general surgery in a small South Texas border city. Staying at the top of this field in skill and knowledge and offering comprehensive care to the community presented challenges. Though we all have access to the same journals, it seems that keeping current requires more effort in a smaller city than it would in a large city with an academic center. Reading journals and e-mail updates and attending conferences became an increasing part of my practice. It is true that we often do not know just how much we do not know until we make the time for continued study.

As in many small cities, physicians in Laredo are frequently concerned that patients are transferred to larger cities for care that could probably be given in our own community. Some cases truly needed a tertiary care center service, but many patients whose condition could well be managed in our community sought services at a medical center because of a perception that it would be more advanced. Patients, physicians, and hospitals alike lost in this high-cost scenario, and it was not a feasible option for many of the poorer patients.

My continuing interest in breast cancer triggered a de-

sire to improve the treatment options available to all of our patients. Bringing up the level of care in the community clearly required a multidisciplinary approach with strong support of the hospital and involvement in multicenter, cooperative group trials. Several factors converged to make this reality for us. Our first step was the realization that we already had laid the groundwork of a great community hospital cancer program.

Connecting with one medical oncologist, an enthusiastic clinician, was the next step. His clinical trials experience during an oncology fellowship made us understand that when the correct team is assembled, good research can be done. We consulted and enlisted the support of a dynamic pathologist, the hospital's part-time tumor registrar, and the hospital administration, thus creating an effective and quite motivated alliance. We obtained the criteria needed to become an affiliate of Southwest Oncology Group (SWOG) and set about to fulfill them.

It is more accurate to consider us a research program without walls and both the medical oncologist and I are in solo private practice. The hospital provides us with a

part-time data manager. I had to learn what an Institutional Review Board (IRB) was and have served as our IRB co-chair since the beginning. Our IRB board meets regularly and the members are great ambassadors to the community to advertise the importance of clinical trials as well as the quality of medical care available locally. Other physicians were interested but cited time constraints for their inability to participate. So, between the medical oncologist and me, we serve as IRB co-chairs, cancer committee chairs, liaison physicians to the Commission on Cancer, and principal investigators for our respective clinical trial interests.

The learning curve in the various documentation requirements—including study notes, shadow charts, and drug accountability logs—was steep but facilitated graciously by the support staffs at SWOG and especially at the American College of Surgeons Oncology Group (ACOSOG). We keep abreast of opening trials and assess whether or not they are studies appropriate for our patients. For surgeons, ACOSOG, in particular, has excellent trials.

The key to successfully enrolling patients is to keep in mind the eligibility requirements. Post-It notes above my desk remind me with brief eligibility notations on the breast cancer trials that are currently open. All eligible patients are offered enrollment as part of my diagnosis discussion. Our enrollment rate of approximately 90 percent is likely

because of the time we spend personally in discussion of the meaning of clinical trials and the consent form.

The first patient enrolled in each trial takes more time in order to correctly navigate the protocol, but subsequent enrollment gets easier. Clinical dictations have always been my routine, and it takes little extra time to personally complete the case report forms. The clinical research associate then enters the data and verifies that the forms are complete and correct.

What has all this effort done for me, my patients, and my practice? First of all, the patients benefit because they are offered participation in a trial that offers what looks to be treatment superior to what is the current standard of care. They realize that they can be a part of cancer research that will help future cancer patients, perhaps even their

own children. As for my practice, having become the local and regional expert in breast cancer care has kept my practice busy and rewarding. For the hospital, the reputation as the provider of choice for cancer care has improved its standing in the community and reduced the flight of patients and revenues northward.

For me personally, involvement in research has given me wonderful confidence that what I am doing is exciting, and worthwhile.

Note from the ACOSOG Group Co-Chairs, David Ota, MD, FACS, and Heidi Nelson, MD, FACS: Dr. Unzeitig has a successful breast surgery practice in Laredo, TX, and is a high-enrolling ACOSOG investigator. Dr. Unzeitig was the first investigator to enroll a patient in trial Z1041 and has had outstanding data quality and audits of his site. We are grateful to him for his participation and for this article.



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