

Endovascular Fellow

TODAY

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Practice Ready

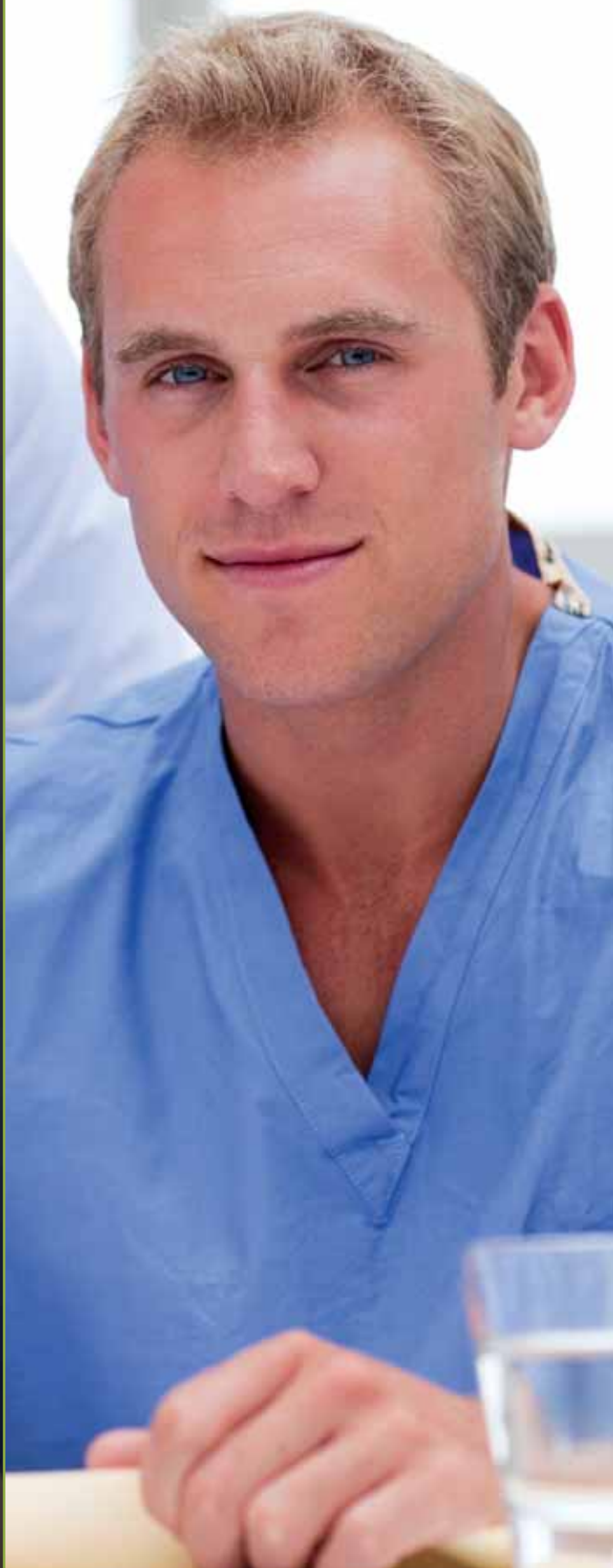
Advice from established vascular interventionists on how to get your career off to a great start.

Before meeting the day-to-day challenges of treating patients, the endovascular fellow must first face an entirely different set of obstacles: what questions to ask and how to respond during interviews, deciding between academic or private practice, and building relationships at the workplace—just to name a few. These challenges can seem overwhelming, and the answers may not always be clear.

Endovascular Today, with the help of Medtronic, Inc., has gathered insights from established vascular specialists into one useful guide, addressing many of the questions endovascular fellows will have as they begin a fruitful career.

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The Job Search After Your Fellowship

What to expect and what to ask as you make your way into the interventional field.

BY FRANK R. ARKO, MD

As a fellow about to embark on your career, the job search process can be time consuming and confusing. If you are uncertain about your career path, plunging into the job market makes little sense. Interviewers quickly eliminate candidates who are unsure of their direction. Self-assessment is the first and most important step in any job search. Self-knowledge allows you to match your interests, skills, goals, values, and potential with a future career. After your training, you should be cognizant of your key competencies as well as your personal concerns including family needs, community needs, education, and finally salary. These are the exact things the people who will be looking to hire you are evaluating.

WHAT TO EXPECT

Telephone Interview

Most practices will have a brief telephone interview before having you visit. Telephone screening offers an introduction and gives some level of assurance that you are appropriate for the opportunity. This is also an opportunity to assess what the job entails and what the expectations from the employer will be. For instance, an academic institution looking to fulfill a space at the VA can quickly be eliminated if one has no interest in working at a VA.

Site Interview

Expect that the interview will last 1.5 to 2 days. Scheduling these interviews can be difficult because coordination of multiple schedules is required. Flexibility in your schedule will be necessary. The employer typically pays all costs of the trip, and they will attempt to coordinate everyone's schedule. Just remember to keep track of all expenses and receipts because they will be reimbursed. If traveling from out of town the night before the interview, the lead person in the group may meet you that evening; if arriving late, expect to meet in the morning. It is important to rest the night before because the interview process can be long, with few breaks in between interviews.

QUESTIONS YOUR REFERENCES MAY BE ASKED

- What are his/her technical abilities?
- How is his judgment?
- How does he interact with others?
- How is his work ethic?
- Does he have any specific strengths or weaknesses?

Come prepared to the interview. The more prepared you are, the easier it will be for you to stand out against the competition. You should dress professionally and wear a conservative suit with a neat and well-groomed appearance. Be on time; a prompt arrival indicates your interest in the opportunity. Concentrate on selling yourself and determining if this position is for you. You should remember that there is no such thing as a perfect opportunity. If you look for everything on your wish list, you may miss the best opportunity by searching for something that doesn't exist.

BE YOURSELF

It is important to be yourself. Be courteous and polite to all physicians as well as the ancillary employees. Often, the ancillary staff is a good judge of character, and the physicians will listen to and want their opinion. Be flexible by showing there is more than one way to handle a given situation. In some instances, interviewers try to trap the candidate into agreeing with a senseless observation or opinion. If you are pressed for answers on a subject on which you may disagree with the interviewer, be honest but not argumentative.

Do not be too brief with answers to questions regarding hobbies, family, and spare time activities. These questions can be an essential way for the interviewer to see your humanity and the real you. Remember, you are competing with people whose qualifications and accomplishments are very similar to yours. The interviewers will want to know that you fit in with the culture of the organization.

In order for them to get to know you, you will need to stress your accomplishments. You need to distinguish yourself from the competition. When asked about your accomplishments, be prepared. Develop a list naming the most important first. You will want to let them know how you can benefit their practice. You need to convey your skill level, the number and types of cases that you performed, your specific interests, and how you will develop those into a successful practice. It is just as important to determine if the opportunity fits your needs and to ask specific questions regarding caseload. For example, if your interest lies in aortic surgery, and the group that you are interviewing with has a large dialysis and venous practice, it is important to determine this during the interview process. You will need to market yourself by appearing competent without being too modest or arrogant. Using case examples of straightforward and challenging cases that you have managed is helpful in this regard.

References

The interviewers will want to know that you are both safe and effective as a physician. Your personal references will often convey this message as well. Whether coming out of training as a vascular surgeon, a cardiologist, a radiologist, or a cardiothoracic surgeon, your personal references will be called, and they will be asked the typical questions (see *Questions Your References May Be Asked* sidebar; see also *Questions You May Be Asked* sidebar).

WHAT YOU NEED TO LEARN ABOUT THE PRACTICE

In general, what you need to determine is what type of practice it is, whether it has any academic affiliations, what the philosophy of the group is, and what the short- and long-range goals are for the practice and for your position. During the interview process, it is helpful to learn as much about each individual in the group as possible because these will be the people that you will be spending a significant amount of time with during the day. You need to determine if the group is cohesive, what their practice styles are, and what their workload is. It is important for you to determine if your personalities are well matched. Are there any specific personality conflicts within the group, and if so, how are these managed? What are the practice's weaknesses and strengths? Why are they looking for another partner? Has someone or is someone leaving? If so, why? Is someone retiring? If so, when? Or, is the practice just so busy that another body is needed, and, if this is the case, what is the type of caseload that it is trying to fill?

To establish whether you are able to work with the other physicians, find out about their backgrounds. It is

QUESTIONS YOU MAY BE ASKED

- What can you tell me about yourself?
- Why are you interested in this job?
- What are your long-term goals?
- Why do you want to work with us?
- Why should we hire you?
- What do you believe you can bring to the group?

of utmost importance to determine their practice style and if they tend to be more progressive or conservative in their management style as it relates to patient management. Conflicting types of patient management can become difficult to manage with competing partners if there is a specific philosophical difference unless the group is trying to expand its practice.

It is essential to determine how you will build and maintain a practice. First find out if there is a genuine need for another physician within the group. How does the group obtain their referrals, and what are the plans to market you as a new member of the group? Attempt to determine if there are enough primary care physicians to keep you busy. Is there a genuine need for another of your specialty within the city, and what is the surrounding competition of other physicians? It is also important to ask what the average waiting time for a new patient appointment is to assess how busy the practice is currently. And finally, are there future plans for continued growth after you're hired?

Educational Benefits

Educational benefits of the practice are important as well. Are there seminars or journal clubs conducted within the group to fulfill CME requirements? Does the group allow and encourage attendance at annual specialty conferences and activity within medical societies? Also, remember that each state requires its own medical license, and it is important to establish if there are any special requirements to obtaining and maintaining a medical license.

Finances and Billing

It is also good to understand the finances and billing within the group. Understanding and knowing the payor mix including Medicare, Medicaid, and private insurance as well as noninsured patients is important to knowing what types of patients you will be treating. Does the practice use an automated or manual system for scheduling, billing, and/or insurance filing? The use of electronic medical records is beneficial to everyone but is associated with a cost to institute to the system.

CONSIDERATIONS FOR YOUR POTENTIAL NEW LOCALE

- What are the rates of state and local sales and income taxes?
- Will there be sufficient cultural and recreational opportunities such as museums, opera, and theater, as well as outdoor activities such as parks?
- What is the average cost of housing?
- What is the average cost of education, including public and private schools and colleges and universities?

Your Time in Practice

Your own personal well-being as well as that of the group is vital. It is important to determine how scheduling of clinics and cases, both in the OR and in the interventional suite, is obtained. Remember that you will not have any patients unless you are taking over an existing practice, and OR time and interventional time may be difficult to come by. As you become more established with a practice, this time will become more available to you, and you will have scheduled OR time. It is important to know how busy the current OR and interventional suite are and at what capacity they are operating.

Ask how much day and night call you will take and how many weekends you will be on call. Early in your career, taking call is a nice way to meet other physicians and help to establish a practice. However, it is important to have a certain balance in one's own life, and call for the most part should be evenly distributed. It is appropriate to ask about your daily responsibilities as well as any administrative or managerial duties that may be asked of you.

Practice Setting

It is important to get a sense of the office and the locations. You will want to know how many there are and to make sure the location is convenient for both the doctors and the patients. Ask if you will be expected to work out of more than one office. Travel between multiple offices can often become inefficient, and one can lose valuable time during the day even if the offices are close. Attempt to define this during the interview process so that you understand your responsibilities to the practice. It is also important to take time to research the area where you are applying (see *Considerations for Your Potential New Locale* sidebar).

SALARY

Finally, as with any job, you will have to approach your potential employer about pay if it has not yet been discussed with you; it is generally easier if the employer first brings up the subject. Salary is rarely discussed during the first interview, especially if the position is in an academic setting. The main goals during the first interview are for both sides to see if they are an adequate fit for each other. If they approach the subject with you, then certainly it becomes a fair question for you to follow up. Those in private practice are often quicker to discuss salary during the first interview. If asked what kind of offer you are looking for, your response should be, "I will consider your strongest offer." Your goal in any interview is to obtain an offer.

This topic during your first job after fellowship can be somewhat intimidating because you need to determine what your worth is and the appropriate pay for an individual coming out of practice. It is perfectly reasonable to ask how much you will be paid in the first year and subsequently. For instance, if the first 1 or 2 years' salaries are fixed and the compensation moves to a productivity basis, you will want to know how the transition is handled and how the other partners have fared during this time. Also, you will want to know how overhead expenses are allocated. Frequently during the first and or second years, you will defer the overhead costs. Depending on how large the group is, the expenses can equal up to half of the group's revenue, and this becomes a significant consideration. It is key to get to know the income-distribution methodology for the group and individuals within the group. Lastly, it is important to understand what the buy-in is and how it works, including how many years it may take to become a partner because this can range from 2 to 5 years.

CONCLUSION

It is important for you to gain as much information as possible during the interview process to ensure that the opportunity fits your needs and expectations. It is also important to remember that it is your first job and that you will have additional opportunities to interview in the future, and the limitations of your first interview and job are tools to learn from for the next time. ■

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Academic Versus Private Vascular Surgical Practice

The good, the bad, and the ugly sides to each approach.

BY LEILA MUREEBE, MD, FACS

I will begin this article with a disclaimer: I am an academic vascular surgeon and have been for my entire career. My second disclaimer is that throughout my training and even in most of my practice environments, I have been involved in private institutions as well. I like to think that I am not terribly biased toward or against either venue in particular. My final disclosure is that this entire discussion will revolve around vascular surgery practices.

WHAT DEFINES AN ACADEMIC OR PRIVATE PRACTICE?

If the practice name has the word *University* in it, you have likely found an academic practice. However, this is not always true, and as Shakespeare wrote, "What's in a name?" If you look at a particular large academic practice in Albany, New York, you will see that the name of the group is very straightforward: The Vascular Group. Nowhere in that name will you find out that every member of that group makes fundamental contributions to academic vascular surgery at every single national meeting. The name of the practice does not reflect the volume of teaching that medical students, residents, and fellows that the members provide. And perhaps the truth of the matter is in that statement. If you find that the institution has a significant teaching component and/or an expectation (or a track record) of publications, you are likely looking at an academic group. The converse is that there are academic groups in which some members are clinical producers and often have limited publications and, sometimes, limited student or resident interaction. There are also private practices that publish extensively and engage in the education of students and residents.

The number of myths surrounding practice types is innumerable, but I will describe a few of them in the following paragraphs.

MYTH ONE

Private practice surgeons have only one goal: making money.

The adage that "money makes the world go around" is true. You cannot provide care without resources, which

means money has to come into the picture. The biggest difference in the arena of money between private and academic practices is the degree of control you have in how you make it and how easy (or impossible) it is to track where each cent goes.

In terms of money flow, what you collect has many destinations other than your pocket or retirement account. In both academic and private practice, each dollar goes to several places. These locations can vary greatly from practice to practice. In a "typical" private practice, your collections have to also pay for overhead, ultrasonographers in your office, office staff (assume at least a receptionist, some facility for coding and billing, and filing systems), and fees for licensing and credentialing. In an academic practice, you not only have the same expenses as the private practice, but you also have taxes. Taxes vary from institution to institution, and they often comprise money for the larger department that can be allocated to several missions or other sections within the department. Some amount often goes to the larger university or to the dean. In a private practice, you often start out as an employee and, in one of several methods, become a partner. Generally, you can find out exactly where the money you collect goes in a private practice. That cannot be said of most university practices. As academic medical centers become more cognizant of the financial pressures facing them, academic surgeons are finding themselves increasingly accountable for their workloads and are often benefiting financially from high workloads in the form of bonuses for productivity or a percentage of their collections. All of the above permutations must be explored when considering accepting a position at either type of practice.

In a private practice, you have a little more control in how you practice. Depending on the particular practice you choose, you may find that you have to broaden your scope beyond what you did during vascular training; you may find that you need to take a general surgery call. However, you may be able to restrict your practice to a single territory, such as venous practice. The scope of your practice depends on several factors. Issues such as the density of vascular surgeons, what the larger group wants, and

what the local referring and consulting physicians are looking for affect your options. Remember, in private practice, these are your choices, as you are choosing the practice. In academic practice, it is more common to have a “straight” vascular practice, but you often find that you have to be a vascular generalist, doing everything from hemodialysis access to treating thoracoabdominal aneurysms. Regardless of whether you choose an academic or private practice, individual members will become more specialized. In large practices, it is not altogether uncommon to find individual members with niches within vascular surgery.

MYTH TWO

Academic surgeons go into academics because they would rather do research than take care of patients.

I have a major issue with this myth. Academic surgeons are responsible for the bulk of training, so if they cannot operate, how can anyone they train be competent? It is true that academic vascular surgeons often have responsibilities in addition to their clinical practice, but these responsibilities very rarely affect clinical practice per se. Those responsibilities also look different today than they did 10 years ago. Today, “academics” comprises more than the basic sciences. Although academic vascular surgeons continue to greatly contribute to the understanding of the molecular and cellular mechanisms behind every aspect of vascular disease, they are also involved in research into outcomes of procedures, decision making in vascular surgery, and clinical trials. They are also increasingly involved in health policy research and in education. All of these count as academic output.

To turn the tables, there is nothing to say that vascular surgeons in private practice cannot engage in these endeavors. In fact, they often do. Occasionally, minimally invasive or novel therapies are more rapidly integrated into private practices, which tend to be more flexible. Thus, when trials to assess these technologies or therapies are designed, private practices play as large a role as academic practice. Although running a basic science laboratory is not likely feasible without a supporting university, education, health policy, and outcomes research are all actively performed by private practice surgeons today.

MYTH THREE

Once you choose a path, you cannot change it.

This was widely quoted to me when I was a resident and a fellow. I was advised to pursue academics because if I did not start there, I could never get there. This simply is not the case. A dean at a southern medical school is a vascular surgeon whose first job was in private practice. And while in that private practice, she presented and published several important articles that influenced vascular surgical practice. No one would ever consider her

transition to academics to be less than thoroughly successful. The converse is true as well. As previously mentioned, private practices are often involved in clinical research, and practitioners may occasionally decide that inquiry drives them more than they anticipated and make the move to academics.

MYTH FOUR

Academic and private practices are diametrically opposed.

Looking at the previous three myths, it should be apparent that the line between private and academic vascular surgery is awfully blurry. This has been a steady change that has occurred during the past 10 years. Each practice looks different. “Academic” and “private” are no longer the distinctions that they once were. Many academic practices are very clinically oriented, with limited academic output. Many private practices have vibrant publications and research output. However, there are several differences that remain. Physicians tend to have more control in private practice. The business of medicine looks more and more like a business every day. Your willingness and enthusiasm toward this fact must play a part in your job choice. The bigger the institution, the slower change is accepted. Much like a ship, the bigger it is, the longer it takes to turn. Academic practices are often part of a larger department, which is itself part of the larger university. This is often the source of the inflexibility that is observed in many academic practices.

FREE ADVICE

No job is perfect, but there is one that will likely be a wonderful fit for your strengths and your desires. Think about where you want to be 1 year after your training. Does the job you are looking at match your mental image? What about at 5 years? How do you feel about changing jobs? It is a lot to digest and a lot to think about. It might help to sit down at a quiet moment (often hard to find during a busy training program) and think about your individual strengths, weaknesses, likes, and dislikes. Take that list with you when you look at positions. When the qualities that you are looking for and those of the job match up, you have found a position that will likely suit you. Do not let the designation make your decision for you. Ideally, this is a position you will hold for a while and enjoy. Take your time looking and making your decision. ■

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Tips for a New Hire: Don't Repeat My Mistakes

One physician's experience of entering the field and advice on building a career during your first year.

BY FIRAS F. MUSSA, MD

Vascular fellows entering the job market should take a moment to reflect and create a personalized recipe for how to land the ideal and best-fit job. With the current economic climate and dwindling reimbursement, many large academic and private practices are reluctant to guarantee big startup salaries and support time for research. I do not wish to paint a gloomy picture of the postgraduate world but would urge fellows to be realistic as well as cautiously optimistic before making career decisions. In this article, I will share a few of the blunders I made when I first started and how to correct them to help you avoid making similar mistakes while continuing to grow professionally and personally.

YOU AIN'T NO DeBAKEY . . . AT LEAST NOT FOR THE FIRST YEAR

Remember that no matter how well trained you are, you still lack real-world experience and have an uphill road to prove your competence as a vascular surgeon. Plan straightforward cases for at least your first 3 months to establish a good reputation among nurses and staff. Asking for help in the operating room is not easy, but it will help you to develop good relationships as well as good outcomes. Do not approach cases with the same cavalier fashion as you might have done as a fellow. Discuss complex cases (including straightforward endovascular aneurysm repair) with at least one of your partners and be prepared to ask for assistance in the operating room even though you might think that you are too good to do so.

DO NOT UPSET THE CHIEF

I think this was my biggest mistake when I began my career. I was completely out of sync with the entire division and, most importantly, my boss. The worst part was that I did not even see it. I was trying too hard to impress myself with what I could do as a member of the faculty. I realized that my plans and achieve-

ments were minimal when I finally looked at the big picture; my boss was trying to make me see things in a more diplomatic way. My recommendation is to understand what you were hired to do and play that role well. Your boss has the ability and connections to help you realize your professional plans and dreams, so be smart and do not step on your boss's toes.

RECOGNIZE WHAT YOU ARE GOOD AT— NOT WHAT YOU THINK YOU ARE GOOD AT

If writing papers or doing research is not your forte, then do not enter academia. If you want to make millions and retire at 40, then you should not have entered this business from the start. Recognize what you are good at and exploit it. Your strong suit may be having good technical skills (rarely the case for new graduates), the ability to write well, obtaining extramural funding, or having a charming personality (can happen occasionally).

DON'T SEND CRAZY EMAILS

When Lincoln lost a battle, he wrote a letter to his general to reprimand him for not following orders. He never sent that letter and lived to win the war. Now that you are the attending, you may think that the world revolves around you. Of course this is a myth, and you better debunk it before starting your job. Your hospital administrator does not care if you do complex cases or trained in the best places. Do not get caught in the moment and send an inappropriate email to the chief of nursing or a hospital executive just because he or she did not provide what you needed in a timely fashion. This will get you nowhere and certainly will backfire on you within your division and department. Building a good relationship with your staff and administration is not only helpful in the day-to-day running of affairs but can also be very handy when you want to introduce new technology and increase your patient outreach.

LIKE YOUR PARENTS, YOU DON'T CHOOSE YOUR PARTNERS

Remember that your employer hired you—not the other way around. You cannot give your employer an attitude when you are considered a guest, particularly during your first year. It is important to treat each relationship with care, making yourself available, asking if you can be of assistance, showing up when you are least expected, taking calls, respecting privacy, and sharing accomplishments. Do not boast, and accommodate others as much as you can. You are disposable until you earn the respect of your partners.

ASK WHAT YOU CAN DO FOR YOUR GROUP, NOT WHAT YOUR GROUP CAN DO FOR YOU

Try to add a new dimension to your group. If your group needs someone to do certain cases, volunteer to take them on; if any of your partners are overwhelmed with mundane paperwork and institutional obligations, offer to help. A big mistake is to think that you are busier than others and that you don't have time for additional tasks. Your attitude should be, "Bring it on. I can do it."

ROME WAS NOT BUILT IN A DAY AND NEITHER WAS THE REFERRAL

The issue of referrals may not come into play immediately, but it absolutely will be an issue down the line. I never had a business-oriented view of medicine, and frankly, I ignored my development in this category. After a while, it became necessary and impossible to ignore; however, I must admit, it is now fun and adds a great deal of satisfaction to my job. There is no magic formula to getting referrals. The power of word of mouth is undeniable despite Facebook and Internet ads. It is naïve to think that you can ask your partners to send you patients if they are too busy. It takes time, effort on your part, and miles on your car to meet primary care doctors and specialists more than once. After each case, you need to do three things: dictate the operative report, talk to the family, and finally, call the referring physician. Look to build your referral base away from your partners' and expand the practice by bringing new patients and not shoveling them around.

MAKE TIME TO STUDY FOR YOUR BOARDS

Completing your boards during your first 2 years of practice is not only a mental relief but also a major boost to your credibility and confidence among your group. In my view, preparation courses are a waste of time and are certainly costly. In order to pass your written boards, you should be proficient in all aspects of noninvasive vascular testing (vascular lab) and have

access to VESAP (Vascular Education and Self-Examination Program). Just like the oral boards in general surgery, passing the vascular oral boards is dependent not only on knowledge but also performance and mental capacity. Practicing with another person is advisable, and going through one textbook is certainly recommended (eg, *Ernst and Stanley's Current Trends in Vascular Surgery* is still a favorite for examiners despite being outdated).

DON'T OVERSPEND

I cannot tell you how to run your finances, but I might be able to tell you that you shouldn't feel too comfortable during the first year or two on your job. Do not buy a house during your first year because you may find yourself relocating if things do not turn out the way you or your partners planned. Similarly, do not plan too many fancy vacations because this would certainly interfere with the image you are trying to convey of being the hungry, blue-collar, willing and able vascular surgeon. Instead, invest in your institutional investing plans (403[b], 401[k], etc.).

MAINTAIN A HOBBY

You may now have the time and finances to support your hobbies. Trying to play sports once every 2 weeks is a good start. I would recommend sticking to the basics and keeping it local. Whatever you decide to do, you can take this time for yourself away from work and the house and turn it into a healthy routine that you can actually look forward to on a regular basis.

MAKE TIME FOR YOUR FAMILY

You might have explained to your significant other or your family that your time is not really yours but your attendings', and you will be gone for what seems like days at a time. Now that this is no longer valid, you will quickly rediscover the beauty of having more time for your family. It is easier said than done given that you want to always be present on the job, able to stay late and do cases, take extra calls if need be, and yet manage to keep your household happy. I think a good way to balance this is on the weekends and long holidays when you can plan an activity or a one-day road trip. This will take you away from work and also bring you closer to home and enjoy quality time with your family. ■

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Defining the Physician-Industry Relationship

The current era of scrutiny of the physician-industry relationship requires special attention to your affiliation with industry as your career develops.

BY ROSS MILNER, MD

Vascular surgery has evolved into a specialty that is highly dependent on medical devices to provide optimal care for our patients. A large percentage of practices use wire and catheter techniques to treat aneurysmal and occlusive disease in many different vascular beds. The exposure to medical device companies makes a vascular surgeon highly susceptible to violating the appropriate physician-industry relationship. This article provides some suggestions on how to handle the complex situation of advancing your career, your practice, and device development while not putting yourself at risk of inappropriate personal gain. I will focus my comments on clinical trial work, educational grants, and consulting work.

CLINICAL TRIAL WORK

Clinical trial work is typically straightforward. The sponsor of the study usually interacts directly with your institution through a research coordinator. The research coordinator is usually an employee of the department of surgery or division of vascular surgery, although sometimes he or she is a hospital employee. The initial approach is a site survey that gauges your interest in participating in a clinical trial. The site-survey also allows the sponsor to determine if you have adequate patient volume to support their trial at your site. I would recommend being as accurate as possible when categorizing your patient volume and completing the site-survey forms. It is more detrimental to your future involvement as an investigator with a sponsor if you are not able to participate in a clinical trial when you provided data that stated you would easily be able to enroll patients.

If your site is selected and you are selected as a site principal investigator (PI), the next step is completion of a nondisclosure agreement (NDA), which needs to be signed by you and your institution. The NDA allows the sponsor to share specifics of the study design with the PI and the participating site. It also may provide details about the specifics of the device that will be

“A significant aspect of clinical trial work as it pertains to the physician-industry relationship is any involvement you may have with the sponsor of the study that may be viewed as a conflict of interest to the study outcome.”

used in the study. The protocol and institutional review board (IRB) submission process can then begin. An important IRB detail for sponsors is how quickly your IRB is able to process submissions. IRB fees are also institution dependent and can be an issue in becoming an active clinical trial site. Finally, a contract needs to be negotiated between your institution and the study sponsor.

A significant aspect of clinical trial work as it pertains to the physician-industry relationship is any involvement you may have with the sponsor of the study that may be viewed as a conflict of interest to the study outcome. Each institution defines conflict of interest based on institutional policies. Either way, your site can participate in a study even if you have received compensation for consulting work or other projects, as long as you carefully disclose your conflicts. As the PI, you may not be able to participate in the clinical work, and you may need to remove yourself from the study completely if you have conflicts. It is not worth compromising your career or the outcome of a study because you think you can manage your conflict yourself. Be honest in your disclosures, and allow your institution to assist in defining what is perceived as a conflict of interest when leading a clinical trial at your site. Most institutions will ask you to provide an updated disclosure on an annual basis. You may have to change your role or involvement in a study if your disclosure statement changes.

EDUCATIONAL GRANTS

The financial situation at most medical centers has made the development of clinical programs more difficult and has limited our ability to support academic endeavors. Many departments have discretionary funds from clinical revenue that are available to support your vascular surgery program, but these funds are not as readily available as they were a decade ago. It is an easy trap to turn to industry to support programs when the resources are more readily available from industry than from your department. You must use care when trying to obtain this type of financial support.

Educational grants can support research, resident and fellow educational opportunities, and lectureship series. An educational grant should not have any dependence on the clinical volume or amount of devices you use from a particular sponsor. Most educational grants require an application and explanation of the necessity of educational support. The grant application is usually for a specific amount of support. A grant that is funded will be awarded to the institution and not to an individual. I would suggest using the department of surgery as a depot for the financial support that comes from educational grants, but this can be handled according to the policies of your department. As long as you do not receive individual financial gain, you do not need to disclose this as part of your individual annual disclosure statement.

CONSULTING WORK

The issue of consulting can be more controversial than clinical trial work or educational grants, but it is easy when handled appropriately. Your institutional policy will dictate if you are able to provide consulting services to industry. If you are able to consult, you must have a consulting agreement that is specific to your consulting task. You and the sponsor are both required to sign this agreement. All consulting agreements need to be approved by the compliance officer at your institution. Your consulting task should be clearly defined; this definition should include but is not limited to the

“Your consulting task should be clearly defined; this definition should include but is not limited to the specific task, time involved for the task, time that the consulting agreement is valid, and a compensation schedule.”

specific task, time involved for the task, time that the consulting agreement is valid, and a compensation schedule. As mentioned earlier, you may have to remove yourself as an investigator in a clinical trial based on any compensation from consulting work. Each institution defines conflict differently, and you must disclose your consulting compensation honestly so that the outcome of a study is not compromised.

CONCLUSION

The physician-industry relationship is a two-way street that needs to be carefully handled. This relationship allows for the continued improvement and advancement in technology to help with patient care. It is important to handle your financial involvement carefully. Your honest disclosure of your role as a clinical trial investigator, educational grant writer, and consultant is imperative to the success of your career and your division. ■

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21st Century Physician Employment Agreements

Critical elements you should consider to help ensure that your agreement suits your specific needs.

BY TERRELL J. ISSELHARD, JD

One of the more perplexing issues physicians confront as they transition from fellowship to practice is their employment agreement. These agreements can vary from an informal offer and acceptance conveyed over a phone call to a complex written contract the size of a small novel. This article addresses the question of when a written employment agreement is appropriate, the advantages and disadvantages of entering into a comprehensive employment agreement, and several provisions critical to providing physicians with the legal protection necessary in their employment relationship.

LIMITATIONS OF ANALYSIS

This article is intended to familiarize the reader with several of the pertinent issues they may choose to address in their employment agreements. It is not a review of all legal issues that will impact your respective agreement. In the United States, employment agreements are governed by the law of the state with the most significant contacts with the contracting parties. In this context, contacts refers to the state in which the contracted employment is to take place, but (as with most legal rules) there are exceptions. A physician may agree to work for a practice with offices in two neighboring states that have conflicting laws regarding the relevant provisions of the employment agreement. Because it is not possible to provide a dissertation on the employment laws of all 50 states within the context of this article, I strongly recommend that any physician preparing to enter into an employment agreement meet with an attorney familiar with the employment laws in the state governing your contract.

WHEN IS AN EMPLOYMENT AGREEMENT APPROPRIATE?

Under the law in many states, an employee hired without an agreement is considered to be an "employee at will," meaning that the employer can fire the employee

"A written agreement can address a wide range of terms and provide the employee with certainty regarding his or her position at the practice."

without cause, notice, or compensation (aside from compensation already earned) at any time. Although various federal and state statutes protect employees from age, sex, racial, and disability discrimination in the workplace, unless there is a verbal or written agreement to the contrary, an employee working for a business organization has no additional legal rights concerning dismissal.

Therefore, the first issue to address is whether it is in an employee's best interest to have a written agreement. The most obvious benefit of a written employment agreement is evidence of the terms of employment. Although a verbal employment agreement is valid and enforceable, the parties may subsequently dispute the exact nature of those terms, and the only evidence of the details will be the parties' own conflicting testimony. A written agreement can address a wide range of terms and provide the employee with certainty regarding his or her position at the practice. On the other hand, the ambiguity of a verbal agreement has advantages: some terms contained in a written agreement (such as a noncompete agreement) may be against the best interest of the employee. An employee who is planning on a short stay at a particular medical facility before moving to another job in the same geographic area may prefer a verbal agreement, trading a degree of uncertainty regarding the specific terms of employment for the freedom to change jobs.

NONCOMPETE AGREEMENTS

A medical practice that has an existing patient base may wish to restrict a new hire from competing with the

practice when the employee terminates employment. It is not a question of if, but when the employee will terminate. In every employee/employer relationship, the employee will ultimately terminate employment, whether due to death, disability, termination (voluntary or involuntarily), retirement, or finding another job.

Enforceability

The enforceability of restrictive covenants presents an excellent example regarding the disparity of the states' treatment of employment agreements. In some states, restrictive covenants are enforceable; in other states, the courts deem these covenants contrary to public policy and unenforceable. A third group of states will enforce such covenants subject to certain limits. In these states, the restriction must be limited as to time (often 1 to 2 years) and to a geographical area that bears a significant relationship to the actual business interests of the medical group. For example, a cardiologist in central Illinois whose practice serves a 50-mile radius of his office may be able to enforce a restrictive covenant that covers that 50-mile radius for a 2- or 3-year period. On the other hand, a cardiologist working within the Chicago city limits may only be able to enforce such a covenant within a 3- to 5-mile radius, and a cardiologist leaving that practice may only lose hospital staff privileges at one or two hospitals.

In addition to the limitations on enforceability, these agreements often face other stumbling blocks. Most states provide that any ambiguity in an agreement should be construed against the party who drafted the agreement (usually the employer). In addition, a restrictive covenant may not be enforced if the employer has materially breached the employment agreement (ie, not paid compensation or kept other promises, such as setting up a promised 401[k] plan). If an employer has failed to meet its contractual obligations, the employee can argue that the restriction would be unfair to enforce. Therefore, it is critical therefore that an employer strictly honor its promises if it wants to enforce a restrictive covenant. Finally, if an employee wants to break a restrictive covenant, the employee should seek legal counsel first to determine whether the state honors such agreements and whether the employer has met all of its contractual obligations.

Damages for Breach of Restrictive Covenant Not to Compete

Depending on how the restrictive covenant is drafted, the consequences of such a breach may be monetary damages, an injunction, or both. Monetary damages are generally a dollar award determined by the court or mediator to compensate the employer for lost revenue caused by the breach of agreement. An injunction would

prohibit the terminated party from establishing a competing medical practice. Some parties agree in the employment contract to "liquidated damages," which represent the sum that the parties estimate that the employer would likely suffer if the employee were to breach the restrictive covenant. These liquidated damages are generally upheld (in those states that enforce restrictive covenants) so long as it is not perceived as a punitive amount. I recommend liquidated damages to my clients because these provisions reduce the likelihood of future court proceedings regarding the actual business loss incurred by the employer.

To Sign or Not to Sign?

When I represent employers, I encourage them to have a restrictive covenant to protect their patient base. It is unfair for a junior physician to move into a community, be introduced to the patient base and financially supported by the established medical practice, and then leave the medical practice and significantly damage it by taking a large number of patients. When I represent an employee joining a medical practice, I advise them to not enter into an employment agreement with a restrictive covenant unless they clearly intend to honor it or unless the restrictive covenant has a prearranged liquidated damages provision that will allow them to "buy out" of the restriction. The costs to both parties in any litigation to enforce or breach the restrictive covenant are time consuming, costly, and uncertain because courts are reluctant to enforce such restriction.

Extending the Period of Restriction of Practice

If a terminated physician goes to court to have the covenant not to compete declared unenforceable, a problem can occur because the court may not decide the issue for 2 or 3 years. If the terminated physician is successful in being allowed to practice during the litigation, the restricted period may thus be ineffective because the employee may be allowed to continue to practice during the litigation and patients will go to the employee. To alleviate this problem, a provision may be included in the employment agreement.

If the employee terminates employment, the period that the employee cannot practice within the restricted area can be automatically extended by the length of any period during which the employee is in breach of the noncompetition agreement and for any period that the medical practice institutes litigation to enforce the restrictive covenants. Therefore, the covenant will continue in full force and effect throughout the duration of such an extended period. For example, if the restricted period is for 2 years after employment and the litigation extends for 3 years after employment, and if the court rules in favor of the medical practice, the employee

would be restricted from providing medical services within the restricted area for the 4th and 5th year after termination of employment.

Termination of Medical Staff Privileges

Upon termination of employment, the employee can also be required to terminate privileges at the hospitals that are in the restricted area and not reapply for privileges at such hospitals for the restricted period after the date of termination of employment. The employee can irrevocably appoint the president of the medical group, or his designee, as the employee's attorney-in-fact to submit such resignations on the employee's behalf if the employee fails to do so after the effective date of the termination of employment. In connection with the relinquishment of such privileges, the employee waives any and all rights that the employee may have by virtue of such medical staff membership, including but not limited to, any rights to a fair procedure or due process under any medical staff bylaws, or rules and regulations thereof, or any part of or supplement thereto governing hearing and appeals.

MALPRACTICE INSURANCE

Deciding who pays the cost of professional liability insurance for the employee upon the employee's termination is probably the most critical and controversial provision in current employment agreements. The rising cost of malpractice insurance and the grim possibility of exposing your personal assets to a judgment makes this both a costly and essential area of negotiation.

Before analyzing the contractual issues, it is essential to understand a few basic concepts regarding medical malpractice insurance policies. Coverage of a physician under a malpractice insurance policy is triggered by events described in your insurance policy. There are two types of policies that have two very different triggers.

Occurrence Policies

These policies cover acts of malpractice that occurred during the policy year, regardless of when the patient or physician is first notified of the alleged malpractice.

Claims-Made Policies

These policies cover acts of malpractice when the claim is reported during that policy year, even if the malpractice occurred years before. This is an important distinction. If the physician is covered by an occurrence policy, he or she is covered for malpractice that occurred during the policy year, even if the malpractice does not manifest itself for years after the policy expires. Under the more prevalent claims-made policy, if the malpractice occurs in 2006 but no claim is made until 2008, the policy that was in effect in 2006 would not provide cov-

erage. A physician under a claims-made policy who terminated employment at the end of 2006 would need to carry insurance to cover those claims that may arise from malpractice that occurred during 2006 but does not result in a claim until years later.

Tail Policy Coverage

The most common situation I encounter in negotiating employment agreements is whether the employer or the employee is responsible for purchasing the tail coverage for the professional liability coverage after termination of employment. A tail policy covers any lawsuit filed after termination of employment that relates to activities performed by the physician while an employee of the medical practice. Many years ago, most professional liability policies were occurrence policies. As a result, there was no need to buy tail coverage because the typical policy provided insurance protection for any claim made for acts that occurred while the physician was an employee, even if the claim did not arise until after termination of employment. Thus, if you are fortunate enough to be covered by an occurrence policy, the cost of professional liability insurance after employment is a nonissue. Unfortunately, most insurance policies today are claims-made policies, and it is that type of policy that most of my clients must deal with on a day-to-day basis.

The general rule has been that medical groups will pay for the professional liability coverage during the period the physician is employed. Once the physician terminates employment, however, most medical groups place the burden of purchasing the tail coverage policy on the terminating employee. One exception to this rule may occur if the particular medical specialty has a reasonable professional tail coverage cost.

When I represent medical groups, I always recommend that the medical group not pay for the tail coverage. When I represent the individual physician, I attempt to carve out situations in which the medical group would pay (ie, the employment agreement is terminated because the medical group has materially breached the agreement or the medical group terminates the employment of the physician without cause). Medical groups are hesitant to pay for tail coverage if they terminate the agreement for cause because it creates a litigious environment, which questions the meaning of "for cause" and "material breach."

An occasional compromise is that the medical group and the physician may agree that they will split the cost of tail coverage if the physician leaves for whatever reason in the short term. For example, if the physician's employment is terminated within 1 to 2 years of employment, the medical group may pay a portion of the cost (say 50%) and the physician pays the remaining

50%, so long as the physician leaves the area and does not compete with the medical group.

Many factors will determine which posture can be used in negotiating an employment agreement. If the physician is highly trained in a subspecialty, an existing medical group may be willing to make an exception and provide tail coverage as an enticement to the physician to join the group. On the other hand, if the medical group has had disappointing experiences with physicians voluntarily leaving the group, and not as a result of the group not fulfilling its obligations, then it is more likely they will not make this accommodation.

Employment With Hospital Systems

Because of the economic climate, a number of physicians and physician groups have or are considering becoming employees of hospital systems. The major advantage of joining a hospital system is that the physician will be insured under the hospital system's professional liability policy as an employee. Thus, if there is a liability claim, the hospital will defend and pay for any claim because the physician is an employee, not an independent contractor. If you are entering into an arrangement with a hospital system, it is important to clearly identify the following factors: (1) whether you are an employee or independent contractor; (2) whether the hospital system's coverage is self-insured, or insured through a third party carrier; and (3) the terms and conditions of the hospital system's insurance policy. If it is an occurrence policy, there is no need for the physician to have to buy a tail policy when he or she terminates employment. On the other hand, if the hospital policy is a claims-made policy, it is extremely important that the physician's employment agreement with the hospital specify whether the hospital or the physician is responsible for paying for the tail coverage, if any.

Changes to Coverage

You should also be aware that when physicians join a hospital system or any other health care provider, the type of insurance coverage can change. Even if they have an occurrence policy on the date of employment, that may not be the situation at the time of termination of employment. Medical groups and hospitals change insurance coverage and policies from time to time, depending on the cost and other circumstances. Therefore, to fully protect yourself, you should clearly spell out in the employment agreement that upon termination of employment, the hospital system will pay all costs and expenses relating to professional liability coverage for the period of employment, including any required tail coverage, regardless of whether the hospital system has a claims-made or occurrence policy at the date of employment termination.

Self-Insurance Programs

Because of the dramatic increase in the cost of professional liability insurance policies from traditional insurance carriers, some medical groups have established their own self-insured insurance programs. When I negotiate an employment agreement for a physician who joins a medical group that has a self-insurance program, I first advise the physician of the major issues unique to such a program. The establishment of a self-insured program should only be considered if conventional insurance policies cannot be obtained, or the cost of conventional policies is economically prohibitive for the group. Extreme caution and care should be taken when establishing such a self-insured program.

A major detriment is the maintenance of sufficient reserves to cover several significant claims that may occur within a short period of time. Although self-insured programs generally have a supplemental insurance policy to cover a portion of the excess claims, any group seriously considering such a program should do an in-depth analysis of the self-insured program. The group should also analyze how to position the entity's assets and the physicians' individual assets in an asset protection program, in the event that the self-insured program does not have sufficient funds to pay significant claims.

CONCLUSION

Your ability to negotiate your employment agreement will be determined in large part by your economic reality and your own needs. If you do not plan to stay at a position long, you may prefer a verbal agreement and a handshake, with the parties filling in the details as you go along, leaving you free to join a competing practice at your leisure. On the other hand, a physician seeking employment at a sought-after practice with an ample supply of resumes may also find that there is no room to negotiate, even the most basic provisions. Regardless of your position, it remains important for all fellows to be aware of the terms of their employment agreement and to seek a legal opinion regarding any provision with which you are uncomfortable before you sign. ■

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Building and Maintaining a Successful Practice

A guide to the many ways community involvement and interaction may help your practice grow.

BY COLLEEN MOORE, MD

Before the ink dries on your contract, the work of building a practice should begin. By learning the local landscape, introducing yourself to and becoming part of the community, and maintaining a professional and welcoming appearance, you can start and build a highly successful practice.

LEARN THE LOCAL LANDSCAPE

Before your first day in the office, it is imperative to identify local physicians and determine their interactions with one another. This investigative process is important whether you have joined a group practice or are setting out on your own. Ignorance of the political landscape can lead to any number of faux pas that can take years to overcome.

This process begins with the medical staff offices of hospitals where you are seeking privileges. Deciphering inpatient consult patterns and the proper involvement of primary care physicians before admitting the first patient are paramount to your success. Understand that local practices may not be the custom where you trained, and early adaptability can lead to more outpatient referrals. In addition to identifying local customs, the medical staff office should be able to provide you with a list of physician contact information for the physicians practicing at that hospital.

Information from local and state medical societies will help you expand your list of potential referring physicians. Much of the information from local medical societies will overlap with the hospital medical staff office. When contacting a state medical society, it is helpful to provide a geographic radius or the zip codes of surrounding areas for a more focused search. If your practice will be in a larger city, it may be wise to choose a smaller radius than if you are moving to a primarily rural or tertiary care environment.

The Internet can also be a resource when compiling a list of potential referring physicians. The American Medical Association Web site can be searched to identify physicians within a geographic area.¹ It is wise to register with the American Medical Association and state and local medical societies because patients and physicians often look to these organizations for information. The final listing can be

referenced with the local phone book to ensure that no physician is overlooked.

The final list can be culled and sorted according to specialty. It is impractical to think that you will contact every physician on the list, so identifying potential referral specialties is important. Primary care physicians, internists, family medical physicians, and nephrologists are logical choices. However, limiting the search to these primary care specialties excludes some potentially fruitful relationships. Neurologists are often the first physicians to evaluate and formulate a treatment plan for acute stroke patients. Early interactions with neurologists can result in multiple referrals for the evaluation and treatment of carotid disease. In addition, fibromuscular dysplasia and many of the more uncommon arteritides have cerebral manifestations. Early interactions with neurologists can ensure that you remain in the forefront of their consciousness when they encounter these patients. Rheumatologists can potentially refer patients for temporal artery biopsies and for complications of Takayasu's and giant-cell arteritis.

Podiatrists and nurse practitioners are often overlooked as potential referral sources. Many are practicing independently in the hospital setting or within a large primary care group. Acknowledging their role in patient care and offering to evaluate their patients can go a long way to garner referrals. It also offers you an outlet to arrange diabetic foot care or set up patients with a new primary care provider.

Gynecologic contacts can be a source of very pleasant, healthy young patients, a demographic not often seen in vascular surgery practices. These women use their gynecologists as primary care providers and are often seeking information about treatment options for varicose veins that develop with pregnancies. Some women desire to preserve their uterus and so ask for uterine fibroid embolization procedures. Postpartum bleeding can be treated with embolization. Nonsurgical specialties that perform these last two procedures can not offer the understanding of post-procedure pain control or resuscitation that comes with the involvement of a surgeon interventionist. This results in better patient care, and the gynecologists are happy to refer to another surgeon.

Much of the focus when young physicians embark on the process of building a new practice is directed toward developing an arterial practice. Venous disease is overlooked and not felt to carry the prestige that an arterial practice brings. In addition to the gynecologists, dermatologists see a lot of venous disease that can be referred on. Women make the overwhelming majority of medical decisions for families, and each family has at least two parents that are aging and may likely require vascular care. A positive experience in the vein clinic can translate into many new arterial referrals.

INTRODUCTIONS TO THE COMMUNITY

Industry representatives are a valuable resource for gathering information about the community you are joining. Ask the local medical device representatives which physicians perform the majority of vascular surgery and the bulk of the endovascular interventions. It is important to gain an understanding of the role you are expected to play and the specific skill set that you were hired to provide. By identifying this early, you can establish a referral toehold.

As your role becomes more defined, it is time to make yourself known to local physicians. This is where your local medical society can provide additional assistance. These societies are designed to assist local physicians and can give you tips on local marketing practices that have been successful and those that do not work with your desired referral base or patient population.

Letters of introduction sent a few months prior to your anticipated arrival are nice. But, most practicing physicians do not take the time to read the letters and they often find the trash can before anyone reads them. If you decide to send out letters of introduction, keep it short and state your educational background and training. Briefly discuss procedures or new skills you bring the community. It is important to be humble in this initial communication. Speak in generalities and do not claim to perform procedures you hope to add to your armamentarium in the future.

Once your start date has been set, it is important that someone is always available to answer the phone. Your office staff will start interacting with referring offices before that first clinic. It is vitally important to educate your office staff on how you would like the phone answered and what information you would like from the referring physicians office. At this time, writing scripts for your office staff is helpful. This way no matter who answers the phone, the answers are always the same. It avoids conflicting information. Also ask for the minimum necessary information from the referring physician at that initial phone call. If they have to work too hard to get the patient seen, they are unlikely to call back. A pleasant interaction during the initial phone call goes a long way toward continued referrals. Office staffs have a large say in directing patient referrals. If the process to refer a patient is too cumbersome or the person on the other end of the phone is unpleasant, it is unlikely that

more patients will find their way to your door.

An effective way to introduce yourself to both physicians and the community alike is through the local newspapers. A small advertisement with a photo, a statement of your clinical interests, the office location, and phone number can be lucrative. Newspaper advertising can be slightly more expensive, but the return on your investment is excellent. This is especially so for more competitive markets such as the cosmetic vein market.

The days of driving to each referring physician's office, introducing yourself, and having a cup of coffee are gone. Although it may be reasonable to visit a few physicians who are likely to refer a large volume of patients, it may be easier to have them come to you. A cocktail party or open house at your home or office provides an excellent opportunity to shake hands and let physicians interact with you socially. This event shouldn't require professional party planners or rival a Hollywood red carpet event. A simple, informal affair is sufficient to allow you and your future partners to discuss the role within the community that you expect to fill and how you can evaluate and treat their patients.

Another professional venue to meet a variety of physicians is in the physicians lounge at the hospital. Although the fare may leave a lot to be desired, the opportunity to socialize can be unparalleled. Attending hospital staff meetings, department meetings or even faculty meetings, for those entering and academic practice, can prove fruitful.

KEEPING UP APPEARANCES

Because appointments are easy to schedule when your office is just opening, and local physicians are apt to try and help you out, referrals will come in at the beginning. To keep new patients coming through the door, however, it is important to stay in the forefront of the local consciousness.

Local medical societies meet regularly and are frequently looking for speakers. Take the initiative and approach some of these groups and ask to speak. These forums provide you with a venue in which to explain your approach to common problems. When selecting a topic, it is important to speak about diseases you are comfortable and able to treat in the community where you now practice. It is important to establish a reputation as a competent surgeon and interventionist before pushing the envelope on the local landscape.

It is also important to acknowledge the local competition. If someone else provides similar services, do not expect to come in and dominate the market. Rather, explain what additional services you may offer or how your approach may differ. In addition, be humble. Presenting an arrogant façade does not endear you to physicians that have been practicing in that community for years. Their methods may be antiquated, but by presenting a distinctive approach in a collegial manner, it is possible that you may be able to alter

the local landscape and get people to come around to your way of thinking.

An additional speaking venue is hospital departmental meetings. Approaching various departmental chairs and asking for 5 minutes to introduce yourself to these small groups provides access to small groups of physicians. These opportunities show your commitment to establishing a successful practice and your desire to form a cordial working relationship with them. It also allows for frank and open discussion about the referral process and what you can do for them.

Establishing a relationship with local health reporters either in the print media or television is a great way to expose your practice to a large variety of people. Coordinating a patient education series during Heart Health Month ties in nicely with your practice. In addition, if you decide to provide free venous screenings, a short press release or piece on the local news establishes you as an expert in the field. The American Venous Forum provides a toolkit that allows you to provide free community screenings to assess deep vein thrombosis risk as well as to assess for the signs and symptoms of chronic venous insufficiency and venous obstruction.²

Another speaking opportunity that can result in a variety of referrals and establishes you as a local expert is the infamous “rubber chicken” dinner. These are often sponsored by local philanthropic organizations. Although the venue may not be glamorous, the attendees are interested and grateful for the time you have spent with them. Make sure your presentation is appropriate for the layman. At the conclusion of your talk, leave plenty of time for questions. Attempt to answer all of the questions that are asked no matter how bizarre or seemingly unrelated. If you establish that you are genuinely concerned, they are likely to self-refer or send a friend or family member.

COMMUNITY INVOLVEMENT

Community involvement is mandatory for any physician starting a new practice. Becoming involved with various community organizations gives an impression that you are there to improve the community and not just to make money. By giving back to the community, you will get more in return than you ever imagined. This does not need to be a daunting task. By simply reading the paper or watching the local news, you can identify organizations that will benefit from your expertise. Social clubs and country clubs are often viewed as elitist; however, these organizations provide an opportunity to interact with a wide variety of people outside the community and can provide access to a variety of organizations with varied political and social agendas.

Often the easiest way to become involved is through children's activities such as sports, dancing, and music. These provide excellent networking opportunities. Becoming a head coach may not be feasible due to the unpredictability of your work schedule, but you can volunteer to assist.

Attend games and practices. Learning names of players and cheering from the stands is a great way to be involved and recognized.

Through active community involvement, potential patients see you as more human and much more like them. Referring physicians recognize that you are there to stay and to improve the local environment. The perception becomes that you are there to stay and not just passing through on your way to bigger and better things. It is important to remember that signing up is not sufficient—it is imperative that you project a sense of commitment and dependability. Keep the commitments you have made. Be more than a name on the roster.

CONTINUED UPGRADES

Just as you continue to upgrade your computer, you must continue to upgrade your practice. Things such as keeping up with dictations and maintaining a relatively flexible schedule early on put referring physicians at ease. They can be assured you have seen their patients and developed a plan of care. In addition, a flexible schedule means they can get patients seen in a timely manner. If you identify patient- or physician-access problems to your practice, acknowledge these with a personal phone call and provide a solution to the problem.

Once your practice has been up and running for a few months, ask someone to be a “secret shopper.” This can be any random person that you trust to give you an honest assessment of your practice. Have them call to schedule an appointment and come in as a new patient. This can provide you with invaluable feedback as to what works well and what needs to be fixed within your practice. Continuous upgrades of your office processes will only make you more efficient and keep your patients very happy.

CONCLUSION

It is easy to sign a contract, but it is much more difficult to establish a practice that encourages patient referrals. By taking the initiative to step to the front of the local medical community and the community at large, you will encourage patient referrals. Once the patient flow begins, it is important to provide patients and referring physicians with the service and care you would expect for your family. Keeping the waiting room full requires constant care and maintenance. ■

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