Life After Residency

A Career Planning Guide

Melissa T. Berhow
William W. Feaster
John G. Brock-Utne

Second Edition

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ISBN 978-3-030-93373-9 ISBN 978-3-030-93374-6 (eBook)
https://doi.org/10.1007/978-3-030-93374-6

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We would like to dedicate this book to our families who are routinely asked to give up extraordinary amounts of their time as we pursue various clinical and academic activities, such as writing this book, while actively practicing medicine.

Melissa Berhow: To my son Logan, who makes it all right in the world.

William Feaster: To my wife Sandi, who tolerated 40 years of new houses and jobs while I pursued my various clinical, administrative, and academic careers, as well as an MBA along the way.

John G. Brock-Utne: To my wife Sue for her 55 years of loving support and companionship as we journey through life, while working on three continents. Also, to the next generation, our six grandchildren, Matthew, Toby, Anders, Jasper, Stefan, and Charlotte.

We would also like to dedicate this book to all the residents and fellows of the Department of Anesthesia at Stanford University. Their many suggestions/questions vastly improved our Career Transition Workshop. As mentioned in the preface, these workshops provided the impetus for this book. We strongly believe that these topics are incredibly important topics for your whole family and yourself as you look to a life after residency.

Preface

The first edition of this book was inspired by the questions and needs of our residents in the Stanford Department of Anesthesiology, Peri-operative & Pain Medicine at Stanford University Medical Center, Stanford, California. They have continued to inspire us, hence a second edition. In addition to updating the information from the original 11 chapters, we have added three new chapters for three distinct sections. These new chapters expand the focus of the book beyond the "transition" period into the "maintenance" period and a glimpse into life beyond medicine.

Part I: Navigating the Initial Transition

After more than 4 years of medical school, more than 3 years of residency, and, possibly, an additional sub-specialty fellowship, you are finally ready to find a real job. You have an exciting and challenging task ahead of you! In the chapters that follow, we will provide you with the knowledge you need to locate and secure a job that is best suited to your practice goals, successfully begin your new practice, and begin to manage your increasing income to your best advantage. The first step in the process is to determine what type of practice best fits your long-term goals. A key part of this decision will include the location you chose for this practice. Chapter 1 will help you narrow your decisions. The next step is getting together a couple of key documents you will need when you approach prospective employers. The first is an appropriate curriculum vitae (CV) which outlines the details of your training and job experience. Accompanying your CV is usually a cover letter that describes your specific interests in the practice you are targeting. Chapter 2 will help you prepare both of these documents. You will then need to identify practice opportunities in your targeted locale. You may want to start this search at least 1 year prior to finishing training. Chapter 3 will get you started with some suggestions on how to perform this search. Once you make your contacts with available practices, and potential employers are interested in you, you will often arrange for an on-site interview. Preparing for this interview is critical: you need to know what questions to ask

and what questions will likely be asked of you. Chapter 4 will assist you in your preparation. If you receive a job offer, how do you properly evaluate it and compare it to other offers that you receive? What can be negotiated further? How do you assess the differences between various groups, buy-in opportunities, salaries, and benefits? Do you need an attorney to review the various documents you are provided? Chapter 5 will guide you in this evaluation.

Part II: Setting Up Shop for the First Time

Once you've found your job, negotiated your best offer, accepted that offer, and have set a date to begin practice, you'll need to attend to several other important matters. First, you'll have to apply for membership onto medical staffs where you'll be practicing. That's not a simple task, as described in Chapter 6. Obtaining and maintaining the proper state license is another important matter covered in Chapter 7. You'll also need to obtain malpractice insurance prior to starting your practice. The major types of malpractice insurance and the important issues associated with them are discussed in Chapter 8. Chapter 9 is a valuable tool to help you manage your finances now that you are finally earning a practicing physician's income. This is a treacherous task with sharks circling, looking to take a large bite out of unsuspecting newly minted physicians' wallets. You also have some key financial tasks and decisions to make, including paying off student loans, buying a house, and investing for your eventual retirement. Bad decisions in any of these areas can be very costly in the long run.

Chapter 10 covers the powers and pitfalls of social media. Social media started as a means to connect at a personal level but has also proven to be a very effective professional tool. This tool, however, can be a double-edged sword. When the lines between personal and professional blur, there can be significant ramifications. Sometimes the obstacles in your path are simply bumps in the road and sometimes they are massive mountains to climb. Chapter 11 provides a starting point for navigating the bigger challenges including taking time off to care for a loved one, cause majore, and termination from your job.

Part III: It's a Marathon Not a Sprint: Sustainability and Relevance for Your Career and Life

It is not just about sustaining a career but being the best you can be for the long haul. Critical to being the best "you" and minimizing burn-out is being mindful of your own well-being (Chapter 14). Chapter 12 tells you about how you can have an effective voice in the hospital decision-making process to the benefit of the patients and all healthcare providers.

And finally, after all this training, some physicians want to look for a career outside of medicine, either to augment a clinical practice or to do something entirely different. Chapter 13 gives you some advice for non-medical career options.

So, get started with the task ahead of finding your first real job as a physician. It is one of the most exciting times of your career, and, often, one of the tasks we least prepare you for in postgraduate education.

Hopefully this book will help you succeed with this task. We wish you luck as you now move to your next step in a hopefully long and successful carrier as a medical doctor.

Stanford, CA, USA Melissa T. Berhow
Orange, CA, USA William W. Feaster
Stanford, CA, USA John G. Brock-Utne

Acknowledgments

We acknowledge our hundreds of residents and fellows at the Stanford University Medical Center, Stanford, CA 94305, USA, and other programs we've been associated with as the true inspiration for writing this book.

We also want to express our gratitude to Roya Saffary, MD, for her writing on social media (Chapter 10); James McAvoy, MD, for his contributions to Chapter 7 on medical licensing; and Sandra Feaster, RN, for expert input to our final chapter on physician wellness.

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Part I
Navigating the Initial Transition

Chapter 1
Finding the Right Fit

William W. Feaster

As a somewhat overused expression says, let's "cut to the chase." You want the perfect job. You want to make a lot of money. You want to live in a great place, with a good climate, near family and friends. You want an interesting mix of patients that challenge you professionally, but you don't want to work any harder than necessary so that you have time to spend with your family. You want to be able to retire early and explore other interests. Is such a job possible? The answer is a definite yes. Will you have to work to find it? The answer is also probably yes. Will you make the right decision the first time? The answer is a possible no. Fortunately, you're not stuck with your initial decision for the rest of your career. But, making the right decision for the right reasons is a good first step. This chapter will help you take that step.

1.1 Choosing the Right Location

Location is the primary driver for job decisions. Your choice of locations may be somewhat limited by your specialty, subspecialty, or sub-subspecialty, but we all have similar needs when it comes to location. For those residents who are married, the primary driver of location seems to be family. There is a practical issue here. If you have children, family is a source of free childcare! Often, both husband and wife have careers and want to have children. Childcare becomes a big issue. Plus, there's the added value of your children growing up around your family. Another issue for married residents is that a spouse may already have a good job in the area where the physician is in training. Staying in that area after practice may have a higher priority than usual. For those less "attached," numerous other issues come

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© Springer Nature Switzerland AG 2022

M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_1

into play. While it varies by specialty, nearly half of all residents practice in the area where they have trained as they have made contacts with other physicians in the area in their specialty. They have likely been recruited by a local physician to join his or her practice or by a large group needing their specialty. For details, visit the AAMC website: https://www.aamc.org/data-reports/workforce/interactive-data/2020-physician-specialty-report-data-highlights.

If family or residency location doesn't dictate your city choice, this is the best chance to ask yourself: "Where do I really want to live for the next 30 years?" Do you want to live in a big city, or an area more rural? What are your primary hobbies? If snow skiing is a priority for you, then the Rocky Mountain States may be an ideal choice. If you love the ocean, surf, sail, etc., moving near one of the coasts is a higher priority. If you love golf and warm weather, then maybe Arizona will appeal to you the most. In short, you'll need to be somewhere you can pursue your passions outside of medicine.

Another key factor that influences location choices is the cost of living. If you are a pediatrician and want to buy a larger home in a nice area with a large yard and good public schools to raise your family (all reasonable goals), and have enough money left over to enjoy life, think twice about taking a job in San Francisco, where even living in the suburbs is prohibitively expensive. On the other hand, if you're a two-physician family, with both in highly paid specialties, it may be a great choice. You can then afford that nice house in Marin County that is a short commute from the "city."

There are several resources to turn to when trying to assess the best or most desirable location for your future practice. For example, *Money* magazine ranks the top 300 cities to live by economy, health, crime, housing, education, weather, leisure, transit, arts, etc. A link to *Money* magazine's website plus additional resources can be found in the boxed inset given here.

Resources for Choosing a Location for Your Practice

Websites:

Money Magazine (annual survey)
https://money.com/collection/best-places-to-live-2020/

Sperling's Best Places (questionnaire-based tool)
http://www.bestplaces.net

Kiplinger's Best Cities
https://www.kiplinger.com/real-estate/places-to-live

Books (not many recent ones, most information online):

David Savageau. Places Rated Almanac: The Classic Guide for Finding Your Best Places to Live in America. Places Rated Books LLC, Washington, DC. 2007.

Bert Sperling and Peter Sander. Best Places to Raise Your Family. Wiley Publishing, Hoboken, NJ. 2006.

Bert Sperling and Peter Sander. Cities Ranked and Rated: More than 400 Metropolitan Areas Evaluated in the U.S. and Canada. Wiley Publishing, Hoboken, NJ. 2007.

Sara Tuff. 101 Best Outdoor Towns: Unspoiled Places to Visit, Live, and Play. Countryman. 2007.

Another source of objective information that may help you choose a location for your subsequent practice is to choose the state with the highest performing health systems. An interesting approach has been taken by the Commonwealth Fund. This nonprofit group has created a State Scorecard that ranks states based on 32 indicators including access to healthcare, cost, insurance, preventive care, premature death, etc. In 2015, their top three scoring states were Minnesota, Vermont, Hawaii, Massachusetts, Connecticut, New Hampshire, and Rhode Island. Thirteen states are in the bottom quartile, many throughout the southern United States. You can check out the details by state at their website https://www.commonwealthfund.org/publications/scorecard/2015/dec/aiming-higher-results-scorecard-state-health-system-performance?redirect_source=/publications/fund-reports/2015/dec/aiming-higher-results-scorecard-state-health-system-performance. While you may change jobs two or three times throughout your medical career, it’s likely that you’ll stay in the same area you initially choose. So, choose wisely.

1.2 Practice “Fit”

In addition to location and family, the right practice “fit” is an important factor in both job choice and job retention. As discussed below, there are a large variety of practice options open to the new physician completing training. Choosing the right practice type is important for long-term success. Choosing the right practice within that “type” may be more important.

A 2006 survey by a large physician-recruiting company, Cejka Search, in partnership with the American Medical Group Association, studied the physician demographics of turnover. While 42% of physicians who left their practices did so to relocate nearer to own or spouse’s family (location, as discussed above), 51% left their practice because of a poor “cultural fit.” Practices recruiting physicians are now focusing more on selecting physicians with professional and personal interests similar to that of existing members.

The demographics of practices are changing. Women are now the majority of medical school graduates, in contrast to the fact that the majority of physicians currently in practice are male and 42 years of age or older. This will likely drive change in the “culture” within existing practices. Desirable work schedules are becoming more important, as are the flexible work hours or part-time options required by women physicians beginning their families.

1.3 Practice Types

Choosing the best practice type to meet your long-term goals is a critically important decision. Practice types can be grouped in general categories, and we will discuss each along with reasons people choose between them.

1.3.1 Government Practice

The first alternative is government employment. The military is an obvious example. Some graduating residents have little choice in this regard. If they financed their medical school education through the military, attended the Uniformed Services School of Medicine, and/or elected to do military residency training, the length of their military commitment predetermines their choice. A further "carrot" that makes the decision to stay in the military after this commitment is completed is retirement benefits, which begin after 20 years of service. Someone attending the Uniformed Services School of Medicine gets 4 years credit as an officer during medical school and may get four additional years in a military residency. He or she then has an additional minimum commitment of 7 years of military service or public health service. When first eligible to leave the military or public health service, he or she has already spent 15 years in government service. It would be silly to leave at that point prior to being eligible for a retirement benefit!

There are many nonmilitary government options. Working for the Department of Veterans Affairs in one of their hospitals or clinics can provide a very secure and satisfying career. Many Veterans' Hospitals are university affiliated and allow providers to have joint academic appointments and teach. Veterans' Hospitals obviously are limited to adult specialties, and most of the patients are men with chronic illness, making the patient population undesirable to some. Other government options include a multitude of county hospitals across the country, some also with academic affiliations. Where these types of government options become most desirable is with job security, time off, predictable work hours, great benefits, and excellent retirement packages. In addition to these benefits, the Indian Health Service, the US Public Health Service Commissioned Corps, and working at county hospitals and clinics add the additional altruistic reward of helping those most in need.

Nonmilitary Government Options

Veteran's Administration: Try this website to see a general listing of jobs available by searching on your specialty. http://www.vacareers.va.gov

Indian Health Service: This website lists current physician recruiters. http://www.ihs.gov/careeropps/

U.S. Public Health Service: This site provides applications and contact information about the USPHS Commissioned Corps. https://www.usphs.gov/professions/physician/

County hospital contacts can be found on local government websites.

1.3.2 *University Academic Practices*

An academic practice has many of the benefits of a government option, but with more focus on research and teaching along with patient care. Academic practices are usually associated with the highest acuity patient populations, where "zebras" are indeed more common than horses when one hears hoof beats. Academic practices focus more on sub-specialization than on primary care. You will likely have some "protected time" to pursue research activities. Depending on the type of appointment to the faculty that you receive, your advancement and even continued practice at the institution may be determined on how productive you are in your research efforts and resultant published articles resulting from this research. You have to weigh this very carefully as you consider an academic option. Most university academic practices have turned to a faculty option that rewards teaching and clinical care over research. The heavy clinical demands of a busy academic practice have forced this change. The "publish or perish" mentality alluded to above doesn't relate to this option, though anyone in academic medicine should be committed to advancing their specialty through some means.

If you have clinical interests in a very specialized area of your specialty, academic medicine may be your only reasonable choice. Certain sub-subspecialties are not paid according to their value but valued in a high-acuity environment for their contribution to care. An example of this might be subspecialists in the areas of genetics or infectious diseases.

1.3.3 *Prepaid Group Practice*

In the Western United States, the best example of this option would be Kaiser Permanente Medical Group. In some areas of California, for example, over 40% of the patients are covered by Kaiser insurance. As a result, they must go to Kaiser facilities for care, and be cared for by Kaiser doctors. There are many advantages of working for a large prepaid group practice (also referred to as a staff model HMO) like Kaiser Permanente Medical Group. The one most frequently touted is the ability to practice medicine free of the constraints of managed care, of authorizations for or denials of testing and procedures deemed necessary for care. Whether this is true or not, Kaiser is a great practice environment for those looking for long-term security, predictable work schedules, a decent salary, and excellent benefits. One disadvantage of Kaiser and all the other options mentioned above is that this is all very big business and that the individual may have little control of his or her practice or income levels.

Entrepreneurship is generally not rewarded in these environments. Income may be guaranteed but is also likely below the very high-income levels attainable in successful private practices in the area. For example, with Kaiser, if a practitioner is "too expensive" to hire, or too difficult to recruit, Kaiser will buy services from community providers who will come to their facilities to provide the service. Those services that can be provided by a less specialized provider will be kept "in house."

A pediatric surgeon may be a typical example. The pediatric surgeon will be paid on a per-case basis to do the neonatal emergencies, but an adult surgeon already on staff will do pediatric hernias, the "bread and butter" procedures of a pediatric surgery practice. A lot of decisions are driven by the economics of the situation. Because of this, quality issues may surface and be inconsistent across these large organizations.

Examples of Prepaid Group Practices

There are a limited number of true prepaid medical group plans. Kaiser Permanente is by far the largest, but smaller ones also exist. Here are some prepaid group practice examples:

California, Oregon, Hawaii, and other national sites:

Kaiser Permanente Medical Group (12.5 million members in 2020): http://www.kaiserpermanente.org

Wisconsin:

Group Health Cooperative of Eau Claire, Wisconsin (70,000 members in 2020): http://www.grouphealth.com

1.3.4 Private Practice Options

Private practices come in all sizes and structures. Large multispecialty groups are technically private practices but share several of the issues mentioned above. They usually have a strong primary care base and may also employ specialists to provide a broader range of services to their patient populations. If large and diverse enough, they may contract with insurance companies to go "at risk" for patients, receiving a per-member monthly capitated payment for all care delivered. This allows these groups to provide a "Kaiser-like" environment without being tied to Kaiser facilities. Unlike Kaiser, they will additionally provide fee-for-service care and accept other types of insurance, including Medicare and Medicaid.

The other extreme of private practice is the solo, office-based practice. Unfortunately (or fortunately), this is a dying breed of practice. With the levels of overhead and complexity of the healthcare payment system now very high, very few physicians are willing to take on the costs or risks of setting up or buying a practice of their own. Small, single-specialty practices with several physician members are a much more common private practice environment. This type of practice allows the physicians to share business resources, facilities, and staff to reduce overhead and share call to make life more palatable. Members of the group are often paid what they collect from patient services, less their shared overhead expenses. Individuals within the group can be more or less focused on working and income, depending on

their individual needs. One individual in the group tends to take more responsibility than the others for running the group's business activities. That may provide an additional incentive for certain individuals in the practice who are interested in the business of medicine to pursue this interest.

Physicians enter private practice over the other options mentioned above for several reasons. They're usually not interested in big business or government and want more say into how their practice is governed. They often are ambitious and entrepreneurial, and enjoy the concept that the harder they work, the more they'll be paid. They want to be compensated for providing patient care, not teaching and research. The downside is not too dissimilar to the discussion in Chapter 9 on risk in investments. Over the long term, practitioners in this environment may make more money than their peers in a large multispecialty group, where their specialty may cross-subsidize other practices, and more than the employee in a university or government. But their income will be more volatile. If the state doesn't pass its budget on time, State Medicaid payments may stop for several months. Practice overhead doesn't stop, so cash flow may become a problem. Workman's Comp and health insurance for your employees may suddenly jump. A contract with a major payer may be renegotiated at a lower rate, and so on. To be successful in this environment, you must be prepared to manage changes in income and cash flows. If you're the type that spends every penny of your paycheck and doesn't have back-up savings, you either need to modify your behavior or choose another practice environment!

Medical Practice Resources

There are many resources you can turn to for starting and/or running a medical practice. One of the best resources for you to tap is to locate a consultant in your desired practice location. The local county medical society may have a listing of consultants used by their local physicians.

For national organizations, look into joining the Medical Group Management Association (MGMA).

There aren't a lot of new books on the subject. You can search on Amazon for others.

Jeffery P. Daigrepont and Lauretta Mink. Starting a Medical Practice. 2nd Edition, American Medical Association, USA. 2003

Christian Rainer. Practice Management: A Practical Guide to Starting and Running a Medical Office. Wyndham Hall Press, Lima, OH. 2004

Marlene Coleman and Judge Huss. Start Your Own Medical Practice (Open for Business). Sphinx Publishing, Chicago, IL. 2006.

Holly Hunt. Essentials of Private Practice; Streamlining Costs, Procedures, and Policies for Less Stress. W.W. Norton & Company, New York, NY. 2005

1.4 What Can I Expect as a Salary?

You shouldn't make a practice-type decision solely based on salary any more than you should base your choice of specialty solely on salary. That said, many students are leaving medical school with very large debt burdens and the ability to repay that debt looms large in practice choice decisions. Where can you turn to understand what influences the salary you will ultimately be paid in your new practice?

One of the best resources is the Medical Group Management Association (MGMA), which publishes a yearly review of specialty-specific salary data, by region, by group type, by city size and other parameters. MGMA members submit data, but the groups submitting data will tend to be larger single-specialty or large multispecialty groups who belong to this type of organization. This annual survey is available for purchase and is much too long or complicated to reproduce any part of it here. I doubt if you will want to buy a survey directly from MGMA. Check to see if the office overseeing your residency programs or the faculty practice has a copy for you to review. There are a few consistent observations of specific survey data.

Data are reported by percentile and show a broad range between the highest and lowest compensation within a specialty. Compensation is generally greater in the Midwest and the South, followed by the Eastern States and trailed by the Western States. Specialists tend to make more money in single-specialty groups than in multispecialty groups. This is possibly due to the "cross-subsidization" mentioned earlier. Groups in small- and medium-sized metropolitan areas tend to have higher compensation than those in large metropolitan areas (>1 million), presumably due to the higher desirability of large cities and greater competition for available jobs.

There are several other factors that might influence the salary you'll be paid. One is rather distasteful but has historically been an issue. Men are often paid more than women for the same job. That has been true for nearly every industry, and medicine is no exception. Part of this may be due to the fact that more women work part-time in order to raise families. Part-time employment generally pays less than the actual percentage of full-time worked. As women continue to enter medicine at a pace exceeding men, this will likely change in the long term, but in the short term, men still dominate medical practices, especially in leadership roles. Another more rational reason for salary differences between practices is payer mix. Governmental payers pay proportionately less for services than private payers. So, if you enter a rural practice with a high proportion of Medicaid patients, net practice income, and thus the salary you can be paid, will likely be lower.

The system under which you are compensated may influence your salary. If you are paid a straight salary no matter how hard you work, your salary may lag your colleagues under a system where productivity is rewarded by bonuses or the salary is fully productivity-based. Compensation will also vary based on your seniority with the practice. If you have been in the practice for two or more years, and have bought into it in some fashion, you are now a shareholder or partner (depending on the practice model) and often are entitled to a share of practice profits not otherwise available to new hires.

The other major influence on your salary is the benefits offered to you as part of your employment. A large organization, especially the government or a university, will have a very rich benefit package, whereas a small private practice may just provide the benefits required by law (statutory). Table 5.1 in Chapter 5 lists both statutory and elective benefits offered by medical groups and larger employers. Universities more uniquely offer two benefits not on this list. As part of a recruitment package, universities may help physicians purchase a home, sometimes on the university campus itself. Also, some universities offer free tuition to your children or pay for some portion of their tuition if they matriculate at another college or university. You need to take the value of all the benefits provided to you along with your salary to accurately compare salaries between different job options. In general, the richer the benefits, the lower the salary. We will cover this in more detail in Chapter 5 when we discuss the evaluation of a job offer.

Chapter 2
Getting Ready for the Job Search

Melissa T. Berhow

You've spent some time thinking about what your ideal job would be and now it is time to find it. Depending on your specialty, you will start looking anywhere from 6 to 18 months ahead of time. In a tight market, you might be starting to express interest as early as 2 years ahead of time. To get the most accurate timeline for your specialty, it is best to speak with your residency director.

Two essential items for preparing for your job search are your curriculum vitae (CV) and cover letter. When reading a CV, on average, a prospective employer decides in 2 minutes whether or not to pursue a candidate. This will be the first contact you'll have with a prospective employer; make sure you make the most of this first impression or else it may also be the last contact with them.

2.1 Why a Curriculum Vitae?

A CV is a detailed document charting your professional life. Depending on your experience, seasoned versus fresh out of residency, it may be only one page long. Starting with a good base for your CV now will serve you well in the future. You'll have many future uses for a well-prepared CV, such as applying for grants, going out of the country for mission work, speaking at conferences, etc. The format listed below allows for easy modifications and additions as you progress through your career. You will be amazed how quickly and easily the details of your past professional life are lost in the memory banks.

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M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_2

2.2 What's in a CV?

Table 2.1 gives a listing of subject headings typically contained in a CV. There are several variations on this format. It doesn't really matter which of the many different formats you use as long as all the relevant information is there. The format we chose to use is one that several commercial curriculum vitae preparation services also use. If preparing your own CV seems untenable, there are several online sites available (e.g., thedoctorjob.com) to help in preparation. When you begin writing your CV, remember these simple tips:

- Keep it short and relevant, usually two to three pages maximum.
- Keep it generic: same CV for all jobs.
- Always spell check and proof read; get someone else to read it to catch those last couple of oops.[1]

[1] Postgraduate training: This includes your residency and any fellowship training that you have completed. Each line should start with the dates of training (e.g., July 2003 to June 2005: Stanford University Hospital Department of anesthesia residency). If you functioned as a chief resident, list that year out on a separate line for added emphasis.

Table 2.1 Sample CV

Sample CV
Name
Contact information
Address
Telephone
Cell phone
Email
Personal information (optional)
Date of birth
Citizenship
Visa status
Board certification
Medical license
Postgraduate training
Education
Graduate/medical school
Undergraduate
Professional experience (chronological order)
Work history
Academic positions
Include position details and dates
Professional societies
Awards received
Publications
Outside interests (optional)

- Write everything out, minimize abbreviations.[2]
- If sending your CV via email, it is recommended to also send a hard copy unless specified otherwise. Email may disrupt the formatting on your electronic file, and you want it to look good!
- Hard copies, if sent, should be printed on good quality paper.

Potential employers will be scanning your CV for gaps in your training and employment. You should account for your time on a continuous basis. If you took a year off to trek in the Himalayas, list it in some way under special interests as traveling or exploring other cultures. Spin it in a positive fashion rather than letting one assume you "dropped out" for a year.

Here are some detailed descriptions of some of the particularly important subject areas in your CV. A sample CV can also be found in the Appendix of this book.

- Professional qualifications include board certifications. Upon completion of residency, most of you will be board eligible (BE) and not board certified (BC). It is useful to list any portion of your certification process that you have completed at the time of applying, for example, written boards (7/20). List all the states in which you have current or prior medical licenses. If you did not renew a license, list why (e.g., moved out of state). Many board certification exam opportunities were delayed or canceled due to COVID; simply note reason for delay on CV.
- Publications: Unless you are applying for an academic job or other position for which prior research experience is directly relevant or have done specialty-specific research during training, having a publication list available on request will usually suffice.

[2] Professional experience: Many of you have worked for some period of time prior to your medical school of residency. List any such work in detail. You may have had a transitional job or moonlighted during training. List the dates and job title. You won't need to list employment in high school unless it is somewhat relevant to the job you're applying for.

File Format Tip

If you submit your resume via email or the web, rather than in hard copy, you run the risk of the formatting, pagination, etc., coming out wrong on the other side and making your documents difficult to read. This is especially common with word processing documents and spreadsheets. To put your best foot forward, you want to make sure that the documents you submit will look to the admissions staff exactly as they look to you. There are several file formats in which you can save your documents so that they will look the same on the other side (.tiff, .eps, .pdf, et al.). You should always follow the instructions in regards to the file type(s) requested; however, at the time of this writing, the most popular and convenient way is to save your document as a .pdf.

The .pdf is the file type for Adobe System's™ "Portable Document Format"™ and has become nearly ubiquitous in its usage. Anyone can download a free copy of the .pdf reader (Adobe Reader™) at www.adobe.com. If you want to create a .pdf file, however, you will need to buy their software. Alternatively, a great way to create .pdf files for free is to download a copy of Open Office (www.openoffice.org). Open Office is a free office suite that includes a word processor, spreadsheet, etc., just like Microsoft Office™, and it includes the built-in ability to create .pdf files. All you need to do is to download Open Office, open your file in it, and then save the file as .pdf file type. Once you have your document saved in the .pdf file type, open it to make sure it looks good to you (the best way might be to download a free copy of Adobe Reader™ to do this) and then submit it.

2.3 The Cover Letter

For each job application, you will send the generic CV and a more customized cover letter. Your cover letter is not simply a rewrite of your CV. Your cover letter is more personal – it is the opportunity for you to explain why you feel that a specific practice is a mutual good fit. Some key things to include in the cover letter are as follows.

- Date of completion of residency and date of availability for employment. It is OK to have a specific start date request, but if you can be flexible, be sure to convey that information.
- Any specialty skills from residency or fellowship: do you have a certain niche that is marketable? For example, you spent 6 months on the cardiac rotation.
- Type of practice you are interested in. There may be certain specialty areas where you feel you possess special expertise and could add extra value to the practice.
- If a job is of particular interest to you because of geography, personal or professional ties, you may choose to mention this. Employers are looking for potential employees who have staying power so having a tie to the practice can be a bonus.
- Name drop: If someone in the practice knows someone from your residency program, it is a sure thing that they will contact them before they contact you. If you have a known connection and that person will be your advocate, it is reasonable to mention it in the cover letter.

Sample Cover Letter
16 January 2021

Dear Dr. Smith,

My name is Jane Doe and I am contacting you regarding potential job opportunities in your practice. I will be graduating from the Stanford Hospital Anesthesia Residency program June 2021 and would be available to start

work Sept 1 2021. I am interested in a broad practice and am comfortable covering OB, cardiac, pediatric and liver transplant anesthesia. Additionally, I did a concentrated 6 months of regional anesthesia and feel that this is a skill that might be useful in your group's setting. The Florida Keys Associated Anesthesia group comes highly recommended from Dr. Brute Force (Orthopedic Surgery, Hurricane Hospital). I am very much interested in living in Key Biscayne; my husband's family lives there and we hope to settle down closer to family.

I have enclosed a copy of my CV with contact information.

Thank you very much for your time. Sincerely,

Jane Doe, M.D.

2.4 Letters of Reference

If you are a viable candidate, your prospective employer will ask for a list of individuals they can speak with, who can attest to your professional qualifications. One constant on your list of references should be your residency director or chair of the department. Similar to the dean's letter when you applied for residency, this letter provides a general overview of you and your performance during training. For other references, it is best to solicit letters from faculty who have some name recognition, and are well networked. If you have a niche, for example, regional or OB anesthesia, it is valuable to have a letter from a faculty member that also has that niche. The names you choose to provide may vary from application to application. If the head of the group is friends with Dr. X at your hospital, it is a guarantee they will have a conversation about you before you sign on the dotted line; it behoove you to list them as a reference. That said, it is also a good idea to ask your potential references if they feel comfortable writing a letter for you before you list them as a reference. You don't want to be surprised at the interview by an unfavorable letter in your file.

Chapter 3
Identifying Practice Opportunities

Melissa T. Berhow

Like all good residents, you are reading this book from cover to cover and have already gone through Chapters 1 and 2. You've spent some time thinking about what you want out of a job, prioritized factors to consider such as location, salary, and flexibility, and you know what you want. But how do you set out to get it?

If you plan on staying near where you did residency, then chances are you have already made some local contacts and it is time to draw on that network. If you are relocating some distance away, you will need to utilize other resources. As a general rule of thumb, the better jobs are usually not advertised. Fortunately, several resources are available for job searches, with some variability depending on subspecialty.

3.1 Popular Resources for Job Searches Alumni Networks

Most residency programs keep a listing of its alumni, the vast majority of whom are happy to talk with a fellow graduate. Check with your department for a listing of its alums. Plan to attend alumni reunions at association meetings. Alumni often use these reunions as a recruiting tool themselves; so be prepared for on-the-spot interviews, for example, have a business card or other contact info ready. Also be ready to say what makes you worth hiring. Have a few key sentences prepared about yourself. Dress well. Even though the alumni reunions are a social event, it is not the time to dance on a table top with a lampshade on your head.

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M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_3

3.1.1 Association Meetings

Whether it is the annual association meeting or a smaller regional conference, these are great opportunities to network and gather information on job opportunities. Many larger association meetings have a job search board and means of scheduling on-site interviews. If you are planning on attending a regional meeting, consider going to one in the geographic area you would like to end up in, not just near where you are doing residency. If you live in Texas but want to relocate to New York, plan on attending a meeting in New York. Again, be prepared with business cards or CVs.

Authors' side-bar: In 2020, most alumni and association in-person meetings were canceled with some switched to virtual. There has been an increased reliance on existing networks to find and fill jobs.

3.1.2 Residency Program Faculty

Although many departments end up being staffed by graduates from local residency programs leading to a somewhat "in-bred" feel, your local faculty can still be a tremendous job search resource. Many jobs are "advertised" by word of mouth, and not formally posted. Discuss your job search with your department faculty. One phone call from a well-connected faculty can make the difference between a "job" and "no job."

3.1.3 Online Postings

Most specialties have online networking sites. For example, GasWorks.com is an online site for anesthesia. There are also nonspecialty-specific sites, such as MDposting.com and healthcare.monster.com. Many of the companies that specialize in locum tenens placements have postings for permanent jobs too, such as kendalanddavis.com.

3.1.4 Professional Publications

Check the advertisements in your professional society's publications. The jobs posted tend to be academic postings or harder-to-fill private sector jobs.

3.1.5 Recruiters

If you are not already, you will be inundated with emails and snail mail from recruiters. Recruiters usually post positions that are harder to fill (less desirable geographically, etc.) but may be a perfect fit for you. If you are interested in exploring a particular geographic region or different practices, locum tenens work might be for you. Recruiters are often the best resource for establishing locum tenens work. Recruiters also can post an ad on your behalf if there is not a job posting immediately available. Once again, the employers that utilize these ads usually don't represent the most desirable positions. That said, some harder-to-fill positions can come with a financial benefit. A former alum of our program lived in California but worked winters in Montana. Because the practice had to provide a significant financial incentive, he was able to get by with working only those 4 months a year.

3.1.6 Regional Hospitals and Clinics

You have searched online, checked your alumni network, and have had no luck. If you have your search narrowed down to a specific geographic area, you may need to do some research online or call regional hospitals to find out names of groups that provide your specialty service. Unsolicited job inquires may require that you be more assertive than you are used to and take you out of your comfort zone. Cold calling to a group and expressing your interest may seem forward but speaks volumes about your resourcefulness.

3.1.7 Co-Residents

Depending on the job market and competitive nature of your colleagues, in larger residency programs, your co-residents can be a great resource. Chances are you are not the only one in your program looking at a specific job or in a specific area. Ask around. Someone else may have already done the leg work.

3.2 Real-Life Job Search Examples

The vast majority of first jobs come from a professional connection that you cultivate during training. Whether you stay on where you did your training, join a group that has many alumni from your program, or sign on where you did an away rotation, your training network is your richest source of potential job opportunities. Below are some real-life examples of finding your first job.

3.2.1 Staying Close to Home

"When I was a resident we rotated through three hospitals. In the fall of my final year of training, I was toying with the idea of doing a fellowship when the chair at one of the three hospitals offered me job. I wanted to stay in the area, so it worked out well. After a few years there, I received a phone call from a former colleague in residency. His practice was looking for a new hire and I ended up changing jobs. I know it is very specialty specific, but I never have actually applied for a job."

3.2.2 Geography

"When I was in fellowship, I started applying for and interviewing for jobs. At first I wanted to stay in CA so I looked around at the places I knew personally. When it became obvious that we couldn't afford to buy the kind of house we wanted in CA and I wasn't finding the perfect job, I began looking elsewhere. First I looked at the hospitals in the DC area near where I went to Med School (Georgetown). I applied to the hospitals I knew personally from med school. I got a contact at Fairfax from a colleague at the VA who knew a guy in that practice and I got an expedited interview through that contact. I got the contact at Washington Hospital Center from an attending at Georgetown. I interviewed at both and neither was a great match for me. Then came my Dad's suggestion. My Dad is an engineer working at a hospital in the Boston area. He went to the chairman's office without my knowledge and asked if he was hiring. He told him about me and the chairman said for me to forward my stuff. I scheduled the interview for my Dad's sake never thinking I'd take the job but it turned out that the job was a really good match for me. I asked a ton of questions and liked what I heard... so here I am."

"The best resource for me was to talk to recent graduates and finding out about jobs in their areas. What I found very frustrating was, unlike the match, some groups hire only in November and some only in February. Each group wants an answer right away which means you either accept the job or turn it down before interviewing elsewhere. The other thing that made it difficult was my girlfriend and I were looking for jobs together in the same field so we needed two openings not just one. Ultimately I heard about my job through a friend of a friend."

3.2.3 When You Need Not One but Two Jobs...

3.2.3.1 Finding a Match for Two

"Our situation was bit hard because both Bill and I needed new positions and we had a bit of trouble finding a good fit for both of us. Eventually it happened that Bill's friend, Jim, with whom Bill had done med school and internship was here, in

Pasadena. Jim wanted Bill to come down and I said, "Sure Jim, if you can find ME a job, we'll come!" Jim then was in the OR with my now senior partner, Mark, and asked if there might be any available openings for a woman surgeon. Mark reportedly said "A woman? From Stanford? We'll take her! Have her call me." I called his cell phone, we talked, we met in May and again in September and verbally agreed on an arrangement that would work."

3.2.4 Faculty Network

"After looking around where I did residency, my husband and I decided relatively late in the game to move closer to family. The thought of having to start all over when most of my co-residents already had signed contracts was daunting. I was sharing my stress with the attending I was working with that day. Turns out he knew someone in the city we were looking at. He made one phone call. I had a phone interview the next day and a signed contract the next week."

3.2.5 Locum Tenens

"I decided to freelance (known as locum tenens) for a little while after residency for a number of reasons. I wanted some flexibility to my schedule for studying and vacations. I wanted to work at possible job locations since that seemed better than just interviewing. Most importantly, I did not know the size or composition of the group that would best fit my needs. Locum was a great way to sample a diverse range of practice styles and organizations and then decide what worked best for me."

"There are two main ways to proceed with a Locums practice, set it up yourself or use an agency. The agencies are best if you want to travel widely, plan on working Locums long term and don't plan on turning a Locums assignment into a permanent job. I chose to set up my own practice since my primary goal was to test fit possible partnership positions. I began by putting together a list of anesthesia department chiefs and recent program graduates in the area. Using both cold calls and introductions from program contacts, I began to book Locums contracts. Most of my initial contracts were for vacation relief during the summer. Some of those turned into recurring work, and after two years I chose one of them for a partnership position."

"Locums work was a way for me to discover what size, organization and acuity of practice I wanted. Some negatives to consider are the potential for unscheduled blocks of time and the stress of constantly entering new environments. Some will find this as a challenge, others as aggravation, but Locums work is something to consider if you are having trouble deciding on a type of practice."

3.3 The Cold Call

It may be that your ideal job is beyond your current professional network and you find yourself forging new connections. The initial contact might be a chance encounter at a professional meeting or picking up the phone and cold calling. In either case, be prepared. Do your homework. Know something about the group you are interested in and have a "script" prepared in your mind. This is your chance to make your potential employer want to find out more about you. If at all possible, speak with the head of the group you are interested in. Your conversation might go something like this...

> Hello, my name is Don Corleon. I will be graduating from pediatric residency at Stanford Hospital and was interested in speaking with you about potential job opportunities in your practice.
>
> "Response 1:
>
> We are not looking for anyone right now
>
> I'm sorry to hear that. I am very interested in your practice. Is it OK if I send you a copy of my CV for you to keep on file if a job opening comes up?"

If they decline your offer to send a CV, take the hint. Don't be offended. Be polite. Say thank you and end the conversation. You never know when your paths will cross again.

> Response 2:
>
> Please tell me more about yourself

(This is what you have prepared for. This is the time to sell yourself and show that you have researched the group.)

> I will be completing my training in June 2008. I spent extra elective months in endocrine clinic and am quite interested in childhood obesity. Given that your patient population is a high risk group for childhood obesity, I believe I could be a positive addition to your practice.

Although the initial cold call might turn into a formal interview, most likely, it will be a brief conversation and a more formal interview (by phone or live) will be set up for a later time. Chapter 4 discusses preparations for the "real interviewer," but here are some do's and don'ts for the cold call.

3.3.1 Things to Do

- Get comfortable: You want to come across as competent and friendly. In a live interview, there are many different ways of delivering this impression. In a phone interview, all you have is what you say (or don't say) and how you say it. If you are not relaxed, this will come across in the conversation. Take your shoes off and hop in that big, overstuffed chair in the living room. Speak slowly and clearly. Keep a glass of water nearby for the inevitable dry mouth. See Chapter 4 for guidance on video call interviews.

- Leave yourself enough time to have an on-the-spot interview. Your future employer needs to believe you want this job. If, after ten minutes, you ask if you can call them back, you will give the impression that something else is more important than securing this job. Leave at least 30 minutes for each phone call.
- Go some place quiet where you can hear and be heard without difficulty. Don't call from Starbuck's or your local gym. Again, a noisy background gives the impression that you are not focusing on the phone call and this job.
- If you call from a cell phone, make sure you are someplace where you have good reception and will continue to have good reception. Even though it isn't your fault, repeatedly saying "Can you hear me now?" doesn't instill confidence.
- Call during reasonable business hours and be cognizant of different time zones. You may be asked to call back during non-business hours so your employer has some time to chat but the initial call/page should be between 8 am and 5 pm.
- Take notes as you go. This shows you were paying attention and allows you to have a more effective interview.
- Respond to any requests they might have in a timely fashion. If they would like to see a copy of your CV, get it in the mail the next day (or at least within 1 week).

3.3.2 Things Not to Do During the Cold Call

- If this practice doesn't have an opening, do not ask if they know of any openings in the area.
- Don't multitask. Yes, multitasking is a necessary skill to master if you are to get through residency. We have all worked out, talked on the phone, watched a movie, and made dinner at the same time. That said, the phone interview is not the time to show off this skill. If you are doing other things while speaking on the phone with your prospective employer, it gives the impression that your other activity is more important than this job. Don't do laundry, microwave dinner, watch TV, use the restroom, etc., during the phone call.
- Don't interrupt your interviewer. Use proper phone manners.

3.4 Timing Your Job Search

Although your first job out of residency will most likely not be the job you retire from, finding the best fit from the start gives you the best chance at thriving professionally. Get started early and give yourself enough time to do comparison shopping; you don't want to have to take a job strictly because you didn't have time to look around. Appendix B in the back of the book lists a timeline for your job search that will work for most residency programs. Please note this timeline is not accurate if you are considering a fellowship as your first "job" out of residency. The bottom line is: Take the time, do your homework and be prepared; this will make for the best career transition possible!

Chapter 4
The Interview

Melissa T. Berhow

After targeting specific job options and establishing initial contacts, it is time to prepare for the interview. As with your interviews for medical school and residency, your future employer is looking for someone who is competent, reliable, and affable (i.e., is likely to succeed). Although some employers may look at you as a short-timer (and may be rightly so if you have a year to burn while your spouse finishes training), most employers want "long-term compatibility." This includes assessing if you are going to fit in well with your coworkers as well as determining if living in the area is compatible with your interests and family needs. Some basics of interviewing are as follows:

- Look like you want the job: You may live your professional life in scrubs, but now is the time to break out the executive wear (or perhaps your cleaned and pressed residency interview suit if it still fits!).
- Be prepared: Find out as much as you can about the practice before you interview. If it is a hospital-based practice, much of the information is available online. Also, do research about the geographic area. You are interviewing them as much as they are interviewing you (hopefully!). Being prepared shows you are serious about the potential job and reflects well on your overall decision-making process.
- Know your strengths: Be prepared to sell yourself to the practice. Invariably, your potential future employer will ask something like "Why should we hire you when candidate X has equally impressive credentials?" The middle of the interview is not the time to search for an answer. Be prepared to effectively communicate your strengths.

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M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_4

Most likely, during residency you have not needed to "sell yourself." So spend some time thinking about the following questions: What do your colleagues, patients, coworkers compliment you on? Read your residency evaluations; what do you receive higher marks on? What is unique about your experiences? What can you bring to that practice that someone else cannot? Do you have a language skill, subspecialty training, or experience that the group could benefit from? It may not be just what you have done but what you would like to do in the future that might be your strongest selling point. Do you have professional interests that you would like to cultivate that could benefit the group?

- Know the exact time and place for the interview, how long it takes to get there, where to park, etc. Arrive at least 10 minutes early.
- Have an idea of questions that you want to ask. Even though it may be a key factor in your ultimate decision, do not start with "What would my salary be?"
- Mind your manners: Sit still in your seat ... don't FIDGET! Make and maintain eye contact. Shake hands at the beginning and end of your interview.
- Be concise in your answers to questions. Ask for clarification if you don't understand a question.
- Be polite to everyone you meet during the interview process. Potential employers need you to fit in with everyone involved in their practice from the security guards to office assistants to other physicians.
- Be sure to turn your cell phone off. If you absolutely have to leave it on, put it on vibrate and apologize to your interviewer that you need to be available for emergency calls.

What you don't do or say could be even more important than what you do do or say during the first interview. Here are a few things to remember to not do during your interview.

- Don't focus conversation on the financial compensation or time off.
- Don't look or act unprofessional.
- Don't argue with your interviewer. Avoid controversial topics even if you are "just making small talk."
- Don't lie. Invariably, the lie will reveal itself. Being unethical buys you a one-way ticket to the bottom of the applicant pool.

4.1 Handling Difficult Questions

Very few candidates have pristine CVs. Whether it is a personal health issue, unexpected job change, or a stint in rehab, your potential employer will undoubtedly ask a question that will force you to discuss a potential weakness. These potential weaknesses fall into two broad categories: weaknesses resulting from past issues and weaknesses resulting from recurrent issues. A past issue might include a year off during medical school for mental health needs, a prior DUI, failed boards exams that are now passed, or termination from a job. When queried about the extra year

during medical school, "I took some time off for personal reasons," should be an adequate answer. You are being honest but not giving any information that might be viewed as negative by your potential employer. There is a chance the interviewer might need more reassurance that this "issue" will not impact the ability for you to perform your job. If the line of questioning continues, "It is a private issue that I would rather not discuss but, it is no longer an issue," is a reasonable response. You are being honest but also refocusing the discussion away from the potential negative to a reassuring positive note.

In contrast to a past issue, answering questions about a recurrent issue is tricky. A recurrent issue is something that has happened in the past and might occur again; a recurrence will potentially have an impact on your future professional abilities. Your employer will want reassurance that you are capable of doing the job described but you cannot do that. You cannot guarantee that there will not be a disruption in your ability to perform your job. A recurrent issue might include a chronic illness, for example lupus, HIV, schizophrenia, being the primary care provider for an ill, loved one. It is difficult to know how best to answer questions about a recurrent issue. Even though your honesty might be appreciated, discussing the issue in full detail and providing full disclosure will undoubtedly be viewed as a net negative by your future employer. It's human nature. You are going to buy the car that has not been in an accident rather than the one that has, even if it has been repaired and seems just as good as the other car. An alternative approach is to just not answer the question. Not answering the question leaves a blank in the interviewer's mind. This blank will be filled in with the worst case scenario answer. If your potential employer sees past this, you will be setting yourself up for potential problems in the future. Not acknowledging the issue will only cause problems when the issue does recur; not mentioning a history of debilitating lupus flares only to have to take time off 3 months into a new job will be a source of tensions in your new group. If at all possible, try to answer the question with a balance between full disclosure and "none of your business." Be truthful but guarded in your answer and focus on what you have done to minimize the weakness and its impact on your professional abilities. For example, "I have had to take time off to care for my child but my husband and I have developed a schedule to minimize any impact on our jobs," "I had to take some time off for a personal health issue but it seems to be in check." In summary, be honest but succinct. Acknowledge the negative and refocus on the positive.

Please note that in the majority of circumstances it would be illegal to discriminate against someone with preexisting conditions, but this does not keep people from harboring negative feelings that, in turn, could impact your success within that organization.

There are also questions that interviewers are not supposed to ask but may; for example, "Are you planning on having children soon?" to the 30-something female candidate. A "none of-your business" doesn't usually go over very well nor does "I am planning on getting pregnant as soon as I sign the contract here so I can take advantage of the maternity leave policy." This is a situation where less is the better answer: "I am planning a family someday but have no immediate plans." If, however, you are already pregnant, a more specific answer is necessary.

Tips for preparing for a video interview:

Out of necessity, video interviews quickly became the default in 2020. Although there may be some upsides, there are also many downsides and require a new skill set when preparing.

1. Find a quiet, well-lit, neutral room with a good internet connection. The quietest place in your home might also be the darkest or have the worst Internet connection. Also not the time to have your collection of Trolls on display.
2. Charge your laptop.
3. Check video image before starting. Adjust level of device so camera is in optimal position both for height and proximity. Remember if you are looking at the speakers eye's on the monitor you may be looking down/away from the camera. Practice listening and talking while looking at camera, not the screen.
4. Find the mute button: you want minimal outside noise. Mute your cell phone and know where your computer mute button is in case surprise noise in your home (e.g., barking dog, loud roommate)
5. Look professional (top and bottom); just in case you unexpectedly stand up.

Sometimes reality doesn't match up with the ideal. Be upfront with the interviewer at the start if you are interviewing from your car, or you have sketchy reception, etc.

4.2 Preparing for a Variety of Questions

During the interview you will be asked many, many questions. Interviewers have a variety of styles. Some begin firing questions at you from the moment you enter the room and others take a more conversational approach. Spend some time thinking through your answers and, maybe, even do a practice interview with a friend. Be prepared but be careful not to come across as over-rehearsed. It is important to be genuine and sincere in your answers. And remember to be honest. There are no right or wrong answers. Just like a personal relationship, a job might be a good fit for one candidate but not another. You are interviewing them as much as they are interviewing you. Below is a list of questions you can expect to be asked.

General questions you can expect to be asked include

- What are your long-term goals?
- Why did you go into this specialty?
- What interests you about this job?
- What are your strengths and weaknesses?
- Describe a situation when you had to work with a difficult person.
- What two or three accomplishments are you most proud of?
- How can you make this practice more successful?
- What is it about this particular group that interests you?
- What made you decide to choose a small private group versus a large group practice?

- What are your professional goals?
- Do you speak any other languages?
- Do you plan to take time off between residency and your new job?
- Do you have support/family/friend ties in the area?
- Are you familiar with the group's call schedule?
- Are you planning on working full time or part time?
- What type of things do you like to do during your free time?
- Why would you like to work in this area?
- Academic practice questions you can expect to be asked include
- What are your research goals?
- What are your academic goals?
- Have you prepared a grant application before?
- Have you received grant funding before?

At some point during the interview you will be asked if you have any questions. Do your homework and prepare a list of your questions ahead of time. Not only does this provide a better first impression, it also results in a more productive interview for you. Start with "bigger picture" issues first before getting down to the details. Also, there are questions that will be more specialty specific. Because there will be some crossover in questions between specialties, we recommend looking through all the specialty-specific questions to see if some might be applicable to you. It is unlikely, and not recommended, to ask all of the questions during a one-day interview. Prioritize your questions especially if there are some answers that would be potential "deal breakers." Most employers will either have a second round of interviews or other format for you to ask additional questions. Especially for the first interview, use your discretion as to who the questions should be addressed to and when it is appropriate to ask them.

Some bigger picture questions you will want to ask include

- Describe a typical "day in the life" in your practice.
- What does your ideal candidate for this job look like?
- What are your plans for the future of the practice?
- What is the management structure of the practice?
- Are group members willing to mentor new hires?
- Why did the last (two) group members leave?

Some more detailed general questions you might want to ask include

- How frequently are you on call?
- How easy is it to pick up extra work?
- How long is the average workday? Hours per week?
- Does everyone have equal access to work?
- How many years before partnership or shareholder position?
- What is the call schedule like?
- Is there a jeopardy call schedule?
- Are there CME lectures readily available?
- What are the conditions for leaving the group?

- How much advance notice is required for leaving?
- Is there a buyout program?
- Is it possible to take patients with you to a new practice?
- Is there a geographic noncompete clause?

Can partners be asked or forced to leave the group? If so, what are the conditions that might lead to such an event?

- How do the partners get along?
- Do partners tend to work together on issues that affect the whole practice?
- Do partners tend to function more like individuals sharing space?
- What staff resources will be available/provided to support the practice?

General compensation questions to ask include

- How is compensation determined?
- What retirement benefits are offered?
- Are you RVU (relative value unit) based?
- Who determines bonuses?
- Could your pay go down if the practice goes down and vice versa?
- When do you make partner and how does your compensation change?
- Who pays for your insurance? Does it cover dental, disability, and long-term disability? Does it change going from employed doc to partner?
- Are they going to start using pay for performance measures (P4P) to determine salary? Are they capturing P4P measures and trying to improve them? If not, again a big warning, you are entering a dinosaur practice.
- What weight does the subspecialty practice have in the group? Do the specialists make much more than you?
- Do they have a good 401 K plan that lets you max out? Typically 42 K?
- Can you moonlight outside the group? Are there urgent care or hospital moonlighting options?
- Do they pay for licenses, DEA, medical societies, CMEs, etc.?

General malpractice and professional affairs questions to ask include the following:

- Do you have your own malpractice lawyer on retainer?
- Are you self-insured or do you have malpractice insurance?
- What is the coverage like?
- If you have a company, do you have to report all claims to the Medical Board? (If you are self-insured, you do not have to but insurance companies routinely pass the info on.)
- Who defends you against a claim by the Medical Board?
- How are patient complaints handled? Is there an ombudsman to deal with them?
- Who evaluates you for partnership? With what criteria?
- That is, productivity, collegiality, competence, sobriety?
- Who makes the decision to hire and also to become a partner? Who gets to fire someone, and is it a group decision, majority, or 2/3s?

- Do they pay your tail insurance if you leave? What happens if the group folds about malpractice claims and insurance?
- If the group goes under, how much would you financially be responsible for?
- Is anyone in the group doing anything on the margin of medical care – botox injections, crazy plastic surgery, workman's comp fraud, etc.?
- If you have a complaint about another physician, who do you bring it up with?
- Are there any inter-physician conflicts that might affect you? Surgeons vs. meds, this department head vs. that one, two queen bees in one office, etc.

Certain jobs, like those in academics, will come with additional issues. Pertinent questions to ask include

- What is required for promotion?
- Average number of articles, lectures expected each year.
- Initial funding or grant options.
- How much time will be allocated to clinical work vs. research time?
- Is there flexibility in this as time goes by?
- What support will be provided for research activity?
- Is there available lab space if needed?
- Is there lab staff available?
- Is there staff support for administrative activities associated with research?

Are others in the department doing similar research? Are there opportunities for collaboration?

Some questions will be unique to your specialty. The following section contains lists of questions to ask and questions that you may be asked organized by specialty.

4.2.1 Anesthesiology

Questions to ask include the following:

- How many hours worked: billable and nonbillable hours?
- How are cases assigned?
- Relationship with surgeons.
- Are you assigned to cases day after call (DAC) or do you receive a DAC?
- How often called in the middle of the night?
- Do new hires get the same call schedule?
- Are you working with cRNAs?
- Is there a preop clinic?
- Are patients usually adequately evaluated prior to day of surgery?
- Are you expected to call the patients the night before?
- Is there a call-relief system for cases that run late?
- What are the different locations that the group covers, for example, hospital, surgery center, office-based practice?

- Availability of ample ancillary services, for example, anesthesia techs, PACU nurses.
- Who assigns the cases?
- Who makes the call schedule?
- How do surgeons respond when you cancel or postpone a case?
- Does your group allow surgeons to “anesthesiologist shop” within your group?

Questions you will be asked include

- Comfort level for ASA 3, 4 cases.
- Are you comfortable covering OB, peds, cardiac cases?
- Are you comfortable performing regional blocks?

4.2.2 Pediatrics

Questions to ask include the following:

- What are the routine ages for regular well child exams?
- Is there an advice nurse? If so, what hours does the advice nurse work?
- Where do the kids go after hours? Is there an urgent care?
- Is there a weekend clinic?
- Where is the closest hospital?
- Are there a certain number of hospital inpatient beds that are reserved for our patients?
- Who rounds on newborns in the hospital?
- Do the OBs or pediatricians perform the circumcisions?
- How many patients do the physicians typically see per day?
- Are there standardized handouts that are given to the patient families for classic childhood illnesses?
- Can the pediatricians determine which patients get longer times allotted for the visit?
- If a pediatric specialty referral is necessary, is the group contracted with any particular organization(s)?
- Who administers the vaccines? Nurses, MAs, or MDs?
- How well is the clinic prepared for asthma exacerbations and anaphylaxis?
- Will the nurses or MAs perform catheterizations?
- What procedures are typically performed in the clinic?
- Does the clinic typically follow the regular immunization schedule?
- Do the pediatricians in the group conform to a set of standards (e.g., starting vitamin D or fluoride at a certain age, screening for anemia, checking screening urinalysis)?
- Do locums help out when pediatricians take their vacation?
- What is the admitting policy? Do the MDs follow patients in the hospital, or do hospitalists take care of the children?

- Do you have the equipment necessary for sedation, intravenous fluids, laceration repair, splinting?
- Are there laboratory facilities readily available? And how quickly are the labs resulted?
- Is radiology readily available? And how quickly are the films resulted? Can the physicians see the films online?
- Is there a radiologist in-house?
- How many male and female pediatricians are there in the group?
- Do the pediatricians dictate their notes or are they hand written?
- Are prescriptions faxed directly from the computers?
- Do you use an electronic medical record? Can the physicians access this at home?
- Can the families access their children's medical records online?

Questions you will be asked include

- What made you choose general pediatrics?
- How did you hear about this pediatric practice?
- What made you decide to choose an office-based practice versus a hospital-based one?
- How do you think your pediatric residency prepared you for this type of practice?
- Why do you think this pediatric practice will suit you?
- Are you familiar with the patient population?
- Do you think that you will still have interest in academic training?
- Do you have a particular interest or niche in pediatrics? Often group practices have established different physicians as the "go to" person for particular conditions, for example, adolescent medicine, orthopedics, and allergy.
- Would you feel comfortable performing procedures in clinic? Various practices differ, but these can include circumcisions, splinting, suturing lacerations, frenectomy, injections, incision/drainage, urine catheterization, lumbar puncture, venipuncture.
- For CME workshops, which pediatric topics would interest you the most?

4.2.3 Internal Medicine

General questions to ask include the following:

- Are you inheriting an existing practice that may have specific characteristics (e.g., elderly patients, Medicare patients)?
- How are new patients recruited? Do you get the problem patients nobody else wants? If you are the only female or of a particular ethnic background in the group, are you going to be "pigeon-holed" into a certain practice, for example, only female urologist, so you get all the female patients.
- What is the panel size of a normal practice?
- Over what time period are you expected to fill up your panel?

- Do you need to recruit in the community or with other doctors to get patients?
- Does the practice have advanced access? (i.e., no backlog for appointments). If not, why? Every reasonable practice should have advanced access.
- Are there opportunities to practice share in the future? Very popular with women with kids who want to practice long term. If they do not have this option, it is a warning bell that you might not get supported during maternity leave, sick kids, etc.
- Are there big competitors in the area for patients? Are there any big changes, mergers, etc., foreseeable in the next 3–5 years?
- What is the general Medical (or Medicaid) Medicare, noninsured, HMO mix of the general population?
- What is the relationship like with the Managed Care part of the organization? Do you have problems getting tests and consults approved, and do you spend a lot of time with paperwork with this? How quickly do they deny or approve? Can you appeal?
- How good is billing? What % do they collect?
- Do you cover concierge practice patients or any other needy-type patients?
- How long are patients waiting to see specialists? Are the specialists in the group or outside? Are they good about communication with you?

Hospital-related questions to ask include the following:

- Do you work with hospitalists? Are they part of the practice, or do they work for the hospital?
- What is the reputation of the hospitalists and do they contact you with admissions, DC, and need for follow-up tests?
- Are you expected to work in the hospital at all?
- Is it easy to get consults even on uninsured patients?
- Are the consultants set up to help out with procedures?
- Is the ICU covered by an intensivist 24/7 or is it you 24/7?
- How many hospitals will you cover? Are they far apart? Could you be required to be in two places at the same time?
- Are the surgeons supportive? Or do they want you to admit all their patients? Do they come in the middle of the night or expect you to do it?
- Will the ED write orders on patients for you and send them to the floor?
- What is the relationship like with hospital administration and other practices? Friendly vs. adversarial.
- Is there good parking at the hospital? Call-room, if you need to spend the night? Doctors' lounge?
- Who has to cover holidays and weekends? New guy often gets this job.
- Is credentialing difficult at the hospitals?

Electronic medical records and workflow questions to ask include the following:

- Do they have one or are planning to get one? Is it any good?
- How much time do they spend answering the electronic medical records in-box lab results, calls? Do medical assistants cover the most or are doctors dealing with it?

- Can patients email directly? How quickly do you need to respond to their questions?
- Does someone cover your inbox on weekends, holidays, vacations, your day off during the week? Are you expected to cover someone else?
- How are lab results dealt with? One person covers the whole department or individual docs get their own results? By fax or in an EMR?
- Do MAs (medical assistants) take patient calls?

Office-related questions to ask include the following:

- Do you get your own office space, or do you need to share with someone?
- How many rooms will you have to see patients?
- Will you be in the main clinic space near other doctors or somewhere off site? Will other internal medicine doctors be available for curbside consults or are you on your own?
- Is there an urgent care on site or nearby?
- What do you do with sick patients? Is there a code team for the clinic? How far away is the hospital? How responsive is EMS?
- Do you have your own MA or nurse or do you share? Do you get to choose your own MA?
- Do the MA's work hard? Who is in charge of them? What do you do if it is not working out with your MA?
- Do the nurses or MAs leave at 5 p.m. and you get to close down the office?
- How quickly can you get stat labs and X-rays? Is there a radiologist available to read films? Can you get CT scans during the day?
- Are you scheduled at 15 minutes or 20 minutes per patient? Huge quality-of-life issue for new docs.
- Are your patients scheduled such that you get breaks in your schedule to catch up, time to eat lunch, etc.?
- If in a joint practice, how is scheduling arranged for the last patient of the day?
- Do you dictate or type into EMR? Are templates available to make it more efficient?
- Is lab available on premises?
- Are the exam rooms nice and fully stocked? Who makes sure they are kept clean and fully stocked? Hopefully, not you!
- Are the receptionists nice and professional? How long do patients usually wait? Is there a mechanism if they are waiting too long?
- Is the office management good? Does the staff have a good relationship with management? What is the usual turnover? (Should be less than 20%).
- How are medication refill requests handled?

Questions you will be asked include

- What made you choose internal medicine?
- How did you hear about this practice?
- What made you decide to choose an office-based practice versus a hospital-based one?

How do you think your residency prepared you for this type of practice?

- Why do you think this practice will suit you?
- Are you familiar with the patient population?
- Do you have a particular interest or niche in internal medicine? Often, group practices have established different physicians as the “go to” person for particular conditions, for example, geriatric medicine, orthopedics, allergy, etc.
- For CME workshops, which internal medicine topics would interest you the most?

4.2.4 Surgery

(See Internal Medicine section for questions on office-based practices.)

Questions to ask include the following:

- How is OR time allocated?
- Will I be given block time?
- When would block time be allocated (i.e., would it be allocated prior to full partnership)?
- Where are the operating room facilities?
- Are they hospital based? Is there a surgery center?
- Are the OR’s office based?
- How will surgical cases be distributed to surgeons in the group?
- Will it be on a “next available surgeon” basis?
- Is there a system of distributing cases based on seniority?

Questions you will be asked include the following:

- Comfort level in performing specific types of cases.
- Long-term goals for practice, for example, specific niche.

4.3 After the Interview

After any interview, while the information is fresh in your mind, jot down any impressions, facts uncovered, additional questions, etc. Depending on the number of interviews that you will be going on and the range of people you will be meeting, detailed notes can be invaluable for sorting through all the information in the comfort of your own home. It is always a good idea to jot down personal information about the people you meet (e.g., Dr. Smith’s daughter enjoys ballet). Referring back to this during subsequent conversations, adds a nice personal touch; this calculated “schmoosing” needs to be balanced with genuine sincerity.

After returning home from an interview, take a few minutes to write a personal note (by hand, not by computer or email) to the person or people who interviewed you, thanking him or her for their time and for the information about their practice you gained from the interview. If you came away with an interest to learn more, and continue as a candidate, say so. If you have no interest in continuing your discussions with the practice, say so, but in a nice way. You are interviewing the group as well as the group interviewing you. Most medical communities are relatively small; think 6 degrees of separation may actually be more like 2 or 3. You don't want to make any enemies at this point in your career.

Chapter 5
Evaluating the Offer

William W. Feaster

To properly evaluate an employment offer, you need to investigate several issues about the group you are joining; know what's included in the offer and what's not; understand compensation systems and employment benefits, especially what you can expect to negotiate and what you probably can't; learn how to evaluate the contract and other documents you are being asked to sign. To make it even more difficult to discuss here, every specialty is different and the laws governing practice and contracts vary by state. The smaller the group, the more important all these issues become. The larger the group, like a Kaiser Permanente, or especially the government, the less relevant many of these issues become.

5.1 Evaluating the Group

There are a few general considerations about a group you need to investigate before joining it. Perhaps the most important one is the group's reputation in the medical community and the reputations of its members. Does the group have a service orientation? Do people like to refer them patients? Do they make themselves available to these referrals or consults? Is anyone in the group considered a marginal practitioner that you would have to "cover" for, or apologize for, if you joined them? Does anyone in the group have personality issues? Some of this is certainly specialty related. The chances of being saddled with a group member with an explosive or difficult personality are much less in a group of pediatricians than they would be in a surgical practice.

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© Springer Nature Switzerland AG 2022

M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_5

What hospital or hospitals does the group routinely use for practice? What are the reputations of these hospitals? Are all the support services required for your practice available at these hospitals or elsewhere in the community? How do the Joint Commission (www.jointcommision.org), Health Grades (www.HealthGrades.com), the Leapfrog Group (www.leapfroggroup.org), and other external agencies rate these hospitals? Is the hospital recognized for nursing excellence or has it achieved the prestigious "Magnet" status from the American Nurses Credentialing Center (www.nursecredentialing.org/magnet)? Another key question is whether the hospital has participated in the various patient safety initiatives sponsored by the Institute for Healthcare Improvement (www.ihi.org).

Some specialties have contracts with these hospitals – often exclusive ones for the hospital-based specialties of anesthesia, emergency medicine, pathology, and radiology. What is the group's relationship with the hospital like? How long-standing is the contract? Are there outstanding issues that are creating a contentious relationship with the hospital? If this hospital contract is terminated, what would happen to the group? The best place to look for answers to these questions is from group leaders or group members during your interviews. If you are concerned about whether or not they are forthcoming with their answers, seek out someone from another specialty for confirming information. The ultimate source for this information is the Hospital's lead administrative physician (Vice President of Medical Affairs or Chief Medical Officer are a couple of commonly used titles for this position). This individual is often responsible for negotiating and renewing these types of contracts.

You will also need to understand the group's structure. A corporation will usually have a well-defined leadership and mechanism of group ownership (shares). A partnership may have a less formal structure, often with a managing partner running the business affairs of the group. Buy-in may be a bit more complicated to define as well.

How efficiently the business of the group is managed is a very important topic of your research. The first question to ask is whether they bill themselves or contract this out. If they bill themselves, how good a job do they do? You can determine this by various billing metrics like how many days, on average, a bill remains uncollected in "Accounts Receivable" (AR). For example, if a group's average days in AR are 45, then that means that on average, a patient bill is collected 45 days after the service is performed. That would indicate good performance of the billing function in the practice. The longer the period before a bill is paid, the less likely it is to be collected. If the group has an average days in AR of 90, not only does that negatively impact cash flow, that also means that many bills are probably older than 120 days after service or more, and less likely to be collected. An outside billing service would require the same scrutiny.

In addition to billing, the higher the group overhead, the less money is available to the providers for take-home salaries. Overhead norms vary by specialty, and you'll have to do some asking around to determine the number for your own specialty. For example, the overhead expense for anesthesia billing is commonly between 6% and 8% since anesthesia has fewer bills of larger amounts. Additional

practice overhead varies from 5 to 15%, for a total practice overhead usually less than 20%. A practice with an office, clinical and business office employees, medical equipment, more bills of smaller amounts, more insurance authorization issues, such as those regarding the "gatekeeper" function of primary care, etc., can expect to pay a much higher overhead. A primary care practice may have an overhead of 50% or more of collections. Billing overhead may be 15% or more by itself. Again, try to find out what reasonable specialty-specific metrics would be for your type of practice.

5.2 Buy-In

Another major issue affecting your future in a group is whether you will be offered ownership in the group. It is usual for individuals to be hired by a group as an employee without any ownership or governance rights in the group. Prior to buy-in, there is usually a waiting period of 1–2 years during which existing group members determine your fit with the group – the quality of your work, your dedication to the group and your (its) patients, how hard you work, how you get along with other members and staff, etc. If your salary is significantly discounted over other group members for that 1–2-year waiting period, that may itself count as your financial "buy-in." If you are paid an amount roughly equal to other partners or owners of the group, then to become an owner in the group, you will be asked to pay for a proportionate share of the group's assets. In a corporation, you will be buying a share or numbers of shares of stock. In a partnership, you will be buying a portion of the partnership's assets, presumably an equal portion based on the total numbers of partners in the group. Where this becomes important is at the end of a fiscal year, when there are additional monies left over after all salaries are paid out, any extra income is paid out to the partners in an amount equal to the portion of the partnership that they own. Corporations will have other formulas for paying bonuses or dividends at the end of the year to their shareholders.

Other advantages of group ownership may be more subjective. It will give you a right to participate in group governance and give you a say in how the group is run, even run it yourself if selected for this task. You may take less call as an owner. You may have priority over the schedule, or patient referrals to the group. You may get the opportunity to own your own accounts receivable, which would be paid out to you if you left the group. It may be harder for group members to terminate you if you're a shareholder or partner. At a minimum, they would need to buy you out.

There may be disadvantages of ownership as well. Before you join, or especially before you buy into a group (especially a partnership), make sure there are no outstanding liabilities or pending lawsuits that would substantially diminish the group's assets. The reason that I mentioned "especially a partnership" is that a partner in a group structured as a "partnership" instead of a corporation (or limited liability company) is fully exposed to both the profits and the liabilities of the partnership. A large judgment against the practice or large business loss may impact your personal

wealth, including things like IRA retirement savings accounts. If you were still only an employee, you would not be liable for this. If you were a shareholder of a corporation, your personal assets would also likely be protected.If you are offered a buy-in by the practice, how can you be sure that the amount you are expected to pay, or future salary you are expected to forgo is reasonable? How do you do a practice valuation? The major components of practice valuation are as follows:

- Assets – These will vary by the type of practice. An anesthesia practice has very little actual assets with the exception of the practice's accounts receivable. These also will have little value if individuals have actual ownership rights over their own accounts receivable. A cardiology practice, on the other hand, may have many assets, an office with many leasehold improvements, major equipment such as echo machines and nuclear medicine cameras, minor equipment varying from computers to EKG machines to furniture, etc. Practices will consider their charts an asset since they are physical items that tie patients to the practice. Portable electronic patient records will eliminate the value of actual charts in the future.
- Cash flow from other business activities or excess practice income – If a practice has other businesses or investments that generate cash flow or an annual excess of revenue over expenses that is distributed to owners, a value can be placed on that cash flow. An example of this would be a large anesthesia practice that did its own billing, but also billed for other anesthesia practices in the region from which it makes a profit.
- A hospital contract – Here, things get dicey. Usually, hospital contracts have a value to the practice in that they guarantee access to business within the hospital and often pay stipends for service. The cash flows from such a contract into the business could be valued, just as the above other business activities. The caution here is that most contracts have early termination clauses, and can be terminated early by either party, without cause, in a relatively short period of time. This reduces their potential value to the practice. Loss of such a contract may even cause the dissolution of a practice.
- Goodwill – Basically, you are buying part of the group member's reputation and referrals. More often than not, this means buying the privilege of working with the group.

To determine the actual buy-in value of the practice, you take all of the objective values listed above, especially actual values such as accounts receivable and physical assets of the practice, and add this to the present value of cash flows from other business sources and excess practice income. You then divide this by the number of owners and get a number for the value per share of ownership. Then compare this to what you are being offered as a buy-in amount. If it's less than your calculation, then you're getting a good deal from a financial perspective. If it's more, you're buying the privilege of working with the group; it's goodwill, the tenuous value of any contracts and any other benefits ownership affords you.

5.3 Compensation Systems

The amount of your starting salary is one of the issues of your new employment most likely to be negotiated. The system under which it is paid is less likely to be open to negotiation. To understand what an offered salary really means, you need to understand basic compensation systems and the benefits included in that salary. We will cover some basic compensation systems common to a medical practice, followed by a discussion of benefits.

Straight salary is a common compensation approach in your first year or two of practice and with large employers like the government or medical groups, part of prepaid health plans. It's how you were paid in your residency and most other jobs you've held prior to medical school. With straight salary, you receive "X" dollars per year, paid in equal installments every two weeks (biweekly), twice a month (semi-monthly), or monthly, usually in arrears (you get your check within 7 working days after the end of a pay period, not in advance). In most cases, you won't be paid "overtime" if you work more than the expected work hours. Physicians are usually considered "exempt" employees, meaning you are exempt from overtime and not paid by the hour. Some large employers, however, provide you with the equivalent amount of time off for the hours you've worked beyond your employment commitment. They may also pay you for the additional time you've worked in lieu of taking it as compensatory time.

Some employers will add a bonus to a straight salary at the end of the year, based on the group's profitability or, you or your specialty group achieving predetermined goals for productivity, quality, and other metrics. Employers like this type of compensation system as it provides an incentive for hard work, efficiency, customer satisfaction, etc. With a straight salary without bonus, you are paid the same amount no matter how good a job you do.

The compensation system that awards productivity above all else is one in which you are paid what you collect from patients, less practice overhead and billing expenses, or, based on units of service worked that are paid on an average corporate "unit value." Straight productivity systems are less common in the first year or two of practice, or in larger group practices, but are very common after you get an ownership interest in a group.

There are other models as well, such as combinations of the above. Some groups pay a straight salary from 7 am to 5 pm. Monday through Friday, and then pay extra for work outside of those hours. Other combinations likely exist. The one basic principle of compensation systems is that they reward and encourage certain types of behavior, for good or for bad. For example, a system utilizing straight salary doesn't reward or encourage high productivity or high-quality work. A straight productivity compensation system awards high volumes of work over quality or work benefiting the group as a whole. When you join a group or large employer, you won't likely be able to get them to provide you with a different compensation system than that they already have in place.

5.4 Benefits

There are basically two types of benefits. The first category (statutory) are those required by law to be provided to an employee. The others are more elective. See Table 5.1. Statutory benefits include payments into Social Security and Medicare (the employer's contribution), state disability insurance, unemployment insurance, and pregnancy (or family) leave. While an employer is "required" to provide these benefits, they may be subtracted from your total compensation, especially if you are an owner of the group and are paid with a compensation system based primarily on productivity. This is less of an issue with large employers such as universities or large groups.

Most employers provide additional, "elective" benefits, including some form of paid vacation, conference or sick leave; health, life, disability, and malpractice insurance (see Chapter 8); pension plan contributions, 401 K or 403B accounts (see Chapter 9); or very elective ones such as a leased car, home office, etc.

Vacation and sick leave can be combined into "personal time off" or PTO. Most employers grant a minimum of 2 weeks vacation, or 3 weeks if considered PTO. Many medical groups offer much more generous time off depending on the age or other life interests of the more senior partners.

Insurances provided through your employer are advantageous to you for several reasons. They are taken out of pretax dollars, and often are lower in cost than if privately negotiated (especially true of larger employers). Perhaps, even more important is coverage without proof of insurability. If you have a preexisting medical condition (juvenile onset diabetes, prior renal transplant, hepatitis, etc.) that would otherwise make obtaining health, life, or disability insurance impossible, this is a HUGE benefit to you.

Table 5.1 Types of benefits

Statutory "benefits":
Social security (employer contribution) and Medicare
State disability insurance
Unemployment insurance
Pregnancy leave
Elective benefits:
Vacation, sick leave or PTO
Health insurance (coverage for preexisting conditions?)
Group life insurance (pre-tax and post-tax)
Group disability insurance
Education
Conferences
Car, home office, etc. (usually taken out of salary)

These last few benefits may be more of a convenience for you and if you elect them, and are taken out of your salary for tax purposes. The advantage of many of these benefits, even if taken from your salary, is that they are taken out of pre-tax dollars before deductions are calculated. They don't show up on your income tax forms as deductions and are therefore less subject to audit. Universities are more likely to offer unique benefits like tuition assistance, for both you and your children, and educational funds out of which you can attend conferences, buy computers, books, etc.

Prior to signing an employment agreement, or selecting a job, it's important that you fully understand what elective benefits your employer will provide you and how these benefits will be paid, whether by the employer or out of your salary. Not only will this expose what would become unpleasant surprises, it gives you the opportunity to compare the total compensation packages more accurately between different employers.

5.5 Comparing Compensation Offers

Let's say you have two offers with different stated salaries. One is with a small single-specialty medical group (Group A) and the other is with a large prepaid health plan with a multispecialty medical group (Group B). Group A offers you a starting salary of $250,000 a year. Group B offers you $180,000 a year. There are many issues that you should consider in choosing between the two offers, but let us look at total compensation.

Both groups provide insurances, but Group A deducts it from your salary, and Group B pays for it. Group A has a pension plan and allows you to contribute $30,000 a year into it. Group B covers all its professional employees with a defined benefit plan of equivalent value. Group A deducts any other professional expenses from your pre-tax salary, such as conference expenses, and Group B provides an annual stipend for conferences. Both groups allow you 3 weeks a year vacation. Group A expects you to work 50 hours a week and doesn't pay you if you work more hours. Group B either gives you compensatory time or pays you for those additional hours worked through additional salary.

Table 5.2 illustrates a theoretical comparison of the total compensation offered by these two groups.

The take-home message here is that one salary is not directly comparable to another without taking into account the benefits offered by each employer and who pays for those benefits. Ultimately, there are a lot of other reasons for choosing Group A over Group B, or vice versa. We didn't cover longer-term issues like pay and other additional befits after becoming a shareholder or partner in the group. But, in this analysis, salary shouldn't be the primary reason for choosing one over another group, because after deductions, your take home pay from both Group A and Group B will be equivalent.

Table 5.2 Comparison of total compensation

Benefit	Group A	Group B
Salary	$250,000	$180,000
Health insurance	($8000)	0
Disability insurance	($2000)	0
Malpractice insurance	($10,000)	0
Pension contribution	($30,000)	0
Conferences and Ed leave	0	$2000
Compensation net benefits	$200,000	$182,000
Paid extra work	0	$20,000
Total compensation	$200,000	$202,000

Note: Negative numbers are in parentheses

5.6 What Else Can You Expect to Negotiate?

The smaller the group you join, the less likely or able that group will be to pay for additional expensive benefits. But there are a lot of other issues you can negotiate that won't cost the group a lot of money. Some larger groups may be willing to pay for moving expenses and temporary housing support during your relocation. Certainly, Group B above has the capacity to do this, as do other large multispecialty groups, universities, and government employers. A general rule of thumb here is that if you don't ask, you probably won't be offered this benefit.

Work hours, full- vs. part time, may be negotiable. What puts you at a disadvantage here is that part-time employment generally pays proportionately less than full time. You may also have to take a full share of call for part-time pay. Negotiating "special deals" for less call may also be difficult. Physicians in groups don't like to grant special deals. They want to hire people who will make their life easier by taking a full load of work and call. You may want to work additional shifts beyond your practice responsibilities, as a hospitalist, providing call coverage for other groups, EDs, etc. If so, it is important that you negotiate away any restrictions in your employment agreement limiting your ability to do this type of work. Restrictions over outside work are most common in university practices or with other large employers.

An important issue in smaller groups that may be negotiable is whether or not you own your accounts receivable after leaving the group. This is unlikely if you are coming into a group at a full salary from day one. The group will need to utilize your collections after you leave to make up for paying you in advance when you arrive. If, on the other hand, you start at a very low or no salary until your collections begin, then you should make sure that you own your own accounts when you leave. In this case, the group didn't go out of its way to front you the money, or perhaps fronted you a loan on your collections that you will have to pay off. This will usually be defined for the entire group, so special deals may be difficult. It is also more likely that you will be able to own your own AR after you buy in to the group, rather than as an introductory employee.

One final and, potentially, negotiable point is who pays your malpractice tail insurance coverage when you leave the group. We will cover types of malpractice insurance and what a "tail" is in Chapter 8, but for the sake of the discussion here, a tail can cost three times your annual malpractice premium and covers you for any future claims from your practice with this group. This is less of an issue if you move to another, similar group where you must maintain malpractice insurance. You won't need to buy a "tail." If, however, you decide to go back into an academic practice, join the military or get another job with the government, join a large pre-paid health plan practice, or cease to practice medicine altogether, you or your new employer will have to pay for this tail coverage.

If you decide to make this change, it is hard to expect that an employer in your existing group would pick up the bill. You would have to make a deal with a new employer for this.

On the other hand, if your existing employer terminated you without cause (a contract clause in most agreements), you may want to try to negotiate the "poison pill" to this provision of mandating that they pay for your malpractice tail with such a termination. They may not agree to it, but like moving expenses, you probably won't get this potential benefit if you don't ask.

In general, negotiations always work more to your advantage if you're in a position of strength. The best strength comes from your new employer badly wanting you to join their group. If your job is in an underserved area and you are trained in a specialty where there is a large shortage, you can get a lot of additional considerations in both salaries and benefits that you won't likely get if you are one of several people applying for one job in a large metropolitan area. You may also be able to leverage a third party, like a hospital, in negotiating additional salary or benefits. Hospitals can legally pay medical directorships, moving expenses, provide forgivable loans and other benefits if they can document that you are moving in from outside the area and there is a shortage of your specialty in the area you're moving to. Try to take advantage of all this if you are eligible.

5.7 Employment Contracts and Other Documents

Let's move on to the employment contract and other employment documents. The larger the employer, it is less likely you will have a formal employment contract to review. For example, in a university setting, you will likely have some sort of an offer letter outlining the basic agreement with your department chairman. Most of the details of your employment are well described elsewhere in human resources documents or department policy manuals. The government or a very large group practice will be similar with the military having its own unique set of contract terms.

If your practice does offer you an employment contract, chances are that it is a standard document offered to all professional employees of the group. It has been developed over many years and has already been reviewed by many attorneys. Because of that, it may be hard to change, unless you change some condition in the

contract for all of the other professional employees in the group. Some things can't be changed at all, such as provisions for retirement contributions into a pension plan. That is completely defined by the legal documents forming the plan.

For Further Review

When evaluating an employment contract, some of the items that require a close review or complete understanding are:

Employment duties: This will usually specify that you will devote your entire professional time to the performance of your duties for the organization. This may become an issue if you want to work part-time for another employer.

Term of the agreement: The contract will likely specify a term and termination date. There often is additional language stating the contract will automatically renew annually if not terminated by one of the parties. This is sometimes referred to as an "evergreen clause."

Salary: An employment agreement usually specifies an amount of compensation if that compensation is guaranteed. If there isn't a "guarantee," and your income is based on the patient care services you provide, then some methodology for passing along payments for your patient care should be specified.

Ownership of accounts receivable: If you leave the practice, does the practice continue to collect on the bills submitted for your services, or do you collect them? Any outstanding, unpaid bills are referred to as accounts receivable. If you don't own them, then you leave the practice with no continuing income unless you already have another job lined up which has a guaranteed salary.

Benefits: Often, benefit details are in some other document such as an addendum to the agreement, or in a document that also applies to the other members of the group. Make sure you get a copy of this document or these documents and carefully review them.

Do-not-compete clause: If you leave the practice, the contract may specify certain penalties if you go into practice in direct competition with the group you are leaving. This may or may not be enforceable in all states.

Termination with or without cause: Termination with cause is usually immediate and is associated with events like getting kicked off the medical staff, your medical license to practice being restricted, dropping malpractice insurance, drug abuse

affecting practice, illegal activities, etc.

Termination without cause should allow either party to terminate the contract with some reasonable notice like 90 days. Make sure you can get out early if this practice doesn't work out.

Arbitration: If a claim or controversy arises out of this agreement, then organizations usually request that it be arbitrated in accordance with the

Commercial Arbitration Rules of the American Arbitration Association. The location of this arbitration or any subsequent litigation is usually specified, as well as the responsibility for any expenses arising from this arbitration or litigation.

Medical Malpractice: Most contracts require that the physician obtain malpractice insurance with certain minimum limits. It will specify who pays for this coverage. It may also specify who is responsible for paying for a so-called "tail" if coverage is terminated. See Chapter 8 for more details. It is very important that all the key issues related to malpractice insurance are written clearly in the agreement and understood by all parties.

At a minimum, you should have someone read the contract who is familiar with employment contracts in general, the terms you can expect, and the basic legal issues, and who can explain the details of the contract to you in terms you can understand. Often, there is someone on the faculty of your residency program who can assist you with this task. If you don't have anyone to do this, you may need an attorney to review it, though this may get fairly expensive if the attorney gets carried away with concerns over issues that aren't likely to be negotiable. Where an attorney may be particularly helpful is with contracts with newly formed groups, those with atypical business dealing, those with a seemingly large buy-in, or those with a do-not-compete clause that would significantly restrict your ability to practice in an area you chose to live long term for family or other reasons. If you do get an attorney, it is very important to get someone familiar with the laws of the state in which you are intending to practice. For example, whether or not a do-not-compete clause is enforceable in California may be completely different from the enforceability of a clause with the same language in Nevada.

Other important issues may not be listed in an employment contract. These are things such as call frequency, time off, case assignments, behavioral standards, benefits, etc. These are often written down in other types of documents such as policies and procedures. These policies and procedures usually apply to the entire group and should be made available for your review. As a general principle, if it isn't written down, it doesn't exist. You have to get everything important to you specified somewhere in writing, either in a policy, a procedure, a contract, a letter, or even an email.

Part II
Setting Up Shop for the First Time

Chapter 6
Medical Staff Credentialing and Privileges

William W. Feaster

It takes longer than you think!

Before you can start to practice with your new employer, you need to apply to the Medical Staff of the hospital(s), ambulatory surgery center(s), etc., in which you'll be working, and request privileges to practice in these organizations. In addition, in order to bill and collect from the various types of insurances, including governmental payers, you will also need to either be credentialed by each insurer, an IPA (Independent Practice Organization) if the insurers delegate credentialing to the IPA, and get the appropriate provider numbers for your new state's Medicaid program (every state is different) and Medicare. This latter form of credentialing is usually done by your practice or billing agency, but you must provide them with the appropriate information. We will focus on Medical Staff credentialing and privileges here since many of the same principles apply to both types. A suggested timeline for how best to plan your credentialing and obtain privileges can be found in the Appendix.

6.1 Credentialing

Credentialing and obtaining privileges are two quite different topics. Credentialing is the verification process that assures the organization that you are who you say you are, that you've completed the education you said you completed, and that you have completed (or are currently in good standing in) the residency training you plan to complete prior to joining their Medical Staff. In addition, they verify any board certifications, that you have a license to practice in their state (and any prior or current state licenses) and any prior Medical Staff memberships. In their application,

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© Springer Nature Switzerland AG 2022

M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_6

they will ask you a variety of other questions such as those covering prior arrests and convictions, malpractice suits, illegal drug use, and the like. Refer to the next chapter for a harrowing story about something as silly as a DUI! All these answers need to be verified as well.

The standard that all Medical Staffs are required follow is to use “primary source verification” whenever possible. That means they can’t rely on the fact that another hospital has verified something like your college education and degree. They must do this again from “scratch” by directly contacting your college or university. The only exception to this is if several organizations have delegated credentialing to a central office (as in a health system) or IPA for insurances, then only the delegated source needs to complete the primary source verification.

There are a couple of sources for verification that exist on the national level, although these are technically secondary sources of verification. The first is the National Practitioner Data Bank (NPDB) sponsored by the federal government. This data bank was established to prevent incompetent practitioners from moving from state to state without disclosure of prior medical malpractice payments or adverse actions taken against them by licensing boards or Medical Staffs. To assure confidentiality, the NPDB is only accessible to entities that meet certain eligibility requirements (e.g., Medical Staff credentialing offices and State licensing boards) and is not generally accessible to the public. To keep the NPDB useful, there is a mandatory reporting requirement for State licensing boards, professional societies, and Medical Staffs to report any adverse actions against physicians, dentists, and other practitioners. Any entity that makes a medical malpractice payment for the benefit of a physician, dentist, or other practitioner must report certain payment information to the NPDB. A companion federal data bank is the Healthcare Integrity and Protection Data Bank (HIPDB). The HIPDB was created out of Health Insurance Portability and Accountability Act (HIPAA) legislation. It is a repository for fraud and abuse in healthcare insurance and healthcare delivery. Together, these two data banks are a valuable source of information that Medical Staffs utilize to verify statements made on Medical Staff applications. For more information on these data banks, visit www.npdb.hrsa.gov.

As you might imagine, all of this verification takes time. Plan on a minimum of 2 months, but 3–4 is more likely. Don’t assume you will just be granted temporary privileges to practice in a hospital. The Joint Commission has restricted this practice to very specific circumstances, none of which you will likely fit. The verification of credentials cannot be hurried. The application, once complete, can be rushed through Medical Staff and Board channels, but this isn’t a good way to start out your relationship with your new hospital.

The first rule governing a successful Medical Staff application is to be complete. Answer all the questions, include all the requested documents, and sign everywhere they ask you to sign. And don’t forget to send the check for the processing fee. You must pay them to do all this work! The second rule is to be truthful. They search a variety of sources to verify your answers to questions. If you lie, chances are they will find out. Just about everything about you is somewhere on the Internet and they

know how to find it! The third rule is to send in your completed application 6 months before you want to start working, or within a week of receiving the application after you accept your new job.

On your application, you will be asked to provide references. All these references will be contacted and will be sent some type of form to return to the Medical Staff credentialing office to which you are applying. Many of the people you list as references will have large stacks of papers on their desks, and this piece of paper will likely migrate toward the bottom of one of these stacks (or into a circular file). It's a good practice to call the Medical Staff credentialing office about 3 weeks into the process and ask them about the status of your application, whether they have received everything they need and whether your references have been received. Assuring that your references are complete is as much your responsibility as the credentialing office.

6.2 Obtaining Privileges to Practice

Once your credentials file has been fully verified, a few more steps remain. Credentialing is different from granting privileges to practice. Both are ultimately necessary to complete the process. A fully credentialed physician can join the Medical Staff, but they can't actually practice until they have been granted the privilege to do so. In your Medical Staff application, you were asked to fill out a request for privileges in your specialty. If you are just completing your training, your training program will attest to your ability and competency to perform a given set of privileges. The department head of the Medical Staff must "sign off" on these privileges.

The completed application, all the verifications and recommendations, and the request for privileges are sent to the organization's credentials committee for review. This group will review all of the documents and determine if there are any issues that need to be more fully explored. For example, one of your references may indicate that you have a difficult time getting along with subordinates, they may ask for additional references or even request a personal interview prior to passing your application along to the Board of Directors for final approval.

After you successfully complete this process, and are accepted into the Medical Staff, you will receive a confirming letter from either the chair of the credentials committee, your department chief, or the president of the Medical Staff. If you didn't already pay Medical Staff dues with your application, you will be asked to pay them. You will receive a copy of the privileges you were granted and be notified whether any you requested were denied. One or more members of the Medical Staff will be assigned as your "proctor" for these privileges. All privileges, when first granted, are only interim until you demonstrate your proficiency as judged by a member of the Medical Staff with similar privileges. It is your responsibility to contact your proctor when you are initially caring for patients at the facility. The number and types of procedures that require proctoring will be listed in your letter.

As a general rule, Medical Staff applications are eventually approved, and privileges are granted commensurate to a new applicant's training and experience. But there are some exceptions to this general rule. Some departments are "closed" due to an exclusive contract between a group and the hospital. The departments that often have these exclusive arrangements are the hospital-based departments of Radiology, Anesthesia, Pathology, and Emergency Medicine. If you attempt to join a Medical Staff and gain privileges in one of these hospitals or other facilities and is not joining the exclusively contracted group, your application will not be accepted. There are other times when privileges you are qualified for may be denied. For example, department chief "A" is one of only a couple of physicians on the Medical Staff of a hospital who performs a very lucrative procedure. You apply for privileges in that hospital for that same procedure and A denies your application, stating that you have insufficient experience in doing this procedure. In this case, your privileges were denied based on economic, not medical reasons. Remember, the practice of medicine is a business, and some put business ahead of medical ethics.

It is unlikely that you'll be a victim of such an event, but if you are, you'll usually have recourse within the Medical Staff bylaws themselves. These bylaws will often outline an appeal process through which adverse decisions such as the denial of privileges can be adjudicated. In our example above, it's likely that A's denial of your privileges was a breach of contract (the contract being the Medical Staff or hospital bylaws), violated due process, had antitrust implications, and might even violate federal antidiscrimination laws. Any one of these arguments, if successful, would be enough to overturn A's decision.

Another issue is confidentiality. Your Medical Staff application is confidential and information in it cannot be disclosed outside of formal Medical Staff committee deliberations. One might imagine that department chief "A" isn't beyond leaking some sort of information that may be intended to discredit his competition if this was allowed. You can ask to view any information you provided in your application, but even you cannot view any of the references, verification work, or Medical Staff committee deliberations on your application.

Throughout this process, especially if you're out of town, it is best to rely on the administrative staff of your new practice to make sure that your application is proceeding through Medical Staff channels and will be completed by the time you show up to work, and that you are going to be properly credentialed with third-party payers by the time bills must be submitted for your services. They know the local personnel and have likely worked with them many times to process new recruits. We intentionally made this process seem very complicated because it is! Respect it as there is nothing worse than showing up at your new job unable to work and draw a salary.

Chapter 7
Obtaining and Maintaining Your Medical License

James C. McAvoy and John G. Brock-Utne

The Medical Board of each state in the union is mandated to make sure that the physicians and surgeons that practice in its state are properly licensed. This is done to protect the consumer from doctors that do not have the proper requirements to be licensed. Some states are more stringent as to what is required than others. California, for example, is one of the most stringent. In the 2003–2004 fiscal year, almost 5000 applications were reviewed by the Medical Board of California, which only granted 4000 licenses. Also, be aware that the Medical Boards do not tend to pay their staff that well; so, sometimes the service or the perceived service you get is not like that of a Four Seasons hotel!

There are three things to remember when dealing with the Medical Board: never lose your cool, always be polite, and make copies of all application materials and correspondence. Use Federal Express, DHL, UPS, Post office, etc., and get a receipt that you have sent it and preferably with a note back from the Board that they received it. After all, it will not help you if the Board misplaces your materials. It is the belief of my residents that when the Board has to sign for receipt of a parcel, then they take it much more seriously [JGBU]. Actually, going to the Board and handing in your paperwork personally is the best of all as it may work wonders for you. Added to that is that you may get to meet someone and then you should hopefully get their name and number. Just to let you know, in California, the Medical Board states the staff is unable to verify receipt of documents when they are not hand-delivered.

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© Springer Nature Switzerland AG 2022

M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_7

7.1 Obtaining Your Medical License

You will find that the Medical Boards take their job very seriously and do a comprehensive review of the application, including a full background check. Hence, it does take time to be licensed. In California, it is recommended that an applicant starts the process 6–9 months before he or she needs the license. The average wait time in the United States is 7 months. As a past residency director [JGBU], I heard many unfortunately frustrating stories from residents when they attempted to get licensed. The recommendation is that if you want to work in a state where you have no license, you must start early in your final academic year of training. If you do not start early, you may find that when you want to start work, the hospital is still waiting for the paperwork to grant you privileges. Sometimes your job will necessitate that you work in different hospitals, which is especially true of private practice employment. Working in more than one hospital is more common than you might think. A previous resident in our department went to Texas and could not start work for the private firm before all 10 hospitals that the firm covered had given her privileges. She could not work for 4 months. You have been warned!

The requirements, application forms, and instructions can be downloaded from the Board's website. Many boards now require Live Scan fingerprints. If you live in a state that requires this, then you must complete the electronic Live Scan fingerprint process. Alternatively, if you live outside the state you are applying to, you may choose this option if you visit the state or send them hard copy fingerprint card. Remember that most Medical Boards do not have Live Scan fingerprint connectivity to any other state. Do also remember that it is your responsibility to ensure that the person rolling your finger print submits TWO digital prints, one for the Department of Justice and one for the Federal Bureau of Investigations (FBI).

7.2 Maintaining Your Medical License (Recertification)

The license to practice must, in most states, be renewed every 2 years. As you might imagine, it is illegal to practice medicine with an expired license. There is no grace period; if a license has not been renewed within 30 days following the expiration date, the Board will notify the physician by certified mail. The renewal of an expired license is retroactive to the expiration date. There is usually, in that case, a fine to be paid. If you have not paid your license for 5 years, the license is automatically cancelled. This means that should you want to work in this state again, you will have to apply for a new license and meet the current licensure requirements. The current license requirements may bear little resemblance to the ones when you originally applied for that license.

You must meet the CME requirements and make sure you have copies of the meeting, etc., that you have attended. From time to time, physicians get audited. The

organizers of the CME program must provide documentation that you have attended, the name of the course, dates of attendance, and duration. There should also be information as to CME hours credited to you by attending this course. Do not send CME documentation with your renewal.

7.3 Continuing Medical Education Information

- American Medical Association
- http://www.ama-assn.org/ama/pub/category/2797.html
- Stanford University School of Medicine
- http://med.stanford.edu/cme/
- University of California, San Francisco School of Medicine
- http://www.cme.ucsf.edu
- Harvard Medical School
- http://cme.med.harvard.edu
- Columbia University College of Physicians and Surgeons
- http://www.cumc.columbia.edu/dept/cme/
- UC Davis Health System
- http://www.ucdmc.ucdavis.edu/cme/
- Mount Sinai School of Medicine
- http://www.mountsinai.org/Education/School%20of%20Medicine/Continuing%20Medical%20Education/
- Keck School of Medicine of USC
- http://www.usc.edu/schools/medicine/education/continuing_education/index.html
- Northwestern University, Feinberg School of Medicine
- http://www.cme.northwestern.edu/

It is only necessary to sign the self-certification statement on the renewal application form and return it with the renewal payment. Be aware that each state has different CME credit requirements for maintaining your medical license.

If you feel that you cannot afford the cost or the time to take a CME course away from your home, you should find out if your hospital has lunch meetings. These are often approved for Category 1 credit and offered to all physicians. If you have problems finding a Category 1 course in your area, you should contact the Board for assistance and suggestions.

If you are audited and cannot show proof attendance at CME programs, most Boards will allow you to renew the license one time following the audit to permit you to make up any deficient CME hours. However, they may, in addition, charge you with an “unprofessional conduct” ruling for misrepresentation of compliance with the CME requirements. Should you do this a second time, then the Board may not renew the license until all the required hours have been accepted by the Board. Until you complete what is required, you cannot work during that time.

7.4 Specialty Certification

The ultimate goal of residency and fellowship training is to become board certified in your specialty; indeed, a board certification requirement within a particular time period after hire (e.g., 3 years) can be written into employment contracts. While the specifics are determined by your field, in general board certification requires successful completion of a training program, followed by written cognitive assessments, oral assessments of judgment and application of knowledge, and/or practical assessments in objective structured clinical examinations (OSCE), often being completed shortly after training is completed. The road to board certification is an expensive one, often totaling several thousands of dollars in registration fees and travel; budgeting for these costly exams is important to ease stress when transitioning into practice.

Once a physician successfully becomes board certified, that certification requires maintenance through lifelong learning and periodic renewal, usually every 10 years. While the subject of maintenance of certification is a contentious one, as you may have guessed, this process also costs a substantial amount of time and money. But fear not! Data suggests that those who complete the requirements for maintenance of certification have a lower chance of adverse action from state Medical Boards. So not only is it in your patients' best interest to continue the arduous process of learning throughout your career, it is in yours, too.

(Sub)Specialty Certification Information
American Board of Medical Specialities
https://www.abms.org/

7.5 Drug and Alcohol Issues

Should you get a driving under the influence charge (DUI) in, for example, the state of California (the rules vary from state to state), this offense is reportable to the Board. Actually, in this state, all misdemeanors are now reportable and will show up if anyone searches the Board website. Indeed, the name and location of every physician facing disciplinary action is listed in the quarterly California Medical Board newsletter. If you are in the process of getting a license in California, having a DUI in the past may seriously delay procuring one. Again, that means that you cannot work as a physician in the interim. Furthermore, the Board may recommend that you go to a clinic like Betty Ford for a very expensive evaluation, even if treatment is not indicated. Even if you get a good report from the Betty Ford Clinic, the Board may insist on a probationary license with many requirements including that you enroll in a 5-year diversion program with random urine testing. This license does allow you to work but with requirements such as attending meetings, implementing worksite monitors, and administering random biological testing for substances. All these requirements will interfere with your ability to perform as a physician. You

may have to wait for up to a year before the Board will give a probationary license. Information from Medical Boards would indicate that, of the doctors that get a DUI, only 25% will manage to get their medical license in that state and continue in their specialty. Another 25% will get their license but change specialty, while 50% will leave medicine all together. Hence, to get any misdemeanor prior to getting a state license can be a real problem. Obviously, the best option is not to put oneself at risk for a misdemeanor. If it has already happened, however, then it is imperative to get involved in the medical system for early evaluation and possible treatment, if necessary. However, be prepared for Board-mandated treatment and monitoring regardless of what any professional evaluations recommend. The Medical Boards have a vested interest in protecting the public and are therefore very conservative in their standards and rulings.

If you have a medical license and you are now up for renewal, any misdemeanor, including a DUI, will be visible. Once again, it is imperative that you have obtained early diagnosis and treatment. Ideally, you will have self-referred to a state diversion program before you are up for renewal. In that case, the Board will look more favorably on your application to renew your license. They will most likely have very few questions to ask as long as you are a participant in good standing. The main benefit of this strategy is that you will maintain a full, unrestricted license, and your board action record will remain clean. If the board finds a criminal record and has to send you to evaluation and a diversion program is required, then you will be given a probationary license. However, be aware that the Board may revoke your license depending on the incident. Also, remember that this information will show up on the Board's website for patients as well as future employers to see.

More states are decriminalizing and legalizing the recreational and medicinal use of marijuana. A gray area remains as how these laws pertain to physicians. For example, the Medical Board of California does not have a formal position on the recreational use of cannabis products by physicians, only that a physician cannot be intoxicated and practice medicine. We recommend against physicians' use of marijuana. Any positive test could put a medical license at risk, given these assays are unable to differentiate between recent use versus current impairment from the substance.

Hence, it cannot be stressed strongly enough, you must at all times prevent putting yourself at risk for any criminal proceedings, no matter how minor, as the repercussions can have dire consequences for you, your family, and your practice. Being professional is imperative for a successful life as a physician (See Appendix D). As you can see the reference to D under point 1 makes no sense. It should be under point 2.

Chapter 8
Malpractice Insurance

William W. Feaster

8.1 Types of Malpractice Insurance

There are two basic types of malpractice insurance coverage – claims made and occurrence. Claims-made policies are the most common type encountered in private practice. Occurrence policies are more typical with very large employers like the government, universities, and prepaid health plan groups.

Occurrence coverage is the "ideal" type of malpractice insurance. Whenever a patient encounter occurs, your malpractice insurance in effect at that time covers you indefinitely if a claim is subsequently made for that care encounter. If you leave the practice, you don't have to worry about maintaining malpractice insurance coverage for any prior events. This is the type of malpractice insurance you probably have as a resident. If you go into practice and you are subsequently named in a lawsuit for an event that occurred while serving as a resident, you will be covered by your residency sponsor or employer, usually a university or hospital. Policy limits are usually higher since they are the limits of the hospital or university and cover more than just your individual liability. Occurrence coverage is initially more expensive than claims-made insurance and is more difficult to buy as an individual or small group. Premiums are front-loaded, without early practice discounts, but also, there is no tail coverage that we will describe later.

Coverage under "claims-made" policies is limited to malpractice claims filed while the policy is in force and premiums continue to be paid. Your current claims-made policy may not have been in force when the event precipitating the malpractice claim occurred, just when the claim is made. How far back this retroactive coverage applies is specified in the policy and determines the premiums being paid.

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M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_8

Claims-made policies are ideal for someone just entering practice. On your first day of work, your residency program covers any prior malpractice liability, and there is no chance a claim will be filed against you. After 1 year, you begin to have a retroactive malpractice risk and this risk is additive each additional year you practice, up to 4 or 5 years, when your risk plateaus and prior patient encounters exceed the statute of limitations for filing a claim (varies by state, but usually 2–5 years after an injury is discovered and sometimes longer for children). Because the risk is increasing, so are your premiums. Your first-year premium may be 20% of your mature premium, and it goes up proportionately each year until that fourth or fifth year of practice after residency, when it plateaus with your risk.

Mature premiums are specialty specific. Primary care specialties are the lowest, followed by those primary care providers who do minor surgeries. On the other end of the spectrum are high-risk specialties such as neurosurgery and obstetrics. Premiums between the two ends of this spectrum may vary tenfold! That's one reason why seeing a neurosurgeon costs a lot more than seeing a pediatrician. Anesthesia is unusual in that one would consider the type of procedural work done by an anesthesiologist would be high risk for malpractice claims. Fortunately, over the past three decades, there has been a strong push for patient safety in anesthesia and the adoption of new monitoring technology has dramatically decreased the risk of injury and subsequent claims.

8.2 Premiums Vary by State

Premiums also vary substantially by state. California has some of the lowest premiums in the country because of the enactment of the Medical Injury Compensation Reform Act (MICRA) of 1975. This California legislation limits awards due to noneconomic damages (e.g., "pain and suffering," often a large component of a malpractice claim settlement) to $250,000. This legislation has been used as a model by other states where excessive malpractice awards have driven physicians' premiums so high that physicians can no longer afford to practice there. More than half the States have now followed California's lead in enacting a similar form of medical liability reform. MICRA is subject to constant attack by personal injury attorneys as it also limits their income when a suit is successfully tried or settled.

A summary of MICRA along with some comparisons of malpractice premiums for various specialties in different states can be found at www.micra.org/about-micra/docs/micra_handbookpdf. The practice you are looking to join can give you the most accurate information about the premiums they pay for their specialty in their area.

8.3 Other Determinants of Malpractice Premiums

Just like with other types of insurance, malpractice insurance premiums are also determined by the amount of coverage purchased. A typical policy provides $1 million coverage for each occurrence and a $3 million in coverage cap each year if there are multiple occurrences. Lower policy limits exist but are inadvisable if you want to protect your personal assets. Higher policy limits are available, but many decide not to purchase them and thus encourage the patient to look to the doctor as the "deep pocket." Most malpractice claims name several physicians as well as a hospital where the event occurred. Most physicians prefer that the patient look to the hospital as the deep pocket.

Premiums are also based on the medical or surgical specialty for which insurance is being purchased. The lowest premiums are generally associated with "cognitive" or nonprocedural-based specialties. Examples of specialties with lower premiums are pediatrics and family practice (without surgical assist or surgical procedures). Anesthesia is an anomaly in that it has relatively low premiums yet is associated with many risky procedures. The specialty of anesthesia has done a remarkable job in reducing the incidence of complications and injury associated with anesthesia, and premium rates reflect these improvements.

Malpractice Insurance Resources

Here are a few resources on the web that may be helpful in your research on malpractice carriers:

1. The Doctors Company website is a good resource: https://thedoctors.com.
2. Specialty societies such as the American Academy of Pediatrics and the American Academy of Dermatology have published articles on this subject, but specialty society access may be required to view this information. The AAD website has several good links for exploring this subject in more depth.
3. For a listing of state insurance department websites, go to the National Association of Insurance Commissioners (NAIC) website: http://www.naic.org/state_web_map.htm

8.4 Other Malpractice Insurance Issues

Just as it is critical that you individually have coverage, it is essential that your group caries coverage as well. As a member of a group, you share liability with other group members, both because you may have also cared for the same patient, and because the group itself may be named in a lawsuit and you want to protect the group's assets (like your accounts receivable).

The other important issue we mentioned in an earlier chapter is the malpractice insurance tail coverage. Coverage under a claims-made policy ceases upon cancellation. If you wish to extend the "reporting period" in which a claim would be covered if filed, you have to purchase what is called a "tail." Tail coverage is quite expensive. It usually costs between two and three times the current annual premium.

If you leave one practice and join another, and continue to pay malpractice premiums, you won't need to buy this tail. You will need to ensure that prior acts are covered by this new policy. If you maintain the same level of premium, this can be arranged. If you stay with the same malpractice insurance carrier, this is easy to accomplish. If you switch carriers, make sure the proper retroactive coverage period is specified in the new policy.

While it is not on the top of your mind right now, when you retire, long-term policyholders usually don't have to pay a tail. Their carrier provides it at no cost. On the other hand, if your group changes carriers just before you retire, you may get stuck with a tail payment.

There are several other issues about malpractice insurance that may come up:

- Part-time employment can be covered with reduced premiums. If you work less than 20 hours per week, you probably will pay 50% of the full-time premium.
- Don't forget that if you do volunteer work in your unpaid hours, you will still need to obtain malpractice insurance for this extra work, paid or not. Hopefully, the clinic or agency you work for will cover you.
- Coverage for locum tenens work is usually provided by the group or the specific physician you are working for. Make sure you get this in writing, preferably from the insurance company providing the coverage.

8.5 How Do You Choose a Malpractice Insurance Carrier?

One final issue about malpractice insurance is the stability of the carrier itself. There are a few leading companies providing malpractice insurance. The largest is a physician-owned cooperative that operates in many states called the Doctors Company. As of this writing, the Doctors Company insures 80,000 physicians nationwide (www.thedoctors.com). The Doctors Company, however, may not be available in your new practice area. A quick search of Google yielded dozens of entries, some much smaller state-specific mutual companies. Even if it's a major carrier, you should ask the following types of questions to assure yourself that the carrier will be able to help you avoid claims, defend you against a claim if it occurs, and pay any judgments awarded:

- Is the insurance company an admitted carrier in your State and subject to State review? (Best place to start is the State's Insurance Commissioner. Along the way, check to see if the carrier has been the subject of any disciplinary actions.)
- How long has the company been in the malpractice field?
- What is the experience of their top management?

- How many policy holders do they currently insure?
- What value-added services do they provide? (For example, risk management programs, education, and publications.)
- What is their financial rating? (Standard and Poor's or A.M. Best.)
- Ask to see a financial statement. Are their corporate auditors reputable?
- Do they have sufficient assets to cover large claims?
- What is their track record for handling claims? Are they quick to settle? Do they take every case to trial?

Hopefully, your future group has already done this homework for you in selecting their malpractice carrier, but you can never be too careful when protecting yourself against catastrophic financial loss. Another useful source on malpractice insurance questions is: https://www.leveragerx.com/malpractice-insurance/ultimate-guide/

Chapter 9
Financial Planning for the New Practitioner

William W. Feaster

Within a month of starting your new job as a practicing physician, your income will immediately jump three- to fivefold, depending on your specialty and the type of job you have entered. After taxes, that ends up being a lot less than you might expect, but nonetheless, a significant increase from when you were in residency or fellowship. One mistake people make when seeing a number like $180,000 on an employment contract is to commit too early to expenditures on new cars, houses, and the like before they see what their after-tax and after-benefit paycheck really looks like. The paycheck impacts of various benefit expenses, such as practice overhead, health and malpractice insurance, were discussed in Chapter 5 and won't be repeated here. Another mistake is to fall victim to the sharks! We will discuss this painful outcome with other pressing issues such as buying a home for a tax deduction, paying off student loans, contributing pre-tax dollars to retirement accounts, and some general concepts of investing.

9.1 Who Are the Sharks?

In this context, we're defining a "shark" as someone who makes money from a commission sale who is intent on taking the largest bite possible out of your income. This in no way implies that everyone who makes a living through commission sales is a shark but be cautious. Sharks include insurance agents, real estate agents, stockbrokers, and a multitude of others, especially those offering you surefire investment opportunities. Why you are such a vulnerable victim is because you are a doctor, and everyone knows doctors make a lot of money. They also know that you're about

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M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_9

as sophisticated in your financial decision making as sports figures. (Important note: If you are invited to an investment presentation and the others in the audience are doctors and sports figures, run, don't walk, from the room!)

9.2 Insurance

There isn't anything inherently bad about insurance agents. They provide you with a product that protects you from a variety of potential adverse outcomes. That is a good thing. What becomes problematic, shark-like, is when they try to sell you more insurance than you really need, either in the type of insurance or the amount of coverage, or if they try to sell you insurance as an investment vehicle.

By its very nature, insurance plays off our fears. It doesn't prevent something from happening but protects our assets if it does. Some of these fears are well founded, like the possibility of getting sick and needing health insurance (very possible, and very expensive), or getting into an auto accident and needing auto insurance (also very possible and very expensive). Some are a bit less likely, but still very expensive like a house fire destroying your belongings or someone tripping on your doorstep and suing you because you are a doctor. So, the basic insurances that cover these routine, day-to-day possibilities are very important. One basic insurance that is very inexpensive, but you would be smart to buy a lot of, is liability insurance. You can purchase a "rider" that insures you above the basic liability levels of your auto and homeowners (or renters) insurance. Basic liability maximum coverages usually are $100,000 per event or $300,000 per year. A rider can increase these levels to $1 million or more for as little as a $100–200 annual premium.

Life insurance is the ultimate fear play. Yes, we all are going to die. Odds are in your favor that you won't die until you are much older. But for now, you need to make sure that if you do die, no one is left paying for your burial or other debts. Once that is covered by a small-term policy, and very small premiums if you are currently "insurable," you need to look at other considerations. The next consideration is whether anyone is dependent on your income should you die. You probably can't buy enough insurance to fully compensate for a lifetime of income, but if you have a spouse and two kids, a $1 million term policy would at least give them a good start to life without you. Again, if you are young and "insurable," this is inexpensive.

What factors influence life insurance premiums? First, there are two types of life insurance – term and whole life. Term life insurance covers you while the premium is being paid and when the term of the policy ends, there is no accumulated value to the policy, no investment. Term insurance is less expensive when you are younger, but the premium rises as you age. Conversely, as you age, you accumulate assets that can be used by a spouse and children to cover your lost income if you die. And when you're retired, most of your income is coming from your investments anyway, so there isn't much outside income to replace. So, as you age, the premiums rise, but your required coverage decreases.

As long as you are insurable, you can change term policies as often as you wish to get the best premiums, secure "level premiums" that stay the same for a given time period such as 10 years, etc. I've used the word "insurable" several times. If you have a disease that increases your chance of dying, you either become uninsurable or are rated as a higher risk and must pay a higher premium for the same coverage. It's like auto insurance, when the premiums go up if you've had traffic tickets or prior accidents. Enter another type of life insurance – whole life. The advantage of whole life is that once you buy it, the premium is set for life, and your insurability will never affect the policy after its initial purchase. If it sounds too good to be true, it is. For this privilege, you'll pay a much higher premium. This higher premium is, in effect, a "pay now so you won't have to pay later" investment. The policy develops a cash value over the years that can be taken out by loan if you need the money, or the policy can be cashed out when you're older to use while you're still living, not after you die. The only problem with all of this is that the rate of return on your "investment," while quite safe, is very favorable to the insurance company. They take your money and invest it at a higher rate of return in the stock and bond market, and pay you a lower, guaranteed return. This is how they accumulate large reserves to fund profits and catastrophic losses due to hurricanes and the like. Some whole life policies allow you to take the investment risk, and thus provide an opportunity for a higher return more closely approximating traditional investments.

Your insurance agent would love you to buy whole life because their commissions on this product are higher than term insurance. An agent looking out for your best interests may suggest that you consider a mix of both. It's not a bad idea to have a smaller, whole life policy that guarantees life time insurability and will have enough value as you age to, at least, bury you in style! You then buy a term policy to meet your more immediate needs and keep the premiums in check.

There are other types of insurance that you will be approached with. Disability insurance is the other important one for you to consider. If you are going to work for a company that offers long-term disability, you may not need an additional personal policy. Physician employees of universities, government, large multispecialty or single-specialty groups and the like, usually are provided with long-term disability insurance as part of their employment. These policies usually pay you 50–66% of your salary and begin paying you this amount of money 60–90 days after you become disabled. These are group policies that don't require proof of insurability. If you will be working in a smaller group or independently, without group disability coverage, you'll need to purchase your own disability insurance. The advantages of privately owned policies are that the premium is set at the time of purchase and is based on the amount of the policy (usually capped at 50–75% of your income), your age, and your medical history. Again, the higher the risk of disability, the higher the premium. Those physicians in a procedural-based specialty, like surgery and anesthesia, may want to get specialty-specific coverage if it is available. If they develop a disability that prevents them from practicing their specialty, they can collect full disability and still work as a physician in another role (retrain in another specialty, medical director for an insurance company, etc.). The other advantages of private disability insurance are that it is portable, is additive to other disability insurance

from your employer, and when paid, is not taxable if purchased with post-tax dollars. Payments through a group employment policy are taxable like regular wages. Most disability coverage ends at age 65.

Finally, there are a couple other types of insurance that you will likely encounter (in addition to malpractice insurance, which is covered in Chapter 8). One is long-term care insurance. That has become very popular these days as the expense of long-term care has been publicized. A young physician just out of training is likely to need medical care, likely to have an automobile accident, may get disabled, but is very unlikely to become disabled to the point of requiring long-term care. Long-term care is primarily for the elderly. If you have an older spouse, it may be worthwhile to consider. If you have a parent who is a dependent, covering them might be advisable. But for a young person, it is a bit difficult to begin paying, albeit at a lower premium, for an eventuality that probably won't occur for 40 years, and, maybe, not even then. The other difficulty of insuring now for a much later eventuality is the unknown of inflation of costs over that long a period, and whether this type of care will be covered in the distant future through some type of social program.

A final type of insurance product is an annuity. Basically, an annuity is a contract between you and an insurance company, under which the insurer agrees to make periodic payments to you beginning now or some future date. You purchase an annuity with either a lump sum payment or with periodic payments. The insurer invests your money and guarantees you either a fixed future payment based on a guaranteed rate of return or a variable payment based on the performance of various investment options (usually mutual funds). There is a death benefit feature, so that if you die before the insurer starts making payments to you, your beneficiary gets at least the amount of your purchase payments. And it is tax deferred like a retirement account since you don't pay taxes on the investment income within the annuity, only on the payments you receive. Sounds pretty good! The main problems with annuities are that your money is difficult to get out before the maturity of the annuity, and the rate of return is often less than a fairly conservative alternative investment. We will discuss retirement accounts later, and these should be your first priority for long-term investments.

9.3 Real Estate Investments

Your most important investment is your home. There are very good reasons to buy one. But, buying a home for a tax deduction IS NOT one of them. What are the good reasons? If you are secure in your job, or at least in your location, buying a house to live in, to fix up, to "nest" in for your family is a great reason. As a real estate investment, it becomes a good investment if you are in it for the long-term and won't be forced to sell it due to relocation in a bad market. Certain areas of the country have historically had significant appreciation in housing (e.g., California and everywhere Californians have moved such as Oregon, Washington, and other Western States). Now (2021) may be a good time to buy a house because the interest rates are at their

all-time lows. Since you will have a good income (and people love lending money to doctors … they generally have secure employment and pay their bills), you should not have a problem obtaining a loan for a reasonably priced house.

Since mortgage interest and property taxes are deductible on federal and state income taxes, and are about the only deduction allowed these days, why isn't it a good idea to buy a house for this tax deduction? After all, your accountant advises you to buy a house so you don't have to pay the government so much money. Well, if you've bought a house for the right reasons, it ends up being your best tax deduction. But if you're buying the house just for the deduction, if you're not yet secure in your job and don't know if you're going to be in an area long term, and if you look to a house as a short-term investment, this may be a very expensive mistake if you are unable to recoup your investment.

9.4 Paying Off Student Loans

While it may seem a bit trite, paying off your student loans should be your first investment priority. Here's why. First, if you don't pay it off and default, your credit will be ruined, and the AMA would deem your conduct unethical. This would disqualify you for membership in the AMA, and your name will be published in the Federal Register as a loan defaulter. Enough of the stick ... now for the carrot! Even though interest rates on these loans have historically been fairly low, they will generally exceed returns for common investments of similar risk (again that "risk" word ... we'll get to it soon). As with the house purchase for a tax deduction, let's look at an example.

Let's take the example of a $200,000 loan, at 4% interest, fully amortized (you pay principal and interest) over 120 months. Your monthly payments would be $2025, and over the 10 years of repayment, you would pay $242,988. Let's take the same loan, and say you had saved $10,000 during your residency, for which you were looking for a suitable investment opportunity. Let's make a $10,000 principal reduction of your loan. Payments reduce slightly to 1923.66 but your total repayment including interest is $230,839, and you save $2149 in interest over the 10-year term of the loan. That's a 2+% no risk, nontaxable return on your investment of $10,000. It just doesn't get any better than that without the assumption of at least some risk. From a risk and tax perspective, the only low-risk, nontaxable alternative investment is municipal bonds that currently (2021) pay around 1%. Not great, but no risk rates of return aren't great right now.

9.5 Contributing Pre-tax Dollars Toward Retirement

Wherever you work, you'll have the option of putting away pre-tax dollars into a retirement account. Sometimes, there is a 1-year waiting period for contributing to corporate retirement accounts, or a similar waiting period for employer matches, but everyone has an option. There's a fairly large range of possibilities.

There are still examples of what would be termed a "defined benefit" pension plan out there. In this case, an organization contributes for you or allows you to contribute to a plan that pays you some predetermined proportion of your salary at the time of your retirement. In the case of federal or state government, this is a guaranteed benefit based on the number of years in their service. In a very large multispecialty group such as Kaiser Permanente Medical Group, partners in the group have a similar benefit.

Nonprofit organizations such as medical foundations, hospitals, and universities usually sponsor a plan under the IRS tax code 403B. The maximum voluntary contribution into a 403B plan is $19,500 for 2021. Employers can also add to these accounts with some amount of match based on a percentage of income.

For-profit corporations will have the option to contribute into a "defined contribution" plan or a Pension and Profit-Sharing plan. As of 2020, you are allowed by the IRS to contribute up to $57,000 (if less than 50 years of age) of mostly pre- tax dollars into these plans, and the money in the plan accumulates without tax on investment gains.

The message here is that if you can contribute to one of these plans, the sooner you start, the better. Let's look at a couple of examples. Let's take a newly minted physician, just out of residency at 30 years of age. In her first year of practice, she begins to contribute to her retirement and puts $44,000 per year into a Pension and Profit-Sharing account in her corporate practice. That's $3666 per month of pre-tax dollars, and a big chunk of salary for someone just starting out, but she knows it's the best thing to do. If she invests this money in the stock market at an average long-term return of 8%, and retires at age 60 to pursue other interests, she will have $5,463,657 in her retirement account! What if she wants to wait a year and starts at age 31? Her account will have $5,002,787 in it at age 60. If she waits until 32, she'll have $4,577,237. By taking home the extra $44,000 or so net of taxes over each of her first 2 years in practice to use for other purposes, she forgoes nearly a million dollars at retirement! That's enough, by itself, to yield $44,000 per year indefinitely. Needless to say, if you have the ability to contribute, do it, do something, anything, just don't wait.

So, if the sharks don't get too big a bite of my money, if I've bought a home for the right reason, if I've paid off my student loans, and I've started to put money away for retirement, how do I invest any additional dollars I have to spend?

9.6 The Basics of Investing

One group of "sharks" mentioned above is stockbrokers. They can be sharks, or they can be your best friends. They are the professionals of investing, just like you are a professional of medicine. If you want investment advice, you don't go to a doctor, you go to your broker. But just like your patients who need to be educated consumers of medical services, you need similar knowledge of the broad range of investment opportunities to make your hard-earned money go to work for you.

In this section, we will cover some of the basics of investing, including a discussion of that "risk" work. We will review the basics when investing in stocks, bonds, and mutual funds, and illustrate the importance of creating a plan to govern your investment activities. The goal of this chapter is to introduce you to these concepts, but like all educated consumers, you will need to pay some attention to all of the other relevant information around you in the daily newspaper business section, radio and television, the intranet, and through one-on- one discussion with investment professionals.

9.7 Keeping Up with Inflation

Inflation is simply defined as either an increase in the price you pay for goods or a decrease in the purchasing power of your money. Inflation varies year by year, and for the last 10 years has varied between 0% and 4%. Let's assume that, on average, it is 2%. If you put your money under a mattress, it loses value at this rate of inflation. So, a dollar today will only have 98 cents of purchasing power next year. If you invest your money in a bank certificate of deposit (CD) currently returning a small 1% yield over 2 years, and if you live in California where there is a 9% state tax in addition to a 33+% federal tax, the yield of that CD after taxes is only 0.57%. While you may want some of your money in CDs as we'll discuss below, realize that an investment in a CD doesn't currently keep up with inflation given the current historically low interest rates. Your net purchasing power still shrinks with this rate of return.

9.8 Cash Investments

This is characteristic of all cash investments. Their rate of return barely keeps up with inflation. But they have other advantages. One is that they are very low-risk and preserve your capital no matter what the economy is doing. For example, if you put $100,000 in that above-mentioned CD in a bank insured by the Federal Deposit Insurance Corporation (FDIC), your $100,000 asset will be returned to you even if the bank becomes insolvent. You may lose your interest earned, and the use of your money for a while, but you'll eventually get the $100,000 back. Cash investments also have the advantage of being quite liquid. Like this CD, their term is normally short. Other cash investments may include short-term T-bills sold by the US government. Unless the government goes under, they'll be paid off on schedule. Money-market mutual funds are funds that invest in various cash investments and are immediately liquid and quite low risk. As a general "rule of thumb," everyone should work toward the goal of between 3 and 6 months' worth of living expenses invested in these relatively liquid cash investments.

To accumulate assets faster than inflation consumes them, you need to look at higher yielding investments than cash. With higher yields come varying degrees of risk. Accepting risk is what investing is all about. Finding the right amount of risk and return that you are comfortable with is part of the challenge of a successful investment strategy. Some ratio of bonds and stock will provide this balance between risk and return in your portfolio.

9.9 Bonds

A bond is somewhat like the CD investment example listed above. Instead of giving your money to a bank for a fixed return over a fixed period, you're giving the money to a corporation. No one insures this money, so if the corporation goes bankrupt, you're just one of many creditors trying to get your money back. So, the risk is higher than with a CD. But it is even more complicated than that. Corporate bonds are also bought and sold. If you keep the bond to maturity, you get your principal investment back, and guaranteed payments along the way. If, instead, you want to sell the bond prior to maturity, its value will be based on the guaranteed interest rate of the bond. For example, if you bought a bond with a 4% guaranteed return (higher than the CD because of the higher risk), but now similar risk corporate bonds are returning 5%, the asset value of your bond, if you tried to sell it, would be worth less than what you purchased it for, so that the adjusted return would be similar to the current 5% rate. So, a bond has both a default risk and an interest rate risk, but overall, these risks are relatively low as reflected by their lower rates of return.

Not all bonds are issued by corporations. One category of bonds that appeals to many investors are bonds issued by a state or local municipality. The return on these municipal bonds may be close to the rate of inflation, but they possess the advantage that the return on the bond is exempt from state and federal taxes.

9.10 Stocks

With stocks, risks and return get really complicated. If you look at the historical rate of return of the stock market as a whole, it yielded a historical average of 8.87% between 2000 and 2019, and thus substantially beat inflation over the same period. That's what you can probably expect in the future over a long-term horizon (20–30 years), but on an annual basis, returns can vary wildly, and reflect events such as the dot-com bust, 9/11, the Great Depression, world wars, and the like. In fact, the historical standard deviation of the stock market returns over the last 100 years is 18%. A really good year in the market may be reflected in a 2 standard deviation swing in the return or 36%! A really bad year can be equally bad. That amount of variation is pale compared to individual stocks, which can boom, and

bust to even greater extents. The way you mitigate the risk of these potential wild gyrations is to diversify your stock holdings. The other way to mitigate the risk is to let the professionals manage your portfolio of stocks to insure they are properly diversified and that there is the appropriate weighting in the various market segments consistent with the economics of that period and your ultimate investment goals. Unless you have a very large sum of money to manage, the best way to accomplish this is through investing in mutual funds. We'll cover that in more detail later.

There are many classes of stocks. You may have heard the terms common, preferred, "blue chip," growth, value, large cap, small cap, etc. In addition, there are US-based securities as well as foreign securities. It would be impossible to cover them all in detail here, but some basic information will aid the discussions that follow.

Stock is issued by a corporation and sold to investors. Some corporations issue two types of stock, common and preferred. They both give the shareholder an ownership interest in the company. Preferred stock entitles the shareholder to guaranteed dividends and a preferential claim to company assets. It is somewhat like a bond in this respect. Common stock doesn't have these advantages, but the shareholder has voting rights to elect the management of the corporation. Common stock may also pay a dividend, but not a guaranteed one. Most stock traded on the exchanges is the common stock of corporations.

Based on the total market capitalization of the company, stocks are divided into large-, mid-, and small-cap. Small-cap refers to companies with under $2 billion market capitalization. Large-cap are over $10 billion and mid-cap is in between. These definitions vary by different brokerage houses. Blue-chip stocks are usually large-cap stocks that have a long track record of successful performance. Large-cap companies tend to have more assets and often pay dividends. Small-cap and mid-cap companies have more potential for rapid growth but also more price volatility. They are more likely to be considered "growth" stocks. Stocks that have a lower price relative to their fundamentals (dividends, earnings per share, total sales, etc.) may be considered "value" stocks.

Based on your investment goals, your portfolio should contain some balance between stocks, bond, and cash investments appropriate to your investment goals. When you are first starting out, it is very difficult to buy enough individual stocks or bonds to meet your investment goals. For the beginning investor, turning to professionally managed mutual funds is the best decision.

9.11 Mutual Funds

A mutual fund is a pool of investor's money that is actively managed by a fund manager or company. Investors buy shares of the fund and are charged a fee by the fund for managing their money. If the fund makes a profit, the profit is returned to the shareholders through appreciation of the fund value and your portion of any

dividends paid by the stocks in the portfolio. Most mutual funds are open-ended, in that the fund issues new shares whenever investors buy them. Some mutual funds are "no-load" in that they do not charge a sales commission when you buy or sell the fund. A fully loaded fund may have an initial sales charge as high as 5%, but in the long run, due to the skill and reputation of the fund managers, yield a higher return than the no-load funds or charge a lower management fee. The bottom line is that, one way or another, if you buy a mutual fund, someone is going to make some money off you.

There are as many types of mutual funds as there are types of stocks and bonds, and market sectors, and they are additionally diverse as to levels of risk and return. One popular type of mutual fund is an index fund. If an investor wants to invest in the general market, assuming the same risk as the market as a whole, and receiving a return no better or worse than the market as a whole, then an index fund is a good way to go. These mutual funds invest in the stocks that make up the major market indexes, like the Standard and Poor's 500. As such, their downside is that they can never outperform the market. There are funds that meet a specific investment objective like growth, and others that provide income. There are various sector funds like healthcare or banking. Funds that are very popular today are international funds that invest in foreign markets and "green" funds that invest in companies deemed to be environmentally responsible.

9.12 Exchange Traded Funds

An Exchange Traded Fund (ETF) is a security somewhat like an open-ended mutual fund in that it is based on a large collection of stocks duplicating an index or focused on a market sector such as energy or technology. What makes these products different is that they are traded like a stock on an exchange. Like a stock, its price changes throughout the day and you may buy and sell shares during the trading day and thus possibly obtain a better price than a typical mutual fund that is only priced once a day at the close of business. Also like a stock, you pay a commission when you buy and sell it and you can get fancy with option trading – puts and calls, selling short and long (not recommended for the beginning investor). The main advantage of ETFs is that you can buy a lot of diversification with as little as one share.

Because ETFs are passively managed (bases on an index of some kind or another), there are minimal annual management fees. They are also more tax efficient, if purchasing them outside of a retirement account. They don't report annual capital gains that are taxable like mutual funds where the managers are actively buying and selling stock to get the greatest return. With some exceptions, you are only taxed on your profits when you sell them. ETFs are a relatively new financial instrument that have some significant advantages for small and large investors alike.

9.13 Sample Portfolios

The overall mix of stocks, bonds, and cash within your portfolio reflects the return you are seeking and the risk you are willing to assume to achieve this risk. Let's look at three different portfolios, one aggressive, one moderately aggressive, and one conservative. These examples are ones from 2007 but are just examples that still are relevant in concept today.

The aggressive portfolio would be typical of someone young who was looking for a maximum return on investment. He or she wouldn't need to access the money invested for several years (if a down year was encountered, would be willing to sit it out for better times) and would not need income from the investments made. This type of strategy fits a young person's retirement fund portfolio quite nicely. Our aggressive portfolio consists of 80% stocks and 20% bonds (Fig. 9.1). Note that a similar portfolio over a 20-year period between 1988 and 2007 would have 4 down years, a 1-year loss as high as −16.08%, but an average annual total return of 11.11%. Since this return likely beat the market, it would have required more sophisticated investment choices than simply investing the stock portion in an index fund.

Our moderate portfolio (Fig. 9.1) reduces the weighting of stocks to 60%, increases bond investments to 30%, and keeps 10% in cash. With this portfolio, the risk is lower as demonstrated by only 3 down years out of 20 and the worst 1-year loss amounting to −10.57%. As expected, the average annual total return of this portfolio is less at 10.05%. Perhaps this is a portfolio typical of a more mature investor, possibly approaching retirement and seeking to preserve capital at the expense of some return. The bonds and many of the stocks in this portfolio are likely paying dividends.

Our conservative portfolio (Fig. 9.1) still delivers a healthy, inflation busting 8.19% return and preserves capital with only one down year by only −2.44%. These investments are now spinning off income through stock dividends, bond payments, and interest earned. This would be a typical portfolio of someone who has retired and is looking to preserve capital and provide income, or perhaps someone who is just very risk adverse.

Fig. 9.1 Example portfolios from the period 1988–2007

	Aggressive	Moderate	Conservative
Cash	0	10%	30%
Stocks	80%	60%	30%
Bonds	20%	30%	40%
Worst 1-year loss	-16.00%	-10.50%	-2.44%
Annual average total return	11.10%	10.05%	8.19%

These examples are illustrative only and compiled from various sources and are not typical of any individual portfolio. They don't consider the overall selection of stocks, the diversification across market sectors, etc. Someone heavily weighted in high-tech stocks during the dot-com bust would certainly have had a maximum 1-year loss between 1988 and 2007 of perhaps −50% rather than −15%. That underscores the importance of diversifying your investments.

The long-term value of adopting the more aggressive portfolio (Fig. 9.1) as your investment strategy for your retirement account, especially at a younger age, is very great. If you return to our above example of contributing $3666 monthly to your retirement account over a 30-year period, recall that an 8% effective annual yield on your investments in this account would net you $5,463,657. If instead you adopt the aggressive portfolio with an average annual total return of 11.1%, your retirement account might contain $10,577,209 or nearly twice as much as the more conservative portfolio would yield! The moderate portfolio's return of 10.05% ultimately yields $8,375,858.

9.14 Dollar-Cost Averaging

As you build your investment portfolio, another important concept designed to reduce market risk is the averaging effect of security purchases at predetermined intervals and for set amounts. If you invest money in the stock market on a regular basis, you'll be buying stock when the price is high, but also when the price is low. Your overall cost-basis for the stocks you purchase will be averaged out over several years. The alternative is to invest lumps of money in stocks at times you determine. This has been called market timing. If you are really good, and just buy stocks when the price is low and just sell them when the price is high, this is a good strategy. Unfortunately, no one, even the market professionals, is good enough to get this right every time.

9.15 How Do You Find a Financial Advisor?

You are a medical professional, not an investment professional. When you need medical advice, you look to another doctor. Similarly, when you need investment advice, you look to a financial advisor. How do you find a good one?

It is just like trying to find a good doctor. You wouldn't look in the yellow pages to find a cardiac surgeon to operate on your heart. You'd ask your cardiologist, colleagues, and friends. You'd probably also want to know what the surgeons' statistics were like – their mortality rate, infection rate, long-term graft patency rate, and the like.

Ask a colleague or friend whether their advisor's practices are reputable. What type of advice have they received? Does the advisor recommend a large volume of

sales and purchases within their portfolio (thus generating large commissions), or do they construct a well-balanced portfolio that just needs some fine-tuning now and then? How has their portfolio performed compared to the market as a whole or to specific indexes? Has the advisor consistently beaten the market?

Another reliable source is to contact the Certified Financial Planners Board (www.cfp.net). This website allows you to verify a financial advisor's credentials. Individuals authorized by the CFP Board to call themselves CFP professionals have experience in their field and have completed an established rigorous education and testing program. They also have agreed to adhere to a code of ethics as part of the CFP certification process.

Some Take-Home Points for Financial Planning

- Don't let the "sharks" take too big a bite out of your money.
- Buy a house for the right reason.
- Pay off your student loans as your first "investment."
- Start contributing pre-tax dollars into a retirement account as soon as possible.
- Learn the basics of investing and learn more every chance you get.
- Establish an overall investment plan that maximizes the return on your money while keeping risks under check.

Further Reading

https://www.investopedia.com/articles/fundamental/03/022603.asp. Investopedia is a good source of general investing information.

https://www.cnbc.com/2014/02/24/warren-buffetts-three-fundamentals-of-investing.html. Warren Buffet is an investing icon, and has guided his company, Berkshire Hathaway to huge success.

https://www.investopedia.com/best-investing-books-5114673. Lots of investing books. Investopedia ranks their "top 10."

https://money.usnews.com/financial-advisors/articles/how-to-choose-a-financial-advisor. Good review of the subject of choosing a financial advisor.

Chapter 10
Power and Pitfalls of Social Media

Roya Saffary

10.1 What Is Social Media?

The genesis of social media was to enable and encourage social interactions and connections while being geographically distanced [1]. Over the past few years, the "social" types of interactions on social media have grown from simply messaging to sharing images, videos and headlines, and live interactive sessions. It appears that much of our lives occur online, and what used to be an outlet for creativity and entertainment has morphed into an all-encompassing world that touches on almost all aspects of life. It is not surprising then that once the power of the reach of social media was appreciated, an increasing number of individuals and businesses seized the opportunity to disseminate information and appeal to a much larger audience than otherwise possible.

To maximize the full potential of social media, it is important to understand the different platforms, the demographics of the user, and the intended use. It is also important to realize that target audiences, uses, and interactions change over time largely driven by the launch of the newest, latest, and greatest platform. In 2015, 71% of individuals aged 13–17 in the United States said they used Facebook; this number decreased to 51% in 2018 [2, 3]. This change attributed to the increasing use of Instagram, SnapChat, and TikTok [4]. As the demographics change, so will the desired content and formatting. This means continually adapting to an evolving market in order to maintain an engaged audience. The users of social media do not have a loyalty to one platform for long, neither should you.

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M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_10

10.2 Why Engage in Social Media?

Social media can be leveraged to reach a large audience. The sheer number of individuals using these platforms allows for dissemination of information to a large number of people very quickly. For physicians who usually engage with a small group of colleagues or patients, this presents an opportunity to address and interact with a much larger audience to educate and inform.

Educating Patients: At some point during your training, you have undoubtedly had someone come up to you and say "when I googled it…..". Before patients would have consulted directly with a physician or looked up symptoms in a textbook, they now have Dr. Google at their fingertips – literally. Type any symptom or disease into the search box and links will appear leading you to websites ranging from the reputable to questionable to straight dangerous. With the large amount of information (and misinformation) comes the need for healthcare providers to educate and guide patients. The power of correcting misinformation using a social media tool has been evident throughout the COVID pandemic [5]. With more and more physicians posting on social media, the general public is able to get a glimpse of what it really looks like in hospitals and how serious the pandemic is. Images of exhausted healthcare providers covered (sometimes makeshift) protective gear have flooded social media platforms and provided a more personal and raw view – something conventional media outlets cannot provide. More and more physicians have embraced social media as the easiest way to counter the lack of adequate information and abundance of misinformation. The educational aspect of social media is not only limited to potential patients but can also be used to educate college students, medical students, and trainees. Current education trend is toward more interactive, active methods of learning. Social media platforms afford the opportunity to develop a personal connection with the audience as well as to educate. This might be through a "Facebook/Instagram live" Q+A session, a YouTube video, or even an Instagram Reel.

10.3 Promoting Your Practice

In addition to creating awareness for medical conditions and treatments, these platforms can also be used to promote small practices and even very well-established healthcare systems. Most if not all larger health systems and universities have social media accounts on multiple platforms at this time to be able to share information quickly and engage with an audience.

This can serve to document life as a physician, share health information in their respective specialties, provide a more accurate view of health care and medicine, or promote a practice. There is also a growing trend of smaller practices to feature their services on social media to be more accessible to the population they aim to serve.

Finally, individual practitioners have also found it helpful to post on social media about their own specialty and engage with their existing patient population as well as attract new patients.

10.4 Social Media to Promote Research

The power of social media with regard to research, education, and teaching is not only limited to physician–patient interactions but also includes discussions between physicians at various stages in their careers. For example, Twitter, the microblogging platform that allows users to send out messages or *tweets* limited to 280 characters, is often used by medical professionals to share new clinical findings or treatments to educate and encourage discussion, collaboration, and potentially lead to advances in medicine [6]. Given the limitation of the tweets, Twitter makes it difficult to provide a lot of in-depth information to serve as an educational platform on its own. Instead, it allows users to disseminate information quickly, and therefore start a conversation on specific subject matter. The fact that anyone with a Twitter account is able to join the conversation results in greater connectivity and a lower barrier for collaboration, which is invaluable for medical research.

10.5 Blurred Lines of Personal and Professional on Social Media

The importance and power of physician presence in social media on education, awareness, and public health has not gone unnoticed. In 2018, Jefferson Health in Philadelphia appointed the first chief medical social media officer to promote effective use of social media among clinicians, trainees, and medical students. Since that first appointment, many medical schools and hospitals have done the same. Hand in hand with using social media as a powerful tool, institutions have also developed very specific social media policies and guidelines for employees posting on different platforms. These guidelines often include clear instructions not to use the institution's identity (e.g., color, emblem, and name) on your profile. It also enforces making it clear that you are NOT posting on behalf of the institution or represent the institution's views. Finally, whatever the code of conduct of the institution is in person will often also apply to your social media presence. Therefore, it is very important that you familiarize yourself with the guidelines prior to posting on social media – even if your aim is not to use your account for educational or research purposes.

10.6 Social Media and Professionalism

Posting on a social media is a very solitary action, and it is easy to forget how far-reaching and irrefutable social media can be. The factors that draw you into social media can also be the ones that get you in trouble. It is important to remember that public profiles are just that – public.

That means anyone is able to look at them, which includes but is not limited to the intended audience. So, your family, friends, classmates, colleagues, your program director, your boss, your potential future boss, any admissions committee or selection committee, and potential future or current patients will have access to what you post, including pictures, links, memes, and whatever else is under your profile. Everyone will have access to everything you post. Why does that matter? It matters because we are often not as vigilant on our social media accounts as we may be in person. We may post content that seemed funny or interesting at the time, without fully understanding the implications and how it may be interpreted. Making the same comment in person is immediately checked by the social cues of the person or group you are interacting with. You have an engaged audience and you can immediately explain what you mean; it is a very contained exchange. This becomes infinitely more complicated with social media posts. Not only is the post immediately accessible to everyone on your contact list, but also by the time you realize your mistake and decide to take the post down, it may have been reposted or otherwise captured and the damage has already been done. It will be far more difficult to explain yourself; it is not easily contained. One of the authors of this book, JGBU, can attest to a young doctor having the contract he/she signed with a practice got withdrawn. The reason was that the partners did not like what the person had posted on Facebook. So be warned.

How do I know what is OK to share? A good rule of thumb is that if you would not say it to someone in person, you should probably not post it. Another way to ensure that your content will not affect you in the future is to pause and think whether you would be embarrassed if your program director, colleague, boss, patients, or even your 10-year-older self saw it. If the answer is yes, then posting it may not be a good idea and you should refrain if possible. It is quite common (and legal) for present and future employers to scan through your social media; how they chose to act on it may or may not be legal. JGBU also feels like they say in the Armed forces: You are talking, but who is listening, so if there is something you should not say, you should certainly not write it.

10.7 Social Media and Legal Implications

Being a physician also brings an extra layer of complexity. In addition to just being embarrassed by a post or potentially not getting a job you applied for, you may encounter serious legal consequences, incur substantial fines, and/or lose your job if

protected health information (PHI) is revealed on social media, thereby clearly violating the Health Insurance Portability and Accountability Act (HIPAA). A common incorrect assumption is that only information (pictures, date of birth, or medical record number) constitutes a HIPAA violation; the HIPAA privacy rule states that PHI is “individually identifiable health information” (that) is information, including demographic data, that relates to the individual’s past, present, or future physical or mental health or condition; the provision of health care to the individual; and the past, present, or future payment for the provision of health care to the individual and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual [7]. Any information that could identify an individual is technically PHI. In 2018, a nurse at Texas Children’s Hospital posted about a patient who had measles. The post was in an anti-vaxxer Facebook group. It did not mention the name, date of birth, or any other specific information about the toddler. However, her place of employment was listed in her profile, and she noted the child’s diagnosis and admission to the ICU. A parent who had a child in the same hospital shared screenshots of the post to the hospital’s page, prompting the hospital to issue an immediate statement and firing the nurse for HIPAA violation [8]. This story brings up two very important points. First, PHI covers a wide range of information and pertains to anything that could result in identification of a patient, including hospital name, date of admission, disease status, and a wide variety of other pieces of information that could narrow it down to the specific patient. Secondly, “closed” Facebook groups are really not as private as you may think. All groups are closely monitored by Facebook itself to ensure adherence to the rules, meaning that anything you post is already being viewed by someone outside of the group. In case of a lawsuit, there is no guarantee that the privacy settings on your account will be honored during the fact gathering period, and therefore your posts could be discoverable and subpoenaed. In addition, anyone in the group can easily take a screenshot and forward your post to others or on their own page. Therefore, while it seems that these groups provide some protection, the information is still reportable and any HIPAA violation discoverable. Using “hypothetical” when describing a case may give you (often false) sense of security. If the details are still unique and specific enough to be linked back to a patient, one could still argue that this is a HIPAA violation.

10.8 Social Media as a Distraction

While HIPAA violations may be an obvious no-no, most people are not aware of other possible legal consequences when posting on social media. In 2014, an anesthesiologist was sued for being distracted during a case, which may have led to the death of the patient several hours later [9]. During the trial, the anesthesiologist was questioned on his social media habits, including posting during cases and posting about patients. While neither of those events occurred during the case, they likely weakened his defense by describing him as a distracted and unprofessional

physician. As laws around social media are still evolving and social media activity is being scrutinized more and more, it is important to understand these implications and act – and post – accordingly. Also, do not forget that all posts are timestamped and can easily be linked to time you on clinical duty [10].

10.9 Social Media and Privacy

It seems odd to expect privacy from platforms that we are so willingly providing with the most private pieces of information about ourselves. Over its lifespan, Facebook alone has endured multiple privacy issues ranging from tracking user's buying habits to allowing third-party applications to harvest the users data. One look at the advertisements that are presented to you through either social media or even elsewhere on the Internet to even your email inbox makes it clear that everything you do online is being tracked, recorded, and used to curate content to your specific interests. Most recently, the new app TikTok came under fire because it allowed the developers access to users' personal information, including their location and email addresses. Before using an application, it is important to familiarize yourself with the privacy rules (read the fine print) and ensure that you protect your privacy as much as possible, which may mean not posting your personal information such as birthday or current location on your profile.

10.10 In Conclusion

No matter how we look at it, social media is here to stay and its presence will likely increase in our day-to-day lives, but it is a double-edged sword. It is impractical, foolish, and misguided to say that all healthcare providers should stay off social media for fear of consequences. On the contrary, it is imperative that more physicians become involved in these interactive platforms and utilize its many features to engage directly with colleagues, trainees, and the public alike; disseminate accurate information, advocate for yourself and our profession, be a leader of change. But also respect the potential downsides; understand the proper use and challenges of social media. Nothing is truly private on social media. What started as a simple means to connect with friends has evolved into a very powerful and far-reaching tool. A simple well-timed post has the ability to advance your career, and a misunderstood post has the legal ability to end it.

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Chapter 11
When Things Don't Go as Planned

Melissa T. Berhow

As 2020 showed us, things do not always go as planned. It may be a change affecting the global landscape, or it may be a hiccup in your corner of the world. Sometimes there is an easy fix, and sometimes there is not.

During your transition out of residency, the biggest hiccup comes from not fully understanding the contract you signed. Before signing anything, read and understand every line. It may be a standard contract, but it can be helpful to have it reviewed by a lawyer. Contracts usually spell out course of action for the more common sticky situations, and most of the answers to the scenarios below will be found in the fine print of the signed contract. (Please note this is not intended to replace the advice of a lawyer.)

1. *You signed the contract, but you choose to not start that job:* Most groups want to have willing employees, and a simple direct conversation can often resolve the situation but not always; often it depends on why you want to void the contract. Breaking a contract to go to a neighboring group is different than breaking a contract for, say, family needs. For example, you signed a contract with group 1, but found a better job in the area group 2. You tell group 1 you are no longer joining but going with group 2. Group 1 sues you for breach of contract and invokes the noncompete clause in your contract (state dependent). This has happened.
2. *You signed the contract, and they no longer need you:* Most employment contracts have a "Force Majeure" clause. This releases the parties from contractual obligations and liabilities if unforeseen events make performance under the contract impossible. Parties are excused from performance as long as the unforeseen event is happening. But after the unforeseen event, the contract is valid again. The graduating class of 2020 had quite an unforeseen event. There were residents

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© Springer Nature Switzerland AG 2022

M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_11

who had signed contracts but didn't start because of the impact COVID; elective surgeries in some areas came to a halt for months.

3. *You are dismissed*: No one goes onto a contract expecting to be terminated, but it happens. Most contracts have a 3–6 month probationary period; you are not guaranteed employment beyond that period. Once you are hired, you may have a renewable contract or heading toward partnership. A dismissal may take the form of a contract not being renewed, or it may take the form of a mid-contract termination. Understanding the procedures and protocols around dismissal is key. You could be doing everything right but still be dismissed from your contract. For example, a group was offering "too good to be true" compensation for working at a local hospital. Deep in the contract it stated, "Physician could be terminated at any time for any reason with 10 days notice." In this particular case, the hospital's prior group left, they needed coverage quickly, and this "too good to be true contract" was a band-aid until they could hire at a lower rate.

   Other than the partners who have bought into a practice, most contracts have obvious renewal points that make for easy termination. For example, many appointments renew every 2 years; rather than firing someone outright, a group may simply choose not to renew a contract or to renew with unacceptable terms (e.g., salary reduction or increased work hours). Most contracts allow for a 90-day notice outside these natural breaks. Dismissal due to concerns surrounding job performance is a complicated legal morass potentially affecting future employment and licensing. Be sure to read and understand the circumstances for termination beyond the care you provide.
4. *Time to leave*: As with many relationships, there may be a time to move on. The cleanest way to move on is to leave at a natural breaking point in the contract (e.g., don't re-sign contract) with as much advanced notice as possible. If circumstances do not allow you to wait for a natural break, your original contract should detail steps to be taken for leaving early. An early departure may not be without significant consequences (e.g., buying your way out of the contract). Take care to review any noncompete clauses. Not all states honor noncompete clauses, and those that do usually enforce for only 1 year (cannot keep a person from working forever). But working through all that can be time consuming and financially draining.
5. *Your group gets bought out:* There is a growing trend for smaller private groups to be bought out by larger corporate groups. These buyouts frequently involve significant payouts to the partners (owners) and salary cuts for the rest. Part of the buyout negotiations may involve temporary contract guarantees, but frequently it means eventually wiping the contract slate clean.
6. *Need for an extended leave:* This is very group and contract dependent. You may or may not have a guaranteed job after an extended leave.
7. *A pandemic happens*: Depending on your specialty, you may be in higher demand, but for many the demand has decreased. Graduating residents have seen start dates delayed and contracts canceled as well as delays to access to board exams. Having an open direct conversation with your future employer is your best option.

Part III
It's a Marathon, Not a Sprint. Sustainability and Relevance for Your Career and Your Life

Chapter 12
Things You Should Know About Hospital Administration

John G. Brock-Utne

> It is hard to imagine a more stupid or more dangerous way of making decisions than by putting those decisions in the hands or people who pay no price for being wrong.
>
> – *Thomas Sowell, Senior Fellow Hoover Institute, Stanford*

You have now completed your specialist training and will soon be joining the faculty of a university teaching hospital or starting in a private practice in a community hospital or outpatient facility. Wherever your career now takes you, there is one aspect of modern medicine that you probably have not been directly exposed to during your residency – hospital administration.

There has been a dramatic increase in the number of hospital administrators in this country over the past several decades. Just between 2005 and 2015, there was a 50% increase in administrators [1]. During your residency, you were shielded from them, but in the future, you will need to interact with hospital administrators. This chapter will serve as an introduction to hospital administration and discuss the following:

- How many hospital administrators do we need, and are they of any value?
- Press Ganey Survey. Any problems?
- Metrics. Benchmarks. Mandates
- Hospital committees. Physician-led healthcare?
- Another take on physician burnout
- Suggested solutions

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M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_12

12.1 How Many Hospital Administrators Do We Need and Are They of Any Value?

All physicians took an oath to improve quality of life and to save lives. Unfortunately, hospital administrators at the helm of our healthcare system are not committed to the same ideal [2]. In a book by Elizabeth Rosenthal entitled *An American Sickness,* she states that the American health system has stopped focusing on health and even science [2]. Instead, they are only concerned with profit.

In 2018, the author (JGBU) compared two similar-size California hospitals, each with about 800 beds and 12,000 employees. There was a large difference in distribution of employees doing direct patient care (45% versus 78%) between the two hospitals. In one hospital, 22% of employees were involved with nonpatient care, while the other hospital had a whopping 65% of employees in nonpatient care roles. Just so you know, there are no state or federal government standards, so every hospital can do their own thing. Each CEO, CFO, and COO decide on their own needs. There are no checks and balances. Interestingly in one of these hospitals, there were 40 VPs while the other had only 6.

Hospital administrations justify their existence by supposedly improving efficiency and quality of patient care [3]. However, the actual value of hospital administration, especially CEO's, has come under increasing scrutiny [4–7]. There is no correlation between hospital CEO salary and hospital quality, financial performance, and community benefit.

To summarize, between 2005 and 2015, physician's wages grew to $37 billion, while the salaries of nonclinical workers grew to $58 billion. Nonclinical workers are employees that have no direct involvement with patient care.

There is an increased financial burden caused by excessive increase in nonclinical workers in the US health care [1]. Dr. Danielle Ofri (*New York Times*, June 8, 2019) states that there has been a 3200% increase in healthcare administrators since 2005, all paid for by patients and their insurance. We need a reduction in nonrevenue-generating healthcare workers.

In 1968, hospital administrators were viewed as being frugal, having a lack of ostentation, with a trace of puritanism and humility [8]. In 2019, those same administrators were described as practicing poor governance, receiving excessive pay, lacking deep corporate culture, and experiencing corporate malaise [8]. We need to get back to cornerstones of hospitals as they were in 1968.

12.2 Press Ganey

Press Ganey (PG) surveys measured patient experience and attempt to provide strategic solutions to hospitals. In many cases, physician salaries depend on their PG score. The range is 1 (poor) to 5 (excellent). Often, if you, as a physician, do not get an average of 5, then there can be a reduction in your salary. Most patients give a

4–5 response, while a considerable proportion give a 3. These scores can have unintended consequences. For example, in 2018 in one university hospital, a physician received an average PG score of 4. That doctor investigated her patient's responses and found that certain population groups never gave more than a score of 3, thereby bringing her average score down. She then refused/minimized her exposure to this low scoring population group, and as a result her salary was raised dramatically!

12.3 Metrics – Benchmarks – Mandates

These terms refer to a variety of different "quality" measurements including average length of hospital stay, time to the patient is seen by a doctor, patient satisfaction scores, hospital infection rates, HIPAA compliance, etc. US hospitals must now report over 500 metrics a year. This is an obscene number as all data collection for all metrics are unfunded/unsubsidized. The hospital pays, which really means the patient and/or the insurance company pays. We need to "reduce" the number of these metrics. However, more and more metrics are added every year. The introduction of HIPAA has made us all much more aware of protecting patient's personal information. That is obviously a good thing. But the hospital's cost of maintaining HIPAA is passed on to the patient by increasing their insurance payments. Hospital expenses to maintain HIPAA compliance include wages to personnel to oversee its implementation, software development, and paying outside companies for document management and shredding.

12.4 Hospital Committees

Hospital leadership touts that all their patient-related hospital committees are physician led. This is not true! Actually, in an unpublished study conducted by the author (JGBU), over 100 anesthesiologists were surveyed at the CSA Annual Meeting in San Diego in 2019. Ninety percent of those surveyed reported that as committee members they were able to attend only 10–20% of all those committee meetings a year. Hence, they could not contribute to the meeting and hospital protocols are being generated by those in attendance, usually nurses and administrators. The lack of physician input leads to an increase in

- Expense for patients
- Burden for patients
- Time wasting for physicians
- Healthcare cost increase without any evidence of improved healthcare delivery

To be clear, physicians cannot attend meetings since they are busy generating income for the institutions. Also, meetings are usually scheduled between the hours of 9 am and 4 pm, times inconvenient for clinicians.

12.5 Another Take on Physician Burnout

Physician burnout has become a major health problem. "Wellness experts" blame physician burnout on personal failure. They believe burnout can be remedied by, for example, coaching of the physician [9]. However, most authorities like the American Medical Association state that burnout is mainly caused by the hospital leadership taking advantage of physician dedication. Physicians are being forced by the hospital to increase their clinical and clerical responsibilities and have little or no control over their working environment [10].

12.6 Suggestions to Solve the Many Problems are Mentioned Below

1. You must become involved in hospital governance and leadership and thereby hopefully take control of your workspace.
2. Medicare and other insurers should link hospitals and medical school's reimbursement to a verifiable ratio of administrators to active healthcare providers. This is to reduce cost associated with nonrevenue-generating healthcare workers.
3. A government/state institution should investigate how many hospital administrators are needed for hospitals of certain sizes, number of sick patients, etc.
4. All future hospital mandates should be paid by the regulatory body that prescribes them, not the hospital. Let the people decide what is needed as regards mandates.
5. HIPAA should be replaced with a law stating that if a healthcare provider is the cause of a HIPAA violation, that worker either loses their license or lose their license after one stern warning.
6. Hospital executives should have their salaries curtailed, and the number of administrators should be decreased. A CEO hospital salary in a large California hospital is over $7 million a year, which includes bonus.
7. Some of the cost savings above [6] should be used to employ physicians to be part of the administration of the hospital management as it pertains to the practice of medicine by attending and contributing to the running of the hospital. This should help to decrease "burnout."
8. Time may be ripe to join a Union of Doctors [11]. Most doctors get a 1099 and therefore are entitled to form a union.

To conclude, you must be involved with the governance of your hospital and hopefully change your workspace to the benefit of all healthcare personnel and the patients we serve. At the same time, always remember to maintain your "good name," that is, be professional (see Appendix D).

Lastly, I like to quote from Margaret Mead:

Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.

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Chapter 13
Careers Outside of Clinical Medicine

John G. Brock-Utne and William W. Feaster

13.1 Introduction

You may be surprised to hear that you are not alone in considering a job change. In general, the average worker will change jobs more than 9.9 times before the age of 35. Unfortunately, for the physician, there are really no choices for job change; you either remain in clinical practice or exit altogether.

This chapter is meant to help you sift through the following two questions:

1. What are some of the common issues and reasons for contemplating leaving clinical medicine?
2. What are some of your options as you set a new trajectory in your life?

13.2 Preamble

If clinical medicine is making your life miserable and mainly for reasons that are out of your control, then don't hesitate, begin looking for alternatives. Remember that the longer you wait to make a transition out of clinical medicine, the harder it can be. It is important you don't waste the best years of your life being miserable.

Did you love the intellectual challenge of medical school only to find third- and fourth-year rotations a long day of scut work without the same degree of challenge, followed by a list of "hurry-up and waits"? You may have found that during

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M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_13

residency your energy was at an all-time low when everybody else seemed to be enjoying themselves round the clock? With all of the constraints on time, were you failing at other important aspects of life outside of work? You didn't go into medicine for the money, but you now see that a large percentage of the sales reps that you work with are 10 years younger than you and many of them are making more than you do. You discover their expense account seems unlimited as they whisk you away to their private golf course and wooing you for your future business. Are you jealous of their freedom? Do you long for the freedom of free time to do what you want with your life? Do you know that your knowledge of medicine is a rare and very marketable asset to any company in the medical arena and beyond, and would you prefer to find an avenue in which you can use it as such? Do you know your work ethic to be superior to anyone outside of medicine but, perhaps, below par within it? Is it the science of your specialty that interests you more than using it to treat patients? In essence, do you find the day-to-day grind in the practice of clinical medicine to be not what you want to continue to do for the rest of your life?

OR,

Do you love medicine, look forward daily to medical/surgical cases and volume? Do you enjoy the status of performing medicine and having patients depend upon your skill as a physician? Do you look forward to clinic so that you can explore diagnostic dilemmas and hone your clinical acumen? Life would feel incomplete if you were not able to deal with people in their time of medical need. You see no concern about performing clinical medicine until you retire.

These are two more dichotomous versions of looking at a physician's role in clinical medicine, and, yet, most of us probably have feelings that match a certain percentage of both. The true soul searching is whether one of the above far exceeds the other and to what degree.

13.3 What Are Some of the Common Reasons People Consider a Job Outside of Clinical Work?

- You are frustrated with current workings of medicine in the United States. You came in to treat patients, but you now see it is more a business. As Rosenthal [1] states, hospitals are being run purely for profit. Because of this, burnout by physicians is common [2]. Burnouts are primarily victims of a healthcare bureaucracy that takes advantages of clinicians' dedication to patient care often at the expense of their own well-being [3–5]. Physicians' burnout is therefore largely a result of the policies of the institutions [3]. It is not as hospital administration will have you to believe that you do not have stress management skills or you have failed to maintain a proper work–life balance [3]. Physicians are placed in situations where they have mandates to increase their clinical and clerical responsibilities but have little control over the environment in which those responsibilities must be fulfilled [3].

- Malpractice insurance can take over a third of a physician's income. In a recent poll conducted by the state of Georgia, 7% of all physicians responding to the survey indicated they plan to leave clinical practice as a result of the malpractice insurance crisis in their state. An additional 4% of respondents indicated plans to retire. The rates were highest among OB/GYNs (13% plan to leave clinical practice and 12% plan to retire) and general surgeons (13% plan to leave clinical practice and 7% plan to retire).
- You meet up with an old friend who now has become a plumber and runs his own business. He does not have your medical school debt. Talking to him about finances, you realize that you may never catch him in real income if you carry on with medicine. According to the *New York Times*, the average physician's net income declined 7% from 1995 to 2003, after adjusting for inflation, while incomes of lawyers and other professionals rose by 7% during the same period.
- You may have been "pushed into" medicine by a parent or family of physicians. In addition, you achieved very good grades in school and everyone said that you would be a fool not to use this to become a doctor. Now, you realize this wasn't your true passion in life, and only that of your family members.
- Your significant other/family pressures you to leave medicine. They feel as though they never see you because of your long work hours, and even when you are available, you have no energy to focus on them. You continue to be unable to make time for key issues related to your wife and children. Simply, they feel they are suffering along with you. You are not alone in this problem. In a John Hopkins study on 1113 postgraduates followed over 30 years, the researchers found that the divorce rates climbed to well over 50% for some specialties especially surgery.
- You may have had a "near miss" in your residency that led you and/or your instructors to reevaluate your suitability for the specialty. Many residents when faced with this dilemma agree with the assessment of their elders but find it hard to accept defeat. The few who do not heed the advice to change into something else, decide to finish the residency either by taking an extra year or two or move to another less competitive program. This circumstance is common, and yet no studies have been done to evaluate how these residents have done in the long term. It may be likely that the resident considers this to be his/her only option and perhaps never considered other alternatives available via a nonclinical route. JGBU has unfortunately seen examples of a resident who persevered in a surgical specialty failed and had to retire to family practice. He could not see any other option but medicine and was miserable for the rest of his life.
- You observe with dismay that the public respect for the physician has fallen dramatically. The popular presses make doctoring look simplistic. Often, patients have unrealistic views of their medical/surgical problem and refuse to see that the disease process or processes will interfere with a continued long and productive life. You struggle with these patients and other similar patient dilemmas.
- Lastly, there may be a physical/mental reason that you decide that medicine is no longer for you.

Having highlighted some of the causes that may lead physicians to consider a career change, you should now look within yourself. There may be several of the above points that are pertinent to you. Then you must ask yourself: Can you change any of these personally, or are they out of your control? Can you find others to discuss your challenges with? Can you find people that have managed to be either unsuccessful or successful with either choice, and do you have the characteristics that you think will make you a success in the nonclinical vs. clinical arena? Ultimately, it is a very personal decision.

Do remember that it is not a good idea to run from a bad experience to an unknown one unless, of course, you are forced to? If you can change most, if not all, of your concerns, then you will most likely choose to stay within clinical medicine. Remember also that although the grass may look greener, often it is not true and a true Utopia does not exist. You should also be introspective about the potential that your need to leave medicine might contain an internal need unmet and that a job change may not resolve the issue.

No matter what the reason, you should know that most physicians that look into a nonclinical career do just that; look. In the end, you will be fearful of jumping off track. Let's face it, you went into medicine because it was something you were capable and interested in doing, it appeared to be a secure form of work, and the intellectual challenge, perhaps, as difficult as any. Clearly, there is no job like it. But today, security is not a foregone conclusion; it is likely with even minor lapses in decision making, you could find yourself in the least secure position of all, and at the most disastrous time of life. If you believe this to be a likely course for your future, you ought to consider strongly other alternatives before this occurs.

If the balance for you is to move away from clinical medicine, there are choices, in fact, very good ones. These may allow you to be more creative, garner more personal freedom, travel, be a leader, work with larger groups of people, and, ultimately, you can hopefully find your fit outside of clinical medicine with your unique background.

Remember, you have achieved something great by just having the opportunity to practice medicine; if, in the end, it is not for you, that does not mean you are a failure. The same work ethic and mental prowess that allowed you to get into medical school and complete residency will carry you toward success in many areas of interest that you decide to pursue.

13.4 How Do You Find Something Else to Do Outside of Clinical Medicine?

Choices exist for the following either full- or part time:

- Work at a hospital as a medical administrator/health care.
- Remain in the medical field and use your knowledge in research.
- Find a home in business within the industry of medicine.
  - Advisor to medical devices and supply company
  - Pharmaceutical industry

- Medical education
- Corporate physician jobs and insurance medicine.
- Healthcare consultant
- Medical journalism, workshops, public speaking
- Medical writer/editor of both peer reviews and open access journals
- Advisor to venture capital funds
- Expert witness/medical malpractice expert
- Advisor to medical startups
- Become an inventor
- Forensic medical examiner/researcher
- Online physician jobs like in telemedicine
- Medical translation if you have the skillset of another language
- Medical IT to assist healthcare systems
- Attorney/paralegal or a consultant or advisors for lawyers

Move outside of medical field altogether
Get creative, invent something, perhaps, related to the medical industry

13.5 Part Timing It

You've spent a long time training to be a physician and you don't want to give it up completely, but you would like to use your knowledge and skills in some other way in addition to your practice. Physicians have a treasure trove of work options in addition to their practice.

There is one caveat. Before pursuing other options, you will need some practice time under your belt to get credibility as a physician (especially with other physicians). How long will that take? Other than taking on additional roles in your practice, or participating on hospital committees, you need to prove yourself as a clinician for a minimum of 3–5 years prior to pursuing a significant role outside of your practice.

Some specialties make getting involved in other jobs quite easy. They are typically specialties without continuing patient responsibilities past a defined work commitment of a shift covering the emergency room (emergency medicine) or a scheduled day in the operating room (anesthesia). Primary care specialties are the opposite extreme. You are responsible for a population of people who have the nasty habit of needing you whenever they are sick and, often, at a time very inconvenient for the other activities you are pursuing.

Participating in other activities outside of your practice is hard work. Chances are you will work more hours than full-time practice, as, at least early on, most of these jobs are additive to your other responsibilities. You'll need to get more education, something that isn't easy to do in a busy practice. You'll need to be patient through all the years of proving yourself clinically, and positioning yourself for these other roles. Along the way, you may make less money rather than more, if you substitute volunteer or lesser-paid activities for patient care.

13.6 Medical Administrator (See Chapter 12)

Getting involved with your clinic/hospital committees and responsibilities within your practice is the first step toward work in medical administration. The hospital/clinic administration gets to know you. For doctors in practices with continuing patient care responsibilities, this is sometimes very difficult to achieve. You may be able to convince members of your practice to cover your clinical work while you spend time doing administrative activities within the practice. However, members of your group may be less willing to cover for you to attend hospital/clinic meetings that they perceived have little direct benefit to them. Unfortunately, because of this many hospital/clinics have no physician input and this can lead to protocols, etc., that waste physician's time and may not be in the best interest of the patient (see Sect. 12.4).

Going up through the ranks of the medical staff is the best way to get involved in hospital administration. You start as mentioned by participating in medical staff committees, eventually serving as chair. These positions can elevate you eventually to Medical Staff President. In this role, you are seen as a leader, directly interacting with the senior management of a hospital. Here you will get good, first-hand knowledge of how things work in this very complex environment. This role prepares you for additional ones where your leadership abilities can continue to be utilized, either in other medical staff or hospital positions.

On-the-job training is essential, but additional education is a must if you want to advance in hospital administration. A master's-level degree in business or healthcare administration is a logical choice if you have the time or energy to complete one. There are numerous "executive" MBA programs available through colleges and universities in all major cities. There are also numerous educational opportunities that incorporate generous amounts of home study, keeping time away from home to a minimum. Some programs allow you to get credit toward a degree for individual classes taken in a conference-like setting or online. Most of these more time-friendly courses are offered in collaboration with the American Association of Physician Leadership (AAPL). Go online at www.physicianleaders.org to review these options. AAPL also offers a certification track for physician executives similar to a board certification in a specialty; however, this hasn't been well recognized to date.

13.7 Industry

If you want to remain in the medical field, perhaps even in your defined specialty, there is always an industry that supports your specialty of interest. Sometimes that industry can be many billions of dollars in size. Options for medical devices, capital equipment, and pharmacology exist and should be explored based upon your interest.

It is often best to show how you can perform in communicating with your colleagues on their level – physician to physician. Hiring personnel will be wary of someone that thinks they are the cat's meow. Show that you are willing and able to

suffer in the job role as anyone else. And above all, make sure you are the best in the company at the skill of interest.

A technical sales representative position can get you necessary face time with many physicians across the country and show your level of intellect to many parties within the company. Soon, you will become the “go to” person for training and advice. Once you have established your value to the company, look toward improving the company and realize that you may be the only person in the company that really knows what you’re talking about. Keep your focus on future perspectives for the company; feel confident in your knowledge and assert yourself where you feel confident in your decisions. The rest of the company has far too much focus on the next quarter. But when they look back, they will recognize that you either warned them of issues or provided them with answers many months or years ahead of the rest of the workforce. This can be great fun as you sell the vision of what the company can achieve for the future, and you can become rather personally invested in the solutions that you are set out to create.

Start by researching areas that are ill defined as to how they will influence the future of that specialty. This is where your knowledge base will be most useful, particularly if the subject matter is difficult. Find ways to communicate the value that you would bring to this company. Ultimately, there are likely examples of leaders in the company that are the same as you, although few and far between. Seek them out as mentors both before and after the job acquisition. By the way, these same companies often spend terrific amounts of money for MDs as outside consultants. You can, with your expertise, save them both money and provide value.

Working in the medical industry can be very rewarding, both professionally and financially. With you on their team, the company will tend to use you to offer a higher degree of product knowledge and legitimacy. Surgical specialties with their dependence on medical devices and capital equipment offer a wealth of opportunities for your knowledge base to shine through. Medical devices offer a disposable income for the company and can garner large wealth quickly but you will likely be used to develop relationships; capital sales can give you access to a higher level of sales interaction as the product usually involves some equipment offered to improve surgical outcome. You will find amazing the number of leaders you will immediately be exposed to. Orthopedics is a prime example as there are many companies that compete to sell orthopedic products. But other specialties offer similar opportunities especially as new, more inventive, minimally invasive procedures are developed. However, using equipment and devices can be technically challenging for a busy physician to integrate into his/her practice, hence the advantage of a person with a medical degree to help the transition.

There are quite a few physicians who want to work in the medical industry, but very few who can show a clear commitment to it. You will need to differentiate yourself from the countless others who have a similar goal. The three “As” of success in practice (available, affable, and able) also apply to the medical industry. If you are asked by a sales representative of a company to give a presentation on their product, and you’re interested in doing work for that company, say yes (available). In your dealings with that sales representative, be friendly (affable) and when you go to give the talk, do a bang-up job on your presentation (able). More invitations

will follow, perhaps an invitation to join the medical advisory board of the company, etc. This builds your medical industry resume, expands your contacts, and gets your foot in the door for a larger role. Soon, you will find other companies seeking your expertise. If you're working with a start-up company, don't expect a lot of money for these types of activities – they just don't have it. Lord knows we have existed on meager earnings before it might be time to take your investment in the form of stock options and profit sharing. Still, remember that you have medical school debt that others in the company do not have, and you offer something very few, if any, can offer in terms of value. When the time is right, stick up for yourself and demand compensation. They will see that you have unique qualities and will not be willing to lose you. A recent study was shown for MDs outside of clinical practice in which their hourly pay rate neared $1000/hour.

13.8 Research

If you like the science of medicine more than clinical practice, you might find a perfect home within research. You are still an MD and your knowledge base can be exceedingly useful in research and your long-term productivity for the science, perhaps, many times greater than if you remained in clinical practice.

As data science and artificial intelligence becomes more prominent in clinical medicine, the close working relationship between the data scientist and the clinician is essential to creating tools to augment patient care.

However, the importance of data validation, its description as part of the method section, and the cleaning and analysis script as a supplemental appendix in big data sets should not be underestimated. Doing so will give the readers confidence that the conclusions are valid.

It is essential to develop a standardized transparent validation process for big clinical data. This process should include statistically appropriate random sampling of the original data. Without such a process, it is impossible to determine the validity of the conclusions for these studies [6].

13.9 Outside of Medicine Altogether

If you know both what you want to do and the location you want to work in, then it can be easy. However, always check your facts. Is this a real job, does it pay, what about housing and schooling, what are the locals like, etc.? A resident, I knew, after leaving residency became a deep sea treasure seeker of the Florida coast and never looked back. However, I know he and his wife did their homework prior to the move and so must you.

If you know what you want to do but are uncertain as to the location, then it can potentially become more difficult. It is imperative that you search the location thoroughly prior to committing yourself. Comparing places is imperative.

If you don't know what to do but the most important thing for you is the region that you want to live in, then this can also turn out to be potentially a big problem. It is imperative that you go there for a visit. Stay in a bed and breakfast for 2–3 weeks. Read the local newspaper to find out who is who in the place and peruse the job section. It is advisable to speak to as many people as you can (in coffee shops, etc.). Survey the real estate market, visit local municipality (looking at house zoning, etc.), schools, supermarkets, and museums. All this will give you a flavor of the place. I know a colleague who, after some years in a specialty, decided he had enough. He went to Hawaii and bought a piece of land. There, he was going to build his dream house. He knew he would need help with the building; so, he very cleverly got a job in the town's hardware store. Not only did he get 15% off on all the materials he bought, but he got to know a lot of plumbers, builders, etc. These became his friends, and soon they were busy helping him building his house at a reduced rate. He is still working in the hardware store 10 years later.

If you don't know what do to and the region you want to settle in is also immaterial, then you have an even bigger problem. There are many publications that may guide you toward a successful nonmedical career (see Suggested Reading at the end of this chapter). You can also get career counseling from specialists in the field, government agencies, or contact a recruiter. Although the latter is really there to "headhunt" you, they should have knowledge about career changes and your aptitude for a special job. At many universities, there are career counseling services that can be useful for you.

13.10 Get Creative, Be an Entrepreneur

There are numerous examples of successful entrepreneurs in medicine and most have advanced degrees, majority being MDs. You have experienced the inner workings of medicine. You know the flaws of performing clinical medicine, and you can dedicate a percentage of your time now to solving them.

The mother of creativity is necessity. Think about your troubles in medicine and what you don't like about it, get creative about inventing solutions. Science tends to integrate technology at a fairly rapid pace, although clinical medicine much more slowly. An exception here is the development of the oximeter.

13.11 Examples Abound

A resident in orthopedics left in his PGY 4 years. After working for several companies in the industry, he started a company on the side for 72 dollars that uses Nintendo Wii's to do home shoulder physical therapy. This creative idea was valued by a venture capital firm at over 4 million within the year.

Another such MD began developing surgeon websites. He has more than 480 websites at the moment and is expanding into other segments that use the Internet

to educate and instruct patients how to make smart decisions about their healthcare choices.

Another MD began a think tank that delivers intellectual property as licensed product to implant companies.

And still another MD began consulting with hospitals to deliver technology advancements and marketing advantages across the entire spectrum of in-hospital care.

The possibilities are endless.

13.12 Conclusion

You and your family will have to make a decision to pursue a nonmedical career or not. Nobody will or should do it for you. The best advice, as to finding out what is the best thing for you, is to ask yourself: “Will this make me happy?” This can be a difficult question to answer. However, the following question may be easier: “What is it that makes you happy?” If it is making wooden tables, being out in the nature, scuba diving for sunken treasures, or working in industry instead of clinical medicine, then, by all means, do your best to make your dream a reality.

Acknowledgment The authors acknowledge the help of Dr. Blaine Warkentine for his valuable contribution to this chapter seen in the first edition of *Life After Residency*.

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Chapter 14
Physician Wellness

William W. Feaster and Sandra Feaster

14.1 Healthy Lifestyles Are Hard to Establish During Residency and During a Busy Medical Career

You may have put aside many of the healthy routines of exercise and diet you initially established during your college years and medical school once you enter residency. Residency is very stressful on both your mind and body. Even with work-hour restrictions, little time is left outside of work to do more than try to catch up on sleep. The stress of this work takes an additional toll on your body, leading to higher levels of cortisol and stress eating.[1] Often residents forgo exercise during residency, and when coupled with the above, can gain significant amounts of weight.

So now you're entering the next phase of your life, the practice of medicine. This phase will last about 30 or more years. If you continue your habits of too much work, high stress, overeating, and little or no exercise, by the time retirement rolls around, your body will be a mess and your longevity will be reduced. You won't be around long enough to enjoy all that money you put away for retirement we discussed in Chapter 9!

You need to both start a new career AND a new lifestyle, focusing on healthy eating, appropriate exercise, and stress reduction. Do it for yourself and your family, they are counting on you. So, let's discuss this further.

[1] https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/stress/art-20046037

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M. T. Berhow et al., *Life After Residency*,
https://doi.org/10.1007/978-3-030-93374-6_14

14.2 Healthy Eating

During residency, time is of the essence. Eating fast, grabbing food on the run, and even nibbling junk food that is in the resident's room or at the nursing station becomes the routine. Think holiday time when all those grateful patients and family bring chocolate, cake, etc. You may not even realize that you are eating it.

Hospitals are not known for providing a broad selection of healthy food choices. I (WF) did a fellowship at Children's Hospital of Philadelphia. A McDonald's restaurant was in the hospital lobby, presumably to provide and alternative and inexpensive food choice for families. Clinical obligations often came up during hours the cafeteria was open (their food wasn't that healthy either), so late evening trips to McDonald's were common. One or two Big Macs, fries, and a milkshake were the routine. Have you ever set a McDonald's shake down when something prevented its immediate consumption? It settled out to a foam layer over a watery base. I hope they've changed that now, but I never went to another McDonald's after leaving Philadelphia!

14.2.1 What You Eat

The first step in eating healthy is to slow down and think. Medical school does not teach much in the way of nutrition, so what is a healthy food choice?

1. If it comes from the ground, it's generally healthy. Think vegetables or fruit from a tree.
2. If it's in a package, the first thing to look at are the ingredients. Here are three things to think about before you open/purchase that package:
   Are there greater than 10 ingredients?
   Can you pronounce the ingredients?
   What is the actual serving size (does the nutritional information match a SINGLE serving)?

If number two and three don't sit well with you – don't eat it! Default to number one. Remember, it's hard to change your taste buds, especially if you have been eating items that have a fair amount of sugar and salt. Most of the fast food contains these two elements. Your body adapts and craves these items, but they will bite you as you get older.

14.2.2 What You Drink

Grabbing that soft drink with caffeine was a staple for many. Those resident refrigerators were stocked full. It doesn't really matter if they were full of sugar or diet. Your body senses them both the same. More people with metabolic syndrome sip on diet soft drinks. Maybe it's coffee or tea – a better choice than soft drinks for sure.

After a long day or stressful day, you may find your alcohol consumption on the rise. Be mindful why you are drinking alcohol and how much. A DUI can cost you your license (see Chapter 7).

14.3 Appropriate Exercise

Exercise is always a challenge unless you are an athlete, and even then, it can be very difficult. There is the weekend athlete, they play hard, and often get injured and sidelined. Trying to manage work obligations, family obligations, and everything that comes in between leaves little time for exercise or other self-care activities. It's important to remember that exercise really is the bargain of a lifetime. It promotes longevity and can help you live longer with less disability. Inactivity leads to increase risk factors of cardiac and metabolic disease. Exercising today can help prevent you from taking medications later in life for high blood pressure, lowering cholesterol and maybe even type 2 diabetes meds.[2]

There are generally three common excuses for not getting exercise:

1. I don't have time
2. I'm not motivated
3. I don't know what to do

The first, I don't have time, is perfectly understandable. You get up, go to work, come home, have family obligations, or need to complete your day's work and then it's bedtime. Just like our work schedule, if you can find a time that you know will work (mornings are often best), you can start small and build up a routine that will last. Putting the time on your schedule/calendar to be sure you get out and move. It could be a short walk at lunchtime. People that move more tend to feel better, sleep better, and are healthier. You can even do "exercise hacks" during the day. Between patients, catch a few squats or push-ups against a counter or wall. A quick 5–10 minutes jumping rope (with or without rope) in the morning before your shower can be incorporated into your daily routine. Your blood will start flowing, and you will begin the day with more energy.

Motivation is a bit more difficult. Often when we are tired or depressed, it's hard to do anything except those items that are absolutely required. Motivation is fickle, it ebbs and flows when it comes to eating or exercising. We humans just aren't that strong, and we'll often give in to temptation. The best way to outwit poor motivation is to make something easy. For example, if you want to start walking or running, but in the morning, you find it's just too hard to get out of bed, you can take a few approaches.

- Put your alarm across the room and set it to give you some extra time to exercise.
- Have your gear set out the night before. Just seeing those shorts and shoes will make it easier to put them on. Once they are on, you have overcome half the battle.
- Now just do something – 1 minute or 1 hour, you are starting a new habit that will become easier each time you do it.

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[2] Foreman, Judy. *Exercise is Medicine*. Oxford University Press, NY, 2020.

The last common excuse is, I don't know what to do. We are told we need 150 minutes of exercise a week. What type, how often, how much at one sitting? You may think you need to attend an exercise class or go to the gym for 1 hour. When you don't have 1 hour, guess what happens? It doesn't happen.

Think differently to redesign your activities to fit your schedule and that of your family. If you have kids, can you take them with you for a walk, play ball with them, or go swimming? Getting exercise together creates a bond and sets good habits for younger children that will take them into adulthood. Is there something you can do with your partner or friends? Maybe it's a bike ride, game of tennis, or even ice hockey. These activities will help with social engagement, get you mind off work, and can lead to a generally brighter outlook on life and your patients.

We can always work harder and longer. But it is your day and you have choices regarding how you allocate your time and activities. Just like in finance and asset allocation, the same goes with what we choose to do during the day and evening. Maybe it's time to do a little shift in your personal asset allocation. We have yet to hear someone bemoan that they wanted on their tombstone –"I should have worked harder." We have seen so many friends and colleagues that spent all their time working in medicine only to regret the time they missed with their family and friends and the ability to just notice the world and all it has to offer. Time goes faster than you think, and each minute lost can never be regained. Even a walk around the block to smell the fresh air and look at the flowers will have positive benefits to your health and mental status.

14.4 Stress Reduction

We know stress is bad for your health. High levels of the various stress hormones and mediators, especially cortisol, can negatively impact a variety of organ functions, especially the brain and cognition, cardiovascular, immunity and metabolic function. For female residents contemplating pregnancy, they can negatively affect your pregnancy and the fetus. You studied all this in medical school. Now it's time to apply it to your health.

Perhaps the best way to mitigate stress is routine exercise. Practices of yoga and meditation are also effective, but out of the scope of this chapter. Adequate sleep is another key to stress reduction. While you probably learned a lot about stress hormones and mediators in medical school, chances are you learned little about sleep and its importance in health and stress reduction. A good book about sleep is a recent text by Matthew Walker, PhD, footnoted below.[3]

[3] Matthew Walker, PhD. *Why We Sleep.* Scribner, NY, 2017.

14.4.1 *The Many Causes of Physician Burnout and How to Avoid or Mitigate It*

Let's assume you've taken care of yourself as we've discussed above. Burnout is still a risk. There's a lot of discussion these days about physician burnout. It's very real and is the topic of books, journal articles, survey results, social media, and other communications.

Populations of physicians have been surveyed by the Maslach Burnout Inventory and other less formal questionnaires. This survey has three subscales to evaluate the domains of emotional exhaustion, depersonalization, and low personal accomplishment.[4] It is also associated with depression and suicidal ideation.

Utilizing this survey and other indicators of burnout, Shanafelt et. al.[5] published that physicians had the highest rate of burnout of other types of employment with nearly 46% of physicians having at least one symptom of burnout. Their article observes that those in family medicine, internal medicine, and emergency medicine have the highest levels. They also asked questions about depression and suicidal ideation as well as satisfaction with work–life balance. Also, 37% and 6.4% of responders, respectively, reported depression and suicidal ideation, and 37% of physicians were dissatisfied with their work–life balance. Those specialties with lower work hours and better work–life balance reported the least amount of burnout. There is a message here!

So, what are the specific causes of this high level of burnout, in addition to the obvious work–life imbalance? On a recent survey of physicians in our Children's Hospital[6], the most common causes listed by our physicians in order of were as follows:

- No control over my workload
- Lack of shared values with organization leadership
- Lack of autonomy in my job
- After-hours workload
- Too much time spent on bureaucratic tasks
- EHR or other IT tools hurt my efficiency

In addition to issues related to work–life balance, specifically after-hour workload, a recurring theme is lack of control over the physician's work with excessive bureaucratic burdens imposed on the practice of medicine. An Electronic Health Record (EHR) reducing efficiency doesn't help.[7] Putting into perspective, however, the EHR has become irreplaceable in today's highly data-driven health care.

---

[4] Maslach C, Jackson S, Leiter M. Maslach Burnout Inventory Manual 3rd ed. Palo Alto, CA: Consulting Psychologists Press, 1996.

[5] Shanafelt, et. Al. Arch Intern Med 2012:172(18):1377-1385.

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Whatever EHR you are using, become an expert at using it to improve your efficiency.

All physicians (including you) will likely experience some degree or type of burnout throughout a career in medicine. So, the question is how you can avoid it or at least minimize its impact on your life and practice.

Establishing good work–life balance, along with a healthy lifestyle incorporating exercising, a healthy diet, and stress reduction as covered earlier in this chapter, is key to a successful long-term practice. This is especially important for those of you who have chosen one of the practices most prone to burnout, as mentioned earlier. As more primary care practices like family practice and internal medicine move to an employment model, establishing work–life balance may be easier for the practitioner, but other issues like lack of autonomy and control of workload may become an issue.

Sometimes, burnout can't be managed, and a career change is the only alternative. Chapter 13 provides the practitioner with several nonpractice alternatives to consider.

Appendix A: Sample Physician CV

Melissa T. Berhow

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Home: 202-456-1111
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Fax: 202-456-2461
Email: Heidi@theeisenhowers.com DOB: 08-18-81
American Board of Anesthesiology: Board Eligible
California Medical License: CA1234567

Postgraduate Training
July 2020–June 2021: Chief Resident, Department of Anesthesiology, Stanford University Hospital and Clinics, Palo Alto, CA.

July 2018–June 2020: Anesthesia Residency, Stanford University Hospital and Clinics, Palo Alto, CA.

July 2017–June 2018: Internship, Yale-New Haven Hospital, New Haven, CT

Education

August 2013–May 2017 Yale University School of Medicine, MD.

September 2009–June 2013 University of California at Los Angeles. BA in Psychology

Professional Experience
January 2017–June 2017: Medical volunteer for Doctors without Borders.

June 2015–August 2015 Volunteer at Hole in the Wall camp for children.

January 2010–May 2010 Diabetes counselor at outpatient clinic in Compton, CA.

October 2010–June 2012: Phlebotomist at Harbor View Medical Center.

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Professional Societies

American Society of Anesthesiologists.

California Society of Anesthesiologist. American Medical Association.

Awards Received

Resident of the Year 2020 Department of Anesthesiology, Stanford Hospitals and Clinics.

AOA: Yale University School of Medicine.

Publications

Lincoln A, Washington G, and Eisenhower H: Use of oxygen supplementation to augment analgesia following neuroaxial blocks in parturients. Journal of Clinical Extras 91(2) 2017: pp. 672–682.

Eisenhower H, Clinton S, and Kennedy M: Comparisons of anesthesia requirements for canines vs. human patients. Journal of Washington DC Anesthesia 61(3) 2016: pp. 6–12.

Eisenhower H and Churchill W: Variability of antiemetic dosing requirements based on pedigree. Journal of Comparative Canine Anesthesia 12(4) 2013: pp. 234–456.

Outside Interests

Traveling, triathlons, fluent in German

Appendix B: Job Search Timeline Worksheet

Melissa T. Berhow

- *10–12 months before graduation:*[3]
  - Prioritize traits of your ideal job. Complete job search worksheet detailed in Chapter 1.
  - Speak with your program's residency director to optimize use of local resources (e.g., alumni networks).
  - Identify regional or association meetings for networking opportunities.

- *8–10 months before graduation:*
  - Prepare CV and cover letter.
  - Print business cards or other "handouts" for use when attending meetings.
  - Attend regional or association meetings.
  - Prepare list of jobs you are interested in.
  - Contact potential employers.

- *6–8 months before graduation:*
  - Practice interviews with local faculty.
  - Actual interviews.

- *6 months:*
  - Review contact and secure job.
  - Begin licensing process if moving out of state.[4]

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Appendix C: Sample Timeline – Months Prior to Anticipated Practice Start Date

Melissa T. Berhow

Six Months
Write or contact the Medical Staff office of the hospital(s) and surgery center(s) in which you intend to practice and request that an application package be sent to you. Some hospitals require a "pre-application form" that much be completed, returned, and reviewed before the application package is sent.

Five Months
Complete application packet and return it with any requested application fees. The application will include a request for references. This is a good time to contact references to let them know they will receive an inquiry from "Hospital X" regarding your application. The application will also include a request for privileges, as well as a series of questions regarding prior malpractice claims against you, any adverse actions from licensing boards or Medical Staffs, drug abuse, etc. It is very important that you answer all of these questions as accurately as possible since they will be checking the validity of all of your answers through database queries.

Four Months
Contact your new practice administrator to ensure that efforts are being taken to obtain any necessary billing numbers from state or governmental agencies and that your credentialing for various insurance companies is proceeding on schedule. At this time, the Medical Staff office is verifying all of your application items, including your medical school graduation, residency completion, etc. References will hopefully be returned soon, or processing your application may be delayed. It is a good idea to call the office and verify that all items pertaining to your application are complete.

Three Months
Your application has likely been verified by the Medical Staff credentials office, and has been forwarded to the Department Chairman for a sign-off on your requested

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privileges. The Department Chairman usually has 30 days to turn this around and return the file to the Medical Staff office.

Two Months

Your application and request for privileges goes to the Medical Staff Credentials Committee for review and approval. If no issues during the verification process arose, this is generally a "rubber stamp." If your license is still pending for the state where you intend to practice, your application may be provisionally advanced pending the granting of your license, or held up at this point until it is granted.

One Month

Your packet of information is finally presented to the Hospital's Board of Directors for approval and ultimately signed off by the Hospital's Chief Executive Officer. At this point, you are fully credentialed in the organization and have been granted interim privileges pending proctoring by assigned staff members.

Appendix D: Tips on How to Maintain Your "Good Name," that is, Being Professional

John G. Brock-Utne

Professionalism is another word for good behavior.

One of my elementary school teachers in a small school (14 pupils in total) in Norway put good behavior this way:

Reputation is what people think you are. Character is what God knows you are.

To successfully transition and maintaining your excellent reputation in your new job it is imperative that you carry on with your good behavior.

Here are some tips in no particular order

1. Be punctual. People do understand that that there are times that you may not be able to be at your designated post on time. But your lateness should not be seen with monotonous regularity.
2. Answer your pages promptly.
3. Always introduce yourself. Make sure the patients and relatives see your badge and make sure they know that you are an MD.
4. Never presume that the person accompanying a patient is a daughter/son or a wife/husband. Always say: And you are?
5. Your job as a physician is divided into three:

   (a). Rapidly recognize the patient's ability to communicate and their anxiety level.
   (b). Collect information necessary for safe patient care.
   (c). Reassure and support the patient with or without medication.
   If you are successful, then the patient will be informed, calm, and motivated to cooperate.

6. Always attempt to follow up with your patients as to how they are doing following your treatment. This to help mitigate hopefully any patient concerns or unhappy patients and/or relatives.

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https://doi.org/10.1007/978-3-030-93374-6

7. A confrontation with a colleague can be difficult to manager. But it must always be done with only the two of you. It must never be in front of patients or staff. Remember that this type of altercation can harm patient care and your reputation.
8. Willingness to help a colleague is vital. It shows that you are dependable.
9. Maintain your medical licenses.
10. Don't post anything silly on social media. I know of residents/fellows who have had their job offer rescinded after the prospective employer/chief of staff read what they had placed on Facebook.
11. Be a member of your professional organization and even contribute by becoming an elected official.
12. Avoid substance and alcohol abuse.

Lastly, if you are professional, you will get a good name. Unfortunately, a BAD name is very easy to get. Also be aware that to get a GOOD name after a BAD name is very difficult.

Good luck, smile, and enjoy being a physician. The latter is imperative to succeed in your quest.

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