The Graduating Surgeon

A PRIMER FOR SURGICAL TRAINEES

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American College of Surgeons
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Foreword

As a profession, physicians, and surgeons in particular, have not performed well when preparing residents and fellows to enter practice, negotiate contracts, or change jobs. Outside of rural practice, it is quite unusual for a surgeon to "hang up a shingle" and begin solo practice. And whether a surgeon chooses to join a group of practicing surgeons or is hired by a hospital, multispecialty practice, or academic health system, most will be employed. Instead, those of us who take great pride in training residents have focused almost entirely on the clinical practice of patient care. This primer from the Young Fellows Association of the American College of Surgeons is an excellent document to prepare residents entering practice and surgeons who are considering changing jobs. The authors are a diverse group of individuals who have assembled a remarkable list of factors to be considered. I have had the privilege to know several of the authors, and I understand the effort they invested as a service to residents, surgeons considering changing practice, and our profession.

The decision of where to accept employment involves a somewhat unique constellation of factors. As the book articulates, the choices one makes during training influences your options, such as whether to pursue fellowship training; whether to work in a community practice or academic setting; urban, suburban or rural; family and geography. It is a daunting task to sign an employment contract, not being certain whether you are signing your life away, whether the innumerable clauses encountered in a contract will prevent future choices, and whether an employer will alter their boiler plate contract. While the salary is an important factor in choosing where to work, other considerations that should influence the decision may be even more important. My class of chief residents from residency were invited to the home of a senior private practice surgeon, and he told us that more important than the salary offer was the quality and esprit de corps of your partners. He advised us to look for partners who had treated their previous hires well, and were committed to our individual career success as much as their own.

This book is a great guide to become educated about the various elements to consider when accepting a position or changing your current employment situation.

Steven C. Stain, MD, FACS
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Introduction

"So… I'm going on an interview for a job tomorrow. What should I ask?"

That was a real question posed to me by a real resident, with genuine sincerity. And that question was the impetus to collate the collective experiences of different surgeons from different specialties into this primer. Hopefully, you will be more prepared than some of those residents were and can maximize the information you get from the process to make the most informed decision possible.

And so, CONGRATULATIONS! You are reading this in preparation of your first job as a surgeon. If you are in the interview process, best of luck to you! If you are a junior resident, kudos on recognizing the need to prepare early.

Finding a job has become a very complex process and attempting to navigate that in the middle of arguably the most important year of training, the final year, can be very challenging. Attempting to become expert in contract law language, malpractice insurance models, compensation structure options, among all of the other non-clinical aspects of finding a job, all while continuing to complete training, maybe even while preparing for board exams, can be daunting, and it is no wonder that graduates are often not prepared for the process. By some measures, the majority of medical graduates will not stay in their first job beyond the terms of the initial contract, as is commonly quoted.

This humble effort is clearly not meant to be comprehensive and complete. Rather, it should be regarded as foundational – a starting point. For the most part, this is an effort to provide you with an introduction to everything you need to know about getting a job and being an attending but weren't taught in training. There are obviously some excellent additional resources available and many sources of information. There are third party products by PracticeLink or the Guthrie center. Some professional journals such as the New England Journal of Medicine or Endovascular Today have special issues devoted to transitioning to practice. Specialty societies may have a job board or tips for the process. Make sure to leverage as much of these as you can. We have tried to highlight some of those where possible and relevant throughout this work.

Clearly none of this would have been possible without the authors' completely voluntary contributions, for which we are indebted. We also thank the Resident and Associate Society of the American College of Surgeons (RAS-ACS) and the Young Fellows Association (YFA), both part of the American College of Surgeons (ACS). Their support in the development of this primer has been invaluable. And of course, we would be remiss if we did not thank Alison Powers from the ACS, without whom the ship would be lost in the night.

We have tried to collate the most important information in this primer, much of which stems from personal experiences and lessons learned by the teacher of life. From finding opportunities to interviewing even to your first contract negotiation, the authors of this handbook have put significant effort to communicating things they learned along the way, things they knew and things they wished they knew or were told, to provide you with a sampling of the topics and salient issues you may consider. While some items (like definitions) are standardized, much can be the opinion of the individual authors. This primer cannot and should not substitute for professional consultations that may take into account your personal circumstances. Still, we hope that you will find the information contained within these pages useful and beneficial for the next steps in your career.

Best of luck on your journey!

Issam Koleilat, MD, FACS, FSVS
Editor, *The Graduating Surgeon*

SECTION 1:

Planning during the Early Years

The Checklist

- ☐ Become a doctor
- ☐ Become a surgeon
- ☐ Find a mentor during training
- ☐ Read this primer!
- ☐ Decide whether or not you want to do a fellowship
- ☐ Network during your training
- ☐ Discuss career planning with
  - ○ Your program director
  - ○ Your mentor
  - ○ Your family and loved ones
- ☐ Identify important factors in your job search
  - ○ Geographic region
  - ○ Practice type
  - ○ Practice setting
  - ○ Other
- ☐ Prepare your CV and cover letter
- ☐ Take a deep breath and
  - ○ Apply to your chosen jobs
- ☐ Have fun on the interview!
  - ○ Don't forget your "thank yous"
- ☐ Consider your options and offers
- ☐ Discuss some more with
  - ○ Your program director
  - ○ Your mentor
  - ○ Your family and loved ones
- ☐ Make counteroffers
- ☐ Accept and sign
- ☐ Actually BE a surgeon
  - ○ Start the new job
  - ○ Join ACS
- ☐ Think about your next job
- ☐ Mentor people junior to you
- ☐ Prepare for your financial future (for example, retirement)

The Timeline

You can't start thinking about your job too early. In fact, some people say that you should always be thinking about your next job because you don't know what will happen and if you have to leave at a moment's notice, you'll be left out in the cold. In any case, here's a rough timeline:

1. Pre-contemplative – Two to five years prior to the predicted start date – start talking to your mentors, other surgeons, your family, your friends and your loved ones. See how others made their choices, how they chose and how they ended up where they did. Join a job board. Many institutions will hire on a periodic cycle (every four to five years, for example) you'll start to see these patterns over time.
2. Contemplative – One to two years prior to the predicted start date – start looking at opportunities. Many are not posted on job boards or in journals. Industry reps might know who's hiring and where would be a good system to work. Program directors and other attendings in training may also know by word of mouth. They can steer you away from "bad" places and give you letters of recommendation.
3. Preparation – One year prior to the predicted start date – start applying early. Things always take longer than you think they will, not just with the interview and the position, but other roadblocks will come up like state licensing, hospital credentialing, board exams, etc.
4. Action – Within one year of the predicted start date – apply and interview. Within one to three months prior to the expected start date, make sure you know where you'll live, how you're moving, look at schools if you have kids, etc.
5. Maintenance – Enjoy! Remember, you could be the world's most gifted surgeon, but what your colleagues, patients and support staff really care about are the kindergarten things:
    - Shares toys
    - Plays nice in sandbox

If you can do those two things, you will be well-liked and people will help you. And remember the three As:

- Affability
- Availability
- Ability

— Dr. Issam Koleilat

How to Network

Networking is a somewhat catch-all phrase that is defined as "the action or process of interacting with others to exchange information and develop professional or social contacts." While many people find a position through the use of physician and surgeon recruiters, others find positions without one by leveraging their personal network.

We have all heard some version of the characteristics required to be a successful surgeon: Be affable, available, and able. If that were enough to build a successful practice, we would all be in great shape. But depending on where you plan to practice, the type of practice you will be in, and your field of practice (especially if you have a niche that you want to focus on), networking is a key component of finding that dream job and then building a busy practice. While face-to-face interactions are still the best way to network, there are a variety of additional aspects to networking that are important for a new surgeon.

The earlier you know, the better

If you know you want to ultimately work in a specific geographic area, training in that region may ultimately facilitate your job search. Attendings you knew in residency or fellowship will likely have more intimate personal connections to people in that region and those connections may help make your job search easier.

Leveraging the people you know

From family members, friends (particularly those training in other places), your own personal physicians, even the device and drug representatives you come into contact with during your training, every one of these people might be a resource for finding a job or even building a practice later. Asking them if they have heard of any openings, or if they know something specific about the position or the team at a particular institution may give you significant insight. Even traveling nurses and scrub techs are valuable sources of inside information! Don't be afraid to ask.

Expanding using unconventional tools

Another area to consider is getting to know some of the other surgeons in your field that are your contemporaries. You probably met some of them during fellowship interviews, although this may be changing somewhat with virtual interviews. These colleagues may be at different institutions but having a network of people going through some of the same "growing pains" can be valuable. This can also be accomplished via social media. There are many Facebook groups that can be great places to connect, such as some of the SAGES Mastery groups. Some places have even posted job opportunities on Twitter! Just be careful what you have posted online in a public space that can be linked to you – you don't want a potential employer to pass on you because of an internet search that revealed a comment you made in high school.

Committees

Joining society committees can be another way of getting to know other physicians around the country. This can help not only expand your circle of friends, colleagues and acquaintances but may give you an advantage over others. Having worked with someone and knowing them may cause a potential future partner to help push for that person's application. Of course, try to join committees you have an interest in, as it makes it less of an obligation and more enjoyable.

Meetings

Attending local, regional, and national society meetings is another option for building your network base. Many meetings will feature a job fair or will have recruiters in the exhibit hall. There are often happy hour events at most of these meetings, which can be good opportunities to meet other surgeons as well.

Things you can easily do

There are a few things you can easily do to develop and maintain your network. Keep in touch with your friends, family and colleagues so that you can reach out to them in the future if you need to. Make and maintain an updated LinkedIn profile. Try to socialize with others at events where there are people who may be able to connect you with potential positions. Setting networking goals can be useful too (e.g., I will meet 10 new people at the regional conference).

Remember, networking is like any relationship – it's not just about you and your needs. Introducing others and helping people in your own network can open doors for you too.

No matter how you do it, identifying the possible opportunities that match your desired practice is a critical first step in finding your job. And knowing who to ask and how to look is just as important as knowing what practice type you want.

—Dr. Rebecca Kowalski

Practice Types and Employment Models

During medical school and as we made our way through clerkships, traying to decide what to do when we finished medical school, one of the first major decision points is medicine is fundamentally split into proceduralists and non-proceduralists. Similarly, practice types largely break down into academic and community practice but the lines between these types have been blurring. Salaries in academia are improving and incorporating productivity measures, just like many in community or private practice will have resident teaching obligations, conduct research and may be involved in large trials. There is no practice type that is perfect for everyone. The first decision really comes down to do what practice type you will prefer (or at least which ones you don't prefer!). There are advantages and disadvantages to each practice type.

Academic practice

Most graduating residents are going to be the most familiar with this model as most of graduate medical education (GME) in surgery takes place within the confines of academic programs. Academic surgeons operate, but also spend time teaching residents and medical students as well as performing scholarly activities. For some surgeons this includes running a lab while for others it may be doing clinical research or database research. Surgeons working in academics have the advantage having residents to assist in the operating room and to help (and often do most) of the floor and office work. In addition, being employed by a large academic center comes with some financial security of being in a large group. However, by being employed by an academic medical center there will be less autonomy in terms of office staff and decisions made that may affect practice.

Community practice

Many residencies are now including opportunities to work with community practices so that residents have the opportunity to practice surgery outside of the halls of academia. There are several types of community practices. These range from independent practices (solo or group) to being employed by a hospital or health system. Unlike academics, community surgeons typically do not have resident support and will be the first call for consults and for nursing questions in the hospital. In addition, because there are no residents, the surgeon typically is the one operating and the hospital may or may not provide a surgical assistant. In many programs there are opportunities to participate in clinical research, but promotion and compensation are typically not tied to research and scholarly activities like it may be in academia.

Independent practice (solo or group)

These are essentially small businesses set up as surgical practices. You have to be able to manage (or have someone else manage) the business aspects of the surgical practice. This includes payroll, taxes, human resources, benefits, and making sure you are compliant with state and federal regulations related to health care. There are advantages to this type of practice. The first is that you really retain complete control over your practice. When you are ready for a new partner or a new employee you can make the decision within your practice. The disadvantage is that these practices are entirely dependent on the surgeon(s) operating and bringing in revenue. When on vacation or when pandemics like COVID-19 occur, these practices may struggle due to a lack of cash flow when there is not revenue coming into the group.

Employed surgeons

Some surgeons will take the route of being employed by either a for profit or a not-for-profit health system. Often, there will be a medical group that is run within these systems as the overarching governance structures. When there is an associated medical group the surgeon will typically be joining a large multi-specialty group. This has advantages as well. If you are not interested in the business aspects of medicine, then you do not necessarily have to worry about those parts of the practice as they are likely to be handled in a central location. These group practices will typically be able to handle the revenue and cash flow disruptions that may happen related to natural disasters better than a small independent group. Unfortunately, the disadvantage of allowing other people to handle the business aspects of medicine, is a loss of autonomy and flexibility. If a surgeon feels like they are ready to add another surgeon to the group, it may take several months to start the process as it will likely have to go through several layers of approval before moving forward.

No practice setting is perfect for everyone, but by spending time deciding what you are really after, you should be able to find a practice that meets most of your needs and allows you to practice surgery in a way that makes you happy.

—Dr. Jason Wilson

Hospital Leadership Roles and Structure

Hospital governance is fundamentally set by a hospital's bylaws and will vary from hospital to hospital. However, most hospital leadership can be split into two groups. There are administrators who have a full-time (or near full time) job to work in hospital administration and there are those who continue to practice medicine but who are willing to serve and lead the medical staff in an elected or nominated process.

The full-time group typically includes the hospital president, the director of operations, the Chief Medical Officer (CMO—in some places the Vice President of Medical Affairs (VPMA)), and the Chief Nursing Officer (CNO). The hospital president is the person who is in charge of the overall vision and strategy of the hospital and helping set the hospital on the course of that strategy. The vice president of operations (sometimes called the chief operating officer or COO) is the person who is in charge of making that vision happen and making sure everything is running in the hospital including construction projects and supplies. The CMO is the liaison between hospital administration and the medical staff. They are often the first person called for any questions about behavior or practice issues within the hospital. The CNO has the same role but for the nursing staff.

Medical staff leadership is different as these are physicians in the hospital who are continuing to practice but have agreed to help the hospital do the various functions required to keep the hospital going. Most hospitals are run by a Board of Trustees which typically will include a mixture of community and physician members. They are ultimately responsible for the hospital. The medical executive committee (MEC) is the group of physicians which reports to the Board of Trustees and provides reports and recommendations about the hospital and medical staff. The MEC is chaired by the medical staff president who is typically elected by the medical staff. The composition of each MEC is going to be governed by the bylaws of the hospital. The MEC will have the chiefs and vice-chiefs of various departments within the hospital (medicine, Ob/GYN, surgery, etc. depending on the size of the hospital), the president-elect (or Vice President), the secretary and the treasurer (sometimes combined).

Committee chairs serve on the MEC as well. Perhaps the most important committee is the credentials committee. The credentials committee serves to decide who can come on the medical staff and to determine what the physician has privileges to do. It is easier to keep a bad physician off a medical staff than to try to remove a bad physician from the staff. The credentials committee is the gateway to obtaining privileges and getting on staff. Most credential committees have staff to obtain application information (including references, case logs, transcripts, etc.) and then the job of the committee is to review these applications (and interview the physician or call references, if applicable). The job of the committee is to make sure physicians who want to join the medical staff are appropriately trained for the procedures that they would like to perform and that there is nothing in their past which would preclude them from joining the medical staff.

The other important committee is the peer review or quality committee whose job it is to help look at how to improve the quality of care provided at the hospital both by assessing benchmarks and evaluating opportunities to improve in specific patient care cases when the standard of care may not have been met by a physician in the hospital. This is also an extremely important committee.

The presence of other hospital executives will depend on the needs of the institution or practice. The "c-suite" may include any or all of the following as well:

- CEO - chief executive officer - responsible for almost every aspect of hospital performance and efficiency. This person may be different than the hospital president who is usually subordinate to the CEO. While the CEO is focused on the relationship of the system to outside entities, the president is typically focused on internal operations.
- CXO - chief experience officer - responsible for the overall experience of a health care organization's products and services.
- CLO - chief learning officer - responsible for the learning initiatives in a health care setting as it relates to training, education and development programs for the staff.
- CI(N)O - chief innovation officer - responsible for the process of innovation and change management.
- CTO - chief transformation officer - responsible for moving the organization forward and supervising the daily actions and initiatives of institutional programs.
- CSO - chief strategy officer - responsible developing, communicating and executing corporate strategic initiatives in conjunction with the CEO.

- CIO - chief integration officer - responsible for the coordination of all the interacting components within the larger system.
- CCO - chief compliance officer - responsible for all compliance activities including planning, implementing and monitoring a hospital or practice compliance plan.
- CMIO or CIO - chief (medical) information officer - responsible for the correct use of information technology.
- CQO - chief quality officer - responsible for the quality of products and services, including quality measures, methodologies and performance indicators.
- CPO - chief privacy officer - responsible for the safety and security of personal, medical and financial data.

—Dr. Jason Wilson

SECTION 2:

The Search

Non-Medical Considerations

A first job is exciting but can also be overwhelming. For the first time in our careers we are searching for a position without going through a match. Surgical trainees are generally in the mindset of needing to have the faculty think favorably of us without as much consideration if it is a place we want to be. Additionally, a job will be more than a temporary place to spend a few years learning surgery. This may be your home for many years to come rather than a step in one's training, so it is important to really think this through.

Other sections of this manual detail how to look for your first faculty position. This section will encourage you to think about other aspects of the search. Now that you have completed training, it is important to take a proactive look at other facets of your life, including important people in your life (family/friends), lifestyle, hobbies, activities, and overall goals. Consider what makes you happy within your career as a surgeon, but also outside of work. Some type of balance is imperative going forward in your life. I guarantee you will have difficult days, and where you choose to settle will affect how you are able to deal with the challenging life of a surgeon. Write down a mission statement for your life taking into account what makes you a well-rounded person. Another way to consider this is by evaluating where you really think your life will be like in 3, 5, 10 years etc.

Considerations

Location/lifestyle

What brings you joy and rejuvenation outside of work? This might mean activities or hobbies, or proximity to family. An example would be easy access to outdoor activities (skiing, wakeboarding, etc.), weather that allows you to do your favorite pursuits, being near one of the coasts or a major airport. The area weather and climate may be important for other reasons such as if you have Raynaud's, migraines, arthritis, etc. Lastly, what might the commute be like? Do you want to live five minutes from your workplace, or is a 40-minute drive acceptable to you? Some practices may have geographical or response-time considerations and so this will become more important in some situations. If this job doesn't go well, are there other opportunities in the same area? Or the converse: are there areas that you would absolutely not want to live in?

Family/friends

Living near family or friends can be another key consideration. The availability of support from friends or family, or even help with childcare can be key to improving quality of life. Consider your partner and where might they want to live, or if there are employment opportunities for that person. Having to share custody of children may present unique challenges and restrict the geography of your search as well. If your children are older, you may want to think about career planning for them including colleges and universities. Remember to not undervalue the importance of being involved with people or activities that bring you joy and can help you decompress from what will at times be a very stressful job.

Financials

Cost of living is another important factor that may have not been previously considered in your choice of location for training. Salary versus cost of living must be taken into account, particularly if one has significant student loans to pay back. There are trade-offs of course to living near the coasts with higher cost of living, possibly higher quality of life, and possibly lower salaries. Do not underestimate this important factor. In some areas, the cost of living can actually offset a salary increase. Costs and spending start to add up even after the attending salary increases income. Remember to devise some sort of savings plan and keep all of this in mind when finding a place to settle. Planning to save about 20% of your income is a good general rule, will you be able to do that with where you choose to practice? Another often given piece of advice is to rent for the first year. This gives you and your family an opportunity to find the best location. When you do decide to buy a home, consider how much space you and your family need balanced with expenses. Renting for a short period of time also ensures that you really like this new job and want to stay long-term!

Culture of your practice location

Institutional culture and future colleagues can tremendously affect your experience in your first job. A position may be perfect on paper, but colleagues or leadership can truly make or break the experience. During interviews and follow up calls/visits, pay attention to how your future colleagues treat you and also each other, as well as any office staff and trainees. This is the time to truly evaluate if you think you can be successful in this practice setting. As a new faculty or staff surgeon, you

will run into situations that challenge you and where you will need to ask for help in the operating room, advice or mentorship or something else. You must feel confident that your partners will be there to support you and mentor you through this transition. Be aware of how people treat each other so you are more likely to be aware of the surgical culture before joining.

Beyond the institution, think about the local culture of the city, town or locale. Are museums and theater important to you, and are these available? Do you want a vibrant night life or a more quiet, small-town feel? How are the everyday, non-medical people and how is it to interact with those people? Are you a member of a particular faith community or other group, and are there members of that community or group in this new area?

Best of luck to you in your search for your first job!

—Dr. Amalia Stefanou

Starting the Search

After completing residency and fellowship training, graduating surgeons are placed in a position they haven't experienced before (at least within the medical field): finding a job. During medical school applying for residency and in residency applying for fellowship, a matching process decides your fate. You rank your top choices, and programs rank their choices, and hopefully there is a successful match. Once the match occurs, that is considered a binding contract. In many ways, that is a simple process as the "decision" is left out of your hands and in the hands of the matching system. After completion of training, however, the dynamic changes: there is no central processing service for interviews and matching. In many ways, this can feel like a daunting, lonely process. However, it is important to know that there are many resources that can be utilized by the graduating surgeon to help them find their "first surgical job".

This section will be broken down into two different sections:

1. How to prepare before looking for a job
2. Where do I look for jobs

How to prepare: Curriculum Vitae

Preparation in many aspects of life and surgery is "key," finding a job is no different. The first question is to know "when to look". Hiring seasons tend to vary by institution but in general prior to starting your final year of training is a good time to start the process. The process should begin by collecting all of the academic and professional achievements you have made during your career and compiling them into a concise Curriculum Vitae (CV). The CV should give a potential employer a window into your background, career and professional achievements.

The following should be included in your CV at a minimum:

- Name, current address, contact information (phone number and email address)
- Medical school, residency, fellowship training
  - Dates of matriculation
- Awards
- Leadership positions
- Publications (including peer-reviewed, abstracts, posters, presentations, etc.)

Do not include:

- Sensitive personal information (e.g., social security number or marital status)
- Clichés; discussing your passions for a disease or research or otherwise may be better located in a cover letter or during the interview discussions.
- Hobbies; better discussed during an interview, hobbies are not very relevant to the job itself or your fit with a potential employer. A CV does not usually have the space for such information that doesn't help establish your credentials or commitment to the potential employer and job.

Make sure that your CV is well formatted and readable. Remove "clutter" like parentheses and reduce full sentences to phrases. Avoid the use of "responsibilities include" or similar syntax. And while it goes without saying, be sure to spell check. While computer spell checkers are reasonable, they will often omit or neglect many issues, or make inaccurate recommendations. A trusted friend or colleague may be a better option.

After compiling your CV, the next step in the preparation process is to put together a cover letter. This cover letter gives a potential employer a window into who you are with information that can't be found on your CV, and also gives them an idea of what your aspirations are and what you are looking for in a job. One of the most important aspects of this process to understand is that finding a job is all about fit – both parties are looking for certain attributes, and matching as many of those as possible is how you find the right job for you.

How to prepare: Cover letters

The cover letter is an important supplement to any job application. This will be sent to the employer along with your CV. In conjunction with your CV, which lists your skills, positions, etc., the cover letter allows you to express why you feel you would be a good fit for a job and why, ultimately, they should consider you. Here is a basic framework of how the cover letter should be written:

1. The initial greeting should be directed toward the person hiring you, whether that be the chief of the division, chairman of department, etc.
2. Begin by mentioning the job position that you are applying for and potentially mentioning how you heard of the job (mentor, etc.).

3. Next, you can mention any relevant prior job experiences or credentials that qualify you for the job. Make sure to point out how these match what the employee is looking for.
4. After explaining why your specific job/education credentials make you a good candidate, this is a good place to highlight any personal traits/qualities that will make you a good partner to have (e.g., good communicator, team player, efficient/organized, etc.).
5. The end of the cover letter should reinforce your sincere interest in the job and how you are a good candidate for the position. Don't forget to thank them for taking the time to review your application!
6. Sign the letter with your name and all relevant contact information (e-mail, cell phone), and include a couple of reference names with their contact information as well.

Cover letter dos:
- Address it to a person, not "To Whom It may Concern"
- Reflect your excitement about the opportunity in the tone of the letter.
- Be upbeat and positive
- Close the letter with an action such as "I'll call you in a few days to follow-up" or indicate when you can meet in person

Cover letter don'ts:
- Don't sound desperate or beg
- Don't sell yourself too hard – let your CV and credentials speak for themselves
- Don't use sarcasm, too much humor (unless you know the person well), or disparaging or blaming language

Looking for jobs

Once you've completed a CV and cover letter, the next step is to find jobs. This begins with identifying what your career aspirations are – do you prefer community/private practice or an academic positions, do you have geographical preferences, etc. There are many available resources to identify potential job openings. The first stop to make is with your mentors, including program directors from residency or fellowship, chairwomen or chairmen, or other attendings who may be aware of any jobs available. They can also be valuable to give advice on certain places to apply, the process, etc.

Others that may be helpful are industry representatives that you may have worked with during your training. Since they often travel to many hospitals they hear about jobs quite often. Further, if you want to find a job in another state, they can reach out to their counterpart in that area who can be of assistance.

Online job postings are another good way to find out about any job openings. Below is a list of websites that you can use to start helping you find a job. While the generic job search websites will have some postings, they are the lowest yield for surgical and especially surgical subspecialty jobs. The highest yield sites for those jobs are the society specific websites which usually have a dedicated area for job postings. Oftentimes these postings will be made by medical recruiters who can also assist you in finding potential opportunities.

When utilizing these websites, you can filter for location, type of practice, and other factors that may narrow your search. This can be very helpful to help go through the seemingly endless opportunities. On each posting, there will be a contact person to reach out to with a CV or a cover letter explaining your interest. Sometimes this is a private or hospital-based recruiter, the chief of the division or a secretary. Other positions may have online forms that need to be filled out through the institution's job portal. It is important to follow the directions in the email on how to proceed if interested.

Websites to use when looking for jobs:

Monster.com
Indeed.com
Linkedin.com
Careerbuilder.com
Hospitalrecruiting.com
Practicelink.com
Mdsearch.com
NEJM Career Center
JAMA Career Center
FACS.org/jobs
Svs.careerwebsite.com

Sometimes job fairs or recruitment agency booths at conference, or even direct mailings may provide clues about open positions. Lastly, family and friends can sometimes serve as a good resource. Many journals have online job boards or will post in the print editions job opportunities as well.

No matter how you find out about an opportunity, the important thing is that you find one that is a good fit for what you are looking for.

—Dr. Khalil Qato

Interviewing

Every institution will have a different process and timeline, but there are also some general principles and steps. It is important to both the applicant and the institution to try to make the best choice in employment decisions. In 2012, one study estimated the cost to fill a vacancy was approximately $88,000 (including recruitment fees, advertisement, travel etc.).

Given that the details of the process may be institution-specific, it is important to remember that any correspondence by phone, interview, email or otherwise with any person may be considered in the hiring process. **Therefore, it's safest to assume you are being interviewed at all times.**

Step 1: Application and submission of CV or resume.

Applying for a job may be as simple as sending an email along with a CV (or resume) to a point of contact. However, some job searches may be run by a recruitment firm and they will screen your application as the first step. Finally, it may involve applying for a position through a more formal (usually online) process with the institution's Human Resources department. Some institutions will request a cover letter and others may not, but even an email of interest is a chance to make a good first impression and it is important to make sure that it is professionally written.

Step 2: Preliminary conversation with a recruiter.

Usually the next step in the process is to discuss the opportunity with a recruiter. The recruiters may be a part of the institution or they may be a part of a recruitment firm. They should be able to provide a more detailed overview of the position than what was available in the advertisement. They may not be able to answer specific questions, but they should be able to at least provide a broad overview of the position. This allows the applicant the opportunity to make sure that the job opportunity is appropriate and the recruiter to make sure the applicant meets the minimum requirements for the job.

Step 3: Second level phone conversation with an administrator or (preferably) a surgeon.

If mutual interest exists after the preliminary conversation with the recruiter, the most likely next step is to have a second phone conversation (interview) with either an administrator or ideally a surgeon in the practice. This is an opportunity to have a more detailed conversation about why the job opportunity exists (growth/succession/etc.) and to be able to ask more detailed questions during this conversation. Just like the first conversation, this is an opportunity to make sure there is still mutual interest in moving forward with the formal in-person interview process.

Step 4: The in-person interview.

It is important for both parties to make the best decision. Physician retention is important because it can be expensive to recruit and replace a physician who leaves because of a bad fit. That is part of why it is critically important to have the in-person interview. This is a chance to make a great impression and to really get a good feel for what the opportunity is about. Every place is going to handle this situation differently, but they often follow a fairly predictable pattern. Most interviews are going to last for one to two days and nights. Typically, there will be a day set aside for interviews. Expect to interview with prospective partners, prospective colleagues, and hospital or group administrators. The applicant will usually be with the recruiter for much of the day. There should be the opportunity to see the campus and office space during the visit so the applicant can get a feel for where they will be practicing. There should also be the opportunity to see where the OR's are and have the chance to ask questions about any particular equipment which may be of importance (robot, special instrumentation, etc.).

There may also be an opportunity to have dinner either the night before the interviews or the night after the interviews. This is a great chance for both sides to be in a slightly different setting to make sure there is a good fit for the culture of the organization. It is important to be nice to everyone involved in the process as many places ask not only the formal interviewers but everyone for feedback.

The final component of the in-person interview is the chance to meet with a local realtor who can give a good idea of what it is like to live in the area. They show neighborhoods that are popular, where physicians like to live, and can give hints about the community. This is a particularly important component of the interview visit as community fit can be a reason for physician turnover.

Remember: The first 30 seconds of an interview are critical in establishing your "first impression."

Questions to ask:

1. Is this job opening related to growth, turnover, or succession?
   a. If this job is due to turnover, why did the previous surgeon leave?
   b. How long have the physicians in the group been in practice?
2. Am I going to be expected to cover one hospital or more than one hospital?
   a. Are there other obligations? Wound care center? Vascular ultrasound lab reading? Etc.
3. What is the expected call schedule going to be?
4. Where are most referrals coming from?
   a. How are inpatient and outpatient consults divided or directed among providers?
5. What is the case volume and spread? The office volume and spread? (What pathology will I encounter?)
6. What is the community like?
7. What is the payer mix like?
8. What are my teaching and/or academic requirements?
   a. What support is available (research nurses, biostatisticians, etc.)?
9. What is the governance structure of the group (if you are joining a practice or employed physician model)?
   a. What and how is the interaction with hospital leadership?
   b. Have there been recent acquisitions, mergers or downsizing?
   c. Are there plans for expansion?
10. What are the hospital or group's mission and vision?
11. How many providers are in the group?
    a. Can you meet with or speak with everyone?
    b. Are there any advanced practice providers (APP: physician assistant or nurse practitioners)?
    c. How are office staff (nurses, schedules, APPs, etc.) assigned to providers?
12. Do you have or are you planning to acquire _____ (surgical equipment of interest to you)?
13. What is the quality and availability of referrals (medical oncology, radiation oncology, GI, OB-GYN, etc.)?
14. Is the geographic area highly competitive?
    a. Is there significant internal competition from other specialties?
15. Is there OR block time?
    a. How is block time shared?
    b. How are emergency cases handled? Does the OR staff need to be called in?
    c. Are ancillary services available in the off hours (interventional radiology, cath lab, etc.)
16. Benefits
    a. What is the malpractice coverage type?
    b. CME allowances
    c. Relocation assistance
    d. Loan-repayment availability
    e. Vacation
17. What is the partnership track timeline and buy-in (if applicable)?
    a. Conversely, what is the process to sell if you are leaving?
18. What are the biggest challenges, least favorite aspects, greatest strengths of the practice, etc.?
19. What are the next steps after this interview?

These are questions to think about and to ask so that you can appear to be engaged in your visit. The more engaged you are and the more interested you are in the visit, the better the interview is going to go.

Tips, dos, and don'ts:

1. Be early. If you have a phone interview planned, be available to take the call on time and when you go to your in-person interview be at dinner and ready to meet your recruiter early.
2. Be prepared. Take some time before your phone interview to research the institution you are joining. In addition, try to get the itinerary a few days before leaving for your in-person interview so you have the opportunity to research some of the people you are going to be meeting. They may be listed on the ACS web page, their institution web page and even LinkedIn. See if there are any connections you can make based on this information.

3. Do your homework. You can look up a lot about institutions and practices online. Most hospitals publish their size (in number of beds) on their websites. They may list their "catchment area" or the size of the population they serve. You can also look up volume and types of procedures by other surgeons in the practice using CMS billing data available for free on the CMS website. You can also use tools like HCAPS (Hospital Consumer Assessment of Healthcare Providers and Systems) surveys to see patient impressions of the facility. You can even use US News or other third-party indices for things like "Best Hospitals to Work for" or "Top 100 Hospitals."
4. Dress conservatively. In general, the advice has always been to dress conservatively. There is no reason you cannot express yourself, but you do not want your attire to be the focal point. For men, do not forget your belt.
5. Take time to write the thank you notes/e-mails on the way home. You can always store them in your outbox to send later. Do not forget to include the realtor who took time to take you around and the recruiter who probably spent the most time with you during the day.[1]
6. If you have questions you did not get answered it is perfectly acceptable to reach out and get those questions answered before you make a commitment.
7. Places that are interviewing you cannot ask questions about your family, children, plans for children, religion or sexual orientation. If these are important, you can discuss them but the organization should not be asking about them.
8. Some places are starting to add a new component to the process of interviews – to have someone come and watch you operate prior to having you join the practice. This is not widespread yet but does exist in some practices.
9. Be realistic about what you want. No position will be absolutely perfect without any negative aspects, so know what you can tolerate, and what your minimum needs are to be happy in that job (be it compensation, devices, etc.).
10. A few don'ts:
    a. Don't misrepresent yourself
    b. Don't be critical or jaded during the interview
    c. Don't discuss your baggage of prior negative experiences unless absolutely relevant, and definitely not from the first handshake
11. COVID-19 has changed a lot of things, and just like it has increased telehealth in our offices it has increased the amount of this process that may be done virtually without the benefit of travel. In-person interviews will likely always be a component of the process as this decision is incredibly important and making sure the fit is right is usually best done in person.

If you are interviewing with a private practice, it may be beneficial at some point to sit with the office manager (maybe not from the very first interview) to review past financials, the pro forma and even what litigation that practice has been involved in. Make sure to keep these discussions courteous and professional.

Step 5: Write thank you notes.

After an in-person interview it is worth taking a few minutes to send a thank you note to the people who took the time to interview. If the experience and opportunity were what you are looking for, then let them know that as well. While many of your emails will be similar, it is worth trying to remember one thing specific about each interview that you can mention in the course of your email correspondence.

Step 6: Follow-up with the recruiter.

Make sure you have taken some time to touch base with the recruiter to get an idea of the timeline of the decision and when you can expect to hear something about the opportunity. Unfortunately, there are still some places that you may not hear back from. It is ok to keep in touch with the recruiter to touch base with them but consider limiting this to once a week (or shortly after they tell you the next step will be decided).

Step 7: The second visit (maybe).

This used to be a common component of the process. Many places would have the applicant (or their top applicants) back for a final visit to make sure that they are sold on each other. This has been less frequent recently, in part to make the process more efficient both in time and resources. However, if this is a part of your recruitment it often will be similar to the first visit with more people involved and there may be more specific discussions related to compensation.

Step 8: The offer.

If everything has gone well, you can expect to get an offer letter (usually by email). Often this will be a letter which addresses the major points of your contract. It should spell out your expected clinical time and/or academic time as well as your compensation and expected productivity. This will not be a full contract that spells out every expectation, but rather it is a broad overview of the most important negotiable features of the contract. It may also include any sign on bonus (or commencement bonus) and moving expenses reimbursed. Some opportunities have a separate "benefits" component, particularly large academic institutions or groups, and fringe benefits may be instead listed in a separate document.

Step 9: Review the offer and consider making a counteroffer.

This is your chance to review the general terms of the offer and decide if it is an acceptable offer or if you want to provide a counter-offer. See the section on negotiating for suggestions on how to maximize your leverage in this space.

Step 10: Start making preparations.

Once you have accepted your offer make sure you find out who your best administrative contact person will be over the next few months. It may be the recruiter, but it may be other people as well. During this time, you will be sent a contract to review which will have full details about compensation, benefits, and other clauses including restrictive covenants (non-compete clauses). It is best to consider having an attorney with health care experience review your contract. Ideally, it is best to find an attorney in the state you will be working in to review the contract as laws regarding employment and contracts vary state to state. For example, different states have taken different views on the enforceability of non-complete clauses and what is considered a reasonable non-compete.

As soon as you are comfortable with your decision to move forward, start working on getting a state license (assuming you are moving) or moving from a training license to a full unrestricted license. For some states, this process is relatively quick, others, including Texas, involve an additional examination that must be taken prior to licensure so starting the process early is important. It may be worth using a service like the Federation Credentials Verification Service (FCVS), a part of the Federation of State Medical Boards. Always refer to the state medical board you are applying to for their particular requirements, but this service keeps copies of your transcripts, USMLE scores, residency certificates, etc. and serves as a clearinghouse for documents to help with licensure. While this may cost more in the short term (and may take slightly longer), very few physicians stay in their first job and having this information stored for the future may pay dividends down the road. As some states can take several months from application to license, start this process early.

In addition, as you get closer to starting your job you will likely start getting paperwork and educational materials from your new employer. This will include application for privileges and credentials at the hospital(s) you will be working at as well as for the group itself. There will also be insurance companies that will require credentialing. The institution or practice should be able to help walk you through this as well. This is another process which takes some time so the sooner you can start the better. There may also be opportunities to start working on marketing materials to get your name out as you are coming on board, and the more responsive you are the faster you can get up and running and busy in your new practice.

Step 11: Starting.

After finishing residency, the start of any new surgical job is likely to feel very slow. Many places will not put you on call right away and when you first start your clinic will be paltry. Take advantage of this time. There will likely be opportunities to network with referring providers and this is a good chance to get out and make connections. If things are slow, go and operate with your new partners as there is always something new to learn. If you have

not taken your boards yet, this might be a good time to study for the board exam before the office gets busier. If possible, consider doing your first few cases with one of your senior partners as you get used to a new environment to help with the transition.

—Dr. Jason Wilson

Reference

1. See "The Importance of 'Thank You' Letters," Nov 5, 2020, for more information. Available at: https://www.myhealthtalent.com/article/repost-the-importance-of-thank-you-letters. Accessed May 28, 2021.

Negotiating

There are many types of negotiations you will encounter in your life and career. These negotiations range from the highly open with ample room for creativity to extract (or lose) value, to the highly structured with limited room for movement on either side. Your negotiation for your first position as a surgeon is more highly structured than you might have imagined. The majority of the risk is on the downside. You have ample room for missteps yet have limited ability to "extract significant value" from the institution where you are seeking employment. In addition, this is not a "single pass" negotiation, or "one and done", like purchasing a home. You will be spending the vast majority of your time and energy working with the same colleagues you will be negotiating with. Our goal is to help ensure your negotiation reflects well on you.

Power and equity

The institution (department, hospital, private practice) has a considerable amount of power. That power is in their experience with the business side of surgery and medicine. Also, that power is in their equity. At a large institution, this equity is large, spread out over many employees that provide care to the community and income to the institution. Many times at a large institution, a surgeon is fungible. In a small private practice, there can be a lot of "sweat equity" or pride in the practice. The surgeon that started the practice had to work very hard to build the practice. You are stepping into the practice not having to put in all that sweat. It would serve you well to keep this perspective in mind and be aware of the position the institution is in and reasons for considering to hire you.

On the other hand, you have power too when joining an institution. Your power is your choice and your up-to-date training. Most of the time, you will have OR time, clinic time, office space, insurance, clinical resources, patients, etc. already worked out and handed to you. Also, you will likely have multiple comparable job offers. You will also have limited pride in the institution you are joining since you did not build it. This allows you to move on if the fit is not right being flexible seeking opportunities and resources elsewhere.

In a large institution or a small private practice, your employer must weigh the risks and benefits (profits) of hiring you. This balance is framed by simple economics: supply and demand. How many surgeons are available with your skill set and how great is the demand for you? Your current mentors may have great insights and ties to the institution you are considering which will allow you to have a better understanding of the demand for you and the supply of alternative surgeons.

We focus this chapter on how you can develop a better understanding of the environment that you are joining, how you compare to the alternatives in the market, and how you can respectfully and professionally maximize your potential while avoiding any disaster scenarios.

Main idea

The goal of the negotiation process is to arrive at a partnership that articulates mutually agreed upon goals aligning the vision/expectation of the institution and you.

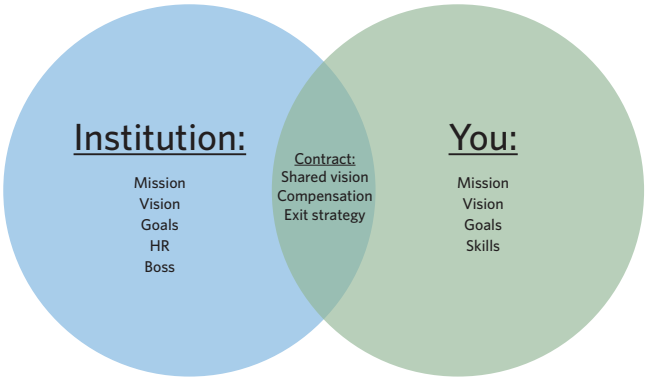

Figure 1. The relationship of the two parties in the negotiation.

Coming away with a nebulous understanding of this partnership can foster discord between both parties putting you at risk for burnout.[1]

As we outline in Figure 1, there are two parties, the institution and you. Each party has unique attributes and goals. The clarity of these attributes and goals can be variable, so the process leading up to the negotiation and during the negotiation should be designed to limit this variability in order to, ultimately, achieve a clear agreement.

You probably have never done this before. You are skilled and well trained at being a surgeon but have limited experience in business or negotiation. You have worked hard to get to this point, have likely incurred a large amount of debt, and many of your non-surgeon friends have a nice place and nice things. You want that stuff too. This combination of inexperience, debt, and desires combine to create anxiety in most young surgeons. In

other words, you are approaching this negotiation with a lot of baggage and little experience. The people you are interviewing with and negotiating with are likely very experienced at it. So, there is a large gap in experience between you and them.

As such, we recommend you approach this process with genuine and open curiosity to understand the position you are applying for and the people you will be working with, which should foster a dialogue of shared interests. If you and the institution do not have shared interests, then you can walk away without hard feelings.

Top take-aways

- Your top goal is to come away with a mutually understood and aligned vision, goals, expectations, and an exit strategy
- Relax, there is far more downside risk than upside opportunity, so you don't need to be worried about negotiating "hard"
- It's not all about the price/salary, it is about ensuring that you are in the right place for this phase of your career and life

The institution

In this section, we attempt to set the context for the role you are entering, the type of institution you are entering, and the nature of how jobs are offered and managed within it. We refer to an institution as the practice, department or hospital that you are going to join.

As described earlier, there are a few main surgeon employment models:

- Academic
- Hospital-employed
- Private practice group
- Private practice group with academic affiliation
- Private practice solo

We focus this discussion on academic, employed or group practices, because going in depth on each type of job is beyond the scope of this handbook. However, our framework and advice should contain many elements that will apply to most surgical roles. Therefore, tailor this information to what you need. Indeed, if you are "hanging your own shingle" in a solo private practice, your negotiations are principally with insurance companies, hospitals for OR time, building contractors for clinic space, and employees rather than with an institution or boss. These critical aspects of a solo practice are beyond the scope of this chapter.

Human resources

All jobs within a large institution are governed by the Human Resources Department (HR), which deals with the hiring, administration, and training of personnel. In other words, HR departments must attract, retain, develop, and offboard the surgeons within the various departments. Their job is to consider the "good of the institution" over the "good of the individual" (while respecting the individual). HR realizes that any exception made for one surgeon must be evaluated in the context of the entire department. HR creates and administers policies, procedures, and pay tables. They must remain structured and consistent to serve the needs of the institution. They might make exceptions but only rarely. Institutions need to compensate employees in such a way that is externally competitive, yet internally equitable. So, the person you are negotiating with at a large institution can be bridled by the limitations of the HR department.

Consider this over-simplified but instructive example. An institution has 20 surgeons. One surgeon demands a 20% raise, and the HR department grants the raise. Question: what would happen if that same raise were applied to the entire department? The answer: it's the dollar equivalent of adding 4 more surgeons to the payroll, however, in this case it is 4 more surgeons without any corresponding productivity increase.

This is a black and white example, but it clearly illustrates HR's perspective. Any exceptions must be thought of in the context of the greater department, and any exceptions could lead to disastrous knock-on effects.

You (versus the alternatives)

The 3 As: While you have many years of training and are highly skilled, there are many viable alternatives to you in the market. In other words, you are not that special (at least when compared to other surgeons appropriate for the job you are applying for). So, having an attitude or being insubordinate is not an option.

The institution is looking for team players that can get the job done, have no attitude, and are a pleasure to work with. Specifically, they are looking for the 3A's:

1. Available – are you ready and willing to do the job and have ongoing and open conversations about your role and career?
2. Able – are you capable of performing the job?
3. Amiable – are you a team player and a nice person?

If you lack any of the 3As, the institution will likely move onto the next candidate.

Also, we recommend you highlight the intangibles that may separate you from the alternative candidates that have similar resumes, such as:

1. Quality (your training pedigree)
2. Work ethic and grit[2,3]
3. Emotional Intelligence[4]

What matters most?

Let's start with a sobering statistic: 50 percent of physicians change institutions within five years of starting.[5]

Common reasons for this mobility include (1) failure to understand the institution, (2) failure to understand the vision of the institution, and (3) failure to understand how you fit in that institution (which can be a failure to understand yourself).

To avoid these pitfalls, we recommend you develop a solid understanding of both who you really are and where you are considering a position. This process is critical to understanding whether the institution is a good fit which improves your chances of having lasting happiness in your new role.

Think deeply on and write down the following items:

1. Your personal mission statement
2. Your vision for yourself and your career
3. Your life goals
4. Your top priority list

The more nebulous these are, the more difficult building on this foundation will be. Think deeply. Be specific.[6] If you have not already considered what is important to you, then your negotiations will have many limitations ultimately adversely affecting your quality of life.

Moreover, you must realize that your role will mature over the first couple years. We recommend revisiting your list at the end of every year. After all "Life moves pretty fast. If you don't stop and look around once in a while, you could miss it." (Ferris Bueller, 1986).

Your contract

Contracts change from institution to institution, but most contracts are highly similar. Contracts typically have the following structural components:

Salary and benefits

- Base salary
- Annual bonus
- Insurance (medical, life, disability, malpractice)
- Retirement funds (401k, 403b) and contribution matching from the institution
- Tuition funds (for your children)
- Signing bonus
- Moving expenses
- Stipend for continuing medical education, meetings, board certifications
- Promotion schedule or benchmarks (assistant professor to associate, or member in practice to partner)

Resources

- Space and personnel for clinical activities
- Personnel and space for research activities including start-up funds and mentorship plan
- Personnel and space for administrative support and activities

Performance benchmarks

- Clinical - relative value units (RVUs), case volume, case mix
- Research - grants, industry funding, clinical trials, publications
- Education - teaching awards, lecture time, student evaluations

Exit strategy

- Non-compete clause
- Intention to terminate
- Termination for cause
- Contingency plan for death, disability, arrest of you or your employer
- Statute of limitations clause, time of performance clause, non-waiver clause, severability clause, arbitration clause, non-disclosure clause, attorney fees clause

The resources and performance benchmarks are the biggest source of variation from contract to contract, depending on whether you seek an academic or private practice position.

It is critical that you understand how the institution will measure and track your clinical performance vis-a-vis your peers. It is worthwhile to ask your current mentors or attendings how they are measured including how many RVUs or cases they do per year. This will give you an approximate of what may be expected in your first position.

The negotiation

There are three types of people entering a negotiation (1) people that think they are great at negotiation, (2) people that think they are terrible at negotiation, and (3) people that are curious and want to learn more about it. We strongly recommend that you focus on trying to be #3.

Be open minded and remember, you are not negotiating against the institution per se. Rather, see this as a process of discovery and a time to come together to a mutual understanding. Also, keep in mind that the person that you are negotiating with is your colleague and is someone that you are going to be spending your life with over the next couple of years. If you see yourself as someone who is going to "win" this negotiation, then you put yourself in a potentially adversarial role toward your future colleagues. If you misplay or overplay this negotiation, then you could severely damage your reputation within your institution.

Also, the negotiation is not all about the price tag (price tag = the base salary and bonus). The HR department defines strict guidelines with plus or minus 5-10% on either side of a median salary range. In other words, for the vast majority of surgeons, the worst you can do is slightly under the median, and the best you can do is slightly over the median. As we mentioned before, any more price flexibility than this on the part of HR could set a disastrous precedent for the entire institution. It's not realistic to expect them to make large concessions for you.

We recommend you focus on (1) where you fit in the vision of the boss and the institution and (2) and what the benchmarks for performance are. If you do not come away with a clear understanding of these two, you have failed in your negotiation. Focus on the institution's goals. Align their goals to your goals. Position yourself as a fit (or not a fit) and then you will realize the role is right for you. Many surgeons view this as a liberating concept. You can mitigate the emotional attachment to your negotiations by seeing them as a chance to align interests and less as two adversaries haggling over money.

Negotiation dos:

- Be informed about the structure of the contract ahead of time
- Realize that the negotiation is not all about the price tag
- Trust your institution. They are not your adversary. They are your colleagues. And after all, there is a small range of outcomes available due to HR's tight control over variation.
- Pre-syndicate and gather information ahead of time - find a mentor that you can test ideas with and gather information
- Have a realistic understanding of your value as a surgeon and as a team member
- Clearly understand where you fit within the vision of your boss
- Clearly understand your performance benchmarks
- Focus on mutual interests and how to "make the pie bigger"
- Use objective data to gather contract comparisons in the market

Negotiation don'ts:

- Treat the institution or your boss as an adversary
- View yourself as indispensable
- Bargain over positions

The negotiation process

Typically, your first interview is for gathering information about the organizational chart of the hospital, department or practice. It is also important to make the impression that you are a mature and informed professional. You should gather information about your likely daily schedule, call schedule, clinical support (NP/PA/residents/administrative assistants/nursing), research support (time, space, mentors, lab technicians), colleagues and competitors, etc. The second and, perhaps, third interview is getting into the crucial conversations about the position and negotiating.[7] It is important as mentioned above to come away from these crucial conversations with a clear understanding. To achieve this, you will need to challenge but also care personally for the institution.[8] Balancing challenge and care is nuanced but necessary.

It's as simple as: Problem, product, proof, price

To achieve a contract that arrives at a partnership articulating mutually agreed upon goals aligning the vision/expectations of the institution and you, we suggest you consider the following approach using the 4 P's of positioning: problem, product, proof, price.

Here is an explanation of the 4Ps framework in the simplest terms:

They have a problem that needs solving → I have something that can help them solve that problem → here are the proof points that I can back up my claims → and this is the agreed upon value of me helping to solve their problem.

Below, we apply the 4 Ps to your upcoming negotiation.

Problem – This is not your problem, it is your boss-to-be's (BtB's) problem. The BtB has a vision or goal that has yet to be realized, and that is the problem. It is critical for you to know what the vision or goal of your BtB is. This gap between what is and what needs to be is the problem you are going to fix by getting hired. Getting your BtB to state this clearly is critical for you to understand if you are the right person for the job (can you do it, do you want to do it). A way to get your BtB to state his/her vision is to say something along the lines of:

"I understand your vision is to achieve . . . Is this accurate because I want to be sure our visions align, and I want to commit to this organization and you?"

Framing the conversation in this fashion allows the parties to understand each other's interests. This also allows you to state in clear language you are interested in joining the team (you are available).

Product – After the BtB clearly defines their vision, you are able to share your vision. Your vision is your "product". If you have made it to this phase of the negotiation process, you should have a pretty good idea what the institution needs, what you are able to do, and if you want to do it. This is where you clearly state what you have in mind to help the BtB achieve their ambitious and fantastic vision. Importantly, as a result of good planning, your vision just so happens to fit in with the institution and fix the problem the BtB has. A way to share your vision in the context of ameliorating the BtB's problem is:

"Your vision that you have laid out for me is ambitious and fantastic. Thankfully, I am well positioned to help you realize this vision. To this end, I will .....over the next few years with the ultimate goal of one day becoming....."

At this point the interests of both parties have been stated. You have now validated the importance of the BtB's problem and shown your interest in helping. You have now stated that you are available and able to help the BtB. You have also shared your career goals and how the BtB may be able to help you get to where you need to get.

Proof – This is where you reference your training as proof that you can help the BtB achieve their vision while achieving your vision. Unfortunately, as a resident or fellow, your proof is very thin. While you have a lot of value, the BtB is risking a lot on you. Your independent clinical, scholarly, administrative ability has been minimally tested at this point in your career. Moreover, your ability to generate revenue for the practice or department is modest early in your career. So, the BtB is making an investment and will not likely see returns on that investment for a few years.

Importantly, your proof should be framed to support your vision and goal of helping the BtB. You do not want to regurgitate your CV. You want to distill it into a fine draft that concisely addresses your skill set to help the BtB. This proof statement should help your BtB see that you are not a risky investment and able to deliver your product.

Your proof can be augmented by support from your current mentors, chairman, program director, etc. A phone call or a face to face from someone who can vouch for you to the BtB will validate your proof and grease the wheels.

Price – This is likely the most unsettling part of the negotiations for the young surgeon. This is also the area that will require the most homework. The BtB has restrictions imposed from HR. It is important for you to trust the system is not going to abuse you. Most organizations and practices have a typical start up package that is not substantively negotiable. Most organizations and practices have a very tight budget and simply are not able to make offers that are >10% of the normal compensation package. Importantly, compensation must be externally competitive and internally equitable. Therefore, your price needs to be around the market value for your region. Also, your price cannot be substantially more than others at your level

in your practice or department. It is typically taboo to ask colleagues at the institution what compensation is. However, there are references that help such as the AAMC Faculty Salary Report.9 If you have good friends in the area, ask them what an appropriate compensation is.

During this part of the discussion, you need to consider and be prepared to address your salary and benefits, performance benchmarks, and other items as listed above. To enter this phase of the negotiation respectfully and professionally, you may want to consider this approach:

"I did some research about what I can do to fulfill your vision. On the backdrop of my accomplishments in training and future commitment to this institution, I believe a reasonable compensation package includes ..."

A few other ways to help determine fair compensation and to prepare for the negotiation:

- Ask recent graduates, your attendings or your mentors if they are comfortable discussing how much they make and how their contract is structured
- Find out how many relative value units (RVUs) the average physician in your field performs yearly. Then find the average $/RVU value in your field. Multiply these two numbers and you have a good sense of what your annual salary should be.
- Make a list of the unique skills that you have that make you more valuable than an average physician in your field. It might be your training, research abilities, or even a specific skill set the new employer doesn't yet have (robotic surgery, endovascular, etc.).
- Think about how much of your salary you may want as a base and how much from performance incentive/bonuses.

Recall that you are not being emotional, and your mind space is curious and desiring to learn more about the organization and how you fit. The BtB should address most, if not all, of the items you brought up in your reasonable compensation package. Alternatively, the BtB may suggest you review the contract and start up package first. Then you can ask questions and receive clarification of items in the contract.

Don't forget:

- If you don't ask for it, you definitely can't get it
- You may value something else more than just the salary (time off, higher productivity compensation as opposed to a base, less call, etc.).

We recommend you have a lawyer or trusted senior surgeon review the contract to be sure you understand the language in it and the implications of what is stated, your responsibilities, your compensation, and the terms therein.

Should I sign the contract?

As stated before, **the key objective of this negotiation is to arrive at a partnership aligning the vision/ expectation of the institution and you.** You will need to protect yourself from making an agreement you should reject while reaching an agreement that will satisfy your interests as much as possible [Getting to Yes, Fisher and Ury]. To protect yourself and satisfy your interests you should develop your BATNA (best alternative to a negotiated agreement). Doing this will allow you to envision a contract in the context of your mission, goals, and priorities. If the contract does not fit your vision closely enough, then do not sign the contract. In other words, any contract that isn't better for you than your BATNA is worse than "no deal" and should be refused. In this situation, ask more questions or respectfully walk away from the negotiations:

"Would you mind walking me through how you get to that start-up package?"

"Are there any incentive structures to get closer to the package I had in mind?"

Again, before signing the contract, you should consider having a trusted senior surgeon or lawyer look over the contract and inform you of the implications of the language in the contract, particularly the salary/bonus and exit strategy language.

—Michael Delatorre and Dr. John McAuliffe

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Noncompete Clauses

One common component of physician contracts is a non-compete agreement or a restrictive covenant. These agreements serve to limit the location a surgeon can practice for a defined time period should either the physician or employer decide not to continue with the employment agreement. These agreements appear in contracts to help the employer from losing a surgeon to a competing hospital or opening up a competing practice. The cost of losing a physician and, in particular, the cost of recruiting and replacing a new physician are part of why these clauses have become so prevalent.

There are three main components to a restrictive covenant: scope of activity, geographical restrictions, and time period restrictions. The geographical restrictions set a certain radius around your place of employment and the time period defines the length of time that the agreement will be in place (typically 1-2 years). Some of these agreements will include the opportunity to pay the employer to nullify the restrictive covenant ("buy-out").

The applicability and enforcement of these covenants is left to state judiciaries to decide. They are enforceable in many states as long as the geographical and time restrictions are felt to be "reasonable." In general, these covenants should be reviewed (with the rest of the employment agreement) with a health care attorney who can provide legal guidance on the state's history of enforcing these agreements.

—Dr. Jason Wilson

Medical Malpractice/Liability Insurance

Medical malpractice insurance or medical liability insurance is a professional liability insurance that covers physician liability from disputed services that result in a patient's injury or death. It is required to practice in all 50 states. It is available through insurance carriers or an organization of medical professionals known as a Medial Risk Retention Group. There are large hospital systems which are also self-insured. For those in private practice, there are group plans available, and for employed physicians medical liability insurance is typically offered by the employing health system. Some professional organizations such as the American College of Surgeons even offer medical malpractice insurance as a member benefit.

There are two basic types of professional liability insurance: Occurrence and claims-made.

Claims-made policies account for the majority of policies available today. They provide coverage for incidents that were filed and occurred while you were with a particular carrier. If you end a claims-made policy, you are not covered for any suits that are filed after the policy is discontinued. However, tail coverage is available. Tail coverage extends coverage for incidents that happened during the time you had the policy but were filed after the policy had ended. Tail coverage can be costly, but many times can be paid for by your employer or negotiated into your contract. Alternatively, nose coverage is available in which you your new employer/insurer extends coverage of a past incident while you were insured by another carrier. For a new surgeon joining a group practice where the group covers the malpractice insurance, it is important to address in contract negotiations who will be responsible for tail coverage if you leave the group.

Occurrence policies provide lifetime coverage for incidents that occurred while the policy was in effect, regardless of when the claim is filed. Occurrence polices tend to be more expensive than claims-made policies.

What to look for when choosing a carrier

The premium is the annual fee paid to the insurance carrier for coverage. The premium is determined by the carrier based on how much money will be needed for claims divided by the total number of those insured (to distribute the risk). Your specialty, geographic location and personal claim history will affect your premium.

You should not just a make decision based on the cost of premium alone. When you compare premiums, it is critical to make sure you clarify every detail. If a premium is markedly low compared to other carriers, it could be because there is a high deductible you must pay before the policy will pay for any costs. It is also important to understand whether or not your carrier is assessable. This means the carrier has the right to assess a surcharge if loses are excessive. Some carriers offer cheaper rates but could be reassessed in the same year.

It is also important to look for a "consent to settle" cause. When a consent to settle cause is in place, a claim against you cannot be settled without your written consent.

If you are employed by an institution that is self-insured, you can contact a representative from your risk management department for further details about your coverage

What is covered?

It is important to understand exactly what your policy covers. Usually, attorney fees, court costs, arbitration, settlement costs, medical damages and punitive and compensatory damages are covered. It also may or may not cover cyber liability or compliance with Health Insurance Portability and Accountability Act (HIPPA), in which case a separate policy should be obtained to cover these. Medical malpractice does not cover liability from criminal acts, sexual misconduct or alteration of medical records.

Most states require a minimum coverage per claim or by the total of all claims that can be made. It is crucial to discuss with an insurance consultant or institution's risk manager the need for additional coverage if needed, for example to protect your personal assets.

Likewise, if you are subject to litigation, it is important to understand the relationship of the insurance carrier's legal representation to your institution, to you and to your personal legal representation. Their primary responsibility may be to the insurance company or to the hospital, and not to you the surgeon. Knowing this may help you better navigate the process and decide if you will proceed with retaining independent counsel or not to better protect yourself.

Avoiding malpractice suits

By age 55, almost half of all physicians will have been sued; general surgeons and OBGYNs face the greatest

risk. Although 68% of these claims were ultimately dropped, they still incurred an average of $30,000 in defense cost. A recent report by Coverys insurance retrospectively looked at 2,579 surgery related malpractice claims over a period of 5 years (2014-2018). Of these, 39% claimed an alleged lack of technical skill while 27% alleged failure in clinical judgement and/or communication. Other problems cited included retained foreign body (7%), performing an unnecessary procedure (4%), wrong site/side (3%) and delay in surgery (3%). The authors suggest that at each stage of the surgical process there are specific areas which can help improve outcomes and avoid claims. For instance, prior to surgery, physicians should ensure patient's understanding and should document clearly informed consent discussions, including the patient response.

Patient satisfaction is very much related to the likelihood of litigation. In a landmark JAMA study, Levinson et al demonstrated that **strong physician-patient relationships and good communication can prevent malpractice suits**. Documentation of this communication and of the physicians thought process is oftentimes the only record attorneys will have when forming a defense against claims.

If you do have a complication, empathize with the patient and family. Discuss the facts (what is known) and what is being done to treat it and to prevent similar situations in the future. Treat this conversation like an extension of your informed consent discussion. Discuss what is known and admit if there is something unknown. If you need, bring a colleague or talk to your institution's Legal or Risk Management departments (may have a different name at your local institution). And make sure to answer any questions the patient of family may have.

—Dr. Sonia Talathi

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SECTION 3:

After Signing

Who's Who in the Office

With regards to pursuing a medical degree and ultimately entering practice, most physicians have had little to no gaps in their training. Certainly, part of that education and training involved seeing patients in the office, but through the lens of a trainee. Little time is typically spent during training actually understanding how the office itself works. Coming out to practice in the office, whether it be in a group setting or in solo practice, can be quite the culture shock. Knowing who's who in the office can help you become more efficient and succeed in becoming clinically busy and engaged.

Reception

This may seem obvious, but this is the person that answers your phone calls. What may not be obvious, however, is that this person is also the first contact between you and your patients. Equally important, this person is your practice's representation to referring providers. It is imperative that both you and your receptionist(s) understand this relationship – poor interaction at this point can often mean patients will be looking for someone else to see and referral doctors will simply send their patients elsewhere.

The receptionist is responsible for routing phone calls and messages through your practice. These can be patients who call with symptoms or general appointment requests. Receptionists also have an understanding of insurance coverages and requirements and may be also responsible for contacting insurance companies for pre-authorization or any other insurance-based issue your office may encounter.

It's important to remember that although the receptionists are an integral part of your clinical practice, they may not necessarily be clinical themselves. For instance, if your receptionist takes a message from a patient with a certain complaint, it may not be appropriate to ask that receptionist further details about the patient complaint as this is not their area of expertise. Both for receptionists and anyone else working in the office, for that matter, if your expectations fall outside of their primary responsibilities, your staff may feel unhelpful and this could lead to poor morale.

Medical assistant

Medical Assistants play a critical role to the daily operations of a clinical practice. They have both administrative and basic clinical duties. On the administrative side, they are responsible for the day-to-day operations of the office. From the moment a patient arrives, they make sure patients are routed through the office appropriately and efficiently. They often clean and stock rooms in between patients.

From the clinical standpoint, they are responsible for rooming patients which includes getting vitals, updating and maintaining their medical chart, getting a chief complaint and even a brief history. They may also assist in minor procedures. Medical assistants can pursue additional education and become Certified Medical Assistants or CMAs, expanding on these responsibilities. Medical assistants are often individuals who are simultaneously on a track to attain further education and specialization within the health care field. Because they are not registered nurses, they command a lower salary. Depending on the financial constraints of your practice and the clinical needs, supporting your practice with Medical Assistants may make more economical sense.

Registered nurse

Having registered nurses as part of clinical practice is an enormous asset. As they are fully clinical, they often function as the physician's right hand. In addition to the clinical duties of a medical assistant, they also triage and manage patients in coordination with the physician. They can order medications and tests on the physician's behalf. Nurses can also provide therapeutic advice allowing you to focus on other aspects of patient care more relevant to you. Administrative duties for the office are often a secondary responsibility for nurses.

Scheduler

Having a dedicated scheduler in the office is truly beneficial. This individual manages your day to day schedule making sure clinical time is used efficiently. They schedule new and established patients for office visits and manage the scheduling of procedures and surgeries. It's important to communicate with them about how to structure your clinical time. When having them schedule procedures or surgeries, it is also important to let them know any specific preferences or equipment you may need, or if a certain case will be more complex and therefore require more than the usual time allotment.

Biller/coder

This is arguably one of the most important jobs in the office as they are responsible for translating your hard, clinical efforts into something quantifiable for your compensation. Each field has its own rules for billing and even this varies depending on the myriad of health care coverage options. Your office may have their own biller or it may be outsourced. Regardless, it is critical to maintain open lines of communication.

Practice manager

The practice manager is responsible for overseeing the overall operation of the office. Their job is to ensure the office staff and resources are efficiently used to maximize patient satisfaction and safeguard those resources by maintaining financial viability. This person can be essential in ensuring staff concerns are heard in a timely fashion, the staff satisfaction and morale is maintained, and that administrative decisions and policies are implemented appropriately.

A final reminder: Never undervalue anyone in your staff. A healthy practice depends on every single individual.

—Dr. Sherazuddin Qureshi

Moving Considerations

It is hard to generalize about what is the best living arrangement for an initial job after training as needs and wants vary widely. Still, there are some important factors one should consider.

First, you have to ask yourself: how do you feel about this job? Most individuals often end up leaving their first job no matter how solid it may seem at the outset. That is not to say some people retire from their first job after a long and productive career, but this is definitely the exception. If the first job is less than ideal, you may want to consider renting to see how things progress. Often, employment contracts offer a 2 to 3-year guarantee. You may be able to negotiate with your lessor for a cheaper monthly payment if you sign a lease longer than one year understanding that you will be in the same job for at least the amount of time you agreed upon in your contract. This can work the other way as well. If you find that your job situation is untenable, you may be stuck with financial penalties for breaking your lease.

If you have school-aged children, you may prioritize better schools which often comes at a premium. In some locations, renting may be equivalent to the monthly cost of a mortgage. The plus side to renting is that at the end of the lease, you are not tied down in any way. If you decide to leave your job, it's a cleaner break and less financially taxing to maintain another property closer to your next job. The downside is that for those 2 to 3 years that you rented, you haven't built any equity which may be important to you. Already, doctors get a later start in life building wealth compared to their peers in other professions. Renting is essentially a "known fixed loss."

If you decide to buy, you may build some equity in two to three years, but if you end up leaving your job, you have to sort out what to do with your property. You may not be able to sell it right away or you may be under on your mortgage. That is more of an "unpredictable loss."

There are many rent versus buy calculators you can find online to guide you. There are many options for physician mortgages you can find online at major banks and credit unions as well. Generally speaking, physician mortgages offer little to no down-payment and have other advantages such as not requiring private mortgage insurance. Again, it's best to talk to your financial institution and see what they offer.

While buying a house allows you to build equity, customize your own place and work toward ownership, it also means that you are responsible for all maintenance, repairs, property taxes and otherwise. Renting allows you to rely on your lessor (assuming they are relatively benevolent) for many if not all of these things. Some properties will even perform renovations for you even if you are only leasing.

Lastly, consider something that may not be obvious. If you are taking your first job outside of where you trained geographically, you usually negotiate a stipend for moving as part of your employment contract. If you use this stipend to move into a rental property and then decide you want to stay in the area and buy another property nearby, that moving cost will be out of pocket unless specifically negotiated.

—Dr. Sherazuddin Qureshi

Onboarding and Starting

The onboarding process can vary depending on practice setting. Typically, there should be a contact person to assist with moving, benefits, and getting ready to start practicing including licensing and credentialing. If the practice you joined covers multiple hospitals, each may have its own credentialing process and so it is a good idea to have copies of your degrees, board certificates, licenses and CV. Additionally, you will need to be credentialed by the payers (the insurance companies). Many of these intra- or extramural credentialing committees only meet once monthly as well. Getting paperwork completed rapidly so as to be credentialed quickly will allow you to start seeing and treating patients sooner. In a productivity-based practice, this is critical.

You will meet many new people in a short period of time. While it would be best to remember everyone, at least try to keep track of the people you are likely to encounter frequently. You may have additional contact people helping you with specific tasks such as privileging, setting up office space, etc. Being available and responsive will really give a good first impression and set the tone for your practice.

Once you begin, it is important to let people know who you are and what services you provide. Find the practices in the area relevant to your field and go meet them or arrange a phone call. Handing out a business card or a face sheet with your picture, training, and the services and procedures you offer as well as are an easy way to get in contact with you will go a long way. Consider leaving a few copies in the Emergency Department. Any new physicians that come on after you, reach out to them as well. A hospital system will likely have a liaison who knows other providers within the system and can be a strong ally to introduce you to others and help you develop a referring network. Understand that when you are meeting other providers, it is typically in their offices in between their patients. Keep introductions brief and memorable.

The best thing to do is to start small, communicate often, and slowly build on early successes. Working hard in training doing complex cases may be empowering and feel great, **but taking these same cases on straight out of fellowship without appropriate support can be devastating to your early practice and reputation**.

You will always be your best advocate but treating those people around you with kindness and valuing their support will help you grow and build your practice. More on this in the sections on Networking and Building a Practice.

—Dr. Sherazuddin Qureshi

When to Stick It Out, and When to Get Out

Regardless of whether or not you are actually looking to leave, you should always be thinking about the next step in your career, your next job, your next move. Not only does this keep you in touch with what is going on in the "market," but it also helps prepare you for future opportunities. Knowing what's out there is additionally useful when it comes to negotiating with your current employer.

Still, no job is perfect and there will be days when you question whether your current situation continues to be a good fit. That said, it is important to set your own barometer as to whether your practice situation has you on a good trajectory or not. How do you accomplish this?

First, look inward. Could you be more available? Are you communicating your needs clearly? Are your expectations appropriate for someone just starting out?

Second, look outward. Is the source of discontent the lack of clinical breadth you expected to see? Perhaps the cases you want to see are already directed to someone more established. How new patient referrals are routed through the practice is also important. Is it by seniority? Next available provider? By diagnosis? Are you lacking in support staff? It may be that you're spending too much of your clinical time doing clerical work because you don't have the staff you need. Maybe you're covering multiple hospitals and cannot physically see patients in different locations in a timely manner. Are there issues with your clinical partners leading to a toxic environment? Some partners may not be vested in your success or openly in direct competition with you due to the practice structure.

Additionally, look at your relationship with the administration. Do you have the support and ancillary staff to complete your clinical and non-clinical duties (e.g., adequate research support, hybrid room, etc.)? Are your vision and career goals in line with the institution? Does there continue to be room for you to grow at the current institution or practice? Does the administration understand your needs and do they support you? Are your ethics being challenged due to, for example, financial reasons? Are the administrative expectations without dedicated time excessive? Is the salary no longer competitive?

Third, are the concerns you have likely to resolve or improve with time? Is it just that you are new and you need more time to get established (it will probably take at least two years to begin to establish your practice)? Can you meet the referring physicians, or will there be upcoming changes that may resolve some of your concerns or allow you new opportunities to address them?

Some might prefer a simpler approach – does your current job still "spark joy." And while this section is not comprehensive, these are some of the questions you should be asking to determine whether to stick it out or to get out.

—Dr. Sherazuddin Qureshi

Your First Renegotiation

You have worked hard. You have been available, able, and amiable. You are no longer a rookie and you are 3-5 years into your first position as an attending surgeon. Now is the time to consider renegotiating your contract. By 3-5 years, your value to the institution is hopefully more than your compensation. Also, the institution and you likely have a clearer understanding of your skill set and goals. So, it is worthwhile to discuss these and adjust the contract as necessary to keep both parties on the same page. The process leading to renegotiation is very similar to your first negotiation. We recommend you review your mission statement, vision, goals, and priority list again tweaking it appropriately based on your experiences these past 3-5 years.

The renegotiation process has a few significant differences. You have a better understanding of what it means to be a surgeon at your institution. You now have an insider's perspective rather than an outsider's perspective. You have a better understanding of how your boss works and how to talk to her/him. Your proof (if you have done a good job) should be robust and more able to support your product.

At about three to five years, you may have seen "greener" pastures and entertaining the idea of taking a job elsewhere for financial, professional, or personal reasons. Know that if you enter a renegotiation when another offer is on the table, you should be prepared to leave your current institution. Importantly, you certainly want to be honest and genuine. In other words, do not use another offer just to leverage your current institution. The other offer should be a viable option for you since you may need to take the offer if your renegotiation does not go well. In fact, we recommend letting your current employer know that you are interviewing elsewhere. There are risks and benefits to this strategy and each work environment must be measured as unique.

The process of the discussion again follows the 4 Ps: Problem, Product, Proof, Price. The problem remains the BtB's vision, but now the current vision. The product is your current vision. The proof is your body of work since starting at the institution. The price is again predicated on your current value and future commitment to the institution. Reference salary medians or regional comparables to give you objective data. Therefore, as stated previously an appropriate way to change your compensation would be:

"On the backdrop of my contributions to this institution and future commitment, I don't believe my current compensation reflects my value. Based on market data and my unique skill set, I think a reasonable salary is ....."

The key objective of this renegotiation, as in the first negotiation, is to arrive at a partnership aligning the vision/expectation of the institution and you. If this alignment cannot be accomplished reasonably, then walk away without burning bridges. It is again about an appropriate fit rather than emotions.

—Michael Delatorre and Dr. John McAuliffe

SECTION 4:

Additional Considerations

Immigration Needs

For surgeons trained outside the United States, there may be several unique considerations. We have attempted to produce a brief overview here of some of the considerations when applying for jobs.

Licensing and certification
Physicians graduating from medical schools in countries outside of the US and territories need to obtain the Educational Commission for Foreign Medical Graduates (ECFMG) certification, and will need to successfully complete the U.S. Medical Licensing Exam (USMLE – all components), before applying for and being issued a state license to practice medicine. While graduates from Caribbean medical schools are required to obtain ECFMG certification, a physician who graduates from one of the seventeen Canadian medical schools accredited by the Liaison Committee on Medical Education (LCME) with an M.D. degree is not considered to be a foreign medical graduate. A physician who graduates from one of these schools does not need to obtain the Educational Commission for Foreign Medical Graduates (ECFMG) certification. It is important to remember that these designations are all based on the location of the medical school and not the citizenship of the individual.

Generally, a graduate of a foreign medical school must complete an Accreditation Council for Graduate Medical Education (ACGME) accredited graduate medical residency program, and successfully complete the U.S. Medical Licensing Exam (USMLE), before applying for and being issued a state license to practice medicine. In many U.S. states, however, a physician licensed to practice medicine in Canada may apply for U.S. state licensure without completing a U.S. graduate medical residency program and/or taking the USMLE.

Organizing paperwork
As with any application process, organization is critical. Have a centralized databank of all licensing, certification, graduation certifications. This should be easy to access and redundant so it can't be lost. Many sources recommended a flash drive, Dropbox, or similar file systems for portability and backup. This would include state medical license, DEA, driver's license and passport, Boards certificates, BLS/ACLS/PALS/NRP cards, ATLS/FLS/FCCS courses, CITI research certifications, Medical school and residency diplomas, College diploma, Birth certificate, radiology license, etc. There are some formal services that will organize, record and verify these, such as the Federation of State Medical Boards (FSMB).

Visa application and processing
It is important to find out from the prospective employer what resources will be available to you to help with immigration and visa processing paperwork. Some employers will not sponsor visa or waiver applications, and this will be important to know early in the process as you may elect not to consider these employers. Knowing the likelihood of success with visa applications and waiver requests from an employer in a specific geographic region and for a specific specialty are also important. While it is easiest to obtain visa waivers from underserved areas, regions with high numbers of primary care physicians applying for the same waivers may increase the "competitiveness" of obtaining one, especially if there are more applications than waivers available in a specific geographic area.

Be prepared to have to undergo additional interviews by the State Department for the Visa, or to provide supporting documentation regarding your country of origin, the sociopolitical climate there, etc. Supporting letters of recommendation may also be required. Ideally, you will want to work closely with a specialized immigration attorney on these matters who will guide you through the process.

Timeline
Make sure to add extra time for any of these situations that apply to you. More time may be required for visa processing and state licensing. Some states can take up to 6 months to process an application for state license, so apply as soon as you know you are taking a job. If you also need a fluoroscopy license, apply early. Testing has to be scheduled and you'll need time to study and obtain the licensure. All in all, the employer will also be able to advise on the timeline, especially if you are applying from out of that position's state.

—Dr. Shannon Castle

Locums and Alternative Employment Options

Locum tenens is a temporary assignment to fill a need. Frequently, this can be an option for those looking to fill a gap in between permanent job positions while looking for permanent positions, "trying out" while looking for a permanent position, as side work for income supplementation, or as a full-time career. Locum tenens work has both positive and negative aspects to consider. The temporary work is often due to the need for call coverage or because of the departure of a surgeon, be it for illness, leave (i.e., maternity), retirement or inability to yet hire a permanent surgeon. Assignments offer the opportunity to travel on someone else's dime (they typically pay for airfare, rental car, housing, and fuel), provide flexibility of schedule, and allow the surgeon to be free of bureaucratic and internal politics of the hospital (for the most part).

Locums work is highly independent, nomadic in nature and often in rural or small urban centers in community hospitals. For anyone considering this option immediately after completing training, this may be a significant concern. Early in one's career, the learning curve can be steep and in some locum settings there may not be much in the way of support by older, seasoned surgeons – you may be the only one available. In particular, while we all want to be the go-to, does-everything surgeon, limits of the facility and resources must be assessed when the assignment starts and the locum surgeon must be wise as to when to treat the patient as well as when to transfer to a center with a higher level of care. For some, this can be a source of frustration but for others it may be liberating. In addition, in smaller, less urban non-academic centers there may be other logistical concerns not initially apparent. Operating room assistants may not be present or may not be as skilled, testing may not be as robust as in large academic centers and the case load may be lower and less complex. Many locum assignments are also limited in duration and frequency which restricts your knowledge of patient outcomes due to the lack of personal follow-up with the patients.

While many opportunities are a one- or two-time assignment, there are options that arise to have an ongoing, recurrent need for a surgeon where the surgeon may return for a period that can be up to many years depending on the circumstances. This allows for the freedom to have a "practice" but one that doesn't have any overhead, no long-term contract, or marriage to a hospital administration. Depending on your personality, this may or may not fit with how you prefer to work. Most assignments are negotiated through a locum tenens service, but some do negotiate and work directly with a hospital leaving out the middle person and potentially increasing income.

Overall, locum tenens pay is often quite generous but it is "contract work." All insurance, retirement and other benefits are up to the surgeon to acquire. This may have some significant tax advantages, even though it will require more work on the part of the individual surgeon. Consider professional consultation with an attorney, tax advisor or financial planner familiar with these situations.

If locum tenens work appeals to you or there is consideration for working in this manner, even if for a short time, it is strongly advised to seek out guidance from a surgeon who is experienced in order to navigate the world of recruiters and the unwritten rules of the environment before you send anyone your CV in order to ensure a good fit for your skills and expertise, an enjoyable work experience, and as in much of surgery – keep you out of trouble.

—The author of this section preferred to remain anonymous

Military Obligations

While you might consider the path of medical military service largely decided, there are still many considerations for a graduate. This section will provide a framework to approach career planning as a surgeon in the military.

For those who maybe do not have experience or who want a quick overview of medical school and residency training for military surgeons, remember there are several routes of accession for active duty physicians:

- Uniformed Services University of the Health Sciences (USUHS) – 170 students/year. Military medical school in Bethesda, MD. Students are active duty officers, have free tuition and receive full pay and benefits.
  - Obligation incurred – 7 years for 4 years of medical school.
- Health Professions Scholarship Program (HPSP) – approximately 800 scholarships/year. This is more or less a scholarship to attend a civilian medical school. Students get paid tuition and a monthly stipend.
  - Obligation incurred – 4 years for 4 years of medical school.
- Financial Assistance Program (FAP) – 20-30 grants/year. For accession after completing medical school while in post-graduate medical training. This program consists of a grant for tuition plus monthly stipend.
  - Obligation incurred - 5 years for 4 years of medical school.

There are also several mechanisms to complete residency programs in the military:

- Full Time In-Service (FTIS) – at a military run residency at a military treatment facility. Residents are active duty.
  - Obligation incurred – 1 year per year of residency
  - Obligation can be served concurrently with a USUHS or HPSP obligation.
- Full Time Out-Service (FTOS) – civilian residency while on active duty.
  - Obligation incurred – 1 year per year of residency
  - Obligation can be served concurrently with a USUHS or HPSP obligation.
- Civilian deferred – civilian residency not on active duty.
  - No obligation incurred.
- The final number of years of obligation/service required will ultimately be determined by which and what combinations of pathways from the above someone takes.

Timeline: What to do

During residency:
Contact your specialty leader (Navy) or consultant (Army and Air Force). These are surgeons that advise the surgeons general and are in charge of deciding who goes to what billet. They probably won't be able to make specific promises but should be able to give you an overview of what kinds of billets will likely be available. Stay in touch with them throughout residency, and make sure they know of any situations that might affect where you can go – spouses, pregnancies, etc.

End of residency:
Finalize your plans with your specialty leader or consultant. Additionally, get in touch with your detailer. This is an officer that's in charge of making sure your orders and other administrative items are taken care of.

First duty station:
As with any new job opportunity, adjust to local culture. It is important to know though that many initial duty stations for surgeons have more of a "military" and less of a "medical" culture than you may be used to. Embrace it and try to experience as much as you can. This will give you a better appreciation of the military patient population as well.

Don't forget to think forward! Career planning is important and finding a more senior physician (who doesn't need to be a surgeon) who can advise you on career progression will be instrumental. Things to discuss include:

- The fitness report or officer evaluation system.
  - Each branch has unique components in its rating system. Make sure you understand how it works so you can use it to your advantage
- How to set yourself up for what you want in the military.
  - Want to be stationed overseas, work with special forces, or do a full career and retire?

- Whatever your goals are in the military, talk to someone with experience that can help you map out a plan for promotions, kinds of duty stations, and deployments that will put you in the best possible position to get what you want from your military experience.

Additional resources

For more details, there are several resources available other that other surgeons or military personnel. Take a look at a few below, and best of luck with your future career!

Official websites
https://navymedicine.navylive.dodlive.mil/archives/category/inside-navy-medicine/medicalcorps
https://www.med.navy.mil/Pages/default.aspx
https://armymedicine.health.mil/Medical-Corps
https://www.airforce.com/careers/specialty-careers/healthcare/career-development

Non-official resources
https://mccareer.org/

—Dr. Erin Koelling

Financial Planning, Wealth Management, and Insurance

What keeps you up at night?

Perhaps not much. After all, surgery residents and physicians are notoriously sleep-deprived. Your patients and your career, of course, are major priorities, but so is your financial situation. Residents generally live modestly but face challenges such as substantial debt and an inability to save for future goals. Surgical residency does not leave you with much time to worry about anything else but succeeding at your career, and even when residency is completed, you are going to face financial challenges that may be difficult to meet on your own. Physicians are in the wealth accumulation phase of their career with many still paying down debt in the early years. Wealth is almost always accompanied by complexity, and as a substantial professional, you may face financial issues that other people do not. These risks can often be planned for and even mitigated, but time is of the essence. Given the unique demands and focus required for both residents and surgeons, it is imperative to have a plan that helps you understand where you are in relation to the goals you have set for yourself, and whether those goals are realistic.

There are important differences between "high income" and "high wealth." Some of the most important starting points include knowing your monthly expenses, setting up a real budget, and assessing your life goals. Try to avoid succumbing to a consumptive lifestyle, and make sure you're thinking long term. That isn't to say not to "treat yourself" after years of study, but rather just beware of the lure of delayed satisfaction and make sure you have a financial plan that you can and do stick to.

Other important questions to ask yourself may include:

- Will I ever get out from under the debt I have been carrying?
- How can I save for retirement when I have expenses that are more pressing?
- What if I cannot work as a surgeon due to an illness or injury?
- What happens to my family if something happens to me?
- What about the rest of my finances, and how do I make sure I am on the right track?
- How can I leave a meaningful legacy without excessive taxes or family conflict?

We will address all of these and provide suggestions and solutions to help you sleep more easily for years to come.

Financial planning starting points

Surgeons understand the vital importance of taking a methodical and highly disciplined approach when caring for patients. Every procedure must be meticulously planned out, each detail accounted for, and all members of the team prepared to perform their respective responsibilities.

Why should the approach toward holistic financial planning be any different? Just like a surgical team providing a continuum of care, it is best to have a team of qualified wealth management experts helping to navigate through opportunities and hurdles of a long-term, comprehensive financial plan. There are two fundamental foundations in most facets of financial planning:

1. Discipline
2. Time

You must have discipline to make monetary contributions, payments and investments on a systematic and coordinated basis over a long period of time starting now in order to take advantage of the powerful effects of compounding.

There are always reasons why you will wait to invest (e.g., purchasing a home, repaying school debt, etc.). The problem with waiting is that you simply cannot recapture that time. Make saving and investing a habit by starting small and increasing as you are financially able.

There is simply no way to recapture lost time when it comes to investing.

For example:

a. If you invested $25,000 once at age 25 into an account averaging 5% interest per year, at age 65 the account will have grown to $175,999.
b. If you waited until age 45 to invest $25,000 once into an account averaging 5% interest per year, at age 65 the account will have grown to $66,332.

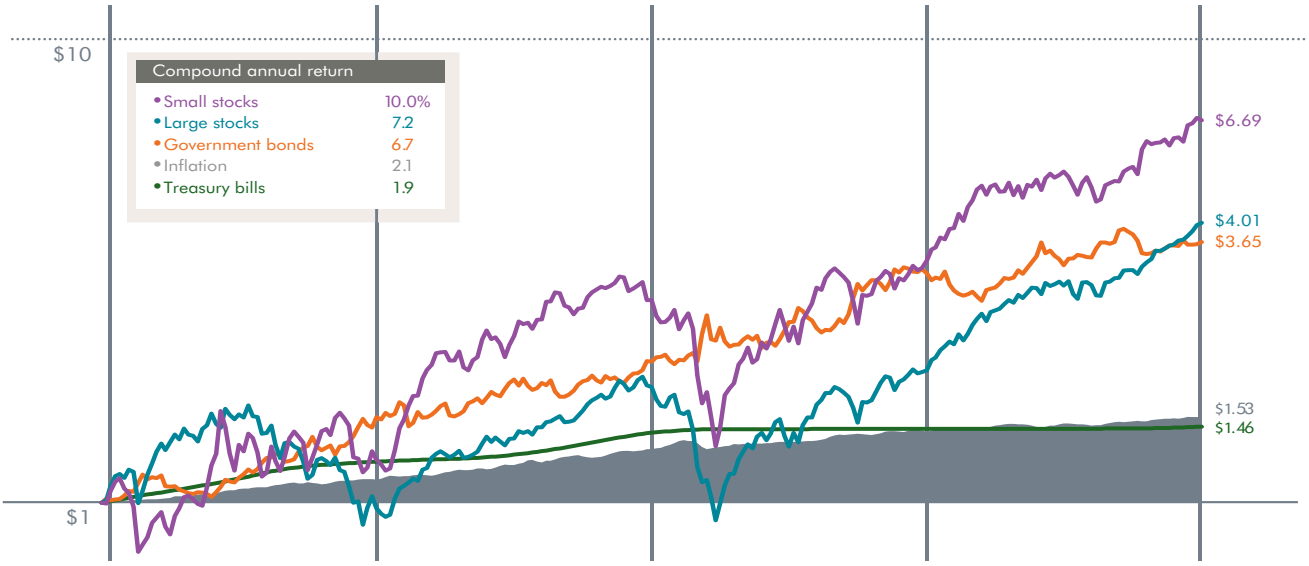
While you might assume the account value in example a) would be 50% greater than in b) at age 65, that is actually not the case since it compounds for double the time, that is not the case. The first account value is approximately 63% greater because the money compounds on a larger sum every year.

In this chapter, you will find an overview of the following facets of wealth management:

- Debt and school loan repayment
- Retirement planning and investing
- Life, disability, and other personal insurance

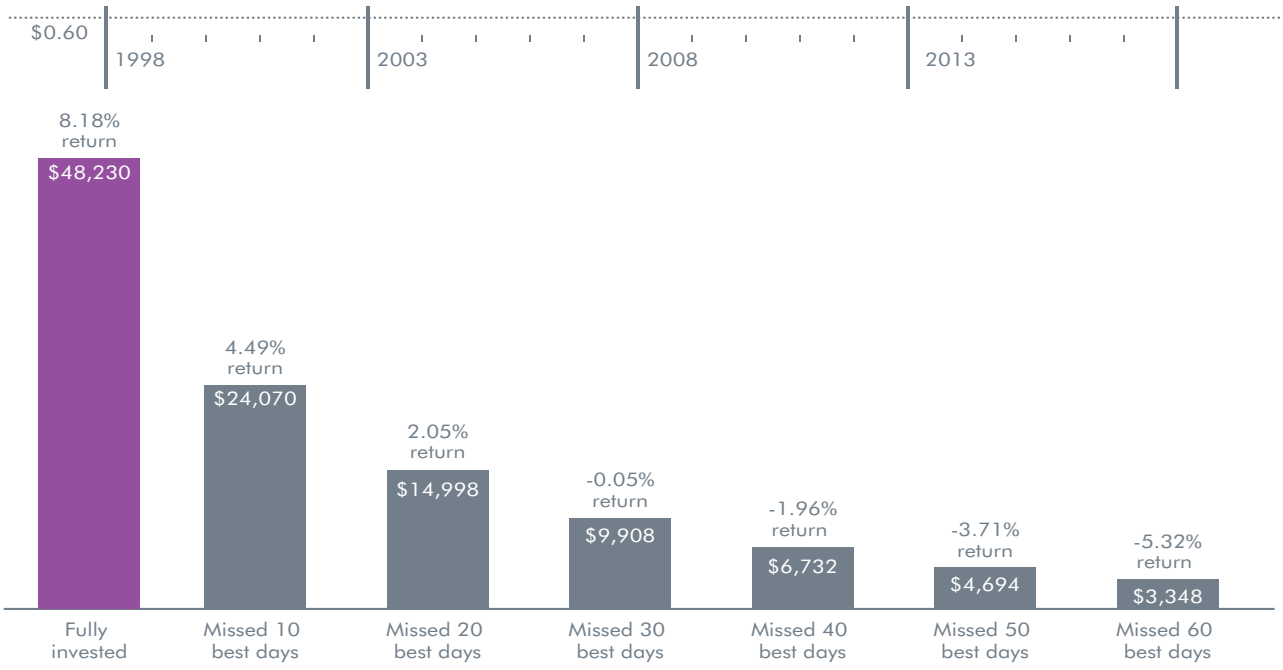
THE GROWTH OF ONE DOLLAR ACROSS VARIOUS INVESTMENTS

Stocks, Bonds, Bills, and Inflation 1998–2017



RETURNS OF S&P 500

Performance of a $10,000 investment between 1/2/1996 – 12/31/2015



Debt and school loan repayment

Many physicians incur substantial medical school debt with an average of $232,000. This means that most physicians have a *negative net worth!* Once they begin earning a higher income, the primary focus becomes eliminating that debt as quickly as possible. The factors to consider for debt repayment include:

1. Type of loan (federal or private)
2. Repayment plan options (i.e. equal payments, graduated payments, income driven plans)
3. Student loan forgiveness
4. Rates and refinancing options
5. Consolidation of debt

Any decisions pertaining to loan repayment are best made as part of a holistic financial plan, and not in a vacuum. For example, one should question how prudent it is to dedicate all available resources to paying off debt since it may negatively affect the ability to compound money in other growth areas.

For example:

a. If you pay down a loan of $100,000 at 5% interest over 20 years, you will pay a total of $158,383.38. The monthly payment would be $659.96.
b. If you amortized the same loan over 30 years, you would pay a total of $193,225.78. The monthly payment, however, would drop to $536.82.
c. If you took the difference of $123.14 per month and invested it into an account averaging 7% interest per year, you would have an account value of $139,582 in 30 years. Accounting for principal paid in and tax on the gains at 25%, you would have made $71,438 in the account. After subtracting out the additional interest, you are still ahead by $36,595.

Many would recommend that you consider rapidly repaying revolving debts with high interest rates at the very least. These are things like unpaid credit card balances and is a good starting point.

The rapid and significant increase in salary from training to being an attending can lead to the temptation of living beyond one's means. If you can resist unnecessary expenditures and continue to live and budget like a resident, at least for a few years, you will put yourself in a better position to becoming debt free.

Retirement planning and investing

Retirement Plan Options: There are a number of investment vehicles designed for retirement, and most institutions offer one or more plan options. Some of these institutions will offer a percentage match of your contribution. Additionally, there are retirement plan options that exist for you to set up as an individual.

- 401(k) Plan – 401(k) plans are tax-deferred defined-contribution retirement savings vehicles. When a tax-deferred contribution is made to a retirement plan, the contribution amount is subtracted from your earnings for that year.
  - Example: If you earn $300,000 per year and make a $10,000 contribution to a "qualified plan" (pre-tax), you will be taxed that year as if you earned $290,000:

  These plans allow employees to make their own tax-deferred contributions for retirement. Oftentimes, employers match a percentage of participant contributions.

  Another benefit to participating in a 401(k) plan is that the money in the account grows tax-deferred. This means that nothing in the account is taxed until the money is withdrawn for retirement.

  Employee contributions into the plan are always 100% vested, meaning they belong to the employee. If the employee leaves the employer, he or she can move the funds out of the 401(k) plan.

- 403(b) Plan – 403(b) plans are the public service equivalent to 401(k) plans. For example, they are available for public educators, some non-profit employers, and hospitals. 403(b) and 401(k) plans operate in similar ways, with the main difference being that they are governed by different sections of the Federal Tax Code.
- 457(b) Plan – The organization establishing a 457(b) plan must be a state or local government or a tax-exempt organization under IRC 501(c). Employers or employees through salary reductions contribute up to the IRC 402(g) limit ($19,500 in 2020) on behalf of the participant under the plan. There are significant tax advantages for participants in a 457(b) plan such as contributions to a 457(b) plan are tax-deferred, and earnings on the retirement money are tax-deferred.

- Simplified Employee Pension Plan (SEP) – A SEP plan allows employers to contribute to traditional IRAs (SEP-IRAs) set up for employees. A business of any size, even self-employed, can establish a SEP. SEP plans can provide a significant source of income at retirement by allowing employers to set aside money in retirement accounts for themselves and their employees. Some benefits of a SEP plan include the ease in which they can be set up and operates as well as low administrative costs, and there are flexible annual contributions which can be beneficial if cash flow is an issue.
- Roth IRA – A Roth IRA is an individual retirement account where you pay taxes on the contributions going into your account, and distributions can be withdrawn from the plan tax-free at retirement. Gross income for the year in which you make the Roth contribution will be higher than if you had made only pre-tax-salary deferrals. Additionally, your employer's retirement plan may allow for an in-plan Roth rollover.

401(k) and 403(b) plans, while offering tax deductions and tax-deferred growth, are taxable at retirement.

The rules for Roth IRA and 401(k) plans have been changing to accommodate a desire to move a portion of retirement dollars into vehicles that have favorable tax treatment at retirement. These particular plans had been far more restrictive for higher wage earners.

You should consult with your accountant to determine if you are eligible to contribute to a Roth IRA by either standard or "backdoor" contributions. Eligibility for additional/multiple retirement accounts based on supplementary consulting work or alternative income streams may also be available depending on your personal financial situation.

Other investment options include 529 college savings plans which are state-dependent as well as other personal investment opportunities (real estate, mutual funds, stock market, etc.). There are also nontraditional methods of retirement planning and investing such as using Health Care Accounts or life insurance plans. Knowing which financial instruments and strategies are best for you along with knowledge of the tax implications are critical and beyond the scope of this primer, but it is important to know that there are options.

Most financial planners will remind you to "Pay yourself first." This means that you should plan for (at least) retirement and ensure that you are contributing to your retirement funds. Consider having the money withdrawn automatically and deposited into your investment accounts.

Deciding which investment options to choose for retirement or otherwise depends upon a number of different factors such as plan availability, age, income, amount invested, and location of your other assets. At a minimum, if an employer is providing a retirement plan with a percentage match, the employee should contribute at least up to the matching limit.

Furthermore, these types of retirement vehicles have some similarities to a mutual fund, and an employee may be able to "rebalance" their contributions. Rebalancing is the process of realigning the weight of contributions in a portfolio of assets. An investor may rebalance based on their personalized risk tolerance. Typically, younger investors will tolerate increased risk which may afford higher returns overall. As the young investor ages, a "conservative," lower risk contribution profile may be more appropriate. Even for those further away from retirement, it is imperative to make prudent and calculated holistic decisions during all stages of your career to help ensure the best opportunity of reaching future goals and objectives.

Life, disability, and other personal insurance

Why is the protection of wealth so vitally important, and how will your family be protected if something were to happen to you? You have been working so incredibly hard, and it would be devastating to lose it all and not be able to support your loved ones, who missed you during your years of training. As a surgeon you are covered against malpractice claims, but what about injury, illness, or premature death? As an employee of a hospital or health care company, you may be covered by group disability and/or life insurance policies. The question is whether these policies will be sufficient to provide you and your family with adequate income to meet living expenses and pursue long-term goals like funding retirement and college for your children. Most companies' group plans are designed to protect the average employee. Highly compensated surgeons typically require more. Individual disability and life insurance policies can provide you with coverage tailored to your specific situation and specialty. In addition, you can take your personally owned policies with you if you ever decide to change

employers or go into private practice. Finally, premiums for disability and life insurance are based on your age at the time of purchase, which means the younger you are when securing coverage, the lower the premium you will be locking in. In other words, now is the best time to consider purchasing individual policies to protect your income, insurability and your family.

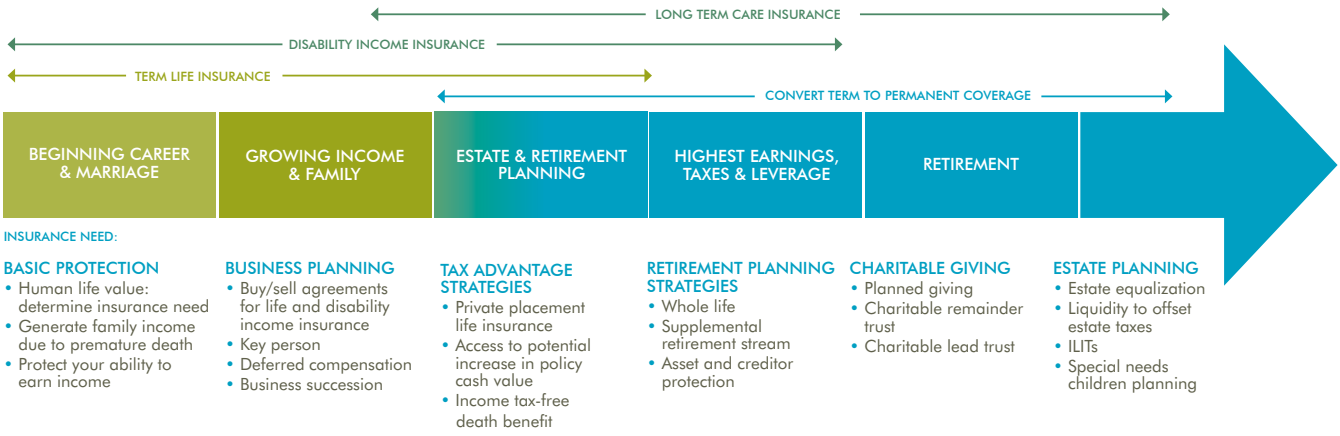
Insurance: The protection pillars of financial planning

Aside from medical malpractice insurance, the primary insurance-related protections you should strongly consider having in place are Disability Insurance, Life Insurance, Long Term Care Insurance, and Umbrella Liability Insurance. What follows is an overview of each.

Disability Insurance (also known as long-term disability insurance, income replacement insurance, or individual disability income insurance): In its most basic form, income provides money for food, shelter and clothing, however it goes well beyond just the basic needs. Your income is paramount to funding all facets of your family's life, including saving for future retirement. When discussing disability insurance with a prospective client, the first question we ask is, "What is your most valuable asset?" Most people do not think of themselves as the answer to this question, but they should. The ability for you to do your job and earn an income is your greatest and most valuable asset, and this especially holds true with highly trained surgeons.

INSURANCE PLANNING LIFE CYCLE

Your financial needs will continually change throughout your lifetime. Selecting the right insurance is a critical element of any comprehensive financial plan. As your circumstances change, so do your needs.

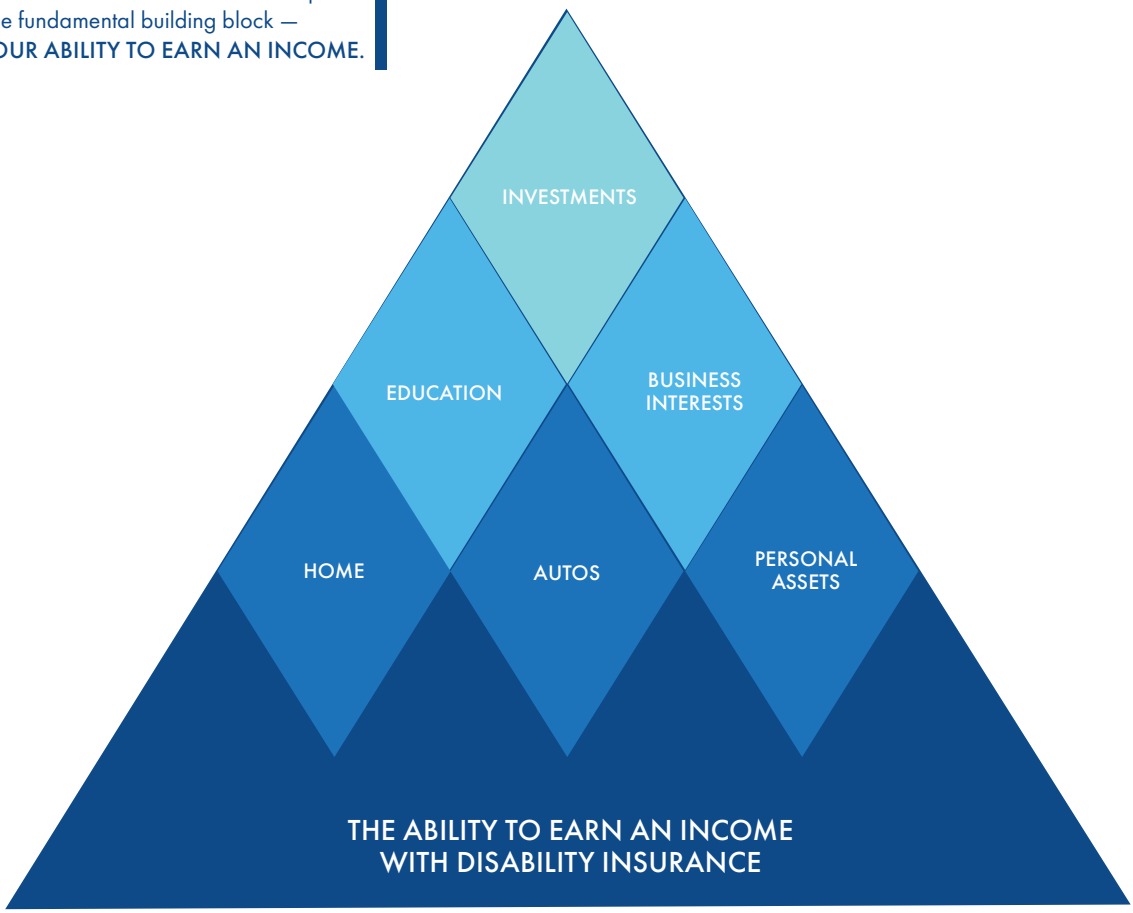


Here are some of the questions that keep our clients up at night:

- With the average absence from work due to a long-term disability lasting almost 3 years, can I afford to be disabled, sick or injured, and unable to work for months or even years?
- Did I sign up for the Group Long Term Disability (LTD) policy at work, and if so, does it cover 100% of my monthly income? Does it include coverage for any other annual compensation, e.g., stock options, bonuses and other incentives? If not, how would I cover the remaining percentage for all sources of income? Can I take the Group LTD coverage with me if I leave my employer?
- How does the policy define disability; what is meant by "guaranteed renewable and non-cancellable"; and what are some examples in which I would qualify for benefits? Do I have "own occupation" or "any occupation" coverage, and for how long?
- What happens if I choose to go back to work but can no longer perform surgeries?
- Should I consider obtaining an individual disability insurance policy to supplement the Group LTD coverage? If so, how much additional benefit would I be eligible for; how much does it cost; are there any available discounts or underwriting concessions; and, can I take the policy with me if I leave my employer?

THE BUILDING BLOCKS OF YOUR FINANCIAL LIFE

Your entire financial structure rests upon one fundamental building block — **YOUR ABILITY TO EARN AN INCOME.**



Life Insurance: Purchasing life insurance is a very important decision for you, your family, and in some cases your business. Your financial needs will continually evolve throughout your lifetime, and as such, you will likely obtain multiple life insurance policies at different times to address changes in circumstances. Each individual's financial goals are unique, and it is prudent to conduct a consultative approach when choosing what type and amount of coverage to obtain. The decisions you make about appropriate levels of protection for your loved ones are best viewed through the holistic financial planning lens, and when considering life insurance, it is important to consider the following:

- Total amount of coverage
- Type of coverage:
  - Term Life (e.g., 10, 15, 20 and 30 year level term periods)
  - Whole Life (e.g., permanent whole life, universal life, variable life)
- Ownership:
  - Will the life insurance policy be owned by an individual or in a trust

LENOX ADVISORS

FINANCIAL PLANNING

ESSENTIAL PIECES OF ESTATE PLANNING

Because we know how important it is to plan your estate – and to keep it up to date – we want you to have the information you need when you work with your estate planning attorney.

GUARDIANS AND ALTERNATE GUARDIANS

Guardianship is a fiduciary relationship created by law for the purposes of one person, the guardian, to manage affairs of another person. Guardians are responsible for the care of your minor children in the event of a premature death. It is important that you name successive Guardians as some individuals may be unable or unwilling to serve. You should also consider whether they will care for your children at the Guardian's home, or if you would you like your Guardian (and their family) to move into your home. Depending on the circumstance, you may wish to consider allocating funds, within your testamentary documents, to cover these expenses.

TRUSTEES AND SUCCESSOR TRUSTEES

Trustees hold and manage assets held in trust for the benefit of your minor children and/or surviving spouse. The trustee does not have to be the same person as the Guardian and most times it is not, which allows for checks and balances. The Guardian is normally someone who knows the children best, while the trustee is someone who is financially savvy. In choosing a trustee, it is important to keep in mind a fiduciary relationship between a trustee and the trust beneficiary. A fiduciary is legally bound to act in the best interest of the beneficiary.

EXECUTORS

Executors are appointed to carry out the instructions that are outlined in your will. Typically, spouses are named as executors for each other's wills, along with at least one successor. You should consider if you would like your executors to be compensated. If so, you could apply a limitation on their annual compensation for fulfilling this role.

CREDIT SHELTER TRUST (CST):

Each spouse can establish a Credit Shelter Trust (aka bypass trust, credit equivalent bypass trust, non-marital trust, family trust, etc.,) under their will in order to fully fund the $11,700,000 Federal Estate Tax Exemption. Under a typical will, CST is the primary vehicle for receiving non-marital deduction property. This is the maximum amount (2021) that each spouse can transfer at death (or during their life time) to anyone other than the surviving spouse. This trust is frequently funded at death with the surviving spouse being named the co-trustee. In many instances, a corporate fiduciary may be indicated, either as sole or co-trustee, if the estate is sizable and/or conflicts in interest are likely to arise. Furthermore, the trustee (assuming the trustee was an independent party) may be given a power in its sole and absolute discretion to distribute principal to the surviving spouse for any reason acceptable to the trustee.

Essentially, after the death of the grantor, the surviving spouse cannot have unlimited access to, or unlimited control of the assets that have been placed in the non-marital trust (CST).

- Given recent changes to Federal Estate Tax Law to allow portability of the $11,700,000 exemption, the Credit Shelter Trust may be used to take advantage of the State Estate Tax Exemption. Most states have not adopted portability and your State Estate Tax exemption must be used at death or it will be lost.

> LET OUR ADVANCE WORRYING BECOME ADVANCE THINKING AND PLANNING
>
> - WINSTON CHURCHILL

PORTABILITY

The new portability laws allow a married couple to pass any unused exemption to the surviving spouse take advantage of both $11,700,000 Federal Estate Tax Exemptions without the need to re-title assets and establish complex wills and trusts (e.g., QTIP, credit shelter trust, family trust or funding the exemption at the first death. While this could greatly simplify your estate planning, there are some distinct non-tax benefits to using trusts. You should talk to a qualified trust and estates attorney about what makes sense for you and your family.

INSURANCE TRUST

Life Insurance Trusts can be used to own a life insurance policy outside of your estate. This can have a great benefit as the death benefit should not be included in your taxable estate and should not be subject to estate tax. You will want to carefully consider a trustee and co-trustee for this trust who will work closely with the surviving spouse and/or children and provide access to the assets in this trust as appropriate.

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uccessor Healthcare Proxy.

name an individual(s) to make
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/3 each at ages 25, 30 and 35.
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that you can use as a guideline (many
nse for your particular situation, but
a way for you to see a wide variety
is, however, important to keep in
w generally supports the idea of
power is not limitless. For example,
sion that actively encourages divorce
amentary freedom against other rights,
and freedom to marry being upheld

- Giving your child a partial distribution at a certain age (let's say 25% at 30) and the balance would remain in trust for the child's life. At a certain age (let's say 40) your child could become co-trustee with the power to hire and fire co-trustees. This would ensure that the bulk of the assets are protected from creditors and spouses but your child would gain indirect assets to the funds.
- Graduate the percentage withdrawals so that they increase with the age of your child.
- Distributions for maintaining full-time student status with a GPA of 2.5 or greater on a 4.0 scale.
- Distributions if your child should become disabled such that he/she can no longer remain a productive, contributing member of a society.
- Distributions to match charitable contributions and medical expenses.

SPECIAL BEQUESTS

You need to specify if there are any particular items (art, jewelry, heirlooms, etc.) that you want to go to specific people/children, etc. These provisions can be included in your will or in a Personal Property Memorandum, a side letter that can change from time to time without changing your will. To make your memorandum legally binding, you just refer to it in your will. You also may want to include distributions to individuals other than your children or to charitable organizations. You don't have to sign the memorandum in front of witnesses as you would a will.

COMMON DISASTER CLAUSE

It is best to include a provision to direct your assets if both spouses and children are to die simultaneously and there is no certainty who died first, an important issue in the determination of the inheritance of property or the distribution of proceeds of a life insurance policy. Frequently assets will be directed to parents, siblings, nieces, nephews, etc.

y unknowns, you can ensure your wishes are carried out by having the proper estate planning documents.
plan for your estate, it's important to understand your entire financial picture. That's where we come in.
l legal advisors, we will help ensure that your plan reflects your wishes for your legacy.

g financial security into financial success.

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There are many factors that will guide these decisions, some of which include your marital status; number of dependents and cost of their support; future education needs; current and anticipated family income; current assets and debt obligations; the time horizon of specific goals and objectives; and possible estate planning and gifting.

Here are some of the questions that keep our clients up at night:

- Am I insurable, and do I have enough life insurance to keep my family financially secure? Should my partner and I carry the same amount of coverage?
- What are the best types of life insurance coverage to have in place between term and permanent, and should that change over time? Should I have a combination of both term and permanent? What are the price variables for each option, and should my partner and I carry the same type of coverage?
- Do we automatically make the children beneficiaries of the policies, and if minors, do we have a Will, Living Will, Health Care Proxy, Power of Attorney, and other planning documents in place? Do we consider putting the proceeds in a trust to protect the children from taxes?
- Should I consider an Irrevocable or Revocable Life Insurance Trust for my estate plan?
- What will happen to my practice if I am no longer around, and will my family and employees be taken care of? Is my buy-sell agreement funded with the appropriate types and amounts of insurance?

Long-Term Care Insurance: Long-term care is a variety of services and supports to help meet personal care needs over an extended period of time. Long-term care may involve non-skilled personal care assistance, such as help performing everyday Activities of Daily Living (ADLs), which are: bathing, dressing, using the toilet, transferring (to or from bed or chair), caring for incontinence and eating. Long-term care services may help maximize your independence and ability to function at a time when you are unable to be fully independent. The need for long-term care may happen to anyone... at any time. It could be you, your spouse or partner, a parent, or even a sibling. The need for long-term care may result from being chronically ill, from a severe cognitive impairment or something as unexpected as an accident or injury.

Long-term care may take place at home, in assisted living facilities, in a community setting such as adult day care, in a nursing home or in a hospice facility. People with long-term care needs may initially receive assistance at home or in community-based settings before moving into more intensive care settings. Long-term care coverage, that is, insurance options for long-term care expenses, may provide more choices and control over where and how you receive care. This may mean you could stay at home and remain an integral part of family activity.

What does long-term care cost? See figures from the "Cost of Care" chart on page 56.

Potential ways to pay for care:

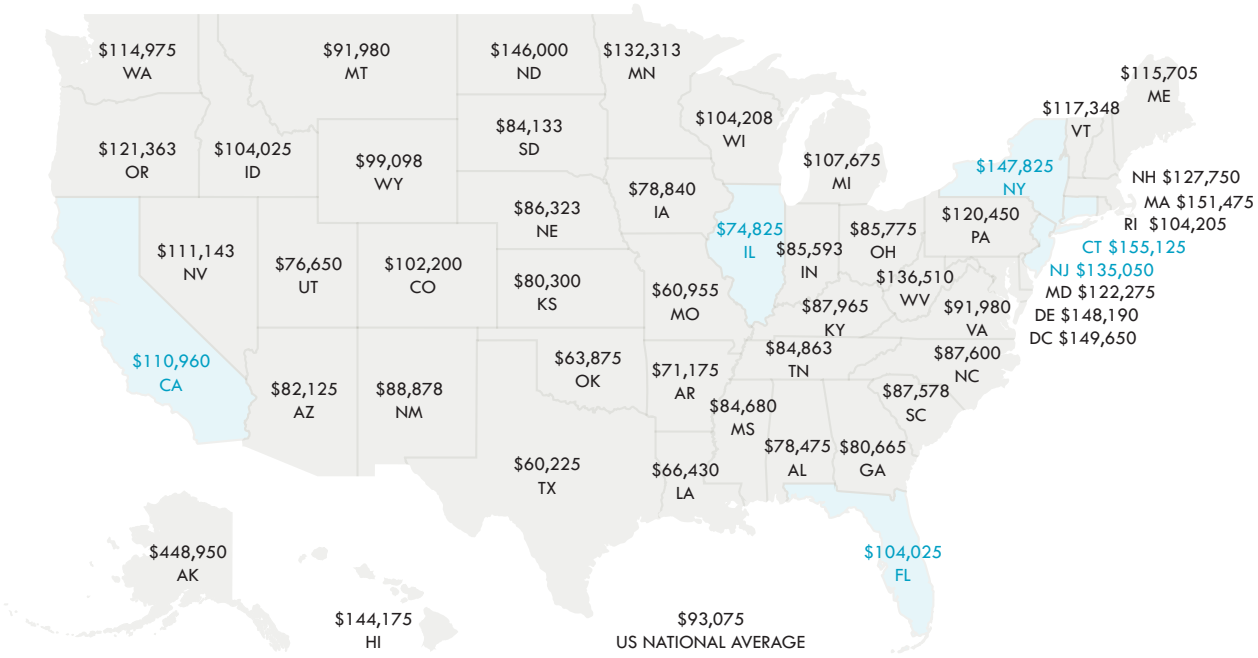
Long-Term Care Insurance Coverage (stand-alone or hybrid plans); Personal Savings (investments, insurance values and/or retirement accounts); Home / Home Equity; Family and Friends; Government Program (to qualify, income and assets must meet state requirements).

Why should you consider long-term care coverage? Long-Term Care Insurance coverage may help you to protect your home, assets, retirement funds, and your estate from being used to pay for care. In turn, those funds may be used to maintain your spouse/partner's standard of living, financial security, and peace of mind. There are multiple coverage options that can help you plan for the high cost of care. While you may also receive support from family or loved ones, you can help plan for possible future care through traditional stand-alone Long-Term Care Insurance or through a policy that combines long-term care benefits with another insurance product. Long-term care coverage can help preserve your independence by relieving family and friends from the burden of providing for your care, allowing you to live where you wish.

THE COST OF CARE

Like many of life's realities, the issues surrounding long term care and the need to be prepared to deal with them are often something people prefer not to think about. Having a plan in place to address the possibility can go a long way toward easing some of the related concerns.

2020 NURSING HOME ANNUAL MEDIAN COST (Semi-Private Room)



COST OF CARE TRENDS

$105,850

National Median cost for a Nursing Home Private Room in 2020[1]

79.17%

Increase in Assisted Living Facility costs since 2004[4]

$24.00

National hourly cost for a Home Health Aide in 2020[5]

Umbrella Liability Insurance: Risk is not limited to fluctuating financial markets. Moreover, while you and your family face risks every day from forces you cannot always foresee, the good news is that you can take proactive and strategic steps to prepare for them.

Your homeowners and auto insurance policies offer liability coverage up to specific limits, but what if you were sued and found liable for more? This is where umbrella liability insurance can help – it can offer greater protection in instances of litigation above your standard coverage policies. Umbrella liability protection typically applies once you have exhausted the liability coverage limits on your homeowners or auto policy. In today's litigious society, it might pay for you to consider adding an extra measure of protection. By doing so, you can conceivably avoid losing your home, retirement savings and other substantial assets. Our recommendation is to have in place umbrella liability insurance coverage that is at least equal to your net worth, and not less than a $1,000,000 limit.

A final thought

Being a surgical resident or young surgeon does not leave you with much free time to worry about anything else but succeeding at your career. You will undoubtedly face financial challenges that may be difficult to meet and analyze on your own. Given the unique demands of your profession and the singular focus it requires, consider enlisting the assistance of a financial planner or wealth management advisor to help address the issues and opportunities between you and your goals. Financial planners and advisors employ a comprehensive approach that encompasses both sides of your personal balance sheet and every facet of your financial life. While there are many considerations, a fiduciary advisor who is fee-only in renumeration for services rendered may have a more vested interest in ensuring that recommendations are the ones best for you and your situation.

Financial advisors can help you identify the key objectives and map out a plan for reaching them within your required timeframe and risk tolerance. In addition to recommending tangible strategies to invest assets, prepare for retirement, and manage risk, they help you navigate through all of the challenges and opportunities during all stages of your exciting career.

—Dr. John McAuliffe

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MIPS, MACRA, and Quality

Classically, surgeons have been paid by procedure – do more, make more. You could be doing surgeries poorly or doing unindicated procedures (not I!!) or you could be the most talented surgeon with no complication. It wouldn't matter because you're compensated on sheer number.

This is slowly changing. While we haven't reached the tipping point into capitated care, it certainly seems to be on the horizon. Recently Congress passed several measures though to help bridge this gap. Here's an introduction to these efforts:

- MACRA – The Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 is a bipartisan effort that created the Quality Payment Program (QPP) which attempts to pay physicians for quality over quantity. MACRA also streamlines multiple quality programs under the new Merit Based Incentive Payments System (MIPS) and gives bonus payments for participation in eligible alternative payment models (APMs)
- QPP – Quality Payment Program – Prior to the QPP, payment increases year-over-year for CMS (Center for Medicare and Medicaid Services) were governed by something called the Sustainable Growth Rate (SGR) which capped spending increases and only mildly accounted for inflation. The QPP repealed this system, instead allowing high-value high-quality CMS physicians to be rewarded with payment increases. Similarly, payments to clinicians who don't meet performance standards are reduced. Under QPP there are two options (check with your practice to see which one you will be participating in):
  - MIPS – Merit-based Incentive Payment System – eligible clinicians have a minimum volume threshold and a minimum number of CMS patients. Performance is measured through several measures including HER (electronic health record) use among other measures.
  - APMs – Advanced Alternative Payment Models – a payment approach that provides for incentives based on quality, cost-effective care in a specific population, clinical condition, or episode of care. There are different types of APMs.

A full discussion of all of these programs is beyond the scope of this primer, but it's good to have an idea. Overall, these programs basically mean that CMS will be watching your outcomes (as a provider and a hospital) and paying you accordingly. There can be penalties for lack of participation. Hospitals and practices should have mechanisms set up to facilitate reporting and meeting regulatory requirements. Ask your hospital or practice administrators for more information.

—Dr. Issam Koleilat

Coding for the Beginner

This is a very important topic and this section will only provide a cursory introduction. The topic may take people a long time to master. It is important to have a general understanding though so that you can formulate good questions and have a framework to start.

Coding can be divided into procedural and "E&M," or evaluation and management. E&M are the patient visits in clinic, rounds, consults, etc. – nonsurgical care. Procedural is exactly that – codes that you use to indicate what surgeries you did so that you can bill for them. The procedure codes are based on the CPT (Current Procedural Terminology) system. While it's an AMA (American Medical Association) product, updates have become a joint effort between the AMA, subspecialty societies and CMS. CPT uses a five-digit code to identify anything you do.

The same codes you use to log cases during training in the ACGME case log system are the same CPT codes here. It's important to know what's included and what's not. For example, a cholecystectomy with cholangiogram has a unique code and you should not use two codes (one for cholecystectomy and another for the cholangiogram). In contrast, there are now separate codes for percutaneous versus open femoral artery access for endovascular aortic aneurysm repair (EVAR) which should be reported in addition to the original EVAR code.

Other things might be included also. The "global period" defines the time during which E&M visits related to the surgery cannot be billed. For most major surgeries that will be 90 days, but simple or percutaneous procedures may have a 0 day global. Other minor surgeries may have a 10 day global. That global starts the day prior to your surgery (day -1 [negative one]).

For example, taking a history and doing a physical the day of or prior to placing a port is not considered "separate and unique" and is included in the port placement code. In contrast, evaluating a patient in the emergency department with abdominal pain and determining they have a bowel obstruction after review of the imaging and therefore deciding they need surgery is separately reportable and should be indicated as so with a "modifier" that signals to insurance carriers to pay attention and not ignore that charge.

Similarly, a patient that has a leg bypass and presents for incisional wound infection is not separately billable. However, a clinic visit for a patient who has a leg bypass with foot debridement who presents 2 weeks later for a check of the foot wound (not related to the actual bypass itself) may be separately reportable and billable with a "modifier."

Modifiers are just that – two digit codes that "modify" the code to which they are attached. There are many modifiers: some for bilateral procedures, surgeon assistant, decision for surgery, separate unique visit during global, etc. Your billing and coding department should be able to give you a relevant list.

E&M codes typically start with 99xxx and are related to bedside visits (inpatient or outpatient). They are based on whether the patient is new or known (within three years) to you and your practice, how much of history and physical you do (here's that 10-point review of systems your attendings in training wanted) and the complexity of medical decision making. Medical decision making is based on imaging and lab ordering and/or review; whether the problems are new, chronic, stable, worsening, etc.; and whether the patient needs some kind of surgery.

There are a variety of combinations that lead to any given code. Sometimes, you can even code based on time if the encounter was longer than expected, and there are methods to document and do that. Most institutions and practices should provide you even with a short training session and maybe some chart audits to make sure you are coding your E&M properly. They can even provide you with "cheat sheets" that you can hang in your office to help remind you.

If you are going to do your own coding, you obviously need more knowledge of the intricacies than if your practice has a dedicated coder. Many specialty societies have dedicated coding courses (the American College of Surgeons and the Society for Vascular Surgery, for example). If your practice has a dedicated coder, knowing who that person is and how to contact them is an invaluable way to ensure that you practice is billing properly (and legally) and that all of your work is counted properly.

Because let's face it, no one is following you around to see how hard you work. They'll just count your codes.

—Dr. Issam Koleilat

Reimbursement

It is of the utmost importance that as you embark on the journey to your first job, you have an understanding of how physicians and hospitals are paid. And it may not be as straightforward as you think. Let's start with hospitals.

Hospitals are compensated for admissions and procedures, at least for the technical or facility portion, based on DRGs, or Diagnosis Related Groups. This is a lump-sum payment for a diagnosis. For example, a laparoscopic appendectomy will be paid a single amount, regardless of whether the patient spent one night or ten nights in the hospital. What modifies the payment for the DRG are other diagnoses (ileus for example) and patient comorbidities. Comorbidities, such as End-Stage Renal Disease requiring dialysis, can significantly increase the "severity of illness" multiplier of the DRG and result in a significant increase in payment.

This is important to the surgeon on two levels. First, most hospitals will track surgeon metrics such as length of stay, cost, etc. The metrics are standardized to the "expected" or "allowable" based on what is associated with that DRG. For example, a patient undergoing toe amputation for "diabetic foot ulcer" has a significantly lower "severity of illness" and therefore is expected to leave the hospital much faster than a patient with "diabetic gangrene." Proper documentation results in accurate coding and therefore a more precise measurement of your metrics.

Of course, many other things go into the DRG calculation. These include things like whether the facility has residents, a high or low readmission rate, if it is located in a high cost-of-living or labor-index area, etc. These all factor into the base rate, which is then multiplied by the severity of illness factor.

Physicians are paid with a similarly formulaic calculation to compute the "professional fee." Each physician function or procedure can be quantified by the RVU system, or Relative Value Unit. The value for any surgery, procedure or even encounter can be found using the CMS physician fee lookup tool using the CPT (Current Procedural Terminology) code (*https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx*). The RVU is made of three components: physician work, practice expenses and professional liability. The physician work component (wRVU) is what most physicians focus on. This is the "effort" you put in each procedure from preop workup, the operation itself, the stress of worrying and the postoperative care. The practice expenses component reflects the overhead of your office. The professional liability component reflects the part of the overhead related to malpractice insurance. The sum of these three makes up the RVU, which is then multiplied by a geographic pricing cost index (GPCI) for your particular locale to calculate the reimbursement that you, as a physician, will receive for a particular procedure. For employed physicians, the employer (academic institution, group practice, or otherwise) will likely receive this on your behalf. Physicians in private or independent practice will bill for and receive this professional fee themselves.

When people talk about productivity as part of their compensation package, they are generally speaking about yearly wRVU or RVU. If your contract has a productivity component, it is important to know how much per RVU/wRVU you will be paid and how many RVU/wRVU you can expect to achieve yearly once your practice picks up (typically after the 2nd or 3rd year). It's also important to know if you will be penalized if you do not meet your productivity targets (i.e. will you owe your employer anything?). These values may vary by specialty, experience and location. Some contracts still calculate productivity in terms of collections, case volume or billed amounts. Each has benefits and drawbacks, but wRVU is largely becoming an industry standard.

—Dr. Issam Koleilat

Hanging Up a Shingle: Solo Practice

While much of what was discussed earlier applies to solo practice, there are a few unique concerns. Like moonlighting or locums work, all additional benefits (health, life and disability insurance, among others) are the responsibility of the surgeon. But unlike locums work, solo practice is a more permanent type of practice with unique considerations like employees. Hopefully, this will provide you with an overview of some of the salient issues.

Before you start, it's essential to know that you are leaving the highly-structured world of education and embarking on a more uncertain path of life – and solo practice isn't the right path for everyone. This decision may be one of the biggest of your career, as it inevitably sets the stage for how you will practice medicine for years to come. It is imperative to understand that starting your own private practice is a life-long commitment that requires relentless work and ongoing effort, but if you do it right, the success is well worth the sacrifices made along the way. My hope is to share my experiences to guide you on how to successfully integrate medicine and business to create the foundation for a successful, profitable enterprise that benefits both the physician and the patient.

"Brand" yourself

You may have taken a marketing class or two in college, but you probably never imagined that "branding" would be part of your success as a physician. In today's day and age it's imperative. This applies to solo, group-based and even hospital-based practice, and the sooner you start the better (if you haven't already). It's essential to establish a flawless reputation for yourself from the get-go and promote an image of trustworthiness, both online and in real life. If you are the type of trainee who isn't prepared or rushes something together at the last second for something like grand rounds, these habits will likely follow you for years to come. Medical specialties are their own microcosms and it's likely you'll cross paths with a former fellow student or professor at some point down the line. You don't know who may end up coming to see you or referring a patient.

"If you fail to plan, you plan to fail"

Location is one of the first decisions you have to make as you plan to start practicing medicine. Perhaps you know where you'd like to establish your business because of family, friends and established roots, or maybe you're open to different locations to find the right market for the services you want to offer. For example, there's a higher demand for aesthetics in metropolitan areas, and you have to consider the availability of hospital-support settings for specialties such as pediatric craniofacial surgery.

Beyond knowing the zip code, you need to know the market. Even with $1 million in my back pocket when I was getting started, I wouldn't have known where in town to open my practice since I wasn't familiar with the "lay of the land." It would have been the biggest waste of money and time. Instead, I jumped at the opportunity to join one of the most highly regarded practices in town, which instantly elevated my "brand" and visibility. But more importantly, the time with them provided the opportunity to save money, analyze the local market (and the potential competitors) and plan for my next career step. Proper planning is essential for the successful execution of any initiative in every aspect of life, and especially in opening a solo practice.

This initial stage of my career also afforded me the opportunity to identify exactly where I wanted to go from there. Between managing my own schedule and observing what was going on around me, I was able to recognize the patient demand for specific treatments and procedures, identify the type of experience I could offer independently and create a targeted list of services I could offer in my own practice in a way that set me apart from the competition. In my case, joining a group practice after completing my residency was a necessary stepping-stone on the path to opening my own practice in a highly competitive market. But pay attention to the contract terms if you do this, particularly the non-compete. You don't want to open a practice too close to the one you just left and then get sued over it!

Commit to staying the course

Whether you start your medical career as part of a group practice or decide to start your own, to achieve success, your first few years of practice should focus on minimizing distractions. This will eventually lead to greater freedom to enjoy the fruits of these efforts. For me, thanks to the initial sweat equity and investment I had put in, I can now after only a short period of five years prioritize spending time with family and close friends, participate in fitness, watersports, travel and doing work around the house as well, things I enjoy outside of medicine.

There's no way around the fact that building a successful business requires commitment. Up front, this means a significant amount of time (and money), but the potential dividends are well worth it. Yes, the dedication necessary for growing the business in its initial stages may mean less time for family, personal pursuits and pleasure, but prioritization is key. It's essential to figure out what matters most to you outside of starting your practice and creating a work-life balance.

Start thinking like a CEO

When considering any sort of enterprise, it's never too early to start thinking like a CEO—and medicine is no exception. You need to put on this hat the second you become certified to practice (if not sooner). It can be difficult especially you start thinking, "I just spent 15 years between college, medical school, residency and fellowship training, now I need to get an MBA?" The good news is, no, you don't have to get yet another degree, but you do need to educate yourself. Tap into your networks, friends, family or even paid consultants if you need. I asked numerous friends with MBAs about the value of getting this degree, and was advised that for my situation it wasn't necessary since I am working outside of a corporate environment, but they all agreed that understanding the fundamentals would help ensure my success.

As a solo private practitioner, you will intrinsically bear the brunt of being the "head doctor in charge," and need to be prepared to handle the business side of your practice. It's imperative that you put processes in place that keep your administrative hires in check. You'll also have to devote a portion of your budget to sales and marketing in order to keep new patients coming through your doors. If this seems like a brave new world to you, I recommend taking the time to research and understand the fundamentals of starting and running any type of business, and applying these principles as you build your practice.

A mentor of mine, plastic surgeon Dr. Edwin Williams, suggested starting by reading The 10-Day MBA by Steven A. Silbiger, which was a relatively quick read about universal business topics such as marketing, sales and hiring. I also subscribed to the Harvard Business Review, and after about a year I realized there are defined categories that are the backbone of building any type of business. Although this summary is by no means a substitute for diving into these business fundamentals yourself, hopefully this will be an introduction.

- Sales and marketing – The fact that you're a doctor doesn't mean you don't have to market yourself, and in order to be successful your business has to be known. This is a big issue for medical professionals, because none of us want to be perceived as "salespeople." Obscurity means patients can't find you, and that is going to make it difficult to create a steady stream of new patients and keep your doors open. Investing the time and money associated with promoting your business is well worth it.
- Prospecting – We'll talk more about creating relationships with local colleagues later, but it's important to be strategic. Reach out to colleagues, friends, family, other physicians and basically as many people as you can so they know you are in town and ready to see patients. This is where most doctors fail. Many physicians believe patients should come to them because they have such-and-such specialty, or because they are the only ones in the state doing a certain procedure. In reality, if you don't meet people (and a lot of them) and let them know what you do, it will take you longer to build a practice.
- Embrace the digital world – If you don't embrace the Internet and social media, you'll be left out in the cold. It's that simple. At the very least, invest in creating a robust website that provides both information and highlights why prospective patients should come to you instead of your competition down the street. This is the place to "brag" about your accomplishments and specialties. There's no denying that we live in a social-media-driven world, so you need to have a solid presence on all of the major platforms, or at least a few major ones.
  - This can become a full-time job in and of itself, which is why I recommend outsourcing this task to someone with experience in the medical space if you aren't willing to take this on yourself.

Make it official

When starting any type of business, it's imperative to create a legal entity, whether an Limited Liability Company (LLC) or a Corporation. To create the optimal framework for your business, you should enlist the help of professionals who can ensure you do this in the way that best suits your financial situation, as there may be significant tax implications one way or another. An essential part of establishing your business is having the

proper support in the form of accountants and attorneys who can look after your financial, legal, liability, tax, asset protection and intellectual property needs. At the very least, find a good certified public accountant (CPA) and a good lawyer! I cannot stress the importance of these two professionals enough.

What's in a name?

Even more important, if you decide to open your own private practice, you need to choose whether you are going to operate under your name or as an independent clinic. It's important to approach this decision with your ultimate end-goal in mind. If you plan to expand your practice to include other providers and locations, or sell it at some point down the line, going with a "clinic" that is not directly tied to your name is probably a better option. I personally decided to take a "boutique" approach that focused on more bespoke care when opening my practice, which is why I ultimately decided to use my own name. However, if you decide to take the "clinic" route, be sure to consult an attorney about trademarking your practice name to protect your overall brand.

Build up your staff

The decision to start a private practice can be daunting and stressful, which is why you need to think about staffing from day one. My first suggestion here is having a very clear idea of the experience you are trying to create for your patients. This dictates the workflow of the office and allows you to identify the staff required for each one of those roles. You do not need to start by hiring a lot of people. You just need to find good people who understand your vision and are willing to wear numerous hats as you grow the practice and generate the income necessary to hire more staff.

A majority of medical practices are over-staffed. If you are a plastic surgeon, don't hire a nurse as your first employee – you can draw your own Botox! Instead, focus on one employee who can help you sell your surgeries and one who will serve as your marketing "team." These were my first two hires, and now that I have grown, I have expanded my staff to include a receptionist who also handles scheduling, call center, nurse practitioner/physician assistant, patient advisor and office manager. Just remember, without building your sales team first, you are no different than every other surgeon in town. Without anyone to help bring patients in, you won't need additional staff. You have to be different. Think like a CEO, not like a doctor.

Accept you're in for life-long learning

As you (hopefully) know, your education doesn't end once you have your M.D. and pass your board exams. It's essential to maintain your certifications, complete continuing education and keep up on the latest developments within your specialty to be at the forefront of your specialty. Once you're out of school and in private practice, there's no one telling you what to do you since you're your own boss. This can be a challenge for many private practitioners, so be sure to stay connected to your specialty's societies and other professional groups. This afford you multiple benefits besides CME credits such as the latest updates on policy changes, a support network, resources for patient information and practices, etc.

Connect with your local medical community

To stay visible and relevant, it's essential to build a network of colleagues who can support you professionally. In addition to prospecting that helps drive business your way, you also need to have trusted, go-to professionals that you can refer patients to if they have needs that extend beyond your realm of expertise. Additionally, networking with local providers of your own specialty can help with call coverage.

An academic presence is always a plus when practicing medicine (whether patients realize it or not), and local journal clubs and chapters of any societies you're a member of are a great way to stay connected with like-minded physicians and promote your visibility within your professional circle. Teaching programs through local hospitals – especially where you have privileges – can also help increase your visibility and expand your potential patient base.

The local medical community may be the initial referral base to your practice. How you advertise and brand yourself will significantly impact what referrals you will get. Medical staff meetings at local hospitals are a great way to meet other physicians, especially hospitals where you have privileges. Talk to local emergency departments, especially at smaller local non-academic hospitals where call coverage may be more difficult for them to have, and offer your services. Meet the nearby primary care doctors, and even offer to present a talk to their staff over lunch. If you are in a specialty that heavily interacts with industry, those companies may have additional resources to help get your practice off the ground, so leverage these networks and relationships.

Financial capital

One of the biggest limitations for doctors opening their own practice is feeling they don't have the money. And let me tell you, you need a lot of money! That money can come from several sources. First is your own savings. You may need to be prepared that the practice may not generate personal income for you given the overhead expenses for a while. Additionally, it takes time to be reimbursed by insurance carriers and patients for the work you do, and that reimbursement does not come right away. For that reason, I would suggest being prepared for at least of 18 months of no or very little income. You have to be comfortable with the risk to reap the benefits. As mentioned earlier, the risk has to be planned and calculated. You can't just wing it! It will be a big financial pitfall if you do it that way.

Family gifts, intra-family loans or financial institution loans are other options. This last could be with a private bank or small business loan. The process of funding via a bank or small business loan is lengthy and may take more time than you initially anticipated. In addition to a business plan, they may want to see business financials. I started my practice with my own money offering limited services and as I was able to show more and more income, I was able to obtain a larger loan from a bank but now with business financials to support my application.

Preparation is critical. And make sure your family is on board because there may be many sacrifices that will affect everyone in the household. Having a plan, including a formal business plan (business pro forma) with expected trajectories for income, expenses and profits will be crucial not only for your own personal preparation but also if you will be seeking external funding such as a bank loan.

Hospital privileges

As a surgeon, there is only so much that you can do in an office-based procedure suite or ambulatory surgery center. You will need the support of a hospital setting. This will require you to apply for privileges at a hospital, meaning that the hospital approves your credentials and bestows upon you the ability to admit, care for and operate on patients in their facilities and within your scope of proactive (what you've been trained to do). There are very few hospitals that have a closed staff model. Privileges will take time to obtain too! Start early. The application process is lengthy and there is a lot of paperwork.

Other considerations

As a solo practitioner, you will need to provide the benefits for all of your employees, including yourself. But other things you might not thing about include regulatory compliance (such as with Medicare/Medicaid quality initiatives, OSHA, HIPPA, etc.). You may also be able to negotiate with payers and insurance companies for your rates, which can be an advantage over group or employed/hospital-based practices where rates are set. You will also need to obtain your own professional liability and malpractice insurance, as well as liability and worker's compensation insurances for the practice, among others. You will also need to decide whether you will manage billing and collections internally or if you will outsource to a company. If you decide to contract out, make sure the company you select has a good history and is in line with your practice's philosophy.

The benefits

After all this, you may be wondering, "Why would anyone go to the trouble?" But the benefits are great once realized. You are in complete control of the practice. You decide who to hire or not, when to take vacation, how much vacation, when to operate versus see patients in consultation, what your call schedule will be like, how many patients to see, etc. You are your own boss. All the profits after expenses are potentially yours, and this can be significant if you offer procedures in your clinic and can also collect the "facility fee." You can customize the care you provide, and potentially reinvent yourself or your practice more easily. Some solo practitioners report that it even increases the physician-patient bond. All in all, it can be very rewarding.

The bottom line

There's no universal step-by-step guide to starting a private practice since several factors come into play including your specialty, the market you are considering entering and more. However, it's important to understand the basics that are necessary for building a medically-based business that will grow and thrive. I wish you the best of luck!

—Dr. Jose Rodriguez-Feliz

Building a Practice

No matter if you are in academic practice, private group practice or a solo surgeon, you will need to build your practice and patient base. The prior sections have discussed many opportunities to meet and connect with referring physicians such as institutional committees, regional or societal meetings, personal networks and even social media. Here are some additional things to think about.

Surgeons are by definition specialists – we depend on patients being referred to our practices. Depending on the type of practice you are joining (or taking over), you may have a built-in referral base immediately when you join. If this is the case, make sure you introduce yourself to the providers who will be sending patients to see you so they have a face to put to your name, and they know what your area of expertise is. Some practices or health systems will automatically do a "meet and greet" with primary care providers. If you don't have this automatically set up then request to do it sooner rather than later as this is a good way to introduce yourself and is much easier to do at the start of your practice. Bring your business cards and be ready with a short "elevator pitch" on what type of cases you do as well as any specific interests you have. Make sure they have a way to contact you easily, whether you choose to give out your personal cell number or email address. When they refer patients to you, be sure to communicate back to them expeditiously so they know what your plan is with their patient.

Taking emergency call is another good way to build your practice but will require work for you on the back end. When patients come back to your office for their follow up appointment, make sure you send a letter to their primary care provider so a) they are aware of what happened to their patient and b) so they know YOU are the one who cared for their patient. This is especially important if their primary care provider is outside of your system.

Another key part of networking is finding colleagues you can depend on, both within your specialty and in other specialties. You are going to run into cases that feel outside your abilities when you first start. It's not a question of "if" this will happen but rather it's a question of "when." Knowing who you are going to call (and knowing that they will come help you when you do) is crucial. Many institutions will have physician networking events periodically which can be good ways to meet a large number of people in a short period of time. Again, be sure to bring your business cards with you to these events.

—Dr. Rebecca Kowalski

Work-Life Balance

"Work is a rubber ball. If you drop it, it will bounce back. The other four balls—family, health, friends, integrity—are made of glass. If you drop one of these, it will be irrevocably scuffed, nicked, perhaps even shattered."
Gary Keller, *The One Thing: The Surprisingly Simple Truth Behind Extraordinary Results*

If you ask people why they became doctors or surgeons, a common reply may revolve around the ability to work in a rewarding profession dedicated to service. However, after years of training and learning and honing your craft, focused solely on patient care, many will enter formal practice only to become disillusioned by forces too often not discussed during those years in training. Limited or insufficient resources, focus on cost and spending, market pressures, bureaucracy and administrative complexities (whether within a practice or from corporate leadership), pressures to see more patients in less time and of course difficulties with insurance carriers can really wear away at any physician. This is compounded by the emotional intensity of doctoring in general and surgery in particular and can really impact anyone emotionally and physically.

For surgeons, these activities all not only take away from direct patient care but also from time in surgery. More and more physicians are completing clinical tasks after hours, whether it be finishing notes, returning emails or otherwise, and this can take a significant toll. Physicians have some of the highest rates of addiction, suicide and burnout. Rates of job satisfaction are not as high as one would expect, and there is suggestion that they die younger than people in other occupations.

Burnout, often also called "moral injury," is a condition of depersonalization, emotional exhaustion and the lack of a sense of personal accomplishment. Clearly, some of burnout may be remedied by changes in one's personal life, but many are related to job factors. An exhaustive discussion of this topic is beyond the scope of this section, but it is important to think about it in preparation for your first job. Knowing what will make you happy, what your needs are and what your responsibilities will be is critical to understanding how a future position may impact you and your life.

While you may think that you'll be fine, you will be "balanced," seeking balance is an ever-elusive target. Unfortunately, there will be no perfect everlasting "balance." Rather, it is best to describe this concept in terms of prioritization. At times one may need to prioritize patients (on call for example). However, other times a family function may take priority over completing that last surgery late in the day because the patient wants to do it before they go on vacation. Understanding that life is a series of competing and shifting priorities may help facilitate improved satisfaction through better-matched expectations, understanding and communication, within oneself and one's social and occupational circles.

Along this line, there are ways to facilitate one's personal life. As we would delegate at work, we may consider doing similarly at home with the employment of nannies, babysitters, professional yard or construction services, personal shoppers, etc. Granted, we may reserve some of these activities for ourselves because we enjoy them, but we should not feel remorse if we choose to outsource these activities to free ourselves up for other things.

There are a lot of important conversations happening around physician burnout, particularly at the national level, and about work-life satisfaction. The best time to start thinking about work-life satisfaction is as early as possible during training. Think about what is important to you and make sure you find a job that will fit your goals and needs best.

Having a frank conversation with your spouse/significant other (if you have one) and your future employer may be critical. As with any negotiation, knowing what the absolute needs are, the wants, and the things you are willing to concede will be very important in the job search process. There are numerous excellent references for work-life satisfaction including:

- Finding Balance in a Medical Life A guided program to help you reclaim a sense of balance in your busy life in medicine. Lee Lipsenthal, MD. Finding Balance, Inc. San Anselmo, CA.
- Resident and Associate Society of the American College of Surgeons (RAS-ACS) Grand Rounds Webinars
  - PTSD/Burnout in General Surgery Residents and Attendings vs Other Specialties by Michael Truitt, MD *https://www.facs.org/member-services/ras/webinars/archive/ptsd*
  - Compassion Fatigue: You Really Can Care Too Much by Michele Manahan, MD, MBA *https://www.facs.org/member-services/ras/webinars/archive/compassion-fatigue*

  - There's No Crying in Surgery by Daniel Eiferman, MD, MBA *https://www.facs.org/member-services/ras/webinars/archive/no-crying*
  - The Impact of Diversity on Physician Resiliency by Karyn Butler, MD *https://www.facs.org/member-services/ras/webinars/archive/resiliency*
  - Physician Heal Thyself? A Reflection on Resident Psychological Wellness by John Mellinger, MD *https://www.facs.org/member-services/ras/webinars/archive/resident-wellness*
- The Happiness Lab Podcast by Laurie Santos, PhD

Here are a few things to think about that may help improve work-life satisfaction:

- Location may make a huge difference in your satisfaction. Living near family or friends, particularly family to help with current or potential future children, may be very important.
- It is very important to make sure you know how you are going to spend time taking care of yourself so that you can help take care of your family and patients. Availability of meditation, exercise, hobbies (indoor or outdoor) and massages and flexibility in your schedule may be a consideration. Some employers offer on-site massages periodically, or have a relaxation/meditation area where you could spend a few minutes during the day. On-site gyms, childcare, etc., may also factor in to your decision.
- Take time to be with your family. There may be ways you can start a clinic day or an OR day a little late to spend more time with family, or a little early to finish early. An occasional three-day weekend can be a great way to get extra family time as well. Decide what commitments and meetings are important to you and which ones will advance your career path the way you desire.
- Manage your money so that you can "buy time" – pay for things you don't want to do or don't have time to devote to (housekeeping, grocery delivery, online shopping, etc.)
- Surgeons will often be asked to serve on various roles that can include medical staff leadership, committee attendance or leadership within an employed opportunity. These will advance your career, but it is important to decide for each opportunity, which are the most important to you and your career. There will always be an opportunity cost and it is important to consider the positive aspects as well as the tradeoffs that each position will bring.

—Dr. Jason Wilson and Dr. Issam Koleilat

Research Considerations

Integrating research into your surgical practice can be very challenging but it is an essential component of academic surgery. Research significantly contributes to medical knowledge, understanding of disease processes and innovation. Additionally, research can help to provide balance and sustainability in an otherwise rigorous surgical practice. Surgeons are uniquely positioned to conduct research based on proximity to diagnosis, direct access to patients and tissue samples and ability to participate in curative treatments. Surgeon scientists have had landmark achievements in the past and continue to contribute to medical knowledge and the overall missions of academic medical centers.

It is important to highlight that research can be conducted in various degrees throughout your career. In general, there are two main tracts: Clinical research and Basic Science/Translational Research. In the staunchest sense, basic science researchers are the true "surgeon scientists." However, clinical research – specifically using comparative effectiveness trials, patient reported outcomes data and observational studies to inform decision making – remains an important part of clinical medicine. Developing a successful and sustainable research program in either track is predicated on several factors: building a foundation, identifying appropriate mentors/collaborators, finding the right job and having protected time to maintain this endeavor. However, there are numerous barriers posed to prospective surgeon scientists by both the current health care climate and academic research support.

In a 2017 study looking to identify barriers to success for surgeon-scientists, the authors showed a 27% decline in the proportion of National Institutes of Health (NIH) funding going to Departments of Surgery relative to total NIH funding between 2017 and 2014.1 The reason for this decline is likely multifactorial and includes decreased available grant funding, increasing demands for clinical productivity (RVUs), increased administrative/regulatory duties including documentation, and evolving expectations of work life balance.[1-4] Given all these barriers to overcome, it is important to develop clear strategies to ensure that surgeon scientists will continue to be a valued part of our academic landscape.

Developing a foundation

Being a surgeon-scientist requires expertise in not only the art of surgery but the methodology of science.[5] Therefore, you need specific/dedicated training in both aspects. Medical School and Residency training are the best places to build this foundation for further research success. However, if you have passed these time points and are still interested in pursuing clinical research there are still ways. There are several accepted pathways for defined clinical research training including advanced degrees in research study design or process. Some examples of these programs include PhD, Master's in Public Health (MPH), Master's in Science (MS), or other undergraduate degrees or various certificate programs. Some institutions may also allow you to audit some of their courses. Many times, interested surgical residents are afforded a period of dedicated non-clinical time during their training to pursuit a basic science research focus, often for one or two years. This time can provide formal research training and develop critical thinking skills necessary to become a surgeon scientist. During this time, the resident is working in a dedicated lab under a defined mentor. Additionally, in many institutions, the resident researcher has the opportunity to enroll in graduate school at this time to obtain an advanced degree. Similarly, medical students can be offered the opportunity to take time off to focus on dedicated research during their studies and can additionally pursuit advanced degrees at this time.

Without any direct experience in basic science research such as a PhD or dedicated laboratory research during medical school or residency, it is unreasonable to think that you will have your own independent basic science research program. However, it is reasonable to become a collaborator or co-investigator in an independent laboratory at your institution that has a similar research focus. Still, having a robust clinical research program is possible without advanced training or dedicated research time outside residency training with the right support (e.g., biostatistics).

It is important to understand that interest and enthusiasm are the most important characteristics required to start and continue the practice of being a surgeon-scientist. As highlighted above, maintaining this practice requires overcoming many obstacles and requires a real passion for both surgery and the scientific method. In order to make the career sustainable, you must really take time for self-evaluation to determine if this is something you really enjoy doing or just something you think you should do. Without real reward and enjoyment from the scientific process, the burden of these often intangible pursuits can feel crushing and ultimately lead to less job satisfaction and even burnout.

Identifying mentors/collaborators

When embarking on a career as a surgeon-scientist, it is extremely important to find appropriate mentorship. Having experience working with and under other more experienced surgeon scientists helps build a framework on how to actually do both things in your practice. The most successful surgeon scientists' study what they see in their clinical practice. Surgical volume and experience work to feed the research and vice versa. Therefore, it is important to identify your research interest and clinical expertise in tandem to be able to identify important clinical questions that need to be answered.

Identifying mentors prior to obtaining your fist job is essential. Throughout your residency training, research experience, and presence at national meetings you will have to actively seek mentorship. This part is not always easy. The current environment often yields little time for real mentorship. Frequently, busy established surgeon-scientists are being pulled in many different directions and will not seek junior people to mentor. However, if approached and met with an eager and knowledgeable trainee these relationships can slowly build. Do not expect to be identified by senior surgeons for mentorship; rather, you should identify senior surgeons and seek mentorship.

Finding the right job

Finishing your surgical training marks the end of a long and arduous path that started in Kindergarten. Most of us, when we reached this point, have not yet applied for a real job in our adult lives and are well into our thirties. This in and of itself sets you up for some major challenges. Additionally, surgical academic jobs are often limited, especially if you have geographic restrictions, and this provides an additional barrier to finding the right job. It is important to realize that no job will be perfect, but you must identify the least imperfect option. When starting out, environment and mentorship at the institution are the most important factors for success. Knowing about your interest in research and discussing it with your potential employer will help clarify every party's expectations, ensure you have adequate support and set you up for success.

Supportive environment

While not all clinical or basic/translational research must take place in classically academic institutions, they often do because of the supportive environment and the available infrastructure. To have a successful research program, there must be access to the resources and personnel required to perform research. This may include shared facilities and equipment, grant management staff with access to research assistants, core laboratories and routine services (e.g., biostatistics, microscopy, gene sequencing), and proximity to collaborators. Access to residents, medical students, undergraduates, or other volunteer or paid research personnel will be vital to your success. Other, less tangible factors may include the overall value of research as seen within the department by the leadership and the clinical volume within the practice. Other, often overlooked opportunities in the practice may be available, even in private practice settings, to perform clinical research with contracted biostatistical support or to participate in large multicenter trials. As a new partner or faculty member, it will be important to have clear expectations from both your partners and the chief/chairperson regarding your expected contributions. These things are often harder to parse out and require directed questioning of both parties.

Financial support/protected time

Ideally, protected time is the most optimal means to both establish and maintain you research program. Protected time allows for dedicated work time to perform research, write grants, analyze data, brainstorm on study designs, and meet with collaborators/students/research assistants. Without this time, the work comes during nights, weekends and time meant for other endeavors, which is not sustainable in the long term. While early in your career you may not have access to this, working to gain protected time is an important goal.

There is no single formula that results in success for surgeon scientists; however, there needs to be a clear division of research and clinical duties. For surgeons, unlike medical specialties, this division of work is necessary on a weekly basis. As an example, someone with a 20% research expectation would be required to spend one day for research per week with the remaining four days in clinical activities such as operating or in the outpatient office/clinic. For medical specialties, this division can often be more continuous (weeks or months dedicated to the lab/research followed by weeks/ months "on service"). Depending on your surgical specialty and the length of your cases, you can better determine your schedule. At the top of the next page is an example of possible schedule with 20% research and 80% clinical commitments. This often can include additional administrative time.

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	OR	Research	Clinic	OR	Clinic
Evening	OR	Research	Admin	OR	OR

Protected time also highlights the institution's value on prioritizing research and compensating you for your efforts. Having to perform research without some formal or informal salary support for this time is in fact not protection. There are various models for compensation to reward academic productivity and each institution is different. Possible options include lower RVU expectations or compensation for grants awarded, manuscripts published and national/international presentations/abstracts.

In addition to having protected time and lower clinical demands/targets, additional start up research support is necessary prior to grant support to start a research program. Traditionally, common start up packages include a fixed amount of money for supplies, salaries for fellows, graduate assistants, and equipment if necessary. This support is usually limited to 3-5 years into career when the researcher will have formal grant funding to support these costs.[5] Other cost considerations include funding for the travel to conferences to present findings. While many departments will cover these costs in part or in full, it is important to understand the policies of your local institution.

There are also many opportunities for extramural funding to help support these costs. While the prototypical objective is a government funded research grant from the National Institute of Health (NIH) in the form of an R grant or K award, there are additional options including smaller government awards, National Science Foundation (NSF) awards, research grants from philanthropic or even some of the surgical subspecialty societies, or even pilot study funding mechanisms from within your own institution. Good mentors and division or departmental leadership can help you identify some options relevant to your research interest and can aid and guide you through the application process.

Committed mentors

Having a good mentor is one the most crucial ingredients for a successful research practice. A mentor has many roles including partner, adviser, teacher, role model, friend and advocate.[6] A good mentor is often hard to find but qualities they often exhibit are experience, respect in her field, eagerness to provide collaboration and networking and advising mentees. Leeds et al provided a great table in a recent manuscript highlighting the qualities of a good mentor:[7]

It is unlikely that any one mentor will perfectly fit all these criteria, so most academic surgeons often seek multiple mentors to fill all the roles. Importantly, this just does not happen! You must actively seek to find these relationships and support them.

Advanced degree support

Finally, if you were not able to obtain a desired advanced degree during either your residency or medical school, there are programs for physicians in practice to obtained degrees in fast-track or executive professional programs. These include MPH, MBA, and MS programs. If this is something you would like to pursue, it would benefit you to discuss this with your future employer early, even prior to signing a contract. Many departments may provide funding for the degree program, a tuition credit, or the degree program may have means to help defray some of these costs from their enrollees. Try and be clear about your needs and the benefits to the department when discussing these, as aligning your interests with those of your prospective employer will ensure your success.

Conclusion

Ultimately, it is important to have clear discussions with your future employer about your research interests and the trajectory of your career. Many employers, mentors or senior faculty may dissuade early immersive involvement in research (especially split time or in a basic science lab) to ensure that early in your career you are operating often and establishing your clinical and technical skills prior to taking time away for research or other administrative pursuits. Frequent mentorship meetings with your identified senior surgeons will help keep your career on track and identify opportunities for furthering your research and academic career, and will help you balance being clinically busy with these pursuits. But in the end, your enthusiasm and interest will be the driving factors.

—Dr. Katie E. Weichman and Dr. Nura Feituri

Quality	Rationale
Promotes others	For the mentee, a mentor's own first-author publication record is less important than that of the latter's prior mentees. It is not uncommon to find a senior faculty member who has an exceptional publication record but has less success getting postdoctoral mentees or mentored junior faculty the same level of success. Mentors who have a track record with mentees receiving mentored grants are an added plus. The causes of such a failure are myriad, but what is important is the outcome. Avoid mentors who do not have a track record of bringing success to others.
Technically resourceful	New entrants to basic science research often find themselves without the equipment or personnel to successfully obtain preliminary research findings. A generous mentor can provide such resources at the most crucial times.
Socially resourceful	Mentors should already have an established social network of other senior researchers in the field. If an issue arises that a mentor cannot help out with directly, a good mentor will have someone they can call who can
Common interests	Mentors do not need to have perfectly aligned research interests, but it is important that a mentor has at least a working knowledge and passion for one's own research topics. Advice, resources, and technical help are difficult to obtain if one's mentor is only vaguely familiar with the details of one's field of research.
Available	Academic faculties are routinely overwhelmed. It is important to ensure that one's mentor has the ability to dedicate an appropriate amount of time to mentorship.
Incentivized	Incentives for mentors take all forms from intrinsic altruism to need for mentored publications to well-defined institutional incentives for mentorship. The driving force of the incentive is unimportant. What matters is that a mentor wants a mentee to be successful and has some form of vested interest in the latter's success.
Experienced	The vast majority of advice comes through prior mistakes. A mentor needs to have made enough mistakes over a research career to help a mentee avoid them.
Extramural funding	An appropriate mentor must have extramural funding from the National Institutes of Health (R-series).

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Become a Member of the American College of Surgeons

The letters FACS (Fellow, American College of Surgeons) after a surgeon's name mean that the surgeon's education and training, professional qualifications, surgical competence, and ethical conduct have passed a rigorous evaluation, and have been found to be consistent with the high standards established and demanded by the College.

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  - One year in independent practice (three years for international applicants)
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  - Names of three Fellows of ACS who can serve as references for you
- Documentation needed to complete your application
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  - A current Curriculum Vitae
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Application Submission Timeline

- **December 1:** Application submission deadline
- **January 31:** Applications must be completed to include three references, current CV, completed postscripts, and surgical case list
- **February 15:** Interview dates are provided to the American College of Surgeons by the interviewers
- **February 28:** ACS Credentials Team provides applicant information (biographical data, CV, references) to interviewers

Application Timeline Overview

- **February–March:** Interviewers provide interview dates and locations to ACS
- **March–May 15:** Interviews conducted
- **May 31:** Interview reports from interviewers due to ACS
- **June–July 31:** Credentials team submits applicants to Board of Regents or Applicant Review Committee
- **July 31:** Applicants are notified of the status of their application
- **October:** Fellowship in ACS is conferred during the Convocation ceremony that immediately precedes the Clinical Congress

Visit *facs.org/Member-Services/Join/Fellows* for more information about the benefits of membership and for resources and application materials!

Contact ACS

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Epilogue

We hope that you've enjoyed this work, and maybe even learned something along the way. All we ask is that you pay it forward: try to incorporate some of the things mentioned here into what you teach up-and-coming surgeons and physicians, be they friends, family, mentees or trainees. Let people know and get the word out, and help support others during this process. As you'll soon learn, it can be a very stressful part of your journey.

Don't forget: just because you signed your first contract doesn't mean the job search is done. Always keep an eye open for the next opportunity. Having goals, plans and aspirations will help you prepare for and subsequently identify those great opportunities when they come along, and will be helpful in reassessing your satisfaction with your arrangement every time you renegotiate your contract. Some people schedule it – they go interview every 4-6 years like clockwork. Whatever your goals are, make sure you plan opportunities to reassess your progress toward them.

Thank you for your interest in this work, and good luck!