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A Radiation Oncologist’s Story:  
High Tech Meets High Touch

Richard S. Pieters, MD, MEd, FACR

I Grew up hearing stories about my grandmother, a missionary and an American-trained surgeon, who brought her doctoring skills to Korea at the turn of the twentieth century. She spent her first few months there learning the language and customs of this ancient kingdom where she’d spend the rest of her life. Working in a preantibiotic era, supportive care was an important part of her practice. Keeping her patients comfortable was sometimes the best she could offer (see Fig. 1). The personal side of medicine, often known as high touch, was as important as her surgical technique. Thus began my appreciation of the interplay between high tech and high touch.

Not surprisingly, as an undergraduate I majored in anthropology and East Asian studies. When later accepted to medical school, I saw myself as a family practitioner. A chance conversation with a radiation oncologist on a shared car ride and a subsequent elective in the field changed my career course. Radiation oncology seemed the perfect way to merge some of my major life influences. I would be able to enlist my math and physics skills, courtesy of my math teacher father, into the service of hands-on doctoring like my grandmother, or so I thought.

Radiation oncology has long been on the leading edge of technological advances in treatment planning and delivery systems. During my residency, computerized tomography (CT) imaging became more readily available. Today, CT-based volumetric planning with the fusion of magnetic resonance imaging (MRI) and positron-emitting tomography (PET) scans, automated beam-shaping devices, and daily field imaging are common in practice. In plain language, with their current tools, radiation oncologists can customize treatment to accurately target the tumor and better spare surrounding normal tissue.

During my residency, rigorous attention was given to mastery of the technical aspects of radiation oncology, but supportive care, though deemed important, was never given the same intense focus. You learned how to address treatment-related side effects on a case-by-case basis. Instruction and feedback on communication skills were not formalized and rarely mentioned, except when a major faux pas occurred.

FIG. 1. My grandmother leaving for a house call, circa 1897, (© Richard S. Pieters, Published with permission.)
when talking with a patient. The prevailing wisdom of the time
was either you had communication talents or you didn’t.¹

Early in my attending career, I was assigned a large pedi-
atriic caseload at a comprehensive cancer center. Because
children are growing, they are particularly vulnerable to the
effects of radiation. They are also at risk for late effects, such
as a second cancer, decades after treatment. Therefore, in-
formed consent discussions on the risks versus benefits of
radiation treatment are important. During the initial consul-
tation, parents sometimes told me they were hearing the word
“cancer” rather than “growth” or “tumor” for the first time.
This sudden revelation could provoke distress for patient
and doctor. I quickly learned I had to gently probe for how much
they knew and gauge how much to share without becoming
too overwhelming. At times, it was a delicate balancing act.

As my career went on, I developed clinical and research
interests in supportive care, late effects, and the palliative
uses of radiation therapy. And then, a few years ago, another
chance meeting occurred. A palliative care service was
starting at the hospital and its multidisciplinary team meet-
ings were held in a conference room adjacent to my depart-
ment. I began to attend as regularly as I could. When a
practice pathway to certification in hospice and palliative
medicine through a mini-fellowship program became avail-
able, I decided to “grandfather” before the opportunity
closed.

Given my clinical commitments, the requirement of 100
hours of participation on a multidisciplinary team presented
a challenge. I used vacation and academic meeting time to
visit other institutions with training programs in hospice and
palliative medicine. I was very fortunate to receive invita-
tions to spend one week at an inpatient palliative care unit
and two weeks at a hospice training program. As a physician
in my 30th postgraduate year (PGY-30), it was humbling
to find myself shadowing the treatment team. However, it
was also rewarding to have the luxury to spend uninter-
rupted blocks of time with individual patients and listen to
their stories.

Through this late-in-career training, I dramatically im-
proved my communication and supportive care skills, par-
cipating in pain management. Dr. Robert Buckman, a
medical oncologist and communication expert, states, “Ef-
efective symptom control is impossible without effective
communication.”¹ Pain management and communication
techniques, such as the SPIKES (setting, perception, invita-
tion, knowledge, emotions, strategy) protocol,¹ were for-
ormally taught to me for the first time in my career. It was
professionally gratifying to learn both the art and science of
these essential skills, particularly breaking difficult or bad
news. Basic competencies in palliative care, such as pain
management and communication on prognosis and treatment
goals, should be incorporated into the training of all physi-
cians.²

I know that this experience has made me a better doctor
and a stronger radiation oncologist. I feel I have finally come
full circle. I remain grateful to colleagues who opened doors
and shared knowledge. At long last, I have found balance in
the dynamic interplay between high tech and high touch in
my chosen field. I hope my grandmother would be pleased.

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