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The Job Search

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Introduction

Why a chapter on the job search? The simple answer is that physicians make mistakes. National experience suggests that 50 percent of physicians change jobs within the first two years.¹ This number is significant and disturbing.

Question: What gives us the authority to write on this subject? Answer: Interest and experience. We have worked in venues that cross a multitude of work cultures.

Prior to medical school, I was an associate in a private dental practice. I have completed two residencies at traditional universities — one state and one private. I have completed a residency and a fellowship at the Mayo Clinic and the M. D. Anderson Cancer Center, respectively, both of which represent the ultimate in multi-group practices. I have been employed by the government-funded U.S. Department of Veterans Affairs (VA) as chief of plastic surgery, and in academic practice at a university hospital with a private multi-group specialty practice. I am now a solo private practitioner. The only stint I need to punch my ticket is the military, although as a closed system the VA is similar. This laundry list illustrates the scope of my personal insight on the job search.

A mismatch in expectation and practice culture is a major contributor to physician turnover. The three top reasons for leaving a practice are (1) poor cultural fit with the practice (51 percent), (2) relocating closer to family (42 percent), and (3) compensation (32 percent).² Low compensation correlates with dissatisfaction, whereas high compensation does not as clearly match satisfaction.³

Not only does the need to find a new job emotionally and financially impact on the surgeon, it also impacts the employer. A primary care practice will spend US\$235,000 to add a physician.² It is quite understandable that the cost to

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add a surgeon is even higher. We believe that the two reasons the physician turnover number is so high are (1) inadequate prioritizations of the physician's values and (2) a failure of cultural fit. The two are intimately intertwined: the first is ineffectively analyzing yourself, and the second is ineffectively analyzing your potential employer.

Priorities

The first step in the job search is to inventory what is important to you and to your family. What are your priorities? Consider *your* goals and things of importance, not the priorities of your attending role models. If family time is a top priority, then becoming an internationally known chairman of a program may not fit.

This personal inventory should include spouse/partner input. Sit with them and have a long talk. Set long-term five- and ten-year goals, and differentiate needs versus wants. What will be your commitment to medicine, and what will be your commitment to yourself and your family?⁴ What are their needs? The following topics might be included on a priority list:

Family	Predictability
Income	Proximity to Family
Autonomy	Vacation
Security	Call
Location	Weather
Power	Sports
Diversity	Work Type
Excitement	Recognition

Sometimes these priorities or expectations for a job are conflicting:

Expectations		
Income	vs.	Lifestyle
Industry	vs.	Family
Environment	vs.	Opportunity
Location	vs.	Patient Pool
Benefits	vs.	Retirement
Security	vs.	Reimbursement

When preparing your priority list, realize that money and success equal money and success. Your priorities do not necessitate doing the same job, cases, or position as your current attending or mentors.

When prioritizing, two big decisions are often opposing: (1) location vs. job and (2) opportunity vs. job. The first tradeoff is that you can settle on a location based on desire, family, or lifestyle, but compromise on your choice of position. Perhaps the ideal job may not be in the ideal location. Consider if an urban/suburban or rural location is a good start for you, then weigh criteria such as family, leisure opportunities, or access to sporting events.

The second tradeoff is accepting a job offer rather than embracing an opportunity. A job opening is often available because it has been vacated by someone else. Why? Chaos provides opportunity; thus, a hospital or department in transition may provide that opportunity to you. So, do not eliminate an opportunity just because the environment seems to be in flux. The Chinese symbol for change is composed of two characters, one representing threat and the other representing opportunity (Fig. 1).

When considering the job search, never underestimate an edge, and use it whenever possible. Joining your father's practice will shave ten years from your developmental process. Do you have special contacts? Do you speak a selective language? Can you make an offer to an ethnic group that seeks a customized service such as Asian eyelids? When I was a resident, a plastics fellow with a last name of one of the signature eponymous operations in plastic surgery graduated one year after his father electively retired. To not take advantage of "passing the baton" seemed strange.

You must analyze your own skill sets. Are you entrepreneurial or do you have no such inclination? Was your lemonade stand the best in the neighborhood? How are your leadership skills? Do you enjoy negotiations? If you do not, then you need to seriously consider being in a position where someone



Fig. 1. The Chinese symbol for "change" is composed of two characters, one representing threat and the other representing opportunity.

else does that for you, i.e., a group practice. In solo practice, the need for negotiation cannot be overstressed.

Dos and **Don't**s for Planning a Job Search⁵

Do think about your work style, ideal work environment, and personal needs before you launch a job search.

Do take your significant other's needs into consideration.

Do learn something about an area — including the housing, economy, amenities, and malpractice climate — before assessing job opportunities there.

Do research various practice types, and decide which is more likely to mesh with your personality and career goals.

Do talk to mentors, medical school faculty, residency program alumni, colleagues, and others to gather information and help clarify your goals.

Do think about getting additional training if you are unhappy in your current job situation.

Don't limit yourself to one type of practice. As a physician, you have many options to choose from.

Don't move anywhere *just* for a job.

Don't rush your job search. Give yourself time to develop and implement a strategy.

The Search

Often the best positions, opportunities, or practices are in the hidden job market. These positions are not advertised, but can be found through networks or resources such as alumni groups. Three-fourths of jobs are not advertised.⁵ You therefore need to network beyond your inner circle, i.e., healthcare consultants, representatives, attorneys, or accountants. **Networking means tapping into the collective experience at your disposal.** A non-threatening way to begin is to solicit an attending from your program to introduce you to several people at a meeting. At each interaction, appeal to the ego by first asking for advice, not a job (Fig. 2).

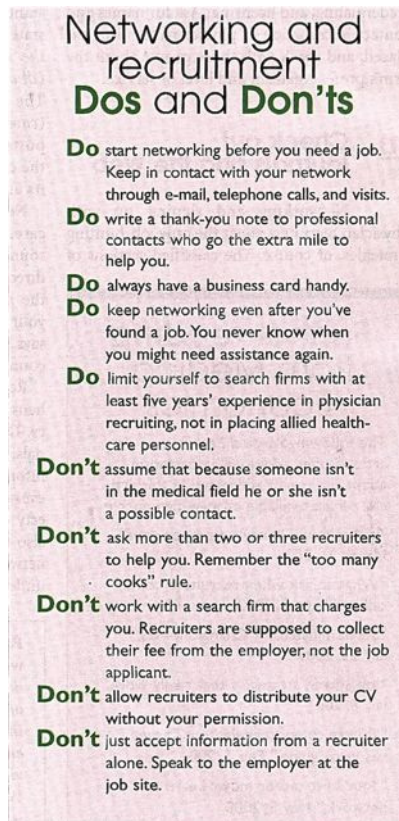


Fig. 2. Networking dos and don'ts.

Recruitment Firms

Search or recruitment firms function either as your agent or as your practice's agent. If the firm represents the practice, ask yourself why this job needs a recruitment firm. In our experience, it is usually location or high turnover in staff. The sales literature all reads the same: "Unique opportunity in a growth practice; four-season environment with excellent recreation, living, and cultural opportunities," etc. However, the information is nearly always lacking. Most agencies work for contingency fees under which the practice pays the recruitment agency, for example, one-third of your first year's salary. The price of their networking for you is that their commission erodes your upfront

bargaining power. Plastic surgery is not such an invaluable commodity that price is not an option. An agent's cut comes from your end in the form of bonuses, moving expenses, or commissions. The only example whereby we can envision a recruiter working for you is if you have such a marketable skill that all power is yours, such as trauma neurosurgeons or interventional radiologists that are needed to fulfill Emergency Medical Treatment and Active Labor Act (EMTALA) functions at hospitals. If you are set on a certain area, write a cover letter to all of the practices in the area to inquire about opportunities.

The "sister" to the recruiter is the career counselor. Career counselors are paid for by you and, as such, you utilize them as a career coach. Their motivation is directed toward your interests. I have found my attorney to be an excellent coach.⁶ The only problem is that I have to talk quickly because he charges US\$500 per hour!

Types of Positions

Historically, the majority of plastic surgeons were solo practitioners; however, times have changed. In 1997, 75 percent of surgical specialists were independent. In 2005, that number dropped to 68.4 percent, a 20-percent change in numbers per year. Specifically, in the case of American Society of Plastic Surgeons (ASPS) plastic surgeons surveyed in 2008, 67 percent were in solo practice, but by March 2009 that number decreased to 58 percent — still a majority, but a lean one. The reasons cited for leaving solo practice were (1) safety in numbers, (2) it allows quicker footing, (3) economies of scale, (4) security, and (5) the benefit of data collection and negotiation. Keys to success included well thought-out governance and a shared central vision. Problems being in a group included division of staff time and jealousy over use of resources.⁶

Finding satisfaction data for plastic surgeons is nearly impossible. However, one recent paper by Rohrich *et al.* sheds insight.⁷ Plastic surgeons over 50 years of age (56 percent of plastic surgeons) are more likely to be solo (65 percent) than general physicians (26.7 percent). The majority of plastic surgeons are satisfied (95 percent) compared to all doctors (84 percent). Plastic surgeons work fewer hours per week (52.2 hours) than the average doctor (53.7 hours), with the majority of that time spent engaged in patient care (88.4 percent). Not surprisingly, reconstructive surgeons work a longer average week (56.5 hours) than cosmetic surgeons (49.7 hours) and are more likely to be in academics than in single-specialty practice.

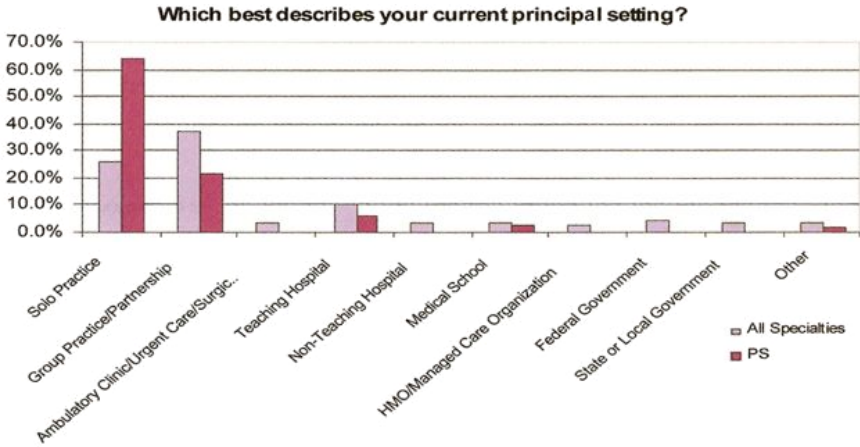


Fig. 3. Principal setting of all specialties (blue) and plastic surgery (red) as of 2006.

An ASPS 2006 survey found 56 percent of ASPS members in solo practice, 15 percent sharing facilities or small groups, and 10 percent in academics (Fig. 3).⁸

Choosing a Practice

What choices are there in deciding on a type of practice? The choice is really not of practice type, but rather of risk tolerance (Fig. 4).

Government

A government position can come in many forms or with multiple agencies. Examples include the Indian Health Service, the VA, the U.S. Department

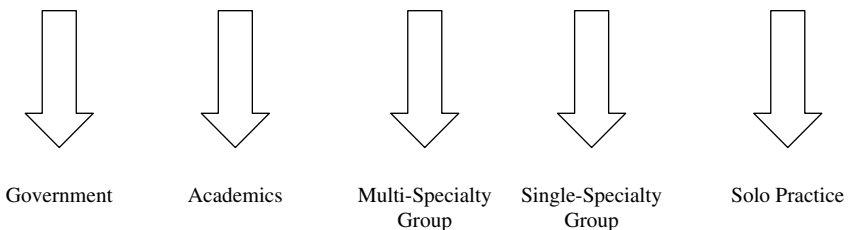


Fig. 4. Types of practice, arranged along a continuum of increasing security (left) vs. increasing autonomy (right).

of State, the National Institutes of Health, and the U.S. Food and Drug Administration. Government agencies can be the gold standard of care (or not). The VA, once criticized by some, now sets the standard in medical outcomes and disease process management. What defines government work is that it is relatively free of insurance hassles, yet is heavy in administrative hassles. It is total security versus no autonomy. The lifestyle, including calls and hours, is often mandated, but may be the most manageable.

Academics

Academics predominantly offers intellectual stimulation and a protected environment. The demands of the inquiring residents' minds require surgeons in academics to keep abreast of and teach the latest techniques. There is considerable security in a built-in referral base of patients, physicians, and emergency rooms. Interestingly, plastic surgery is a specialty in which some of the greatest thinkers are not in academics *per se*, but are academicians in the truest sense of answering questions. But the cost is a loss of autonomy: "If you are a control freak, and a lot of doctors are, take that into account because, as an academic physician, you aren't going to be in control."⁸ Although a chairman may appear to wield a great deal of power, it is the president of the university (over the dean) who makes final decisions.

Two things have changed academic practice: (1) clinical income and (2) duty hours. The classical model of academic medicine, where you started at one rank and were paid according to promotions that were tied to publications, is changing. That model included protected research time and subsidized teaching responsibilities. Within the new academic model, income is generated from clinical practice, similar to a multi-group practice, and is frequently called a faculty-practice plan. The income is also supported by research, administrative, or endowment funds, but less so than in the past. Now, in much of academic practice doctors have to generate their own salaries, whether through teaching, research, or seeing patients. This changes the academic career paradigm — the idea of moving among institutions to be promoted from associate professor to professor — which may not be feasible in the future. You may relocate, but you cannot relocate your patient base and, consequently, your income. The field of academics has fundamentally changed; unless you have such specifically sought-after skills or research experience, you are more likely to advance by remaining at the same institution or by moving no farther than to another institution in the same city. Be wary of signing a non-compete agreement. In Washington, D.C., some of the most successful

career academics have bounced between the various universities. Moreover, it makes for a smoother transition to move from the university community into the local community, where you still have your patient base, as I have after ten years in practice.

In terms of duty hours, two core changes in the academic field are the 80-hour resident work week and the need for increased resident supervision. These rules require more hands-on time to do the cases, so academic practice increasingly resembles a multi-group specialty practice. The days when residents operated unsupervised on clinic patients, for maximum resident benefit, are long gone.

The following grouping outlines some of the disparities in academics.

Advantages	Disadvantages
Release from business	Less control
Intellectual freedom	Limited input
Stimulation	Inertia of change
Research	Income
Skill enhancement	No equity
Challenging cases	Time-consuming, non-income-generating meetings and committees
Personal interactions	
Positive reinforcement from teaching	
Security	

Some of the positives and negatives constitute two faces of the same coin. There are great opportunities for personal interactions, but then a political war may ensue. “Do you play well in the sand box? How big a sand box do you want to play in?”⁹ The following is a list of tradeoffs compiled by the chairman of our institution (Georgetown University Hospital) in 2005:

- Pluses:
 - Resident support
 - Convenience
 - Brand name
 - Malpractice insurance rate
 - Administrative infrastructure
 - Human resources
 - Favorable managed care contracts

• Minuses:

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO) — rules, roadblocks, paperwork
- Cost of PUBS, particularly for self-pay patients
- No help from managed care offices, such as “carving out” or “opting out”
- Lack of space and slow response time to needs
- Neglect of physical space and patient care areas
- Insensitivity to marketing
- Difficulty in adopting new technology
- Antiquated technology systems
- Ineffective human resources (difficulty dismissing support staff)
- Security issues
- Fringe plans including disability, health, and retirement

In sum, it is possible to maintain academic affiliations even if you are in the community; however, it requires energy, and it must be a priority over purely income-generating activities.

Multi-specialty group

This group, with a mix of primary care and specialties (ideally a 50:50 ratio), is in the center of the “security vs. autonomy” spectrum. It sacrifices decision-making capabilities for the benefit of a captive referral base. One of the crucial components is physician ownership. Group sizes vary from ten physicians to the enormity of the Mayo Clinic. As size increases, governance and autonomy become more remote; however, economy of volume increases. Generally, income is favorable for plastic surgeons in a multi-specialty group, although not as generous as that earned in single-specialty groups. To be pro-physician, a multi-specialty group must operate independently of the hospital as priorities differ. The hospital’s goal is to improve its bottom line, not enhance physician income. Practice building is substantially easier for the plastic surgeon whose high-income-generating potential can yield effective bargaining power. Although a multi-specialty group offers a potentially good lifestyle with built-in call coverage, the culture of the group must be right. Is the practice focused on balance or on productivity? What is the group’s reputation? Finally, what is the eventual buy-in cost, i.e., is there an equity stake? Groups with a substantial percentage of capitated patients will not favor surgical services, especially those performed by plastic surgeons.

Single-specialty group

This model has many advantages and is common in plastic surgery. Group sizes vary from 2 to 11 people.⁷ Normally, this model works better if a spectrum of partners exists to provide different skill sets and types of services. The single-specialty group offers, in all probability, the peak of potential income because economies of scale facilitate minimizing the overhead. Although the single-specialty model offers interest, stimulation, and companionship, the potential for fracture exists. A built-in system for call and schedule coverage exists. Single-specialty groups are often busy, yet there is less independence than in solo practice.

Benefits and Drawbacks of Group Practice⁷

Benefits

- Greater negotiating power with vendors, hospitals, and payers
- Access to more capital for purchases/investment
- Economies of scale that provide greater access to recruiting and retaining exceptional personnel
- Ability to cite rigorous outcomes-based data due to the large patient base and share information on a day-to-day basis
- The likelihood that advanced electronic medical records (EMRs) will be used in the practice, eliminating or reducing paper records and allowing information to flow off-site
- Development of a stronger brand for the practice
- Greater quality assurance
- Lifestyle improvement through partners who share coverage of the practice

Drawbacks

- Slowness in making decisions/ implementing change
- Difficulty in balancing personal goals with what is best for the group
- Discrepancies in access to personnel or other resources
- Potential for interpersonal conflict
- Interdependence on peers

The potential for ownership and equity exists, but the details must be spelled out to assure a balance of power between junior and senior partners. The success of the group depends on the philosophy of the founding senior partner. If he or she places the group's benefit before his or her own, this is an ideal situation.

Solo practice

It is obvious that solo practice provides the most autonomy and carries the biggest risk. It does allow easy decision-making, and the implication of those decisions is only as good as the surgeon who follows through. It allows flexibility and, potentially, high income; however, the risk of isolation and stagnation requires greater need for interaction outside of the practice. A genuine problem with solo practice is coverage of call when the surgeon is away. Finding adequate coverage requires thought; otherwise, it becomes draining. It is important not to rush to financial overextension when starting a solo practice because no economy of scale exists; you cover the entire "nut."

If you are considering solo practice, you need the following: (1) desire for independence; (2) market research on location and patient access; (3) careful financial planning (you may need enough money in case you do not draw a salary for one year); and (4) versatility.

Because this model is a balance of risk vs. investment vs. autonomy, you must address the two biggest issues — patients and money. This requires a business plan. A start-up expense of US\$500,000 is not unreasonable. An upmarket space with an operating room facility and spa services will require closer to 1 million dollars. This amount must cover start-up, insurance, and working capital to stay in business. Options for financing a solo practice include (1) a term loan, which you repay over a certain period, but for which you may need a personal guarantee; (2) a line of credit, which you use or repay and use again; or (3) lease financing for equipment, which is similar to a car lease.

A Good Business Plan ...⁹

- clearly expresses your concept, how it fits into a continuum of care, and what problem or need it addresses
- outlines risks and contingent plans
- documents market demographics and need
- differentiates you from the competition
- outlines the proposed organization structure
- makes realistic financial projections
- tells investors what they can expect to gain for their risks.

Job Expectations

It has been said that an expectation is a resentment waiting to happen. To avoid unrealistic expectations, information is crucial to create a correct mental setting. You must possess a realistic sense of income and patient needs, which translates into practice success. These data are available and considerably more reliable than hearsay or lore.

Need

Learn the ratio of plastic surgeons to population in the location(s) you are considering. The density of plastic surgeons is readily available from the ASPS Practice Management Resource Center (www.plasticsurgery.org). What it reveals is not what you may think. Los Angeles, California, does not contain the highest density of plastic surgeons. In fact, conservative Washington, D.C., has the highest density per “state” at 1:26,000. By contrast, San Francisco, California, Rochester, Minnesota (Mayo Clinic), and Naples, Florida, are in a select group of cities with a ratio of 1:15,000 or less.

What is the optimal physician-to-patient ratio to start a viable practice? This is clearly cultural- and case-sensitive. However, the 1:100,000 ratio has been thrown out as an ideal; 1:70,000 as solid; and 1:40,000 as a minimum. Thus, Brownsville, Texas (1:335,222), or Johnson City, Tennessee (1:480,000), may represent a more favorable ratio. This clearly does not equate ratio with demand, but it compares considerably better than in areas with population densities exceeding 1 million: San Francisco, California (1:13,115); West Palm Beach, Florida (1:22,100); Miami, Florida (1:30,045); and Orange County, California (1:30,280). Although the people in these areas may want to support another plastic surgeon, they do not *need* one. Most residents practice within 90 miles of their graduating program; thus, more saturation will exist in areas of close proximity to a program.

Income

Income data are difficult to obtain to compare with other specialties or to generate realistic expectations. Without such data, what constitutes fair market value and worth are difficult abstracts.

Within the plastic surgery discipline, the first myth to dispel is the perceived imbalance between private and academic practice incomes. A number of recent studies have shed light on this myth.^{10,11} Physicians having the same experience/age range earn nearly equivalent incomes; however, academic surgeons, by performing considerably more relative value units (RVUs) of work,

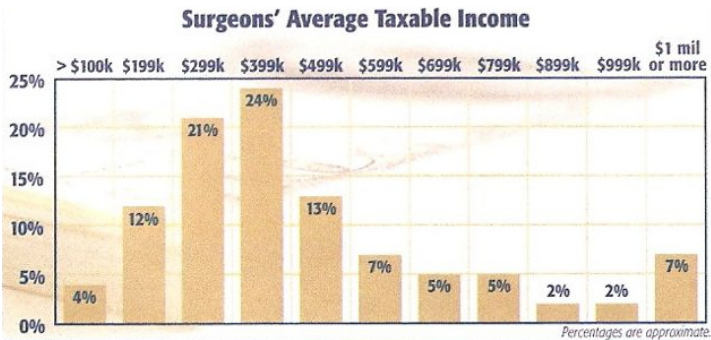


Fig. 5. Surgeons' average taxable income.

perform 7,101 RVUs compared to 5,962 RVUs in private practice to generate the same income. Surprisingly, the average annual salary for the plastic surgery faculty is US\$370,000.

The graph shown below (Fig. 5), from an ASPS lifestyle survey, shows that most incomes range from US\$299,000 to US\$499,000.¹² The financial superstars earning US\$1 million or more comprise only seven percent of our population. But, again, money is only one factor less important than culture. This I can attest to having taken an 80-percent pay cut to improve my environment, and I have never been happier.

Taxable income

More accurate data are available for academic income. The Medical Group Management Association (MGMA) reviewed 85 individual reports on academic surgeons who spent at least 65 percent of their time in clinical practice; moreover, 16 percent of the time was spent teaching and 9 percent, researching. The median starting compensation was US\$205,570. Taken as a whole, the mean base salary was US\$239,641 and the median total was US\$310,000 (90th percentile: US\$591,522). This, in turn, was compared to a similar group of private practitioners (80 respondents from 37 practices) with a mean total compensation of US\$366,141 and a median total of US\$324,837 (90th percentile: US\$636,304).¹³

In conclusion, academic physicians make nearly as much, on average, as their private practice counterparts. Further details are shown in Fig. 6.

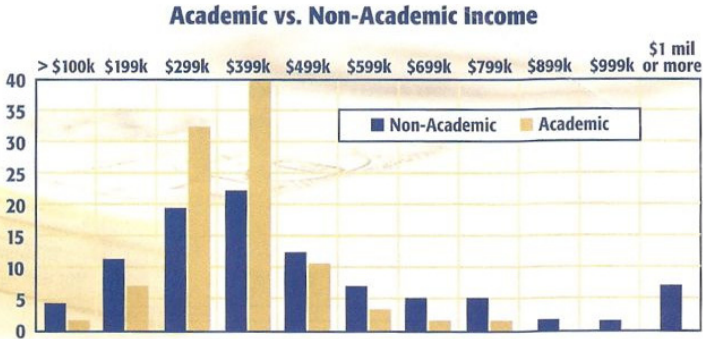


Fig. 6. Academic versus non-academic incomes.

Of utmost importance to those seeking their first job as an instructor or assistant professor is the starting salary. Below is the breakdown of those incomes for the plastic surgery faculty.

Instructor

25th Percentile	US\$79,000
Median	US\$148,000
75th Percentile	US\$302,000
Mean	US\$183,800

Assistant Professor

25th Percentile	US\$186,000
Median	US\$214,000
75th Percentile	US\$256,000
Mean	US\$241,000

The good news is that if you stay the course and ascend to chief resident, the mean income is US\$436,800; even better, as chairman, the income is US\$799,000.⁵

As an indicator of clinical activity, two measurable parameters exist — collections and gross charges. In academic surgery, where surgeons’ productivity is increased by resident work multipliers, residents can help you move bigger cases and help look after sicker patients. The following are collection and billing numbers for partial clinical, full clinical, and private practice surgeons.

Collections

Academic — 67 percent clinical (42 individuals)

Mean: US\$762,492

Median: US\$578,875

Academic — 100 percent clinical (55 individuals)

Mean: US\$979,159

Median: US\$745,374

90th percentile: US\$1,683,254

Private Practice (33 individuals)

Mean: US\$784,819

Median: US\$683,086

90th percentile: US\$1,434,897

Gross Charges

Academic — 100 percent clinical (46 individuals)

Mean: US\$2,014,320

Median: US\$1,931,126

90th percentile: US\$3,185,747

Private Practice (34 individuals)

Mean: US\$1,240,339

Median: US\$1,180,324

90th percentile: US\$1,890,139

The difference in gross charges between academic and private practices, as well as the relative closeness of collections, reflects the increased self-pay of private practice and consequently less write-offs.¹⁴

Selling Yourself

Once you have confirmed a location and a practice type, you must now sell yourself. Your correspondence should be of top quality. A focused cover letter addresses the practice's needs and changes the focus to them, while at the same time touting your values, experience, and skills. Your curriculum vitae (CV) should be up to date and easy to navigate. Prior to your interview, research the practice. You have only one opportunity to create a positive first impression. The first interview is about selling yourself. Rather than focusing on compensation and call, discuss governance and service. During the interview, do not

tell the employer what you can do for them; rather, ask them what they need from you. Then, be certain to emphasize how you can add to the practice. Make a point to meet or to call everyone in the practice. Do a post-interview debriefing, write down your comparisons, and make sure of a post-interview call or letter thanking the practice for their time. Consider contacting the last person who left the practice.

Information is power. You must be prepared for an interview, you must know the practice group or institution, and you must know the surrounding environment and the ratio of plastic surgeons to the community. All of this information is readily available on the Internet.

Because evaluating different positions with limited time between interviews is difficult, make a comparison list. Note the following comparison from my job search (Table 1).

You should be cognizant of the practice environment, patient mix, and involved expenses. This list allows you to compare apples with oranges. It can contrast clinical income, benefits, and location. It can be as broad or as detailed as your personality dictates.

Table 1. Academic job comparison.

	University 1	University 2
Chairman	Indecisive, manipulative (4/10) Know personally Lost money (2/10)	Controlling, egotistical (6/10) International reputation Generates lots of income (9/10)
Hospital System	World-renowned Huge network	No reputation Bankrupt
Division	No respect	Major force
Demographic	1/11 attending	1/3
Ratio per Capita	1:66,000	1:29,000
Income		
Start	US\$150,000	US\$150,000
5 yrs	US\$210,000	US\$300,000
Payback	US\$0	US\$49,000
Case Mix	5/10	9/10
Referral	None	Wide open
Risk	2/10	7/10
Reward	3/10	7/10

Next, put the list away for a week. If you return to it and emotionally you do not like the findings, re-evaluate your priority list. When weighing positions, think again about needs versus wants and compromise versus reality. Discover peripheral information about the practice. You particularly need to know upfront the pathway to partnership.

Red flags

- A wife as an office manager — There will always be preferential treatment.
- Retiring or slowing down senior partner — What is the plan for retirement and the funding of that retirement?
- Practice name — Is it egocentric? There is a big difference between your role at “Advanced Plastic Surgery” and “Minnie Mouse Esthetic Center.” The first name has more potential, unless you are Mickey Mouse.
- High office overhead — Are you being recruited to cover costs? If so, this is not a long-term feasible relationship; rather, it is a revolving-door relationship.

Mama’s (or papa’s) list

“Because if momma isn’t happy, then no one’s happy.” When you are closing in on a decision, revisit the needs of your spouse/partner. Their evaluation list can add enormously to long-term success. Remember, 36 percent of individuals relocate based on a significant other’s needs. Table 2 is my significant other’s list from 1999. We picked choice B, and now she never wants to leave.

Show me the money

When you are content with the position, the environment, and your cultural fit, it is time to look at the books. You need as open a book as is feasible, and if

Table 2. Spouse/partner life choices.

	A	B
Cost of Living	5/10 (moderate)	8/10 (high)
House Choice	75 percent	100 percent
Friends	1	6
Family	0/10	0/10
Activities	3/10	8/10
Population	Blue collar	White collar
Visitor Destination	2/10	9/10

the practice does not want to share it with you after you have made a few visits to the practice, a problem exists. It is valuable to see numbers from the last person with a similar position, including billings, receivables, and overhead expenses.

When you discuss finances, avoid the money question: “How much will I make?” Rather, concentrate on the real issues: (1) patient mix, (2) productivity potential, (3) collection rates, and (4) controllable and fixed expenses.

Income is generally gross collection minus expenses. These expenses can be substantial if they include infrastructure costs, surgical center costs, or heavy overhead. A benchmark for very successful collections in plastic surgery as gleaned from practice advertisements is US\$1.2 million. This seems to be the “magic number”. Most practices, academic or private, have profit and loss statements. If possible, ask to see one for a comparable employee.

Remember that, unless you are in solo practice, you probably will have much more control over production than you personally will have over expenses. When joining a practice, find out about ownership, hard assets, and financial risks and liabilities. What will be the buy-in cost, “blue sky”, or retirement transition? “blue sky”, or the goodwill of the practice name, was a more relevant concept prior to changes in managed care penetration. Unless the practice is the only real show in town, “blue sky” may have little value.

Respect

Never accept a position with someone you do not respect or whom you consider undercompensated. You want to strive to be that person, and lack of respect will lead to dissatisfaction. It is a rare situation where you will earn more, or outshine, your employer. If you do, it will not be pretty.

Contracts

Prior to a contract, there is a letter of intent, which serves as a binding document while the contract is being written. A health care attorney should review the contract. This is not a role for a friend of a friend or “Uncle Johnny” because the long-term costs are too high. Rather, the reviewer should be a seasoned professional who is familiar with the laws and practices of your proposed location. Get the details in writing and get the contract reviewed.¹⁵

The contract is critically important if things do not happen as expected. A contract is like a prenuptial agreement: you only need it in a divorce. The

contract should include the following:

- Job Description — This includes what job you will be performing, on whom, and for how many hours per week. On-call responsibilities are an important point to be negotiated if this matters to you.
- Compensation — Low compensation correlates with dissatisfaction, whereas high compensation does not correlate so clearly with satisfaction. A fair compensation is essential. Individuals need to work for what they think they are worth as long as that is not inflated. Salary needs to be defined, as does the bonus structure. That is, upon what measure of productivity will raises and bonuses be based? Acceptable measures are RVU, charges, and collections. The RVU scale is the only measure of true work because charges are dependent on what fee structure is utilized and collections are dependent on the payer mix. Profitability, or residual money left after gross income minus expenses, is a common model, but it does not favor physicians because expenses are not a variable which they directly control.
- Benefits — Insurance, retirement, and personal development expenses should be covered. Costs of attending meetings are real expenses for surgeons, as are multiple hospital dues and license fees. We suggest US\$10,000 as a minimum need per year; for the long term, US\$25,000 in development expenses is more realistic to cover continuing medical education, recertification, travel, books, etc.
- Malpractice — What is important is not what the employer pays, it is what is not covered. There are two types of malpractice insurance: (1) occurrence-based, which covers you indefinitely for acts that occurred during coverage; and (2) claims made, which only covers for claims filed while the policy is in effect. The latter is much cheaper, yet requires a tail policy to cover suits after you leave the practice. Who pays for this must be defined.
- Termination Clauses — You need objective, rather than subjective, standards. There are two types of termination: (1) not for cause, which usually provides a notice period of 3, 6, or 12 months. This clause works to the benefit of both parties. Six months is a good compromise for a surgeon; and (2) for cause, which sets forth on what ground(s) you can be fired. Clear infractions, such as loss of license or felonies, are simple, but you must consider lesser issues. What happens if one of the other partners simply does not like you?
- Partnership and Governance — You need specific parameters to buy into a partnership. What is the track, what is the time frame, and what is it

ted to? Do not be too aggressive on this point as it is their assets at stake. I witnessed one of our fellows lose a plum position by pushing this time frame. Remember, it is their hard-earned practice at stake. More importantly, is it spelled out?

- Loan Agreements — Sometimes, hospital loan agreements or salary support is included. What are the repayment terms, what is forgiveness, and what are the repercussions if you leave prematurely?
- Receivables — Who owns your uncollected money when you leave or retire? This can realistically be US\$400,000 or so. It changes the impetus of how productive you will be in your last months.
- Restrictive Covenants — There are three components of a non-compete agreement: (1) non-competition, which sets forth the area and period of time in which you cannot practice close to your old job; (2) non-solicitation, which sets forth rules about attracting patients to leave with you (this needs to be balanced with patient care interests); and (3) non-employment, which sets forth rules about poaching staff when you depart. Appreciate that these restrictive covenants are written to protect the practice, not you or the patients' interests.

The most important covenant is the restrictive non-competition covenant. It must be reasonable, perhaps one year. It should be a realistic radius from the main office, rather than an overlapping radius from all satellite offices and affiliated institutions. A recent graduate asked me to review a contract, which was excellent except for the non-competition clause, which included radii around all satellites, offices, and affected institutions that, in sum, eliminated Manhattan and most of the remaining boroughs of New York City. Do not sign such a contract unless you include a buy-out clause.

Unfortunately, the larger the institution with which you are negotiating and the lesser your name, the more the employer controls the hiring process. If you are not comfortable negotiating, have your attorney do it. It is critical to invest time and money in this aspect of the process, because invalidating a contract costs a lot more of both.¹⁶

Getting Started

No matter which position you accept, getting started requires working back from the longest deadline. In attractive states in which to practice, acquiring

licenses can take up to nine months. No license means no provider number, which can take six months. No provider number means no reimbursement.

It is important to settle in to fit with the culture. The primary reason that physicians leave positions is lack of fit; thus, be careful. Sit back, absorb the culture, and do not try to correct it early in your employment (Fig. 7). “As a new associate, it’s up to you to adapt to practice culture, not the other way around.”¹⁷

When developing your surgical practice, be careful not to overstep boundaries. How do you handle call duties, particularly when covering other surgeons’ patients? What happens if these patients subsequently want to come to you? This has the potential to become very unpleasant. Consider mentorship

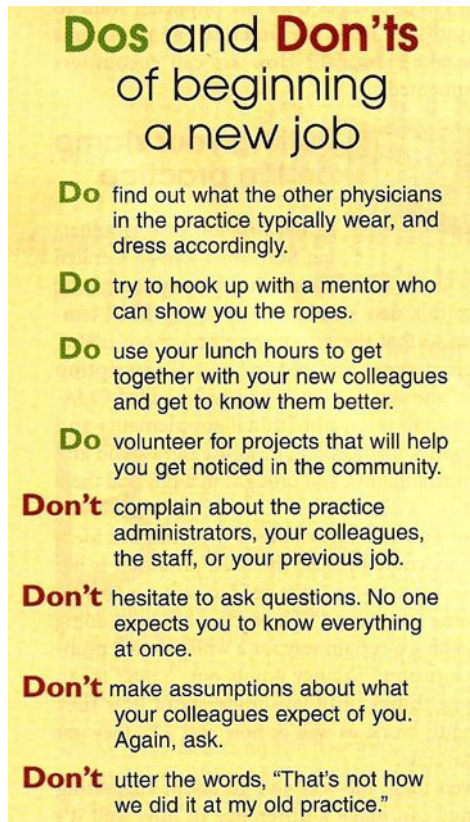


Fig. 7. The dos and don'ts of beginning a new job.

and ask for advice. Senior surgeons appreciate that and, face it, you do not have all of the answers.

Returning to practice

Licensing and renewal of credentials can be a significant process. Maintenance of both is easier than reinstatement. If you are walking away from a practice, be certain to address tail insurance coverage.

Unrest

It is not uncommon for young surgeons, as their productivity increases, to develop some unrest and financial dissatisfaction two or three years into practice. We define this as the two-year question: “I bring in amount A, yet I am only getting paid amount B. Is this fair?” The problem is often a disconnect between the amount of the practice investment and what the physician thinks he or she is worth. Note the diagram in Fig. 8.

Observe the break-even point at which a new hire with a base salary generates income sufficient to exceed his or her expenses. This break-even point is variable based on the environment, workload, and aggressiveness of the young surgeon, and it often occurs around two years’ practice. The surgeon might appreciate that the practice invested the amount below the break-even line during the first two years. The practice needs to recoup its investment prior to discussing payment of salary or bonus based on the surplus after the

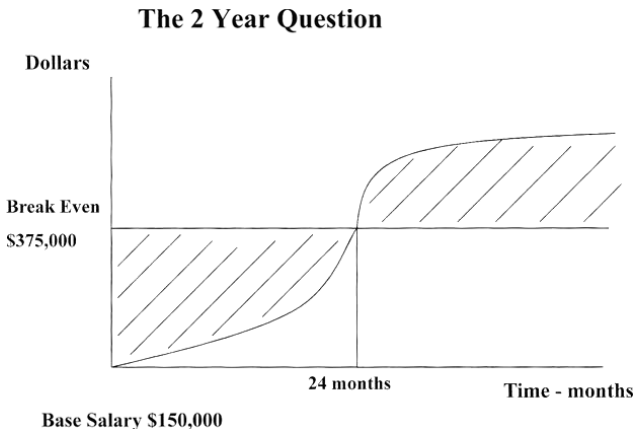


Fig. 8. The two-year question.

break-even. Both parties can appreciate what is involved, without emotional distress, by reviewing it in this figure form. Although it does not mean that you do not get a pay raise, some payment on investment is appropriate. At my last position, you had to repay all of the start-up deficit from your bonus. This was fair, upfront, and out-of-the-box thinking. Then, you received most of your excess income in bonus after first reinvesting 10 percent in the department.

Keep in mind that during the emotional negotiation period, it is business, not personal. Consider yourself a top candidate with unlimited potential, while taking into account that the practice, university, or group has its investment to protect. I recommended one of our best fellows to a practice in which a friend was a partner. It would have been a great fit, but our former fellow's husband irritated the partners by pushing too far during negotiations. It is essential to consider the analogy that, when emerging from residency, you are like a horse in the Kentucky Derby. Your odds may be great, but from the practice's viewpoint you are just as likely to break a leg as you are to win.

Conclusions

1. Do a personal inventory. What are your needs versus your wants?
2. Consider location versus job, and job versus opportunity.
3. Practice types are a balance of security and autonomy.
4. Culture and fit are very important to success.
5. Information is power.
6. In negotiations, productivity formula, buy-in, and restrictive covenants are crucial.

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