

# Oncologist in the Hot Seat



An All in Cancer/Women in Cancer Series

Featuring:

**Dr. Kathy Pritchard**



MD, Medical Oncologist, Sunnybrook Odette Cancer Centre

Senior scientist, Evaluative Clinical Sciences, Odette Cancer Research Program, Sunnybrook Research Institute

Professor, Departments of Medicine and Public Health Sciences, Faculty of Medicine, University of Toronto



**What was the greatest challenge that you faced to get where you are in your career today, and how did you overcome it?**

I think the greatest challenge is about work/life balance. You probably overcome it by working too hard! I think many of us lean too far to the work side. Especially when I started; we didn't really get maternity leave and you were kind of trying to keep your head down and not be noticed for being off work for too long. It's become much more sensible now. I think that it's the hardest thing for me, and the thing I would maybe do somewhat differently if I had the opportunity to do it over again knowing what I know now. Although maybe at that time I couldn't have done it differently. It's a double edged sword.

The other piece of it is focusing. Many of us, certainly I do, like to do different kinds of things. I think less is more. Focusing more is better, and it's something I try to help other people do. Don't do 5 projects half well, do 2 projects really well. On the other hand you always look back and regret the things you didn't do. It's always a balance. The first tamoxifen adjuvant trial we did, we talked about looking at bone density, when nobody knew anything about bone density with these agents. We talked about it but we didn't do it. When you're getting a big randomized trial off the ground, it's always a tension point between doing many sub- studies and never getting the trial done at all. One of the things I wish we had done more of is looking at the cognitive aspects in the randomized trials. We had proposals but they just got to be too much and we never

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did them. You can put your finger on a few things that turned out to be real issues going forward; we could have learned a lot more sooner.

We all get trained to multitask. You go to the emergency room and there are two people; one in congestive failure and one person with a complicated history. You have to go treat the one who is in congestive failure first before you go and treat the guy who has a complicated history. You learn to take a quick look and do what you have to do first in terms of the time constraints. We're repeatedly put in environments where we have to multitask to survive, and cut certain corners. In terms of being an investigator, it's almost flipped over. You want to do things very carefully and very well, rather than just charging in all directions. All these things are about balance- not going all the way to one end of the spectrum.

**You mentioned women putting their heads down and working hard while trying to maintain work life balance. Do you think there are differences the way men and women handle work life balance?**

I think now men are more similar to women in regard to work life balance. I only have sons so I can only reflect on my own children through the eyes of men. I see my oldest son who now has 4 kids, and he draws some very firm lines between work and home, and really works hard to make it balanced. He is very hands on with his children and I think he has all the same issues as a woman would encounter. Maybe that's expected more from men now that most guys don't have a stay at home wife. The very traditional roles where the wife stayed at home and the husband worked were easier in a way because it was clear who did what, and what each person's primary responsibility was. But even then, there had to be some kind of balance. Out of the dads that almost never came home, many of them were doctors! My cousins used to come and stay at my mom and dad's place when their father, a family doctor, was flying around the countryside. They were about 8-10 years younger than me and my brother. They were fascinated by the fact that my father came home at the same time every night, and that we ate dinner at the same time every night.

**Why did you choose oncology as a career?**

I like internal medicine and oncology is a lot of internal medicine; it's diagnosing and symptom control. I was very interested in immunology actually. My first research and oncology job was actually a tumor immunology job in melanoma. It's kind of ironic considering immunology has kind of come around in the loop again, and it was one of my interests in the beginning. I worked in the lab for a year and you could read all the information about immunology and melanomas in mice and get excited all over again even though you knew it didn't work in people. A lot there suggested it was a way to go, we just didn't get a handle on it at that time.

I also remember as a pathology student being very interested in seeing an autopsy where a patient – and nobody probably gets interested about anything when seeing an autopsy anymore, because I don't think anyone ever sees an autopsy anymore – but I remember seeing a woman who had been treated for breast cancer and had been well for 10 or 12 years, and then had a recurrence out of

nowhere, as they do, and two years later died. I remember being very fascinated with what happened to the breast cancer where it went, and what happened in the meantime and really thinking about it. That was when I was a second year student. At Queens's we used to have a very strong pathology department with very strong clinical connections, I don't know if they still do it the same way, but we sure did. We had a pathologic conference every Friday, that and medical grand rounds were very important, and we went all the time and we always read the case and reported on the case, we had to have a student diagnosis, and a resident diagnosis. I learned *a lot* from that and we don't do any of that anymore. I very nearly became either a pathologist or a psychiatrist. Although I realized I could probably only do psychiatry about 3 days a week.

### **What do you look for in a mentee? What do you think are the benefits of a mentor-mentee relationship?**

I love enthusiasm. I love to see someone who is really interested and keen to learn about things. It makes us enthusiastic when we see younger people being enthusiastic; I think it is very positive. Showing enthusiasm and interest is the most important thing. The relationship can be huge. I think you can have many mentors and you can learn different things from different ones. You can have some main mentors, but I think it's a learning process both for the mentor and the mentee. I certainly learn a lot from watching my students and I gain a lot of enthusiasm and energy from them. Hopefully it goes both ways. I think it's a really important relationship and I think the idea that you have to have one mentor or a formal mentor isn't necessarily the only way to go. I can certainly name a number of people from whom I learned a lot. Some of them were younger or more junior than me, but they had a skill set that knew more than I did. Two people that I regard as being my research mentors are **Pam Goodwin** and **Mark Levine**, both of whom are younger than me. I started working with them when they were much younger than me, especially Pam, but they taught me a lot about research. It doesn't necessarily have to be a senior person, but just someone who knows a lot about an area that you might be interested in but aren't as skilled or trained in as they are.

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I see so many enthusiastic young people. Some people my age, and younger, say “residents aren't what they used to be, they don't work, they get 6 months to a year maternity leave; they're never on call like we used to be!” I find residents and students are just like we used to be. Some of them are great and enthusiastic and will go the extra mile and some of them don't. I find that there are a lot of enthusiastic, hardworking people just like there always were. People are all doom and gloom about students not working 48 hour stretches and say that they just aren't as interested as we used to be, and I don't think that's true for one minute. I think it's much more sensible actually. Shortly after I came up here to work, I had 3 little kids who were 2, 6 and 9. So I had little kids, and there started being a lot of 7:30 AM meetings, and they were all about clinical epidemiology so it was near and dear to my heart. But after a while I started saying “I don't do 7:30 meetings, the only things I do at 7:30 are things that can be done horizontal”. I got some shocked looks but I found that people stopped inviting me to 7:30 AM meetings.

Other people who have been mentors to me were **Don Cowan**, he passed away last year, I ended up working for him about 6 different times, including in my first melanoma job. He was a

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wonderful clinician, and I learned a tremendous amount about treating patients well, in every sense. When clinical epidemiology was evolving, he kept saying “what’s clinical epidemiology anyway?” I said “You should know because you are a clinical epidemiologist” and he said ‘No I’m not! No I’m not. I don’t even know what it is”. I said “you’re the first person who taught me that when you do a study you have to include all the patients in a report, not just the ones you followed more than 3 weeks, and

the first person that taught me just because patients who respond to the treatment do better, doesn’t mean the treatment is better” I showed him a whole bunch of things. And he said ‘Well that’s just common sense!”. **Norman Boyd** is the person who said to me “the trouble is that common sense isn’t common.” **Don Cowan** was definitely a great mentor to me, and **Don Sutherland** as well.

**Norman Boyd** had done clinical epidemiology training at Yale, during a time that nobody did clinical epidemiology. Maybe even before McMaster had clinical epidemiology. I used to go into Norman’s office and ask him how to do different projects all the time. I spent half my life in his office. Finally after I had been on staff for about 6 years I said “I’m going to take some courses at McMaster, do you think it’s a good idea?”, he said “oh thank god I thought you were going to be in my office forever!”, I said “have I been bugging you Norman?” and he said “well not really”. I spent a lot of time asking him questions before I realized I needed to get formal training. Those would certainly be people who were important mentors, but there were lots of people that have taught me lots of different things along the way.

**With your experience in clinical epidemiology, at this point in the environment of trainees, do you think it is something that should be strongly recommended for extra training for trainees who are interested in pursuing academic oncology? Or do you think that the training programs themselves should incorporate more of the clinical epidemiology training for all oncologists?**

I think both. I think high school students should get taught clinical epidemiology. There was a very interesting discussion on CBC this morning about homeopathy and what kind of data supports homeopathic practice. Were studies randomized or cohort? They were really getting into it, but people don’t understand what is good data and what isn’t. The interviewer in this case was trying but didn’t totally get it. The homeopathic doctor she was interviewing didn’t get it, or didn’t want to get it. It was quite interesting. From listening to what I talk about, my kids could have told you what kind of studies are good and bad, but I don’t think the average man on the street who hears these things can be a good judge. I think how to understand what medical treatment you should or shouldn’t get should be taught at a much more fundamental level. Look at all the people who say vaccinations cause autism and so on. When there is virtually no data to support that anywhere. It is about critically appraising literature, and that should be taught at all levels. I certainly don’t want to be treating the patients the same way I did in 1978, when I started out. I knew I wanted to treat patients better and I wanted to do studies. We’ve

been lucky enough in Canada to be a part of some practice changing studies, in breast cancer for example. I think that's really exciting, and we still are continuing to be a part of these big studies.

### **Do you consider yourself a leader in your field?**

I guess so. Leading in clinical trials by its nature, and maybe any kind of leadership, has to be leading with consensus. You can't just tell people what to do, you have to talk to people a lot, and I've kind of enjoyed doing that. So I guess that's why I've ended up doing it, I have the temperament for it. I enjoy working with groups like that. I think I have been a leader, but I also think we have had tremendous intellectual and infrastructure support through the NCIC CTG. People like **Joe Pater, Elizabeth, Lesley Seymour, Lois Shepherd**, fabulous people that I've worked with. And really Joe has been the core of that since the beginning. We were all lucky to have that opportunity, and also a group of investigators who were really collegial across the country and were willing to work together. So I think if I've been a leader I have been lucky to be one.

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I always laugh because about 7 or 8 years after I started working at Women's College, **Dr. Hill** was leaving as our chief and **Ken Shumak** had just come as our chief, and we were talking about recruiting someone, they both said they didn't think the person really knew what they wanted to do or to accomplish. I said "I'm not sure I really knew what I wanted to do when I was at that stage" and **Dr. Hill** nodded and said "oh yes, you did. You knew what you wanted to do, you very much knew what you wanted to do." And I looked at her and said "Well am I doing it?" I couldn't remember being that sure about it at all, but I think that what I wanted to do was be part of clinical trials, and I think I expressed that strongly to her. I don't think I had the idea that I would become as much of a leader in clinical trials as I did. I wanted to be part of the team; I didn't see myself as leading the team. That sort of evolved for me. So when I asked if I'm doing what I want to do, she had very much thought that's what I wanted but I don't know that I really had that idea.

I guess I had more focus than I realized. I knew I wanted to do clinical trials. I didn't want to go on treating GI patients with 5-FU. The poor GI patients. We would say "You can get intravenous 5-FU every two weeks or so, and there might be a 10% chance that you might respond, or you could go to your cottage! I used to talk to people about going to their cottages! When you think about some of the treatments and the areas we didn't know much about before, we have come such a long way. So I certainly wanted things to be better, and I saw myself as playing a role in those things, but I don't think I saw myself doing as much of a proportion of my career in research as I have done, or being as much of a leader. I think I sort of evolved into it.

## Was there a tipping point, or was it just more a natural evolution over time?

It just kind of came along. It was a function of who was and wasn't there and who was and wasn't doing things. A number of people I worked that were senior like **Don Sutherland** and **Bill Meakin**, moved into more administrative jobs. I took a couple trials that I had worked on with them and ran them. Even ending up in breast cancer was sort of a happenstance of what was available when I was looking around to spend another year in Toronto because I didn't have a job. **Dr. Meakin** approached me about working for him, because he had money for a fellow. Very shortly after that someone approached me from Women's College about working in the breast centre there. So that was golden for me. I did different work there; I did general oncology and general internal medicine for nine years, before I came up to Sunnybrook. Then I started doing only breast cancer.

In terms of a job for teaching and for interest, my job at Women's was the most fascinating because I worked with a haematologist and two internists on a team. We did admissions, and at Women's College we had many interesting admissions being right downtown. A lot of people from the University of Toronto health services, because a lot of the family doctors at Women's worked at U of T. We used to see people from all sorts of countries with uncommon infections, and we had quite an interesting emergency room. As general oncologists we saw a lot of people with PUOs, and all sorts of diagnostic problems. There were a lot of interesting cases that were fun. When I moved here and I was only able to do breast cancer, I think it helped me concentrate on my research. But in terms of a practice job, the general job was very interesting. I did a lot more teaching. I think I saw myself initially as being more of a teacher and doing some research. It evolved into being more about research.

## Do you think that sometimes we're too focused on subspecialties?

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I certainly didn't have a big game plan of where I wanted to end up. I knew in general what areas I wanted to work in, and then I just followed my nose. Whereas you talk to people now, you say "where do you want to be in 5 years?" "10 years?" "2 years?", and I guess I could have answered those questions but I'm not sure I would have answered them in the same way as what eventually happened. I never even intended to go into medicine in the first place. One of my best friends in high-school was a woman who wanted to be a doctor, and she was very idealistic. I thought it sounded way too serious and too much work. My stated aim in going to Queen's to University - I don't think I told my parents - was "to get my own apartment and have fun!" That is what I told all my friends. Although I was a serious student and I did study. I met some women in residence who almost never cracked a book. I couldn't believe that anyone would have the opportunity to come to university and not study. But I did get my own apartment and have lot's of fun. I was in science, and when I met the women who were pre-medical students, many of them weren't very focused. I thought if they could do it then so could I. So I switched.

## Who has been the most influential leader to you throughout your training, and why?

I think **Don Cowan** would have to be at the top of my list. I worked for him as a melanoma fellow, I worked with him when I was a resident at PMH, and a resident in medical oncology, and then I came here to be a staff and he was the head of medicine at Sunnybrook. So I worked for him in many different incarnations. He was a very fine doctor and a very fine person. He was a fabulous teacher, and I think there are a lot of people who were really inspired in medicine by him. He also had this very practical approach to clinical trials where he was telling you to do all these things that were clinical epidemiology principles even though he didn't quite realize it. And he was a delightful guy, so he would certainly be one of my biggest mentors. Other people are **Bill Meakin**, who I worked with as a fellow in breast cancer, **Ken Shumak** certainly was, and **Don Sutherland** for sure.

My high-school science teacher, **Mr. Horwood**, was another mentor to be. He was the guy who got me interested in science when I wanted to become an English and History teacher. I kept getting detentions in his class because I was either: giggling, passing notes, or talking, of course. Then he gave me a "universal detention", which means you have to come in for a week. You had to come in when he came and leave when he left. Who knew that teachers had to come in at 7:45 and stay until 6 at night? He had students after school and showed them all sorts of science projects. He assigned me to wash glassware but I got to watch these students learning so many things. I'm sure this man did this to me on purpose, I'm sure he figured I was just bored and I needed to have my nose rubbed in something to get interested. It was after I had this "universal detention" that I became interested in science.

I think high school is an important time where students should be learning about assessing data, and how to make judgements about what you believe in science. Fortunately or unfortunately, most of time stories trump data. I think in my old age I've come to the understanding that patients respond better to a story about other patients you've had. "I had another patient like you and who would have thought she would have done so well, but when we gave her Herceptin all her liver mets shrunk, and just like you I told her I thought she should never stop taking it. Six years later she's still doing well and she's still taking it". I think they respond to that much more than they respond to "10% of patients like you can still be in remission 6 years from now". Patients want to know that it can happen and that you see them as being in the category that it can happen to. When I was younger, if a patient asked me "what would you do if I was your mother?" I would always say 'well, everybody is different' I didn't like answering questions like that, and now I answer them in a heartbeat. I think we're taught not to do that, but it's all about how you communicate with people. That's so important and that's something I learned from **Dr. Cowan**. He really sat down and took the time, and he was a real role model.

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