LIFE AFTER RESIDENCY

OR

WHAT I WISH SOMEONE TOLD ME WHEN I WAS A RESIDENT

Patrick K. Lee, MD
Professor
Director, Dermatologic Surgery
Director, Micrographic Surgery and Dermatologic Oncology Fellowship
Associate Residency Program Director
Department of Dermatology, University of California, Irvine
SET YOUR PRIORITIES

- What do you NEED to do
- What do you WANT to do
Historical perspective

Institutional medicine
e.g. academics
Now

Kaiser Permanente

private practice

[Images of healthcare professionals and television show cast]
MAKE WORK DECISIONS BASED ON “3 Dimensions”:

- Money - debt, responsibilities, greed
- Profile - what helps the visibility of your work and practice, e.g. academics, seminars, consultancy jobs, etc
- Ego - all the bad connotations but also what makes your identity, what being a doctor is about, etc.
- Combinations of the above
The “4th Dimension”

- **TIME** - Everything changes with time: what you need and what you want, how much you need it and how much you want it

- Remember: your job is not the end-all, be-all for the rest of your life
CHOICES

- Fellowship
- HMO
- Academics - full-time/part-time
- VA
- Multi-specialty
- Private practice
Private Practice

- Employee
- Independent contractor
- Associate/Overhead share
- Solo - corporation, LLC, sole proprietor
- Partner - corporation
Fellowship

- Can view it as a “transitional” year - use it as time to figure out what you really want and how you want to go about obtaining it
- Derm fellowships don’t necessarily keep you from doing general derm
Fellowships

- Procedural dermatology/Micrographic Surgery and Dermatologic Oncology Fellowship
- Mohs micrographic surgery
- Dermatopathology
- Pediatric dermatology
- Cosmetic/laser
Procedural dermatology

- ACGME - approved
- Done in conjunction with Mohs College and Dermatology Residency Review Committee
- 1-2 year fellowship with focus on 3 areas: cutaneous oncologic surgery with an emphasis on Mohs surgery, cutaneous reconstructive surgery, cutaneous cosmetic surgery
Program faculty must collectively perform at least 1000 dermatologic surgery procedures/fellow/year.

At least 600 of those procedures must be Mohs micrographic surgery, so MMS remains cornerstone of training in Procedural Dermatology.
Cosmetic procedures specified: sclerotherapy, chemical peels, soft tissue augmentation, rhinophyma correction, hair transplantation, dermabrasion, small-volume liposuction, and laser surgery

NOT specified: method taught (didactic vs. hands-on), extensiveness of knowledge fellow must possess
Procedural Dermatology

PROS

- THE surgical/procedural fellowship
- Subspecialty - more prestige?
- More money
- More competitive --> more money
- Refer less --> more money, control
- Academic positions – e.g. fellowship director, chief of derm surg, etc
- ACGME accredited
Procedural Dermatology

CONS

- Competitive
- No grandfathering for programs - Accredited but NOT certified by ABD yet
- In short term, may not offer more than a Mohs fellowship, depending on your practice - often have cosmetics anyway
Mohs Micrographic Surgery
PROS

- Teaching?
- Subspecialty
- Reconstruction opportunity
- More money
- More competitive
- Refer less

- Academic position?
- Cosmetics included often
- If you want to be a Mohs PERSON
Mohs Micrographic Surgery

CONS

• Some fellowships are 2 years - ACMS requires 600 cases
• “Slave labor”
• May have to move
• Teaching?
• Pay may be less than when a resident
• Most academics will be Proc Derm
Dermatopathology

PROS

- Great, exciting field, need for good ones
- Read own slides----> refer less, more money
- More competitive, academic
- Send no slides out
- Many dermpaths still do Gen Derm
- Can theoretically do Mohs - let Plastics close - need to be comfortable with frozen sections
Dermatopathology

CONS

- Need to really love it, may take you away from general derm
- Competitive
- May have to move
- Fellowship pay may be bad - Ackerman?
- Can be difficult to build practice - area saturation/referral patterns, managed care
Pediatric dermatology

- Greater than 20 programs nationwide - NYU, Hopkins, San Diego, etc
- 12, 18, 24 month programs, match thru SPD
- Board certification by ABD like dermpath; thus far, non-ACGME
- Dermatology residency with primary certification in dermatology
Pediatric dermatology

PROS

- Good for academics
- Subspecialty
- Research
Pediatric dermatology

CONS

- ? Effect on practice in nonacademic setting
- More training, i.e., time
- Usually not more money
- Depending on setting, may not be more than severe eczema and warts; beware of dumping
Cosmetic/Laser

PROS

- Not as hot as before but still worthwhile fields
- “Cutting edge”
- If had cosmetic experience as resident, can then enhance skills
- Credential may impress patients
Cosmetic/Laser
CONS

- Vague
- Necessity?
- American Academy of Cosmetic Surgery - not accredited, not ABMS certified
- No governing board - ASLMS?
- With Procedural Dermatology, these fellowships cater to a specific practice situation, i.e. primarily cosmetic
Accreditation applications due June 15

Both ASDS members and non-members are encouraged to apply by June 15 for 2016-16 accreditation status for their dermatology programs in the ASDS Cosmetic Dermatologic Surgery Fellowship Program.

A later deadline — Sept. 15 — is available for early approval for the 2016-17 program year.

Program applications and application criteria are available online at asds.net/cosmetic-accreditation.

All ASDS-accredited programs are one year in length and begin on July 1, Aug. 1 or Sept. 1 of each calendar year. By the end of the year, each Fellow must perform 300 and observe 1000 cosmetic dermatologic surgery cases under direct supervision of the program director in at least five of eight categories of procedures. The categories include:

- Wrinkles and folds (soft-tissue fillers, neuromodulators, fat transfer)
- Rejuvenation (microdermabrasion, non-ablative laser and light-based treatments, non-ablative fractional resurfacing, light chemical peels)
- Resurfacing (medium/deep chemical peels, ablative laser resurfacing, dermabrasion, fractional laser treatments)
- Veins (ambulatory phlebectomy, laser varicose vein surgery, pulsed-light therapy, sclerotherapy)
- Body contouring (cryolipolysis, laser lipolysis, ultrasound/radiofrequency fat removal, tumescent liposuction, ultrasound/radiofrequency tissue tightening, other energy-based or chemical modalities)
- Lifting (brow lift, blepharoplasty, facelift)
- Hair treatments (hair transplantation, hair removal)
- Scar revisions (fractional/vascular laser, keloid excision, acne scar excision, Z-plasty, subcision, TCA/CROSS, injection treatment)

Coverage of the breadth of the procedures within each category is essential. Fellows must also be exposed to experiences designed to augment their training as writing and reviewing clinical manuscripts, research, attending and/or presenting at conferences and teaching residents.

The training is held in the office or facility of the Fellowship director where the majority of training time is spent. Each program must have at least two faculty members to adequately support the educational needs of one Fellow.

Current programs (and their directors) include:

- Cosmetic Laser Dermatology in San Diego (Mitchel P. Goldman, MD)
- Hollywood Dermatology and Cosmetic Surgery Specialists (Eduardo T. Weiss, MD)
- Laser & Skin Surgery Center of Northern California (Suzanne L. Kilmer, MD)
- Maryland Laser, Skin and Vein Institute (Robert A. Weiss, MD)
- Massachusetts General Hospital Dermatology Laser and Cosmetic Center
Program applications and application criteria are available online at asds.net/cosmetic-accreditation.

All ASDS-accredited programs are one year in length and begin on July 1, Aug 1 or Sept. 1 of each calendar year. By the end of the year, each Fellow must perform 300 and observe 1,000 cosmetic dermatologic surgery cases under direct supervision of the program director in at least five of eight categories of procedures. The categories include:

- Wrinkles and folds (soft-tissue fillers, neuromodulators, fat transfer)
- Rejuvenation (microdermabrasion, non-ablative laser and light-based treatments, non-ablative fractional resurfacing, light chemical peels)
- Resurfacing (medium/deep chemical peels, ablative laser resurfacing, dermabrasion, fractional laser treatments)
- Veins (ambulatory phlebectomy, laser varicose vein surgery, pulsed-light therapy, sclerotherapy)
- Body contouring (cryolipolysis, laser lipolysis, ultrasound/radiofrequency fat removal, tumescent liposuction, ultrasound/radiofrequency tissue tightening, other energy-based or chemical modalities)
- Lifting (brow lift, blepharoplasty, facelift)
- Hair treatments (hair transplantation, hair removal)
- Scar revisions (fractional laser, keloid excision, acne scar excision, Z-plasty, subcision, TCA/CROSS, Injection treatment)

Coverage of the breadth of the procedures within each category is essential. Fellows must also be exposed to experiences designed to augment their training as writing and reviewing clinical manuscripts, research, attending and/or presenting at conferences and teaching residents.

The training is held in the office or facility of the Fellowship director where the majority of training time is spent. Each program must have at least two faculty members to adequately support the educational needs of one Fellow.

Current programs (and their directors) include:

- Cosmetic Laser Dermatology in San Diego (Mitch P. Goldman, MD)
- Hollywood Dermatology and Cosmetic Surgery Specialists (Eduardo T Weiss, MD)
- Laser & Skin Surgery Center of Northern California (Suzanne L. Kilmer, MD)
- Maryland Laser, Skin and Vein Institute (Robert A. Weiss, MD)
- Massachusetts General Hospital Dermatology Laser and Cosmetic Center (Matthew M. Antman, MD, JD)
- McDaniels & Cosmetic Center (Daniel H. McDaniels, MD)
- Northwestern Medical Faculty Foundation Dermatology (Murad Alam, MD)
- Skin Care and Laser Physicians of Beverly Hills (Derek H. Jones, MD)
- SkinCare Physicians (Jeffrey S. Dover, MD)
- UPMC Cosmetic Surgery and Skin Health Center (Suzan Obagi, MD)
HMO

- Being an employee at a corporate medical entity, e.g. Kaiser
- NOT being in practice with HMO/capitated contracts - “HMO without walls”
HMO
PROS

- Set salary and very competitive
- 401k, benefits, retirement, paid meeting time, etc
- Usually regular hours
- Often good for second income - can be part-time, although maybe no benefits
- Good for starting family
- In past, board certification wasn’t a requirement
HMO
CONS

- Employee - staff conflicts?
- Set salary - ceiling, ?phase out over time
- May have little/no say in how things are run
- Productivity very much prioritized; may have to “make up” hours
- “Customer service” prioritized
- May not be paid commensurate with training, e.g., Mohs, dermpath, etc - little incentive to work hard
- May have little/no say over schedule - crowded hours, distant locales
HMO CONS, contd.

- May not treat the way you want to, e.g. Aldara, etc.
- Approach to practice: employee mentality - “I’m on my break”
- Finite meeting time
- “Hidden” from basics of private practice
- If you like to teach, may have no choice in who or what you teach, e.g. FP’s?
Academics

PROS

- Set salary
- Benefits
- Good for starting family
- Profile/title
- Productivity/research/publications
- Teaching
- Ego
Cons

- Tough gig full-time because often required to generate at least salary, which is tougher now with resident clinics
- Starting salary often guaranteed for 1-2 years, then based on productivity
- Often at mercy of administration re: money, time, billing, etc.
- Staff conflicts?
- Pressure to produce either income or publications or both - tenure tract?
Academics
CONS, contd.

- Research – may be at mercy of budget and/or grants
- Teaching - often lowest priority, either residents, students, or both
- May have finite meeting time
- Responsibility: signing residents’ charts
- “Dumping ground”
- “Hidden” from basics of private practice
Pros and Cons you are familiar with
Prototype situation for looking at job opportunities objectively because both the pros and cons are pretty easily discernible
Like Academics without any sugarcoating
PRIVATE PRACTICE

- Employee
- Independent contractor
- Associate/Overhead share
- Solo - corporation, LLC, sole proprietor
- Partner - corporation
Multi-specialty group

- HMO
- Physician-owned HMO model
- Employee
PRACTICE CONSIDERATIONS

- What is overhead?
- Practice profile - insurance makeup, marketing?
- How much are you worth? Own boss vs employee
Overhead - things that are the cost of doing business day to day: rent, utilities, staff, supplies/equipment, leases, loans, etc

NOT: malpractice, dues, CME costs - “Professional costs”

Usually ~55%, low: 35-40%, high: 60-70%
PRACTICE CONSIDERATIONS, contd.

- Keep in mind: you earn ~45%
- 45% - other expenses = <45% left over
- ~66% (after taxes) x <45% = <30% take home pay
- You take home <$0.30 for every dollar you earn
PRACTICE CONSIDERATIONS, contd.

- Practice profile - HMO/PPO/Indemnity/Cash - define terms
- <20% any one payer/HMO
- Marketing and/or word of mouth
- Remember: YOU ARE WHAT YOU TREAT - what your practice is in the beginning, it will remain - you reap what you sow
What are you worth?
Assume you are offered $400,000/year
What does it take to generate that? How hard do you have to work?
Assume 50% overhead - You need to generate $800,000/year
Assume you work 50 weeks/year - that is $16,000/week
Assume you work a 5 day week - that is $3200/day
Assume you work an 8 hour day - that is $400/hour
$400/hour is $100.00/15 minutes
Can you generate $100.00 every 15 minutes?
PRACTICE CONSIDERATIONS, contd.

• YOU SHOULD BE ABLE TO!
  • Remember: Always pay attention to the “business” around you
Private Practice Employee

- Pros and Cons can be similar to being an employee in an HMO or other medical entity
- May be more difficult now with managed care contracts
- Should offer malpractice, benefits, etc
- Taxes - if employee at more than one office, can be difficult
Employee

Ask:
- What do I bring to the practice?
- Why am I being asked to join? “Warm body”?
- Guaranteed salary? What kind of hours? Coverage?

Partnership potential? Buy-in

Again, TIME: after a certain amount of time, often want 1 of 2 scenarios:
- Work less and make same money
- Work same and make more money
- Boss says: got new “warm body” who will work more for less money
Independent Contractor

- Exactly what it sounds like - “contractor” with overhead agreement
- Itinerant doctor, “good to go”
- NOT locum tenens
Independent Contractor

PROS

- You are your own doctor
- No long-term commitments
- Work as much as you want or need
Independent Contractor
CONS

- All business related concerns are your own responsibility: taxes, malpractice, benefits, etc
- Different offices: travel, hours, etc
- Keeping track of patients
- Not your own practice - like employee
- Restrictive covenant
Associate/Overhead Share

- Two or more separate practices share office space and thus, overhead
- May be single or multi-specialty
Associate/Overhead Share

PROS

- Share overhead - should decrease each physician’s overall overhead
- If single specialty, may be able to carve out own niche depending on what you bring to the practice
Associate/Overhead Share
CONS

- Depending on situation, may still not be your own practice
- Share charts/patients?
- Coverage?
- More senior people may have more say - may be like employee
- Buy-sell agreement?
Solo practice

- Sole proprietor
- Corporation
- LLC
Managing a small practice

By Victoria Houghton, assistant managing editor, May 01, 2015

Dermatology World: Tell us about your practice.

Dr. Jacobson: Inverness Dermatology & Laser now has three physicians. Shellee Marks, MD, Kathleen Beckum, MD, and me. We also have one physician assistant, Mary Beth Templin, PA-C, and 17 amazing staff members. Our practice sees about 150-180 patients per day. This number will increase as our third physician builds her practice.

Dermatology World: You were in a multi-specialty clinic for about seven years before starting your own practice. What inspired you to go in the private practice route?

Dr. Jacobson: I was hesitant to go out on my own because I was not experienced in business and was busy with three children, including a new baby. My former practice had wonderful patients and I enjoyed...
Buying a practice/Practice worth

- Market approach - compare with other practices sold in area
- Asset approach - what would it take to reproduce the practice, tangible and intangible assets
- Income approach - future monetary benefits, two years gross receipts?
Solo practice

PROS

- Own boss, can’t be fired
- Ego
- Keep overhead as low as you want
Solo practice
CONS

- Demanding gig
- It’s all unpaid vacation
- Own boss, like it or not - overhead first
- If buying a practice, ask: are you same profile as the seller? What is the profile of patients?
- Not worth what they were before
- Coverage?
Sole proprietor

- Less common now, like a shopkeeper
- May be hard to keep business separate from personal
- Taxes are more difficult: S.E. tax 15%, Medicare, SSI
- Business expenses - deductions harder, no reimbursement
Corporation

PROS

- Separate business from personal
- Employee of corporation: W-2, pension plan, health insurance (pre-tax), expenses reimbursable (cell phone, pager, laptop, etc.)
- More personal protection - staff speaks for corporation
Corporation
CONS

- Harder to hide money
- Costs
- Corporate records
LLC

- Limited liability company
- Similar to corporation, looser restrictions
- Designed to give personal protection
- Depending on structure, may not be able to do benefits, etc.
Partnership

- Generally a corporation
- Generally larger practices
Partnership

PROS

- Usually all benefits of a corporation
- Usually an established practice, like a law firm - associate, partner, etc.
- If do buy-in/partner, can make more money and have more say – passive income
Partnership
CONS

- Like a marriage
- If several partners, like polygamy
- Binding - money, liability, etc.
- Lot of paperwork