Career Evaluation and the Decision Process for Plastic Surgery Graduates

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Summary: National experience shows that 50 percent of physicians change positions within the first 2 years of practice. Because of market pressures, medicine in general and plastic surgery in particular are shifting away from solo practice. The authors examine the primary reasons for turnover and discuss job search priorities for recent plastic surgery graduates and established surgeons in job transition, with a current analysis of the different job opportunities available, ranging from government to private practice. The advantages and disadvantages of different positions are compared and income data are presented. Academic income is close to that of private practice at a mean of $366,141 annually but requires more work as measured by an overall higher relative value unit of productivity. The concept of creating a personal inventory before seeking the best job match is introduced. (Plast. Reconstr. Surg. 128: 559, 2011.)

As 60 percent of plastic surgeons are older than 50 years and 52 percent plan to retire within 15 years, positions for new graduates do exist. National experience suggests that 50 percent of physicians change jobs within the first 2 years of practice. A mismatch in expectation and practice culture is a significant contributor to physician turnover. The top three 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). Low compensation correlates with dissatisfaction, whereas high compensation does not as clearly match satisfaction. Two factors contributing to high physician turnover are inadequate prioritizations of the physician’s values and a failure of cultural fit. The two are intimately intertwined: the first is ineffectively analyzing oneself, and the second is ineffectively analyzing one’s potential employer. An expected 22 percent increase in the aged population will create a manpower shortage in the next 10 to 15 years. Anticipation and careful career planning must start immediately.

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 $235,000 to add a physician. The current economic climate has left many group practices and health care facilities in a holding pattern for signs of an economic turnaround before expending recruiting and salary resources. New surgeons are more likely to be recruited to a reconstructive rather than cosmetic practice, and the average “fill time” for a position is 6 to 12 months.

The first step in the job search is to inventory what is important to you and to your family. What are your priorities? These are not the priorities of your attending role models; rather, they are your goals and things of importance. This personal inventory should include spouse/partner input. Set long-term 5- and 10-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? What are their needs? The following topics might be included on a priority list:

- Family
- Income
- Autonomy
- Security
- Location

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• Power
• Diversity
• Excitement
• Predictability
• Close to family
• Vacation
• Call
• Weather
• Sports
• Work type
• Recognition

Sometimes, these priorities or expectations for a job are conflicting:

• Income versus lifestyle
• Industry versus family
• Environment versus opportunity
• Location versus patient pool
• Benefits versus retirement
• Security versus reimbursement

When preparing a priority list, realize that money and success equal money and success. It does 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 versus job and (2) opportunity versus job. The first tradeoff is that you can settle on a location based on desire, family, and lifestyle but compromise on your choice of position. Perhaps the ideal job may not be in the ideal location. Consider whether an urban/suburban or rural location for you is a good start. Into this enter other criteria such as family, leisure opportunities, and access to sporting events. Those residents who are older and trained by traditional training programs or with dependents are less likely to pursue fellowship training, whereas those going into academics are more so. Placing priority on location also means realizing regional differences in compensation within the job market. A preference for big cities on the coasts may come at the cost of salary. In contrast, rural Midwest hospitals that may find it difficult to even find interviewees are more likely to extend signing bonuses and premium salaries to lure prospective surgeons. The overhead costs of a practice such as rent, staff, and insurance are also higher in the Northeast and California and will ultimately come out of the surgeon’s salary. Data collected on hospital salaries indicate that, on average, Midwest and Southeast starting salaries for surgeons are 10 to 15 percent higher than comparative Northeast and West positions. This is also directly related to the penetration of managed care in particular geographic markets. California may have such regional strength in closed systems such as Kaiser Permanente Group that it may preclude other career options.

The second tradeoff is to decide whether this is an opportunity or a job. A job has often been vacated by someone: Why? The alternative is not a defined job but an opportunity to develop a practice. Chaos provides opportunity; thus, a hospital or department in transition may provide just that to you, so do not eliminate an opportunity just because the environment seems in flux. When considering the job search, never underestimate an edge, and use it whenever possible. Joining your father’s practice will shave 10 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?

You must analyze your own skill sets. Are you entrepreneurial or do you have no such inclination? 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 else does that for you (i.e., a group practice). In solo practice, the need for negotiation cannot be overstressed.

The following do’s and don’ts for planning a job search should be considered:

• 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 not limit yourself to one type of practice. As a plastic surgeon, you have many options from which to choose. Plastic surgery is what plastic surgeons do, not the other way around.
• Do not move anywhere just for a job.
• Do not 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; rather, they are found through network or resources such as alumni
groups. Three-fourths of jobs are not advertised. You therefore need to network beyond your inner circle (i.e., health care consultants, industry representatives, attorneys, or accountants). Networking means tapping into the collective experience at your disposal. A nonthreatening way to begin is to solicit an attending from your program to introduce you to several people at a meeting. At each interaction, first ask for advice, not a job.

RECRUITMENT FIRMS

Search or recruitment firms function either as your or 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,” and so forth. Nearly always, the information lacking is where? 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 for 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 forms of bonus, moving expenses, or commission. Free resources include journals and the Internet.

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 use them as a career coach. Their motivation is now directed toward you. An example is a contract attorney.6

TYPES OF POSITIONS

Historically, the majority of plastic surgeons were sole practitioners; however, times change. In 1997, 75 percent of surgical specialists were independent. In 2005, that number dropped to 68.4 percent. Specifically, for American Society of Plastic Surgeons members surveyed in 2008, 67 percent were in solo practice. By March of 2009, that number decreased to 59 percent—still a majority, but a lean one.1 The reasons cited for leaving solo practice were the following: safety in numbers, it allows quicker footing, economies of scale, security, and the benefit of data collection and negotiation. Keys to success included well-thought-out governance and a shared central vision. Problems in a group consist of division of staff time and jealousy over use of resources.9

Finding satisfaction data for plastic surgeons is difficult; however, two recent articles shed insight10,11 (Fig. 1). Plastic surgeons older than 50 years (56 percent of plastic surgeons) are more likely than general physicians to be solo: 65 percent versus 26.7 percent. The majority of plastic surgeons are satisfied: 93 to 95 percent versus 84 percent of all doctors or 79 percent of surgical oncologists. Seventy-eight percent of plastic surgeons would make the same career choice. Plastic surgeons work fewer hours than the average doctor (52.2 hours versus 53.7 hours), the majority of which is patient care, which is 88.4 percent. Not surprisingly, reconstructive surgeons work a lon-

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**Fig. 1.** Current distribution of practice type as reported by the American Society of Plastic Surgeons Task Force. (From Rohrich RJ, McGrath MH, Lawrence WT. Assessing the plastic surgery workforce: A template for the future of plastic surgery. Plast Reconstr Surg. 2010;125:736–746.)
ger average week (56.5 hours) than cosmetic surgeons (49.7 hours) and are more likely to be in academics than in single specialty practice. Certain factors were associated with greater satisfaction: (1) group practice over solo practice (odds ratio, 1.65; 95 percent confidence interval, 1.0 to 2.71), (2) resident education (odds ratio, 1.88; 95 percent confidence interval, 1.06 to 3.31), and (3) a predominately cosmetic practice (odds ratio, 2.42; 95 percent confidence interval, 1.25 to 4.66). An American Society of Plastic Surgeons 2006 survey found 56 percent of American Society of Plastic Surgeons members in solo practice, 15 percent sharing facilities or small groups, and 10 percent in academics.9 A more recent study reported that of recent graduates, 56 percent are entering private practice, 20 percent are entering academics, and 24 percent are entering fellowship.1

CHOOSING A PRACTICE

What choices are there? The choice is really not of practice type, but rather of risk tolerance.

Government

A government position can come in many forms or with multiple agencies. Examples include the Indian Health Service, the Veterans Administration, the U.S. Department of State, the National Institutes of Health, and the U.S. Food and Drug Administration. Government agencies can be the criterion standard of care or not. The Veterans Administration, 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 but heavy in administrative hassles. It is total security versus no autonomy. The lifestyle, including calls and hours often mandated, can be stringent, but may be the most manageable.

Academics

An academic setting predominantly offers intellectual stimulation and a protected environment. The demand of the inquiring residents’ minds requires 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 what is the balance or cost? It is autonomy. “If you are a control freak, and a lot of doctors are, take that into account because, as an academic physician, you are not going to be in control.”12

Two things have changed academic practice: clinical income and duty hours.13 The classic 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, as in a multigroup practice; this is frequently called a faculty-practice plan. The need to negotiate external support for call coverage, recruitment support, and gain sharing profitability is important for deferring overhead.14 Thus, 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 to another institution to be promoted from associate to professor—may not be feasible in the future. You may relocate, but you cannot relocate your patient base and, consequently, your income. Thus, the field of academics is fundamentally changed; unless you have specifically sought-after skills or research, it is more likely to advance at the same, or another, institution in the same city. Thus, be wary of signing a noncompete agreement. Moreover, it makes a smoother transition to move from the university community into the local community, where you still have your patient base.

Two more core changes in the academic field are the 80-hour resident work week and the need for increased resident supervision. This requires more hands-on time to do the cases and, presently, academics resembles more of a multigroup specialty practice.

The days when residents operated unsupervised on clinic patients, for maximum resident benefit, are long gone. Table 1 outlines some of the disparities in academics.

<table>
<thead>
<tr>
<th>Table 1. Advantages and Disadvantages of an Academic Practice</th>
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</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
</tr>
<tr>
<td>Release from business</td>
</tr>
<tr>
<td>Intellectual freedom</td>
</tr>
<tr>
<td>Stimulation</td>
</tr>
<tr>
<td>Research</td>
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<tr>
<td>Skill enhancement</td>
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<tr>
<td>Challenging cases</td>
</tr>
<tr>
<td>Personal interactions</td>
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<tr>
<td>Positive reinforcement from teaching</td>
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<tr>
<td>Security</td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
</tr>
<tr>
<td>Less control</td>
</tr>
<tr>
<td>Limited input</td>
</tr>
<tr>
<td>Inertia of change</td>
</tr>
<tr>
<td>Potential income</td>
</tr>
<tr>
<td>No equity</td>
</tr>
<tr>
<td>Time-consuming, non-income-generating meetings</td>
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Multispecialty Group

This group, with a mix of primary care and specialties (ideally, a 50-50 split), is in the center of “security versus autonomy.” It sacrifices the benefit of a captive referral base for decision-making capabilities. One of the crucial components is physician ownership. Group sizes vary from that with 10 physicians to one the size of the Mayo Clinic. As size increases, governance and autonomy become more remote; however, economy of volume increases. Generally, income is favorable, although it is not as generous as in single-specialty groups. To be pro-physician, a multispecialty 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 because, as a high-income-generating individual, you may have good bargaining power. Although it offers a potentially good lifestyle with built-in call coverage, you must find the right culture. Is the practice focus balance or productivity? What is the group’s reputation? Finally, what is the eventual buy-in cost? Is there an equity stake?

Groups with a substantial percentage of capitated patients will not favor surgical services and, particularly, plastic surgeons. A recent trend is hospitals hiring their own faculty for care fields such as trauma, orthopedics, and hospitalists. Larger centers are adding plastic surgeons to cover emergency room call and to work in reconstructive wound centers. The key in negotiating these contracts is tying compensation to work relative value units, not collections. This makes income independent of the hospital’s payor mix (Table 2).

Single-Specialty Group

This model has many advantages and is common in plastic surgery. Group sizes vary from two to 14.7 Normally, this model works better if a spectrum of partners exist who provide different skill sets and types of services. The single-specialty group is, in all probability, the peak of potential income because of economies of scale. Although it 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.

The potential for ownership and equity exists, but its potential must be spelled out to balance power from junior to senior partners. The success of this group is pivotal on the philosophy of the senior creating partner. If he or she places the group’s benefit before his or her own, this is an ideal situation.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Drawbacks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater negotiating power with vendors, hospitals, and payers</td>
<td>Slow to make decisions/implement change</td>
</tr>
<tr>
<td>Access to more capital for purchases/investment</td>
<td>Difficult to balance personal goals with what is best for the group</td>
</tr>
<tr>
<td>Economies of scale provide greater access to recruiting and retaining exceptional personnel</td>
<td>Discrepancies in access to personnel or other resources</td>
</tr>
<tr>
<td>Ability to cite rigorous outcomes-based data because of the large patient base and share information on a day-to-day basis</td>
<td>Potential for interpersonal conflict</td>
</tr>
<tr>
<td>The likelihood that advanced electronic medical records will be used in the practice</td>
<td>Interdependence on peers</td>
</tr>
<tr>
<td>Coordinated records</td>
<td>Conflict over resources</td>
</tr>
<tr>
<td>Decreased buy-in</td>
<td>RVU-based compensation</td>
</tr>
<tr>
<td>RVU-based compensation</td>
<td>Decreased buy-in</td>
</tr>
<tr>
<td>Greater quality assurance</td>
<td>RVU, relative value unit.</td>
</tr>
<tr>
<td>Lifestyle improvement through partners who share coverage of the practice</td>
<td>Potential for interpersonal conflict</td>
</tr>
<tr>
<td>Less billing stress</td>
<td>Interdependence on peers</td>
</tr>
</tbody>
</table>

Solo Practice

It is obvious that solo practice provides the most autonomy and carries the greatest 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 interaction outside of the practice. This isolation was identified as a cause of decreased satisfaction among plastic surgeons. A genuine problem with solo practice is coverage of call, which requires thought and trust in other providers. It is important not to rush to financial overextension when starting a solo practice because no economy of scale exists: you cover the entire cost of the practice. Financial security rather than income becomes a greater focus. 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 (ability to cover several months of overhead without revenue); and (4) versatility.

Because this model is a balance of risk versus investment versus autonomy, you must address the two most significant issues—patients and money. This requires a business plan. A start-up expense of $500,000 is not unreasonable. An upmarket
space with operating room faculty and spa services is closer to $1 million. 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.

**EXPECTATIONS AND REALIZATIONS**

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 in any of these models. These data are available and are considerably more reliable than hearsay and lore.

**Need**

Learn the ratio of plastic surgeons to population in the location(s) you are considering. Information regarding the density of plastic surgeons is readily available from the practice management resource center at http://www.plasticsurgery.org. What it reveals is not exactly 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 magic number of physician-to-patient ratio for starting a viable practice? This is clearly culture- and case-sensitive; however, the 1:100,000 ratio has been offered as an ideal, with 1:70,000 as solid and with 1:40,000 as a minimum. Thus, Brownsville, Texas (1:335,222); or Johnson City, Tennessee (1:480,000), may represent more favorable ratios. This clearly does not equate ratio with demand. 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 help compare with other specialties or to generate realistic expectations. Without such data, fair market value and worth are difficult abstractions. The data shown in Table 3 are representative of the average salaries for established physicians.²⁴

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Practice Revenue</th>
<th>Total Compensation 5 Years Ago</th>
<th>Total Compensation</th>
<th>Compensation 5 Years Ago</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology (interventional)</td>
<td>$800,000</td>
<td>$442,000</td>
<td>$320,000</td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>$800,000</td>
<td>$530,000</td>
<td>$396,000</td>
<td></td>
</tr>
<tr>
<td>Orthopedics</td>
<td>$800,000</td>
<td>$410,000</td>
<td>$367,000</td>
<td></td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>$700,000</td>
<td>$360,000</td>
<td>$292,000</td>
<td></td>
</tr>
<tr>
<td>General surgery</td>
<td>$450,000</td>
<td>$328,000</td>
<td>$255,000</td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$425,000</td>
<td>$332,000</td>
<td>$303,000</td>
<td></td>
</tr>
<tr>
<td>Internal medicine</td>
<td>$300,000</td>
<td>$194,000</td>
<td>$176,000</td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>$260,000</td>
<td>$206,000</td>
<td>$176,000</td>
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</table>


Within the plastic surgery discipline, the first myth to dispel is the perceived imbalance between private and academic practice income. A number of recent studies have shed light on this myth.²⁷,²⁸ Physicians of the same experience/age range earn nearly equivalent incomes; however, academic surgeons must perform considerably more relative value units of work—7000 relative value units compared with 5962 relative value units—in private practice to generate the same income. Surprisingly, the average annual salary for plastic surgery faculty is $370,000.²⁴

An American Society of Plastic Surgeons lifestyle survey demonstrated that most incomes range from $299,000 to $499,000.²⁹ The financial superstars earning $1 million or more constitute only 7 percent of our population but, again, money is only one factor, and is less important than culture.

**Taxable Income**

More accurate data are available for academic income. The Medical Group Management Association reviewed 85 individual reports on academic surgeons who spent at least 65 percent of their time in clinical practice; moreover, they spent 16 percent of their time teaching and 9 percent researching. The median starting compensation was $205,570, and a study by Levin found it to be $219,000.³⁰ Considered together, the mean base salary was $239,641 (90th percentile: $591,522). This, in turn, was compared with a similar group of private practitioners (80 respondents from 37 practices) with a mean total compensation of $366,141 (90th percentile: $636,304).³¹,³² These numbers were confirmed by Levin in a recent survey of academic salaries where median compensation was $364,460 on a collection of $699,814.³³ In summary, academic physicians make nearly as much, on average, as their private practice counterparts, but it does require more work.
CONCLUSIONS

1. Conduct a personal inventory. What are your needs versus your wants?
2. Set major priorities: 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.

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REFERENCES