

THE BUSINESS OF PLASTIC SURGERY

2nd Edition

*NAVIGATING A
SUCCESSFUL CAREER*

EDITED BY

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The Business of Plastic Surgery

Navigating a Successful Career

2nd Edition

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For all plastic surgeons—in hopes that they avoid our own stumbles and soar high in their careers.

For Siobhan, and our special editions—Raquel, Max, Shaine & Tova.

Joshua M. Korman, MD, FACS

For Paco, Diego, and Siena, my loving safety net in life.

Heather J. Furnas, MD, FACS

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Preface to the 2nd Edition

Plastic surgeons train for many years to become skilled and educated clinicians, but we are woefully unprepared to run a private practice or academic division, to negotiate a contract, or to build an operating room when we need one. Since the first edition of *The Business of Plastic Surgery: Navigating a Successful Career* in 2010, the world of health care, technology, and marketing has continued to evolve. To adjust to this changing landscape, we have expanded some topics, introduced new ones, and eliminated others for this new edition. This book covers all professional stages, from the medical student and trainee to the young, mid-career, and senior plastic surgeon.

With the rise of the financial hurdles in starting a solo practice, combined with the pervasiveness of insurance contracting, more plastic surgeons are opting for salaried positions. We have included chapters on academic, solo, and group practice, but were unable to include a chapter on large multispecialty groups. The health care corporations required content control over employees' manuscripts, stipulating a positive perspective, and potential contributors were either unwilling to write under those circumstances or had their manuscripts rejected.

We have added chapters on saving money, reviews, making videos, and career transitions from early and mid-career to retirement. To help college and medical students considering our profession to plan their trajectory, we have also included a chapter called "Beginnings."

Since the chapter on "Stress" was published in the first edition, physician burnout has become an increasingly recognized cause of distress in medicine. We have addressed both internal and system-wide causes of physician burnout in plastic surgery in several chapters, and you will find a wealth of specific suggestions and solutions offered in the chapter, "Taking Control of Your Life."

The first edition's chapter on "Women in Plastic Surgery" has evolved into a broader view of the changing face of plastic surgery. We are grateful to the authors of "The Changing Face of Plastic Surgery" who have shared their deeply personal experiences and perspectives on underrepresentation by race, ethnicity, sexual orientation, as well as gender.

Several authors have generously included examples of contracts and other legal information, all of which are meant only as a guide and cannot substitute for the advice of a licensed professional.

We have used *he* or *she* in the chapters, except where it is clear and evident that the person/patient being talked about is female, so then we have used only *she*. Similarly, we used only *he* when it is clear that the person is male.

Even among close colleagues, few offer a transparent look at their practice secrets. Our authors have done just that. We are profoundly indebted to each of our contributors for their honesty and genuine missionary spirit. It is our hope that you, too, will pass along your own pearls to your colleagues. Plastic surgery is a small specialty. The more we help each other, the stronger all of us will be.

We are grateful to our families for their patience during the long nights and weekends of writing and editing, and acknowledge Max Jaime Korman for his cover design of both editions (the first at age 12, and this one 10 years later).

We hope the chapters in this book serve to help you launch or renew a rewarding career, navigate the rapids, and reach destinations you've always dreamed of.

Joshua M. Korman, MD, FACS
Heather J. Furnas, MD, FACS

From the Preface to the 1st Edition (2010)

The idea for this book came from a general feeling that we did not learn anything about the business side of plastic surgery while we were in training. In fact, after almost 20 years in practice, the information in this volume is what we would have liked to have known when we first started our professional careers, as well as through the years of practice. Plastic surgeons are as diverse as the procedures we perform, but most of us have two things in common: an MD degree and effectively a “Bad in Business” degree. Long gone are the days of the good insurance reimbursements and

increasing your practice volume based on your fine reputation. Health maintenance organizations (HMOs) and provider panels did away with both. With the commoditization of the specialty, many patients are happy to settle for the cheapest price in town. Times have changed, and we have to change with them. There are many aspects of running a practice that were not even on the radar screen 10 or 20 years ago. This book collects the expertise of disparate professionals to help you practice smarter.

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1 Beginnings

Chris Reid

Abstract

This chapter introduces the reader to the field of plastic surgery and to the pathways to become a plastic surgeon. Goals and objectives are outlined for the college/undergraduate, medical student, and resident to successfully navigate the course to becoming a board-certified plastic surgeon. Also included is discussion of fellowship choices in plastic surgery.

Keywords: plastic surgery residency, sub-internship, sub-Is, fellowship, board certification

1.1 Plastic Surgery: What Is It?

Welcome to the amazing field of plastic surgery. Within it lies incredible opportunity to help patients, tailor a practice to one's own personal interest, and allow for continued personal enrichment.

Plastic surgery is an evocative specialty. Just the words conjure Hollywood actors who have had *work* done, resulting in endless jokes for late night television. Plastic surgeons do perform facelifts and breast augmentation. And a plastic surgeon won a Nobel Prize for performing the first kidney transplant, and another started the subspecialty of hand surgery, treating war victims after the world wars of the 20th century. Plastic surgery is without a doubt the most diverse surgical discipline, spanning all age groups and organ systems, operating from the top of head to the tips of toes, and treating both cosmetic and reconstructive concerns. The public is most familiar with the aesthetic identity of plastic surgery, but the primary training of plastic surgeons is focused on the adage of restoring form *and* function. This collectively describes procedures that address structural or functional losses that may be the result of congenital, traumatic, oncologic, burn, degenerative, or other pathologic processes. Included within the discipline is *also* the practice of aesthetic surgery, which is directed at reversing the effects of aging and degeneration or enhancing aspects of one's appearance. Aesthetic surgery is most accurately a subdivision of plastic surgery, which focuses on restoration and reconstruction.¹ Even during reconstructive procedures, plastic surgeons optimize the aesthetic aspects of reconstruction.

Many practicing plastic surgeons focus on aesthetic surgery, and even on particular areas, such as surgery of the nose or breast. Plastic surgeons often split their time, performing both cosmetic and reconstructive surgery. This division of time depends on market factors, the surgeon's interest, and often chance. Those plastic surgeons who focus entirely on reconstructive procedures are, as a rule, working in academic centers, which provides the insurance reimbursement patterns and infrastructure to perform complex reconstructive plastic surgical procedures (see Chapter 3). Those not in an academic practice are often hard pressed to not focus at least some practice time on aesthetic surgery, which has a significantly larger reimbursement-to-work ratio than reinsurance-based reconstructive cases. Although it is unrealistic for a single plastic surgeon to execute the entire breadth of the specialty, many surgeons do have diverse practices. An attractive aspect of the field is the ability to make of it what they want and serve patients in whatever capacity they wish.

Plastic surgeons are innovators, contributing to the exciting evolution of the specialty. Procedures and technologies in common practice now were unknown a few decades ago. Just as neuromodulators such as botulinum toxin were serendipitously found to improve wrinkles while being used to treat eyelid spasms, surgical treatment of migraine headaches was developed by a plastic surgeon observing patients in his aesthetic practice.^{2,3,4}

The long and storied history of plastic surgery includes the development of skin grafting at the beginning of the 20th century following the severe injuries inflicted on the world's patients during World War I. In the 1930s, plastic surgeons were instrumental in pressing car companies to make shatterproof windshields; later they assisted in writing the language for the Flammable Fabrics Act for regulations with manufacturing of clothing such as children's pajamas. Microsurgery, craniofacial surgery, and the development of the Vacuum-Assisted Control (VAC) device to heal wounds have all been innovations by plastic surgeons.⁵

More recently, plastic surgeons have been responsible for developing and refining composite tissue transplantation such as face and hand transplants. Evolving technologies and newly defined anatomy have opened up the entirely new field of supermicrosurgery. The tiniest of lymphatic vessels, just 0.2 to 0.8 mm, can be reconnected. Many plastic surgeons in practice now never imagined that these feats were possible when they entered the field.

1.2 Am I a Good Fit for Plastic Surgery?

If you are interested in plastic surgery but have not yet started medical school, it is to your benefit to explore further. In addition to learning about plastic surgery, you will no doubt learn more about the medical field. Shadowing a surgeon in your community can be a great introduction to plastic surgery. Most practicing surgeons fondly recall this experience and without hesitation will often graciously open their doors so you can experience what it is that they do. These experiences allow you to see firsthand what the practice of plastic surgery is like and begin to assess your "fitness" for the specialty. While not all plastic surgeons share same interests, there are similarities that unite members of the field.

In addition to shadowing, pursuing humanitarian work via mission trips can be worthwhile and enlightening. Plastic surgeons tend to do more of this type of work than those in other medical disciplines, typically through programs providing service to the underserved, either globally or regionally. Becoming engaged in these groups can be particularly rewarding and can serve as the beginnings of a career of helping communities facing unimaginable challenges. For more information, contact the university affiliated plastic surgery groups in your area. Many people enjoy these opportunities so much that they continue them throughout their training and their careers.

1.2.1 Traits that Make a Good Plastic Surgeon Problem Solver

In many fields of surgery, the goal is to learn the steps to making a diagnosis, executing a procedure, and then caring for the patient during recovery. One example is the treatment of appendicitis. Nearly all surgeons would approach and treat it in essentially the same manner with minimal variation. However, plastic surgeons focus more on

principles and techniques that can be applied across a broad range of situations, sometimes not previously encountered. Many seasoned plastic surgeons will tell you that they learned more in their initial years of practice than during their residency, as they began to practice the skills and techniques they were equipped with during residency to new situations. Even the common plastic surgery equivalent procedures to appendectomy will have numerous ways to approach and treat; choosing the best approach boils down to solving the problem. For example, there are numerous variations in the common plastic surgical procedure of skin grafting in regard to harvesting technique, management of harvest site, dressing application, and adjunctive measures to promote healing.

Being a plastic surgeon requires being a good problem solver. If you are someone who likes to tackle challenges and explore new ways to find solutions, then you may be well suited for the field. In their role as problem-solvers, plastic surgeons fix the problems or complications that other surgeons encounter and cannot fix themselves. Surgeons from other specialties will call on plastic surgery, for example, for creative ways to close a wound. These roots in identifying and solving problems allow us to help others.

Determination

No doubt any person completing medical school and serving as a physician is intelligent and will contribute to this noble profession. According to National Residency Matching Program data, plastic surgery residency choice is consistently among the most competitive of all.⁶ Plastic surgery applicants rank highest or near the top of nearly all objective measures listed, including test scores, AOA, and research experiences. There are a comparatively small number of positions, and the competition for these spots is fierce. Further, because the field is challenging and broader than almost any other, training requires a longer-than-average residency, typically 6 years or more. The length and rigor of the training require intelligence and determination to complete successfully. Plastic surgery also offers the opportunity for potential independence from declining insurance reimbursement, something not afforded by many other fields. If you are someone who has done well scholastically early in life and had an aptitude and love for creative learning, then plastic surgery may be a good fit. However, given the hurdles posed by the competitive metrics used in selecting positions for training plastic surgeons, it may be particularly challenging for individuals who are slow learners or not good test takers.

Artist

We are a visual species, and much of the work plastic surgeons do is visible to the world. A patient does not generally see the tumor removed by a neurosurgeon, while a reconstructed breast or nose is visible every day. Decisions of timing the repair of a cleft lip and other congenital deformities are based on how humans appear to others because that impacts how they experience the world. Future success is correlated with normal or better appearance. Many of the body parts plastic surgeons reconstruct serve no physiological purpose, but they impact psychological function. For the mastectomy patient, the breast may have previously served for milk production, and is now not essential for survival. Some women elect not to have breast reconstruction, and they can live normal healthy lives. However, long-term survival and satisfaction studies show that women do better after having breast reconstructed because it provides

a sense of wholeness, an aesthetic appearance they desire, and a component of their sexuality.^{7,8,9} An even more extreme example is the face transplant, which allows the patient to interact and look more normal.

Artistry plays an important role in plastic surgery. Even when rebuilding parts of the body, the aim is not only for it to function well, but equally important to look as if no surgery had ever been performed. The field of aesthetic surgery is consumed with the appearance of things. Being successful requires an appreciation and understanding of the aesthetic of the human body to be able to create or correct it, whether the part be a nose, a breast, or an eye. Humans naturally develop asymmetrically, so plastic surgeons must develop a keen sense of observation for their own sake as well as for their patients. It is no surprise that many plastic surgeons are or have been an artist in some form, whether in music, painting, sculpting, or otherwise. These traits have been held in such high esteem over time that one long-held tradition of many residency interviews was to have applicants carve an ear out of a soap bar. Their manual dexterity and probability of success was associated with the quality of their soap ear. For the prospective trainee thinking this field is for you, not all plastic surgeons have a history of artistic achievement. However, you may find that the artistic side of you is simply yet undiscovered. Conversely, if this all sounds boring, then perhaps you would not be suited to plastic surgery, given the amount of attention devoted to art.

Team Player

Medicine is a team sport, and plastic surgery is no exception. Delivery of care to patients requires the concerted efforts of a surgical team (anesthesiologist, surgeon, nurse, surgical technologist) as well as a full office staff. Further, plastic surgeons are often at the service of other specialties, assisting them as they work closely toward a common goal.

In a recent review of selection factors for residency in plastic surgery, Liang et al identified that the trait of being a team player was of particular importance.¹⁰ During residency, it is imperative that residents be able to work well as a team, not only to safely provide patient care, but also to allow for each other's growth and education. Further, residency requires that you interface and integrate into the health care system with others from a multitude of disciplines. The person lacking the ability to work in a team will continually face challenges throughout training and likely become a burden on their residency. In the past, has working as a team been something you enjoy and excel at? Experiences in organized sports, school projects, extracurricular clubs, or groups can be an indication. In fact, when selecting prospective applicants to medical school or residency, these experiences are highly valued by admissions committees and residency directors.

Dexterity and Spatial Sense

"Do you like working with your hands?" This fundamental question is how many medical students choose between a nonprocedural (internal medicine, hematology, etc.) and a procedural specialty (surgery, interventional cardiology, etc.). When training programs consider possible surgical applicants, many place particular value on manual dexterity. If dexterity is not someone's forte, it is not likely that they will be successful or happy in a surgical or procedural specialty. An additional quality that plastic surgeons value is strong spatial sense. Many of the procedures plastic surgeons perform require thinking in three dimensions and volumes and how to create an appearance or

structure. The prevalence of 3D photography and CAM-CAD medical modeling in plastic surgery is no surprise.

There may not be great early experiences that can show a person whether they are particularly gifted with these skills, and often aptitude is discovered during early surgical rotations in the medical school. Individuals who have hobbies or who have performed tasks with fine motor hand movements are likely at an advantage, and necessary skills may come easily.

1.3 Path to a Career in Plastic Surgery

Do not be discouraged by the seemingly excessive amount of time it takes to become a practicing surgeon: 6 years after medical school (minimum), 10 years including medical school, and 14 years if you include college! Time truly does fly. Many look back fondly at their years of training, and plastic surgeons think it is worth it to get to do what they do.

Admission to a residency in plastic surgery requires successful graduation from medical school. Residency positions are highly competitive, so attending a medical school that has a plastic surgery training program may increase your chances. In addition to the name recognition, being at a top-notch institution during these formative years can jump-start your progress. For those unfamiliar with the process of medical school training, ► Fig. 1.1 illustrates the typical timeline for plastic surgery training.

1.3.1 How to Get into Medical School

How to get into medical school is already the subject of many books, and resources online and in print abound. Successful admission can be broken down into several objective and subjective measures. An applicant's prior performance is the best metric of future performance and this is how medical schools approach selecting students as well. Two primary numbers are fundamental: Grade Point Average (GPA) and Medical

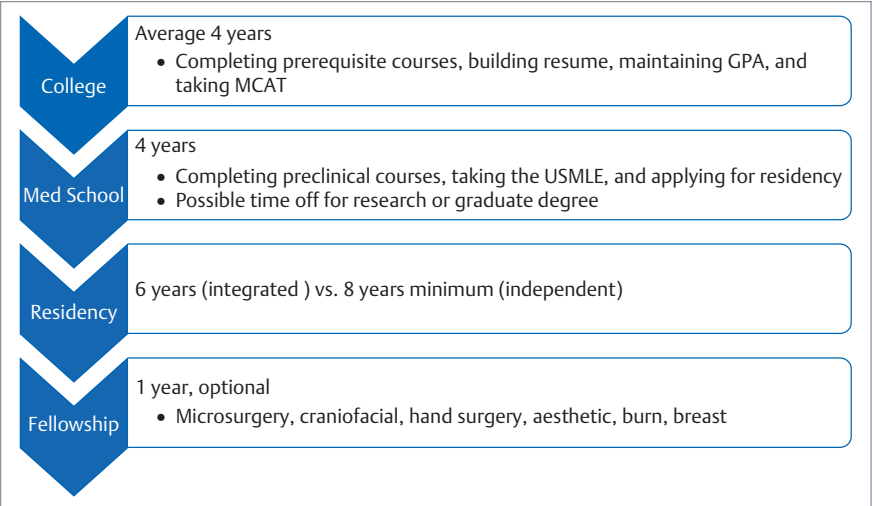


Fig. 1.1 Typical timeline for plastic surgery training.

College Admissions Test (MCAT) scores. The GPA of one's collegiate endeavors serves not only to represent intelligence and scholastic aptitude, but also shows a long-term performance measure because it encompasses all the years in college. MCAT scores serve as a metric to compare all applicants to one another. Having undergone considerable change since its induction in 1928, the test is now an electronic exam, delivered at a testing center. The MCAT is utilized by all US medical schools and currently covers subject matter of physical sciences, biological sciences, and verbal reasoning. Anyone planning to take it should utilize the abundance of books, preparatory courses, and question banks available for students to prepare.

Why are the GPA and MCAT important? Both scores provide objective data for admissions committees to rank students for interview and then admission. The sheer volume of material that is included in applications would require an army to sift through its entirety, so medical schools rely on these objective measures to establish cutoffs, and then more selectively review applications. Every school will have different cutoffs, which are correlated with the school's prestige, ranking, size, whether they are for-profit or state-funded, and whether they are traditional (allopathic) or osteopathic medical schools. Applicants strategize to optimize their performance, like focusing every day during college on maintaining a high GPA and preparing methodically for the MCAT. There will always be someone, somewhere, studying longer and harder. The performance, specifically on the MCAT, may not be directly related to one's abilities, but may have more to do with the time dedicated to doing well on the day of the exam. Those that perform well on this exam have devoted many months to studying and made significant personal sacrifices during a period of life when most others are focusing on having fun.

Applicants who meet a medical school's objective cutoffs may be offered interviews so they can evaluate the applicant's subjective qualities. Schools look for students who are mature, driven, dedicated, altruistic, and diverse. It also helps to be part of an underrepresented minority or be the first in one's family to go to college. The applicant can make a case for being a good candidate by completing experiences in research and/or volunteering over a long period of time. What is not well-received is a litany of short-lived experiences. If you are involved in research, try to commit to it for months or years, and then complete the project and commit to it for months or years. If you volunteer, do not make it a one-time event, but return or find opportunities that are for extended periods. Medical schools are looking for dedication and genuine interest.

Typical experiences involve volunteering with worthy, altruistic groups, holding leadership positions, and getting exposure to the medical field. Students often find out about opportunities through their colleges premedical career office. There are many different premedical groups established, which are student-run and designed to allow for further discovery of careers in medicine. College premedical career offices have a list of active groups at a student's respective institution. Additionally, most prospective students seek out opportunities volunteering in a hospital or clinic. Classically referred to as "candy-striping" (due to the old uniforms worn by student volunteers), these experiences allow students to see what actually takes place in an Emergency Room, hospital ward, or clinic. To get involved, hospitals or clinics will have specific volunteer service information available online.

Whichever experience students select, and often there are several, the importance of showing dedication cannot be overstated. Experiences should span an extended period, on the order of months or years. Many opportunities require that students make a commitment for this time period.

Research is an additional area that many students become involved in. Because most medical schools are located at academic sites, students can easily find research opportunities. Research experience can demonstrate interest and aptitude to admissions committees. Like volunteering, research endeavors should be carried out over an extended period of time. The research focus is not particularly important, but it should show a student's interest in inquiry, problem solving, and dedication. Students are able to find these opportunities by establishing relationships with professors. Given that these positions are often unfunded, professors are partly reliant on students becoming continually involved, and they are inclined to facilitate and support students who volunteer for research opportunities.

Questions to ponder when selecting a research position include: Have others been successfully involved in the past? Will there be appropriate supervision and guidance? Is the subject matter interesting? Can the work be completed in the expected timeline? Will there ultimately be a finished project such as a presentation or article that will be published?

1.3.2 How Can a Medical Student Prepare for Career in Plastic Surgery

One common attribute of successful plastic surgery residency applicants is that they display an early interest in plastic surgery. Perhaps this is because the residency is so competitive that folks who decide late do not feel that they can mount a sufficiently substantial application to be successful. Or perhaps it is that many people *do* understand what plastic surgery is, and so only the ones who learn and dedicate to it go the distance. Nevertheless, only a small portion of medical students choose plastic surgery, and even fewer land residency training positions. Applicants should dedicate considerable time during medical school amassing the most impressive resume possible.

Much of the same criteria that lead to success in medical school admission also hold true for plastic surgery residency applications. The primary objective measures are the United States Medical Licensing Examination (USMLE) and Alpha Omega Alpha (AOA) status. The USMLE Step 1 is taken after completing the second year of medical school (the first step of three) and serves a way to benchmark an applicant's performance to all others in the country. AOA Medical Honor Society is not present at all medical schools, but is common at most, and this distinction is generally awarded to the top quartile of students based upon excellence, performance, and quality virtues. In an effort to make the application review process manageable, residencies will enforce varying cutoffs for application review and subsequent interview. The same recommendations for MCAT and GPA also stand for the USMLE and AOA.

The subjective measures of most importance for plastic surgery residency applicants are letters of recommendation, preferably from leaders in the field. Students complete clinical clerkships during their third and fourth years of medical school. Faculty they work with will complete summative evaluations regarding their performance, admirable qualities, and make recommendation about their ability to perform successfully in the field and during residency. Being a diligent student and dedicated team player, together with a curious mind, manual dexterity, and a good sense of spatial relationships, is an opportune way to have a strong letter written on your behalf.

An additional area of focus for applicants is research and scholarly activity. More than in many other fields, applicants to plastic surgery are some of the most well-developed and well-published researchers. As a result, there is an increasing trend for applicants to have taken a "gap year" and spend time in a lab. Some seek it out as a

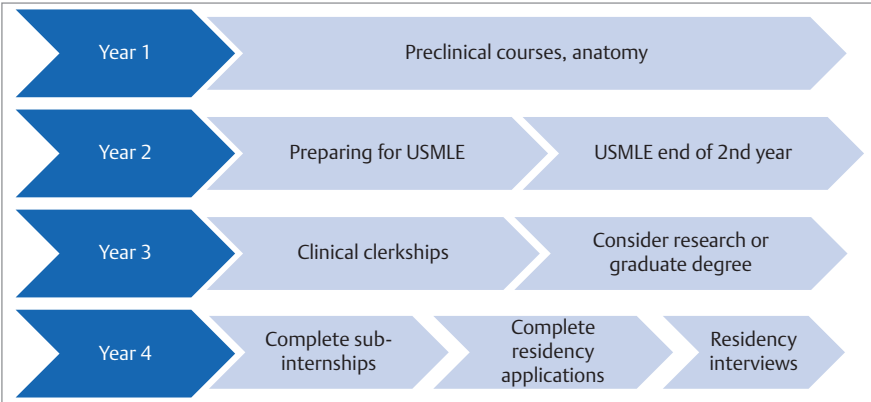


Fig. 1.2 General timeline for prospective plastic surgery applicant during medical school.

refreshing time to perhaps reduce the speed of life that is common during medical school. Others perhaps are slick enough to be able to remain productive with research endeavors without taking time off. Others take the time off for research to bolster other aspects of their application that may otherwise not be competitive enough. The most common time to take off for research is between the third and the fourth year of medical school. It should also be noted that concomitant with taking a year off, many dovetail this time with pursuing advanced degrees. Many plastic surgery applicants possess an additional graduate degree. (Women wishing to have children should give careful thought to timing a research year, delaying the end of residency, among other considerations discussed in Chapter 25. See ►Fig. 1.2.)

1.3.3 Plastic Surgery Residency Paths

Around 15 years ago, the paradigm of training plastic surgeons began to change. Historically, residents usually completed plastic surgery residency *after* having completed a prerequisite training in a surgical specialty (general surgery, otolaryngology, orthopedics, urology, neurosurgery, or oral and maxillofacial surgery). One had to complete a residency before being able to complete another residency. Originally, plastic surgery training was 2 years long, but this was extended to 3 years in 2012. This track is referred to as the independent training pathway. The track that has many more available training positions is the integrated model. Integrated training begins immediately following completion of medical school and encompasses 6 years of residency. The integrated pathway will likely maintain its predominance, and the long-term viability of the independent track is uncertain.

Why have two tracks? This has been long debated and there is no clear answer to the superiority of one over the other and why not just have one pathway. Anyone interested in plastic surgery during medical school should try for the integrated track. With an interest in plastic surgery, there is no compelling argument that one should spend 5 years in a different residency before completing 3 more years in the area they desire most. On the other hand, a medical student who will not be able to secure a plastic surgery residency position has another chance. By proving their dedication and professionally developing themselves further, they will likely have a better chance reapplying after completing an alternative residency. The independent path is also for the medical

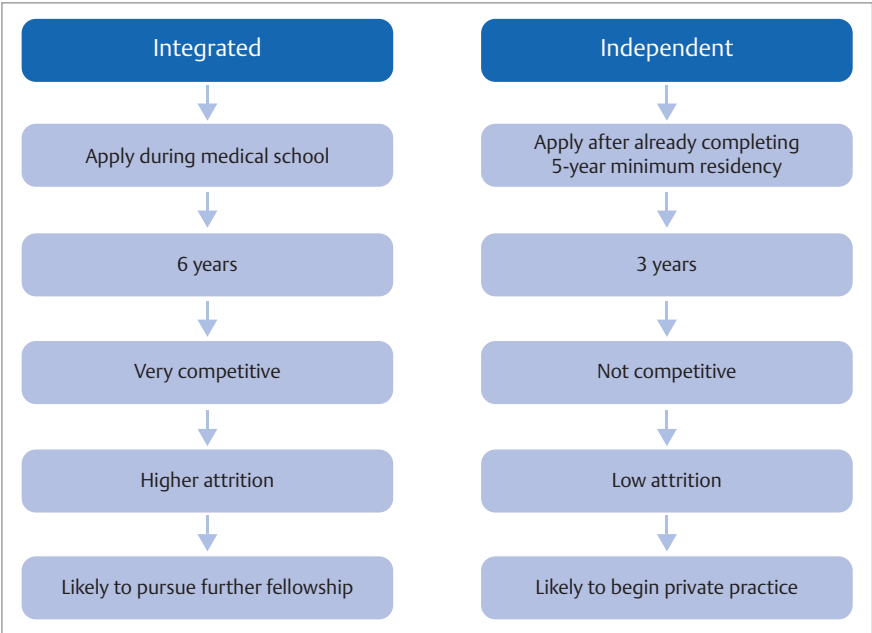


Fig. 1.3 Comparison of two plastic surgery training pathways.

student who, for whatever reason, was not exposed to plastic surgery during medical school and finds out only after starting residency that what they desire most is to practice as a plastic surgeon.

Others have compared the performance of the residents in each of the two pathways, along with their future choices. Integrated pathway residents are more scholastically accomplished, more likely to remain in academics, are better test takers, and are more likely to pursue fellowship training. Independent residents have a low attrition rate, are less likely to pursue a fellowship, and possess greater technical skills during residency.^{11,12,13,14} At one point, there was a less than 50% chance of matching into the integrated pathway, and it was widely regarded as one the most competitive residencies. In comparison, despite the fewer number of positions, the independent track is less competitive. Objective measures of independent applicant quality are lower in comparison to their integrated counterparts. However, proponents argue that the independent pathway residents possess more maturity and advanced technical skills, and it is important to ensure an alternative recruitment portal for potential plastic surgeons that may not have decided on the specialty until after medical school.

► Fig. 1.3 illustrates a comparison of the two training pathways.

1.3.4 Interview Process

Regardless of the pathway chosen, the interview process is similar. There has been an abundance of literature conducted regarding strategies for success, what factors are deemed important by programs and interviewees, as well as the costs involved. Rod Rohrich, who has trained over 100 plastic surgeons during his tenure at UT Southwestern, outlines 25 tips particularly helpful during plastic surgery residency interviews

Table 1.1 Dr. Rohrich's 25 tips for plastic surgery interviewing¹⁵

- Interview starts the moment you enter the city
- Do your research
- Don't "fake it"—*be yourself*
- Be humble
- Meet as many current residents as possible
- Maintain good eye contact and be polite
- Give a polished 60- to 90-second sound bite about yourself
- Practice your sound bite and the information you want to share
- Don't bear any gifts
- Maintain good posture—*stand and sit tall*
- Dress in conservative, professional attire
- Good manners
- Be professional during social events before, during, or after the interviews
- Be genuine in responses
- Always smile and mean it
- Have a firm handshake—*but not too firm*
- Don't use "I" more than a couple of times during interview
- Be courteous at all times—*everyone's opinion counts*
- Always be positive about other programs
- Give every interviewer equal attention—*particularly in group interviews*
- Share what makes you unique
- Ask some salient questions
- Know your strengths and weaknesses, successes and failures
- Be a good listener
- Enjoy the great and unique opportunity

(► Table 1.1) to help applicants find “not only their home for the next several years, but also the best match for their personality, lifestyle, and work ethic.”¹⁵ His article is a must-read for prospective applicants and serves as a reference for anyone interested in applying for plastic surgery residency. Additionally, it is a nice refresher for anyone preparing for fellowship or job interview. The aim is to present a polished, professional picture of one's own self and to showcase all of the best strengths and accomplishments, while at the same time demonstrating mature, thorough self-understanding.

Sub-Internships

Many applicants explore a prospective residency training program by doing a sub-internship there. Most often this takes the form of a 4-week elective taken after the completion of the third year of medical school. Students select programs that they want to learn more about, are particularly interested in completing residency at, or want to gain exposure from. They are expected to perform at the level of an intern and display a focused interest in plastic surgery. Significant attention has been paid to the value

of sub-internships and the role they play in influencing the probability of being offered a residency position. Drolet et al showed that strong performances during sub-internships were the most important factor in matching at a residency program.¹⁶ In 2014, nearly half of the successful integrated applicants matched at programs where they had rotated at during a sub-internship.

The value of the sub-internship is relatively intuitive, as it allows for a month-long trial period, much like a working job interview. Additionally, students are better able to decide about their suitability and desire to train at a program for at least 6 years of residency. Without a sub-internship, most applicants are left making this critical decision based upon a single-day interview, word of mouth, and advice from mentors. Critics of the process argue that during the weeks a student spends at a program, they are inevitably going to falter and risk leaving a worse impression than they would have during an interview day. But this is likely not that common. Additionally, sub-internships allow students to interact with faculty that can write them letters of recommendation. It is commonplace, almost expected, for students to receive letters from leading faculty at the programs where they rotate. Sometimes students will rotate at programs with high-profile faculty for the ability to learn from them, and importantly, request a letter of recommendation. Furthermore, students benefit from sub-internships as a means to strengthen their plastic surgery knowledge and skills. This period of prerequisite preparation is considered an unspoken requirement, and a person not completing some sub-internships may be ill-equipped to begin as a surgical intern.

Most applicants perform two to four sub-internships, one of which is at their home institution. Silvestre et al reviewed the patterns of residency match over a 5-year period and found that 15% of students matched at a program affiliated with their medical school and nearly 50% matched in the same geographic region as their medical school.¹⁷ This regional bias is not surprising and is likely related to a multitude of factors. Applicants interested in matching far from where they have previously resided can show a commitment by completing sub-internships in those areas. Students should schedule sub-internships at locations that will ultimately be a good fit for the next 6+ years. The sub-internship can also provide additional value to the applicant during the process (see ►Table 1.2).

Interview Costs

Medical students often have to borrow more than \$250,000 to become physicians.¹⁸ In addition to the substantial cost of medical school education, there is considerable expense involved in matching in a plastic surgery residency. The current average reported sub-internship rotation cost is \$3,591.¹⁶ Claiborne et al reported that applicants spend an average of \$6,000 on the interview process.¹⁹ Susarla et al reported 63% of applicants spending in excess of \$5,000 on the interview process, while nearly

Table 1.2 Key points for selecting sub-internships
• Places that you ultimately want to train
• Places with unique reputation
• Places with prestigious faculty
• Geographic region where you would like to live
• Clinical environment that fosters growth

20% of applicants spending over \$10,000.²⁰ Various groups have discussed redesigning the process to reduce expenses for applicants, as it has been estimated to cost programs \$2,763 per applicant interviewed.²⁰ To date, there have been no significant changes or indication of imminent improvements.

What Does the Program Value?

Residency program directors are tasked with selecting applicants capable of completing residency and ultimately attaining board certification in their specialty. This is their primary metric as enforced by the Accreditation Council of Graduate Medical Education. However, there is more nuance to the process and other attributes that are valued equally. Simply put, programs want residents who will be hard workers and a good fit. Each applicant has a different personality and environment in which they will flourish, just like residency programs and their staff. People often talk about, “how they just want to work with someone they get along with, especially during late nights or long hours in the OR.” Some objective measures continually rise to the top. ►Table 1.3 summarizes the traits that have been found repeatedly in successful applicants. Essentially, they are hard-workers who have a track record of strong achievements.

What Does the Applicant Value?

In selecting and ranking potential residency programs, applicants have many factors to weigh, including geography, proximity to family, area of potential future practice, and partner consideration. After the applicant has made a best effort to optimize and prioritize the above, other factors arise that have been shown to be important during the interview process. Applicants place particular importance on resident happiness,^{24,25,26} which they evaluate based on the quality of interactions with residents and faculty during the interview day or during sub-internships. Applicants are also interested in programs with good mentorship and faculty support of residents in an environment offering substantial clinical and research experiences. Another key determinant for applicants is the call schedule and minimizing the amount of time that they need to spend on general surgery rotations during their residency training. This is only relevant for the integrated pathway applicants, as independent pathway applicants have no general surgery rotations during their 3-year residency.

1.3.5 Plastic Surgery Fellowship

Majority of the plastic surgeons who graduate each year do not pursue fellowships and many go directly into private practice.¹⁴ So what is the benefit of pursuing an advanced fellowship? Those entering private practice may not find one necessary for their careers, with the exception of an aesthetic fellowship, and would delay time to

Table 1.3 Residency program’s view of attributes of successful applicants ^{19,21,22,23}
• Strong letters of recommendation
• Publications
• Research experience
• Work ethic: “Grit”
• High USMLE score(s)

actualizing their earning potential. A majority of academic plastic surgeons are fellowship-trained in an area of sub-specialization present in academic medical centers. Why to do a fellowship is a multifactorial decision that depends on personal decision and career plans.

Fellowships in plastic surgery are usually 1-year long. Currently, fellowships are offered in microsurgery, craniofacial, hand surgery, aesthetic, breast, and burn. Most, though not all, fellowships are offered to those who have completed plastic surgery training. Some plastic surgery residency applicants first complete a fellowship to make themselves more marketable and to advance their preparation for plastic surgery practice. This tactic is available only to independent pathway residents.

The most common reason residents apply for fellowship is probably to make themselves more marketable for a future job. In academics, the focus is on greater specialization; interested individuals must take a fellowship to be able to market a unique and desirable skill. Some complete fellowships because the geographic area they would like to practice is in need of specialist, and fellowship training allows them to fill the niche.

Graduates of plastic surgery training programs should have some familiarity with all aspects of the field and be able to independently perform much of it. However, as the field is notably broad, rarely do residents become proficient in *everything*. Additionally, their program may not offer good exposure to certain areas, so a fellowship can allow one to develop additional skills.

A fellowship is a great opportunity to become an expert in a particular area of plastic surgery. Fellowships tend to offer better service to education ratios, allow for a protected year of career development, and perhaps, facilitate the transition to independent practice. Fellowships may not increase one's earning potential, beyond securing employment that would have not otherwise been possible.

1.3.6 Becoming Certified by the American Board of Plastic Surgery

The American Board of Plastic Surgery (ABPS) is the only one of the 24 members of the American Board of Medical Specialties (ABMS) that certifies in plastic surgery. Arguably the most difficult board certification to attain, the process in plastic surgery is the longest and most involved of any specialty. Like all other residencies, there is an annual in-service-training exam, intended to evaluate residents' continued progression and prepare them for the written board examination. At the time of completion of residency, residents become eligible to take the first portion of the certification process, which involves sitting for a written examination. This is offered in the autumn of the year after graduation and is taken both by those completing fellowships and by those who have started their practice.

After successfully completing the written examination, currently, candidates of the ABPS must then complete 1 year of independent practice, which does not include fellowship time. During the year they complete a 9-month case collection period, encompassing all clinical activity they perform. The ABPS checks case logs and then selects cases for review. The candidates must submit extensive records, including all documentation for in-patient and out-patient care, photography, and billing records for the cases selected. The candidates then complete an oral examination of their submitted cases as well as of the cases the board prepares for the examinees. After becoming ABPS certified, a Maintenance of Certification (MOC) program follows. The goal of the MOC program is to ensure lifelong learning and safety. (Refer to ► Fig. 1.4.)

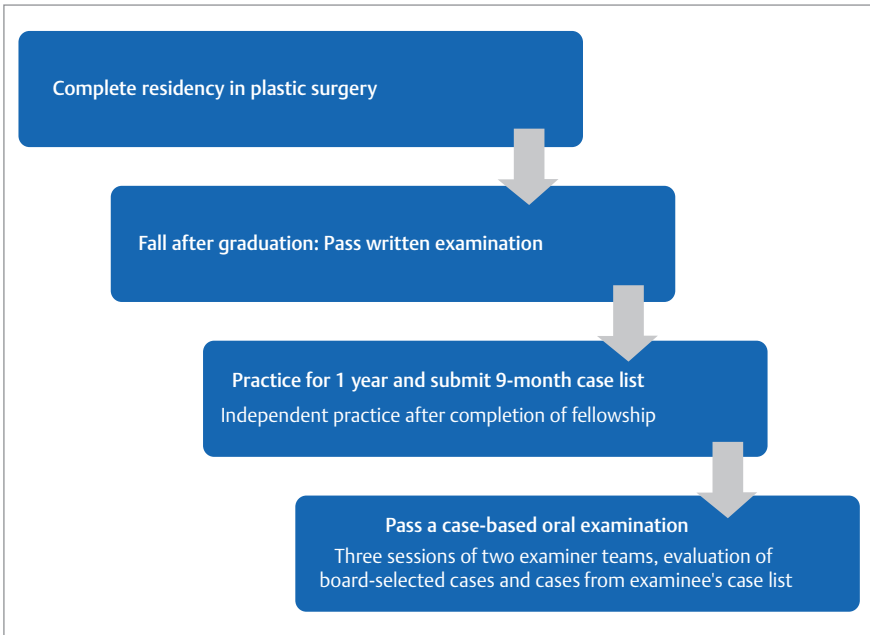


Fig. 1.4 Process of certification by the American Board of Plastic Surgery.

1.4 Foreign Medical Graduates

Many physicians who completed medical school or practiced in other countries have an interest in coming to the US. The current licensing processes for medical practice in the US present very steep challenges to both foreign medical school graduates (FMGs) and those who are already practicing physicians in other countries. Any person who graduates from a medical school not in the US must complete all the USMLE steps (1, 2 CS/CK, and 3). This is challenging for US graduates and likely even more difficult for others who may not speak English as a first language. Further, FMGs have done comparatively worse matching into residency positions across all specialties. Those who are already in practice in other countries are required to repeat a residency in the US or Canada to be able to practice in the US. Like FMGs, they tend not to fare well in the residency match process compared to US graduates. An additional challenge is navigating the visa process for training and then sponsorship in the US.

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2 The Job Search

David A. Sieber

Abstract

Finding a job is not easy, and as surgeons we are ill-prepared for this task despite our years of training. There are many potential pitfalls during this process, which can hopefully be reduced or eliminated by increasing your knowledge. This chapter provides some tips on how to prepare for the job search. Making lists of priorities helps to narrow down your search both by location and by job type. Various types of jobs are discussed in detail as well as the pros and cons of each. Ideas on where to look for jobs and how to identify potential red flags in practices are also covered. Although this process may seem daunting, you have been well trained and will be better equipped for the job search by the end.

Keywords: job search, academics, private practice, multispecialty group, solo, group, contracts, loans

2.1 Introduction

If there are two things they do not do a good job teaching in medical school and residency, they are: how to run a business, and even more importantly, how to find a job. Just like any career your family or friends may have, it is becoming more common to not remain at a single job for your entire career. According to the Medscape National Physician Burnout & Depression Report 2019, 44% of physicians consider themselves to experience burnout.¹ The good news for plastic surgeons is that they are among the least likely specialties to experience burnout (36%), and they scored the highest of all (41%) in being happy at their jobs.

So, what makes me qualified to give advice about jobs? I went the more traditional route to becoming a plastic surgeon by completing a 5-year general surgery residency before embarking on a 3-year plastic surgery residency, and then completing my training with an aesthetic fellowship. I then entered into a partnership that lasted only 4 months and me needing to hire an attorney to get everything sorted out, a situation that I had never even dreamt of just a year before! Before the dust even settled and realizing that I was now on my own, I decided to enter into solo practice. I reincorporated and hung my own shingle in the most expensive city in the United States, entered into an office share arrangement with another fantastic plastic surgeon, and have been doing great ever since! Life often throws curveballs; we just need to learn how to navigate around them, or better yet, avoid them altogether.

The rate of new jobs for physicians in 2016 increased by 13%, higher than the national average for other jobs. Now is as good a time as any to be a doctor in the United States.² So what are some causes of failure for a plastic surgeon's first job? The three top reasons for leaving a practice are: (1) poor cultural fit with the practice (51%), (2) relocating closer to family (42%), and (3) compensation (32%).³ Low compensation correlates with dissatisfaction; however, high compensation does not as clearly match satisfaction.⁴ With mounting school and personal debt, many doctors are eager to get out and start paying off their debt. This is often seen in young doctors who "take a job" because of the high pay, but it may be poor cultural fit. Although the job pays well, ultimately it becomes a chore to go into work every day, leading to poor job satisfaction.

A major contributor to physician turnover is a mismatch in expectation and practice culture. This is why it is so important to first prioritize what is important to you, then seek out jobs with those priorities in mind.

2.2 Priorities

What are your priorities? Consider *your* goals and things of importance, not the priorities of your attending role models or even your colleagues. If family is important, then moving across the country for a sought-after academic career may last only for a few years. If being close to the ocean is something you need, taking a high-paying job with unbelievable benefits in Nebraska will be satisfactory for only so long.

This personal inventory should always include spouse/partner input. Sit with your spouse/partner and have a long talk. Bring a notepad, or an iPhone, and make lists. What items are non-negotiable? What is a high priority but something you would be willing to compromise on? Write all of these things down, let that list sit, then go back to it after some more thought. It should be a similar exercise to what you did when looking at medical schools and residency programs; think about what is really important to you. Set long-term 5- and 10-year goals and differentiate between needs and wants. What will your commitment be to medicine, and what will your commitment be to yourself and to your family?²⁵ What are their needs? See ►Table 2.1 for a sample list of topics to discuss. Your path to a successful and rewarding career does not necessitate doing the same job, cases, or position as your current attending or mentors. After years of being matched to residencies, this really is the first time since medical school where you are the architect of your own future. However, plastic surgeons who have completed specialized fellowships, such as microsurgery or craniofacial, may have more difficulty finding jobs in preferred locations because of the need to be at an academic institution.

Ideally, you will land the right job the first time around. If you always knew that you wanted to end up in solo practice on the West Coast, but instead sign a 2-year contract for a job in the Midwest at a multispecialty group to save money for startup costs, you are essentially delaying your ultimate goals by another 2 years.

When considering the job search, use any edge or connection you have. Finding a job in plastic surgery is like any other career. It may be more about whom you know than what you know. Joining an already established practice will expedite the growth of your practice with all the tangible items needed to run a practice already in place. Reach out to all the people you know who are in a position to help you land a job or who may know of others looking for a partner. At the very least, they may be able to offer advice.

Table 2.1 List of potential priorities when looking for a job	
Cost of living	Predictability
Income	Proximity to family
Autonomy	Vacation
Job security	Call
Location	Weather
Prestige	Sports
Diversity	Work type
Excitement	Patient mix

Analyze your own skill sets and determine how hard you want to work. Are you naturally entrepreneurial? Was your lemonade stand the best in the neighborhood? How are your leadership skills? Do you enjoy negotiations? If you do not, then consider a position where someone else does that for you, such as a group practice. Solo practice may be the most challenging the first few years, when taking out practice loans and weathering a low-revenue stream.

2.3 Choosing a Practice

Now that you have figured out what is most important to you, the next step is figuring out which practice model works best with your personality and goals. Each person has different financial and personal goals for their practice. Prioritize what is the most important to you while you look at various opportunities.

2.3.1 Government

A government position can come in many forms or with multiple agencies. Examples include the Indian Health Service, the Veterans Affairs (VA), the U.S. Department of State, the National Institutes of Health, and the U.S. Food and Drug Administration. Government work is often well-regulated with predictable hours, benefits, and pay. This security comes at the loss of autonomy that you may have with other opportunities. While government jobs are free of insurance hassles, they are often associated with bureaucratic and administrative aggravation. As with any large organization, you will work daily with staff you cannot hire or fire.

2.3.2 Academics

Academics offers intellectual stimulation and a protected environment (see also Chapter 4). The demands of the inquiring residents' minds require surgeons in academics to keep abreast of the newest research and to teach the latest techniques. There is considerable security in a built-in referral base of patients from physicians and emergency rooms. If you do not get along with a referring doctor, it is not a big deal because there is typically a well-established referral pattern in place. The tradeoff is a loss of autonomy.⁶ Clinicians in academics will have bonus structures based on participation in teaching activities such as journal clubs, grand rounds, and teaching conferences. Often the amount of time you invest has a direct correlation with the amount of money you receive.

Two things have changed academic practice: (1) clinical income and (2) duty hours. The classical model of academic medicine, where you started at one rank and were paid according to promotions that were tied to publications, is changing. That model included protected research time and subsidized teaching responsibilities. In the new academic model, income is generated from clinical practice, similar to a multigroup practice, and is frequently called a faculty-practice plan. Academic practices are being run more like businesses, placing more emphasis on what generates revenue: you. The income is also supported by research, administrative, or endowment funds, but less so than in the past. Now, in much of academic practice, doctors have to generate their own salaries, whether through teaching, research, or seeing patients. This changes the academic career paradigm; the ability to move among institutions to be promoted from associate professor to professor may not be as feasible in the future. You yourself can relocate, but you cannot relocate your patient base and, consequently, your income. Plastic surgeons are becoming more and more tied to their patient base, despite the type of practice they are

in, making it now more critical to find a practice that is a good fit the first time around. The academic practice has fundamentally changed; unless you have specifically sought-after skills or research experience, you may be more likely to advance by remaining at the same institution or by moving to another institution within the same city. Moreover, a transition from a university into the local community can be smoother, with an already established patient base, but if you are changing your surgical focus from, say, reconstruction to aesthetic surgery, your previous patient base may be less helpful. After building a reputation and national and international recognition, transitioning to another academic location in a position of leadership will be easier.

Two core changes in the academic field are the 80-hour resident work week and the need for increased resident supervision. These rules require more hands-on time to do the cases, so academic practice increasingly resembles a multigroup specialty practice, but with residents. The days when residents operated unsupervised on clinic patients, for maximum resident benefit, are long gone. Allowing residents to participate in a procedure requires a certain amount of comfort on your part to provide them the hands-on experience necessary for educational purposes.

Some of the positives and negatives of academics constitute two faces of the same coin (► Table 2.2). There are great opportunities for personal interactions and titles of recognition, but how well you navigate through the layers of politics, whether personal or professional, can depend on the answers to the following questions: “Do you play well in the sand box? How big of a sand box do you want to play in?”⁷ Consider these factors carefully before making a decision. It is always possible to maintain academic affiliations even if you are in the community; however, teaching must be a priority over purely income-generating activities because it requires energy and dedication.

2.3.3 Multispecialty Groups and Large Healthcare Organizations

With a mix of primary care and specialties (ideally a 50:50 ratio), the multispecialty group is in the center of the “security versus autonomy” spectrum; it sacrifices autonomy for the benefit of a captive referral base. One of the crucial components is physician ownership. Group sizes vary from 10 physicians to the enormity of the Mayo Clinic. As size increases, governance and independence become more remote. However, economy of volume increases. Generally, income is favorable for plastic surgeons in a

Table 2.2 Disparities in academic practices	
Advantages	Disadvantages
Release from business	Less control
Intellectual freedom	Limited input
Stimulation	Inertia of change
Research	Income
Skill enhancement	No equity
Challenging cases	Time-consuming, nonincome-generating meetings and committees
Personal interactions	
Positive reinforcement from teaching	
Security	

multispecialty group, although generally not as generous as that earned in a single-specialty group. 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 whose high-income-generating potential can yield effective bargaining power. A multispecialty group offers a potentially good lifestyle with built-in call coverage, but the culture of the group must be right; it needs to be a good "fit." Is the practice focused on balance or on productivity? What is the group's reputation? Will you be doing what you want to and are trained to do? Unless spelled out in a written contract, promises can be broken, rendering your fellowship irrelevant to your actual practice. Finally, what is the eventual buy-in cost—is there an equity stake and when will you be able to actuate that option?

Be aware that in multispecialty practices, you can be pigeon-holed into what you are allowed or assigned to do. Groups are often looking for someone to be the "breast and body" surgeon, especially when a facial plastic surgeon is looking for a nonfacial partner to keep patients within the practice and funnel them into an owned operative room or medical spa for increased revenue. These types of arrangements severely limit what you are able to accomplish professionally. With promises of being referred all patients requiring surgery below the clavicles, these opportunities may seem appealing. It has been my experience that the surgeons who say they turn away multiple referrals a week are usually inflating how busy they actually are and the number of referrals they are actually seeing. You trained for 6 to 9 years to be able to do what you like, whether that is breast, body, or face procedures. You are like a new bird ready to jump out of the nest. Do not let someone clip your wings as you are ready to leap. Once you stop doing face, it is hard to go back.

2.3.4 Single-Specialty Group

This model has many advantages and is common in plastic surgery (see also Chapter 5). Group sizes typically vary from 2 to 11 people,⁸ but they can be as large as 20+. The single-specialty group may offer the peak of potential income because economies of scale facilitate minimizing the overhead. The single-specialty model offers call and schedule coverage, professional stimulation, and companionship. However, the potential for fracture exists, especially among surgeons with similar surgical interests. Single-specialty groups are often busy, yet there is less independence than in solo practice (►Table 2.3).

The details of ownership and equity must be spelled out to assure a balance of power between junior and senior partners. The success of the group depends on the philosophy of the founding senior partner. The ideal group prioritizes the group's benefit above the founder. Most buy-in structures salary the new junior partners for 2 years (even as long as 5 years) before they are able to buy in and reap the benefits of group practice. Some practices provide a baseline salary, but the total salary depends on productivity. In general, the baseline salary will not be as high as if you take a job with a larger institution. The smaller group would not recoup the costs of hiring and employing you for around 2 years, so a bonus structure is in place to incentivize you to build up your own patient base. Other practices have a total equality model, meaning once becoming a partner, the total revenue generated is split evenly within the practice. This model typically takes a long time to buy into, but once an associate makes partner, everyone is afforded the same benefits.

Joining another plastic surgeon is a good option for many. The benefits are typically similar to those of a larger group (a baseline income, call coverage, professional

Table 2.3 Pros and cons of group practice ⁸	
Benefits	Drawbacks
• Greater negotiating power with vendors, hospitals, and payers	• Slowness in making decisions/ implementing change
• Access to more capital for purchases/investment	• Difficulty in balancing personal goals with what is best for the group
• Economies of scale that provide greater access to recruiting and retaining exceptional personnel	• Discrepancies in access to personnel or other resources
• Ability to cite rigorous outcomes-based data due to the large patient base and share information on a day-to-day basis	• Potential for interpersonal conflict
• The likelihood that advanced electronic medical records (EMRs) will be used in the practice, eliminating or reducing paper records and allowing information to flow off-site	• Interdependence on peers
• Development of a stronger brand for the practice	
• Greater quality assurance	
• Lifestyle improvement through partners who share coverage of the practice	

conferring, and camaraderie), but personality match is particularly important since you will likely be sharing tight quarters with your colleague. During one of my interviews, the person who was interviewing me told me that I had passed the “canoe test.” They would be able to tolerate me if it was just the two of us stuck in a canoe. Flip the question around: Would that other person pass the canoe test?

Length of time in the career should also be considered. Although it seems like it would be a good idea to start a practice with a co-resident, this often does not work out as you end up competing for the same patients. Depending on the circumstances, this type of competition may lead to animosity between the two of you. It might be better to look for someone who is at least 10 years ahead of you in practice. They may be transitioning from reconstruction to cosmetic surgery, and they may want to offload those reconstructive cases. In other instances, a more senior partner may be hiring because they have built up a practice where they could really use another set of hands to take on some of the caseload. Get a sense for why they are hiring a partner and what your role will be within the practice. It is also a good idea to see if they have ever had a partner before. If so, why didn't it work out?

On the opposite end of the spectrum is the surgeon who is getting ready to retire. It is best to be able to work together for at least a year or two before you take over the practice. If they retire right after you come in, there may not be adequate time for a smooth transition. In an ideal situation, the other surgeon would slowly introduce you to their patients: “This is the fantastic new surgeon who is going to take over the practice.” That way, the patients will feel as though they already know, and hopefully, trust you as their surgeon. Problems can arise if the senior surgeon does not actually retire on schedule. Sometimes their identity is so wrapped up in being a plastic surgeon that they find it too difficult to quit. Protect yourself before entering into a partnership by doing your research, asking a lot of questions, and looking at the practice's financial statements. Ideally, your potential partner will have written a business plan to justify the new position. This is your future and your livelihood, so you have the right to ask as

many questions as you see fit. Look out for these red flags: The other person seems annoyed with your questioning, is not able to provide you with straight answers, or outright denies you information. Just like in life, those relationships which work out the best are built around trust, honesty, and transparency. This is, of course, a two-way street. If you are dishonest about your abilities, or communication skills, do not expect to get what you are unable to give. Junior partners must recognize that senior partners have spent years building infrastructure, patient loyalty, and value. Senior partners must create a path to success for the incoming physician.

2.3.5 Solo Practice

Solo practice provides the most autonomy, which is probably why it was associated with the lowest burnout rate in Medscape's 2019 Burnout Survey,¹ but it carries the biggest risk (see also Chapter 4). Flying solo allows you the freedom to choose what you want to do at the expense of taking on all associated responsibility and costs for those decisions. It allows flexibility and, potentially, a higher income. However, working solo puts you at risk of isolation and stagnation, so there is a greater need for interaction outside of the practice. Depending on your chosen location, a genuine problem with solo practice is call coverage. An alternative to solo practice is an office share arrangement, whether with another plastic surgeon or a complementary specialist, such as dermatologist or ENT specialist. From a financial standpoint, you are helping to share overhead costs, only taking on half of what you may pay in pure solo practice. As with any group or affiliation, personality fit is essential to its success. Sharing with a compatible partner can give you a sense of camaraderie and, when sharing with another plastic surgeon, someone with whom to discuss cases. Being in an office share helps to offload a lot of the initial expenses you may otherwise have in starting from the ground up (furniture, syringes, gauze pads, etc.), and it may also help in adding you into a well-established network of surgeons able to provide call coverage.

If you are considering solo practice, you need the following:

- Desire/need for independence.
- Careful financial planning: you need enough startup money planning to not draw a salary for 1 year. Although there are *physician loans*, I have not found these to be helpful or even worth considering because they still require you to have collateral to back the loan. When I finished training, all I had for collateral was an old car, which was not worth much money.
- Persistence, hard work ethic, and the drive to build your practice from the ground up.
- Business acumen.
- Specialty niche to set you apart, particularly if you are in a large metropolitan area with no shortage of excellent plastic surgeons.

Because the solo model is a balance of risk versus investment versus autonomy, you must address the two biggest issues: acquiring patients and money. This requires a business plan and your accountant should help you with it. A good business plan does the following:

- Clearly expresses your concept, how it fits into a continuum of care, and what problem or need it addresses.
- Outlines risks and contingency plans.
- Documents market demographics and need.
- Differentiates you from the competition.
- Outlines the proposed organizational structure.

- Makes realistic financial projections.
- Tells investors what they can expect to get for their risks.

For a sample business plan, see Appendix 4A.

An accountant is a critical part of your team. They can be from another state, but it makes sense if they are local as they will be more familiar with state laws. Another good resource is other surgeons in private practice you know from training, as they should be able to estimate monthly overhead for their location. They may even have a templated business plan that they used, which would make creating one for yourself as simple as plugging in your own numbers.

The amount of cash you actually need to start a practice depends on a lot of variables, such as location: Are you going into a turnkey office or are you building your own? A startup expense of \$500,000 is not unreasonable, but \$200,000 to \$300,000 is a more realistic number for a brand-new practice. An upmarket turnkey space with an operating room facility and spa services will require closer to \$1 million, assuming it is already built, but it is best to develop these additions after you are established in your area. There is nothing worse than having a brand-new spa with no one in it. The initial loan must cover startup cost, insurance, working capital to stay in business, marketing, website, salary, etc. It took me 6 months in solo practice before I was making more money than I was spending each month. To be cautious, you need enough money to live on for 6 to 12 months after starting a practice. If you are applying for loans right out of training, you may be very disappointed. Since the financial crisis of 2008, banks are much more careful in who they lend money too. Being a physician no longer carries the weight it once did. You will not be able to get a business loan without a W2 showing that you are an employee of a corporation or without enough collateral to back up the value of the loan. If you are fortunate enough to get a loan from a family member, that may be your best, or even only option.

Options for financing a solo practice include:

- A *term loan*, which you repay over a certain period, but for which you may need a personal guarantee. You may have difficulty qualifying for this coming out of residency with no collateral and student debt.
- A *line of credit*, which you use or repay and use again; interest is paid only on the outstanding balance.
- *Lease financing for equipment*, which is similar to a car lease.

2.4 Types of Positions

There is little written about rates of satisfaction among plastic surgeons, but one paper by Rohrich et al provides some insight.⁸ Plastic surgeons over 50 years of age (~56% of plastic surgeons) are more likely to be solo (65%) than general physicians (26.7%). Nearly all plastic surgeons are satisfied (95%), compared with all doctors (84%). Plastic surgeons work fewer hours per week (52.2 hours) than the average doctor (53.7 hours), with the majority of that time being spent engaged in patient care (88.4%). Not surprisingly, reconstructive surgeons work a longer average week (56.5 hours) than cosmetic surgeons (49.7 hours) and are more likely to be in academics than in single-specialty practice.

According to the 2019 Medscape survey on burnout and depression,¹ when comparing physicians based on type of practice, the burnout rate was highest (49%) among those working for healthcare organizations. Single-specialty and multispecialty groups ranked the same (44%), academic and military physicians were slightly lower at 42%, and solo practitioners had the lowest burnout rates (41%).

2.5 Recruitment Firms aka “Head Hunters”

Everyone has to make money, even the recruitment firms. You may have received a mailer ad for a “Unique opportunity in a growth practice; four-season environment with excellent recreation, living, and cultural opportunities.” Although this sounds enticing, you will quickly find that all job ads sound strangely similar and are always followed by “call for more information.” These firms are in sales just like anyone else, and someone has to pay them for their work. Typically, the practice pays the firms once you sign a contract, and the “finder’s fee” is quite hefty. The higher your negotiated salary, the greater the finder’s fee the hiring establishment must pay. Thus, having a company charging their commission while networking for you erodes your upfront bargaining power.

2.6 When Should I Start Looking for a Job?

A good rule of thumb is to start looking for a job about 12 to 18 months prior to the end of your residency/fellowship. This allows enough time to travel, interview, and consider your options. Ideally, you should have a good idea of what you will be doing and even have a contract signed about 6 months prior to completing your training. You will need that extra amount of time to acquire hospital privileges, sign insurance contracts, get a state medical license (if you are moving to another state), and design your website. By completing these tasks prior to starting, you can hit the ground running. If you are going into a hospital or group practice, much of these tasks will be taken care of by the human resource (HR) department or your appointed administrator. It takes more time to set these things up if you are going into solo practice, as you will need to recruit people to help review contracts, design your website, and do other administrative tasks.

2.7 How Do I Find Jobs?

There are a number of outlets to begin the job search. One print source that is still good for information is Plastic Surgery News (PSN), published by The American Society of Plastic Surgeons (ASPS). The American Council of Academic Plastic Surgeons (ACAPS) has mostly academic listings, which are updated monthly (<http://acaplasticsurgeons.org/jobs/>). ASPS also keeps its own job board, which tends to be more complete and has listings from across all types of practices (https://www1.plasticsurgery.org/Job_Opportunity/JobOpportunityBoard.aspx). The listings on other websites, such as CareerBuilder and Indeed, tend to be of lower quality. Another option is to talk to your program director about possible jobs. Groups looking for partners and senior solo practitioners looking for someone to take over their practice will often send program directors details about these opportunities. Some people choose a location first, then look for a job by reaching out to surgeons in that community. Busy plastic surgeons may be considering bringing on a partner, but never find the time to formally advertise for the position.

2.8 Should I Do a Fellowship First?

Whether or not to do a fellowship is a common question and for good reason. After already training for 6 to 8 years, doing one additional year may not seem like a big deal, but significant others may have had enough of “resident life.” Depending on

what type of career and practice goals you have, pursuing a fellowship may or may not be a good idea. For those interested in academics, fellowships are often required to acquire the specialized skill set necessary for hand, pediatrics, or large reconstructive micro cases. Many community hospitals even require a hand fellowship to take hand call. If you are interested in a certain geographical area, contact the local hospitals to see what their requirements are for additional training.

After 8 years of training, I decided to do an aesthetics fellowship at UT Southwestern in Dallas for a number of reasons. First, after completing my plastics training, I did not feel adequately trained in the gambit of aesthetics procedures to start in solo practice. Not only did the fellowship help to refine and expand my aesthetic skill set, but it also introduced me to a new professional network, which is perhaps even more valuable. Doing a fellowship allows you to work with some of the most skilled plastic surgeons in that niche, possibly giving you access to opportunities to publish and teach, which would otherwise be unavailable. When you are first starting, especially on your own, it is helpful to know that you have experts available to you for questions about difficult cases.

2.9 Need

When I first started looking for jobs, many advised me to see if there was a need in the area. As of 2016, the top three spots for the most plastic surgeons per 100,000 people were Miami, Florida (3.9), Salt Lake City, Utah (3.1), and Los Angeles, California (2.98).⁹ Although plastic surgeon density is certainly a factor to consider, don't let it prevent you from starting a practice in a particular city, especially if you already have connections there to get you started. You will be competing with a larger number of surgeons for the same patients, but if you are well trained, possess the necessary social and business skills, and get good surgical results, then you should be able to succeed. Although the start may be slow and difficult, it is still possible to be successful in a busy and competitive city.

2.10 Income

Based on the Medscape Physician Compensation Report in 2018, the average annual salary for a specialist is \$329,000 and \$223,000 for a primary care provider.¹⁰ The good news for plastic surgeons is they have a high average compensation, ranging between \$320,000 and \$590,000,^{11,12} depending on the number of years in practice, academics versus private, and geographical location.^{1,2} According to an unpublished ASPS 2018 Economic Environment survey, the salary range is wide: 14% of surveyed ASPS members earned under \$200,000, and 12% earned over \$1 million.

Within the plastic surgery discipline, the first myth to dispel is the perceived imbalance between private and academic practice incomes. A number of recent studies have shed light on this myth.^{13,14} Physicians having the same experience/age range earn nearly equivalent incomes; however, academic surgeons, by performing considerably more relative value units (RVUs) of work, perform 7,101 RVUs compared to 5,962 RVUs in private practice to generate the same income. A 2018 study looking at lifetime revenue of surgeons in academic versus private practice¹⁵ found that academic plastic surgeons' salaries are just 2% less than those of private practitioners. Plastic surgery and general surgery were the only two disciplines in which academic surgeons' salaries were comparable to that of private practitioners.¹⁵

2.11 Selling Yourself

Once you have confirmed a location and a practice type, you must now sell yourself. The first step is updating your curriculum vitae (CV), which is the first opportunity others will have to evaluate you. It should be well-organized, concise, and easy to navigate. Your correspondence with potential employers should be thoughtful, carefully crafted, and thoroughly proofread. Include a cover letter that addresses the practice's specific needs. Frame your values, experience, and skills as solving a problem or challenge for that practice.

Prior to your interview, research the practice so you can formulate pertinent questions. Find things you have in common with the surgeons in the practice so you can connect with them on a personal level. You only have one opportunity to create a positive first impression, and once someone has formulated an opinion about you, it is often difficult to change. The first interview is not only about selling yourself, but also about evaluating whether this practice will be a good fit or not. Depending on the type of practice you are interviewing for, you may meet with a variety of people from other plastic surgeons, administrative staff, members of HR, and even nurses and coordinators within a practice. You are interviewing them as much as they are interviewing you. Find out what they need in their practice and what your role would look like. Although compensation and benefits are important, they should not be the focus of a first interview. Instead, use the time to determine whether or you would be able to work with the others in the practice and whether this practice meets the personal requirements on your list or not.

After each interview, keep a record of whom you met with and your impressions of the practice. As you interview with more and more people, this log will allow you to compare notes on each job. After each interview, send either a handwritten note or an email thanking the practice for their time, including highlights of the things you liked about the practice and why it may be a good fit for you.

If they are hiring to fill a vacancy after someone recently left the practice, consider contacting that person. The practice may tell you the person left because they were not a good fit, but the other person may tell you a completely different story. The more information you are able to gather on any aspects of the practice, the better. Information is power.

When weighing positions, think again about needs versus wants and compromise versus reality. When you are closing in on a decision, revisit the needs of your spouse/partner. Their evaluation list can add enormously to long-term success. Remember, 36% of individuals relocate based on a significant other's needs. ► Table 2.4 is my wife's list from 2015.

Red Flags to Look Out for During Interviews

- **A wife as an office manager:** There will always be preferential treatment.
- **Retiring or slowing down senior partner:** What is the plan for retirement and the funding of that retirement? Are they leaving as soon as you start, or will they phase out as you ramp up your practice? Or have they really not yet made a firm decision.
- **Practice name:** Is it egocentric? There is a big difference between your role at "Advanced Plastic Surgery" and "Minnie Mouse Aesthetic Center." The first name has more potential, unless you are Mickey Mouse.
- **Outrageously high office overhead:** Are you being recruited to cover costs? If so, this will not be a long-term feasible relationship.

Table 2.4 Spouse/partner life choices		
	A	B
Cost of living	5/10 (moderate)	10/10 (very high)
House choice	10/10	0/10
Friends	0/10	0/10
Family	0/10	0/10
Activities	2/10	10/10
Population	Blue collar	White collar
Visitor destination	2/10	10/10

2.12 Show Me the Money

When you are content with the position, the environment, and your cultural fit, it is time to look at the books. You need as open a book as is feasible, and if the practice does not want to share it with you after you have made a few visits to the practice, it is a problem. If there is an issue with financial transparency, this is a very red flag. It is valuable to see numbers from the last person with a similar position, including billings, receivables, and overhead expenses.

When you discuss finances, avoid the money question: “How much will I make?” Rather, concentrate on the real issues: (1) patient mix, (2) productivity potential, (3) collection rates, and (4) controllable and fixed expenses. That being said, you should have a pretty good idea of what your take home salary will be and whether it is guaranteed, production based, or a combination.

Income is generally gross collection minus expenses (overhead). These expenses can be substantial if they include infrastructure costs, surgical center costs, or large staff salaries/benefits. Most practices, academic or private, have profit and loss (P&L) statements. If possible, ask to see one for a comparable employee. If they have never had a comparable employee, then they likely have a business plan that has been generated in anticipation of hiring someone. Ideally, they will let you take some of this information to review with your accountant to see if everything checks out.

Remember that in solo practice you will have maximum control over expenses, but less control on production. As a solo practitioner you “eat what you kill,” so if you never go hunting, you will go hungry. In group practice, expenses are more fixed, and you are going to hopefully be fed business to bolster your productivity. When joining a practice, find out about ownership, hard assets, and financial risks and liabilities. Most practices will require you to remain a practice employee for a specific amount of time before allowing you to buy in as a partner. Before joining any practice, you need to know what this transition looks like. There are various models ranging from a lump-sum buy-in to paying a little each month until you have met your buy-in. These plans for transition should be well spelled out in any contract you review. (See Chapter 5 and Chapter 21.)

During the emotional negotiation period, keep in mind it is business, not personal. You may consider yourself a top candidate with unlimited potential, but the practice, university, or group has its investment to protect. Through experience, they may have a more realistic view of the costs of supporting your potential position and the time it may take until that investment pays off.

2.13 Respect

Be cautious of practices that do not seem to respect their employees. You have trained for a long time in order to be viewed as a peer or colleague of those you are working with. Ask how long most of the employees have worked there. Offices that have respect issues often act as a revolving door for employees. Senior surgeons in such a practice are more likely to treat you as another employee. This goes for the office staff as well. Listen to how the staff addresses the surgeons in the practice. Staff that refers to junior partners by their first name often lack the respect necessary for a cordial and healthy work environment. Even if you are a very relaxed individual, the staff should always address you as “Dr.,” especially in front of patients.

2.14 Contracts

Prior to receiving a contract, you will receive a letter of intent, which serves as a binding document while the contract is being written. A healthcare attorney should always review the letters of intents and the contracts. A good attorney is an often costly, but very much necessary, part of your team. The contract review is not a role for a friend of a friend or “Uncle Johnny” because the long-term costs are too high. Rather, the reviewer should be a seasoned contract attorney who is familiar with the healthcare laws and practices of your proposed location, and someone who is looking out for your best interest. Contract language is difficult for the layperson to understand.

A contract is like a prenuptial agreement: you only need it in a divorce, and when you need it, it better be good. The contract should include the following:

- **Job description:** This includes what job you will be performing, on whom, and for how many hours per week. On-call responsibilities are an important point to be negotiated if this matters to you.
- **Compensation:** Low compensation correlates with dissatisfaction, whereas high compensation does not correlate as clearly with satisfaction. A fair compensation is essential. Individuals need to work for what they think they are worth as long as that is not inflated. Salary needs to be defined, as does the bonus structure. In a small group, expect a lower baseline salary with a bonus incentive that allows you to be appropriately compensated when your productivity is high. Find out what metric is used to measure the productivity on which raises and bonuses will be based. Acceptable measures are RVU, charges, and collections. The RVU scale is the only measure of true work because charges are dependent on what fee structure is utilized and collections are dependent on the payer mix. Profitability, or residual money left after gross income minus expenses, is a common model; but in academic or group practice settings, it does not favor physicians because expenses are not a variable that they directly control.
- **Benefits:** Insurance, disability, retirement, and personal development expenses should be covered. Costs of attending meetings are real expenses for surgeons, as are books, recertification, travel, continuing medical education, multiple hospital dues, society fees, and license fees. Depending on the practice setting, \$10,000 might be reasonable minimum per year to start, and \$25,000 might be reasonable long term. Alternatively, some practices allow for a certain number of meetings. Each meeting can easily cost \$5,000 to \$10,000, depending on location and the optional courses.
- **Malpractice:** Most important is not what the employer pays, but what is not covered. There are two types of malpractice insurance: (1) occurrence-based, which covers you indefinitely for acts that occurred during coverage; and (2) claims made,

which only covers for claims filed while the policy is in effect. The latter is much cheaper yet requires a tail policy to cover lawsuits after you leave the practice. Who pays for this must be defined. The tail policy covers you for the statute of limitations, usually a 2- to 6-year period after the time of injury for which the patient is able to take legal action. These statutes vary in time according to each state.

- **Termination clauses:** Standards must be objective, rather than subjective. There are two types of termination clauses: (1) not for cause, which usually provides a notice period of 3, 6, or 12 months. This clause works to the benefit of both parties. Six months is a good compromise for a surgeon; and (2) for cause, which sets forth on what ground(s) you can be fired. Clear infractions, such as loss of license or felonies, are simple, but you must consider lesser issues. What happens if one of the other partners simply does not like you?
- **Partnership and governance:** You need specific parameters to buy into a partnership. What is the track, what is the time frame, and what is it tied to? Do not be too aggressive on this point as it is their assets at stake. A normal time period for partnership is after 2 to 5 years of employment. More importantly, is it spelled out?
- **Loan agreements:** Sometimes, hospital loan agreements or salary support is included. What are the repayment terms, what is forgiveness, and what are the repercussions if you leave prematurely?
- **Receivables:** Who owns your uncollected money when you leave or retire? In an insurance-based practice, this can realistically be \$400,000 or so. It changes the impetus of how productive you will be in your last months. Insurance claims may take 6 to 12 months to collect depending on the state: Are you OK leaving these behind?
- **Restrictive covenants:** There are three components of a noncompete agreement: (1) noncompetition, which sets forth the area and period of time in which you cannot practice close to your old job; (2) nonsolicitation, which sets forth rules about attracting patients to leave with you (this needs to be balanced with patient care interests); and (3) nonemployment, which sets forth rules about poaching staff when you depart. Appreciate that these restrictive covenants are written to protect the practice, not you or the patients' interests.

The most important covenant is the restrictive noncompetition covenant. The duration must be reasonable, perhaps 1 year. The defined radius should be based on the main office, rather than incorporating overlapping radii from satellite offices and affiliated institutions, which would effectively prevent you from working anywhere in that city. Although these covenants are present in nearly all contracts, they are not enforceable in every state. In California for instance, restrictive covenants are almost always voided if they end up in court, as the state supports employees' ability to practice their trade unrestricted. Do not sign such a contract unless it includes a buy-out clause. The buy-out clause typically nullifies the restrictive covenant but at an expense to you. The buy-out clauses I have seen have ranged between \$200,000 and \$500,000. The longer you have been at the practice, the higher the buyout.

Unfortunately, the larger the institution with which you are negotiating and the lesser your name, the more the employer controls the hiring process. If you are not comfortable negotiating, have your attorney do it. The time and money you invest will be worth it because invalidating a contract costs a lot more of both.¹⁶ It is always a good idea to talk to peers of yours who have recently joined the job market. What was their experience? What did their contract look like? Whom did they use to help them

negotiate it? Many people do not like talking about money, so ask those close to you for the nitty gritty details.

One last thing to consider before signing a contract or taking a job is making sure to have others evaluate your plan. By the time you finish your training, you should have formed close mentoring relationships with attendings and peers. It is good to have someone with your best interests in mind review your contract or job plan, so you many want to sit down with a trusted mentor and go over everything. Keep in mind that academic mentors may not have positive feelings about your plans if they involve starting a solo cosmetic practice. Ask other family members and other friends for their opinions. The more information you can gather, and the more diverse the perspectives you hear, all the better.

2.15 Getting Started

No matter which position you accept, getting started requires working backward from the most distant deadline. In attractive states in which to practice, acquiring licenses can take up to 9 months. No license means no provider number, which can also take 6 months to receive. No provider number means no reimbursement. Joining an institution that has dedicated individuals to fill out the required paperwork streamlines the process. Figuring out what you need and where to go to find it as a solo practitioner is a much greater challenge. It took me about 6 months to get my California medical license, which was approved only after multiple unanswered calls and emails before finally talking to someone on the phone. Persistence is key. Do not forget about your congressman. Someone in their office is dedicated to help constituents through bureaucracy. One phone call can make a huge difference.

Getting hospital privileges can sometimes be tricky, depending on who oversees the department responsible for extending these privileges. When I first started, a plastic surgeon in the area was the chief of general surgery at a local hospital, and he dragged his feet as long as possible before finally signing my privileging paperwork. If you know someone already at the hospital, ask them for advice on getting privileges. Like some species in the animal kingdom, it is not unusual to witness plastic surgeons eating their own kind. In academic positions, getting these privileges is often a straightforward matter of filling out the proper paperwork. They typically will need information about your medical school, residencies, a valid medical license and Drug Enforcement Administration (DEA) license, letters of recommendation from three sources, and an updated CV. Most hospitals meet on a monthly basis to review the new applicants. The person you are in contact with in the credentialing department should be able to tell you when these meetings occur.

Depending on what type of practice you set up or join, you may need or want to set up your own website as patients typically start their search for a plastic surgeon online. Finding a company and building out a website is at least a 6-month process. A good place to check out various web and marketing company booths in the Exhibit Halls at the ASPS and ASAPS meetings. Look online at other people's websites and note the web design/support company listed at the bottom of the page. You will need to optimize both the web design elements as well as the content. I wrote nearly all of the content for my website, ensuring that the message I was delivering was mine, and not that of some general content writer. However, it is a long and time-consuming process.

Once you start your job, it is important to settle in to fit with the culture. Do not try to change anything when you first start; soak in how things run and study each

person's role in the practice. The primary reason that physicians leave positions is lack of fit, so be careful. As a new member of the team, it is up to you to adapt to current practice culture, not the other way around. Many people get worn out after enduring the "new associate" role for a couple of years. Ideally, you will be in a position where, after observing over the months, you are able to make your own recommendations on how to improve things. You ultimately want to be a part of the team and not just an observer.

When developing your surgical practice, be careful not to overstep boundaries. How do you handle call duties, particularly when covering other surgeons' patients? What happens if these patients subsequently want to come to you? A good contract will spell out a protocol. If there are no defined steps, senior surgeons appreciate your honesty. It is always better to address these issues sooner than later so that resentment and distrust never come into the picture.

2.16 Unrest

As their productivity increases over 2 to 3 years of practice, young surgeons may develop some unrest and financial dissatisfaction. This usually occurs when the amount of revenue you generate exceeds your salary plus bonus. I define this as the 2-year question: "I bring in amount A, yet I am only getting paid amount B. Is this fair?" The problem is often a disconnect between the amount of the practice investment and what the physician thinks he or she is worth.

Observe the break-even point at which a new hire with a base salary generates income sufficient to exceed his or her expenses; it is usually at about 2 years. This point is variable based on the environment, workload, and aggressiveness of the young surgeon. After 2 years of investment (i.e., losing money to support you), the practice is just now breaking even. The practice needs to recap its investment prior to discussing payment of salary or bonus based on the surplus after the breakeven. Both parties can appreciate what is involved, without emotional distress, by reviewing the numbers. Although it does not mean that you do not get a pay raise, some repayment on investment is appropriate. We sometimes forget that plastic surgery is also a business and should be run like one. Make sure there is a system in place to track the revenue you are bringing into the practice. The last thing you want to happen after 2 years in practice is for a senior partner to "estimate" your value towards the practice.

2.17 Boards

Depending on the type of practice you ultimately choose, reaching your required case number for board certification can sometimes be difficult. Being in solo practice, during my first month I did one breast augmentation on a friend of my older brother; during my second month, I did another breast augmentation on my neighbor. If you are in a new city with no connections, it takes time to build up a network of referrals and a long time to get patients to write the reviews you need online to attract new patients. It can take even longer for direct patient referrals.

I submitted a case list my first year in practice that met the minimum number of required cases, but the list was denied by the board for having too few cases of sufficient complexity (sewing up lacerations often do not count). It was not until my second year in practice that I had amassed enough cases to sit for the boards. This can be

frustrating, as patients want to know why you are not yet board certified. Patients almost universally understand after I explained the vetting and time required to become a board-certified plastic surgeon.

If you are in a group or academic practice, getting cases numbers should not be an issue. If you are joining another plastic surgeon who is going to “feed” you cases, make sure there is something in writing explaining how this is going to play out. Those joining other surgeons should pretend they are in solo practice. Consider generating new patient leads your responsibility and not necessarily that of the practice. Sitting around waiting for your practice to bring in new patients often times ends up as an unhealthy source of resentment when new patients are not showing up on your schedule. In my own practice, most of my first patients found out about me because they saw me on a regular basis at places I frequented around town. I did a breast augmentation on the woman who cuts my hair and a breast augmentation on another stylist from the same salon. I was able to generate multiple new patients through the gym I worked out at. Always tell people you are a plastic surgeon and always carry business cards in your pocket because you never know when you might have an opportunity to meet potential patients.

2.18 What If It Does Not Work Out?

If you made it to this section, then you should have a very good idea of what needs to happen for you to succeed. That being said, not all jobs turn out to be as advertised. Jobs to relationships: If you get that feeling that things are not going to work out, it is always better to move on to plan B sooner than later. Depending on your financial situation, it is usually not a good idea to quit your job until you have something else lined up. If things do not work out, you will need to start back at the beginning of this chapter evaluating what is important to you. Maybe you took a job because of the money, but it was not a good fit. Or you relocated to somewhere far from family without realizing how important proximity to family really is. Either way, reestablishing those things that matter the most to you (and your spouse/significant other) is always the first place to start.

What if you are mid case collection for your boards when you decide to move on? It may be inconvenient, but it is not the end of the world. Before changing jobs, make sure that you have all of the necessary privileges and licensing in place so that you are able start a new case collection period on July 1st. Even though getting your boards out of the way is important, it is even more important to make sure that you are in a job you love and where you will be able to succeed and flourish.

2.19 Conclusions

Whether you are about to begin your career as a plastic surgeon or you are changing direction midstream, start your job search about 12 to 18 months prior to your planned start date. Sit down and make a personal inventory of your needs versus wants. What are those things that *really* matter to you? Your success comes down to choosing the right job for you and making sure it is a good fit both personally and professionally. Information is key. Talk to peers and mentors for information as well. No matter what type of job you decide to do, being a plastic surgeon is one of the most rewarding vocations. You worked long and hard to get where you are, now sit back, relax, and enjoy your career.

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3 Academic Career

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Abstract

A career in academic medicine has many rewards, such as teaching, being in an intellectually stimulating environment, engaging in research, and benefiting from the prestige of an academic title and the institution. However, there is a loss of control as a complex political bureaucracy in academia and incentive structures may not seem ideal. This chapter reviews what to look for, how to look for a job, and what might make it right or wrong for you.

Keywords: academic medicine, salary, grants, research, incentive, benefits package, teaching

3.1 Introduction

A career in academic plastic surgery is a challenging and rewarding path that drives research and innovation, creates legacy through teaching and publication, and contributes to the evolution of our specialty. When comparing the common practice types, namely, private practice, hospital employment, and academic practice, one of the primary trade-offs is autonomy versus being part of a multidimensional team environment. Autonomy in private practice is often linked to financial independence (though subject to changes in the business cycle), whereas hospital and academic-based practices provide the stability of salaries (and compensation packages). Fortunately, in plastic surgery, unlike most other disciplines, plastic surgeon academic salaries are on average similar to that of private practitioners. As detailed in Chapter 2, a study in 2018 looking at lifetime revenue of surgeons in academic versus private practice found that academic plastic surgeons' salaries are just 2% less than those of private practitioners. Plastic surgery and general surgery were the only two disciplines in which academic surgeons' salaries were comparable to that of private practitioners.¹ In academic practice, the loss of autonomy is offset by several important considerations which can be generalized into three primary categories: clinical, educational, and scientific.

An academic health system can provide multidisciplinary clinical care with the necessary team support that enables a surgeon to perform complex craniofacial, burn, microsurgery, and vascularized composite allotransplant surgical procedures. Without the support of other specialties, trainees, and research infrastructure to monitor and report outcomes, developing a clinical practice in these subspecialty areas can be prohibitively difficult.

If one has a passion or interest in teaching, an academic career offers the opportunity to teach a wide variety of medical students, resident trainees, and fellows. This continual stimulus of teaching and research provides an environment for life-long learning. The pursuit of research endeavors and innovation of procedures advancing the care of patients are facilitated through infrastructure, access to other disciplines, and other attractive components of academic practice. One's experience and productivity in academic practice are recognized by titles in the professorial rank, along with awards not available to plastic surgeons who work outside of academia.

The mission of an academic institution typically revolves around three pillars: clinical care, teaching, and research. An academic practice typically touches these three pillars in different allotments of time and energy, based on the type of academic

practice that is structured. One may sacrifice loss of autonomy as an employee of an academic institution. However, depending on the type of academic practice, the loss of financial autonomy can be mitigated by creating different incentive models. Not all academic practices are based on a pure base salary model; some are based on collections, relative value units (RVUs), and academic bonuses linked to both clinical productivity and academic outputs.

The loss of autonomy in academia is manifest in more than just the financial realm. There is also a loss of control over support staff, who can be hired or fired. Decisions about resource allocation ranging from administrative staff, clinic space, operating room time, and research facilities are brokered through a dense political hierarchy. Most critical decisions are made by the department chair, the dean, and the administration of the health system. Depending on the structure of the plastic surgery division or department and their relationship with the power brokers, resources may be scarce or plentiful. The contribution and value of plastic surgery to the health system are not routinely accounted for during combination procedures with other specialties that receive the credit for admission. The essential services plastic surgery provides to other specialties for complication mitigation are also difficult to incorporate into basic calculations of contribution margin. Academic plastic surgery entities are mostly supported by the clinical dollars of the health system and the difficulty in accurately accounting for contribution margin and value added to the system may limit the ability to compete for scarce resources from the health system. Deployment of accurate metrics of financial accounting is a critical component of academic practice in order to consolidate resources required to perform complex surgical procedures that are difficult to coordinate outside of an academic center.

An academic career offers opportunities to participate in complex surgical cases that require the diverse resources of an academic medical center. Complex microsurgical or craniofacial operations require microscopes or bone-plating sets, specialized postoperative care units, and multidisciplinary care—resources not typically available to the private practitioner. Many successful academic plastic surgery divisions or departments of plastic surgery are affiliated with high-volume cancer centers, trauma centers, or children's hospitals. These provide the challenging cases that attract excellent clinical plastic surgeons and in return provide some of the resources to perform these cases well. Subspecialties that require the resources provided by an academic medical center, like microsurgery, craniofacial surgery, and vascularized composite allotransplantation, are, by necessity, tied to academic settings more than some other plastic surgery subspecialties.

The second major reason to choose a career in academic plastic surgery is the desire to teach and train the next generation of surgeons. Many academic plastic surgeons count the transmission of clinical and scientific knowledge to their trainees as their greatest satisfaction. Continually interacting with young people in a residency or fellowship program is invigorating and challenging. The vast majority of training programs occur within an academic setting because the mechanics for reimbursing the program for the salaries of residents comes through government funding. The extensive compliance paperwork and record keeping required is more easily done in large hospitals with central offices that cover multiple residency programs in different disciplines. This setting fosters a close relationship between resident education and the academic medical center. One main attraction to remaining in academic medicine is often the desire to teach and instruct residents.

Many private plastic surgeons have adjunct or voluntary faculty privileges at academic programs. These private practitioners can contribute an important aspect of resident education by regularly interacting with plastic surgery trainees as part of the clinical faculty. However, by definition, the word adjunct means “supplementary” rather than “essential” and it is essential for plastic surgeons to figure out for themselves how important titles are to them (see Chapter 3.6). This voluntary relationship can allow for trainees to attend the clinic and operating rooms (ORs) of voluntary academic faculty. In addition, these voluntary faculty can also obtain clinical privileges to see and operate on patients in an academic setting. This benefits both the trainee and the plastic surgery faculty in that both can participate in an academic experience that ultimately benefits patient outcomes. The clinical faculty can introduce new and innovative techniques that might often not filter in as quickly in an academic setting. This cross-fertilization allows a dialogue between academics and the community. It is not uncommon for private practice surgeons to cross back into academics based on both professional and geographic opportunities.

The academic plastic surgeon often performs research to improve the practice of plastic surgery or to develop new technologies to improve patient care. Pure basic science inquiry requires full financial support from the division or department, since grants alone may not support one's salary, particularly at the beginning of a career. As scientific grants are awarded, the financial burden of the faculty position is reduced. Biomedical research requires significant infrastructure, such as laboratory space, tissue culture hoods, microscopes, and molecular reagents, as well as the access to core animal and imaging facilities. Biomedical research also requires a steady stream of undergraduates, graduate students, and postdoctoral fellows willing to work in the laboratory for several years at a relatively low salary in exchange for research training. Clinical, translational, educational, and global health related research in plastic surgery also thrive in an academic setting where there are multiple tiers of students and trainees, motivated to participate in the pursuit of scientific inquiry. Not surprisingly, the vast majority of research in plastic surgery occurs within academic medical centers. One must usually be a faculty member to participate in research as a principal investigator in an academic medical center. Ways to participate in research in private practice include clinical evaluation of new drugs or devices in industry-sponsored trials or the refinement of existing surgical procedures. However, the plastic surgeon interested in pursuing fundamental research on wound healing or vascularized allograft transplantation, or in understanding the etiology of aging, should consider a career in academic plastic surgery.

3.2 Choosing an Academic Career

A strong interest in clinical challenges, research, or teaching is not sufficient to guarantee a satisfying career in academics. It helps to have achieved some level of accomplishment and experience in one of these areas, even at the resident or the fellow level. The person interested in basic science research and running a laboratory must have spent dedicated time, usually at least a couple years, doing benchwork in a surgical or basic science laboratory. Tangible evidence of accomplishment, such as authorship of papers or presentations at national meetings, is also required. Conversely, a resident who is interested in doing complex, technically challenging plastic surgery may be best served by publishing case reports, clinical series, and surgical outcomes. Demonstration of teaching excellence at the resident level can be demonstrated through teaching awards and participation in educational

programming. These marks of accomplishment help demonstrate the traits that division chiefs and department chairs look for in potential new plastic surgery faculty members.

3.3 Different Models for Academic Plastic Surgery

Academic surgeons, especially early in their careers, frequently lack control over aspects of their professional life. Unlike the private practitioner, the academic surgeon may have little control over his or her schedule, practice patterns, administrative and clinical support staff, peers, and work environment.² Although institutional models vary in the degree of autonomy an academic surgeon has in choosing/hiring support and ancillary staff, most hospital and academic medical center administrators hold significant influence over the clinical practice of an academic plastic surgeon. In some cases, plastic surgeons are allowed to set up a private practice model within or outside the academic medical center, while strictly limiting their medical center involvement to discrete parts of their practice such as burn surgery, craniofacial, or microsurgery. This setup preserves a large amount of personal freedom and financial flexibility and, in many respects, resembles private practice. Unfortunately, because the majority of academic medical centers oversee the practitioner's clinical revenue, this arrangement is quite rare.

A more common situation is the academic medical center that supplies much of the infrastructure for the academic plastic surgeon. Although convenient, it can limit the surgeon's ability to hire and fire personnel, grow or expand the practice, and hire new partners or relieve older partners as the practice evolves. These limitations can obstruct the efficient running of a practice and can become sources of frustration. In many cases, there is a clinical productivity expectation; exceeding this monetary goal is rewarded with a bonus. However, tracking productivity and billing efficiency in this type of practice is difficult and requires oversight to ensure accuracy, as the data impact decision making within plastic surgery divisions.

The most extreme version of working with a medical center's infrastructure is working directly for the hospital for a set salary, regardless of the number of cases performed. The academic surgeon has very little control over his or her practice, billing, and time, and there are few incentives to increase clinical productivity. This model is seen in the U.S. Department of Veterans Affairs (VA) Hospitals. In return for a salary, the surgeon essentially performs services at the request of the academic surgical center. Although there are no overhead costs, the surgeon can sometimes be viewed as a shift worker. The benefits this system offers are the opportunities for research funding and a dedicated patient population that can provide an excellent environment for academic surgeons to develop clinical expertise and pursue scholarly activity.

3.4 Compensation

Academic plastic surgery programs may have various sources of revenue including hospital support, medical directorships, income from the federal government such as the Veterans Administration, grant funding, philanthropy, and endowments. Academic plastic surgery has become increasingly reliant on the faculty's clinical productivity and the revenue it generates. The demand for clinical productivity competes with the important academic mission of research and education. Compensation models vary and should be thoroughly investigated when considering an academic career and negotiating for a first job. Compensation is frequently tied to clinical productivity through

RVUs or collections, and factors in academic rank, scholarly activity, and benchmarks such as the standards of the Association of American Medical Colleges (AAMC). Most academic plastic surgery programs offer a base salary and a bonus incentive structure that is based on clinical productivity and funded through the clinical revenue of the individual surgeon with a lesser bonus structure tied to academic productivity.³ Academic medical centers usually offer extensive benefit packages including (but not limited to) pensions, retirement plans, malpractice, insurance portfolios, and disability incentives. When comparing compensation models at different job opportunities, compare the total compensation package, including benefits that each offers and the cost of covering those expenses if the institution does not cover them.

Depending on the fiscal performance of the academic medical center, compensation can be significantly decreased. As the surgeons are not billing for their services directly, their professional fees are taxed by division chiefs, department chairs, deans, and hospital administrators. The surgeons' fees and diagnosis-related group (DRG) hospital revenue generated by plastic surgeons can be a ready source of capital to correct financial shortfalls caused by the inefficiencies of the academic medical center. These sorts of issues need to be evaluated on a case-by-case and even state-by-state basis, as there are significant regional differences in remuneration policies, care of the uninsured, regulations regarding balanced billing, and similar issues. These regional issues can significantly impact the financial viability of plastic surgery divisions, leading to wide disparities in salaries, administrative support, and other resources. If an academic surgeon considers a change of practice type, these numbers should be carefully considered with the total compensation package for a clear comparison of academic medicine with other types of practice that may not provide generous benefits. Low compensation correlates with dissatisfaction; however, high compensation does not as clearly match satisfaction.⁴ In medical centers that have extremely high contracts with insurance companies for facility reimbursement, physicians' compensation is based on RVUs that can amount to significant numbers, even after all the bureaucrats take their cut. The compensation for division chairs and chiefs can be much higher than the vast majority of those in private practice. Division and department heads are more likely to be able to set their schedules, time away, and sabbaticals. Moreover, they typically have a legion of trainees to take care of the mountain of electronic paperwork, freeing the academic surgeon to maximize numbers of clinical cases, and other academic and nonclinical interests.

Publishing in academic plastic surgery is important for promotions along the tenured faculty member track. Typically, a number of years is required to move between assistant professor, associate professor, and professor positions. Having a body of published work is a testament to an academician's clinical expertise, facilitates peer recommendations and promotions, and establishes one's expertise in a particular area, leading to book chapters, invited journal commentaries, and invited review journal articles. The expertise demonstrated by publishing can result in an increase in the number of clinical referrals.

The division/department enjoys recognition for a publication when a member of its faculty is published as the corresponding author, as the contact information highlights the institution. Work that is presented at regional, national, or international meetings also highlights the home institution where the work originated. Awards that the work wins will also be associated with that specific division/department. Furthermore, the division/department is recognized when a faculty member speaks as an invited lecturer to present this work.

3.5 Institutional Structure

Aside from issues of remuneration, other concerns that impact the academic surgeon's job satisfaction relate primarily to the bureaucracy that is inherent in any large structure. In a major academic medical center, the extensive rules for compliance with federal and state regulations typically require a significant time commitment, resulting in less efficient time management than in a private practice setting. For academic plastic surgeons who are interested in performing basic science research, the National Institutes of Health (NIH) has its own set of bureaucratic regulations governing how money can be spent and requiring significant oversight to ensure compliance. Managing grants and fulfilling the reporting requirements can require up to 10 to 20 hours per week, time that will not be available for clinical practice. Moreover, the NIH salary support is typically far less than that obtained from clinical practice. Similarly, those involved in training programs as the program director or chairman must adhere to significant Accreditation Council for Graduate Medical Education (ACGME) and Residency Review Committee (RRC) restrictions on how one can run the residency or fellowship training program, resulting in significant compliance paperwork. The ACGME requires that program directors and coordinators have protected time dedicated to these roles, but in institutional systems with productivity-based compensation, funding for that protected time is difficult to secure and is rarely covered entirely by the Graduate Medical Education entity. Thus, one can lose control over one's time. In most cases, this is offset by the unique opportunities provided by an academic career in plastic surgery.

3.6 Academic Advancement

An important consideration when evaluating opportunities in academic plastic surgery is the institution's model for faculty promotion. Over the course of one's career, one is expected to advance from an instructor to an assistant professor to an associate professor and eventually to a full professor in plastic surgery. For very ambitious plastic surgeons, goals may include an endowed professorship, division and department chief, medical school dean, and even government cabinet level jobs. Depending on the specific medical center, this can be relatively easy or exceedingly difficult. In the past, there was a requirement for significant academic performance including a prolific number of peer-reviewed publications and NIH funding to advance throughout one's career, especially in tenure-granting institutions. Many institutions now have a variety of different academic tracks that include nontenure pathways, which base promotion on variables like clinical productivity, education, and service. Requirements vary tremendously among academic medical centers and their affiliated medical schools, but for those faculty members who are interested primarily in teaching or clinical practice, obtaining NIH funding can be a high bar to clear. Fortunately, many institutions have alternative pathways for promotion, such as clinical or educational tracks, that can be tailored to one's career goals so that academic requirements do not limit opportunities for advancement or become a source of frustration for the faculty.

The challenges of an academic practice contribute to difficulty in the retention of junior plastic surgery faculty. Following the completion of training, 20 to 30% of training program graduates will enter an academic career. Over the next 5 years, many will then leave. The most common reasons for leaving are inadequate compensation and lack of autonomy.¹ Many feel that they did not understand what they were getting into

when they first took an academic position. The lack of understanding in terms of the pros and cons of an academic medical center and an academic career often leads to disappointment and disillusionment. Although an academic career can be exceedingly fulfilling, there are definitely trade-offs that need to be considered prior to committing oneself. Despite the fact that women represent half of the trainees in plastic surgery, female representation in academic plastic surgery has not achieved parity. The factors that contribute to the higher female academic plastic surgeon attrition and low academic leadership representation are discussed in Chapter 24.

3.7 Getting a Job

There is a well-defined process for obtaining a job in academic plastic surgery, starting in residency. (See more in Chapter 2.) Typically, in the final year of training (chief resident year or fellowship), look for academic plastic surgery opportunities advertised through the American Council of Academic Plastic Surgeons (ACAPS), American Society of Plastic Surgeons (ASPS), the American Society for Aesthetic Plastic Surgery (ASAPS), and specialist societies. Read the job solicitations very carefully as they vary greatly. Some institutions will be looking for someone to build up their laboratory efforts, while others need someone to perform specific clinical work, like hand, craniofacial, or complex microsurgical reconstruction. Know what type of job you are applying for to avoid surprises later. Ask questions up front and define both the institution's and your own academic goals during the recruitment process. Academic institutions have strict policies about the recruitment process which can take many months. Occasionally surgeons may be hired on a short-term contract when their services are needed more expeditiously and then the recruitment process for the academic position may actually start after they have started working. This process can be misleading to individuals looking for a job because some postings may not correspond to actual open positions. When investigating posted job opportunities or potential opportunities that are not advertised, enlisting mentors and sponsors can be very useful to have a more complete understanding of the market.

The next step is for the candidate to visit the institution so that each can evaluate one another. If there is mutual interest, a second (and perhaps third or fourth) visit is typically scheduled, at which point serious negotiations begin. For someone who is interested in purely clinical practice or in teaching, the candidate will want to evaluate the position based on factors including block OR time, administrative support, and the adequacy of the base salary, RVU targets, incentive structure, and projected total compensation. For someone who is interested in research, protected time and dedicated startup funds are the factors that will be absolutely essential for success. A candidate contemplating a research-based career needs at least 50 to 75% of protected time for a period of 3 to 5 years, as well as a dedicated annual research budget of at least \$50,000 (and ideally \$100,000) to set up and maintain a laboratory. Dedicated and committed laboratory space will also be required. Setting up a new faculty person for a research career is much more expensive than hiring someone for a clinical job. For this reason, a research position is unlikely to be offered to someone who does not already have a significant publication record in the basic science literature. As noted above, if one is thinking about a career in scientific investigation, it is essential during your training to have basic science experience and publications usually through a dedicated 2-year (or longer) experience in the laboratory.

In evaluating the institution, one must be aware of the different models through which academic plastic surgical centers are organized. Some are departments, and some are divisions. These relationships will factor into the long-term success of the division and of each individual faculty member. In general, it is important to have a chair who has the respect of people within the medical center and within the department of surgery. Without a strong leader, resources will invariably be removed from the division, leading to unhappiness among the faculty. In the situation where the plastic surgery is a department, the chief has much more autonomy to set up a financial package and practice structure, however they may also have less bargaining power with the dean than chairs of larger clinical departments such as Medicine.

After being recruited by the academic center, if the candidate is interested, meaningful negotiations will begin with the chief of the division/department of plastic surgery or the dean of the school of medicine, frequently with a letter of intent. Everything is negotiable, and one must make sure to get what is necessary to succeed; failure benefits no one. If all goes well, a contract will eventually be signed, at which point the stressful part really begins. The first few years in practice are critical for the long-term success of an academic plastic surgeon. During the first 5 years, it is important to identify mentors and colleagues within your division or department who can help you reach your goals. They can be within or outside of plastic surgery. Meet with these mentors often and seek their advice, protection, and clinical guidance. Appraise your progress the first few years of practice to make sure you are on track; a mentor can provide this type of evaluation. Having a mentor also adds to the camaraderie of academic plastic surgery, which is one of the nicest things about being an academic. You can spend time with a group of people with a wide spectrum of interests that are very different from yours but who are able to work together towards a common goal.

3.8 Summary

In conclusion, academic plastic surgery offers amazing opportunities to perform complex and innovative procedures, work in a highly skilled and inspiring multidisciplinary setting, teach the next generation of plastic surgeons, and use scientific inquiry to advance our understanding of our fascinating field. There are important trade-offs to understand when choosing this pathway. Academic jobs offer less autonomy to control the aspects of your practice and may be associated with time-consuming obligations. However, if one wishes to pursue excellence in clinical practice, teaching, or research, it is a rich and fulfilling practice that opens many doors that are not available to the private practitioner. In addition, academic plastic surgeons can routinely be asked to take on leadership opportunities within their institution and beyond. In this milieu of academic professionalism, the plastic surgeon not only takes care of patients, trains the next generation of surgeons, and investigates fundamental questions of science, but can also rise in leadership within the institution and societies at large.

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4 Solo Practice

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Abstract

Solo practice is a great option for the entrepreneur with a dose of optimism, a taste for risk, and touch of creativity. On the other hand, the changing medical climate with its additional costs and regulations has prompted fewer plastic surgeons to choose to open a practice alone. An option that still offers more independence than a salaried position is a small group. This chapter reviews the process that a plastic surgeon should go through in choosing whether a solo or small group is best, where to practice, and how to prepare.

Keywords: solo practice, entrepreneur, small-group practice, business plan, meeting agenda

4.1 Introduction

Choosing the type of practice to pursue after training is one of the most critical and difficult decisions a plastic surgeon will make. There are many factors to consider, and many choices to weigh: academics, health maintenance organization (HMO), large multispecialty group, large single-specialty group, small group, and solo practice. Often a surgeon's first choice does not work out or serve as a springboard, resulting in a change of course.

There may be certain traits and qualities (creativity, entrepreneurialism, and independence) that draw a doctor to the field of plastic surgery, and those same traits may also draw them into solo practice. The field of plastic surgery lends itself to solo practice in part because patients associate results so closely with the skills of a specific plastic surgeon. Physicians in other specialties are more able to field phone calls and distribute new patients to any doctor in a group. Parents are generally happy to be assigned to any pediatrician in a good group, and adults are similarly thrilled to be able to find an available internist in a well-respected group. Plastic surgery, however, is a visual and artistic field. Patients are more likely to attribute good results to an individual surgeon's unique qualities. (This may also present challenges when it comes to selling a practice at the end of a career.)

The changing healthcare landscape is having a dampening effect on solo practice. The April 2009 issue of American Society of Plastic Surgeons' (ASPS) *Plastic Surgery News* featured a cover story about the growing trend of plastic surgeons considering joining group practices in order to save money.¹ Increased numbers allow more clout in negotiating better deals, along with the sharing of overhead costs. While the majority of plastic surgeons are still in solo practice, that number has fallen by two percent annually for the last two and a half decades.¹ Nonetheless, solo practice will still be attractive to many plastic surgeons with its lack of encumbrances, including working with other independent-minded plastic surgeons that can be associated with a group practice.

4.2 Evolving Vantage Points from Residency through Practice

In a 2015 survey of residents and board-certified plastic surgeons, Koltz et al found that senior residents valued geographic location, surgical case variety, and teaching above a

guaranteed salary and incentive.² On the other hand, attending surgeons valued base salary and incentive structure as more important. Attending surgeons who are incentivized by the number of cases performed were more satisfied with their incentive structure than those based on relative value units. Incentive structure was significantly correlated with surgeons' job satisfaction. Bonuses doled out at the discretion of the chief/chair were more likely to make one feel that they were not compensated to the level their contract led them to believe. Even though academic surgeons were more satisfied than private practitioners with their case variety, they were significantly less satisfied with their incentive structure and payer mix.²

In fact, the salary associated with an academic, large-group, or hospital-based practice can be attractive for the plastic surgery residency graduate with educational debt. Despite that, solo practice is attractive because it offers freedom.³ *Plastic Surgery News* published the results of an informal poll in which plastic surgeons, most of whom were employed by hospitals, large groups, or academic centers were asked what kind of practice they would choose if they were finishing residency. Nearly 80 to 90% said they would choose solo or private practice. Almost 100% of solo practitioners responded they would choose solo practice again.³ Given that academic plastic surgeons' average salary is just 2% less than that of the average private practitioner,⁴ the greater dissatisfaction with the incentive structure may be related to limited control.

Among nonacademic career salaries, the high salaries guaranteed by hospitals for the first years of practice may not be sustainable. The level of productivity to maintain that salary may not be achievable, resulting in going solo or joining a practice when the contract has ended.³ Snyder cited a panel of hospital-employed plastic surgeons discussing their salaries.³ Salaries in the first 5 years started out dramatically higher, but private practitioners caught up by 5 years and then surpassed their hospital-based colleagues after 8 to 10 years.

Will solo practice survive while large healthcare organizations are buying up practices? We can expect the entire infrastructure of healthcare to change as tech giants such as Amazon and Apple enter the market. Even plastic surgery groups have grown, with some numbering 20+ plastic surgeons. Plastic surgery societies are developing tools to help members weather these changes. ASPS is developing new practice models for members wishing to remain in private practice. The American Society for Aesthetic Plastic Surgery (ASAPS) is providing Aesthetic Neural Network (ANN) and Surgeon as Consumer (SAC) to assist in business planning and purchasing decisions (see Chapter 18).

4.3 Location

Where to practice is a difficult decision that encompasses many factors. Of course, the most desirable areas are the most expensive and the most competitive. On the other hand, a more remote or rural setting can be more restrictive if, say, you are a microsurgeon and the hospital has no microsurgery program. Even if you are happy with all professional aspects of an area, you still need to feel comfortable in the community. After you start a solo practice, it is difficult (but not impossible) to pick up and leave to start all over again.

Once you have whittled down the area in which you would like to practice, it is time to ferret out information about reimbursement rates from insurance companies. Even if you plan to be a cosmetic surgeon, a cosmetic practice can take a few years to build up; in the meantime, you will need to rely on call stipends and insurance reimbursements to support you. Reimbursements vary greatly from region to region; the authors have seen state-to-state reimbursements for the same procedure vary by a multiple of four.

Other costs that vary tremendously include real estate, employee salaries, registered nurse (RN) wages, state taxes, and malpractice coverage rates. In a cosmetic practice, the level of training the state requires for physician extenders performing nonsurgical treatments also varies. One state may allow an aesthetician to perform a treatment that another state requires a significantly more expensive nurse practitioner. When combined, these variations can have a momentous impact on your financial security, your lifestyle, your work life balance, and your retirement savings. The easiest time to act on these variations is at the beginning of your career.

4.4 Is Solo Practice for You?

Although solo practice has been declining as a choice for plastic surgeons over the last couple of decades, it is still the ideal choice for the plastic surgeon who has a dose of optimism, an entrepreneurial bend, and a desire for independence. While the business aspect of running a practice is time-consuming, it can also be interesting and stimulating. The highs can be very high; the lows can be very low. The practice the solo practitioner builds can be a strong source of pride. As one of the last bastions of entrepreneurial medicine, it can make for an extraordinarily rewarding career.

Decades ago, when a plastic surgeon could open an office with one secretary, an appointment book, a telephone, some basic furniture, and little else, most plastic surgeons practiced solo. While solo practice still offers many advantages related to independence and unilateral decision-making, the increasing complexity of regulations, technology, and even staffing, joining forces with one or more plastic surgeons is becoming a more attractive option. According to unpublished 2018 statistics from the ASPS, fewer than half of plastic surgeons in the 35 to 44 years age range are in solo practice compared with nearly 80% of those 55 years and older, while over half of those in the younger age range are in small-group practice compared with just over a fifth of those 55 years and older (► Fig. 4.1). (Unpublished statistics, American Society of Plastic Surgeons. 2018, personal communication.)

Let us take a look at the advantages and disadvantages of a solo practice and a small-group practice:

Advantages of Flying Solo

- Ideal for those with an entrepreneurial bend. Some people enjoy the excitement and creativity of developing a business plan; setting 1-, 3-, and 5-year goals; and developing their staff to deliver exceptional customer service.
- No partner to compromise with. Even the simplest decisions can become contentious if they are being made by more than one person.
- Practice name can be Your Name (identifiable). Until you try to sell your practice, hanging a shingle that carries your own name is an effective way to get your name out there.
- Have control of mission/values/culture/hiring/firing.

Disadvantages of Flying Solo

- Difficult starting out in debt and without board certification.
- Limits idea-sharing.
- May be lonely.
- Tough if pregnant, disabled, or on a long vacation.
- Expensive—you have no idea.

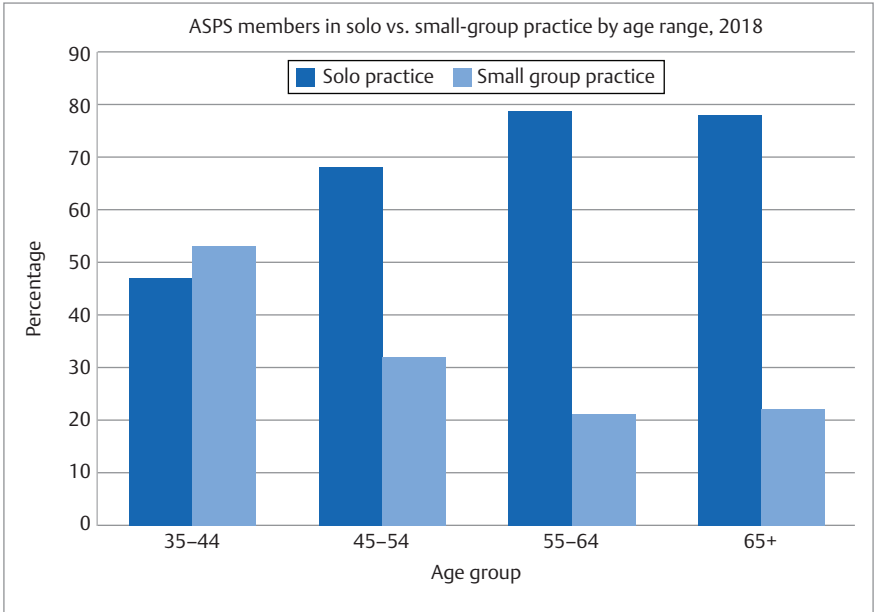


Fig. 4.1 A comparison of solo versus small-group practitioners, based on a 2018 survey from the American Society of Plastic Surgeons.

Advantages of a Small Group

- Can share ideas and connect with a mentor.
- Call coverage easier to find when you want to leave town.
- Less financial risk if pregnant, disabled, or on vacation.
- Technology purchases less onerous.
- Share overhead.

Disadvantages of a Small Group

- It is like a marriage and may disintegrate.
- Buy-in may not be fair and equitable.
- Colleagues may not be clinically and ethically compatible.
- You may bear legal liability by association. If a partner gets sued, you can be sued too. (Example: Partner having an affair with an employee.)
- If you join a core specialist who is not a board-certified plastic surgeon, you may be reduced to a “general” or a “body” plastic surgeon.

4.5 Elements of a Solo Practice

4.5.1 Entrepreneurship

The entrepreneur will naturally be attracted to a solo practice. Entrepreneurs tend to be optimists, which helps in tolerating the financial risks taken on when starting a

practice and when making major purchases. Generally, the plastic surgical resident is brimming with confidence in his or her future financial prospects. He or she has been told, "There's always a need for someone well-trained like you. With your great personality, you'll do great." Few people warn that there are actually a lot of well-trained plastic surgeons, most of them having more experience and established connections. The world may, in fact, not necessarily be waiting for your hard-won knowledge, superb judgment, and excellent hands. *You* may not know that, but the banks do. We remember meeting with bankers soon before starting a private practice, and how stunned we were to find how difficult it was to borrow money along with the reluctance of bankers to make this crucial loan. It was only after starting the practice and learning the phenomenon of delayed payments and "usual and customary" underpayments that we understood the bankers' reluctance.

As an entrepreneur, however, the solo practitioner can change his or her practice without consensus, permission, meetings, lawyers, etc. A creative, energetic person can take failures and impediments and turn them into opportunities for change and improvement.

Your choice of an entrepreneurial versus a salaried practice may be partly determined by personality. The entrepreneur is more reputation dependent, whereas the salaried plastic surgeon has a captive audience of patients.

4.5.2 Independence and Responsibility

One of the most attractive elements of a solo practice is independence. You are truly your own boss. If you want to take Wednesdays off, you can (finances permitting). If you need to take off early to pick up your children, you can. Practice decisions are entirely yours. If you decide to purchase a new laser, no one but the bank can tell you no.

The flip side of independence is responsibility. If business is slow or reimbursements are inadequate, the surgeon is the last one on the food chain to be fed. Not taking a paycheck home for a few weeks or longer is stressful. While everyone else in the office is working a 40-hour week, the solo practitioner is the one having to come into the office on weekends and stay late on weeknights trying to turn things around.

4.5.3 You are the Boss

As much as surgeons love to operate, if you are a solo practitioner, you have another very important and potentially time-consuming job: being the boss. In previous decades, being the boss was easy because the practice of medicine was less complicated. As the practice of medicine has become more complex, office staffs have expanded duties, responsibilities have grown, and the job of being a boss has grown as well.

Not all plastic surgeons are born with the gift of managing people. Those who fall short in this skill would be wise to hire a sharp, creative, people-savvy office manager who will, you hope, be trustworthy. Whoever manages the practice should have people skills and psychological insightfulness. Both traits promote a smooth-running office. Most of us were never coddled in residency, so the idea of positive feedback, gentle education to correct errors, and team spirit may not seem like necessary ingredients of a business. The real world is, however, different from a surgical residency, and learning to inject a dose of patience and kindness becomes easier when you realize that happy employees make for a better bottom line.

4.5.4 Writing a Business Plan

If you are starting a solo practice or if you are starting a small-group practice with one or more colleagues, you should know how to write a business plan. While a bank may require a business plan before extending a loan, the process of analyzing your practice opportunities and challenges, reviewing your financial needs, developing a marketing plan, and forecasting your revenue stream can serve as a compass.

Any effective business plan should state in detail what the opportunity is (e.g., offering new techniques, new technology, or unique expertise), who the customers are, why competitors should be alarmed by your arrival, and how the company operates and earns revenue. Refer to Appendix 4A for a business plan outline.

4.5.5 Networking

Being in solo practice can be lonely. Without other physicians in the practice, it is possible that the solo practitioner is the only person in the office with a college degree. Besides, being the boss of all the other employees requires a certain distance between the doctor and the office staff. It is unlikely that the boss will go out with the rest of the staff on a regular basis to “happy hour” or to the movies. Everyone should, of course, get along, but the person who pays the staff and can fire the staff is generally not the best candidate for an employee’s best friend. This distance ensures that if a problem arises, it can be resolved with less emotion.

Because being at the top can be lonely, it is important to network with colleagues. Plastic surgical colleagues naturally have the most in common professionally. Sometimes local relationships can be fraught with the barbs of competition, but jealousy is best buried to allow friendships to develop. It is ironic that the people who have the most in common often have very little to do with each other and are sometimes incommunicado. It takes a mensch to accept a competitor’s advertisements, success, and public promotions as a necessity of doing business that does not cloud a friendship. Networking with friends from one’s residency, from meetings, and from the hospital allows sharing of practice “pearls” or advice on clinical cases, and general discussions about plastic surgery. Plastic surgeons would do best to view each other as colleagues rather than competitors. It prevents manipulative and/or dishonest employees from moving from one practice to another, only for the next plastic surgeon to realize that they should have checked with their neighbor first before extending an offer of employment.

Becoming involved in organized medicine, whether at the local level or at the national specialty level, can be fulfilling while also promoting social connections. Volunteering in local clinics, residency training programs, medical missions in developing countries, etc. are other ways to become part of a larger tapestry of medicine. We are fortunate to be a part of a specialty that allows so many opportunities.

4.5.6 Hospital and Emergency Call

Hospital privileges are important to obtain early on as there is little a surgeon can do without access to an operating room. Find out about proctoring and on-call requirements, if any. Proctoring can be difficult, depending on the community, and some areas have abandoned it altogether. If there are few hospitals and few plastic surgeons in the area, scheduling a case in a hospital with an available unpaid proctor can be difficult.

The proctor may be reluctant to help a new competitor become freely ensconced in the medical community. In addition to hospital on-call requirements, associated stipends and/or reimbursements may impact your consideration of an area for opening up a practice. Some hospitals provide a stipend to take call, while other hospitals still require call without paying anything for the service. While a stipend may help, especially early in one's career, the impact that call has on one's elective practice, not to mention one's personal life, must be considered.

Once a doctor agrees to be on a formal call schedule, he or she must comply with the laws described by the Emergency Medical Treatment and Labor Act (EMTALA).⁵ State laws vary regarding on-call duties. In California, if a physician is on call for the Emergency Department (ED), he or she is considered to be available at the hospital. Thus, taking emergency call would obviate the ability to do surgery in one's own facility. Exceptions are made for surgeries done in hospitals. If the plastic surgeon (or any physician) is on call while seeing patients in the office, the ED physicians are legally prohibited from referring an ED patient to the plastic surgeon's office or other facility to be evaluated and treated. In California, any on-call physician who is in violation of the above policies may be subject to fines of \$50,000 and possible exclusion from Medicare and Medi-Cal (California's Medicaid) programs, especially with repeat offenses.⁵

Society's tolerance for demanding and accepting superhuman work schedules of their doctors may be coming to an end. Already, residencies are officially restricted in the number of hours that they can require their residents to work in a week, a move supported by research on physicians-in-training.⁴ (Unpublished statistics, American Society of Plastic Surgeons. 2018, personal communication.) Sleep deprivation has been demonstrated to impair physician performance. Weinger and Ancoli-Israel's meta-analysis indicated that recurrent sleep deprivation impacted mood, cognition, and motor abilities.⁶ The liability of doing a delicate case after 24 hours of taking call and doing emergency cases will undoubtedly increase as the results of sleep deprivation studies enter the courtrooms. While large groups may be able to allow a day of rest after a night of call, the solo practitioner is generally not in a financial position to be able to do so.

In some communities, taking call can result in a loss of income. Patients may be unfunded or underfunded, yet the surgeon must pay for postoperative care in his or her office, including staff time, dressing changes, sterilized instruments, etc. The days of financially jumpstarting one's practice by taking call are ending or have ended in many communities, unless a workable stipend is provided.

It is important to find out the economic viability of taking call in your community before committing to a formal call schedule. Working with the hospital for some sort of remuneration for taking call should help defray losses and may support your practice economically. Additionally, it is important to negotiate other aspects of on-call duties. Some hospitals have an age limit after which physicians do not have to take call. However, medical executive committees have been known to put a hospital's interests foremost and can change that age limit arbitrarily if there are too few people taking call. On-call requirements can last until the age of 60 years. Another issue to negotiate is determining who is responsible for finding on-call coverage during periods of unavailability. Physicians have traditionally taken on this responsibility. Failure to find coverage can result in the surgeon's inability to attend a meeting, a wedding, or other important events. In a small community with few other plastic surgeons, finding coverage can be an onerous task. Hospitals have the staff and resources that individual physicians do not have. Furthermore, individual specialties are not required to provide call every night as

long as the hospital has a plan for treatment of a patient requiring that specialty's care (such as transferring the patient to another hospital).

Early on in private practice, most plastic surgeons are not saddled with the costs of a large office, a private office ambulatory surgery center, and a large staff. At this early stage, when the overhead is relatively low, taking call can help pay the bills if a stipend is offered or if the demographics allow payment for services rendered. Once the overhead increases, however, the time that call takes away from one's elective practice can impact the ability to generate the income necessary just to break even. For example, if one's overhead is \$30,000 per month, the plastic surgeon needs to generate \$1,500 every weekday to stay in the black. Accounting for vacations, paid staff holidays, and meetings, that leaves even fewer work days for the plastic surgeon to generate income. If the surgeon is available 15 work days a month, he or she must bring in an average of \$2,000 per day to stay afloat. Thus, a stipend and reimbursements from ED cases may make financial sense early in one's practice, but later on, taking emergency call can result in a loss of income. Find out what your on-call duties will be not just when starting out, but a few years into your practice.

If you decide to put your name on a formal call schedule, the hospital should have a clear schedule that has specific dates and times in which call is taken. You could be liable if there is any question by the hospital as to who is on call at a specific time. If another physician is covering your call for a few hours, it is crucial that the hospital be formally informed, as failure to do so can result in liability.

Large, competitive communities will be less affected by on-call duties, especially if call is less frequent or if it is not a money-losing activity. Taking call is a valuable service to the community and is a great way to pick up cases, especially when just getting started. However, it is important to make sure that all the responsibilities and liabilities taken on by a physician are clear before blindly agreeing to take emergency call.

4.5.7 Family and/or Hobby Time

As more women become plastic surgeons, as more male plastic surgeons have working wives, and as more men in general spend more time running the home and raising children, the amount of time one can take off is an important consideration. Solo practice is beneficial in that the surgeon can determine his or her own hours. Unfortunately, the overhead must be covered every month. For women who plan to have children in the future, the most difficult struggle is how to afford not to work during any difficulties in pregnancy and delivery. If one is the main breadwinner, the stress is especially acute. Finding a good childcare option is extremely important. Considerations must be made for emergencies, cases that go later than anticipated, ED on-call duties, and if one's child is sick. Generally speaking, having children is not a boon to the pocketbook, but that does not seem to deter many people from having them. For those who want to be active in their children's lives, the income takes a further hit. Volunteering in schools, coaching sports teams, driving on field trips, and being available to pick up one's child or children after school, all take time away from professional productivity. Staying afloat financially while devoting time to the kids requires remarkable efficiency. All these factors should be considered before embarking on building an outpatient surgery center or a medical spa. Those enterprises require huge monetary outlays and have huge overheads, and their management requires a lot of time. For most solo practitioners, it is generally best to keep the overhead as low as possible to accommodate their families.

4.5.8 Developing a Practice

Some hospitals are willing to help a physician establish a practice through loans, an income guarantee, or support in marketing and promotion. This assistance clearly varies by community and is likely to be absent in a competitive area. Nonetheless, a discussion with the medical staff office is worthwhile.

A bank loan is necessary for all but a lucky few to fuel a nascent medical practice. A loan of \$300,000 to \$400,000 or more may be necessary to cover the costs of starting a solo practice. Banks will, of course, want to see a business plan. Drawing up a business plan can be daunting for a person who has never started a business before, but banks can often provide an outline to serve as a guide. Please refer to Appendix 4A to find an example of a business plan outline. Society meetings, such as those held by the ASPS and ASAPS, often have courses offered by consultants who specialize in plastic surgery. These consultants are usually very expensive and may be out of reach for a plastic surgeon right out of training, but they can be very helpful. Ask for references if you decide to hire one.

Most plastic surgeons begin their practices doing emergency cases and reconstructive surgery. Depending on one's interests, it is important to let the patients know of the other procedures that you do. Marketing and monitoring can help your practice grow.

Established patients will be your best source of future revenue. Keeping contact with them through e-newsletters, social media, seminars, open houses, patient appreciation events, etc. will be more cost-effective than trying to bring new patients in from the world at large. There are a number of resources for internal marketing, some of which are mentioned later on (see Chapter 10).

4.5.9 Staff

When first starting out, the most essential person to have is a receptionist. When patient flow is slow and there are few cosmetic patients, the receptionist can double as a patient coordinator (PC), giving price quotes and following up with patients.

Training your staff is an investment in your success. Unfortunately, the person who has spent most of his or her adult life training to be a plastic surgeon is generally not well versed in training staff. Consultants specialize in training. Ask around to get a personal recommendation from a colleague who has a well-run practice.

In the past, plastic surgery practices often hired RNs to stock rooms, take out sutures, etc. As RNs have commanded higher and higher wages in some regions of the country, some receiving greater hourly compensation than primary care physicians, hiring one may be prohibitive. A good medical assistant can do many of the things that an RN has historically done in a plastic surgeon's office. Those services that fall under the purview of an RN may be able to be scheduled 1 or 2 days a week.

4.5.10 Billing

Many practices use a billing company. The billing company collects a percentage of the physician's reimbursements. As electronic health records (EHRs) become more prevalent, online billing software is becoming increasingly popular. A Google search of "medical billing software" brings up a list of different brands of software, most of which are on-demand, Internet-based, and integrated with specialty-specific EHRs. As software is constantly improving, both for EHRs and for billing, online reviews and personal recommendations will help in choosing the best system.

4.5.11 Relationships and Referrals

In most professions, referrals are based on financial incentives. Commissions, kickbacks, finders' fees—call it what you will—are based on money. In medicine, fee splitting is illegal to protect the patient from decisions based on financial incentives. Multispecialty groups have found legal ways around this, since physicians within these groups refer to each other, and bonuses and salaries come from productivity within the group.

In solo practice, referrals come from relationships, and building these relationships is important in medicine. Even in a hard, cold environment with competitors and difficult hospitals, it is worth reaching out to physicians in your community. When you enter a community or even if you have been there for a while, an email or a holiday or thank-you card is worth the effort to keep your name out there. Attending conferences in hospitals or giving talks to groups of physicians are common ways new physicians increase their exposure in the medical community. Referrals for reconstructive procedures need to be filtered through the insurance web of approval, but thank the referring doctors.

In cosmetic surgery, many referrals come from other patients and allied professionals. It is just as likely that a potential patient will listen to her hairdresser as to her internist. If you want to continue to build a network of referral sources, it is wise to get to know personal trainers, aestheticians, hairdressers, and other individuals who are likely to be seeing potential patients. If you develop good relations with these people, they may permit you to put your brochures or business cards in their places of business, which only helps to widen your referral net. Whatever techniques you choose to use, do not forget the code of ethics of the American Board of Plastic Surgery (ABPS) and the ASPS. It is wise to read these because your competitors most certainly will.

4.5.12 Location

It may take 2 to 5 years to build a private practice, so it is much more difficult to pick up and leave and set roots elsewhere than if you left one salaried position to accept another one elsewhere. If you do not like a geographic area or if you have to move for a spouse's new job, it is best to leave early when your practice and overhead are still small.

4.5.13 Small-Group Practice

It is common for a young, new associate to be disconnected between the amount of revenue he or she brings in and the amount he or she is costing the new employer. While the new associate is developing a referral base, the practice is paying for a compensation package, malpractice, website updates, marketing, office space, a computer and software licenses, support staff, and more. It typically takes 2 years for the small-group practice to break even after hiring a new associate. New associates can command salaries in the \$300,000 to even \$500,000 range out of training for salaries positions. Of course the business model for a large institution paying a salary to cover patients who may be on a waiting list is very different from a private practice. The new associate may not appreciate the lower salary offered by a private practitioner, typically \$150,000 to \$350,000, who has a financially solid practice and a business plan to get you started, as a starting point. Through entrepreneurial efforts, this arrangement may work out better financially over the long term than starting with significantly higher salary at a large institution. It is natural for the new associate to feel underpaid and for the senior

associate to feel the younger surgeon is not working hard enough. Both parties should look at the practice numbers and the trajectory over the next 2 to 3 years and beyond.

4.5.14 Hiring Staff

- Hire slowly. Fire quickly.
- Fire: Get rid of position, reduce hours.
- Bad employees bring down the morale of good employees...who may quit.

Before you hire anyone, decide what staff positions you absolutely need. Hire slowly and fire quickly. To start, you will need someone to answer the phone. That job title might be “receptionist” or “front office coordinator.” Often wrongly considered to be a low-level position, the receptionist is your face to the public. She knows when to transfer a call and to take down the caller's name and phone number before pushing that hold button. Choose front office staff based on smartness and personality, not medical experience. You can teach the medical information, but you cannot teach personality.

If you plan to do a significant amount of cosmetic surgery, you should consider hiring a PC, sometimes called a *patient care coordinator* (PCC). When a patient calls your office and asks how much a breast augmentation costs, you do not want the person who picks up the phone to answer, “\$6,999.” End of conversation. The PC should be well trained in how to provide the information the patient really wants to know. She wants to know that the surgeon is certified by the ABPS, has done thousands of breast augmentations, uses the latest implants, was trained at well-known University Medical Center, and uses an accredited facility because patients' safety is the surgeon's number one concern.

You may start out as your own *practice manager*, but when your practice is busy, you would not have time to negotiate better terms with credit card companies, arrange for the heating, ventilation, and air conditioning (HVAC) people to come fix the air conditioner, screen new hires, and manage the other staff while you are in surgery or seeing patients all week. Your practice manager should not only be organized and analytical, but also have people skills. She should be efficient and capable of identifying ways to save the practice both time and money. A good practice manager stomps out drama in the office. At the same time, “trust but verify” is important when dealing with any employee. The definition of *embezzlement* is theft by a trusted employee.

Knows others' success = her success. To find someone, you can advertise on a number of companies. Titles you might consider, in addition to *practice manager* include *practice administrator* or *chief operating officer*, depending on the size of your fiefdom.

Other positions to consider are medical assistant, licensed vocational nurse, registered nurses, nurse practitioner, or physician's assistant. The busier you get, the more you will need to maximize your time so that you spend your time doing tasks that require an MD degree. Of course, anytime you hand off a duty, such as suture removal or calling a patient to see how she is doing after surgery, you will need to thoroughly train the person representing you.

Job Descriptions

Write a job description for every position. An effective job description is comprehensive but succinct. Organizing the text with headings and bullets makes it easy to edit. Clarity

is essential. Define specific duties and available tools to carry out those duties. Tools could include practice management software, a laser, available online webinars, or the practice's training manual. Each employee should review and update her job description annually. That way if her husband suddenly gets a transfer to another state, you would not be saddled with reconstructing all the duties she has taken on and the others she no longer does since you hired her 8 years ago.

At annual or quarterly performance reviews, each employee should be given specific, objective, and measurable goals. For example, if your PC books 10 patients for surgery out of every 50 patients she quotes, her goal may be to increase her conversion rate from 20 to 30% in the next quarter. She is unlikely to improve if she has not had any training. If she has potential, she might benefit from being sent to a course or from hiring a consultant. If you support your employee, she will be more likely to be able to meet her goals.

Screening Job Applicants

What skills do you want your new hire to have? Most plastic surgery offices will require some basic arithmetic and writing skills. A basic worksheet given for job applicants to fill out with the help of a calculator can screen out those who have not mastered sixth grade math or writing skills. Sample questions include finding 10% of a number and 5% of another number, calculating the average of five numbers, and writing a paragraph on a favorite movie, book, or vacation spot. If an employee is unable to utilize a calculator or write in complete sentences without misspellings, she is unlikely to be a good fit. Have the applicant display computer skills as well. If working with Excel, PowerPoint, Word, or social media is part of the job description, develop screening exercises to test familiarity with those digital tools.

Employee Handbook

Create an employee handbook with the help of a lawyer who is familiar with your state's labor laws. Each new employee should receive a copy before they begin their employment. Topics covered range from work hours, conduct, and dress to pay periods, Health Insurance Portability and Accountability Act (HIPAA), Occupational Safety and Health Administration (OSHA), and paid time off. When the handbook is updated, new copies should be distributed to all staff. Include your mission statement and your values that help define your company culture.

Onboarding New Hires

Onboarding involves teaching employees the knowledge, skills, and company culture to function effectively. Starbucks sends their new hires to Starbucks University, but most plastic surgeons have to cobble together their own training program, and that takes time. In the ideal world, we could send our staff to a Plastic Surgery Staff University to learn how to answer a phone, deal with difficult patients, run a staff performance review, and take out sutures, but nothing like that exists. Fortunately, there are consultants who can help. While staff training is not cheap, not training your staff is indirectly even more costly.

If an employee looks promising after clearing the worksheet, computer skills test, interview, and references, you can invite her back for a working interview during which time she is paid. If she performs well, and you hire her, the first 3 months of

employment can be established as a probationary period. During this time, the new employee should demonstrate that she is punctual, respectful, dresses appropriately, and takes initiative.

Policies and Procedures

Over time you may find repeated staff errors may drive you to establishing a resource that can serve for training new employees and refreshing established ones. The more duties you hand off, the more you will probably see the need for consistent staff education. For example, some day you may find you have better things to do, like adding on another case, than taking preop and postop photographs. No one else in your office has gone through a plastic surgery residency and presented photos as part of an oral board examination, so you are likely to be the only one with the necessary critical eye...until you train someone else to understand consistency of position, framing, background, and lighting.

Ask a staff member to take notes from webinars, conferences, and training sessions with a consultant. These notes can serve as the beginning of your training manual. The manual can be written, in webinar form, or a series of videos. Allow employees time during the day to read or watch the material. Then test them on their knowledge.

4.5.15 Your Practice Culture Begins with You

You are the star or one of the stars of your practice. The spotlight is on you, even when you are stressed. The staff is watching you. Be kind. Compliment them when they do something well, and address serious problems in person, not by email.

4.5.16 Financial Aspects of Your Practice

To really understand your practice numbers, you should have a basic understanding of financial statements. Even if you have an accountant, you will have a much better grasp of your business numbers if you can decipher a balance sheet, an income statement, and a cash flow statement. Several excellent resources are listed at the end of this chapter. The better you understand your finances, the better you will be able to do, and more solid your practice decisions will be. Purchasing decisions should be based on sound metrics, not just gut feelings.^{7,8} The 80–20 rule states that 80% of your practice revenue likely comes from 20% of your patients and can guide your marketing plan. Each patient who consults with you is associated with costs: marketing, supplies, linens, photography, staff time, and your time. You pay an opportunity cost for the time you spend seeing patients who do not book surgery. Even if you do not have a waitlist of people waiting to move up on your consultation list, you could be using that time to create a video, write an eBook, or go for a walk for your health and peace of mind.

When a patient books surgery with you, figure out the revenue per hour. If an abdominoplasty fee is \$10,000, and it takes you 2 hours, your hourly revenue is \$5,000. If a facelift fee is \$15,000, and it takes you 5 hours, your hourly revenue is \$3,000. If you take your cases to a surgery center or a hospital, subtract additional costs (such as implants) from the revenue.

$$\text{Revenue} - \text{Cost of Goods Sold} = \text{Profit}$$

If we divide both sides by the duration of the surgical case in hours, we arrive at the hourly profit.

$$(\text{Revenue} - \text{Cost of Goods Sold})/\text{Time} = \text{Profit}/\text{Time}$$

Of course, your profit is actually your operating income, which you will use to cover your practice expenses. If you own your own operating room, you need to subtract all costs, including anesthesia, staff, supplies, operating room costs, and recovery room costs.

$$\text{Revenue} - \text{Fixed Costs} - \text{Variable Costs} = \text{Operating Income}$$

Paying all expenses in your own operating room can teach you the value of a quick turnaround time, efficient surgical skills, and well-trained surgical technicians who put the appropriate tool in your hand before you ask for it (see Chapter 18).

4.5.17 How to Run a Meeting

Well-run meetings are the best way to communicate. Because they make a demand on so many people's time, meetings are costly to a business. The longer a meeting is, and the more who people attend, the more expensive it is. If your meeting lasts an hour, you are paying for every attendee's total hourly compensation package. If there is no reason to hold a meeting, cancel it or use the time for role playing, training, or practicing skills.

To maximize efficiency, only those who need to attend should be invited. Others can put their time to better use. The agenda, the minutes from the previous meeting, and additional information should be emailed to invitees ahead of the meeting.^{9,10,11} Simple announcements do not need to take up valuable meeting time. Everyone should read the attachments *before* the meeting. The meeting can commence with questions and comments about the attachments and approval of the minutes or correction of any errors.

The agenda should have a stated purpose.⁹ If you cannot articulate a purpose, then there is no reason to have the meeting.^{10,11} Develop a list of topics and assign a presenter and specific duration in minutes for each one. If a presenter runs over, the topic can be continued at another time. If a speaker runs off on a tangent, the facilitator or meeting leader should interrupt with an agreed-upon signal, such as "one minute left" or "time" or something humorous like "Peter Pan." (Refer to Appendix 4B for a meeting agenda.)

Any props that will be needed should be gathered well in advance. The meeting should start precisely on time without delay, and, while it is fine to end early, it should not extend beyond the allotted time. Meetings should be scheduled for the minimum time possible. If someone brings up a topic that is not on the agenda, put in the "parking lot" to be added to the agenda of the next meeting or to cover at the end if there is any time. Only urgent matters should derail the meeting's agenda. With advance preparation, emailing information in advance, and timing presenters, a half-hour meeting may be able to accomplish the same thing as an hour-long meeting without efficient planning and timing.

Meetings should be arranged so everyone sees each other. Arrangements to consider are a to arrange chairs with no tables in a semi-circle around the presenter. Alternatively, people can stand in a semi-circle. If attendees are sitting around a long conference table, it is easy for people to hide behind someone else or be overlooked. The staff should be well-versed in the mission and values of the practice and carry out the objectives by aiming to achieve goals. Andy Grove, former chairman and CEO at Intel

pioneered the use of Objectives and Key Results (OKRs).¹² The “Objective” is the strategy, and the “Key Results” are the measurable tactics to get there. Any goal must be associated with a deadline. John Doerr, venture capitalist with Kleiner Perkins, adopted OKRs and describes how effectively they can be used to increase the growth of a company in his book, *Measure What Matters*.¹³

The last part of a meeting should be a wrap-up. Review next steps, which generally include action items, who is in charge of them, and when the deadline is. Particularly if the meeting was unique in some way, you can discuss in what ways the meeting went well and in what ways it could be improved. These are called the *pluses* and *deltas*. Finally, giving a shout-out to recognize different employees' specific accomplishments or achievements can be an inspiring way to end the meeting. The goal of a morning meeting is to instill excitement for the day's work ahead.

It is tempting to address a problem by presenting what happened and telling the group what to do. Avoid lecturing in a top-down way to attendees. This approach allows clear communication of the needs of the practice, but it is unlikely to get team buy-in.

4.6 Monitoring Your Practice

You can measure how many consults you see and how many of them have surgery. You can measure your revenue, and you can measure your expenses, but how do you measure the soft skills, like how your staff answers the phone? After all, the person answering the phone creates an impression of your office and ultimately represents you. No one should be assigned to answering phone calls without basic training. Even with that training, best practices may be forgotten. The only way you will really know how well (or poorly) your staff is answering the phone is to hire a *mystery shopper*. There are several consultants who offer the service, and you may be able to find one by word of mouth or in the Exhibit Hall at a national plastic surgery conference. More important than the score and the evaluation is the recording itself. Does the receptionist sound too serious? Give her a mirror so she makes sure she is smiling when she answers the phone. Does she ask the caller's name and number before transferring the phone to the PC? Does the PC go into surgical details, even though she is not a plastic surgeon and has never examined the patient? Each step to a phone call must be taught.

4.7 Marketing

You will find much more information about marketing in other chapters, so we will just simmer the information down to the two things that are most important to a patient searching for a plastic surgeon: before-and-after photos and online reviews. You have control over photos, as long as your patients give you written permission, but reviews are quite independent of the doctor.

4.8 Conclusion

Starting a solo practice offers many advantages in terms of freedom, but it comes with responsibilities. There are financial and personal rewards, but there are also financial and personal risks. You will be more successful if you have an entrepreneurial spirit along with good organizational and managerial skills.

4.9 Appendices

4.9.1 Appendix 4A

Business Plan Outline

1. Executive Summary
 - Purpose of plan: Describe why there is a need for your business and what your company does.
2. Background
 - Experience, qualifications: Give an overview of you and your team, and describe why you are ideally suited to build your business.
3. Business Charter
 - Description of product(s) and service(s).
 - Unique selling proposition: Mention any new technology, new techniques, or other marketing angles.
 - Targeted market niche: Describe the market segmentation (e.g., women ages 18–50 years).
4. Market Analysis
 - Characteristics: Suburban with few competitors or urban with stiff competition.
 - Market factors: Income level, education level, average age (e.g., retirement community vs. young technology workers).
 - Competitive evaluation: Describe your competition and what about you is unique enough to attract customers.
 - Market potential: Anticipated population growth; unique services or procedures you will offer that your competitors do not; personal characteristic that distinguishes you (e.g., being the only Spanish-speaking Hispanic in a community of Latin American immigrants).
5. Marketing Plan
 - Sales forecast: Anticipate your sales, gross margin, and net profit for each of the first 5 years.
 - Selling strategy: Describe the different layers of your marketing strategy, including events, patient education webinars, and videos.
 - Strategy statement: State your objectives for the first year of operation. Identify a new technology or procedure you will offer that is not currently offered in your area. Aim to increase the number of operations you do by a given percentage within a year. Develop a comprehensive website, and keep no-shows on clinic day down to less than 5%.
 - Price: Describe your pricing strategy and anticipate monthly sales month by month and by years.
 - Advertising and promotion: Describe your website plan (chat application, virtual consult), social media, newsletter, and events.
 - Product/service warranty: Describe the policy on revision surgery, skin product warranties etc.

- Keys to success: Identify how you will distinguish yourself to patients (excellent care, patient education, and customer service), how you will motivate staff (e.g., profit-based incentives), and how else you will distinguish yourself (e.g., Saturday hours, no wait times, easy parking). Finally, identify how the practice will thrive financially by keeping overhead low and optimizing inventory.
6. Operation Plan and Organization
- Legal form/ownership: Type of practice (e.g., sole proprietorship, S-Corp).
 - Ownership: List the owner(s).
 - Labor force: Describe the employee positions you will fill (e.g., one receptionist, one practice manager, one medical assistant, and one nurse).
 - Management compensation: Describe the package, including salaries, bonuses, health insurance, and retirement.
 - Training: Describe your onboarding process and how you will continue to train established employees in-house as well as through courses, seminars, and consultants.
 - Professional support: Describe the doctor's continuing education and the staff's in-house training methods as well as employee education through webinars, conferences etc.
7. Financial Plan
- Startup costs: Document your startup expenses, assets, investments, and loans. Summarize what the costs are for, such as furniture, a computer system, telephones, supplies etc.
 - Sales forecast (cash flow analysis): Develop a pro forma profit and loss, a pro forma cash flow, and a pro forma balance sheet for years 1 to 5 of practice.
 - Startup capital: List capital needs, such as medical equipment, office supplies, furniture, insurance, and marketing.
 - Monthly expenses: Anticipate payroll expenses, including all benefits and taxes; marketing; depreciation; medical and office supplies; janitorial services etc.
 - Breakeven analysis: Based on anticipated expenses, determine the monthly revenue necessary to break even, then based on your projections, determine the number of months after opening you anticipate your startup practice will break even.

4.9.2 Appendix 4B

Meeting Agenda

Time: 08:00–08:25 on Designated Date

Invitees: Name only those who need to be there. If the meeting is about how to remove a drain, only the nursing staff need attend.

Purpose: Every meeting should have a clearly articulated purpose.

Preparation: Please read this agenda and the other attachments before the meeting. Meeting time should not be taken up with sharing routine information.

Meeting Agenda			
TIME: 08:00–08:25 on Designated Date			
INVITEES: Name only those who need to attend			
PURPOSE: Articulate the purpose of a meeting			
PREPARATION: Please read this agenda and the attachments before meeting			
Topic	Duration	Leader	Process
Introduction to new meeting format	5 minutes	Name 1	Presentation
Questions/comments about information sent with agenda	2 minutes	Name 2	Q&A
Changes/approval minutes from last meeting	2 minutes	Name 3	Group
What makes a good meeting?	5 minutes	Name 2	Brainstorming
What makes a bad meeting?	5 minutes	Name 2	Brainstorming
Suggestions for next week's agenda	2 minutes	Name 1	Brainstorming
Pluses and deltas	2 minutes	Name 1	Group
Information—See attachments: 1. Minutes of previous meeting 2. HBR article on creating an agenda	Read before meeting		

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5 Group Practice

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Abstract

Group practice in plastic surgery offers significant advantages in today's changing medical landscape. In addition to consistent patient coverage during time away, and colleagues to confer with, group practice offers economies of scale and shared financial risk. Compromise and a good contract are vital to ensuring practice longevity.

Keywords: group practice, negotiating power, shared risk, compromise, contract

Editors' Note

For this chapter we asked experts from three different parts of the United States to weigh in on the inner workings of a group practice in plastic surgery. This chapter is a composite of their valuable experience and wisdom. Several sample employment agreements are provided at the end of the chapter.

5.1 Introduction

Physicians in general tend to be highly intelligent, autocratic, Type-A individuals. Plastic surgeons add artistry and creativity to the mix, explaining why most plastic surgery practices are solo in nature. Chances are that most of us worked closely with those above and below us on the training ladder, but almost never had to work cooperatively with those at our same level of training. So why would plastic surgeons want to put themselves in a position that requires close cooperation and significant compromises with other surgeons?

5.2 Advantages of Group Practice

Joining an established group has obvious advantages for the young physician. Historically, most plastic surgeons in private practice have been solo practitioners, but that is dramatically changing: \$300,000 to \$400,000 typically covers 2 months of operating expenses, and a revenue stream does not start for weeks or even months. (See Chapter 2 and Chapter 4.) Joining a group, on the other hand, limits your financial liability so you can focus on building a patient base.

A plastic surgery group practice offers camaraderie and a ready second opinion from a colleague. After-hours call is shared, and your patients' care is reliably covered during vacation, educational leave, pregnancy, or illness. Those that have an aesthetic fellow can more easily teach, hold a monthly journal club, perform research projects, and cover after-hours call. Group practice is like being in an academic practice without the politics or committee work obligations.

Financial advantages include purchasing power to obtain better pricing for everything from medical supplies to marketing to retirement account options and insurance coverage (including malpractice). The larger the group, the greater the discount, generally starting at 5% for a group of 5 to a maximum discount of 30% for group of 30 or more. Other financial advantages of a group practice include:

- Efficient use of office space, equipment, and staff.
- The power to negotiate more favorable contracts with third-party payers, hospitals, and group purchasing organizations.

- Better predictability of regular expenses.
- Potential for highly effective marketing campaigns for group branding.
- The stability and reputation to draw potential desirable new members and staff.
- Greater cost efficiency in an accredited, private surgical facility utilized by all members of the group.
- Potential for the younger surgeons to get busy faster through effective marketing of an established group and in-house referrals.

5.3 Disadvantages of Group Practice

Of course, these advantages come with significant drawbacks. Group decision making is by consensus or vote, so partners will not always get what they want. Invariably, one partner will bring in more revenue or work harder than another. Unlike other surgical specialties, most plastic surgery practices have a payer mix of cosmetic and insurance patients, which introduces a wide array of variables, including workload, practice mix, practice settings, and reimbursement models. Consequently, what works for groups in insurance-based specialties (like orthopedics) may not apply to plastic surgery. Furthermore, group practices may disagree on the income distribution resulting from revenue-generating physician extenders or medical spas, real estate, and surgery centers that the group owns. Dissent can also arise over equitable distribution of expenses, utilization of resources (like staff, space, and equipment), and the ethics of various marketing strategies. It is no surprise that reimbursement, workload, and ownership disagreements often present the greatest challenge to a group's success.

A partner who becomes embroiled in litigation or bad publicity can negatively impact the group. Furthermore, if a partner harasses staff, all partners bear legal responsibility exemplified by the multimillion-dollar settlements that have happened in many states—costs that are not covered by medical liability insurance. Groups should consult a labor lawyer regarding staff and physician training in the prevention of workplace harassment.

Other disadvantages of group practice include:

- Delayed or abandoned decision-making, particularly for larger purchases, resulting in missed opportunities and stymied growth.
- Overshadowing of a younger group member by more experienced surgeons, hampering referrals and practice growth.
- The emotional and financial costs of dissolution if the group fails.

5.4 Why a Group Practice Adds a Partner

There are a variety of reasons to add a new nonowner physician:

- To replace an aging or retiring group member.
- To fill a need in the community and create group diversity.
- A source of income for existing owners.
- Support for owners who want to take more time off.
- To grow the group to take advantages of better pricing and utilization of excess capacity.
- To offer new procedures or subspecialty expertise to capture market share.
- To expand the group's reach into a different demographic associated with a specific age, gender, and ethnicity.

An established group has likely invested in branding, marketing, equipment, real estate, leasehold improvements, and staff training. When a key physician leaves, each remaining member assumes a greater portion of the liabilities. Adding another physician will promote continuity and provide additional income to dilute costs for the owners.

5.5 Finding a Group Practice

If you are looking for a job, start your search by articulating your short- and long-term goals ahead of time: what do you want your life to look like in 5, 15, and 30 years? In the meantime, look at job listings in American Society of Plastic Surgeons (ASPS) *Plastic Surgery News* and post on the “Job Opportunities” section of the ASPS website. Groups, in turn, can also post ads. Society meetings provide a rich opportunity to network, and groups interested in hiring often rely on word of mouth, particularly from colleagues involved in training programs. (Groups with residency affiliations or fellowship programs have a huge advantage in seeing if a surgeon would be a good fit.) Surgeon recruiting agencies (headhunters) send job seekers’ biographies over a nationwide network, and they do all the recruiting work, but they are also expensive. If the employer finds a comparable candidate not using a headhunter, one referred by the headhunter probably would not get the job. Contract a headhunter *only* after exhausting other less expensive ways of finding a job. (See also Chapter 2.)

5.6 The Working Interview

When a job seeker finds an interesting group practice, first check the practice’s website, social media, and other marketing materials to look for deviations in taste or professionalism. The State Medical Board and the National Practitioners Data Bank can reveal historical malpractice claims or judgments levied against the partners. If all looks good, the group can invite the prospective surgeon for an initial evaluation or a formal interview. Some practices hold two interviews, and the group pays expenses for the second, more in-depth interview.

The job seeker should visit the central office as well as any satellite offices. The candidate should interview with each partner individually as well as talk with each staff members to assess practice morale. In a formal interview, the surgeons and administrator should discuss the steps to possible association, the group’s financial health, any legal issues affecting the practice, and potential income opportunities, including expenses involved.

The candidate should then ask the local hospital’s chief of plastic surgery, the chair of surgery, and any physicians acquaintance in the community about the group’s reputation.

Possible constraints must also be considered: is the group boxed out of reconstructive surgery opportunities by large multispecialty organizations employing their own plastic surgeons? After doing a hand, craniofacial, or micro fellowship, will a new associate be competing in a saturated market? Does the group and the local hospital have the necessary staff and resources to provide the specialty care the new associate plans to do? Will the group refer new patients internally, or does the new associate have to hustle for his or her patients?

Group members may not be “best friends forever,” but they should share trust, professionalism, collegiality, and philosophy in achieving business goals. Ask frankly about any personality quirks that affect the partnership.

Favorable group attributes include:

- Longevity.
- Potential for ownership and a clear pathway to achieve it.
- Stability of providers as well as support staff.
- Competent nonphysician management team.
- System of checks and balances to mitigate the risk of embezzlement, to include periodic audits by an outside reputable accounting firm.
- Closely monitored procedures to govern critical items such as a clearly defined procedure for protecting patient privacy when posting before and after photos on the group's website or social media platforms.
- A policy of having no family members or close personal friends in decision-making positions or handling money.
- Willingness to share the group's and its affiliates' balance sheets and profit and loss statements.
- Transparency regarding previous or ongoing legal challenges.
- Plainly defined policies and procedures to address high-stakes issues such as Health Insurance Portability and Accountability Act (HIPAA) and Occupational Safety and Health Administration (OSHA) compliance, sexual harassment, government reporting, and use of social media by providers and staff.

5.7 The Associate Physician versus the Employed Physician

As you consider a position with a group, think about what employee category is best for you. An associate physician is usually treated as an independent contractor. Compensation is typically productivity based. The group is not responsible for deducting Federal Withholding, Social Security, or Medicare taxes from his or her compensation; the physician receives an IRS Form 1099 from the group at the end of the year. The associate physician should have a lawyer create a legal entity, typically a Professional Association (PA) or as a Professional Limited Liability Company (PLLC), to protect him or her from being personally liable for the group's nonmedical malpractice judgments or debts. These entities are governed by state laws and vary by state, so have an attorney or certified public accountant (CPA) advise you on navigating pertinent federal and state laws as well as helping you negotiate things like group health insurance, payment for business travel, and personal leave. The associate will be considered to be and paid as an employee by the entity, not the group, and the entity, not the physician, will be the contracting party when joining a group.

A big advantage of being an independent contractor is the ability to have a Simplified Employee Pension (SEP), allowing you to contribute up to 25% of the salary for each of the entity's employees. (It is likely that the associate will be the only employee of the entity.) For 2017, the maximum tax-deductible contribution was \$54,000, compared to \$5,500 to \$6,500 for a traditional Individual Retirement Account (IRA). As a nonowner member of the group, the entity's SEP is not restricted by the group's retirement plans that the group may have. The entity is not liable for the group's obligations such as office leases, vendor contracts, mortgages, or capital equipment loans, but the price of that freedom is that the group retains a portion of the entity's income.

Rather than hiring an independent contractor, however, the group may want the new physician to be an employee. (See Appendix 5E for an example of an Employee

Contract.) Physician employees, who are W-2 employees, are generally entitled to the same benefits provided to nonphysician employees, including group health benefits, pension plan, and paid time off. The group is responsible for collecting Federal Withholding, Medicare, and Social Security taxes from the physician's compensation. An employed physician can be compensated solely by a base salary or a base salary plus a productivity bonus when defined revenue levels are achieved.

The physician employee enjoys a predictable paycheck and being exempt from the group's financial obligations, like office leases, vendor contracts, mortgages, or capital equipment loans. The disadvantages include the possible requirement to participate in the group's pension plan, possibly limiting personal IRA contributions, and, unlike an "eat what you kill" plan, harder work may not result in higher earnings.

No matter what type of employment relationship the new associate and the group agree on, the first step in an association is a job offer. There are seven principles to consider in any offer.

5.8 The Seven Principles of an Offer

While exact numbers vary by time and place, certain basic principles should apply to evaluating any associate or partnership offer:

1. Base salary and salary ramp up, bonuses, and revenue expectations
2. Workload
3. Benefits
4. Practice buy-in
5. Purchase options on other assets, e.g., real estate and nonsurgical services
6. Buy-out
7. Practice management

To better understand what each of these seven principles means, let's take a deeper dive.

5.8.1 Salary

Most young plastic surgeons believe they are worth more than they really are, and most senior plastic surgeons believe that younger surgeons get paid well, but do not want to work commensurately. Take home pay is what is left over after overhead and other benefits are paid. Among the partners, that is a fairly simple calculation. Most groups will have a payment model either based on individual production ("eat what you kill") or relatively equal salaries with bonus potential based on revenue production. If you kill less, you will eat less, but how much less can have an impact on the group's ability to pay expenses. Most established groups have an overhead percentage that's fairly constant year to year. To avoid a shortfall to pay expenses with the "eat what you kill" model, each physician should be responsible for a minimum overhead expense over a "reconciliation" period, such as a month or quarter of the year. After covering overhead, salary and bonuses are what is left over. For example, for revenue of \$1 million with 60% overhead, \$400,000 is left over. The hard part is deciding what is fair to a new partner.

If the new associate's revenue is not enough to cover salary and benefits by the end of 2 years, there may be a "claw-back" provision or a salary cut. If revenues exceed expectations, there may be a stepped-up salary ramp to reward the over-producing junior partner. A reasonable portion of the revenue generated by the new employed physician may be shared among the partners. While 10% should not raise

any eyebrows, what about 30%? These processes will already be in place in well-established groups, but pay issues are often a work in progress to be negotiated in small, growing group practices.

Expenses

Each group determines how practice expenses are divided among the partners. Commonly, any fees received are the property of the billing partner (“eat what you kill”). Although some groups may divide fees received and expenses equally, this is not the norm. Most groups base expenses on productivity, assuming that the high-producing partner uses more practice resources. A low-producing associate pays a lower overall dollar amount of the expenses, which may be a higher percentage of gross productivity.

An expense formula may be based on *fixed* and *variable* costs. Fixed costs include office rent, utilities, administrative personnel costs, computer expenses, and practice marketing costs. Variable expenses include clinical personnel costs and medical supplies and are based on each partner's productivity. Expenses are determined monthly and adjusted quarterly and again at year's end to accommodate for variability from time away from work. Some practices assign expenses based on relative value units (RVUs) rather than on fees collected to compensate for poorly reimbursed reconstructive cases with disproportionately high resource utilization. Each month, the number of RVUs billed is divided by the variable cost basis, and a cost per RVU is determined. Each physician is then expensed based upon the number of RVUs billed that month. Again, the number is corrected quarterly and at year's end.

Some expenses may be directly attributable to a surgeon, like the cost of breast implants and injectables, malpractice premiums, license fees, membership fees, educational expenses, and a personal website. The costs associated with the support of a new associate (salary and benefits exceeding the fees received by the new associate) are divided equally and expensed to each partner monthly.

Pricing, Revenue, and Expenses

Although a group may establish set pricing, more experienced surgeons can command higher fees, so less experienced surgeons can build a referral base by charging less. A uniform fee schedule for all surgeons may unintentionally slow the growth of a new surgeon's patient base. On the other hand, patients may “shop” more than one surgeon in the group when fees vary. A good rule of thumb is if a patient consults with surgeons who are close in experience, none should charge less than the first surgeon. Close communication between patient coordinators (PCs) and surgeons, facilitated by posting the quote in the electronic medical record (EMR), prevents conflict between partners.

One of the better ways to distribute income fairly is the “eat what you kill” model, despite the hair-splitting. When salary is based on productivity, if you produce less you will make less money. To avoid a shortfall to pay expenses, each physician should be responsible for a minimum overhead expense over a “reconciliation” period, such as a month or quarter of the year.

For physicians with similar practices, the money to cover the cost of a base level of resources should be claimed by the practice prior to owners receiving distributions. An established group should track ongoing operational expenses and assign a minimum overhead requirement to each owner.

The practice's patient data management system should track revenue by provider. A report of the physician's gross earnings should be generated at least monthly, with directly related expenses deducted. The result is the "net payments." A percentage of these net payments is paid to the physician, less individual expenses, and the remainder is retained by the group to pay shared base expenses. For example, if the physician is paid 50% of net and 50% is retained to pay group expenses, the monthly distribution is what is left after subtracting the projected overhead, based on the monthly average. Because it is always more difficult to "ask for money back" at the end of the reconciliation period, the monthly distribution should always be at least 10% less than what any of the physicians' overhead is expected to be.

Determining how to divide expenses among the owners is by far one of the biggest challenges. It depends on the structure of the practice's partnership and on the level of an individual's ownership in the practice: equal shareholder, partial shareholder, or an associate with no ownership status? Practices may have differing requirements, like one with an aesthetic component partnered with a reconstructive or hand practice to insulate against market fluctuations. The "best way" is the method the parties agree upon.

5.8.2 Workload

Workload refers to how much one is expected to work, how much call one takes, and the type of work done. In a group practice, income-producing activities include surgery, clinic consultations, nonsurgical clinic-based treatments (e.g., injectables and skin care). Non-income-producing activities include practice management, human resource duties, technology, marketing, and insurance contracts. Total revenue production is the most important aspect of the workload, followed closely by productivity. To calculate "productivity," divide revenue by hours worked to get revenue per hour worked. Parameters should be established to distribute the right mix of patients and workload.

5.8.3 Buy-in Provisions

When a new associate becomes more established, he or she may bring in monthly income that exceeds his or her salary and benefits, and this excess money is divided among the partners and added to their monthly income. The new associate's fee collections are tracked to determine when the group has recouped appropriate start-up costs for the new associate. The group typically wants the new associate to be productive enough to cover his or her own salary and benefits, achieve board certification, and fit in well with the group as a team player. Although group decision-making is often "majority rules," it is important that there should not be strong dissent by any one partner of the group regarding the offering of partnership to a new associate.

Sometimes the group may vote not to offer partnership, but to continue the current employment structure. The employed surgeon would have the benefit of not paying the buy-in expense or any capital expenditures the group incurs, such as buying a new laser or an EMR system. Continued employment, however, means the inability to vote in practice decision-making and not receiving potential additional income from building ownership, an ambulatory surgery center, or a medical spa.

Buying into and becoming an owner of an established group plastic surgery practice is no small decision. There are a variety of ways that this can be accomplished, but exactly *what* is being purchased should be clearly defined, as the new owner will be acquiring assets as well as liabilities. The new associate should know if the buy-in is

based on assets, such as real estate, the office build out, and surgical supplies; if group-owned surgery center and/or medical spa assets are to be included in the buy-in; if the cash flow generated by these entities, including physician extender services, will be included; and if the purchase includes the group's goodwill or brand. This "goodwill" may hold some validity, depending on the reputation of your new partners and the trickle-down effect a new partner gets from joining a good group. The new associate would have to decide whether goodwill is worth the additional expense.

Formulas can determine asset value, such as real estate (capitalization rate valuation) as well as the cost to buy into a medical spa income stream. From an accounting point of view, buying assets has more predictable value than does buying a practice's name and reputation.

It is equally important to find out the amount and terms of outstanding loans or leases that the practice has.

Tangible assets, like office equipment, exam room chairs, surgical instruments, and lasers, depreciate over time and new assets are acquired. Each partner owns a share of these assets, which the group's accountant can value at any time. The group determines the cost of the buy-in with the assistance of its accountant. The new associate would pay that buy-in cost to the partnership and enter into a partnership agreement. (A boilerplate partnership buy-in agreement is shown in Appendix 5E.)

After all questions are answered, and all parties agree on a buy-in amount, the payment arrangement should be negotiated and a payment plan discussed. The new owner may be required to make one single cash payment, or the group could accept installments over a period of time. The contract should establish whether the new owner can participate in the group's decision making while paying the installments.

5.8.4 Purchase of Other Assets and Basic Furnishings

For the group-owned surgical facility or medical spa, the buy-in cost may be based purely on cash flow; alternatively, the current partners may encourage a young associate's full partnership by providing a discount to the market value. A pure cash flow valuation holds less validity than it does in, say, a fast food franchise, since surgical facility and medical spa success depends on the continuing practice of the senior partners. Nevertheless, many med-spas have assumed a larger share of cash flow and hence asset value. Small businesses are often valued as a multiple of earnings before interest, taxes, depreciation, and amortization (EBITDA) with a multiple range of 8 to 12 based on growth rates and risk.

5.8.5 Benefits

A group practice offers substantive advantages over a solo practice in benefits, including retirement, life insurance, disability insurance, and reimbursement for practice and related expenses such as travel and automobile. Retirement benefits, usually defined contribution plans such as 401k and profit-sharing plans, are capped at approximately \$55,000 per year. Additional pre-tax dollars may be captured in defined benefit plans where the total amount of money set aside may increase substantially to \$200,000 plus—but so does the total cost to the practice of covering all employees. Like most retirement plans, defined benefit plans require coverage of all full-time employees. The total potential pre-tax savings make these plans favorable with more "highly compensated employees" in a "top-heavy" plan, such as a group surgical practice.

Life and disability insurance policies are essential to protect the practice against unexpected events. The practice that purchases life insurance for the partners must decide the amount of coverage and the distribution of those funds in the event of death. Normally, the practice would buy these policies with post-tax dollars. The death benefit would be tax-free and may also include “key man” compensation to the practice, practice buy-out, real estate asset buy-out, as well as distribution to the estate of the deceased.

Group disability policies are significantly less expensive than individual policies. Nevertheless, many insurers require that the insured have both individual and group plans. The disability policies owned and paid by the group must clearly define benefit distribution, including “disability overhead” (to compensate the remaining partners for loss of revenue due to the disabled partner), disability buy-out, and disability distributions to the individual. To balance risks with costs, various scenarios should be diagrammed on a flow chart and discussed.

5.8.6 Buy-out

When a partner retires or leaves the practice, some practice contracts attach a monetary value for a buy-out equal to the current buy-in and define a time period during which this should occur. A lump-sum buy-out is usually impractical from a practice cash flow perspective (just like for a new associate buying in), so it is usually spaced out over several quarters. Potential conflicts include late or missed payments. Another option is a distribution of life insurance policies that may be transferred without a tax liability, such as one termed a life cycle LLC with a life insurance policy at its center. (See Chapter 23.) A group practice may decide to take out a \$5 million policy on each partner to benefit the estate of the deceased as well as to fund the practice's buy-out of the estate's share of the practice. The premiums may be financed and the cash value of the policy invested to allow this value to grow. The collateral requirements of a single individual's policy would be prohibitively expensive, but a suitably large policy for a group, particularly with a range of ages, becomes practical and valuable. The policy may be considered an asset during a retirement buy-out, such that the departing partner receives the life insurance policy plus any retained cash value as an asset in lieu of a cash buy-out.

5.8.7 Management

While providing opportunity and security, group practice creates significant management issues. Important group decisions require a consensus or at least a vote. Larger groups have more employees and thereby greater management complexity, but also the potential benefit of having different points of view.

Meetings take time and energy, but they are essential for decision-making and for the management and long-term health of a group practice. In addition to physician's roles in management (see Chapter 5.9.7), the practice manager plays a key role. The best manager would be competent at finance, practice and surgery center management, insurance contracting, risk management, human resources, real-estate management, information technology, and managing surgical personalities. No single individual can handle all these tasks, so “outsourcing” or “insourcing” is necessary. The manager must have the freedom to develop other managers and divisions within the practice. The single-manager model is associated with *three risk zones: financial planning, strategic planning, and culture.*

Financial Planning

In a group practice, there are significant cash flows passing through and within the practice. Careful accounting practices are critical to prevent either intentional or inadvertent diversion of funds. The practice manager must work closely with the internal recorder or bookkeeper, one of the partners must periodically review the checking and credit card accounts and an accountant should review these cash flows at least quarterly. Risks abound not just at the bookkeeping level, but also between managers and vendors, and between a manager and employees (see Chapter 10, section on “Embezzlement”).

Strategic Planning

Most group practices require a strategic plan to maintain practice growth and development. Strategic planning, which can be conducted on a Saturday, is important in setting the group's growth, development, and direction. Topics include marketing, incorporating new techniques and technologies (e.g., hair replacement and noninvasive body contouring), new physician extenders, and new information technologies. The group can plan staffing adjustments, set goals for improving patient satisfaction, or plan renovations to your physical plant. This is also the opportunity to discuss opening a satellite office, or investing in an ambulatory surgery center, and the timing of adding an associate, based on how many surgeons are needed for sharing call and overhead expenses, while maximizing use of office and operating room space and personnel.

Strategic planning can help the practice know when senior partners plan to phase out, what new business opportunities there might be, and how these changes might impact the group. Such planning helps to perpetuate the group, despite changing conditions and personnel.

Many surgeons would prefer to “outsource” these efforts while they focus on surgery, but the surgeons must still play an active role in marketing and outreach. Since clinical care and patient outcomes are the ultimate purview of the surgeons, they have a valuable perspective regarding what may or may not work with respect to practice expansion.

Culture

Most practices have a distinctive culture that is ultimately a reflection of the surgeons. Every surgeon has a unique personality and a unique style of managing patients and staff. All successful practices have a motivated and engaged staff that make patients feel comfortable and optimize the surgeons' time. Practice managers also have unique personalities and management style. Over time, they will also contribute to the practice culture. Dysfunctional management styles may not be obvious initially, but an inattentive group of surgeons can foster a dysfunctional or poisonous work environment at worse.

5.9 The Contract

A clearly defined contract constructed by a knowledgeable attorney is essential to a successful partnership (see also Chapter 21). It will not solve all conflicts, but it will help mitigate the more important ones. Have an attorney evaluate the terms and the language and feel comfortable with the provisions before signing.

We have already covered the seven principles of an offer. In addition, the contract should cover whether the group covers the fees for obtaining hospital privileges, medical malpractice premiums, educational meeting fees (including travel) expenses, and even the fees associated with taking the American Board of Plastic Surgery examinations.

The time frame of the employment contract should be specified. Some contracts are for a 1-year term with subsequent renegotiation annually, while others are for 3 or 5 years (see Appendix 5B and Appendix 5C for examples). The contract should also state requirements to achieve partnership, and the circumstances for remaining an employee. Some contracts offer an enticing base salary several fold larger than your salary as a resident. A bonus structure may be included as a practice-building incentive. A base salary that is sufficiently high and a work-life balance that is satisfactory may result in less inclination to beat the bushes for patients and qualify for that bonus. Consequently, some groups offer a much lower base salary (similar to that of a chief resident) and include a lucrative bonus structure that rewards hard work. Do not be offended if you are offered a subsistence-level base salary, since you may earn far more with the bonus if you hustle, and that early strong start can pave the way to partnership. In fact, groups generally offer a partnership stake only after the new associate has demonstrated the drive and ability necessary to succeed in the community.

The contract should have a cancellation clause that is agreeable. Some contracts will include a “noncompete” provision requiring a departing associate to leave the community, although such clauses may be difficult to enforce. A detailed contract, written by an attorney, will help avoid conflicts later. Far wiser to spend the money up front for a solid agreement than to pay an attorney later to dissect what the original intent actually was. For highlights of a group contract, see Appendix 5A. Appendix 5B is an example of an initial 3-year term and ►Fig. 5.1 is an accompanying financial spreadsheet. Appendix 5C is an example of a subsequent 5-year term. Both contracts state that the associate may become an owner at any time during the contract term if the associate accepts the appropriate share of the group’s liabilities. For an example of an employment agreement, see Appendix 5D, and for a boiler-plate buy-in agreement, see Appendix 5E. Appendix 5F is an example of an Aesthetic Fellowship Agreement, which is essentially an employment contract.

5.9.1 Expenses

Operating expenses, such as insurance (other than personal medical liability), office property taxes, accounting fees, and patient data management software are usually shared equally. Other expenses can be broken down into several categories as discussed next.

Staffing Expense

No matter the staff position, employee benefits such as rest and lunch breaks, sick leave, family leave, vacation time, educational opportunities, and retirement benefits should follow all state and federal laws.

The partners generally share equally the cost of administrative positions such as Practice Director, Medical Records, Billing, Reception, and Check-in/Check-out.

Clinic support staff can vary among physicians; some want a physician’s assistant, and others are content with medical assistants. All physicians should agree on a base level of clinical staff qualifications for excellent patient care as well as the staff’s compensation package.

A physician with support staff beyond the base requirement would bear the individual expense (hourly pay, overtime, payroll taxes, healthcare premiums, pension plan contributions, continuing education, and paid time off), which can be deducted from that physician's salary or distribution. The staff member would be a group employee, since seeing someone with similar job duties treated differently lowers staff morale.

Another arrangement is having a "floater" assigned to clinics according to need, with the respective physician(s) charged accordingly. This is more difficult to manage, requiring the employee to report hours, but it is more cost effective for the group. A physician's staff "need" must be clearly defined, since a physician seeing 65 patients in an 8-hour clinic with five minor procedures needs additional help more than a physician seeing 30 new consults and follow-ups.

Patient Coordinator

Each physician should work with a PC or personal assistant, who communicates with new patients, quoting fees, scheduling surgery, and providing guidance through the administrative process to surgery. A PC is usually assigned to one physician.

The coordinator's base salary should be paid by the group, with an agreed upon maximum. In addition, each physician should have an incentivizing bonus structure commensurate with the physician's surgical revenue. In a group practice, a PC can help another physician whose PC is out of the office, so the PC should be aware that a portion of her compensation is paid by *all* the physicians, and that she is part of a team.

Marketing/Call Center

Physicians are encouraged, within the guidelines of the partnership agreement, to create their own identities in the community to strengthen public awareness of the group as a whole. The marketing staff can report the hours spent on behalf of an individual physician so that each physician is charged appropriately. The marketing director or practice administrator should monitor each partner's use for distribution of costs; instead, a partner may elect to personally pay for an outside source for graphic design, search engine optimization (SEO), ad placement.

The most efficient way to manage inquiries is to use a call center to answer phones, chats, and emails promptly and to book the patient for a consult. The service should be monitored to make sure calls are directed properly and patient consults distributed appropriately. The group should share the cost equally among partners. Staff should be monitored such that calls are directed properly and patient consults are allocated appropriately.

Supply Expense

A group practice can command volume pricing, making monthly expenses somewhat predictable. When payments are posted, some supplies, such as toxins, fillers, implants, and compression garments are easily allocated to the appropriate physician. Partners may share clinic supply costs equally, since it is difficult to track individual physician usage of dressing supplies, exam table paper, suture, and syringes. Significant disparities in type and number of patients may necessitate detailed supply tracking, which is a tremendous burden to the staff. A simpler, less accurate approach is to assess dollars spent on clinic supply costs over a quarter and allocate costs according to the number of clinic patients the physician saw in that quarter.

5.9.2 Profit Center Profits: Medical Spa

A medical spa can be established as a business entity separate from the group medical practice, with the help of skilled attorney, allowing owners to receive a medspa income stream after partially retiring from the group practice. The easiest formula in distributing profit and losses is to do so equally among the owners. However, physicians who support these services more or who refer patients for procedures with a larger profit margin may prefer to divide income and expenses based upon a formula that rewards support of spa services and productivity. A clear path for purchase of capital equipment should also be defined. (See also Chapter 19.)

5.9.3 Office Space Expense and Building Ownership

In general, plastic surgeons spend about 60% of their time in the operating room, and 40% on consultations, post-op care, and performing minor in-office procedures. Sharing expenses equally makes sense for partners with similar staffing and office space needs. However, the physician who uses more clinic time and office space should cover proportionally more overhead according to the calculated share of usage.

Depending on the location, office building ownership offers tremendous advantages for a group practice. The mortgage liability is shared among the partners, and the cost is divided equally, making ownership much less expensive per partner than it would be for a solo plastic surgeon. The partners can form a separate corporation that holds the mortgage, and the practice pays rent to the corporation for the use of the building. Each partner's equity in the building increases as the mortgage is paid off. Rental income above that needed for maintenance of the building is paid back to the partners as passive income, for which there is a tax advantage.

A new partner may be offered the opportunity to buy a share of the building, with the buy-in based on a current appraisal minus any outstanding loans. The buy-in can be made in one payment, or the group can finance it. For example, a new partner might pay for his or her share in the equity of the building over 5 years, with an interest rate on the outstanding balance of prime plus 2%. A partner who retires or leaves the practice would be repaid his or her share of the building over 5 years with the same interest rate. Financing both the buy-in and the buy-out prevents large shifts in the building's budget. A 5-year buy-out also spreads the retiring partner's tax burden over a longer period of time.

If the group practice owns more than one building and/or ambulatory surgery center, the various ownership agreements (and separate corporations) can be varied according to the needs of the group and its individual partners.

5.9.4 Payment Processing Expense

Most aesthetic surgery practices accept a variety of payment methods, including credit cards, third-party financing plans (CareCredit), cash, and personal checks. However, the costs associated with accepting all forms of payment add up. For credit card payments, the "merchant processor" (the third-party who processes the payment transaction, charges the patient's card or bank account, and sends you the money) charges a fee based on the amount of the transaction, along with other variables discussed later. There are also costs related to accepting personal checks, cash, and payments from third-party financing companies. Services such as Telecheck can electronically deposit checks directly into your account and provide insurance against

nonsufficient funds (NSF) or fraudulent checks. The fee these services charge is a percentage of the face value of the check. For the safety of staff, it is advisable to have an armored car service such as Brink's or Pinkerton pick up cash as well as checks that are not electronically processed and deliver the deposits securely delivered to your bank.

Third-party financing companies such as CareCredit or Prosper charge a fee to the physician based on the gross amount of charges. These fees vary widely and depend upon the type of plans that the physicians agree to accept and the volume of the practice's transactions.

Payment processing fees should be allocated to each physician based on his or her gross receipts (►Table 5.1 and ►Table 5.2). Most patient data management systems are capable of tracking payment type, but it is virtually impossible to track the many variables that go into calculating the fee that a merchant charges to process a credit card, including the type of card used, whether the card was swiped or the number entered manually.

An equitable solution for the "eat what you kill" model starts with evaluating the group's established history of fee processing costs. Select a time frame, usually the

Table 5.1 Example showing physician monthly compensation				
	Jan (\$)	Feb (\$)	Mar (\$)	Quarter (\$)
Physician gross receipts	350,000	325,000	375,000	1,050,000
Implants	(5,540)	(4,000)	(5,000)	(14,540)
Garments	(2,590)	(1,800)	(2,800)	(7,190)
Toxins	(2,000)	(1,500)	(2,000)	(5,500)
Fillers	(3,500)	(3,500)	(4,000)	(4,000)
OR time	(63,526)	(62,000)	(63,000)	(188,526)
Anesthesia	(24,750)	(22,000)	(24,750)	(71,500)
Miscellaneous OR supplies	(8,834)	(7,500)	(8,500)	(24,834)
Net payments	246,260	222,700	264,950	733,910
Physician distribution	123,130	111,350	132,475	366,955
Retained to pay shared expenses	123,130	111,350	132,475	366,955
From the Physician Distribution, individual expenses paid by the group on behalf of the physician are deducted each month:				
	Jan (\$)	Feb (\$)	Mar (\$)	Quarter (\$)
Physician distribution	123,130	111,350	132,475	366,955
Payment processing fees	(6,405)	(5,948)	(6,863)	(19,215)
Loan payments	(2,345)	(2,345)	(2,345)	(7,035)
Newsletter printing			(2,690)	(2,690)
Newsletter postage			(4,912)	(4,912)
Marketing	(10,000)	(8,000)	(12,000)	(30,000)
Patient coordinator bonus	(6,600)			(6,600)
Net amount of monthly check	97,780	95,058	103,666	296,503

Table 5.2 Example showing physician quarterly production bonus

	Jan (\$)	Feb (\$)	Mar (\$)	Quarter (\$)
Remaining to pay shared expenses	123,130	111,350	132,475	366,955
Equal share of quarterly expenses				(325,000)
Equal share of associate income				60,000
Quarterly bonus				101,955

previous 12 to 18 months, and using your patient management system, obtain type of gross payments received per provider (cash, credit cards, checks etc.).

Your financial management system (such as QuickBooks) can be used to obtain the following items, which your accountant or administrator should be tracking:

- Merchant processing fees paid.
- Third-party financing acquisition fees paid.
- Fees paid for electronic processing of checks.
- Fees paid for armored secure pick-up of cash and of checks not electronically processed.

This information is used to calculate a “payment fee” for each payment type per physician, which can be deducted from the physician’s salary or distribution on a monthly or quarterly basis. To simplify, the fees can be “averaged” to determine a flat percentage “payment fee” charged against each physician based upon total gross receipts. The averaged payment fee should be reviewed at least annually and adjusted accordingly.

5.9.5 Capital Expenditures

Decisions to acquire a long-term asset, such as equipment, or to improve an existing asset, such as a building improvement, should have clearly outlined levels of approval in the partnership agreement. For example, items less than \$100,000 may require a majority vote, while items over this amount may require a super-majority or unanimous vote. Purchases are either made with a loan or lease, with payments shared equally among owners, or, when required, a single payment is made with a “cash call” from each owner.

5.9.6 Utilization of Practice Resources

Usage of shared practice resources, which is closely tied to allocation of expenses, should be clearly defined in a contract, or at the very least, a method articulated for resolving unforeseen resource-related conflicts. Conflict can arise when one physician infringes on other physicians’ clinic schedule without proper notice, an individual partner uses the marketing staff, or a personal assistant is asked to perform additional duties not related to the group. *Communication is vital, as a physician may need to see a patient for an emergent issue, and it is not his or her clinic day.* Cooperation among partners is essential.

Surreptitious activities include providing incentives for staff to “steer patients” to the provider or encouraging the group to use a particular vendor to obtain special

personal favors. Such activities must be strictly forbidden and met with significant consequences, such as a high financial penalty or expulsion from the group.

5.9.7 Governance

Each group must decide how it is to be managed administratively. The distribution of governance duties among owners of the group is related to the size and type of practice. Some groups have a single physician-manager (usually, the founder or most senior member of the group). This physician will oversee the day-to-day management of the group and make decisions on behalf of the group. Some physician-managers are fairly autocratic, while others make only small decision, leaving the big ones to discuss as a group and reach a consensus. A smaller group of two to four physicians may elect to collaborate on all decisions or nominate a “managing partner” who can make daily decisions, while requiring votes on more far-reaching decisions, such as hiring/firing staff and purchasing equipment.

Some groups rotate the physician-manager annually, giving each partner an opportunity to learn the nuts and bolts of running the partnership (from signing the vendor checks to helping our administrator make decisions regarding employee issues), although there is less continuity in style and perhaps philosophy.

Larger groups may find it is convenient to have a nonphysician administrator handle the day-to-day operations of the group, organize the staff, develop and monitor the budget, and oversee the marketing plan. Outside consultants can be hired to meet specific needs, such as website development, information technology issues, and specific marketing projects. While an administrator can command a high salary based on experience and education, the cost is divided equally among the partners and is therefore fairly reasonable.

The group's staff administrative director should be skilled in leadership, finances, accounting, and human resources, and possess excellent communication and interpersonal skills. Most group practices will require more than one person to manage all of the activities required to support the providers. The structure and size of the plastic surgery group will determine the type of nonphysician management team required. Management or “team leader” positions can include coding and billing; marketing, public relations, and social media posts; information technology; ambulatory surgery center (ASC) director; spa and ancillary services manager; and benefits and human resource manager. Some individuals may have more than one of these titles. For example, the marketing manager may be skilled in computer technology and can also be responsible for maintaining the patient data management/EMR systems. The administrative director should have the ability to coordinate leadership team's activities, while communicating with the physician delegated to oversee this part of the practice. A group practice has the resources to attract and retain talented staff leaders. Most practices require that the administrative director have at least a 4-year college degree and often a Master's in Business Administration or a Master's in Healthcare Administration. However, the value of years of experience can also be important and should never be discounted.

The administrator must have the power to oversee the staff. Hiring and firing should be the administrator's purview (with the advice and consent of the partners). Individual partners should not get bogged down in the minutiae of personnel issues, as it only undermines the authority of the administrator. When an employee speaks to a partner regarding an office issue, it is important the partner avoids taking sides or making promises. Sometimes an employee may be an asset to one partner but toxic to the office

environment. The partners must focus on the overall health of the office and defer personnel decisions to the administrator and the physician-manager.

The administrator can participate in a nationwide consortium of large plastic surgery medical group managers. This group meets annually in person and frequently by phone/email to discuss issues and brainstorm solutions; the shared experience benefits the group.

Larger groups of physicians, as well as groups that have an ASC and/or nonphysician providers (e.g., licensed nurse practitioners, physician assistants, registered nurses, and estheticians), may elect to assign duties to physicians based on an administrative area of the practice. Typical delegations would include:

- Medical Director of the ASC
- Group Marketing and Public Relations
- Human Resources/Clinic Management
- Research and Publications
- Fellowship/Residency Program
- Ancillary Services Director (medical spa, nonphysician providers)

Compensation for leading these areas of the group practice can be defined in a contract; although, determining a monetary value to each role is an arduous task. If all owners contribute in some way to the success of the group, it is best to keep compensation arrangements for these duties simple.

Each area of responsibility should have clearly defined duties, decision-making limits, and budgets. These positions can either be rotated on a periodic basis or maintained indefinitely, particularly if an owner is gifted in this area. Assigning responsibilities should be based on each physician's unique skills.

Physician governance activities must be balanced with productivity. Administrative duties do not generally produce income, and therefore, can be considered counterproductive to the success of the practice.

No matter the management arrangement, the group should hold a monthly corporation meeting to discuss issues, view financial statements for the prior month, and make plans for the future. The process of gaining consensus can be arduous, but the resulting decisions are not made frivolously.

5.10 Patient Referrals

The allocation of patients among physicians can be contentious because each patient brings in not only a single fee, but also a potentially large referral base. One patient can refer three friends, who each refer two friends. Each patient is especially important to the new physician whose referral base is usually very limited. Even with aggressive print marketing campaigns, social media, web-based advertising, and the information on plastic surgeons available through the internet, direct patient referrals continue to be most important source of patient acquisition for the established aesthetic surgeon. Statistically, direct patient referrals have the highest conversion rate to surgery compared to other sources of patients.

Individuals may choose a group practice based on its reputation in the community, seeking the "best" physician in the group for a particular procedure. Conflict arises without clearly defined methods for fairly assigning these referrals to the providers. A variety of ways can be used to achieve this, depending upon the structure of the group:

- If a provider has a particular specialty that others in the group prefer not to perform, the group can agree to refer all such patients to that provider.

- A pre-established rotation whereby patients are referred to the “doctor of the day” (or some other rotation system based on a pre-established rotation). The level of ownership in the practice may dictate the rotation for these patients, so a nonowner associate physician may get fewer rotation days than an owner.
- If a physician has paid for his or her own marketing campaign, patients responding to that promotion can be assigned to that physician. A fail-safe method must be in place to avoid conflicts arising if a patient is directed to another physician.
- Direct patient referrals for a particular physician should be directed to that physician without exception.

Rotation rules will not prevent conflict and misallocation of referrals, so to nurture trust among providers, referrals must be handled by nonbiased staff (like a call center) who are given clear guidelines and trusted to make decisions. For example, if a potential patient wants surgery with an established physician owner who is booked for 3 months, the call center can direct the caller to another physician in the group, rather than losing that patient to an outside physician. The patient may see an advantage in having surgery with lower fee. Retaining a patient in the group increases the likelihood she will utilize the group’s nonsurgical services on a regular basis.

5.11 Conclusion

While the group practice of plastic surgery is not for everyone, it offers distinct advantages. A group offers collegiality, with the ability to discuss patient problems and possible solutions as well as the ability to pool. By pooling resources to purchase, a practice can have significant variety of equipment and personnel available, more constant coverage, and a wider variety of skills, which are appealing to health plans than an individual provider. What you give up in personal autonomy is repaid in the freedom that comes from having nights, weekends, and vacations free from worry about your patients’ ongoing care. Well-constructed agreements must be in place for all, whether owners, associates, or employees, for a group to survive, flourish, and grow. Flexibility and compromise are essential for long-term success. As long as members have reasonably compatible goals and share a common philosophy for achieving them, the advantages of the group plastic surgery practice far outweigh the disadvantages.

5.12 Appendices

5.12.1 Appendix 5A

Highlights of a Group Contract (Courtesy of Christopher K. Patronella)

The Partnership: The type of entity that will be registered with the state.

Warranties: All members warrant to each other that they are licensed to practice medicine in the state, and have full corporate power to enter into the agreement.

Professional Development: Partners will seek to maintain a high standard of professional competence by the adoption of an individual program for advancement and continuing medical education. Board-eligible owners will be required to become board-certified within a specific time frame, and to maintain this certification. There

may also be requirements for membership in certain professional societies, such as ASPS and ASAPS, which must be attained within a defined time period. Failure to attain and to maintain such certifications and memberships should have consequences to include fines or expulsion from the group.

Activities of the Partners: Each partner will discharge his duties as a partner in good faith and in a manner that is reasonably believed to be in the best interests of the partnership and the partners, subject to the other provisions of this agreement. A partner may engage in activities other than providing medical and surgical services to patients as such partner desires so long as such devotion of time, energy and personal resources does not materially interfere with the partnership's business. The proceeds from such other activities, including, but not limited to, preparation and publishing of articles and books, the development and marketing of medical equipment, devices and procedures, and the making of speeches and presentations, shall not belong to the partnership. The partnership shall be entitled to deal with affiliates of partners as long as all terms and conditions of such dealings are not more onerous than, or different from, the prevailing market terms, conditions and prices available from non-affiliated third parties, and provided that the partnership shall give prompt notice of any such dealings to all the partners.

Professional Liability Insurance: Although insurance laws vary among states, it is highly advisable that all physicians be covered under the same policy to avoid potential conflict for shared patients or facilities. As mentioned before one of the advantages of being in a group is the possibility of discounted professional liability insurance premiums. Minimum limits required, as well as qualifications of the insurance company, should be clearly outlined in the agreement.

Term: All partnership agreements should have a beginning and an end date. The "end date" can simply be defined as the partnership will continue until the winding up and liquidation of the partnership and its business is completed following a liquidating event. What constitutes a liquidating event should be defined in the agreement.

Capital Contributions: Each partner shall own a defined share of the assets; these assets and their related values should be listed.

Future Contributions: The partnership may require that the members make a capital contribution, sometimes referred to as a "cash call" for repairs, maintenance, taxes, new equipment, etc. There should also be language that defines the consequences for not making such a contribution when it is voted upon by the members. For newer owners, this may be a burden; the agreement can have provisions for allowing an owner to repay his share to the partnership via a short-term loan with a reasonable interest rate.

Allocations and Distributions: The formula used for distributing profit to the owners should be clearly outlined, along with the timing of distributions. For example, distributions for the previous month are made by the 10th of the following month.

Accounting and Records: The agreement should state that the partnership will maintain separate books of account for the partnership which shall show a true and accurate record of all costs and expenses incurred, all charges made, all credits made and received, and all income derived in connection with the operation of the partnership business. The owners should expect to receive reports on a periodic basis to include a profit and loss statement, a balance sheet, and any other reports as requested by the

partners. In addition, any partner should, at his own expense, be able to require an independent audit of the partnership.

Authority Over Checking Accounts: The partnership may delegate authority to the practice administrator of the partnership to sign any purchase order or authorization for an account withdrawal up to a specific amount. Any withdrawal or purchase order approval in excess of his amount may require the approval of at least one or more partners.

Restriction of Authority: The agreement should list actions that a single partner is unauthorized to perform. Some examples are: any act which would make it impossible to carry on the business of the partnership; hire a new physician; confess a judgment; create any personal liability for any partner other than that personal liability to which any partner may have agreed to in writing; effect the sale of all or substantially all of the assets of the partnership.

Meetings of the Partners: Owners should establish a regular meeting schedule with a general outline of what shall be discussed at each meeting, who shall be responsible for organizing the meeting, where meetings will be held, preservation of meeting minutes, and means to address partners who do not attend the meetings. There should also be provisions in place to allow for a partner to take emergency action without a meeting with or consent of the other partners.

Marketing: Should the owners recognize the need for a plan to promote the group via social media, print, radio, etc., provisions for the management of the plan and its results should be defined. There should be a procedure for distributing equally among the physicians of the partnership the patients produced by the marketing program, with the option that the partners may from time to time vary the distribution procedure to increase the number of patients assigned to a particular physician or physicians to balance the number of patients among them. Establishing clear rules for acceptable marketing in advance, with a voting majority required for new ideas, and an approval process for group and individual marketing programs is also a necessary component.

Adding New Physicians: It is advisable that adding a new associate, employee, or owner physician be a unanimous decision among existing owners. There a list of qualifications that must be met by the candidate prior to association with the group, and a procedure for assimilating the new physician into the practice, whether the physician be an associate, employee, or owner.

Liquidating Events, Dissolution, and Winding Up: A liquidating event can as simple as the partners deciding they no longer want to be partners. Whatever the reason, the agreement should have provisions for dissolving the partnership and winding up the affairs. Upon the occurrence of a liquidating event, there should be a complete accounting of liabilities and property; and the property should be liquidated as promptly as possible for fair market value. Proceeds should be applied and distributed in the following order: first, to the payment and discharge of all of the partnership's debts and liabilities (including all expenses incurred in liquidation) to creditors other than partners; second, to the payment and discharge of all of the partnership's debts and liabilities to partners; and finally, the balance, if any, is paid to the partners in accordance with their capital accounts, after giving effect to all contributions, distributions and allocations for all periods. There should also be provisions on the treatment of patient charts and records.

Resolution of Conflicts: Should owners be unable to resolve issues among themselves, the agreement should address procedures for mediation, arbitration, how an owner can demand arbitration, and the fees for such activities. All should agree that the final decision of the arbitrator is binding, and not subject to judicial review.

Change in Status: There are a variety of reasons why a partner would want to change his status in the group. He or she may want to take more time off to deal with family or health issues, partially retire, etc. There should be a process whereby he or she relinquishes some of the rights for a reduction in liabilities.

Exit Strategy: Joining a group of like-minded individuals in a business venture is an exhilarating event. All are envisioning a long-term relationship; otherwise they would not have invested time and resources into coming together. Expectations and goals change; unexpected events occur that change the best of plans. In a group where there are older members who are slowing down, together with younger members who are building a career, it can be in the best interest of all members to preserve the integrity of the group. The exit strategy should address retirement, disability, death, and expulsion of a member.

Retirement: The retirement of a high-producing group member requires careful planning. This is particularly important if there is more than one high-producing member and they are close in age. Ideally, the agreement should require that a group member provide sufficient notice of retirement to the partnership. There should also be a waiting period before another partner in the group provides notice of retiring or changing status. For example, if the retiring partner gives three years notice, another partner must wait 18 months before he/she provides notice. If for any reason, the retiring member does not adhere to the time frames, there should be monetary penalties. For example, if a group member decides that he wants to retire in two years instead of three, he will owe the group one year of his/her share of the average overhead.

Disability: Each owner should acquire and pay for business overhead insurance policy in which the partnership is the beneficiary. Should an owner become disabled, the policy should cover most if not all of his average monthly overhead. The agreement should outline actions taken depending upon how long the owner is unable to work, when the policy will begin paying benefits, and how long the benefits will be paid. For example, if the policy is to begin paying benefits at 60 days, but the partner is able to return to work in less than 60 days, then arrangements will be made for his/her share of the overhead to be repaid over the next 6 months. If the partner will be disabled for a year or, the partnership may elect to purchase his share of the assets, less any debts. In some cases, after a physician has recovered from a debilitating event, he/she may wish to return to practice. Language in the agreement should address this possibility, or perhaps not allow it. In most cases, the probability of the return of the disabled member can be reasonably predicted. The insurance policy allows for the partnership time to plan for the future and to make changes in operations, sell assets, bring another physician into the group, etc.

Death: Whether sudden or expected, the death of a key member of the group is a traumatic experience. Provisions in the partnership agreement can keep it from also being a financially devastating event. Each member should acquire and pay for a term life insurance policy payable to the group. The amount of the policy is obviously dependent upon the group's structure and the liabilities of the group. Upon the death

of a partner, his or her personal representative (executor), will immediately be deemed to have offered to sell to the partnership all of the “Deceased Partner Interest” for a “Redemption Price” set forth in the agreement. The Deceased Partner Interest shall be transferred to the other partners equally. The partnership must purchase all of the Deceased Partner Interest, leaving no Deceased Partner Interest to the spouse, heirs, successors, etc. of the deceased owner. Payment for the Deceased Partner Interest should not be required until the representative provides a release or other assurances to the reasonable satisfaction of the other partners and the partnership that the partnership is protected from any liability for death taxes related to the Deceased Partner Interest. The deceased partner’s spa consultant patient base, clinic patient base, websites, website content and phone numbers shall transfer to the partnership.

Expulsion: The agreement should clearly define the consequences for when a physician behaves badly and the formal process whereby a member is expelled. If the physician is indeed expelled from the group, the procedure of the deposition of his share of group assets and debts should be defined.

Divorce/Spouses: The rights of divorced or surviving spouses should be outlined in the agreement and signed by the spouse. This can be a great source of consternation for the group as well as spouses if this is not clear to all parties in advance.

5.12.2 Appendix 5B

Professional Services Agreement: 3-Year Term (Courtesy of Christopher K. Patronella)

THIS AGREEMENT (the “Agreement”) is made and executed by and between THE PRACTICE, and ASSOCIATE, P.L.L.C. (“Dr. Associate”). _____M.D., P.A., _____ M.D., P.A., and _____, M.D., P.A, are the “Partners” (owners) of the Group.

WITNESSETH:

WHEREAS, the Practice is engaged in a plastic surgery medicine practice; and
WHEREAS, the Practice provides professional medical and related services (“Services”); and

WHEREAS, Dr. Associate is a physician duly licensed to practice medicine in the State of ____; and

WHEREAS, Dr. Associate is the sole Member of his Professional Association; and

WHEREAS, the Practice desires to engage the services of Dr. Associate under the terms and conditions of this Agreement; and

WHEREAS, Dr. Associate desires to assist the Practice by rendering professional medical services as set forth herein;

AGREEMENT

NOW, THEREFORE, in consideration of the premises herein and other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, and with intent to be legally bound, the parties mutually agree as follows:

ARTICLE I SERVICES

I.1 RELATIONSHIP: The Practice hereby engages Dr. Associate and he accepts such engagement to render professional medical services on behalf of the Practice as an

associate physician and independent contractor of the Practice. Dr. Associate is the sole member of Associate, M.D. P.L.L.C.), and will be the individual providing the services.

I.2 ACTIVITIES OF DR. ASSOCIATE: During the term of this agreement, Dr. Associate will:

- a) Render medical and surgical services to patients in the manner and extent permitted by the applicable state statutes and canons of professional ethics;
- b) Provide training, supervision, and direction to non-physician personnel as may be reasonably required and appropriate for the operation and success of his practice;
- c) Provide medical and surgical services pursuant to any "on duty" and "on call" assignments scheduled by Dr. Associate;
- d) Use Dr. Associate's best efforts to promote the interests of the Practice;
- e) Be and remain a physician duly licensed by the State of Texas and comply with and be governed by the ethics and standards of care of the medical community in which Dr. Associate will provide services hereunder;
- f) Make entries on patient medical records consistent with the Practice's procedures and assist the Practice in the preparation of third-party payment claim forms and other reports and documents as reasonably appropriate;
- g) Seek to maintain and improve his professional skills;
- h) Promote the activities of the Practice and enhance professional standing in the community, by diligently pursuing positive, constructive, relationships with patients, hospital administration, and other members of the medical community, and conscientiously marketing the Practice's services consistent with Practice policies, professional ethics, and applicable law; refrain from discussing confidential and strategic Practice information with unauthorized individuals; make no disparaging remarks about the Practice, its physicians and its staff.
- i) Perform such other duties upon which the Practice and the Dr. Associate may from time to time mutually agree; and,
- j) Without limiting the foregoing, Dr. Associate's primary duties will be in the field of plastic surgery.

I.3 DEVOTION OF TIME: It is agreed that the relationship between the Practice and Dr. Associate is mutually beneficial. Because the Practice dedicates marketing, promotional, and public relation resources which include Dr. Associate, Dr. Associate is expected to devote adequate time for the development of his practice. The Practice will provide adequate clinic facilities, staff, and time for Dr. Associate to treat patients in its office locations. The Practice considers clinical research in the field of plastic surgery an important part of its contribution to the medical community; and Dr. Associate is encouraged to devote a portion of his time to participation in ongoing research projects implemented by the Practice. Although the Practice's staff will post clinic appointments on behalf of Dr. Associate in the patient data-management system, he is responsible for the maintenance of his own clinic scheduling patterns.

I.4 DR. ASSOCIATE'S QUALIFICATIONS: Dr. Associate will exercise his best efforts to maintain hospital medical staff privileges as necessary to perform his duties hereunder. He warrants that he is licensed to practice medicine in the State of Texas, and that he is board-certified in plastic surgery, or is board-eligible and will seek and obtain certification by the American Board of Plastic Surgery within one year of association with the Practice. Dr. Associate will maintain this board certification throughout his association with the Practice. He will seek and obtain membership in the American Society of Plastic Surgeons (ASPS) and in the American Society for Aesthetic Plastic Surgery (ASAPS), and will remain a member in good standing throughout his association with the Practice.

1.5 POLICIES AND PROCEDURES: Dr. Associate will abide by and adhere to existing operating policies and procedures of the Practice.

ARTICLE II TERM

II.1 DURATION OF ENGAGEMENT: This Agreement will be for a period of three (3) years or until Dr. Associate becomes a co-owner of the Practice, whichever comes first, commencing 12:01 a.m., July 1, 2018.

II.2 RENEWAL OF ENGAGEMENT: The Practice will provide written notice to Dr. Associate no less than six months (January 1, 2021) prior to the end of the engagement stating the Practice's intent to renew or not to renew the engagement for another term. Should Dr. Associate intend to renew or not to renew the engagement for another term, he is to provide written notice to the Practice of his intent no less than six months (January 1, 2021) prior to the end of the three year term. Should both parties agree to another term of engagement, the Practice will present Dr. Associate with a new agreement for Professional Services to commence immediately at the end of the current term, which ends June 30, 2021 at 12:00 A.M. The new Agreement, which begins 12:01 A.M., July 1, 2021, shall be signed and executed no less than 3 months (April 1, 2021) prior to the expiration of the current Agreement. This Agreement will thereafter continue as agreed under the provisions hereof unless and until terminated as set forth below in Article IV. Should the agreement not be signed by Dr. Associate and executed on or before the 3-month deadline (April 1, 2021), it will be presumed that he intends to not renew the engagement.

ARTICLE III COMPENSATION, BENEFITS, AND ACCOMMODATIONS

III.1 PAYMENTS FOR DR. ASSOCIATE'S SERVICES: For convenience to Dr. Associate and to his patients, the Practice agrees to collect payments from patients and third party payers, and pay certain expenses for him. Dr. Associate is expected to remit all payments received for his services to the Practice for accounting and processing. Payments include those received for plastic surgery and related services, whether performed at Practice facilities or at other facilities.

III.2 COMPENSATION TO DR. ASSOCIATE: The Practice desires to assist Dr. Associate in the successful launch of his practice by guaranteeing him a payment of at least \$10,000 (Ten Thousand Dollars) each month for the first 12 months of Dr. Associate's association with the Practice. If Dr. Associate's Adjusted Net Payments (ANP) is less than \$25,000 in a month, he will be advanced the difference between 40% of his ANP and \$10,000 so that he will receive a total of \$10,000 for that month (40% of \$25,000 = \$10,000). Dr. Associate will be compensated and the advance repaid to the Practice in the following manner:

- a) For each of the first 12 months, 40% of his ANP, or \$10,000, whichever is greater, will be paid to him by the 5th day of the next month.
- b) If 40% of ANP is less than \$10,000, he will be advanced the difference between 40% of the ANP and \$10,000. The difference will be added to the advance balance owed to the Practice.
- c) If 40% of ANP is equal to or greater than \$10,000, there will be no advance for that month.
- d) Beginning the month immediately AFTER 40% of Dr. Associate's ANP is \$10,000 or more, he will begin to repay the advance balance over the next 12 months. The balance is divided by 12, which equals the monthly repayment amount.

- e) If later during the first 12 months of Association (prior to July 1, 2019), 40% of his ANP is less than \$10,000, he will be advanced the difference so that he will receive a check for \$10,000. This difference will be added to the advance balance owed and the monthly repayment amount will be adjusted to reflect the new balance owed, such that the entire advance balance will be repaid within 12 months after the first month that 40% his ANP was at least \$10,000.
- f) After July 1, 2019, 12:00AM, Dr. Associate will paid be 40% of his ANP for the duration of the contract; there will be no more advances, with the exception of an advance for a personal or medical leave of absence as outlined in Section III.5 of this agreement.

III.3 MARKETING ACCOUNT: 10% of Dr. Associate's ANP is withheld in a Marketing Account for his personal marketing, advertising, web site SEO, web site development/enhancement, public relations, newsletters, imaging, business cards, brochures, or any other self-promotional activities. Other approved activities would be for rental of space at a non-Practice facility in order to build Dr. Associate's practice in another geographical area. The dollars in the Marketing Account may be used as soon as there is a balance. Dr. Associate is encouraged to talk with the other six Practice surgeons, as well as Practice management and marketing staff, to determine the most effective use of these dollars. The 10% may not be used for anything that does not involve promoting Dr. Associate's practice, such as the purchase of personal items like vehicles, clothing, furniture, artwork, etc. See Article IV for details on marketing, advertising, and promotional endeavors.

III.4 ANP DISTRIBUTION EXAMPLE: For an example of possible compensation scenarios see ► Fig. 5.1. This exhibit is for illustrative purposes only to assist in the explanation of Dr. Associate's compensation plan. It does not imply a guarantee of income.

III.5 TIME OFF: Dr. Associate will be granted up to 3 weeks personal time off. Time off for continuing education activities will be granted on a case by case basis after review by the Practice. Should Dr. Associate require more than 3 weeks, but less than 3 consecutive months, time off from his practice for reasons other than continuing educational activities—such as for a medical or personal leave of absence—he will have the option of receiving an advance from ACPS of \$10,000, repayable to ACPS by the 3rd full month after his return. For example, if Dr. Associate were to take 8 weeks off beginning on March 2, 2020, returning to work on April 27, 2020, a \$10,000 advance will be repaid to ACPS in 3 equal deductions from his monthly distributions on June 5 (for May receipts), July 5 (for June receipts), and August 5 (for July receipts). This repayment is in addition to the repayment of any advance due as outlined in Section III.2 of this agreement.

III.6 DETERMINATION OF "ADJUSTED NET PAYMENTS" or "ANP": "Adjusted Net Payments" ("ANP") or "net collections" are determined by deducting the following items (expenses) from gross amounts collected from patients or third party payers attributable to the Services provided by Dr. Associate:

- a) Implants;
- b) Garments;
- c) Anesthesia fees;
- d) Operating room fees;
- e) Supplies not included in the operating room fee;
- f) Cost of consumable products including but not limited to "injectables" such as Botox, Dysport, Restylane, Juvederm, Perlane, Radiesse, etc.;
- g) Medical supplies used in minor surgical procedures performed in the clinic setting;

Exhibit 1: Associate 3-year contract											
MO		ANP	40% of ANP	Advance to total 10,000	Repay Advance	Total Paid to OD/month	Cummulative Advance Owed	10% of ANP Set Aside for Mark.	Mark. Dollars Spent	Running Mark \$ Balance	
1	2018	AUG	5,000	2,000	8,000	10,000	8,000	500	-	500	
2		SEP	3,000	1,200	8,800	10,000	16,800	300	-	800	
3		OCT	8,000	3,200	6,800	10,000	23,600	800	(250)	1,350	
4		NOV	10,000	4,000	6,000	10,000	29,600	1,000	(2,500)	(150)	
5		DEC	15,000	6,000	4,000	10,000	33,600	1,500	(1,000)	350	
6	2019	JAN	21,000	8,400	1,600	10,000	35,200	2,100	(1,000)	1,450	
7		FEB	23,000	9,200	800	10,000	36,000	2,300	(1,000)	2,750	
8		MAR	25,000	10,000		10,000	36,000	2,500	(1,000)	4,250	
9		APR	27,500	11,000		8,000	33,000	2,750	(2,500)	4,500	
10		MAY	30,000	12,000		9,000	30,000	3,000	(2,500)	5,000	
11		JUN	32,500	13,000		10,000	27,000	3,250	(2,500)	5,750	
12		JUL	35,000	14,000		11,000	24,000	3,500	(5,000)	4,250	
13		AUG	37,500	15,000		12,000	21,000	3,750	(5,000)	3,000	
14		SEP	40,000	16,000		13,000	18,000	4,000	(5,000)	2,000	
15		OCT	42,500	17,000		14,000	15,000	4,250	(5,000)	1,250	
16		NOV	45,000	18,000		15,000	12,000	4,500	(5,000)	250	
17		DEC	47,500	19,000		16,000	9,000	4,750	(4,500)	500	
18	2020	JAN	50,000	20,000		17,000	6,000	5,000	(5,000)	500	
19		FEB	52,500	21,000		18,000	3,000	5,250	(5,000)	750	
20		MAR	55,000	22,000		19,000	-	5,500	(5,000)	1,250	
				36,000	(36,000) =advanced by Practice						

Fig. 5.1 Exhibit showing Associate 3-year contract.

- h) Rental fees for equipment provided by third-party vendors; rental fees associated with the use of Practice-owned specialized equipment including but not limited to lasers;
- i) Fees to assistants not employed by the Practice;
- j) Post-operative homecare visits to Dr. Associate's patients his request;
- k) Merchant processing fees for acceptance of credit cards and for personal check verification on behalf of Dr. Associate's patients; these fees are at the Practice's discounted rate;
- l) Any collection and/or legal fees incurred in the collection of a debt owed to Dr. Associate by patients;
- m) Fees for outsourced insurance collection services;
- n) Personal accounting and legal services; and costs for any special supplies or services not normally provided by the Practice.

From time to time, additional expenses not listed here may require inclusion in deductions from collections received by Dr. Associate. He has the right to examine the books of the Practice at any time for the duration of contract term with the Practice.

III.7 OFFICE SPACE, SERVICES, AND FACILITIES: The following will be provided by the Practice and is included in the 50% of Dr. Associate's ANP retained by the Practice:

- a) Adequate office space.
- b) Insurance claims filing; billing and collection services; (provided these services are provided in-house). Collection services contracted outside of the practice are paid for by Dr. Associate.
- c) Access to patient data base;
- d) Telephone access and communication features such as voice mail and email;
- e) Non-physician medical and administrative staff;
- f) Use of Practice Fax machine, copy machine, and other related office equipment, excluding personal computer (IT personnel will be provided to allow access to required Practice data bases via Dr. Associate's personal computer);
- g) Business cards and Practice stationery with Dr. Associate's name included;
- h) Pager and answering service;
- i) Business-related long distance phone calls;
- j) Postage for any mail used for the purposes of marketing. (Mass mail-outs which promote Dr. Associate only will be paid for by Dr. Associate.);
- k) Other facilities and services suitable to his position for the performance of his duties, as may be reasonably determined by the Practice.

III.8 GROUP HEALTH INSURANCE BENEFITS: As an associate plastic surgeon, Dr. Associate and his dependents will be eligible to enroll in the Practice's group health insurance plan on the first day of the month falling within 90 days of his start date. However, since Dr. Associate is currently a Fellow at the Practice, he is already covered under the group health insurance plan and there should be no interruption in coverage, unless he desires to seek coverage elsewhere. If Dr. Associate wishes to provide health insurance benefits to a spouse or any dependents, he will be responsible for the monthly premiums for said dependents. Neither Dr. Associate nor his dependents are required to avail themselves of the Practice's group health benefits plan, and may seek health benefits coverage elsewhere. Should the Practice elect to no longer provide and pay for group health insurance benefits for employees and physicians, the Practice will provide at least three months advanced written notice of this decision to Dr. Associate.

ARTICLE IV
MARKETING, ADVERTISING, PROMOTING, AND PUBLIC RELATIONS

IV.1 “ MARKETING” PATIENTS: “Marketing” patients, defined as patients who contact the Practice without specifically requesting one of the physicians, will be distributed among the physicians in the Practice as defined by majority vote of the partnership. Practice will provide Dr. Associate with a pro rata number of cosmetic patient appointments scheduled per month in which the patient did not request a specific physician, provided there are sufficient marketing patients seeking Practice services. Patients specifically requesting a physician will be distributed to that specific physician.

IV.2 PRACTICE (“GROUP”) ADVERTISING/PROMOTIONS: The Practice considers marketing, promotional campaigns, and public relations activities a major contributor to its past and ongoing success. The Practice is aware of the value of marketing the Practice as a group. Practice participation in marketing and advertising endeavors will be determined by unanimous vote of the Partners. The Practice will include Dr. Associate in all advertising activities which specifically promote all physicians in the Practice as a group; and such participation is included in the Practice's group marketing budget. There will be no additional charge for such activities, provided there is no charge allocated PER PHYSICIAN by the vendor. Dr. Associate will be expected to participate in group marketing activities as directed by the Practice by cooperating with marketing personnel for photo shoots; contributing material for practice publications; attending events; maintaining his own website; and participating in the continuing education of staff.

IV.3 DR. ASSOCIATE ADVERTISING/PROMOTIONS: Any marketing endeavors, campaigns, promotions, and continuing education on behalf of Dr. Associate which are outside of those developed by the Practice or agents of the Practice, and do not include promotion of the entire Practice, may be paid for from the 10% Marketing Account. Such marketing projects will require the prior approval of the Partners' majority vote, but it is expected that Dr. Associate will use good judgment with regard to the quality, venue, and distribution of marketing endeavors, ensuring that they represent the positive reputation of the Practice in the community. Should the Partners, by majority vote, feel that the venture will have a negative impact on the Practice, Dr. Associate will be notified that he must immediately discontinue the venture. Like the Practice, Dr. Associate must abide by all marketing standards set forth by ASPS and ASAPS. Continuing to participate in unapproved marketing ventures is a cause for termination of this contract, at which time Dr. Associate will be asked to leave the Practice.

IV.4 INTERNET PARTICIPATION: The Practice has developed and promotes numerous web sites that feature all physicians of the Practice. Dr. Associate will be included in these web sites and an outbound link to his personal web site will be provided as appropriate. Inbound links from Dr. Associate's web site to the group websites will be allowed as appropriate.

IV.5 WEB SITE OWNERSHIP: Dr. Associate is free to purchase his own URLs/Domain Names. He will be responsible for all costs associated with the purchase, development, optimization, and maintenance of such. However, Practice requires that all content be in good taste and adhere to all legal requirements, as well as ethical guidelines set forth by the American Society of Plastic Surgeons (ASPS) and the American Society for Aesthetic Plastic Surgery (ASAPS).

IV.6 SIGNATURE BROCHURE: It is recommended that Dr. Associate have a professional brochure which promotes Dr. Associate and reflects the elite status of the Practice. The size and exterior graphic and design of the brochure should be similar to that of

other physicians in the practice to promote the strength and unity of the group. This may be paid for by Dr. Associate, and the 10% Marketing Account, as described in Section III.3, may be used for this purpose. The brochure will have the legal name of the Practice, "The Aesthetic Center for Plastic Surgery" on the front of the brochure along with Dr. Associate's name. The back cover of the brochure will be the same for all physicians of the group: the brochure will have the official group photograph of all of the physicians, the office locations and main telephone number. Dr. Associate will have control over the content, internal layout, color selections, photographs, etc., provided that these are in compliance with Practice requirements and ASPS and ASAPS guidelines. The Practice suggests that Dr. Associate wait until such time as he has obtained board certification, admission into ASPS, and enough before/after photos to warrant printing.

ARTICLE V TERMINATION OF AGREEMENT

V.1 TERMINATION OF DR. ASSOCIATE: This Agreement will terminate upon the first of the following to occur:

- a) **TERMINATION BY DR. ASSOCIATE:** If, for any reason, Dr. Associate terminates this Agreement prior to the expiration of the term of this Agreement as referenced in Article II, he must do so in writing with at least 3 months notice to the Practice. The Practice will disburse to Dr. Associate any amounts collected by the Practice for services performed by Dr. Associate during the 3-month period per Article III of this Agreement. After Dr. Associate provides written notice of his intent to leave, the Practice will continue to provide the same services as outlined in this Agreement; and Dr. Associate will continue to remit all payments received to the Practice as outlined in Article III. Should Dr. Associate wish to terminate the Agreement with less than the required 3-month notice period, the Practice will be relieved from the obligation to pay any other amounts to Dr. Associate otherwise due pursuant to Article III of this Agreement.
- b) **DEATH OF DR. ASSOCIATE:** The death of Dr. Associate will terminate this Agreement. Any professional fees collected by the Practice for services rendered by Dr. Associate will be disbursed by the Practice to Dr. Associate's estate pursuant to the terms of Article III hereof.
- c) **ILLNESS OR OTHER INCAPACITY:** If Dr. Associate, during the term of this Agreement, fails to perform his duties hereunder as a result of illness or other incapacity for a period of more than 3 (three) consecutive months, the Practice may, at its option, terminate this Agreement as of a date to be specified in a notice of termination, such date to be not less than 30 (thirty) days after the sending of the notice. If Dr. Associate's illness or incapacity will have ended, and Dr. Associate will have assumed his duties hereunder prior to the date specified in the notice of termination, he will be entitled to resume performance of his duties hereunder as if such notice had not been given.
- d) **TERMINATION FOR CAUSE:** If Dr. Associate fails to maintain his license to practice medicine in the State of Texas; fails to maintain necessary hospital privileges; fails to maintain uninterrupted certification by the American Board of Plastic Surgery; fails to maintain malpractice insurance coverage limits designated by the Practice; fails to perform his duties in a competent manner; is convicted of, pleads guilty to, nolo contendere to, or receives deferred adjudication for a felony; is convicted of, pleads guilty to, nolo contendere to, or receives deferred adjudication for a misdemeanor involving moral turpitude; embezzles or otherwise steals from the Practice; is under the influence of alcohol or drugs while performing any professional services for the Practice; or undergoes treatment for drug or alcohol

addiction under the authority of a regulatory board, such as the Texas State Board of Medical Examiners, the Practice may, at its option, terminate this Agreement and such termination shall be treated as a voluntary termination by Dr. Associate under Section V.1-A, and Dr. Associate shall be liable to Practice for any amounts due under Article III as if the termination were a voluntary termination by Dr. Associate.

- e) **DISSOLUTION:** The dissolution or liquidation of the Practice, whether voluntary or involuntary, will terminate this Agreement upon ninety (90) days advance written notice of same from the Practice to Dr. Associate. Any professional fees collected by the Practice for services rendered by Dr. Associate will be disbursed by the Practice to Dr. Associate pursuant to the terms of Section III.1 hereof.
- f) **EXPIRATION:** The expiration of the term of this Agreement, as provided for in Article II, supra, will terminate this Agreement.

V.2 EFFECT OF TERMINATION ON OFFICE EQUIPMENT/MEDICAL RECORDS:

Dr. Associate has the right to his patients' medical records when he leaves. However, since these patients were seen and treated while he was an associate of the Practice, the Practice reserves the right to continue to contact these patients with Practice newsletters, E-Blasts, post-cards, emails, etc., to inform them about Practice promotions and events. The Practice retains exclusive ownership of the office space (including all benefits and privileges associated with the lease thereof) plus all telephone numbers, supplies, equipment, marketing brochures (except for Dr. Associate's personal brochure as discussed in Article IV) and written/telemarketing information and packages, patient evaluation forms, pre- and postoperative care forms, should this Agreement be terminated and otherwise no longer be valid. Dr. Associate retains ownership of all equipment and furnishings paid for by Dr. Associate.

V.3 EFFECT OF TERMINATION ON MARKETING ACCOUNT: Should Dr. Associate's agreement be terminated by any of the events outlined in Section V.1, he will forfeit any balance in his Marketing Account (Section III.3).

V.4 EFFECT OF TERMINATION ON ADVANCES: Should Dr. Associate's agreement be terminated by any of the events outlined in Section V.1, he will be responsible for repaying the balance, if any, on advances issued to Dr. Associate as described in Section III.2.

ARTICLE VI INSURANCE/INDEMNIFICATION

VI.1 INSURANCE: Dr. Associate will carry a medical malpractice liability insurance policy to be issued to cover any claims arising out of the performance of Dr. Associate during the term of this Agreement. The policy will be written on an occurrence basis and minimum coverage limits will be \$500,000/\$1,500,000. Should circumstances dictate that these limits be changed, the Partners will determine new minimum limits by majority vote. Dr. Associate will be given a minimum of 60 days written notice informing him of the change. The policy will be in effect during the entire term of this Agreement. Dr. Associate will be solely responsible for paying the premium for this policy. Although not required, it is strongly recommended that Dr. Associate elect coverage with the same insurance carrier as the Practice. Should Dr. Associate seek coverage with another carrier, the carrier must be approved by the Practice in advance and the carrier must meet minimum ratings as determined by the Practice.

VI.2 INDEMNIFICATION OF PRACTICE: Dr. Associate hereby indemnifies and holds the Practice and its Partners harmless for any claim or cause of action based on

negligence, bad faith, or malpractice of Dr. Associate, which may be asserted against Dr. Associate or any of his agents, employees, or representatives.

VI.3 INDEMNIFICATION OF DR. ASSOCIATE: Practice hereby indemnifies and holds Dr. Associate harmless for any claim or cause of action based on negligence, bad faith, or malpractice of other physicians in the Practice or the Practices agents, employees or representatives.

ARTICLE VII ASSIGNMENT/SUCCESSORS

VII.1 ASSIGNMENT: Neither this Agreement nor any duties or obligations hereunder will be assignable by Dr. Associate without the prior written consent of the Practice. In the event of an assignment by Dr. Associate to which the Practice has consented, the assignee or his legal representative will agree in writing with the Practice to personally assume, perform, and be bound by the covenants, obligations, and agreements contained herein.

VII.2 SUCCESSORS: Subject to Section V.1, this Agreement will be binding on the heirs, executors, administrators, legal representatives, successors, and assigns of the Practice.

ARTICLE VIII ADVANCEMENT

VIII.1 CONSIDERATION AS PARTNER/CO-OWNER in Aesthetic Center for Plastic Surgery, LLP (ACPS, LLP), the "Practice": The Practice will evaluate Dr. Associate for partnership in the Practice based upon satisfactory adherence to the terms of this Agreement, and if his productivity is adequate to cover his share of Practice expenses. This offer may be considered at any time during the three years of this Agreement.

ARTICLE IX EFFECT OF TERMINATION

IX.1 NO NON-COMPETITION BUT TERMINATION OF PRIVILEGES: It is agreed that in the event of termination of this Agreement, either by voluntary withdrawal of Dr. Associate, or by his dismissal by the Practice, or for any other reason, Dr. Associate may continue to practice medicine at any hospital, medical office building, or outpatient surgery center in Houston. However, it is agreed that Dr. Associate's staff privileges at ACPS The Surgicentre shall be automatically terminated in the event of a termination of this Agreement.

IX.2 ASSUMED NAMES: The Practice utilizes the names of: [Practice should list all web sites, logos, etc.]

Dr. Associate will have no claims to these titles or names, other than those claims described in Section IV.6 and can only utilize such names while Dr. Associate is associated with the Practice by independent contractor agreement, unless the Practice and Dr. Associate have agreed otherwise.

ARTICLE X GENERAL

X.1 NOTICE: Any notice required or permitted to be given under this Agreement will be sufficient if in writing and sent by mail to the other party's residence or principal office, as the case may be, and will be effective when received.

X.2 AMENDMENT: No amendment or modification of this Agreement will be deemed effective unless or until executed in writing by the parties hereto with the same formality attending execution of this Agreement.

X.3 ENTIRE AGREEMENT: This Agreement supersedes any and all other agreements, either oral or in writing, between the parties with respect to the subject matter herein, and no other agreement, statement, or promise relating to the subject matter of this Agreement that is not contained herein will be valid or binding unless in writing and signed by both parties.

X.4 ATTORNEY'S FEES: If any action at law or in equity is brought to enforce or interpret the provisions of this Agreement, the prevailing party will be entitled to reasonable attorney's fees in addition to any other relief to which he may be entitled.

X.5 LEGAL CONSTRUCTION: In case any one or more of the provisions contained in this Agreement will for any reason be held to be invalid, illegal, or unenforceable, in any respect, such invalidity, illegality, or unenforceability will not affect any other provisions and this Agreement will be construed as if such invalid, illegal, or unenforceable provisions had never been contained herein.

X.6 GOVERNING LAW: The validity of this Agreement and of any of its terms or provisions, as well as the rights and duties of the parties, will be governed by the laws of the State of Texas.

X.7 COUNTERPARTS: This Agreement may be executed in one or more counterparts, all of which together will be one and the same instrument.

X.8 LIMITATION OF AUTHORITY: Without the expressed written consent of the Practice, Dr. Associate shall have no authority to pledge the credit of the Practice or any of its employees, bind the Practice under any agreement or release or discharge any debt due to the Practice, or transfer any assets of the Practice.

EXECUTED, at Houston, Texas, on this the _____ day of _____, 2017, but effective for all purposed from and after 12:01 am, July 1, 2018.

THE PHYSICIAN:

Associate, M.D., P.L.L.C. DATE

THE PRACTICE:

_____, M.D., P.A. DATE

STATE OF

COUNTY OF BEFORE ME, the undersigned authority, on this day personally appeared Drs. _____, _____, _____, and _____, known to me to be the persons whose names are subscribed to the foregoing instrument, and acknowledged to me that all persons executed the same for the purpose and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE THIS _____ Day of _____, 2017.

NOTARY PUBLIC in and for the State of
My commission expires: _____

5.12.3 Appendix 5C

Professional Services Agreement: 5-Year Term (Courtesy of Christopher K. Patronella)

This Agreement for Professional Services (this "Agreement"), made and executed as of _____, 2018, by and between THE PRACTICE and _____, M.D., P.A., (the "Associate").

WITNESSETH:

WHEREAS, the Practice is engaged in a plastic surgery medicine practice; and

WHEREAS, the Practice provides professional medical and related services ("Services"); and

WHEREAS, the Associate is a Physician duly licensed to practice medicine in the State of Texas; and

WHEREAS, the Practice desires to engage the services of the Associate under the terms and conditions of this Agreement; and

WHEREAS, the Associate desires to assist the Practice by rendering professional medical services as set forth herein;

AGREEMENT

NOW, THEREFORE, in consideration of the premises herein and other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, and with intent to be legally bound, the parties mutually agree as follows:

ARTICLE I SERVICES

I.1 RELATIONSHIP: The Practice hereby engages the Associate and the Associate accepts such engagement to render professional medical services on behalf of the Practice as an Associate/Associate/independent contractor of the Practice.

I.2 ACTIVITIES OF ASSOCIATE: During the term of this Agreement, the Associate will:

- a) Render medical and surgical services to patients in the manner and extent permitted by the applicable state statutes and canons of professional ethics;
- b) Provide training, supervision, and direction to non-Associate and Associate personnel as may be reasonably required and appropriate for the operation and success of her practice;
- c) Provide medical and surgical services pursuant to any "on duty" and "on call" assignments scheduled by the Associate.
- d) Use the Associate's best efforts to promote the interests of the Practice;
- e) Be and remain an Associate duly licensed by the State of Texas and comply with and be governed by the ethics and standards of care of the medical community in which the Associate will provide services hereunder;
- f) Make entries on patient medical records consistent with the Practice's procedures and assist the Practice in the preparation of third-party payment claim forms and other reports and documents as reasonably appropriate;
- g) Seek to maintain and improve her professional skills;
- h) Promote the activities of the Practice and enhance professional standing in the community, by diligently pursuing positive and constructive relationships with patients, hospital administration, and other members of the medical community, and conscientiously marketing the Practice's services consistent with Practice policies, professional ethics, and applicable law.

- i) Perform such other duties upon which the Practice and the Associate may from time to time mutually agree; and,
- j) Without limiting the foregoing, the Associate's primary duties will be in the field of plastic surgery.
- k) **DEVOTION OF TIME:** It is agreed that the relationship between the Practice and the Associate is mutually beneficial. Because the Practice dedicates marketing, promotional, and public relation resources which include the Associate, the Associate is expected to devote adequate time for the development of her practice. The Practice will provide adequate clinic facilities, staff, and time for the Associate to treat patients in the office locations. Although the Practice's staff will post clinic appointments on behalf of the Associate in the patient data-management system, the Associate is responsible for the maintenance of her own clinic scheduling patterns.
- l) The Practice considers clinical research in the field of plastic surgery an important part of its contribution to the medical community. The Associate is encouraged to devote a portion of her time to participation in ongoing research projects implemented by the Practice. Associate shall write a minimum of one research paper during the term of this contract.

1.3 ASSOCIATE QUALIFICATIONS: The Associate will exercise her best efforts to maintain hospital medical staff privileges as necessary to perform her duties hereunder. The Associate warrants that he is licensed to practice medicine in the State of Texas, and that he is board-certified in plastic surgery, or is board-eligible and will seek and obtain certification by the American Board of Plastic Surgery within 3 (three) years of the initial date of this contract. Associate will maintain this board certification throughout her association with the Practice. Associate will seek and obtain membership in the American Society of Plastic Surgeons (ASPS) and in the American Society for Aesthetic Plastic Surgery (ASAPS), and will remain a member in good standing throughout her association with the Practice.

1.4 Failure of the Associate to adhere to the following will constitute grounds for immediate termination of this Agreement by the Practice:

- (i) Maintain her license to practice medicine in the State of _____;
- (ii) Obtain and maintain hospital medical staff privileges during the term of this Agreement;
- (iii) Maintain uninterrupted certification by the American Board of Plastic Surgery; and
- (iv) Maintain malpractice insurance coverage limits designated by the Practice.

1.5 POLICIES AND PROCEDURES: The Associate will abide by and adhere to existing operating policies and procedures of the Practice.

ARTICLE II TERM

II.1 DURATION OF ENGAGEMENT: This Agreement commences on August 01, 2017 at 12:01 AM (the "Initial Date"). This Agreement will have a term of four (4) years and eleven (11) months (August 1, 2017 to June 30, 2022) unless terminated earlier in accordance with Article IV hereof.

II.2 RENEWAL OF ENGAGEMENT: Each party shall provide written notice to the other party no less than twelve (12) months prior to the end of the Initial Term stating its intent to renew or not to renew this Agreement for a period of five (5) years—July 1, 2022 to June 30, 2027—(a "Renewal Term," and together with the Initial Term, the

"Term"). Should both parties agree to a Renewal Term, each of the Practice and the Associate shall execute a new agreement for professional services, in a form determined by the Practice in its sole discretion, which shall commence on the date of expiration of the then current Initial Term or Renewal Term, as the case may be, of this Agreement. This Agreement will continue until the end of the Term as agreed under the provisions hereof unless and until terminated as set forth below in Article IV.

ARTICLE III COMPENSATION AND BENEFITS

III.1 COMPENSATION: For convenience to Dr. Associate and to his patients, the Practice agrees to collect payments from patients and third party payers, and pay certain expenses for him. Dr. Associate is expected to remit all payments received for his services to the Practice for accounting and processing. Payments include those received for plastic surgery and related services, whether performed at Practice facilities or at other facilities.

III.2 DETERMINATION OF NET COLLECTIONS or "ADJUSTED NET PMTS" (ANP): For convenience to the Associate and to her patients, the Practice agrees to collect payments for Associate from patients and third party payers, and pay certain expenses for Associate. Net collections (ANP) are determined by deducting the following items (expenses) from gross amounts collected from patients or third party payers: implants; garments; anesthesia fees; operating room fees; supplies not included in the operating room fee; cost of consumable products including, but not limited to, "injectables" such as Botox, Dysport, Restylane, Juvederm, etc.; rental fees for equipment provided by third-party vendors; rental fees associated with the use of Practice-owned specialized equipment including, but not limited to, lasers; fees to assistants not employed by the Practice; post-operative homecare visits to Associate's patients at the request of the Associate; merchant processing fees for acceptance of credit cards and for personal check verification on behalf of Associate's patients; any collection and/or legal fees incurred in the collection of a debt owed to Associate by patients; and fees for outsourced insurance collection services. Associate is paid 50% of her monthly ANP, less any outstanding overhead amounts owed to the Practice as described in Section III.3. Items deducted from the 50% of ANP include marketing fees for individual (non-group related) marketing efforts, including preparation of photos for use in advertising, or other marketing expenses not described as "covered" by the Practice in this contract; cost for the preparation of before/after photo books; personal accounting and legal services; and costs for any special supplies or services not normally provided by the Practice. From time to time, additional expenses not listed here may require inclusion in deductions from gross amounts or from the 50% ANP paid to Associate. Associate has the right to examine the books of the Practice at any time during the duration of this Agreement.

III.3 OVERHEAD CALCULATION AND RECONCILIATION

- a) **OVERHEAD CALCULATION:** In order to provide adequate staff, facilities, supplies, and patient management necessary to grow and maintain the Associate's practice, expense is incurred by the Practice. The following minimum overhead schedule is based upon Associate's historical performance, and the expectation that Associate's practice will grow such that contributing a fair share of overhead will not be burdensome. Associate will be responsible for contributing the following minimum amounts for the duration of the Agreement:
 - August 1, 2017 through June 30, 2018, Associate is responsible for minimum overhead expense of \$25,000/month (\$75,000 per quarter) or 50% of her Net Collections (ANP), whichever is greater.

- July 1, 2018, through June 30, 2019, Associate is responsible for minimum overhead expense of \$29,000/month (\$87,000 per quarter) or 50% of her Net Collections (ANP), whichever is greater.
 - July 1, 2019, through June 30, 2020, Associate is responsible for minimum overhead expense of \$33,000/month (\$99,000 per quarter) or 50% of her Net Collections (ANP), whichever is greater.
 - July 1, 2020, through June 30, 2021 Associate is responsible for minimum overhead expense of \$37,500/month (\$112,500 per quarter) or 50% of her Net Collections (ANP), whichever is greater.
 - July 1, 2021, through June 30, 2022, Associate is responsible for minimum overhead expense of \$42,000/month (\$126,000 per quarter) or 50% of her Net Collections (ANP), whichever is greater.
- b) **OVERHEAD RECONCILIATION:** During the month following the last month of the previous quarter, Associate's minimum contribution to overhead expense during the last quarter will be reconciled. For example the third quarter 2017 would be reconciled in October, 2017. Should 50% of Associate's ANP for the previous quarter be less than her share of the actual overhead expense, the difference will be deducted from the first distribution owed to Associate for the first month of the next quarter. For example, if 50% of Associate's ANP totals \$80,000 for quarter of October-December, and her share of actual group expense obligation is \$87,000 for the same quarter, then Associate will owe the Practice \$7,000 which will be deducted from her 50% distribution for the first month of the next quarter (January).
- c) **LIMIT ON CUMULATIVE OVERHEAD OWED TO PRACTICE:** At the end of a quarterly reconciliation interval, should overhead owed to the Practice by Associate exceed her total ANP for the month immediately following the previous quarter, meaning there is not sufficient distribution to deduct what Associate owes from the previous quarter, Associate will be asked to pay the Practice her share of last quarter's group expense by the 15th day of the 2nd month of the next quarter. For example, at the end of the October-December quarter, if Associate owes Practice \$20,000 in overhead expense, and her total ANP for the first month of the next quarter (January) is \$30,000, Associate will not receive a 50% of ANP distribution (\$15,000) for January. Practice will apply the entire \$15,000 to the \$20,000 overhead owed, and Associate will pay the Practice the remaining \$5,000 in overhead (\$20,000 – \$15,000) by the 15th day of the second month of the next quarter (February 15). Should Associate fail to meet minimum overhead requirements outlined in this Agreement, the Practice at its discretion can choose to (i) terminate this Agreement in accordance with Article IV and/or (ii) withhold any such amounts that are due to Associate, including compensation and future collections.

III.4 OFFICE SPACE, SERVICES, AND FACILITIES: The following will be provided by the Practice and are included in the share of Net Collections retained by the Practice in the minimum overhead requirement.

III.5 ADEQUATE OFFICE SPACE:

- a) Access to patient data base;
- b) Telephone access and communication features such as voice mail and email;
- c) Adequate non-Associate medical staff, administrative staff, and clinic space/time contingent upon activity and volume of patients.
- d) Use of Practice Fax machine, copy machine, and other related office equipment, excluding personal computer (IT personnel will be provided to allow access to required Practice data bases via Associate's personal computer);

- e) Business cards and Practice stationary with Associate's name included;
- f) Pager and answering service;
- g) Business-related long distance phone calls;
- h) Postage for any mail used for the purposes of marketing which identifies all members of the Practice;
- i) Other facilities and services suitable to her position for the performance of his duties, as may be reasonably determined by the Practice.

III.6 "MARKETING" PATIENTS: "Marketing" patients, defined as patients who contact the Practice without specifically requesting one of the Associates, will be distributed among the Associates in the Practice as defined by majority vote of the partnership. Practice will provide Associate with a share of cosmetic patient appointments scheduled per month in which the patient did not request a specific doctor, provided there are sufficient marketing patients seeking Practice services. Patients specifically requesting an Associate will be distributed to that specific Associate.

III.7 ADVERTISING/PROMOTIONS:

- a) The minimum advertising/marketing budget for the following calendar year will be determined prior to December 31 and will be based upon two percent (2%) of Gross Revenue of the four (4) most recently completed accounting quarters. For example, if the gross income between October 1, 2014 and September 30, 2015 is \$19,000,000, the group marketing budget for 2016 will be \$380,000. If the Practice is presented with a marketing opportunity in which it is likely that the group advertising budget will be exceeded, it will require a majority vote by the Partners before it will be presented to the Associate Associate(s) for consideration. After it is presented to the Associate Associate(s), the Practice will pursue the endeavor if a majority vote by the Partners as well as the Associate Associate(s) is obtained. Should the majority elect to pursue the endeavor, then all Partners and Associate Associate(s) will be required to pay an equal share of this endeavor.
- b) Any marketing endeavors, campaigns, promotions, and continuing education on behalf of the Associate which are outside of those developed by the Practice or agents of the Practice, and do not include promotion of the entire Practice shall be paid for entirely by the Associate personally. Such marketing projects will require the prior approval of the Partners' majority vote, but it is expected that the Associate will use good judgment with regard to the quality, venue, and distribution of marketing endeavors, ensuring that they represent the positive reputation of the Practice in the community. Should the Partners, by majority vote, feel that the venture will have a negative impact on the Practice, the Associate must immediately discontinue the venture. Like the Practice, Associate must abide by all marketing standards set forth by ASPS and ASAPS. Continuing to participate in unapproved marketing ventures is a cause for termination of this contract, at which time the Associate will be asked to leave the Practice.

III.8 INTERNET PARTICIPATION: The Practice has developed and currently maintains one or more sites ("group sites") which promote ALL Associates and services the practice offers. The maintenance and promotion of these group sites is a part of the group marketing expense budget. The Associate is expected to participate in not only the development of her own section of the site, but to contribute her knowledge to the improvement of the site(s) overall. Should the Associate desire changes to her information on these group sites which is beyond the basic development and maintenance available to all Associates represented on the site, this will be considered an individual expense to the Associate.

III.9 PERSONAL WEB SITE OWNERSHIP: The Associate is expected develop, promote and maintain her image in the community. This includes ownership, development, maintenance and promotion of her own personal web site within the guidelines of the Practice and ASPS and ASAPS standards.

III.10 SIGNATURE BROCHURE: Each plastic surgeon of the Practice is expected to have a professional brochure which promotes the Associate and reflects the elite status of the Practice. The size and exterior graphic and design of the brochure should be similar to that of other Associates in the practice to promote the strength and unity of the group. The brochure will have the legal name of the Practice, "The Aesthetic Center for Plastic Surgery" as well as the Practice logo on the front of the brochure along with the Associate's name. The back cover of the brochure will be the same for all Associates of the group: the brochure will have the official group photograph of all of the Associates, the group web site (www.MyBeautifulBody.com), the office locations and main telephone number. Associate will have control over the content, internal layout, color selections, photographs, etc. The Associate will have a brochure completed and printed within 6 months after the commencement date of this Agreement. Associate is expected to continue to print and distribute her brochure to prospective patients, updating as necessary.

III.11 GROUP HEALTH INSURANCE BENEFITS: As an Associate Plastic Surgeon, Associate will be eligible for group health benefits 90 days after he begins her affiliation with the Practice. The Associate will be responsible for payment of her premium. If the Associate wishes to provide health insurance benefits to a spouse or any dependents, he/she will be responsible for the monthly premiums for said dependents.

ARTICLE IV TERMINATION OF AGREEMENT

IV.1 TERMINATION OF ASSOCIATE: This Agreement will terminate upon the first of the following to occur:

- a) **TERMINATION BY ASSOCIATE:** If, for any reason, Associate terminates this Agreement prior to the expiration of the Term of this Agreement, he must do so in writing with at least 12 months' notice to the Practice. The Practice will disburse to the Associate any amounts collected by the Practice for services performed by the Associate during the 12-month period per Section III.3 of this Agreement. After the Associate provides written notice of her intent to leave, Practice will continue to provide the same services as outlined in this Agreement, provided that Associate continues to pay the Practice her minimum overhead requirement. Should Associate wish to terminate this Agreement with less than the required 12-month notice period, the Practice will be relieved from the obligation to pay any other amounts to the Associate otherwise due pursuant to Section III.1 of this Agreement. In addition, Associate will be required to pay her share of the overhead as defined in Article III, Section III.3, for each month less than the 12-months required notice. For example, if minimum overhead expense is \$33,000 per month, should the Associate leave with two months left in her contract Associate will pay the Practice \$66,000 (\$33,000 for each month short of the 12-month notice period). This is due no later than 30 days after Associate's last day at the Practice.
- b) **DEATH OF ASSOCIATE:** The death of the Associate will terminate this Agreement. Any professional fees collected by the Practice for services rendered by Associate will be disbursed by the Practice to the Associate's estate pursuant to the terms of Section III.1 hereof.

- c) **ILLNESS OR OTHER INCAPACITY:** If the Associate, during the term of this Agreement, fails to perform her duties hereunder as a result of verifiable illness or other incapacity for a period of more than three (3) consecutive months, the Practice may, at its option, terminate this Agreement as of a date to be specified in a notice of termination, such date to be not less than thirty (30) days after the sending of the notice. Upon termination of this Agreement by the Practice, Associate is responsible for her share of the overhead owed per Section III.3 of this Agreement for ONLY the months of disability prior to termination of this Agreement.

If the Associate's illness or incapacity will have ended in three (3) or less consecutive months, and the Associate will have assumed her duties hereunder prior to the date specified in the notice of termination, he will be entitled to resume performance of her duties hereunder as if such notice had not been given. Associate must pay the overhead due for the time he was incapacitated. This should be paid within 30 days upon her return. Should Associate provide a written request to return to the Practice after this Agreement has been terminated, acceptance of Associate's return will require majority vote by the Owners. Associate will be notified of the results of vote and terms of Associate's return within 45 days after receipt of the Associate's written request to return.

- d) **TERMINATION FOR CAUSE:** If the Associate fails to maintain her license to practice medicine in the State of Texas; fails to maintain necessary hospital privileges; fails to perform her duties in a competent manner; is convicted of, pleads guilty to, nolo contendere to, or receives deferred adjudication for a felony; is convicted of, pleads guilty to, nolo contendere to, or receives deferred adjudication for a misdemeanor involving moral turpitude; embezzles or otherwise steals from the Practice; is under the influence of liquor or drugs while performing any professional services for the Practice; or undergoes treatment for drug or alcohol addiction under the authority of a regulatory board, such as the Texas State Board of Medical Examiners; or fails to comply with the minimum required overhead requirements as outlined in Article III, the Practice may, at its option, terminate this Agreement immediately.
- e) **TERMINATION WITHOUT CAUSE:** At any time during the Term of this Agreement, the Practice may terminate this Agreement without cause, upon at least 12 months' advance written notice to the Associate.
- f) **DISSOLUTION:** The dissolution or liquidation of the Practice, whether voluntary or involuntary, will terminate this Agreement upon ninety (90) days advance written notice of same from the Practice to the Associate. Any professional fees collected by the Practice for services rendered by Associate will be disbursed by the Practice to the Associate pursuant to the terms of Section III.1 hereof.
- g) **EXPIRATION:** The expiration of the Term of this Agreement, as provided for in Article II, supra, will terminate this Agreement.
- h) This Agreement will terminate if Associate becomes a partner in the Practice.

IV.2 EFFECT OF TERMINATION ON OFFICE EQUIPMENT: Associate has the right to her patients' medical records when he leaves. The Practice retains exclusive ownership of the office space (including all benefits and privileges associated with the lease thereof) plus all telephone numbers, supplies, equipment, marketing brochures and written and telemarketing information and packages, patient evaluation forms, pre- and post-operative care forms, should this Agreement be terminated and otherwise no long be valid. Associate retains ownership of all equipment and furnishings paid for by Associate.

IV.3 EFFECT OF TERMINATION ON MARKETING: Upon termination of this Agreement, Associate will remove all references to the Practice from Associate's personal web site(s) within 30 days of termination of this Agreement. The Practice will remove all references to the Associate from its web site(s) within 30 days of termination of this Agreement. With regard to other Practice marketing venues, such as print, radio, television, etc., references to Associate in will be removed as soon as possible, as some of these marketing media have been prepared in advance or are already in production, and are not easily changed.

ARTICLE V INSURANCE/INDEMNIFICATION

V.1 INSURANCE: The Associate will carry a medical malpractice liability insurance policy to be issued to cover any claims arising out of the performance of the Associate during the term of this Agreement. The policy will be written on an occurrence basis and minimum coverage limits will be \$500,000/\$1,500,000 (annual claim limit/aggregate limit). Should circumstances dictate that these limits be changed, the Partners will determine new minimum limits by majority vote. The Associate will be given a minimum of 60 days written notice informing him of the change. The policy will be in effect during the entire Term of this Agreement. The Practice will be responsible for paying the premium for the policy, but the cost of the premium will be deducted from the 50% of net collections paid to Associate.

V.2 INDEMNIFICATION OF PRACTICE: Associate agrees to hold the Practice and its Partners harmless for any claim or cause of action based on negligence, bad faith, or malpractice of Associate, which may be asserted against the Associate or any of her agents, employees, or representatives.

V.3 INDEMNIFICATION OF ASSOCIATE: Practice agrees to hold the Associate harmless for any claim or cause of action based on negligence, bad faith, or malpractice of other Associates in the Practice or the Practice's agents, employees or representatives.

ARTICLE VI ASSIGNMENT/SUCCESSORS

VI.1 ASSIGNMENT: Neither this Agreement nor any duties or obligations hereunder will be assignable by the Associate without the prior written consent of the Practice. In the event of an assignment by the Associate to which the Practice has consented, the assignee or her legal representative will agree in writing with the Practice to personally assume, perform, and be bound by the covenants, obligations, and agreements contained herein.

VI.2 SUCCESSORS: This Agreement will be binding on the heirs, executors, administrators, legal representatives, successors, and assigns of the Practice.

ARTICLE VII ADVANCEMENT

VII.1 CONSIDERATION AS PARTNER/CO-OWNER in THE PRACTICE: The Practice will evaluate the Associate for partnership in the Practice based upon analysis of the foregoing services to be performed hereunder and compliance with the terms of this Agreement. If Associate's performance is reasonably acceptable to the Practice, and when Associate's productivity is adequate to cover expenses, Practice may offer Associate partnership status in the Practice. This offer may be considered at any time during the term of this contract.

ARTICLE VIII GENERAL

VIII.1 NOTICE: Any notice required or permitted to be given under this Agreement will be sufficient if in writing and sent by mail to the other party's residence or principal office, as set forth in the Practice's books and records, and will be effective when received.

VIII.2 AMENDMENT: No amendment or modification of this Agreement will be deemed effective unless or until executed in writing by the parties hereto with the same formality attending execution of this Agreement.

VIII.3 ENTIRE AGREEMENT: This Agreement supersedes any and all other agreements, either oral or in writing, between the parties with respect to the subject matter herein, and no other agreement, statement, or promise relating to the subject matter of this Agreement that is not contained herein will be valid or binding unless in writing and signed by both parties.

VIII.4 ATTORNEY'S FEES: If any action at law or in equity is brought to enforce or interpret the provisions of this Agreement, the prevailing party will be entitled to reasonable attorney's fees in addition to any other relief to which he may be entitled.

VIII.5 LEGAL CONSTRUCTION: In case any one or more of the provisions contained in this Agreement will for any reason be held to be invalid, illegal, or unenforceable, in any respect, such invalidity, illegality, or unenforceability will not affect any other provisions and this Agreement will be construed as if such invalid, illegal, or unenforceable provisions had never been contained herein.

VIII.6 GOVERNING LAW: The validity of this Agreement and of any of its terms or provisions, as well as the rights and duties of the parties, will be governed by the laws of the State of Texas.

VIII.7 COUNTERPARTS: This Agreement may be executed in one or more counterparts, all of which together will be one and the same instrument.

VIII.8 LIMITATION OF AUTHORITY: Without the expressed written consent of the Practice, Associate shall have no authority to pledge the credit of the Practice or any of its employees, bind the Practice under any agreement or release or discharge any debt due to the Practice, or transfer any assets of the Practice.

EXECUTED in Houston, Texas, on this, the ____ day of _____, 20__.

THE ASSOCIATE: _____

Dr New Associate M.D., P.A.

THE PRACTICE: THE AESTHETIC CENTER FOR PLASTIC SURGERY, L.L.P.

PARTNERS:

Dr Partner 1, M.D., P.A., Partner

Dr Partner 2, M.D., P.A., Partner

Dr Partner 3, M.D., P.A., Partner

5.12.4 Appendix 5D

Employment Agreement (Courtesy of Debra J. Johnson)

This Agreement is made on this day, _____, by and between _____, a professional corporation, hereinafter referred to as "Employer", and _____, MD, hereinafter referred to as "Employee".

Term: Unless terminated sooner as provided herein, the term of this Agreement shall be for one year from _____ to _____. This Agreement will be renewed annually upon the agreement of both parties.

Compensation: Employer shall pay to Employee during the term of this Agreement a beginning annual salary of _____, payable biweekly. This salary shall be subject to State and Federal tax withholding as required by law. This salary shall be adjusted annually as Employee's fee income increases. Employee shall eventually pay back all to Employer all salary received.

Service: Employee agrees to devote his/her entire time and attention to the practice of Employer and not to engage in any other business or occupation. In this connection, the making of passive investments shall not be construed as constituting another business or occupation. Without prior expressed authority of Corporation's Board of Directors, Employee shall not render services of a business or commercial nature to any other person or firm, whether alone or as a partner. Employee may be asked to participate in and perform certain duties pertaining to the business of Employer. Employee also agrees to provide _____% of Employer's on-call time.

Vacation: Employee shall be entitled to _____ weeks of paid vacation during the year of this contract. Office closures due to holidays are not considered vacation time off.

Disability: In the event Employee is mentally/physically disabled, the Unemployment Insurance Code of the State of _____ shall govern disability payments.

Continuing Education, Professional Fees, and other Employee Expenses: Employer shall pay necessary dues, membership fees, and other similar expenses in local, state, and national medical societies and associations as shall be agreed upon between Employer and Employee. Employee is entitled to one week of paid time off to attend medical conventions as approved by Employer.

Employee is expected to furnish a mobile telephone and automobile to use in connection with the provision of services.

Professional Liability Insurance: Employers shall be responsible for premium payment on behalf of Employee. If Employee's contract is terminated, Employee shall acquire and maintain tail coverage for any errors and omissions that might have occurred prior to termination of employment.

Life Insurance: Employer shall be responsible for life insurance premium payments for Employee, with a defined benefit of _____.

Major health and medical insurance: Benefits shall be available to Employee (and family) as provided for all eligible employees of Employer.

Profit-Sharing Plan: Employee is eligible to participate in the qualified profit-sharing plan of Employer after one year of service as defined by ERISA.

Professional Conduct, Obligations, and Restrictions: The Employer will assign patients to the Employee.

The Employee shall not engage in the practice of medicine outside of the employment with the Employer. All fees and compensation received from the practice of medicine shall belong to the Employer. The Employee shall at all times endeavor to practice

in the interest of the Employer, and shall give full time, attention, and utmost skill to said employment. Employee is allowed to provide call coverage at hospitals and to retain payment for such service, but only during days and nights when Employee is not on call for Employer.

The Employee can only refuse to treat a patient if approved by the Employer, and such refusal must be consistent with the Code of Ethics of the American Medical Association.

Employer shall determine professional fees charged by the Employee.

Termination of Contract: Either party upon 60 days written notice may terminate this Agreement. Employer may terminate this Agreement immediately if Employee engages in any personal misconduct or substance abuse, is found guilty of a felony, or is disciplined by any professional organization. In the event of termination, Employer shall retain all medical histories, files, and records. With a patient's written request, medical records and images shall be made available for copying by and at the expense of the withdrawing Employee.

5.12.5 Appendix 5E

Buy-In Agreement (Courtesy of Debra J. Johnson)

This Agreement, made on _____, is executed by and between _____, a professional corporation (herein "Corporation"), and _____MD.

The Corporation and _____MD have agreed that in exchange for the consideration described herein, _____MD shall become a shareholder in the Corporation. There are currently ____ shareholders in the Corporation. Each of the shareholders is in agreement with this buy-in as evidenced by the signatures below.

The shareholders entered into a stock redemption agreement on _____.

_____MD and his/her spouse evidence their Agreement to be bound to the terms of such stock purchase agreement by their execution of the copies of the agreement attached hereto.

The agreed-upon buy-in for _____MD's interest in the Corporation is \$_____. A promissory note attached hereto shall be executed to evidence _____MD's indebtedness with respect to this buy-in.

Following this Agreement, a new employment contract in the form attached hereto shall be entered into between _____MD and the Corporation.

Any claim or controversy arising out of any provision of this Agreement shall be settled by arbitration in accordance with the rules of the American Arbitration Association and consistent with the laws of the State of _____.

_____MD's position as a plastic surgeon within the specialized practice of the Corporation offers the opportunity to learn the particularly unique specialized and sophisticated services previously developed by the other shareholders in the Corporation. In addition, certain specific, unique, and proprietary-type procedures may be disclosed to _____, MD as a result of his/her involvement with the Corporation. For the foregoing reasons, _____, MD agrees that in the event employment is terminated with the Corporation, whether voluntary or involuntary, _____, MD will refrain for one year following the date of separation from utilizing those procedures as a sole physician or as part of any position or medical group, within 50 miles of the present corporate office location.

Partnership Buy-Out Agreement

The parties to this Agreement: _____ MD and _____, a General Partnership, hereby agree to the following:

1. _____ MD was a General Partner of _____.
2. The effective date of this withdrawal and purchase shall be _____.
3. Pursuant to the Agreement by the parties, the total buy-out of _____ MD shall be the sum of \$ _____. Such sum shall be paid in one lump sum upon the signing of this Agreement.
4. _____ agrees to indemnify and hold _____ MD from any and all liabilities and debts of the Partnership incurred from and after _____.
5. Notices to the Partnership shall be given to it at its principal place of business. Notices to _____ MD shall be mailed to (mailing address) or delivered personally.
6. The parties to this Agreement acknowledge the law firm of _____ to have represented the Partnership, the related Corporation and several of the partners including _____ MD. As such, they are in a Conflict of Interest with respect to representing any one single party. Each party is instructed to obtain individual counsel with respect to the meaning and effect of this documentation.

5.12.6 Appendix 5F

Employment Agreement: Aesthetic Fellowship Program (Courtesy of Christopher K. Patronella)

This agreement is made and executed by and between ____ a Texas Professional Association, hereinafter referred to as "Employer" and Dr. _____, M.D., hereinafter referred to as "Employee".

1. **Term.** Unless terminated sooner as provided herein, the term of this Agreement shall be from July 1, 2018 through June 30, 2019.
2. **Compensation.** Employer shall pay to Employee a base salary of sixty thousand U.S. dollars (\$60,000.00) for the term of this twelve (12) month contract, payable biweekly, with the first pay day being July 27, 2018. This salary shall be subject to withholding of State and Federal taxes as required by law. The employee will be salaried and will not be eligible for overtime pay or quarterly bonuses.
3. **Service.** Employee is responsible for all aspects of patient care for those patients designated by Employer. As requested by Employer, Employee will observe and assist in operative procedures performed at _____, P.A. (the "facility"), as directed by the surgeon. Employee will also participate in the post-surgical care of these patients until they are discharged from the facility. Employee will participate in the clinic setting as directed by the surgeon. The Employee may also be asked to participate in and perform certain duties pertaining to the business of the Employer as well. Within the first 60 days of employment, the Owners will review Employee's performance to determine Employee's eligibility to consult with patients and perform cases independently. Fees paid by patients desiring to have procedures performed by Employee will be paid to Employer and will belong to Employer.
4. **Devotion of Time.** Employee agrees to devote her entire time and attention to the practice of Employer per the schedule developed by the Employer, and not to engage in any other business or occupation. The making of passive investments shall not be construed as constituting another business or occupation. Without

prior expressed authority of the Employer, Employee shall not directly during the term of this Agreement, render services of a business or commercial nature to any other person or firm, whether alone or as a partner, or as an officer, director, employee or shareholder of more than ten percent (10%) of the stock of any other corporation.

5. **Paid Time Off.** The Employee shall be entitled to fourteen (14) days of paid time off ("PTO") for vacation and sick leave. Employee is eligible to use PTO time after ninety (90) days of employment. PTO may be taken in increments of one day. Time off should be coordinated with Employer to ensure patient care needs are met. PTO has no monetary value; Employer will not pay Employee for unused days at the termination of the contract. Employer will pay Educational Leave for attendance at meetings pre-approved by Employer. Employer's office is closed for designated holidays during the year. Employee will be paid for these days. Holidays include: New Years Day, ½ Day Spring Holiday (Good Friday), Memorial Day, July 4th, Labor Day, Thanksgiving, Friday after Thanksgiving, ½ day Christmas Eve, Christmas Day.
6. **Death of Employee:** The death of Employee will terminate this Agreement. Any compensation, as outlined in this agreement, owed by Employer to Employee will be disbursed by the Employer to Employee's estate pursuant to the terms of Item 2 of this agreement.
7. **Illness or Other Incapacity:** If Employee, during the term of this Agreement, fails to perform her duties hereunder as a result of illness or other incapacity for a period of more than 2 consecutive weeks, the Employer may, at its option, terminate this Agreement as of a date to be specified in a notice of termination. Such date to be not less than 5 (five) days after the sending of the notice.
8. **Medical Conventions, Education, Professional Fees and Journals and Other Employee Expenses.**
 - a) Employer will pay the attendance fees, as well as reasonable expenses (travel, airfare, and lodging) of attending one medical convention/meeting pre-approved by Employer. Attendance and fees for additional meetings must be pre-approved by Employer.
 - b) Employee is expected to furnish her own automobile in connection with her services.
 - c) Employee is expected to furnish her own cell phone in connection with her service.
 - d) Employer will pay for credentialing fees to pre-approved and required facilities.
 - e) Online Journal subscriptions to the Aesthetic Surgery Journal and the Plastic and Reconstructive Journal will be provided.
9. **Insurance.**
 - a) **Malpractice Insurance.** Employer shall pay premiums on the malpractice insurance on behalf of Employee in the sum compatible with the established standards of Employer so long as Employee is employed by Employer.
 - b) **Life Insurance.** Employer shall pay premiums on life insurance coverage on the life of the Employee in the same amount provided other employees, effective July 1, 2018.
 - c) **Major Health and Medical.** Benefits shall be available to Employee and her family as provided from time to time for all eligible employees of Employer. Coverage for Employee will begin on July 1, 2018. Employer will pay for Employee's premium. Any coverage for a spouse or dependents will be paid for by Employee via payroll deduction.

10. **Expenses.** Employer will cover expenses such as office parking, postage for Employer-related business, standard office supplies, answering service, and other supplies and services suitable to her position for the performance of her duties, as may be reasonably determined by the Employer.
11. **Other Provisions.** Employee will be provided access to patient data base; given telephone access and communication features such as voice mail; non-physician medical and administrative staff assistance; use of Fax machine, copy machine, and other related office equipment, excluding personal computer (IT personnel will be provided to allow access to required Practice data bases via Employees personal desktop computer, laptop, or tablet).
12. **Patient's Professional Conduct, Obligations and Restrictions.**
 - a) The Owners will assign patients to Employee.
 - b) Employee will adhere to the curriculum and duties set forth by Employer during the contract term.
 - c) The Employee shall not engage in the practice of medicine outside of her employment with Employer and all fees and compensation received from the practice of medicine shall belong to Employer. The Employee shall at all times endeavor in the practice of her profession to further the interests of Employer and shall give her full time and attention and her best efforts to the utmost of her skill to said employment. For purposes of this Agreement, the term "practice of medicine" shall mean and include, generally but not exclusively, the performance of any act or service involving application of medical arts knowledge and science.
 - d) The Employee shall refuse to treat a person as a patient if so requested by the Employer in writing, in which case such a person shall no longer be considered a patient of the Employer, but such refusal to treat a patient or dismissal of a patient shall be consistent with governing laws in the State of Texas.
 - e) The Employer shall have the final say on setting professional fees charged by the Employee.
13. **Termination of Contract.** This agreement may be terminated by either party upon sixty (60) days written notice delivered to the other party; or
 - a) This Agreement may also be terminated by Employer if the Employee engages in any act of personal misconduct or substance abuse or is found guilty of a felony or is expelled, suspended or otherwise disciplined by final action of any professional or scientific organization of which she is a member of; if she resigns from such organizations under threat of disciplinary action; or where the Employee is adjudicated, bankrupt or insolvent or takes proceedings for liquidation by arrangement or composition with creditors. Employee will be bound by the guidelines in the Employee Handbook. In the event of termination of this Agreement, the Employer shall retain all medical histories, files and records, but at the patient's request, shall make the same available for copying by and at the expense of the withdrawing Employee.
 - b) Specific case histories of patients, records or photographs showing the type of work, skill and results of work performed by the withdrawing Employee or deceased Employee shall, upon request, be provided to the Employee or her estate, provided the disclosure thereof does not violate medical ethics or is released in writing for such purposes by the patient or her authorized representative.
 - c) In the case of the death of Employee during the term of this Agreement, her estate shall be entitled to receive and shall have delivered to it all of her personal effects, records and files relating to personal affairs of the Employee.

14. **Severability.** If any part of this Agreement shall be determined by competent authorities to be invalid, the remainder hereof shall be construed as if the invalid portion had been omitted.
15. **Miscellaneous.**
 - a) All notices given hereunder shall be mailed to the Employee at the principal office of the Employer or such other address as the Employee may specify in writing.
 - b) The parties hereto agree that they will execute any and all further instruments and will perform any and all acts necessary or proper to effectuate and carry out the employment created by this Agreement.
 - c) For a period of 12 months after the termination of this agreement, Employee will not recruit or hire any employee of Employer or any of Employer's affiliates who were employed by Employer during the Employee's tenure at ____.
16. **Binding.** This Agreement shall bind and inure to the benefit of the parties hereto, the heirs, executors, administrators or personal representatives of the Employee, and any successor or assign of Employer.

EMPLOYER:

By: _____

EMPLOYEE:

By: _____

6 Transitions

James H. Wells, Vincent R. Hentz, Bernard A. Shuster, Charles H. Thorne, and Heather J. Furnas

Abstract

Sometimes something in life or career needs a change. With the high rate of physician burnout and more parents in the workforce, plastic surgeons are increasingly evaluating personal factors in their professional lives. Desire for greater work–life balance, health concerns, and changes in family structure can all be the springboard for change. The first part of the chapter examines reasons for early and mid-career change and how to adjust the tiller so to catch the wind in a better direction. The second part of the chapter looks at transitioning into retirement. For those who have dedicated years to preparing for a career and then spent decades honing their craft, no decision is more fraught with fear than deciding if, when, and how to retire. There is no “one size fits all” model for transitioning from a busy professional life to something different. Retirement is a continuum of life in the context of full engagement in life. When contemplating if and when to retire, keep in mind the following mantra: always retire *to* something, not *from* something. Regardless of how each of us envisions the transitioning from an active professional life to one of retirement, or conceptualizes what retirement means to us, we should seek stability in financial, personal, and psychological health. Financial planning is perhaps the most important consideration in achieving security and should be started even during residency and continued throughout one’s career. Consider your health. Prepare yourself physically for an enjoyable retirement by common sense measures such as regular exercise. Prepare for psychological stability. How will you redistribute time and energy in retirement? Define what is most important now and decide how to continue the most satisfying activities into retirement. Learn humility. The surgeon that has cultivated a lofty persona, one tightly tied to his or her identity will have a difficult time with this transition. Above all, cultivate continued engagement in all aspects of life. Here is the key to success: (1) enough money, (2) outside interests, other than medicine, and (3) believing that one’s self-worth is not dependent on being a doctor.

Keywords: burnout, changing careers, job change, retirement, transitions, financial stability, health, psychological stability, engagement

Editors’ Note

Some plastic surgeons find an internal or external need to make a change in the direction of their career. Because the reasons vary across the arc of a career, the five authors give their perspective from mid-career movement to preparing for transitioning into retirement.

6.1 Part I: Adjusting the Tiller Early- and Mid-Career

Bernard A. Shuster, Charles H. Thorne, and Heather J. Furnas

When the winds are moving your boat in the right direction, sometimes you need to adjust the tiller to get where you want to go. In this chapter, we lay out a game plan if your sails are luffing. The how-to instruction is followed by two personal stories and the lessons learned.

Bernard A. Shuster, MD, MBA

As plastic surgeons, sometimes we want to adjust the tiller of our career course, and sometimes we need to. Over the course of a career that typically spans 30 to 40 years, most of us become hyper-focused and develop a specific expertise within a subspecialty. We may develop a comfortable clinical and business environment that fosters a balance between work and life, whether we are in solo private practice, fully employed, or in academics. If only things always stayed the same...

Most products, services, and business models have a characteristic life cycle, starting with an early period of growth, followed by a period of maturity, and a subsequent wind-down phase. The classic example is the life cycle of a computer: A revolutionary new model comes out, it sells well, reaches a point of maximum adoption, and then it is slowly phased out. Within that life cycle comes a decision point: follow the same course or chart a new one. Changes might enable more growth or merely delay the phase-out period. There are no right or wrong approaches. The life cycle of a solo private practitioner begins with opening an office. The practice grows for 5 to 10 years through covering emergency room (ER) call and cultivating referral sources. The mature practice may be stable for 20 years, after which the surgeon winds down and ultimately retires. A group practice follows a similar course, with a new surgeon coming on and eventually buying in as the more senior surgeon retires.

With the current rate of change in both technology and the socioeconomic environment, however, can a plastic surgeon reasonably expect to maintain the same practice model, with long periods of stability, over the course of a career?

Compared with today, the specialty was comparatively static in previous decades. Technology was limited to endoscopy and lasers, and microsurgery took years to become the standard of care for many reconstructive procedures. Changes in health care delivery are now evolving so quickly that they are disrupting established business models. Digital marketing channels, once unimaginable, have forever changed how plastic surgeons communicate with the public.

Traditional social structures are also evolving. Plastic surgeons have a growing interest in gaining better control of their lives as job demands have increased, such as entering data into electronic health records, as they struggle to maintain a healthy personal and family life. The impact of stress on one's health, the evolving family model, and a greater interest in a balanced life can serve as a catalyst for change. In this changing environment, is it reasonable for a surgeon in his or her 30s to expect the original choice of practice type, location, or group to remain unchanged over the next 40 years? While most of us choose a path, stay on it, and have satisfactory careers, we receive no training in recognizing when there is a need for change and what to do about it.

Creating Change

Creating change is a three-step process: be self-aware, plan, and implement.

Self-Awareness

First is the self-awareness that change is desired or needed, a step that may not be quick, easy, or intuitive. For example, it may take a few years to realize the importance of spending more time with growing children or moving to a different location. Alternatively, competition from a growing hospital-based group may be slowly eroding one's case load. An academic may want to transition to private practice, a solo

practitioner may want to join a group, or vice versa. The decision for the need to change is generally not a rash one.

Planning

Second is crafting a plan by developing a vision and determining how, when, and what to change to get there. Taking the time to plan increases the chances of success. Your vision should define what you plan to accomplish in both your life and your practice in 1 year and in 5 years.

This planning step is particularly important for those with an internal impetus for change. The surgeon wanting to reduce work hours by 20% for more family time will need to identify the external pressures responsible for those long hours. Because it can be difficult to examine our own lives objectively, a helpful exercise is to reflect on another surgeon in your situation: What does that person need to change? The late Andy Grove, an early founder and executive of Intel, was once discussing a tough decision with several other Intel executives, including Intel's chairman and CEO, Gordon Moore. He turned to Gordon and asked, "If we got kicked out and the board brought in a new CEO, what do you think he would do?" Gordon answered, "Why shouldn't you and I walk out the door, come back and do it ourselves?"

Because a successful practice in plastic surgery is closely associated with reputation and a sufficiently large patient pool, it is not very mobile. Momentum in terms of personal life, family ties, and professional relationships tend to keep us in a location. Nonetheless, unless you own your own building, it does not have a brick-and-mortar anchor, so a change in geography is certainly possible. Most geographic considerations arise during the early part of a career, but, more senior surgeons, offering their experience, sometimes relocate and join younger surgeons with the time and energy to run the practice. The downside to relocation is the loss of traction one has developed professionally and personally, but digital media has greatly lowered the barriers for new market entrants. It is now easier for a surgeon to relocate, invest in a robust digital presence, and gain traction in months rather than the years it took in the past.

The planning phase is the time to weigh trade-offs. Alterations in practice environment can take many different forms, such as transitioning from academics to private practice, changing a solo practice into a partnership, or leaving private practice for salaried employment. The transition from academics is one of the more straightforward. Over time the academic plastic surgeon has the opportunity to develop a faithful following and gain a reputation in the community, easing the transition to the local private sector. Because the change in lifestyle depends on nature of the respective practices, it can either improve or worsen. Whatever the change, an "eyes wide open" approach is important in weighing the trade-offs. Improved economic incentives in the private sector come with increased risks.

Improving one's work-life balance might be accomplished by taking less call, reducing work hours, taking on an associate, joining a group, or even becoming an employed physician. However, call and hour reduction can result in a drop in income, and taking on an associate comes with the financial obligation to provide a salary, benefits, and other practice costs. Joining a group or becoming employed comes with a loss of autonomy. Thought should be put into balancing these trade-offs.

For service industries, such as ours, most of our expenses are fixed so any reduction in revenue will result in a drop in income. The planning phase should include overhead cost reduction. Determine the value of the time that you gain as you implement changes that result in a reduction of practice revenue and compare that with the value of the income

lost. If the reduction in work hours will lead to a reduction in income by “\$X” and one values the time gained to be greater than “\$X”, then the reduced work schedule is warranted. Before bringing on a new associate, perform a breakeven analysis to determine how many cases will need to be done to offset the increased cost. Assign an approximate financial value to the intangible benefit of a lower work load and add it to the calculation. For changes that will result in a loss of autonomy, like giving up solo practice to join a group, the value gained must be carefully weighed against the freedom lost, especially for experienced surgeon who have been on their own for a long period.

Implementation

After weighing the trade-offs of change and solidifying the plan, the third step to creating change is the implementation of the plan. In addition to establishing a timeline with benchmark goals, progress should be monitored regularly and adjustments made when necessary. The Objectives and Key Results (OKR) management structure developed by Andy Grove can serve as a helpful model. Briefly, OKRs guide growth by establishing reach goals. To reach those goals, establish an inspirational and aspirational “objective”, like achieving greater work–life balance. Then develop three to five associated “key results” that are measurable and have deadlines, like: (1) cut my weekly work hours by an hour by June 1; (2) volunteer one Friday per month in my daughter’s school, starting this week; and (3) enroll in ballroom dancing lessons with my partner starting next month. Excellent resources include Andy Grove’s *High Output Management*, John Doerr’s *Measure What Matters*, and Christina Wodtke’s *Radical Focus*.

Changing Careers

Total career changes are rare. Some plastic surgeons return to school for additional advanced degrees, most commonly law degrees and Master’s of Business Administration (MBA). These additional degrees typically lead to careers in health care administration, law, or a biomedical field. Many find their prior knowledge helps in their new career, which can be quite fulfilling. Other surgeons may find that the knowledge gained from an additional advanced degree can enhance their existing practices or provide a doorway to parallel endeavors. Many degree programs are designed to accommodate the demands of a practice. Executive MBA schedules often range from 1 day a week to a single long weekend per month. Nonetheless, the significant out-of-class time requirements necessitate a serious commitment. Similar programs are available for law. Alternative options include focused, nondegree programs that many universities offer.

Assess and Adjust

Plastic surgeons spend years acquiring the necessary knowledge and skills, and they place their reputations on the line continuously. Accordingly, surgeons typically have little opportunity to make many changes, and when they do, they need a high degree of confidence out of success. Despite thoughtful planning, outcomes may not be favorable. We have discussed three steps for a successful tiller change: desire, planning, and implementation; but there is actually a fourth equally important step: assess and adjust. Constant assessments and adjustments are necessary to achieve best outcomes.

The Coca-Cola Company’s launch of “New Coke” in 1985 exemplifies a change gone wrong. Customers hated it. Recognizing this, the Coca-Cola Company concluded an adjustment was necessary: re-introduce the prior formulation as “Coca-Cola classic,”

and sell the two products side by side. Consumers were not appeased. The company ultimately returned to marketing the original formula simply as Coca-Cola. Was the company worse off for making an attempt at change and failing? Actually, the Coca-Cola company had been losing market share for 15 years; the consumer response to their final change increased demand and empowered their brand. When we, as individuals, or as plastic surgery practices, identify a potential benefit from change, how will each respond?

Stories from the Front Lines: Charles H. Thorne, MD

I always wanted to be a doctor.

When I graduated from Yale College in 1974, I applied to medical school, but, although I thought I was a big-man-on-campus and had played varsity sports, etc., I was not accepted. When I complained to my mother that Harvard had not even offered me an interview, she ripped into me for being a spoiled brat and suggested that I do something for someone else, and she added, “for a change.” So I withdrew my applications to the schools from which I had not yet heard (like UCLA) and entered the Peace Corps. I worked for 2 years in West Africa, which was a spectacular experience, but was, more importantly, an incredible amount of fun. While living in Akim Oda, Ghana, I returned to my dwelling one evening to find goats eating my mail—which I later discovered contained my acceptance to UCLA Medical School (they had misplaced my letter withdrawing my application). When UCLA eventually tracked me down, I had to admit that I was committed to the Peace Corps for 2 years and that I could not accept their generous offer. Completing this unlikely story, Dr. Martin Pops of UCLA replied that I could start medical school whenever I wanted; I just had to let them know when.... What an incredible gift of freedom. I gleefully arranged to matriculate in 1976, and attacked my West African experience like teenagers eating a pizza.

Peace Corps

So what does the Peace Corps have to do with adjusting the tiller in your plastic surgery career? The Peace Corps motto is “flex and cope.” Just as one modifies an operative plan based on unexpected circumstances, so, too, a career path may require altering based on changing conditions. After completing residencies in Surgery at the Massachusetts General Hospital, Plastic Surgery at NYU, and a Craniofacial Fellowship at NYU, I joined the NYU faculty with my best friend John Siebert. For over 25 years, I toiled at NYU and Bellevue, working with residents and attempting to make a name for myself in craniofacial and pediatric plastic surgery.

Along the way, there were other events. The pediatric neurosurgeon who referred me cases died unexpectedly. I had a rocky relationship with my Chief, who was not interested in turning over to me the craniofacial cases that he had spent his entire career attracting (I would not have, either). I became interested in ear reconstruction and developed friendships with Burt Brent and Francoise Firmin, who helped me tremendously and served as role models; they were in private practice but made frequent and numerous contributions to the literature. And patients requesting cosmetic surgery started knocking on my door. If I had been sufficiently busy doing pediatric plastic surgery, I do not think I would have ever made the switch to an aesthetic surgical practice; at least that is my story and I am sticking to it. Even if that is stretching the truth slightly, it is absolutely true that cosmetic surgery found me; I did not seek it or market it or pursue it other than trying to take good care of my patients. I was, however, on the upper east side of Manhattan, where the demand for cosmetic surgical services is insatiable.

The Coolest Practice

For the sake of this narrative, I wish I could say that developing a private practice in aesthetic surgery was because I wanted to spend more time with my daughter or devote more time to research or immerse myself in Buddhism; rather, it just evolved. Do I have regrets? Honestly, there are times when I say I was stupid to wait so long and that I could have made so much more money for my family if I had devoted myself to cosmetic surgery at a younger age. But at the time I was idealistic and viewed the active pursuit of a cosmetic surgery practice as a Faustian bargain. My current practice is a combination of aesthetic surgery of the face and ear reconstruction and it may be the coolest practice on the planet.

Several years ago, Joe McCarthy retired as Chairman at NYU and when it became clear that a non-NYU person would be his replacement, I began to develop an exit strategy. I worried that a new Chairman would resent the old guy who had been there for 30 years and who the residents still looked to for advice. Around 5 years ago, in 2014, I accepted the position as Chairman of the Department of Plastic Surgery at Lenox Hill Hospital. I have been able to continue my practice of aesthetic surgery while building a department and specifically a unit dedicated to pediatric plastic surgery, my first love. We have assembled what I honestly think is the best team in the world for this type of work, and I think I can retire in a few years feeling I have been extraordinary lucky to have had a remarkably rewarding, interesting, and diverse career in plastic surgery, even if my wife, Alisa, and I live in the same two-bedroom apartment in Manhattan that we bought as residents in 1986.

Reflections

To conclude, one must always ask “would I have done anything differently”? It is so hard to say from this perspective. I do not think I would have been happier if I had switched to cosmetic surgery earlier and missed out on all the people, patients, residents, struggles, and complications that came with my early experience. The sad thing is that my model, if anyone ever found it desirable, may not be easily emulated in the current practice environment. So when I accept large amounts of money for listening to patients obsess about their wrinkles or their prominent ears, I feel incredibly lucky. I just do not think I would dare wish that my career had evolved differently...except my wife is tired of our apartment.

Heather J. Furnas, MD, FACS

My father was my inspiration for me to become a plastic surgeon. He was the quintessential devoted doctor who worked 18-hour days, taught, lead a division of plastic surgery, advanced the specialty, published, and volunteered his skills in underserved countries. I, too, wanted to devote my life to plastic surgery, but I also wanted to be able to raise a family. That meant making choices.

Parenthood

My son was born a year and half after I started a private practice with my husband, Paco Canales, and my daughter was born 2 years later. We looked for a nanny, but we never found anyone we felt comfortable enough leaving our children with. Even though hospitals required 24-hour availability, they had no childcare services to help out young parents. We had no family nearby, so we relied on a home daycare, a preschool, and

after-school care as the kids got older. By covering for each other so one person could be available to drop off the kids in the morning and pick them up in the afternoon, we made it work.

Not having backup childcare forced us to be efficient. When we built an operating room in our office, we studied the steps of each operation and the turnaround in between. By simply paying attention, we were able to cut out a lot of wasted time. We trained the team to see that we could all make a surgery patient feel welcome and cared for when he or she arrived in the operating room without chatting with him or her for 20 minutes, as one of the anesthesiologists liked to do. The surgical techs learned to hand us a loaded needle holder as soon as we needed it. Anytime the surgeon was standing waiting for something was an opportunity to improve. We removed inefficiencies in our surgical steps as well. We increased the number of cases we could do in a day and still leave enough time to pick up the kids.

While raising kids, I was involved with the state medical society, in which I served as a delegate, and the county medical society, of which I became president. Paco stayed with the kids while I went to my committee meetings. I think they particularly enjoyed those evenings when Mom was not around to monitor their video watching or junk food. That schedule was sometimes tenuous, though, like when my toddler daughter hit her head on our cement driveway and threw up. My husband called the pediatrician and tried not to disturb me, but my daughter would not stop calling for her mama. After he called me, I fled the meeting and spent the night doing *q 2-hour neuro checks*, just as I had done when covering the neurosurgery service as an intern, and I took her to the pediatrician the next day.

Some schools helped working parents by providing after-school care, but not all. The most onerous was a public school that scheduled an early release every Wednesday at 1:30 p.m. This forced one of us to truncate the workday to be available to pick up our daughter.

Since algebra scores at that school were poor, with the principal's blessing, I started an algebra club. I taught algebra on those Wednesday afternoons and on weekends and holidays. I read five algebra books to prepare. My teaching sessions were 3- and 4-hour marathons broken up with breaks. Creating lesson plans, teaching, and writing quizzes and tests took up a significant part of my time, but it was a particularly rewarding experience. The best part was that the kids had fun, and those who finished my class all did well on the state test.

When my kids were in high school, they had founded a speech and debate club, and managing the club became my other job for 4 years. The faculty sponsor was new to speech and debate, and I knew nothing myself, so I read up to be able to train the parents to judge. I scheduled parent judges for tournaments and practices, spent many weekends judging myself, and helped organize an annual showcase so parents could see their kids in action. (Speech and debate are not spectator activities, and parents cannot judge their own children.)

During the days of soccer and basketball games, violin and piano lessons, birthday parties, cooking dinner for four, and volunteering at school, I sometimes felt like I was swinging like Tarzan vine to vine, but I was not sure if I would reach the next one on time. We forgot the kids' piano lessons every couple of months, and the teacher would call to make sure we were OK. We left the kids stranded a few times at school, but they were always safe.

The outcome of all that chaos was that Paco and I were able to spend a lot of time with our kids. We brought them to the office when they were sick and closed the door, and we left them with neighbors for the middle-of-the-night emergency when we were both needed. On weekends, we brought them to the hospital as we made rounds, and they sat at the nurses' station drawing on progress note paper.

Reconstruction to Cosmetic Surgery

Paco and I made a big adjustment to the tiller when the kids were both under 10. Insurance reimbursements were plummeting, and we were forced to use a credit line to cover our practice overhead. (For example, our last transverse rectus abdominis myocutaneous flap [TRAM] breast reconstruction was reimbursed at \$256.) Many excellent doctors were leaving the state or joining Kaiser. We considered our options:

1. Leave Sonoma County.
2. Get a salaried job.
3. Give up an insurance-based practice.

Starting a practice at some other place would mean starting all over again, and we knew it was unlikely for both to get salaried jobs at the same place, so we chose option 3. Slowly we pulled out of insurance companies and rebranded ourselves as cosmetic plastic surgeons.

When I was a resident, plastic surgeons I encountered spoke of cosmetic surgery patients as being more difficult and more demanding than reconstructive patients. At some time, I am sure that was true before cosmetic surgery was widely accepted, but after "Extreme Makeover" hit the airwaves, the general public could see that regular people's lives were improved after surgery. Although I was not expecting to see the same level of gratitude from my cosmetic surgery patients as from my reconstructive ones, I did. Some of the transformations were remarkable. A teen with tuberous breasts with severe asymmetry was depressed and had multiple fresh cuts on her palmar forearms. I rarely saw her eyes because her hair covered her face. Her psychiatrist gave her blessing for the procedure. At stage one I reduced one breast, delaying implants until she was 18. Two years later, when she came for her breast augmentation and lift of the smaller breast, I could not recognize her. She looked me in the eye and smiled. She was bright and articulate, and the whole office fell in love with her. Her mother said her distress was all about her breasts. Simply reducing the one side had led her recovery, and the breast augmentation really made her feel normal.

Patient after patient showed me how indistinct reconstruction and cosmetic surgery procedures were. Often, method of payment determined the category. Some patients approved for insurance coverage elsewhere came for breast reconstruction or upper blepharoplasty. Under our roof they were having cosmetic surgery.

When we gave up reconstructive surgery, we also gave up emergency call. It was extremely difficult to cancel a facelift patient who had taken her only vacation to have her surgery in our office. Working all night and then showing up to do a day's worth of cosmetic procedures was not in the best interests of our patients. It was the way we were trained, of course, but working 36 hours is not best for the patient on the table in those last waking hours. We explained to the hospital that they could get coverage if they paid for it, but they liked the old model of having plastic surgeons take emergency call gratis. Many of the cases they called me for were for simple lacerations when they were busy, so instead of calling in another emergency doctor, they called in the free plastic surgeon in the middle of the night. While they paid other surgical specialties stipends to take call, they told the plastic surgery section that we had taken the Hippocratic Oath, and taking call was our duty to the community. At the same time, the hospital made it impossible for us to perform abdominoplasty at the time of hysterectomy because they had increased their operating room fee from around \$1,200 to \$32,600.

Of all the changes we made, the one that led to the biggest improvement in my quality of life was giving up emergency call. Running a practice, raising two small kids, and

taking emergency call had led to burnout. Even if the ER never called, on call nights I had an underling anxiety and slept fitfully. Calls at midnight announced, "We'll need you to come in after the patient has his CT scan," preventing me to sleep until 2 a.m., when they really needed me. Increasingly, I awoke in the morning, exhausted, with a pit in my stomach as I faced another day. The tunnel into the future was darkening, just a long row of call nights and little sleep. I was normally cheerful and upbeat, but that person disappeared in the relentlessness of unfunded work and sleep deprivation. My children shone sunshine in my life. They buoyed me up and chased away the heaviness of the day.

We were a house of two plastic surgeons, so our family took twice as much call as everyone else's. When Paco was on call, I awoke with him, and then I had difficulty sleeping, especially when he was gone. Did he need my help? Did he need to take the patient to the operating room? I was limping along psychologically when I asked Paco to please ask our colleagues to consider our family one person when it came to the call schedule. They all agreed. Most of the emergency cases were unfunded, so there was absolutely no upside for them. They gave up their own freedom to give us relief, and I will be forever grateful.

Giving up emergency call allowed me to recover. Chapter 24 on Burnout describes an awakening of hospitals that are realizing that external pressures and demands placed on doctors lead to burnout, and they are finally paying attention now that studies are showing that burnout can affect patient care and patient satisfaction. In those days, our small specialty accepted emergency cases from all over the county, beyond where we had privileges. Finally, we stood up as a specialty and refused to continue to take forced, unfunded call for a hospital that made no effort to welcome our cosmetic patients.

Another positive change was operating in our own facility. When we switched our type of practice, we built an operating room suite, which made a huge difference in our efficiency. We did not have to commute to the hospital or wait for hour-long turn-around times. Our cases could start on time because we were never delayed by the previous surgeon or by a trauma case. As an added bonus, we no longer had to carve out time from our days to take care of our medical records.

What I missed was the camaraderie. Even though I did not like wasting time waiting for a case to begin, I enjoyed mingling with other surgeons and anesthesiologists. I missed getting to know the nurses and scrub techs in the operating rooms, in the recovery room, and on the wards. When I see one of them around town, I feel like they are an old friend...because they are.

Empty Nest

First my son and then my daughter flew the nest. I missed them, but they were where they should be, and now I could do things I had never had time to do. After avoiding meetings as much as I could, so I did not miss time with my kids, I stopped having to push to fulfill my continuing medical education (CME) hours every cycle. I started joining committees, and I even submitted a couple of papers to present at a meeting for the first time in years, and American Society for Aesthetic Plastic Surgery (ASAPS) said yes, I could present. I was a senior plastic surgeon, yet I felt like I was just starting out.

A short time later, I connected with Dr. Rod Rohrich on Twitter, and through our communication about issues pertaining to women in plastic surgery, he invited me to guest edit a series of articles and videos on the topic. The other three guest editors were

Drs. Deb Johnson, Anu Bajaj, and Loree Kalliainen. He opened up a door for me. I had been thinking of the issues we wrote about for years, and the series of articles gave us the opportunity to address some of the challenges women face, challenges I had personally faced. Through that series and some work I was doing on labiaplasty, I began collaborating with some of the Stanford residents.

The Twitter message I had sent Dr. Rohrich that opened the door to that series was, “We’ve been focusing on how to make an academic career and raising children in parallel. We should also look at the two in series. Why not give women the opportunity to jump into an academic career after they’ve raised their children? Many women have a lot of productive years left after their kids fly the nest.” Of course, I had women like me in mind. I had been raising children, reading bedtime stories, and volunteering in schools. Even though I did not have a lengthy curriculum vitae, he gave me chance, and I am grateful for that opportunity.

Medicine, especially surgery, tends to look at the short term. My article with Drs. Rebecca Garza and Jane Weston¹ outlined suggestions to facilitate childbearing in residency. In my own experience, I was burned out fulfilling the hospital’s relentless call demands while raising two young children with a surgeon father. Our institutions, rules, and regulations can be unforgiving, overlooking that while we care for others, we have to care for each other, too. As traditions fall and the field becomes more diverse, we must examine and change the infrastructure to allow us all to thrive. I was not preternaturally disposed to depression when I was spiraling downward. I was reacting the way most people would to an unreasonable situation. I want to give a shout-out to Drs. David Marcus, John McAvoy, Barry Silberg, and Kent Mellersteig for giving our family a break in taking call when they did not have to. It made the world of difference to our family and to my personal well-being.

The low reimbursements and unfunded call forced me to take a road neither my husband nor I would have taken, and that has made all the difference. I had not planned to become a cosmetic plastic surgeon operating in an office operating room suite, but I am glad I am. It has given me control over my life, when I felt like I had no control at all.

6.2 Part II: Transitioning into Retirement

James H. Wells and Vincent R. Hentz

Editors’ Note

Few of us are thoroughly prepared to leave a career that is part of our identity. We put it off, deny that we age, and put off planning until retirement becomes an unexpected necessity. Late career (over age 70) performance for surgeons is increasingly coming under scrutiny. Drs. Wells and Hentz have done the specialty a great favor by offering solid advice on how to prepare well.

James H. Wells, MD

Outside of a preselected age that we all consider at some time in our careers, there are other considerations in planning for retirement. A number of factors determine the optimal time or chronological age for retirement. Health concerns may limit one’s ability to continue practicing. Serious debilitating illness or in the case of a surgeon, an uncontrollable tremor must be a first consideration. Physical and emotional burnout

can also necessitate closing or leaving a practice. On the other hand, financial concerns may necessitate working more years. The type of practice you have may create additional time constraints. The solo practitioner may hope to bring on an associate to take over the practice, but that takes time. An existing partnership may want to hire a younger associate and facilitate the exit strategy of a senior partner who is less willing or able to shoulder a full call schedule and surgery load.

Because it takes time to sort through many issues that need decisions to end or to transfer a practice, it is best to begin planning a minimum of 5 years before your desired or anticipated retirement. Those years will allow a smoother transition of patients to another physician. The easiest plan is to transfer patients to another physician within the practice or one who is taking over. If an intrapractice transfer is not possible, those patients under continued care for a still unresolved diagnosis or incomplete surgery should be transitioned through a direct referral to a qualified and respected colleague.

Retirement impacts your family, so they should be included in the planning process from the beginning. Even though it is your retirement that is under discussion, input from your spouse and key members of your immediate family should be valued, to avoid making surprise announcements before any final decisions are made.

The decision to retire can be difficult for a surgeon trained to work hard, put patients first, and power through sleepless nights. Our sense of self-worth has been clearly defined by our practice of surgery and the dependence of our patients, staff, and family. We all need a reason to get up in the morning, and for years, even decades, that reason has been surgery. Following retirement, the transition from a very busy and demanding surgical practice to having time available without demands is a change that may require adjustment. It is not bad to be lazy some of those mornings after retirement or even leading up to retirement.

Reasons to Retire

The reasons to retire are all personal. While some have a preferred age for retirement, others having had a full, long career without outside interests, may retire later than the person who wants to finally spend time pursuing a long-neglected hobby, travel, or just spend more time with family.

Health issues can impact one's ability to practice however, without restrictions. As a surgery practice evolves, new skills may be required while the aging surgeon may not have the specific training or ability to develop or acquire those new techniques or skills. Interests change as well, and what once filled the surgical schedule may no longer be as gratifying.

Changes in family dynamics, such as the need to care for a child or grandchild, an aging sibling, spouse, or parent, may require more time away from practice. Sometimes there is less a need and more a desire to spend time with friends and family.

After devoting years of time and energy to plastic surgery, some surgeons develop an increased interest in topics and skills away from surgery. The demands of a surgical career may have prevented sufficient time to master a musical instrument, learn to paint, or travel for long stretches of time.

More attention is being paid to mental and physical burnout among physicians. While there are steps to address the problems contributing to burnout, which are discussed in a separate chapter, in some cases, leaving the practice of medicine can bring relief. The competitive nature of medicine today with increasing regulations and marketing very likely will add stress for some and not for others. Another condition that can impact our ability to function optimally is cognitive impairment, which may be

difficult to recognize or accept in ourselves. There is an increased interest in beginning some basic cognitive or skill testing in physicians at age 70 to identify at risk doctors. Nonetheless, acceptance of those physical or mental changes can allow preparation and planning for retirement while avoiding an unfortunate medical error resulting in mandatory retirement.

On a more positive note, if you have sufficient financial security that no longer necessitates a continued income, you have the freedom to retire when you wish. In some instances, the desire for geographic relocation may prompt plans to retire.

Retirement and Health

Should plastic surgeons retire when they are still healthy? The simple answer is, “Yes.” Retirement is more enjoyable while you still have your health; retiring after the onset of cognitive or physical impairments changes the nature of “retirement.”

Retirement is also enhanced when you leave the practice of medicine while your reputation is positive and without controversy. You want to retire when your patients will miss you in positive manner. Even if you are healthy physically or emotionally, legal or financial issues may not make for a happy and preferred retirement.

As you plan your age of retirement, take into account your family history and longevity. In order to stay healthy, regular health checks and some type of exercise routine should be part of the pre- and postretirement plan.

Career Risks of Practicing Too Long

Timing retirement after the loss of good health and cognitive impairments puts you at risk of having a serious patient complication due to unrecognized alteration in your skills and judgement. The incidence of unrecognized early cognitive impairment increases approaching age 70. If there is any question of impairment, consider testing to evaluate. Once your skills and judgment are impaired, the ensuing complications will most likely impair your reputation. Retiring under such conditions can be psychologically and emotionally trying, not withstanding the financial costs.

Cognitive impairment can also result in financial missteps, leading to litigation. Partnership conflicts can result in practice breakups, which in turn can result in litigation or added expenses to dissolve the practice.

Early dementia may go unrecognized before retirement and become more pronounced after retirement when routine activities are replaced by the *need to create activities*. In a similar way, a sudden unexpected health event does not allow a calm and normal transition from practice to retirement. Virtually all of us can remember colleagues who died suddenly, or became physically impaired to the point of requiring full-time caregivers, or divorced after many years of what appeared to be a happy and admired marriage. This does not describe a retirement picture anyone desires or contemplates.

Transitioning from Being Very Busy to Having Time

Although sudden retirement is sometimes a necessity for health reasons, going from a full schedule to no schedule can be difficult psychologically. Instead, establish plans to gradually transition away from being the fully engaged practicing plastic surgeon.

There are various ways to slow down, but two to consider include:

- Reduce your work hours initially by half days and eventually by full days.
- Begin to exclude lengthy and technically demanding cases to shorter and less complex procedures.

As you reduce the time you spend in your practice, fill that time with nonpractice activities of interest to you, such as:

- Art
- Music
- Travel
- Volunteer activities
- Nonmedical graduate education

Slowly increase the time you spend on these nonmedical activities as you continue to slow down your medical practice activities. During this transition time, assure that you maintain good health, so add exercise as a regular part of daily and/or weekly activity.

Staying Active in Plastic Surgery

Leaving the clinical practice of medicine does not have to mean leaving medicine altogether. You can remain involved in local, state, or national organizations. You can connect with old friends and keep learning by continuing to attend plastic surgery meetings. By maintaining plastic surgery journal subscriptions, you can keep up on topics of interest.

If you live near an accredited plastic surgery program, you can become a community member of the volunteer teaching faculty or offer to teach operating room nurses who work with plastic surgeons in your community. Many large hospitals have RN First Assist (RNFA) teaching programs that needed experience and skilled surgeons as teachers. Another useful activity is to become a surveyor for accreditation of ambulatory surgical center organizations that include plastic surgeons. You can also create an advisory or second opinion service for plastic surgery patients.

If you still feel the need to do some surgery, become involved with overseas mission trips. This most often involves reconstructive surgery such as cleft lip and palate surgery. Burn reconstruction is another needed skill set especially in third world countries still living and cooking on open fires.

Staying a Part of Plastic Surgery if Disabled or Otherwise Unable to Operate

Assuming the absence of cognitive impairment, remaining or being part of a teaching faculty without surgical responsibilities or becoming involved with an accrediting organization can be rewarding ways to stay involved professionally. Both these activities depend on experience rather than active surgery.

You can contribute to the specialty by writing historical articles for journals (something long lost) regarding plastic surgery procedures or surgeons who have made an impact on the specialty. Your past experience can be valuable in serving as a guide or the historical memory for the organization and specialty on behalf of local, regional, or national societies. Interviewing senior or retired colleagues for a video history of our specialty is another option during retirement years.

Leveraging your experience can help increase the philanthropy component of the specialty to help fund research or clinical projects for the specialty. You can become involved with research projects that utilize skills and expertise. Your experience can also be valuable as a consultant for industry that provides materials and products for plastic surgery.

To connect with the public, consider participating in speakers bureaus seeking speakers on topics relating to plastic surgery. Patients who feel the need may appreciate your services by providing second opinions. Be wary, however, of being drawn into any medical legal expert witness testimony situations. The American Society of Plastic Surgeons established an expert witness affidavit program to avoid having retired physicians removed from the active practice environment and possibly not up to date on the newest issues in plastic surgery offering opinions for compensation.

Financial Preparation for Retirement

To be prepared financially to retire, first figure out where you are going to retire. Are you going to stay where you are or sell your house and move? If you move, are you staying in the same city, the same state, or are you moving to another state? If you are uncertain about a planned new location, move there for a month to assess the environment for possible retirement. Gather data on the cost of living in a planned retirement location to help with your financial planning. You will need to know your current debt and anticipated future debt and measure it against your retirement income. Understand the tax situation and consequences of selling and moving out of your current state. Anticipate health care expenses, including any special needs, for both yourself and your spouse. Are the health care specialties available where you plan to relocate? Determine if you have a need for extended care insurance.

Make a list of anticipated future expenses:

- Education costs that you plan to provide for children or grandchildren.
- Replacement cost of current automobiles.
- Estimated future travel expenses.
- Tax requirements and expenses.
- Charitable giving plans.

As part of your planning, consider finding an organized retirement community with support and activities consistent with your desired retirement living style. Even if this is not an immediate plan, it might be something of interest based on age and medical or potential medical issues. Challenges that come with aging include climbing stairs, driving, and vision. Allow for the potential need for assisted living in the future and recognize that you will eventually be in need of medical care...so forget spending adventurous golden years in the "wilds of Alaska."

Even if you remain fit, your spouse's health issues may interfere with your desired retirement plans. Include those health issues in the list of expenses you anticipate in retirement expenses and consider them as you look at long-term health planning. You could find yourself as the caregiver for an aging or unhealthy spouse.

While we cannot see into the future, lost housing due to natural disasters or fraud perpetrated on you from dishonest financial advisors, makes any long-term financial planning that much more difficult. Live conservatively unless you have a nest egg that is 5 to 10 times larger than you could ever imagine needing. Recovering financially after your peak production years is a steep hill to climb.

Responsibilities in Closing a Practice

You will have a number of responsibilities to attend to before you retire:

- Notify your state medical board of your change in status.
- Cancel your drug enforcement administration (DEA) license.

- Send a notification letter to your patients announcing the date of your retirement and to whom you will transfer their care.
- Transfer patient care to another physician.
- Transfer or store medical records and business records.
- Notify your liability carrier, include an evaluation of potential issues, and assure you have tail coverage.
- Establish office insurance coverage for equipment and office furniture until you sell or transfer the practice to another physician.
- Clear your accounts receivable and office of vendor debt.
- For leases, review possible issues regarding the remainder of the lease; find out if you can vacate the lease without penalties, or transfer it to the next physician.
- If you own your office building, establish if you will be able to lease it to the new tenant, which can be a source of retirement income, or if you need to sell it. Get final statements from vendors and suppliers.
- Notify utility companies of date on which you will close your practice.
- Notify professional associations and other organization to which you are paying dues and decide which memberships you wish to continue.
- If you are over age 62, notify social security office and get advice regarding collecting benefits and optimal timing.
- Change your mailing address and cancel subscriptions.
- Check with your state medical association who often have work books prepared with retirement do's and don'ts.

If you are selling your practice, there are more things to consider. If you have existing partners, study the buy/sell agreement. In the absence of such an agreement, you may need to negotiate the sale of your interest in the practice with the other partners. If you are solo, you may need a broker to help you sell the practice.

Dangers (Financial/Physical/Psychological) of Retirement After an Active Career

Although we have long mastered large bodies of knowledge, financial planning without the assistance of skilled advisor can have a negative impact. The beginning of one's career is the ideal time to begin financial planning for retirement with a skilled advisor.

Residual legal issues that require time and energy to address can be distressing when entering retirement. Practice-related lawsuits, if tail coverage is not in place after retirement, can be particularly stressful, both financially and emotionally.

Early cognitive impairment unrecognized during final years of practice can advance to full dementia or Alzheimer's disease, negating the best laid retirement plans. A failure to undergo periodic physical exams within 5 to 10 years of retirement can lead to unrecognized health issues with physical, financial, and emotional consequences. Even with preventative care, unexpected major cancer, cardiac, or neurologic issues can derail retirement dreams.

Natural disasters can result in depletion of your retirement funds if you do not have sufficient insurance coverage for loss of material items or physical injury. Read through your policy carefully, since you might believe your policy covers complete loss, only to find you are underinsured after you have lost everything.

What Plastic Surgeons Do Not Know About Retirement But Should

Without a well-defined plan for retirement, you will likely experience difficulty successfully retiring away from your “lifetime” identity. Assuming you have no health issues that impair your ability to operate, you can return to surgery. To do so, however, you must maintain some degree of knowledge and skill base and licensing. It will be easier to remain in your career practice location than move to a new community. While possible to move, trying to do it “solo” without joining an existing practice or organization is like starting all over again. You need the energy and vigor of a young surgeon that you may no longer possess.

Do not plan for the “perfect” retirement. Given your health and financial understanding at the time of retirement, establish realistic plans for unexpected contingencies. You cannot predict the future, so plan by considering the good, the bad, and the ugly.

In addition to all the advance planning, accept the fact that “medicine” will do just fine without you.

Making Retirement Rewarding

Set a target date and work toward that goal. Do not set the bar too high or too far out. Practicing until you are told to STOP for patient safety reasons is not the target you should set for yourself. No one receives a gold medal because they operated up to their last day, dropping dead at the operating table.

Develop a plan with your spouse that is realistic regarding finances, health, travel, and living conditions and location. Doing this together and achieving agreement jointly will prevent misunderstandings, resentment, and stress later. Plan experiences that both you and your spouse or significant other can enjoy.

Spend time exercising to maintain your physical health and mobility and mental health. Maintain connections to key friends and relatives, no matter where the retirement path takes you.

As surgeons trained to work through sleep deprivation and illness, we sometimes deny the existence of ailments or weakness. Take good care of your health, get a good primary care doctor, and do not delay signs of possible health issues. Seeking medical advice sooner is better than later and regular check-ups are better than irregular ones.

Finally, close your practice without outstanding debt or legal issues that will require time and energy.

Retirement is the time to enjoy the fruits of your labor.

Vincent R. Hentz, MD

For those who have dedicated 30 years to preparing for a career and then spent decades honing their craft, aside from decisions such as when and whom to marry, no decision is more fraught with uncertainty and trepidation, even fear, than deciding if, when, and how to retire. To a greater or lesser degree, for all of us some part of our identity is tied to practicing our profession. Thus, even the concept of simply slowing down, of doing less, can seem like excising a part of ourselves, of becoming somehow diminished, and the idea of retiring equates with disappearance. Getting old is inevitable but as the late comedian George Burns said: “You can’t help getting older, but you don’t have to get old.” Still, except for those who plan, or do not plan to die in the operating room or in the office, the rest of us will experience this transition from pedestal to park bench, from “who’s who” to “who’s that!”

We know colleagues who, in our opinion, retired for the wrong reasons, either too early or without enough preparation and then wander about, lost in the fugue of inaction. Nelems² relates the story of a mentor who had no outside interests or hobbies. Once retired he lapsed into a state of depression and died an early death. About another colleague Nelems writes “His postretirement years...were barren. Without hobbies and interests, he had no purpose to live.” We know colleagues who should have retired sooner, before their diminishing physical, technical, and intellectual skills harmed not only their hard-won reputation, but also their patients. Malcolm Muggeridge³ has said that “few men of action have been able to make a graceful exit at the appropriate time.”

Accept the Inevitable

A better course is to accept that slowing down or retirement in its broadest sense is simply another of life's transitions. Just as we build our skills in order to successfully transition from student to respected professional, success in this transition to retirement, however this is individually understood, requires developing a different set of skills or resources that address the fears associated with transitioning, specially loss of prestige and lack of purpose.

A key element of this transition, alluded to in the previous paragraph, is this: The concept of retirement is as unique as our DNA. There is no “one size fits all” model for transitioning from a busy professional life to something different. Nonetheless, just as we know colleagues who have “failed” at retirement, and colleagues who neglected to retire when they should have, we know and likely admire those colleagues who, by all apparent measures, have transitioned well. Likely this is because they have viewed life as a journey, have planned ahead, dealt successfully with unexpected events, and most of all, have developed many concurrent interests outside the realm of medicine.

In the following pages, I will try to address what are these necessary skills and how can one attain them. I will pose a series of key questions that we need to ask and answer for ourselves in order to successfully navigate this transition. I will relate my own experience where it might be generalizable and draw from the experience of others.

Defining Retirement

Dictionaries tend to associate work with the generation of income, whereas retirement is described as that point at which one leaves the workforce, earning no money. However, there is no arbitrary boundary between work and stopping work. Retirement is a continuum of life in the context of full engagement in life. I will return to this concept of full engagement later in this chapter.

Preparation by Learning from Other Surgeons When and How to Transition

A collaborative study between the American Association of Medical Colleges and 11 specialties, including plastic surgery, was published in 2008.⁴ One study goal was to examine the workforce issue, of which retirement age is a component of the equation. The survey found that approximately 90% of plastic surgeons retire by age 70, a third before 60, another third between 60 and 64, and a final third between 65 and 69. Retirement is deferred until age 70 and beyond by 11%.

The survey identified two retirement populations, one with a mean retirement age of 59. Characteristics of this group included poor health and the perception that the

pain of practice outweighed the pleasure. This declining interest in clinical medicine is a symptom of burnout. The population deferring retirement typically expressed “a passion for operative plastic surgery and a continual drive for the attainment of excellence, expressed by all, in one form or another, as “I believe that I am still getting better.” Many had teaching responsibilities, which provided a sense of gratification and prestige. Need for income played little or no role in their decision. However, many in this population lacked diverse outside interests. They worried that they would be bored and therefore “will quit when I have to,” implying a belief that they will know when to retire or someone else will impose this on them.

A similar survey⁵ of retired orthopaedic surgeons found that the main determinants of retirement were job dissatisfaction, a consequence of increased regulation, and low reimbursement; the determinants of continuing practice were high professional satisfaction, financial need, and the ability to do part-time practice. The most rewarding features of retirement were freedom from schedules and time to travel or pursue other interests. The most difficult aspect of retirement was the loss of role, expressed as “loss of prestige and loss of medical fraternity.” The plastic and orthopaedic surgeons surveyed in these studies who most likely had deferred or would defer retirement were concerned that keeping busy or finding activities to occupy their time was or would be a challenge. These were the surgeons most likely to be or who were more preoccupied with their professional role and had not developed any major nonprofessional interests before their retirement.

Reasons to Retire

We should retire at the right time, whenever that may be, and for the right reasons, whatever those may be. Sometimes fate plays a role, and we are forced to retire because of illness or accident. On the one hand, chronic illness provides a span of time over which to make transitional financial and psychological adjustments. In contrast, a serious accident offers no such opportunity. The disability insurance policy we wisely bought may provide some level of financial stability. Family, friends, fellow plastic surgeons, and our psychiatry colleagues can help us with psychological transitions.

When contemplating if and when to retire, keep in mind the following mantra: always retire *to* something, not *from* something. If the primary impetus to retirement is never again having to listen to a complaining patient, then you are retiring from something, a wrong reason. While the initial experience may feel like a burden relieved, ultimate and long-lasting satisfaction may escape you. In order to retire to something, begin early to carefully plan volunteer activities, new hobbies, and even a second career so that retirement years are fulfilling and enjoyable.

When to Retire

The decision to end a career or redirect a clinical career is complicated and very personal. All careers will end, and the key question is when it is time to retire or redirect. Hambrick and Robertson⁶ advised asking and honestly answering a series of questions, which I paraphrase here:

- How do I really feel about my clinical practice? Is it still fun? Do I get gastritis just thinking about going to work?
- Am I still at the top of my technical and patient care game?
- Have I accomplished my career goals?
- How is my health? Am I experiencing physical or emotional limitations that likely preclude me from accomplishing more?

- What are my financial obligations and financial resources vis-a-vis, what I need versus what I want?
- What does my spouse/family think? Marriage vows frequently include the phrase “for better or for worse.” They do not include “I’ll make you lunch every day when you retire.”
- Do I have a life to retire to? Where will I go when I do not go to work?

Achieving Stability in the Transition with Sufficient Planning

Knowing that we will, almost inevitably, someday retire, should generate an early interest in the when’s, why’s, and how’s of retirement. So what is the initial step? Is it deciding what retirement means to me? Pondering this question is itself a transition, with the answer likely a moving target as we evolve through our professional lives. Regardless of how each of us envisions the transition from an active professional life to one of retirement, or conceptualizes what retirement means to us, we should seek stability in its several iterations. For example, when retired, we will all need the basics, that is, food, shelter, and health care. Underlying all this is assurance that we will have the means of paying for these basics, and hopefully more. Achieving the financial stability needed to make the transition is obviously a *sine qua non* of successfully retiring at the time of and into mode of your choice. Ideally, someone, starting with your parents, has been thinking about this time almost since you were born.

We may not always realize that they and others, including the federal government, play an early role in the decision-making through the Social Security taxes that you surely paid as a resident. Later, if you are in private practice, you may have paid into a 401-K plan; if you are salaried, your employers provided a pension or, more likely now, an individual retirement account. Self-employed professionals have the choice of sheltering some current income from immediate taxation by contributing to these financial instruments. I look at these as financial “vehicles” because these instruments are an important means of transitioning successfully from an active practice to semi-retirement, to retirement.

If to you retirement means a simpler life, the required level of financial resource is much different than someone who views retirement as the time to explore all the interests and activities that he or she failed to do preretirement. Financial stability, while key, is but one of the three legs of the retirement platform, and your financial advisor has many tools to help you achieve your targeted level of financial stability. Of the remaining two legs, one, physical stability or health cannot be as easily predicted, but it can be planned for. On the other hand, psychological equilibrium will be more under our control.

The First Leg of Transitioning: Planning for Financial Stability

Unless we have acquired wealth by virtue of birth or luck, we work in part to acquire adequate income and financial security for as long as needed. The course we chart is our own. Financial planning is perhaps the most important consideration in achieving security and should be started even during residency and continued throughout one’s career. Unfortunately, because residency includes little, if any, instruction on financial planning, you need to find a good advisor who can help you develop a portfolio of secure investments and annuities to provide security. Meet yearly at a minimum to review and reassess your potential retirement income. This annual financial reassessment is also a good time to review your own likely evolving ideas about retirement life

and activities. Good advisors can help you develop and achieve financial security and provide the discipline to carry out the needed planning for life after plastic surgery.

Financial planning for retirement involves assets and income. In retirement, a greater asset base yields greater income. Achieving this involves becoming financially informed. Several years before I transitioned, during a motorcycle trip into Glacier Park, I asked a financial advisor motorcycle friend for advice on managing my retirement funds. He asked if there was a way to continue to earn money when I transitioned from full-time academic surgery to something different. His meaning was clear. For every year you work beyond 65, your retirement fund will increase by 9%. For every year you work beyond 65, regardless of how long you live, you will have 1 year less to finance. Above all, become involved in your financial planning. Because this is not part of a residency curriculum, you will need to broaden your reading because there is lots of help outside our literature. Consider reading the book *Can I Retire?* by Mike Piper, C.P.A.,⁷ which is a powerful framework of less than 100 pages that will help you answer the title question.

Financial Planning for Women Plastic Surgeons

Johnson et al⁸ offer sound advice applicable to all plastic surgeons but in particular to women surgeons. They address the uniqueness of women plastic surgeons, including living longer, and thus needing financial resources longer. Women plastic surgeons with family responsibilities may have fewer earning years and consequently need to maximize retirement savings when possible. If you are a young woman plastic surgeon, do read this article.

The Second Leg of Transitioning: The Role One's Health Plays in Decision Making

Paying attention to one's health seems obvious, but my observation is that surgeons in particular do not listen to their bodies until it is too late. Pay attention to your genetics. When my father died at age 99 and my mother about the same age, I decided that it was unlikely that the words "sudden and massive" would appear in my obituary. I needed to prepare for possibly a longer professional life and surely a longer life of retirement. If your genes predict the opposite, decide if you want to expend all the healthy years practicing your profession, or reserve some of those healthy years for retirement. Prepare yourself physically for an enjoyable retirement by common sense measures such as regular exercise and going to the dental hygienist. Increase the chances of retiring while still healthy and decrease the chances of retiring toothless.

Aspiring to physical fitness is easily embraced, even by those with health-related challenges, yet increasing the level of current activities takes mental fortitudes. The authors of *Younger Next Year*⁹ talk about setting back one's biologic clock by exercising 6 days a week. They offer dietary advice and provide evidence that aging-related mental and physical decay can be put off. In fact, they say, many illnesses can be eliminated.

The Third Leg of Transitioning: Optimizing Psychological Satisfaction by Making Choices While You Still Have Control

None of us has the perfect professional or personal life. The aspects of our professional life that we particularly disliked would not be part of retirement, although they may play a role in the timing of transitioning. How do we deal with down-shifting the

professional activities that bring us pleasure? We cannot have it all in retirement, so we must, no surprise here, prioritize. If you are working, you are likely now expending near maximum time and energy in your profession. How will you redistribute time and energy in retirement?

First, try to define what now gives you the greatest satisfaction and then assess what achieving this costs in terms of energy and other resources. Do the same for those current activities that are farther down the satisfaction scale.

Second, consider if it is possible to continue, in a reduced fashion, the currently most satisfying activities while leaving time and energy for activities that add to a successful slower pace or retirement. Continuing the most pleasurable parts of your profession is likely high on the priority list. If continuing to care for patients, but at a lower volume, or even simply working as a general physician is high on the satisfaction scale, then you need to consider how to achieve this.

For many, it may be impossible for economic reasons to simply reduce the scale of current professional circumstances by, for example, reducing office hours, seeing fewer patients, or operating less. The fixed overhead costs must still be paid. You may create friction among your practice colleagues if your preretirement lightened work load complicates their lives or simple is not economically feasible. Some humility is required in transitioning from doing it all to limiting your practice. The surgeon that has cultivated a lofty persona, one tightly tied to his or her identity will have a difficult time with this transition. If you decide to limit or redirect your practice and you are within an organization, the next decision is whether to stay there or change location. Usually, this is answered when you and your partners or group can agree on two items:

1. What patient service is needed that you can provide?
2. Are the finances acceptable? That is, will the institution and you each make sufficient funds to proceed with the service?

If a reduced practice is not desired or even feasible, consider other alternatives. Common solutions including volunteering your skills to resident or fellow teaching programs, to clinics serving the underserved, or to overseas service missions. For me, volunteering my clinical expertise on a yearly basis to a hand clinic on the Navajo Reservation has been greatly rewarding. If teaching, research, writing, or editing is high on the satisfaction scale, how can these be included in your ideal retirement life and at what level? For myself, after 40 years on the faculty, I knew that continuing to teach was high on my retirement satisfaction scale. I have achieved this by staffing a busy weekly hand clinic at one of our teaching hospitals, and by assisting medical students and residents in less complex cases. This latter aspect, teaching less complex cases, required some humility on my part, but accepting this was necessary to my personal transition. Remembering the suggestion of my financially savvy, motorcycle buddy, there is additional satisfaction in that, in exchange for this limited teaching and patient care I earn some additional income beyond my minimum distributions, social security, and Veterans Administration (VA) pension.

The level of satisfaction per activity will evolve as your career evolves, which should compel us to continually assess what role, if any, these activities will play in our retirement planning. We are in the habit of yearly meetings with our financial advisor to assess whether we are meeting financial goals. Why not take this opportunity to consider what your retirement priorities are, and what steps are required to achieve the really important ones.

Practical Advice When You Approach Retirement Age

Social Security

You have likely contributed into the Social Security System. Your financial planner can help answer the question: When do you file for Social Security? If this income is not immediately necessary, it is better to delay filing as this likely results in a larger monthly check.

I Have a Practice. Can I Sell It?

Surgeons may be under the impression that their practice has no real financial value. However, assuming you have a well-established and reputable practice, it may represent a financial ideal for a new surgeon. Seek out professional advice to assist in analyzing practice finances and employee resources and how to structure payments that are favorable to both the seller and the buyer. Such payments may represent a key retirement financial stream. Do not just close the door and walk away.

You Have Retired: Now What?

Your financial advisor becomes a more important person. Together, determine your personal sustainable withdrawal rate. The suggested annual rate is no more than 3 to 4% of your principal. Be disciplined. Do not overspend. Greater withdrawals result in paying higher (than necessary) taxes and reduced reserves. If you are overspending, adjust for the added expense by returning to work to increase reserves or by downsizing. You might consider selling your home or other property to increase reserves. Get professional advice to assist with questions of capital gains taxes, whether to buy or rent in the same area, or whether to move to an area with a lower cost of living. Before changing residence, you should carefully consider the effects of altered expense, comfort, and routine.

Achieving Psychological Equilibrium: Don't Worry...Be Happy and Stay Engaged

A plastic surgery career is time consuming and challenging. Figuring out how to remain challenged in retirement is critical to prevent boredom and depression. Actively planning your retirement will set a course for continuing a fulfilled and enjoyable life. Just as achieving financial stability in retirement requires planning begun early, so does achieving psychological equilibrium. I have previously mentioned periodically inventorying which activities keep you most engaged and deciding how to stay engaged into retirement, which is key to both psychological and physical health. Studies have shown that engagement results in higher levels of satisfaction and lower mortality. Furthermore, engaging in productive activities generates improved physical and mental health, and helping others makes our own lives more satisfying.

Nelems² talks about extending engagement into a third dimension that includes autonomy, mastery, purpose, and quality of life and philanthropy. *Autonomy*, as described by Daniel Pink,¹⁰ Al Gore's former chief of staff, "is our desire to be self-directed." The greater our autonomy, the more we can engage in our world and on our terms. Practicing plastic surgeons typically enjoy a high degree of autonomy, but in

transitioning, we also have the opportunity to increase our level of autonomy. Our children are out of the house and we can hand over responsibilities to others.

Mastery, according to Pink,¹⁰ is “the urge to get better at stuff.” As practicing plastic surgeons, we have mastered technical procedures. Transitioning allows us the time to master new skills such as creative thinking, networking, giving away one’s talents for free, and exercising one’s influence. *Purpose*, according to Nelems,² is “work that is meaningful, the polar opposite of work for profit, work that creates money.” As surgeons, particularly academic surgeons we give away our ideas, as I am doing now in writing this chapter. Why? Because giving is meaningful. The plastic surgeon, regardless of age, who has psychologically prepared for transitioning to retirement has figured out how to remain engaged and fully autonomous masters of their universe, one driven by purpose and meaning. *Quality-of-life* experiences, according to Nelems² is equated to “harmony with others.” This involves dedication to a sense of accord and absolute rejection of social isolation. Regardless of age and one’s life experience, harmony and collegiality can be learned and enhanced. *Philanthropy* means more than giving to a favorite charity. Everyone has something to give, even if it is only time. Give generously. You will live longer and more happily.

Final Thoughts

I look at my professional career as not a single entity but rather like a good book with many chapters. Transitioning means accepting that some professional chapters can be permanently closed. At times in my career I ran a successful research laboratory, captained a large professional organization, gave birth to and nursed for many years an enviable trans-specialty hand surgery training program, and achieved academic distinction at my university. These chapters are complete and over. I made my contributions, they gave me satisfaction, and I do not need to return to any of them

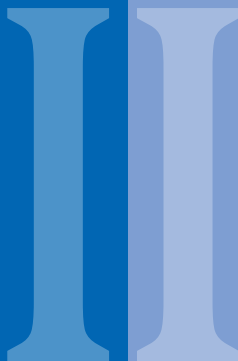
In his article about retirement, Ritter⁵ offers perhaps the wisest advice encapsulated in the comment of a 64-year-old surgeon who had been retired for 3 years. He wrote: “One needs three things for successful retirement: (1) enough money, (2) outside interests [other than medicine], and (3) knowing in one’s heart that one’s self-worth is not dependent upon being a doctor. When one has these three characteristics, one can retire at any time, regardless of age or how long one has worked.”

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Part II Marketing and Monitoring

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7 How to Get the Media's Attention

Jennifer L. Walden and Adam J. Rubinstein

Abstract

Communicating with the media is a way to inform the public of our own practice, our specialty, and patient safety. This chapter addresses how to reach the media, how to prepare for an interview, and how to approach the experience. A media appearance is designed to serve the reporter's purpose, not your purpose. Learn how to craft a message and how to be your best in print or on camera.

Keywords: media, television, agent, radio, newspaper

Editors' Note

Getting the media's attention requires experience, knowledge, skills, and nuance, all of which our contributors, Drs Walden and Rubinstein, have. Their combined different perspectives provide an excellent compass.

7.1 Learning the Basics

Jennifer L. Walden

With the onslaught of internet marketing, social media, and mainstream media talking about plastic surgery, our specialty is routinely confronted with widespread exposure, scrutiny, and misrepresentation. While it is not something a physician traditionally learns in residency, knowing how to field questions from the media is becoming an increasingly important tool. The following are points that may be useful to the plastic surgeon business owner building a clientele in his or her community:

1. If you have the opportunity to educate the public on issues such as the safety or quality of a product you use or manufacture, or a service provided that may be deemed informative and educational, then do so. Performing a public service announcement or educational media segment serves as a golden opportunity to promote your practice through goodwill.
2. Avoid blatant self-promotion. Speak mainly for your organization or practice as a whole, and avoid composing every statement in the first person. Emphasize the quality of your media events over the quantity; you will likely benefit more from participating selectively in relevant media events or segments rather than every request that comes your way.
3. Review any material that someone else submits to the media on your behalf, whether it is your business associate, executive assistant, or a public relations (PR)/marketing specialist. Their perception of what sounds promising to say about you or the choice of topic may be different from your own and may not be how you would have phrased it.
4. Respect your patients' privacy. If a member of the press wants to include them in their segment, get their written permission first and reassure them that participation is entirely optional. If they do agree, they may wish to change their name to protect their anonymity.

5. Was our business involved in a major transition, merger, acquisition, or adverse event? Ask for professional help of a well-recommended PR firm to get your message across in case of a grand opening, location or name change, or damage control. Your money is well spent with professional help; you pay for results in successful control of the messaging.

7.1.1 How Do I Prepare to Go on TV?

What do I wear? What should I avoid? How should I sit? What do I need to be aware of (e.g., blinking too much)? Should I film myself beforehand to practice? These are some of the questions that cross one's mind when you have an opportunity to go on TV.

A TV interview is an excellent opportunity to reach our key consumers—patients. Research tells us that women make the majority of health care decisions in households, and we know that women still consume broadcast media (on TV and online).

If you have an opportunity to do a TV interview, the first question to ask yourself is—why am I doing this interview?

- Am I the focus of the story?
- Is my patient being featured in the story?
- Am I the health care expert in a larger story?
- Is this a positive story or a potentially brand-negative story?

It is also important to understand what type of TV interview you will be doing:

- Will it be a “live” conversation with a news anchor?
- Will it be recorded, edited, and used as part of a larger story?

Once you understand the larger context, you can craft your key messages. Communicate no more than three key messages and one “home-base” message. If questioning gets off-track, you can always go back to these messages.

Because TV is a visual medium, appearance counts. Male physicians should wear a suit and tie, or a white lab coat over a long-sleeve, button-down shirt with a tie. Solid colors look best on screen. For female physicians, if you choose to wear a dress or skirt, look closely at the length. You do not know where you will be seated for the interview. It could be a bar-height chair that would make it hard to wear a skirt that hits above the knee. Men and women may choose to powder your nose to eliminate shine. Spray your hair to avoid distracting flyaways.

TV magnifies quirks and mannerisms. Remember that you are likely to appear from a variety of angles, so you should always look interested and comfortable. Remove items from your pockets, and do not carry anything in your hands during an interview. It is okay to talk with your hands.

Sit forward in your chair, leaning slightly forward. Pay attention to your posture. You would not want to slouch, swing your legs, or swivel or rock your chair. These motions can distract from the content of the interview. Look at and speak to the anchor or reporter during the interview.

Before starting media interviews, enroll in media training. I always recommend that my colleagues participate in a media training before starting media interviews. It is particularly helpful to do a training that includes mock interviews, complete with a videographer, so that you can observe the recording and critique yourself. Enlist an impartial third party to watch it as well and give feedback too. After an interview, I like to watch my media interviews after they are done to look for areas of improvement.

Common Mistakes

When doing TV interviews, a common mistake people make is to get caught off guard when being asked a negative question, particularly when the subject is challenging or controversial. This can be especially hard on “live” TV. A good rule of thumb is that you do not have to answer the question just because it is asked. Instead, go back to your home-base message. Be positive. Do not answer a negative question with a negative answer. To stop the negative impression, share your “positive” message and stick to it.

Another common mistake is getting distracted. There is a lot going on behind the scenes in a TV studio. When doing an interview in a studio, it can be easy to lose focus on the interview. Pay close attention to the anchor or reporter, and try not to get distracted by bright lights, floor managers, and studio techs. They will be walking around, even talking during your interview. Arrive at the studio early, so you can get comfortable with this environment.

One of the most common mistakes people make when doing live TV is thinking they are off camera when their image is still being broadcast as the show cuts to commercial. They either start taking off the microphone too soon or make an unpleasant face. Hold still with a pleasant look until the anchor, reporter, or producer tells you the segment is over.

In a crisis situation, a common mistake is avoiding the situation when confronted with media. This only prolongs negative news coverage. It is important to get as many facts into the open as quickly as possible. The public appreciates transparency, and it looks bad when key details are covered up. The truth has a way of coming out. The quicker the unflattering news is out, the faster you can deal with it and move on.

Finally, a common mistake is avoiding an apology, thinking it is an admission of guilt. If you are in a difficult situation that has caught the media's eye, it is almost always advisable to apologize. Some people do not apologize at the advice of their attorney. However, a PR expert will advise just the opposite. Offering an apology, as long as it comes across as being sincere, will help you move more quickly past the incident. People and companies are sometimes quick to apologize, but those words can sound empty unless they have a meaningful context. Being sensitive to the crisis and showing humility will go a long way.

7.1.2 Should I Always Say “Yes” to Being in the Media? When Should I Say No?

Not all media is good media. Sometimes you are best served by trying to talk a reporter out of doing a story. Here are some examples of when you might consider saying “no” to a media opportunity:

- You are being asked to comment on a study, procedure, or technology that is highly controversial.
- You are being asked to comment on a patient who has not signed a privacy release form allowing you to discuss his or her case.
- Commenting may be offensive to a majority of your patients and/or colleagues.

If you are the subject of a potentially negative story, you will want to weigh the benefits of participating in an interview versus submitting a written statement versus declining to comment. It is typically best to have some “real estate” in the story.

7.1.3 Can Being in the Media Hurt Me?

Choose your media outlets carefully. You will want to make sure that any media outlet with which you do an interview is representative of the level of excellence and quality with which you want your practice associated.

For example, do you think a story about you on the cover of the *National Enquirer* helps foster a positive reputation about your practice? Likely not. On the flip side, a story about your practice in *Women's Health* magazine would have the potential to position you as an expert in front of a key audience.

7.1.4 What Not to Do

There are two things you should never do. They seem basic, but people do them all the time. First, do not answer a question if you are not certain of the answer. It is okay to say you do not have the information with you, and you will get back to the reporter, or simply say you do not know. While it can be uncomfortable, particularly during a live interview, this is better than giving information that proves to be incorrect.

Second, do not lie. Sometimes the truth is uncomfortable, especially if it paints us in a less-than-favorable light. In the end though, the truth will always serve you better.

Today's news stories now have a long shelf life with digital media. What was once considered yesterday's news can now be found online for years after the interview is conducted with a simple Google search of your name. This makes it all the more important to give only information that is factual and honest.

7.1.5 Do I Need to Keep Up Media Appearances Long Term?

I have found it productive to keep up media appearances. It has helped me build my business and develop relationships with members of the media. It is always best to form a relationship with a reporter, anchor, or producer when working together on a proactive, positive story. Once you have formed that relationship, foster it. Stay in touch with him or her. Then, if a crisis media situation comes up, you will have already built up trust with that person. It is not ideal to initiate a relationship with a member of the media during a crisis event.

7.1.6 What Do I Do If I have been Misquoted by a Reporter in a Way that Makes Me Look Bad?

If you have been misquoted or misrepresented, it is perfectly acceptable to reach out to the reporter about the story. Explain why you think the representation of your comments was either unfair or inaccurate. By this point, the story will have already run, but you can ask the reporter to update/correct the online version that will live on. If the reporter is not open to feedback, and you feel strongly that an error has been made, you might consider contacting the station's assignment manager or the producer of the newscast on which the story aired.

If this approach is not effective, and the error is egregious, consider pulling advertising if you advertise with that media outlet.

When expressing frustration with a story, you do not want to permanently burn a bridge with this reporter or the media outlet. Keep conversations respectful, and know that the station may or may not change the story, no matter how strongly you feel you are right.

7.1.7 Social Media

Social media is probably the single most important game-changer for marketing and consumer messaging in the last decade for the vast majority of businesses including the plastic surgery practice. Properly managed and harnessed social media can offer less expensive and more wide-reaching solutions for getting across your message and brand to the public. See chapter on “Digital Marketing and Advertising” (Chapter 15).

7.2 Making Connections

Adam J. Rubinstein

In the world of marketing your practice, the million-dollar question is how best to connect the public to get my name out there, attract patients, and build my practice. There is a multitude of options and opportunities to choose from but it is hard to know which ones will work for your practice specifically. The bad news is that there is no magic formula; no secret sauce that allows you to get ahead of your competition. The good news is that lots of options can work so you should have a wide variety of possible outlets and techniques to work with.

First, choose the identity of your practice. I am not talking about what name you should call it or what stationery style you should use. Each practice has a personality that is a reflection of the practitioner at the helm. The Greek aphorism, “know thyself,” is the key to defining your practice. Each of us have special interests, special skills, favorite procedures, committed causes, and our own style. All of this should be reflected in your practice. Where one doctor may have success being flamboyant on social media (hopefully tastefully, to be discussed later), other doctors may be more at home networking at a Habitat for Humanity event. List your key attributes and interests to best define your practice's image to the public. If you try to use techniques that make you uncomfortable or that conflict with who you and your practice truly are, you are setting yourself up for failure.

Now that you have defined the flavor of your practice, you are ready to start doing some outreach. The nature of your outreach should be consistent with the personality of your practice. It is easy to connect with people when you share something in common. The easiest way to begin leveraging your special interests is in social media. It goes without saying that every practice should have a presence on Facebook and in Instagram. Twitter is also helpful, particularly to keep in touch with your established base and promote your Facebook and Instagram. Create Facebook and Instagram posts that share your special interests; adding content to your profiles apart from your practice and the services you provide will reinforce the personality of your practice. Over time, as you establish a reputation related to your interests, your social media audience will be some of the most loyal patients and followers you can have. Your following will grow and you will quickly be seen as an authority in your field and be known for those special interests as well. Platform popularity changes, so make sure you know the apps your target audience prefers.

The reputation that you develop on social media can help leverage other opportunities in growing your practice. For example, if you are an animal rights advocate, you can promote an upcoming animal rights event on your social media. You might even consider donating as a sponsor of the event for more exposure. Some of your patients may have learned about the event through your posts, and they may bring friends who are unfamiliar with you or your practice. The event is a great opportunity to network with

them. Make sure to post photos of you with some of the other attendees. Tag them and encourage them to post and tag as well. This is a great way to grow your social media presence and, in turn, your practice.

You can take this one step further. When events happen that are newsworthy, you might be positioned to make comments or be featured in a story in the local press. For example, if the news covered a child injured in a dog attack that required plastic surgery, you might be an excellent candidate to comment on the subject. If you are already known in your community as a plastic surgeon with a passion for animal rights, it is not a stretch to think you would be a good expert for such a story.

Apart from social media, you may find other opportunities in your local community to spread your name and reputation. Many local newspapers and magazines have weekly or monthly features related to plastic surgery. The format can be a question-and-answer forum or a regular column on plastic surgery-related subjects. In some cases, these are pay-for-play opportunities, meaning the person writing the articles or offering advice has paid the outlet (i.e., newspaper, magazine, or TV/radio station) for the right to be that expert. In smaller markets, neither the provider nor the outlet pays the other, but both benefit from the relationship. The outlet gets good content, and the provider gets exposure. If no such opportunity exists in your community, you can suggest one to the outlet of your choice. These relationships can last for years and go a long way toward validating your expertise as well as spreading your name.

Truly, any opportunity to connect with the public, whether virtually or in person, is worthwhile. Keep an open mind and consider all options that present themselves. The more contacts you make with people, the more your reputation grows. The more media you work with, the more they will seek you out when the right story comes along; and when you have a story to pitch, you will have a list of contacts to reach out to for coverage.

7.2.1 How Do I Hire a PR Agent?

What Do I Look For? What Do They Do? How Do I Know if Someone is Good?

Hiring a PR agent is something to consider once your practice is reasonably mature and has a good patient base. Your practice should be known in your community and have a reputation that is recognized for good results. In my opinion, hiring a PR agent prematurely can damage the practice and possibly damage your credibility with the media. When you are pitched as an expert and are working with the media, it will not reflect well if you are not quite the expert they were expecting when your agent pitched the story. That can hurt your relationship and possibly limit future opportunities with the same member of the media.

A PR agent's job is to find opportunities for you to be featured in the media. They will get to know you and your practice and then search for stories to which you can potentially contribute. They will also pitch stories about you, your patients, and your practice to the media. Their success will be directly related to the quality of connections they have with the media and the quality of stories you have to pitch. More experienced PR agents with more extensive and better-quality contacts will cost more than less experienced agents. The breadth of the media they will pitch can also affect the cost of their services. A PR agent that specializes in your local market would likely cost you less than an agent pitching national media. Some agents are more adept at booking one form of media over another, some might have great radio contacts, some do better with TV, and some specialize in print media.

The right PR agent can definitely open doors to getting you placed in the media, but there is a lot you can do on your own. If you or one of your staff has a story to pitch and you have the time, you can make calls to the local news desks yourself. You do not have to be an agent to pitch stories. Some of the biggest stories I have been featured in were ones that my office staff and I pitched directly. All you need is a good story to present to the right person. A PR agent can facilitate that conversation a lot and take the time to have those conversations when you are busy working in your office, but in the end, you need results. From a business perspective, a relationship with a PR agent is a success when the revenue derived from the PR agent's work is greater than the cost of that agent's services. It is nice to see yourself on TV or in print, but if you do not make any more money out of it, the relationship may not make good business sense.

Of course, there is branding value to having your name and face out there, but when you are paying for the services of a PR agent, you should be reaping the tangible rewards. Agents may charge for their services by the hour, by the story, or with a monthly retainer. Paying by the hour is probably the most expensive way to go, unless you are hiring someone for a specific story. If the agent is only pitching one story, and you plan on using him or her once, then an hourly arrangement is the fairest for both of you. If you find an agent that you like, consider hiring him or her on a monthly retainer, defined as a set fee each month for all services rendered. Although a monthly retainer allows you to budget appropriately and places a cap on your PR expenses, the downside is that it removes some incentive for the agent to work hard on your behalf, since longer hours do not translate into bigger billing. A good agent will still work hard to keep you in the press, knowing you will discontinue the relationship if you are not getting results. Another arrangement is pay-per-story, in which you pay a fee for every story in which you are featured. Typically, the larger the audience, the greater the fee. The pay-by-story model incentivizes the agent to get you exposure, but it may be expensive if you end up doing a lot of stories. As long as the money you have paid is less than the money you have made from the stories, it is a winning relationship.

7.2.2 What to Know about Speaking to a Reporter for Print, Radio, and TV

So you have an interview scheduled. Now you have to be prepared to say the right things the right way. The way you prepare and the way you speak with the media will vary depending upon the particular media involved. It is obvious you can do an interview on the phone with a magazine reporter in your pajamas, but not for a TV appearance. However, there are other more subtle differences to be aware of.

When you are being interviewed by any member of the media, there are some basic rules to follow. First and foremost, *be truthful*. Do not shoot from the hip and make up statistics. Do not present your opinions as facts. Do not make grand claims about results, risks, or lack thereof. If you have something negative to say, make sure it is grounded in fact and not opinion. Everything you say becomes a public record that will represent you forever. Make sure that record reflects well on you.

Every interview has a purpose, both for the media and for the expert. Do your best to know the media's purpose for the interview. The same topic can be used to emphasize very different points. For example, if you have been asked to speak about breast augmentation, the reporter might be doing an article about tips for people thinking about choosing to have a breast augmentation, or the article might be about a recent

report that claims implants are dangerous to patients and should be banned. Clearly, the nature of the questions you will face will differ, depending upon the scenario. Knowing the media's angle for the story can help you organize your thoughts prior to the interview.

Next tip: *Prepare well.* You might be one of the world's leading experts on the interview topic, but if you do not prepare you are not likely to come across as that leading expert. Preparation is important for all interviews, but it is absolutely essential for live radio and TV interviews. Once you know the topic and the media's purpose for the interview, prepare yourself to come across in the best light possible. Anticipate the various questions you might face and give thought to your best answers. Whenever possible, request a list of questions from the reporter. When a list is available, you will be able to completely prepare for those questions. If no list is available, create one yourself and prepare the best answers to those questions. Prepare talking points that help you communicate your central message. Always have three to five important points to include in your responses to the questions. Data is always compelling. Check references to be certain your talking points are 100% accurate. Using our breast augmentation story example, you might research the number of implants placed in the US in 1 year. That large number can be used to emphasize both the popularity and the safety of the procedure.

If you are doing a print or radio interview, prepare notes that you can refer to during the interview. You can also prepare notes for a TV interview, but never look at them on camera. Study your talking points ahead of time, and know them well, because being seen referring to written notes immediately diminishes your credibility as an expert. Prepare and rehearse both your main points as well as interesting supportive tidbits so that they come across naturally, as if each point of information is just one of the many you have to offer.

An interview has two participants and each may have a separate agenda. The reporter will have a message he or she is trying to convey with the story being produced, and as the expert being interviewed, your take-home message may or may not be the same. Always be respectful of the media's purpose for speaking to you. Make sure you can answer their questions and provide useful information for their story and their goal. You can also deliver your own message, whether it is in line with or in opposition to theirs. Going back to the breast augmentation example, if the reporter is doing a story about tips for women considering breast augmentation, you can prepare a list of helpful tips and interesting information. That does not mean you cannot also tactfully mention your charity work related to breast cancer research. A related topic that is not contrary to the main subject of the interview is usually welcome and more easily included during your interview.

Do not try to include anything that is off topic and/or completely unrelated. You can, however, respectfully include information that might somewhat conflict with the take-home message the interview is trying to convey. For example, a story designed to discuss the higher complication rate and dangers related to Brazilian Butt Lift (BBL) procedures could be an opportunity to talk about your Society's work on a task force researching and recommending best practices to help keep members and their patients safe. In a story that is trying to portray BBL procedures as dangerous, you might not be asked a direct question about the work of the task force, but you can include that information in your answers. It is easier to include information that speaks to your own goals for the interview when doing live radio or TV, but if presented in a respectful and nonconfrontational manner, your message can make it through the editing process of print and recorded media stories as well.

One last tip, the media has their agenda for the interview and the story. Rarely will that agenda be talking about you personally. Do not try to use interviews with the media for your own marketing purposes, and do not present yourself as the best of the best. Unless the interview is *specifically* about you, always remember that it is *not* about you. Be professional, provide good information, and answer the questions you are asked. Stay on point. As long as you provide what the reporters need, you will be invited back for future opportunities. If you make the interview an ego feeding session, you are not likely to hear from that reporter again. Be a good expert, and you will build a relationship with the media. The relationship will lead to more opportunities to be a resource for future stories.

7.2.3 Contacting People with TV Shows and Journalists and Creating Your Own Opportunities to Get into the Mainstream Media

PR agents exist because it is not easy to get into the media, particularly mainstream media. Being asked to contribute to a story, or getting coverage for a story that you pitch, is all about relationships. The reason PR agents are more successful than the general public in getting their clients included in a story is that they have direct relationships with the reporters and/or producers doing that story. Media opportunities are much easier to arrange when the decision-makers doing the story are a phone call away and are familiar with you or your agent. Fame begets fame. That is to say that the more you appear on TV, radio, and in print, the more likely you are to be asked to appear. Producers want to have experts they can count on to look and sound the part. If you have already made appearances that have gone well, chances are that you can be counted upon for a good appearance again. The problem is, how do you get that ball rolling?

It is much easier to be included in a local story. Get to know your local reporters that cover health issues. The best way to start a relationship with a member of the media is meeting a reporter/producer in person. Of course, if you are already doing a story it is easy to make their acquaintance. Take a few moments to chat with them and get a sense for their special interests. Sometimes they will have stories they are working on that you might be able to help with and contribute to. Sometimes they have nothing on their plate and are looking for good stories. That is an opportunity to pitch anything in your practice that you would like covered.

You would not always have the chance to speak with a producer or reporter in person. You can always reach out by email or phone to make introductions. Email is less intrusive and more respectful of their time; phone calls should be reserved for pitching a story. A simple email introducing yourself as a possible resource for future stories is a good start. Be succinct but include a few simple details that show why you are an authority in your field. When you have a story to pitch to that person, it would not be the first time they have heard of you. If you get lucky, they might just have a need for an expert at that time. Make your introduction, but do not be pushy. They cannot reach out to you if they do not know you, but they would not reach out to you if you are annoying.

As you build your network of media contacts, you will have a better chance of being included in a story as well as getting coverage for your own story. The media are always interested in good stories, but what makes a story good? Nearly all stories covered by the media share one common element: human interest. Typically, for you

as a surgeon to get a story covered, you will need a patient. The patient's personal experience might make the story interesting. Or the story might feature a patient having a new and exciting treatment. Without a patient who is willing to participate, however, the media will be far less interested in covering your story. Stories likely to get coverage typically include a unique patient experience or problem, a new technique that improves upon the standard techniques, or a new technology that offers better options to patients.

If you have a story that you think might be interesting, you can reach out to your local media. Traditionally that would start with a press release. PR agents are skilled at writing these releases and getting them distributed, but you can certainly write them yourself. There are many online outlets that can help distribute your press release. Make sure your press release is brief, concise, and tells a compelling story. Always include a brief bio about yourself and any main contributors to the story. Include contact information so the media will know where to reach you if they would like to cover the story. With the ease of issuing a press release through online services, thousands and thousands are distributed every day. Consequently, press releases have become less effective for contacting the media about new stories. They are still an effective tool, but are less likely to attract attention on their own.

This is where your network of media contacts becomes helpful. Whether following up after issuing a press release or being the first contact about a new story, a phone call to the right reporter or producer can be very effective. Call once and leave a message if you cannot speak with your contact directly. Allow time for them to get the message and call back, be patient. If you have not heard back after a number of days, one more phone call may be worthwhile. Do not make several calls to the same member of the media. They are very busy and will contact you if they are interested and have an opening to cover your story. The bigger the story, the more appropriate it may be for mainstream national media. The more appearances you have made in the media, the more likely you will attract attention and coverage of your story. It is OK to contact competing media about the same story, but be honest about any coverage you are getting or have already gotten. Networks like to be the first to cover a story. If your story is already in production by network A, you should let network B know if they call back with an interest. Do not let anyone think they have the exclusive story or are breaking the story for the first time if that is not true. You will certainly damage your relationship with both outlets. However, a story that is covered locally could still be of interest in other markets and/or possibly nationally. A big story that gets local coverage is sometimes easier to pitch nationally. Having "tape" of local coverage to include in your pitch to larger outlets can be helpful.

One important principle in gaining media opportunities is being available. If you pitch a story, you must be ready to participate in it when the media is available. They will have their own time frame for working the story into their flow. If you cannot be flexible with your time and availability, you will have difficulty getting a story covered or being interviewed for your comments. When the media calls, you need to be available to answer. Interviews for everything but TV can be done from anywhere in the world. I once did an interview for a magazine article while touring Chichen Itza because that was when the reporter was available. There are plenty of other people who would be happy to be included in the story being covered. If you are not available, you might lose your opportunity. Conversely, a reporter that knows that you go out of your way to contribute will be more likely to call upon you when the need arises.

7.2.4 Preparing to Go on Radio

Going on radio is a little more challenging than being interviewed for a printed story, but a little easier than preparing for TV. The challenge of radio is that the interview will probably be live. Some shows are recorded and edited, but most radio appearances are done live. You will have to think on your feet and be prepared with knowledgeable and concise answers to the questions you expect to be asked. You may have to switch gears and go in a new direction depending upon the flow of the interview and the host's agenda. Regardless of the topic, you should be relaxed and comfortable. Radio appearances are nothing more than conversations you have about a topic that matches your expertise. With a little preparation, you can come across very well.

Radio appearances are usually brief, typically only a few minutes. You may be able to get a list of questions that you will be asked before the day of the appearance. If that is not possible you can also request a "preinterview," which is a conversation between you and the host that occurs before the date of your scheduled interview. During a pre-interview, you can get a sense for the host's style and what he or she will ask you. A preinterview is a casual conversation that is not usually recorded, so you do not need to prepare. Once you have all the info about the interview you can get in advance, you can start preparing.

As you would do for any interview, you need to get your facts straight. If you were not able to get the actual questions in advance, make a list of likely questions. Review the relevant facts and become familiar with any statistics or interesting trivia you might want to reference. Prepare a short list of talking points. Once you have all of your ideas organized, practice giving your answers. This can be as simple as speaking to yourself out loud or having a mock interview with someone else as the host. Hearing yourself is very different from simply thinking about what you would like to say. If no one is available to help you, record your answers and listen to the recordings. Make sure you like your answers, your choice of words, the pace of your speech, and the effectiveness of your message. It is common for your nerves to accelerate your pace of speaking, making you sound rushed and nervous. It can be helpful to consciously think about speaking very slowly, even too slowly. Often, when you listen back to yourself, you will find you are actually speaking at what comes across as a relaxed pace. As you listen to yourself, count how many times you say "um" and "uh," and concentrate on eliminating them as you continue to rehearse. I strongly recommend this exercise, particularly if you have little experience speaking on radio.

The most important thing to think about when being interviewed is to stay relaxed and calm. Radio has the advantage of not being a visual medium. You do not have to worry about your appearance, just your verbal performance. This is particularly true if you are not required to go to the studio for the interview. You can wear anything you want as no one listening will know. You can stand up, sit down, or pace back and forth, whatever makes you the most comfortable. Maximize your environment to put yourself in the best position to succeed. Try to use a landline when doing a remote interview. If you have to use a cell phone, make sure you are in a spot with a great signal. The interview is slotted for a set time and duration, and you do not want to lose some or all of that time trying to get reconnected. Once the interview starts, breathe, relax, and let the conversation flow. You may have heard the old advice to smile when speaking—it is a good practice. Your smile will help you feel relaxed and your listeners will really be able to hear it too. If you are tense, it will come across in the way you speak. If you are smiling, even if you are forcing it, your voice will sound better. When you are in the moment, trust your preparation and have a good time. You will have prepared, practiced, and maximized your environment. Now just have fun!

8 The Wonderful World of Marketing

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Abstract

Internal marketing is a powerful way to keep the patients who love your practice interested in what you offer. In external marketing, you are trying to prove yourself and your practice to the public, who is also looking at everyone else's marketing materials. However, internal marketing is successful only if it engages your established patients and offers them what they are interested in. Start by defining who you are through a mission statement; then create value, whether monetary, functional, social, or psychological. Differentiate yourself with a unique selling proposition (USP). Then define your target audience. When they contact you, provide a unique customer experience. Events help show your culture in a fun way. A successful event takes planning starting weeks in advance, and the return on investment is evaluated with objective metrics. Putting together a successful marketing program can help bring out the best in your practice.

Keywords: marketing, branding, unique selling proposition, USP, event, internal marketing, editorial calendar, marketing campaign, online content

8.1 Introduction

When done well, external marketing attracts the customers (also known as “patients”) who value the goods and services you provide. Internal marketing retains established customers by continuing to fulfill their wants and needs. To retain patients and keep them coming back, the ultimate goal is to develop a relationship. Relationships are based on feelings, and emotions play a fundamental role in decision making.

8.2 Who Are You?

To market yourself, you must first understand who you are.^{1,2} Developing a mission statement and values forces you to articulate who you are, what you are trying to accomplish, and how. For example, several years ago we articulated our mission: *We aim to add joy to our patients' lives through genuine caring, generosity of spirit, and the quality of our work* (© Plastic Surgery Associates).

What is the larger purpose of your practice? To arrive at an answer, it is helpful to break the one big question into smaller ones:

- Why should your practice exist?
- Who needs your services?
- Why should they care about you?

To further develop the description of your identity, define your values. Your core values are the beliefs that influence your behavior, and they will be the starting point of your brand identity. Live by those values and lead by example. They should be the bases of your company culture and should be cultivated top-down. If your values are a part of every workplace operation, patients will recognize your practice's commitment to its ideals. A successful brand identity that absorbs those values will answer these three questions for existing patients and potential patients: (1) Who are you? (2) What do you do? (3) Why should I care?

Now that you have your mission and values established, what is your company narrative? Tell an engaging story about yourself or your practice. What inspired you to become a plastic surgeon? Were you once a Navy Seal or a professional athlete? Introduce your practice with a narrative that captures interest, and you will have your audience's attention. A strong company narrative helps strengthen your internal company culture, and that is your foundation for effective marketing.^{1,2}

As you develop your story, answer some, if not all, of these questions:

- What is the intrinsic value of your services and products? What practical problem do they solve?
- How do your services and products make your customers feel? Confident? Special?
- What is unique or uncommon about your practice compared with others?
- What inspired you to develop or join this practice?
- Who is the person most likely to want to buy plastic surgery from you? Be detailed.
- Are you as a person a major part of the appeal of your practice? Do you want to be?
- What do you do to demonstrate your values?

8.3 Create Value

When you think of marketing, you might think of it in terms of advertising and sales, and its purpose is to push products and services onto customers. In reality, marketing is a value proposition through which you educate the consumer that what you offer is high value and will contribute to greater happiness or improved quality of life. By conveying information in a way that elicits an emotional response, a marketing campaign can educate target audience into making a better choice for themselves. If the marketing is ethical and honest, the result will be satisfied customers. People are more influenced by how they feel than by facts, which is why credit card ads show long marriages celebrated with diamonds and ads for watches show a mother and daughter to illustrate that the timepiece is a family heirloom. That emotional response is associated with the perceived value.¹

Consequently, marketing should focus on creating value for the customer. Value can be much more than monetary. Customers can find value in efficient service, humans (not robots) answering the phone, accessible online education, no wait times, attentive staff, and the calm atmosphere of a beautiful office. To market most effectively, think like your customers. Since we are not always successful at mind reading, at least try to understand what they want and value by running a survey with them.

When you have an idea about what your customers want, how can you deliver that service in a unique and compelling way? Why are you the best person to improve their lives through plastic surgery? That is the value you have to communicate to your customers daily.¹

Merely being a great plastic surgeon is not enough to attract new patients or maintain their loyalty. People act based on how they feel. The patient with asymmetry or poor tissue tone may mistake her anatomic limitations with a poor result. Marketing is about education and answering the questions they may not even know to ask in easily understood terms. Focusing on your board certification, number of articles published, or television shows you have been on puts the spotlight on you. That information is effective for those who know what they want, but your qualifications should be secondary to a focus on the patient and how your services can benefit her.

8.3.1 Types of Value

We often perceive value as an intrinsic quality of a product. People pay \$1.99 for a black ballpoint pen because that is the value they place on that pen. You can sell a pen with an additional red cartridge for more since the value just went up. But if people do not want two colors, the pen might be valued less. The customer, not the pen itself, determines the value. We can identify four different types of values that a patient might perceive in the procedure, services, and products in a plastic surgery practice: monetary, functional, social, and psychological.¹

- *Monetary value* is associated with the customer's money and the service or product he or she is purchasing with that money. Customers will purchase that service or product if they feel the price is fair.
- *Functional value* is associated with fulfilling a purpose or solving a problem. Removing a malignant melanoma may save a life and an upper blepharoplasty may improve peripheral vision.
- *Social value* is associated the way a service or product connects the customer with others. A breast augmentation may give a woman the confidence to go to the beach with her friends more often.
- *Psychological value* is associated with how much a service makes people feel appreciated, respected, comforted, or hopeful. Facial rejuvenation may make a patient feel less invisible.

Each of these values is of varying importance to different people. Develop your marketing program based on which values matter most to your target audience. For example, Walmart emphasizes monetary value, and Harry Winston emphasizes psychological value. Marketing a \$2,999 breast augmentation may sound alarmingly low to the patient looking for psychological value, and she is likely to go elsewhere.

8.4 Communication

Your brand's success comes from participating in an ongoing conversation, not dictating your treatment plan. Look through the eyes of your target audience. Adjust your message according to their expectations. Do not overpromise or talk patients into a procedure or treatment that is not in their best interests. If you resort to emotional bullying to get people to sign up for a procedure or products they do not need, you are probably talking to the wrong audience or you are not listening.²

It takes empathy to see things from your patient's perspective. The most effective sales pitch is a conversation. Ask questions, listen, and answer the listener's concerns.

8.5 Unique Selling Proposition

Your unique selling proposition (USP) is the way you differentiate yourself from your competitors. A vague promise of best results elicits no emotion and is not an effective hook. Instead, focus on developing a relationship with your patients. The way you answer the phone (with a smile and no robots); a responsive, beautiful website; an interesting social media presence; an informative newsletter; and a warm greeting, all have a profound impact on the emotions of your customers. Relationships are a powerful driver of brand loyalty, so it is worthwhile to train your staff to reflect your positive company culture.²

Your brand is your practice's personality. Once you have defined it through your mission and values, your company story, and your website design, be consistent in all forms of communication. Your target audience should develop a mental impression of who you are and what you stand for.

8.6 Who Is Your Target Audience?

Establishing a specific niche will help you differentiate yourself from others. What can you offer that would be uniquely appealing to your target audience? Write down all the benefits of each of your products and services. Next, write down the characteristics of the people they would benefit. Narrow your target audience by gender, age, location, level of education, income, occupation, etc. For example, you might target mothers between the ages of 25 and 45 with incomes of more than \$90,000. Your marketing campaign will be effective only if you have a clear vision of the type of person you want to reach. Marketing to the viewer is more important than featuring product or procedure attributes. The more targeted your marketing, the better your return.

8.7 Customer Experience

Learn what your customers experience from their first email or phone call to the time they drive into the parking lot all the way until the time they leave. Break the customer experience apart into its components. Can your website visitor easily navigate to the desired page in no more than two clicks? Do videos load quickly? Does your staff answer the phone by the third ring? If a customer is put on hold, how long before the staff picks up? Any step that wastes time, requires extra effort, or is not pleasant will lead to customer attrition and they will end up getting their plastic surgery someplace else, even if their results are not as good as yours.^{1,2}

8.8 Engage with Your Target Audience

Know your audience: How do they prefer to get information? What aspirations do they have? What motivates them? The more you know them, the better you can target your messaging. Segment your audience to target each one. The choice of words, tone, and approach will vary tremendously depending on the demographic you are aiming at.

Effective communication is more than just words. Clothing, body language, posture, tone of voice, eye contact, and facial expressions all transmit a message. Appearing at-ease and comfortable is reassuring. Be clear about your core message.

Only after conversing with the patient and indicating that you have a clear understanding of her problem should you enter into a solution with a product or procedure. Leading with the product or procedure may leave the patient focusing on her fears about the risks or concerns about the costs without appreciating the improved quality of life she would likely experience if she committed.

8.9 Branding

To build a brand, start by defining who you are through your mission, values, and company narrative. Then look at your competitors' market presence and look for ways to differentiate yourself. Your brand will develop not just from a website or some social media accounts, but by bringing out your company's personality across

platforms. Personality is about people, so your website, blog, newsletter, and social media should be personal. Your content can feature not just you but also other members of your team, and describe how each person contributes. Viewers ignore stock photos, so use images of real people (who sign a release), like you, your staff, and your willing patients.²

Develop a color scheme, a font, and core message so that your print and digital media share the same recognizable look and feel. Your website should convey a clear message, look fresh, and be easy to navigate quickly. Perform regular updates, since an outdated look can imply that your practice does not keep up either. Your social media audience should be able to spot your brand through its consistency.²

As you develop content, run surveys with your target audience, such as a group of volunteer patients, to learn what their subjective experience is and what they prefer. If you are marketing an event on social media or in a newsletter, do A/B testing to see which of the two versions gets a better response. Your target audience's preference may be different from your own, and theirs is the one that matters.

Tell a story that instantly conveys your compelling uniqueness.^{1,2}

8.10 Writing Good Content

Write for a lay audience. Whether you or your staff or an outsourced hire writes your content, be consistent in your writing style. Article, blog, website, and social media styles all differ, and social media platforms differ from one another, but each one should have a consistent voice.

Depending on your geographic location, a sixth-grade reading level may be most appropriate, and clever punch lines can help keep the reader interested. Prose should be broken up into several short paragraphs, and important points can be set off with bullet points to make difficult concepts more approachable. Large expanses of text can be intimidating, whether on a website or in a blog, so break them up with images and videos.

While education marketing is not of interest to everyone, it is a great way to gain traction curious and interested readers. Best of all, education is infinitely scalable. A video can be embedded in a blog, which can link to other blogs and to other pages on the website, which can in turn feature more videos, etc.

Many newsletters are simply a list of ads, but a good newsletter provides great content written in an engaging style. The content should be fresh and something already published on your website. The subject line should grab the audience's attention so they open it, then write the content to back it. Include tips, news about plastic surgery, updates on statistics, etc. Tell stories and anecdotes to illustrate your point. Articles should be short and concise. Readers who feel duped by content that does not live up to the promise of the catchy title may unsubscribe or identify you as spam. If you create a newsletter, choose a good email management system, like Constant Contact or MailChimp, and make sure it is mobile responsive. Design the template with your branded colors, text, logo, and images. Publish regularly; once a month is typical for a plastic surgery practice.

Write about new procedures, technology, and techniques; mission trips; volunteerism; and educational content related to procedures, and include a patient anecdote to make it real. It does not have to be written first person by the doctor; it can be about the doctor, but the surgeon needs to approve all content. Write about one specific topic per email. Have a theme.

Balance your content so it is 90% educational and 10% promotional. Leave out the promotional part unless you really have something timely and newsworthy to share.

8.11 Blogs

An engaging, well-written, high-quality blog will likely be out of reach of most plastic surgeons unless they are dipping their toe into the water of creative writing or creative nonfiction. Nonetheless, a blog can provide evergreen content and can be a great reference for patients. You can embed videos and make them truly educational. You can have a blog button on your website. The ideal blog is interesting, well written, and reveals the writer's personality. You can have someone else create the content, but establish a few rules first and vet it before it is published.

- Provide good information.
- Be accurate.
- Include good keywords, but do not let that stifle the writing.

A blog is searchable and can help increase the authority of your website. It provides updated content on a regular basis. You can provide a link to the blog in your newsletter, if you would like.

8.12 Social Media

The use of social media is a way to connect people to your website, post your blogs and videos, and engage with followers. For more information about social media, please refer to Chapter 15 which is devoted to digital marketing and advertising.

8.13 Marketing Campaign

When developing a marketing campaign to promote products, services, and procedures, unless you specialize narrowly, you are unlikely to appeal to everyone you would like to attract.

Start with these five questions¹:

1. Who is your target audience?
2. What do they value?
3. How can you give them what they value better than the competition?
4. What method of advertising will be most effective?
5. What are the product or service benefits to communicate to your target audience?

Segment your audience and focus on a smaller target. The 22-year-old breast augmentation patient would not be interested in facelifts. Your campaign will work only if they want what you are offering. Marketing breast augmentation to a wealthy retirement community is a clear mismatch.

End any written piece or ad with a call to action, like an invitation to schedule a consultation, sign up for a virtual consult, go to your website, sign up for a newsletter, download an ebook, or register for an event. Track your metrics, including newsletter open rate, website bounce rates, etc. Social media, newsletter, and particularly Google Analytics are helpful in determining how to adjust your marketing efforts.

8.14 Editorial Calendar

Organizing your newsletter, blog, videos, social media posts, and office events can be overwhelming unless you start by looking at your entire marketing efforts from a bird's eye view (► Fig. 8.1).¹ In addition to scheduling content, an editorial calendar is used to create unifying themes and develop ways to repurpose items you have already created. The viewer should experience a cohesive and consistent company brand across all platforms. Elements of a good editorial calendar include:

- What needs to be done by whom and when it needs to be completed.
- A plan to leverage content across all digital media, including blog posts, newsletters, ebooks, social media, videos, press releases, podcasts, interactive media, and website pages.

Establish content goals, like one blog every week, one newsletter every month, and one webinar every quarter. Surveying your patients or other market research can help you establish your target audience's interests and expectations.³

Mark down events, such as open houses, seminars, holiday-themed gatherings, and product or technology launches. Use each date as the endpoint for content to create excitement for each event across different platforms. Brainstorm with your staff about all the possible content you can create, then assign roles and deadlines for each step of content creation and publication date.

For example, for a video, you might schedule filming for an hour. Include equipment, such as lights and tripod. Identify a camera person and the person being filmed. Schedule the editing process, including length and whether you will write subtitles. Next, schedule a deadline for writing the brief description and keywords, if applicable, and publishing the video.

<u>Sunday</u>	<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>	<u>Saturday</u>
August focus-hydrfacial, botox (men + women)			1. Insta-hydrfacial promo / IGTV hydrfacial		3. Insta- novato office (for event promo)	4
5	6	7. Insta-prevention botox	8. Insta- males getting MedSpa Treatments	9	10. Insta story-botox facts	11
12	13. Email-reminder for event	14	15. Insta story-event gift bags sneak peak	16	17. Insta- event graphic/ RSVP reminder	18
19	20	21. Insta story-event décor sneak peek	22. Email-"don't miss" reminder for event	23	24. Event-hydrfacial @ novato 9am-12pm	25
26	27	28. Insta story-event highlights/ recap (for events highlight)	29	30	31	

Fig. 8.1 An Editorial Calendar is an essential part of a well-organized marketing program. Due dates for blogs, posts, videos, and other content are combined with the steps of event planning.

Do not leave the video to fly on its own. Schedule a deadline for writing supporting content: the blog post in which the video will be embedded, the newsletter that will feature the blog or the video, the social media platforms that will link to the video.

Share your editorial calendar with everyone in your practice. Whether they have a role or not, the staff can see the lead-up to events. Other duties can be added, such as:

- Changing the office decorations to fit a theme or a season.
- Creating a poster featuring before-and-after photos, announcement of an event, or a staff's favorite product.

Before filming or posting a person's image on a digital medium, get written consent first, whether the subject is a member of your staff or a patient. This step can be added to the list of duties.

8.15 Other Marketing Ideas

Staff who have had surgery are effective ambassadors. Match them with patients consulting about that particular procedure. When a staff schedules a procedure, ask them to journal about their journey and publish it as a blog. They might take videos of themselves along the way to be used for a single video about their experience.

VIP programs are designed to make customers feel that they are getting added value (think of access to airport lounges for platinum credit card customers) or special savings. In medical spas (medspas), VIP programs often involve giving select customers discounts on nonsurgical services, or invitation to special events. Some practices print out special cards that announce the carrier of the card as a VIP and ask to have the customer present the VIP card with each purchase. The VIP programs can be difficult to maintain: sometimes customers forget their card and want the discount; other customers simply do not like carrying another card in an already jammed wallet or purse. If you create and pay for a beautiful set of VIP cards that say 15% off but you then find yourself losing money and in need to change the card to 10% off, it creates a problem with the original recipients of the card. Or if you constantly have to remind VIP customers that only certain treatments qualify for that discount, you can also build resentment. Maintaining a separate list of VIP customers can also create added work for your staff.¹

Subscription programs are a newer form of creating customer loyalty. The subscription service is described more fully in Chapter 20, but simply stated, the customer pays a monthly fee for a specific treatment plan much akin to other subscription services like Netflix, Dollar Shave Club, or Stitch Fix.

Focus groups of patients can help give your marketing efforts direction. Some may be interested in being featured on your website and your brochures. Photos of real patients establish a trustworthiness that stock photos don't.

Swag items like cups, bags, jackets, and visors may be more easily distributed from a medspa than a plastic surgeon's practice, since few people want to advertise that they go to a plastic surgeon.

8.16 Events

When done well, an event can help establish a loyal following of patients and attract new ones to the practice. Events require planning. Refer to Appendix 8A to see an example of preplanning. Appendix 8B shows an example of the schedule for the day of the



Fig. 8.2 A promotional ad for an event should be enticing. The same ad should be posted across digital platforms as well as in hard copy in the form of posters and fliers in the office.

event itself. Everyone's roles should be clearly defined. Event goals should be set and net profit measured accurately, accounting for all fixed and variable costs. Following are salient points when planning your next event:

- Designate one staff member as the lead person to take the event from planning to completion. As your events grow, you may need two staff members.
- Organize the event either around a treatment (say, Coolsculpting) or around a holiday (Valentine's Day, Mother's Day, Black Friday).
- Make a calendar for the entire year, or add to your established Editorial Calendar, so you have plenty of time to think about how to publicize the event, what hours, what day, what food will be served, whom to hire, and what to rent (tents, photo booths, entertainment).
- When you have a date, create a flier to post across your social media platforms. Send the file to a printer and have posters and fliers or cards printed to have available in the office (► Fig. 8.2).
- Create a budget and stick to it.
- Invite reps of noncompeting technologies (e.g. you do not want a rep explaining why their filler is better than the filler at the next booth).
- Ask reps for financial support. If they are unable to donate money, they will many times help with food and drinks or even donate consumables for demonstrations or actual product for injection demonstrations.
- Ask the reps to come to the event and use them to explain their product or technology (you have a limited number of staff members and they will be very busy during the event).
- Create challenging but realistic goals for the event. If the goals are met or surpassed, reward the staff! This can be a celebratory dinner, a day at a spa, or a monetary bonus. A bonus or reward creates buy-in for the goal and makes sure every staff member is working hard to achieve that goal.
- Create event specials that incentivize patients to come to the event. You can say that certain treatments can be purchased at a discount but only for event attendees. Announce prominently that every hour of the event will include a raffle and make the raffle prize exciting (a Clarisonic brush, a basket of skin care products).
- Try to avoid discounts. It is better to create added value. For example, if you have two syringes of filler, you can have a skin care product of your choice up to a certain dollar amount. Offer a free peel for those who buy a certain dollar amount in skin care products. Or offer a free bottle of eyelash grower for those who reach a certain

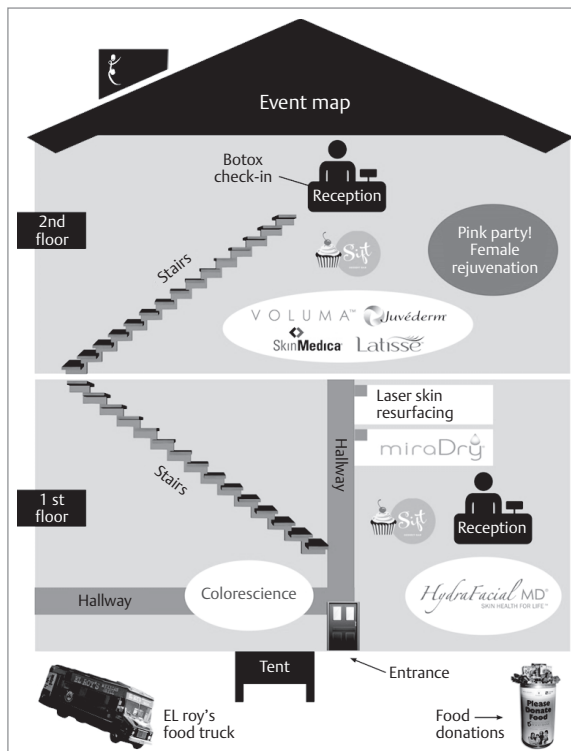


Fig. 8.3 A playful scavenger hunt map for an event adds to the festivity while also guiding visitors to all booths and presentations.

dollar amount. Use your judgment and make customers feel like they are saving money and getting value.

- Create a scavenger hunt map so customers are encouraged to visit all stations (► Fig. 8.3). For those who get their map stamped at all stations, give them 10 extra raffle tickets. This ensures that all reps get equal access to the customers. The last thing you want is to see the rep who helped you with the food and drink getting no foot traffic near their station.
- Create a set expiration date for completing any treatments. Having a purchased treatment on the books creates some accounting work and you do not want to have to carry open treatments on the books for very long.
- Have extra staff around bottleneck points. Usually this means having extra staff to be able to check patients in and out, as well as rapidly completing sales (nothing discourages sales more than seeing a long line to check out).
- Have a debriefing the day after the event. Praise the staff's effort, announce whether the goals were met, and announce the staff rewards or celebration.

One word of caution on events: a properly planned event takes a lot of staff time to plan. If you have too many events per year, you may find yourself spending too much time on events and too little time on running and building your practice or medspa. Be strategic. If customers know that you have an event every 4 months with a Botox or Dysport special each time, they will only buy the Botox or Dysport at the time of the discount. If you have more than two events per year, make sure that you limit and vary what the specials will be for each event.

Internal marketing is about building goodwill that compels patients to choose you over competitors and keeps them coming back. If you are there for them with service, attentive care, and excellent results, your patients will become your biggest fans. No brand awareness campaign can compete with that. Your best advertisement is a satisfied patient.

8.16.1 Virtual (Online) Events

Virtual events are an important growing trend made possible by advances in technology. Today, 4 billion people are connected to the Internet, and 92.6% are connected via mobile devices. Of these users, 85% (3.4 billion) connect online and spend an average of 6.5 hours online per day.⁴ A virtual event can reach a wide audience, as attendees don't have to leave work, fight traffic, or even get out of their pajamas to attend. These events are much less expensive, can be planned in as little as two weeks, and can be very lucrative.

The QVC television channel is an excellent model for a virtual event. QVC functions on providing quality, value, and convenience—hence the name. Providing quality and value is the basis for many office events, and making it virtual adds the winning convenience factor.

Another success story using exclusively virtual events is the Rodan + Fields skin care brand. Founded in 2000, the company was soon acquired by Estée Lauder Companies who put the product in department stores. But 7 years later, the original owners bought back the company and relaunched it, marketing through online events, now called a consumer connected commerce business model. In 2018, Rodan + Fields was the number one skin care brand in North America with sales of over \$1.5 billion in yearly revenue.⁵

When planning a virtual event for your office, go heavy on marketing, get people to register, and keep in regular contact with the prospects before, during, and after the event. Advertising and marketing on Facebook and other social media can attract attendees from around the world, and it is not unusual to have thousands of visitors attend your online event.

Live demonstrations and raffles for appropriate products and services during the event are strong incentives to get people to login to the event, along with specials available only for those who purchase during the event. Attracting potential customers and patients is the first step; but, as with any patient, having them join your community requires attention and care.

8.17 Appendices

8.17.1 Appendix 8A

How to Plan a Successful Event

12 weeks prior to the event:

- Establish event focus
- Define goals
- Set date/time
- Send save-the-date to staff and reps

10 weeks prior to the event:

- Determine specials
- Establish staff roles
- Send event details to staff and reps:
 - Staff roles
 - Specials
 - Where to document RSVPs
 - Ask reps for gift bag and food sponsorship

8 weeks prior to the event:

- Create event posters/flyers
- Send posters/flyers to print
- Create marketing calendar:
 - Email the schedule
 - Social media calendar
- Create email invite
- Create promotional images/videos for social media
- Create Eventbrite event

4 to 6 weeks prior to the event:

- Send event invite, schedule future email reminders
- Create/post Facebook event
 - Invite all staff and potential attendees
- Set posts for social media
- Launch paid social ads
- Add Eventbrite widget to website
- Order food for event (including staff!)

3 to 7 days prior to the event:

- Send run-of-show outlining event day logistics
- Call/email RSVPs
- Create event gift bags

Event Day!

Post-event:

- Request feedback from staff and reps
- Measure event success:
 - Number of attendees
 - Number of treatments/packages/products sold
 - Event revenue
- Thank event attendees on social media

8.17.2 Appendix 8B

Scheduling the Day of the Event

ALL DAY EVENT

Thursday, November 9th

Staff: 10:00 a.m.–7:00 p.m.

Patient Appointments: 11:00 a.m.–6:00 p.m.

Run of Show:

10:00 a.m.: Tent/Tables/Lights Arrive (set up by 10:30 a.m.)

10:00 a.m.: Staff Arrives

10:15 a.m.: Group Photo

10:30 a.m.: Sift Cupcakes Arrive

11:00 a.m.: EVENT STARTS!

11:30 a.m.: El Roy's Taco Food Truck Arrives (start serving @ 12 p.m.)

6:00 p.m.: El Roy's Taco Food Truck Departs

6:30 p.m.: Tent Pick Up

(Staff roles: Each person assigned a role with specific hours)

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9 Optimizing Your Practice

Jon Hoffenberg

Abstract

This chapter provides elective medical practices with an implementable process to streamline patient phone calls, consultations, and scheduling, while maximizing average order and booking percentages, with the ultimate goal of practice profitability. As doctors attend medical school, not business school, many areas of business efficiency that impact profitability, total revenue, and surgery schedule maximization often go untaught. The approaches discussed in this chapter allow even the least business-savvy doctors and medical practice administrators to make simple changes to run a more fully optimized medical practice.

Keywords: sales, efficiency, optimize, booking ratio, consultation, patient coordination

9.1 Introduction

How can 10,000 people doing something a specific way for 50 years be incorrect? I asked this question after 4 months working as a patient care coordinator in my very first practice. I was a unicorn; 20-something male, without an iota of medical or elective medicine experience, and I questioned the power of plastic surgery to change lives in positive ways. I had taken the position exclusively on commission pay, largely to consult for a friend of a former coworker. I promised to figure out how to streamline the sales process, improve efficiency, and hire great team members by learning the job myself. So it was settled. I was going to see it through, but it sure seemed like the current protocols and processes were ineffective.

Perhaps due to naivete, lack of training and industry experience, or my analytical mind, I decided to be as scientific as possible in my approach to “solving the mystery of how to optimize a plastic surgery practice.” Everything, I had decided, would be A/B tested, and nothing would be taken for granted. As I sat at my desk observing the months of compiled data, I shook my head in disbelief as I realized that nearly every typical “best practice” I was aware of was seemingly dead wrong. As I compared processes between my rather successful practice and those of my doctor’s peers, each followed a largely similar process. Indeed, how *could* 10,000 well-educated, intelligent, hardworking doctors implement practices that simply lacked efficacy?

Is it any wonder that plastic surgeons focus on maximizing how many consultations they see each week? Or that they often believe patients regularly select the first doctor they visit? Or that spending more time with each patient will result in higher booking ratios? Our data based on over \$100 million in sales overseen during the past decade show that these are mistakes, and yet affecting change on a national scale can be difficult. Treating a culture of change is challenging, so let us dive into the keys to optimizing your practice.

9.2 Optimizing Practice Surgery Conversion

9.2.1 Sales is Service, Service is Sales

A common misconception perhaps exacerbated by the worst elements of our industry is that sales is a bad thing, that selling is something we do “to” people, not “for” people. In the movie *One Flew Over the Cuckoo’s Nest*, Jack Nicholson’s character undergoes aggressive and painful electric shock therapy. This and similar depictions of the treatment would make anybody skittish about undertaking it for depression. The reality in 2019 is that electroconvulsive therapy (ECT) is performed under general anesthesia; it is painless and quite effective. Although the sentiment is softening, doctors often treat the word “sales” as taboo. For example, most plastic surgeons refer to their plastic surgery salespeople as “patient coordinators” or “patient concierges (PCs),” when their primary role is to fill the doctors’ surgery schedule. Similarly, embracing the medical practice as a business is often considered antithetical to quality care and service. I do not agree.

We would all agree that treating patients with respect and educating them during an initial phone call with pricing, healing, and other pertinent information actually increases sales by focusing on service. Further, increasing in-office booking ratios, encouraging people in an ethical manner to schedule surgery or treatment, and building up the doctor’s accolades and reputation not only increase sales, but improves service levels and patient satisfaction. Indeed, great salespeople improve service, and great service improves sales. Sure, being a pushy, rude, aggressive salesperson hurts service and patient care, but it also hurts booking ratios and does not increase sales. Below we will outline the specific steps to improving booking ratios. Those steps focus on education and preparation, two cornerstones of excellent service and patient care. Running the business like a business and maximizing sales done in an ethical manner is more easily accomplished if outcomes are superb, patient care is paramount, and service levels are high.

9.2.2 Creating Three Dates

Most people make small decisions quickly and complex decisions slowly. Few people go through the Wendy’s drive-thru 10 times before ordering, just as not many people get married on a first date. Big decisions, like selecting a spouse, house, job, or a surgeon to use a scalpel to open their body, create a much slower, anxiety-ridden decision-making process. Sayings to describe this anxiety that surrounds life’s “four big decisions” include “fools rush in,” “getting cold feet,” and “we don’t kiss on the first date.” In my first practice, I realized that despite using solid, proven sales techniques, as well as superb service skills, many of my patients said, “You are amazing, and so is the doctor. I am comfortable with the price, but I simply want to go home and think about it.” Once patients left, they rarely called back to schedule; most ended up having surgery somewhere else. Given that patients may delay contacting a doctor’s office for days, weeks, or even months before contacting a doctor, we felt like we had done a disservice to the patient. By educating them about one of the best doctors in the market, we were actually increasing the chances that the patient ended up selecting a less-qualified surgeon. So, we lost income, and the patient had a higher chance of having a poor outcome—it was a lose-lose situation.

With time we realized that patients were feeling anxiety—a false fear. If we could help them overcome that anxiety or never have it to begin with, we would have a great chance of them proceeding with our practice. They wanted the surgery, they had done

their research, and they simply had a stressful moment leading to irrational thought. So we decided, like we would if we were dating or looking at houses, to create a “feeling of three dates,” consisting of multiple touch points to ensure patient comfort, outstanding education, and industry-leading service. Our theory was that if we combined proven sales techniques and value-building methodologies with simply allowing more time and more contact to tamp down anxiety, booking ratios would increase.

From that moment forward our booking ratios shifted from around 30% same day with a 10 to 15% callback ratio to 80 to 90% same day booking ratios. Our revenue, profit, efficiency, and patient happiness skyrocketed. We simply did a “1st date” in-depth phone call for 10 to 20 minutes with every surgical and noninvasive patient prospect, a “2nd date” preconsultation meeting between the PC and patient, and a “3rd date” doctor consultation, price presentation, and closing. This concept became the starting point and a core process that launched our consultancy a decade ago.

Date 1: The Initial Phone Call

The “1st date” initial phone call is the most important step in improving booking ratios and growing practice revenue. Not only is this the first impression a patient receives from your office, but they will develop a clear understanding of the practice. In many cases, they will be ready to schedule surgery when they arrive at your offices, as long as nothing goes terribly awry during the live meeting.

In an ideal setting, the receptionist should answer the phone. When the patient expresses interest in a high-dollar-value procedure, like a breast augmentation or a higher-paying insurance case, or treatment, like an injectable filler or Coolsculpting, the call should be transferred to the most sophisticated communicator in the practice, which is usually the PC or practice administrator. If your practice does not have these roles, hire for them immediately or, if you are a brand-new practice, as soon as budget permits. Here is a simple implementable YellowTelescope Word Track you can use to train your receptionist:

“Thank you for calling Dr. ____ Plastic Surgery. My name is _____. How may I be of service? Great. You found the right place! May I please have your first name and a contact number in case we are disconnected? Wonderful and thank you. I am going to transfer you to our fabulous Patient Concierge, _____, who will be able to answer all of your question and help you schedule a consultation should you desire. May I place you on a brief hold while I transfer you? Perfect. Thank you so much.”

Once the PC has answered the phone, she will invest time gathering a bit of information about the patient, giving the patient pertinent information in preparation for the consultation, and then, if appropriate, scheduling a consultation. Here is a simple outline for your PC to reference, including another Word Track to utilize at the start of the conversation:

“Thank you for holding. This is ____, Dr. ____’s Patient Concierge. How are you doing today? Great. _____, who you spoke with a moment ago mentioned you are interested in information regarding _____. You certainly found the right place. What I’m going to go ahead and do is gather a little bit of information from you, and then I can give you a bit of information, and at that point, assuming things look good, we can get you on a schedule. How does that sound?” (Notice this is purposefully written in a conversational manner and should come across accordingly. The tone is service-focused, but is also meant to “take control” of the call using directive language.)

“Gather/Give/Get”: The Three G’s of a Call

1. Gather:

- a) **Demographics:** Collect the patient’s name, phone number, email/home address, marketing source, date of birth, height/weight/age, and other pertinent medical history information.
- b) **Goals:** Ask a variety of questions about what they hope the doctor can accomplish. Be thorough and ask several questions. The PC should be able to paint a picture of the patient mentally to avoid common pitfalls like a 28-year-old arriving for a facelift consultation or a patient saying they want Botox and realizing later they were bothered by lip volume and needed injectable fillers.

2. Give:

- a) **Doctor accolades:** Provide a review of 5 to 10 key bullet points that will build value and educate the patient about the doctor. Include board certifications, experience, education, specialization, PR/media/awards, charity work, bedside manner, and more.
- b) **Procedure and recovery overview:** Review the basics of the procedure, healing time, when the patient can work from home and return to the office, and provide childcare and travel information.
- c) **Ballpark price range:** Give an idea of the possible price range, quoting highest and lowest numbers, aiming to land somewhere in the middle.

3. Get them on the schedule:

- a) **Time frame:** Ask the patient, based on the pricing and healing time, when they might wish to proceed if they determine they love the doctor postconsultation.
- b) **Outline deposit and booking process:** Review what will happen during the consultation and include how they would be able to reserve a date for surgery or have the nonsurgical treatment as a part of that outline. Utilize this powerful Word Track:
“So when you arrive, you’ll meet our wonderful front office team and fill out your paperwork. Then, I’ll greet you and spend a few minutes going through some paperwork and putting our names with our faces. At that point, the doctor will meet with you, do an examination, make a recommendation, answer all of your questions etc. She is super down to earth and will take whatever time you need to feel 110% comfortable. At that point I’ll print out your price quote within the range you already know, and it will be decision time. If for any reason you don’t feel we are the right fit, no problem. You’d continue your search. Assuming you do love the doctor, which I think you will, and most people do, we’ll get you on the schedule and in order to do that we simply will collect a deposit of ____% during your visit. That deposit holds your date but you can change it or cancel and receive a refund until 3 weeks prior so you take no risk. It is like a Valentine’s Day dinner reservation in that we do tend to book up a bit in advance, but this allows you to get a date without being stuck if you reconsider. Does that make sense and assuming you love the doctor you can be prepared?”
- c) **Schedule the appointment:** Assuming the patient is interested and seeking treatment or surgery in a reasonable time period, we then select a date and time for their appointment. Ensure they write it down or put it in their phone. Remind them the doctor will be taking time to meet with them and to let the PC know if they needed to cancel. Collect the consult fee, if any, and end the call on a positive and warm note with a friendly thank you and goodbye.

When performed properly, the patients leave each call feeling heard and understood, with a clear picture of what differentiates the practice from its competitors and clear answers to the basic questions every patient might have, such as how much time off of work is needed and how much the procedure might cost.

You will also notice that we recommend having a refundable deposit for surgery and that you allow the patient to change dates or cancel until a few weeks prior to surgery. By offering this, you increase the chances a patient books, minimize irrational anxiety during the decision-making process, and overcome the four most common objections: “I want to think about it,” “I want to double-check my schedule,” “I need to speak to confirm with my spouse,” and “I have one more appointment with a competitor before I decide.” Because the deposit is refundable, they can reserve without risk. We have tracked cancelation percentages, and they are nearly as low as if you have a nonrefundable deposit.

Date 2: The Pre-Doctor PC Consultation

To create the feeling of a second “date” with the practice, in order to reduce anxiety and improve education, service, and patient satisfaction, we encourage practices to have the same PC who spoke to the patient by phone, or worst case another staff member, meet with the patient before the doctor consultation, live, in the office. This should take, on average, another 10 to 30 minutes and we recommend spacing consultations no less than an hour apart, and ideally 90 minutes. The outline differs in no way from the phone call other than certain steps are slightly shorter, while others are slightly more detailed. Here is an outline of the PC consultation:

1. **Gather:**
 - a) **Demographics:** Update any missing information not gathered by phone and confirm there is nothing glaring the doctor must be notified of in the patient’s medical history.
 - b) **Goals:** Review what was discussed by phone and have the patient show or explain in more detail what they seek to ensure the PC has a clear picture of the patient’s goals.
2. **Give:**
 - a) **Doctor accolades:** Review briefly the doctor’s experience, accolades, and specialization.
 - b) **Detailed procedure review:** The PC should outline, chronologically, the preop visit through the day of surgery and continue through healing and recovery. She should cover what is to be expected on the patient’s journey with the practice. Be extremely thorough as we are approaching decision-making time. Show photos using a photo book, PowerPoint, or website as many people are visual learners and it underscores the doctor’s abilities.
 - c) **Ballpark pricing:** Quickly review pricing that they already knew from the initial phone call.
3. **Get them ready to schedule:**
 - a) **Time frame:** Double check their time frame remains the same as it was during the phone conversation.
 - b) **Review deposit process:** Remind them how they can get scheduled with a deposit if they love the doctor and the refundable nature of the deposit to ensure they do not feel rushed or pressured.
 - c) **Get the doctor:** The PC can now find and prepare the doctor with all of the pertinent information.

Date 3: The Doctor Consultation and Closing

The patient has now had two positive “dates” with the practice. She loved her thorough, educational, and positive call with the PC several days ago. She has now met the front office staff and the PC she spoke to, and is pleasantly surprised by the knowledge, confidence in the doctor, and thoroughness of the PC. The patient is now ready to meet the person she is already impressed with and in whom she sees value in a “3rd date” doctor consultation. Here is an outline and key tips to ensure providing a superb doctor consultation:

1. **Get prepped by the PC:** The PC has just invested 10 to 20 minutes on an initial call and 10 to 30 minutes live in a preconsultation meeting. Ensure they provide you with the details before you walk in the door. This would include a bit about the patient’s goals, history, personality, and other key information. A typical 60-second prep-talk from your PC might look something like this:
 “Doctor, Susie Smith is in room 2. She is 38 with 3 kids over 10 years old. She is done having children and wants a breast augmentation. I let her know she’d likely need a lift as well as she is complaining of sagging and recently lost 50 pounds and is at her goal weight. She is friendly with reasonable expectations and wants surgery next month. She is ready to go. By the way, she met you at a charity event 3 years ago, so you should say ‘nice to see you *again*’ not ‘nice to meet you’. She’s ready when you are...”
2. **Relax and sit down:** Be a proverbial “duck on water.” No matter how busy the day is, take time to sit with the patient and build rapport in a relaxed manner. After a couple minutes of chatting, the patient feels more comfortable and knows you care.
3. **Ask permission to land:** Before approaching the patient or touching them in any way, let them know you are about to start the examination and ask if it would be ok to take a look and provide your thoughts. This creates greater comfort and a belief from the patient that you are an intuitive and caring doctor.
4. **Make a clear and directive recommendation:** Sit down again, outline your thoughts and be clear about what you recommend. Information exists online among other places. The patient is coming to you for a recommendation, an opinion, and a plan of action, not simply information, so ensure you conclude with a directive plan. Utilize this powerful Word Track at the end of every consultation:
“If you were my sister/brother/son/daughter, I’d recommend the following course of action...”
5. **Ask for their questions:** Patients do not need more time from you. They want their questions answered so ask at least two times if they have any questions at all and be patient while answering them. When patients complain that they did not get enough time with the doctor, we remind our clients that “time is just a feeling, not a reality.” As an example, we have all had a great 2-hour flight and a time we were stuck on the runway for 2 hours. In both cases it was 2 hours, but one “felt” like an eternity. Patients are busy. They do not desire being in your practice for hours—just try running an hour late—rather, they want to have their questions answered and feel you were thorough, so simply make sure you have done exactly that by asking them several times if they have any remaining questions.
6. **Warm goodbye:** Welcome them to reach out with further questions, give a friendly handshake, and wish them well.

To complete the “3rd date,” the PC would, at this point, print out the price quote, review it with the patient, and ask simple closing questions. Here is our suggested Word Track for a low-key but effective closing question:

“So I printed your price quote, and sure enough, the final total as you can see here is exactly what we discussed by phone and prior to the doctor meeting you. I know you were seeking a date next month. Did you have any other questions before we get you on the schedule?”

And just like that, the patient in most cases would select a date and proceed. Throughout the process, the focus is on education and preparation. By the time they see the actual price, there is no “new news.” They knew what they needed to prepare for in terms of pricing, healing, childcare, work, and scheduling, and were educated on why the prices were what they were and were sold on the doctor’s accolades and experience.

With national average same-day surgical booking ratios typically hovering around 15 to 20% with similar callback percentages, it is no wonder that simply adding the “three dates” process for education and preparation of patients for their plastic surgery journey has resulted in 100% of our long-term clients achieving same day booking ratios of 60 to 90% since 2008—truly optimized practices.

9.3 Optimizing Lead Efficiency

While many readers might assume a chapter on practice efficiency would begin with avoiding inventory waste or reviewing a profit and loss statement, and both of those are worth doing regularly, we believe in working through the most important aspects of practice efficiency first. Because of that we started with optimizing the consultation process, which in essence is optimization from the time a patient calls through the time they schedule and pay for a surgery or treatment. Often we can only perform the “three dates” if we reach a patient, and unfortunately most practices do a poor job of connecting and contacting patients, despite investing heavily in marketing to generate patient inquiries by phone and through the internet. So how does a practice maximize efficiency with incoming leads, and what does the data tell us about best practices in maximizing our patient inquiries?

9.3.1 The Data

While we have been able to track data for clients for many years, our data may be slightly skewed because we simultaneously train and coach those clients to improve. Here are some key data points that will inform the reasoning behind our recommended process:

- Leads responded to in 2 hours or less are reached 76% more than those that are responded to after 2 days.
- Of the people who have not been reached, 55% are actually still interested.
- If your practice follows up four times, it will reach around 48% of patients.
- If your practice follows up six times, it will reach around 55% of patients.
- If your practice follows up eight times, it will reach around 60% of patients.

The data tells the story: if you do not have a PC who, whenever not in consultation, is talking to new patients, contacting fresh leads, and following up with older leads multiple times, your practice is losing masses of revenue. We now know what our gut told

us and our client results proved—many people who ignore several contacts by phone and email from the office are, in fact, still interested. We reach many patients 1 to 2 full months later after 4 to 8 contact attempts. We also know that if you are not following up at least twice in week 1 after receiving a lead and weekly thereafter, for at least 8 more weeks, money is being left on the table for your practice.

And now for the scary part. We conduct dozens of calls with potential new clients every few months. One of the questions on our internal intake questionnaire is how often their PCs follow up with leads that are not reached the first time. In the majority of the cases, the answer is one of the following three paraphrased responses:

- “I actually have no idea.”
- “I think once, perhaps the week after assuming they have time.”
- “We have no process after the first call and assume if the patient is interested they will call back.”

So let us discuss how to ensure your practice is optimized now that we understand the data.

9.3.2 Reaching Out and Leaving Messages

At one point, my original practice had five full-time PCs. The average PC followed up with around 300 patients per week by phone and email. It was hard work, but we booked a lot of surgery and grew by several million dollars in annual sales throughout those years. The system we used to contact 1,500 or so patients per week back then is the same we recommend now. Depending on your practice structure, we also recommend texting, if legally allowable and HIPAA & HITEC.

The steps of the system we use are as follows:

1. **1st contact:** Call and email the patient immediately or as soon as possible. If that is 1 minute after receipt, even better! Imagine a thermometer made out of excitement, beginning the day at zero and already half way up to the top by the end of that first day.
2. **2nd contact:** Call and email 1 or 2 business days later while their excitement level is still potentially high.
3. **3rd to 10th contacts:** Continue to call and email weekly for 2 to 3 months to maximize results. Leave positive messages and emails, only. Here is a Word Track for a proper phone message:

“Hi Susie, this is ____ with Dr. ____’s office. Thank you again for your inquiry you sent to us requesting some information on rhinoplasty. I’d love to answer any questions you might have so wanted to circle back with you to see how we can be of service. I’m here from 9 to 5 or you can email me—my number is 111–1111. If for some reason we don’t connect sooner, I’ll try to check back with you next week and I look forward to hearing from you. Have a wonderful day.”

9.3.3 Keeping Track of Patients

While I do recommend reading *Moonwalking with Einstein*, trying out for the World Memory Championships, and mastering the art of building memory palaces to keep track of which patients are due for each follow-up contact, you should simply buy and utilize a contact management software instead. In our industry, there are many options, though currently Nextech, Patient Now, Modernizing Medicine, Inform and

Enhance, MacPractice, DrChrono, Brickell, and a few others tend to be seen most often. Whichever you choose, ensure the system has the ability to take detailed, time-stamped layperson notes from the PC so you can later refer back to the patient's file and learn about their history. Further, do not purchase the software unless it has a "to-do list" or "task manager" that allows you to assign a task and a due date to any patient in the system.

Once you purchase this system and train your team to use it effectively, you can have your PC track every single patient throughout the patient lifecycle without ever having to remember anything, take work home, access any paper chart, or lose any efficiency. Because the task manager and notes are your memory stored in the computer system, the PC and team in general can focus on patient care and in making dozens or hundreds of outgoing patient calls and emails during nonclinic times, such as when the doctor is in surgery. To see this process in action, you can watch this video: https://www.youtube.com/watch?time_continue=10&v=mQkrvmPINik.

Once you have a computer system that is optimized for patient care and profitability by empowering your PC and team to be able to track and notate patient progress, nearly every system should be robust enough to handle the rest of the doctor's needs. Surgeons often gravitate towards software that handles insurance, dictations, and other medical-focused needs, but to run a medical specialty like a luxury retail store, it is prudent to "start with sales."

Here are a few other suggested items your computer system should contain in no particular order:

- **Integrated calendar:** Some electronic medical record (EMR) systems and customer relationship management (CRMS) systems do not have a calendar to schedule patients. Do not use Outlook or other programs that are not robust or may violate HIPAA. Ensure the system you select has a simple calendar on which you can schedule patients and that it integrates with their charts in HIPAA and HITEC compliant manner. If you plan to have more than one provider (like multiple doctors, an aesthetician, or a nurse injector or physician assistant) ensure it can show, in real time, multiple "columns" so you can see each provider's schedule side by side.
- **Inventory management:** Used to track fillers and relaxers, skin care, and medical supplies, inventory management software is only as accurate as the information being input, so it should be simple to use and utilized from day 1. We have seen more than 10 practices have more than \$10,000 in various sorts of missing inventory.
- **Insurance management:** This is used when you plan to perform hand surgery, breast reconstruction, Mohs, septoplasty, balloon sinuplasty, or similar insurance-based procedures. The system you pick should match your needs. If you move to a more cosmetic and profitable model, you might need less of a focus on software that functions well with insurance.
- **Document storage with printing:** As you develop pre- and postoperative instructions and other documents that must be printed, edited, and updated, have your computer system store them for easy access and printing. Most computer systems allow them to be updated and to have blanks filled in before printing.
- **Quoting system with QuickBooks integration:** This gives you the ability to quickly create quotes for each procedure, operating room, and anesthesia fee. Most systems have this capability. Ensure it syncs properly with QuickBooks, which is the typical format, so it can dovetail with your bookkeeper or accountant for maximum accuracy and efficiency.
- **Source tracking:** Confirm your system can track multiple marketing sources, including email newsletters, internet inquiries, doctor/patient referrals, and beyond.

The better systems allow you to optimize your marketing plan by tracking the source of each lead.

- **Reporting:** The numbers any computer program spits out are tied to the accuracy of inputs. The optimized practice looking to lead in a competitive market should have the ability to create real-time reports on everything from marketing sources to profit-per-hour to consult-to-surgery-ratios.

9.4 Tracking Your Success: Are You Truly Optimized?

At this stage, we now have a superb PC who is actively tracking down hundreds of patients per week to ensure they are contacted through several methods on a multitude of occasions. Once the patient has been reached, you have implemented a powerful “three dates” concept to ensure patients are educated and prepared as value is built and booking ratios rise accordingly. You have mastered your own portion of the consultation as well with warm bedside manner, plus thorough and directive recommendations as you float through your day like a twig on the shoulders of a mighty stream. It is now time to find out if these steps to optimization are working. Let us take a look at what metrics matter, warning signs to look for, and how to avoid the many “misdemeanors of management.”

9.4.1 What Metrics Matter

Data is as likely to be misunderstood as interpreted correctly. Here are some misdemeanors of misinterpreting data and what the facts actually show:

1. **(Don't) Bring 'em in:** Most practices bring as many people in for consults as possible. The data shows that full consult schedules do not necessarily translate into full surgery schedules. We do not recommend focusing on, nor incentivizing your people based on, how many patients they can get in your doors. While we would love every practice to be full, we want the patient to be prepared, interested, and ready to proceed within a few months, which our “1st date” ensures. In rare cases, the patient proceeds farther in advance, but only if they are 100% ready to do so today. The temptation, particularly for newer doctors, is to think “I have the time. Why not just bring more people in to get to know them and maybe they will buy or come back later,” but we see no evidence of this intuitive idea working in practice. Sure, perhaps the first few months after opening it might not hurt just to get one's proverbial feet wet, but the standard process outlined in this chapter should be done as a long-term practice. Some single-doctor practices see fewer than 13 surgery consultations in a week and consistently achieve monthly revenues of \$600,000. Quality is much more important than quantity; if you can achieve both, even better. Instead:
 - a) Track lead-to-surgery or lead-to-payment ratios. The goal is to have patients desiring treatment or surgery to schedule, so you can skip the middle of the funnel. Track the total number of leads and see how many buy and how they spend. The starting point is that simple.
 - b) To get more granular, the greatest indicator of lead-to-surgery or lead-to-payment will be to track the number of consults who schedule surgery or consult to payment. As noted above, in-office booking ratios are paramount and impact overall practice growth much more directly than lead-to-consult ratios, which obfuscate at best, and provide completely erroneous senses of success at worst.

2. **(Don't) Worry about cancellations:** The availability heuristic dictates that humans tend to give too much credence to what they just saw. If you get a speeding ticket, you likely snail-pace the rest of the trip home and claim “the cops are really out today” even though they have been out every day and you just finally got caught. Similarly, it seems like canceled consultations and surgeries come in torrents. They do not, barring a local hurricane or blizzard, but it feels that way. Do not worry about canceled appointments or surgeries. There will be some. Cancellation rates will be around 20% of consultations and 5 to 10% of surgeries in nearly every market in the country with minor variation, so get ready to deal with it. Charging \$5,000 for every consult might do the trick, but you will be out of business quickly for other reasons. Instead look at no-show percentages. If a patient has the courtesy to reach out to reschedule, to let you know they do not, after all, have money to proceed, or simply do not wish to proceed, we can accept that and thank them. We have a chance to speak to them to see if we can challenge their thought process. If you have rampant no-shows, however, the patient is saying, without words, that they did not value the appointment enough to call, or even forgot entirely. This points to a PC problem and should be addressed. Essential PC skills to be taught include firming up appointments, building a warm rapport with the patient, booking their consults less far out (another reason not to clog your system by bringing everyone in), and other solutions. You can monitor the PC by listening to calls, tracking show rates, which should not climb past the 5 to 7% mark.

► Table 9.1 is an example of a “high-flying practice” compared to a national average practice, illustrating what metrics matter, how to pick out steps on the ladder to peruse for opportunity, and the impact each can have.

Table 9.1 Comparison between a high-flying practice and a national average practice			
	High-flying practice	National average practice	Notes
Patient inquiries (same)	1,000	1,000	Example for a typical year
Patients reached (10 vs. 4 follow-ups)	600	450	Most practices fail to even try four times!
Consultations scheduled (YT process vs. “bring ‘em in”)	300	400	Bring in less, but more prepared/educated patients
Consult show % (80 vs. 70)	240	280	Slightly better firming up
Booked surgery same day (80% of YT practice vs. 20% national average)	192	56	The big difference in office booking ratios!
Called back to book surgery (same: 20%)	11	56	Less follow-up work if they already booked
Total surgeries booked	203	112	Nearly double!
Total revenue (\$7,000 average as an example)	\$1,421,000	\$784,000	The power of optimization
Lead-to-purchase ratio (the key metric)	20.30%	11.20%	These are typical national averages vs. top clients
Abbreviations: YT, yellow telescope.			

When you perform a “deep dive” into your efficiency numbers, you can look at the “top of the funnel,” through surgery bookings and profitability, and then benchmark those against a top-performing example to tease out areas of opportunity. Too often, doctors look at the practice results in a binary format. The practice either is, or is not, doing well. Most practices have areas of great success and others of great opportunity. We have seen practices with 90% booking ratios from consult-to-surgery, but with no follow-up system for leads who do not reply to a first contact. This will result in top-of-funnel problems, as the practice will not reach enough volume, and consult numbers will suffer. Similarly, we have seen practices that excel at contacting and following up with patient inquiries, but a poor PC or lackluster doctor consultation format leads to 5% same-day in-office booking ratios, demonstrating a middle to bottom of the funnel concern, which is equally detrimental. To optimize the practice, reinforce what is working and take positive steps weekly to improve areas of weakness.

Conduct a quarterly to semiannual audit of areas of the business that can impede funnel efficiency. Here are a few suggested audits:

- **The reception desk:** From just outside the front office, record or listen to 2 to 3 hours of incoming calls, in-office greetings, and check-outs to assess personal interactions between patients and your front desk personnel. More tenured doctors with little time to listen start to assume things are being done well, but nothing replaces the two ears of one owner or senior manager hearing what is really happening. Is demeanor positive? Are Word Tracks being followed? Are there delays? Is the phone consistently being answered in a timely fashion, or at all? Is the ringer on? Are the team members polite to one another? Do all team members “smile while they dial” and have a pleasant voice with a smile on their faces? Is a cash management system created by your bookkeeper or accountant in place and being utilized?
- **Wait times:** Delays are inevitable. Our data does not show that it will impact sales negatively (and in fact may increase booking ratios on the surgery side), but if it becomes commonplace, it is a poor practice and can result in negative online reviews, which can damage the business in long run.
- **Office presentation:** Each week do a 5-minute walk-through of the office to ensure cleanliness of bathrooms, waiting room, and the office in general. Disorder, disorganization, and dirtiness are the three Ds to avoid. Investing millions in build-outs will not result in increased sales, but meeting a “minimum acceptable threshold” of presentation and cleanliness is important. While an amazing build-out may be an aspiration that brings joy, a practice with a respectable, simple, clean office space can outsell some of the most beautiful (and least profitable) practices around.
- **Before-and-after photos:** If you are established, a large photo book, PowerPoint presentation, or similar computer program to showcase ideally hundreds or thousands of patient results will contribute significantly to your practice booking ratios. Photos help search engine optimization (SEO) and web marketing on your website and serve as proof of your experience and specialization. We recommend the following Word Track:

“By the way, did you review my photos before you decided to proceed with me doing your surgery? Great. And did you find that process helpful in understanding who was right for you and what we could accomplish compared to our peers? Wonderful. One thing I’d love to ask is if you might be willing to ‘pay it forward’ and allow us to utilize your photos for nonmass viewing so other patients just like you can see our work and be helped just like other patients who gave consent helped you. That means we will not

use your images etc. in mass emails or mailings without you approving, but we can, for example, show your photos to patients in our photo book in the office or put them on our photo gallery on the website. If that'd be ok with you, I'll have our front desk get the quick permission and it would be a great help—of course no pressure at all as we want you comfortable.”

In this way, the patient can easily decline, but understands the true value they could provide and is being asked in open and honest fashion by the business owner, which we think is a positive and classy approach.

- **PC's consultation:** Just as you would want to hear your front desk team in action, listen in on a PC phone call and “2nd date” preconsultation monthly to ensure adherence to the process and program. Any deviation can cause massive losses in conversion ratios and be the single greatest factor impacting profitability on the practice after good surgical outcomes.

9.4.2 Motivating Staff

Incentives and Pay

As your practice grows, you likely will have some combination of the following positions. Here we outline our suggested methods for compensation and motivation. Surely, different states have varying laws that should be considered just as some doctors may not feel comfortable with certain pay structures. With that said, we have outlined what our data shows to be best practices:

1. **Practice administrator:** For your senior manager, we recommend giving a substantial base pay coupled with an override or bonus, paid monthly, on total sales of the entire organization. In most practices, the doctor wants the surgery schedule full, followed by a robust noninvasive practice, followed by growing skin care sales, followed by a smattering of insurance cases that often, but not always, do not pay as well. By paying a flat override on total sales, you accomplish this in an elegant manner, as surgery is typically most costly; the override pays them most on your top priority, and so forth, down the ladder of importance. Every market varies, but recently, we filled a position at a base pay of \$60,000 per year plus a 1% override on all practice revenue, which equated to an \$80,000 to 90,000 per year opportunity. You may also consider adding an additional bonus for keeping costs low as a percentage of revenue to motivate the person to make prudent decisions on spending. We do not recommend paying bonus on profit alone, as this can accidentally disincentivize the manager from investing in machinery or high-ticket items, even when necessary; new office build-out or one \$100,000-laser can ruin their income for a full year.
2. **Patient concierge:** If you have just one PC, we recommend giving them a smaller base plus more aggressive incentive based on what they personally sell. This might in many markets look something like a base pay of \$X0,000 per year plus 3% of directly sold surgery and services. If there are multiple PCs, we recommend the same structure; if they share a lead, they split the bonus. A practice that has grown substantially should have a dedicated noninvasive PC whose sole role is to work with nonsurgical patients. In our experience with a variety of practices, early results are beyond impressive. One client in California recently doubled their monthly sales to over \$300,000 per month in noninvasive sales within 30 days of hiring a superb nonsurgical PC.

3. **Physician extenders (injectors, aestheticians, etc.):** This is a sales position that produces profit, so we recommend a modest base pay with a large opportunity through bonuses and incentive pay to earn more as the person performs more services. We also like to offer a higher percentage bonus on self-generated leads to motivate these team members to network and build a clientele instead of sitting around waiting for the practice to hand business to them.
4. **Medical and front desk:** There is no question that not all positions should earn bonus or commission pay. If a person is not involved in selling or providing, we recommend a base pay, an annual or semiannual review for small pay raises, and perhaps an annual feel-good bonus if the business grows. As needs arise, creating small contests can work wonders. For example, if you want your nurses to collect positive reviews from happy postop patients, you can certainly offer them a bonus, gas card, or Starbucks gift certificate for each one they generate, but the core of these roles should not be incentive-based in our view.

Not every employee is money-motivated, and it is worth simply asking each employee what their hot button is. Some need or want more income. Others may want recognition or extra time off. Still others may simply want to be a part of a positive family environment. Some doctors may simply refuse to offer incentive pay. With that said, people do work to earn money and we have no evidence suggesting a monetary incentive did not create motivation within the staff. We recommend that bonuses, commissions, and contests be paid monthly or quarterly and almost never yearly. We find it is impossible to stay motivated to win something 365 days from now, but getting the “Pavlov’s Dog” treat we all crave on a regular basis forms better habits and company culture. So do not be afraid to provide a small holiday bonus, but know that you are largely doing so out of the kindness of your heart, as it may not produce increased results.

Team Meetings and One-on-Ones

Practice efficiency and optimization begins with well-conceived pay structures and incentives, which motivate behavior when nobody is looking. Incentives alone are not enough. We recommend backing up the behaviors you incentivize with regular one-on-one meetings and team “hangouts.” While there is no perfect plan, and practice size and other factors impact the ideal schedule, we recommend the owner or manager of a practice have a one-on-one for 30 minutes with every employee at least once every 2 weeks in addition to a 30-minute team meeting at least once every 2 weeks. (For more information on meetings, see Chapter 4.)

The suggested outline for each one-on-one is simple:

- *“What do you have on your list for me today?”*—a chance for each employee to ask questions, vent, and get what is needed to succeed.
- *“Let me now review what I have on my list for you today.”*—an opportunity for the management to review updates, events, get questions answered, address concerns, and set a course of action.
- *“What do we agree that we’ll both have completed for our next meeting?”*—a review of action steps and accountability to ensure weekly progress.

The suggested outline for a team meeting is just as simple:

- *Hot updates*—review what is positive and happening in the practice.
- *What’s new*—educate, roll out new products and services, answer team questions.
- *Review the coming schedule*—things to plan around, changes, pitfalls to avoid.

- *Lightning list*—any hodgepodge items that are worth discussing as a team; ensure all team questions are addressed, but that all team questions are positive.
- *Growth*—conclude with 2 minutes of personal or professional growth topics. Review ideas from a recent book, give out a book, listen to a few minutes of a key speech or audio book or tutorial on a new service you provide, develop a secrete in-office handshake or team t-shirts. Do something to get better at every meeting and have a bit of fun.

Indeed, one of the biggest keys to efficiency is avoiding losing good team members. Retention is absolutely paramount if you wish to grow. And if a team member has regular one-on-one access to management, regular team meetings to learn and ask questions, and is happy today, it is exceedingly unlikely that she will quit before the next meeting. This leads to impressive team retention ratios and greater optimization.

Teaching Opportunities

We wanted to provide a word or few about ongoing teaching and the importance of education for your team. We believe basic phone skills are fairly intuitive. If we need to spell out the concept of being pleasant, taking a phone number in case disconnected, keeping service levels high, or how to take a reasonable message, then it may be time to stop reading and contact any number of great consultancies out there.

Rather, we believe that creating simple protocols and then adhering to them with regular checks constitute the habits necessary to master the business and improve optimization. For instance, we have provided a three-step outline to a one-on-one meeting and if you conduct them consistently as recommended, the particular topics and nuances of those meetings will fall into place. As these protocols become habit, the habits turn into culture and with time, the culture permeates the organization for lasting resonance and results. Most patients having lip fillers first need numbing cream, so does it make sense to schedule that patient for numbing at the same time as a Botox patient? Yes. Does looking at your schedule to map out simple inefficiencies every quarter always warrant opportunity for greater profit? Yes. Is it prudent to consider hiring more help when you become too busy so you can focus on the most profitable and enjoyable aspects of your career? Yes. But simply having the meetings and adhering to the outline and protocols will naturally solve many of these challenges. The problem is not that doctors are not smart or capable enough or even unaware of problems. Rather, it is the lack of time, execution of well-planned meetings, and lack of creation and implementation of protocols that lead to inefficiency.

9.5 Summary

Optimizing a plastic surgery practice is fundamentally a process of setting and executing well-planned team and individual meetings in which a variety of key protocols are finalized and implemented. Those protocols start with improving in-office and overall surgery and treatment booking ratios and continue with maximizing patient contact through proper follow-up, computer notation, and multiple contact points. They then progress with tracking results in real time through superb computer systems on which team members are properly trained. The protocols end with the selection of superstar team members who are paid fairly and incentivized properly, while being managed in servant-leader fashion for longer-term retention. Each of these protocols eventually permeate the organization until they are ingrained in the culture for all-time. Growth will ensue.

10 Upping Your Game with Systems

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Abstract

The organization of your practice and the systems you put in place will have a huge impact on your bottom line and your level of frustration. This chapter shows you how to look at your practice analytically to optimize your schedule, your personnel, and your time. Implementing systems can improve the flow of money and reduce the risk of embezzlement. Your revenue goes up and your frustration level goes down when you maximize your productivity through the use of systems without expending more time.

Keywords: schedule, organization, motivating staff, managing, telephone intake, flow of money, practice efficiency, embezzlement

10.1 Introduction

Managing a physician practice is the ultimate “multitask” in business. Most entrepreneurial ventures allow the entrepreneur to be dedicated full-time to the development of the venture and to the functioning of the business. There is, however, a difference in the case of the physician entrepreneur. The physician’s primary effort should be devoted to providing quality care, refining surgical skills, and developing the clinical practice. If that is the case, then who manages the business? The true entrepreneur, physician or not, will decide, “I will manage the business.” In that case, how does a business owner, who is also the primary revenue-generating employee, fulfill both responsibilities? This chapter will help address that question.

10.2 The Organization and Systems

According to Dictionary.com, the term “organization” is defined as: “Something that has been organized or made into an ordered whole.” In the case of a physician practice, the “ordered whole” is the sum of more parts than most people ever realize. To make order of the whole, first dissect the component parts. By breaking the business into smaller parts and focusing on each aspect individually, we end up with more manageable units, making the task less daunting. Approaching a practice systematically is very similar to the systematic approach physicians take in tackling problems in clinical medicine. Much like a clinical problem is broken into parts, entrepreneurs should break their organization into parts. The irony, however, is that the practices I visit usually exhibit no significant organization or identification of the component parts that make up the practice as a whole.

A simple solution to this disorganization is the use of systems and processes. By taking every major function of the business and applying defined rules and processes to the execution of this function, effective management emerges as a possibility. Taking it one step further, the codification and requirement of staff to follow these processes relegates the physician owner to the role of “systems inspector” rather than that of coder/biller/receptionist/nurse/aesthetician/patient coordinator (PC)/bookkeeper and finally surgeon.

Developing systems addressing all areas of the functional practice allows the surgeon to provide objective guidance for the staff. This guidance facilitates execution of business processes in a fashion consistent with the desires of the physician owner.

Having objective systems in place, the physician can then focus on his or her key role—providing excellent clinical care—while being assured that the remainder of the business operates in the efficient manner envisioned when the venture began.

The mere establishment of systems for practice operations, however, never guarantees that they will be followed. The owner must inspect what is expected. It is paramount as a business owner to ensure the staff is actually following established procedures and processes. Address and correct deviations immediately. Failure to correct a problem or deviation from policy sends a de facto message to the staff that the deviation is acceptable. To manage and run an efficient operation, any system needs regular evaluation, feedback, and correction to stay on point.

10.3 Thermodynamics and Practice Management

Entropy is a thermodynamic concept establishing the tendency of all matter in a closed system to move toward a greater state of disorder. A simple example is the construction of a house. To build a house, significant energy (labor, machines, and materials) is applied to the creation of order of various pieces of matter (lumber, nails, wiring, plumbing, etc.). When complete, the energy expenditure results in significant order of the matter (materials). This order is what we call a house.

Now fast-forward and suppose you walk away from this house and never maintain it, repair it, or protect it. In other words, you never put energy towards maintaining the order of the matter. What will happen? Undoubtedly, the house will deteriorate and eventually fall down, and ultimately many of the component materials will return to their most random state. Wood will rot, nails and pipes will rust away, and in the end all components will eventually return to their lowest molecular derivatives.

The practical application of this principle to the business of practice management is that any system, no matter how well-established, thorough, or valid, will move toward a state of greater disorder without the input of energy. This energy input is the essence of business management. A business owner, no matter how intelligent and well-meaning, will fail if he or she does not deliver the energy necessary to maintain the established systems. Much less energy is needed to maintain a well-ordered system than the initial energy required to establish the system or the energy necessary to recover a broken one.

10.4 Operational Systems in Practice Management

In order to demonstrate the details involved in developing functional systems defining the scope of management, let us explore the most important ones. The example systems represent a composite best practice model and will not necessarily meet the needs of every practice or every physician. Best practices should be adapted to fit the most efficient process for your practice.

10.4.1 Patient Intake and Handling

Handling Phone Calls

As with any business, the initial patient interaction with the practice is a critical juncture, determining whether the patient takes the next step in the relationship (i.e., scheduling an appointment) or leaves and calls a different practice. The receptionist answering the telephone holds one of the most critical positions in any plastic

surgery office, yet he or she is often the least experienced, lowest-paid employee in the practice. The staff person on the phone determines whether the caller hangs up or comes in for an appointment.

Given the importance of call handling in the overall success of the practice, having defined systems in place outlining the expectations and responsibilities of the staff regarding incoming calls is critical. What are the components of a successful telephone handling policy?

- Make sure a live person answers the call (with a smile). Does anyone have a positive story related to an automated attendant?
- Use names (staff member's and patient's names).
- Handle the call or know where to direct (training).
- Use voice mail minimally.
- Do not use an answering service as a crutch during lunch or late afternoons.
- Establish a system for handling calls from referring MD offices.
- Set up a backline for staff, families, and vendors.

Creating a systematic and repeatable process for handling the calls as they come in will maximize the chances that the patient will ultimately schedule an appointment. Many practices employ a "cheat sheet" to ensure that proper dialog occurs on each and every phone call. A telephone intake record (TIR) can serve this purpose. A sample TIR is included in Appendix 10A, but can always be customized to suit the needs of the individual physician.

Appointments/Templates

The unexpandable constant in any surgeon's practice is his or her time, not only time spent in the operating room, but also time spent in the clinic. You can make more money, but you cannot make more time, so the productivity of every minute must be maximized. Clinic time is often viewed as a necessary evil for surgeons who usually prefer spending their time operating. Establishing appointment scheduling templates is essential for efficient use of the surgeon's clinic time. Putting the right patient in the appropriate appointment slot during clinic hours ensures that the physician sees the maximum number of patients during his or her clinic time, runs on schedule, and is able to provide patients with the quality visit they expect. Appointment templates designed around the type of patient visit help a practice accomplish this goal. A typical plastic surgery clinic day template is shown in ► Fig. 10.1.

The underlying concept in the schedule template is to allow adequate time for new patient appointments, while accommodating the postoperative, follow-up, and local procedures necessary in any practice. In a typical plastic surgical new patient consult, best practice dictates that the patient first be greeted by the physician while clothed. This recognizes the patient's need to be most comfortable in a setting where the capture and transmission of information is often critical. The majority of cosmetic patients are women, and the majority of plastic surgeons are men. Oftentimes the patient is uncomfortable in a clinical setting, and the last thing she wants to do is meet her potential surgeon for the first time while undressed, in a paper gown, showing a part of her body about which she is most insecure. On the other hand, some patients fear being abandoned for half an hour when it takes them only 30 seconds to change. The patients can be given the option of changing into a warm, commodious, high-quality cloth gown if they wish. When given the option, many patients jump at the prospect of not being left stranded in the exam room. The important element is to give patients control of the decision.

Scheduling template		
Time	Room 1	Room 2
9:00 AM	New patient	
9:15 AM		Post-op
9:30 AM		Post-op
9:45 AM	New patient	
10:00 AM		Post-op
10:15 AM		Post-op
10:30 AM	New patient	
10:45 AM		Follow-up
11:00 AM		Post-op
11:15 AM	New patient	
11:30 AM		Post-op
11:45 AM		Follow-up
12:00 PM	Lunch	Lunch
12:15 PM	Lunch	Lunch
12:30 PM	New patient	
12:45 PM		Post-op
1:00 PM		Post-op
1:15 PM	New patient	
1:30 PM		Post-op
1:45 PM		Post-op
2:00 PM	New patient	
2:15 PM		Post-op
2:30 PM		Post-op
2:45 PM		Follow-up
3:00 PM	Office procedure	
3:15 PM		
3:30 PM		
3:45 PM		
4:00 PM	Office procedure	
4:15 PM		
4:30 PM		
4:45 PM		
5:00 PM		

Fig. 10.1 A scheduling template.

After the initial meeting and procedure discussion, the physician should ask the patient to change into the exam gown and robe and then excuse himself/herself, unless the patient has already done so. Some practices have staff take photographs at this stage. The advantage is that the photographs are already done at the time of the initial consult. The downside is that it takes time, ties up a room, and if the patient does not book her surgery (or must lose weight or wean or otherwise undergo a change necessitating more photographs), the time taking photos is wasted. An alternative is to delay taking photographs until the patient schedules surgery. The photographs can be taken during the preoperative visit. Another reason to delay photography is patient vulnerability. Patient who has just come in and is not yet sure whether or not she wants surgery may feel uncomfortable having photos taken of her labia, breasts, or the panniculus that causes her embarrassment. If the patient does change and have photographs taken, the surgeon can see other patients on the schedule such as those coming in for postoperative visits. These are usually shorter in duration, simply involving a brief physician-patient encounter, taking a quick look at the results, and answering patient questions. Upon completion of the postoperative visit, the new patient should now be ready for the physical exam. The physician returns with escort in tow, conducts the exam, and then discusses the proposed treatment plan. The patient may then dress and talk to the PC about price quoting and scheduling. Once again the physician is free to conduct another postoperative or follow-up visit, while the next new patient is brought to the consult room.

Busy practices may assign suture, staple, and drain removal; dressing changes; and routine recovery instructions handled by support staff to allow the surgeon to perform the duties that require surgical training. When possible, each staff member should do only the duties that require their level of training. A medical assistant can take a blood pressure, but should not remove a drain. A nurse can remove a drain, but should not establish a surgical diagnosis and treatment plan.

The most efficient clinic scheduling system allows the office and the physician to run on time. Exceptions and double-bookings should be used sparingly, since these scheduling add-ons can throw the entire schedule into disarray, resulting in a negative patient experience, especially for new patients, who may then choose another practice.

The scheduling template can be further refined by considering the surgical interest of new patients. Breast augmentation patients are more likely to schedule and complete surgery if they are seen within 10 days; beyond 10 days, the data show the incidence of no-shows and cancellations increases dramatically. Blocking slots in the appointment schedule specifically for breast augmentations can improve patient attendance in this demographic group.

New Patient Paperwork

While the use of electronic medical records (EMRs) is common, some cosmetic plastic surgery practices still operate with traditional paper charts. It is cheaper and more efficient to make permanent charts for cosmetic patients only *after* they schedule surgery to save resources. What new patient information should be included in a chart? While obviously the medical-legal information (such as patient history, dictation, operative notes, and exam findings) is included, other items are important as well. For the cosmetic patient, a copy of the TIR should be included. This allows the physician to refer quickly to the document before meeting the patient and get a sense of her desires, motivations, and interest level. The surgeon can use the personal information to bond

with the patient. Topics to warm up with include occupation, kids, location of previous surgery, referral source, or an upcoming wedding or high school reunion. For the reconstructive patient, the TIR can yield relevant data for a letter to the referring doctor, giving an update on the care and progress of the patient. It is important to keep referring physicians apprised of the patient's treatment and progress so that the doctor will be assured the best care is being given and will continue to refer patients.

Most insurance plans require patients to have a referral in order to access specialty care. Insurance plans will not reimburse specialists for office visits that were scheduled without a valid referral. It is the patient's responsibility to obtain this referral. Therefore, it is important to have a patient intake procedure that includes not only a verification of insurance benefits, but also referral requirements. Once this information is verified at the initial telephone call, the staff can then inform the patient that a referral is required. The patient will then have the time to ensure the referring provider completes the referral and transmits it to the office. Upon receipt, this referral should become part of the patient's chart. As part of the appointment confirmation process, the staff should also confirm receipt of the referral and verify it is valid for the scheduled visit date.

With referral needs and verification systems in place, patients will be much less likely to appear for their consult without the referral. Nonetheless, some patients will still arrive for appointments without the proper referral. In these instances, we recommend the patient be sent to the reception area to call their referring physician and obtain the referral. While this measure may sound draconian, it is burdensome and inefficient to have the front desk staff track down multiple referrals for patients while trying to conduct a clinic day. It can also disrupt the orderly flow of a clinic day schedule. The time the staff saves that patient is time taken away from others who have come prepared.

The Consult

A successful cosmetic consult begins before the patient even arrives. The cosmetic patient must be adequately qualified before she can schedule a procedure at the time of the consultation. Skipping this preparation step wastes the time of both the practice and the patient, who may lose her enthusiasm to go through with surgery. The practice can streamline the prep process by creating videos for the patient to watch before their consultation. For the scheduling process to flow, the staff should inform the patient of the following:

- What the procedure will likely cost;
- What will happen during the consult;
- Educational content on the procedure being considered;
- Information about the office and its staff;
- Finance and payment options available; and
- Recovery and healing times.

The better the patient is informed prior to their arrival, the less time the patient and the physician have to spend establishing a minimum level of background information. The physician can instead spend consult time focusing on the individual patient's needs. This usually provides for a richer consult and reduces the number of decision points for the patient. The patient can then consider whether they:

- Are comfortable with the physician;
- Are getting a good value for their money;

- Feel they will have a safe, predictable result; and
- Will like interacting with this physician and the office staff.

While the qualifying information is an important first step, other actions need to be taken as the patient prepares for and arrives at consult. If the patient has scheduled the appointment a while ago and the schedule is full, the staff should have a system in place to maintain contact with the patient to ensure they arrive for the consult. This system should include an appointment confirmation 2 days before the consult. The practice should confirm appointments 48 hours in advance to allow patients to adjust their schedule if they have forgotten about the appointment. Likewise, 2-day advance confirmations allow the practice some time to schedule another patient should the patient indicate that he or she cannot keep the scheduled consult time.

The new patient should walk into a neat and professional-looking office and be greeted by an unhurried and friendly staff who appear to be there only for her. The waiting time should be minimal, and the movement from reception to consult should happen quickly. With the advent of managed care, physicians' schedules have grown in response to the downward reimbursement pressure. As a result, patients suffer lengthy waiting times during most of their interactions with the health care system. The plastic surgery office can differentiate itself by eliminating waiting times for its patients. Having a clinic schedule that reflects the value of the patients' time will be rewarded by word-of-mouth referrals and happier patients ready to schedule.

Some practices follow the tradition of having the surgeon first meet the patient in a tastefully appointed consultation room. Surgeons in other practices keep all patient interactions limited to the examination room. Shuttling from consultation room to exam room costs time, and patients may prefer a streamlined visit. The surgeon can discuss expectations and desires of the patient and perform a physical examination. Once the optimal procedure has been confirmed after considering the patient's goals and physical findings, the surgeon can discuss procedure-specific details, recovery and healing times, and other relevant information. For improved efficiency and more effective teaching, these topics can be covered in a video, which can be part of the informed consent. The surgeon can review the key findings. Alternatively, well-trained staff can deliver this routine information. After the consultation, while the patient is getting dressed, the doctor can discuss the recommended treatment with the PC, including a recap of the discussion with the patient, and any other information the PC needs to prepare the price quote. The coordinator should also find possible surgical dates before meeting with the patient. The PC shares the quote, covers financing options, and addresses objections. Statistically, about 20% of patients schedule surgery at the time of their consult. This low number can reflect poor advance preparation and limited screening. Patients with health problems, financing challenges, and other challenges that will prevent them from being good surgical candidates should not be given an appointment. Nonetheless, even the most interested patients may not schedule at the time of their consultation. Consequently, your practice must have systems in place for a regular follow-up with patients after the consult. One-day and 1-week postconsult phone calls improve surgical scheduling. If a patient has not scheduled within 7 days of the consultation, they are four times less likely to schedule.

To improve their operations, many practices send out postconsult surveys and questionnaires. This valuable feedback can help improve the effectiveness of preconsultation paperwork, office contact, patient service, and the actual consultation. A truly

evolved practice listens to its patients and makes the necessary changes to improve. Sometimes the least likeable patients give us the best feedback. (The nice ones may be too polite to say anything.)

10.4.2 Surgery Deposits and Prepayment

A surgeon's most valuable resource is his or her time. To reserve this valuable time, a surgical scheduling deposit should be required. There are multiple methodologies regarding scheduling policies, but the amounts are mostly irrelevant. More important is the patient's demonstrated commitment to the procedure and the surgery date. The deposit amount can vary; some practices require a fixed amount such as \$500 or \$750, while others require amounts ranging from 10 to 25% of the total surgical quote. A deposit can be refundable up to 2 or 3 weeks before surgery, after which it is nonrefundable, with only extreme exceptions justifying a refund. If a patient elects to cancel surgery and reschedule outside of that time frame, the deposit is moved forward and applied to the new date. A window of 3 weeks allows enough time for the practice to fill the opening on the surgical schedule.

Nonetheless, there is a date after which the surgical deposit is no longer refundable except for essential reasons (heart attack, death in the family, or natural disaster). At approximately 10 to 14 days from the scheduled date of surgery, the office should require payment in full for the surgery. Cash, a bank certified check, and credit cards are all acceptable forms of payment. If the practice accepts personal checks, adequate time should be given to allow the checks to be cleared by the bank, and verification should be made that there are sufficient funds. It is exceedingly difficult to collect surgical fee after the surgery has been completed.

If a patient financing company is used to finance the surgery, certification of the patient's credit approval is necessary to move forward. Most finance companies will verify approval and intent to fund the surgery.

10.4.3 Revision Policy

In order to provide the best patient experience and surgical outcomes, revisions are a necessary component of cosmetic surgery practices. A revision policy should be created and given to the patient at the time of quoting. The policy might list a finite number of revisions in order to keep the surgeon's time efficient as well as reduce the associated expenses related to performing revision surgery. The risk of promising revisions is that the patient may feel she is in the driver's seat, that a revision is her right, even if no surgery can improve the patient's complaint, such as inherent asymmetry. Each practice should carefully consider all factors as they determine the best approach for them. Some practices offer unlimited free revisions, while others charge slightly reduced surgical fee and supply expenses. Regardless of the policy, the objective should be quality of the ultimate outcome and the patient's satisfaction. The revision policy is more for those patients who seem inconsolable with regard to surgical outcomes and less for those who may need a slight scar revision to be happy. Common components of a revision policy may include the following:

- Free revision must be within 1 year of the original date of surgery.
- The practice may want to pass through the cost of supplies if the revision is done under local anesthesia.
- If the case is done in a facility not belonging to the physician, it may be necessary to further define the financial policy of the facility regarding the cost of supplies and anesthesia.

Of course, the surgeon should do what is right for the patient. In some instances, even with a limited revision policy, if the surgeon feels some responsibility for the result, he or she can pay for the facility, anesthesia, and waive all fees. The goodwill generated can be worth the monetary loss, which can then be considered a marketing expense.

10.4.4 Financial Controls

Embezzlement

The primary reason to have good financial controls in any business is to maximize profits by increasing revenues and reducing expenditures. Embezzlement is defined as theft (from an employer) by a trusted source (such as an employee). In a plastic surgery practice, fraud is very common, often hard to detect, and a significant cause of physician burnout. Plastic surgery practices present the perfect conditions for manipulative and dishonest employees: busy physicians, valuable inventory, variable financial oversight in the office, and a lot of cash (see ► Fig. 10.2).

The incidence of fraud in small businesses (less than 100 employees) is staggering. According to a recent global study on occupational fraud by the Association of Certified Fraud Examiners, 22% of cases lost more than \$1 million.¹ The famed criminologist Donald R. Cressey's landmark triangle presents the required three components for fraud to occur: greed, opportunity, and rationalization.

While greed and opportunity are easy to understand ("I want it" and "it is easy for me to get"), rationalization may seem counterintuitive at first. Some ideas on rationalization are easier to think about ("I deserve it"), but the root cause may be far more nefarious. The employee thinks of herself as a good person, and good people do not steal from good people. Therefore, it is important to think of the employer as a bad person, which therefore justifies the continued theft. In a plastic surgery office, instead of continuing to promote the physician to generate more revenue to steal, it means converting the "good doctor" into the "bad doctor." A rise in the number of negative reviews is one important clue to look for embezzlement in the practice. Not only is the

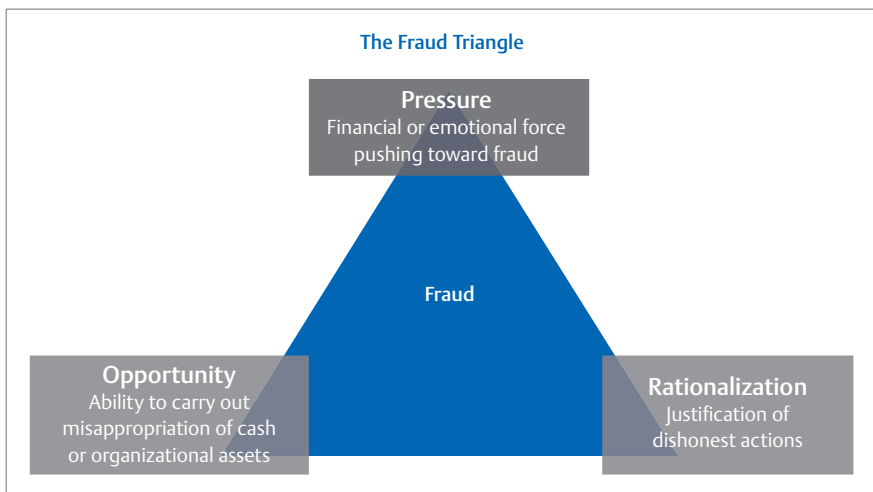


Fig. 10.2 The triad of fraud.

fraudster stealing present funds, they are actually stealing future money, and unchecked, can destroy practices and wreck lives.

Employees in a practice can steal a little (stamps, coffee pouches, stationary), or they can steal a lot (cash, injectables, skin care). Creating a culture of monitoring begins with having monitoring cameras in places where financial transactions occur, or where injectable inventory is located. It is also important for the person quoting a procedure *not* be the same one to collect the funds. This avoids collecting funds in exam rooms where having cameras may violate HIPAA rules. It also avoids side deals where dishonest patient care coordinators or practice managers can make deals with patients to pay in cash for lower prices and then personally pocket the funds and remove the patients from the schedule to avoid detection.

Cash

Cash is a challenging commodity. Patients often choose to pay with cash to avoid having to explain to spouses about their aesthetic expenditures. Sometimes they also like to pay in cash to get discounts, as the practice can avoid credit card fee, or with some practices, to avoid depositing the cash and thus hide revenue from the Internal Revenue Service (IRS).

To avoid having any cash slip through your fingers (and out the back door), cash should be collected by someone other than the person who quoted the fee. It should be counted in front of the person paying with cash to avoid discrepancy and awkward interactions with the patient. The patient should be given a cash receipt. The collecting employee should then place the money in an envelope, seal it, and then both the collecting employee and the patient should sign the envelope. The envelope should be noted with the day, time, and office location (if there is more than one practice location). The envelope should then be placed through a mail slot in a locked box bolted to the wall. The key should only be in the hands of an owner (not the office manager), who then removes the cash from the box periodically and takes it to the bank for deposit. At the bank, photos of the envelopes along with the bank deposit slip is made and sent to the designated financial oversight manager.

Inventory Controls

In a structured, well-run business, systems keep operations running efficiently with decision points pointing to what actions should be taken and when. Cosmetic plastic surgery offices with significant product inventories, such as injectables and skin care products, require inventory management and tracking systems to ensure that these are being properly handled and sold for the correct price. A formalized system is an important protection against embezzlement. Products are given away or stolen every day in physician offices. No matter how rudimentary, a formalized system enforces policy, physical counts, and general awareness of the flow of material through the practice.

Basic inventory starts with a simple formula:

$$\text{Starting Inventory} + \text{Purchases} - \text{Sales} = \text{Ending Inventory}$$

A simple Excel spreadsheet, as shown in ► Table 10.1, can be created and kept current with a few minutes' attention each week. In order for this tool to be truly effective, a physical count needs to be made periodically to verify the expected inventory level. Discrepancies should be noted and explained by the staff responsible for maintaining the items. If problems persist, disciplinary action may need to be taken.

Table 10.1 A simple inventory spreadsheet

Item	Beginning inventory	Purchases	Sales	Ending inventory
AHA	12	6	9	9
Tretinoin	16	9	10	15
Sunscreen 4 oz	7	6	3	10
Sunscreen 2 oz	8	10	12	6

Table 10.2 A more detailed inventory spreadsheet

Item	Cost (USD)	Beginning inventory	Purchases	Sales	Ending inventory	Value (USD)	Physical count	Variance	Reason
AHA	9.41	12	6	9	9	84.69	9	0	
Tretinoin	17.99	16	9	10	15	269.85	14	1	??
Sunscreen 4 oz	3.46	7	6	3	10	34.60	10	0	
Sunscreen 2 oz	2.99	8	10	12	6	17.94	5	1	??
					Total	407.08			

Once the system is in place and the staff is comfortable with the process, additional enhancements can be added to the tracking sheet. An example of this is given in ►Table 10.2. Any variance, positive or negative, as noted in two entries with question marks, should be investigated and accounted for immediately. The appropriate responsible staff should be informed and also held accountable for the variance if it remains unexplained.

It is amazing what a simple inventory system can do to preserve the high-value products in a medical office. The staff who is aware that the practice is watching the inventory is less likely to lose track of where it is going.

Not all items need to be tracked and recorded through a formal inventory system. The intent is to track those high-value items that are considered to be *critical items*.

Injectable Inventories

Combining increasing inventory levels with sloppy or nonexistent inventory controls is a recipe for disaster. If all the plastic surgery practices in the U.S. were to audit their injectable usage as compared to their injectable purchases, a majority would discover that products are missing or otherwise unaccountable.

For practices without an inventory system in place, a quick mathematical calculation can be conducted to determine if the product is being used properly. The calculation is simple; let us use Botox as an example.

- Let us assume the Botox cost per 100 units = \$600, or \$6 per unit.
- The practice has Botox purchases for the last 12 months amounting to \$75,000.
- The practice reports Botox revenue for the last 12 months of \$136,000.

Table 10.3 Botox log					
Date	Patient	Provider	Units	Waste	Units on hand
1-Jan	PURCHASE				1,000
10-Jan	Doe, John	Dr. J	85	15	900
12-Jan	Doe, Jane	Dr. J	30		870

The audit would look like this:

- Total Botox units purchased in the last 12 months = \$75,000/\$6 per unit = 12,500 units or 125 vials.
- If the practice sells Botox for \$14 per unit, the expected revenue on the sale of 12,500 units would be 12,500 × \$14 per unit = \$175,000.
- Assume 10-percent waste and no free product was earned through purchase rewards; the practice could expect a net revenue of \$157,500 from Botox sales.
- Given that there was \$136,000 of Botox sales and no dramatic change in inventory levels, the practice is “missing” almost 36 vials of product, amounting to \$21,500 of lost revenue.

This happens more than anyone can imagine. A simple solution is to implement a modified inventory procedure much like a controlled substance log. A simple injectables log may look like the example shown in ►Table 10.3.

The log should be reconciled daily, weekly, or monthly, depending on how closely the practice wishes to monitor the product. Conducting inventory checks weekly, rather than annually, will prevent a major surprise at the end of the year. A small bag or purse can easily contain \$25,000 worth of inventory. Letting employees know that inventory is being checked regularly can serve as a deterrent from theft. The most likely employee to steal products is a nurse injector who works at multiple facilities. In that case, the nurse injector may “borrow” a vial of Botox with the intention of returning it. Whether by benign or willful neglect, that vial of Botox may never be returned. If not noticed, the behavior can worsen, with the potential additional loss of dermal fillers, skin care products, Coolsculpting cards, and even consumable tips for lasers. Other techniques for theft include overdiluting the Botox (producing more product to inject and then stealing undiluted vials) or taking staff vials and selling product to another office or having private events elsewhere.

A Special Word on Services for Employees

Many vendors provide offices with complimentary product for staff. Remember this is not *free*, it is *included*, in exchange for purchasing product sold to patients. Providing product at no cost to employees encourages theft, as employees rationalize why they deserve to take as much as they want (see triad of fraud in Fig. 10.2). Educating the staff about overhead and asking them to pay practice cost are useful ways to control the product.

10.4.5 Practice Finance

Nowhere is it more important to have reliable systems in any practice than in cash handling and finances. Funds flow in and out during the operation of businesses, and retrospective reports are created to monitor this flow. These reports are commonly known as end of day close (which ensures proper daily monitoring of finances), and profit and loss (also called income statements). Profit and loss statements are historical documents many business owners use to evaluate their financial performance for some previous period, be it the previous month, quarter, or year. They are the foundation of a practice's financial measures.

The quest to have accurate and useful financial statements begins with bookkeeping. An accounting program, such as QuickBooks, can be used to enter revenue as it is received and bills as they are paid. The diligence and attention given to the initial setup of the financial software goes a long way to ensure the relevance and accuracy of data you will be able to access later. To make an essential comprehensive chart of accounts, create a list of line-item categories of revenues and expenses within the practice. Many practices go wrong in the way they establish the chart of accounts, which must be concise, simple, and relevant to the data that the physician owner will need to evaluate the financial performance of the practice. It is best designed to avoid miscategorizing (such as improperly placing employee meals into the meals and entertainment category—this will spark a tax audit). A recommended chart of accounts is included in ► Table 10.4.

The Flow of Money

Money arrives at the practice in multiple ways. Cash and checks are accepted in the office by practice employees, or arrive by mail or electronically from credit card merchant services, insurance companies, and government payers like Medicare. It is important to have a system in place to ensure the money is:

- Properly collected;
- Properly recorded;
- Properly deposited; and
- Properly accounted for in the financial system.

In a perfect world, the physician owner of the practice would be present to receive every cash payment, check, and credit card transaction. The reality is that payments must be delegated to *trusted* office staff to receive and properly care for the money. “Trusted” is the crucial component of the definition of embezzlement, and practice owners must be vigilant to *trust but verify*. Most importantly, it is important to create a culture where every employee knows that an oversight system is in place. Simple systems can be created that provide control and verification of the proper handling. Most practice management systems encounter forms (charge sheets) created with unique numerical identifiers. An encounter form should be created for every transaction that occurs within the practice. Examples of such transactions may include:

- New patient visits;
- Follow-up visits;
- Postoperative visits;
- Surgical procedures;
- Local procedures;
- Skin care treatments;
- Skin care consultations; and
- Skin care product sales.

Table 10.4 Sample revenue portion of the chart of accounts

Labor

Clinical salaries

Administrative salaries

Billing office and reception salaries

Aesthetician salaries

Contract labor and other

Payroll (P/R) taxes, benefits, workers' compensation

Advertising and marketing

Answering service

Association dues

Bank fee

Dues and subscriptions

Equipment lease

Gifts and flowers

Instruments

Insurance—general liability

Interest expense

Laboratory

Laundry and linen

Legal and accounting

Meals/entertainment

Medical supplies

Clinic supplies

Botox

Restylane

Other

Meetings and travel

Miscellaneous expense

Office expense

Office supplies

Parking

Payroll service

Photography

Postage and delivery

Rent

Repairs and maintenance

Taxes and licenses

Telephone

Table 10.4 (Continued) Sample revenue portion of the chart of accounts

Transcription
Utilities
Total operational expense
Precompensation margin
Physician discretionary expense
Physician salaries
Physician benefits and payroll tax
Malpractice insurance

By documenting each interaction and tracking it with a unique identifier, the practice can reconcile these transactions at the end of the day by verifying what should have been received from each visit was actually received. Most systems either track encounter forms automatically or provide a report of encounter forms issued for any period of time. The physician can use this report, generated independent of staff actions, to reconcile the day's events.

Each day, the appropriate designated staff member should compile the encounter forms along with the receipts for the accompanying payments and summarize the day's activities in what is called a *daily close*. The daily close is a compilation of all encounter forms created for the day along with the associated payments and receipts, all summarized into one batch. From this batch, the physician or office manager can reconcile the activity in the daily close with the expected revenue activity derived from the practice's encounter form tracking report. Special attention should be paid to encounter forms that are missing, incomplete, or lacking a corresponding receipt when one is expected. Credit card batches should be closed at the end of every business day.

The person in charge of making bookkeeping entries should use the daily close to enter the receipts into the appropriate revenue categories in the practice's financial system. This process requires tremendous diligence to ensure the funds are tightly controlled, facilitating reconciliation with the bank statement at the end of the month.

At the end of each financial period, the practice's financial institution usually issues a bank statement. This statement *must* be opened by the physician owner or other staff who does not write checks or pay bills. The statement must be analyzed first by someone in the practice who is not in a position to embezzle funds. Once a review of the statement and canceled checks has been conducted, the statement may be forwarded to the bookkeeper for reconciliation in the practice's financial system. The reconciliation should be performed as soon as possible after receiving the account statement so that discrepancies and errors can be corrected before too much time passes and memory fades.

The QuickBooks application is an excellent system for recording bills and invoices as they arrive. Each day, as the mail is opened, bills can be entered into the system and set to the appropriate terms of that vendor. Cash flow can be controlled by timing when bills are due and paid. This process allows the office manager or physician to predict the practice's cash demands in the future by generating a simple aging report with the click of a mouse.

10.4.6 Human Resource Systems

The years of training prepare plastic surgeons for success in the operating room, but not for success in business. Choosing the staff to hire is the most important decision you will make for the success of your practice, yet surgeons receive no training in human resources. Your staff are your face to the public. They answer calls, schedule appointments and surgeries, field all manner of questions, collect money, order supplies, pay bills, and support the physician owner. The following are some basic rules in hiring, developing, and retaining the office staff.

Applications and Interviewing

Start by determining the practice's needs before selecting potential candidates to interview. While everyone's personality is different, there are some personalities that are better suited to the dynamic environment of a cosmetic surgery practice. Figuring out how to identify and choose personalities and skill sets in potential employees will be a career-long challenge. Each applicant should complete the employment application—a generic and objective document allowing for an “apples-to-apples” comparison of applicants' experience, employment history, expected salary requirements, and previous employers. Find a standard form and use it consistently in your practice. Schedule the qualified candidates for an interview.

The interview is your best opportunity to evaluate a candidate's personality, demeanor, presentation, and knowledge, and it is the point at which most hiring mistakes are made. Most interviewers spend a great deal of the precious interview time talking about the practice and the position the candidate is considering, which does not help you evaluate the candidate. Spend the majority of the interview asking the candidate questions that will help you gauge their personality and organizational skills; for example, ask about their previous employment history, views on patient service, and how they have handled personal or professional challenges. Look for verbal and nonverbal red flags, such as:

- **Late arrival for the interview:** Will they show the same disregard for the time of the patient and the surgeon?
- **Unkempt or unprofessional dress:** The business of plastic surgery is truly an image business, and candidates who understand that will dress appropriately. If the candidate cannot attend a function as important as a job interview with a professional appearance, he or she may not come to work dressed appropriately or treat patients professionally.
- **Never smiling during the interview:** The ability to transmit warmth and comfort through a smile will be important when competing for cosmetic patients, and the lack of awareness to do so reflects inadequate emotional intelligence for the job.
- **Being misleading or indirect regarding previous employment and the reasons for leaving:** Everyone has bad experiences in the work environment, and growth and maturity develop through the ability to overcome them and learn from them. Extra attention should be given to checking references if a candidate has a questionable employment history.

Keep your eye out for red flags. There are a multitude of them—enough to fill a book. The characteristics associated with employee success include:

- Being punctual;
- Presenting a professional appearance;
- Smiling when you meet them;

- Having good eye contact and body language;
- Speaking and communicating well;
- Feeling comfortable when speaking to a superior; and
- Showing indications of organization.

References

Do not skip checking references. Previous employers may give limited information, such as the hire date, the termination date, and whether or not the candidate is eligible for rehire. The more information they offer you, the better. Previous employers can be tremendous sources of information on how an employee performed as well as on their strengths and weaknesses. Often they are reluctant to put some things in writing, so if you are serious about a candidate, call all references.

A background check can be conducted for an additional expense. Of course, this needs to be disclosed to the candidate. In a typical background check, criminal history as well as credit reports can be obtained. A background check should specifically be performed on candidates being considered for positions requiring the handling of significant amounts of money. Physician practices are commonly embezzled from in the form of cash, products, and other materials.

Social networking sites, such as Facebook and Instagram, offer possible additional employee information. While the individual's profile page may be restricted, many are not. The information from the candidate posts on these sites may offer clues that support a hiring decision or confirm a decision not to hire. Nonetheless, decisions should not be based solely on a candidate's social media posts.

Hiring and Training

Assume you have found the perfect candidate. You can make a formal offer of employment, consisting of a simple offer letter outlining the job description, the terms of employment, and the compensation package. The start date should be included along with any special considerations agreed upon in the interview. After the employee signs and dates the offer, the letter joins the initial application in the newly created employee file. The employee can then be given an employee handbook and a job description.

An experienced practice should have an onboarding checklist, policies and procedures, and educational materials for staff training. An experienced employee with a similar job description should be paired up with the new employee for one-on-one training and mentoring. When the employee arrives for the first day, the employee will be shown how to clock in and clock out and complete the tax and payroll paperwork. The mentor can offer instruction on the use of the practice management system early during the training process. When training is limited, result is often a frustrated, low-productivity employee. Some will quit; others will struggle through the difficulties while operating at a solid level of mediocrity, and then quit. It is rare for an employee to excel when they lack support. To retain and develop employees into true human assets in the practice, processes must be in place to maximize their potential. The systems in the most effective businesses integrate a new employee into the office, establish expectations, and train them on the procedures and policies that will impact their job. A well-written employee manual should convey the practice

culture through its mission and values. The legal aspects of an employee manual vary from state to state, but the core policies and procedures outlined should be easy to create. The manual should outline the following areas of office protocol:

- Punctuality standards;
- Dress code expectations;
- Office surgery policy;
- Vacation and sick policy;
- Progressive discipline policy;
- Work rules;
- Computer and electronic media policy;
- Benefits;
- Holiday schedule; and
- Core structure and governance, including a grievance policy.

Day-to-day functions are addressed by a current, thorough job description, the onboarding checklist, and training materials. Training documents include educational materials, such as printed documents, websites, videos, books, and instructional courses. The job description does two things: first, it explains in detail the specific office functions required of the particular position. Second, it creates expectations and performance measurements for the position. This latter component is essential in establishing a baseline of accountability for the employee.

These materials comprise the essence of a management structure: expectations and performance guidelines of which the employee is aware. Articulating the specifics establishes a system of accountability for the position. It is now up to the owner and the management of the practice to enforce this accountability and address shortcomings through additional training or progressive discipline.

Discipline and Terminations

Unfortunately, structured employee discipline and work improvement programs are rare in smaller physician practices. Practices operate with, and accept, mediocrity until a tipping point is reached. At this point, employees will leave or ultimately be terminated.

If handled properly, an extensive amount of time and money should have been invested for the thoughtful hiring and thorough training of any given employee. A logical progressive discipline policy is essential to protect your investment and should be described in the employee handbook and implemented. Progressive discipline is simply a standardized set of steps used to address negative office behavior, deviation from policy, and poor performance. A progressive discipline policy creates the foundation of solid documentation that may be used to defend against unemployment claims legal action brought by terminated employee for wrongful termination.

A simple progressive discipline policy may include the following:

- **First policy violation—verbal warning:** The verbal warning should be a formal discussion with the employee in which the policy breach is clearly explained to the employee. The proper course of action and expectation for improvement should be outlined so that the employee understands clearly. Consequences for failure to improve should also be discussed with the employee and documented, dated, and signed by the employee. The warning will become part of the employee's permanent employment record.

- **Second policy violation—written warning:** The written warning is second in the sequence of progressive discipline and is considered to be a second violation of the *same* office policy. Once again, the breach should be explained clearly, be stated in writing, and reference made to the previous verbal warning. Steps for improvement should be clearly outlined, along with the consequences for failure to improve. At this stage, the consequence may be articulated in specific language, “Failure to improve may result in additional disciplinary action up to and including termination.” Expectations have clearly been established; at this point, failure to improve means that the employee is either incapable of or unwilling to improve their behavior. There are two options after this, as discussed next.
- **(Optional) Third policy violation—probation:** In some instances, it may be desirable to offer a “third strike.” Probation provides an objective, last chance for improvement. Quite simply, the employee is informed in writing that, for some specified period of time, any further violation will be grounds for termination. Usually, if an employee has made it to this stage, their destiny is a done deal. It is just a matter of time before they are let go. This third stage of discipline provides for a truly defensible position regarding unemployment and legal exposure.
- **Final violation—termination:** After two to three violations of policy, it should become clear that the employee is not improving their behavior. Inevitably, it is in the best interest of the office operationally and financially, as well as for staff morale, to terminate the employee. If a clear progressive discipline policy is in place, it should not be a surprise to the employee when they are terminated. In fact, experience shows that when a progressive policy is in place, many underperforming employees will simply leave after having their behavior documented. Should they make it through the entire evolution of the discipline policy and continue to fail, the termination becomes a perfunctory process.

Terminations should always be done in the presence of another trustworthy staff member. Ideally, it should be done at the end of the day in order to reduce the disruptions to the office operations and other staff members, as well as to preserve the dignity of the terminated employee. There should be no display of emotion, no negotiation, and no blame. The process should very clearly involve an outline of the policy violations without discussion, the result (termination), and a thank-you for the service. In an at-will state, no reason needs to be given. Additional written material can be used as material for legal action, even if the complaint is frivolous. Any legal action requires a lawyer, which is a drag on the bottom line. On the day of termination in an at-will state, the employer can let the employee go; it will not be a surprise, given the previous trail of documentation that the employee had signed. A trusted employee should escort the terminated staff member to their workspace to collect their items and return any office property they possess. Any passwords, keys, and other proprietary office property, whether physical objects or organizational knowledge, should be returned or captured. Examples may include the processes for filing payroll, logging into the time clock system, and accessing bank accounts.

It is never enjoyable to terminate an employee; unfortunately, it is a necessary event in the management of a business with employees. It is human nature to feel bad, and if you are indeed human you will feel bad. Avoid the overpowering need to negotiate and justify your decision with the departing employee. The time for this discussion was well before the problem reached this stage. You will be doing yourself and the employee a favor by keeping all emotions, sympathy, and justifications out of the termination

Table 10.5 Basic list of precautionary methods
1. Conduct background checks on potential employees (individual must be advised and agree to a background check).
2. Have at least two employees count cash received. Store cash in a secure place until the end of the day, when the bank deposit is made.
3. Count cash in front of the patient so a discrepancy can be identified immediately.
4. Give a cash payment receipt to all patients.
5. Cash payments must be logged on the daily A/R sheet and the bank deposit. These items must be reconciled and balanced every day. There must be a separation of duties between the person receiving cash and the person responsible for maintaining the accounting records.
6. Use electronic deposit systems to save time, but cash deposits should be made frequently. Some banks will pick up from the office, saving staff time. If that service is not available, consider paying for a company like Brink's to pick up and take your deposits to the bank.
7. Consider cameras in areas where inventory (Botox, filler, Kybella) is kept and where money is handled.
8. Have a locked refrigerator for Botox (and have that refrigerator connected to back-up power in case of power outage).
9. Have a numbering system for each vial of Botox or filler that arrives in the office. Use Botox or filler in numerical order.
10. Account for every unit of Botox from each vial using a Botox log. Track not just the vial numbers, but the actual units delivered from each vial.
11. Conduct inventory checks on a weekly basis and let all employees know this is a routine policy.
12. Have a separate person (accountant or bookkeeper) review financial system reports.

discussion. A simple statement of fact, the outcome, and a departing wish of good luck are all that is really needed. If you wonder whether you made the right decision, simply ask yourself, “Will the practice be better tomorrow without this employee?” If the answer is “yes,” then the correct decision has been made.

A modern plastic surgery practice is a multimillion-dollar operation that cannot be directly visually monitored by the owner(s). Establishing preventative systems and processes (►Table 10.5) will identify episodes of inefficiency, rectify mistakes at an early stage, and deter detrimental employee behavior.

10.5 Appendix 10A

Telephone Intake Record:

Name: _____

Procedure: _____

How did you first hear about our practice?

Referral Source: _____

Detail: _____

I would like to make sure that I answer your questions and give you the information you need about the procedures you are interested in. Would you mind if I ask you some questions?

• How long have you been considering having this procedure done?

• Are you familiar with this procedure? What do you know about it?

• Do you know anyone who has had this procedure? What did you think of the results?

• Do you have any concerns as you think about _____?

• Do you have any family members who have questions or are unsure of your decision to have _____?

- Have you been to any other offices? It is important to be informed, research your options, and choose your doctor carefully.
- Is there a special event coming up you are preparing for?
- Once you have determined where you want to have your surgery, do you have a time frame in mind?

What do you know about Dr. _____?

Great bedside manner

Board-certified by the American Board of Plastic Surgery

Top doctor recognition

Emphasizes the highest standard of safety and quality care for our patients

Locally/regionally/nationally well known

Lectures/teaches other leading plastic surgeons

We always let our patients know in advance the cost of the procedure.

Ballpark fee given: _____. Is that what you expected?

Objection to price: Other patients have felt the same way, but once they see their end result, they are happy they spent the extra money. Dr. _____ does great work, and his patients love him.

- We have several different payment options available. We accept credit cards, checks, cash, and financing through several agencies.
- I would like to refer you to our website for additional information and to review some of our before/after photos.
- **Consult:** Based on your needs, I would love to schedule a consultation for you. Our consultations are ____ minutes long. You will watch a video, meet the doctor, review before-and-after pictures, get a finalized fee quote, and review surgery dates. The fee for this consultation is ____.
- **Objection:** Many patients have commented on the quality of our consultations. The doctor will spend at least 30 minutes with you and provide you all the information to make the right decision about your concerns.

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Daytime Phone: _____ **Other Phone:** _____ **Cell Phone:** _____

DOB: _____ **Interest Level:** _____

Appointment Date & Time: _____

Wait List Request? _____

Inquiry Only: As you are calling around trying to determine where you will have your consult, I would like to send you some information about the doctor and the procedure you are interested in. Can I get your contact information?

Reference

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11 Saving Money

Jay Shorr and Mara Shorr

Abstract

There are many ways a medical practice can save money throughout its life cycle, most of which the physician owner may simply not be aware of. Large and small, these can add up to a fortune. In this chapter, we discuss several ways to save money.

Keywords: business plan, saving money, credit cards, leases, investments

11.1 Introduction

In a small business such as a medical practice, every penny adds up to make a dollar; over time, small items will become thousands, if not millions of dollars, that affect the practice's bottom line. As a physician owner of a medical practice, it is important to recognize that your primary attention is taking care of patients. It is not possible for humans to devote 100% of their attention to multiple tasks.

The number one component of any business operation is proper planning. This includes a well-designed business plan to include financial, human resources, operational, administrative, and marketing sections. Many business owners, including some medical practice owners, fail in their first few years because they run their business by the seat of their pants without ever having a well-executed plan. The proper design of a business plan allows you to recognize the actual costs and efficiencies associated with your ongoing practice, so you can continually modify it along the way as internal and external factors may change. A SWOT (strengths, weaknesses, opportunities, threats) analysis is often a first step in establishing a business plan.

11.2 Ways of Saving Money

It important to note this list is not a fully comprehensive list, and money can ultimately be saved in many, many more ways than the following list.

11.2.1 Preventing Mistakes

Medical practice owners often lose money because of the reasons discussed next.

Not Negotiating the Expenses Related to the Private Practice Space Itself

Look at the physical space you will lease or own and determine whether it is the exact space you will need to fit your needs. Is the square footage appropriate for the needs of your practice? Will you grow out of it before the term of the lease expires? Is there room for expansion? While you may be looking to grow into a specific space, do not overshoot the number of treatment rooms that you will need before you have picked up the patient volume. This is true whether you are leasing or owning the space. Examine the lease to determine if you can negotiate the following items in your favor:

- Street signage;
- Building updates;
- Payment for common area maintenance (CAM) fees; and
- Expanding or reducing the hours the practice is allowed to be open.

If you are renting or leasing your office space, you are usually paying by the square foot; think about the actual useable space that you need. Oversized reception areas and exam rooms may be nice to have but are expensive if not properly utilized. The practice of plastic surgery has evolved: the classic physician's office with a big desk where the patient comes for a consultation and sits opposite the physician has gone the way of the suit and tie in many practices.

A lease is a major fixed cost to your bottom line, and most of them are signed with 3-, 5-, and 10-year terms, with optional renewals. When negotiating these leases, make sure that you understand what extra fees you may be responsible for, including, but not limited to, utilities, CAM, janitorial, maintenance (general and routine), security, and real estate taxes. Many times there are escalation clauses associated with your lease that might increase each year either by defined dollar amounts or a defined percentage. If the landlord's real estate taxes increase, are you responsible as a proportion of your square footage?

In major traffic areas, landlords charge parking fee for staff and patients. This is a major profit center for the landlord and a large expense to you if you do not pass this along to your patients. Attempt to negotiate this fee upfront. Other items to negotiate are tenant improvements; landlords will often help with construction and design costs in exchange for a longer lease.

Overpaying for Patient Financing Programs

While some providers believe that a patient should not have a procedure they cannot afford to pay for upfront, many practices welcome third-party patient financing programs. In this way, the physician is paid in advance, while a patient is able to finance their procedure over a period of time, from 6 months to 5 years, depending on what the patient chooses and what is provided by the third-party specific lender. Naturally, interest-free loans are most attractive to patients, but they are most expensive to the practice. The longer the terms for free interest to the patient, the more it costs the practice. Similarly, the longer the standard interest loan to the patient, the more it ultimately costs the patient, and the less it costs the practice. The practice can choose to accept only certain plans (such as no interest for 6 or 12 months only), but the lender determines the cost to the patient and the practice. It is important that you read all of the details prior to signing a contract with a specific patient financing vendor. Make sure to consider the following items, including, but not limited to:

- The amount for which the patient will be approved. For example, if your practice charges a global fee of \$20,000 to the patient, will the patient need financing for the full \$20,000—and will the patient financing program only approve the patient for \$7,500? Will this cover the procedure that they are interested in or leave the patient falling short, unable to pay for the procedure with your practice?
- If the practice is charged 9.9% for the loan to the patient (who is paying much more), allowing the patient to also finance the operating room and anesthesia as part of the global fee costs the practice more than it charged to the patient.
- Consider whether the patient needs a certain minimum FICO credit score in order to be approved for the procedure. Some institutions would not approve patients with a poor FICO credit score (579 and lower), while others need patients to have a “good” credit score (a minimum FICO credit rating of 670). If the patient financing institution your medical practice is working with would not approve financing for the majority

of your patients, those patients would not be able to afford your procedures. This may require working with a secondary lender at much higher interest rates to the patient.

- The *patient* is charged an interest rate. Many institutions will have a 0% interest introductory rate to the patient for a certain period of time, typically 6 to 18 months. However, your practice will need to make the patient aware that once that introductory rate runs out, the patient will incur penalties should they not pay off the balance before the end of the introductory period.
- The *practice* is charged an interest rate. In many situations, when the financial institution pays the practice directly, it often charges a processing rate. Take note of what you are charged because the interest rates vary widely, from 0 (a rarity) to nearly 20% interest, with the average falling around 7 to 12%. For example: If the practice's rate for the patient's procedure is \$10,000, and the financial institution charges the practice a rate of 10%, then the practice receives only \$9,000 from the patient, losing \$1,000 for a single procedure. The practice loses even more if it pays for the facility fee and anesthesia, since it is charged 10% on those additional fees!

While there are a few industry leaders available when it comes to patient financing programs in the medical space, review what is currently available on an annual basis. There are few patient financing industry leaders, but new programs come into the industry as others leave on a fairly regular basis.

A Win-Win Option

Many consultants and vendors offer programs in which patients can open a new credit card with a 0% interest rate. Consider offering your patients this as an option, since you are paid within 24 to 48 hours of the patient's charge, with no additional fees charged to you. It is a win-win for both you and the patient.

Warning About Theft

When accepting patient financing, patients should provide two forms of identification, at least one of them government issued. Lenders will often audit practices for specific transactions, and if the practice does not have these documents, the lender will take back the funds. This identification requirement avoids theft from lenders. Having this policy serves as a theft deterrent, and if the patient *does* commit identity theft, the practice is covered.

In addition, if you keep financing information on file, including credit cards, make sure that the information is both encrypted *and* that your practice has a signed credit card authorization form on file.

Overpaying for Your Credit Card Processing

The number one reason that any small business overpays on credit card processing is because they simply do not take the time to understand how it works and evaluate what charges are being incurred with each purchase. Understanding how the system works is the first step. The processing fees for every credit card and every transaction are not identical. For example, Visa, MasterCard, American Express, and Discover, each have a different processing rate. These are called *interchange rates*. It is important to know that you do not deal directly with the credit card company. Each medical practice must use a merchant processor, which can be an independent company or

even your financial institution (bank). Each merchant processor adds independent fees beyond those the credit card company charges, and you have leverage to negotiate these rates.

If a credit card has benefits associated with it, such as miles or points, the transaction fee will be higher. The less secure the credit card processing company views the transaction, the higher the processing rate for that particular transaction. A credit card purchase made when the customer hands a physical credit card to the merchant is considered to be more secure. For example, if the credit card is not present at the time of the transaction and the numbers are punched into the system instead of swiped, or if the zip code is not entered, credit card companies view the transaction as less secure, and it charges your practice higher processing fees. In other words, if your front desk team takes a credit card transaction over the phone instead of in person, your practice will be paying a higher processing rate.

It is easy to miss paying attention to the charges incurred from these high processing rates, and yet your practice may be carrying out the vast majority of its transactions by credit card. To raise your awareness, regularly monitor your credit card processing fees for any irregularities. In addition, request a specific credit card processing fee evaluation annually from your processor. It is a competitive industry, and most vendors will offer competitive rates to secure your business. Review what the rates are and request an analysis from two other competitors. Your next step is simple. You have two options, as discussed next.

Option A

Your current credit card company will decide to match those rates that its competitors have sent to your practice. Of course, this option will require negotiation and take back-and-forth time. The easiest option for your administrative team is to stay with the same credit card processing company at the negotiated new lower rates.

Option B

If your current credit card processing company is not able to or interested in lowering your processing rates, it may be time to move to another company to secure those rates. You will want to determine a few things before making the switch:

- Do you need to purchase a new credit card processing terminal? If so, evaluate those costs and their effect on the balance of your proposed savings. For example, if the terminal is \$200 to \$500, how long will it take you to make up the savings from switching to the new processor?
- Does the new credit card system connect with your current practice management or electronic medical record (EMR) and your key performance indicator (KPI) system? For example, are all transactions from a particular patient directly syncing in their patient record at the point of sale (POS), or will you have to manually enter it into your system? This may be a software issue and not a credit card terminal concern. Do skin care sales sync with the corresponding patient record?
- Does the credit card processing system and terminal sync with your existing accounting software? How is gratuity listed, if your state allows gratuity for any additional employees within your practice, such as aestheticians? All of these things are important to know ahead of time.
- Will your current credit card processor charge you a fee if you break your contract? Again, balance out how savings will be affected.

Losing Money on an Event in Your Practice

Hosting an event in your medical practice serves to drive sales. Whether it is a grand opening, a holiday open house, or a lunch-and-learn event to promote a particular procedure, if you are a private practitioner, you are going to host a number of events through the life of your medical practice. Tracking monetary items associated with the event is essential to determine both the return *and* the investment when analyzing your return on investment (ROI).

Expenses associated with your event should include the following:

- Staffing wages for the event, both during the event as well as before and after the event. Include any overtime incurred.
- Operational overhead.
- Cost of medical supplies for the event—get as much as possible donated by your vendors.
- Event decor.
- Event food and beverages.
- Marketing costs associated with the event, including digital marketing and print expenses.

Your ROI should be 350% of your initial investment. If it is not, analyze where expenses can be lowered and how to increase purchases. Better yet, get the vendors to pay for some of the event. In general, the event must be held in your office in order to get reimbursement from vendors.

11.2.2 Track Your Expenses on a Monthly Basis

When you initially sign a contract, your rates are then secured. However, many practices owners and managers do not track when their contracts renew. Upon renewal, vendors are able to increase their rates, whether that be for supplies, postage meters, biohazardous medical waste, website hosting, or other items. Practices should track when *each* of their contracts expire and renew automatically, as many contracts have an auto-renewal clause with an elevated rate incorporated at that point in time. Check what the mandatory notification clause is for auto-renewal clauses. These range on average 30 to 90 days. If you do not have an electronic system, write down the expiration date of each new contract on your calendars, either paper or electronic. Renegotiate your rates *prior* to the contract's expiration or auto-renewal date. Make sure that a built-in rate increase does not take effect, and if it does, consider a new vendor.

11.2.3 Join a Group Purchasing Organization

There is a difference between a group purchasing organization (GPO) and a group buyers' club.

Group Purchasing Organization

A GPO helps health care providers, such as hospitals and medical practices, realize savings and efficiencies by aggregating purchasing volume and using that leverage to negotiate discounts with manufacturers, distributors, and other vendors. Actual medical GPOs have governmental regulations and reporting structures. There is no fee to be associated with the GPO, as it is paid by the supply vendors for their affiliation and sales volume.

Group Buyers' Clubs

These typically independent organizations have vendor affiliates (not associated with a GPO) that offer discounted pricing due to their higher purchasing volume. There may be a fee to join the buyers' club, which is governed by the buyers' club and is not regulated by any governmental organization. There are numerous buyers' clubs in the medical sector. Joining a GPO allows the medical practice to save money on routine supplies. A private medical practice, small or large, is limited in the volume of supplies they purchase, restricting their leverage on discounts and rebates. However, in group purchasing, practices across the country essentially band together to receive significant discounts or manufacturer rebates, typically ranging from 10 to 30%, depending on the items purchased. Items that a medical practice can save on through a GPO membership include, but are not limited to:

- Capital equipment purchases;
- Credit card merchant fees;
- Workers' compensation dividend rebates;
- EMRs;
- Fingerprint time card management systems;
- Education certifications and conference admission;
- Remote capture banking;
- Skin care products;
- Website management and search engine optimization;
- Biomedical hazardous waste cost reduction;
- Neurotoxins and dermal fillers; and
- Lasers, radiofrequency (RF) devices, skin tightening and body contouring devices purchases and repairs.

11.2.4 Medical, Surgical, and Office Supplies

While there are multiple GPOs and group buyers' clubs available, a medical practice should keep several things in mind when selecting the right one:

- Pick a GPO or buyers' club that relates to your specialty. Although some supplies, such as table paper, bandages, and gauze, are used among multiple specialties, others, such as needles, syringes, sutures, lipo/smoke evacuator tubing, and filters, are specialty specific. Evaluate the items that you would purchase to ensure your practice will reap the benefits.
- Make sure the GPO or buyers' club you join is reputable. Speak with references. Make sure the organization is not involved in any lawsuits. In addition, clarify if there are any fees associated with membership.
- Confirm the specific system used for ordering supplies. Most GPOs and clubs allow you to continue ordering from your local vendor representative and simply letting them know that your practice is now part of the GPO. Confirm that this would be the case for your practice with both the GPO and the local representative.
- Read the fine print to confirm that you are able to be a part of more than one GPO.

11.2.5 Utilize Marketing Efforts that are Already Available to You

In the past, marketing by medical practices to patients was considered blasphemy. However, the rules and public perception have certainly shifted. For a time, practice managers and owners were forced to spend quite a bit of money on Yellow Pages, print magazine ads in local publications, television and radio advertising packages, and pricey billboards.

However, in today's digital marketing age, you can reduce expenses on effective marketing campaigns by employing the programs listed next. (See also Chapter 15 on Digital Marketing and Advertising.) Your practice should be getting a 350% return on your investment for its marketing expenses. See the following ROI formula:

$$\text{ROI \%} = \frac{(\text{Return} - \text{Cost of investment})}{\text{Cost of investment}} \times 100$$

- **Social media:** Utilize both organic (unpaid) *and* sponsored or boosted posts (pay per click [PPC]) on the social media channels that best match your demographic, and do not waste time on those that do not match. For example, at the time this textbook was published, Snapchat attracts a millennial demographic, while Instagram attracts both Millennials and Generation X, and Facebook attracts both Generation X and Baby Boomers. Know the age group your practice is trying to attract, and do not waste time or money on the others.
- **Search engine optimization (SEO):** Think about when you enter a search term (such as “nose job” or “rhinoplasty”) in an internet browser, such as Google. The first listings that appear have a higher SEO ranking than those websites that come up lower on the list. Obviously, as a medical practice, you want your practice's website to come up as high on that search list as possible. While a monthly maintenance charge of \$1,000 to \$2,000 is not unusual, depending on your geographic area around the globe and how competitive the market is, you should know exactly what you are getting for that monthly fee. The majority of the time you will employ a digital marketing agency to assist you, and they should deliver regular reports. Someone on your team should review the reports and check if the ratings have increased and that the company is focusing on relevant search terms. The reports can show you if you are paying big money for poor results, such as paying to optimize your site for laser hair removal when your practice does not even perform the treatment.
- **Text message reminder software:** Regularly message your patients about their appointments using either your practice management software or a third-party software that speaks to your practice management software. Messaging can be used to remind patients of their upcoming appointments, alerting the patient that they have not been back to your practice in 3 months (known as patient recall messaging), or even sending the patient a customized birthday message. Losing a patient from your practice is the same thing as losing money from the practice's pocket. According to a study by Anthony Quinn, of Marketplace Consumer Financing Platform, and published on LinkedIn on February 6, 2016, it costs \$400 to acquire a new patient, which means that losing a patient could cost not only that amount, but their potential lifetime value to the practice.

- **Vendor reimbursements for marketing programs:** Vendors will often provide cooperative marketing programs and materials to promote their products, such as injectables, capital equipment devices, and breast implants. Restrictions vary by state law, so ask your local vendor for policies regarding reimbursement for marketing materials, like brochures, PPC advertising campaigns, and event-related materials.

11.2.6 Build Relationships with Your Vendors

Not only will your local vendor representatives let you know when end-of-the-quarter deals on consumables arise, if you have a job opening in your office, they can alert you of great candidates in the market.

Connect with your vendor representatives at the end of the quarter and at the end of the year to find out deals available on items you intend to purchase. Vendors often need to meet their quotas at this time and are willing to negotiate.

However, do not get sucked into buying supplies that your practice does not need. If you have a large supply of neurotoxins or a backlog of vitamin C serums, do not purchase a high volume that will expire before you have a chance to sell it. Inventory ties up cash you could be using for something else, and if the items are stolen or get damaged by temperature changes, you bear the loss of all that oversupply.

11.2.7 Know Where in Your Patient Cycle Your Practice is Losing Money

Each step of the patient life cycle (see ► Fig. 11.1) could be costing money to the practice.

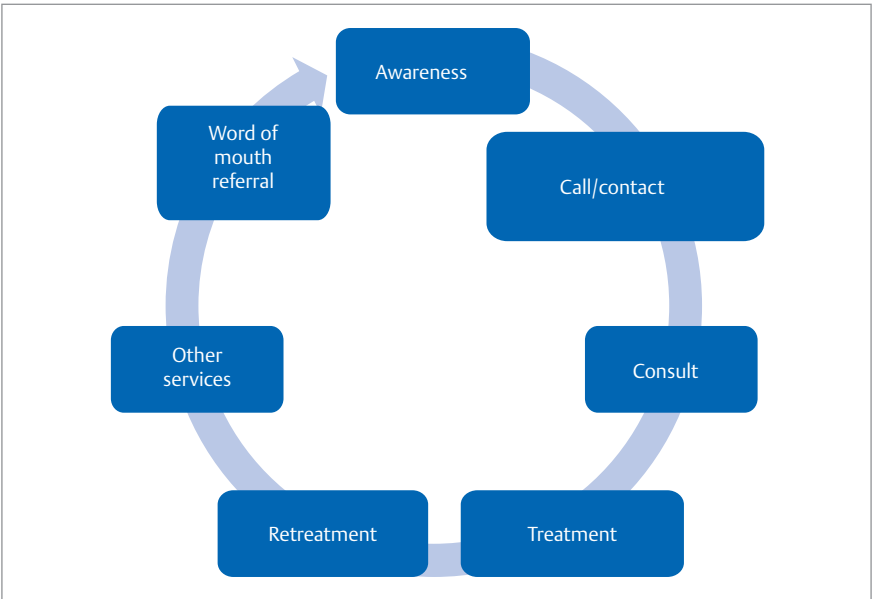


Fig. 11.1 Patient life cycle.

Things to Consider in the Steps in the Patient's Journey

1. Awareness

- Are potential patients not aware of your practice?
- Are potential patients not aware of each of the services that you offer?
- Are you tracking the number of calls your practice is getting from new patients versus existing patients?

2. Call/contact

- What is the patient experience and staff phone script when a potential patient calls your practice?
- Are each of your team members capable of converting a phone call to a patient consult?
- Is your staff answering emails as soon as they come into the practice?
- How soon are your staff members returning missed calls?
- Do you have enough staff members to answer the phone during the course of the day, or are you missing calls altogether?

For the initial phone call, train your patient coordinator to credential the doctor and any physician extenders the patient will be seeing to assure the patient prospect that they have reached the right practice.

3. Consult/treatment

- How many patient consults are resulting in booked treatments for the practice? Why is this number what it is...both the good *and* the bad?
- Why are the consults that are not closing *not* closing? Consider if this is due to poor financing, inadequate pricing, poor explanation of the procedure, unhappy personality of the patient care coordinator, or something else.
- How is the practice following up with patients who are not booking during their initial consult?

4. Retreatment

- Are your patients coming back to get the same treatment again, such as ongoing neurotoxin treatments (applicable to certain nonsurgical procedures)?
- Are you booking retreatments when a patient checks out of their current treatment?
- Are you reaching out to current patients for retreatments when the time is due?

5. Addition of other services

- Are patients aware of each of the services you offer in your practice? For example, do nonsurgical patients know about your surgical offerings, and vice versa?
- Is your practice sending out email marketing to cross-promote services?
- Are you introducing other services to your patients during your patients consults?
- Do you have customized marketing materials (branded canvases in the office, before-and-after photobook in the reception area, a checklist of interested treatments for the future) for the practice?

6. Word of mouth referrals

- Are your patients referring other people to your practice, either through word-of-mouth or by promoting your practice on social media?

For treatments requiring maintenance, like neuromodulators, book the patient's next appointment before they leave the office. Practices often assume that when they check a patient out, the patient will let the practice know if and when they want to come back, but this is often not the case. A delay in the patient's next neuromodulator treatment

can mean fewer total treatments per year and lower revenue. When the patient checks out, the staff should give the patient two or three options and allow the patient to adjust their appointment time as needed.

To use the neuromodulator example, a patient without an appointment made at check-out is more likely to have three treatments per year instead of four. Let us say that the average treatment is 40 units at \$12 per unit totaling \$480 per treatment.

Four treatments per year = \$1,920

Three treatments per year = \$1,440

A single missed treatment means a loss of \$480 per patient per year.

If your practice sees 500 neuromodulator patients per year, the difference is \$240,000. If your practice sees 1,000 neuromodulator patients per year, the difference is \$480,000.

11.3 How to Make a New Piece of Equipment Profitable

Technology offers the cosmetic plastic surgery practice greater nonsurgical options and the possible addition of physician extenders to your private practices. So how should the surgeon-owner evaluate whether a laser, RF device, fat reduction and muscle tightening technology, microneedling, or platelet rich plasma (PRP) would be a good investment?

Consider the following before purchasing a new piece of equipment:

- *Determine the practice's need for the piece of equipment.* Does the device fill a hole in the practice's list of services or is it a duplication of technology of something else you already have? Does the device fill a gap, such as vaginal rejuvenation in a female-dominated patient base, or is the practice looking to bring in a new male patient base, in which a shockwave therapy for male patients who suffer from erectile dysfunction (ED) might make sense?
- *Evaluate who is offering the modality in your market, how long the modality has been on the market, and confirm it has been proven safe and effective.* While you do not need to be the first practice on the market to have the device, you also do not want to be the last. Who else in your geographic area has the piece of equipment? You do not want to purchase the device in an oversaturated market. Make sure that the research has been done on the device. Does the treatment involve a lengthy recovery? Is the treatment painful?
- *Determine the ongoing rate for the procedure.* Your decision to purchase should factor in the overall price of the device, the price of consumables, and the suggested/average procedure fee, according to the device company's suggestion and what your particular geographic market will bear. Determine your lowest acceptable net margin and calculate the number of monthly treatments necessary to perform to make sure to not fall below that percentage. (See Chapter 19, A Successful Medspa.)
- *Consider which of your practitioners are able to treat patients with the equipment.* If you are the only practitioner in your office, you may not want to spend your time performing a nonsurgical fat reduction procedure that can be performed by an aesthetician. On the other hand, if you have a busy surgical practice and employ an aesthetician, that modality may be a great fit. However, if your state allows a nurse

practitioner or physician assistant, but *not* an aesthetician to operate the device, the practice may not be in the market for it. Consult your state board of medicine, health care attorney, or bona fide consultant for advice on which provider is able to provide which treatment in your particular state.

- *Negotiate the purchase of capital equipment to maximize specials and deals.* Find out if the vendor has to meet a specific quota based on the end of the quarter or the end of the fiscal year. This is important because the vendor representative is often able to discount the piece of equipment or offer additional items that would boost the value of the contract. However, do not get caught up in a “show special” at a conference if you are not 100% ready to purchase the piece of equipment. Ensure that you have the maximum warranty possible, reviewing possible exclusions. (For example, does a warranty transfer if the piece of equipment is sold to another owner?)

Compare pricing of a similar or competitive device that performs the same procedures to ensure the pricing you are presented with is the best available. Spell out details about warranties, financing, rebates, returning products, cooperative advertising, and shipping/handling. If you cannot get all of the items you want included in the deal, ask to speak with the device company’s supervisor, or the highest possible level of authority. The manager (or the manager’s manager) may have the power to authorize a deeper discount and include more of the items mentioned above. Do not neglect using a third-party consultant who negotiates capital equipment on behalf of medical practices. These third-party negotiators know the best deal possible and are able to negotiate on your behalf. As already mentioned, your greatest opportunity to negotiate is at the end of the quarter or year-end when the vendor is eager to meet a quota.

Confirm, in writing, the exact interest rate for the device, as well as monthly payment amounts (principal and with interest). Confirm whether you are being charged service fees, warranty costs, fees for both parts and labor for machine breakdowns, and any early payoff fees if the practice chooses to do so in the future. Once the deal is set, put everything in writing. If that sales representative leaves, an email goes missing, or someone misrepresents a verbal agreement, the thing that you were promised may no longer be available when you move to redeem it.

- *Finally, do not be afraid to walk away from the deal if it does not make sense to purchase.* If you are not able to get exactly what you want or need, you are better off not making the purchase in the long run.

Part III

Internet University

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12 Website Optimization

Steven Fruchter

Abstract

This chapter takes a deep dive into the world of “search engine optimization” for your website that actually works. You can be the best plastic surgeon, but if no one sees you, they will never know.

Keywords: website, responsive design, mobile-friendly ranking, Google algorithm, SERP, Search Engine Result Page, sitemaps, redirect, conversion rate optimization, AMP, Accelerated Mobile Pages

12.1 Introduction

When you think of website optimization, your first thought might be “it’s all nonsense.” You might have worked with multiple marketing agencies claiming to provide search engine optimization (SEO), which is the process of affecting the visibility of a website or a web page in a search engine’s “natural” or unpaid “organic” search results. After seeing continuous limited results, you might have deemed SEO nothing more than snake oil. I do not blame you. The acronym “SEO” is overused and misused by those claiming that they can do it if you trust them and pay them, and then you get zero results. When done right, you will never need black hat practices (aggressive SEO tactics aimed at cheating algorithms) to gain the results you want.

If you are a doctor practicing in any country, other than Russia (their main search engine is Yandex.com) or China (their main search engine is Baidu.com), the majority of your organic search traffic will come from Google’s algorithm, so that will be our focus. Google’s algorithm tries to find the best result or the best answer to a user’s query, and then it ranks the results in order of what it deems the best by utilizing over 200+ Google-determined signals. In this chapter, we will focus on the main factors that will boost your overall Google rank across your entire website.

For a quick overview of how this is accomplished, let’s use a Tummy Tuck procedure page on your website as an example. Start by writing an in-depth and unique procedure page. Then structure it properly (a key step), add images and formatting, and finally submit it to Google’s index. Google’s index goes, “Wow! Look at all this new, unique content I’ve never seen before! Let’s see how it performs with a query that it matches.” Normally this is where the story ends. However, because we took the extra effort to mark it up properly and structure the content as a “conversion funnel” (personalized path to engagement with your product), your result on the Search Engine Result Page (SERP) will include more information and will be more compelling than others. With an engaging search result, more potential patients will click on it, and more of those people will click on another link on the page they land on, going deeper into your website instead of bouncing back to Google. Now the algorithm thinks to itself, “Wait a second. This content seems relevant to people searching for this topic. This might be the best result for this query. Let’s keep trying it out.” This is how you can get on the first page, stay there, and move up to the top. The strongest path to great SEO is simply being better than others at leveraging Google’s tools. This works better than trying to game the system or using black hat strategies like purchasing links that ultimately can do a lot of damage to your business.

12.2 Hosting of the Website

Everything starts with the foundation of your website. This part can get technical, but you should be aware of it because it drastically affects your ranking in Google.

12.2.1 Speed of the Website (Load Time)

Google is constantly pushing people to have the fastest page load-times possible. On April 9th, 2010, Google publicly announced that they were including a new signal in their search ranking algorithms: site speed. Site speed reflects how quickly a website responds to web requests. Not only is site speed a ranking factor, but the faster your page loads, the lower your bounce rate and the higher your conversion rates. People will be more likely to stay on your site and contact you for a consultation rather than resuming a Google search. On July 9th, 2018, Google rolled out their new “Speed Update” algorithm in mobile search results as a search ranking factor. Prior to that, speed was used as a factor in ranking, with an exclusive focus on desktop searches.

You can see the average time it takes for Google to download a page on your website by visiting your Google Search Console, which displays a graph that usually indicates something like 800 to 1000 milliseconds. Above this graph is another one showing how many pages Google crawls through on your website daily. It is best to reduce the time Google takes to download a page to about 100 to 200 milliseconds. For comparison, it takes roughly 400 milliseconds to blink your eye. When your website is at these download times, Google will be able to index your entire website in the time it takes to crawl through only a few pages of most websites.

You can speed up your response by using actions such as *caching*, *minifying* all of your files, and using *lossless compression* on your images. You can also *Gzip* all files via the web server, leverage browser caching, ensure *asynchronous JavaScript file loading*, and other server-side tactics.

- *Caching* is a must. Caching saves a temporary copy of the page after all of the programming and database hits have been executed on your web server so that your web server can serve static files. Basically, it serves prebuilt pages. Without caching, each request dynamically executes and builds the pages each time, which is very slow and costly.
- *Minifying files* makes them as small as possible by removing unnecessary spaces, commas, other unnecessary characters, comments, formatting, and unused code. Then the small files are merged together, and variable names are made to be as small as possible, such as changing a variable “\$counter” to be just “\$c.”
- Plastic surgery websites tend to use a lot of high-quality images with large file sizes. To accommodate these file sizes, you should use *lossless compression*, which is a compression technique that decompresses data back to its original form without any loss. The decompressed file and the original are identical, so you can shrink your images down to, say, 70 to 80% of their original size and not lose any quality.
- Enabling *Gzip compression* on your web server compresses all files before being sent.
- *JavaScript asynchronous loading* is simply another technical setting, but it is very important. Try to have your JavaScript files run asynchronously, or they will stop the entire page from loading until they finish executing. Browsers have to build a Document Object Model (DOM) tree by parsing Hypertext Markup Language (HTML) before they can render a page. If your browser encounters JavaScript during this process, it must stop and execute it before it can render a page. Basically, if JavaScript files are set synchronously on your site, the rest of the page can be delayed by JavaScript processing.



Fig. 12.1 The lock symbol showing that the website is encrypted.

12.2.2 Secure Socket Layer Encryption

On August 6th, 2014, Google publicly announced they would give a ranking boost to websites that served files using encryption via Secure Socket Layer (SSL). When you go to your bank's website, Google, or Facebook, a little green lock icon appears next to the uniform resource locator (URL) or the address you type after "www." (see ► Fig. 12.1). The green lock means the website is encrypted and secure. An encrypted website not only gets a ranking boost, but also facilitates "HIPAA" compliance. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides data privacy and security provisions for safeguarding medical information if a patient were to send you their personal information via your contact forms.

12.2.3 XML Sitemaps

Extensible Markup Language (XML) sitemap is a roadmap of your website in the computer's language that tells Google of existing pages to crawl through and when those pages were last updated. Without a sitemap, Google's robots will try to find every link on their own. By providing them an XML sitemap in your Google Search Console, you are guiding the Google robots by literally providing them a map to your website. Some people create a page that is visible for humans to read with links to the main pages on their website. Regardless of what any salesperson tells you, this is *not* a sitemap. Create an XML sitemap, and submit it to Google without question.

12.2.4 The 301 Redirect

A 301 redirect tells web browsers and search engines that a web page or site has been permanently moved to a new location. It is equivalent to providing the post office with a forwarding address when you physically move from one address to another. This HyperText Transfer Protocol (HTTP) status code, which is the equivalent of a conversation between the web server and the browser, is often overlooked or misunderstood and has been the number one destroyer of a website's link equity or ranking power.

Often, when rebuilding their websites, people change their URL architecture. For example, an original URL might be <https://growthmed.com/breast-augmentation/>, and it changes to <https://growthmed.com/procedures/breast/breast-augmentation/>. This change is a good one, unless you forget to do the proper 301 redirect that tells Google the old URL is now at the new URL location. Without the 301 redirect, Google will continue to send people to the old URL, and they will receive a 404 status code, meaning the page no longer exists. In reaction to receiving the 404 status code from queries, Google simply removes the page from their index, and the ranking power that the page previously had is wasted. If they did a 301 redirect, then 90 to 99% of the ranking power from the old URL would be passed to the new URL, and Google would update their index indicating the new address of the page.

Some people have attempted to save time by creating a “301 wildcard redirect,” meaning any page that hits a 404 is sent to the homepage of the new website. The flaw in this fix is that because the new site’s content is completely different, Google sees this as a different page and dismisses it, essentially throwing it in the trash as well. When you update your URL architecture, create a one-to-one 301 redirect from all your old URLs to the new ones so you do not lose your ranking.

Lastly, try to avoid long 301 redirect chains, meaning you 301-redirect to a new URL, which then 301-redirects to a new URL that again 301-redirects to a new URL, and so on. Not only is this slow with multiple web requests made before reaching the final destination, but you also lose link equity along the redirect path.

12.3 Design

There is much more to web design than making it visually pretty. You want to build your website so that it is viewable on any device. The best way to do this is to build your website as a *responsive design*. Google has been adjusting its algorithm ranking based on how mobile-friendly your website is, and it will continue to do so. Once a potential patient lands on your beautiful website, you want to keep the potential patient’s attention so they do not immediately *bounce* (push the back button and return to Google). Lastly, your end goal is to have a potential patient visiting your website call your office or submit a contact form on your website. A successful site design continuously guides them along those paths.

12.3.1 Responsive Design

Responsive website design is a relatively recent innovation to create websites with an optimal viewing experience, easy reading, and navigation with minimal resizing, panning, and scrolling across a wide range of devices (from desktop computers to mobile phones). Google recommends responsive website design because it:

- Makes it easier for users to share and link to your content with a single URL.
- Helps Google’s algorithms accurately assign indexing properties to the page rather than needing to signal the existence of corresponding desktop/mobile pages.
- Requires no redirection for users to have a device-optimized view, thus reducing load time.
- Saves resources when Googlebot crawls your site. For responsive web design pages, a single Googlebot user agent only needs to crawl your page once, rather than crawling multiple times with different Googlebot user agents to retrieve all versions of the content. Maximizing crawling efficiency indirectly helps Google index more of your site’s content and keep it appropriately fresh.

12.3.2 Mobile-Friendly Ranking

On April 21, 2015, Google released their mobile-friendly algorithm update. This update was called *Mobilegeddon* by researchers because it was going to give a ranking boost to all mobile-friendly websites over non-mobile-friendly ones. Researchers feared that rankings would change across the board, because Google basically said, “If your site’s pages aren’t mobile-friendly, there may be a significant decrease in mobile traffic from Google Search.” Mobilegeddon was one of the first updates for which Google gave the

public a full explanation of what was happening, while it was happening, and how long it would take to roll out. This unprecedented disclosure preceding an algorithm update triggered a fear of noncompliance and resulted in most websites immediately converting to be mobile friendly. Consequently, the release of the algorithm did not have the big negative impact that researchers feared.

Google defines a mobile-friendly web page as one in which the text is readable without tapping or zooming, tap targets are spaced appropriately, and the page avoids displaying unplayable content and horizontal scrolling. ► Fig. 12.2 illustrates the difference between a mobile-friendly and a traditional design.

This mobile-friendly update was more than just an algorithm update; it represented a cultural shift for Google because everything after this update revolved around the mobile device. On March 26, 2018, after a year-and-a-half of experimentation, Google announced that they were starting to migrate sites to mobile-first indexing. Google's crawling, indexing, and ranking systems have typically used the desktop version of a page's content, which may cause issues for mobile searchers when that version differs from the mobile version. In mobile-first indexing, Google will use the mobile version of

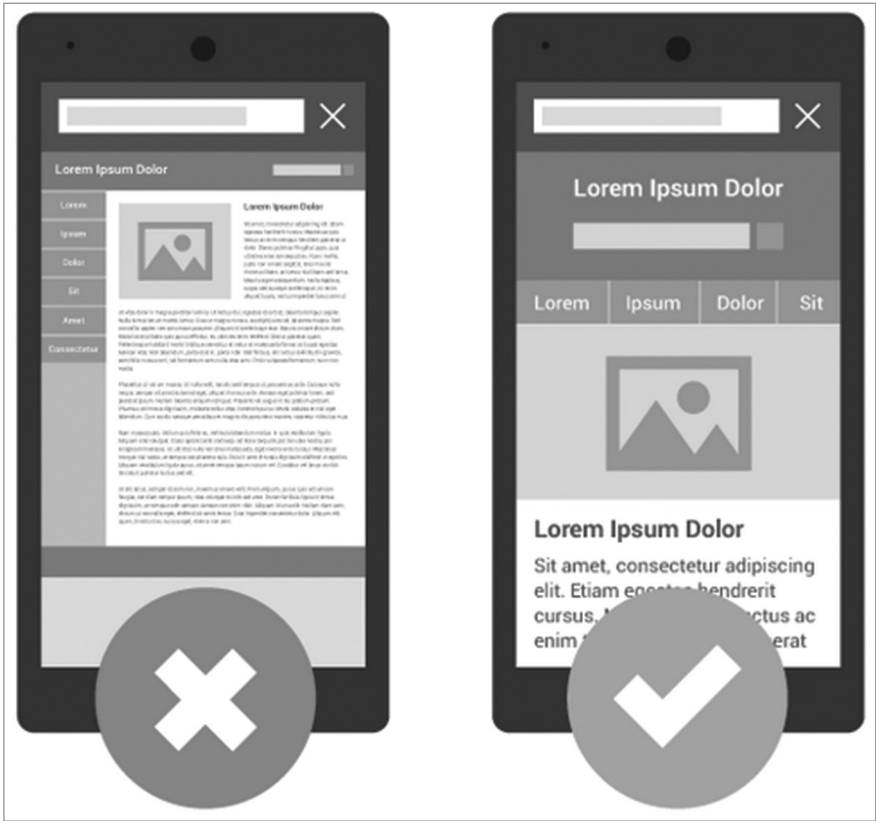


Fig. 12.2 Google posted this to show the difference between mobile-friendly and traditional design.

the page for indexing and ranking to better serve the user base, which are primarily mobile searchers. Google still has one single index that they use for serving search results. They do not have a separate “mobile-first index,” but they will be using the mobile versions of content now.

12.3.3 Bounce Rate

A *bounce* occurs when someone visits your website and leaves with no interaction. Your bounce rate is the percentage of visitors who bounce off your site. Google Analytics for your website can show you the bounce rate for your overall site, segments of your site, and specific pages. If a user searches for “breast augmentation,” sees your result in the organic listing, clicks on your result, but then clicks the back button to go back to Google’s search result page, it might signal to Google that the user did not find a relevant answer to their query on your page.

On March 23, 2016, Andrey Lipattsev, Search Quality Senior Strategist at Google, said in a question and answer session that the three main ranking factors are “content, links, and RankBrain.” *RankBrain* is Google’s name for a machine-learning artificial intelligence system that is used to help process its search results. RankBrain’s main purpose is to improve search results for users by better understanding their search intent. If a user clicks on your page and leaves without any interaction and does not stay for more than a minute, it could signal to RankBrain that your site is not what they are looking for. As a result, RankBrain might not give that page a high ranking. Lowering your bounce rate will signal to Google that the user successfully found the answer to their query on your page. Google’s primary goal is to rank pages that deliver the best result/answer to a user’s query/question at the top.

Following are a few ways to lower your bounce rate: First, improve the readability of your content by avoiding huge chunks of text. Next, break your text into manageable pieces using subheadings, bullet points, images, videos, and bolding words. Also, ensure your font is big enough to be easily read. If your text is too small for people to read it easily, they will quickly bounce. Avoid pop-ups, opt-ins, and advertisements above the fold and provide the user with what they were looking for right away. Finally, beware of paralysis of choice. Overwhelming a visitor with too many options makes it harder for them to find the information they’d like, causing them to bounce. Keep your website as minimalistic as possible by not overwhelming them with options; simplify navigation, sidebars, and calls to action.

12.3.4 Conversion Rate Optimization

Conversion rate optimization is a system for increasing the percentage of a website’s visitors who take a desired action on a web page. Your desired action is to have your website visitors call your practice or fill out a contact form to get more information about a procedure and become your patient.

A simple strategy to do this is to make your phone number visible at all times by including it at the top, usually the right-hand side of your website. As a website visitor scrolls down the page, your navigation should scroll with them, always appearing at the top of the screen. The same goes for contact forms. Usually, you will place a contact form in the sidebar of your website, but the contact form should lock into place so that it is always visible to the users as they scroll down the page. The website visitors should not have to search around your website for a phone number or a contact

form. It is also good practice to include a call to action on all pages to promote contact and link to the contact page. Make it as easy as possible to contact you at all times. When visitors have a split-second desire to ask you a question or inquire about a consultation, an additional click can spell the difference between a new patient and another bounce.

The more pages a visitor views, the more likely they are to contact you. To get visitors to navigate internally to other parts of your site, utilize calls to action related to your photo gallery interlinking monthly specials or other procedural pages. Enticing the potential visitor to spend more time on your website helps lower your bounce rate, which helps raise your site's Google search rank.

12.3.5 Accelerated Mobile Pages

The web development community is already moving on to a new mobile format called Accelerated Mobile Pages (AMPs). As mentioned, Google and Google users love fast-loading websites, so Google became a big advocate of an open-source framework geared toward web pages designed to load near instantaneously. This framework ultimately became AMP. It accomplishes instantaneous page loads by allowing you to only use a stripped-down version of HTML to display content. You cannot use your own JavaScript, and you must use their off-the-shelf JavaScript library and extensions to do certain tasks. AMP is very restrictive because it wants to be as lightweight as possible to ensure efficient load times for the user. Also, Google will cache these pages, so when a user clicks on an AMP result from their search result page, they will load your AMP result from within their own servers. This means AMP results will not reach out to your server to get the page—Google will just serve it instantly to the user, which makes it even faster.

Google started displaying AMP results within their mobile search results for their “Top Stories” section in February 2016, and by September 2016, Google started linking to AMP content in the main mobile search results area. AMP links in Google search are identified with an icon. As seen in ► Fig. 12.3, a small lightning bolt symbol indicating an AMP result page appears next to the domain in the first result on the Google mobile SERP.

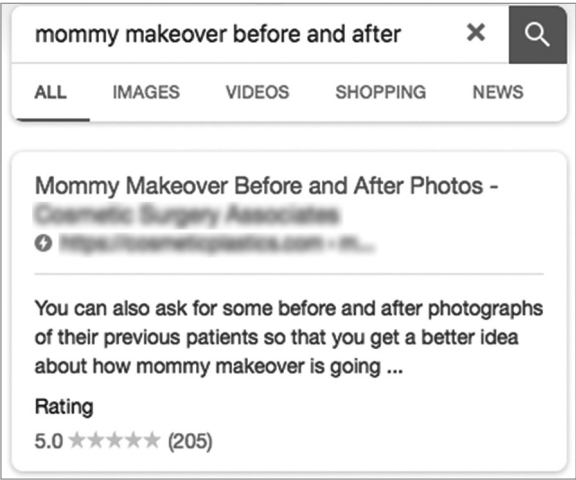


Fig. 12.3 Google mobile Search Engine Result Page displaying AMP result first.

The AMP framework looks and sounds wonderful, but it also creates problems. Although users get the result immediately, they tend to bounce and never go to your actual website, resulting in bounce rates of nearly 99% for AMP-enabled pages. To get users to go from the AMP page to your website, the design of your AMP result page, including header, navigation, and calls to action, should look as alike as possible to your normal mobile website. If the user feels like they are still on your website, you can utilize similar tactics explained above to guide them to click to another page within your website, bringing them back into your conversion funnel, and getting them to contact you for a consultation.

12.4 Content

12.4.1 Google Panda Algorithm Update

February 2011 was the initial release date of the Google Panda algorithm update. The change aimed to lower the rank of “low-quality sites” or “thin sites,” particularly “content farms,” and return higher-quality sites near the top of the search results. Google continued to release updates to the Google Panda algorithm about once a month for the next few years, culminating in rolling the Panda algorithm into their main algorithm in July 2015.

If the majority of your website has duplicate or thin content, Google is more likely to penalize your entire site, even removing your site from its index altogether. Previously, Google used to roll out monthly updates, so after fixing the problem, there was a lag time before you could see traffic flow improve. Now, Google’s updates are continuous, so the algorithm catches your website corrections much more quickly.

The Panda algorithm is notable because businesses that relied on black hat tactics (cheating) and/or enjoyed good positions in Google despite not having the good content took catastrophic hits to their business, resulting in a massive freak-out. Companies that were once generating tens of millions of dollars or more per month went bankrupt. The most common black hat strategy was to generate as many web pages as possible in an attempt to fill up Google’s index to maximize matches to queries. The black hat tactics included autogenerating pages, creating very thin content (i.e., a 120-word paragraph), and duplicating pages from other people’s websites. Other tactics included copying and pasting one sentence from one website and another sentence from another website, but changing stop words (a, an, and, the, etc.) to fool their algorithm into thinking the content was unique. Black hat strategists even created filters for categories, tags, and date archives on blogs to redisplay the same content with different URLs. For the most part, these tactics no longer work. Steer clear of these strategies. Most websites that have these issues and take the time to correct them, quickly see their pages start to rise in Google rank—sometimes overnight!

Duplicate and Thin Content Penalty

Duplicate content comes in two forms: external and internal. External duplicate content is copied from an external source, like another website. A Breast Augmentation procedure page copied from another website and placed on your website will be considered duplicate content. Internal duplicate content refers to identical content appearing on more than one page of your website. An example is blog posts that are copied and

placed under different parent pages to generate a new URL, providing absolutely no new content or value, which Google also has to crawl through.

Thin content is exactly what it sounds like. A page with only one image or a Breast Augmentation procedure page with only a single paragraph provides little value for the potential patient. Some websites break up the Breast Augmentation procedure content into one- to two-paragraph parts that are placed onto separate pages. The thinness of the content results in low-quality pages. On the other hand, if all those pages were merged into one, the resulting content could have been an impressive 1,500+ word in-depth page that Google would consider relevant to the topic.

In-Depth Unique Content

Google wants in-depth, unique content focused on one topic that remains relevant for months or even years. They will reward you handsomely if you supply it. To get an idea of in-depth, unique content, think about a Wikipedia page, which provides a comprehensive description about a single topic. The page is broken up into sections similar to this chapter. People writing a Wikipedia page are not trying to think about keyword density, how many times to write a keyword on the page, or what relative keywords they should use. If you write a 1,500+ word procedure page all about the Vaginal Rejuvenation procedure and structure it properly, you will cover all the things that black hat SEO tries to shortcut its way into without the risk of hurting your rankings (see ► Fig. 12.4). A legitimate, high-quality article also provides those key words—it just takes work.

12.4.2 Structuring a Page

There are many elements to a page, but our central aim in page structure is to send every signal possible to Google indicating what the page is about. Your URL, title of the page, and main heading tag (called an “H1”) should all reference the same thing. The topic of a page about Rhinoplasty should be 100% clear, with zero ambiguity. The URL should say “rhinoplasty,” the title of the page should say “rhinoplasty,” the main heading H1 should say “rhinoplasty,” and all of the content, including images, should be about rhinoplasty.

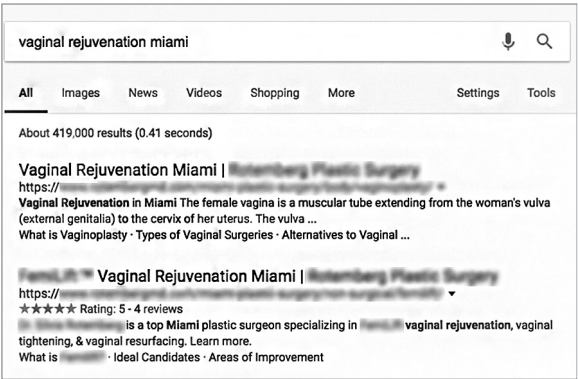


Fig. 12.4 In-depth content structured properly ranks.

URLs

URL, which stands for Uniform Resource Locator, is usually located at the top of your web browser where you can type the address to your website or specific web page (e.g., <https://growthmed.com/>). You want to utilize a hierarchical URL structure over a flat URL structure. The path segment of hierarchical URL structure is organized by subcategories, whereas a flat URL structure is no more than one level deep. For example “surgical procedures” could have “body” and “face” subcategories or subdirectories, providing search engines and people with a semantic understanding of how your site’s content is structured (e.g., <https://growthmed.com/surgical/face/rhinoplasty/> vs. <https://growthmed.com/rhinoplasty/>). Hierarchical URL structures make it clear that a page is about a specific surgical procedure or about a specific body part. Some people had used flat URL architectures with the false assumption that if the path segment was closer to the domain, it would signal a higher importance of the page and result in a higher Google ranking. They branched all pages directly off the root of the domain. However, if everything is important, nothing is important. Just as content should be structured for optimal search engine understanding, your URL architecture should be structured for Google’s understanding.

Meta Titles

Meta title refers to the title of a web page, which is not necessarily visible in the content. A web page’s meta title is displayed for the Google search result. A tabbed browser shows the title of the page. (Tip: For a page that has a long title, hover your mouse over the tab to see the entire title; see ► Fig. 12.5.) The title tag in its raw HTML format looks like this: `<title>Hi This Is A Title For A Page</title>`. The abundant online advice about how to structure the title tag of your page mostly consists of obsolete strategies that no longer work or are just bad ideas.

Title tags should be simple and short; the primary keyword should appear at the beginning of the meta title. Beyond about 50 to 60 characters long, title tags will get truncated when displayed on Google’s result page. Google will rewrite bad titles for you, so please do not go crazy with keywords in titles. Make sure every page has a title tag with a unique title. The name of the procedure you are targeting should be mentioned first, followed by the city you are targeting, and finally the name of your practice for branding purposes. For example, if you are going after VASER in Denver, CO, your title should simply be: “VASER in Denver, CO | GrowthMed Plastic Surgery.” (See ► Fig. 12.6 for an example.)

After your result for VASER is on the first page on Google, which lists the top 10 results, add descriptive words to the title that may help the click-through rate (CTR) for your result. For example, you could make it “VASER in Denver, CO - Cost - Reviews | GrowthMed Plastic Surgery,” or “VASER in Denver, CO (Insiders Guide) | GrowthMed Plastic Surgery,” etc.

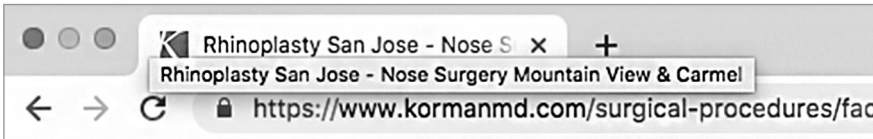


Fig. 12.5 Tooltip: Hovering over tab to display entire meta title.

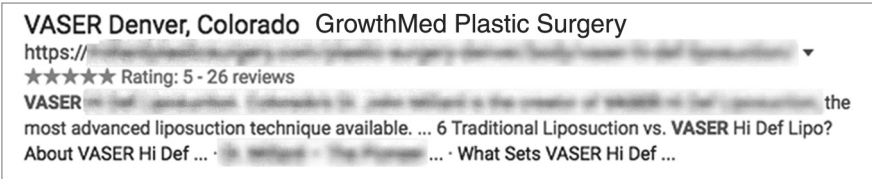


Fig. 12.6 Meta title displayed on Google’s Search Engine Result Page.

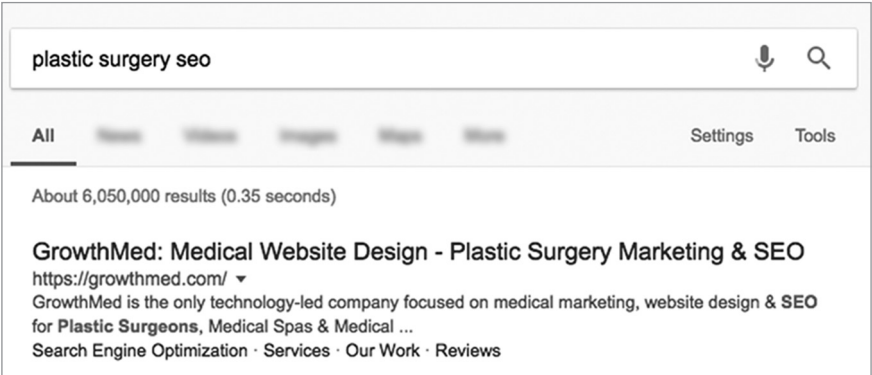


Fig. 12.7 Meta description of GrowthMed.

Meta Descriptions

Meta description is the description people see on Google’s result page after they type in a query. They can read what the page is about and decide if they want to click on it. A raw meta description tag looks like this in HTML: `<meta name=“description” content=“Natural Plastic Surgery group specializes in cosmetic surgery of the face, breast, and body.”>`. Although meta description tags do not have a big impact on search engine rankings, they are extremely important in gaining user click-through from SERPs. These short paragraphs are a webmaster’s opportunity to tell searchers exactly what is on the given page. Think of the meta description as an advertisement for the page. Include your keywords in the page description, since Google will bold them when people search for them. Limit the length to 135 to 160 characters, and do not put your keywords at the end, since Google will truncate the last characters exceeding the limit. Do not duplicate your meta descriptions. Finally, add a call to action at the end. For example, you can end with “click here to read more.” (See ► Fig. 12.7 for an example.)

Headings

A good article is broken down into sections, or a table of contents, similar to a Wikipedia page (or this chapter). Structure your text with headings and subheadings by using the proper HTML markup. HTML is what the Google spiders/robots read when they are crawling your page. For these spiders/robots to understand what the

Contents [HIDE]

- 1 What is a mommy makeover?
- 2 Who should get a mommy makeover?
- 3 Types of procedures
 - 3.1 Short incision facelift
 - 3.2 Breast lift
 - 3.3 Breast reduction
 - 3.4 Breast augmentation
 - 3.5 Tummy tuck
 - 3.6 Liposuction
- 4 What to expect following a mommy makeover
- 5 consultation
- 6 what is the cost of a mommy makeover?

Fig. 12.8 Table of contents for a Mommy Makeover procedure.

page is about and how each section of your content relates to the rest of the page, simply use HTML heading tags. The most important one for a page is the <H1> tag because it signifies what the page is about. If the main topic of the page is Mommy Makeover, then “Mommy Makeover” should be the only <H1> tag on the page. The next section might be “Types of Procedures Included,” which should be an <H2> tag. Under that section, you might have subsections like Breast Augmentation, Tummy Tuck, and Liposuction that would be wrapped in <H3> tags. Notice how the structure is topically similar to a table of contents. With this structure, a robot can follow and understand your content and how it is structured. (See ► Fig. 12.8 for an example.)

Body Content

This is how you make the page pretty and easy to read. First rule: Eliminate big blobs of content. People simply avoid large blocks of text. Remember, we want to make the site a valuable asset and a good user experience for the potential patient. To determine whether or not your site is a good user experience, Google assesses elements like images, videos, bolded words, bulleted lists, and tables. These elements keep the web visitor on your page instead of bouncing back to Google and also show Google what the page is about so that relevant Google searches become likely to land on your page.

Images are great, but Google's spiders struggle to understand what the image is, which is why the ALT attribute was created. The ALT attribute is part of the tag in HTML that is used by screen readers, but Google also uses it to understand in plain text what the image is about. This is a great place to emphasize what the page is about, but do not overdo it with keywords because this can lead to a penalty.

Google can detect when content is emphasized through bolding, bulleted lists, tables of information, and boxes around important content. Google can potentially use this emphasized content in what are called *featured snippets*, in which a user enters a question at the top of the page, and Google pulls data from your web page to answer the question (see ► Fig. 12.9 for an example). This will become even more important as more people use voice search.

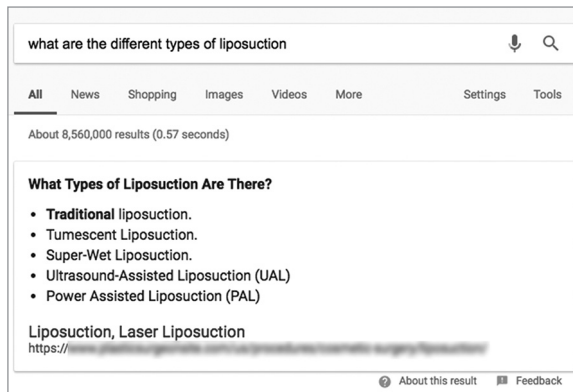


Fig. 12.9 Featured snippet in Google's Search Engine Result Page.

12.5 Schema Markup

Schema markup is a code (a shared vocabulary) that webmasters can use to structure metadata to help search engines understand the content being published. Schema was created initially in 2011 by a collaboration between Google, Microsoft, Yahoo, and Yandex. The markup tells search engines exactly what the data on your web page means in a structured way.

Schema can be used to define hundreds of elements to help a search engine understand the information displayed on a web page. It is an open-source initiative, and the vocabulary continues to expand. Schema.org provides an example: `<h1>Avatar</h1>` tells the browser to display the text string "Avatar" in a heading 1 format. However, the HTML tag does not indicate what the text string means. "Avatar" could refer to the movie or refer to a type of profile picture, making it difficult for search engines to intelligently display relevant content to a user. If you have a web page about the movie Avatar, including a page with a link to a movie trailer, information about the director, and so on, your original HTML code might look something like this:

```
<div>
  <h1>Avatar</h1>
  <span>Director: James Cameron (born August 16, 1954)</span>
  <span>Science fiction</span>
  <a href="https://growthmed.com/avatar-trailer/">Trailer</a>
</div>
```

Now let us add Schema markup:

```
<div itemscope itemtype="http://schema.org/Movie">
  <h1 itemprop="name">Avatar</h1>
  <span>Director: <span itemprop="director">James Cameron</span> (born August 16,
  1954)</span>
  <span itemprop="genre">Science fiction</span>
  <a href="https://growthmed.com/avatar-trailer/" itemprop="trailer">Trailer</a>
</div>
```

Search engines can now understand not just that `https://growthmed.com/avatar-trailer/` is a URL, but specifically that it is the URL for the movie trailer.

Medical Website Design - Responsive Plastic Surgery Web Design ...<https://growthmed.com> > Medical Marketing Services ▾

★★★★★ Rating: 5 - 10 reviews

GrowthMed specializes in elegant and creative responsive Plastic Surgery website designs. Custom optimized **Medical website designs** for conversions.

Fig. 12.10 Result on Google's Search Engine Result Page displaying review stars from Schema on the web page.

12.5.1 Search Engine Result Page Optimization

Adding Schema markup to your HTML improves the way your page displays in SERPs by enhancing the rich snippets that are displayed beneath the page title. For example, you could have a testimonial written on your web page, but to Google it is just a bunch of words. Implementing Schema enables Google to identify the review, the author of the review, the date it was published, and its star rating. Google can now interpret the total number of reviews on your web page, and their average score; information it can display when your web page shows up on Google's search result page. (See ► Fig. 12.10 for an example.)

Under the title in ► Fig. 12.10, the green URL has an arrow and "Medical Marketing Services" in plain English instead of the remainder of the URL, which would include forward slashes like the following: *<https://growthmed.com/medical-marketing/website-design/>*

Google can display the URL like this because Schema explains how the website is structured.

You can use Schema to tell Google you are a plastic surgeon and to identify your office physical address, your specialty procedures, your procedure price ranges, your phone number, your social network profiles, your company logo, your patient testimonials, and so on. Schema can enable you to sculpt your organic Google search result to look similar to the paid advertising displayed at the top of the page. Once Schema takes a listing to prominence in SERPs, visibility usually greatly improves the CTRs to your website. Combine this with tactics for lowering your bounce rates and you have an amazing combination to rocket to the top of Google's rankings.

Less than one-third of Google's search results include a rich snippet with Schema.org markup. Schema offers a huge opportunity—few things in SEO can move the dial as quickly as a strong Schema strategy.

12.6 Links

Links or URLs are at the heart of the Google algorithm. In January 1996, Larry Page and Sergey Brin, the founders of Google, had begun collaboration on a search engine called BackRub (later renamed Google), named for its unique ability to analyze the "back links" pointing to a given website. The founders had their "AHA!" moment when they realized that if they utilized links as votes for websites (PageRank algorithm), their search engine would provide superior results over all the other major search engines at that time including Yahoo!, Lycos, Infoseek, AltaVista, and Ask Jeeves. The number of links paired with the anchor text (text describing what the link is for) indicated the preferred result for given keywords based on searchers' votes.

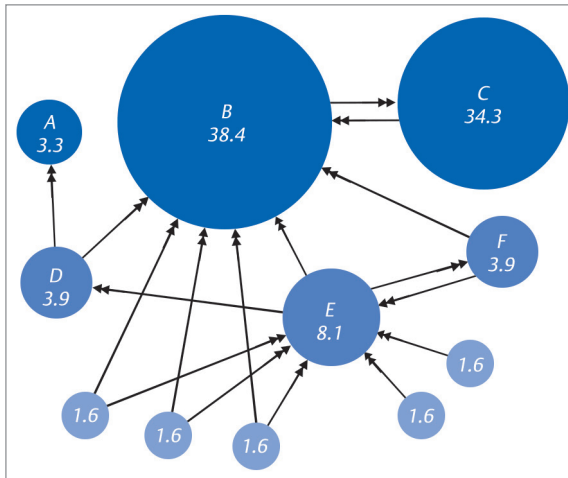


Fig. 12.11 PageRanks for a simple network, expressed as percentages. (Google uses a logarithmic scale.) Here, Page C has a higher PageRank than Page E, even though there are fewer links to C; the one link to C comes from an important page and hence is of high value.

12.6.1 PageRank Algorithm

PageRank (PR) is an algorithm used by Google to rank websites by their search engine results. PR was named after Google cofounder, Larry Page. PR measures the importance of website pages (► Fig. 12.11).

PR uses its vast link structure, reflecting the uniquely democratic nature of the web, as an indicator of an individual page's value. In essence, Google interprets a link from page A to page B as a vote, by page A for page B. But Google looks at considerably more than the sheer volume of votes or links a page receives; it also analyzes the page that casts the vote. Votes cast by pages considered "important" weigh more heavily, making those other pages "important."

PR is not the only algorithm used by Google to order search engine results, but it is the best known and the first one the company used.

12.6.2 Paid/Unnatural Links

Ever since people understood the role links played in Google rankings, people have tried to manipulate the system with black hat tactics, which is very much a cat-and-mouse game. Google tries to block black hat tactics; if they catch you doing them, they penalize the website you are trying to rank. The following is provided by Google to describe what they view as unnatural links: *"Any links intended to manipulate PageRank or a site's ranking in Google search results may be considered part of a link scheme and a violation of Google's Webmaster Guidelines. This includes any behavior that manipulates links to your site or outgoing links from your site."*

Following are examples of link schemes that can negatively impact a site's ranking in search results:

- Buying or selling links that pass PR, such as exchanging money for links or posts that contain links; exchanging goods or services for links; or sending someone writing pertinent content containing the link in exchange for a "free" product. Excessive link exchanges ("Link to me and I'll link to you") or partner pages created exclusively for cross-linking.

- Large-scale article marketing or guest posting campaigns with keyword-rich anchor text links.
- Using automated programs or services to create links to your site.

Additionally, unnatural links (those not editorially placed or vouched for by the site's owner on a page) may violate Google's guidelines. Here are a few common examples:

- Text advertisements that pass PR.
- Advertorials or native advertising where payment is received for articles that include links that pass PR.
- Links with optimized anchor text in articles or press releases distributed on other sites.
- Low-quality directory or bookmark site links.
- Keyword-rich, hidden, or low-quality links embedded in widgets that are distributed across various sites.
- Widely distributed links in the footers or templates of various sites.
- Forum comments with optimized links in the post or signature.

The best way to get other sites to create high-quality, relevant links to yours is to create unique, relevant content that naturally gain popularity in the Internet community. Creating good content pays off: Links are usually editorial votes given by choice. The more useful content you have, the greater the chances someone else will find that content valuable to their readers and link to it.

12.6.3 Google Penguin Algorithm Update

Google launched the Penguin Update in April 2012 to better catch sites deemed to be spamming its search results by buying links or obtaining them through link networks designed primarily to boost Google rankings.

Google's war on low-quality content started with the Panda algorithm update, and the Penguin update was an extension and addition to the arsenal for fighting this war. Penguin was Google's response to the increasing practice of manipulating search results (and rankings) through black hat link building techniques. The algorithm's objective was to gain greater control over and reduce the effectiveness of a number of black hat spamming techniques.

By better understanding the types of links websites and webmasters were earning, Penguin worked to ensure that natural, authoritative relevant links rewarded the websites they pointed to, while manipulative and spammy links were downgraded.

If your site's rankings have taken a hit since Google Penguin, you probably need help, since your traffic from Google will continue to diminish and your website may be completely removed from their index and not show up at all. You will need to identify bad links and either have them removed or "disavow" them. You can disavow links through Google's disavow tool, which allows you to upload a file with URLs and domains that you have links from, saying: "I don't want these links to count."

If they place a manual penalty on your website for having an excessive amount of unnatural links, you will need to request websites that linked to you unnaturally to remove those links. Record those emails. If they do not remove the links then you need to disavow the links and email Google to explain all of the steps you have taken to correct the problem. After you complete the two-part action of removing the problematic elements and essentially asking Google for forgiveness, they should remove the penalty and re-index your website.

Google can identify unnatural links by seeing an exact phrase that appears in a high number of links, all of which attach to your site at almost the same time. For example, you may have 100 links from usually low-quality websites where the anchor text all says the same thing.

Example of a link where the anchor text says “Breast Augmentation”:

```
<a href="https://growthmed.com/procedures/breast/breast-augmentation">Breast Augmentation</a>
```

The example above shows a link that goes to your breast augmentation page. The anchor text with the keywords you should get “votes” for is “Breast Augmentation,” meaning you are trying to rank for the term “Breast Augmentation.” Having an unnatural amount of people from low-quality website linking to you all at once with the exact same phrase is unnatural on the web. It can potentially work in the short term, but if you are caught, your entire website can be penalized all at once. Just do not do it!

12.7 Google Local Business Page

A Google local business page is essential for local SEO. Claim your business and enter all the information requested, such as categories, store hours, photos, and description. Next comes reviews. Have a procedure in place to get as many reviews as you can from your patients and you will win at the local SEO game. Local results appear for people who search for businesses and places near their location. The local SEO map pack portion appears in position 0, at the top of the page, now. They are shown in a number of places across Google Maps and Google Search. For example, Google will try to show you the nearby practices that you might like to visit if you search for “CoolSculpting San Jose.” In ► Fig. 12.12, Google uses local results to suggest some options.

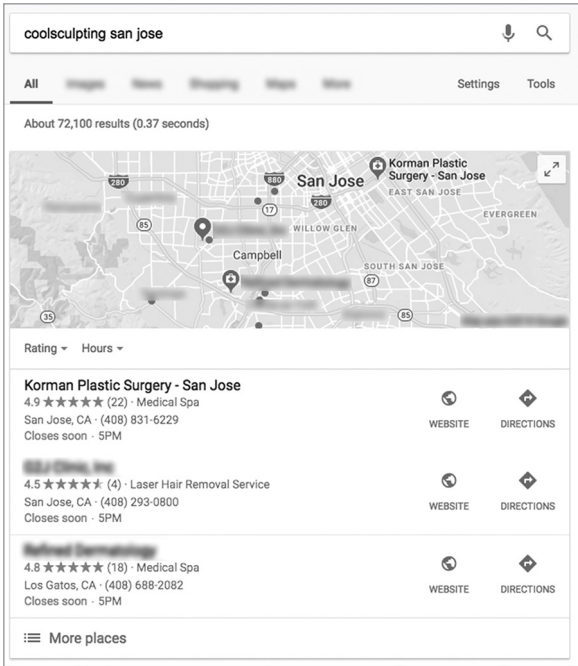


Fig. 12.12 Google My Business listing for local SEO.

12.7.1 Local Optimization

The process to verify and claim your Google Business Page usually takes about a week. Google will send you a postcard with a secret code to ensure you are actually at the specified location. Once this is done, you may find that your business does not appear for relevant searches in your area. To maximize how often your customers see your business in local search results, take advantage of Google My Business by adding the relevant information discussed next. Providing and updating business information in Google My Business can help your business's local ranking on Google and enhance your presence in Search and Maps.

Local results are based primarily on a combination of relevance, distance, and prominence to identify the best match for searches. For example, Google algorithms might decide that a business farther away from the patient's location is more likely to have what they are looking for and rank it higher than a nearby business. Fill out your local business phone number in your website's correct URL. Choosing the proper categories for your business is another big part of your local ranking. Having fewer, specific categories is preferable. For example, two categories that reflect your practice, such as Plastic Surgeon and Medical Spa, are preferred over choosing five, such as Plastic Surgeon, Medical Spa, Laser Hair Removal, Hand Surgeon, and Medical Facility. Once again, complete all requested information, like store hours and wheelchair accessibility. Upload pictures in all allotted areas, like the office interior, the office exterior, and the staff. The more you fill out, the better for your SEO. When writing the description about your business, use good keywords regarding surgeries you perform and your local city, but do not overdo it; the text should feel like natural speech. Lastly, your position in web results affects local search optimization, so SEO best practices also apply.

12.7.2 Google Reviews

Google review count and score are factored into local search ranking: More reviews and positive ratings will improve a business's local ranking. The rate at which you garner reviews is directly correlated with how quickly you rank. Encourage your patients to include the keywords that you want to rank for in the review. For example, if you want to rank for CoolSculpting San Jose, ask patients to include the procedure and location when filling out their testimony.

Quite a few review services, such as Yelp, Facebook, HealthGrades, Vitals, offer multiple options for patients to fill out reviews. Do not guide your patients to these. Focus your energy on getting Google reviews, as they are easier to acquire and will greatly increase your visibility on Google Search. The others will not provide this benefit.

12.7.3 Google My Business Posts

Google Posts are almost like "mini-ads" or "social media posts" that show up in Google search in your Google My Business listing (in the Knowledge Panel and on Google Maps). You can include a picture and an ad for a special service you are offering that week, or anything you want to say about your business. This useful, targeted information will help your business stand out. This content can help a Google Business Page show up in a search for keywords that match the text inside a Google Post for that business. The first 100 characters are what show up in the Knowledge Panel. Make these characters count, and make sure your sentence does not get cut off.

12.8 Conclusion

This chapter has provided the nuts and bolts of optimizing a website from scratch and implementing the tactics that will help you get noticed by potential patients. As should be abundantly clear, online marketing is fraught with a number of potential pitfalls, but at the same time, it represents an enormous opportunity to connect with new patients and grow your practice. When done right, online marketing is an asset you can bank on. Spend time finding a trustworthy vendor-partner while your site is being built, as well as “after the sale.” Your practice’s ongoing promotion is crucial to generating a healthy stream of web-based leads.

If you want your website to be a true success, your vendor-partner cannot “set it and forget it.” As long as your vendor-partner evolves with the constant changes, you will do great. Just like any other company, when Google offers a new feature, they want people to adopt it as quickly as possible. If Google releases something new, an ideal vendor-partner will implement new strategies along Google guidelines before everyone else does. Google tends to give some benefit to webmasters that adopt their new features. Using them before your competitors will help put you on top. Choose a knowledgeable technology partner and not one that is just a good talker. Action speaks louder than words in this industry.

13 How to Make and Post Effective Videos

Heather J. Furnas, Abby A. Karcz, and Matthew Schulman

Abstract

Plastic surgeons can use videos for academic purposes, to market their practice, to increase patient care efficiency, and to improve staff training. A good video takes planning. After establishing an objective and a target audience, planning should be done with the use of a storyboard and a script. Investing in good lighting and sound is more important than the quality of camera. Some videos can be done live and posted directly, and others require editing. Either way, the goal is to hook the audience within seconds. Video performance can be measured, depending on purpose, by social media platform analytics, indirectly on Google analytics, amount of time saved in teaching patients, staff training outcomes, and for peer-reviewed video articles on Altmetrics. A single video can be posted across multiple platforms for greatest exposure. A picture may be worth a thousand words, but a video is worth even more.

Keywords: video, video making, film, film editing, marketing, social media, Facebook, YouTube, Instagram, lighting, camera, sound, microphone

Editors' Note

In the first part of this chapter, Dr. Furnas and Ms. Karcz present an overview of video making; in the second part, Dr. Schulman focuses on creating videos for social media.

13.1 How to Make and Post Effective Videos

Heather J. Furnas and Abby A. Karcz

Why do some videos go viral? The key is to hook the viewer within seconds by eliciting emotion, providing entertainment, piquing curiosity, and giving information. They are visually appealing and well-paced. The best ones tell a compelling story that the audience cannot leave before it ends. In this chapter, we will discuss why videos can help your practice, how to plan them, and what elicits enough interest for people to watch till the end. Although surgeons are not Hollywood directors, we can still learn to grab people's attention with a clever, funny, entertaining, educational video. Throughout this chapter, the person in front of the camera will be referred to variously as *talent*, *subject*, and *you* (the reader).

13.1.1 Planning Begins with Establishing an Objective

Plastic surgeons have several reasons to take an interest in creating their own videos. The academic surgeon can use videos to:

- Instruct residents.
- Demonstrate a surgical technique for a lecture.
- Illustrate a peer-reviewed article.
- Promote your just-published article on social media.
- Upload a webinar or a podcast.

The private practitioner can use videos to:

- Introduce the surgeon, staff, facility, and procedures on a practice website.
- Market through patient education.
- Introduce a new technique or treatment.
- Show the public behind the scenes, such as marking a patient or in surgery.

All plastic surgeons can use videos to save time and improve staff and patient education with:

- Information about a procedure.
- Steps for preparing for surgery.
- Postoperative instructions.
- Patient safety topics.
- Staff training topics.

13.1.2 Your Audience

Before production, define your target audience. They should determine the topic, style, length of video, and distribution platform. A video is only valuable if it appeals to that audience. You can survey your patients regarding the platforms they use and the types of posts they favor, as Sorice et al describe.¹ Alternatively, you can simply look up the demographics of the different social media apps you use to determine the best platform for your target population. For example, patients wanting lip augmentation are likely to be women aged 18 to 35, and they are most likely to be on Instagram.² At the time of this writing, Instagram limits video length to 60 seconds, so you can now edit accordingly.

13.1.3 Video for Marketing

By 2021 consumer internet traffic is expected to make up 82% of all internet video content, a jump of 9% in 5 years.³ Platforms like Facebook and Twitter favor videos over photos, expanding the video-posting user's reach. Videos are a marketing goldmine for the following purposes:

- Videos' superior search engine optimization (SEO) attract more visitors to a website.⁴
- Videos embedded on the landing page increase the contact-form-completion rate by up to 80%.⁴
- Adding video to email newsletters can double, even triple, the click-through rate.⁴
- Online purchases increase by 64% when featured products appear in a video.^{5,6}

Videos are only successful when they resonate with your audience, so give them what they want. What you think is interesting (all the accolades and awards to talk about...) may not interest your target audience. Make your video about your viewers. Intrigue them, help them, and entertain them. Answer their questions and demystify plastic surgery. They may not understand the importance of your qualifications, but they will develop trust in you.

13.1.4 Improving Office Efficiency with Videos

What information do you recite to patients multiple times a day?

- Descriptions, risks, benefits, and alternatives of a procedure
- Preop preparation
- Postop instructions

- FAQs
- How to use skin products after laser resurfacing
- How to choose an implant size

Now that you have chosen one of these topics, how can you make your video memorable? The video one of the authors (HJF) created, *Labiaplasty Explained*, masquerades as a cooking show and uses a cookie dough model to explain the anatomy and demonstrate the two most common procedures. (Available at: <https://www.youtube.com/watch?v=Bzrs5Uc-LhU>.) Patients see it before their consultation, and others involved in their care can view it at any time. The consultation can be streamlined to address the patient's individual concerns without spending time explaining all the points already made in the video. Patients can sign a line added to their surgical consent indicating that they have watched the designated informative video(s).

13.1.5 Staff Education

Staff training takes time and is often ignored or inadequate. Repeated errors and poorly implemented policies and procedures can lower employee job satisfaction and lead to surgeon frustration. Videos can standardize teaching new staff and keep current staff skills sharp. Good training topics include photography, how to answer the phone, how to greet a patient, how to handle a difficult patient, how to prep an exam room, and... how to make a video. Staff education videos should be added to your onboarding checklist and can become part of your policies and procedures. Once you have uploaded them to your YouTube channel, you can set them to private viewing—that way your competition's staff will not graduate from your own onboarding program.

13.1.6 Setting Goals to Guide Content

As you come up with content ideas, include “evergreen” videos, which have an unlimited life span. The labiaplasty cookie dough video is evergreen, whereas the promotion of an upcoming event is deciduous. A balance of enduring and expiring videos plays well on social media.

To decide on an idea for your next video project, think of a practice objective. What do you want to improve? What metric are you going to use? What is your deadline? If you want to increase your next year's breast augmentation volume by 8%, videos that might help you achieve this goal include:

- A series on information about breast augmentation surgery.
- A video of patients describing what the procedure has done for them.
- An intraoperative view of the surgery itself.
- A Q&A video (or a series) answering common patient questions.

Post a video regularly and widely: on your YouTube channel, across your other social media platforms, in your blog, and in your newsletter. You might post a quick single-scene video every week or post an edited multiscene video once a month. To define how you will achieve your goal, develop three to five key results that are measurable and have a deadline. Examples include:

- Increase July's website visits referred from social media by 10% over January.
- Increase the number of website contact forms filled out in July by 10% over January.
- Increase Q3's consultation numbers by 10, compared with Q1.
- Decrease the website's bounce rate by 5% over Q1.

Track the social media metrics to see the performance of your video (discussed further). If one video performs better than the others, create more like it.

Following are two more examples of how to utilize videos in your practice:

1. For academic purposes, demonstrate your surgical technique for an article submitted to a peer-reviewed journal. (Example: Trim Labiaplasty. *Plast Reconstr Surg Glob Open*. 2017;5(5):e1349. Available at: https://journals.lww.com/prsgo/Fulltext/2017/05000/Trim_Labiaplasty.8.aspx)
2. For marketing purposes, to see two more new patients on a clinic day without increasing office hours, create an educational video about abdominoplasty for patients to view prior their consultation. (Example: "Tummy Tuck Explained with Pizza Dough," Available at: <https://www.youtube.com/watch?v=2CWVdivOXrc>)

13.1.7 Narrow the Topic

Covering too much information in one video overwhelms the viewer, who may leave. Deliver one take-home message per video, and no more than three. For ideas, think of common target audience questions:

- How much does a breast augmentation cost?
- How is a facelift performed?
- What is the difference between saline and silicone gel implants?

After you have answered several questions about a single surgical procedure, you will have a video series. Write your ideas down and put them on a video-making calendar. Brainstorm with your staff. They are the ones answering the phones, so ask them periodically: What does a lay person want to know?⁷

13.1.8 The Videography Team

You can either outsource production to a professional videographer or use resources within your practice. Hiring a professional may be best for a large project, such as a feature practice video on the homepage of your website. The cost of hiring a videographer ranges from \$1,000 to \$10,000. In addition to searching the Internet for local companies, you can enter a request for a videographer on Productionhub.com, place an ad on Craig's list's "Gigs," or go to Thumbtack.com and type "video production" in the search bar. After finding a few options, ask each candidate to show you *recently* completed video projects. Older projects may have been created by a now dispersed team. Consider the video's purpose and value to the practice as you balance quality with each company's quote.

In-house video creation is the best way to build content. Costs are lower, and you can upload social media videos directly. Creating formal, edited videos requires greater skill and familiarity with film editing software. Provide them with the resources, equipment, and time to watch online editing software tutorials.

13.1.9 Optimizing Equipment

Good lighting and adequate sound are far more important than camera quality. Film editing software allows some correction, such as stabilization, color grading, and sound amplification, but nothing will compensate for bad lighting and poor sound quality. Thoughtful advanced planning and good equipment can prevent an afternoon wasted by filming unusable footage.

Lighting

The most common arrangement is three-point lighting (► Fig. 13.1).⁸ Each of the three lights plays a role. The *key light* is the brightest of all and is the dominant light on the subject. The *fill light* reduces the shadows created by the key light. The fill light should be less bright than the key light; if it is of equal brightness, the subject can appear flat. The *backlight*, sometimes called the *hair light*, enhances three-dimensionality by creating a visual separation between the subject and the background. The backlight does not need a diffuser, since it will not create shadows on the subject's face.

Professional lights, when strategically placed, minimize shadows and avoid distractions. Soft boxes placed over the lights minimize glare, and reflectors reduce shadows. A light with a broad surface hits the subject more evenly, so the bigger the light's diameter, the better the result.

If you have access to windows, position the camera so the natural light hits the subject from the side. If the subject faces the window during filming, the footage may be overexposed.⁹ Do not set up the shoot with the window or the key or fill light directly behind the talent,⁸ and the backlight should also not appear directly behind the talent. Instead, position it above or below the camera frame.

Common lighting problems include shadows from overhead fluorescent lights, underexposure, overexposure, and inadequate light power. A backlight that is too strong overpowers dim key and fill lights, resulting in an underlit face and a bright hair halo.⁸ Additionally, a warm light blends poorly with a cool light, so avoid mixing color temperatures. When shooting outdoors, direct sunlight can be too harsh, so try to set up the shoot in the shade.⁹

Whatever the lighting conditions, the videographer should eliminate shadows on your face.

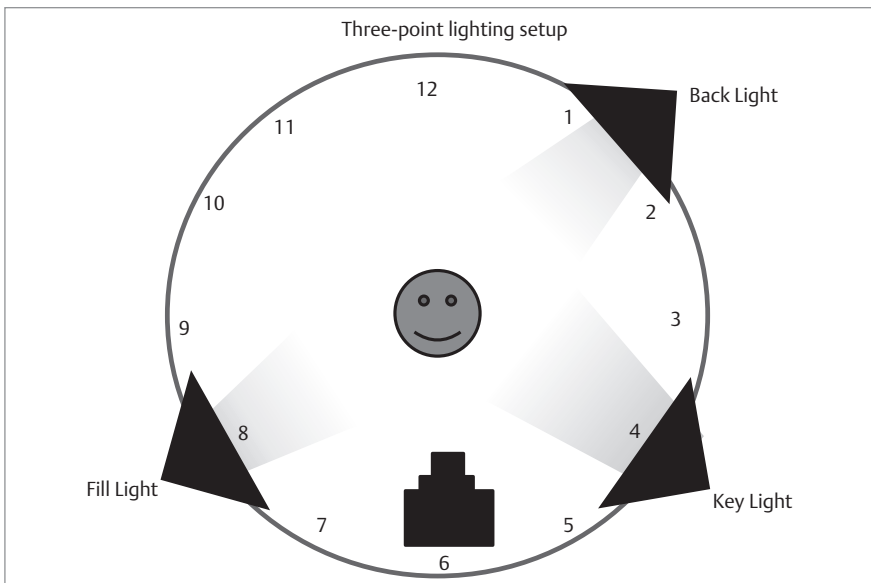


Fig. 13.1 In the three-point lighting system, the key light is brightest, the fill light removes shadows, and the back light improves three-dimensionality by separating the talent from the background.

Microphone

The microphone in a laptop, desktop, or smartphone may be sufficient for less formal spontaneous videos filmed at close distance, but for Facebook or Instagram Live and edited videos, a lavalier microphone ("lav mic") will provide clearer, more audible sound. The small microphone is clipped onto the talent's collar or neckline, and the cord can be passed beneath the dress or jacket, where it will not be seen.¹⁰ The talent should wear attire that will accommodate both the clip and the transmitter pack. The transmitter pack can be placed out of sight on the chair or in a pocket if the subject is standing. Test the mic after it is clipped in place before the camera rolls.¹⁰

Camera

A video's purpose may dictate what type of camera you use. Social media applications allow direct-from-smartphone video uploads, and the quality is excellent. Although the video quality of smartphone is continuously improving, the quality of other cameras is improving as well. Both digital single-lens reflex (DSLR) and mirrorless camera (compact system camera [CSC]) offer higher quality footage than does a smartphone,^{11,12} with options a smartphone does not offer, like zooming in and out without losing pixel density, for a more formal, edited video. Whatever camera you use, keep a second charged battery on hand for a DSRL or mirrorless camera and a charger, mophie, or power bank for a smartphone. Do not let a dead battery end your filming session.

If you are using a smartphone, clean the camera lens to avoid blurriness. Orient a smartphone horizontally to allow landscape shooting, unless you are shooting for a social media app designed for vertical orientation (► Fig. 13.2). Once you have set up



Fig. 13.2 For this live demonstration, the smartphone on the left is oriented horizontally on a tripod for Facebook Live, and the smartphone on the right is held vertically for a brief Snapchat post. For filming on YouTube, the camera should be horizontal, and for Instagram, it should be vertical and set at "square."

your scene, stabilize the camera with a tripod. A wheelchair or a skateboard on a smooth surface can be used as an *ad hoc* dolly if the videographer is moving with the subject.

Teleprompter

The talent can speak extemporaneously, but “um’s” and disorganized ideas are distracting. Memorizing takes time, and mistakes can result in multiple retakes. On the other hand, reading from a piece of paper, a laptop, or a cue card can sound stilted, and the loss of eye contact can create a distance from the viewer. The best solution for a lengthy script may be a teleprompter. Newscasters, politicians, and others giving important speeches rarely look down at a paper script, maintain eye contact with the viewer, and speak without verbal tics. Video bloggers (“vloggers”) and web personalities are increasingly using them, even when streaming live.¹³

Green Screen

A green screen is a solid green background positioned behind the talent during filming. With the appropriate software, the film editor can replace the background with another image, either static or moving, so that the talent can appear to be speaking in front of a practice logo, a building, or a series of lecture slides. The videographer should position the person roughly 9 feet away from the green screen backdrop. This way, shadows fall off before hitting the backdrop and any green light reflected onto the subject is greatly reduced.^{14,15}

13.1.10 Video Duration

Optimal length varies by topic, purpose, and distribution channel. A video about a new surgical technique for an audience of plastic surgeons might last 5, 8, even 10 minutes, but 2 minutes is the optimal sweet spot for most lay viewers.¹⁶ Consequently 2 minutes is a good target for your YouTube and website videos. Optimal and allowed video durations vary by social media platform. At the time of this writing, Twitter limits video duration to 140 seconds, and Instagram maxes out at 60 seconds. Facebook videos perform best in the range of 60 to 90 seconds. Facebook recommends their Live videos last a minimum of 20 minutes, and up to 4 hours, to expose the user to more viewers, increasing the chance of interaction.^{17,18}

YouTube video time limits range from 15 minutes to 20 hours, depending on your default settings. The ideal duration depends on the video’s purpose. A didactic video, a feature movie, or a webinar will be longer, but videos aimed at the patients should be around a 2-minute duration.¹⁶

13.1.11 Storyboards

Measure twice, cut once. This aphorism is as apt for videos as it is for surgery. Prior to filming, plan each scene with an outline or storyboard. A storyboard consists of a series of visuals, often drawn like cartoons, to define the sequence of shots. Each shot is drawn on a card. Uncomplicated videos can be done on text-only storyboards without drawings.

Unless your video is a simple single scene, a storyboard facilitates communication with the video team. Begin with a list of all the ideas, steps, and notes. Include explanations like what is happening in a scene and details like camera angles, special effects, music, and sound. Think about varying the background, using props, and incorporating action.⁷ After determining the scenes to film, arrange their order, the physical arrangement of the characters, and the placement of the physical props. The drawings show what is in the foreground, what is in the background, how many chairs are in the camera frame, and where that dagger is hidden. Plastic surgery is a visual field, so show rather than tell whenever you can. Change scenes, incorporate movement, and move back and forth between two scenes to keep the video interesting.⁷ End with a call to action, like visiting your website or signing up for a newsletter. When you are happy with your storyboard, review it with your team, get feedback, and make changes.¹⁹

If you are planning to post your video on a specific social media platform, keep each site's guidelines in mind as you create your storyboard; a view of female nipples may result in suspension of your account on some platforms.

For longer, edited videos, shoot B-roll footage to enhance a feeling or illustrate what a speaker is saying. Suggestions for B-roll footage for a plastic surgery practice include the doctor walking down the hallway, the doctor scrubbing, the doctor in surgery, a patient being escorted to an exam room, a receptionist greeting a patient, and a patient coordinator speaking on the phone. Look at news broadcasts to see how they pull footage off the shelf to illustrate what the reporter is saying. B-roll film typically has no spoken lines, so no microphone is needed. Instead, music or voice-overs are added during the editing process. Set up good lighting, and start shooting. When you are done, archive the footage so it is accessible for future projects.

Working out the details on a storyboard before filming can save a lot of production time.

13.1.12 Scripts

One in five viewers leaves a video after 10 seconds,²⁰ so the beginning must be compelling. Unless there are no written or spoken words, write a script. The better the writing, the better the script. Tell a story, elicit emotion, entertain, use humor, be positive, and appeal to your audience's needs and desires.²¹ Cut out empty words, clichés, and tangents. As Shakespeare said, brevity is the soul of wit.²² Finally, end with a call to action, like signing up for a newsletter, visiting the practice website, or downloading a free ebook requiring an email address.

13.1.13 Title

A great title may be the only thing attracting a viewer to your video, so spend time composing those precious few words. Draw out emotion. For example, focus on the emotional outcome of a procedure rather than on the procedure itself.²² (Which video would you want to watch: "How a Silicone Gel Breast Augmentation is Performed" or "Breast Augmentation: The Secret to Self-Confidence in a Summer Dress"?) Include keywords in your title to improve searchability, even if you sacrifice a clever double-entendre.

13.1.14 Video Consent

Anyone featured in a video should sign a consent, whether employee, colleague, or patient. Plastic surgery societies such as ASPS (American Society of Plastic Surgeons) and ASAPS (American Society for Aesthetic Plastic Surgery) can provide consents that have been vetted by their committees and staff. The consents should include all media channels where the content may be distributed (web, social media, publications, etc.). Whether you use a society's version or create your own, run it by your legal team for approval. Make sure you have "consents signed" on your production day checklist.

13.1.15 Filming

Start with a production day checklist:

- Equipment check:
 - Camera
 - Two camera batteries
 - Two memory cards
 - Lights
 - Microphone
 - Other props:
 - Teleprompter
 - Green screen
- Review outline/storyboard with participants
- Obtain video/photo consents

After you are organized and ready, set up your lights, tripod, and camera. The videographer needs to position the talent in the camera frame. If you are the talent, and you are speaking directly to the audience, look directly into the camera. If you are answering a series of questions as if you are speaking with an interviewer (even if you are not), look just to one side of the camera. A professional videography team will ask you to look at the interviewer asking you questions. When the talent looks a few degrees off center to one side, the viewer has a sense of being a fly on the wall listening to the conversation. Think about how movies are made. The actors rarely look directly at the camera unless they are speaking directly at you. Check out news shows, documentaries, and interviews to see how the pros do it. Sometimes they are looking right at you, and sometimes they are looking at someone else (or seeming to).

The videographer can set up two cameras, one to capture the speaker's profile, and the other to capture a frontal shot, but such details are beyond the scope of this chapter. That said, you can shoot the same scene more than once, moving the camera from a frontal position to a profile view with different takes of the same scene. Showing different angles can make a talking head more interesting, as you will see on news broadcasts and talk shows.

Viewers are drawn in by a confident speaker, and on-camera physical cues can convey that sense of confidence. When seated at a table, put your hands on its surface, not on your lap. To appear engaged, sit on the front-third of your chair and hold your shoulders back (► Fig. 13.3). Sitting back can convey a lack of interest or energy.

Check that the lav mic is not picking up rustling of clothing. Turn off all telephones and the HVAC; close windows and doors to the outside if there is audible automobile or air traffic. If a loud truck or a siren passes by, retake the shoot.



Fig. 13.3 The talent should sit in the front-third of the chair with shoulders back to convey confidence.

When you are in position, have the videographer scrutinize your tie, collar, hair, and necklace clasps. This appearance check is not about vanity; an errant necklace clasp or a crooked tie will distract your audience, and they may miss your central message. After you have checked the microphone, you are ready to roll.

During filming, the videographer should constantly check that your face is in focus and in good position within the camera frame. In surgery, the action should appear in the center of the camera frame. Pay constant attention to lighting, positioning, and sound. Operating room (OR) lights can white-out the focus of the action; the surgeon's head or arm may obstruct the view; and surgical staff may inadvertently say something that does not belong on camera. Although we all know patients bleed during surgery, the aesthetics are not good on camera, so minimize the show of blood, pass off bloody laps, change gloves frequently if needed, wash the patient's skin, and frame the field with clean towels before filming. For the lay audience, you only need to film a brief part of the operation, and explain what you are doing. A video for surgeons should be edited so you do not waste your audience's time with a tedious dissection or repetitive suturing.

As you film, replay each shot in the view screen to check the quality, light, and sound. Retake the shoot as needed.²³ Check the background and change it if it is distracting. If people are talking nearby or milling about while you are recording, move to a quieter location.⁷

Clothing

Black or white clothing can appear harsh, and small stripes and linear patterns can create a wavy geometric pattern with older cameras.²¹ A suit or ensemble in a lighter charcoal or navy shows well on camera, and women may want to consider wearing a

jewel-toned dresses. Professional female newscaster favor form-fitting clothing and avoid wearing jackets, which can look disproportionately large on camera. A white clinical coat communicates your expertise, so invest in a fitted white coat, and have it pressed and steamed.¹⁰ Keep in mind where you will clip your lav mic and place the transmitter pack as you plan your wardrobe.

For full-body shots, women should inquire in advance if they'll be standing or seated. When seated, a skirt or dress moves up the leg, which can distract the viewer, taking away from the speaker's message. To keep the viewer focused on what you are saying, wear a below-the-knee skirt or dress, or wear pants.¹⁰

Hair

Use a hair product to flatten down flyaway hair. If nothing else is available, lotion serves the purpose in an emergency.¹⁰

Makeup

In our society, we expect women to wear makeup on camera, but men should also do so. In particular, men on camera are increasingly wearing concealer.⁹ Before applying makeup, wash your face to remove the oil, and avoid shiny moisturizer so the lights do not reflect on camera. Makeup can be a little heavier than you might usually wear. Women might consider subtle false eyelashes, depending on the look you want. Experiment and film practice takes of yourself with a smartphone.¹⁰

Jewelry

Wear pearls, discreet jewels, or simple hoops. Avoid bangly, dangly, shiny earrings that reflect and distract. Remove jewelry that comes into contact with the lav mic (click, bang, boom).

Glasses

Avoid wearing glasses. If you must, wear antiglare lenses set in frames that show your entire eye. Women who wear glasses may specifically want to overdo their eye makeup, since the lenses will dampen the eyes' definition. Use eyeliner, and this might be the time to consider subtle fake eyelashes.⁹

Speech

Rehearse aloud about ten times before recording for a natural delivery without um's and uh's. Even if you use a teleprompter, rehearse a few times for flow. Enunciate clearly. Speak slowly, calmly, and use a lower register. When nervous, many people shift to a higher pitch and speak too quickly. Pretend you are speaking with a nonphysician friend, and use simple, lay terms.

For footage that will be edited, when the camera starts rolling, look at the camera with a smile, wait a moment, and then begin speaking. That moment of space allows the editor to cleanly cut the scene without cutting off part of a word or starting the scene with your face in a half smile or with your eyes closed. Similarly, at the end of a scene, wait a moment without saying anything. Just keep smiling. The film editor will love you.

Do not end a sentence in an up-voice¹⁰ ; the film editor can't cut there, and that segment may have to be rejected. In an interview, the interviewer and interviewee should avoid talking over one another. Often video content is based only on the talent's responses, and the interviewer's questions are excluded; the interviewer, often a member of your staff interviewing a patient, must be trained not to speak over or interrupt the patient. If the subject answers the question, and the interviewer cuts in with "That's great," the answer can't be isolated, and the entire take may need to be rejected. Do more than one take, and study the playback each time. Make necessary changes until everyone is satisfied.²¹

A film editor runs through the footage, chooses little pearls, and strings them together. A pearl may precede and follow inconsequential verbiage. If the speech is clear, no one is talking over anyone, and there is enough silent space before and after that precious passage, the film editor can dissect it out and discard the uninteresting words. Think about the editing process as you film so you will remember to give the film editor those valuable spaces.

For casual videos, turn on your smartphone camera and start talking. Talk about what you know and show your personality.⁷

You

Be authentic and relatable. Avoid jargon and pompous language, and do not be condescending. Keep it simple. Share stories and get personal. And smile—always remember to smile.¹⁰

13.1.16 Live Videos

Live videos hit the scene in 2016 and have risen in popularity ever since. Social media users prefer live videos over regular posts, and both Facebook and Instagram make it easy to go Live directly.²⁴

Plan ahead—live video is a one-shot deal. There is no chance for editing or retakes.¹⁰ Organize what you are going to say, including a beginning, a middle, and an end. Before going live, check all the equipment, its functionality, and the script. Begin the live video session by introducing yourself and what you are going to say, and then say it. During the broadcast, pose questions, and ask viewers to leave answers in the comments section. In addition to recruiting a camera person, assign a second person to monitor and relay incoming questions so you can answer them.

As you approach the end, summarize what you said. Finally, end with a call to action: sign up for a consult, a newsletter, a free ebook, or something else enticing. Well before showtime, build hype and promote the time and date on your website, newsletter, and on social media. You can also embed a video on landing pages.

A long live video attracts greater engagement, but you can make one that lasts just 2 to 20 minutes.¹⁰ Even if you do not get much initial traction, you can hope for more viewers over time. If you post regularly, you can create your own regular show, and your followers will know when to tune in.

You can do a one-person-show live broadcast in a hotel with a smartphone, a tripod, and a ring light. Hold a smartphone slightly higher than eye level with the camera tilted slightly toward you. Looking too acutely up or down at the camera can be distracting to the viewer. Maintain eye contact with that tiny lens on your smartphone as if you were looking into a single listener's eyes.²¹

If you are using your laptop camera, raise the laptop so you are not looking down at it. Position yourself so you do not have a window or a light behind you.¹⁰ If you are walking or moving about, keep your phone steady so the camera remains in focus; otherwise the viewer can become disoriented.

13.1.17 Editing

An edited video has a different feel from a live video, just as a live television show differs from a production. The film editor's job is to attract and maintain the interest of the audience by cutting scenes, speeding up others, adding Ken-Burns zooming movement to static images, and adding titles, captions, and sometimes music.

If you are the editor, after you have filmed all the scenes on your storyboard, upload the footage and start editing. If you are posting on social media from a smartphone, you can edit with apps that allow you to splice clips, do time lapse, and put on watermarks. Smartphone apps like Magisto and Adobe Premiere Clip offer features like clip adjustments, text overlays, and filters. Before you post, choose a good cover image.⁷

Editing software products like iMovie, Final Cut, and Adobe Premiere Pro allow you to create longer, more dynamic videos. iMovie, which comes preloaded on Apple computers, is easy to learn, and free classes are offered at your local Apple store. Final Cut and Adobe Premiere Pro are costlier and require more training, but they have more editing features.

Back up video clips onto the cloud and/or a hard drive. Avoid using your computer's hard drive to store footage, since uncompressed digital video consumes space, and computer hard drives can fail.²³

Opening

If you start your video with a static title in front of a static background for 1 second... 2 seconds...3 seconds..., you will lose viewers. Avoid plodding, generic, computer-generated music. Pique the viewer's curiosity, create movement, and get to the point.

Speeds

Many activities can be effectively shown at double or quadruple the normal duration. Speeding up the video allows you to post a lot of content in a short time. Include just enough footage to suggest an action. If you are closing a wound, you might show the beginning in double-time, edit out most of the closure, and end the shot with tying the last knot, again in double or quadruple time.

On the other hand, if a voice-over explanation takes longer than an action, use slow motion.

Transitions

Sometimes a movie works well without transitions between film clips, but in some instances the result can be jerky, like following a clip of a distance shot directly with a clip of a close-up. "Transitions" in editing software programs allow scene changes to flow. If you do use them, use cross-dissolve between scenes. It may be tempting to choose athletic transitions, with gymnastic flips and turns, but they can distract and annoy your viewers. Study the transitions in movies and on TV, and check out how the pros do it; it is mostly cross-dissolve.

Music

Music can warm up and energize a video, but it can drown out speech if it is too loud. Louder music is perfect for footage with captions and no words, but as soon as there is audible speech, reduce the sound so the speech is readily audible. For complicated explanations, silence may be best. You can split a music track and intersperse the parts throughout the video during nonspeaking sections. Fade in and fade out to avoid abrupt transitions.

To find music that you can use without violating copyright laws, look at software programs, like iMovie, which include generic and royalty-free music. There is one downside: the music can sound, well, generic. Online sites like Getty Images Music (<https://www.gettyimages.com/music>) sell music for commercial use. Choose a term for the feeling you hope to create for your viewers, like “happy” or “positive,” then type that into the search bar. (Make sure to read the usage rights.) If you are a musician (or you know one), your music may sound unique and fresh.

Subtitles

Most of your patients are watching video on their mobile devices instead of a desktop.²⁴ Because silent mode is private and less distracting to others, most mobile users (and 85% of Facebook video viewers) watch videos in silent mode.²⁵ Your audience will potentially grow if you write subtitles, which have the additional advantage that they serve as metadata, increasing the probability people will find your video.

13.1.18 Uploading and Posting

Facebook, Twitter, or Instagram videos tend to be less formal than some of the ones posted on YouTube, which invites longer videos. For fun-themed marketing, consider Instagram, but for patient education, think of YouTube. Videos need to load quickly, and YouTube provides the fastest load times.⁷ Since YouTube is the second-biggest search engine, behind Google, pile on the metadata. As you upload your video, YouTube will ask you to enter keywords. A keyword can be a phrase, not just a word. Think of what people type into their search bar.

13.1.19 Measuring a Video's Performance

An individual social media app's analytics can tell you how many times a video has been viewed, liked, and shared on a social media platform. Google Analytics show the impact social media has on driving viewers to your website and can identify trends in website referrals from social media channels. Check if those metrics are going up since you started posting more videos.

To measure how a video helps increase the reach of a peer-reviewed article read, take a look at its Altmetrics. Altmetrics (<https://www.altmetric.com/>) calculates an Altmetric Attention Score based on the online attention an article receives through social media, blogs, news articles, and reference managers such as Mendeley. The type of source is weighted to reflect its reach: the weighted value of news articles is 8; blogs, 5; Wikipedia, 3; Twitter and Google Plus, 1; LinkedIn, 0.5; and Facebook and YouTube, 0.25.²⁶

Let us take a look at the Altmetrics of an article published in *Plastic and Reconstructive Surgery* by one of the authors (HJF).²⁷ In the month of publication, the author created a 30-second talking-head video. Later in the month, it was followed by another

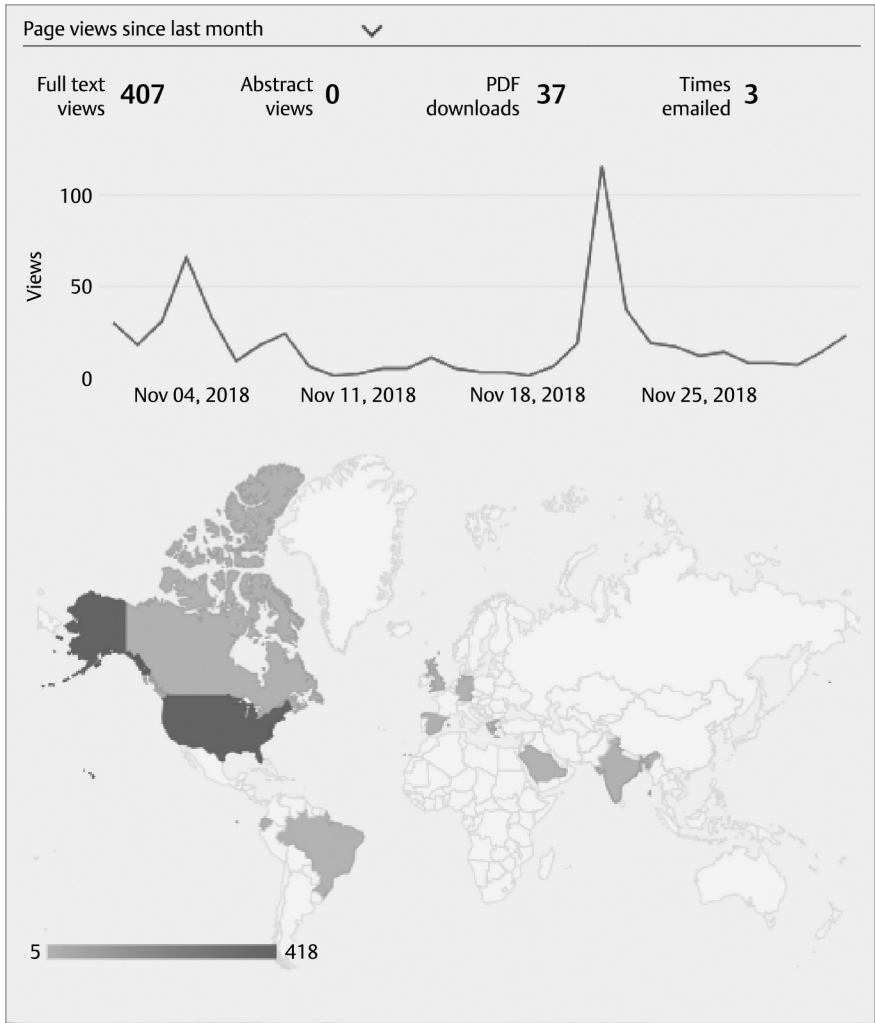
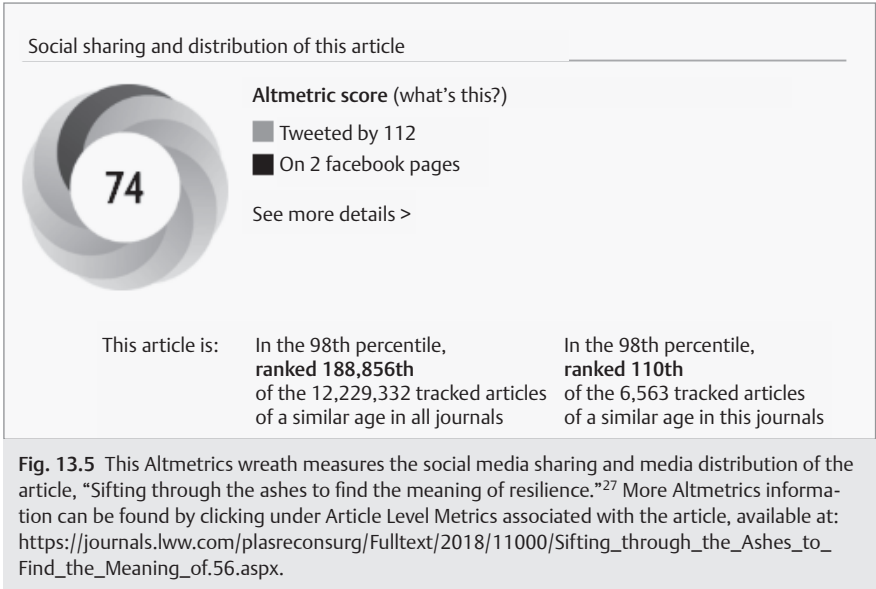


Fig. 13.4 This Altmetrics graph shows 1 month's page views of the article, "Sifting through the ashes to find the meaning of resilience."²⁸ The spikes correlate with social media posts of two videos the author created to promote the article. This graph can be found by clicking on Altmetrics associated with the article, available at: https://journals.lww.com/plasreconsurg/Fulltext/2018/11000/Sifting_through_the_Ashes_to_Find_the_Meaning_of.56.aspx.

28-second video that was edited to include several scenes. By tagging and mentioning the journal (and vice versa), both author and journal could “like,” share, and repost each other’s posts.

The spikes in the linear graph in ► Fig. 13.4 coincide with the video postings and the combined social media efforts of the journal and the author, the Altmetrics Attention Score rose to the 98 percentile of all tracked articles of similar age (► Fig. 13.5). The correlation of a high Altmetrics Attention Score with number of citations is not yet well-defined, but the score does indicate that social media efforts increase the chances that an article will be seen by a wider audience.²⁶



13.1.20 Repurposing Videos

Making a good video is hard work, but once it is done, you have a tool to use many times over. Here are some ideas to maximize the use of your masterpieces:

- Share videos on different social media platforms.
- Trim a longer video to the first 20 seconds, and post it on social media with the caption, “Curious about [put topic here]? Watch the full video: [link].”
- Embed videos on different pages of your website: FAQs, about-the-doctor, information about procedures, etc.
- Add videos to your marketing emails.
- Email educational videos to new patients and to callers inquiring about a procedure.
- Embed videos in your blog posts.
- Add videos to publications.

13.1.21 Final Thoughts

Videos capture your audience's attention in the highly competitive digital space. Use them to attract patients, to increase the efficiency of your clinic days, and to improve staff training. A picture may be worth a thousand words, but a video is worth even more.

13.2 More on Videos and Social Media

Matthew Schulman

The way in which society processes information has changed considerably over the past decade. With the growth of social media and 24-hour digital content, we have moved away from written text as the main source for information. This means that video has become a powerful means of communication and video content is rapidly becoming one of the most important sources of information for the consumer. Any successful business must recognize this trend and find a way to incorporate video content into the practice. Video content plays a vital role in website content, social media content, and direct communication with patients.

13.2.1 Length of Video

The specific length of your videos will be directly dependent on the platform in which it will be featured and the intended role. As described above, viewers have an attention span of just a few minutes, so long videos will likely have a higher *bounce rate*—the number of people clicking away from the video prior to completion. Shorter videos have the greatest percentage of *complete views*—the percentage of people who view the video from start to finish.

When deciding your video length, consider its purpose. Videos intended to be entertaining, including a “teaser” for a longer video, may do better with a limited length. However, videos intended to be more educational with more factual information should be longer, and hence the risk of a higher bounce rate increases.

Knowing how long the average user spends on each platform will help you determine the best length for your video. Twitter and Instagram users rapidly scroll through content, called “browsing” and “surfing.” To match the user behavior, videos on those platforms should be limited to 1 minute. Facebook users accept longer videos of up to 3 to 4 minutes. As for your website, basic analytics will tell you exactly how much time a visitor spends on your site, generally about 3 to 5 minutes, so the 3-to-4-minute rule applies here as well. Remember, these visitors *chose* to visit your site—provide them with useful content, and they are likely to watch longer videos to the end.

YouTube visitors spend a much longer amount of time on this site, even watching multiple videos per visit, so longer, informational-heavy videos (10 to 20+ minutes) will have a low bounce rate.

13.2.2 Camera, Lighting, and Sound

The trifecta of a successful video is camera, lighting, and sound. Poor quality videos will perform poorly, no matter how valuable the content. Following are some basics to making a good quality video.

Video Camera and Stabilizing Devices

The video quality is determined by both the recording device *and* the device the viewer is using to watch your video, so you do not need to record in high definition 4K at 60 frames per second, since your website and social media platforms will not play it back

at this same quality; a video of 1080p will provide excellent video quality and an excellent viewer experience. You can create video content by simply using a high-end smartphone. A separate reasonably priced recording device such as a video recorder or a video-enabled camera provides some advantages. A high-end video recording device costs about \$500 to \$1000.

You also need to invest in a floor-mounted or table-top tripod to stabilize the device while recording. A shaky image from a handheld camera is distracting, and tripods allow you to record when you are by yourself. Be sure your tripod has the appropriate attachment to hold your recording device, whether camera phone or a video recorder. Tripods cost about \$30.

A Bluetooth remote to control your recording device will make it much easier to record videos, or take photos, when you are by yourself. For about \$20, it eliminates that difficult maneuver of running to touch “record” on the device and then running back to your position.

If you plan to recording action-oriented videos, consider investing in a stabilizing device called a *gimbal*. These handheld devices allow smooth movement of the camera along a single axis, allowing you to create smooth videos while the camera is moving, giving them a more professional look.

Lighting

A poorly lit video is neither clear nor vibrant. High definition cannot be appreciated in a dimly lit room, with distracting shadows, or with the glare of a bright window behind you. When ambient light is insufficient, use an external light source in the form of light boxes or a ring light. Position these lights in front of the subject, avoiding glare on reflective objects such as eyeglasses or mirrors. The three-point lighting system was discussed earlier in this chapter, but you can set up two-point lighting with the fill and the key lights, leaving out the backlight. The setup is just like ► Fig. 13.1, minus the backlight.

Sound

The microphone on your camera phone or video recorder is often very poor or too far away from the subject to pick up the sound. As mentioned previously, use a clip-on lavalier microphone, which is extremely affordable and will plug in directly to an input jack on your recording device. You can also attach multiple microphones to a single audio jack using a simple splitter that is commercially available, which will allow you to place a different microphone on each person. You can also record your sound as a separate sound file that can be added to your video during the editing process.

Editing

The final step of any video will be the postproduction editing process. A competent video editor is crucial for your projects. With the many editing programs available, you may be able to do this yourself, but your video may require an experienced editor to do more advanced editing. A good editor can make a good video out of poor footage, but conversely, a bad editor will make a bad video out of good footage. Most editors charge about \$100 to \$150 per hour and can complete a 5-minute video in about 1 to 2 hours. They will be able to edit your raw footage, incorporate before and after photos, add captions, logos, and music to your project. They will also be able to add your contact

information and any “call to action.” If your budget is limited, search for a film student in your area.

If you use music, make sure it is not distracting or overpowering. Soft instrumental music can play in the background better than musical vocals, which will compete with the speaking in your video. Your video will likely exist well after a song is current; so timeless, nonspecific music works best. Do not use songs in a commercial manner in your videos because that is prohibited. Be aware of music copyrights, as discussed before, and use royalty-free music. You can purchase the use of a royalty-free song from several music sites for about \$20 to \$50. You then own this music and are free to use it anyway you wish. Most social media sites will remove videos with copyrighted music from the sites. Libraries with thousands of choices are also available in a variety of digital formats and lengths to help you easily incorporate the chosen music into your videos. If you purchase three songs, you will have enough music for dozens of videos.

13.2.3 Content

There are five general categories of videos: entertainment, education, instructional, branding, and marketing.

1. **Entertainment:** These are videos designed to attract viewers through amusement and enjoyment. These may include personal anecdotes, behind the scenes footage, or activities outside of the office. Entertaining videos give you a unique opportunity to show your personality and allow viewers to bond with you. They tend to feel more personally connected when they have a better sense of who you are as a person, not as a professional. These videos can be very highly viewed and have potential to go “viral,” dramatically increasing your viewership and reach. However, one must exhibit some caution and restraint when creating entertaining videos. Any video that is posted will reflect you as a professional. You must always be aware of how the public will perceive this video. You must act professionally and responsibly, even in videos that are showing activities outside of work. If in doubt, do not post. The audience will be a variety of people, many of whom are young and have no interest in your professional services.
2. **Education:** These videos are designed to provide information to the viewers. These may include information about a procedure, recovery, professional training, or any other aspect of your profession that people are wondering about. They may take the form as a “talking head” video or a patient experience. These videos do best when you incorporate diagrams, images, and before and after photos. The audience for these videos will likely be prospective patients who are in the research phase of their journey.
3. **Instructional videos:** These videos are designed more toward the professional. Instructional videos will include more detailed explanations about the indications for a procedure and your specific techniques. You should include intraoperative footage and technical diagrams. Your audience will be mostly colleagues or physicians-in-training who are interested in the technical aspects of a procedure. A small percentage may be the general public who may be interested in the procedure and desire to see actual surgical footage. While these videos will require more graphic images, be mindful that some social media sites will remove content that is too graphic in nature.
4. **Branding:** Branding videos are designed to set your company or services apart from others. This may be a video about yourself and detailing your education, training, and experience. It may also be a video that highlights the variety of services that

you provide in your office, and the skills of your office staff and physician extenders. Common examples of branding videos are “About the Doctor,” “Meet Our Staff,” and “About Our Services.”

5. **Marketing:** Marketing videos should be compelling, inspiring, and actionable. These may be videos designed to get followers, compel sales, or encourage consultations. They are directly tied to a measurable return. Marketing videos should be focused on the measurable goal and they need to include a specific call to action. The viewers will see these are advertisements, so be careful not to over use these videos. Because “call to actions” are more effective when they are time sensitive, marketing videos have a limited lifespan and need to be changed more frequently. This will require more resources.

13.2.4 Where Should You Post Your Videos?

So, you created a terrific video—where should you post it? Consider the user characteristics of the platforms to help you match the video type to the video platform.

1. **Entertainment:** These shorter videos show a more personal side of you and are best suited for Instagram, a site with short videos that are easily shared between users and have a high engagement rate. Viewers are likely to tag a friend, comment, and look at your short bio containing a link to your website.
2. **Education:** These videos are longer and more professional in nature. Educational videos that provide information of wide interest do well on Instagram. Educational videos also do well on Facebook, where users spend more time and are more likely to watch educational videos multiple times. Sharing and comments will be similar on Facebook as on Instagram.
3. **Instructional:** Sites like Facebook and Instagram will likely censor graphic videos, making it likely that an instructional video will be removed and possibly placing your entire account at risk. Colleagues who will most likely watch instructional videos may not be on Facebook and Instagram, so YouTube, which will not remove graphic videos, is best for these videos. (They may apply an “18 and over” restriction.) YouTube is the perfect platform for longer videos because its analytics are set up to reward longer videos, since “viewed minutes” is a strong measure to the site.
4. **Branding:** Branding videos are perfect to introduce a viewer to your website. Incorporate these videos to present information on the appropriate website page. Additionally, branding videos perform very well on YouTube.
5. **Marketing:** These actionable videos do well on any platform, as long as you remove them after a certain time. Marketing videos offering a time-limited discount or service do well on Instagram, Facebook, and Twitter. They can also be effective in presenting a special promotion in video format as part of an email campaign. To place them on your website, you need a “current promotions” section designed for changing videos or a place on your homepage that allows for monthly changes. Change them regularly and remove old videos so no one calls your office about a special that is months or years old.

YouTube is an extremely versatile video platform, allowing you to customize your own channel with a variety of different video types. All of these videos discussed in the chapter can be placed on your YouTube channel. You can create different video categories on your channel, so visitors can choose the type of video they are looking for. As an added bonus, YouTube offers the potential of monetizing videos with a large number of views.

13.2.5 Live, Unedited Video

There is another category of video that warrants discussion. Many social media platforms allow posting of live and unedited video content. This is seen in the stories section of Instagram and Facebook, Live function of Instagram and Facebook, and also Snapchat. In these functions, users are able to post events being filmed as they are happening, such as live discussions about topics, answering questions, showing procedures, and behind-the-scenes footage. When posting a video as it happens, there is no capability for postproduction editing. These platforms do allow simple editing tasks, such as adding filters and adding captions, but, for the most part, they are designed for posting raw footage. Live videos offer a powerful and effective way to communicate your message with your audience. Your viewers will relate to the raw, unedited “realness”; they expect some verbal stumbles. They will be able to see your true personality and the personality of your staff. Live video shows your human side and will help your branding. Some platforms allow you to archive, but the archived versions lose the power of live video. Whether through Facebook, Instagram, or Snapchat, live video is a way to truly set yourself apart from the rest. The basic principles described earlier regarding recording device (image stabilization, sound, and lighting) still hold. In fact, it is even more important that live video is of a good quality because you cannot fix any issues in postproduction.

Some people are just not good in front of the camera. If you are a person who does not come across “likeable” on camera, or you are a poor public speaker, it may be better to stick to packaged video content that can be professionally edited in postproduction.

13.2.6 How Often to Post Videos

How often you post videos depends on the platform you are using. For Facebook and Instagram, I recommend posting a combination of still photos and prepackaged videos, like one video for every three or four photos. Mixing up your content will keep your followers interested. Since your followers on one social media platform may not be following you on another, you can “multipurpose” a video and post it on multiple platforms. Make sure you are not posting the same material across platforms on the same day, however. A simple social media calendar will help you keep your posts organized.

When adding videos to your YouTube channel, stick to a consistent schedule. I recommend adding a new video per week. Your YouTube channel subscribers will get an email alerting of a new video. Establish a standard day and time that you add each new video so that your subscribers will anticipate your new video. The loyalty that builds is much like people waiting for a new episode of their favorite television show.

When using live video materials for Facebook and Instagram stories, as well as Snapchat, I advise posting content daily. Followers will appreciate the consistency. Since these videos are not prepackaged, they can be done quickly and easily. It will take just a few minutes to speak directly to your followers.

13.2.7 Managing the Workload

The entire process of creating video content may seem overwhelming, especially after reading my recommendations for how often you should introduce new videos to your followers. However, with some simple organization, this can be quite manageable.

In my practice, I create the raw footage myself, for the vast majority of my videos. I utilize all the things I discussed. A camera phone, tripod, Bluetooth remote, lavalier

microphone, and two box lights. With these items, all I need is myself, discussion topics, and a little bit of time. After a 5- to 10-minute setup, I am able to record raw footage for about four to five videos in about 60 minutes. I then send this footage, with any other images I want to incorporate, to my video editor. My editor can then prepare these as a group, and this gives me about 1 month of videos to add to my YouTube channel and social media platforms. To make the process easier, I always keep a list of questions or procedures to serve as topics for upcoming videos. Much like anything in your practice, you need to devote the effort. You should have your staff block off a few hours once a month, and this will become your “video day.” This becomes protected time, much like you would have for a recurring meeting.

If you are not as technically proficient, you may find it easier to enlist the help of a staff member. You will find that many office staff are already experienced in recording videos in their own personal lives. They can be a huge asset to you and you will find that most of the assistance you will need is already in house.

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14 All about Reviews

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Abstract

Online reviews and before-and-after photos are the two most important factors in influencing a patient's choice of plastic surgeon. Unlike before-and-after photo galleries, surgeons have no control over third-party patient review websites. Patients review physicians, whether the reviews are solicited or not. Negative reviews are permanent, and unless they can be proven to be fraudulent, or written by someone other than the patient themselves, the only way to combat them is to attract good reviews. To do so requires running an excellent practice, surveying patients about their experience, and implementing changes to address complaints.

Keywords: reviews, online reputation management, Yelp, Google, Facebook, Vizium360, RealPatientRatings, patient satisfaction

14.1 Introduction

Consumers are inundated with choices. Across the spectrum of goods and services, ratings and reviews are now a ubiquitous factor in buying decisions for everything from detergent to electronics to restaurants, and inevitably, to plastic surgery. Having experienced their usefulness across a variety of purchase decisions, medical consumers increasingly use ratings and reviews to narrow provider choices. In 2011, only about 11% of patients used ratings and reviews to vet physicians according to Pew Research.¹ As of 2017, 72% use online reviews as their first step when seeking a provider, while 19% use reviews to validate the choice of a doctor they have tentatively selected.² According to a 2016 RealSelf survey, up to 80% of consumers indicate that their research intensifies *after* they choose a doctor or schedule a procedure, and 86% of their consumers would not choose a doctor without reading a review.³

In an orthopaedic study, the authors compared the scores from provider-initiated (survey-based) internal patient satisfaction scores with ratings on four high-traffic physician review websites (Healthgrades.com, UCompareHealthCare.com, Vitals.com, and RateMDs.com). Survey-based systems had a higher percentage of positive ratings and a lower percentage of negative ratings than did the commercial websites.

14.2 Factors Other than the Surgeon Can Affect Reviews

More than medical quality and downgrade ratings, consumers judge other factors such as rude staff, old magazines, limited parking, and no soap in the bathroom.⁴ A rude staff member (including a trusted patient care coordinator or practice manager) may be a symptom of embezzlement within the practice (see Chapter 10).

Plastic surgeons may not like the way consumers have chosen to buy, but unless retirement is imminent, your practice's marketing and management activities should be adjusted to use ratings and reviews to attract patients to your practice and convey quality to consumers. Accurate ratings not only protect your organization's reputation, but also enable consumers to make more informed decisions more quickly. Everybody wins.

In the past, good doctors avoided ratings and reviews because they saw it as a rigged system that produced inaccurate and unfair information. Today, physicians and practices respond variably:

- Ignoring or complaining about ratings and reviews lowers the chances a consumer will choose your practice. Ultimately, the transparency of ratings and reviews will be as necessary to your success as your photo gallery. In fact, an ASJ study found that the combination of satisfaction with ratings and reviews and the photo gallery increased scheduling rates by a combined average of 67% for augmentation, facial surgery, and mommy makeovers.⁵
- Some practices publish only positive patient feedback and hide negative feedback, but consumers mistrust this level of perfection. Google⁶ and Yelp⁷ prohibited such “review-gating” in 2018 to protect consumers from manipulated ratings with “unbelievable” 5.0 scores.
- Virtually all practices now have a proactive strategy for monitoring their reputation and adding reviews to consumer websites like Google, Facebook, Yelp, and RealSelf. This is a vital practice activity that requires organization and discipline. Ideally, the practice has access to technology that supports these activities.
- Transparency about your patients’ experience in the form of ratings and reviews provides a powerful marketing opportunity. Use ratings and reviews throughout the patient journey. Unique content from survey-based ratings and reviews, such as those provided by Vizium360 (realpatientratings.com) and Press Ganey, fulfills consumer needs for trusted content, improves rankings, and speeds online conversions. Additionally, patient feedback reinforces your team’s successful activities and pinpoints needed changes. You can then use the ratings and review content throughout the patient journey to speed conversions.

14.3 Step One: Implement a Review Strategy for Consumer Sites

The top three websites for all reviews are Google (32%), Facebook (21%), and Yelp (18%).⁸ RealPatientRatings is another website that reviews only plastic surgeons. It elicits reviews directly from patients to populate content for practice websites, but to populate Google, Facebook, and Yelp with your reviews, you want to be strategic in asking patients. Do they have a Gmail account or Facebook account or are they regular Yelpers? Because the review’s rating value of your practice is so important to your professional success, particularly if you are in private practice, you need to be actively involved yourself. You want to get your happy patients to post your reviews. A good strategy to get good reviews is to survey your patients. If the survey identifies an unhappy patient, then reach out to them and address their concerns before they simmer and stew and dump their emotions on Yelp.

14.3.1 Asking for a Review

Choose an articulate candidate with a positive outlook, ask for a favor (not a review), give instructions and email a link, set a deadline, and follow up. Assign a staff member to monitor your online reviews, and when a negative one is posted, decide whether to respond or not. If you respond, do so within 3 days, and observe HIPAA-compliant communication practices. Speak in generalities and take the conversation offline. Address

patient concerns. Patients with complaints that are addressed with care and compassion may ultimately become your most highly satisfied patients.

The unhappy patient may find relief in leaving a 1-star review with a lengthy litany of complaints, but the happy patient does not necessarily have that fire in her belly driving her to rave about you with a 5-star review. To get reviews, you need to ask. You or your staff can drop a handwritten note asking how they're doing, what a privilege it was to do that person's surgery, and then asking for a review with instructions on what to do. Ideally, you have multiple ways of asking patients, including using one of the many reputation management tools that will monitor your ratings and reviews and help you invite patients electronically to leave reviews on key sites. Texting and emailing invitations and links facilitate the process because you or your staff can send a link to the desired review website, along with instructions. But the most effective way to elicit a review may be to ask directly.

You will turn patients off if you dive right into the question: "Would you mind writing a review?" The patients have just dropped their savings in your practice to have their surgery with you. And now you want them to do free marketing for you. Reviews serve two purposes: Not only do they help a well-reviewed practice attract patients and increase their revenue stream, but they also provide information for other consumers. Reviews offer an independent opinion from a consumer who has used a product or had a service. We have total control over the content we write on our website, but we have zero control over what patients say about us or how they rank us on review websites. Consequently, the patients who leave a review are, in fact, providing a service for other people trying to make the best decision about choosing a surgeon.

Start out by taking excellent care of the patient. Make sure she is happy with her care and her results, and get to understand her outlook on life and how well she expresses herself. Someone with great results but who never smiles or says much may leave a lukewarm review. Patients who aren't fluent in English or are poor writers might not be good candidates. Some of those patients have been known to choose a single star to indicate that the practice is Number One!

As you are caring for your patients, you will identify patients who are enthusiastic about their experience. One option might be, "Would you mind sharing your experience online to help others who are considering this procedure?" Patients often respond, "Of course! That's how I found you." Hand them a card with instructions and have your staff send an email with a link. Offer multiple review website options. Some allow anonymity and others do not. Those with a Gmail account can be anonymous if their name isn't part of their email address.

But you are not done. The minute that patient, who has the best of intentions, walks out of your office, she's thinking about getting back to work, all the errands she has to run, and picking up the kids before after-school care ends. That review may be vital to you, but she'll forget about it. So you need to set a deadline and arrange for a follow up: "If you think you'll be able to get it done this weekend, I can have [Staff Name] follow up with you on Monday to make sure your review got posted." You or the staff person should ask the patient how she prefers to be contacted. Then remind the person by text or email. You might want to send three or four reminders.

At the next follow-up visit, if the staff never confirmed that the review was done that Monday, that staff member should ask the patient if she ever got a chance to post the review. If she did not, it is inevitably because she forgot, not because she really does not want to leave a review. (If you or the staff sense reluctance, stop asking.) You or the staff should ask again and set another deadline. Happy patients have the best of intentions, but they forget. If you ask a third or fourth time, they are likely to view it as

a gentle reminder rather than nagging. Put yourself in your patient's place. If you love a practice, a product, a restaurant, or a book, you *want* to tell others about it.

When your patient leaves a great review, have your staff indicate it in the chart or a review log so you can personally extend a genuine verbal thanks. Do not reward people for good reviews unless you state online that you do. Reviews are considered to be commercial speech and are regulated by the Federal Trade Commission.

14.3.2 Fake Reviews

Fake negative reviews can hurt your star rating, and unless you can make a case to the review website, the reviews will stay. People who leave negative reviews include disgruntled ex-employees, competitors, and online reputation management companies looking for business.

Many staff members get cosmetic procedures at a discount as a benefit of working for a plastic surgeon. It is tempting for them (and for you) to write a review. Do not. Reviews by staff are considered to lack integrity. Review sites track the Internet Protocol (IP) address of the post, and they can punish you for staff reviews. Even reviews by friends and family are frowned upon. The risk is too high to rely on reviews from your inner circle, so you need to do the hard work and ask your patients.

14.3.3 What to do about Negative Reviews

Assign staff to monitor reviews or use one of the many automated services that monitor hundreds of sites. Do not let negative reviews accumulate without a response—it makes it look like you do not care. Even if you do not actively solicit reviews in your practice, your unhappy patients will still post reviews, so in this review-centric consumer environment, you have to invest in the staff time to identify surprise negative reviews.

Despite your best efforts, every practice experiences some negative feedback. The ultimate test is how you respond to the patient and what your organization does with that feedback. There is no need to obsess about a few negative or unfair reviews (everyone gets them). Ideally, you want to hear negative feedback privately and internally *before* the patient resorts to airing her disappointment on multiple consumer sites:

- Build in “early-warning systems” that encourage practice teams to identify and report patient issues while they can still be addressed privately during the care and recovery process.
- Ask patients if they have any concerns they would like to be addressed on postop or posttreatment visits. Proactively address their concerns up to and including revisions and refunds. Your internal goal should be to turn critics into advocates.
- Survey your patients routinely to be sure you know what they think. Use survey data to identify and fix systemic patient issues that reduce patient satisfaction and could lead to negative reviews. Use patient feedback to improve business performance including conversions, retention, and referral.

In the long run, dealing with the issue is better than fighting or ignoring it. If it is a systemic problem, you need to fix the issue to avoid repetition. Reducing the finger pointing and negative emotions enables teams to develop a positive approach to negative feedback and improve the experience for other patients. If you can associate negative reviews with particular procedures, then you should either improve your technique or stop doing the procedure.

Responding to service failures is both art and science. The service recovery paradox holds that consumers who are happy with the resolution of their service issues are more likely to remain customers and to spread positive word of mouth. Their loyalty is greater than consumers who did not have their service issue addressed or never had a problem in the first place.

Patients who experience a problem and are highly satisfied with the practice's resolution are more likely to recommend and to return for future treatment than those patients that did not experience a problem. Even with a dedicated team, strong service systems, and ongoing surveying, you will still receive the occasional negative review on consumer sites. There are significant limitations as to how medical practices can respond, but acknowledgment and proactivity are important.

- **Respond promptly:** For sites that allow it, such as Yelp, respond promptly by asking the patient to contact you. Do not exacerbate the problem with delays. According to Yelp, prompt responses, within 3 days, increase the likelihood that a negative review will be changed or removed. Consider this review to be an emergency and have the highest level person possible within the practice take charge of resolving the matter quickly.
- **Take it offline:** Taking communication offline is essential in medicine. Make a public response and then, to the extent the site allows, send a private comment expressing concern about the patient's review and asking for follow-up contact to deal with their disappointment. Do everything you can to figure out who the patient is and try to get some insight from your practice team.
- **Highlight your strengths:** If a review site enables you to respond publicly, leave a public message highlighting your strengths, and making it clear you want the reviewer to contact your practice for resolution.
- **Be sincere and admit your mistakes:** Once you are in contact with the patient, your goal should be to de-escalate the problem. Consumers who experience problems want to know their concerns are heard and, ideally, that their communication will yield organizational changes that prevent the problem for other patients. Acknowledging such system or service errors can increase satisfaction and such patients will frequently amend their reviews after positive intervention by the practice.
- **Provide restitution if it is warranted:** While it is true that there are rare instances where a patient is holding the practice hostage for a refund, larger brand and reputation issues warrant refunds when appropriate. If refunds are given, be sure your release of claims has a clause that precludes the patient from future social media posting (see example later in this chapter).
- **Correct inaccuracies:** This advice is harder with the HIPAA restrictions to public responses but it is sometimes possible to identify negative reviews from a competitor and remove them successfully. To the extent possible, verify that reviews are from your patients. One of the authors (MBVO) has had occasional negative reviews for other practices with similar names and has been able to get the patient or site to retract the review. If you think it is not your patient and the site enables you to respond privately, ask the patient the name of their provider.
- **Ask loyal customers to share their experiences:** You might be surprised to find your loyal patients come to your defense without being asked, when they recognize extreme criticism that does not reflect your quality.

- **Be consistent:** Each practice needs brand consistency in its responses. Avoid expressing negative emotions. Whatever problem is being reported, a kind response indicates that the practice understands the seriousness of the complaint and has a history of resolving unhappiness. Your response is a form of marketing to other consumers considering your practice. It needs to be polite, professional, and restrained.
- **Understand how ratings and review sites work:** Depending on the website, you have different options about responding. Your reputation management vendor can guide you about how the various sites work and what they will do to help you with an inappropriate negative review. See Chapter 12 for more information on the impact of reviews on your SEO.

How difficult is it to remove a negative review once it is online? If the reviewer posts the same verbiage on more than one review website, you can contact the company and let them know. They will often remove duplicated content. If the person was not the actual patient, it generally violates the review site's terms of service and the site will take it down if asked. If the person was not your patient or there are obvious untruths, you can challenge the review. However, most negative reviews are there to stay, so the best response is to get more positive patient reviews. If you only have two Yelp reviews, and one is a 1 star and the other is a 5 star, your average rating is 2.5 stars. On the other hand, if you have twenty 5-star reviews, that 1-star review still leaves you with an overall rating of 4.7 stars.

14.4 Step Two: Surveying Your Patients to Validate Satisfaction and Improve Practice Performance

Creating great patient experiences takes effort and a willingness to let your patients drive change in your practice. Your opinion may be right, but theirs is the one that counts. If what they want is medically appropriate, then the fastest way to success is to adapt your business to their needs and expectations. Ignore consumers at your peril. In the words of Peter Drucker, if you cannot measure it, you cannot improve it.

Survey-based systems provide significant data to validate or improve practice performance. Additionally, survey-based systems provide insights into patient experience issues that can potentially deter patients from coming to your practice. How do you know what patients think? You have to ask them. Having surveyed cosmetic patients since 1988, one of the authors (MBVO) found that virtually all of their expectations are reasonable and rational. Implementing changes patients identify can produce many positive benefits including increased satisfaction, higher conversions, and enhanced profitability.

If patient feedback mandates change, then note when changes are made and track the applicable metrics. If the baseline metric (i.e., consult conversions) is improved by the change, then continue it. Tweak as necessary. Continue to monitor the numbers to confirm the change is having the desired effect. If not, look for another solution. Just as physicians require labs and an EKG to evaluate a patient's surgical readiness, practices need metrics about patient satisfaction. This data enables you to develop strategies to

improve your practice's reputation and revenue. Benchmarks provide insight into the potential business impact of patient-identified issues.

Failure to achieve operational excellence inhibits business success and puts a practice's reputation at risk. To pinpoint issues and opportunities, practices need diagnostic surveys to gather feedback on important touchpoints in the patient journey. Benchmarks can then serve as an internal reality check among providers in a practice, within a region, and nationally.

The customer experience management (CEM) methodology enables you to track the patient journey through a defined series of decision stages, from consideration to choice to retention and referral. Use conversion rate metrics to measure movement between stages, and use benchmarks to evaluate business performance at each stage (► Table 14.1).

Your patients move through a series of decision points in prepurchase, purchase, and postpurchase categories. They are using ratings and reviews throughout the process. Practices must recognize these decision points, determine deliverables at each stage, and track data to confirm the effectiveness of their strategies. The patient's commitment and interest levels increase as they move through the lifecycle. The ensuing long-lasting relationship increases patient loyalty and practice profitability.

In each conversion step, a patient moves forward from one stage to the next when they are "highly satisfied" or "satisfied" that the practice has demonstrated quality and can meet their needs. The better you understand their needs at each step, the more effectively you can fulfill them. Unless prospective patients receive the information or support they need at their current stage, they will not have confidence to progress to the next step. They may exit your practice, discontinue their search completely, or, more likely, go to other practices looking for the answers to their questions that your practice failed to provide.

14.4.1 Striving for Five: Focusing Your Team on Creating Memorable Patient Experiences

Right performance measurement can be used to set goals to improve the performance of management and staff. Gaining as many 5-star ratings as possible necessitates creating a service system that increases the ratio of highly satisfied patients. To do that, the process improvement methodology called "545"⁹ can be used to differentiate the "highly satisfied" patients (5s) over those who are "satisfied" (4s). The results can guide changes in care and communication to improve how the organization provides patient satisfying services that convert more 4s to become 5s. Specific responses can be tied to each patient-staff touchpoint service to develop a strategy to improve those interactions with lower scores

There are a number of ways to measure patient satisfaction. Top Box, used by Disney, HCAPS, and Mayo Clinic, focuses on the most important aspects of team performance that wow consumers and accelerates business success. The 5-scale is converted into three categories based on subsequent and very different consumer behavior:

- **Affection:** Only "highly satisfied" patients who give 5s are in this group. They are more loyal, use practice services more frequently, and are more likely to refer. They have the greatest customer lifetime value (CLV). The greater loyalty among highly satisfied consumers results in higher revenue and improves profitability.

- **Indifference:** Patients who are “satisfied” (4s) exhibit the same neutral behaviors as those who are “neither satisfied nor dissatisfied” (3s). They may remain in your practice, but they have a lower likelihood to schedule at the time of consult or to

Table 14.1 Evaluating business performance using the customer experience management methodology		
Methodology		Ratings and review strategy
Customer experience management	Patient journey	Define touchpoints and tactics per stage in the patient journey. Per key decision point, use ratings and reviews as social proof to increase conversions, loyalty, and profitability.
Awareness	Inquiry	Make sure your practice website has ratings content that ranks for review searches for your practice name(s), provider(s), and procedures. Implement robust strategy to increase reviews on Google, Yelp, Facebook, and other key consumer sites. Share ratings and reviews in social media posts. Add ratings and reviews to digital and print programs to increase conversions. Quote ratings and reviews in your message on hold.
Knowledge	Appointment	Proactively reinforce online ratings and reviews by transparently including scores in your communications, verbal or written, to validate their interest in your practice and increase engagement. Your goal is to have your practice included on their “short list” or consideration set as evidenced by having a consultation.
Consideration	Consult	Demonstrate quality using ratings and reviews in pre- and postconsult touchpoints about your practice, providers, and procedures. Validate quality at consult and include in consult tools such as TouchMD. Share information about consult quality with specific consult ratings. Survey postconsult to validate quality and gain feedback to better meet patient needs at this critical juncture in the patient’s decision.
Selection	Surgery or treatment	Validate patient’s choice with postselection communications about provider, practice, or procedure. Remember that patients are highly likely to check reviews again after scheduling treatment or surgery. ³
Satisfaction	Satisfaction	Verify satisfaction using ongoing surveying to gather patient feedback, pinpoint service issues and opportunities. Use the continuous feedback internally to improve team performance. Publish 100% verified reviews. Proactively invite patients to provide reviews on key consumer sites.
Loyalty	Retention	Validate their decision to remain part of your practice. Regularly update your patient base by sharing ratings and reviews on social media and in your marketing. Keep your quality in the forefront. Consider including satisfaction scores with your referral gifts from your surgical practice to your medspa.
Advocacy	Referral	Request referrals and include provider or procedure ratings and reviews to validate quality. Include in footer of “thank you for your referral” communications.

refer after treatment. They are much more likely to leave your practice or choose a different provider for future procedure as they are unpredictable and unreliable. It is important to emphasize that patients who report themselves as “satisfied” are, in fact, neutral.

- **Defection:** Patients who are either “dissatisfied” (2s) or “highly dissatisfied” (1s) are most likely to leave your practice, share negative word of mouth, and post negative reviews on social media. Service recovery techniques should be used to minimize the number of these patients.

Improving the patient experience is a team activity. Encourage team collaboration to explore new ways to enhance service and deliver memorable patient experiences that earn high ratings. Motivating and recognizing team effort is especially important in private practices that tend to underestimate the importance of team contributions to successful ratings and reviews. According to unpublished Vizium360 statistics, 35% of reviews on realpatientratings.com include a reference to “staff.”¹⁰

Your staff aligns around your values and what you do, not what you say. It all starts at the top. If you avoid phone calls, are always late, or show irritation about your responsibilities, you give your staff permission to mirror your behavior. If they believe that great patient experiences are your primary goals, they will work harder to support a practice mission that involves getting more and better ratings and reviews.

Patient satisfaction is a value around which a team can organize, especially when feedback from the patients themselves is what guides practice priorities. Not all measures of employee satisfaction relate to compensation. Staff can be highly motivated by serving on a team that “makes a difference” for patients and enhances their enjoyment of their lives.

When you share reviews with your team and recognize individual effort, it motivates greater effort on their part because their individual efforts are recognized and valued both by the patients and by the organization. Patient comments in surveys and reviews often mention both team efforts, such as, “great staff,” and individual contributions to patient experiences, such as, “Susan, the nurse, was always there for me.” Calling out and complimenting those referenced by patients increases the likelihood that your staff will repeat behaviors that patients value.

This sharing creates a sense of joint mission and esprit de corps.

By focusing the team on creating great patient experiences, ratings and reviews reinforce shared values. The entire team learns what patients value and they use this feedback to adjust future behavior to create even higher patient satisfaction.

14.5 Bringing It All Together: Marketing with Ratings and Reviews

Marketing with ratings and reviews has a positive, additive impact on all other marketing. All this consumer-driven commitment and teamwork is going to make it easier to attract patients and keep them! It actually has a name, that is, service marketing.

Ratings and reviews build brand awareness because the content of reviews is more believable than anything you can say about yourself. Use the positive feedback from your patients to tell the real story of your quality to consumers. Use it liberally within all of your marketing and internal follow-up systems.

The benefits of reviews in retail of marketing with reviews have been reported for years. Google and the other search engines value the customer feedback that ratings and reviews provide. BazaarVoice reported the following impact of adding ratings and review content to the performance of other marketing:¹¹

- **Website:** +79% in conversion rate
- **Social:** +78% in “buy now” behavior
- **Eblasts:** +193% in click-throughs
- **Digital marketing:** +35% in click-throughs

Adding reviews to product pages positively impacts conversions, average order, and return rate.¹² The plastic surgery equivalent of “product pages” is procedural web pages. Providing ratings by procedure improves both search results and rankings.

Having ratings and reviews on key consumer sites is a must. But this does not mean you should not also have a strategy for reviews on your own website. Google has made it very clear that review content impacts local search. Review counts and scores are now factored into Google’s local search ranking.¹³ While Google reviews are critical, they often require the patient to come out of anonymity, which can be a big hurdle for cosmetic surgery patients.

To benefit from Google’s emphasis on reviews, practice websites should contain review content that ranks for local review searches. Consumers searching reviews specifically about you can then be directed to a review section on your practice website. Google wants fresh, authentic ratings and review content that is coded correctly so it is “seen” by the search engines. If your practice website does not rank in the top three positions for these key searches, your practice will become increasingly dependent on leads generated by consumer websites that attract the consumer with review content. A decreasing percent of these patients find their way to your practice website after visiting a consumer rating site.¹⁰ As patients look for your reviews, they will click on links to consumer sites, like Google, Facebook, Yelp, and more than 70 other medical review sites. Frequently, conversions occur on these sites rather than the practice website. Do the scores on the various consumer sites reflect the true quality of your practice?

People who are looking specifically for your reviews are actively considering you or your practice. Take charge of your own ratings and reviews, especially for your name, your practice name, and the SEO ranking of your own website. To assess your practice’s strategy, complete the online searches listed in ► Table 14.2, and compare the rankings of consumer websites versus your own website.

Consumers and healthcare providers alike do best in a transparent system that creates trustworthy new content loved by Google. Your strategies should include the following characteristics:

- Survey-based system that provides insight to better manage your practice and drive predictable patient satisfaction scores:
 - 100% verified reviews
 - Frequency
 - Recency

Table 14.2 Developing your review strategy		
Search	Consumer sites	Your website
Provider name	Provider profiles on national consumer sites will rank for your name, but, ideally, given Google's emphasis on local search, they should rank lower than your own website.	Ideally, your website should rank #1 for your own name even without the word reviews.
Provider name + reviews	Consumer sites generally dominate this search because they have the content that merits SEO rankings.	Ideally, your website should rank in the top 3 because it has relevant review content. Many practice websites lack the content to rank for this key search despite Google's emphasis on local search.
Practice name	How consumer sites rank for this search varies, but, in any event, your goal is to have your practice website rank higher for this search.	Ideally, your website should rank #1 for this search or in the top 3. If it does not and you are paying consumer sites for leads, getting review content on your website should be a priority.
Practice name + reviews	Sites that list practices by practice name rank well for this search.	Your website should rank #1 for this search as well. It needs review content by practice name to do so.
Procedure name	Consumer sites organized by procedure have a distinct advantage for this search. Most consumer sites however do <i>not</i> rank for these searches.	This is a big opportunity for practices with transparent procedure ratings and reviews. Practice sites can rank organically for these important searches if your website contains procedure-based ratings and review content.
Procedure name + reviews	In the absence of local sites ranking for this search, consumer sites rank strongly for these searches.	Practice sites can rank for these review searches and there is a competitive advantage in doing so.

- Adheres to most common methodologies:
 - Ratings based on a 1 to 5 scale where all scores are counted
 - Ratings distribution showing ratings across the spectrum from 1 to 5
- Provides unique content for your practice website that follows best practices:
 - Automatically updated fresh new content
 - Trusted source
 - High authority
 - Statistical validity (>30 ratings)

14.6 When There Is No Choice but to Sue the Patient

Joshua M. Korman

The thought of actually suing a patient seems among the least likely actions in a medical practice. But I did. Two years after a successful cosmetic procedure, the patient decided that she was no longer happy with the procedure, demanded a revision, then quickly changed her mind and wanted some of her money back. I agreed to refund her some of the surgical fee in exchange for a complete release of claims including not posting disparaging information online. (I obtained the agreement "Release of All Claims" from my malpractice carrier, reprinted below.)

A few months after she received the funds, the patient began posting negative reviews and demanding more money. Letters from my attorney pointing out the agreement stopped the reviews briefly, but every few months the postings began again. At first the reviews were from relatives and friends of the patient, which were not covered by the agreement, but I was able to have them removed, as review sites generally prohibit third-party anecdotes. Then the patient personally began posting negative reviews and ignored multiple warnings from my attorney. Finally, we served her for breach of contract, fraud and deceit, defamation, and intentional inflictions of emotional distress. This prompted her to finally hire an attorney, who explained the consequences of her actions. Losing a law suit would affect her credit history and cost her significant funds. Eventually she agreed to withdraw all postings, but she still wanted the ability to post generally about the procedure without mentioning me or my practice. My attorney thought that was reasonable, but I disagreed, knowing that she could omit my name but mention identifying characteristics that would result in the same disparagement. Finally, after several thousand dollars in attorney fees, we agreed to not continue the lawsuit, with the patient removing all negative postings, and agreeing to severe financial repercussions should she violate the terms of the new agreement.

RELEASE OF ALL CLAIMS

Nothing contained within this agreement is to be construed as an admission of liability or wrongdoing.

The parties agree to maintain the contents of this settlement agreement and the subject matter related thereto confidential and further agree not to disclose the contents hereof to any third parties except their legal counsel or a court of competent jurisdiction for the purposes of enforcing any of the provisions hereof. Neither of the parties shall disclose the terms of this agreement, or who paid the settlement amount, to any third parties unless as permitted or required by law. Further, the undersigned agrees that he/she may not disseminate any information, either directly or indirectly, about, XX M.D., regarding any subject on the Internet or any other electronic and/or print means of communication or otherwise, and that any violation hereof shall constitute grounds for legal action against the undersigned for damages and/or equitable relief in a court of competent jurisdiction. The undersigned hereby warrants and represents that she has completely removed all such postings that she has previously made on the Internet and will refrain from future posting any disparaging remarks referencing the insured on all media, print and Internet, including any and all social media sites.

In executing this agreement, the undersigned acknowledges that she has completely satisfied himself/herself that he/she fully understands all of the legal consequences of this agreement, and that he/she has voluntarily decided to execute the agreement.

In consideration of the sum of \$_____ the undersigned releases and forever discharges XX M.D., and their employees from any and all actions, claims or demands that the undersigned has, or at any time in the future might have, arising from or relating to medical/surgical care provided to the undersigned by XX M.D., or their employee(s).

In acceptance of this sum, the undersigned agrees to indemnify and hold harmless the above-named party(s) from and against all liens and subrogation claims that may arise now or in the future.

Date (Patient)

(Witness)

14.7 Final Thoughts

Consider this RealSelf data (presented at a recent ASAPS conference)³:

- 97% of patients expect your practice to engage online.
- Reviews generate greater trust (68%) than training and education (15%).
- 80% indicate their research intensifies *after* they choose a doctor or scheduled a procedure.

To buy from us or even consider us, consumers need to trust us. The public assumes that ratings and reviews provide the social proof that we can be trusted. Ultimately, patients choose and remain with your practice throughout the patient journey because you and your staff validate their trust by consistently delivering surgical quality and creating memorable patient experiences.

Fast Facts about Ratings and Reviews

- 88% of online shoppers incorporate reviews into purchase decisions.⁴
- Ratings and reviews increase conversions both online and in-office. Today’s perpetually connected consumer checks ratings and reviews to narrow choices.
- Consumer satisfaction with reviews and photo galleries increases scheduling by 67%.⁵
- Reading reviews prior to consult increases same-day surgical conversions by 41%.¹⁴
- 85% of consumers trust reviews as much as personal recommendations.¹⁵
- Consumers research 24/7/365 using online ratings and reviews. Your practice must have an accurate review presence online. You can no longer filter out the unhappy patients as you could in pre-Internet days, when you had control of who talked to prospective patients.
- Consumers need to see negative reviews to trust positive reviews.¹⁶
- A study at Stanford found that a few negative reviews increased consumer trust of the positive reviews, a phenomenon that is described as the “blemish effect.”
- A Reevoov study found that bad reviews actually improves conversions by 67% because those planning to make a purchase pay close attention to bad reviews.
- 44% say a review must be written within 1 month to be relevant.⁴
- Consumers choose products and providers who have more reviews.^{17,18,19}

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15 Digital Marketing and Advertising

Logan Pence and Bill Fukui

Abstract

The Internet allows plastic surgery practices the opportunity to gain more control over their marketing. For the private practitioner who must attract patients, participation is a must and demands a familiarity with the business side of plastic surgery, including business development, marketing, and advertising. Successful campaigns are the product of planning and coordinating multiple channels to work together.

No longer can you simply build. Marketing today is more than building a website and generating leads and new patients. Greater complexity requires thought and planning, starting with an effective mission statement that guides your marketing and brand. Create realistic but effective goals, and commit to an action plan to ensure implementation. You will need to formulate a goal-focused budget and build a strong team that turns these marketing investments into profits. Beyond foundational marketing principles, it is also important to stay up-to-date with changes in the marketplace, consumer behaviors, technology, and marketing channels. You can leverage online consumer research and your own Google Analytics data to uncover better ways to market in a mobile world, build a higher-converting website, boost search engine marketing results, and even convert more Facebook and Google paid advertising into lead and patients.

After learning how to select the right digital marketing strategies and channels to fit your marketing goals. You will find blogging can impact your search engine optimization (SEO) results, how to get more out of your social media efforts, how blogging can improve your SEO results, and that, with a few tips, you can get more return on investment (ROI) from your pay-per-click (PPC) campaigns.

After implementing these strategies, you can track your practice's progress and success.

Keywords: cosmetic surgery marketing, cosmetic surgery advertising, cosmetic surgery SEO, plastic surgery advertising, plastic surgery website design, plastic surgery SEO, plastic surgery social media, plastic surgery marketing plan, plastic surgery staff training

15.1 Introduction

With the rapid growth of information available online to potential patients, digital marketing and advertising has become an important element of every successful aesthetic practice. Successful digital marketing requires educating yourself on marketing strategies and best practices to grow your business through industry-related videos and blogs. In addition to ongoing education to stay up-to-date, you will need to create a plan and build a team to facilitate your marketing endeavors. The better you understand how digital marketing works, the better you can maximize your online presence through data analytics and testing, which will allow your aesthetic practice to thrive in today's market. The best digital marketing programs create new content on a regular basis and modify strategies as times change. The best aesthetic practices continuously look to grow and improve their marketing plans by understanding the data available. Without the appropriate effort and budget for digital marketing, results will be subpar. A successful digital marketing and advertising plan can transform a below-average practice to a market leader.

15.2 Developing a Digital Marketing Plan

Every aesthetic practice should create a digital marketing plan. A well-organized marketing plan is a broad system, comprising multiple channels with various moving components, all of which lead consumers to your practice, primarily through your website. This plan includes several essential components, such as your website, social media pages, and an up-to-date Google My Business listing. However, a successful digital marketing plan in today's market is alive, and needs to be fed, nurtured, massaged, and adjusted over time. Aspects of this marketing plan are dynamic and exciting, but most aspects should remain templated and consistent. Components of a consistent digital marketing plan include a new 500-plus word blog posted each month, and three posts a week on Facebook. Your monthly blogs can be used for 24 Facebook posts—once when first posted and then reposted after 6 to 9 months. Other components might include adding multiple sets of before-and-after photographs, a video, and procedure-specific reviews on each procedure page of your website.

Let's review the sections to be included in a digital marketing plan.

15.2.1 Section 1: Executive Summary

This section is a basic summary of your marketing plan. Although it comes first in the written plan, this section should be completed last, once you have worked out all the details of the actual plan.

15.2.2 Section 2: Mission Statement

The mission statement is a single sentence that clearly explains to your staff and potential clients what your practice stands for and what they can expect to experience from your brand.

Example:

- Our focus as a full-service plastic and cosmetic surgery practice is to provide an exceptional patient experience, specializing in natural results through high-quality surgery and superior service.

15.2.3 Section 3: Short-Term Marketing Goals

A marketing plan should have four to six short-term marketing goals, achievable within the next 12 months. All goals should be SMART: specific, *measurable*, *attainable*, *realistic*, and *timely*.

Examples:

- Increase new leads to an average of 325 per month.
- Each month acquire five new reviews across Google, Facebook, and RealSelf.
- Increase monthly marketing to 6% (on \$5M, \$300,000 per year or \$25,000 per month).

15.2.4 Section 4: Long-Term Marketing Goals

This is a list of three to five goals for your practice to achieve within the next 3 years.

Examples:

- Maintain a marketing budget at 4% of gross revenue.
- Open a second location on the west side of town.
- Design and launch new website for Medical Spa.

15.2.5 Section 5: Review of Procedures and Services

This section lists every procedure your practice offers, in order of priority. The highest priority is subjective, but they should include the most profitable procedures, the ones you most enjoy performing, those with the highest marketing demand, and those which you are hoping to increase over the coming years. This will help your marketing team place the appropriate effort into each procedure.

Examples:

- Breast Augmentation
- Mommy Makeover
- Gynecomastia

15.2.6 Section 6: Buyer Persona Profiles

This section includes the demographics and characteristics of target clientele. It includes detailed psychographic data and the specific needs and wants, as it relates to your service offering.

Examples:

- Young women looking to improve their body image.
- Men and women looking to slow down the aging process.

15.2.7 Section 7: SWOT Analysis

Evaluates your business's strengths, weaknesses, opportunities, and threats (SWOT); this provides a chance to step back and look at the practice from multiple angles.

Examples:

- Look at the strengths the practice has over the local competition, including reviews, location, and hours.
- Try to create plans on how to move the weaknesses into opportunities for improvement.

15.2.8 Section 8: Competitor Profiles

Choose five practices in your direct market and build a competitive profile for each.

Examples of competitive data include:

- Web vendor
- Number of reviews across various sites
- Staff size
- Number of photos in online gallery
- Service offerings

15.2.9 Section 9: Sales and Growth Goals

Review past performance and determine where you want your practice to be in the future. Total revenue can be broken down into smaller categories, such as surgery, retail, and nonsurgical, and then individual procedures placed within each category.

Example:

- Generate 1 million in revenue by doing \$800K in surgery (\$400K coming from breast augmentation), \$25K in retail, and \$175K in nonsurgical procedures.

15.2.10 Section 10: Strategies and Action Plans

This is where you outline all the moving parts in your marketing plan. From web vendors to email blasts, this section provides details of your various marketing projects and who is ultimately responsible for delivering each project. This section should be as detailed as possible and include a calendar of ideas to use throughout the upcoming year.

Example:

- Send out 12 newsletters on a monthly basis using the email service iContact, have one event every quarter, add 10 new sets of before-and-after photos to each gallery, increase average spend per client by developing a loyalty program, and post on Instagram three times per week.

15.2.11 Section 11: Marketing Budget

All marketing expenses need to be put into one document. The marketing budget can be created in Excel and compiled from a chart of your accounts in QuickBooks.

Examples of budget items include:

- Website vendors
- Pay-per-click (PPC) through Google AdWords or Bing
- Facebook marketing
- Reputation management software
- Content creation
- Print

A detailed marketing plan is essential to prioritize your team's focus and determine goals. Your marketing plan is your road map and guides how and where marketing funds are going to be spent, allowing you to evaluate the value of your investments and adjust your marketing strategy accordingly (► Fig. 15.1).

15.3 Digital Marketing Budget

Create a marketing budget by putting your marketing expenses into one document. The marketing budget will help with decision making and ensure marketing expenses are consistent with marketing goals. You can readily ascertain whether a new marketing program will fit within that budget, saving your time and energy. To get the most out of your marketing budget, you should allocate funds for reputation management, email creation and distribution, search engine optimization (SEO), PPC campaigns, and funds for internal marketing, such as events, marketing folders, and business cards.

A marketing budget first requires creating a short-term business goal of projected sales for the year. Next, break this goal into categories, such as surgical and nonsurgical, followed by subcategories for individual procedures. Evaluate your practice's past performance before creating your business goals for the upcoming year. How much revenue did your practice generate last year? How much did you spend on marketing? How successful was each marketing campaign? How much growth do you hope to achieve this year? Most businesses aim to grow at least 10% in the coming year, although some strive for as much as 100% growth. Once you have your past performance, your projected revenue for the upcoming year, and the amount of funds you are currently spending on marketing, you can set a percentage to create your new marketing budget. Your team can then allocate funds and implement plans to achieve this revenue goal.

As you create your new marketing budget, review how much money was spent the prior year and evaluate how well these endeavors performed. This information will

Marketing budget						
		Jan	Feb	March	April	May
Website						
	www.JonesMD.com	\$2,400.00	\$2,400.00	\$2,400.00	\$2,400.00	\$2,400.00
Paid directory listings						
	RealSelf.com	\$250.00	\$250.00	\$250.00	\$250.00	\$250.00
Pay-pre-click						
	Tummy tuck	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00
	CoolSculpting	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00
	Botox	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00
	CoolSculpting	\$750.00	\$750.00	\$750.00	\$750.00	\$750.00
	Adwords management	\$400.00	\$400.00	\$400.00	\$400.00	\$400.00
Social media	Facebook ads	\$500.00	\$500.00	\$500.00	\$500.00	\$500.00
Other		\$2,000.00	\$2,000.00	\$2,000.00	\$2,000.00	\$2,000.00
Reputation management		\$500.00	\$500.00	\$500.00	\$500.00	\$500.00
Print	Internal marketing	\$1,500.00	\$1,500.00	\$1,500.00	\$1,500.00	\$1,500.00
Promotions		\$250.00	\$250.00	\$250.00	\$250.00	\$250.00
Marketing spend		\$10,050.00	\$11,550.00	\$10,050.00	\$10,050.00	\$11,550.00
Projected reveune		\$200,000.00	\$200,000.00	\$200,000.00	\$200,000.00	\$200,000.00

Fig. 15.1 An example of a marketing budget.

help you determine how much to budget toward marketing. Most marketing budgets should fall between 3 and 15% of the practice's total revenue. As an example, if your business generated 1 million in revenue last year, and you spent \$80,000 on marketing, your marketing budget represents 8% of your total revenue.

Where your practice is in its business life cycle influences what percentage of your projected revenue should be directed toward marketing endeavors. The percentage is based on several factors, such as location, current revenues, and business objectives. Every practice is unique: A practice that is brand new, one that has just opened its second location, and one that wants to grow by more than 30% next year will each need to commit different percentages of revenue to marketing. Consider a scenario in which you have been in practice for 3 years. You generated \$1.2 million in year 2, \$1.5 million in year 3, and your projected revenue for year 4 is an estimated \$2 million. Your year-over-year growth rate is 25%. To achieve this 25% growth rate again, you will need to spend at least the same amount on marketing as last year, *plus* an increase, to drive the projected growth.

The marketing budget includes both fixed and variable costs. Fixed costs are expenses that do not change, such as auto-renewing and 1-year agreements. Examples of fixed costs include ongoing SEO, reputation management, and billboard and directory listings. Variable costs change, depending on a variety of factors. Examples of variable costs include Google AdWords, Facebook marketing, and a videographer. Some costs can fall into either category, depending on your agreement with the specific vendor. For example, one live chat company may charge a fixed fee each month for unlimited usage, while another may charge per chat or per lead acquired. In the latter case,

the bill will vary depending on usage in any particular month. Fixed and variable costs have both positive and negative attributes, and it is important to know the types of expenses in your budget and when each agreement ends.

Finally, your marketing budget will depend on the competition in your local area. For example, a practice in a suburban area may not see much competition. In contrast, urban markets can be very competitive, and a practice here will need to keep pace with local competitors. This may mean driving up the cost-per-click for PPC, proactively increasing the number of practice reviews, or adding additional videos. Keep close track of competitors' reviews and their Google ranking to ensure you stay ahead of their marketing efforts.

15.4 Building Your Digital Marketing Team

To create a successful digital marketing strategy, you must be able to manage or delegate the management of your marketing efforts and the various moving components that encompass a marketing plan. An effective marketing team will include both internal and external resources, working closely together to get the most out of your marketing budget. With the complexity of today's social and digital technology, a team with broad experience is essential. Clients (patients) need to be engaged in real time and kept engaged throughout the customer life cycle to maximize the return on your marketing investment.

Your internal marketing team includes every staff member in your practice. The way your staff interacts with clients significantly affects the customer experience, and ultimately, how the customers view and share information about your practice. Positive customer experiences drive more business to your aesthetic practice through patient referrals and positive online reviews. Your internal team should have a decision maker to oversee all endeavors and consistently move marketing projects forward. Depending on the size of your practice, this decision maker may be the doctor, the office manager, or the marketing director. Ideally, your practice will have a coordinator, or someone who can generate content for the practice, to help the external team continuously generate new traffic and leads. Examples of content may include before-and-after photos, videos, and photographs of the doctor, office, and staff. It is difficult to grow a practice without sharing new content with the external team to place on your website and share on social media. This coordinator should also map out a patient's predicted journey through the practice, to understand key marketing opportunities along the way. A coordinator also ensures that all marketing campaigns align with the broader goals of the practice and serves as a liaison between the rest of the organization and the external marketing team.

The external digital marketing team typically includes a web vendor or a digital marketing agency, and may also include a marketing consultant, content writer, videographer, PPC company, live chat vendor, and other services. While most projects overseen by the external team could technically be completed by an internal team, few plastic surgery offices can afford to hire a full-time marketing director, social media expert, content writer, and web developer to work in house. The doctor, business manager, and marketing director are unlikely to be able to remain current as digital experts, so a digital marketing agency and other marketing vendors can be of help.

The external web vendor or digital marketing agency you choose should include a CEO that leads the agency and sets standards for the marketing team. The agency should include account managers, content writers, on-page SEO specialists, social

media managers, graphic designers, front-end and back-end developers, email marketing experts, a video optimization team, search engine marketing (SEM) managers, PPC managers, and others. This external team can be a powerful tool for operating a profitable practice, driving business traffic, and growing an audience.

Having the resources to staff each of these external team roles and to fulfill demands in an ever-changing digital marketing space can be difficult for even the best digital marketing agency. Thus, much like in investing, diversification lowers risk. Vendors that specialize in different aspects of digital marketing can work together to maximize your marketing plan. Continuously assessing the size and strength of your marketing team will help you get the most out of your marketing efforts. The difference between success and failure can depend on your knowledge of digital marketing and having the right team by your side.

15.5 Navigating the Whirlwind Internet Environment

As consumers spend more time and money online, particularly the growing financially viable millennials, the number of platforms and options to market to them continue to expand. Cosmetic-focused consumers are leveraging more online resources as part of their decision-making process, and your practice has the opportunity to gain valuable exposure in more places online than ever. Digital marketing has expanded beyond having a website and doing SEO, Google AdWords, and PPC advertising.

The evolving complexity of leveraging each platform requires Web-savvy personnel to collaborate with comprehensive Internet marketing providers. Cosmetic-related practices are spending increasingly more resources on online marketing, and many of them have made the Internet their primary marketing and advertising medium. Simply put, digital marketing has become highly competitive, increasingly sophisticated, and expensive.

Although the costs and risks of online marketing are rising, a recent study showed the most popular information source for patients prior to having their first surgical appointment was Internet searches (56.9%).¹ Although patients eventually choose a surgeon based on a personal consultation, it is increasingly important to build your online visibility and credibility prior to their office visit.

The rapid change in online consumer habits, the emerging and evolving platforms, and the competitive plastic surgery marketplace mean many “evergreen” digital advertising strategies do not stand the test of time. Nevertheless, the timeless principles and strategies of digital marketing allow practices to play an active role in their marketing like never before.

15.6 Marketing Plastic Surgery in a Mobile World

The most fundamental element to your Internet marketing is still your website. It is often the most overlooked vehicle to expand your organic visibility, build your brand, and generate more quality leads. This is increasingly important as we continually move toward a mobile-dominated Internet. As of 2018, 52.2% of all website traffic was generated by a mobile phone.² In some markets, mobile plastic surgery-related traffic makes up an even higher percentage, so your online marketing should be designed with a mobile-first view.

15.6.1 Mobile Responsive Design versus Mobile-First Design

Most practices have a “mobile-friendly” or responsive website that recognizes whether a visitor is using a smartphone or a desktop, then dynamically changes the layout to fit in the user’s screen size and position. However, responsive websites are neither all developed in the same way nor do they perform at the same level. In most cases, websites are designed with the desktop view as the primary design, and the mobile view is a slimmed down version. Elements are either squeezed into a smaller screen or they are eliminated. This applies to responsive template website designs, which offer little flexibility to make mobile-centric changes.

Mobile-first development is built on the premise that mobile users view, engage, read, and navigate very differently than those using a desktop. The mobile layout is developed first as the main design and then expanded, with elements added to leverage the larger desktop view.

15.6.2 Website Design Strategies

Website usability “best practices” have remained largely intact for years, but the growth of mobile is changing the way we view and design websites. Early Nielsen Norman Group research (2006) conducted an eye-tracking and heat-map study that showed website visitors reviewed web pages in an “F” pattern.³ Most of visitors’ attention was on the top left corner, dissipating as they moved down and to the right. This was a foundation for much of the website design industry.

More recent research (April 2018) indicates that mobile views are changing website behavior, and the standard “F” pattern design is giving way to more vertical user habits (scrolling) and other viewing patterns.⁴ Previous eye-tracking data revealed 80% of viewing time was focused “above the fold” (before scrolling down). That percentage has dropped to 57%. However, it is important to place priority elements high on the page, as 74% of viewing is done in the first two “screenfuls,” and only 26% scrolled further down.⁵

Adding heat-mapping software is inexpensive and can be used along with Google Analytics to help you determine how your pages are performing and whether changes need to be made. Generally speaking, you will want to keep your home pages more concise and give your internal pages more room for substantive and visual content.

15.7 Leveraging Google Analytics

The most critical way to continually improve your online marketing results is access to your website’s full Google Analytics (GA) data. Surprisingly, many practices do not have access. Limited reports that marketing agencies send typically offer no real insights for improvement. Every practice should request and review their GA data and receive some training to access, interpret, and incorporate this data into their strategies. The underlying goal is to identify data and trends that can lead to actionable items, and your GA data can reveal opportunities in almost every aspect of your marketing efforts.

15.7.1 Website Design Hints

Most practices recognize fundamental GA information such as audience overview data: (1) *average session duration*, (2) *bounce rate*, and (3) *pages per session*. This data may give an overall assessment of the health of your website and marketing, but it does

not stimulate specific actionable ideas. One important area of GA that can provide such insight is mobile traffic and performance to assess the effectiveness of your mobile design and sets the bar regarding measuring design improvements. Secondary mobile data reveals deeper insights into the performance of individual pages. This data can identify primary pages that need additional promotion and if they need improvement to engage and convert mobile visitors. Excessive bounce rates, short average time on page, and high percent of “exits” indicate a page may need some work.

15.7.2 SEO-Related Data

How visitors engage with your website impacts your overall search engine rankings, so bounce rates, time on site, and pages per session can provide some SEO insight. However, page-specific data can give more improvement hints. One of them is “Entrance” data.

Keep in mind not all visitors enter your website through the home page. “Entrances” data shows how frequently visitors enter your website through a given page. This is important when considering the SEO performance of a high-value page. For instance, your primary breast augmentation page is usually optimized with the goal of appearing high for breast augmentation–related searches. Low entrance numbers can identify weak performing pages that need more SEO attention.

15.7.3 Paid Advertising Insights

GA offers crucial PPC conversion tracking information about your Google AdWords campaign, but other data can be equally helpful. One of them is day-of-the-week and time-of-day traffic. Knowing popular days and times can help you strategize a more effective PPC schedule. It can also assist in developing more effective landing pages that are designed to convert more telephone calls during working hours and email/chat leads during times your office is closed.

These are just a few samples of how GA data can help guide marketing decisions. The more you become an expert at your own data, the more creativity you will bring to identifying new opportunities, strategies, and tactics.

15.8 Choosing the Right Media Makeup

Before they had websites, plastic surgery practices’ marketing options were very limited. TV was dominated by ABC, NBC, and CBS. Radio was limited to a couple formats, and most major markets had one newspaper. The good news for surgeons was their intended audience had fewer choices and was much easier to target.

Today, our attention is disrupted by hundreds of channels, Internet radio, and online news, not to mention digital media, videos, and of course, social media. We have an overwhelming number of platforms, and even options within each platform. Choosing the right media combination is a much bigger task, but essential to achieving marketing goals (► Fig. 15.2).

A fundamental aspect in selecting the right marketing channels is to time when each channel reaches your target audience in the sales funnel. Mass media advertising can still gain an immense amount of immediate visibility, branding, and even leads. However, like all “interruption” advertising, Internet ads on Facebook, Bing, Instagram, and even Yelp give you tremendous reach with low costs per impression, but the



Fig. 15.2 Coordinating marketing efforts across all platforms yields the best outcome.

conversion rates are low. Search-related marketing and advertising, on the other hand, reaches a more concentrated and targeted audience that is later in the sales funnel. Search audiences are much more qualified, but they are more expensive to reach.

15.8.1 Hands-on Search Engine Marketing Strategies

The vast majority of practices do not have a full-time digital marketing specialist managing their SEO campaign, so they retain an agency to handle their organic search exposure. For the most part in the past, practices felt they had no ability to control or substantively contribute to their organic rankings. However, successful online marketing increasingly focuses on user experience and the “real” nature of your practice, patients, reputation, and authentic content. Search engines embrace and value user engagement signals, and this is the area of SEO where your practice can participate and make a difference.

Blogging

Blogs have been a staple in the SEO industry for many years, yet some question their usefulness in an increasingly complex SEO environment. First, content and blogs continue to be a major part of SEO strategies, but most practices have relinquished blogging and new website content development to their SEO agency.

Second, just like social media, the quality and type of content determine the engagement and value of your blogs. Studies indicate that⁶ *authentic* content (personal pictures, videos of events and happenings in your practice) many times outperforms popular surgical photos and videos, even before-and-afters. High-engagement, rapport-building content should not be limited to social media.

Third, simply posting lots of blogs does little to boost the credibility of your website—it just makes it bigger and more bloated, diluting the higher quality content of your site. Effective blogging incorporates link strategies to important priority pages. The content should be timely, topical, and interesting, and then blog needs to be promoted to reach an audience. There are many ways to drive good traffic to blogs, including: promoting it in multiple social media platforms, boosted posts, e-newsletters, follow-up sales materials, and press releases.

As for volume, there is no single magic number that ensures results, although research indicates three to five posts per month is most common. Studies also show excessive posting can exhaust your audience and sacrifice the quality of your content. As a rule of thumb, you should concentrate more on the quality and promotion of your post, rather than the frequency.

Other Content Marketing and Public Relations

Thought leadership content, such as professional journal articles, quotes in news articles, and courses you present are all valuable assets for promotion. If they are online and accessible, be sure to request a credit link to your website. Also, drive traffic to them through linking-building strategies mentioned earlier. These types of assets can get listed high on search engines when consumers research the surgeon or the practice, and are great to protect your namespace credibility and boost your brand and reputation.

Directories and Other Online Websites

Another way your practice can directly impact your online visibility and website credibility is to get links and traffic from informational websites like RealSelf, Zwivel, Healthgrades, American Society of Plastic Surgery (ASPS), Smart Beauty Guide, and others. These types of consumer resource websites are highly credible and have solid domain authority with search engines, so links from them are useful for SEO, and in some cases, drive high-quality traffic and leads. However, unlike professional society websites, some of the commercial companies charge a monthly fee. Use Google Analytics to check referral traffic volume, and monitor leads from them to judge the cost and value of each.

Paid Advertising

There was a time when search engine PPC advertising was the only game in town when it came to paid advertising. Changes in platforms and technology now allow practices to take more control of their paid advertising. A number of high-volume websites, like Facebook, Bing, RealSelf, Yelp, and others, are leveraging their audience and developing easy-to-use dashboards, so practices can run their own paid advertising campaigns.

To ensure you get the most out of your paid advertising efforts, here are some quick tips:

1. Create as many segmented campaigns as needed. Do not skimp here. The more targeted, the better the results.
2. Limit campaigns to weekdays/working hours if the goal is lead generation.
3. Invest in custom landing pages that are custom to each campaign and focused on conversion.
4. Utilize live chat and other conversion strategies.
5. Monitor all leads, including call tracking phone number.

15.8.2 Social Media

Social media has become the primary marketing platform for practices that want to take more control of their digital marketing. Not only are the platforms built for practices to easily manage, plastic surgery is an ideal subject matter that transcends all social media channels.

Even as demographics shift, such as Facebook's growing mature audience volume, the channel remains a staple for plastic surgery digital marketing. In fact, social media has been able to defy traditional advertising and marketing rules of thought. Snapchat demographics, which skews to youth, flies in the face of conventional marketing wisdom and has generated cosmetic surgery-aged leads and built substantial exposure and branding for many progressive-thinking practices. The Millennial generation, which has grown into the professional workspace and target wage-earning demographics, continues to dominate the direction of social media activity and cosmetic surgery opportunity.

However, social media remains a medium for agile marketing practices. Changes in social media users, trends, behaviors, and activities happen faster here than any other marketing channel. We will try to provide more timeless information and insights.

Choosing the Right Social Media Platform

Choosing the most appropriate venues for your practice will depend largely on the surgeon's comfort level, staff, commitment, and vision. At the time of this writing, the primary social media channels for cosmetic practices are Facebook, Instagram, and Snapchat.

Facebook, because of its enormous audience size and penetration in all demographic profiles, continues to be the dominant platform industrywide. It also gives Facebook the greatest staying power of all three platforms (remember MySpace?). In fact, as more mature audiences have increased their engagement and activity, the opportunity to market more expensive body contouring and facial procedures continues to increase. Since Instagram is owned by Facebook, it also appears it will likely be around for some time.

Snapchat has had mercurial growth in a very short period of time for some progressive marketing practices. The ability to post a wider variety graphic of visual content than other platforms, along with "selfie" consumer trends, has fueled much of its growth in the plastic surgery industry, despite its youth-dominated audience. Only time will tell if the platform maintains its growth or marketing viability in light of competition with other platforms and changing demographics.

Keys to Social Media Success

Although each platform may attract a different segment of the general population with different message types, there are common threads that drive social media success.

- **Commitment to consistency:** All social media marketing requires commitment and investment of resources to deliver consistency in both content and frequency. Practices that do not have the resources and time to commit to all platforms need to identify the one that best fits the comfort level of the surgeon, the personality of the practice, and its patient base. Social media posts are typically more frequent than blogging, so commit to at least six to eight posts per month.

- **Visual content:** Regardless of which social media platforms your practice chooses to utilize, including your website blog, visual types of content, including photos, gifs, videos, and graphics drive the majority of high user-engagement posts. In fact, Instagram and Snapchat require content to be visual. Visual content allows the practice to be more creative and personal.
- **Practice engagement:** As mentioned earlier, content that revolves around and includes your practice and its people receives the most views, likes, shares, and comments. The most important element to successful social media marketing is practice participation. Mercenary social media campaigns run by outside agencies alone may produce more posts, but they lack the engagement of highly successful campaigns where the agency collaborates with the practice.

Practice owners must have a role in monitoring and guiding the direction of their social media brand. Just like websites, social media content not only projects the image of your practice, but you are responsible and liable for the information and content that is posted. This is not intended to intimidate you or prevent you from embracing and leveraging these channels with a creative spirit. Successful social media marketing requires thought, planning, time commitment, but mostly accountability at the staff and practice-owner levels. Practices that conduct regular staff meetings or huddles can easily incorporate social media updates for both surgeon and team.

15.9 Stay Current

Since online marketing changes quickly, it is essential for the practice to stay abreast of marketing-related news and updates, beyond what their agency may share. Use this short list of useful marketing resources and newsletters to start. As you and your marketing support staff receive insights, your sources will expand and you will find resources that fit your interests and align with your marketing philosophy. Here are some suggestions:

<https://www.hubspot.com/resources>
<https://moz.com/blog>
<https://searchenginewatch.com>
<https://neilpatel.com/blog>
<https://moz.com/moztop10>
<https://www.marketingprofs.com/newsletters/marketing>

15.10 Transitioning and Newly Employed Surgeons

Whether you are finishing your residency, starting your own private practice, or are an experienced physician, there are always opportunities for building and improving your online brand. Even if you move your practice to another city or join a group practice, “Dr. + your name” will always represent your brand.

Consistency across the Internet is key for digital marketing success. Take a moment to do a Google search for your name and city, combined. You are likely to find multiple listings already exist that are not complete or that provide potential clients with inaccurate information. It is vital to have a digital marketing plan that makes sure your name and/or practice, address, phone number, profile image, and most importantly, a working link to your website are complete and accurate. It is also important that the first ten listings on Google's organic search results, and even the next ten, are claimed

and optimized. As you do the Google search, look for your name and any cities you have practiced in over the years. There is a strong chance that you will find some listings with old, outdated information. Also, make sure the National Provider Identifier (NPI) registry has accurate information, as this data is used for many third-party websites. You do not want wrong information to be pushed out across the Internet.

The next step in controlling your online brand is to create multiple social media pages for you and/or your business. Ideally, you will use the same username and handle across *all* social media platforms, making it easier for potential clients to find you. When setting up these social pages or other online listings, it is better not to use your personal email, as you may need to provide access to this email to a marketing partner in the future. Take the time to create a separate business email, preferably an @domain address, to use for all your business's digital assets. This will also help you manage these assets more efficiently, with all information housed in one location.

Next, start building your own database of client names, phone numbers, and email addresses to be used for future marketing opportunities, including promoting new products and procedures. Other ideas to advance your reach include getting involved in your local community, answering potential clients' questions on online forums, and writing a monthly blog, either for your own website, one of your society's websites, or a social media platform. Finally, be sure to have a nice headshot of yourself to use across all of these social media channels. As you navigate through the ever-changing world of digital marketing, you can significantly influence your client's perception of your practice through digital marketing.

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IV

16 Building and Managing Your Own Surgical Suite

Gordon Merrick and Joshua M. Korman

Abstract

Deciding to build your operating room is a daunting decision. This chapter serves as an excellent guideline in building your operating room from start to finish, including requirements, whom to hire for what job, a timeline, and finally how to run your surgical suite when it is up and running.

Keywords: Medicare, surgical suite, ASC, architect, accreditation, AAAASF, AAAHC, IMQ, operating room, ambulatory care, surgery center, outpatient surgery

Editors' Note

Federal and State governmental regulations continue to evolve. This chapter provides valuable information, but by necessity, you should double check current regulations with your respective authorities.

Some surgeons see owning and operating their own office-based surgery (OBS) or ambulatory surgery center (ASC) as a dream, while others see it as a nightmare. For those who see the “dream,” this chapter can provide some guidance in designing, building, and managing your successful center. Part I focuses on the process from thinking about it to actually doing it. Part II provides ideas to running your facility safely, efficiently, and profitably.

16.1 Part I: The Process

16.1.1 Why Develop Your Own Surgical Suite?

Depending on where you practice, the impetus for developing your own operating suite may vary, but many reasons are universal, including (1) convenience of scheduling; (2) cost savings over using a hospital's or another surgeon's operating room (OR); (3) control of turnover time; (4) control of quality of care, including choice of anesthesiologist, instrumentation, and equipment; and (5) time saved by avoiding travel to and from another surgical suite. With your own operating suite, you can start operating as early as you want, dictate and see a post-op, make a few phone calls, and then return to the OR for the second case. This time saved is a precious commodity. Other benefits include the ability to return to the OR for unexpected complications.

In some states, reimbursement by insurance for covered procedures is a huge incentive. Reimbursement can drive the consideration of building a surgery suite. If facility reimbursement is a motivation to build an OR, then one must consider which accreditation agency to use and whether to seek Medicare-deemed status.

16.1.2 Which Agency to Use for Accreditation?

There are several considerations when deciding which accreditation agency to use for your facility's approval. The big three are the Accreditation Association for Ambulatory Health Care (AAAHC) (www.aaahc.org), the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF) (www.aaaasf.org), and the Joint Commission (www.jointcommission.org). The Institute for Medical Quality (IMQ) (www.imq.org) is related to the California Medical Association and now operates across the country. All of these agencies provide the deemed status option to achieve Medicare certification as well.

In choosing an accreditation agency, consider three things: reimbursement from third-party payers, paperwork, and physical facility requirements. There are also credentialing and personnel considerations. Which agency you use depends upon your reason(s) for seeking accreditation (see Chapter 16.1.10). See ►Table 16.1 for a basic comparison of the agencies.

If you decide that Medicare certification is beneficial for your facility for reimbursement purposes, know that which agency you use to achieve Medicare approval is not important to payers. That is, Medicare certification supersedes the accreditation. You should choose the agency that suits you and avoid any other consideration, such as non-Medicare reimbursement or “reputation.”

16.1.3 Third-Party Reimbursement

If the number of your reimbursable cases is above 33%, you should seriously consider Medicare-deemed status, as payers are pushing more and more for Medicare approval for the facilities they reimburse. Medicare-deemed status refers to Medicare certification through one of the accreditation agencies instead of through your State Health Department. Please note that although you may see only one Medicare case per year, you can benefit greatly by receiving Medicare certification, as payers administered in your area may require Medicare certification for ASCs to receive reimbursement. While AAAHC and Joint Commission have been around the longest as agencies that inspect multispecialty practices and facilities, and insurance companies recognize them more than the other agencies, some payers, like Aetna, have long required Medicare certification for reimbursement for outpatient surgery centers. While several assembly bills have been written to require Medicare certification for all outpatients' surgery centers, none have passed—as of yet. Not all states require Medicare certification to bill private insurance companies, however. State licensure allows you to do so in some states, such as Texas.

Insurance companies will pay the surgeon more to do a procedure in the office, since they do not have to pay a facility fee billed by a hospital or a surgery center. So, if you plan on billing for the use of the OR, establish a separate entity (LLC, LP, Corp.—your state may require a “professional” designation), then obtain a tax ID number and a National Provider Identifier (NPI) number for that entity (see Chapter 16.2.2).

Increased recognition does not mean increased reimbursement per case, but it does mean increased “awareness” by payers; in other words, you will get paid more often. While a payer that reimburses a facility will not reimburse more based on accreditation or Medicare certification, they may still pay the center when another unrecognized accreditation would have yielded a rejection.

Table 16.1 Comparison of the accreditation agencies for OR surgical suite approval					
	AAAASF	AAAHC	Joint Commission	IMQ	Comments
RN required	Yes	Sort of	Sort of	Sort of	All but AAAASF are not absolute; but each surveyor expects to see an RN/PA in charge, not a tech/MA.
Board certification	Yes	No	No	No	Board eligibility is okay for all but director for AAAASF.
Hospital privileges	Yes	No	No	No	All agencies want proof that the surgeon is qualified. Requirements vary (proctoring and/or privileges).
Surveyor leeway	No	Yes	Yes	Yes	AAAASF surveyors can say a lot during the inspection, but the Central Office can snap them back into reality.
Timing for initial survey	6 weeks	6 weeks	6 weeks	6 weeks	Each agency has their version of an “Early Option” so make sure they know that otherwise the time may be longer.
Third-party reimbursement	\$	\$\$\$	\$\$\$	\$	AAAASF and IMQ have not lobbied payers, so AAAHC and Joint Commission are better for reimbursement—Medicare is best.
Physical Facility					
OR size	4 ft around table	Appropriate, safe	Safe	Safe	AAAASF provides a plan review service for a small fee.
Recovery room	Required, but no number of beds	Unclear	Unclear	Unclear	
Clean/dirty areas	Want separate; but if flow is good, combined area is fine with “separation”	Unclear—leave leeway to surveyor	Unclear—leave leeway to surveyor	Unclear—leave leeway to surveyor	
Abbreviations: AAAHC, Accreditation Association for Ambulatory Health Care; AAAASF, American Association for Accreditation of Ambulatory Surgery Facilities, Inc.; IMQ, The Institute for Medical Quality; MA, medical assistant; OR, operating room; PA, physician assistant; RN, registered nurse; tech, technician.					

16.1.4 Paperwork Requirements

Organizations that are widely recognized by third-party payers are under more scrutiny and, thus, require more paperwork. Assume that the greater the benefit of the approval, the more difficult it will be to gain approval. Many people ask how many hours per day/week/month maintaining the accreditation process takes. Once the structure is established, and the office gets past the initial ramping-up period, the basic, daily tasks (completing logs and checklists) should take no more than half an hour of staff time in addition to other tasks in the office (see Chapter 16.2). Most approvals require the same logs (OR temperature, refrigerator temperature, pathology log, autoclave log, biological monitoring, etc.). Every few months, credentialing of physicians and licensed personnel must be updated and documented, since licenses, Drug Enforcement Administration (DEA) registrations, certifications, and insurance expire. While some variances occur in logs and checklists, and some agencies require much more in terms of medical staff and personnel files (e.g., more background checks), these are not regular, time-consuming activities. The big variables come in quality improvement and the environment. In very broad terms, the amount of paperwork required by each organization from the most paperwork to the least is as follows:

- **Medicare:** It does not matter which agency you use if you are seeking Medicare-deemed status certification; the Medicare process will increase the amount of paperwork. Even if it is just because the surveyor has to go through more paperwork, the surveyor will make sure you also have to go through more. There are very few specific paperwork requirements exclusive to Medicare, but there are some (e.g., a backup power log showing testing of the generator at full load for 30 minutes every 30 days and checking of the fire safety devices each month).
- **Joint Commission:** In 2018, the Joint Commission was required to testify before Congress regarding the number of Condition-level deficiencies (Conditions are the BIG problems, Standard-level deficiencies are the wrist-slaps) that the Centers for Medicare and Medicaid Services (CMS) or State Health Agency surveyors found during their “validation” visits but the Joint Commission surveyors did not. This has led to a renewed “focus” by Joint Commission surveyors on any and every detail. Naturally, this means Joint Commission surveys are very difficult. In addition, our organization has found that Joint Commission’s regular accreditation standards are not far removed from Medicare standards.
- **AAAHC:** Just an eyelash under the paperwork requirements of the Joint Commission, the AAAHC is firmly entrenched in the “if you didn’t write it down, it didn’t happen” camp. Regular quality improvement studies, minutes of meetings, and gobs of credentials and credential verification activities are required. The AAAHC requires some specific policies that may not seem to be a part of your practice or your surgery center (e.g., how would you respond to a terrorist attack?) but, if you have read the standards book cover to cover while taking notes, you will be okay.
- **IMQ:** While IMQ is making inroads into states outside of California, they are still not well known. Their paperwork requirements are just a notch below that of AAAHC, we think. The two big differences between IMQ and AAAHC are size and responsiveness. If you have a question for IMQ, you can expect to speak to the appropriate person and obtain a response within 24 to 48 hours. I have not had the same luck with the more established agencies.
- **AAAASF:** AAAASF remains the most relaxed in terms of paperwork. However, they have the most detailed physical requirements of any of the accreditation agencies

and I would recommend using their standards for the physical environment when designing an office-based surgical suite. AAAASF surveyors *have* been exposed to the regulations of other agencies and their interpretation of standards is getting a little more stringent. The amount of credentialing and quality improvement (QI) activity is still less than that of the other accreditation agencies and the Central Office is good at redirecting AAAASF surveyors that may veer off the intended path. Do not heed the stories of yore regarding the laxity of AAAASF surveys. While the AAAASF has not aggressively sought recognition by third-party payers, it has worked well with states that require accreditation.

Note

All the above paperwork requirements of the AAAASF, AAAHC, Joint Commission, and IMQ are in relation to their *regular* standards, not Medicare standards. As stated previously, there will be a leveling process when seeking Medicare approval.

16.1.5 Physical Requirements

The accreditation agencies do not provide the clearest direction regarding physical requirements for the surgical areas, but the AAAASF provides the most guidance. Most states either have their own very prescriptive requirements, or they adopt the guidelines of the American Institute of Architects (AIA) or the Facilities Guidelines Institute (FGI) for their state license. Do not listen to those who tell you that ORs of 400 square feet, showers for staff, and step-down areas are required for accreditation or Medicare certification (unless you are in a Certificate-of-Need [CON] state). Medicare says little about the physical facility besides fire/life safety issues. People often confuse surgery center approval standards, and apply state *license* requirements to Medicare *certification* and *accreditation*. However, outside of the AAAASF, surveyors are given large amounts of leeway in how they interpret the physical standards.

All the agencies and their surveyors want to see a space that has some logical flow to it. They are interested in: (1) patient privacy (not only when talking about their surgery, but also when walking the hallway when their backside is exposed); (2) infection control (vague air conditioning requirements, low traffic flow past the OR, no dragging of hazardous waste bags through patient areas, one-way flow of dirty instruments from washing to wrapping to sterilization); and (3) awareness of patients' fear and trepidation (preoperative patients should not walk past recovering patients to get to the OR nor should bandaged patients be escorted to their car in a wheelchair in view of the waiting room). The Joint Commission and AAAHC use words like "adequate," "appropriate," and "safe." Here are a few of AAAASF's requirements for surgical facilities (they have separate standards for procedural centers that are limited to nonsurgical procedures such as epidural injections for pain management and gastrointestinal endoscopy):

- Seamless flooring in the OR with 4-inch self-coving;
- Washable ceiling in the OR ("hard lid" of sheetrock or washable tiles are acceptable, either mylar or vinyl-covered drywall) and above the scrub sink;
- A 4-foot space around each side of the table (rolling carts do not count as obstructions as they can be moved to allow emergency personnel around each side of the bed in an emergency); and

- Separation of clinical areas from surgical areas. Assume that there must be a door to the surgical area that includes the OR, recovery room, sterilization, and janitorial areas. No consult rooms, exam rooms, doctor's offices, or lunch rooms should be within the surgical area.

There are no standards anywhere that tell you the basics of space planning for a surgical suite that we know of. Just because someone else you know got away with having their bathroom double as the sterilization area does not mean that it is okay for you. Be observant if you work in another surgeon's OBS suite and note down what you like and do not like. Check out more than one. Assume that the surgeon whose office you are observing did the same thing and tried to trim down the amount of space required, cutting corners where possible. Do not assume you will be able to cut more corners; instead, focus on improving flow and making your space work for you while considering patient, staff, and purveyor flows (e.g., Where will deliveries be dropped off?) and patient comfort.

Then there is Medicare. There are a few ways to educate yourself, your contractor, your architect, and your engineers about the physical requirements for Medicare certification. You can find the form that Medicare and accreditation inspectors use when surveying a surgery center for compliance with Medicare guidelines. It is known as the CMS2786R, and you can find it at <http://www.cms.hhs.gov/cmsforms/downloads/CMS2786R.pdf>. The other way is to purchase the Life Safety Code checklist from the publishers, NFPA, or purchase the Physical Environment Checklist from AAAHC, which is a lot more focused than the voluminous original version. Know that the standards for Medicare certification apply not only to your suite, but the floor you are on and the entire building. The standards include the following:

- The building in which the surgical suite is housed must meet minimal fire-rating standards. The suitability of the building depends on how many floors the building has and which floor will house the surgical suite, among other things. Fire sprinklers may be required for the suite, and you must assume if they are required for the suite they are required for the entire building, not just your suite or your floor. A surgical suite in a stand-alone, single-story building has fewer requirements than a surgical suite on the fourth floor of a five-story building. The rating also becomes more stringent the more the patients may be "incapable of self-preservation," and the higher up in the building the surgical suite is located. *Note:* In California and a few other states, State building code requires automatic sprinklers for the entire building if general anesthesia is to be administered, regardless of the type of accreditation.
- Physical separation (at least a 1-hour firewall) from the surgical suite to any other occupancy, including your office, the place upstairs, and the office downstairs. You will have architects and contractors saying that the 1-hour separation is not required per State code and they may be right, but you need to be firm and tell them you are looking for approval from a higher power—Medicare.
- Autonomy of the space. This subject has been discussed previously, but we mention it here, again, as it can seriously affect your decision-making when looking for a space. This is where the Medicare-certified center, including the waiting area and the sterilization area, cannot share any space with another facility. Some surveyors balk at having a telephone/computer within the walls of another tenant (a neighbor who happens to be you, usually), so be sure to allow

enough space for those items in the surgery area. Assume that the Medicare surgery center will have multiple owners; it must have a lease just like any other tenant. If you must use some of your own office space for the surgery center, set up a lease for that space. It sounds silly, but you *are* dealing with the Federal government. Also see “Physical Requirements for a Medicare Surgery Center” later in this chapter.

- Difficult electrical requirements, including a Type 1 essential electrical system (EES) for those who wish to perform procedures utilizing general anesthesia in their OR. This is one of the more painful parts of the physical process as engineers, architects, and contractors often disagree about the interpretation of the codes and they often do not agree with State codes. The code states there must be a generator, but currently there is a waiver to allow battery emergency power. No one knows if or when that waiver will be removed. Just because you were approved 5 years ago does not mean that you will pass once the code has changed as some codes are not able to be “grandfathered.”

16.1.6 State License

If you decide to be so bold, a state license for your ASC may be in the works. The difficulty of obtaining a state license depends largely on whether you practice in a CON state. To put it in brief, the CON was created to protect hospitals. The process includes submittal of many documents (lease, architectural and engineering plans, environmental effect reports, etc.) before you receive initial approval. Then, notices are sent to the local hospitals and the hospitals can argue against the development of the new center if it will negatively affect their bottom line. If there is capacity available (open OR time), the hospitals will successfully argue against the new surgery center, saying it will harm the hospital, which in turn will harm the community because emergency services and gratis services will need to be cut and the surgery center will be skimming from the top, etc.

In a CON state, a significant investment is required just to make the submittal to the regulating Board. Several surgeons who can bring substantial volume and can make an initial investment must form a significant critical mass before the decision to move ahead can be made.

If you are in a state without a CON, there are usually very succinct and detailed guidelines regarding the construction of the center, including large ORs, lots of sterilization space, many bathrooms, etc. Many states without their own guidelines defer to the guidelines of the AIA or now, the FGI. The AIA requires large ORs, step-down areas, exam rooms, and other space-eating requirements. California has relatively mild architectural requirements, but its mechanical, plumbing, and electrical requirements are “simplified” versions of the hospital code and tend to be overly stringent.

Obviously, state license regulations vary from state to state, and you need an expert to help you determine whether you and your proposed space can meet those requirements. Sometimes this can be an architect, sometimes a general contractor, or, most often, a surgery center consultant. Make sure you are fully informed of the state's requirements before you sign a lease, purchase property, or dive into the CON process.

For example, in California, a state license for an ASC that is owned by a physician (with as little as 1%) is not available—you cannot get a state license if you have ownership. This occurred after the Department of Public Health bowed out of the

process due to a court loss. While legislation has been considered that would require all outpatient centers to be *at least* Medicare-certified, if not licensed, nothing has passed. In Texas, you can have a state-licensed ASC without Medicare certification, so obviously requirements vary by state.

16.1.7 Approval Terms

Know the difference between *accreditation*, *certification*, and *licensure*. Only the State can license your facility. Only Medicare can certify your facility. The Joint Commission, AAAASF, IMQ, and AAAHC can provide accreditation for your office and facility. As previously stated, all the accreditation agencies can also provide Medicare-deemed status certification if your facility (your certified surgery center can be called a “facility” while your office cannot) meets the physical and administrative requirements. If your State requires accreditation of offices that do more than local anesthesia, your office may receive accreditation and be State-approved, but that is not the same as being State-licensed. So, if you are accredited and an insurance company asks for your office’s license, the only license you may have is your business license. By now, you would think insurance companies would know this, but they like to make things difficult.

Medicare-deemed status certification is the program that allows surgery centers to obtain Medicare certification through accreditation agencies rather than through the State Department of Health. The deemed status route is more expensive than regular accreditation, means more work for you and your staff, includes more stringent physical requirements, and, for the most part, takes longer from the receipt of the application by the accreditation agency to the day of the survey. Medicare surveys are unannounced, so scheduling them requires patience and good planning.

In some states—New York, for instance—how you refer to your space makes a difference. New York is a CON state and, with legislation that took effect in July 2009, prohibits OBS practices from calling themselves a “center” (as in a surgery center), “facility” (as in a hospital), or other related terms. Payers insisted they were confused by OBS facilities that called themselves a “center,” assuming they were CON-approved facilities. Now the State has very stringent requirements for naming these practices if they are other than the physician’s name. So, in addition to the State’s control of the naming of your office, your policies and procedures must reflect your State’s preferences and requirements.

16.1.8 Development/Construction Recommendations

If you are going to build from scratch, build a suite that can at least be accredited, since states are headed in the direction of requiring accreditation (there are other reasons to be accredited listed later in this chapter). If you can afford to take on the financial responsibility of potentially additional space and additional cost, pursue Medicare certification (if you are not a CON state). If you are seeking reimbursement for the use of your OR, be aware of the payer environment as many payers are now requiring Medicare certification for all surgery facilities to whom they make payments. If you have a reasonable number of reimbursable cases that you perform each month, you should consider designing a suite that meets Medicare guidelines. Medicare certification may also be an insurance policy against future regulations that may require Medicare

certification for facilities seeking reimbursement or for those performing procedures under intravenous (IV) sedation or general anesthesia. *Note:* You *can* perform cases under local anesthesia and be reimbursed for the facility fee.

16.1.9 Differences between Accreditation and Medicare-Deemed Status Certification

The upside to Medicare certification is reimbursement for use of the facility. The downsides include the upfront expense for construction, the long-term rental expense of increased square footage, and the slight increase in staff paperwork to fulfill Medicare requirements.

Physical Requirements for a Medicare Surgery Center

The standard Medicare-certified surgery center is an autonomous legal entity that does not share any space with another entity (e.g., your office/clinic) and operates solely as one surgery center. In recent years, however, CMS has allowed several variations of this. First, they allow “two in one” arrangements. You have probably heard of these arrangements where the space is one entity on Monday, Tuesday, and Wednesday, and another entity (legal name, accreditation, and/or certification) on Thursday and Friday. This is often used for In-Network and Out-Of-Network entities utilizing the same space and, sometimes, pretty much the same medical staff. This arrangement is also used when the initial entity is not as busy as it once was and is trying to cut down on expenses by sharing the space. I have spoken with several attorneys who still believe this arrangement is somehow illegal, but CMS has published guidelines to address situations where two entities inhabit the same space.

Another interesting development is CMS allowing surgeons to use what was once their office-based surgical suite as a Medicare-certified surgery center. There must be either a physical or temporal separation. So, if the facility meets the physical requirements (fire, electrical, etc.) for Medicare, the space can be used as a clinic (complete with exam rooms, consult rooms, surgeon's office) 3 days a week and a surgery center the other 2 days a week. Again, the space must include the basics of a Medicare center, but this new development saves space and money in the long run. Another option is to build an office and an OBS facility.

The standard Medicare center is a “single-use” facility where only one thing happens: surgery. So, the Medicare-certified suite has its own waiting room, sterilization area, recovery room, janitor's closet, and its own OR that is not used by or connected to an adjacent office practice. The Medicare center can be separated by a firewall from an office practice or other occupancies, but dirty areas such as a corridor cannot open straight into the OR. There are no written size requirements for Medicare certification. Just like accreditation standards, the regulations use terms like “adequate” and “safe.” Your state may have requirements, but not Medicare. So if you are doing only light sedation and only blepharoplasties, you do not need a 225-square-foot (15' × 15') OR. But if you are doing surgeries requiring armboards, general anesthesia, lasers, or liposuction machines, you may need a larger room (consider the 4' around the surgical table from AAAASF). Similarly, there are no guidelines for the number or type of rooms or the size of the support rooms. That does not mean you can do what you want; you must still please the surveyors who may work in larger, well-designed spaces. Some basic tenets to follow have been discussed next.

Operating Room

Assume that, with general anesthesia, you should not go smaller than a basic 225 square feet. Do not assume that a 22.5' × 10' room will do. Be reasonable and be aware of the details. The AAAASF standard of 4 feet around each side of the bed is a good place to start. Anesthesia machines, video towers, and lasers take up a lot of room.

Recovery Room

Do not assume that an exam room will be a good size for a recovery room. Stretchers are usually 30" (with rails up) × 78", and do not turn on a dime. To accommodate patients being discharged on a stretcher, leave enough space to move the stretcher around and to move things around the stretcher. The recovery area must also have a nurses' station, where Schedule II–V medications can be stored in a double locking cabinet; forms can be kept; and records for ordering, invoices, and supplies can be stored. You may or may not need a privacy curtain around the stretcher. If you do, make sure it is fire-retardant. Having a door from the recovery area to the public corridor or exterior is very desirable, so that recovering patients do not get pushed past nervous patients awaiting their procedures in the waiting area.

Janitor's Closet

This is often forgotten, but you must have a way to clean up your center. A fire-rated room with a rated door and walls and a ceiling with automatic closure must be created to house a janitor's sink, a mop, and a mop bucket. The mop must have extra heads and one mop handle designated for OR use only. Try to allow enough space to store your biohazardous waste (usually in a 30-gallon trash can). That way, all your very dirty, hazardous stuff is in one place.

Clean/Dirty Utility Area(s)

The accrediting agencies do not require that a facility have a separate room for each function. However, when being inspected for Medicare certification, it is very difficult to convince inspectors that a room combining these functions can achieve the air conditioning requirements for each function (positive pressure pushing air out of the room for clean, and negative pressure keeping all the nasty, dirty air in the room for dirty utility). There *can* be one room for washing, rinsing, preparation, wrapping, and sterilization of instruments using the FGI guidelines, but it is difficult to get Medicare approval.

If dirty and clean areas are combined, the flow of the room should be one-way from bringing the dirty instruments in, to the sink, to the counter top, to wrapping, placement in the sterilizer to removal. Speak with your scrub technicians and nurses to make sure that adequate space is allotted to perform each function. The AAAASF requires a physical separation of clean and dirty areas, but this can consist of a Plexiglas divider on the countertop with signs indicating each side.

Always keep your dirty area smaller than your clean area. To allow maximum storage, nothing should be stored in the dirty room except dirty equipment and soiled, bloody items. In the clean room, you can store sterile packs, sterile supplies, etc. Know what kind of sterilizer you will want. If you are planning to use a tabletop unit, make sure that upper cabinets are not directly above the unit and that you have a ceiling fan above the sterilizer to prevent false alarms from your smoke detectors and/or sprinkler heads.

Waiting Area

You must have a separate waiting area for your center's patients with the caveat provided previously. Do not count on the benevolence of your surveyor allowing you to use your practice's waiting room for your center. *Note:* AAAASF has a plan review process for a nominal fee. We recommend this for those using AAAASF. The size of the waiting area is not specified, so use that to your advantage. If you expect to have a maximum of two people in the waiting area, make a very small waiting area. There is no requirement for a receptionist in the waiting area. Small Medicare-approved centers have had just two chairs in the waiting area. The room can be equipped with a buzzer that the patient presses upon arrival. The preoperative nurse can then open the locked door to greet and escort the patient to the pre-op area. If you will be seeing workers' compensation patients, consider a larger area. Remember, you do not make money in the waiting area and you have no need to impress patients at this point, since they have already chosen to have their surgery with you.

Storage

The more storage, the better. No, it does not make any money, but it will ensure that your center works efficiently and effectively. Storage is necessary in the clean room, and space must also be available for purveyors to drop off their dirty boxes. One mistake many people make is not providing an area for dirty boxes to be dropped off, as they cannot be stored in any clean or sterile area. The hallway is not appropriate because the boxes would block a fire exit. Consider an unused area of the recovery area, especially if a door designed for patient discharge from the recovery room leads to the exterior.

Flow

One-way flow is always the best. Just as in the clean/dirty area, the entire center should have a one-way flow so that there is no crossing back over for patients. The flow should allow patients to go from check-in to pre-op, then to the OR, to the recovery room, and finally to get discharged from the recovery room (patients can walk or get wheeled in front of recovering patients, but it is not best; privacy curtains can at least prevent pre-operative patients from seeing recovering patients, but it is possible for them to hear occasional moaning).

Air-Conditioning Requirements

Accreditation has no specific requirements for the air-conditioning system, even for the OR, but AAAASF requires that the OR temperature be maintained between 68°F and 72°F. On the other hand, CMS has adopted ASHRAE guidelines that are very specific and, of course, more expensive to comply with. The requirements include HEPA-type filtration, in addition to humidity, temperature, air exchange, and air pressure requirements. Most State building codes require a separate air-conditioning unit for the OR to ensure proper air changes and good infection control. If litigation ever occurs and you have adopted the CMS guidelines—or something close—you will feel much more comfortable knowing you have a system that is similar to what Medicare requires. IMQ now requires that ORs maintain 20 to 60% humidity and have an air exchange rate of 12 to 20 times per hour.

Medical Gas

Piped medical gases (in-wall) are not required by any agency or by Medicare. Side tanks in the OR are permissible as long as they are attached to the anesthesia machine. Most codes do not allow “storage” of gas tanks (if they are not attached to the machine, they must be storage) in the OR/procedure room. Small oxygen tanks (E-cylinders) at each bedside in the recovery room are acceptable as well. Some form of suction is also required in the OR and recovery areas. Accreditation agencies vary on whether each bed must have its own suction device (in addition to the crash cart) or whether beds can share a portable suction machine. Piped gases are very expensive, but much more aesthetically pleasing than side tanks and portable suction units. The standard requirement is that there be oxygen and suction available for each bed, including pre-op beds. While the Life Safety Code seems to be very prescriptive, different medical gas designer/installers give different answers as to how many suction and oxygen outlets are required at each bed if you decide to go with piped gases.

Space for Backup Power

For accreditation and Medicare certification, the uninterruptible power source (UPS) is currently acceptable. As previously mentioned, CMS has provided a waiver to allow UPS battery systems instead of generators, but that waiver may be pulled at any time. All agencies but the AAAASF require 90 minutes of backup power to be provided to patient areas for the monitors, lights, surgical table, anesthesia machine, etc. The AAAASF requires 120 minutes of backup power. Your electrical engineer will respond to your prepared equipment list, which should include the voltage and amperage of each item as well as which equipment will be on the backup power (not everything has to be). This information will determine the size of the UPS required. Smaller UPS units are economical when compared with generators. However, large UPS units (more than 20 kVA) are less cost-effective than generators. Note that if you do not give the engineers an equipment list, they can make up whatever they want and you are then at their mercy. They often plan for only about 80% capacity of true needs. You must get the equipment under control; otherwise, a large portion of your budget will go to a gigantic and unnecessary UPS.

If you are able, plan for a generator (propane, diesel, natural gas). Usually, a generator takes up about one parking space due to required clearances around the unit. Do not forget to plan for the generator when you are planning the space for your surgery center, because your city may have restrictions on where it can go. Furthermore, some building developments may have made agreements with the city regarding how many square feet (or minimum percent) of the development must be landscaped, and the generator may cut into that landscaping. Your city will have minimum parking requirements for medical business occupancies (an average is five spaces per 1,000 square feet), and the generator will take up one of those spaces.

Many fire departments do not allow generators to be installed on roofs due to the difficulty of getting fuel to them. Some do not allow natural gas generators, some do. California requires that you apply for a generator that has been approved by the Air Quality Management District (AQMD). In addition, you or your staff must obtain approvals and signatures from local residents and businesses to install the generator within a certain distance of any schools.

Some new projects will not have the option of a generator, as your city may require that things like the building's elevator be on the backup system. This is an example in which a UPS system would be cost-prohibitive when compared to a generator.

Despite the difficulty, if you have the option, go with the generator for the extra added "insurance," knowing that a generator meets state licensing regulations and the Life Safety Code, and that any future code revisions will not negatively affect your center.

16.1.10 Why Be Accredited?

Recognition of Quality

Since the publication of the first edition of this book, patients have become much more aware of accreditation and know that some of the accreditation websites (AAAHC and Joint Commission currently) have searchable databases so patients can check if your facility, whether office-based or Medicare-certified, is accredited. In addition, some state Medical Boards also have databases listing ownership of the surgical facility and the agency that approved it. Many surgeons have taken to placing the accreditation agency's logo on their website and marketing materials to help patients know the accreditation status. When discussing surgery with the patient and letting them know it will be performed in an accredited setting that is inspected at least every 3 years can be a good marketing tool that puts patients at ease.

Risk Management

If something untoward should ever happen in your OR and your state does not require accreditation, having the stamp of approval can be beneficial. Accreditation is another shield that can protect you from prying attorneys' fingers. Accreditation can provide your practice a layer of validity and protection, and show that you and your staff have a habit of providing quality patient care and attention to detail. During depositions, the presence of excellent record-keeping bolsters the defense. In addition, at regular intervals you have had an inspector walk through your space to ensure compliance with hundreds of other standards. You have mounted a significant defense without uttering a single word. On the flip side, not having accreditation when your colleagues in the area are accredited can be problematic.

State Requirement

More and more states are requiring accreditation for those offices that provide anything more than local anesthesia. When California first adopted this regulation (AB 595, which became Health and Safety Code 1248), many physicians tried to skirt the gray line by saying, "The patients breathe on their own and are awake and alert." California's law was distilled as "If you yell fire, can the patient walk out?" If not, you had to be accredited. In New York, the law is much more specific. If your state requires accreditation, you have no choice. If the State-adopted effective date has not yet arrived, do not procrastinate as you may have to postpone surgeries if surveyors are not available before the deadline. Note that the effective date of your accreditation is not the day you apply, and it may not be the day of the survey but be when the accreditation agency approves the survey results or any plan of correction.

Reimbursement

Reimbursement is the icing on the cake for some and the main impetus for others for developing a surgical suite. Reimbursement for surgical facilities can be significant, although less significant than in past years. Although there are the odd cases where reimbursement is substantial (5–10 times Medicare or more, depending on how aggressive you decide to be in billing), many payers are looking at 100 to 150% of Medicare as the reimbursement for most procedures (see Chapter 16.2.3). If hand surgery is a big part of your practice, reimbursement should be a motive for developing an ASC. As discussed in Chapter 16.1.2, careful consideration must be given to your payer mix (HMOs, PPOs, Medicare, and cash) and your volume before thinking of reimbursement as a motive for developing a surgical suite. As stated previously, you do not need to perform surgery on a Medicare patient to see a financial benefit from Medicare approval as many payers are requiring Medicare certification for those facilities they reimburse a facility fee. The one caveat is that the center must bill at least one Medicare patient a year to remain an active Medicare provider. It can be a very simple, local anesthesia case. Depending on your state, if reimbursement is your primary focus (because of your volume of third-party reimbursable cases), you need to consider Medicare certification or state license.

16.1.11 Tenant Improvements versus Free-Standing Building

When you have made the decision of creating your own surgical space, the next question is whether to find a medical office building and then lease the space and build out the suite, or to seek a long-term investment and build or purchase your own building. The two biggest differences are time and money. A brand new building can provide a good long-term financial return while ensuring that your landlord treats you well. The benefits of owning real estate need no embellishment. If you find a location that allows for your space and the potential for additional, income-earning space, even better. There are some rare opportunities that arise whereby an existing free-standing building can be converted to a surgical space. Once you are up and running, there are companies that seek out medical buildings' housing surgery centers to purchase. The major concern of the existing building will be the presence of fire sprinklers and the parking requirement for medical use in your locale. New building permits must meet the Americans with Disabilities Act of 1990 (ADA) access requirements, of course.

The downsides of a free-standing building are the upfront hurdles and the long-term upkeep of the building. The biggest upfront hurdles are time, time, and time. The design process will take three times longer than you think...and that is just for the shell. If your city has an architectural review board, be prepared. If/when your exterior is approved, you and your team must ensure that there is limited impact on street traffic flow, the natural habitats of spotted owls, etc. Of course, on a long-term basis, you, as landlord and landowner, must keep up the building, including the parking lot, landscaping, roof, stairwells, and common areas.

16.1.12 Equipment Considerations

You must know early on what your plans are for equipment, as the engineers must decide on the electrical and heating, ventilating, and air-conditioning (HVAC) systems that can handle your needs. You will also need to know if you require 220 V or use a

dual headlight versus a single headlight, if you want wall-mounted versus table-top monitors in pre-op and recovery, etc. Do not assume that the engineers and the architect know the size or the electrical draw of all the equipment, even if they are experienced. Their level of amnesia from one job to the next is frightening. Take the initiative and research the equipment. Take notice of the equipment where you are currently doing your surgeries. Ask the staff if they like the recovery monitors and ask the anesthesia providers if they like the anesthesia machine and anesthesia monitors, but try to spot the prima donnas. Do not assume you must buy the latest and greatest color monitor and anesthesia machine with the smallest miniscule footprint and the largest LED HD monitor.

Always consider refurbished equipment as an option for almost all your equipment needs. The two areas that tend to be more problematic for refurbished equipment are OR lights and large sterilizers. Other than those two items, consider refurbished surgical tables, stretchers, monitors, and stools. Purchase refurbished equipment from someone local or someone who has been used by one of your peers. Many purveyors will simply purchase a piece of equipment at a hospital auction, wipe it down, and sell it. You want to make sure that your seller does testing, replaces parts, etc. *Do not* assume that what you see on eBay with no warranty/guarantee is fully functioning. As always, if the price is too good to be true, it probably is. Whether you buy new or used, recruiting a talented and reliable biomed engineer to call on as needed is vital to your continued viability (see Part II of this chapter).

16.1.13 Construction Preparation

Just as you should assume that everything will take longer than expected, assume that each phase of the project will take three steps where you thought there was one. Once the space has been chosen and found to be appropriate, the design phase begins. Being prepared is essential to a smooth and timely process. The following steps will help:

1. **Prepare a wish list for your rooms:** Give your space planner/architect an idea of how much space you need, what functions you want to cover, and how busy your practice will be. Put all the things you want to include, such as a spa room, laser room, aesthetic room, private shower, etc. Start with all the things you want and let your professional decide what can fit in. Preparing the list before you look will give you a better idea of how much space you will really need, which may be different from what you had hoped you would need. While you are looking for a space, you can have the space planner/architect look to determine if your wish list will fit (they will eventually charge for these visits).
2. **Prepare an equipment list for the surgical area:** Once you have found the space and have finalized the design, the equipment list will help the designer and the electrical and HVAC engineers, and you will see if all the equipment will fit in the space available. Engineers want to design a system that will not fail, so they will want to know all the functions that will take place with the equipment, their electrical draw (in amps), and their voltage (almost everything is 110 V in the United States, but you never know if any of your equipment will be an exception). Providing a layout of the OR and recovery

areas can maximize the efficient use of your space (later on, you will need to indicate where you want power outlets to be placed; do not leave it to the engineers or architect).

3. **Consider colors:** It may not be surprising, but this aspect often takes the longest time of any of the preparations. Get your spouse, or significant other, or—be smart and hire an expert to avoid a relationship disaster. If you are in the aesthetic business, your office must reflect an aesthetic awareness. Unless you are a born artist with color and texture awareness, do not be afraid to invest in a professional who can guide you. If nothing else, an expert will provide you with resources and will open your mind to different options.

Choosing the Key Players

- **Realtor:** Surprisingly enough, the realtor can play an important role in finding the right space and can open up your options.
- **Architect:** Often the architect is the first person you will choose besides the contractor. This can be the most important person on your team. With the right architect, you have an advocate who can stand by you throughout the entire development. Many architects will see you through the entire construction process, while others will leave you hanging during the construction. Some architects assume they are done when they complete the drawings. Some follow through by making construction site visits to ensure that the contractor will follow what the drawings say and not make strange assumptions. It is worth paying extra for the right architect who has surgery center experience and who will see you through at least part of the construction process. If they do not know surgery centers, architects and engineers can double the space and double the budget by specifying hospital-type air conditioning, plumbing, and electrical equipment.
- **Engineer:** The engineering team, usually chosen by the architect, is extremely important and must have experience with surgery facilities. The engineering team draws out the electrical, plumbing, and HVAC systems (known as mechanical, electrical, plumbing [MEP] systems). If they design to the stricter State standards for full-blown multispecialty surgery centers that do total knee and spine work, you will spend thousands of dollars too much. Do not assume that they know what they are doing or that the architect knows what to tell them. They often do not verify simple things like the height of the ceiling. This may not seem important until they tell you that your OR ceiling must be as low as 7'6" for clearance for all the ductwork. Incidentally, if you must have a low ceiling (e.g., you are in New York on garden level), consider a bonnet for your surgical light. You can run the ductwork around the exterior of the room and leave height for a real surgical light that will not hit your head. You can do the same thing in hallways by running the ductwork where height is not as important. Humidification is important for the OR.
- **Contractor:** This team member is perhaps second in importance only to the architect. The contractor can often even cover mistakes that the architect and engineers have made, but they can also magnify the mistakes of the engineers and architect. Do not use your brother-in-law or the guy who did your patio cover. Experience matters with surgical spaces, but experience with hospitals does not mean that the contractor will be good with a surgery center.

- **Consultant:** This is a big question: do you hire an accreditation/certification consultant or do you go it alone using a nurse who has been through a few surveys? Experience from many physicians says make the investment, but be careful. Picking the wrong consultant may mean he or she recommends the wrong architect, who in turn recommends the wrong contractor and engineer. An experienced and honest consultant can work with a less informed architect and contractor to steer them away from oversized generators and 8-foot hallways, male and female staff showers, etc. Passing the accreditation and Medicare survey is more than just paperwork; an experienced consultant can assist in choosing the right location or the right building prior to making a significant investment. Many a project was downsized after the fact because the physician brought in the accreditation/certification consultant *after* the building was purchased or the shell completed. The consultant can save you money by keeping the engineers from overdesigning for nonexistent equipment (like planning for 220 V when not required and then assuming it needs emergency backup power) or from assuming that the equipment draws much more power than it actually does (which causes the “requirement” for a larger backup power unit). The consultant can also inform the engineers and the architect about the difference between state licensing (which requires 400-square-foot ORs and staff showers) and accreditation (which does not). The consultant can also help in the design of the space so the accreditation/certification inspector does not tell you that physical changes must be made; for example, you must rip up that travertine you had shipped in from Malta to allow for a new door. Consultants do not have licenses, only clients, so check their references—more than one.

The order of involvement is usually as follows:

1. **Consultant:** The person writing this is a surgery center consultant, so, of course, I think you should get a consultant involved early on in the process. Hopefully, the experienced consultant can steer you away from spaces that will not work for your practice and/or accreditation.
2. **Real estate broker:** Unless you have found the magical space while wandering the streets, you should find a broker who knows what a surgery center is, knows that sprinklers are required for most uses, is familiar with medical parking and whether a space needs a conversion from retail to medical, and knows simple ways to discharge patients in a wheelchair.
3. **Architect:** In an existing building, the architect designs the space. If the project is from the ground up, the architect designs the building.
4. **Engineers:** The engineering team tells the architect what he or she forgot as they design the electrical, mechanical or HVAC, and plumbing systems. These people are very important; do not ignore them. They can cost you lots of money or save you from disaster.
5. **Contractor:** We all know the horror stories of change orders, so good planning is essential and good architects and engineers are crucial, or you will hear the dreaded phrase, “It is not on the plans!” repeated many times. The contractor should provide a bid only after the engineered drawings are complete; otherwise, the contractor is bidding blind and guessing at requirements. Always get more than one bid, even if your best friend is the perfect contractor with years of experience. Sometimes people miss details, and if you do not catch those oversights early, the change orders to fix it are costly.

Timeline and Milestones

For a tenant improvement (TI) project, the tasks that must occur include the following ones. The information that is pertinent to a new building is included in square brackets.

1. *Locate a suitable building/space* (consider issues such as exiting, fire rating, visibility). This will likely take weeks. [For a new building, it will likely take months.]
2. *Choose the accreditation/deeming agency* (this may be the number 1 task if Medicare is involved). This will take 1 week once you have chosen your priorities. [You better know this before you find the building.]
3. *Design and finalize the space plan.* Assume 4 weeks or less if you are diligent, or more if you have more than one person making recommendations to the architect. [Add 4–6 weeks for the shell design, and more if you have an Architectural Review Board in your city.]
4. *Prepare the construction documents* (after you have provided an equipment list and layout to the engineers). Assume 4 weeks. [Assume 6–8 weeks plus more if the city rejects the exterior.]
5. *Submit the plans to the city for approval.* Assume 4 weeks for TIs. [Assume 6–8 weeks for new buildings plus soils work, environmental impact, etc.]
6. *Begin construction.* Assume 13 to 18 weeks for standard TI work with no major structural issues or change orders. [Assume 3–9 months for exterior work, then add the TI time.]
7. *Purchase equipment.* Sometime after TI work begins, start getting ready to order equipment. Make decisions on the equipment as soon as you can and be ready for lots of people to provide alternatives. Assume 6 weeks for delivery of new equipment. Refurbished equipment is sometimes difficult to get if it is a hot item, but can often be delivered the next day if available and if the purveyor is local. Timing is very important, since you do not want expensive equipment getting damaged or stolen at the construction site if they are delivered early.
8. *Recruit staff.* If you are not moving from a current location to a new spot, and if you have not located your clinical staff, you cannot begin planning too early. Keep in touch with staff who you have worked with and thought to be competent. You do not need to hire them when construction begins, but do not wait until 1 week before your survey date to panic and hire a registered nurse who told you she had gone through an accreditation process once at the hospital. If you respect their opinion, get them involved in some of the planning of the surgical areas as they may provide insight that your architect cannot, especially in regard to patient flow as well as outlet and light switch locations. Anesthesiologists can help with air flow (so they do not complain later on about how cold they always are). Try to get your nurse or scrub technician involved with the design of the instrument area.
9. *Get your application in.* Do not wait until you are ready to open your doors to send in your application, as you will be left waiting with bills for rent, payroll, loan payments, etc. All agencies have a time limit for the applications, so do not send them when you have located the dirt lot for the parking area. All the accreditation agencies take about 6 weeks to show up for Early Option

surveys (you have not seen any patients). If you want a survey soon after you have completed construction, get the paperwork in early. Note that Medicare paperwork is filed separately, so if you are considering Medicare certification, you can send that in a little earlier than the accreditation paperwork, as the accreditation agencies will want to see a copy of the Medicare paperwork and to date there is no expiration date for a Medicare application.

10. *Begin accreditation/certification paperwork preparations.* Medicare requires that a center have written agreements with ancillary providers including laboratories for pre-op and pathology, radiology (even if you do not think you need it), medical waste pickup, janitorial service, linen, consultant pharmacy, peer review, hospital transfer, etc. Identify these providers so that you or your staff can contact them to get the paperwork in place. It usually takes lots of phone calls, so I recommend you delegate this. Some providers are not familiar with the process, so you will have to provide a template for an agreement. Keep it simple. Medicare surveyors often require backup documentation for your ancillary providers, so start making those requests early. The hospital transfer is not always required, but it is nice to have—start asking early on.
11. Receive equipment. Do this close to construction completion, when the space can be secured and someone you trust is there on a regular basis.
12. Receive final construction approval. For the AAAHC, this document is necessary to schedule a survey. Just the final sign-off on the construction card will do, so you do not have to send a Certificate of Occupancy. A temporary occupancy approval will also do. All agencies want to see some written approval at the on-site survey.
13. Prepare for your survey. There is much to do after construction begins and before the survey, so do not assume that you will be ready the day after you start moving boxes in. There are in-services, fire drills, credentials, etc.

16.1.14 Time Investment for You

Assume that your time investment will be quite significant when starting an office-based or Medicare-certified surgery center. *Do not forget your congressman.* There is designated staff in every congressional office to help constituents cut through red tape. If you get frustrated with a governmental agency for taking way too long to approve your application, your congressman can help. Meanwhile, here is a list of who you will need to spend time with:

- **Broker:** There will be meetings where you drive around town with the broker to find a suitable location. You will have meetings to find the right space, and then meetings to negotiate and finalize the lease. Even after the terms of the lease are agreed upon, you will probably meet once or twice more with your broker along with your attorney.
- **City:** You may be required to visit the city and schmooze a little. Maybe the city does not want a medical space in the “perfect” location you have chosen or there is not enough parking in the lot (you can sometimes get a variance if you tandem park or have a valet). If you have an Architectural Review Board, plan on meeting with them and bring the architect.

- **Architect:** You will have meetings with architects (at least two architects, please) to look at their work and to see if you can get along with them. If you must negotiate every agreement, you will meet with them to do that. Then, there will be more meetings with the chosen architect to get the space plan correct. Look at your agreement to see if there are limitations on the number of meetings or plan iterations the architect will provide, and be aware that, if you run over that amount, you will be billed. Be fair with them—revisions take time! Most revisions can be done over fax/phone/email to relieve your time investment. Then, meet to go over the details and the final version. Choosing finishes can take a great deal of time and is very important, so do not put that off or assume that the architect will do a good job. You can hire a designer who has a good reputation and has improved the design and feel of other spaces. Having your spouse do the colors is not recommended, and doing it yourself involves more time than you know or want to invest. If you care how it looks, hire someone who knows what they are doing. Assume at least two meetings to choose finishes, no matter if you have a designer or not. Changes in finishes can be costly, and many high-priced items have long lead times. If not ordered early, those changes can slow the construction process and cost you lots of money both in construction costs and in the loss of potential income by not being able to utilize the space.
- **Engineer:** You will probably not meet with the engineers directly as the engineering team is usually chosen by the architect.
- **Contractor:** Once the architectural and engineered drawings are complete, the set of drawings will be sent to contractors for bidding. Get at least two bids, but do not get more than three, as this can alienate the contractors or cause them to lose interest. They will need to visit the site to verify measurements including ceiling height, the location of the generator and HVAC units, restrictions on parking, etc. You do not need to be there with them while they measure, but assume that you will meet with them at least twice. Meet with each contractor at least twice to get a feel for their knowledge as well as to see if you can get along with them. Once the construction starts, do not be an absentee owner. If you are building a brand new building, assume that you will be having many more headaches requiring many more meetings. Meet with the contractor on a regular basis (weekly is good) to get a feel for the progress and to make decisions such as the placement of outlets and switches along with unanticipated circumstances. The subcontractors will have questions about locations of things and the purpose of items in the plans (e.g., “Why is this fan above the autoclave area?”).
- **Equipment:** When you purchase equipment, you will have meetings with the seller, whether it be McKesson or an independent distributor. I strongly advise against purchasing equipment from an auction or online. These items are as is. You do not want to have to repair newly purchased equipment yourself. Leave it to experts.
- **Consultant:** If you are planning to be accredited or certified, hire an accreditation/certification consultant early in the process. Have them visit the site a few times, first to check on the location’s feasibility, and then during the construction process to see if anything jumps out (check the agreement and make sure site visits are in there). The consultant should meet with you, the architect, the contractor, and the subcontractors. You will then need to meet with the consultant again in separate meetings as construction is completed and accreditation preparations begin in

earnest. You can delegate much of the paperwork to your office manager/business office manager/clinical manager. You should be in contact with your consultant throughout the process, asking questions that the contractor may relay to you regarding equipment placement, the size of the backup power, etc.

16.2 Part II: Managing your Surgical Facility

After all the sweat and equity you have devoted to design, build, equip, and accredit/license/certify your surgical suite, you now need to optimize. You can either choose to be the lone user and have your office staff work in the OR when you do, or have more surgeons work in the facility and have a separate designated staff. Although you can evolve from one to the other, it is helpful to have a vision early on as written out in the business plan.

16.2.1 Growing the Business

If you have developed a Medicare-certified center, get other physicians (not necessarily plastic surgeons) to use the facility. There are many states that keep a close eye on who uses the center. Know your state's requirement regarding physician ownership in terms of who can be an owner (user-only?). With a Medicare-certified center that has its own waiting, recovery, and discharge areas, it is much more likely that other physicians will show interest in your space. If other physicians fear that their patients will perceive that they are going to *your* surgery center, other physicians will most likely not want to use your center or participate in its ownership. And there are the guidelines of the Office of Inspector General (OIG) regarding physician ownership of surgery centers insisting that physician-owners perform one-third of their cases at the center and derive one-third of their income from the Center.

The benefits of bringing in other physician-users can be significant. While you are on vacation, your physician-partner could be performing a week's worth of cases that could pay for a significant portion of your vacation. The downside is that the space is no longer your own sandbox to do with as you wish. So, with increased income-earning ability comes some democracy (depending on how you structure your entity and who gets to vote on matters such as capital equipment purchases or construction improvements). Other physicians, even those who practice in your specialty, may want different sutures, different equipment, or different staff. Be prepared to make decisions based on economics and experience (theirs as well as yours)—not on emotion. And, of course, be prepared to compromise. Realize that getting other surgeons to use your facility may not be easy since they may not want to line your pockets. Still, in the days of declining reimbursement, if you manage the center and the other surgeons just need to bring their cases and collect distributions at the end of each quarter, it can be a good deal for everyone. One important way to avoid difficult feelings with partners is to consider not taking a management fee. As the owner of more shares than the others, you will get more distributions each quarter, and your partners will not object since you are making it easy for them to continue to bring their cases to the facility.

There are entire seminars held on the subject of selling “shares” (sometimes called “units”) in a surgery center. This is related to but different than percentage ownership. The most important issues in determining shares and share price is

risk. Obviously, the earlier someone becomes involved in the development of the center, the more risk they take and the lower their price should be. Theoretically, physician who joins you in the venture while in the design phase *should* (not “must”) pay less than the physician who joins the project when the center is ready for business, who in turn should pay less than the physician who joins when the center is breaking even. If you are already up and running, the value of the surgery center is often appraised at earnings before interest, taxes, depreciation, and amortization (EBITDA). This is essentially yearly profit. You cannot sell shares for less than reasonably valued. It is also illegal to give a surgeon a “cut” of the dollar volume they deliver to the center. If someone owns 10% of the shares, then they can only receive 10% of the annual distributions of the center. It is important not to sell a large number of shares to practitioners whose cases do not bring in significant and steady income no matter what they promise you ahead of time. Best to go slow and increase shares or percentages with demonstrated results. Long surgeries (especially cosmetic cases) do not generally generate much profit.

Setting the share price is as much art as it is science. The easiest way is to add up the cost of construction, plus the cost of professional fee (architect, lawyer, CPA), plus the cost of equipment, plus the operating capital required to float the business until it can support itself; then, divide that number by 100 and that is your price for 1% of the business. Do not gouge. The money is in the use of the center on a long-term basis, not on the sale of shares. You do not want to scare away the new surgeon in the area who is building his or her practice but is business-savvy. Be reasonable in setting the share price and how much control you think you need. If you have several physicians who show interest, do not be afraid to sell a good portion of your shares if it means you can make money off those hard-working, quality surgeons. A legal structure may be established that allows for voting control while having minority interest. Do not forget that every buy-in agreement needs to have clauses to remove an owner if necessary. It is toxic to a center if owner-users do cases at multiple outpatient facilities. Some cases require the hospital, but users should be required to perform a certain number of cases each quarter to ensure sound footing for the center.

16.2.2 Billing for the OR

Unless there is a state law prohibiting it, and you are doing noncosmetic work that is covered by the patient's insurance, attempt to be reimbursed for the expense you underwent to provide a personalized, nonhospital surgical experience for your patients. Do not rely on hearsay or gossip to determine if billing for the OR is illegal.

In-house versus Outsourcing?

Billing for the OR is not rocket science, but many dollars are not captured due to the lack of experience of a biller/collector. So, do not assume that the office person who does your professional fee billing knows how to bill for the facility. There are many nuances that an outside expert can provide which results in more income. And you do not have workers' compensation and health insurance issues as well as payroll taxes to pay with an outside billing source that helps early on when cash flow may be tight. The biller/collector is incentivized to collect because if you do not get paid, they do not get paid.

16.2.3 Establishing Insurance and Fee for Service (Cosmetic) Fee Schedules

There is no longer big money in ASCs but it can be steady and consistent. You do not have to only bill Medicare rates as you will be leaving money on the table. Of course, you do not want to be the tallest blade of grass and be constantly sent for review. One rule of thumb is a multiple of Medicare. Know that payers will always ask for “reasonable and customary” fees and ask for a reduction in fees. Leave some room for negotiation. If you feel comfortable doing it, ask patients to show you an explanation of benefits (EOB) for a procedure you performed on them at another facility.

This schedule is usually based on time, rather than type of procedure or relative value unit (RVU). A spreadsheet should be recorded by a designated employee. Decide if you will use room time or cut time as the start, and make sure that you charge additional for extra equipment such as breast funnels or special liposuction machines.

16.2.4 Establishing a Legal Entity

If you bill for the surgical entity, you must establish a separate entity. Some states require that the entity be a “professional” entity, but not all. Many states take quite some time to approve medical entities. Some states have very particular restrictions on what can and cannot be in a name for a surgical entity (e.g., New York does not allow “Surgery Center” or “Surgical Center” without a CON/Article 28).

16.2.5 Rewards

Many know the benefits of owning an OR that is available at a moment’s notice. The benefits of providing a convenient and safe environment for your patients can be immeasurable. The time savings for you as the surgeon can be substantial. If you can receive reimbursement for the cases you perform at your center, it can be quite profitable.

16.2.6 Risks

The risk in not receiving accreditation can be payment of a fine and a loss of license, depending on your state. Financially, the risk to building an accredited OR is the cost of the additional floor space, the equipment expense, and the wages for OR personnel. Many years ago, some surgeons felt the risk of having their own OR was too great and they decided to keep working at the local hospital. Most surgeons have moved past this obstacle.

Another risk concerns the flow of money (see Chapter 10). Many insurance companies (including Medicare) provide for electronic deposits, but some checks still come by mail. It is most efficient to use a check management system provided by banks to directly deposit checks without physically going to the bank. For procedures not covered by insurance (cosmetic procedures) or for those without insurance, a printed fee schedule should be used. Plastic surgeons should pay for the facility by check or credit card, as they will have collected the facility fee at the time of the preoperative visit. There is no reason for cash to be accepted by the center. Between monitoring what is paid for each cosmetic procedure along with not accepting cash, the risk of embezzlement will be reduced dramatically.

16.2.7 Expectations

Do not assume that having your own OR will solve all your woes and double the size of your practice and income. Competition is stiff, so if you can offer a lower OR fee than a competitor because you run your OR efficiently, you may create a competitive edge. You will not get rich from the collections from your OR, but it can pay for itself and significantly more, depending on your mix of cases. But, do not forget that your OR *will* cost you money to operate.

16.2.8 Ongoing Accreditation

Although each accrediting agency is slightly different, if you have a Medicare-deemed facility, you will be surveyed by the accrediting organization once every 3 years. In the intervening years, you complete a self-survey that is designed to keep your center up-to-date between the on-site accreditation surveys. These 3-year surveys are unannounced and the surgery center must provide the agency with a few months of surgical schedules. It is important to complete the surveys and other corrections well in advance of the expiration of your accreditation certificate so that your accreditation does not lapse.

16.2.9 Medicare Surveys

The 3-year surveys consist of two parts (and either one may happen before the other): a life safety and accrediting agency survey. Life safety includes examination of the physical plant, with review of everything from coving on the floor to plans and fire sprinkler examinations. The second survey examines charts, narcotic logs, drugs for expiration dates, and more. Each of these surveys usually takes 1 to 2 days. Deficiencies are noted and corrections are then required to be implemented.

No facility should ever be complacent following agency surveys to think that it is over for another 3 years. The Centers for Medicare & Medicaid Services (CMS) periodically conduct validation surveys on the deemed status agencies. Ostensibly this is to check on the work of the agencies, but in reality, it is another double survey, often within a couple of weeks of the agency surveys. These CMS surveys can last a week or more, and the inspectors work hard to find deficiencies you never dreamed of.

16.3 Summary

The benefits of having an office-based operating suite are not a mystery and not new. The leap to a Medicare-certified center is newer and requires more risk, but provides the potential of more benefit. Many payers are requiring Medicare certification and some states are considering legislation requiring Medicare approval. Be careful, do your homework before you start, and the rewards—both subjective and financial—can be substantial.

Acknowledgment

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17 Publishing for the Profession and for the Public

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Abstract

This chapter guides the plastic surgeon through the publishing process in peer-reviewed scientific journals as well as writing books and articles for the public. Scientific writing includes proper study design, manuscript organization, and submitting according to a journal's specifications. Reviewers' comments must be addressed item by item, and the manuscript resubmitted within the defined time frame. Writing for the public can be done in several ways, including self-publishing and through an established publisher. Steps to finding a publisher include writing a book proposal, a query letter, and finding an agent. Submitting an article can require similar steps if your aim is a competitive newspaper or magazine.

Keywords: peer review, open access journal, meta-analysis, randomized controlled trial, cohort study, case-control study, case series, case report, evidence-based medicine, level of evidence, agent, book proposal, query letter

17.1 Introduction

The word *publish* is derived from the Latin word *publicare*, meaning *to make public*. Plastic surgeons have a wealth of experience *to make public*, not just to advance the field, but also to shed some light on our lives for the medical student, the patient, and anyone curious about the person holding a scalpel. Publishing in peer-reviewed journals demands a unique form of writing and depends on rigorous study design. Publishing for the general public follows a different set of standards and priorities that can be equally challenging. This chapter offers detailed instructions on maximizing your chances at getting published in a relevant journal, as well as in books and articles for the lay public.

17.2 Writing for the Profession

Publishing the results of innovative clinical and experimental findings in peer-reviewed journals moves the specialty forward and improves patient care. Findings may alter clinical practice or provoke further questions, giving rise to further studies. Unlike many other types of writing, however, contributors receive no direct financial remuneration. Academic centers focus on research and innovation, so they reward faculty members who contribute to and advance the specialty through research and publications. In the absence of a grant, institutional funding, or any other source, authors themselves fund the costs, including the research, illustrations, and IRB approval (see Chapter 17.1.12). For the private practitioner who will receive no promotion or tenure, the payback comes in the form of acknowledgment, contributing to the specialty, and moving the specialty forward and improving the care we give our patients. In the words of Paul Cederna, "If you do innovative things, you will not get credit for it until you write it up and publish it in a peer-reviewed journal."¹

The best time to start writing is actually as soon as you have your idea. By starting early on writing the methods, you can refine your approach as you develop your idea. Is your idea original? You should even start putting together your tables to help you

clarify what data you need to gather and how you are going to analyze it. After you have completed your study, you are ahead of the game in writing it all up.¹

Choosing a target journal before you begin writing gives you the opportunity to develop the format described in the author instructions on their website. Altering the manuscript format after you have written it takes time. Of course, your paper might be rejected by your target peer-reviewed journal, particularly a prestigious one. Things to think of when choosing a journal include where the work will be best received and perceived as having the greatest impact. Online availability, library holdings, as well as personal subscriptions all impact how accessible a journal is. Indexing in electronic databases like MEDLINE/PubMed (National Library of Medicine) can exponentially disseminate your manuscript to a wide variety of readers, authors, and investigators.

When choosing a target journal, authors should consider the novelty of their work, the applicability of the study, the soundness of their methodology, the strength of their data, and the target audience when submitting a manuscript to a particular journal. Is the journal very selective or does it publish most of the manuscripts that are submitted? Are the standards so high that it would likely be a waste of time and resources to submit a manuscript to that journal? In contrast to the writing for the public, where unless you have an agreement to write for a certain publication, you can send your submission widely, in scientific writing, you must submit your manuscript to one journal at a time. You can submit to another journal after a rejection or withdrawal of your manuscript from consideration.

17.2.1 Impact Factor

Work published in a high-impact journal will be more widely noticed. High-impact work can play a significant role in the authors' career development, especially in academics, where such work can play an important role in job negotiations and granting opportunities. The *h-index*, which is based on a scientist's most cited papers and the number of citations received in other publications, is used to assess the impact of an author's body of research, and plays a role in academic promotions. Journals themselves have a *journal impact factor*, derived by dividing its articles' number of citations by the number of citable articles over a period of 2 years, which is used to measure a journal's influence. Authors with high hopes for their papers generally submit to journals with higher impact factors. A journal's impact factor is associated with its ability to reach a broad readership.² Citations, however, lack immediacy and depth, accumulating only after the sometimes months-long submission, revision, and publishing process. Consequently, the scientific community sometimes uses a journal's impact factor as a standing for an article's impact, which is itself a flawed metric.^{3,4} The impact factor of *The New England Journal of Medicine* at the time of this writing is 72.406, and that of *Plastic and Reconstructive Surgery* (PRS) is 3.946. The difference is a factor of size: PRS serves a small field and thus has fewer readers. In fact, it has the highest impact factor of all plastic surgery journals at the time of this writing.⁵

The *impact factor* is a fraction created to offer researchers a measure of a journal's significance.⁵ The numerator is the number of citations a journal has in the previous 2 years, and the denominator is the total number of articles published in those 2 years. Although most journals likely make appropriate decisions to accept articles based on objective, unbiased factors, the journal can inadvertently influence its impact factor by either publishing an article that will likely be cited widely, even though it is not very significant, or rejecting a significant article that may be unlikely to be cited. For example, methods and review articles are often cited more than primary research articles, so

journals publishing disproportionately more of those will be cited more often, leading to an artificially high impact factor.

Historically, outside academic libraries and subscribers of professional journals, peer-reviewed articles were effectively inaccessible to the public. Now anyone can type in a keyword into a search bar or encounter a link on a social media post, and one in five medical journals is open access, so those articles are accessible to the public. This accessibility improves the spread of medical knowledge, but since citation rate reflects only published authors' interest in an article, public readership is not accounted for by the impact factor. In an extreme case, Mendeley's most widely read article had over 50,000 readers, yet it received just five citations in Scopus.³

Altmetrics is a better reflection of public readership. Altmetrics (<https://www.altmetric.com/>) calculates an Altmetric Attention Score based on the online attention an article receives through social media, blogs, news articles, and reference managers such as Mendeley. The type of source is weighted to reflect its reach: the weighted value of news articles is 8; blogs, 5; Wikipedia, 3; Twitter and Google Plus, 1; LinkedIn, 0.5; and Facebook and YouTube, 0.25. Like the citation rate, the Altmetric Attention Score has its limitations, since social media can be gamed, and public sources may be unreliable. Citations and Altmetrics reflect different audiences; the citation score is a better measure of an article's scientific impact, and the Altmetric Attention Score is likely a better measure if it has social impact.³ (See Chapter 13 for more about Altmetrics.)

17.2.2 Evidence-Based Medicine

Evidence-based medicine (EBM) is defined as “integration of the best research evidence with clinical expertise and patient values.”⁶ David Sackett and a group of epidemiologists from McMaster University in Ontario started the EBM movement in 1981. Level of evidence is divided into three categories: prognostic/risk (levels 1–5), diagnostic (levels 1–4), and therapeutic (levels 1–5),⁷ shown in ►Fig. 17.1. Today several of our peer-reviewed, scientific journals identify an article's level of evidence rating on a colorful pyramid (►Fig. 17.2). These ratings range from 1 (cohort, comparative, or randomized controlled studies of adequate power) to 5 (expert opinion and case reports).^{7,8} Becker et al found a rise in the number and percentage of plastic surgery randomized controlled trials over two decades (1990–2010).⁹ Despite assumptions, level I is not always the best study choice to answer a research question.¹⁰ If a level I controlled randomized trial is done poorly in the randomization or blinding process or has low power, the results may not be reliable.¹⁰

In a study of EBM in aesthetic surgery, Rohrich and Cho found a high number of randomized controlled studies in aesthetic surgery, but few were meaningful and properly conducted, underlining the difficulty in conducting such studies.⁷ Challenges include funding, variability in techniques and surgical skills, and perhaps most notably, the unsuitability of certain surgical procedure for trials. Given these limitations and the importance of publishing plastic surgical innovations, levels III and IV have an important role in moving our specialty forward.^{7,10}

17.2.3 How to Publish?

The video of the teaching course, “Getting Your Paper in Shape for PRS and PRS Global Open” is a stellar guide beginning with Pusic's instruction on “Getting Your Paper to the Starting Line.”¹ In Andrea Pusic's words, “A great study equals a great paper.” To

ASPS Evidence Rating Scales



Evidence Rating Scale for Therapeutic Studies

Level of Evidence	Qualifying Studies
I	High-quality, multi-centered or single-centered, randomized controlled trial with adequate power; or systematic review of these studies
II	Lesser-quality, randomized controlled trial; prospective cohort or comparative study; or systematic review of randomized controlled trials
III	Retrospective cohort or comparative study; or case-control study
IV	Case series with pre/post test; or only post test
V	Expert opinion developed via consensus process; case report or clinical example; cadaver study; or evidence based on physiology, bench research or "first principles"

Evidence Rating Scale for Diagnostic Studies

Level of Evidence	Qualifying Studies
I	High-quality, multi-centered or single-centered, cohort study validating a diagnostic test (with "gold" standard as reference) in a series of consecutive patients
II	Exploratory cohort study developing diagnostic criteria (with "gold" standard as reference) in a series of consecutive patient
III	Diagnostic study in nonconsecutive patients (without consistently applied "gold" standard as reference)
IV	Case-control study; or any of the above diagnostic studies in the absence of a universally accepted "gold" standard
V	Expert opinion developed via consensus process; case report or clinical example; cadaver study; or evidence based on physiology, bench research or "first principles"

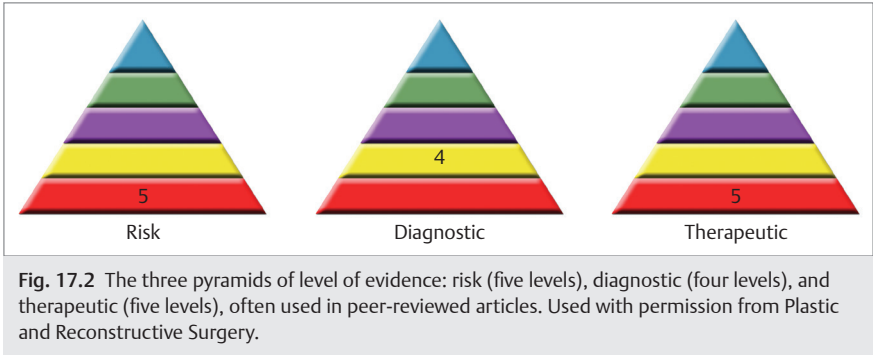
Evidence Rating Scale for Prognostic/Risk Studies

Level of Evidence	Qualifying Studies
I	High-quality, multi-centered or single-centered, prospective cohort or comparative study with adequate power
II	Lesser-quality prospective cohort or comparative study; retrospective cohort or comparative study; or untreated controls from a randomized controlled trial
III	Case-control study
IV	Case series with pre/post test; or only post test
V	Expert opinion developed via consensus process; case report or clinical example; cadaver study; or evidence based on physiology, bench research or "first principles"

Fig. 17.1 Different types of articles are associated with different levels of evidence, as shown in this table. Used with permission from The American Society of Plastic Surgeons.

conduct a great study, come up with a great idea, develop the best study design, then carry out the study.

The basic purpose is to make a contribution to the specialty by solving a problem or coming up with an innovation. Think about what you do every day. What have you noticed that others have not written about? What technique could be improved? What are you passionate about? Choose something others will care about as well, especially



if it will matter enough for them to change their practice. That is, level of interest will help your paper get published.

After you have chosen a topic, search PubMed for what has already been published in that area. If your study has already been done, pivot a little to find a unique angle. Always think in terms of making a contribution.

Now that you have figured out what you are going to study, start by writing a clear hypothesis. The hypothesis will help you hone in on a comparison group and an outcome measure. Describing a technique is not research. The Internet is filled with different trademarked facelifts for which there is no evidence of better outcomes. If you have a new technique, your hypothesis might be that your new technique has a lower infection rate or can be done faster. Now you have your comparison group (patients treated with the standard technique) and an outcome measure (infection rate or operative time). Next pick the best study design.

17.2.4 Study Design

There are four research question categories: treatment, prognosis, diagnosis, and economic/decision analysis. How to best address your idea depends on mapping out your approach with a good study design. A poorly designed study can ultimately result in questionable results and a paper not suitable for publication. Yang et al offer a basic primer on clinical research.¹¹ First, the study must measure what it intends to measure. Unreliable results can arise from *bias*, *confounding*, and *chance*. A study is subject to *bias* at each stage of the study. For example when doing a literature search, a collection of recently published English-language articles may not include pertinent studies published elsewhere, steering toward wrong conclusions. Significant bias arises from studying patients among whom participants were lost to follow-up, since outcomes of those patients are unknown and maybe significantly different from the other participants. A *confounder* is an extraneous risk factor that can distort the result.¹¹ The better the study design, the more valid the results, and more useful they are in clinical practice.¹¹

17.2.5 Systematic Review and Meta-Analysis

A meta-analysis has the unique advantage of synthesizing results from many studies. It is a comprehensive survey of a topic in which all of the primary studies with the highest

level of evidence have been systematically identified, appraised, and summarized according to an explicit and reproducible methodology. During the process of collecting primary data, the authors include studies that are generally statistically similar enough so that the results can be combined and analyzed as if they were one study. A good systematic review or meta-analysis can offer a clearer picture of a topic of investigation. A systematic review starts with a hypothesis and a preplanned research study. The subjects studied are original, scientific studies.¹² As with any good research study, a systematic review should be reproducible. A meta-analysis quantitatively assesses the data collected during a systematic review.¹² A systematic review can be expanded into a meta-analysis if the data are homogeneous, and therefore comparable, across all studies included. Bias reduction, which is addressed by Kelley and Chung,¹² improves the quality of the results.

The meta-analysis has numerous strengths, but has several weaknesses as well. The results of several primary data sets rarely coincide; instead, they overlap or merely identify a trend. The number of patients in a single study may not be large enough to support a decisive, high-powered conclusion. Additionally, the authors reviewing all primary data available related to the current topic may include studies that support a particular preferred conclusion and omit studies that do not. Consequently, authors should explain exactly how the chosen studies were evaluated for inclusion. As readers, we should then ask ourselves, "Do these reasons make sense?" A peculiarity of meta-analysis is that it may amplify publication bias because studies with documented positive or statistically significant findings are published more often than those that have a negative or an insignificant result. If the authors include only published studies, several weakly positive studies may now result in a strongly positive review. To address this potential confounder, it is important to consider whether negative studies exist.

17.2.6 Randomized Controlled Trials

After the meta-analysis, *randomized controlled trials* (RCTs) provide the next greatest level of evidence in the evidence-based medicine (or surgery) paradigm. This type of work typically exhibits random (ideally a double-blind) assignment, an intervention, and a control group. The study covers a specific period of time and measures a specific outcome or outcomes. Briefly, a randomized controlled study is one in which there are two groups. One group receives an experimental treatment under investigation. The control group receives either no treatment or some standard default treatment, such as a placebo. In randomized controlled studies, patients are randomly assigned to either group. Random assignment reduces the risk of bias and increases the probability that differences between or among the groups can be attributed to the treatment, and not to the selection, of subjects in each group. The control group allows comparison of the experimental intervention with alternatives, including standard choices. For these reasons, RCTs are commonly accepted as the standard and highest-level method of answering questions regarding the effectiveness of a particular therapy.¹³ For example, stating that a particular medication can reduce microvascular flap complications to 1% is not very informative without knowing how many patients have complications without further treatment or with a different treatment. Certain research questions cannot be answered by randomized controlled studies for ethical reasons, such as studying the prospective effects of smoking on microvascular flap success by asking one group to

smoke two packs per day, which is known to be harmful, and another group to abstain. Finally, RCTs have the advantage of being prospective studies, further minimizing bias. However, they can also be very expensive and time-consuming to administer.

17.2.7 Cohort Study

A *cohort study* compares one group of patients with a particular condition to another group not affected by that condition and is the best type of observational study for identifying cause and effect.¹¹ Both groups are followed and compared over time. Sometimes the initial group receives a treatment that the second group does not receive. We discussed the ethical issues associated with a randomized controlled study to document the effects of smoking on microvascular flap complications. A reasonable alternative would be a cohort study in which a group of people who already smoke is compared to a group of nonsmokers. This type of study can be performed prospectively to see what, if any, microvascular flap complications may develop. Cohort studies, in general, are relatively high-level evidence studies, but are also associated with several weaknesses. First, they are not as reliable as randomized controlled studies, since the experimental group may differ from the control group in an unknown way. Furthermore, like randomized controlled studies, they can be expensive and time-consuming. Both cohort studies and RCTs are also subject to changes over the course of the study. For example, subjects may expire, move away, or develop other conditions. New and promising treatments sometimes arise and can be adopted by some of the patients. This and other factors can prove confounding to an investigation.

17.2.8 Case-Control Study and Cross-Sectional Study

Case-control studies are similar to cohort studies. As another type of observational analytic study design, case-control studies can be more useful in testing potential cause-and-effect when the outcome is either rare or lengthy.¹¹ Whenever a randomized controlled study is not possible, a cohort or case-control study should be considered.¹⁰ A *cross-sectional study* is ideal when the primary question is about a condition and its association with an exposure or treatment.¹¹ A cross-sectional study looks at people with similar characteristics but who differ in one key characteristic at a specific time. Participants are usually separated into groups (cohorts).

Both types of studies identify patients based on current information, but case-control studies have the disadvantage of being retrospective, unlike cohort studies. In a case-control study, subjects who already have a certain condition (e.g., microvascular flap failure) are compared with patients who have not developed this condition (e.g., their microvascular flaps survived). For example, patients who exhibit microvascular flap failure may be asked how much they may have smoked in the past. Their answers would be compared with those of a sample of patients with successful microvascular flaps using the same procedure by the same surgeon around the same point in time.

Case-control studies are less reliable than either RCTs or cohort studies, as they are retrospective and do not demonstrate causation. The main advantage of case-control studies is how rapidly they can be done because the data are gathered simply by asking patients about their past history. As such, it is possible for researchers to quickly

discover effects that would otherwise take many years to show themselves. For this reason, case-control studies are often the first study to suggest a new hypothesis, which can then be corroborated (or refuted) with results from an RCT or a cohort study.

17.2.9 Case Series and Case Reports

Case series and *case reports* are mostly retrospective descriptive observational studies of the treatment of individual patients and are the lowest-level evidence articles found in the literature.¹¹ Nonetheless, they play an important role in developing a hypothesis, and they can spawn more controlled studies.¹⁰ They can be beneficial if a patient has a rare condition and the physician is uncertain regarding what treatment to pursue. Case series and case reports use no control group with which to compare outcomes and hence have no statistical validity, so other study designs should be used whenever possible.

17.2.10 Survey Research

Surveys are a type of observational study. Because they are based on questions, wording must be carefully structured to be as neutral as possible. Language should be appropriate for the audience. Likert scales, typically 1 to 5 (strongly agree, agree, neutral, disagree, strongly disagree), offer more nuance than a Yes/No binary scale. After researchers have developed a survey, the draft should be administered to a cohort who can give feedback about ambiguous questions and other problems. Nolte et al give the basics of conducting a survey study.¹⁴

17.2.11 Patient-Reported Outcome Measures

Historically, clinical outcomes have been measured from the surgeon's perspective, such as appearance, complication rates, and objective function measures, such as range of motion and two-point discrimination. Patient-reported outcome measures have been developed to understand the patient's perspective, since a result that looks great but has not improved a patient's quality of life might not be the success it was thought to be. Pusic et al have pioneered this unique class of questionnaires that have revolutionized our understanding of clinical outcomes.¹⁵

It is hard to do a randomized controlled study, which would be level 1 EBM. On the other hand, it is easy to do a retrospective, single-surgeon study, but the impact will be low. If you can do a multicenter prospective study, you will make a contribution to move the level up from 5 to the middle of the pyramid, and you will produce a paper that will be more likely to make an impact on the specialty and, consequently, get published. As you develop your idea, ask yourself: Is it being conducted ethically? Is the sample biased?

The quality of a study is enhanced by working with a team. A team is more fun, the research quality will be better, and your study will have a greater impact. Look for others with complementary skills sets, like a biostatistician, or a database developer. If you are doing a clinical study, consider your patient volume and consider inviting colleagues to join you in a multicenter study. Try to establish the authorship order early on, and certainly before you submit your article. The first and last authors are the positions

with the greatest prestige. Generally the senior author's name is last. Settling the order early can prevent resentment and anger later on. If the paper is accepted, changing the order could result in rejection of the paper.¹

Poor study design can also lead to rejections. Malay et al provide a road map on performing a root cause analysis to identify solutions to past problems. The process starts with¹ defining the problem,² breaking it down using a visual map to analyze the root cause, and³ formulating an action plan to solve the problem. The study can then be redesigned.^{16,17}

When you put your study together, you can submit for Institutional Review Board (IRB) approval.

17.2.12 Institutional Review Board

As a response to the atrocities masquerading as “medical research” during World War II, the Nuremberg Code was developed with three core principles: capacity to consent, freedom from coercion, and comprehension of the study's benefits and risks.¹⁸ The Nuremberg Code served as the foundation for IRB decision-making. An IRB, known as a Research Ethics Board (REB) in Canada, is a committee that aims to protect the rights and welfare of research subjects by approving, monitoring, and reviewing biomedical research conducted on human subjects.¹⁸ All human research must receive IRB-approval before a study is initiated. McEvenue et al give advice on the three options (use an external, commercial IRB; partner with an institution that has an IRB; start an IRB for your private practice).¹⁸

17.2.13 Writing Your Manuscript

Each journal varies in their submission process, but elements of what makes a paper good is common to all. In his experience as editor-in-chief of *Plastic and Reconstructive Surgery*, Rohrich advises you to write clearly and concisely. Journals may vary in word-count requirements, but 3,000 words is this journal's maximum and a good rule-of-thumb for any paper.¹ Use simple words; convoluted wording with an abundance of syllables does not sound more academic. Rather than “at this point in time,” say “now”; “It is very important to always remember to irrigate the pocket” can be shortened to “Irrigate the pocket.”

A great paper tells a story.¹ Scientific papers pose problems, which is the hypothesis. The action is the methodology, and the results are the falling action. The discussion is the denouement, tying up the pieces and giving the reader something to think about. The best scientific writers are simply good writers. Look at the Author's Guide or Author's Instruction on the journal website and follow the instructions carefully.

Abstract

A manuscript usually begins with an *abstract*, which is a concise representation of the text of the manuscript, structured to a journal's preference. Think of the abstract as a trailer for your article. Its purpose is to summarize your study in few words, but if it is written well, it can pique people's interest in reading the article itself. When publishing in peer-reviewed articles that are not open access, people who do not subscribe to the journal and cannot read your article without paying can still read your abstract. Spend as much attention writing your abstract as you do writing the paper. Each journal will have its guidelines, including word limits and structure. Word limits

may range, from 250 to 500 words. In general, original articles and experimental studies should have a structural abstract that includes Background, Methods, Results, Conclusion. Other types of articles, like case reports and new ideas can be written as summaries.

Background

Next, the *background*, or *introduction*, should establish a logical case and context for the current study and clearly state the research hypothesis. The introduction should include a brief literature review and touch on the manuscript's relevance to the mission of the journal. Overall, the introduction must provide a basis for why this study is important. You have to do a literature search to find out what has already been published, and this information can go into your "Background." Reading through the literature can help you develop your idea further.¹

The *background* lays the foundation of the study and establishes the goal. This is the place to put down the history and what is known, based on a review of the literature, then build up to what is not known or pose a question to be answered. Editorials, commentaries or discussions, descriptions of ideas, and an opinion piece written by experts in the field can provide unique perspectives and may contribute to background information.

After crafting the history and framing the angle of your study, state your hypothesis at the end of the background section. You can include a direct sentence that begins, "The purpose of the study is..." or "The aim of this investigation is to..." Now the reader is primed to find out more.¹

Methods

Describe the study design and materials used in the *methods* section. If you used a machine or software, note the pertinent information, such as the manufacturer and where the company is based. Write as if you were instructing someone else how to repeat the study, since that is actually what you are doing. Following the introduction, the methods section outlines the design of the study that aims to answer the authors' question or explore their hypothesis. The acquisition of appropriate control data is of utmost importance in the methods section; its absence can render the study unpub-lishable. In this section, the authors establish the study's validity and reliability and address confounding variables, such as unique materials, so that the study is reproduc-ible. Information regarding human and animal subjects should be clearly stated. Finally, a plan for statistical analysis of the data is discussed under the methods section. Information can be cited from previous peer-reviewed reports. This common practice reduces the manuscript length, increases its readability, and strengthens this section with supporting data from commonly accepted practices.

Results

Report the findings in the *results* section. This is not the place to interpret the results; merely state the facts. Tables and figures can be helpful in presenting the data. Reading through numbers laden with confidence intervals is more laborious than looking at a well-organized table. Even a table can be improved by converting the data into a chart. Choose the most appropriate visual presentation, whether a bar, linear, or pie chart. Use colors that are easily distinguishable from one another. A pie chart with varying shades

of blue slows the reader down. Use blue, green, yellow, red, orange, and purple instead. Do not burden the paper with too many tables, figures, charts, and other visual aids. Each must serve an important purpose and facilitate examination of the data, which is possible only if it is easy to follow, logical, and straightforward. Data should be presented in the most appropriate form, whether in relative or absolute terms, and actual numbers should be included, if applicable. Authors should first present the data and then establish their statistical significance, where appropriate.

Like charts and table, illustrations must serve a purpose, too. If they come from another source, you will need written permission from the source. Medical illustrations should be done by a professional. If you do not know any professional, you can find one online. If you submit a paper documenting a well-done study with great writing and beautiful illustrations, your paper should be accepted.

Photographs should be well lit. Patients featured in clinical photographs should have no makeup on (unless the paper concerns the wearing of makeup). Consistency is essential. Poor photographs may themselves be rejected, which can result in rejection of the entire paper if they are essential to its core. The color, lighting, and patient's distance from the lens should match in before and after views for reliable comparison. Photographs should not be manipulated. Query the journal about possible digital manipulation of tattoos to de-identify a patient. If the journal allows it, it should be noted in the caption, and patient authorization and permission to publish should still be obtained.

Photographic and video consent: The journal will have a consent you can have patients sign. Alternatively, if you create your own, it should ask the patient to consent to platforms "including but not limited to the following: print, visual, electronic, or broadcast media." The text should avoid details that might identify patients unless they are essential for scientific purposes. Identifiable body parts can be cropped out of the photograph, but bars over patients' eyes are generally no longer accepted. Patient authorization and permission must be obtained if identification is at all possible. English-speaking journals will generally request that consent forms be in English. The journal will not publish an image without an appropriate consent, regardless of the reason. If a patient is unable to provide consent due to legal incompetence or death, permission must be provided by the power of attorney, who must also provide proof of power of attorney.¹⁹

Videos can add depth and clarity to a paper. Like a good paper, however, a good video should be short (5 minutes or less) and well edited. If you are filming surgery and narrating as you operate, make sure there are no audible OR sounds. The staff should be alert to not speaking and creating no distractions. Alternatively, the film clip can be muted during the editing process and the narration done as a voice-over. Creating captions helps emphasize the content while making it easier for nonnative English speakers to understand. For more on how to create a great video, see Chapter 13.

Discussion

Now that you have presented the data, interpret this under the *discussion*. This can be the most creative part of your paper, revisiting the background like a story arc and clearly framing and interpreting the findings. Draw from the background and establish why the results of your study are important and what makes your study unique. A scientific paper, like an article on the front page of a newspaper, is not the venue for an opinion. Save that for an editorial. As you interpret the data, ask yourself, does it support

your conclusion or are you showing bias? If the data might mean a certain outcome, but the data is not sufficiently conclusive, develop that idea as conjecture and suggest future directions and opportunities for further study.

You may feel passion about your topic. Maybe you are disproving something or identifying something that you feel strongly about. As tempting as it is to use superlatives and strong emphasis, keep your emotions at bay. The more in control you are as you write, the stronger your paper.

You are not done yet. Read through your paper with a critical eye. What are its weaknesses, flaws, and limitations? Gather them all together and describe them in a paragraph devoted to limitations. Maybe you could have included more patients in your study or it could have been prospective rather than retrospective. If you had patient attrition, which limited the length of your follow-up, point that out. If you do not identify these limitations, your reviewers certainly will. Describe ways that could have made your paper better and pose questions that you or others might address in future studies. Once you have self-flagellated, stand tall again and declare your paper's strengths: "Despite these limitations, this study is the first to investigate..."

Your reader may not intuitively grasp the significance of the paper's findings, and so spell it out clearly.

Conclusion

Distill your paper's salient point(s) into a final message, which will be your *conclusion*. Write it as a one-paragraph take-home message.

References

Following the conclusion, the *references* should be listed according to the journal's specifications. This section should demonstrate consultation of the current literature, but items should not be too many, too few, too old, or too obscure.

Figure and Table Legends and Extra Digital Content

Figure and table legends follow the references. Figures and tables should be noted by number in the body of the manuscript, but the legend is listed at the end. If there is no legend, the manuscript should indicate so.

You may want to provide a link to a database, videos, or other digital content. The journal will offer instructions on how to include those items. As with figures and tables, every item included should play an important role in communicating points to the reader. (You are a busy person with no time to waste, and so is your reader.)

The Title and the Title Page

Put some thought into crafting a short title (less than 20 words), and loading it with three or four keywords at the beginning. Titles of scientific papers are often precise and descriptive, but very long and boring. You do not need to write the paper in the title—all you need to do is to convey the topic. Even better if you create interest. The title should be clear and easy to understand.

The impact of the choice of title on an article's reach is hard to measure. Nonetheless, an article by Zhou et al²⁰ may lend a clue. The journal *Microsurgery* has a higher impact factor than *Burns*, yet its Altmetric score is lower. The long, detailed

Microsurgery titles, such as “Are Patient with Low Body Mass Index Candidates for Deep Inferior Epigastric Perforator Flaps for Unilateral Breast Reconstruction,” may be less intriguing in a keyword search compared with those of *Burns*, exemplified by “Burnt Wives—A Study of Suicides.”^{3,20}

The *title page* includes: title, authors with their highest academic degrees, their affiliations, and their full financial disclosure, commercial associations, funding, and grants. List each author's role on a separate page. Up to ten authors are typical. Beyond that the remaining participants are generally included under acknowledgments except under specific circumstances, to be determined by the journal. Corresponding author contact information is also included.

If you are not a native English speaker, ask a colleague who is to edit your paper or consider hiring a professional writer to bring it up to fluent standards. A nonnative speaker may not realize how difficult their written English sentences, grammar, and syntax may be to understand. Nonfluency does not necessarily mean your paper will be rejected, but submitting a well-written, easily understood paper works in your favor.

Each author should make a defined contribution. Some journals will ask each author's specific roles, and some authors include them even if it is not required. Roles should be defined with ten or more authors.¹

Ask all contributing authors for their disclosures and conflicts of interest. If one person is an investor in the machine being tested, that fact must be disclosed. You will be asked to list funding for the research as well. You can also include a cover letter to the editor-in-chief, though that is not required.

During the online submission process, you may be asked to suggest keywords for your article. Think in terms of what people will be typing into a search bar. Keywords include phrases, not just single words. You may also be asked to come up with a short running title of just a few characters as well as a short line to describe your article. Provide the journal with the best tools possible to make your article searchable.

17.2.14 Peer Review

After you go through the submission process, unless your paper is missing basic elements, the manuscript will be sent out for peer review. Typically two to four voluntary experts in the topic will be asked to assess your paper. They will look at many aspects, including the hypothesis, study design, the quality and organization of the paper, whether the results support the conclusion, and how complete the list of references is. The reviewer will also fill out a rating form regarding novelty, importance, soundness, relevance, as well as conflict of interest between author and reviewer. Depending on the journal, this rating form may also contain an area to designate an overall recommendation to accept, reject, revise and resubmit, or provisionally accept pending revision. The reviewer is also typically asked to give confidential feedback to the editor. The reviewers will be anonymous, and, depending on the journal, you and your coauthors may or may not be anonymous to the reviewer.

After a few days or weeks, depending on the journal, you will receive an email from the journal's editor-in-chief informing you of the status of your paper. You may have full faith that your paper is flawless and the writing is ethereal, but the chances are it will not be accepted right off the bat. It might even be rejected. Ouch. Yes, that hurts, and it is frustrating after all your work, but you will likely be given valuable advice from the reviewers to help you improve your study design.

Do not take reviewers' comments personally. Few papers are accepted without a revision, and the reviewers' goal is to make your paper better. If it is not knocked out of the running, you will likely receive paragraphs or bullet points with questions and comments. When you read them, you might feel like yelling, screaming, or crying. Give yourself a few days to let those emotions die down. But do not wait too long—journals usually have a set window of time (typically 30 to 90 days) for revising and resubmitting the manuscript. After that, the submission process expires.

After you have recovered, read through the comments and break them down into individual action items. If they do not like your study, sell it to them. If they glossed over a point and asked you to include it, do not get defensive and point it out. If they missed, so will other readers. Frame the point better in the manuscript. If they found problems with your statistical analysis, hire a statistician. If they ask you to add more animals, either add more animals or offer a compelling reason why that is not possible. Every comment needs a fix—either make the change, or explain why you cannot, or give a clear rationale why it is not necessary. If a reviewer is confused, explain the point not just in your response to the reviewer; include that clarification in the paper itself. Your reviewers represent your audience. If they're confused, some of your audience will be as well.¹ You might quibble over a small point that you might feel has a neutral impact on the paper. Change those little things. The reviewers are trying to help you get to the finish line, so treat their advice with respect. By taking the reviewers' suggestions, you will improve the study, the organization, the analysis, and perhaps include important references you missed. If you take their advice, it *will* be a better paper. Even if it is rejected, every paper can find a home.¹

Make your revisions in red font (or according to the journal's specifications) so the reviewers can easily identify what you have changed. Your changes should leap off the page. Then prepare your response to your reviewers. Thank them for their time and helpful comments that have helped make your manuscript a better paper. After that, address each of the reviewers' points with your response. If they praise you, thank them. If they point out a negative, thank them for bringing it to your attention. If you have changed the text to address a concern, make it easy for the reviewer to see what you did by copying that passage and pasting it into your response. The reviewer will want to be reassured that you made the changes recommended, so make it easy to see. The tone of your answers should be polite and respectful, not defensive. Remember, your reviewers can still reject your paper if they do not feel you have addressed their concerns.

After you have submitted your revision, the peer-review process starts all over again. Each journal will have its own threshold for revisions. Some journals allow one round; others will allow two, three, or more revisions.

If the manuscript is ultimately rejected, it can be submitted to another journal. If the manuscript is ultimately accepted, it will enter the publication queue, which can be weeks or months, depending on the journal. The manuscript is formatted to the journal's specifications, and the editors may request clarification of manuscript information, such as figure quality and references. These requests are returned to authors in the form of a galley proof, after which the manuscript gains the status of being "in press" and is slated for publication in an upcoming issue. Sometimes an article will be published online well before it is published in print, or it may be published electronically only.

If you get your article published (hooray!), you can help disseminate it by posting on social media. Include the journal's handle and a link to the article. To increase the reach of your post, include a short video (30–60 seconds). See Chapter 13 for more about promoting your article with a video.

17.2.15 Delays

Your paper can experience a delay in processing, be sent back, or be rejected if the word count is too high, there are too many authors or figures, or if there are no references.¹ If you send previously published images without permission for usage, your paper will be held up until the journal receives the letter.¹ If you do not respond to reviewers' comments or make no changes to your manuscript in red, your paper will be rejected.

17.2.16 Presenting the Abstract at a Conference

You can begin your journey to writing your paper by writing an abstract and submitting it to present at a state, regional, or national meeting. An alternative is to submit it in the form of a poster. Presenting an abstract gets your foot in the door with your idea. You can get feedback at the meeting that can help strengthen your paper. You should list your presentations on your title page, including where the meeting was held and on what date, offering a level of credibility, since meetings, like journals, vet abstracts.

Before submitting, choose an upcoming conference, and check the abstract submission deadline. Follow the format for submission. If your abstract is accepted, put together a presentation, usually using slides on Microsoft's PowerPoint. The slide after your title slide should indicate all disclosures and conflicts of interest. As you put your slides together, focus on making them visually appealing not heavily laden with dense text. Organize your slides well in advance of the meeting so you have sufficient time to rehearse. Time yourself until your presentation is flawless (or close to it), and you are able to finish on time or before—time limits can be as short as 3 minutes. Speaking longer than the time limit is rude to the other speakers, the moderator, and the audience, all of whom likely have other obligations immediately following the session. See Chapter 13 for information about public speaking.

17.2.17 Open Access Journals

Open access journals entered the scientific publishing stage in the early 1990s.²¹ The author retains the copyright in an open access journal. To have an article published, the author must pay an article processing charge (APC). The charge can run from \$50 to over \$3,000²² and is generally paid by the author, out of research grant, or by an employer. Conventional journals cover costs through subscriptions, ads, and pay-per-view charges. Open access is free to everyone. Hybrid open access journals give individuals the option of paying a fee to make an article open access.

The first open access journal in plastic surgery was *Plastic and Reconstructive Surgery, Global Open* (PRSGO), setting the stage for others to follow. PRSGO and *The Aesthetic Surgery Journal Open Forum* (ASJOF) both use the Creative Commons License, which gives the authors ownership of the copyright. With this license, anyone is able to download, use, reuse, and share the article, as long as they credit the original authors and source.

Traditional journals have restricted space and authors pay nothing to publish. The journal is incentivized to select the best research article, and it experiences no financial loss when it rejects an article. *Hybrid journals* are traditional journals offering authors the option of paying an article processing fee to make an article open access. They still have a base of subscribers. Stand-alone open access journal may lack this foundation. Thus, the business model for open access journals can create a conflict of interest between profitability and accepting only high-quality content, since there is a financial incentive to publish as many articles as possible.

17.2.18 Predatory and Hijacked Journals

At the same time that open access journals accepting peer-reviewed articles are gaining legitimacy, this potential for profit has resulted in the practice of predatory publishing.²² Fishing for profit, predatory journals email potential contributors, like you, inviting you to submit an article or to serve on their editorial board.²¹ Although some open access journals give a price break to authors submitting from the developing world, processing fees may nonetheless exclude potential authors without funding or disposable income from submitting, creating a “submission bias.”²² To verify that an open access journal is legitimate and meets peer-reviewed journal standards, check that it is indexed on the Directory of Open Access Journals (DOAJ, www.doaj.org).²¹ You can also verify that the publisher belongs to the Open Access Scholarly Publishers Association (www.oaspa.org), Committee on Publication Ethics (www.publicationethics.org), and the International Association of Scientific, Technical, and Medical Publishers (www.stm-assoc.org).²¹ A University of Colorado librarian, Jeffrey Beal, has written about predators in his blog, Scholarly Open Access, available at: <https://scholarlyoa.com>.²³

Incidentally, related to predatory journals are *predatory conferences*, which appear to be scholarly venues, but are merely fraudulent profit centers. Not to miss an opportunity, predatory conference organizers have entered the feeding frenzy, inviting the attendees of legitimate meetings to book hotels at discounted rates.²³ When they arrive at the hotel, duped attendees have no reservations nor opportunity for a refund.²³

Another form for scholarly journal fraud to look out for are *hijacked journals*.²⁴ Since predatory journals tend not to have reputable indexing, their tactics generally do not ensnare seasoned authors, so the fraudsters stepped up their game. Taking the name of a reputable journal, hijackers register under expired domains or manipulated URLs. With the International Standard Serial Number (ISSN), the eight-digit identification code for print and electronic media, including journals indexed by Thomson Reuters, the hijackers copy the legitimate journal websites, including impact factors, and tempt authors with promises of quick publication. With minimal or nonexistent peer review, published medical and scientific articles may be junk science.²⁴ The articles are likely ephemeral, disappearing as soon as the legitimate threatens legal action. Hijacked journals are likely to have been registered in the last 2 years with Google page rankings of under 4.²⁴

For further information about publishing peer-reviewed articles, *Plastic and Reconstructive Surgery* has an excellent collection of articles entitled “How to Get Your Research Published,” available at <https://journals.lww.com/plasreconsurg/pages/collectiondetails.aspx?TopicalCollectionId=162>.

17.3 Writing for the Public

Plastic Surgery is an evocative subject. Many people are ignorant of who we are and what we do, but they generally have strong opinions about the specialty. Whether it is a magazine cover entitled, “Whose Are Real and Whose Are Fake?” or “Miracle Face Transplant,” editors often allocate significant amount of real estate in their publications to topics related to plastic surgery. This is simply because it sells. Very often, articles are written by writers who do not know very much about the specialty, and misinformation is further disseminated. Having articles written by experts rather than misquoted by writers looking to grab a headline helps to clarify what we do for those who seek our advice and treatment.

Writing for the lay public is very different from writing a scientific article. A personal voice warms up the narrative, whether you are educating the lay audience about how to choose a plastic surgeon or you are telling your personal story. Medical writing encourages some of the worst writing habits, such as dry titles and the passive voice. Our operative notes have no subject: “The patient was brought to the operating room, placed on a well-padded table, and induced in the usual manner.” This style of writing is boring and will not sell.

Writing is a craft that can be learned through online courses, blogs, and books. In addition, writing groups and/or coaches can give you the feedback you will need to improve. Among many excellent books about writing include *On Writing Well*, by William Zinsser; *On Writing*, by Stephen King; and *Bird by Bird*, by Anne Lamott. The best way to improve is to read material by good writers and to write every day (or as much as you can). Do not let bad writing get in the way of your goal. Give yourself permission to write badly or you will never get started. Your first draft is your starting point, not your final product. And everyone needs a good editor. It is well worth paying a freelance editor to work on your drafts, as your final product will inevitably be much better.

17.3.1 Writing for Print and Online Newspapers and Magazines

By far the biggest challenge to getting our voices heard in the general press is to have the opportunity to write for popular publications. Local magazines either want commercials to generate revenue from you, or they are concerned about angering your potential advertising competitors if they allow one plastic surgeon to write for them without it clearly being an advertorial. Most national magazines do not accept unsolicited material, which can lead quickly to frustration and wondering why it is worth spending many hours writing in the first place.

Unless you are a hugely popular politician or writer, you cannot expect a high-profile publication (print or electronic) to publish an article you just wrote because you were interested in a topic. Staff writers for publications are often tasked with writing what the editor thinks is an interesting topic. Freelance writers spend their careers pitching stories and ideas to editors, and for many it is a steep climb. For the practicing plastic surgeon with a day job, it is important to work smarter, not harder.

- Write what you know about. Make a list of topics that you know about and find interesting.
- Contact your local newspaper and find the right person on the editorial staff (do not let the advertising department pretend they can help you).

- Make a list of publications (print and electronic) that cover medical interest stories. Then find the right person to contact and send query emails.
- Be resourceful and persistent. If you do not get a response to your first email, try again, and then connect the dots with someone you know who can get you noticed.

Writing original content for your own website may be the easiest way to get your writing out to the public. But you have to allocate enough time to do so on a regular basis, which may be hard, given the rest of your very busy life. Somehow you have to build your writing credentials, just as you have done in your medical career.

17.3.2 Writing a Book

As plastic surgeons, we live interesting, sometimes challenging lives, and every patient comes to us with a story. Our daily lives are filled with material that could fill a book. You yourself may have fantasized about being the next Abraham Verghese or Atul Gawande.

To start, decide on the type of book you would like to write. Some doctors write factual books about a topic, such as Gawande's *The Checklist Manifesto*; some write memoirs, such as cardiac surgeon Kathy E. Magliato's *Heartmatters*; and some write fiction, such as Abraham Verghese's *Cutting for Stone*. New York plastic surgeon Gerald Imber wrote a gripping account of William Halstead with his historical nonfiction book, *Genius on the Edge*. Whatever type of book you decide to write, read others like it to give yourself an idea of how it is done. Besides, to write a book proposal, you will need to do so to describe the competition and how your book will offer something new.

As you are sifting through ideas, think of a problem you can solve or an idea you can explain. Suggestions include:

- Description of all a patient should know about a particular procedure.
- A memoir.
- A political topic, such as challenges in the delivery of health care.
- A crime or mystery fictional novel based on a plot related to plastic surgery.
- Historical fiction.
- Creative nonfiction biography.

17.4 Publishing

You can self-publish or find a publisher. If you plan to self-publish because the quality of your work is not good enough to find its place in traditional publishing, you will have difficulty finding a reading audience beyond your friends and family. Getting published is not the same thing as getting read. It may actually be harder to sell your book if you self-publish, unless your goal is to give it to a limited audience, such as your patients. Similarly, your goal in writing a self-published eBook may be to serve as the reward you give to website visitors who give you their email address.²⁵

In traditional publishing, if you are writing nonfiction, you will need to compose a book proposal convincing enough for a publisher to agree to pay you to write the book. Start with a query letter. Jody Rein's and Michael Larsen's book *How to Write a Book Proposal: The Insider's Step-by-Step Guide to Proposals that Get You Published* is helpful for putting together a nonfiction book proposal.²⁶ *Writer's Market* publishes a useful annual guide that provides information about getting published along with a list of literary agents, book publishers, and consumer magazines.

17.4.1 An Agent

If you take the route of traditional publishing, you will need an agent. Otherwise anything you submit will be ignored. Agents are publishing industry experts with contacts with publishing house editors.²⁷ Publishing is a relationship business, and they should know which editor or publisher will have an interest in your type of work. An agent receives a commission on your work (typically 15%). For that commission, they handle negotiations, contracts, and making sure you are paid by the publisher. Your agent is your partner in business.

To find an agent, you will need to create a sales pitch in the form of one-page query letter. A query letter for a novel will be different from that of a nonfiction book. When writing a query letter for a novel, your goal is to hook the agent or editor, so they will ask for the manuscript. A query letter for a nonfiction book is more like a business plan. If your book is creative nonfiction, like a memoir, the writing must be exceptional, which may be a hurdle for the first-time writer. The story should be unique and compelling.

You will also be expected to help sell the book with a platform. A platform is a means of reaching potential readers, whether through social media, as a widely known figure in your field, or as an established author of articles in the lay press.

17.4.2 Book Proposal

Book proposals will vary according to type of book, but a good one should answer the following three questions:

1. **Why should I care?** What message are you conveying and why should anyone be interested? Why should your particular book exist? What is unique about it?
2. **Who should care?** Who is your target audience? (Is there a market for your book?)
3. **Why are you the best one to write this book?** What is your level of authority? What are your credentials? Do you have the marketing platform?

The goal of your book proposal is to make the case that your idea is a timely, marketable idea written by a credible authority who is marketing savvy and has an audience. The publisher expects *you* to provide the marketing platform as well as the reading audience.

According to long-time publisher Jane Friedman in her book *Publishing 101*, a book proposal should include the following:

1. **A cover page with the table of contents:** Even if you have not completely written your book, you will need to have a detailed plan.
2. **An overview:** Summarize your proposal in one to three pages. Because you need to be fully versed on the contents of your proposal, write it last, and write it well.
3. **A description of your target market:** Describe whom you envision reading your book. Your audience might be all plastic surgery patients, breast cancer patients, or some other subset of the population.
4. **A competitive analysis:** Look in bookstores in the section you would expect to find your book. Write down the titles of books most like yours. Do an online search as well and include websites, blogs, or entities with a similar theme and audience. While you do not want to present a rehash of a tired topic, neither do you want to present a topic no one has ever written about.

5. **Your bio and your platform:** Make a solid case for why you are the leading expert to write this book and why you will attract an audience who will buy the book.
6. **A marketing plan:** Describe how you will market and promote your book, naming specific resources you will use. Do you have a sizable email list; a popular blog; a large Instagram following; a radio show? State numbers, open rates, and anything else that will give the agent or editor a clear picture of how strong your marketing efforts would be if you started a promotion today. List your speaking engagements, leadership roles in professional organizations, coverage in regular media, and sales of previous books you have published (traditional as well as self-published).
7. **A chapter outline:** Give a brief description of each chapter.
8. **Sample chapters:** Include at least one chapter, and choose the best, most addictive one that will make the reader crave for more.

As you put your book proposal together, imagine you are the agent who wants his or her 15% of a successful book or the publisher hoping to make a profit. Focus on the marketplace rather than the book's content. You are writing a business proposition. What sets your book apart, why will it sell, and how will you help it sell?

If great writing is not among your skills, and you do not have the will or the passion to hone your craft, you can hire a ghostwriter.

17.4.3 How Good Is an Agent?

An agent's list of clients and publishers that he or she has recently sold to serves as a measure of how good he or she is.²⁷ Look on their website for a list of current clients or search PublishersMarketplace (<https://www.publishersmarketplace.com/>) for agent-publisher deals. Search for any agent you are considering online and look for mentions and references. They should be a member of the Association of Authors' Representatives, Inc. (<http://aaronline.org>). If the agent is new, look at their previous experience in the publishing industry. Whoever you are considering as an agent should believe in your work and be excited about the topic.

Your agent will be pitching your book to publishers. A good agent will give you feedback. After a few rejections, your agent should help you improve your query letter or book proposal.

17.4.4 Rejection

The chances are your book will not be accepted right away. If you have finished your book, leave it alone. When you go back to it, you will be able to look at it more critically. In the meantime, keep submitting your book.

17.4.5 Acceptance

Even if your publisher markets your book, which it may not, you should take your book's promotion into your own hands. Unless you are one of their star authors, they probably will not invest a lot of time or money promoting your book. To get a buzz going about your book, you can read out directly to your audience, email the people on your list, ask independent bookstores for support, and hire a publicist.

A Quick Word on Writing for Movies and Television

Before you pitch your next hit television show, do not forget to register your written work with the Writers Guild of America (wga.org).

17.5 What's Next?

If you have the talent, the interest, and the audience, your voice as a plastic surgeon can serve to open the door for the public to catch a glimpse of some part of our world. We are unlikely to convince people to see a board-certified plastic surgeon just because we say it is safe. The way to reach people is through stories. Let them feel our fatigue through the years of our demanding training. Let them feel the joy of a patient transformed by a replant, a breast augmentation, or a craniosynostosis case. If we write so we can put the reader in our world, then we have done our job.

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18 Technology, Trends, and Traps

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Abstract

Until 20 years ago, plastic surgery was a field mostly devoid of high-tech devices. The introduction of endoscopic surgery and laser skin resurfacing in the mid-1990s led the way to a technological revolution that now offers nonsurgical solutions for many of the aesthetic concerns of today's consumers. From websites to electronic medical records, from lasers to Vasers, and from modalities for skin rejuvenation and vaginal rejuvenation, plastic surgeons must now be technologically savvy to establish a successful practice. Big data applications have emerged, allowing plastic surgeons to manage their practices on a smartphone. A career that once required only technical skill in the operating room now also requires knowledge of laser physics, marketing, finance, information technology, and managing a team of physician extenders. It is an exciting time to be in the field and this chapter zooms in on the pearls and pitfalls of a 21st-century plastic surgery practice.

Keywords: technology, laser, CoolSculpting, ROI, accounting, subscription services, ANN, big data, Surgeon as Consumer, Aesthetic Neural Network

18.1 Introduction

Artificial intelligence, big data, key performance indicators (KPIs), and subscription services are terms that, a decade ago, no one would have predicted to be in the lexicon of a plastic surgery practice. One quick glance at the exhibits halls at any plastic surgery meeting will highlight the explosion of technology in our specialty. In fact, since 2009, spending on nonsurgical cosmetic procedures has doubled to an astounding market of more than \$6 billion per year.¹ From nonsurgical fat reduction to nonsurgical vaginal rejuvenation, this market includes many technologies that were not even in the horizon 10 years ago.

In the past, every resident about to finish plastic surgery training got the same sage advice for a successful private practice: be affable, able, and available. In other words, do good work, be patient, be nice, and your business will grow. As far as accouterments, all one really needed was a pair of loupes and an anatomy book. Fast forward to today's 21st-century world: Before you enter practice, you must create a website, obtain a large credit line through a bank, acquire MBA-like skills so you can run your practice, have a significant social media presence, and hope you are prescient to know which device technologies will be around in next 5 years. The terminology is now vastly different than it was 20 years ago. From lasers to Vasers, from 3D computer imaging to electronic health records, most of us could not have imagined the vast change in the technological landscape that has been wrought in the past two decades.

18.2 Big Data: Measuring What Matters

Big data and the field of predictive analytics have influenced today's businesses by offering a better understanding of who the customer is, how they think, when they buy, how to run marketing campaigns, and even how to reduce postoperative recovery times. Having accurate, detailed, up-to-date information about a plastic surgery practice has been difficult up to now. In the past, a plastic surgeon would meet monthly

with an accountant and receive monthly or quarterly reports like a profit-and-loss statement or a marketing report. However, these reports were, by definition, a month old (or even worse—3 months old) so decisions that could have or should have been made in real time could only be made after the train may have already left the station.

The ability to have instant data on one's practice, from inventory, daily sales, to return on investment (ROI) on marketing dollars, can take a good practice to an elite practice without spending any more money. Having access to timely information specific to our practices allows us to ask the right questions and make the right decisions instantaneously. The American Society for Aesthetic Plastic Surgery (ASAPS) has recently introduced the Aesthetic Neural Network (ANN) (► Fig. 18.1). ANN utilizes artificial intelligence methods to allow a plastic surgeon to benchmark his or her practice with those of other aesthetic surgeons in real time. This data can be used to analyze which procedures are most profitable, how to price procedures and products, and where inefficiencies lurk within one's practice. According to Barry Fernando, MD, who has spearheaded ANN, "aesthetic surgeons from [around] the country share their de-identified data related to the practice of aesthetic surgery." Participants benefit from business intelligence (BI) tools to improve the dynamics of their practice. ANN creates real-time tables and graphs that show plastic surgery practices where to focus their energy for improving growth, maximizing profitability, and reducing expenses. The data is available instantaneously on any smartphone, allowing for quick decisions (► Fig. 18.2). In addition, the American Board of Plastic Surgery (ABPS) has recently recognized ANN as an acceptable alternative to the Tracer Procedure Log for Continuous Certification.

ANN's dashboards provide insights into KPIs that are relevant to aesthetic plastic surgeons (► Fig. 18.3). The four dashboards are: (1) *The ANN Monitor*, which shows production and sales metrics; (2) *The Return Patient*, which shows the lifetime value of a returning patient; (3) *The Repeat Procedure*, which tracks recurring procedures, such as dermal fillers and neurotoxins; and (4) *Conversion Rate*, which tracks individuals converting from consultation to a paid service and allows for evaluation of the process at many levels. For the future, ANN plans to incorporate educational material, clinical and technical data relevant to specific procedures, and will even have protocols for how to



Fig. 18.1 The Aesthetic Neural Network. (Courtesy of the American Society for Aesthetic Plastic Surgery.)

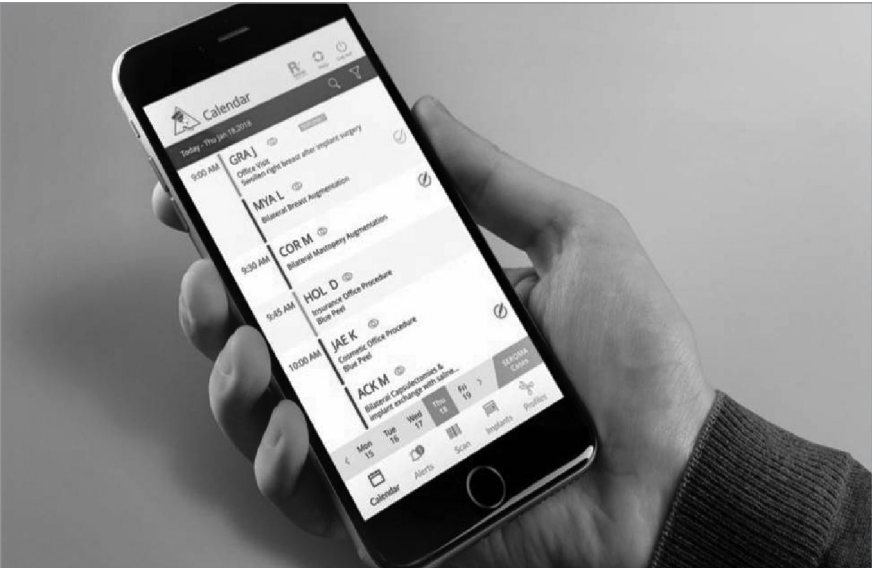


Fig. 18.2 Data from the Aesthetic Neural Network (ANN) is immediately accessible on a smartphone. (Courtesy of the American Society for Aesthetic Plastic Surgery.)

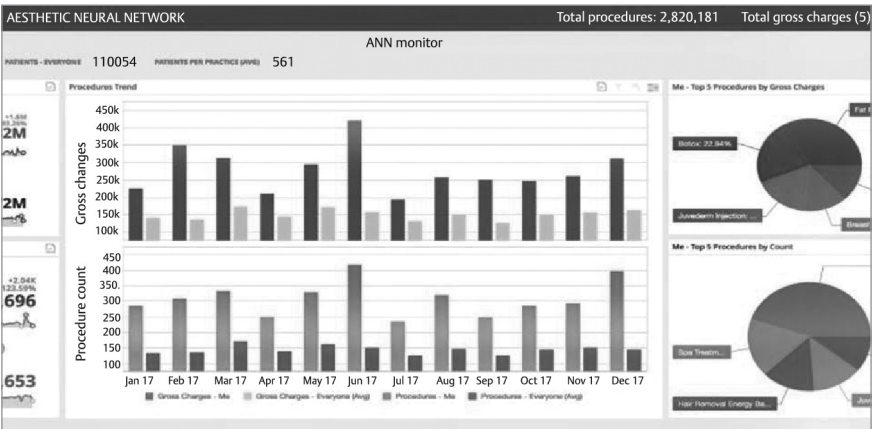


Fig. 18.3 Aesthetic Neural Network dashboards. (Courtesy of the American Society for Aesthetic Plastic Surgery.)

best treat complications like late seromas in a patient with textured implant. All of these will be available on the smartphone, allowing the physician to make immediate, evidence-based decisions.

As of this writing, ANN awaits an Application Programming Interface (API) so that ANN can access data from physicians who are Cloud based in their patient management software.

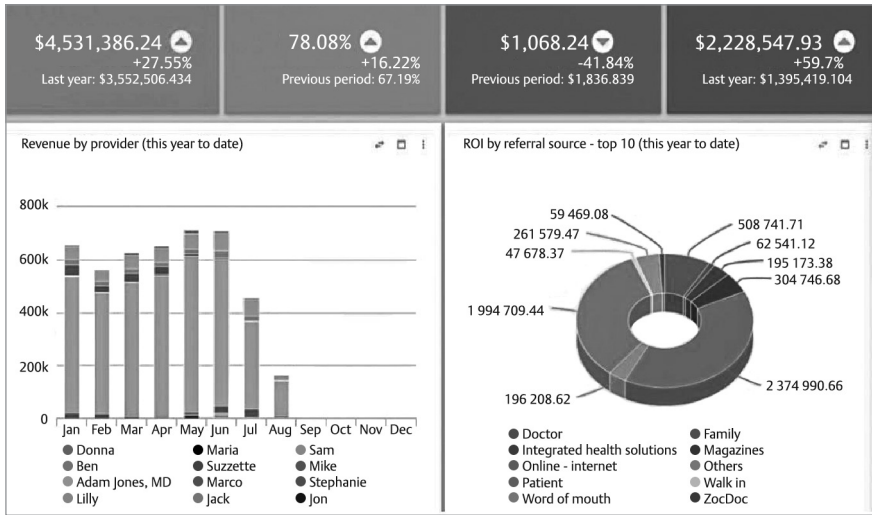


Fig. 18.4 All AtlasKPI reports are mobile responsive. (Courtesy of AtlasKPI.)

18.3 Real-Time Data Analysis

A 21st-century plastic surgery practice is much more than a doctor going to the hospital to complete the cases on the day's surgery list. More and more practices have added medical spas that provide nonsurgical treatments provided by physician extenders. Running a practice now as a successful business not only requires a great plastic surgeon at the helm, but also a knowledge of Human Resources, standard business and accounting practices, marketing skills, and a strong web presence.

Until now, medical practices have not had real-time data with which to make business decisions. Recently, the application company called AtlasKPI entered the plastic surgery market. Offering 50 KPIs for analysis, the AtlasKPI Practice Management Dashboard became the first business intelligence tool created specifically for the aesthetic industry. Integrated with the core systems that practices depend on, doctors and managers are now able to "manage by the numbers," leveraging data collected from their EMR, accounting, and marketing software to increase efficiency and practice profitability. HIPAA-compliant data is available in real time on the cloud and on smartphones; automated notifications are sent when attention is needed. Marketing ROI, revenue by provider, cost of goods sold (COGS), and 47 other reports are updated daily onto your smartphone (► Fig. 18.4). The ability to make decisions on a daily basis using the practice's own data saves both time and money. It also allows the plastic surgeon to make intelligent decisions when purchasing new equipment or evaluating the ROI of different lasers or machines utilized in the practice.

18.4 Beware of the "Latest Technology"

As you start your practice or redirect your surgical focus in a cosmetic direction, you will be asking yourself a barrage of questions, like: How do I decide how to best grow that practice in today's hyper competitive landscape? Which devices and software programs should I purchase? How do I purchase devices for my practice without

drowning in debt? Purchasing and financing new equipment is a subject that rarely gets addressed during residency, and there are few resources for the established practitioner to turn to. The following principles are meant to elicit the questions that you should ask before making any purchase decisions. Each plastic surgeon's practice is unique in size, style, and scope of practice. For some, having little or no technology makes sense. For others, a limited menu will suffice, and for a select few, having many devices in their practice may be the way to go.

For those of us who have heard the phrase "the latest advance" refer to almost any new device that becomes available in the plastic surgery market, it comes as no surprise that the latest technology is not necessarily the best technology. Many techniques that have been around for decades still work very well and require no more instrumentation today than they did 25 years ago. You may want to defer purchasing expensive devices until you have acquired enough board cases or until you have enough patients in your email list so you can use internal marketing techniques to publicize your new laser acquisition. An older, well-respected colleague once told me that he was done learning new techniques. As a matter of fact, he said, "I am trying to forget some of the things I learned." In the golden years of his career, he was clearly successful without any technological adjuncts, and he was busy and happy with his results. He saw no need to climb a new learning curve so late in his surgical career.

For the modern practitioner, however, there is a combination of pressure from patients who want the "latest" because they saw a segment on a plastic surgery television show, from vendors who self-servingly peddle their wares at trade shows, and from one's own desire to remain ahead of the competition. Plastic surgery is consumer driven, and consumers are driven by what they see or hear in the media. Technology does not make a good surgeon, but lack of technology in one's practice can be perceived as old-fashioned, or worse, out of touch with the latest techniques.

18.4.1 Will It be Here 5 Years from Now?

It is difficult to know when a breakthrough in technology is here to stay. Every month, practicing plastic surgeons are bombarded with advertisements from emerging, new invasive, and noninvasive technologies, not to mention ads for newly improved surgical equipment. Companies take their case straight to the consumer through carefully orchestrated marketing blitzes. All one has to do is linger at the grocery line cashier and scan the headlines of magazines to learn what these supposed breakthroughs do. Stories abound of products that are a new hit with celebrities or products that have the magic label "as seen on TV." In less than a year, many of those magical products will have been pulled from the market due to unwanted or unforeseen consequences.

Some plastic surgeons cannot tolerate the uncertainty and unpredictability of these new technologies. Bad outcomes can lead to unhappy patients, repeat surgery, and, of course, litigation. Even if there is no threat of a lawsuit, the perceived lack of results can lead unhappy patients to request a refund, give you a one-star online review, or tell every one of their friends about their poor experience at your office.

To use stock market terminology, the "bears" among us prefer to use techniques that are tried and true without venturing outside of our comfort zone. If it isn't broken, why fix it? This approach is understandable, particularly for the surgeon who may soon be contemplating retirement. Those surgeons have good results with minimal financial outlay in technological adventures that require time to pay for themselves.

The “bulls,” on the other hand, are forever optimistic about new technology. They are hoping their new acquisition will be the equivalent of having invested in Microsoft when it first became available as a public offering. There is nothing more enticing than having a tool that no other plastic surgeon in one's community has. Of course, the quandary is how to predict the longevity of a new technology and whether to commit precious resources to such a company. Tempting as it may be to sit on the sidelines, for the young, or even the mid-career plastic surgeon, there are many reasons to venture into buying new equipment and devices. Before purchasing, you need to ask yourself a few questions.

18.4.2 Facts to Consider before You Purchase

First, what needs are you trying to fill? Is it to add laser skin resurfacing at the end of a facelift procedure? Are your patients clamoring for a particular device? Are you trying to start a medical spa? Are you looking to have your office space utilized while you are in surgery? Who will perform the treatments—you or a physician extender?

Besides the possible physician extender, what additional staff will you need to deliver the treatment and handle the increased traffic through your office? Will you need additional office space to house the device(s) without making your office look like a suburban family's garage?

Finally, will your nonsurgical technology cannibalize your surgical practice? That is, if you incorporate a nonsurgical fat reduction device, will your liposuction practice suffer?

Once you decide you want to add nonsurgical devices to your practice, and once you have a budget in mind, then you are ready to do some research.

Research does *not* begin by calling the rep and asking for information. A great starting point for research is to ask your colleagues for their particular experiences. However, your immediate competitors may be less than forthcoming if they have a “home run” device, as the last thing they want is another plastic surgeon competing for those patients. Luckily, ASAPS has a great resource called “Surgeon as Consumer” (SAC), which is a section within the ASAPS website. SAC allows you to see the unbiased opinions of many surgeons who have purchased and rated almost every technology available for purchase. The comments on that section will help give you an idea on price, ease of delivering a treatment, potential technical pitfalls, and additional staffing requirements that having that equipment will require.

Another important, free resource is the consumer ratings information on RealSelf. Every surgical and nonsurgical treatment has a RealSelf “worth it” percentage given to it by patients who have had the treatment. Reading through all the comments on any device you are considering is important. Beware of very new technologies with few RealSelf reviews, since early on industry insiders who have had the treatment can populate these reviews. In addition, RealSelf just launched a service similar to ASAPS's SAC, in which physicians themselves rate devices they have purchased for their practices.

18.4.3 Predicting the Future

Since I went into practice in 1990, medical innovation has brought plastic surgeons products and techniques that are undoubtedly worthwhile. Among those I count as winners are computer imaging and photo archiving, endoscopic surgical techniques,

laser technologies, and advanced forms of fat grafting. Some advances may be too expensive for the individual surgeon to implement, but they make sense for group practices or large multispecialty clinics.

On the other hand, there are so many devices that either disappeared from the market or underwent enough changes as to be unrecognizable, that it pays to research each device thoroughly and proceed with caution. Plastic surgery offices are littered with stories of poor investments in technologies that no longer exist or of machines that cost more to run than they bring in revenue. Just take a look at the expansive secondhand market for expensive plastic surgery machines.

18.4.4 Should I be One of the First to Buy to Get an Edge on My Colleagues?

The rapid addition of new technologies in our field creates a quandary. Should you be the first in your community to acquire that new \$125,000 machine? In general, I prefer not to be the first one on the block with the latest machine. Invariably, the earliest users find that there are quick upgrades to the technology as long-term results, feedback, and complications start to come in. A faster, sleeker version is probably already in the pipeline as you are buying the original, soon-to-be-outdated machine. The salesperson will glibly describe the wonders of a machine he or she is about to sell you without ever mentioning that in 3 months the company will come out with a better product. They will also gloss over complications reported by early users, while emphasizing the benefits and financial return to the practice.

Quarterly sales goals demand that a salesperson meet certain thresholds despite their inside knowledge of what may be coming soon. I once bought a multiplatform laser where one of the heads was outdated before we actually got to use it. The company demanded an additional \$20,000 for the new head, even though the original head had never been used and was clearly in line for replacement when we signed the papers. Do ask the salesperson when a new upgrade or new heads are expected in the market. If it is soon, negotiate a free upgrade before finalizing your purchase. The actual cost of a device can sometimes double after the new upgrades are out, thus making it impossible to figure out the cost-benefit ratio of a brand-new technology. The next statement deserves bold font: **It pays to have in writing a guarantee of free upgrades and service for at least 12 months after your purchase.**

As a rule, I also prefer not to be the last one on the block. When every patient starts asking for a particular technology by name, it becomes harder to continue to say "I get good results out of my 1957 Ford relic." Patients expect any cutting-edge practice to keep up with the latest advances. It then behooves us as plastic surgeons to decide if a particular technology is worth the price and whether the technology delivers the proposed results. Patient satisfaction ratings offer an important perspective concerning results. There are many patient blogs and websites specifically set up to give feedback on treatments that patients have had. If you visit one of these online networking sites, you can get a general idea of how happy patients are with their results, how willing they would be to undergo the treatments again, and just how much money they are willing to spend on a particular treatment. Although this constitutes an unscientific approach, in the end, patient satisfaction will drive or kill your business. If a particular technology continuously gets low marks from customers, stay away from it, despite what vendors and brochures may tell you.

18.4.5 Avoiding a White Elephant in Your Treatment Room

So, how do we avoid being one of those practices that never should have bought an expensive white elephant that sits idle most of the time? All of us practicing plastic surgeons have a limited budget to run our practices. Employee salaries, marketing, rent, supplies, and insurance are costs that never go away and continue to rise each year. Deciding how much to budget for new technologies is a complex matter that cannot be answered in a short paragraph, but there are guidelines that can be followed to avoid being taken advantage of.

18.4.6 What Is the Clinical Research that Supports the New Technology?

Although white papers abound about all the devices that are out in the market, pay most attention to white papers that appear in peer-reviewed journals. Interested companies will contract with a plastic surgeon to be an early user and then that plastic surgeon compiles their experience into a white paper for the company. I take these company-provided papers with a large grain of salt. It is too easy to be elated by being the first in your community to use a device and to have a 3-month waiting list. It is human nature to want to spin the most positive view, so papers written specifically for a company tend to be less rigorous than peer-reviewed papers.

Surely one of the worst ways to decide whether to buy a new device, program, or system is the fact that you saw it at an annual national meeting. Shiny brochures, friendly salespeople, an evening extravaganza sponsored by the company, peer pressure, and “a great financial deal that expires at the end of the show” are some of the reasons many of us arrive back in our offices with signed documents for very expensive machinery with a verbal promise of more patients. Gluttony in the halls of a crowded exhibit hall invariably leads to indigestion while scanning the empty waiting room of one’s practice. It is best to leave emotion behind even when it means we will not get “the deal” available at a society meeting. Instead, wait until you return home, then contact colleagues who already own the machine and ask them hard questions. Would they buy this machine again? What is the worst complication they have had? How often do patients demand their money back? It is easy to be misled by salespeople, but it is harder for a trusted colleague to sell you down the river with a device they are not happy with.

Another sure way to be misled is to listen to the written testimonials sent into your office by “experts” in the field who are willing to teach you not only the technology, but also how to get your practice to boom as a result. Invariably, many of these experts are mercenaries who will pitch one machine today and the next highest bidder’s machine tomorrow. I have received personal letters from one such expert who, in one year, associated himself with three different companies with similar technologies. Each letter made the newest company sound like the “real deal,” backed by his expertise in the area. It is disturbing to see more physicians become pawns of the companies. Companies will often offer a retainer or a salary, and—shazam!—the doctor has never seen better results in his career. Some doctors now earn a substantial income teaching courses on how to use the products and technology these companies sell.

18.4.7 Customer Service after You Buy Is of Utmost Importance

For any new technology you purchase, you will have a customer service representative. Before you buy, it is imperative that you poll several colleagues who own that particular machine about what happens when the machine breaks down (they usually do at some point during the lifetime of the lease). How quickly does your sales representative return calls when a repair is needed? We know the reps return calls very quickly when they are trying to make a sale, but their true measure is how well they respond when you are having problems. How does a 200-pound laser get returned to the company for service? Who pays for the shipping or FedEx charge? How quickly does the laser get returned, and, in the meantime, do you get a free replacement? These are extremely important questions to ask before you put down any money. When you have a broken-down laser in the middle of a fully scheduled day of treatments, the fallout can impact your revenue as well as your reputation. Most patients will understand, but they will not be happy, as they may have scheduled a day off work. Since you have to be forthright about the problems with the machine, they will lose some confidence in the treatment. If the machine broke down in the middle of a treatment, the patient walks out with half a treatment, and you will have to refund the full fee.

18.4.8 Beware of the Cheaper Version

New technologies invariably spur competition among rival firms. No one wants to miss out on a particularly lucrative slice of the pie. You will see immediate sprouting of competing technologies that supposedly deliver the same results, although at wildly varied prices. It is tempting to choose the cheapest machine, since they are all supposed to produce the same results, but beware!

A number of years ago, a new laser hair reduction machine was marketed at a fraction of the cost of the mainstream laser hair reduction machines. We did our due diligence and called the individual responsible for the white papers the company sent us. He, of course, told us that the particular machine was one of several he used in his practice (he probably received a commission from each company). He encouraged us to go ahead with the purchase. Since he was a well-respected name in the laser device community, we purchased the machine.

The quick lesson is that when something seems too good to be true, there is cause for concern. At the time, the machine cost us 20% of the cost of a comparable laser hair reduction machine. We were ecstatic at our business acumen and were able to pay in cash for an even better deal. Unfortunately, the machine was slower, more cumbersome for the operator, more painful for the patients, and much less reliable than anything on the market at the time. Several patients were burned and demanded their money back. Not a single patient had a good laser hair reduction result. We ended up literally throwing the bargain laser hair reduction machine in the trash after returning thousands of dollars to unhappy customers who saw no results. (We could not ethically sell it to anyone.)

18.4.9 “All You Need Are Three New Patients per Month to Cover the Payment”

One measure of how long it will take to make your investment back is the relation between the cost of your lease and the number of treatments it takes to cover that lease. When an eager salesperson tells you that “all you need are three new patients per month” to cover your lease payment, they are omitting a lot more than they are telling you. Let us consider a lease payment for Magic Laser Extraordinaire (MLE). After the salesperson has knocked off 10% of the price, thrown in some disposables, and let you defer your payments for 3 months, your new laser arrives at your office with a \$150,000 price tag and a 5-year lease that “only” costs you \$3,000 per month.

In order to keep the pitch simple, the salesperson has told you that if you charge \$1,000 per patient, you only need to have three patients per month to cover your lease payment. Before you sign a purchase agreement, consider the additional associated costs with any and all machines:

- Lease or loan payment
 - Annual service warranty (up to 10% of the purchase price every single year)
 - Rent of the space you will dedicate to the machine (even if you own your office, you could be using that space in a different way or making money on the space by renting it to another doctor)
 - Marketing costs to promote the new technology
 - Cost of consumables associated with the machine
 - Updates to the website
 - Additional office or medical supplies that may be needed
 - Compensation of the physician extender who will deliver the treatment
 - Additional secretarial expense associated with additional appointments and patient visits
 - Occasional refund for an unhappy patient
- Several of these costs merit additional discussion.

Physician Extenders

Many of the technologies available, whether laser hair reduction, Intense Pulsed Light treatments, fractional resurfacing, or others, are run by physician extenders (► Fig. 18.5). Depending on your state of residence, this means that your new machine will be run by either a nurse, an aesthetician, a medical assistant, or a physician assistant. The salary and benefits that the physician extender commands can be significant, especially in a



Fig. 18.5 Physician extenders will provide many of the new treatments.

state where only nurses or physician assistants are allowed to run the machines. So, if you are paying \$40 to \$50 per hour for the person to run the machine, remember to account for that in your costs. (Be sure to include all associated benefits, bonuses, and taxes in addition to salary.) If the physician extender is doing an additional 10 hours of work per week performing initial patient evaluations, follow-up visits, and charting, then remember to allocate another \$400 to \$500 to your actual weekly costs (\$1600–\$2000 per month added to your lease cost).

Independent Contractors

Some nurses would rather work as independent contractors rather than salaried employees. These nurses usually want a share of the profits and sometimes will go in with the doctor on the purchase of the equipment. I would avoid this type of arrangement, but if you contemplate it, make sure you have a contract lawyer review the terms of employment as well as exactly who pays for the lease. Recently I spoke to a nurse who had been sharing lease payments with a doctor. When the business went south because of the economy, the nurse quickly exited and left the doctor holding the entire lease payment for the remainder of the 5-year contract. Her name had not been on the original lease and they had a “gentleman’s agreement” that she would pick up half the lease payments. With a departed nurse and no business, the doctor is left to figure out how to continue to make payments, while the nurse is looking for employment elsewhere not burdened by any financial commitments.

Extended Warranty

Laser companies minimize or neglect to mention the cost of continued service for the machine. While most lasers come with a 12-month warranty, a continuing warranty beyond 12 months can cost an additional 10% of the purchase price per year. If your device cost \$120,000, the extended warranty can cost \$1,000 per month! Remember to add that \$1,000 to your lease payment to calculate the total cost. If you elect not to continue the warranty service program, you risk having to pay for service at a time when you are desperate. The rates for uncovered service are extremely high, and you will be in a position of weakness when you call. In addition, you will be forced to rent a replacement laser at a high cost until yours is repaired.

Marketing

No one will know you have “the latest weapon” unless you get the word out. While many of us with established practices can utilize internal marketing techniques, sometimes it requires a combination of both external and internal marketing to make sure you can bring in the very patients you are targeting. No one can tell you how much to spend, but marketing campaigns for new technologies can sometimes be very expensive, and they may require you to use radio, newspapers, or seminars in addition to internal marketing and website update costs. Some use a rule of thumb to spend 10% of the cost of the machine on marketing any new technology during the first year.

Consumables

Many devices work on the principle of the old Polaroid camera or modern-day printers. Give the customer the camera or printer for cheap, but charge a lot for the film or the printer ink. Likewise, many nonsurgical devices require “tips,” “cards,” or other

consumables that are expensive and need to be factored into the cost of each treatment. Some consumables can cost up to 30% of what you charge the patient for a treatment, which takes a significant bit out of your profit margin. Ask any plastic surgeon how much they “make” from a device and they will likely give you a monthly dollar number. Ask them how much their consumables cost, and they will usually stare at you with a blank look. Not only must you track the cost of each consumable, but you will also have to carry inventory, which is the same as keeping idle money sitting on the shelf. So the extra tips and cards you keep to prevent running out in the middle of a treatment day may mean you do not have the cash you need to pay all your bills.

Hidden Costs

Our city charges an equipment tax of 1% of the original sales price every year. (Depreciation of the value isn’t allowed.) The tax on a \$120,000 machine is \$1,200 per year, or an additional \$100 per month, which we have to add to the machine’s fixed costs. No one ever tells you that your accounting bill is also about to go up, but it will. After you hire a physician extender, the accountant will be addressing employment accounting. You will pay your accountant for lease discussions, payments, and monthly reports so you can study the ROI. You will be spending more on supplies as well, whether you purchase new cameras and disc or cloud space to store more photos, more towels in your spa, or additional patient gowns, drapes, and other exam room supplies.

Expectations

Bringing the latest technology to your community also raises expectations. Beware of raising the expectations too high, for you will soon be returning money to unhappy patients who believed that a noninvasive procedure would offer facelift results. Expectations are higher in a plastic surgeon’s office than in a dermatology office or in a medspa run by an internist. If a nonsurgical fat reduction treatment fails at a spa run by an internist, the patient may ask for their money back, and you, the plastic surgeon, may then get a referral for liposuction at your full fee. If it fails at your own office, the patient may not only want a refund, but if you offer liposuction you may feel obligated to do so at discount, since your own nonsurgical device “failed.”

Staff

If a new technology is truly successful, then traffic through your office should really ramp up. With increased traffic come new appointments, more phone calls, and more follow-ups. Simply stated, your present staff will have more work on their laps, and at some point, you will need to hire additional staff.

Additional Office Space

Do you have enough space in your office to add an additional one or two laser machines (► Fig. 18.6)? Crowding existing rooms sabotages the calming environment that your practice or medical spa is trying to create. Unfortunately, adding space or dedicating a new area to the new equipment is the only way to allow room for treatments and follow-ups to proceed without overcrowding. Of course, adding space means a higher monthly rent.



Fig. 18.6 Additional space is needed for multiple machines.

Reliability

We once purchased a laser that had continuous problems. The company blamed our staff, whom the company had trained extensively. The machine broke down repeatedly, resulting in frequent rescheduling of patients, idling nurses, and angry customers who demanded something for the time they wasted showing up at our office. We had to ship our machine for repair, wait for the company to ship us a replacement, and have our staff reschedule entire days of treatments. Despite repeated assurances by the company that the latest repair would be the last one, we ended up sending our \$150,000 laser back to the company more than five times in the first year. The disturbance that each mechanical failure caused in our practice paled in comparison to the patients' loss of faith in the laser and their loss of faith in our practice. I would urge you to spend a significant amount of time speaking with present owners of the machine to ensure they are happy with its performance, and, more importantly, to ask them if they would buy the machine again.

18.5 How Do I Pay for an Expensive Machine?

Always keep your accountant in the loop. Tax laws, such as Section 179, change frequently; what applied in your previous discussions may no longer hold true. Your accountant will be aware of potential tax implications (both good and bad) of any large purchase you are contemplating. They will also be able to help you make a decision on how best to pay for the equipment.

Is it better to buy or lease? That question will and should come up with every acquisition you make during your practice. The answer may differ during different portions of your career. Ask your accountant, and make sure he or she reads the terms of a loan or lease before you commit to something that may take you 5 years to finish up. An experienced accountant will also help you determine the true cost of the machine and how many new patients you actually need to treat to be in the black, after factoring in marketing costs, staff time, and maintenance contracts.

It is also helpful to develop a close relationship with a bank. Most banks are eager for your business, and they will usually assign you a personal banker if you also make the practice deposits into that bank. Many cities have smaller, community-based banks with outstanding reputations. I have found that the community-based bank usually delivers more personalized service than the national brands. As a rule, you should always have a credit line open with your bank for times when cash flow is tight. A line of credit will protect you from seasonal revenue fluctuations, or after a natural disaster that directly affects your practice. Spend some time getting to know your personal

banker at a time when you do not really need the bank's services. Getting to know the banker over a cup of coffee will make it easier to make a call at a time of need. The personal banker should know you and your business so well that, at some point, all you need to do when purchasing a machine is to tell them the price of the machine you are purchasing and the terms you want, and they should deliver the papers to your office for signature.

18.6 Future Trends of the Aesthetic Market: Subscription Services

As medical spa services have skyrocketed, it has become important to get technology that offers the best possible nonsurgical correction without breaking the patient's budget. You want patients to return for continued treatments, be they a series of intense pulsed light (IPL) treatments or ongoing neuromodulator treatments. Retaining those patients has always been a challenge. Sending ongoing reminders to hundreds of patients can become burdensome for the staff and intrusive for patients. On the other hand, not sending reminders is a sure way to fail.

As an alternative to the boom and bust of traditional appointment making, medical subscription services are starting to appear. It is estimated that Americans spend over \$800 per month on subscription services. The convenience of fast home delivery and the relief of utilizing an expensive object like a car without owning or maintaining it have given rise to the subscription economy. A myriad of companies have flourished by launching monthly membership plans for chocolates, razors, prepaid delivered food plans, pet food, and even men's socks. For a monthly fee, these items magically appear at one's doorstep, bypassing long lines at the shopping mall. Entertainment plans such as Netflix and Spotify offer a massive library of movies and music for a simple monthly fee.

A subscription model for plastic surgery practices would have been unrealistic until the arrival of all the nonsurgical treatments in the past decade. Since so many of the treatments are offered in a series, and so many require ongoing maintenance, a paid subscription service for nonsurgical services makes sense. HintMD is the first company to introduce the subscription model to a plastic surgery setting. Rather than having a twice or thrice yearly large bill for nonsurgical services, HintMD offers the patient a monthly payment program. After clinical evaluation, the patients sign up for a customized, yearly treatment plan of neuromodulators, fillers, and/or skin care. Because it is a yearly plan and the patient is committed to returning to the practice, patient retention and utilization go up. Spreading the cost of full correction over 12 months takes away the sting of a large bill that may give the patient pause before opting for a less expensive less-than-full correction. Subscriptions keep customers from constantly looking for a better deal that another practice may be advertising, or a Groupon offer that they may see in an online ad. Subscription services for aesthetic practices are in their infancy, but given the constant addition of new, nonsurgical treatments, and the popularity and rapid rise of subscription services in other industries, the trend will surely continue upward.

We cannot turn the clock back to the days when all we needed to succeed was diligence, a pair of loupes, and knowledge of anatomy. Plastic surgery and technology are forever tied at the hip. We can only expect the field to become more crowded, the expectations to become higher as the media selectively plays up the benefits of the newest devices. Balancing the risks, financial and medical, of a new technology will

continue to require a plastic surgeon to use common sense, investigative skills, and to remain slightly skeptical of any device that promises to revolutionize the field. Our field has always been one where creativity is rewarded. There is a saying that "he who dies with the most toys wins." In plastic surgery you only win when the toys pay for themselves before they become obsolete.

Reference

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19 A Successful Medspa

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Abstract

Medspas have a high failure rate because the owners are not running them like a business. This chapter starts with the first question: Is a medspa right for me? Then the chapter moves through the planning considerations, how to compensate clinical staff (bonus or commission?), and many other considerations. Objectives and key results are discussed as important tools for growth. Success does not just happen. It takes relentless focus, time, and energy. If it is your passion, and you have the right tools and knowledge, you can succeed.

Keywords: medspa, medispa, medical spa, dayspa, OKRs, objectives and key results, Lean Thinking, Six Sigma, inventory, compensation, bonus structure, commission, fixed costs, variable costs, embezzlement, accounting, financial statements, customer satisfaction, entrepreneur

19.1 Introduction

Since medieval times, people sought the healing waters of Spa, a town in Belgium. Over the centuries, the concept of the spa and the advances of medical science merged into a *medical spa*, also known as *medspa* or *medispa*. The medspa offers nonsurgical medical treatments to enhance appearance, such as lasers and Botox, and may also provide traditional spa services, such as facials and massages. A plastic surgeon with a cosmetic practice may want to consider establishing one for several reasons:

- As a service to surgical patients.
- So that patients do not go to nonsurgeon competitors.
- To bring in additional nonsurgeon-dependent revenue.
- To weather economic slumps, which impact surgical more than nonsurgical procedures.
- To extend a career (and revenue) in practice after surgical skills or desire to operate wanes.

Many medspas fail, often because plastic surgeons give them limited attention and fail to see their potential, ensuring their demise. A medspa is a business, not a hobby, and those who take it as seriously as their plastic surgery practice are much more likely to succeed.

A medspa is not for everyone. Running one like a true business takes time and attention. Plastic surgeons are busy in surgery and seeing surgical patients. They may not have the interest or vision to build a nonsurgical following.

But for the entrepreneurial plastic surgeon, a medspa invites cross-fertilization between a surgical practice and nonsurgical treatments. For example, a patient who may believe that cryolipolysis in a medspa could get rid of an abdominal panniculus can be steered toward an abdominoplasty, and the surgical facelift/laser patient can benefit from minimally invasive ongoing medspa treatments to maximize results. The large surgical patient base that can develop after a few years in practice can develop into many potential medspa patients.

19.2 Starting Out

Start with a business plan. (Refer to Appendix 4A.) Even if you are not taking a bank loan, having a business plan will force you to articulate why you are starting a medspa, what will distinguish you from the competition, what services you will provide, what products you will sell, what technology you will need, whom you will need to hire, etc.

You will also need to make a number of critical decisions before you launch.

- Medspa at same location as the plastic surgery practice or a different location?
- Spa as a separate corporation/business or still within the confines of the practice?
- How much space will be needed?
- Anticipate staffing needs (admin, NP/PA, RN, aesthetician).
- Choose technology offerings (lasers, IPL, Visia, etc.).
- Business plan for purchasing or leasing equipment.

19.3 Qualities of a Medspa Space

A medspa should be:

- Quiet
- Calming
- Relaxing
- Uncluttered

Advantages of an Offsite Location

- May be more conducive to a quiet spa atmosphere.
- Less intimidating for patients/clients who may be afraid of surgery.
- Does not take up plastic surgery office space.
- May expand your patient base in a different neighborhood.

Disadvantages of an Offsite Location

- You may not be available to immediately consult regarding a question or a problem.
- More expensive to rent a second site.
- Less control over the daily operations.
- Inconvenient for surgery patients who need spa appointments for a treatment that augments the surgical result.
- Less cross-referral with surgery.

Advantages of an Onsite Location

- Convenient for patients.
- Encourages staff to ask you regarding clinical questions or problems.
- Facilitates cross-referral to surgery.
- Easier for all staff to have a treatment so they can talk about it with interested patients.

Disadvantages of an Onsite Location

- It takes extra space, which you may not have.
- May not be conducive for a quiet spa.

The space requirements for a medspa include:

- Surface space and chairs/standing area for staff to make appointments and document treatments.
- Room for all those expensive machines.
- Fully equipped patient treatment rooms.
- Storage space for products, paper supplies, gowns, and towels.
- Computers, printer, fax, scanner.
- Generator-backed refrigerator for Botox (too much to lose without a backup).
- Storage space for staff purses, coats, and other belongings.

19.4 Developing the Infrastructure

You can have a medspa as part of your plastic surgical practice, but to truly achieve its full potential, a medspa should be set up as a legally separate entity. The advantages of doing so include:

- Better tracking of the medspa's financial success or failure.
- Flexibility to bring in a partner into your surgical practice and offering a separate buy-in for the medspa.
- Flexibility to sell the practice while continuing to operate the medspa.
- Greater flexibility to open up one or more medspas in separate locations.

Before you make any significant moves or investments, consult with your accountant and lawyer. They will know how to properly incorporate a new entity with the Secretary of State and they can advise you on other matters like fictitious business names. Another good resource is the American Med Spa Association (AmSpa americanmedspa.org). This organization provides legal, compliance, and business resources for medspas. Because requirements can be vastly different from one state to another, it is imperative to be on solid footing from the very beginning. AmSpa also offers periodic nationwide conferences that can be helpful before or after you have started a medspa.

As the physician, you will be at the top of the medspa structure. Unless you want to manage the spa yourself, you will need to hire or identify a manager. Your plastic surgery practice manager could also oversee a small medspa, taking care of payroll, speaking with reps, managing inventory, etc. A larger spa will demand much more time, and a separate spa manager will facilitate smooth sailing. You can set up the structure so your spa manager answers to your practice manager or directly to you. That arrangement will depend on the capabilities of the managers, the size of the entities, and your level of interest in the running of the spa.

19.4.1 Staff Education

You can send your staff to train to do different treatments, but some topics you should address yourself for quality control. You must provide effective and engaging teaching tools, including videos, online courses, webinars, articles, and books. Teach the physician extenders anatomy so they understand the nuances of injecting Botox and filler.

The kit is simple and should have a copy of your protocol within the kit. At a minimum, the kit should have:

- Hyaluronidase (have at least 1,000 IU available)
- Baby Aspirin
- Nitropaste
- A warm pack

Report all significant adverse effects to the manufacturers and also rely on advice from the company's clinical department for the latest recommendations on any adverse effect.

19.5 Keep Track of Your Inventory

Even if you trust the people in a neighborhood, if you parked your car and left a laptop inside, you would probably hide it under a jacket, close the windows, and lock the doors. An open car with a purse, wallet, or laptop inside is tempting enough to turn a nonthief into a thief. You should run your office in the same way.

Let us use Botox as an example.

- Do not assume 100 units/vial of Botox.
- Units get wasted.
- Staff may comp patients without documenting.
- Staff may take Botox, especially if they work at another practice.

Track product inventory frequently and compare that number with the number of units sold.

You may be storing thousands of dollars of Botox in a refrigerator, but if the power goes out in the middle of the night, or while you are on vacation, how do you know your Botox is safe and unaltered? You do not! Have an electrician connect the refrigerator to a backup generator. Your computers may go on the blink, but your Botox will be safe.

Consider putting a lock on the refrigerator if it is in an accessible area. Even a small lock can deter theft. If the refrigerator is untended, patients or employees can pilfer the contents, particularly if they are injectors themselves or know someone unscrupulous who is.

Identify each vial with your own medspa inventory separate from the Botox lot number. As the Botox shipment arrives each vial is labeled with a numbered sticker. When you first implement this method, the vials are labeled sequentially starting with vial #1. This provides an easy count when anyone opens the refrigerator and can just scan what the last number is (► Fig. 19.2). A master register is also kept tallying the number of units placed into a patient from each vial. This allows one to count how many units per vial are being delivered. Having an ongoing register also prevents vials of Botox from disappearing from the office. If everyone knows that the doctor and the office manager keep an eye on exactly how many Botox vials are in house at all times, it is less likely that a nurse who injects at multiple practices could be tempted to "borrow" a vial and then forget to replace it.

All units must be tracked. If you inject five units of Botox as a touch-up on the nose, create a bill, and discount it 100%. You have just sold five units for \$0.00. Check the units sold against the vials used. Although each vial has 100 units of Botox, it is unlikely you will actually inject all 100 units, since Botox is in the hub or a small amount is lost when getting rid of an air bubble. A discrepancy may be the first clue that the most popular Botox injector created her following by charging for 15 units, but injecting an additional



Fig. 19.2 Serially number every Botox bottle, and document its use for every injection.

ten units on the house. Bringing stolen Botox home to inject friends at a discounted rate can be quite profitable, and you would not be aware of your injector's side business without tracking inventory. Staff members who know that you track inventory closely are less likely to steal.

19.6 Long-Term Success

A successful medspa will always have its consumers as a guiding light. You must establish a relationship just like you would in a plastic surgery practice. The customer deserves a 5-star experience so that they return to you rather than looking for the next Groupon or other local special.

Beyond customer service, as the owner of a medspa, you will be the last one to be paid. The Internet is rife with reports of countless medspas failing and going bankrupt. In general, those medspas were run with little supervision. The physician paid for the rent, salaries, and overhead of the medspa figuring there was always a profit at the end. That was a recipe for failure, as evidenced by individually owned as well as chain-owned medspas that failed very frequently.

Analyze each service you provide for its stand-alone profitability, not for the convenience of the client or the preferences of the staff. In our medspa, the staff was surprised when we disallowed all waxing services. The cost to deliver each waxing service was higher than what we could charge since we were competing with much lower overhead day-spas in the neighborhood. The same was true for massage. Once we explained to our staff the numbers, they understood that it was also to their benefit to terminate those services and to concentrate on services that produced income for the medspa and could generate bonuses for the staff.

19.7 Operational Measures

“For long-term growth and success, measure what matters.”
—Kaplan

After investigating 12 top-performing companies for a year, Kaplan and Norton² devised a balanced scorecard to give managers a bird's eye of the business's financial and operational measures:

1. Financial performance
2. Customer satisfaction assessment
3. Internal business processes
4. Learning and growth

In general, the factors of most interest to customers are time, quality, service, performance, and cost. Consequently, these factors should be measured objectively and managed if the medspa falls short. Internal business processes can be measured by inventory cycle time, quality of results and skin care products, employee skills, and practitioner productivity. Metrics should be adjusted as the medspa grows, new medical technologies appear, and software changes. Improving value for the customer results from having the flexibility to improve and innovate.

Not all changes result in positive financial performance, which is why it is so important to track objective metrics. Strategic planning for the future should be based on all the numbers that reflect a medspa's performance.³

19.7.1 Financial Performance

- Pay attention to profit margin.
- Meet with your accountant at least monthly to review revenue and expenses.
- Consider using a bookkeeper or financial oversight manager.
- Consider adding an app that shows you daily performance (like AtlasKPI, see Chapter 18).
- Be efficient.
- Maximize services and product sales revenue.
- Do not let the mantra “all business is good business” lead you astray. Groupon deals are not profitable, and they will not develop loyal customers.
- Costs are *always* higher than anticipated.

19.8 Clinical Staff Compensation

Medspas often fail because clinical staff compensation is proportionally greater than the income they generate minus the overhead to support that position. Employee compensation must work for both the employee and the medspa owner. The staff is unlikely to be aware of the overhead you bear, and they will assume the profit is much higher than it actually is. Transparency in the flow of revenue coming in and expenses results in greater staff awareness and trust, particularly when they see their compensation is a fraction of the fee a patient pays.

At a minimum, your costs will include the following:

- The staff's total compensation (including taxes, benefits, compensated personal in-house treatments, and training and conference expenses; in calculating the cost

of a treatment, the clinical staff's total compensation for the duration of care, including evaluation, treatment, and follow-up, should be included under variable costs)

- Marketing
- Computer, telephone, and software expenses
- Receptionist time to make appointments, call no-shows
- Rent and furniture
- Accounting and legal expenses
- HVAC
- Cost of goods sold
- Technology used (laser leases, consumables, tech support)
- Insurance
- Laundry
- Medical and office supplies
- Cost of unscheduled time and no-show or cancelled appointments
- Staff support
- Autoclave costs

These fixed costs must be included when analyzing the cost of providing a service. The staff member who does not understand the costs is likely to feel that he or she is under-compensated and is more likely to become disgruntled. Establish incentives so that the clinical staff are motivated and invested in their own success. For some that may mean a flat salary, but for many employees, productivity-based financial rewards are effective at acknowledging hard work and aligning their interest in improving their productivity with yours in staying in the black.

19.8.1 Commission versus Performance Bonus?

A *commission* is paid to a practitioner for each patient treatment, independent of total productivity. Usually a commission is paid as a percentage of the fee of a service delivered or the price of a product sold. A *bonus* is paid when a practitioner reaches a target monetary goal (► Fig. 19.3a). Excellent hourly compensation cannot be independent of productivity. It takes initiative to have a completely booked schedule, patient retention, and top reviews. To promote teamwork and cross-referrals between aestheticians and nurses, you can give individual bonuses a boost when the team reaches its goal (► Fig. 19.3b). Because nonclinical staff play an important role in team performance by speaking about produces and offering great customer service, they may also be bonused (► Fig. 19.3c).

Ideally, the staff and the medspa owner work together as a team, which is why educating your staff about where the revenue goes is so important. Similarly, if a client is unhappy with a service, and you return her money in full, the staff often expects to be paid their bonus/commission. Since the revenue disappeared, so did the bonus or commission. If the staff was culpable in some way for the client's unhappiness, they will be more likely to learn from the experience if they lost their bonus/commission. However, if the staff did an excellent job, you can let them keep the bonus/commission, but educate them about the financial picture: not only did the medspa lose by giving out, say, two computer treatment cards for the technology used, 50 units of neuromodulator, and four syringes of filler, but the medspa also covered the practitioner's salary and all the costs listed above. Consumables may have cost \$1,000 in addition to the employee's salary and all overhead costs. Paying a bonus/commission on top of that loss is a poor

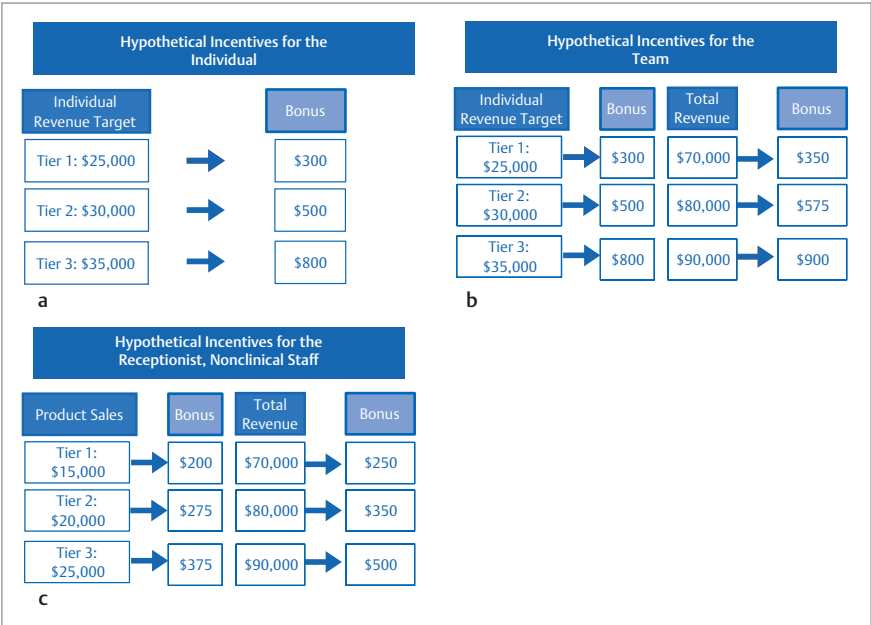


Fig. 19.3 (a) A bonus structure should be developed based on fixed and variable costs plus a desired profit margin for the medspa. The more productive the staff member, the higher he or she moves up the bonus tier structure. (b) To promote staff unity and cross-referrals between aestheticians and nurses, individual bonuses can be augmented when the team does well. (c) Because nonclinical staff can do a lot of teaching about products, and they may be the basis of suggesting which practitioner to see for what, a bonus structure may be appropriate for them.

business practice and should be done only under exceptional circumstances. The employee will understandably be upset unless you educate them so that they understand. This topic should be addressed proactively to all clinical staff so that it does not come as a surprise when money is refunded to a patient.

19.9 Fixed and Variable Costs

Fixed costs do not take a vacation.

- Employee's *total compensation package* (not just salary!) for the duration of the appointment.
- Portion of rent for the room, phone, computer, receptionist, insurance, equipment leases, and tech support.
- Variable costs appear only with a given treatment.
- Medical supplies.
- Device consumables.
- Laundry.

If we look at the hypothetical example of an RN's schedule (► Fig. 19.4a), we see that 5 of the 8 hours have no patient appointments, yet the fixed costs still accrue. Those 5 hours cost the medspa \$635, an amount that is unlikely to be offset by the treatments done the rest of the day. Does it make sense to pay the nurse's compensation package

plus a commission on the four patients she treated? (Remember, the spa is losing money that day.) A bonus system makes more sense. A bonus represents an appreciation of the hard work performed to cover the costs of doing business plus a modest profit for the medspa. A bonus can be calculated quarterly.

The hypothetical schedule of the busy RN has a happy ending (► Fig. 19.4b). Together the fixed and variable costs added up to \$3,491, but the total revenue for the day was \$5,250. That means the margin was a healthy \$1,759. If that nurse continues working so diligently, she will have earned her bonus.

19.9.1 Buying a Machine

When you consider purchasing a machine, you should first consider if you have the space. If so, who is going to run the machine? Whether an aesthetician, medical assistant, registered nurse, nurse practitioner, or physician's assistant will run the machine depends on the laws of the individual state in which you practice. Some states are very restrictive, and others are quite lenient.

Do not be fooled by machine reps. Historically, neuromodulators and fillers give you the best return on investment (ROI). Reps need to meet their sales quotas and they fail to consider factors like overhead when they tell you, "After doing just two treatments a month, the rest is *pure profit!*" Call around and email colleagues who may have the device you are considering. Use resources with peer feedback not provided by the company selling the device, such the Surgeon as Consumer page on the website for the American Society for Aesthetic Plastic Surgeons and read colleagues' evaluations (log into the ASAPS members only website and click on Surgeon as Consumer).

To figure out if purchasing a specific machine would be a good business decision, you will need to do some basic algebra. Ignore the rep's optimism, and estimate your internal and external marketing costs to create awareness. Of course, you will need to pay not only your clinical staff, but all staff involved, from the person answering the telephone to the person taking photographs. Figure out the total compensation for the time each client will require from the receptionist, other support staff, and the clinical staff who performs the treatment. You will also be paying rent for the treatment space and the space to store it. Yes, you would be paying for that space with or without that machine, but devoting that space for one machine means you do not have the opportunity to use that space for another, possibly more profitable purpose. Add up the costs for all medical and/or office supplies used per client, plus an estimate for photography. After all, your photo archiving software, the memory card, the camera, and camera replacement after wear-and-tear are not free.

Now that you have figures for your costs, you will need to figure out how much revenue the machine should generate to cover costs. The company rep can give a price range for the treatment in your geographic area or you can call around. Once you know the going price, you can calculate how many treatments you would need to perform in a month to break even (► Fig. 19.5).

But you do not provide a service just to break even. How will you cover pay raises, bonuses, supply price increases, or the purchase of new practice management software if you have nothing left over at the end of a treatment? A healthy business is profitable, so choose a monthly or quarterly profit goal for the machine you are considering. Add associated taxes, and come up with a pretax profit goal, or target *operating income*. To analyze a specific category, like Botox, CoolSculpting, MiraDry, or Fraxel, you need to find out how much revenue you need to generate for each treatment to be profitable. Revenue will be the price of the treatment times the number of treatments. Identify the

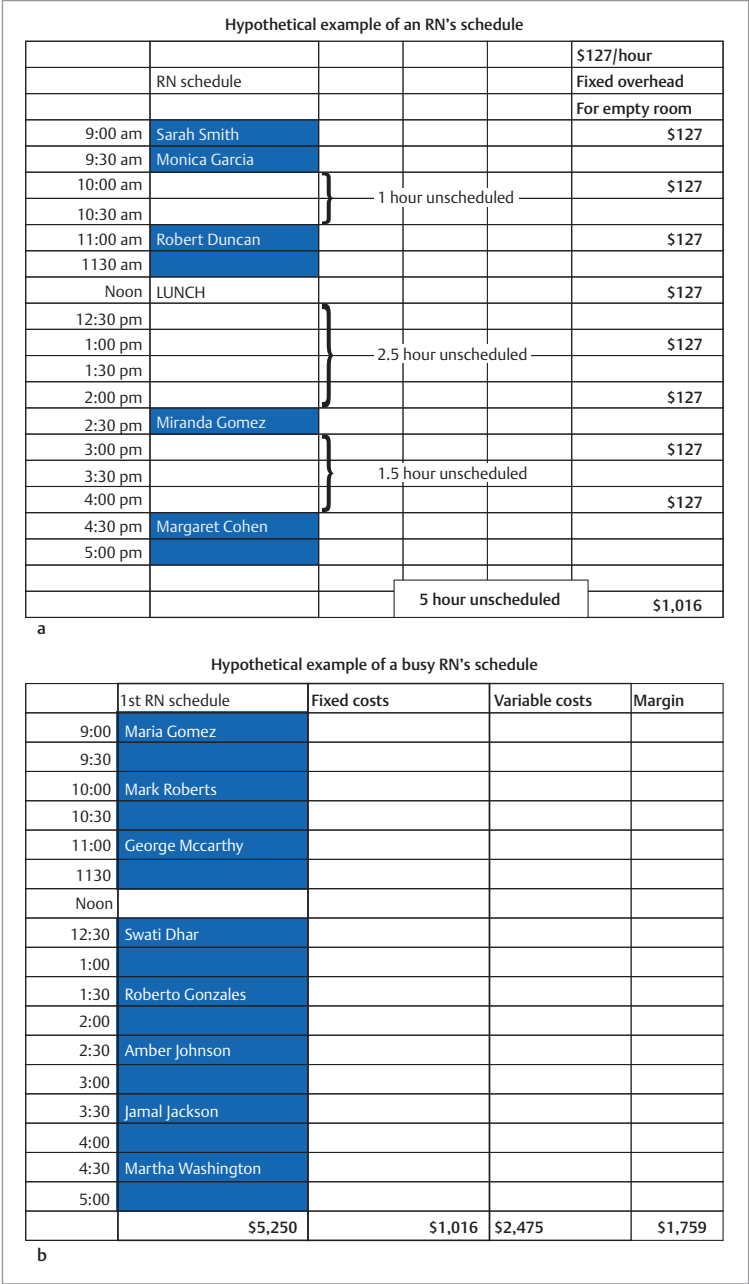


Fig. 19.4 (a) Fixed costs run whether a nurse is doing a treatment or not. Although the nurse brought in revenue for the 3.5 hours of treatments she did, the room sat idle for 5 hours, and each hour cost the medspa \$127. Staff may not understand that even though they are generating revenue, the medspa can still be losing money. **(b)** When the nurse has a full schedule, the revenue (\$5,250) is greater than the fixed costs (\$1,016) and the variable costs (\$2,475). The margin is a healthy positive number: \$1,759.

How many treatments are needed to break even?

Going price = \$150

X = Number of treatments

$$(\text{Fixed costs}) + (\text{Variable costs})(X) = (\text{Price})(X)$$

$$\$3450 + \$102(X) = \$150(X)$$

$$\$3450 = \$48(X)$$

$$X = 71.875$$

Answer: 72 treatments

Fig. 19.5 To calculate how many treatments with a machine or service are needed per month or quarter to break even, calculate the fixed costs. Add to that the variable costs associated with each treatment multiplied by X , the number of treatments. The revenue (price times X) must equal (or surpass) these costs. Solve for X .

Start with your pretax profit goal and work backwards:

X = Number of treatments; Price = \$150

FC = Fixed Costs

PPG = Pretax Profit Goal

Variable Costs = VC

$$(\text{FC} + \text{PPG}) + (\text{VC})(X) = (\text{Price})(X)$$

Fig. 19.6 To calculate how many treatments are needed to earn a monthly or quarterly profit goal, add that goal to the fixed costs. Add those values to the variable costs times X , the number of treatments. That sum equals the price times X . Solve for X to find the number of treatments needed to be performed in the designated time period.

values for the variable costs, the fixed costs, and the desired operating income over a specific unit of time, such as a month or a quarter. Now you can solve for X , the number of treatments necessary to achieve your profit goal (► Fig. 19.6).

19.10 Prevent Embezzlement and Losses

Chapter 10 is a useful reference for anyone running a medspa. Rules to be followed to prevent embezzlement and losses are listed in brief here:

- Personally sign all the checks.
- Review all bills and credit card statements.
- Staff must verify ID with all checks.
- Have your bank teach your staff how to distinguish counterfeit money.
- Have at least two people count cash for deposits and initial deposit slips, and place cash in a box with a slot that only owners have the keys to.
- Track your inventory.

19.10.1 Comped services

In general, it is best to avoid discounted pricing and comping services, but occasionally there is a good reason to do so. If a patient is unhappy with a treatment, comping a

treatment may be the right thing to do, especially if the result of a previous treatment was not what was expected or desired.

- Bill the patient 100% of the fee.
- Discount the fee 100%.
- Give the receipt to the patient.
- Result: happy, appreciative patient.
- Accurate tracking of inventory (e.g., Botox).

19.10.2 Accounting

To optimize time with your accountant, learn how to read financial statements.^{4,5}

An income statement will tell you the following:

- Is the medspa profitable?
- How do results compare with prior period?
- What is the gross profit (loss)?
 $(\text{Revenue}) - (\text{Cost of Goods Sold}) = \text{Gross Profit or Gross Margin}$
- What is the gross operating income (loss)?
 $(\text{Gross Margin}) - (\text{Operating Expenses}) = \text{Operating Income or Loss}$

Financial statements give a picture of how a business is performing. The *balance sheet* is a snapshot of the company's financial position at a specific point in time; the *income statement* is more like movie or video that shows financial activity over a period of time (month, quarter, or year); and the *cash flow statement*, as its name states, reflects the incoming and outgoing flow of cash over that same accounting period.⁶

19.11 Medspa or Dayspa?

Remember the definition of medspa? A medspa is a spa with a medical program, supervised by a licensed health care professional. These spas offer medical treatments such as lasers, microdermabrasion, Botox, and other medical beauty procedures *as well as traditional spa services such as facials and massages*.

If your medspa offers facials, waxing, or massage, you might want take a look at the numbers. What is your overhead to provide that service? (Remember rent, computers, staff support, and all those other costs.) How much can you charge for these nonmedical treatments? If the revenue is less than the overhead, get rid of the service. You are not running a charity.

19.12 Rightsizing Inventory

It may seem reasonable to carry a large inventory to make sure you do not run out when you are serving a client, but that extra inventory ties up resources, measured in terms of *inventory carrying costs*, including associated taxes and insurance. The money sitting on the shelf in the form of extra skincare products or fillers could be used on staff training or new technology. If the inventory is damaged, stolen, or has an expired shelf life, the costs are even higher. One of the biggest reasons small businesses fail is that so much money is tied up in heavy inventory that the medspa has too little cash flow to survive.

Inventory efficiency is measured in terms of *inventory turns*, calculated by the cost of goods sold by the value.^{6,7} If your spa can generate more sales on lower inventory, resulting in a higher number of inventory turns, you are maximizing efficiency.

A 20-turn item is a fast mover, and a 5-turn item is a slow mover. Consider inventory turns as you look at your skincare products. You might consider removing the slow movers from your inventory. Limit the number of brands you carry to three or four, and limit the types of products to those that turn over quickly. Do not duplicate types of products. Each should meet a unique need.

Low inventory leaves more available cash for the business. To keep it low:

- Streamline your product lines and injectables.
- Check inventory frequently and keep track of inventory on your patient management software.
- Ignore efforts by sales reps who push inventory by offering discounts that tie up your money. Do not bite.

19.13 Customer Satisfaction

The success of your medspa will depend largely on how satisfied your clients are with their experience. Customers give positive ratings if you meet or beat their expectations. Satisfied customers become *loyal* customers, who save the company marketing expenses. Loyal customers return even if the competition is selling Botox at \$7 per unit. Loyal customers will sing your praises to others.

Customer ratings result from their peak and end customer experiences. Get bad experiences over up front. Require advance payment for treatments, just like your surgical practice, give policies of cancellation, etc. early in the appointment. All interactions with customers, whether on the phone or in person, should end with a feel-good experience. If a procedure is painful, end with something positive.

You should poll your patients after any medspa treatment. If you ask nothing else, you can get a good measure of client satisfaction by asking these two questions:

1. How satisfied were you with your recent experience? (10-point scale)
2. How likely is it that you would recommend this medspa to a friend or family member? (10-point scale)

Disappointing your customers can be very costly and can lead to the following:

- Low retention of repeat services, like Botox injections.
- Few repeat product sales.
- Bad online reviews.
- You will have to pay marketing costs to find new patients to come in the door.

You cannot afford to disappoint many customers.

19.13.1 Unhappy Clients

Unhappy clients can blast your reputation on social media and write negative reviews that can threaten the success of your practice. If a client has legitimate concerns, take care of her with a refund or credit. Write off the costs as a marketing expense and an investment in goodwill.

When unhappy clients are unreasonable, give money back and have patients sign a letter agreeing not to sue or write a bad review. It is rare, and it saves time and emotional energy. A single angry, belligerent client can sour your days. Most clients are satisfied with a full refund. Then make a pop-up note in your practice management software never to reappoint that person again.

19.14 Establishing Good Internal Business Processes

Harvard professor Michael Porter identified three types of market strategies: low cost, differentiation, and a combination of the two.⁸ The low cost approach attracts customers who see good value. A differentiation approach attracts customers on such characteristics as quality, service, and prestige. This approach generally has higher margins and greater customer loyalty. Combining the two approaches is difficult because service costs money. For example, the Ritz Carlton would not survive if it charged Motel 6 prices.

Good internal business processes promote high productivity and efficiency. Two practices adopted by businesses are *Lean Thinking* and *Six Sigma*.^{9,10}

Lean Thinking aims to eliminate waste and reduce variation. “Mapping” processes involves evaluating each step in carrying out a task. Some steps add value for which a customer will pay, and others add nothing. Nonvalue steps may be minimized or eliminated. For example, if an aesthetician were to wrap up every product sold in giftwrap and ribbon, clients might resent the time lost while waiting for their product. If clients perceived this gesture as a waste of time more than they appreciated the presentation, no value is added, and the giftwrapping should be eliminated.

Six Sigma is a standard deviation term referring to an extremely low level of defects or variations (3.4 defects per million opportunities). The more sigmas, the narrower the variation band for a process. Automation, consistency, measuring, and monitoring promote fewer defects. Human processes have more errors than automated processes. In a medspa, humans deliver services. Even technology, like lasers, is operated by humans, leaving room for a lot of variation. Consequently, it is important to train your clinical staff well. If one nurse does a laser treatment, but she's on maternity leave for the next one, the replacement nurse should deliver the second laser treatment in a consistent manner with little variation. Uniqueness is admired in fashion and cuisine, but not in the manner in which a clinical practitioner delivers a medspa treatment. Consistency promotes client confidence.

19.15 Human Resources

Employee turnover is costly. It can take months or more to train a staff to perform well in his or her job. Aim for retention. Give your employees the tools they need to reach their potential. Assess employee satisfaction with surveys.

Give employees clear expectations with meaningful, measurable goals. If you tell one of your nurse injectors, “Improve your client retention rate,” she is unlikely to be fired up and ready to book every client's next appointment before they walk out or get on the phone to encourage old clients to return. You could instead say, “Your retention rate is very low, just 10%. I'd like you to work on bringing that up to 20% by June 30 of this year.” Get her buy-in by asking her how she plans to do that rather than by telling her. If the suggestions are hers, she is more likely to follow through. When she walks out after that performance feedback, she will be ready to work toward her goal.

Performance measures should be based on established, objective standards that express the priorities of the company. Each employee should receive a tangible guide for daily work. People naturally try to match or beat what is expected of them.

19.15.1 Getting the Most Out of Your Employees

Objectives and key results (OKRs) have been popularized by successful tech companies, such as Intel, Sun Microsystems, and Google.¹¹ An *objective* is *what* is to be achieved. Objectives are significant, concrete, aspirational, and inspirational. *Key results* are the measurable, time-bound benchmarks to get to the objective. Effective OKRs are aggressive but realistic.¹¹ If the team routinely hits all their objectives, they are not aggressive enough.

If your medspa has 12 services on the menu of services, then each one should be addressed separately with the employee who is delivering that service. For example, you can set OKRs for each technology. You can say, "Our objective for this quarter for Miracle Laser is to achieve Top Tier Rewards status with the company." Explain to the employees why this is a good objective: your medspa pays less for each treatment card from the company the higher your tier status is, and your medspa will have a preferential listing on the company website to attract patients more easily. The key results you may want to see are¹² to: (1) treat 10 patients per month with 30 treatment areas; (2) obtain five before-and-afters each month; (3) obtain five online reviews for the treatment each month.

An important part of making OKRs work is to make them public, so everyone knows what everyone else's OKRs are, and to monitor them frequently. The owner or manager should meet with each team member weekly to check the progress and coach them to succeed. OKRs are about team-building. At the end of the quarter, each team member should work with the owner or manager to set new OKRs for the next quarter. When employees have input in developing their OKRs, they feel ownership. The manager and owner succeed when each employee succeeds, so coaching is an important part of the process. OKRs are much more likely to produce a result than a top-down command to "do more Miracle Laser treatments and get those numbers up."

Successful organizations have demonstrated that employee performance is a function of talent, motivation, and support, defined by the *performance equation*:

$$\text{Performance} = f(\text{talent} \times \text{motivation} \times \text{support})$$

Support is a necessary ingredient. A talented, highly motivated employee will lose motivation without the tools and information necessary for him or her to perform well.

19.15.2 Strategies to Motivate Your Team

Communicate the big picture of the medspa's purpose. Create a mission statement, display it prominently, and refer to it frequently. Develop clear performance expectations. OKRs are reach goals and should not be the basis of bonuses. If they are, the staff will set unambitious OKRs. Instead, set up a bonus structure independent of OKRs. The bonus structure might include not just revenue generated, but also a specific monthly number of patient reviews, a specific monthly number of web consents obtained, and an absence of legitimate patient complaints. When an employee reaches his or her goal, recognize and celebrate the success.

To create a high-performance workforce, provide the necessary tools and invest in their training and education. Provide regular monthly or quarterly employee feedback and coaching, whether done by you or by your manager with your input. Hold employees accountable for their goals. If they fall short, coach them so they can succeed.

Feedback is a powerful employee motivator. Ongoing feedback is more important than a 1-hour annual review. Conversations, feedback, and recognition (known as CFRs) are methods that look forward at future goals and performance, whereas annual reviews always look backward. Conversations aim at driving performance; feedback aims to evaluate progress and guide future improvement; recognition is a form of appreciation for contributions to the team.¹¹

19.15.3 Systems and Protocols

If you find shortcomings or failures in your medspa, focus on the holes in the system rather than blaming an individual. Systems that rely on memory or on only one person usually fail. The whole team can learn from a mistake so that it is not repeated in the future. That applies to better injection techniques, better settings on a laser, or better choice of a patient. Any significant complication should be incorporated into the policies and procedures manual by way of a modification to the way a treatment is conducted in the medspa.

19.15.4 Training Your Sales Staff

- Sales = Education.
- Education = Sales.
- Number 1 goal: Help patient achieve her goal(s).
- Staff often assumes patient's goal is to purchase the cheapest treatment/product.
- Train staff to feel comfortable offering the treatment that delivers the best results, not the highest savings.
- If staff prioritizes the patient's budget over results, patients will be disappointed, and the medspa will not grow.

19.16 Marketing

A common misconception is that if a product is great, customers will buy it. But when does a customer know a product is good? After the sale. Think of a good product or service as a customer *retention* tool, but customer *acquisition* depends on marketing (and word of mouth).¹³

To develop a marketing strategy, answer three questions:

1. Who are your customers?
2. What do they value?
3. How can you deliver that value better than the competition?

Consider your competitors.

- Do not engage in price wars. If you drop your price, so will your competitor.
- Let the other medspas offer the cheap Botox.
- Offer excellent service, deliver great results, and make people feel good every time they come in!
- Purchasing is done with emotions and justified with logic after that.¹³

Organizational Pearls

- Sell peace of mind, not board-certification as patients may not even understand the differences in boards.
- Do not sell a commodity. Sell an emotional goal. For example, do not focus on selling Botox. Focus on the end result: having a smooth, wrinkle-free forehead that makes you look relaxed and youthful. Aim to sell confidence, not services or products.
- Identify all employee roles and define the tasks each employee performs.
- Create checklists for employees to use to make sure they properly complete these defined tasks. Systems and checklists are of utmost importance. If an employee is absent and another employee takes over a treatment series, he or she should be able to refer to a checklist that enables the treatment to be completed as if the absent employee had performed it. Checklists are what airline pilots depend upon. Make sure your medspa has checklists for every technology that is utilized and make sure checklists are followed each time. Hospitals have reduced medical errors by having checklists and time outs, so the more thorough your preparation is before any treatment, the less likely you are to stumble upon a complication.
- Reject “toxic” customers. They waste time, risk bad reviews, they are prone to no shows or cancellations, and they may want a refund or free re-treatment despite reasonable results.
- Your medspa manager must have a bird’s eye view of the direction of the medspa, the goals for each employee and each technology, and he or she must be in charge of maintaining the 5-star service culture that is customer-centric and forward thinking.
- Your medspa will become a real asset only if it can run without you. If all the systems, protocols, checklists, and precautions are followed the way you have designed them and the medspa flourishes when you are away, then you have created a saleable asset.

19.17 Business Systems

Business systems are the building blocks to your medspa. If your business cannot be operated without you, then it is not a saleable asset, and you are stuck, regardless of how good or profitable it is. That is why business systems are so crucial. Having documented systems is what enables the business to run without you.

What gets measured gets managed. Without metrics a business owner is like a boat captain at sea without a motor, at the mercy of each day’s currents. At minimum, your medspa should be able to track, measure, and respond to the following:

- Lead generation
- Conversion rates
- Training for each staff member, including HIPAA and OSHA
- Hiring strategy
- Marketing
- Inventory management
- Custodial office upkeep
- Management of online reviews
- Customer acquisition costs
- Profit and loss

Keep track of these revenue figures, marketing metrics, and other significant numbers on a company dashboard. Real-time data has been used in many industries for years, but only recently is it available for medical spas and plastic surgery practices. A company called AtlasKPI provides 50 key performance indicators for a practice, updating each of them in real time. (See Chapter 18 for more information.) The data is accessible on a smartphone, so business decisions can be made with precision.

Commercial software solutions like Geckoboard can also automatically pull data in real time from a variety of sources, making measuring and managing your metrics easy.

A dashboard is a great early warning system for problems and can keep you and your team excited, motivated, and accountable. Smart business owners also tie incentives to hitting key metrics. Take the team to dinner if the churn rate stays below a certain threshold or tie bonuses to certain metrics.

19.18 Summary

A medspa owner is an entrepreneur dealing in the results, unlike others working within an economic model based on time and effort. If an entrepreneur creates value, the money will follow. When we acquire, retain, and satisfy a customer, we create value. The higher the value, the greater the revenue.¹³ Time-sucking peripheral activities distract from productivity. Examples include checking emails or holding meetings with no defined purpose (and consequently no action-items). Relentlessly focusing on activities that build value are essential to reach your financial, growth, and reputation goals. In the words of Alan Dibs, “For the entrepreneur, time is not money, value is money.”¹³

All the value of a past traditional business derived from physical assets (plant and equipment; real estate; inventory and distribution infrastructure). Today the value of a business relates to its customer base and to the public it has access to. Reproducible, measurable systems in a business are so valuable that people will pay for that in the form of a franchise. That gives you an idea of the costs of creating a business yourself.

Owning a successful medspa takes time, energy, and dedication. We hope that the principles we outlined will guide you to success.

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20 Medical Inventions: From Idea to Funding

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Abstract

Plastic surgeons are innovators, and many have ideas for inventions. If you come up with a good idea, this chapter helps you protect it, develop it, raise funds, and take it to the finish line.

Keywords: nondisclosure agreement, invention, medical device, prototype, proof of principle, 510(k) premarket notification

“Don’t worry about people stealing an idea. If it’s original, you will have to ram it down their throats.”

—Howard Aiken, computing pioneer

20.1 Introduction

Many people have good ideas. Physicians have a lot of good ideas, partly because they are inquisitive people, and also because physicians see opportunities in the course of their practice—things that could be done differently or better. Many plastic surgeons are also entrepreneurial, so it is logical to believe that plastic surgeons often come up with some clever ideas. What is not so clear is what to do with a good idea. This chapter is designed to help guide you through the process.

There is a well-publicized myth that some people thought the U.S. Patent and Trademark Office would close at the start of the 20th century because there was nothing left to invent. Ideas are like the universe, ever-expanding. There is no shortage of good ideas; it is what to do with them that matters. There are big ideas such as personal computers and organ transplants, and there are smaller ideas such as the pulse oximeter. In the world of plastic surgery the big ideas have included microsurgery and the wound VAC. As a medical student in the early 1980s, I asked my chief resident in general surgery about using gynecological laparoscopic techniques to do general surgery operations. He thought that was the dumbest idea he had ever heard of. Obviously, I was not the only one who thought of that.

20.2 Step 1: A Good Idea

When you think of a good idea, write it down. Many famous people keep notebooks close at hand to jot down anything that might be useful. Our brains are like the freeway—we have so many things going on at the same time that we may lose a passing thought unless we know when to get off the exit. Somehow, the shower seems to be an excellent place to come up with good ideas. Maybe it is the hot water on the scalp that stimulates the neuronal connections. A really good idea seems hard to forget. It may start as a fleeting thought, but then when you least expect it, you think about it again.

However you come up with it, *write it down and date it*. This is useful for at least two reasons: first, it puts the idea on your radar screen and second, it documents when you came up with the idea in case you need to prove it later on.

20.3 Step 2: Protecting Your Idea

There are many ways to protect your idea. You could just not tell anybody, but then not much would happen to it. It is also useful to remember that most ideas have been thought about before. In fact, many inventions and “discoveries” of the last century were known thousands of years ago in previous civilizations. They were just never patented thousands of years ago; it was the latecomers who got the patents and received the credit (and the profits!). There is a section in the Code of Ethics of the American Society of Plastic Surgeons which states that a member may be subject to disciplinary action if “the member seeks or obtains a patent for any invention or discovery of a method or process for performing a medical procedure or employ trade secrets, confidentiality agreements or other methods that limit the availability of medical procedures and the dissemination of medical knowledge.”¹ This means that should a light bulb shine above your head, you should be as educated about the process as possible.

20.3.1 Method versus Device Patents

There are method patents and there are device patents. Method patents are much broader and also harder to obtain. Device patents are narrower, but are easier for a competitor to design around. In general, regardless of the type of patent you apply for, patent attorneys will tell you that generally one patent is just the center and then, as you grow, you build fences around the first patent in the form of other patents.

When you apply for a patent, there is a bit of a catch-22. You do not really know everything about your invention when you apply for a patent. You want to put in as much as you can to start building the fence, but at the same time you do not want to end up being your own *prior art* (an idea of yours that blocks you from getting an additional patent later on). Before you embark on protecting your idea, it is worth spending the money for an hour to consult with a good patent attorney. There are many ways to get ideas patented (online, etc.), but it is worth beginning with professional advice. Do not be dissuaded by pessimistic patent attorneys, and do not be deluded by those who will take your money just to take you down the yellow brick road. Ultimately, you need to get advice, but use it wisely.

20.3.2 The Nondisclosure Agreement

Appendix 20A and Appendix 20B are two examples of nondisclosure agreements. These are general agreements, which should be signed by anyone you tell confidential information regarding your idea. Of course, nondisclosure agreements are only as good as the people who sign them. A lawyer I once hired told me that when he worked as an attorney for a big medical device company, they would hear ideas and then promptly figure out ways to design around them. Nevertheless, it is important to get these agreements signed to help prevent individuals from unwittingly divulging information. However, as will be discussed later on, few venture capitalists will ever sign a nondisclosure agreement, which is why patent applications are better done sooner rather than later.

20.4 Step 3: Building a Prototype

Regardless of whether you are thinking about a method or device patent, you should design a prototype first. Even if your idea involves complex machinery with an integrated circuit, you still should figure out a way to build a “kluge” prototype to see if it will work. Think hardware store before you think expensive industrial design company. Even before you make the trip to the hardware store, try to draw out different ideas in your notebook. Date everything, and remember that drawing is a very inexpensive way to make progress. You have more information and knowledge than anyone else at this point. Do not let practicality get in the way; reality will sink in soon enough.

After you have drawn out a few different ideas, go to the hardware store and get supplies to try to build a prototype. You will probably learn things from that expedition. Afterwards, you can go back and forth between the prototype idea and the drawing board. Do not ignore anything, and do not cross anything off. Tracking every detail will help you refine your device.

At some point in this process, you will need to gain additional information. With the use of the World Wide Web, you have access to a worldwide web of information. As with patients learning more about plastic surgery, you will find a lot of good information, but you will also encounter some confusing and conflicting information. Eventually, you will need assistance.

Lawyers are not the ones to help you design a prototype; they are there to help protect your idea. Engineers are the ones who can help you work on the device or improve your idea. There are many types of engineers (electrical, mechanical, biomedical, industrial, structural, software), so you need to figure out which kind you need. Mechanical engineers can generally help with tubes and clips, while electrical engineers are better for wiring and electrical connections. Sometimes you need more than one kind of engineer to help make your prototype, though it is probably best just to start with one. Remember, they should definitely sign a nondisclosure agreement, and you will need to figure out how much to pay them. They generally will not work for free, and most seasoned engineers know not to take “stock” in exchange for their work (usually there is no stock yet at this point, and promised stock is even more questionable). Set an hourly rate or a not-to-exceed amount before they begin working on the project.

While you are working on the prototype, you will learn more about how to develop your idea. This is a good stage to begin work on the patent application. Most companies will not look at anything unless a patent application has already been filed, so start early. Patents take years to issue. You do not need an issued patent to show it around, but an application is helpful.

20.5 Step 4: Proof of Principle

Once you have a prototype, the next step is *proof of principle*, which is when you show that your device or method actually works. This is usually where cost becomes an issue, especially with most medical devices because you bump against human subject issues. Unlike the proverbial “start the company in the garage,” any device or system that you plan to market for human use must be approved by the Food and Drug Administration (FDA). An entire industry has been built around figuring out the best path to approval. Since you absolutely cannot do it by yourself, you need expert help, and help costs money. Proof of principle usually comes in the form of clinical trials, which is another overwhelming process that requires assistance.

The FDA delegates Institutional Review Boards (IRBs) to act as their agents for the first line of approval and clinical studies. There are IRBs set up in many hospitals, but there are also independent IRBs to do clinical trials in an outpatient and clinic setting. Before you go to the FDA or to the IRB, you should think about the regulatory path for your device. Minimize your errors because the clinical trial process is very costly. To begin, determine if your device is a nonsignificant risk (NSR) device or a significant risk (SR) device. The decision, which is made by the investigator, is very important, as detailed below from FDA guidelines:

The effect of the SR/NSR decision is very important to research sponsors and investigators. SR device studies are governed by the IDE regulations (21 CFR Part 812). NSR device studies have fewer regulatory controls than SR studies and are governed by the abbreviated requirements [21 CFR 812.2(b)]. The major differences are in the approval process, record keeping, and reporting requirements. The SR/NSR decision is also important to the FDA because the IRB serves, in a sense, as the FDA's surrogate with respect to review and approval of NSR studies. The FDA is usually not apprised of the existence of approved NSR studies because sponsors and IRBs are not required to report NSR device study approvals to the FDA.³

The next decision point is to determine if your device requires a 510(k) premarket notification, investigational device exemption (IDE), or Premarket Approval (PMA) application submission. In general, a 510(k) clearance is for devices that are basically like other devices on the market, do not require invasive techniques, and have proven safe technology. A PMA is the longest and hardest approval to get. Breast implants require PMAs because they are “permanent” and they are placed inside a human. Breast tissue expanders, on the other hand, are 510(k) devices because they are temporary and the materials used in them (saline, silicone envelope) have been used for decades in a variety of technologies. As mentioned before, you cannot do this work alone; you need guidance and assistance from expensive experts.

20.5.1 510(k) Premarket Notification

This is the primary mechanism by which medical devices are accepted to the market in the United States. This notification is made under Section 510(k) of the Federal Food, Drug, and Cosmetic Act, and shows the intention to manufacture a medical device for use in the U.S. market. Its purpose is to demonstrate to the FDA that the device to be marketed is “substantially equivalent” to another that was on the market prior to May 28, 1976, or to a device that has already been accepted through the 510(k) submission process. Most devices, unless they employ novel technologies or applications, can be submitted for review under this process. The FDA will require data—descriptive data and performance data—to back substantial equivalence claims in order to support this type of submission.

There are a number of variations to this process, for example, the Abbreviated 510(k) for products conforming to agreed standards or the Special 510(k) for changes to existing devices.

20.5.2 Investigational Device Exemption

New devices cannot be used in human subject trials without prior permission from the FDA and an IRB. The application filed for this approval is called an investigational device exemption (IDE). It allows for the investigational medical device to be used in a clinical study to collect safety and effectiveness data, in support of a PMA application or a 510(k) submission to the FDA. A device is:

“An instrument, apparatus, implement, machine, contrivance, implant, *in vitro* reagent, or other similar or related article, including a component part, or accessory which is: recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them, intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.”⁴

20.5.3 Premarket Approval

This involves the formal approval by the FDA regarding the safety and effectiveness of a medical device based on valid device-related scientific data, rather than comparison data as in the 510(k) process. This process mostly applies to Class III medical devices, which have the most novel and complex technologies. Applications are subject to rigorous scrutiny by the FDA.

For existing Class III devices, any changes to the product, the process, or the indications for use must be approved by the FDA through a PMA Supplement submission.

In short, the regulatory path is quite confusing, but having a clear regulatory path is crucial to the success of any medical invention. Knowing the basics will help in beginning to ask the right questions of your experts. However, as in tax preparation, it is best to have a general idea of the rules.

20.6 Step 5: Getting People to Understand the Value of Your Idea

Howard H. Aiken, the computing pioneer, famously wrote, “Don’t worry about people stealing an idea. If it’s original, you will have to ram it down their throats.” In the 10 years since the first edition, I have found this to be more true than ever. As with many inventions, adoption happens at different rates. In medical inventions this resistance can be a significant obstacle, given the cost of development of medical devices. Success of a medical device is achieved with acquisition by a large medical device company, ideally one who already operates in the plastic surgery space. As a result, the only way that a company will acquire your device (no matter how original it is or how well it works) is if there is enough preexisting adoption in the market. If you start selling the product, any acquirer will want to see the *growth* occurring quarter over quarter. If you have not started selling the device, the company will have to gauge the interest in the marketplace. They will ask the “thought leaders” already on their payroll as advisory board consultants, hired to gauge the value of new devices poised to enter the market. But large companies do not want to deal with any degree of risk, and as a result, they want to see a fully formed product, already being sold, and gaining strength in the market.

20.7 Step 6: Getting Funding

Whether you are buying supplies at the hardware store for your first prototype or trying to raise series C (third round) venture capital funding, you still need to ask the same questions: how much money do you need, and what do you need the money for? The

difference between the hardware store and the venture funding comes down to how much money you should invest yourself before you ask others for money. Several film producers are well known for avoiding using their own money as an investment for making movies.

20.7.1 Your Own Money

Much of the decision to use your own money depends on how much you believe in your idea. In general, if *you* do not believe in your idea, no one else will either. Still, you do not want to spend every last penny of your own money on this venture. Even if you think it is the greatest idea since the pyramids, it is still a risky venture. The real question is, how far will your money get you before you need more money? Set milestones that include things like prototype, proof of principle, etc.

20.7.2 Money from Relatives

It is not hard to find success stories where big companies were started by a young entrepreneur who borrowed \$10,000 from his or her relatives to get the business started. But it is equally important to remember that, for every bright star, there are a thousand broken hearts on Broadway. Specifically, borrowing money from relatives is generally fraught with human relation obstacles. Nevertheless, it is important to figure out how far the money will go and when you will need additional funds. For example, if your uncle Henry lends you \$20,000 for 50% of the company, then the post-money valuation is \$40,000 (since the price was set when he lent you the money for a certain percentage of the company). This \$40,000 will be the “pre-money” valuation before the next round of funding. If your Aunt Henrietta (on the other side of the family) later puts in \$20,000 for 50% of the company, the post-money valuation will still be \$40,000 (no bump-up in value), but your Uncle Henry’s share will be diluted so that his ownership after the Henrietta round will be 25% (half of what he had before). If, however, value has been put into the company (such as making a prototype or applying/receiving a patent), then the value for the company has gone up, so you can perhaps convince Aunt Henrietta that if she wants to invest, the value has doubled, so the post-money valuation is now \$80,000. Her \$20,000 will only buy 25% of the company. Uncle Henry would need to put in an additional \$20,000 if he wants to maintain his percentage in the company. So, before you start taking money from relatives, make sure you and they understand the complications that can arise while going forward, both financially and emotionally.

20.7.3 Crowdfunding

An increasingly popular method of getting funds is from a variety of crowdfunding sources. These are generally web-based services that accelerate funding by raising funds from individual pledges. Obviously you need to provide sufficient information to entice potential investors, while making sure to be in compliance with any regulatory requirements. It is also important to know how much these funding sites charge and where in the world they are located. Some sites are free to sign up, make, or donate to a campaign. However, after the project raises funds, there may be a fee (5–10%) on the amount raised, but that fee may be reduced if the goal is raised. This helps encourage entrepreneurs to work toward meeting their goal. Other sites are linked to a social media site, and may charge per transaction. Other sites work if someone only wishes to receive a cut of sales but does not mind giving up control to the online community. The user can submit ideas for feedback. Then, if chosen by the online community, the site,

not the user, develops the product and the user makes a percentage on the site revenue for the product.⁵

20.7.4 Grant Money

Entrepreneurs do not necessarily find grant money attractive, but the funding can often be much more valuable than venture capital. Grants tend to have deadlines, reports, milestones, and a long lead time from application to funding. In addition, they give out amounts in thousands, not millions of dollars. Obviously, there are several hurdles with grant funding, but they usually do not have financial strings attached (you do not have to give away a percentage of the company for the money). For example, the Defense Advance Research Projects Agency (DARPA), an agency of the U.S. Department of Defense, gives significant grants each year but, as with most grants, the lead time is long, and the chance of success is unpredictable.

20.7.5 Small Business Loans and Bank Loans

Bank loans can be good, if you can get them. The main problem is that you generally need to personally guarantee those loans. You are already taking on all the risk yourself, but you will not ultimately be rewarded with the value. In the best case scenario, your loan will help you make enough progress to get funded and the loan will get paid off, but you will not get any extra “credit” for taking the loan out in the first place. Small business administration loans are an excellent source of funding new businesses, but again, some amount of collateral is often required and the risk to you increases.

20.7.6 Angel Investors

These tend to be individuals or groups of individuals with “high capacity” (people with money to invest who are looking for the next big thing). Many are social networking groups or groups who fund early-stage companies. The investments are usually up to a few hundred thousand dollars. Before taking money from angel investors, make sure that they have access to larger investment pools for the next round. The good thing about angels is that, unlike venture funding, they are more likely to invest in ideas that do not necessarily have a billion dollar future.

20.7.7 Venture Capitalists

There is a reason venture capitalists are called as such or modern-day loan sharks: They have money, and you do not. You need their money, so they can basically name their price. When choosing a funding source, it is better to take money from someone who inherently brings value to your concept. What this means is that while Aunt Henrietta was very nice to invest \$20,000 in your project, she probably does not know too much about it. As a result, she probably cannot find the right people to work on the project, get the right board of directors, etc. Most importantly, when you need \$200,000 instead of just \$20,000, Aunt Henrietta will most likely send you on your way, if you even have the guts to ask.

Venture capital companies have money—relatively lots of money. They do not like investing a few thousands, or even a few tens of thousands, of dollars into a company. It takes too much of their time. They want to find companies which are just starting but have proof of principle, have no encumbrances (like Aunt Henrietta), are going to make a

gazillion dollars, whose market value is \$500 million or more, have great patent protection, etc. In other words, they want to minimize their risk. At the same time, legions of cheerleading entrepreneurs are sure their idea will change the world and come knocking at the venture capitalists' doors in search of a few million dollars to make that happen.

Medical devices are different from technology and other devices specifically because of governmental regulation. Understanding your regulatory path is crucial to your success with venture capitalists. Venture capital firms talk to each other, and they generally play "follow the leader." One firm will lead the round and then go to other firms to load the boat of risk, and also to establish a cabal to set the valuation. In this way, they basically decide how much of your company you will have to give away to get their money.

Usually, entrepreneurs are grateful to have anyone give them the money they think they will need. The days of companies like Microsoft are over, when Bill Gates was able to give away only a relatively small amount of the company for the first big tranche (infusion) of funds into the fledgling entity. It is not unlikely to have to give up 50 to 80% of the company. What you are left with will be further diluted as the company requires further investment. It is helpful to find investors who are able to invest further in future rounds. They will do so to protect their investment (as in the Henrietta example above), and to attract other investors at a higher price. This increases the value of the company.

At the end of the day, companies go one of three ways: (1) they go out of business, (2) they get acquired, or (3) they go public. The vast majority of medical companies that do not go out of business get acquired. However, when first presenting the idea for the company to venture capitalists, it is a good idea to think of a platform technology and show how your idea can support further development of other products. Venture capitalists do not like a "one-trick pony." They think big. They are interested in companies with a potential market value of over \$500 million.

20.8 Conclusion

Successful medical inventions begin as good ideas. But the good idea is only the beginning of a road that is long and full of twists and turns. For surgeons who are accustomed to quick decisions and actions, it is easy to get frustrated, not only by the process, but also by the expense and the need to get help at almost every step of the way. This tortuous route is designed to protect patients and to bring new ideas to market. Those who persevere can sometimes find success, and have the chance to see their idea spring to life.

20.9 Appendices

20.9.1 Appendix 20A

Mutual Nondisclosure Agreement

This Agreement is made effective on ____ by and between ____ (first party) and ____ (second party) (collectively, the "Parties"), to ensure the protection and preservation of the confidential and/or proprietary nature of information disclosed or made available or to be disclosed or made available to each other. For the purposes of this Agreement, each party shall be deemed to include any subsidiaries, internal divisions, agents, and

employees. Any signing party shall refer to and bind the individual and the entity that he or she represents, whereas the Parties desire to ensure the confidential status of the information that may be disclosed to each other.

Now, therefore, in reliance upon and in consideration of the following undertakings, the Parties agree as follows:

1. Subject to limitations set forth in paragraph 2, all information disclosed to the other party shall be deemed to be "Proprietary Information." In particular, Proprietary Information shall be deemed to include any information, marketing technique, publicity technique, public relations technique, process technique, algorithm, program, design, drawing, mask work, formula, test data research project, work in progress, future development, engineering, manufacturing, marketing, servicing, financing, or personal matter relating to the disclosing party, its present or future products, sales, suppliers, clients, customers, employees, investors, or business, whether in oral, written, graphic, or electronic form.
2. The term "Proprietary Information" shall not be deemed to include information that (i) is now, or hereafter becomes, through no act or failure to act on the part of the receiving party, generally known or available information, (ii) is known by the receiving party at the time of receiving such information as evidenced by its records, (iii) is hereafter furnished to the receiving party by a third party, as a matter of right and without restriction on disclosure, (iv) is independently developed by the receiving party without reference to the information disclosed hereunder, or (v) is the subject of a written permission to disclose provided by the disclosing party.

Notwithstanding any other provision of this Agreement, disclosure of Proprietary Information shall not be precluded if such disclosure:

- a) is in response to a valid order of a court or other governmental body of the United States or any political subdivision thereof,
- b) is otherwise required by law, or,
- c) is otherwise necessary to establish rights or enforce obligations under this Agreement, but only to the extent that any such disclosure is necessary.

In the event that the receiving party is requested in any proceedings before a court or any other governmental body to disclose Proprietary Information, it shall give the disclosing party prompt notice of such request so that the disclosing party may seek an appropriate protective order. If, in the absence of a protective order, the receiving party is nonetheless compelled to disclose Proprietary Information, the receiving party may disclose such information without liability hereunder, provided, however, that such party gives the disclosing party advance written notice of the information to be disclosed and, upon the request and at the expense of the disclosing party, uses its best efforts to obtain assurances that confidential treatment will be accorded to such information.

3. Each party shall maintain in trust and confidence and not disclose to any third party or use for any unauthorized purpose any Proprietary Information received from the other party. Each party may use such Proprietary Information in the extent required to accomplish the purpose of the discussions with respect to the subject. Proprietary Information shall not be used for any purpose or in any manner that would constitute a violation on law regulations, including without

limitation the export control laws of the United States of America. No other rights or licenses to trademarks, inventions, copyrights, or patents are implied or granted under this Agreement.

4. Proprietary Information supplied shall not be reproduced in any form except as required to accomplish the intent of this Agreement.
5. The responsibilities of the Parties are limited to using their efforts to protect the Proprietary Information received with the same degree of care used to protect their own Proprietary Information from unauthorized use or disclosure. Both Parties shall advise their employees or agents who might have access to such Proprietary Information of the confidential nature thereof and that by receiving such information they are agreeing to be bound by this Agreement. No Proprietary Information shall be disclosed to any officer, employee, or agent of either party who does not have a need for such information for the purpose of the discussions with respect to the subject.
6. All Proprietary Information (including all copies thereof) shall remain the property of the disclosing party and shall be returned to the disclosing party within one week after the receiving party's need for it has expired, or upon request of the disclosing party, and in any event, immediately upon completion or termination of this Agreement. The receiving party further agrees to destroy all notes and copies thereof made by its officers and employees containing or based on any Proprietary Information and to cause all agents and representatives to whom or to which Proprietary Information has been disclosed to destroy all notes and copies in their possession that contain Proprietary Information.
7. This Agreement shall survive any termination of the discussion with respect to the subject and shall continue in full force and effect until such time as the Parties mutually agree to terminate it.
8. This Agreement shall be governed by the laws of the United States of America and as those laws that are applied to contracts entered into and to be performed in all states. Should any revision of this Agreement be determined to be void, invalid, or otherwise unenforceable by any court or tribunal of competent jurisdiction, such determination shall not affect the remaining provisions of this Agreement, which shall remain in full force and effect.
9. This Agreement contains final, complete, and exclusive agreement of the Parties relative to the subject matter hereof and supersedes any prior agreement of the Parties, whether oral or written. This Agreement may not be changed, modified, amended, or supplemented except by a written instrument signed by both Parties.
10. Each party hereby acknowledges and agrees that, in the event of any breach of this Agreement by the other party, including, without limitations, the actual or threatened disclosure of a disclosing party's Proprietary Information without the prior express written consent of the disclosing party, the disclosing party will suffer an irreparable injury such that no remedy at law will afford it adequate protection against or appropriate compensation for such injury. Accordingly, each party hereby agrees that the other party shall be entitled to specific performance of a receiving party's obligations under this Agreement as well as further injunctive relief as may be granted by a court of competent jurisdiction.

11. The term of this Agreement is for two (2) years after the date of last disclosure of any Confidential and/or Proprietary Information, commencing on the "Effective Date."

AGREED TO:

Signature _____
Printed Name: _____
Title: _____
Company: _____
Date: _____

AGREED TO:

Signature _____
Printed Name: _____
Title: _____
Company: _____
Date: _____

20.9.2 Appendix 20B

Nondisclosure Agreement

This Agreement is made effective as of ____ by and between ____ (hereinafter the "Company") and ____ (hereafter the "Receiving Party"), to assure the protection and preservation of the confidential and/or proprietary nature of information to be disclosed or made available by Company to the Receiving Party in connection with certain discussions.

In reliance upon and in consideration of the following undertakings, the parties agree as follows:

1. Subject to the limitations set forth in Paragraph 2, all information disclosed by Company to the Receiving Party shall be deemed to be "Proprietary Information." In particular, Proprietary Information shall be deemed to include any information regarding inventions, trade secrets, patents, patent applications, know-how, discoveries, samples, formulations for producing any such sample, media and/or cell lines, processes, formula or test data relating to any research project, work in process, research and development plans, engineering, manufacturing, marketing, servicing, financing or personnel matter relating to Company, its present or future products, sales, suppliers, clients, customers, employees, investors or business, whether in oral, written, graphic or electronic form. Proprietary Information shall also include all third party information and information that Company has received from others.
2. The term "Proprietary Information" shall not be deemed to include information which the Receiving Party can demonstrate by competent written proof: (a) is readily available to the public through no act of failure to act on the part of the Receiving Party; (b) is hereinafter furnished to the Receiving Party by a third party, as matter of rights and without restriction in disclosure; (c) is known by the Receiving Party at the time of receiving such information, as evidenced by its records; or (d) is the subject of a written permission to disclose provided by Company.

3. The Receiving Party agrees at all times during the term of this Agreement and thereafter that it will take all reasonable steps necessary to hold all Proprietary Information in trust and confidence and shall not disclose any Proprietary Information to any third party or use any Proprietary Information in any manner or for any purpose not expressly set forth in this Agreement. The Receiving Party may use such Proprietary Information only to the extent required to accomplish the intent of this Agreement.
4. The Receiving Party shall advise its employees who might have access to Proprietary Information of the confidential nature thereof and agrees that its employees shall be bound by the terms of this Agreement. The Receiving Party shall not disclose any Proprietary Information to any employee who does not have a need for such information, nor shall it disclose any Proprietary Information to any third party without Company's written consent.
5. No rights or licenses to trademarks, inventions, trade secrets, copyrights, or patents are implied or granted under this Agreement. Proprietary Information shall not be reproduced in any form except as required to accomplish the intent of this Agreement.
6. This Agreement shall continue in full force and effect for so long as the Receiving Party continues to receive Proprietary Information. This Agreement may be terminated by either party at any time upon thirty (30) days' written notice to the other party. The Receiving Party's obligations under this Agreement shall survive termination of this Agreement and shall be binding upon Receiving Party's heirs, successors, and assigns.
7. The Receiving Party agrees to indemnify Company for any loss or damage suffered as a result of any breach by the Receiving Party of the terms of this Agreement, including any reasonable fees incurred by Company in the collection of such indemnity.
8. This Agreement contains the final, complete, and exclusive agreement of the parties relative to the subject matter hereof and supersedes all prior and contemporaneous understandings and agreements relating to its subject matter. This Agreement may not be changed, modified, amended, or supplemented except by a written instrument signed by both parties.
9. The Receiving Party hereby acknowledges and agrees that in the event of any breach of this Agreement by the Receiving Party, including, without limitation, the actual or threatened disclosure of Proprietary Information without the prior express written consent of Company, Company will suffer an irreparable injury such that no remedy at law will afford it adequate protection against, or appropriate compensation for, such injury. Accordingly, the Receiving Party hereby agrees that Company shall be entitled to specific performance of the Receiving Party's obligations under this Agreement, as well as such further relief as may be granted by a court of competent jurisdiction.
10. The parties' right and obligations will bind and insure to the benefit of their respective successors, heirs, executors, and administrators and permitted assigns. This Agreement shall be governed by the laws of the State of California, excluding its conflicts of laws principles. If any provision of this Agreement is found by a

proper authority to be unenforceable, that provision shall be severed and the remainder of this Agreement will continue in full force and effect. Any notices required or permitted hereunder shall be given to the appropriate party at the address specified below or at such other address as the party shall specify in writing. Such notice shall be deemed given upon the personal delivery, or sent by overnight courier upon written verification of receipt, or certified or registered mail, return receipt requested, upon verification of receipt.

IN WITNESS WHEREOF, the Receiving Party has executed this Agreement as of the date first above written.

Agreed To (Company):

Agreed To (Receiving Party):

Signature

Signature

Address

Address

References

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- [2] Yock PG, Zenios S, Makower J, et al. Biodesign—The Process of Innovating Medical Technologies. 2nd edition. Cambridge University Press; 2015
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Suggested Reading

Yock PG, Zenios S, Makower J, et al. Biodesign—The Process of Innovating Medical Technologies. 2nd edition. Cambridge University Press; 2015

Part V

Watching Your Back

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21 Contracts

Michael S. Byrd and Bradford E. Adatto

Abstract

Reading a contract intimidates physicians who are unfamiliar with contracts, provokes emotion to those who have been burned, and hypnotizes physicians not interested in the finer details of a contract. This chapter focuses on providing the business a legal basis for why a properly developed contract will better assure alignment of expectations and ultimately offer more protection to both parties. Additionally, this chapter details the tools a plastic surgeon can use to evaluate a contract. We also examine the advantages and disadvantages of the different types of contractual relationships physicians may encounter in their career. These relationships include the hospital, private practice, partners, staff, and patient.

Keywords: recruitment agreement, income guarantee, letter of intent, noncompetes, compensation, independent contractor, hospital employment, partner, private practice, group practice, retirement

21.1 Introduction

Reading a contract intimidates physicians who are unfamiliar with contracts, provokes emotion to those who have been burned, and hypnotizes physicians not interested in the contract's finer details. Why not skip the contract formality and shake hands to seal the deal? In health care, legal reasons often exist to require an arrangement be in writing, such as the federal anti-referral and anti-kickback laws. From a business point of view, contracts are necessary to minimize risk. Most people recognize that a contract protects when things go wrong, but perhaps more importantly, a contract pushes the parties to agree on how the relationship will work. Stated negatively, unmet expectations are the primary source of failed relationships.

21.2 Oral Contracts: Not Worth the Paper It Is Written On

The problem with oral contracts is that they are, in fact, enforceable in most states. When expectations are not met, that enforceability inadvertently causes expensive and unpredictable litigation. With no evidence apart from the word of the two parties, litigation costs spiral, and ultimately the result comes down to the judge or jury deciding whom to believe. On a practical level, hand shake oral agreements rarely address anything but the most basic of terms for the relationship, so the risk of unmet expectations escalates for both parties.

21.3 Chart on the Life Cycle of a Plastic Surgeon's Practice

This chapter will focus on arrangements the plastic surgeon will encounter, from the first employment contract to the sale of the practice. The goal of this chapter is to equip the plastic surgeon with the tools to evaluate each type of relationship, to understand

the importance of aligning the relationship with career goals, and to recognize the contract as an important piece of the relationship.

The chapter structurally takes a physician on a journey through the life cycle of relationships experienced and the associated contracts in the business of plastic surgery. The considerations for two plastic surgeons (or plastic surgery practice) entering a relationship will be highlighted.

21.4 Preliminary Considerations for all Contracts

Before considering drawing up a contract, determine whether the relationship works from a personality, business, and career goal perspective. This can be done through due diligence and by the physician mapping his or her Plan A and Plan B for the relationship.

Prior to embarking on a certain route of medical practice relationship, analyze which medical practice relationship will best align with your long-term and short-term career goals. Identify your Plan A, which includes a prioritized list of your career goals. Also measure how the relationship under consideration allows you to accomplish these goals. Plan B, on the other hand, is your backup plan if the relationship ends for some reason. Formulating Plan A and Plan B informs whether the relationship makes sense and whether the contract aligns with those plans.

The following two scenarios illustrate Plan A and Plan B.

21.4.1 Scenario 1

Joe, a plastic surgeon, is nearing the completion of his residency in Dallas, Texas. Before Joe enters into negotiations with a private practice opportunity, he identifies his Plan A: to gain experience and board certification in the Dallas practice and then to return to practice in his Ohio hometown. By understanding Plan A, Joe need not focus on contractual provisions such as practice ownership. Instead, Joe's focus should center on the skills of the physicians in the practice and the potential high surgical volume to gain experience and board cases. By knowing that Plan A calls for a practice departure, Joe must further focus on post-termination rights and obligation, including tail insurance, website and social media rights, and before-and-after pictures. Joe's Plan B is to join the faculty at an academic institution in Dallas to achieve his goal of training and case collections for his boards. Consequently, a noncompete clause (which is not relevant for Plan A) now must be negotiated if it would prevent Joe from practicing at the academic institution.

21.4.2 Scenario 2

A practice or a hiring physician must also have Plan A and Plan B. Plan A for the practice, Smith Plastic Surgery, is to bring on a new physician to help with the overhead, have a colleague to share and discuss clinical issues, and to increase utilization of a new surgery center owned by the practice. Smith Plastic Surgery will not include ownership provisions and may choose a compensation model that focuses on sharing overhead rather than on making a profit from the joining physician. Plan B may be to return Smith Plastic Surgery to normal without disruption and without losing patients if the relationship does not work. Smith Plastic Surgery may then include noncompete language to protect the practice from losing patients.

The key to the Plan A and Plan B exercise is to challenge both sides to identify what they want and why they want it, as this brings clarity to the match for a particular relationship and the terms to negotiate in the contract. The clarity created by this process helps negotiations and helps bring the parties into alignment.

21.5 Due Diligence

Prior to entering a new relationship, find out more about the person or practice on the other side of the arrangement by searching online or calling colleagues who have worked with the other side. For example, a physician looking to join a practice may be influenced if a high volume of physicians have been leaving a practice and the physician talks to those prior physicians. Additionally, an online search revealing a scathing patient review history for the practice may stifle the desire to be associated with the practice. Beyond the personality and reputation of the practice, the following are additional examples of due diligence steps to be taken:

1. Scrub in with the physician to determine whether there is clinical alignment for a relationship;
2. Spend time at the practice to meet the other members of the team;
3. Visit any hospitals that will be a part of the practice; and
4. Learn about the community, the competition, and the patient population.

21.6 Letter of Intent

Having done the groundwork in understanding the boundaries for your Plan A and Plan B and conducted your due diligence, now is the ideal time period for you, the plastic surgeon, to engage in communication with potential medical practice opportunities that may align the best with your career goals. At this time, seek out the key business terms and conditions from the medical practice. These terms are often communicated in a detailed offer letter of intent (LOI), letter of understating, or term sheet. For this chapter, these terms will collectively be called an LOI. The LOIs can be extremely formal with several attachments, or as informal as written on a back of a napkin.

The purpose of an LOI is to communicate and ensure that the parties concur on the material terms, whereas the contract that may follow will formally bind and memorialize the practice relationship between the surgeon and the medical practice(s). While reviewing the LOI, the plastic surgeon must pay specific attention and evaluate if the material terms, such as compensation, noncompete, nonsolicitation, term and termination, malpractice insurance, and benefits, are acceptable to the surgeon. Voice any terms that are disagreeable. Negotiating after the contract has been drafted will not only frustrate the other party, but may sour the relationship.

21.7 Authority Does Matter

Once you satisfy the due diligence investigation, and LOI, the first step when the contract does finally arrive is to answer basic questions to confirm authority. Overlooking this step can be catastrophic in an enforcement situation. The basic questions are as follows:

- Does the contract list all the correct parties to the agreement? Confirm that the parties' legal names are in the actual agreement, and not just a nickname for the company or individual.

- Is the person authorized to bind the entity executing the contract?
- Finally, the signature lines must also list the correct party and capacity by which the person is signing. For example, an individual name listed on the signature block means the person is signing as an individual. This not only fails to bind the practice, but actually inadvertently binds the physician who may be meaning to sign on behalf of the practice.

21.8 Medical Practice Relationships

Plastic surgeons, after undergoing extensive residency, and fellowship for some, will reach the juncture of deciding the direction to pursue for their future medical practice. At this crucial point, the young surgeon must evaluate the benefits and challenges of the different types of medical practice relationships. The three major types of medical practice relationships available to a plastic surgeon, from an employment perspective, are: (1) academic relationship; (2) hospital relationship; and (3) private practice relationship.

21.9 Medical Practice Relationship: Academic Relationship

In academic employment agreements, the practice relationship is with a state medical school or a private medical institution. Academic employment agreements are typically basic in terms of content and may not list more than the essential terms and conditions such as noncompete, initial compensation, and the nature of the appointment.

When evaluating the academic employment agreement, understand that, in addition to the terms and conditions in the employment agreement, the plastic surgeon will also be bound by the organization's policies, procedures, and rules, which will govern the faculty appointment. These rules are usually covered in the medical staff bylaws, department rules handbook, and tenure rules handbook. Review all documentation that will set the boundaries of the employment relationship to see a full picture as to whether the relationship aligns with your Plan A and Plan B.

The faculty appointment will always be coupled with some or all of the following responsibilities: (1) academic teaching responsibility; (2) research responsibilities; and (3) clinical responsibilities. Keeping this in mind, the surgeon must enquire with the employer and understand what roles and responsibilities will be required of him or her in that faculty position.

21.10 Medical Practice Relationship: Hospital Relationship

A hospital relationship may take on many forms, but this chapter will focus on the relationships from an employment perspective. The two major types of hospital relationships are: (1) recruitment agreements and (2) employment agreements. Recruitment agreements are also known as relocation agreements, income guarantee agreements, or net income guarantee agreements. Since income guarantee agreements are more commonly used in daily practice, this chapter will discuss it in detail.

21.10.1 Purpose of a Recruitment Agreement

Recruitment agreements are not employment agreements. Rather, they are a forgivable loan offered to guarantee a certain income level while the physician starts practice. From the physician perspective, the purpose is to have a source of income while starting a practice. From the hospital perspective, the purpose is to secure a surgeon to fulfill an area of need for hospital patient care.

Recruitment agreements can be a two-party agreement between the hospital and the surgeon or a three-party agreement among the hospital, the surgeon, and the medical practice ("group practice"). In a three-party agreement, in addition to the recruitment agreement (between the hospital, the surgeon, and the group practice), the surgeon and the group practice must also execute an employment agreement to be in compliance with federal regulations.¹ Recruitment agreements can only be offered to a physician who resides outside the geographical area served by the hospital, a resident of the same geographical area, or a physician who has been in practice less than 1 year in that same geographical area. This restriction is the genesis of the arrangement being named a recruitment or relocation agreement.

21.10.2 Benefits of a Recruitment Agreement

Recruitment agreements have a unique benefit to each party involved. It is a great tool for hospitals with a need for a physician or surgeon in a certain specialty to entice the surgeon to relocate and provide medical services to the geographical area served by the hospital and thereby capture a new revenue stream that was not available beforehand. Recruitment agreements allow hospitals to legally loan money through collection guarantees to surgeons or medical practices without violating the Stark or Anti-kickback laws. Medical practices in the area are incentivized through this arrangement because the hospital typically bears the burden of the huge start-up expenses incurred in recruiting the new hire. In addition, the new hire may further alleviate some of the overhead expenses and likely increase the revenue of the practice. These funds delivered to the practice or physician are not compensation to the physician or practice. Instead, it is a loan to cover the income and certain limited practice overhead² ("guarantee amount"). Recruitment agreements, in addition to income or cash collection guarantee, may provide help with payment of student loans and certain benefits, and this makes it an attractive offer to young surgeons. Further, the surgeon is specifically recruited to serve the patient population of the geographical area served by the hospital, and group practice is incentivized to assure a steady patient flow. Finally, the surgeon's burden of worrying about management and administrative responsibilities, such as locating office space or identifying appropriate vendors, will be minimized, since the hospital can assist in carrying out those responsibilities, or the group practice has already developed established relationships.

¹ Physician and hospital arrangements are heavily regulated by Federal Self-Referral (Stark) and Anti-Kickback Laws. Properly developed Recruitment Agreements allows hospitals to legally comply with federal law prohibitions.

² Practice expenses are limited by federal law to "incremental practice expenses," but may include malpractice premiums, life, health and disability insurance, employee salaries, utilities, accounting, rent, supplies, telephone and automobile expense, marketing expense, and professional fees ("Practice Expenses"). 42 C.F.R. § 411.357 (e).

Table 21.1 Physician compensation in an income guarantee agreement

Month	Surgeon's collections	Total monthly hospital payment	Total recruitment payments to surgeon
January	\$0	\$40,000	\$40,000
February	\$20,000	\$20,000	\$40,000
March	\$40,000	\$0	\$40,000
April	\$10,000	\$30,000	\$40,000
May	\$36,000	\$4,000	\$40,000
June	\$65,000	\$0	\$40,000

21.10.3 What Is Income Guarantee?

The essence of the income guarantee is the guarantee that the physician will make a certain predetermined and fixed income during a defined period of time ("income guarantee"). This period of time is generally called the guarantee period, typically 12 months, and can legally be extended up to 36 months.³ The hospital is required to loan an amount, usually paid monthly, the difference between the surgeon's collections less the guaranteed amount. Therefore, if the physician's collection equals or exceeds the guaranteed amount,⁴ the hospital is not required to loan the surgeon or the practice that month for the salary, but could still be responsible for any incremental practice expenses. The physician's collections and the hospital's payment are inversely proportional. ► Table 21.1 illustrates the inverse proportionality nature. To be clear, during the guarantee period (at least until the amounts borrowed are zero), the surgeon cannot be paid more than the income guarantee. The assumption for the net income guarantee in ► Table 21.1 is \$40,000 per month.

21.10.4 What Are the Hospital's Obligations in a Recruitment Agreement?

Hospital's obligations typically include payments for some or all of the following: (1) income guarantee; (2) moving bonus; (3) signing bonus; (4) student loans; (5) practice expenses⁵; (6) benefits such as health care, life, disability, and professional malpractice insurance; and (7) forgiveness.

³ 42 C.F.R. § 1001.952 (n) (3).

⁴ Guarantee Amount is subject to Excess Receipts or Cap on Total Guarantee. During the Repayment Period, addressed under Physician Obligations, the physician must repay all payments made by the Hospital, with interest, unless forgiven. The hospital may forgive the repayment if the physician commits to stay and stays for a predetermined number of years following the Guarantee Period and provides medical services to the geographic area served by the hospital.

⁵ Hospitals are not required to pay Practice Expenses in a Cash Collection Agreement. As such, most practices avoid this type of arrangement. Further, the Practice Expenses vary drastically depending on whether the Practice Expense payment is made to the Group Practice or the Surgeon in solo practice. Federal regulations limit the types of expenses that may be covered under Practice Expense Payment to an existing medical practice. Coverage of expenses by a hospital is not similarly restricted when entering into an arrangement with a new solo practice.

Forgiveness means, the hospital will forgive the requirement to repay the funds paid by the hospital (including income guarantee, moving expenses, signing bonus, and any additional payments) on a pro rata basis if certain conditions are met by the surgeon. Conditions required to be met will be discussed in the following section.

21.10.5 What Are the Physician's Obligations in a Recruitment Agreement?

Surgeon's obligations typically include: (1) practicing medicine full time in the surgeon's specialty; (2) providing medical services in the geographical area served by the hospital during a specified time period; (3) maintaining active license to practice medicine, maintaining staff memberships and privileges at the hospital, and complying with medical staff bylaws; and (4) repayment of all funds paid by the hospital during the term of the practice agreement ("repayment of guarantee").

It is imperative for a surgeon to understand the repayment of guarantee obligation prior to signing a recruitment agreement. The recruitment agreement will require the physician to repay *all* funds provided by the hospital following the guarantee period. The funds included are not just income guarantee payments, but also any additional payments made by the hospital such as moving expenses and signing bonus, along with the interest accrued on all such payments. Usually the total funds paid by the hospital are evidenced in a promissory note. Typically the surgeon is required to sign it. The physician may avoid the repayment requirement by continuing to provide the medical services for a predetermined period of time, known as the repayment period. The repayment period can be several years, generally dependent on the time frame of the guarantee period. If the surgeon decides to terminate the recruitment agreement prior to the end of the repayment period, then the surgeon must repay all or a portion of the funds paid by the hospital during the guarantee period.

21.10.6 Hospital Employment Agreement

Hospital employment agreements differ from private practice employment agreements and, like most things, contain advantages and disadvantages. A physician's Plan A and Plan B may be useful tools to filter whether the hospital employment structure will work.

One of the major advantages of a hospital employment is the compensation; the surgeons employed typically receive a high guaranteed salary with a built-in bonus structure along with guaranteed benefits. In 2017 and 2018, all hospital employment agreements that our firm reviewed for plastic surgeons had compensation above \$450,000. For a physician wanting to focus solely on the clinical side, another major advantage is that the institution they work under handles all business- and management-related matters. For surgeons desiring more control and input over management decisions, however, this practice setting has drawbacks. Unlike solo practice settings, a hospital-based surgeon cannot buy a new device or instrument without obtaining approval from the hospital management, which is often a slow, bureaucratic process. Surgeons also have little input in employment decisions, the hiring process, or in the training of their staff. Further, although the starting salaries for these positions are high, there is less salary growth potential, and there is no ownership or equity that develops over time, as is customary in a private practice.

Additionally, building an aesthetic practice in a hospital setting typically is, at best, challenging. From the hospital perspective, elective cosmetic cases take too long relative to the facility fee that may be charged. From the physician perspective, hospital facility fees typically cost more than a local surgery center, and hospital operating rooms are built around efficiency with little regard for an elective patient's experience. Finally, physician's performance is typically tracked by relative value units (RVU) compensation system. This system places value on an exhaustive list of surgeries, though notably elective aesthetic cases do not have values in the RVU system. Consequently, hospitals struggle to recognize aesthetic production.

A surgeon's level of satisfaction and growth in a hospital setting will be dictated by his or her Plan A and Plan B. A surgeon with an entrepreneurial spirit and a risk-taking aptitude will be frustrated in a hospital employment environment. On the other hand, a surgeon desiring a stable platform and an ability to focus solely on practicing his or her craft as a plastic surgeon may be drawn to the hospital employment structure.

21.11 Medical Practice Relationship: Private Practice Relationship

Surgeons gravitating toward a private practice are typically drawn to professional autonomy and the ability to directly influence the business of their practice. Historically, the private practice setting dominated the world of plastic surgery. While hospital employment has become more common for a reconstructive plastic surgeon, the traditional private practice model remains the most popular model in aesthetics.

Like the other employment models, the Plan A of the employed physician remains a litmus test to identifying the right practice. A distinct difference in practice profiles exists between the practice offering a platform for a young plastic surgeon to build a practice and a platform for a plastic surgeon to step in with a steady patient flow to build expertise and board cases.

The private practice must also have a Plan A. The practice must determine the purpose for hiring a physician. The practice's strategy is directly impacted by that purpose, whether it is to alleviate overhead costs and obtain coverage for calls; accomplish the practice's exit strategy by hiring a surgeon who can eventually buy out the practice; or to add additional plastic surgeons to grow and build the reputation of the practice.

An additional factor that both the practice and the new hire must consider is whether there is alignment in the desired practice specialty of the new physician. Discussing the practice specialty is key in understanding if the practice and the new hire's interests are in alignment and if the private practice has the resources to support the new hire's practice. A practice recruiting a new hire with interests in reconstructive surgery or insurance-based cases must either have the platform to support such cases or be willing to expand the practice to serve such cases.

The takeaway for the new hire is to understand if the practice has the platform to support their specialty interest. Likewise, the practice must contemplate during its hiring decision if the new hire's specialty interest will align with that of the practice.

21.11.1 Collections versus Billing

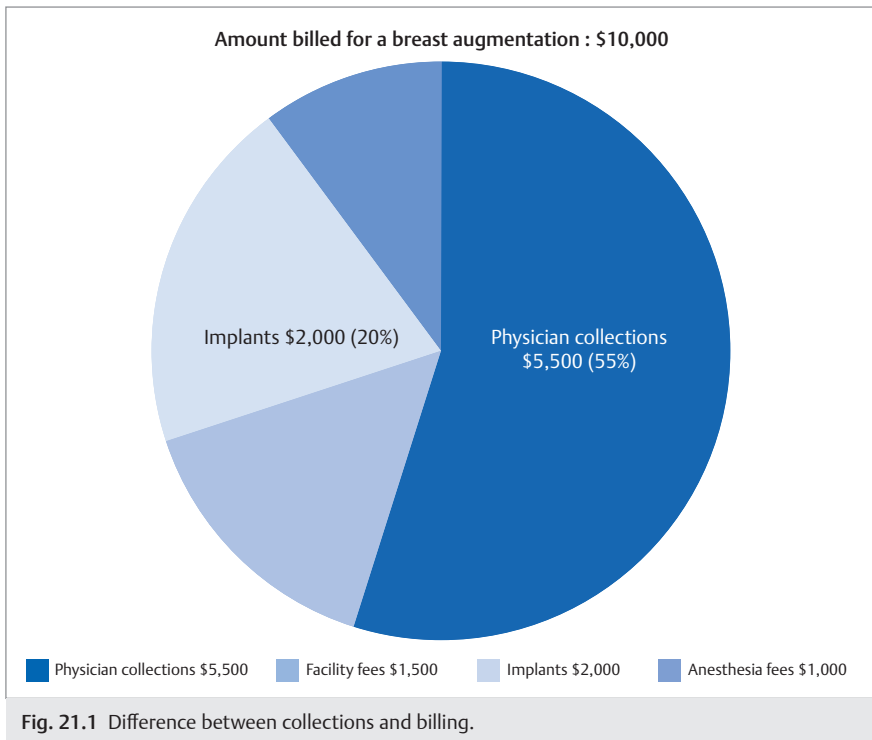
Surgeons often confuse billing with collections and are surprised when their compensation reflects the collections amount and not the amount billed for the surgeon's services. Additionally, confusion arises when the parties do not clearly define the collections that count toward measuring productivity. A typical plastic surgery case includes the following components: (1) provider fee; (2) facility fee; (3) anesthesia fee; and (4) costs of goods sold, like implants. The handling of these components varies from practice to practice. For the sake of the cosmetic patient experience, some practices collect one fee to cover all the components. Before an employed physician joins the practice, it is imperative to identify what components count toward collections and to appropriately track the components from the fee collected. To make matters more confusing, the facility fee may in some legal structures be shared with an employed physician, whereas in others sharing creates a risk of violating state or federal anti-kickback laws.

The most common means to track physician production is to credit the physician for collections relating to the physician's work (the provider fee component). Physician collections will include all revenue actually received by the practice for services performed by the physician related to any of the following: (1) professional services personally rendered by physician, including evaluation and management fees, consultation fees, hospital fees, and physician performed procedural fees; (2) services rendered by physician *incident to* such personally performed professional services; and (3) professional component collection ("physician collections"). However, in this common structure, physician collections will not include: (1) facilities fees; (2) anesthesia fees, and (3) any payments made for medical supplies, implants, medical or cosmetic products, pharmaceuticals or other medications, durable medical equipment, and disposable instrumentation or devices ("hard costs"). Further, physician collections will also not include chargebacks, credits, refunds, rebates, or overpayments.

Defining the types of activities that count toward the physician collections also varies by practice. Some private practices, based on the idea that it is taking risk by guaranteeing a salary to the physician, view any funds generated by the plastic surgeon as money that flows through the practice. In this scenario, professional services include all of the following fees or payments received by the practice for physicians:

1. Provision, administration, or personal supervision of any medical service to patients, including clinical or surgical procedures;
2. Teaching, lecturing, research, and publication of articles of a professional and/or medical nature, including the writing of papers during a fellowship;
3. Serving as a medical director;
4. Expert testimony, consultation, assistance, or advice in medical-legal matters;
5. Rendering care to beneficiaries under any managed care or indemnity plan;
6. Reading or interpreting test results or administering any test;
7. Clinical, administrative, or supervisory services rendered to any hospital or health care facility; and
8. Any fees collected as a part of the fellowship program ("professional services").

Many practices take a less comprehensive approach and allow the physician (with some boundaries) to keep certain nonsurgical income generated on the physician's own time. Because the contract may make the distinction difficult to readily identify, misalignment of expectations commonly occurs with the definition of professional services.



As can be seen from the chart in ► Fig. 21.1, minimizing facility, anesthesia, and other hard costs will increase the portion of physician collections.

21.11.2 Compensation

Compensation is tricky, which makes an apples-to-apples comparison of one contract to another dangerous. The common compensation models used in plastic surgery are: (1) straight percentage-based compensation, (2) low guaranteed salary or monthly stipend with percentage-based compensation, and (3) guaranteed base compensation with incentive compensation. In viewing these three models through the lens of a risk spectrum of the employed physician, the first model typically has high risk and high reward and the other two models move toward lower risk and lower upside. A physician joining a busy practice with a low base and high percentage payment may make far more than a physician joining a practice with a \$350,000 base salary and high barrier to achieve incentive compensation. Consequently, the practice must be intentional in designing a compensation model that fits the business of the practice and the risk profile of the hired plastic surgeon(s). Similarly, the employed plastic surgeon must be discerning in evaluating the true compensation opportunity for a practice.

In painting a picture as to common numbers used for the various compensation models, it is instructive to consider each model separately. The straight percentage models typically pay in the 40 to 50% of physician collections range (facility fees are

excluded). From the practice perspective, the number should be set close to or below the practice's overhead. Practices commonly fall into a trap of setting the percentage based on numbers used by a colleague, and end up setting the practice up for failure by paying compensation greater than the overhead cost. For example, if practice overhead is 65% and physician compensation is set at 40% of collections, the model is untenable on a long-term basis.

The compensation in the second model described before typically is set more conservatively. The compensation may be set anywhere from as low as \$50,000 to \$150,000. The percentages tend to be similar to the first model (40–50%), but payable after the collections cover the compensation paid. Again, the percentages should be set with an eye toward practice overhead.

Compensation for the third model discussed consists of the following two components: (1) base compensation and (2) incentive compensation. This model is the common model used for attracting top talent, as practices are often competing against hospitals and other practices around the country. Based upon the private practice employment agreements that we have drafted or reviewed over the last 3 years, the base compensation typically ranges between \$200,000 and \$350,000 and the bonus compensation will kick in once physician collections surpass an “overhead threshold.” The overhead threshold is an amount that will vary by practice, but usually is set based upon a multiple of two to three and a half times (“multiple”) the base compensation. Practices structure compensation in this manner to incentivize the new hire to generate revenue that will not only equal but exceed the total cost of the new hire's salary and related overhead expense.

Sample Provision 1

Compensation: For all services rendered by Physician in connection with this Agreement from and after the Start Date, Physician will receive fees equal to X% of Net Physician Collections. This fee is payable to Physician by the 15th day of the month following the month in which the collections were received.

1. “**Physician Collections**” means all revenue actually received by the Practice for services personally performed by Physician (“Professional Service(s)”), including facility fees received in conjunction with the Professional Services.
2. Physician Collections will not include any compensation for television programming, technical or facilities fees (except as provided above), or amounts received from anesthesia, medical supplies, medical and cosmetic products, services performed by other professionals (including services performed by others incident to Physician performed services), and ancillary fees such as fees from referrals for noninvasive medical spa services.
3. “**Net Physician Collections**” means Physician Collections less chargebacks, credits, refunds, rebates, or overpayments.

Sample Provision 2

Compensation: Practice will compensate Physician as follows (see also ► Table 21.2):

Base Compensation: For all services provided by Physician in connection with this Agreement from and after the Start Date, Physician will receive base compensation equivalent to an annual salary of \$XX. To the extent that Physician Collections is not

Table 21.2 Physician compensation structure in a private practice employment agreement

Year	Base salary	Multiple	Overhead threshold (multiple × base salary)	Net physician collection exceeding overhead threshold	Percentage of net physician collections ^a	Compensation
Year 1	\$200,000	2.5	500,000	\$50,000	30%	\$215,000
Year 2	\$200,000	2.5	500,000	\$100,000	30%	\$230,000
Year 3	\$200,000	2.5	500,000	\$150,000	35%	\$252,500
Year 4	\$200,000	2.5	500,000	\$250,000	35%	\$287,500

^aIndicator of the practice's risk tolerance.

greater than Physician's base compensation, any shortfall of the base compensation will be recovered by Practice from future Physician Collections prior to any payment of Bonus Compensation as set forth below.

Bonus Compensation: Physician will have the opportunity to earn an incentive bonus determined as follows. Physician will receive an amount equal to Y%⁶ of Physician Collections in excess of Overhead Threshold⁷ that are received by Practice during each Contract Year⁸ ("Bonus Compensation"). Bonus Compensation is payable within 30 days of the end of each Contract Year.

21.11.3 Considerations in Private Practice Employment Agreement

Apart from the compensation provision, there are various other provisions that one must pay specific attention to while drafting or reviewing the agreement. For all plastic surgeon contracts, the benefits⁹ should be addressed. Unmet expectations may arise if the practice and the physician are not on the same page regarding vacation expectations, continuing medical education (CME) reimbursement, and malpractice insurance. The average vacation time among the contracts we have prepared or reviewed over the last 3 years is around 4 to 5 weeks (including time off for CME). Malpractice insurance is typically covered by the practice, although the party responsible for payment for tail insurance if the physician leaves varies.

Restrictive covenants for the physician if the contract is terminated must be considered by the practice and the physician, as this potentially impacts either parties' Plan B. Restrictive covenants include: (1) nondisclosure agreement, (2) nonsolicitation of

⁶ The percentage here is determined by practice and usually ranges between 25 and 50% depending on the practice's goals, overhead, and risk tolerance. However, 30 to 35% is the most common range.

⁷ "Overhead Threshold" = Multiple × Base Salary.

⁸ "Contract Year" means each 12-month period during the term commencing on the Start Date and ending 12 months thereafter.

⁹ Benefits typically include vacation time, health insurance, malpractice insurance, retirement plan, professional fees, and CME allowance.

employees, and (3) noncompetes. Most contracts contain a nondisclosure agreement and nonsolicitation of employees. The noncompete, for states that allow them, tends to be an important negotiation point and can be a provision that will cause one of the parties to not go forward with the relationship.

Another important issue, particularly for a cosmetic practice, ties to the ownership of before-and-after pictures if the contract is terminated. On the one hand, the photos are the work of the departing physician and may not be used by the practice when the physician leaves. On the other hand, the practice may not want the physician to easily compete with the practice with photos that were developed during the employment period. Contracts have trended toward allowing the physician to take before-and-after pictures upon departure, though there are usually strings attached or boundaries created to protect the practice.

Most contracts do not allow a physician access to patient files upon departure. This may be troubling for a young surgeon who is trying to amass and document cases to obtain board certification. Additionally, access to the patient charts is needed when a malpractice lawsuit arises. Discussion for a carve-out (to allow access to patient files in these limited circumstances) is warranted.

Because plastic surgery generally, and cosmetics practice specifically, lends itself to a culture of building the surgeon's practice versus that of the practice, marketing is a challenge. Even for a partnership, a tension exists by the fact that partners are often competing for the same patients. The tension is no different in an employment scenario. Marketing strategy, website ownership, social media strategy, and branding must be discussed and even included at times in the employment contract. Many employment relationships and partnerships fail due to the negligence to communicate and align as it relates to practice marketing and the marketing done by the individual physicians.

21.11.4 Considerations outside the Private Practice Employment Agreement

The employment agreement does not include every aspect of the relationship. An attempt to define how the relationship will work in every detail is unrealistic, as the relationship will be built primarily by working together. However, many issues not covered in a private practice employment agreement must be discussed. ►Table 21.3 lists the issues and related questions that must be considered prior to entering into the agreement.

However, this does not mean that each of the points listed in ►Table 21.3 must be discussed. If the new hire's Plan A is to relocate to their hometown after obtaining the board certification or gaining sufficient work experience, then discussions on future partnership will be of little value. On the contrary, if the practice desires the new hire to consider partnership opportunity at a certain point in time, discussions on ownership and buy-in costs are recommended.

21.12 Medical Practice Relationship: Independent Contractor Relationship

The two common types of private practice contracts are: (1) employment agreement (discussed in Chapter 21.10.1) and (2) independent contractor agreement, also known as professional services agreement (PSA). The practice and the joining surgeon must understand the legal difference between an employee and an independent

Table 21.3 Issues not generally addressed in a private practice employment agreement

Issue	Questions
Referrals and patient flow	• Does the practice have relationships with hospitals that may lead to referrals? • Does the practice have connections in the community that may lead to referrals? • How will the patient consultation calls be referred within the practice? How will they be distributed between the senior and junior surgeon?
Scope of practice	• Does the practice have any restrictions on what type of procedures the new hire can perform? For example, an oral and maxillofacial surgeon may want to bring someone just to perform breast and body procedures. Alternatively, a surgeon who wants to retire in a few years may just want to bring someone in to share the caseload.
Advertising and marketing	• Is the practice responsible or willing to share costs in advertising and marketing the new hire? • If so, a discussion as to specifics of the advertising and marketing efforts will be useful. • Will it be the new hire's responsibility to build his or her own website?
Future partnership/ownership	• Is the practice willing to offer a partnership opportunity to the new hire in the future? If so what does the timeline look like? • What will be the buy-in cost at that point of time? • What will the buy-in include in terms of revenue-sharing and ownership? Specifically, does it include ownership only in the practice or related ancillary entities as well?

contractor. Both practices and young plastic surgeons often hear about the benefits of an employment relationship or an independent contractor relationship and incorrectly perceive that they can simply choose which designation to make for the relationship. In reality, both the IRS¹⁰ and each state have a test that looks at the characteristics of the relationship to determine whether a relationship is employment or independent contractor. Significant penalties await a practice that misclassifies someone as an independent contractor.

A practice is not required to pay payroll taxes on compensation to an independent contractor. However, the practice is required by law to pay employment taxes on compensation to employees. Since the practice can avoid employment taxes by classifying a person as an independent contractor, the IRS is unforgiving of misclassification of an employee as an independent contractor. The practice will be liable for all of the back taxes due from a payroll perspective plus penalties imposed by the IRS. The risk for misclassification to the practice is clear. Risk exists, however, in a more subtle form for the physician joining the practice. A surgeon whose Plan A is to eventually obtain

¹⁰ IRS Fact Sheets. <https://www.irs.gov/newsroom/understanding-employee-vs-contractor-designation/>. Published 2017. Accessed August 21, 2018.

ownership interest in a practice will potentially become an owner of a practice with risk of IRS penalties for misclassification. We have seen negotiations for ownership fall through due to the extreme risk of the practice's aggressive treatment of all providers as independent contractors.

As with any medical practice relationship, regardless of whether one chooses an independent contractor or employer–employee relationship, there are benefits and risks attached to both. From the practice perspective, the benefits of an employment relationship are: (1) more control; (2) typically restrictive covenants will be more enforceable; and (3) assurance that the employed physician may not practice elsewhere (at least without permission). The employed physician enjoys the following benefits of employment relationship: (1) eligibility to participate in health insurance, 401k plans, and other defined benefit plans; (2) protections afforded by law to an employee; (3) practice provided malpractice insurance; and (4) practice provided surgical instruments and other tools of the trade.

The independent contractor relationship, on the other hand, allows the employed physician to create an individual pension or 401k plan, deduct business expenses, and practice independently. The practice does not pay employment taxes, avoids typical employee liability risk, and does not pay for benefits.

One's determination of which relationship may be more beneficial will primarily depend on their Plan A and expectations from that relationship. A surgeon desiring a guaranteed salary, with benefits, such as health insurance, malpractice insurance, dental insurance, participation in retirement plan options, etc. will benefit as an employee. On the other hand, a practice may desire an independent contractor relationship where the practice has a Plan A to share overhead and increases utilization of the surgery center and with a Plan B to have the practice minimally disrupted if the physician leaves.

The decision for the practice and the physician starts with determining whether an independent contractor relationship or employment relationship works best. Then the relationship must be built around the requirements for the relationship status chosen. The IRS and state use an independent contractor test. If the parties claim an independent contractor relationship, the arrangement in practice must meet the factors tested. Generally, the level of control exerted by the practice, and the amount of independence allowed to the hired person will determine whether the surgeon is an employee or an independent contractor. Practices must look to the list of eleven factors on IRS's website in determining whether the practice's relationship with the hired person is that of an employee or an independent contractor. However, not all factors will be relevant to every practice and the list of factors on the IRS's website does not claim to be an exhaustive one. The IRS will generally weigh some or all of the factors on a sliding scale basis in determining whether a person is an employee or an independent contractor.¹¹

Factors that provide evidence of the degree of control and independence fall into three categories:

1. **Behavioral:** Does the company control or have the right to control what the service provider does and how the service provider does his or her job?

¹¹ IRS Independent Contractor vs. Employee. <https://www.irs.gov/businesses/small-businesses-self-employed/independent-contractor-self-employed-or-employee/>. Published 2018. Accessed August 21, 2018.

2. **Financial:** Are the business aspects of the service provider's job controlled by the company? (These include things like how the service provider is paid, whether expenses are reimbursed, who provides tools/supplies, etc.)
3. **Type of relationship:** Are there written contracts or employee type benefits (i.e., pension plan, insurance, vacation pay, etc.)?

An independent contractor relationship should typically be established between the practice and an entity owned by the independent contractor surgeon rather than with a surgeon as an individual. An entity may not by definition be an employee; thus, misclassification risk is mitigated by having two entities contract in an independent contractor relationship.

21.13 Medical Practice Relationship: Partner Relationship

In the life cycle of a surgeon's journey, the employment or independent contractor relationship may evolve into an opportunity to become an owner of a medical practice. Similarly, in the life cycle owning a medical practice, it may make business sense at some point to bring in partners. The structure of an ownership arrangement must be rooted in the underlying purpose for each party. For example, the joining physician may desire to join as an owner for a number of reasons, ranging from participation in the profits of the practice and ancillary businesses (surgery center, medical spa, real estate, etc.) to having a voice in running the business, potentially buying out the senior physician, or simply to have an overhead sharing platform. Similarly, the selling physician may be motivated to have a physician join as the first step in selling the practice to sharing call or sharing risk and overhead.

As discussed in every other type of medical practice relationship, being in alignment from an expectations perspective going into the partner relationship is imperative. We have noticed over the years that four primary areas tend to determine whether the parties are sufficiently aligned for success. These four areas ("the 4Cs") are: (1) cost, (2) compensation, (3) control, and (4) contingencies.

21.13.1 Cost

On the one hand, cost is as simple as it sounds: how much is it going to cost for a surgeon to become an owner. However, the parties must discuss and understand the details of the price required of a buying surgeon to become an owner of the practice and what the surgeon will receive in return. The parties must evaluate the actual ownership as well as the assets and income streams that are being acquired. For example, a \$100,000 purchase for 50% of a practice with a high overhead in an "eat what you kill" practice with no assets may not be a good deal. Yet, a \$500,000 purchase for 50% of a practice with \$400,000 a year in profits from midlevel providers for injectables and other spa services may be a great deal. If the buying physician will buy into \$200,000 of profit distribution, the return on investment will take less than 3 years.

Both the practice and the buyer must assess the value of the practice. The process used to value a practice ranges anywhere from a back of a napkin valuation to hiring one or more certified business appraisers. The valuation of a practice will be based on the fair

market value (FMV) of the practice. To put it simply, FMV is what a willing buyer is willing to buy the practice for and what a willing seller is willing to sell the practice for in an arms-length transaction. Business appraisers will use one of the following three approaches in determining the valuation of a practice (see also ► Fig. 21.2). In general, one of the first two approaches is used in the valuation of a medical practice. The third approach, market approach, is not typically used because there does not tend to be available transactions for sales of practices for an appraiser to rely upon as a comparison.

Cost Approach

Here, the appraiser will compute the valuation of a practice based on the practice's net asset value (i.e., value of assets less liabilities). This approach is commonly used where the value of the practice is devoid of practice goodwill (the practice's established name and good reputation), and the practice may or may not have professional goodwill (the surgeon's established name and good reputation). Because most practices do not have a ton of assets, this approach tends to yield a low valuation.

Income Approach

Here, the appraiser will consider the revenues, expenses, net income, and profit of the practice and arrive at a multiple for the valuation. In general, a positive cash flow and a record of net profit generated independent of professional goodwill will increase the multiple and the value of a practice. The valuation of the practice will also take into

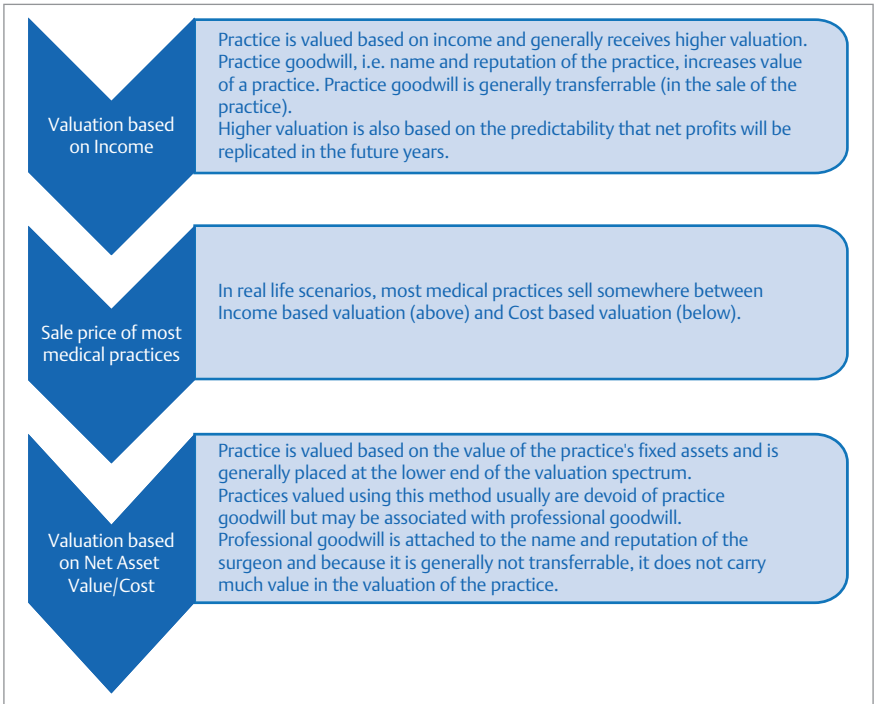


Fig. 21.2 Spectrum depicting valuation of a medical practice.

consideration the predictability of replicating the positive cash flow in the future. This approach tends to yield a higher valuation; the challenge is that plastic surgeons often have a high degree of professional goodwill. An appraiser will be reluctant to use this approach if the appraiser concludes that the source of the revenues ties mostly to the reputation of the surgeon.

Market Approach

The valuation in this approach is based on comparable sales, that is, sale price of other similar medical practices. In industries such as real estate, comparable sales information can be easily derived from publicly traded data. Since medical practices are not publicly traded, data related to comparable sales is almost never available and thus this approach is typically not used for valuing a medical practice.

In order to ensure alignment of expectations from a payment perspective, the respective parties entering into the partner relationship must conduct thorough due diligence. The surgeon interested in purchasing the practice must find out if the purchase of the practice will include some or all of the related entities such as ASCs, medical spas, and management company. Similarly, the owner of the practice must contemplate if the ancillary entities will be included in the sale of the practice or a future option-to-buy will be created.

21.13.2 Compensation

In the context of the 4C analysis of areas to discuss for partnership, “compensation” refers to compensation among owners of a practice and not compensation under an employment scenario. The partners of the practice must discuss and agree on how to divide the revenue and overhead costs (expenses) of the practice. The three basic compensation models seen in plastic surgery practices are: (1) eat what you kill model, (2) enterprise model, and (3) communist model.

Eat What You Kill Model

Eat what you kill (EWYK) model is the most common model among plastic surgeons. The concept of this model is that each partner will receive the collections they generate less allocated overhead of the practice. Revenue generated from other sources such as an ASC, midlevel practitioners, or a medical spa must also be allocated. The formula used to share and distribute overhead varies with each practice. Common formulas range from a simple equal allocation of expenses or the split may be computed using a more complicated formula with multiple methods of dividing various categories of overhead. For example:

Method A: Overhead can be divided into (1) direct expenses and (2) shared expenses. Each partner will be responsible for their direct expenses, such as malpractice insurance, salaries of dedicated staff or nurse, and schedulers or practice coordinators specific to the partner. The shared expenses will be split amongst the partners based on their respective use of the practice's resources, such as common staff, surgical supplies, and anesthesia. Allocating overhead based on use is generally referred to as *production-based use*. So, if a partner produces 60% of the revenue of the practice, then 60% of the production-based overhead will be allocated to that particular partner.

Method B: Under this method, overhead can be divided into (1) fixed overhead and (2) variable overhead. Fixed overhead such as rent will be divided evenly among the partners. Variable overhead may be split amongst partners either (1) based on the partner's production-based use or (2) evenly. In general, production-based sharing of variable overhead would be beneficial to a new surgeon joining a practice or a senior surgeon slowing down his or her practice in preparation for retirement.

EWYK model will generally work best for a single-specialty practice rather than a multispecialty practice. In a multispecialty practice with an orthopaedist, internist, and a plastic surgeon, EWYK can work, but the owners must be particularly attuned to the overhead requirements of each specialty and develop a fair allocation system. Even within a single-specialty practice such as plastic surgery, some partners will primarily perform purely aesthetics cases, and some will perform commercial payer cases. Insurance-based cases will generally have a much higher overhead, requiring a larger staff to assist with licensure, billing, and collections. Further, commercial payers take anywhere between 60 and 90 days to compensate the surgeon for the cases.

Enterprise Model

In this model, each of the partners will make a guaranteed salary, and the profits of the practice will either be distributed equally to each partner or shared based upon a productivity formula. The guaranteed salary can be allocated equally to each partner or varied based on productivity differences of the surgeons or based on the seniority of the surgeons. Generally, when each partner's guaranteed salary is computed to be distributed in equal shares, the profits are split based on the partner's productivity. For example, if 70% of the practice's revenue is produced by partner A and the other 30% by partner B, then partner A and B will be allocated 70 and 30% of the total profits, respectively.

Since the compensation in the enterprise model is based on productivity, it works well in most practice environments. The enterprise model will be an ideal compensation model for practices that want to motivate the partners to work together to grow the profits as a team. It is also an ideal choice for practices whose business plan is to grow the practice's brand name and goodwill. Business appraisers value practices with an enterprise compensation model higher than they do practices with an EWYK model.

Communist Model

The communist model operates like any other traditional nonservice business. Here the partners share the revenues, expenses, and profits equally irrespective of each partner's productivity. As one can imagine, this model is easily susceptible to partner disputes. Typically, practices that deploy the communist model tend to chip away at the model over time by carving out exceptions to compensate for special types of production among the partners. For this model to work, the partners typically must have a deep, trusting relationship. Consequently, this model is commonly seen in husband-and-wife plastic surgery practices.

21.13.3 Control

Decision-making creates another important area of risk in the ownership relationship. The practice must establish who will have the authority to decide and execute (1) day-to-day business decisions and (2) major business decisions for the practice. For

example, let's say a physician practice hires a younger surgeon to buy into the practice and ultimately take ownership of the practice. There are numerous ways to structure control over a practice's decision-making issues. Authority may be given to the senior surgeon to make day-to-day decisions for a certain predetermined time period. The authority to make and execute the major decisions remains with the senior surgeon for that predetermined time period, but there may be certain decisions that require both to agree. The practice agreement can be structured to reflect that after the predetermined transition period, the roles are reversed.

The practice must also define what qualifies as day-to-day decisions and major business decisions. This varies based on the partners' expectations and vision for the growth of the practice. For example, Practice A could define the decision to enter and execute a lease agreement for a \$200,000 laser as a day-to-day decision. On the contrary, Practice B could state any expenditure over \$5,000 for any purpose is a major decision and therefore must obtain a majority or unanimous approval. Regardless, the owners must communicate and clearly delineate in the medical practice agreement the day-to-day decisions, the major decisions, and the processes to execute them.

21.13.4 Contingencies

Contingencies are the final C of the 4Cs that owners of a practice must discuss and agree on prior to entering into a practice agreement. Parties must discuss and decide the terms and conditions that will govern a situation if an unexpected event were to occur. The unexpected events (the "what-ifs") can include: (1) death of a co-owner; (2) disability of a co-owner; (3) decision of a co-owner to leave the practice; (4) bankruptcy; or (5) divorce of one of the co-owners. Divorce of a co-owner is an important factor to consider, especially in the community-property states where each spouse will have equal rights in all earnings. This means that the spouse of the co-owner undergoing divorce may be able to claim a right in the practice. To avoid such scenarios, the practice agreement can proactively include language requiring the spouse of the divorced co-owner to sell-back any interest that may be received in the divorce settlement.

It is also imperative for the practice to preplan the valuation method to determine the value of the practice. The valuation of the practice could be based on a (1) predetermined value; (2) predetermined formula; or (3) preagreed appraisal process. While the parties are always free to negotiate a valuation of the practice, the pressure created by an unexpected event raises the importance of a pre-agreed-upon fallback approach if the owners cannot agree.

Once the valuation method or purchase price of the practice is established, the next step is to determine the process to buy, sell, and distribute the ownership interest of a co-owner. Most importantly, the practice must decide if they would be willing to pay the entire buy-out amount in cash at closing or if they would rather establish a cash flow process where a fixed amount with interest will be paid over time. The parties must consider the impact to the practice in such a scenario, as the practice will be losing a revenue stream with the exiting physician and have a financial obligation for the buy-out.

21.14 Staff Relationships

In general, any person on one's staff, from the receptionist to the physician, can have an employment agreement. We recommend employment agreements for anyone who is a registered nurse (RN) or has a higher qualification such as a nurse practitioner (NP),

physician assistant (PA), or physician (MD) (“midlevel or physician practitioners”). Midlevel and physician practitioners establish a close relationship with one of the most important assets of a medical practice—patients. In order to protect the practice’s main asset, it is strongly advised that employment agreements with a midlevel or physician practitioner contain restrictive covenants. Depending on the state’s laws, the employment agreements may contain some or all of the following types of restrictive covenants: (1) nondisclosure provision (all states allow this provision)—here the parties agree that confidential information of the practice will not be disclosed to outside third parties; (2) noncompetes (some states may not allow this provision); (3) nonsolicitation of employees (almost all states allow this provision); and (4) nonsolicitation of patients (not all states allow this provision).

Clear articulation of compensation is another important reason to have an employment agreement with midlevel and physician practitioners (and sometimes other employees). The practice must check with its state rules to determine whether commission is legal.

21.15 Patient Relationships

Maintaining good patient relationships is key to the success of a plastic surgeon’s practice. Typically, a patient who engages a plastic surgeon for a procedure is required to sign a host of forms related to HIPAA and consents for use of before-and-after photos on social media, websites, or for academic purposes. Another important agreement that plastic surgeons should add to their portfolio of patient relationship forms is a “refund agreement.” At the beginning of a patient relationship, the involved parties are usually amicable with each other, but the relationship can quickly turn sour if the patient is unhappy with the procedure they receive. Under such circumstances, patients typically expect or demand a refund; it is strongly advised that practices and plastic surgeons enter into a refund agreement with the patient before proceeding with a partial or complete refund. This protects the reputation and integrity of the practice and plastic surgeon by preventing the disgruntled patient from suing, and it contractually dissuades the patient from spreading and posting disparaging reviews and comments. (See Chapter 14.7 for a sample refund agreement and what can be done if the patient violates the agreement.)

22 The Wheel of Misfortune: Managing Medical Liability in Plastic Surgery

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Abstract

Malpractice litigation is an inevitable component of a plastic surgeon's career. Most of the litigations stem from breakdown in communication. This chapter first provides guidance in avoiding a lawsuit, the second section focuses on managing litigation when it occurs, and the third mentions other areas of liability exposure. Forewarned is forearmed.

Keywords: malpractice, litigation, liability, lawsuit, suit, sue, medicolegal, medmal, standard of care

A plastic surgeon practicing in the United States will find it virtually impossible to finish his or her career unblemished by a claim of malpractice. One of the major causes of “physician burnout” is the prevalence of lawsuits.¹ (See also Chapter 24.) Fortunately, given the recent heightened awareness of this very real issue affecting the physician population, there is a growing number of publications related to the subject, including three books recommended for any health care provider faced with a lawsuit (see Suggested Reading at the end of this chapter). The first part of this chapter focuses on how to avoid litigation, while the second part is devoted to managing a likely or verified claim.

22.1 Part I: Avoiding Litigation

As anyone reviewing significant numbers of plastic surgical claims can testify, well over half of the claims are preventable. Most are not based on technical faults, but rather on failures of communication and patient selection criteria. Patient selection is the ultimate inexact science. It is a melange of surgical judgment, gut feelings, personality interactions, the surgeon's ego strength, and, regrettably, economic considerations. Communication, on the other hand, is the *sine qua non* of building a doctor–patient relationship. Unfortunately, the ability to communicate well is a personality characteristic that cannot be readily learned in adulthood. Regardless of how brilliant the mind is or how deft the hands are, someone who appears to be cold, arrogant, or insensitive is far more likely to be sued than one who relates to people at a “human” level.

The common denominator of all malpractice claims is a breakdown in communications and a loss of or inability to build rapport. It is highly unlikely that you will commit no errors in your career. It is, however, entirely possible to alter the subsequent outcome of an error by adhering to a few simple rules.

22.1.1 Standard of Care

Malpractice is defined in legal lexicon as “treatment which is contrary to accepted medical standards and which produces injurious results in the patient.” Although most medical malpractice actions are based on laws governing negligence, the law recognizes that medicine is an inexact art and that there cannot be absolute liability. Thus, the cause of action is usually the “failure of defendant/physician to exercise that reasonable degree of skill, learning, care, and treatment ordinarily possessed by others of

[†]Deceased

the same profession in the community.” In the past, the term *community* was accepted geographically, but this is no longer true. Now, on the supposition that all doctors keep up with the latest developments in their field, *community* is generally interpreted as the “specialty community.” The standards are now those of the specialty, without regard to geographic location. This is usually referred to as *standard of care*.

Standard of care has special implications in plastic surgery, a specialty that encompasses many variations to achieve the same end. Thus, to a certain extent, the plastic surgeon has more latitude than do other surgeons.

22.1.2 Warranty

The law holds that, by merely engaging to render treatment, a doctor warrants that he or she has the learning skill of the average member of his or her specialty and that he or she will apply that learning and skill with ordinary and reasonable care. This warranty of due care is legally implied; it need not be mentioned by the physician or the patient. However, the warranty is for service, not for cure. Thus, the doctor does not imply that the operation will be a success, that results will be favorable, or that he or she will not commit medical errors that are due to a lack of skill and care.

22.1.3 Informed Consent

For centuries, Anglo-Saxon common law has respected the individual's right to the integrity of his or her person; any unauthorized harmful or offensive touching has technically constituted battery. Thus, a physician who treats a person without that person's consent is usually guilty of battery.

How does informed consent differ from routine consent? In the former, the patient has sufficient understanding of the nature, purpose, and risks of the procedure to make an intelligent decision to accept or reject the procedure. Obviously, in discussing the risks, a certain amount of discretion must be employed. Is this consistent with “full disclosure” of the facts necessary for informed consent? The emphasis is the word *informed*. While attempting to define the yardstick of disclosure, the courts divide medical and surgical procedures into two categories:

1. Common procedures, which incur minor or very remote serious risks (including death or serious bodily harm), for example, the administration of antibiotics.
2. Procedures involving serious risks, for which the doctor has an “affirmative duty to disclose the potential of death or serious harm and explain, in lengthy terms, the complications that might possibly occur.”

Affirmative duty means that the physician is obliged to disclose, on his or her own, without waiting for the patient to ask. It is the patient, not the physician, who has the prerogative of determining his or her best interests. Thus, the physician is obliged to discuss with the patient the therapeutic alternatives and their particular hazards.

The question of how much to explain, and in what detail, is dictated by a balance between the surgeon's feelings about his or her patient and the requirements of the law. You need not, in the words of a justice of the U.S. Supreme Court, “engage in an orgy or open-minded disclosure.” It is simply not possible to tell all patients everything that can happen without scaring them out of their surgery. Rather, as the law states, the patient must be told the most probable of the known dangers and the percentage of that probability. The rest may be disclosed in general terms while reminding the patient that he or she also has a statistical probability of falling down and hurting himself or herself that very same day.

Obviously, the most common complications should be volunteered frankly and openly, and their probability—based on your personal experience—should also be mentioned.

In summary, although it may seem the ultimate platitude, the best way to stay out of trouble is to be honest, warm, and compassionate. If you use common sense and behave toward the patient as you would want another physician to behave toward your spouse, it is highly unlikely that you will have need for this information.

Unfortunately, in the current state of the art, any or all of this information is wasted unless you document it. There is an 11th commandment: *write it down!*

However, the corollary to write it down is *don't change anything you wrote down before without clearly documenting that it is an alteration*. Altering records after the fact leads almost immediately to a losing position in court.

22.1.4 Patient Selection

The growing popularity of aesthetic plastic surgery has, unfortunately, created a carnival-like atmosphere in which advertising by unqualified practitioners is only one aspect. In this climate, it becomes imperative to establish clear criteria for patient selection; without these, there will be an inevitable parallel increase in patient dissatisfaction and litigation.

Who, then, is the ideal candidate for aesthetic surgery? There is no such thing, but the surgeon should note any personality factors that will enhance the physical improvements sought. There are basically two categories for turning down a patient: (1) anatomic unsuitability and (2) emotional inadequacy. Since the latter is by far the more important, the inexperienced surgeon must learn to differentiate between healthy and unhealthy reasons for a patient's desire for improvement. Motivation rather than specific psychodynamics should be the plastic surgeon's overriding concern. Is it a pragmatic desire to improve one's appearance or rather a pathologic focus of channeling subconscious problems on a physical fault?

Strength of motivation is *critical*. It has a startlingly close relation with patient satisfaction. Furthermore, the strongly motivated patient will have less pain, a better post-operative course, and a significantly higher index of satisfaction regardless of the result.

Great Expectations

Increasing experience invariably teaches the plastic surgeon to avoid patients who expect surgery to change their lives. The surgeon who operates on someone with a large, crooked nose and large hang-ups is likely to produce a smaller, straighter nose and larger hang-ups, or worse. Plastic surgery, regardless of its excellence, is dubious therapy for severe personality disturbances.

The "Important" Patient

Beware of patients who make a conscious effort to impress everyone with their stature, their profession, their standing in the community, their peer groups, and the like. Such individuals often suggest that their successful result will immediately bring on a flood of referrals and undying fame. They often turn out to be very difficult patients with a weak ego structure that needs constant shoring up. They are difficult to satisfy and are prone to forget their financial obligations.

Failure to Establish Rapport

The experienced aesthetic surgeon can usually determine within minutes after entering the room whether the individual sitting there will become his or her patient or not. Early in the conversation, there may be discernible “bad vibes.” To take on as a patient a person whom you truly dislike is a fatal mistake. A clash of personalities cancels out all other factors, regardless of how challenging the case is.

The “Surgiholic”

Beware of the patient who has had multiple or repeated aesthetic procedures. Such a patient may have a distorted body image. Aside from the technical difficulties involved, you will suffer from comparison with the other surgeons. If you are more successful, you may wind up like Sir Harold Gillies' favorite image of the patient running along beside your coffin pleading, “One more, please.”

22.1.5 An Ounce of Prevention

There should be a frank discussion of fees and costs, if not by you, then by someone on your staff. Experience has shown that payment in full (and in advance) for cosmetic surgery diminishes subsequent unhappiness with final results. Financing is increasingly popular, and dissatisfied patients may find their monthly bank statement a festering wound.

For patients treated under local anesthesia or conscious sedation, no operative permit should be signed after sedation is administered, since it may be held invalid. Every member of the surgical team should understand clearly that the patient, under the influence of narcotics, may misinterpret the most innocent words or jokes. Under no circumstances should there be arguments of any kind. There should be no swearing for any reason. Assistants and/or observers should be warned to save questions and comments for later. Finally, there is no such word as “oops” in the operating room; whether the surgeon drops a hemostat or comminutes the nasal bones, the word simply does not exist. It helps to talk to the patient and to be highly visible at the beginning and end of the procedure. Also, if the surgery is being performed with local anesthesia, it is extremely therapeutic to have music in the operating room. Music not only defuses the unfamiliar and terrifying atmosphere, but also covers up the sounds of the operating room (which in themselves may be quite anxiety-producing).

At the end of the operation, the surgeon should immediately report to the family. If no family members are present, a telephone call may be a very inexpensive investment. Discharge instructions should be clear, specific, and in writing. Availability during the first few days is essential. Giving the patient the surgeon's mobile phone number is an excellent way to establish strong bonds and rarely does the patient overuse the number. It also often leads to positive reviews. Also, if the surgeon signs out, it should be to someone equally competent, and the patient should be apprised in advance.

When dressings come off, there are innumerable questions, all of which require simple, reassuring answers. These questions will be fewer and less anxious if they have been answered preoperatively. It is also advisable for the surgeon to be present for the first postoperative visit if at all possible.

All litigation in plastic surgery has as a common denominator: poor communication. Underlying all dissatisfaction is a breakdown in the rapport between patient and surgeon. This vital relationship is often shattered by the surgeon's arrogance, hostility, and

coldness (real or imagined), and mostly by the fact that “he or she didn’t care.” There are only two ways to avoid such a debacle: (1) make sure the patient has no reason to feel that way, and (2) avoid the patient who is going to feel that way no matter what is done.

22.1.6 Effective Communication as a Claims-Prevention Technique

Although the doctor’s skill, reputation, and other intangible factors contribute to a patient’s sense of confidence, a substantial part of what is called “rapport” between patient and doctor is based on forthright and accurate communication. It is faulty communication that most often leads to the inevitable vicious cycle which follows: disappointment, anger, or frustration on the part of the patient, reactive hostility, defensiveness, and arrogance from the doctor, deepening patient anger, and finally a visit to the attorney.

The art of listening, as well as that of expression, both verbal and nonverbal, merits serious attention in your efforts to reduce malpractice lawsuits.

Listening

Obviously, hearing and listening are extremely dissimilar processes. Unlike hearing, which is the perception of physical stimuli to our ears, listening is the active cognitive process of interpreting what is heard, evaluating that information, and deciding how that information may be used. It is a fact that people like those persons who demonstrate their interest by listening and talking with them. It is also a fact that people are reluctant to sue someone they like. Therefore, learning to listen can be a powerful claims-prevention tool.

Accurate communication is a two-way process. It is a give-and-take situation. Many psychiatrists and psychologists define listening as “giving” of oneself, while talking is defined as “taking” from others. On average, 70 to 80% of our total waking day is spent in some form of communication, and 45% of that is listening. These percentages translate into an average of 6 hours of listening daily.

In the practice of medicine, this figure may be a conservative estimate. Of the four basic communication skills—listening, speaking, reading, and writing—the last three get the most attention in our educational efforts. The most used skill is the one least formally taught. The generally mistaken assumption is made that if you can hear, you can (and will) listen. Not so! Efficient listening requires conscious effort.

Not Allowing Distractions

The surgeon’s office environment permits interruptions that make effective listening difficult. If possible, distractions that steal attention (such as cell phones and smart-watches) should not be allowed when communicating with a patient.

Listening Not Only for Details or Facts

Medical training and examinations are geared toward facts and figures. Consequently, there is often a failure to take into account the equally important emotions, behavior, and intentions of the patient.

Reflective Feedback

This technique indicates to the speaker whether his or her message is being understood. This is accomplished by asking questions, making statements, or offering visual cues that indicate whether you understand, agree, do not understand, or disagree with the message. It is withheld until you confidently understand what the patient is trying to communicate. Use of this technique also makes it clear to the speaker that you are listening carefully.

Listening with Your Eyes

It is reported that 80% of all communication of emotion from one person to another is nonverbal. You can stay attuned to what the speaker is saying through his or her body positioning, eye movement and contact, physical contact, and other body language. It helps to “listen” with your eye. Two books written by Desmond Morris, *Manwatching* and *Bodywatching*, are excellent references on the subject.

Communication

Tailoring Your Language

One of the most common complaints in patient attitude surveys has to do with physicians’ use of complex terminology or medical jargon. There is a substantial choice of words available to communicate with the patient, depending on his or her level of intelligence and educational level. You may even have to resort to basic description using Anglo-Saxon terminology. Just make sure you are understood.

It is best to choose words that do not produce anxiety. While “excise” might be misunderstood, “cutting it out” sounds painful. “Removing it” is a better way to convey the message without inducing stress.

Repetition

Various studies have shown that the average patient retains 35% of what he or she has been told. Thus, it does no harm to repeat, in summary form, the essential points of your message at the end of the consultation or examination. It will strongly reinforce what you have said.

Requesting Written Questions

The anxiety of a visit to the doctor often causes patients to forget important questions or information until they have left your office. The French call this *esprit d’escalier*, or “spirit of the staircase,” which is where many people remember what they forgot to ask (as they are leaving down the stairs). Encourage patients to write down whatever questions occur to them and to bring their lists with them on their next visit. If they already have a list, do not—by word or body language—express impatience. In the event of an unfavorable outcome, the conversation about that list may prove extremely useful in your defense.

Physicians should not permit their own emotions or frustrations to reflect on the patient. The anxieties of preoperative and postoperative patients often act as a lens that greatly magnifies the physician’s body language. A frown or a simple “hmmm” may

exacerbate that anxiety. A sigh, raised eyebrow, or look of skepticism when evaluating a colleague's results is enough to trigger a visit to the plaintiff's attorney's office.

Positive rapport, on the other hand, can weather all sorts of treatment failures and complications. The art of effective listening and speaking is rewarded by friendship, understanding, and good rapport. In the doctor–patient relationship, this interaction assumes critical importance, since the treatment outcome may literally depend on it.

22.1.7 Anger: A Root Cause of Malpractice Claims

As plastic surgeons, we tend to forget that medical litigation is inevitably a distillate of a simmering cauldron of emotional, psychological, and even psychiatric ingredients. All malpractice claims have anger as one of their root causes. It may be on the part of the patient, the doctor, or both, but anger is always present. If we understand and learn to control this emotional aspect of medical misadventures, we can dramatically modify the outcome of an unfavorable result.

Virtually every patient contemplating medical treatment experiences variable degrees of anxiety. They seek reassurance from the surgeon against their uncertainties. An unfavorable outcome evokes feelings of despair and helplessness that may quickly turn into hostility. Regardless of the true cause of the result, such hostility will be focused on the most convenient and visible target—the doctor.

An unfavorable outcome also produces anxiety for the physician. More often than not, patient complaints are interpreted as personal affronts that strike at the doctor's sense of professionalism, pride, and competence.

When the complaint is perceived by the doctor as being unwarranted, this complex human interaction may quickly degenerate into mutual hostility. A vicious cycle is then established: the physician's anxiety, guilt, hostility, and arrogance are countered by hostility of the patient, and the physician's hostility mounts. In this climate, the possibility of a lawsuit quickly becomes a probability.

It is very difficult, if not impossible, to be objective when one is a party to an incipient lawsuit. Nonetheless, if it were possible to change the course of events prior to the onset of mutual hostility, the vast majority of malpractice actions could be avoided. The pretreatment or preoperative consultation, during which informed consent is obtained, can become a unique occasion for the doctor–patient relationship to be firmly established through the sharing of uncertainty.

The Normal Psychodynamics of Patients' Anger

It is entirely appropriate for patients to feel a sense of bewilderment and anxiety, especially when elective surgery does not go smoothly. The borderline between anxiety and anger is very tenuous, and the conversion factor is uncertainty—the fear of the unknown.

How do we cope with uncertainty? Blaming someone else places the responsibility elsewhere and gives one a sense of “control,” which, however inappropriate, is easier to cope with psychologically. A patient frightened by a postoperative complication, uncertain about the future, may gain a distorted sense of security by blaming the physician. The natural consequence of this distortion, then, is: “If it is the doctor's fault, the responsibility is the doctor's to correct.”

The patient's distorted perceptions may clash head-on with the physician's understandable anxieties and wounded pride. The patient blames the physician, who in turn becomes defensive. It is at this critically delicate juncture that the physician's reaction can set in motion, or prevent, a natural chain of reaction.

The physician must make a supreme effort to put aside feelings of disappointment, anxiety, defensiveness, and hostility that are natural to all of us when we are attacked. The physician must understand that he or she is probably dealing with a frightened patient who is using anger to gain “control” of the situation. The entire mood and subsequent developments can be changed by whatever understanding, support, and encouragement seem appropriate to the situation.

One of the worst errors in dealing with angry or dissatisfied patients is to try to avoid them. Although this is an understandable reaction, it is easily the surest way to hasten the arrival of a summons and complaint. As difficult and stressful as it may be, the more you talk and *listen* to that patient, the more likely you are to avoid converting an incident into a claim. If you assume that at least 50% of the effort necessary for effective communication is your responsibility, you will successfully defuse the ticking time bomb. It is necessary to actively participate in the process rather than follow your natural instincts and run away or hide.

22.1.8 General Guidelines

1. The consequences of illegible handwriting can be costly. If you still use paper charts, make certain that your entries in all medical records are clear and readable. If possible, dictate, type, or enter into the patient's computer file all long entries that require more than brief or routine annotations.
2. Never squeeze words into a line or leave blank spaces of any sort. Draw diagonal lines through all blank spaces after an entry.
3. Never erase, overwrite, or try to ink out *any* entry. In case of error, draw a line across it and write “error” with the date, time, and your initials in the margin.
4. Never *ever* add anything at any time unless it is in a separately dated and signed note. Remember that the entry date or ink type can be accurately determined retrospectively. Also be aware that the plaintiff's attorney may have a copy of the patient's original records, and any alteration after the fact will seriously compromise the defense of your case.
5. The date and time of each entry may be critical. *Be sure* that each page is dated and bears the patient's name, and that each progress note is accompanied by the date and time.
6. Avoid personal abbreviations, ditto marks, or initials. Use only standard and accepted medical abbreviations.
7. Retain your records for a minimum of 7 years from the date of the last entry.

22.1.9 Common Errors of Commission and Omission

It is imperative that you always:

1. Document when you are absent, with the name of the physician you have signed out to, along with the date and time.
2. Record pertinent observations and follow-up in any abnormal situation.
3. Ensure documentation of laboratory and radiologic examination results with a system which requires that all such reports will be seen, evaluated, and initialed by you or a colleague prior to filling in the patient's chart. This is particularly important when dealing with laboratory or pathology reports, X-rays relating to fractures, or computed tomography (CT) scans.

4. Justify your failure to comply with, or rejection of, a consultant's advice.
5. Document in detail your viewpoints and reasons for disagreement on patient care between you and a hospital utilization review committee or preferred provider organization (PPO).
6. Explain any delayed responses to nurse or house staff calls; enter the dates and times.
7. Respond to nurses' pertinent observations of the patient and record the follow-up in your progress notes.
8. Document the patient's verbatim statements:
 - *Wrong*: "Patient apparently fell."
 - *Correct*: "Patient states: 'Tried to get up, tripped and hit head on the corner of the bed.'"
9. Record negative reaction to any treatment or medication.
 - Remember to always use objective, accurate, and specific language.

22.1.10 The Patient's Records

The following entries should appear in the office and/or hospital records of each patient:

1. History and physical, specifically noticing absence of abnormality.
2. Past history, with particular emphasis on current medications, allergies, drug sensitivities, or previous surgery.
3. Specific notation on the patient's experience, if any, with smoking, drug or alcohol abuse, or previous surgeries.
4. Progress notes, entered after each office visit, on any change in status. If negative, your follow-up should be indicated.
5. Signed and witnessed consent forms for special procedures or surgery.
6. Medications, treatments, and specimens (where sent).
7. Patient's response to medications or procedures.
8. Documentation of the patient's failure to follow advice, refusal to cooperate, or failure to keep appointments. Missed appointments should be logged. Record your follow-up telephone calls and letters.
9. All significant laboratory, pathology, and X-ray reports, and the dates when ordered and read.
10. Copies or records of instructions of any kind (including diet) and directions to the family.
11. Consultations with other physicians and their written (or oral) responses, with the date and time recorded.
12. Thorough documentation of any patient's grievance, including the date and time.
13. Preoperative and postoperative photographs. The critical importance of these cannot be overemphasized. They should be of the same pose, lighting conditions, and quality. In plastic surgical claims, these photographs can literally spell the difference between an attorney's refusal to take the case and a substantial plaintiff's verdict.

22.2 Instructions to Patients and Personnel

1. Always record your instructions in writing. Keep a copy in the patient's record.
2. Review your instructions with the patient and family.
3. Ensure comprehension. Ask and record if there are any questions after instructions.
4. Include in your instructions (when applicable):
 - a) Specific wound care.
 - b) Limitations of activity, position, or exercise.
 - c) Dietary restrictions.
 - d) Specific instructions on medications, including possible side effects.
 - e) Follow-up appointments.
5. Document:
 - a) Language limitations, attempts made to overcome them by translators, and your notation if comprehension appears to be questionable.
 - b) Any literature provided to the patient and family, and/or informational videos.
 - c) Copy of instructions given.
 - d) Patient's failure to comply with instructions, and that the patient was informed of risks of noncompliance.
6. Record patient noncompliance. A situation that requires special procedures and attention relates to a patient's noncompliance or outright refusal to follow the doctor's orders or recommendations. This problem may be more apparent to your staff than to you.
7. The staff should record missed appointments in the chart and call them to your attention. If the patient's noncompliance carries the potential for possible injury, a *certified* return-receipt letter expressing appropriate concerns for the patient's welfare and (when indicated) warnings regarding the consequences should be sent.
8. Set up suspense files for all tests, procedures, and consultations. If the tests are not carried out, the staff should call this to your attention, and the patient should be reminded. Patient noncompliance and all callbacks to the patient should be recorded in the chart. Copies of all letters to the patient should be included.
9. In case of continued noncompliance, and if circumstances warrant, a *certified* return-receipt letter should also indicate the withdrawal of your care. Notations of all actions and copies of all letters sent to the patient should become a permanent part of the patient's record.
10. Use cautions and labels. Identify any drug allergies, and instruct the staff to display them prominently on a color-coded label placed in a specific location on the outside of the patient's chart. Special labels should also be used for identifying smokers and if the case is a medicolegal or compensation case.
11. Establish telephone routines with insurance companies and attorneys. The staff should not discuss the patient's medical problems or records without a release signed by the patient (or legal guardian) and the approval of the appropriate person in your office. The date, time, and name of the person calling and the purpose of the call should be recorded in the patient's chart. When requesting authorization from an insurance company to perform a treatment, tests, or other procedures, the staff must make sure that the patient has given a general release as a member of a plan. They should record the date, time, and name of the person authorizing the treatment, test, or procedure.

12. Enhance communication with patients in the office. Encourage your staff to initiate personal contact with patients by expressing warmth and individual attention. Impress on the staff that they may represent the first, last, and most durable impression that patients have of your office and therefore of you. The staff can make the impression a favorable one by their demeanor. When patients comment on your staff unfavorably, you should investigate; when the comment is favorable, be sure to convey that.

22.3 Part II: Managing a Possible, Impending, or Verified Malpractice Claim

22.3.1 Steps to Manage

Step 1: Notify and Seek Assistance from Your Insurance Carrier

Anger is a root cause of a malpractice claim. Earlier in this chapter, we have discussed what a physician can do in an attempt to alleviate the patient's feelings of disappointment, anger, and hostility. While it is important for a physician to maintain one's objectivity when dealing with a patient who expresses anger and disappointment, it is also important for the physician to report instances of possible litigation immediately to their professional liability carrier as well. Prompt and timely reporting of adverse outcomes and events (including patient threats) ensures that a timely coverage analysis is made by your insurance carrier and you will have confirmation that the claim/incident has been received and accepted. In many instances, your insurance carrier can also provide you with immediate assistance from a claims, patient safety, or legal professional and give timely advice regarding disclosure techniques as well as proper documentation and communication strategies for these types of situations. Your insurance carrier can also serve as a valuable intermediary between you and the patient to settle the matter before a plaintiff attorney gets involved. Remember, it is not only in your best interest, but also your insurance carrier's interests to avoid or mitigate your exposure in the event of an adverse outcome or situation where you have a dissatisfied and very angry patient. Lawsuits are lengthy, stressful, expensive, and time consuming, so do not hesitate to get your insurance carrier or seek out independent legal advice early on in the process.

Step 2: Consider a Refund

One solution that is sometimes given consideration by a surgeon is to offer a refund to a patient who is dissatisfied, demanding, or angry about the outcome—or the surgeon may not be satisfied with the surgical outcome and feels the need or obligation to offer a refund to the patient. More likely, a surgeon is considering a refund because the patient has made disparaging remarks on social media sites. Pursuing this avenue to resolve or avoid a potential landmine down the line is perfectly reasonable. As noted above, it is strongly recommended to contact your insurance carrier or legal representation before exploring this option with a patient. Many times, your insurance carrier or legal advisor can provide you with a formal “release form” with language that expressly states that in exchange for a monetary refund, the patient signs and agrees to

hold the physician harmless, agrees to full confidentiality, agrees to assume responsibility for any third party liens, remove disparaging social media posts, and forfeits any rights to pursue future legal action (see Chapter 14.7 for a sample agreement). If one is considering returning actual dollars to a patient from one's own resources (avoids any claims history), it is always good practice to have some type of written agreement. If you choose to have the carrier pay the refund or larger monetary amount, make sure you get a clear understanding in writing about the required reporting levels to state medical boards and the National Practitioner Data Bank (NPDB). Although refunds are a popular example of an "early resolution technique" that has become pervasive in the medical-legal and patient safety fields, patients sometimes ignore the agreement and continue to disparage the practitioner on social media sites. Under those circumstances it might be necessary to take the unusual step of suing the patient for breach of contract (see Chapter 14).

Step 3: Coping with a Lawsuit

The effects of facing a lawsuit mimic the stages of grief one experiences after the death of a loved one. The symptoms are real and can be debilitating, so the more insight one has on how detrimental a lawsuit can be to one's physical, mental, and emotional well-being the better. In addition to the resources listed at the end of this chapter, some state medical societies offer confidential mental health referral hotlines, and one's own personal medical insurance company may put you in touch with a mental health provider.

While you may feel powerless and not in control when dealing with a lawsuit, you actually do have a lot of control and should not hesitate to engage in the entire process with your legal team. Many professional liability policies have a Consent to Settle provision written into the policy. That means that the physician holds the right of consent and the insurance company cannot settle a case without your express knowledge and consent. Further, you should actively engage with your attorney and insurance claim professional when selecting appropriate experts to assist in the defense of your case. Your attorney may also enlist you to provide him or her with relevant research or authoritative articles to assist in asserting your defense. The more time and effort you put into your case and preparation to testify, the more in control you will feel. Just as you benefit when your patient is engaged in the outcome you are trying to achieve with your surgical expertise, a lawyer with expertise in the courtroom will benefit if you are engaged and participate in the outcome.

22.3.2 Why Not to Countersue

A physician who is successful in getting his or her malpractice claim successfully dismissed or adjudicated may understandably be compelled or express a strong desire to go on the offensive and contemplate filing a Malicious Prosecution Suit in retaliation against the patient who initiated the action. In the overwhelming majority of cases, your assigned legal counsel likely already waived that right on your behalf in order to secure a voluntary dismissal of the malpractice case. Voluntary dismissals are typically negotiated on your behalf with the express understanding that you, as the defendant, agree to waive any future malicious prosecution and costs incurred in the initial lawsuit in exchange for the dismissal. In a typical setting, you, as the named defendant, would agree to and be estopped from pursuing any future litigation against the plaintiff and your professional

liability carrier likely would waive any further pursuit of recoverable costs in the underlying matter. It would be expected that your assigned attorney would have this conversation with you in advance of the acceptance of said offer to dismiss the case.

In a circumstance where your attorney obtains a judgment on your behalf either by successfully defending the case through a jury trial or receiving a favorable ruling by the court, your right to file a countersuit against the plaintiff would theoretically still be intact. Although it may appear palatable to pursue your own action in the immediacy of obtaining such a favorable outcome, it is still unlikely to be a worthwhile pursuit or good use of your valuable time and financial resources. The patient attorney's first response in this type of outcome would typically be to immediately threaten an Appeal of the Judgment, which has the potential of dragging the case on for many years to come as it meanders through the costly Appellate Court System. There is never a guarantee that your Judgment would be upheld at the Appellate Court level.

Even in circumstances, where a Motion to Appeal your favorable Judgment is not threatened or postured by the opposing counsel, there are still a myriad of reasons to forego further action and instead focus on putting the entire distasteful and emotionally taxing experience behind you. Specifically, it would not be unusual for the plaintiff to be viewed as "judgment proof," meaning the plaintiff has no significant assets, so you would be unable to obtain any type of financial recovery in the event of a successful Malicious Prosecution Judgment on your behalf. Further, as any physician will easily concede, litigation is a tiresome and emotionally taxing endeavor that takes a huge toll on one's emotional well-being. Prolonging this experience would not be beneficial to any physician's mental, emotional, or physical health. The burden of proof to show through a Court of Law that a lawsuit filed by the patient and their attorney was "malicious" is very high and difficult to overcome.

Pursuing this type of legal remedy against a patient is very costly and not associated with a high likelihood of success. The physician would bear the cost of hiring their own attorney to file and prosecute that action. Your malpractice attorney does not specialize in that area of the law, and your professional liability policy will not cover the costs, as it would be outside the scope of the coverage.

In the event your malpractice case is on the precipice of being favorably discharged, a physician should focus on moving on with one's professional and personal life. Recognize that you have likely endured a very stressful period of your life and sacrificed a lot of time and effort to achieve the favorable outcome—*likely at the cost of time spent with family, friends, and colleagues*. It is far better to look for valuable insight, takeaway.

22.3.3 Other Areas of Liability Exposure

Your Professional Liability Policy is only one piece of the puzzle needed to protect your practice and financial well-being. Consult with an insurance professional to ensure that you have secured other lines of coverage necessary to protect yourself from the hazards of practicing in today's litigious society. Workers' compensation, general liability, employment, errors and omissions (E&O), benefits administration, umbrella or excess coverage, earthquake and flood insurance are some of the other lines of coverage that may be recommended. A growing line of insurance coverage that is becoming increasingly necessary in today's environment is **Cyber Liability insurance**. Depending on the terms of coverage you select, Cyber Liability can protect you in the event of physical damage to your computer hardware and software, protect you against viruses and ran-

software attacks that could cause significant disruption to your practice. Also, Cyber Liability insurance can protect you from significant liability if your confidential medical records and information are stolen, misplaced, or simply inadvertently disclosed to the public. Violating HIPAA and patient confidentiality laws can result in substantial statutory fines and expenses associated with notifying all affected individuals of a data breach. While many professional liability policies do provide additional coverages for protection against investigations by State Medical Boards, Government Entities, and Hospital Privilege disputes, **Professional Administrative Defense coverage** is another type of coverage needed in today's environment. You should consult with an insurance professional to ensure that you have a comprehensive insurance portfolio. Your insurance professional can ensure that you have sufficient coverage and limits to protect your personal assets.

Since 1996, when the Health Information Portability and Accountability Act was enacted, financial and legal liability resulting from HIPAA violations and data breaches continues to be a rapidly expanding area of exposure. The explosion of digital technology and electronic medical records has only added fuel to this inferno of liability exposure. Those in private practice, in particular, should ensure that all of their electronic devices are encrypted and protected. It would be advisable to consult with an IT professional and legal consultant and ensure that all your hardware, software, personal data assistance (PDA) devices are well protected and encrypted to prevent theft and ensure confidential and private communication and transfer of data and information. You can still potentially be held liable if you securely release your confidential medical information to a third party and they are a victim of a breach. Even if you are never subject to any type of lawsuit from a patient, the expense of statutory and regulatory fines can be exorbitant.

In addition to the exposures discussed above relating to the rapid expansion of technology at our fingertips, there are other areas of exposure a physician should be aware of. Today, almost everyone spends a significant amount of time on their PDA devices. It is important to comprehend how these devices pose a risk to your patients. There have been some recent cases that have gained national notoriety involving physicians who become distracted by using their PDA's to access social media and other news sites while operating or treating a patient. In the event of an adverse outcome, if litigation ensues, and it is discovered that the physician was using or was distracted by a PDA device that resulted in patient harm, the case would result in a higher settlement or verdict and also, possibly, result in severe administrative or privileges consequences. The book *Distracted Doctoring: Returning to Patient-Centered Care in the Digital Age* provides useful insight into the pitfalls of being exposed and having access to this information while attempting to practice medicine.

In the area of medical liability, forewarned is forearmed.

Reference

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Suggested Readings

Facing a Malpractice Lawsuit

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Charles Sara C, Frisch Paul R. Adverse Events, Stress, and Litigation

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in Malpractice Lawsuits

Communication Skills

Morris D. Body Watching. Crown Publishers. New York, NY. 1985

Morris D. Manwatching: A Field Guide to Human Behavior. Harry N. Abrams, Inc. New York, NY. 1979

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23 Building and Protecting Your Wealth: In Three Acts

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Abstract

This chapter explains financial protection throughout one's career. Different types of insurance are defined and explained, along with information on protecting your assets, what you need to know about taxes, and much more.

Keywords: disability insurance, life insurance, protecting your assets

Editors' Note

We asked the authors to present this important topic chronologically to help the reader focus on where they are in the life cycle of their own medical practice. Act I is for those early in their career, Act II is for mid-career, and Act III details retirement planning. It is never too early (or late) to get a sound financial education.

23.1 Act I: Financial Focus for Young Physicians: “First, Build Your Foundation”

23.1.1 Young Physicians' Greatest Asset: Future Value of Income

The most important factor in the building of a foundation is to protect what the young physician has already built. Many young doctors with little savings, and often large student loan debts, may ask: “What have I built? I am in severe debt!” The answer is that they have actually built a significant asset that needs protecting—the value of their future incomes.

Given the significant investment made to become a practicing physician, it should not be surprising that the value of a doctor's future income is also significant. For example, let us assume that a plastic surgeon has a starting salary of \$300,000, including benefits. Assuming this surgeon plans on practicing for 30 years (with 3.5% annual inflation), the present value of this annual income is \$5,517,613, even without a raise, including inflation. An asset this valuable is worth protecting.

What is needed to protect this asset depends on whether they are protecting it for only themselves or for dependents as well. In both situations, doctors need to protect their ability to earn this income in the future, which is why disability income insurance is the number one tool for young plastic surgeons to implement.

23.1.2 The Need for Disability Insurance

The disability of the family breadwinner can be more financially devastating to a family than premature death. In both cases, the breadwinner will be unable to provide any income for the family, but in the case of death, the deceased earner is no longer an

expense to the family. If the breadwinner becomes disabled, he or she still needs to be fed, clothed, and cared for by medical professionals or family members. In many cases, the medical care alone can cost hundreds of dollars per day. Thus, with a disability, income is reduced or eliminated, and expenses increase, leading to creditor problems or even bankruptcy.

23.1.3 Employer-Provided Coverage Is Often Inadequate

If you are an employee of a university or other large corporation, your employer may provide long-term disability coverage. Group disability often limits either the term of the coverage or the amount of benefits paid. For instance, benefits may last only a few years or benefit payments may represent only a small part of your annual compensation. Since this is most commonly an employer-paid benefit, the money received during your disability will be income taxable to you. Additionally, employer or group disability coverage can be terminated at any time for any reason, leaving you without coverage.

Take a good look at what the employer-offered policy covers, and buy a private policy if you and the insurance professional on your advisory team decide you need it.

23.1.4 Getting the Best Insurance Coverage for the Money: Personal Disability Coverage

When getting your own disability policy, consider the following questions:

1. *What is the benefit amount?* Most policies are capped at a benefit amount that equals 60% of income. Calculate how much money your family would need if you were to become disabled.

Find a company that offers at least 60% of predisability after-tax income with maximums of \$17,000 monthly. You can also purchase supplemental policy to your individual and/or group coverage. Carriers will participate up to \$25,000 or \$30,000.

2. *What is the waiting period (elimination period)?* This is the period of time that you must be disabled before the insurance company will pay you disability benefits. The longer the waiting period before benefits kick in, the less your premium will be. Essentially, the waiting period serves as a deductible relative to time—you cover your expenses for the waiting period, then the insurance company steps in from that point forward.
3. If you have adequate sick leave, short-term disability, and a sufficient emergency fund, choose a policy with a longer waiting period to save money. Though waiting periods can last as long as 730 days, a 90-day waiting period may give you the best coverage for your money.
4. *How long will coverage last?* It is best to get a benefit period of coverage that lasts until age 66 or 67, at which point social security payments will begin. Many policies cover you for only 2 to 5 years, which would be an inadequate period unless you are 62 to 67 years old. Unless you are so young that you have not yet had time to qualify for social security, a policy that provides lifetime benefit at costly premiums is generally not worth the added expense.
5. *What is the definition of disability?* Definitions vary from insurance company to insurance company, and even from policy to policy within the same company. The definition of disability used for a particular policy is of utmost importance.

The main categories are “own-occupation,” “any-occupation,” and “loss of income.” The own-occupation policies are the most comprehensive because they pay a benefit if you cannot continue your own occupation, even if you can and do work another occupation after the disability. Two important elements to look for in an own-occupation policy are:

- Are you forced to go back to work in another occupation?
 - Will you receive a partial benefit if you go back to work slowly after the disability and still make less than you did before the disability?
6. *Does the policy offer partial benefits?* If you are able to work only part-time instead of your previous full-time hours, will you receive benefits? Unless your policy states that you are entitled to partial benefits, you will not receive anything unless you are totally unable to work. Another question to ask: Are extended partial benefits paid if you go back to work and suffer a reduction in income because you cannot keep up the same rigorous schedule you had before you became disabled?

Important Note: Partial benefits may be added on as a rider in some policies and should be seriously considered, as only 3% of all disabilities are total disabilities. Some policies even have a recovery benefit to cover the insured's loss of income from a business's loss of clients due to the insured's inability to serve clients. The insured does not have to be disabled at all—there can just be loss of income due to disability-related attrition.

7. *Is business overhead expense (BOE) covered?* As a practice-owner, whether you have \$10,000 or \$20,000 of monthly disability benefit, you likely do not have enough to cover your lost income *plus* the costs of running the practice. Though most companies limit what an individual can get in monthly benefit (often 60% of after-tax monthly income—capped at \$30,000 per month), many carriers still offer up to \$50,000 or more per month to cover business overhead expense.
8. *Is it noncancelable or guaranteed renewable?* If a policy is “noncancelable,” you will pay a fixed premium that will not increase throughout the contract term. A “guaranteed renewable” policy cannot be cancelled, but your premiums could go up. Ideally, you want a policy that is *both* noncancelable and guaranteed renewable.
9. *How financially stable is the insurance company?* Before buying a policy, check the financial soundness of your insurer. If your insurer goes bankrupt, you may have to shop for a policy later in life, when premiums are more expensive. Standard & Poor's, A.M. Best Co, Duff and Phelps, and Moody's all rate insurers.

23.1.5 Protecting Future Income for Dependents: Life Insurance

Young surgeons with financial dependents—typically, children and spouses, but sometimes other family members too—need to focus on protecting their future income value against disability as well as death. For this reason, life insurance is tool number two to protect your foundation. To determine the amount of coverage you need, calculate the expenses to be covered in the event of your death, such as a mortgage, education funding for children, income support for your spouse, car loans, and other debts. Following are some of the most common types of life insurance.

Term Life Insurance

Given its affordability, term life insurance is the most common type of life insurance policy. The term policy premium is low compared to other types of life insurance policies because it carries no cash value and provides protection for a limited period of time (referred to as a *term*). This limited time frame is usually 10 to 20 years, though some companies offer a 30-year term product. A term life insurance policy pays a specific lump sum to your designated beneficiary upon your death, playing an important role in providing temporary death protection for your family (or practice/partners as part of a buy-sell arrangement).

Whole Life Insurance

Whole life insurance pays a death benefit to the beneficiary you name and offers you a cash value account with tax-deferred cash accumulation. It has a fixed premium which cannot increase during your lifetime (as long as you pay the planned amount), and your premium is invested for you long term. Because it has the cash accumulation component, whole life insurance can offer benefits such as tax reduction, wealth accumulation, asset protection, and estate planning. However, whole life insurance does not allow you to invest in separate accounts (i.e., money market, stock, and bond funds). Thus, your policy's returns will be tied to the insurance company's ability to invest its capital—which is often tied to interest rates.

Universal Life Insurance

Universal life insurance is similar to whole life insurance, but with more flexible premiums. It may be attractive to younger buyers who may have fluctuations in their ability to pay premiums. Because it is so flexible, universal life insurance can offer benefits like tax reduction, wealth accumulation, asset protection, and estate planning. If the insurance company does poorly with its investments, the interest return on the cash portion of the policy could decrease. In this case, less money would be available to pay the cost of the death benefit portion of the policy, and future premiums may be necessary in addition to the premiums originally illustrated.

A Hybrid: Equity-Indexed Universal Life Insurance

Equity-indexed universal life insurance (EIUL) is a universal policy that allows you to select from a list of stock market indices to grow your cash value. If the investments fail, there is a guaranteed minimum death benefit paid to your beneficiary upon your death.

EIUL gives you more upside than a traditional UL policy because the insurance company contractually agrees to credit the policy's cash value with the same return as the stock market index that the policy holder chooses, realized over the same period of time, and subject to a cap and a floor. The stock market index choice is typically the S&P 500 Index, but it can be the Dow Jones, NASDAQ, EAFA, or other. Thus, the policy owner has the upside of the indices to the cap, but the risk of the same indices to the floor. Typical floors for an annual return range from around 0% (no loss of principal), with caps around 10%.

EIUL policies vary from carrier to carrier. Some only allow for 50 or 75% participation of the rate of return from the S&P. This means that if the S&P 500 returns 10%, you may only get 5 or 7.5%. (Others offer 100% participation.) The policyholder must pay particular attention to the carrier's contractual obligations.

23.1.6 You Refinance Your Mortgage When Rates Go Down...Did You Know You Can Do the Same for Your Life Insurance?

If you purchase a WL, UL, EIUL, or other type of permanent life insurance policy, you may not be locked in to that policy, or even type of policy or insurance carrier. In fact, you may have the flexibility to move to a better-performing, less costly, or otherwise superior policy without tax consequences.

Consider this: When interest rates fall, many of us consider refinancing our mortgages. We review the long-term savings versus the refinancing costs, and then we make a decision. Refinancing is a common practice with home mortgages, investment properties, and even business loans.

You can do something functionally similar with a life insurance policy. Unlike a mortgage, you do not actually *refinance* an existing cash value life insurance policy; rather, you exchange it for a new one, using the 1035 Exchange provision of the tax code. This is generally a simple process, but it usually requires new underwriting. This is important, because just as you would not refinance your mortgage if the closing costs are higher than the expected interest savings, similarly you should not exchange a policy for a new one if your health has worsened since you first acquired the policy because the costs of the new policy will likely exceed the costs of your existing policy.

With the help of a knowledgeable advisor, you can determine these factors in advance and model the numbers so you have all the information before making the exchange. Note that, if you have maintained a healthy lifestyle and remain in good health, there may be further financial incentive to exchange the policy.

There are at least five important reasons to consider exchanging life policies:

1. Industry-wide cost of insurance reductions
2. Cost structures between companies
3. Moving to policies with lower access costs
4. Moving to mutual companies
5. Taking advantage of new product features

If you would like more information on this strategy, please contact us at carole@ojmgroup.com and we can send you an article specifically on this topic.

23.1.7 Protecting Assets from Potential Liability

In this litigious society, asset protection planning is an integral part of any plastic surgeon's comprehensive wealth plan. Obviously, medical malpractice liability is the leading source of liability on most surgeons' minds. However, physicians should also consider their liability for employee claims, vicarious liability because of employees, claims due to slip/falls at the practice, premises liability for the accidents of renters or visitors at other properties they may own, car accident lawsuits and claims because of teenage children drivers.

In the pursuit to shield wealth from potential liability, it is essential that surgeons employ a multidisciplinary approach, since insurance, legal, and financial tools all play important roles. We will start with insurance here and move on to legal and financial tools.

First, do not fall victim to three common myths plastic surgeons often have about asset protection planning.

Myth 1: “My Assets Are Owned Jointly with My Spouse, So I’m Okay”

Most married surgeons hold their homes and other property in joint ownership. Unfortunately, this ownership structure provides little asset protection in both community and noncommunity property states, other than those states that protect tenancy by the entirety (TBE), as described later in the chapter.

In community property states, community assets will be exposed to community debts regardless of title. Community debts include any debt that arises during marriage as the result of an act that helped the community. Certainly, any claims resulting from a medical practice, income-producing asset (rental real estate), or auto accident would be included.

Even in noncommunity property states, joint property is typically at least 50% vulnerable to the claims against either spouse. Therefore, in most states, at least 50% of such property will be vulnerable.

Myth 2: “My Assets Are Owned by My Spouse, So I’m Okay”

One of the most common misconceptions about asset protection is that assets in one spouse's name are protected from claims against the other spouse. This type of asset ownership often happens when one spouse has significant exposure as a surgeon and one does not.

Unfortunately, simply transferring title of an asset to the nonvulnerable spouse does not protect the asset. The creditor is often able to seize assets owned by the debtor's spouse by proving that the income or funds of the debtor were used to purchase the asset. To determine if the asset is reversible, three questions can be asked:

- Whose income was used to purchase the asset?
- Has the vulnerable spouse used the asset at any time?
- Does this spouse have any control over the asset?

If the answer is “yes” to any of these questions, then the creditor may be able to reach these assets. Even if a surgeon was somehow able to muddy the waters on these questions with regard to an outside liability, another important question arises. If a surgeon can effectively argue that the asset in the spouse's name is truly the spouse's alone (for legal form *and* substance), the consequences in a divorce scenario could result in the nonphysician spouse claim that asset (as it was effectively gifted to them) before the splitting of the remaining joint assets. In other words, be wary of a tactic that relies on having your cake (legally, the asset is the spouse's, not joint) and eating it too (legally, the asset is joint).

Myth 3: “My Living Trust (Or Family Trust) Provides Asset Protection”

As you will learn later in this chapter, while revocable living trusts are valuable for estate planning, they provide no asset protection while you are alive.

23.1.8 Baseline of Asset Protection: The Mixed Blessing of Property and Casualty Insurance

Property and Casualty (P&C) insurance is an important part of any surgeon's asset protection plan—for both practice and personal assets. In fact, we make it a part of our comprehensive asset protection review for our clients; we utilize a national firm with access to the largest P&C insurers, and even Lloyd's of London and other syndicates when cost-effective insurance is difficult to find.

What Is P&C Insurance?

P&C insurance is referred to as “property and liability” insurance because it protects people from all types of liabilities. Examples of P&C coverage include automobile, homeowners and renters, umbrella liability, professional liability, medical malpractice, general liability, flood, earthquake, premises liability, errors and omissions, and products liability.

P&C insurance is designed to “indemnify” the insured. The insurance industry's definition of “indemnify” is to “make whole” or to restore the status quo. In other words, if you suffer a loss and have P&C coverage, you will be “put back” into the same financial place you were before the loss (minus any applicable deductibles or copayments). P&C coverage will cover your legal bills, the costs of adjusters, estimates, expert testimony, and other associated costs and adjustment expenses, as well as the actual loss.

Best Uses of P&C Insurance

As we mentioned above, there are several types of P&C insurances. The most common P&C personal insurances are homeowners (or renters) and automobile insurance.

Another common type of P&C insurance is the umbrella liability policy. For a reasonable premium, you can get an additional one to five million dollars of excess liability insurance on top of the liability protection you may have from your homeowners or auto policies. An umbrella policy is an inexpensive asset protection, which a surgeon should seriously consider purchasing.

Other popular P&C coverage includes professional liability insurance and premises and products liability insurance. For a physician, medical malpractice insurance, premises liability insurance, and other overhead insurances are wise options, if not requirements.

Four Limitations of P&C Insurance

While some P&C insurance always makes sense as part of the asset planning for every doctor, there are limitations to this tool. That is why the other asset protection tools described in this chapter may be better, in addition to any insurance. Let us examine these limitations individually.

1. **Policy exclusions:** Often, clients are unaware of the P&C exclusions and policy limitations in “fine print” until it is too late.
2. **Inadequate policy limits:** Even if your insurance policy does cover you in a particular lawsuit, the policy coverage may be well below what a jury will award. You must pay any excess above the coverage out of your own pocket.

3. **Insurance forces you to lose control of the defense:** Even if your insurance policy covers against a specific claim, consider the consequences of filing a claim. You have lost negotiating power because your insurance company will dictate when the case is settled and how much the case settlement will be. While this may not matter with a personal injury car accident lawsuit, a case against you professionally is another matter. Here you may not want to admit liability and settle, while your insurance company does.
4. **Claims bring ever-higher premiums:** An additional consequence of relying solely on insurance to protect you from lawsuits is that, once you make claims on the policy, your premiums rise. There is a likelihood that you will endure a number of lawsuits over your lifetime, and your insurance cost will rise with every claim, even if you are not at fault.

Recommendations to Manage Limitations

To manage the four limitations of P&C insurance as outlined above, we recommend the following preventive measures:

1. Know your policy.
2. Do not skimp on coverage.
3. Consider an umbrella policy.
4. Get a second opinion on existing policies every 5 years.

23.1.9 The Sliding Scale of Asset Protection

Like a physician who judges the severity of a patient's illness, asset protection specialists use a rating system, such as from -5 (totally vulnerable) to +5 (superior protection), to determine the protection or vulnerability of a client's particular asset (see ► Fig. 23.1).

Initially most clients' asset planning scores are overwhelmingly on the negative side of the scale. The reasons vary. Typically, personal assets are owned jointly (-3) or in their individual names (-5). Both of these ownership forms typically provide little protection.

23.1.10 Important Planning Ground Rule: Fraudulent Transfer/Voidable Transaction Laws

The timing of asset protection has a fundamental impact on its effectiveness because federal law and the laws of every state have what are called either *fraudulent transfer laws*, *fraudulent conveyance laws*, or most recently, *voidable transaction laws*. These laws can be used by a judgment creditor (someone with a successful lawsuit judgment) to undo transfers.

This means that to be effective, asset protection planning must be implemented not only before you have a claim against you, but also before you could reasonably foresee that a claim would arise. Consequently, the best time to implement asset protection planning is when you have no claim against you and cannot foresee any such claim.

23.1.11 Exempt Assets: The “Best” Asset Protection Tools

Exempt assets are those asset classes that a state law (or federal law, if in bankruptcy) specifies are beyond the reach of lawsuits and creditors in its statutes, or case law interpreting such statutes. In other words, these are assets that the law “exempts” from

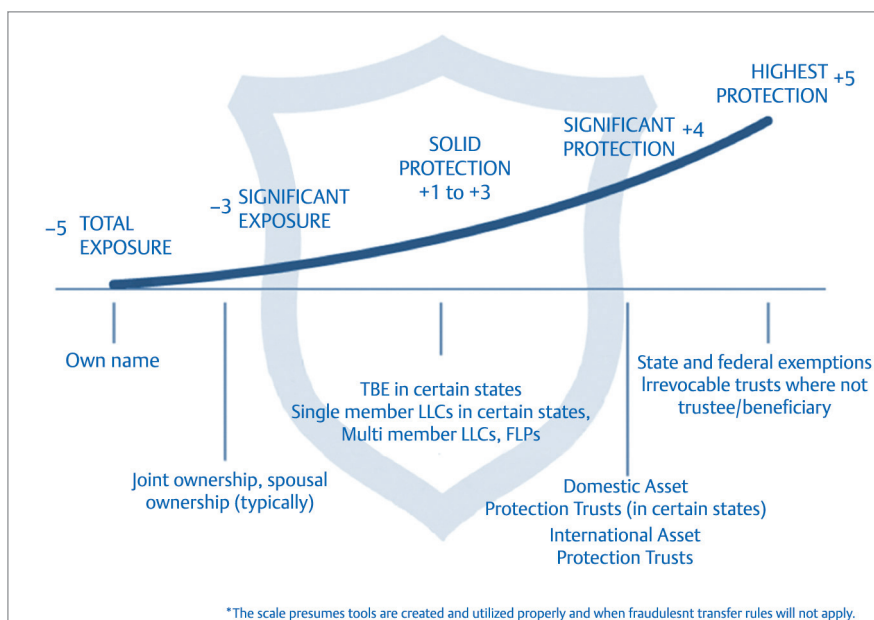


Fig. 23.1 Scale of asset protection.

creditor attachment. Such exempt assets are the best asset protection tools for the following reasons:

1. **No legal/accounting fees:** The legal tools in the middle of the scale typically involve initial and ongoing legal fees, state fees, accounting fees, and even additional taxes. Exempt assets do not have these costs and also afford better protection.
2. **No loss of ownership or control:** Many legal tools, when used properly, may require giving up some level of ownership or control to family members or even third-party trustees. By using exempt assets, you can own and access the asset at any time while enjoying the highest (+5) level of protection.
3. **Superior protection:** The legal tools explained below offer protection that ranges from “+1” to “+5”. Exempt assets always enjoy the top (+5) protection up to their exempt amount.

State Exempt Assets

Which assets are exempt and thereby at the top (+5) level of the scale? Every state is different, so we will focus on the three most common state exemptions here. Feel free to contact us at mandell@ojmgroup.com to learn more about the exemptions in your state.

Qualified Retirement Plans and Individual Retirement Accounts

Most, but not all, states have significant (+5) exemptions for qualified retirement plans (QRPs) and individual retirement accounts (IRAs). Some states only protect a certain amount in such asset classes or protect qualified plans more significantly than they do IRAs. It is essential that a surgeon understand the exemptions for such assets in their state and build wealth accordingly.

Primary Residence: Homestead

Many surgeons consider the home to be the family's most valuable asset. Perhaps you have previously heard the term *homestead* and assumed that you could never lose your home to bad debts or other liabilities because of this homestead protection. The reality is that few states provide a total (+5) shield for the home.

Most states only protect between \$10,000 and \$60,000 of the homestead's equity. Some states, such as New Jersey, provide no protection, while other states, such as Florida and Texas, generally provide unlimited protection for equity (with some geographic restrictions). Each state has specific requirements for claiming homestead status. Your asset protection advisor can show you how to comply with the formalities in your state.

Life Insurance

All 50 states have laws that protect varying amounts of life insurance. For example:

- Many states shield the policy death benefits from the creditors of the policyholder. Some also protect against the beneficiary's creditors.
- Many states protect the policy death benefits only if the policy beneficiaries are the policyholder's spouse, children, or other dependents.
- Some states protect a policy's cash surrender value in addition to the policy death benefits. This can be the most valuable exemption opportunity.

Quasi-Exemption: Tenancy by the Entirety

Tenancy by the entirety (TBE) is not a "+5" exempt asset, but it is a state law-controlled form of joint ownership that can provide total protection against claims against one spouse. TBE is available in about 20 states, although its effectiveness is diminishing. In some of these states, TBE only protects real estate; in some states both real estate and personal property (like bank accounts) can be effectively shielded by TBE. In those states that protect it, assets held in TBE cannot be taken by a party with a claim against only one spouse. These assets are immune to such a claim.

While this is a very powerful benefit, there are some risks with TBE, including the following:

1. **Joint claim risk:** TBE provides no shield whatsoever against joint risks, including lawsuits that arise from your jointly-owned real estate or acts of minor children.
2. **Divorce risk:** If you rely on TBE for protection and you get divorced before or during the lawsuit, you lose all protections from TBE.
3. **Survivor risk:** If you rely on TBE for protection and one spouse dies before or during the lawsuit, you lose all protections from TBE.

23.1.12 Beyond Exempt Assets: Family Limited Partnerships and Limited Liability Companies

Most plastic surgeons will need to go beyond exempt assets (or TBE) to shield most of their wealth. After exempt assets, the most popular tools to shield assets from potential claims against the surgeon personally are family limited partnerships (FLPs) and limited liability companies (LLCs). If someone successfully sues a surgeon, the claimant will not be able to get to the assets in an FLP or LLC, if established properly (with the right language in the documents) *and* maintained properly. In fact, the law normally

allows for only one remedy in such a situation: a *charging order* against that surgeon's interest in the FLP or LLC. The charging order is something a creditor can be granted by a court against a debtor's interest in an FLP or LLC. Essentially, this order allows the creditor to get distributions.

In other words, the creditor must legally be paid any distributions that would have been paid to the debtor, but they cannot force any distributions to be disbursed. In fact, the charging order neither:

- Gives the creditor FLP/LLC management rights.
- Gives the creditor FLP/LLC voting rights.
- Forces the FLP general partner or LLC manager to pay out any distributions to partners/members.

In other words, despite the charging order, you remain the general partner of your FLP (or managing member/manager of the LLC). You make all decisions about whether the FLP/LLC buys assets, distributes earnings to its partners or members, shifts ownership interests, and so forth. Judgment creditors cannot vote you out because they cannot vote your shares. Thus, even after creditors have a judgment against you, you still make all decisions concerning the FLP/LLC, including whether to pay distributions to the owners. This puts you in a position to negotiate with the creditor, often settling for pennies on the dollar. Because FLPs and LLCs put you in such a powerful negotiating position, while also maintaining control, we consider these in the “+2” range on the scale.

How to Use FLPs and LLCs

You can own virtually any asset through FLPs and LLCs. Plastic surgeons may own land, rental properties, the practice office, and other real estate in LLCs. In addition, such entities can own other practice assets, such as equipment (and then lease it back to the practice), or even family assets like second homes, securities portfolios, boats, or planes. As with any legal tool, following the adage “do not put all of your eggs in one basket” certainly applies to LLCs and FLPs. Many surgeons may end up with more than one such entity, to separate and protect key practice and personal assets.

23.1.13 Using Trusts to Protect Assets

Since many surgeons use trusts as part of their estate planning at some point in their career, here are some trust vehicles that can be used for protection.

Revocable Living Trusts: Illusory Asset Protection

Revocable living trusts, also called “family trusts,” allow the grantor (person who sets up the trust) the flexibility to make changes to the trust in the future. This is why they are called “revocable.” Because of this, however, living trusts provide absolutely no asset protection. While revocability and flexibility are valuable characteristics for estate planning purposes, these characteristics render the revocable trust moot for asset protection purposes.

Irrevocable Trusts: The Asset Protectors

While revocable trusts offer no asset protection, irrevocable trusts are outstanding for this purpose. Once you establish an irrevocable trust, you forever abandon the ability to undo the trust and reclaim property transferred to the trust. With an irrevocable trust, you lose both control of the trust assets and ownership.

For many plastic surgeons considering asset protection planning, an irrevocable trust may be too harsh a medicine to utilize. In essence, you have to give away the asset (at least most of it, even if it is to family members) in order to protect it. Contrast that to the FLP and LLC, where you can maintain control and ownership, which is also true for top-protectors exempt assets and TBE. If estate planning is also a high-level concern, then such trusts become more attractive; there are many to consider, with acronyms like QPRT, GRAT, GRUT, and CRT.

Domestic Asset Protection Trusts

Domestic asset protection trusts (DAPTs) are unique irrevocable trusts in which you can be both the grantor (establishing the trust) and a beneficiary of the trust. When there is no lawsuit concern, you can access the trust assets as beneficiary—but if you have lawsuit claimants after you, the trust can be written so that the trustee cannot make distributions to you, as you are “under duress.”

A DAPT can allow you both access to the trust assets when the coast is clear and protection when lawsuits and creditors are lurking, so it can be very attractive for clients who live and practice in a state with DAPT trust legislation. In such states, a DAPT is at least a “+4” tool. The only reservation is that these statutes are relatively new (many less than 10 years old) so they have not been tested like older state exemption statutes. Some surgeons may be advised to consider using a DAPT in a foreign state if their home state does not allow DAPTs, but there may be significant risk to this approach. Please contact us at mandell@ojmgroup.com if you are considering such a strategy.

23.1.14 Special Topic: Divorce Protection

The most common threat to a plastic surgeon’s financial security may be divorce, and the most effective time for planning is before the marriage. Transfers made once the marriage has begun will be looked at extremely skeptically by the courts (recall the fraudulent transfer laws referenced earlier).

Community Property States

Many of the country’s western states have community property law which generally stipulates that, if there is no valid pre- or postmarital agreement, the court will equally divide any property acquired during the marriage, other than inheritances or gifts to one spouse. Even the appreciation of one spouse’s separate property can be divided if the other spouse expended effort on that property during the marriage, and the property appreciated concurrent or subsequent to the effort expended.

Equitable Distribution States

Noncommunity property states are called *equitable distribution* states because courts in these states have total discretion to divide the property equitably or fairly. The court will normally consider several factors in deciding what is “equitable,” including the length of the marriage, the age and conduct of the parties, and the present earnings of each spouse, along with future earning potential. The danger of equitable divorces is that courts often distribute both nonmarital assets (those acquired before the marriage) and marital assets (those acquired during marriage), to create a fair arrangement. Consequently, courts often split up property in ways that the ex-spouses never wanted or expected.

The Prenup

A premarital agreement (aka prenuptial agreement, premarital contract, etc.) is the foundation of any protection against losing assets in a divorce. A premarital agreement is a written contract between the spouses, specifying the division of property and income upon divorce, including disposition of specific personal property. Each state has stringent requirements as to the validity of such agreements, and surgeons should seek guidance from experienced family law counsel.

23.2 Act II: Two Common Mistakes Plastic Surgeons Make with Their Finances and How to Avoid Them

“The investor’s chief problem—and even his worst enemy—is likely to be himself.”
—Benjamin Graham, Professor, Economist, and the father of value investing

23.2.1 Being Human: Succumbing to Fear or Greed

Many plastic surgeons will suffer from the same failings that most human investors must guard against: the pull of fear and greed.

Most investors can hurt themselves and their financial goals by succumbing to fear and greed. Let us briefly examine some of the data.

Why Market Timing Fails: The Data on Individual Investor Behavior

One of the most common symptoms of fear/greed investing is attempting to time the market. This can be driven by greed (“The market is cranking...time for me to put all my cash in/move from a balanced portfolio to all stocks”) or fear (“The market is falling off a cliff, I need to get out/go to cash/sell”). Individual investors get crushed in the long run when they try to time the market.

Dalbar Study

The Quantitative Analysis of Investor Behavior study is generally known as the Dalbar study.¹ Dalbar, Inc. is a well-known firm that evaluates, audits, and rates business practices of investment companies, registered investment advisors (RIAs), insurance carriers, and other financial professionals.

Their study on investor behavior has been published every year since 1991. The main objective as stated by the researchers themselves is “to improve the performance of independent investors and investment advisors by managing behaviors that cause investors to act imprudently.” The study attempts to provide some guidance on how and where investors’ behavior can be improved.

According to the 2018 release of the Dalbar study, the average equity mutual fund investor underperformed the S&P 500 by a margin of 5.04%. While the broader market losses of -4.38%, the average equity investor was down -9.42%. In 2018, the 20-year annualized S&P 500 return was 5.62% while the 20-year annualized return for the average equity investor was only 3.88%, a gap of 1.74% annualized.

The Dalbar’s data suggests that behavioral factors (outlined in the following text) cause most investors’ greed/fear reactions to kick in, leading to a *cycle of loss* that starts when the investor abandons their plan (if they have one) and gets out of the market at the worst possible time, followed by a period of remorse as the market recovers. The investor then reenters when the news media indicates improvement in the market. The study found that “investment results are more dependent on investor behavior than on fund performance.”

The Dalbar study has shown over 25+ years that individual investors often underperform their selected investments based on emotions and human behavior, leading to what we call the *behavior gap*.

Other studies have attempted to quantify how much the investor behavior typically costs. Morningstar, which provides investment research to professional investment advisors and the general public, also researches investor behavior. After monitoring mutual fund investors’ cash flow for 10 years, they used investor returns to determine the total return for the average investor between 2000 and 2009 was 1.68%, compared with 3.18% for the average fund itself.² Investors lost over 47% of the fund performance due to their market timing decisions. In other words, an investor who did not try to time the market, but stayed in for the highs and lows, performed nearly 94% better than those who tried to time it. Morningstar concluded that most investors read too much into *recent* performance (bias), letting fear and greed influence their decisions and making bad situations worse.

Missing Only a Few Days Can Have a HUGE Impact

If you accept that market timing does not work and that it will cost you significantly over the long run, the question then becomes: How much?

Morningstar studied the impact of missing the best trading days in the S&P 500 over a 20-year time frame spanning from 1994 to 2013. The results showed that missing only 20 of the best days—or 1 trading day every year—would have cut an annualized return from 9.2 to 3.0%, a loss of two-thirds of an investment return.³ This drastic performance deviation could result from being out of the stock market for a *mere 1 day per year*.

23.2.2 Bad Advice: Failing to Get Quality, Unconflicted Investment Advice

Beyond succumbing to the basic emotions of fear and greed, the second leading mistake surgeon investors make regarding their finances is failing to get quality, unconflicted investment advice.

The abbreviated discussion of the most popular options for investment advice follows below. For a more comprehensive discussion of all options, please contact the author for a free copy of the book *Wealth Management Made Simple*.

Option 1: Do-It-Yourself

Definition

An individual investor who builds a portfolio and selects their own individual investments without the assistance of a professional advisor.

Why Would One Choose to Do It Yourself?

To reduce expenses and self-educate.

Reducing fees is nothing to scoff at—fee drag can make a difference on overall performance of your investments. It is imperative that, if you choose an advisor, you understand how they are compensated and how this will affect your planning.

It is certainly possible to manage your own wealth and achieve success in the long run, but in most cases, the typical *do-it-yourselfers* are prone to bias, inconsistent attention, and other obstacles that hinder their long-term success, as described before. Objectivity is very difficult. Will you succumb to greed or fear? Perhaps 98% of the time, not...but the 2% is where you can do irreversible damage to your long-term plan (just ask those older plastic surgeons, close to retirement, who went to cash in 2009 and waited years until they believed it was safe to invest again).

Why Not Do It Yourself?

Investing well takes time, and there is an opportunity cost of professional time. Every hour spent researching stocks, evaluating portfolio risk, trading, waiting on hold to speak with your discount broker, or communicating with your tax advisor or attorney regarding your investments is time you are not seeing patients, building the practice as a business, doing the activities you love, spending time with your family, etc. Also, while plastic surgeons may be experts in their field, how much time do they typically have after the clinical and business demands of their practices, family obligations, and sleep to dedicate to this important task?

A professional advisor has access to the best technology and the benefit of scalability; a do-it-yourselfer does not. Trading, rebalancing, tax analysis, and other tasks can be extremely time-consuming without the benefit of leading technologies. Do-it-yourselfers may be locked out of private equity, real estate investment trusts, and other ancillary investment opportunities that come across the desk of professional investment firms for review.

Theoretically, no one has a greater interest than you in protecting and looking after your investments. However, your personal interest in protecting and looking after your investments may be the single greatest factor working *against* your investment performance. Most investors are risk-averse, biased creatures prone to putting too much

credence into noise, trends, and herd mentality. In the legal field, there is an old saying (often attributed to Abraham Lincoln): “An attorney who represents himself has a fool for a client.” In many cases, this adage also applies to finance.

Option 2: Automated Investment Management (Robo-Advisors)

Definition

A *Robo-Advisor* (Robo) is an online, automated algorithm-based portfolio management/investing service provided with little or no human interaction.

Why Would an Investor Use a Robo?

Robos are typically low cost and have low account minimums, so they attract do-it-yourself clients and younger clients who are just starting to save.

Why Elect against Using a Robo?

Planning is generally not customizable for high net worth individuals/families with complex planning needs, like most plastic surgeons. While a handful of Robos are experimenting with offering a team of customer service representatives, the phone representative may be able to address basic questions, but they do not currently provide traditional financial advice. Neither do they provide sophisticated taxation; asset protection; retirement, education, insurance, or estate planning services. Furthermore, nobody knows how this technology will perform during a bear market.

Most of the Robo services today only allow for cash transfers and deposits and are not capable of account transfers that include established positions. This model can work for beginning investors, but long-term investors will be unable to participate, based on holding quality investments currently and large capital gains. Many of the current products being offered limit the types of accounts that can be created and have numerous restrictions, such as the inability to create trust accounts, accounts for LLCs or FLPs, which may not allow for asset protection or estate planning.

Perhaps most importantly, Robos require large cash positions, which can be a drag on performance. Cash requirements provide an opportunity for the Robos to generate revenue from your assets that are not invested. While these costs may not be substantial, they are a hidden expense that a nonastute investor may not recognize.

Option 3: Brokers

If you choose to work with a professional advisor, an investor's first choice may be a broker dealer and or bank-based advisor. Brokers and banks tend to be popular because they are the largest corporations with the most marketing.

A broker dealer is generally a person or firm in the business of buying and selling securities, operating as both a broker and a dealer, depending on the transaction. Here are some well-known examples of such firms:

- *National/global broker dealers* include Merrill Lynch, Morgan Stanley, and UBS.
- *Regional brokers* include firms like Raymond James and Edward Jones.

- *Bank-based advisors* are affiliated with large banks like Wells Fargo and Bank of America; they usually refer to themselves as “financial planners” and/or “financial consultants.”
- *Independent broker-dealers* run their shops under their own names but are generally affiliated with larger corporations and sell products from outside sources.

We tend to lump these types of firms into the same category because all of them share the following fundamental component generally—they *are not fiduciaries and are required only to abide by the suitability standard* (more information is provided in the following text).

Definition

A broker (also known as a registered representative) executes security trades for a commission or fee. The broker or bank representative is employed by the firm holding your assets (also referred to as a “custodian”). The term “broker-dealer” is used in U.S. securities regulation parlance to describe stock brokerages because most of them act as both agents and principals. A brokerage acts as a broker (or agent) when it executes orders on behalf of clients, whereas it acts as a dealer (or principal) when it trades for its own account.

Why Would an Investor Use a Broker?

Many individuals have a perception that value is tied to the size of the firm. Some of the benefits of working with some of the world’s largest broker-dealers are the tremendous research capabilities, unique investment offerings, and the convenience of branch offices throughout the world.

Why Elect against Using a Bank Representative or Broker?

The top reason is the conflict of interest present in a relationship where the compensation of the individual making recommendations is based on the product he or she uses for the investor.

A lack of transparency in the fee-based products also means it is difficult for an investor utilizing this type of relationship to understand what they are paying. Also, the broker’s “suitability” standard is significantly weaker, from a client’s perspective, than the higher “fiduciary” standard, discussed further in the subsequent text.

How Do You Know if You Are Working with a Broker?

See the “four questions to ask” later in this chapter. Most firms have realized the negative connotation that the name *broker* implies and have begun calling members of their sales force *financial advisors*.

Broker’s Suitability Standard

As we have referenced before, a broker has a lower standard of duty, called the “suitability standard.” This means the broker does not need to act in the best interests of the underlying customer. Instead, their actions must only be “suitable” for the client.

Instead of having to place his or her interests below those of the client, the suitability standard only details that the broker-dealer must reasonably believe that any recommendations made are suitable for clients, in terms of the client's financial needs, objectives, and unique circumstances at the time of the interaction. *A key distinction in terms of loyalty is also important, in that a broker's duty is to the broker-dealer he or she works for, not necessarily the client served.*

Most brokers even today have a very convoluted fee structure for their clients. In a time where clients are demanding transparency and lower-cost options, you will still see sales loads on mutual funds, trading commissions, as well as many account service fees.

Option 4: Registered Investment Advisors

Definition

A registered investment advisor (RIA) is defined by The Investment Advisors Act of 1940 as a "person or firm that, for compensation, is engaged in the act of providing advice, making recommendations, issuing reports or furnishing analyses on securities, either directly or through publications." *An investment advisor has a fiduciary duty to his or her clients, which means that he or she has a fundamental obligation to provide suitable investment advice and always act in the clients' best interests.*

Why Would an Investor Use an RIA?

An RIA must adhere to a *fiduciary standard* of care laid out in the U.S. Investment Advisors Act of 1940, requiring investment advisors to act and serve a client's best interests with the intent to eliminate, or at least expose, all potential conflicts of interest that might incline an investment advisor, consciously or unconsciously, to render advice that was not in the best interest of the advisor's clients.

► Fig. 23.2 is helpful in this context. For a fiduciary, the client is at the center of the relationship; all advice must be in the client's best interest. However, for an advisor who must satisfy only the suitability standard—the product is at the center. It does not matter whether the product fits or procurement is in the client's best interest as long as the product was seemingly suitable at the time of sale and/or advice.

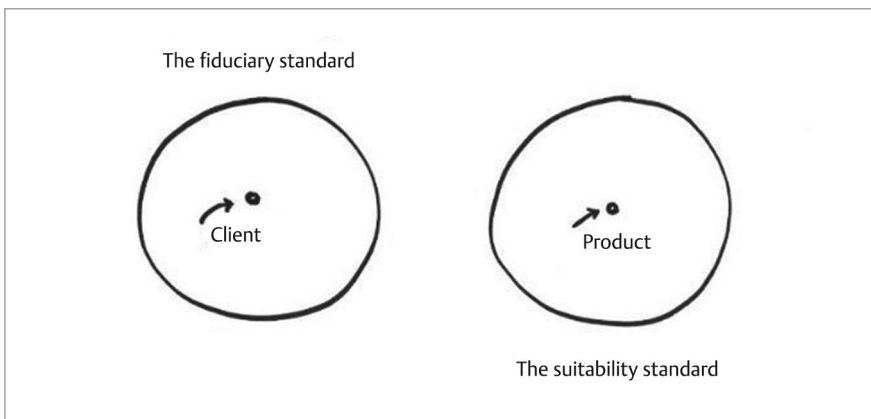


Fig. 23.2 The fiduciary versus suitability standard.

1. **Independence:** Independent RIAs are not tied to any particular family of fund or investment products, so whether you need help with retirement planning, a tax situation, estate planning, or managing assets at multiple places, independent advisors have the freedom to choose from a wide range of investment options to tailor their advice based on what is best for you.
2. **Independent custodians:** RIAs use independent custodians to hold clients' assets, including some of the world's largest custodians such as Schwab, TD, and Fidelity. For many investors, this provides a reassuring system of checks and balances because your money is not held by the same person who advises you about how to invest.
3. **A simple fee structure (transparency):** RIAs typically charge a fee based on a percentage of assets managed. This structure is simple, transparent, and easy to understand. It also gives your advisor an incentive to help grow your assets. When you succeed, your advisor succeeds.

Is Your Advisor Working for You? Four Important Questions May Give You the Answer

In order to get unbiased quality investment management, the following four questions can be helpful. A higher level of transparency will increase your trust level, and trust is the most important component of the advisor–advisee relationship. The following questions consider transparency and increasing the level of trust in the relationship.

Question 1: Does your advisor owe you a fiduciary duty as a client, or are they held only to a “suitability” standard?

This may be the most important question of all. For those not in the industry, this may seem like a subtle difference, but the result can have a substantial impact on the client.

Example

Client A contacts his broker and expresses an interest in investing \$50,000 in U.S. growth stocks. The broker invests the client assets in Fund XYZ, which charges a sales load of 5.75% with operating expenses of 0.68% annually. The client will immediately pay a one-time fee of \$2875 on the trade on top of the recurring fund-management fee. In this case, the suitability standard has been met. Client B contacts his RIA with the same request. The investment advisor purchases an ETF with a gross expense ratio of 0.18% and pays a commission of \$8.95 on the trade. This client pays his RIA a management fee of 1% of the assets, which equates to \$500 per year on \$50,000. The advisor has met the fiduciary standard. In this very realistic example, the front-loaded fees paid by Client A would require a commitment of approximately 9 years to this fund family before that commission is equal to the sum of advisory fees paid by Client B.

Question 2: Can your advisor provide a detailed explanation of how they are compensated?

Do your advisors receive commissions on any of the investments they will be recommending? Beyond commissions, compensation can come from sales charges on mutual funds or from a higher operating expense on a specific class of funds.

Private equities, structured notes, hedge funds, and nontraded REITs can offer various fees arrangements that may not be transparent. These investments may have a higher point of entry for an investor under the brokerage model in order to compensate the salesperson facilitating the transaction.

An RIA operating under the fiduciary standard may be able to offer the same investment at a lower cost simply because they are not taking a cut before your money goes to work for you.

Example

Client A is approached by his broker to invest in a nonpublicly traded real estate investment trust. The client sends in a check for \$100,000, and the security is priced at \$10 per share, so the client receives 10,000 shares. The broker receives a 7% commission from the real estate investment trust sponsor. Client B is approached by his RIA to invest \$100,000 in the same privately held REIT. The advisor charges a 1% management fee and does not accept compensation from the REIT sponsor. In this scenario, the commission is returned to the RIA client in the form of a reduced purchase price for the shares. Client B receives a discounted price of \$9.30 from the sponsor and is able to purchase 10,752 shares of the same REIT with his \$100,000 investment. Client A would have to hold the investment for approximately 7 years before his 7% commission matches the sum of fees paid by Client B to his advisor.

Question 3: Does your advisor's firm make money in other ways on your individual investments?

Request clarification on the ways that your advisor's firm may receive financial benefit from the securities you own in your portfolio. As an example, mutual funds commonly offer revenue-sharing arrangements with a broker-dealer firm. You will not see these fees appear as a line item on your statement because they will be hidden within the underlying investments. This lack of transparency will not only prevent a client from recognizing the true cost of the relationship, it may also create a bias in the research provided to the client's advisor. This scenario can apply to closed-end funds, exchange-traded notes, and other securities that will impact the bottom line of the firm, even if your investment representative may not receive additional compensation.

Example

Discount brokerage firm XYZ offers to manage client assets at a reduced cost of 0.80% of assets under management for Client A. The rep at XYZ purchases \$150,000 of retail shares of a bond fund with an operating expense of 0.75%. The rep does not receive compensation for choosing this fund; however, his firm (XYZ) receives revenue sharing directly from the fund company. An RIA for Client B charges 1% for his services and purchases institutional shares of the same fund with an operating expense of 0.46%. RIAs often have access to the lower cost shares offered by certain mutual fund families. In this scenario, the discount brokerage relationship results in a slightly higher cost to Client A because of hidden revenue sharing, despite the brokerage charging a lower management fee for their service.

Question 4: Does your advisor utilize proprietary securities?

Proprietary products are not always easily recognizable, as they can be branded under a different name. In-house products are not necessarily poor investments when the recommendation is made to a client. The problem arises when circumstances change, and it is no longer in a client's best interest to continue to own the underlying security. Will the in-house research recommend that their team of advisors liquidate the position in each of the firm's client accounts?

Example

XYZ firm runs a highly rated international bond fund with heavy exposure to European bonds. A team of brokers are looking out for their clients and contacts their research team to express concern about the recent drop in price of the investment. The research team of XYZ assures the brokers that they have adequately hedged the portfolio. A month later, concerned about the potential liability of a poorly performing investment, XYZ firm removes the fund from the institutional portfolios they are managing. The large redemptions create a significant drop in the price of the fund. A notification is then sent to the brokers explaining the firm's position after the price drop has occurred. The individual investor has faced substantial losses, while the firm has minimized the damage to their largest institutional clients.

23.3 Act III: Retirement Planning: Three Long-Term Planning and Preretirement Tactics to Consider

"By failing to prepare—you are preparing to fail."
—Benjamin Franklin

23.3.1 Treat Your Retirement Like a Patient: Have a Plan and Monitor It

Certainly, your secure financial health is important enough to treat with the care you would dedicate to a patient's physical health. A secure retirement requires a dynamic, flexible blueprint that outlines the steps you will take to reach your goals. Your plan should help you make sensible decisions about your money that can help you achieve your goals in life. It should not be a *set-it-and-forget-it* static plan, and it is not just about buying financial products.

Our vision of the best possible plan is one that provides you with evolving, well-coordinated wealth management that fits *your* needs. The plan should have an advocate/leader or *Financial Quarterback*, the person who will field your first call when you have a question concerning any financial matter.

Elements of a Comprehensive Wealth Management Plan

The elements of your plan may differ from someone else's. In fact, your specific circumstances (age, income, goals, etc.) will often dictate which elements should be emphasized. A sound plan involves more than saving, investing, and rebalancing. If you want a

plan that is truly comprehensive, you want to consider additional sophisticated strategies as you begin to accumulate wealth.

Generally, the elements of a sound wealth management plan should include:

1. Investment planning
2. Asset protection planning
3. Tax planning
4. Insurance planning
5. Education planning
6. Financial modeling/retirement projections
7. Estate planning

Further, wealth management planning will help you:

- Categorize your risk appetite
- Put a number to your goals (what is achievable and what looks difficult)
- Map your current and future cash flows to your financial goals
- Map your existing assets to your financial goals
- Make a statement of your net worth
- Look at the adequacy of your insurance
- Shield your assets from potential lawsuits
- Reduce taxes where possible today, potentially further increasing saving
- Employ *tax diversification* techniques
- Help you build a fund for your retirement
- Guide your investment portfolio

23.3.2 Build Flexibility throughout Your Plan

Many factors that may determine your ability to achieve your financial goals are beyond your control, so flexibility should be fundamental to your wealth management plan. Changes in income (or cash flow), changes in tax rates, market changes, potential changes in liability and in your personal health can all severely hinder you from reaching your goals.

Changes in Income and Cash Flow

These changes are important to consider in any wealth management plan. Most plastic surgeons cannot accurately predict their income in future years, so flexibility is essential.

You can incorporate income/cash flow flexibility into a plan by living below your means and prioritizing saving each month, quarter, and year. These two elements may combine to position you to weather any temporary or even long-term hits to income/cash flow.

Another tactic could be implementation of a savings vehicle that allows for uneven funding/investments. An example in the QRP arena would be defined contribution plans that allow flexibility in contributions each year [profit-sharing plans or 401(k) plans], as opposed to defined benefit plans that can require a certain level of funding or cause underfunding penalties (cash balance plans or pensions). Even more relevant would be to utilize nonqualified plans that may allow much higher contributions than defined contribution plans when income is high but can allow contributions to be skipped entirely in years where income wanes.

Another example would be in the asset class of permanent life insurance, discussed early in the chapter. Here, funding flexibility would favor a universal life policy, where funding is flexible year-to-year, over a whole life policy, where funding must occur each year.

Changes in Tax Rates

In 2017, the tax code was overhauled for the first time in 30+ years. Of course, that did not mean that tax rates had not changed since then—in fact, they changed with both prior presidential administrations (Obama, Bush II). Moreover, all of the personal tax changes passed in the 2017 Tax Act are scheduled to *sunset* back to the pre-act provisions in 2025. At least that is the law at the time of this writing. The bottom line is the tax code is always changing, and even *permanent* tax changes are only permanent until a future Congress and President change them again. See the charts in ►Fig. 23.3 that show the highest marginal federal income tax rate over time and the federal capital gains tax rate over time.

Examining these charts, it seems quite possible that we could see tax rates continue to rise even more over the long term, regardless of short-term changes that might be made in the next 4 to 8 years. Even if they return to mean rates of the 20th century, we

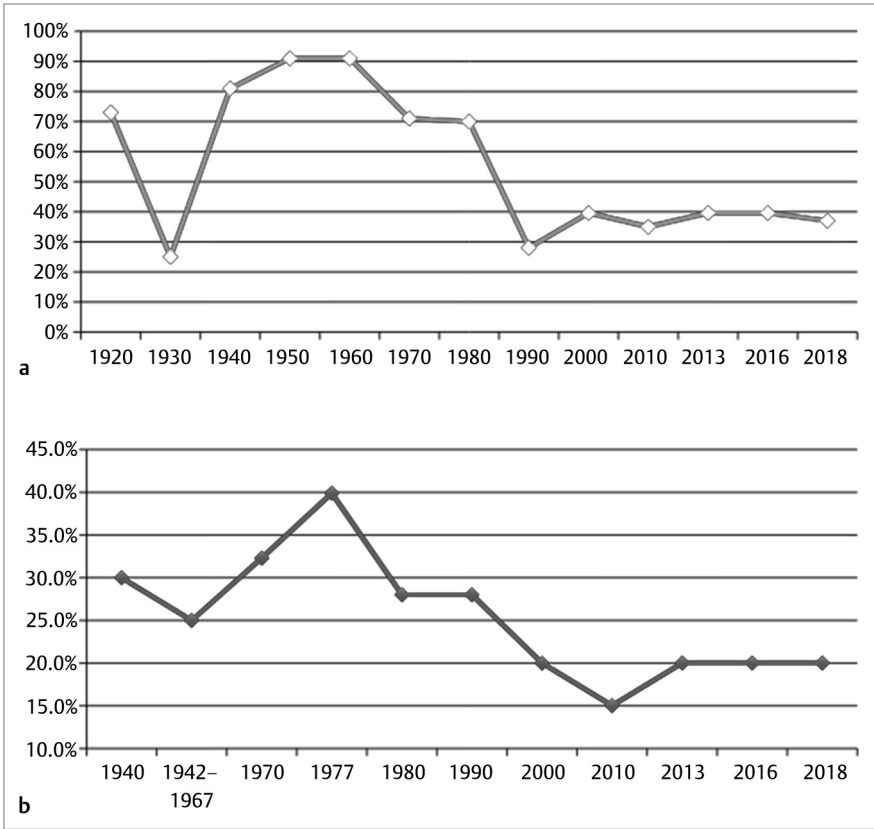


Fig. 23.3 (a) Federal income tax rates. (b) Federal capital gains tax rates.

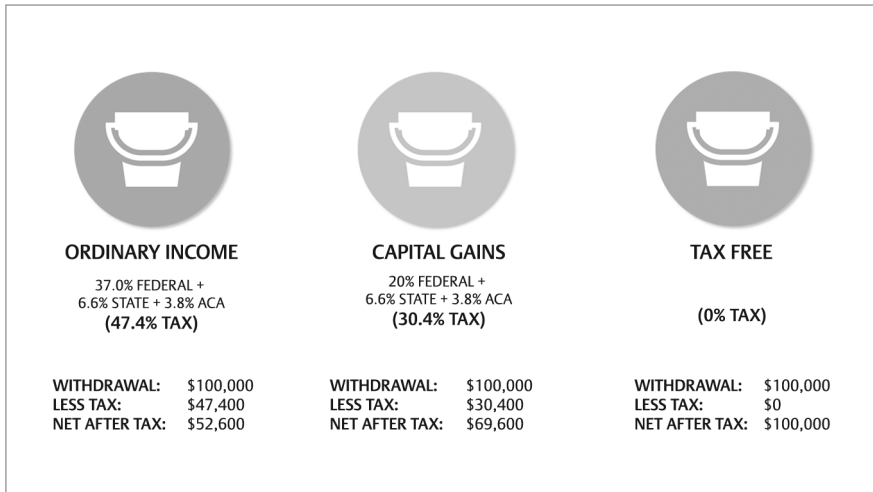


Fig. 23.4 Financial fitness: tax diversification.

will experience a sharp increase in tax rates. Thus, it makes sense to build in flexibility for this possibility.

A *tax diversification* approach can help alleviate some potential issues. Essentially, this means building up wealth in three *buckets*: (1) those subject to ordinary income tax rates upon distribution in retirement, (2) those subject to capital gains rates, and (3) those not subject to tax upon distribution. While most plans focus only on asset class diversification in the context of investing, it is crucial to also diversify your tax rate exposure. ► Fig. 23.4 illustrates the value of having differently taxed “buckets” to draw on when you reach retirement. As the retirement/distribution wealth phase may last for many years or decades, being diversified across such tax buckets puts you in a position of strength and gives you options of where to draw income, depending on the tax rates then in effect.

Changes in the “Market”

The reason we put the word “market” in quotes is that we mean more than a small sample of the stock market in the United States, such as the Dow 30 or even the S&P 500 indices. There is volatility in all securities, commodities, real estate, and other asset marketplaces in the United States and worldwide, and your portfolio and wealth management plan should accommodate this. Using a diversified portfolio can reduce overall risk and volatility, thereby giving you more flexibility to weather downturns in certain industries, asset classes, or even geographic regions.

Changes in Your Health

Health is the most important element of all. At one extreme, being in good health is a blessing and can allow you to continue to practice plastic surgery and create more wealth, as well as allow you to share it, enjoy it, and even give it away. On the other extreme, poor health can keep you from practicing, and can even lead to premature

death, which can have a devastating economic impact to a family. For these reasons, it is fundamental that a conservative wealth plan build flexibility around changes in health by securing the proper insurances to shield your ability to earn income (disability insurance and life insurance, as previously discussed). Long-term care insurance or riders that provide such coverage in life insurance policies can also be an important part of your plan, even for parents or in-laws.

23.3.3 Do Not Expect a Practice Exit without Advance Planning

Many plastic surgeons may not be properly preparing for a practice exit. Instead, they are avoiding the issue of a buyout or practice sale until a few years away from their planned retirement, when it is often too late to properly plan. As a result, there are few if any sale opportunities and even an internal transition to younger physicians is less lucrative than possible. To avoid this trap, consider the following strategies to implement at least 5 years, and in some cases much longer, before a planned exit.

- **Implement a systems-based practice:** Ask any business exit strategy consultant and they will tell you that it is crucial to systemize as many of the business operations as possible. When there are systems and written procedures for every element of the business other than the surgeon's medical decisions, it is that much more valuable to a potential buyer. An example is a written 30-point procedure for cleaning the bathroom. That type of systemization that should be part of the DNA of the practice for years, if not decades, before any potential exit.
- **Recruit a younger surgeon:** Because the practice of medicine is tightly controlled by regulations, many surgeons do not have the possibility of selling their practices to nonphysician investors. Plastic surgery practices are often sold internally to a younger surgeon who starts as an associate and then becomes a partner and the purchasing party. If this is the plan for your practice, or even a likely possibility, recruiting that physician and seeing if he or she is the right fit cannot be delayed until close to the planned exit of the senior surgeon. It may take 5, 7, 10 years or longer to find the right associate, train them properly, see that they can handle the patient load, and determine their financial ability to purchase the practice shares at a price you think is fair. In addition, getting them to buy in on the long-term plan is imperative. The formula should include the practice value, fair rent if the senior surgeon owns the building and will continue to after the sale, and other possible ancillary issues.
- **Design a compensation plan that fits the long-term plan:** Another tactic to consider, when recruiting and hiring a younger associate, is to implement a compensation package that ties to the long-term plan. For example, a nonqualified retirement plan could be designed so the funding grows tax beneficially and is owned by the practice for years to decades. If the associate hits their goals and stays for the duration, they vest into the plan. If they do not hit their goals, or leave the practice, the entire value stays with the practice (i.e., the senior surgeon). This may

not only motivate and incentivize the associate to stay for years but could also provide a significant part of their buyout fund if the timing of vesting coincides with the senior surgeon's exit and sale of the practice.

Three Tactics to Use as You Approach Retirement

To enable a successful retirement on your terms, three specific tactics should be employed in the years leading up to retirement: developing a budget, reviewing asset allocation, and designing a withdrawal strategy.

Developing a Budget for Retirement

It may seem like overly simplistic advice, but budgeting can either push a retirement plan to success or drive it to failure. While many believe a budget is simply an awareness of what one is spending, its actual purpose is to ensure that one lives within their means and that every dollar earned is deployed with strategic purpose. To accomplish this, one must have a written and managed budget, not a simple mental tally of expenditures.

Deciding how much to save today will depend greatly on how much one expects to spend during retirement. There is no way to determine that without attempting to project future expenses. One can accomplish this by creating various budgets based on assorted postretirement factors including location, size of home, hobbies, frequency of vacations, and other postretirement lifestyle expectations. These budget exercises provide a broader view of how effective a retirement savings plan can be based on various lifestyle decisions. Most helpful may be to model high, medium, and low projected retirement budgets.

Reviewing Asset Allocation

As surgeons age, they need to reallocate their assets into increasingly conservative investments to best limit their exposure to loss. Additionally, careful consideration must be made to properly limit downside risk, potentially through fixed income and alternative investments.

The idea of reallocating to more conservative assets can be troubling to those who are focused on maximizing returns because conservative investments tend to have limited upside potential. To understand why this move is often more beneficial than seeking higher returns in later life, a plastic surgeon needs only to be familiar with *sequence of returns risk*.

Sequence of returns risk is the danger that the timing of liquidation and withdrawal from a retirement account will coincide with a downturn in the market. If it does, then it effectively reduces the overall potential performance of the entire portfolio because a greater number of shares will need to be liquidated to get the income expected, thus leaving fewer shares in the portfolio to grow.

Sequence of returns risk may not be important during the accumulation phase when time horizons are long, but during the withdrawal phase it is one of the most critical factors in the overall success of a retirement plan, making it a higher priority than chasing returns.

Note

Sequence of returns risk revolves around the timing or sequence of a series of adverse investment returns. In the hypothetical example shown in ► Fig. 23.5, two portfolios, A and B, begin with \$100,000 each. Each aims to withdraw \$5,000 per year. Each experiences exactly the same returns over a 25-year period—only in inverse order—or “sequence.” Portfolio A has the bad luck of having a sequence of negative returns in its early years and is completely depleted by year 20. Portfolio B, in stark contrast, scores a few positive returns in its early years and ends up two decades later with more than double the assets with which it began.

SEQUENCE OF RETURNS RISK				
Hypothetical example				
Year	PORTFOLIO A		PORTFOLIO B	
	Return	Balance	Return	Balance
0		\$100,000		\$100,000
1	-15%	\$80,750	22%	\$115,900
2	-4%	\$72,720	8%	\$119,772
3	-10%	\$60,948	30%	\$149,204
4	8%	\$60,424	7%	\$154,298
5	12%	\$62,075	18%	\$176,171
6	10%	\$62,782	9%	\$186,577
7	-7%	\$53,737	28%	\$232,418
8	4%	\$50,687	14%	\$259,257
9	-12%	\$40,204	-9%	\$213,374
10	13%	\$39,781	16%	\$262,594
11	7%	\$37,216	-6%	\$242,138
12	-10%	\$28,994	17%	\$277,452
13	19%	\$28,553	19%	\$324,217
14	17%	\$27,557	-10%	\$287,296
15	-6%	\$21,204	7%	\$302,056
16	16%	\$18,796	13%	\$335,674
17	-9%	\$12,555	-12%	\$290,993
18	14%	\$8,612	4%	\$297,433
19	28%	\$4,624	-7%	\$271,962
20	9%	\$0	10%	\$293,658
21	18%	\$0	12%	\$323,297
22	7%	\$0	8%	\$343,761
23	30%	\$0	-10%	\$304,885
24	8%	\$0	-4%	\$287,890
25	22%	\$0	-15%	\$240,456
Arithmetic mean	6.8%		6.8%	
Standard deviation	12.8%		12.8%	
Compound growth rate	6%		6%	

Fig. 23.5 A hypothetical example showing sequence of returns risk in two portfolios.

The hypothetical example in ►Fig. 23.5 demonstrates two investors taking 5% of the initial principal. Portfolio A and B have the exact same mean return over a 25-year period with identical risk (i.e., standard deviation). Portfolio A ran out of money. Portfolio B experienced a 140% increase in value at the conclusion of the 25-year period. Why? Because of the sequence of the returns.

Your initial feeling may be complete despair, recognizing you have no ability to influence market returns in retirement. Neither investors nor advisors can control the timing of stock returns; however, they can control risk. By managing risk, you can manage the range of possible outcomes, ultimately increasing your odds of success.

Designing a Withdrawal Strategy

Selecting a Withdrawal Rate

A fundamental pitfall in static retirement plans is setting a withdrawal rate that is fixed over a retirement period. For many plastic surgeons, the retirement stage of life may be 20 years or more. In that time, investment yields may vary widely and both tax rates and personal spending habits could also change. Because of all these changing variables, it is essential that flexibility be built in to retirement planning, both in initial models (high, middle, low) and when reviewing the plan each year (or more frequently). Only by having flexible planning models and periodically adjusting them based on real-time results can one expect to follow a model that can endure throughout retirement, regardless of how many years, or decades, that retirement may last.

Making Room for Taxes

No one knows what tax rates will be upon retirement. This does not mean surgeons should ignore tax planning, but that they should model taxes as retirement expenses and design a strategy to minimize their effect. To do this, one must understand how taxes will impact withdrawals and liquidations. Having a plan that considers which withdrawals will trigger ordinary income taxes, which will incur capital gains, and which will realize no tax is essential. As discussed earlier in the chapter, a long-term tax diversification “bucket” strategy will prove extremely valuable in the distribution phase of retirement.

23.4 Conclusion

As we explained at the outset of this chapter, we faced a significant challenge in selecting a few key strategies to help plastic surgeons build and preserve their wealth. We chose to move chronologically, from how young surgeons can protect their financial foundation, to how those in practice can shield assets from potential liability and avoid fundamental investing mistakes, both in their own behavior and in finding the right professional advice. Finally, we focused on the number one financial goal for all physicians: getting to a financially secure retirement, both in terms of long-range planning and what to focus on when close to, and within, retirement.

When a Natural Disaster Strikes (By Francisco L. Canales)

"Are you evacuated?" my nurse texted in the early hours of October 9th, 2017. "???" I responded. I had been fast asleep in an Orlando hotel during the annual ASPS meeting. "Massive fire. Your neighborhood is gone." My wife, Heather Furnas, was enjoying the last few moments of her peaceful sleep. Within hours, we learned that a devastating wildfire had consumed over 5,300 homes in addition to ours. Everything we owned, including my car and two fireproof vaults was gone. All that was left were ashes. The conflagration had reached temperatures over 2000°F. Many people we knew had driven through flames, barely escaping with their lives.

As we stood in a FEMA line wearing N95 respirator masks 2 weeks later, we shared stories with our friends and neighbors. While still processing the shock of losing all our family photos and mementos, we went through the motions of replacing the paper essentials: passports, copies of wills and trusts, licenses, life insurance policies, and more. Heather and I tried to remember with our foggy, PTSD-rattled brains every lost item that demanded immediate replacement.

Soon we would find out what happens when a disaster of this magnitude hits. (Our disaster wasn't unique.) There is an immediate surge in home prices, labor costs, and all materials needed for rebuilding, such as lumber and steel. The price to rebuild a house skyrocketed, which meant that 97% of those who lost their homes were underinsured for replacing their homes. Updating your homeowner's insurance every year and with every upgrade seems obvious in the retrospect. How many of us wished we had not just paid the annual premium, but tried to figure out annually if that coverage was enough. (The insurance companies are under no obligation to help you.) Our rebuild estimates came in at over 200% of the initial cost of the house 12 years prior.

Other things we learned that we wish we'd known: Keep copies of all your important documents on the Cloud. Copies of passports, birth certificates, marriage licenses, wills, and trusts should all be accessible online if a disaster ever wipes out your household. Scan your precious photos from the pre-digital age, including wedding albums, photos of your children, and photos of your family's trips abroad. It is not sufficient to have them on a laptop; store those photos on the Cloud as well. All our laptops, desktop computers, hard drives, and flash drives burned in the fire. Our office was under threat for 2 weeks, and our tech support person rescued our servers and took them to his house for safe-keeping. Had they burned, we would have lost everything connected to work. (The Cloud is great for work as well.)

Disasters are not the time to test your memory—PTSD ravages it. Pick one day of the year to film every room in your house, every closet, every drawer, every kitchen cabinet, all the frames on the walls, and every item of any value. Insurance companies demand an item-by-item list of everything in your house before they will reimburse you for the contents. Reconstructing your possessions on memory alone is ineffective and will cost you both emotionally and financially, so take photos, or better yet take a video, and back up the files to the Cloud.

Do the same photographic documentation for your office. Check your insurance limits and make sure you have enough coverage to rebuild and replace all your furniture, every vial of Botox and filler, every laser, computer, and all the operating room equipment you own. Our office was in the evacuation zone for 3 weeks, and we were unable to do surgery, any patients, or generate income for 3 weeks. Make sure you carry insurance for business interruption and coverage for your monthly overhead.

We used to see reports of hurricanes, tornadoes, fires, and other natural disasters and feel shock and sadness and then go on with our day. We looked at them from afar, never imagining the day when we would be the ones in the news. For many of my friends who watched the national news, it was the first time they realized exactly where Santa Rosa, California was. It's kind of like being the subject of a case report, and it's best not be an interesting patient.

Be prepared. You never know when your hometown will be in the news.

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24 Taking Control of Your Life

Heather J. Furnas and Joshua M. Korman

Abstract

Increasing medical demands associated with an alphabet soup of acronyms (EHR, MACRA, MIPS, ICD-10), long work hours, work-life imbalance, and educational and practice debt combined with perfectionist tendencies can result in burnout. The result can be a cynical practitioner compromising his or her personal and professional lives with aggressive, angry behavior. Women plastic surgeons experience greater burnout rates than men, and solutions to issues impacting primarily women are offered. This chapter presents steps to recognize the symptoms and take concrete steps to take control of your life. To address the external causes, the chapter offers suggestions of information to present to superiors. Incidents of successful institutional change are offered as examples. By taking control of your life, you can feel better, be healthier, have better relationships with staff, and enjoy camaraderie with your colleagues.

Keywords: burnout, stress, maternity leave, EHR, Maslach Burnout Inventory, MBI, pregnancy, managing up, work life, work-life balance, gender gap, camaraderie, financial

24.1 Introduction

Work-life balance and physician burnout have been increasingly grabbing the spotlight in both the lay and the professional media. Medicine tends to attract women and men with perfectionist traits, since the others are weeded out by the rigorous premed curriculum and the MCAT examination. In medical school, we learn the consequences of a seemingly minor oversight. Although the “standard of care” in theory allows for human error, medicine practice is often practically intolerant of a mistake because the consequences can be dire. Did you make a breast reduction pedicle too narrow? The black nipple is unforgiving. So too can be the patient’s malpractice attorney.

Surgeons are trained to work long, hard hours. After their many years of training under conditions not found in other careers or even nonsurgical specialties, surgeons adapt and learn to accept a professional life that threatens to take over one’s personal life. Surgeons may work all day, be up on call during the night, and continue to work the next day as well. Such a work ethic is applauded, whereas devotion to one’s family or personal life is not. Call schedules in a small community with few other plastic surgeons may be frequent with no end in sight, and there is no thanks or gratitude for the personal sacrifice they make to support the hospital.

The adoption of technology, electronic health records (EHR), and increasing regulations have expanded the demands on physicians’ time. The practice of medicine has increasingly forced physicians to become data entry technicians, adding hours of burdensome drudgery to already long work weeks. At a time when *physicians* became *providers*, lumped in with and indistinguishable from other clinical workers, medical records became primarily vehicles to justify and maximize billing codes. The days of comprehensive hands-on physical exams and asking open-ended questions to uncover clues of distress have eroded away. Physicians are under constant pressure to complete their chart work in a timely manner, their faces glued to a computer screen. Hiring a scribe is yet another cost the private practitioner must bear in addition to paying for the EHR software.

Choosing the right code from the bloated ICD-10 with its nearly 70,000 diagnosis choices and hassles with payers add a further burden to a list that includes complex evaluation and management (E&M) coding requirements, Maintenance of Certification (MOC), Health Insurance Portability and Accountability Act (HIPAA) requirements, surgery center accreditation reporting, and other regulations. Software is often slow or inefficiently organized, swallowing physicians' time like a black hole. Electronic record keeping minimizes human touch and eye-to-eye contact, eroding the doctor-patient relationship. Linking patient satisfaction survey results to performance bonuses adds further stress, especially when the surveys may ask questions over which the physician has no control. Academic medicine places greater pressure on clinical productivity than in the past, adding to the stresses of reaching publication, grant-writing, and research goals. In private practice, physicians are stressed with running a business in addition to providing care to their patients. Business cycles have significant impact on plastic surgeons whose primary revenue comes from disposable incomes that can evaporate during hard economic times. Embezzlement by office personnel (see Chapter 10) and malpractice litigation (see Chapter 22) are also important causes of physician burnout.

24.2 Burnout: A Normal Response

These relentless demands and burdens can lead to physician burnout. On average, physicians work 10 hours a week more than other professionals, and nearly 40% work 60 or more hours.^{1,2} Courses, lectures, and articles often frame burnout as if it is the sufferer's fault and can be addressed with yoga, deep breathing, and meditation. That presumption ignores the natural impact of external factors beyond the sufferer's control. Burnout is a normal response to an abnormal situation.³

Occupational burnout is commonly measured with a survey developed by Christina Maslach et al in 1970s.⁴ According to the 22-question Maslach Burnout Inventory (MBI), burnout has three characteristics³:

- Emotional **exhaustion** from being overextended by work.
- Depersonalization manifested by experiencing a loss of compassion when caring for patients, possibly resulting in **cynicism**.
- Loss of personal accomplishment through a **sense of being ineffective** and losing competency. The physician feels his or her work has no purpose and is not helping anyone.

In a widely cited paper on burnout and work-life balance among physicians compared with the U.S. population, Shanafelt et al surveyed over 7,000 people and found that nearly half (46%) of physicians reported at least one symptom of burnout.² Interestingly, the authors found that higher education levels *reduced* the risk of burnout in nonmedical fields, in contrast to a medical degree, which *increased* the risk. The investigators concluded that the origins of burnout "are rooted in the environment and care delivery system rather than the personal characteristics of a few susceptible individuals."¹ In another study published in 2015, Shanafelt et al surveyed nearly 7,000 physicians and found over half (55%) of physicians reported burnout.⁵ Another survey of physicians published in 2016 found that half (49%) of respondents experienced burnout frequently or always.⁶ All three major studies found that about half of physicians are burned out, so it is no surprise that a mere 10% of doctors would recommend medicine as a career.⁷ In order to escape the factors contributing to burnout, physicians are increasingly lowering their patient load, working part-time, practicing concierge medicine, or leaving clinical medicine for administrative positions.

24.3 Impact on Patient Care

Burnout impacts more than just the physician. Patient care is also impacted, which is why burnout is attracting the public's attention. A one-point increase in depersonalization on the MBI is correlated with an increase of 11% in reporting a medical error.³ Lower patient satisfaction survey scores and malpractice lawsuits are also correlated with physician work dissatisfaction.^{3,8}

The role of EHR on physician burnout is significant. Despite low EHR user satisfaction rates, four out of five physicians spend significant time performing clerical tasks using EHR and computerized physician order entry (CPOE). College students apply to medical school to treat patients, not to check boxes, yet physicians spend 2 hours in front of a computer screen for every hour they are with a patient, more time than they spent on paper medical records. EHR have eroded physician productivity, and stolen facetime not only with patients but also with other health care workers.

Burned out colleagues who infest the environment with cynicism contribute to physician burnout.⁹ Physician isolation, a culture of physician toughness, top-down toxic cultures in health care organizations that leave physicians with little autonomy, and hospital appointment questions concerning any history of treatment for mental health issues also contribute to promoting burnout or leaving it unchecked.

Burnout impacts not only the medical environment, with an increase in errors and higher physician turnover, but also physicians' personal lives.^{3,9} Physicians refer to the time they spend completing their electronic charting at home as "pajama time."⁸ The consequences include divorces and relationship breakups, substance abuse, depression, and suicide. Physician turnover and lower work productivity resulting from burnout is costly to hospitals and other health care institutions.

Addressing factors in the workplace that lead to physician burnout is essential to improving patient safety and quality of care, maybe even more important in reducing medical errors than checklists, improving teamwork, and establishing work unit safety scores. In the 2015 survey by Shanafelt et al, 10% of the physicians with symptoms of burnout reported committing at least one major medical error during the previous 3 months.⁵ Physician burnout also influences quality of care, turnover rates, and patient satisfaction.

Burnout and medical errors independently double the likelihood that a physician considers suicide, contributing to a suicide death rate that is higher than that in other professions.^{9,10}

Physician burnout is associated with greater malpractice risk, an increase in disruptive behavior, more drug and alcohol abuse, higher divorce rates, and higher incidence of depression and suicide. The behavioral changes affect family, patients, staff, and the workplace. Institutions are taking an interest in reducing burnout to reduce medical errors and raise patient satisfaction ratings.⁴

24.4 Stress versus Burnout

Stress is not all bad. Some amount of stress motivates us to meet deadlines, master exam material, and rehearse for a presentation. When we finish our work and pass these deadlines, we can catch up on sleep and regain our energy and enthusiasm.⁴ We cross over into burnout when we can no longer recover, and we spiral downward.⁴

During training we learn to endure marathon hours with little sleep, exercise, or healthy nutrition. As surgeons, we are trained to power through exhaustion. To fight burnout, a first step is getting rest, exercise, nutritious food, and taking time to

recharge.⁴ Caring for those we love helps prevent the cynicism that develops with burnout. A career in surgery can cannibalize the time we need to nourish our personal relationships. Finding purpose from hobbies, family time, and other interests helps preserve our sense of self. As the late poet Mary Oliver famously asked, “What is it you plan to do with your one wild and precious life?”

Often we are blind to our cynicism and neglect people we love, especially because enduring stress is part of the surgical culture. We may be as unaware of it as a fish is of the water it swims in.

After recharging, the next step is to identify causes of stress⁴:

- Your scheduling template and patient volume requirements
- Electronic Health Records (EHR); Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); Children’s Health Insurance Program (CHIP); Merit-Based Incentive Payment System (MIPS); the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10)
- Support staff
- Superiors
- Compensation formula and other financial considerations
- Patient dissatisfaction and litigation
- Taking frequent call
- Difficulty getting call coverage
- Changes in health care
- Increasing regulations
- Time demands to attend meetings

Adding to these stresses are the holes in your training: surgeons learn all about surgery, but our residency programs offer little or no training in business or leadership, skills that facilitate success in our careers. Lacking these skills, we may struggle running a practice and leading our staff.

Drummond identifies four causes of burnout:

- The practice of medicine in general
- Your specific job
- Conditioning we go through in our medical education
- A struggle to find the time and energy for a personal life

24.4.1 The Practice of Medicine

As the rules change, physicians are impacted by EHR, MACRA, MIPS, ICD-10, and more.

24.4.2 Your Specific Job

The private practitioner must figure out how to hire staff, train, manage, fire, market, and control the overhead. An employee in a large practice or institution must navigate around bureaucracy.

24.4.3 Our Medical Education

Surgeons may not be born workaholics, but training conditions us to accept an unbalanced life. The many years of long hours condition us to accept workloads that crowd out our personal lives. Our personal lives tend to lose when they are placed in front of a physician’s two prime directives: (1) the patient comes first and (2) there is no room for

weakness. In Drummond's words, "The key to the depth of our brainwashing is the intensity and length of the education process we use to produce a board-certified physician."⁴ He has identified five characteristics that often emerge from our training⁴:

- **Workaholic:** We work hard and get angry when others do not work as hard.
- **Superhero:** We believe we should save everyone and get upset when we cannot.
- **Emotion-free:** We learn to be detached to carry out our jobs caring for patients.
- **Lone ranger:** We do things ourselves without asking for help from our team.
- **Perfectionist:** There is no room for error in patient care, and this perfectionism carries over to other aspects of our lives.

Unfortunately, what does not emerge from training is any sense of how to handle finances, which in the face of educational loans and delayed revenue generation puts additional pressure to perform in an area with no education or training.

24.4.4 Personal Life

Nurturing personal relationships, timing when to have children, infertility, raising children, getting exercise, paying off educational loans, and finding time for hobbies can all be challenging when we have been trained to put work first.

24.5 Symptoms of Burnout

Physicians experiencing burnout feel like they are on a treadmill that is speeding up. Even though they work harder, they feel like they can never catch up. They feel disillusioned by what their career has become, despite the idealism they started out with when first entered medical school to help people. While a physician experiences these feelings of hopelessness, others may observe disruptive behavior, a poor attitude, cynicism, and a loss of energy.

24.6 Possible Outcomes

Drummond describes four possible outcomes for a physician experiencing burnout:

- You recognize it, and you change your actions, habits, routines, and your relationship with your career. By doing these things, you recover.
- Burnout becomes a chronic condition.
- You experience a fallout, such as divorce, substance abuse, depression, or suicide.
- You change careers or retire.

24.7 Higher Burnout Rate among Women

A career in surgery impacts women uniquely. Based on a male model, surgical training programs are not designed to accommodate pregnancy, breastfeeding, and childcare. Even though women comprise a small majority of medical school classes, their numbers fall off in surgery training program applications, from a low of 15% (orthopaedic surgery) to a high of 36% (general surgery).¹¹ The high female faculty attrition rate has been found to result from male cronyism, a feeling of invisibility and isolation, the absence of effective mentors, few female role models, and a work culture that is incompatible with family life. Losing women from academic careers plays a role in female medical specialty choice; if women are well represented among residents and faculty, female medical students are more likely to choose a career in surgery.¹¹ Furthermore,

when women are nearly equally represented among residents, gender stereotyping disappears. Greater number of female surgeons increases their comfort level, supporting the theory that members of an underrepresented sex or race are seen as individuals rather than representatives of their group when they reach a critical mass of 35%. That comfort level fosters a sense of community, with the benefits of greater retention and lower levels of burnout.¹¹

Women desiring a family life are more likely to choose a nonsurgical career with a greater female representation. That self-selection along with the surgical culture may in part explain the gender differences on the personal and professional lives of male and female plastic surgeons. Compared with their male colleagues, the survey of American Society of Plastic Surgery (ASPS) members found that female plastic surgeons are less likely to feel recognized, respected, accepted, or included compared with men, and they were five times as likely to have experienced sexual harassment. Women respondents were significantly less likely than men to feel they could effectively negotiate a better salary, academic advancement, leadership position, and/or authorship. In their personal lives, women were twice as likely to be single as compared with men, and training and/or career significantly influenced the timing of marriage.¹¹

Women plastic surgeons differ significantly from men in the number of children they have. Reflecting the long years of training and the poor support of pregnancy for residents, women were significantly more likely than men to have experienced infertility, to have fewer children, and to have remained childless.^{12,13} Among those who had children, reflecting the struggle to achieve work–life balance, over twice as many women were dissatisfied with their level of involvement with their children compared with men.^{11,13}

24.8 Work–Life Balance

Physicians may feel they are in a bind. In his memoir, *When Breath Becomes Air*, Paul Kalanithi, states, “Putting lifestyle first is how you find a job—not a calling.” While answering a calling may work for the plastic surgeon with no children or one with a partner who takes full responsibility for domestic life, the changing gender roles along with the increasing demands placed on physicians contribute to making the noble life of the hands-on, priest-like doctor caring for three generations of patients an anachronism. Men and women have increasingly merged their roles, so that men are more likely to take on “life” roles and women are likely to take on “work” roles. The components of “life” include family, sleep, exercise, personal time, and social life.¹⁴

Given the work demands of a plastic surgeon, achieving work–life balance may at times be impossible, and this imbalance can result in loss of satisfaction in both work and life, mental health impairment, family conflict, and burnout.¹⁴ Factors associated with burnout include^{14,15}:

- Having work–life conflicts within the previous 3 weeks.
- Resolving the conflict in favor of work.
- Long work hours (the more hours worked, the greater the risk).

Achieving personal goals requires an investment of time, energy, and money,¹⁶ which may be in short supply. Furthermore, working harder, longer hours is typically rewarded, while taking time for one’s personal life, even getting pregnant and delivering during residency, can breed resentment in the workplace.^{12,17} Medical students frequently choose nonsurgical specialties because surgical career associates with irregular work schedules that leave no leisure time and little control on one’s workday.¹⁴

Female medical students are less likely to choose a surgical career because of the perception of greater work–life imbalance in surgery.¹¹ In a survey study of members of the ASPS, just under half the women were satisfied with their work–life balance, compared with two-thirds of men. Women were also less likely to feel that their stress level was manageable, that they got sufficient sleep, or that they pursued hobbies. Female plastic surgeons enter academic practice at the same rate as men, but their attrition rate is significantly higher, leaving a paucity of women as professors, chiefs, or chairs. Despite changing gender roles, women still typically take on more domestic responsibilities, including childcare and household chores, compared with men.¹⁴ Women's greater domestic responsibilities take time, resulting in lower publication rates compared with men.^{11,14} Addressing the factors that uniquely impact women, including gender bias, support of pregnancy and raising children, and adjusting academic expectations to allow for women with young children to advance their careers, will be important in closing the gender gap in perceived work–life imbalance.

24.9 The Role of Money in Burnout

Physicians do not like to talk about money, as it runs directly against the image of the caring doctor who cares deeply for the health of patients and welfare of people. Though many physicians in other specialties work hard to convince elected officials to be allowed to call themselves plastic surgeons, ironically, large numbers of plastic surgeons attempt to steer clear of the title. As the public often thinks of plastic surgeons as rich, greedy, and superficial, many within the specialty prefer to be known as craniofacial, hand, burn, reconstructive, or microsurgeons. These are generally not subspecialties for rural communities, and the cost of living can be quite high. Coupled with educational loans, and the lack of time and money to be a thoughtful and educated investor, it is not uncommon for financial stress to further contribute to burnout.

For the private practitioner whose revenue comes primarily from cosmetic surgery, downturns in the business cycle, embezzlement risk, and lack of diversification can have significant impact. During the breast implant crisis of 1991, the FDA removed silicone gel implants from the primary breast augmentation market. At the time many plastic surgery practices relied heavily on breast augmentation as their primary procedure, and following the huge loss of revenue, plastic surgeons sought refuge in academic and large group practices. During the economic recession that began in 2008, disposable incomes quickly turned into home foreclosures. Elective cosmetic surgery was no longer affordable, and some plastic surgeons had no choice but to become employees of large groups or retire and downsize. Private practitioners are also at constant risk of embezzlement by untrustworthy employees (see Chapter 10).

Though investment professionals stress the need for diversification and the need to *save for a rainy day*, it is not surprising that without proper financial education and training early on, money woes can contribute significantly to burnout.

24.10 Solutions to Burnout

Burnout will improve when the system contributing to the emotional pain is reformed. Failing to recognize that and instead prescribing healthy eating, meditating, and yoga, while beneficial, will not resolve the problem. Worse, pressuring physicians to change their own behavior without addressing the external causes imply that burnout is solely the result of the physician's failed internal coping skills. The high incidence of physician burnout will reduce when the external causes are recognized and addressed.⁸

24.10.1 Electronic Health Records

EHR software is sure to improve, especially when institutions universally recognize the consequences of requiring physicians to click a mouse hundreds or thousands of times during the workday. To reduce the time you spend with the mouse, spend time with a colleague with greater EHR skills than you, create templates filled with repeated information, learn and use quick keys and shortcuts, chart the bare minimum to fulfill medicolegal requirements, and use bullets—well-crafted sentences add no value as long as your content is understandable. Measure the impact of these changes by tracking outstanding charts, the time between your last patient and when you walk out of the door to go home, and the time you spend on EHR at home. These numbers should be dropping if your changes are making a difference.⁴

Perhaps in the future, EHR and electronic bills will be performed directly through artificial intelligence,¹⁸ but until then, spending time looking over the shoulder of a colleague with advanced EHR skills may help, as can shifting data entry duties to clinical staff, as well as hiring a scribe. The employed physician can present the data from studies establishing the negative impact of EHR on physician well-being and its association with reduced quality of care. After discussing the physician's own average daily time devoted to EHR, superiors may understand the financial benefits of hiring a scribe at a lower hourly cost to the institution.^{4,8}

24.10.2 Improving Physician Autonomy

The Mayo Clinic launched strategies to combat physician burnout, which lowered burnout rates from one-half to one-third of physicians. Topics they identified to help ameliorate physician stresses include organizational recognition that physician well-being is a high priority, considering the negative consequences of productivity-based pay, adopting work-hour flexibility for greater work-life balance, and providing resources for self-care and resilience.¹⁹

Solutions that have helped include leaving institutions with rigid schedules and treatment protocols for physician-owned groups, all for greater autonomy. In addition to promoting physician “self-compassion,”²⁰ institutions must also recognize that physicians must be free to seek mental health help without implying that such actions threaten hospital privileges. Dropping the questions that deter physicians from seeking the help they need would help physicians feel free to reach for help when they need it. The less the medical environment stigmatizes physician emotional vulnerability, the more physicians will themselves be able to acknowledge their emotional suffering and accept help.

24.10.3 Compassionate Leadership

Countering toxic institutional culture starts with effective leadership. Vivek Murthy, former U.S. Surgeon General, asserts that organizations should hire people based on their quality to treat others in a positive manner rather than their potential to win a Nobel Prize. In his words, “Kindness is spread more quickly than infectious diseases.”²⁰

24.10.4 Improving Collegiality

Physicians have lost the collegiality they used to have. Doctors' lounges in hospitals have become a thing of the past. Interactions with other physician colleagues, casual

conversations, discussion of cases, and sharing experiences have largely disappeared in many institutions. Interacting with colleagues less has exacerbated a physician's sense of isolation. Gathering places for physicians can foster a sense of community and support. Institutions may view this investment in physical space as an indirect investment in patient care. Plastic surgeons should view each other more as colleagues and less as competitors (both within academic centers and in private practice). For many years, Honolulu's competing plastic surgeons have met monthly to enjoy a meal together and discuss difficult patients. Outside of work, a group of friends to socialize beats any drug or antiaging supplement at combating burnout.¹

24.10.5 Wellness Officers

As hospitals grapple with the fallout of burnout, some are hiring “wellness officers” to develop a cultural shift. In addition to Tait Shanafelt, Chief Wellness Officer at Stanford, Dr. Jonathan Ripp fills that role at Mount Sinai Health System in New York, and Dr. David Rogers, a Pediatric Surgeon, serves at UAB Medicine in Birmingham, Alabama. Dr. Rogers notes that his hospital has a doctors' dining room, but the physicians say they have no time for lunch. He invites the doctors to fill out a Mayo Clinic Well-Being Index, which includes questions like: “During the past month, have you worried that your work is hardening you emotionally?” and “During the past month, have you often been bothered by feeling down, depressed, or hopeless?”⁸

24.10.6 Maternity, Breastfeeding, and Childcare Support

To allow women to enjoy the same reproductive options as men, our institutions will need to develop comprehensive parental support, including adequate leave, flexible scheduling through hiring plastic surgery coverage rather than burdening fellow residents with extra work, onsite 24-hour daycare, and accommodations for and support of breastfeeding. Maternity support during peak fertility years will lower health risks to both mother and infant and decrease age-related infertility.^{12,13,14}

Support of women's reproductive desires during their prime fertility years will improve the surgical culture and encourage female medical students to choose their specialty based on interest rather than avoidance of the surgical culture. Female role models and active mentorship can nurture and groom women for career success through career advice and introduction to opportunities. Recognizing the importance of work-life balance in minimizing burnout, particularly among women with families, will promote their professional success. Flexible schedules, including the option of part-time training over a longer period and the ability to work less than full-time, will promote greater retention of women with families.^{12,13}

24.10.7 Accepting that You Are Not Indispensable

The demands in medicine are limitless. As long as there are people, there will be someone needing care. The patient comes first. As research increasingly indicates that the burned out physician is more likely to commit errors and experience lower patient satisfaction scores, indirectly the best way to put patients first is to take care of ourselves. Learn to say no. Place personal life priorities high. Maintain hobbies and spend time with loved ones. Children grow up from birth to their 18th birthday in just 6,574 days.

24.10.8 Achieving Work–Life Balance

Work–life balance will require a cultural acceptance of the importance of family and leisure time across our specialty, our health care institutions, and society at large. The first step in reducing burnout is recognizing that many nonpatient-related demands, including burdensome call schedules, inefficient surgery and clinic schedules, demands of electronic record keeping and billing, financial burdens, and requirements to attend meetings and conform with time-consuming regulations, tear surgeons away from home. Supportive, nurturing leadership both in our institutions and our professional societies will be an important first step.

24.10.9 Communicate and Delegate

Whatever your work setting, analyze the steps throughout your day and look for inefficiencies. Develop questions to spark brainstorming, such as: Why are the rooms not always well-stocked on clinic days? Who can help fill out work-release and disability forms? What repeated in-person explanations can be videotaped for a patient education video library?⁴

Open up communication by holding monthly meetings. And do not cancel them. See Chapter 4 and Chapter 5 for information on how to run effective meetings. Survey the staff periodically about problems, suggestions, and questions. Digital surveys, such as SurveyMonkey, can allow anonymity. Put your issues and theirs on the agenda. Brainstorming during the meetings should result in action items assigned to individuals or teams. Every action item needs a deadline. Progress reports should be presented at upcoming meetings. A formal system of objectives and key results (OKRs) is described in Chapter 19.

Thank your staff for their specific individual accomplishments and efforts. We were not trained hearing a constant stream of thanks, so thanking others may not come naturally. Set reminders for yourself—your praise will work wonders in inspiring your staff.⁴

24.10.10 Managing Up

If you are employed, you probably have a boss. Use his or her preferred method of communication (email, text, in person, or phone) and the preferred style (bullet points, full reports, updates, or just final reports). Do not waste his or her time. Frame requests to align with your boss's priorities and goals. For example, if you ask for more block time, present the greater profits the department could anticipate. When you promote your boss's goals, he or she may be more receptive to helping you reach your goals.⁴

Building trust with your boss takes facetime, so set up regular meetings (monthly or at least quarterly). Ask what his or her goals are for the quarter and for the year, and find ways you can help. Do not complain, and do not mention a problem without suggesting a solution. End each meeting on a positive note to leave that lingering feeling.⁴

24.10.11 Institutional Relief

Relaxation techniques and deep breathing do not address EHR demands, the call schedule, short maternity leaves, and poor breastfeeding accommodations. The external stressors should be addressed through a dialogue with the organizational leadership.

Dike Drummond recommends an approach that utilizes a three-part physician engagement formula⁴:

1. *Educate the leadership about physician burnout.* There are a number of important resources to share with leadership that spell out steps developed by Drummond, Stanford, and the Mayo Clinic.^{1,4,19} As more organizations integrate similar programs, the resource list can be expected to grow. The Mayo Clinic and Stanford programs are described in the following text.
2. *Survey the medical staff about specific practice stressors.* Questions can include rating of career satisfaction, listing the top three stressors in a workday, and a description of the present work culture and the desired work culture. Other questions to ask include: Does someone at work care about you? Does anyone at work encourage your development? Have you received recognition for good work you have done?⁴
3. *Address the contributing factors with a physician-led burnout prevention working group.* The group develops a plan of action based on the survey results. Success depends on funding and administrative support. According to Drummond,⁴ work-life balance improves with:
 - Onsite exercise facilities and lunchtime walking groups.
 - Organization-centered social activities.
 - Participation in community charity events as an organization.
 - Developing a culture of care and support.

The Mayo Clinic and Stanford are two vanguards making changes to reduce physician burnout. Their programs are outlined next.

The Mayo Clinic

In addition to offering lactation rooms, childcare assistance, and concierge services, the Mayo Clinic developed a program to give physicians more control of their work environment. The solution, called Listen-Act-Develop, was developed by radiologist Stephen Swenson, MD, Medical Director of Leadership and Organizational Development at Mayo Clinic.¹⁹ The model is notable for a formal listening forum to hear from physicians as they discussed the most troubling features of their work, such as burdensome clerical work, process inefficiencies, and unnecessary lack of control of their schedules.

The Listen-Act-Develop model identified three factors promoting physician support¹⁹:

- **Choice:** Allowing physicians greater flexibility and control over their lives established the value of physician input. The new paradigm treated physicians as architects of the health care delivery model, rather than construction workers following someone else's blueprint.
- **Camaraderie and social connectedness:** Allowing time to socialize with colleagues and team members elevated spirits and improved collaboration. Seeing each other at a meeting or over a meal boosted camaraderie and lowered indicators of burnout. Even better, schedule monthly or quarterly get-togethers with competitors so they can become what they should be—colleagues.
- **Excellence:** Being part of something meaningful raises spirits. Organizational leaders established relationships with physicians that invited conversations and greater understanding of their perspective. Treating physicians as partners rather than as employees inspired greater effort. According to Dr. Swenson, "If [physicians] are treated as employees or cost centers, that is how they will behave."

Stanford Emergency Medicine Department

Five of every 10 doctors leave an academic medical faculty within years of joining, and four leave academics completely. To combat the burnout leading to attrition, Stanford's Emergency Medicine Department established a "time banking" program. To ease work-life conflicts, doctors were able to bank time spent doing the unrewarded work of mentoring, committee work, and covering colleagues' shifts. The banked time could be used toward work or home-related services, such as babysitting, grant writing help, dry cleaning pickup, handyman services, and web support.¹

The program was inspired by Phillip Pizzo, former Dean of the medical school, when he noticed that talented women physicians, including his daughter, were giving up promising research and career opportunities for family. He established a task force that found the established family-friendly policies, such as paid parental leave, sabbaticals, flexible scheduling options, and part-time work benefits, were being ignored. The task force hired a design firm to shadow doctors with cameras and speak with medical staff. Their conclusion was that the family-friendly policies were ignored because they violated Stanford's culture of achieving excellence through complete devotion to work. Taking advantage of the family-friendly policies risked jeopardizing one's reputation as a serious, dedicated worker.

The program resulted in jumps in job satisfaction, improved work-life balance, greater collegiality, and more research grant applications. They attracted more fellows and had no turnover. The time bank program also promises to improve the high attrition rate of women in academic medicine. Not only do women do more housework at home, they also spend more time at work performing unrewarded teaching, mentoring, and committee work at the expense of research time. When such work was rewarded by time banking, more men volunteered, allowing more women to concentrate on their research with the grant-writing assistance, courtesy of banked time. Job satisfaction jumped by 60%.

At a cost of 1% of the budget, the program was "extremely cost-effective," according to Paul Auerbach, Former Chief of Emergency Medicine. The grant-writing assistance resulted in improving the success rate and receiving grants, bringing in more research funds. Hannah Valentine, a Cardiologist and Chief Officer for scientific workforce diversity at the National Institute of Health, states, "We're talking about we get greater excellence by paying attention to work-life issues."¹

To prevent work from metastasizing into personal time, plastic surgeons in group practice settings can relinquish care of their patients to their partners when not on call.¹⁴ Caring for patients as a team rather than individually allows for dedicated leisure time for all partners. Flexible time would allow a surgeon to block off time to attend a child's soccer practice, attend an exercise class, or meet up with friends. When those in leadership positions take advantage of and publicly celebrate extended family leave and part-time schedules, then others will feel more confident that using such benefits will not have a negative impact on their careers.¹⁴

24.11 Recovery

As physicians, we focus on problems. We have been trained to look for subtle clues to identify what is wrong with a patient. This problem-centric focus can invade our private lives. We look for mistakes, errors, and shortcomings, judging ourselves and others critically, but perfectionism is a double-edged sword. Focusing on what we do well and

what others do, too, we can lift ourselves up. A positive view leads to a better quality of life for us as well as for those around us.⁴

Articulate your professional and personal goals, then break each down into manageable steps with deadlines.⁴ (OKRs are great for this. See Chapter 19.) Celebrate each time you achieve a step toward your goal. The celebration can be small, like cheering when you move a post-it from the “To Do” side to the “Done” side, but celebrate nonetheless. When patients, staff, and colleagues accomplish something, reward and celebrate them as well. The joy that sparks in their lives will brighten yours.

24.11.1 Get a Financial Education

Buying a winning lottery ticket is unlikely, but getting a financial education is worth the time and effort, regardless of what type of practice you work in. Seeking help from the right financial advisor sounds like a good idea, but finding one who truly has your best interests in mind is not so easy. Medical practices have their own peculiar financial opportunities and regulations, and it helps to find advisors who understand your particular financial situation. Some plastic surgeons go to business school sometime in their career (see Chapter 6), but the earlier you learn about finances the better.

24.11.2 Describe Your Ideal Practice

What types of patients do you want? What do you want your schedule to look like? Describe your ideal practice setting, geographic location, reimbursement type, and minimum salary. Now list these same aspects of your current job, and identify the elements that overlap. Identify how to get greater overlap by changing your present job to look more like your ideal job (or look for another job altogether). This is your “master plan”. Share it at home and at work so your support circle can help.⁴

Choose the easiest item to change; change it. For example, if you personally call every patient the day after surgery, train a staff member to do so instead. When that change has been implemented, celebrate. Document the change in a journal, and describe what you learned, what went well, and what you would do differently. Maybe next time you might consider creating a video for staff training so you can stop repeating the same corrections. Now move onto the next step.⁴

In addition to holding formal meetings with your support staff, meeting for brief huddles in the morning can motivate your staff and raise morale. In those 2 to 10 minutes, you can review patients and challenges, identify staffing needs, and also wish staff members happy birthday, happy work anniversary, and celebrate a job well done yesterday. Start and end with a positive note. Get to know your staff as people. Meetings and huddles take time, so it is tempting to cancel them, but the rewards are greater efficiency and higher team morale, which can raise your own morale.⁴

24.11.3 Reducing Stress

Mindfulness

Mindfulness refers to focusing on the present moment without judgment. Keeping the mind in the present promotes relaxation. The past can conjure up regrets, and the future can elicit anxiety, so every time your mind wanders, return to the present.⁴

Some people meditate, but not everyone can find the time, the place, or the interest level. On the other hand, anyone can take a deep breath. Whenever you feel tense or stressed, take a deep breath, hold it, then exhale completely.⁴

Stop Repeating Repetitive Tasks

We discussed the importance of creating templates to reduce repetitive chart entries and to create videos of instructions and information you repeat regularly to patients. If you explain postop instructions to every breast augmentation patient, have someone hold a camera one day as you explain things the same way you have done several times a day. Now patients can view the video before they see you, and all you will need to do is answer questions. If they ask the same questions, create another video. Put the video on your website and YouTube channel, and email the link to your patients. They are a great resource for caretakers as well. Creating a full library of patient education materials takes time, but each video you make will save you time and cut down on stress.

There are also other ways to save time—if you repeat a task that does not require an MD degree, delegate. You do not need an MD after your name to perform suture removal, clinical photography, charting, and patient education.

24.11.4 Work–Life Balance

Medicine can crowd out your personal life. Work has a way of insinuating itself into the top priority position. Our appointments, surgery, meetings, and presentations all make it onto our work calendar, and it is important to fight back with a personal life calendar that you prioritize just as much as you do your work. Schedule whatever you need and whatever you want: exercise, time with your partner, time with your kids, time with your friends, your piano lesson, time to write, and even time just to relax. And do not cancel those appointments any more than you cancel your work appointments. Protect and defend that time. It is your life. Learn to say “no.” You are booked, tied up, otherwise engaged. Showing you care about your health and the special people in your life can improve your relationships with your family as well as your friends.

As you nurture your personal life, make a list of all the things you want to do, like a bucket list, and fit them on your calendar.

24.11.5 Remove Guilt

The biggest hurdle to keeping a commitment like reading in your second grader’s class once a week may be the guilt you feel in prioritizing your personal needs. The more you defend it, the better protected you are from the suffocating tentacles of burnout. When you leave work, really leave it behind.

24.12 Final Words

A number of factors contribute to physician burnout. We can control some of them, but many are part of our system. Do what you can in your practice, at your institution, and at the state and national levels. Do not just complain; learn how systems work. Becoming involved in medical societies is a way to channel your frustrations with the status quo to effect change. Burnout is in part a product of our professional culture, and that will take time to change. The more we speak up with concrete suggestions and take action, the healthier and happier the members of our specialty will be.

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Suggested Reading

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25 The Changing Face of Plastic Surgery

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Abstract

Although the demographics of plastic surgery are changing, some groups remain underrepresented compared with their presence in the U.S. population. Patients often seek concordance in choosing a plastic surgeon, and a lack of representation of certain groups can impact patient care. Moreover, diverse organizations benefit in decision making when considering different perspectives. This chapter interviews a panel of plastic surgeons from underrepresented groups, or who have mentored such groups, to lend insights into how the specialty of plastic surgery can attract and nurture members of demographics that are deterred from applying to plastic surgery training and who do not ascend into leadership positions. Each panelist answers a question about his or her own personal experience.

Keywords: diversity, underrepresentation, minority, black, African American, Hispanic, Latino, white, Caucasian, gender diversity, pregnancy, maternity leave, gay, sexual orientation, stereotype, female plastic surgeon, male plastic surgeon

Editors' Note

To better understand the underrepresented segments of our specialty, a diverse panel of contributors generously share their perspectives and personal stories to shed light on sometimes overlooked issues and solutions to make plastic surgery inviting to all.

25.1 Introduction

Several studies have been written about professional gender gaps and differences between male and female plastic surgeons,^{1,2,3} but much less has been written about underrepresented ethnic groups⁴ and even less on gaps based on sexual orientation. The challenges, biases, and experiences of underrepresented groups in plastic surgery deserve greater attention.

Plastic surgery is a more diverse specialty than it was in past decades, but it is significantly less diverse than the physician population in general,^{4,5,6} and it is far from representative of the U.S. population (► Fig. 25.1 and ► Fig. 25.2). While a lack of diversity might seem to be a social rather than a medical concern, it is, in fact, both. Cultural and implicit bias may decrease the chances that African Americans and Hispanics apply to medical school, and the chances are even lower that they will apply to plastic surgery residency. Unlike underrepresented ethnic/racial groups, women make up a slight *majority* in medical school; yet, although their numbers have increased, they remain a solid minority in plastic surgery training programs (37% according to unpublished 2018 ASPS statistics). Studies indicate that gender bias and family-unfriendly policies deter women from applying to surgical residency programs, reducing the pool of female candidates.^{1,7}

Why does diversity in plastic surgery matter? In addition to the social concerns, compromised medical outcomes can result from a lack of physician diversity. For example, a 2018 study performed by the Institute for Economic Policy Research showed that black men, who have the lowest life expectancy of any demographic group, had a 19%

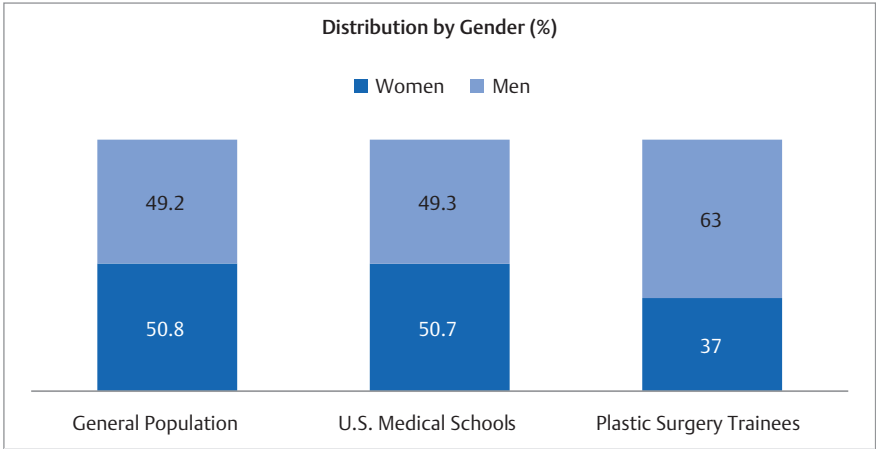


Fig. 25.1 Distribution by gender across the United States, in medical schools, and in plastic surgery residencies.^{8,9}

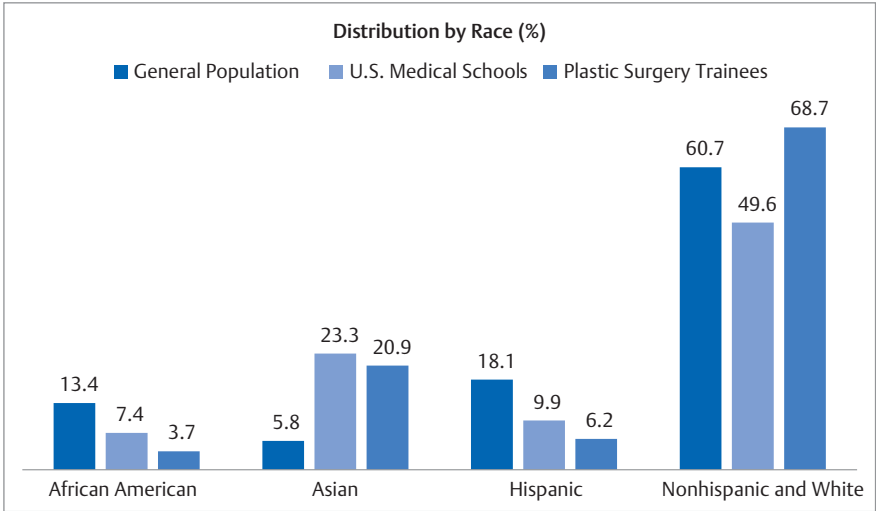


Fig. 25.2 Distribution by race/ethnicity across the United States, in medical schools, and in plastic surgery.⁴

reduction in cardiovascular mortality when cared for by African American doctors compared with a control group. The patients were significantly more likely to talk about health concerns and follow through with recommended screening when their doctors were also African American.¹⁰ In another 2016 study, African American women were found to be significantly less likely to have autologous breast reconstruction, even after controlling for a number of factors, including socioeconomic status, pathological stage, age, body mass index (BMI), and other diseases. The authors concluded that discrimination potentially played a role in the disparity.¹¹

Congruence, or a feeling of sharing the same gender, cultural background, race, or ethnicity, can play a role in how comfortable a patient feels with a doctor. When given the choice, one in four female plastic surgery patients prefers to see a woman.¹¹ If an African American woman would feel most comfortable with an African American female plastic surgeon, she would not have many to choose from.

Recruiting and admitting a member of an underrepresented group into residency, onto the faculty, or into a group is a first step, but it is not enough. For academic women, attrition is often related to a poor work–life balance.² Improving female faculty satisfaction rates and retention will follow when professional goals are brought in line with a satisfying personal life. The more female faculty an institution retains, the more likely it is to attract more women.^{2,8} Other groups may experience a lack of support and mentoring from superiors and colleagues, leading to a sense of isolation.

Given its importance to medical outcomes, diversity has become a priority in medical education, both in the recruiting of students and in the recruiting of faculty.¹² In this chapter, we hear from a diverse panel of plastic surgeons to offer their insight into their own experiences as well as discuss how we can improve diversity in our specialty.

25.2 Panel Discussion

Question

Several groups are currently underrepresented in the field of plastic surgery. Does this matter?

Calobrace:

Plastic surgery, and surgery in general, has been traditionally a “good ole boys” specialty run basically by all white men. It has evolved over the years. It can be very hard to feel as though you are a part of the team. I would find myself trying to be perfect, afraid that not being the best would give someone ammunition to get rid of me. It was a horrible feeling wondering who was going to stand up for me if something happened, however unfair it might be. We need diversity for patients, trainees, and faculty because we *all* need advocacy, and diversity provides that. Diversity also provides the opportunity for improved cultural sensitivity, which is particularly important in plastic surgery.

Phillips:

Underrepresentation of certain groups in plastic surgery is an issue. Some patients are not comfortable with physicians who are of different gender, ethnicity, sexuality, race, or even religious or political beliefs. This is especially true when discussing an issue that is delicate or embarrassing. These differences can also impact how we deal with our colleagues and those we supervise. Sensitivity to these issues makes us better able to provide the support needed for greatest development and productivity. We all are most productive when we are free from fear of reciprocity or stigmatization, or even simply isolation.

Kpodzo:

Our patients and trainees must see a representative range of plastic surgeons, including faculty. Women comprise about 16% of plastic surgeons in the United States, according to unpublished 2018 ASPS statistics, but we do not track the percentage of underrepresented minorities. Access to care for minority patients correlates with the improvement of cultural, racial, and gender-based barriers. Patients belonging to minority groups receive better self-rated care by a racially/ethnically diverse workforce.¹³ Minority physicians are more likely than their Caucasian counterparts to care for poor and underrepresented groups of patients.¹³ Having a racially concordant physician improves factors impacting health, such as communication and an understanding of cultural beliefs and practices. Like the previously mentioned 2016 study, a 2017 study also found African American women less likely to undergo postmastectomy breast reconstruction, with an odds ratio of 0.36:0.71.¹⁴ Increasing the number of minority physicians will improve this outcome. Many of my own patients search online to find a black physician. The number of black/African American and Hispanic/Latino American medical school graduates was 6 and 5%, respectively, in 2015. In fact, 39% of all full-time faculty identify as women, of which only 4% identify as black or African American, Latino or Hispanic, Native American or Alaska Native, or Native Hawaiian or Pacific Islander.⁸ Unfortunately, these numbers have plateaued, limiting our ability to improve minority group health disparities.

Similarly, it is essential for trainees to see a representation of themselves among faculty members. A diverse faculty will attract a diverse group of trainees and improve mentoring, promotion, and equitable salary for underrepresented groups.

Rios:

The lack of diversity can result in less effective outreach of the plastic surgery brand to our potential patients and trainees.

In my experience, the Hispanic culture generally assimilates well into the United States but maintains its cultural roots, especially near the border and among recent immigrants. This identity is reinforced with the integration of the Hispanic culture's food, style, and Spanish language in the United States.

Without diversity in our plastic surgery societies, we miss opportunities to cultivate the trust of the Hispanic patient. I cannot overstate the advantage I have by being able to do my consults in both English and in Spanish.

As a past trainee and member of our society, I find it disappointing that a specific gender and race continues to dominate our leadership positions, as is quite evident when our societies publish the names and photos of the upcoming slate of officers. The societies and training programs have been doing better in promoting diversity. Our meetings are much better now that international faculty are being invited to speak. These efforts show how plastic surgery will improve as a specialty as it continues to promote diversity.

Armstrong:

Diversity is important for all patient populations. Living and working in an area that has a fairly large group of African American patients, I have found that many patients have been pleasantly surprised, openly commenting on the diversity of our resident

trainees. Majority patients are positively affected as well; those with a European ancestry have been exposed to plastic surgery residents or doctors from diverse backgrounds, which undoubtedly, helps shape their view of medicine.

Garza:

Patients are in vulnerable situations and seeking care and guidance from their physicians; they should have the ability to find a surgeon they can relate to. In training, we all emulate those who train us, mimicking their surgical techniques and patient management practices. But we also observe our mentors' personal lives. With a more diverse group of faculty, we will be better able to recruit surgeons who bring a wider variety of experiences and values to our practice. This will allow trainees to form more meaningful relationships with their mentors and experience a more supportive environment during the stressful years of training.

Question

What factors promote faculty and leadership diversity?

Armstrong:

Leadership that is forward thinking is the key to creating an atmosphere that embraces diversity. Many institutions often do not think about what a diverse training environment means to the medical community as a whole. The general success of the trainees is an important factor in maintaining diversity. Leaders must create a culture of achievement among students, residents, fellows, and faculty.

Calobrace:

First and foremost, the program has to see that individuals of diverse backgrounds, whether it be race, age, gender identity, sexual orientation, religion, or socioeconomic status, are worthy and capable of being a part of the faculty or leadership. Leadership must desire diversity and see that it improves the patients', trainees', and faculty's quality of experience. Diversity provides exposure, exposure provides understanding, and understanding provides open-mindedness and acceptance.

Garza:

Diversity in leadership and faculty will promote diversity in trainees and their success. We must move away from measuring each individual's success with the same metrics and accept that diversity in plastic surgery is essential.

Kpodzo:

Programs that have been successful in diversifying their faculty and leadership come in two varieties: (1) programs established at historically minority institutions, such as historically black colleges and universities; and (2) programs where the surgery chairperson and senior level academic leadership have prioritized creating a diverse faculty in their hiring decisions, through mentorship, promotion, and leveling of compensation.

Phillips:

Diversification takes a conscious effort and resource support from administration. Minorities, by definition, are not plentiful in the ranks to which we recruit, so we need to make connections with other medical and surgical disciplines to provide support and collegiality. The better our needs are filled for mentoring and making connections in our surgical discipline, community/institutional leadership, national professional growth, and personal needs, the less we experience stress and burnout, and the more productive we are. These connections require investing both time and money to make them work.

The leadership must educate all involved—staff, residents, faculty—of the importance of diversification, or else the insidious comments and lack of support will undermine their efforts.

Rios:

Awareness and the willingness to be a little uncomfortable are probably the most important factors in promoting diversity. Greater awareness in our societies and training programs of the many qualified candidates spanning different cultures, genders, and lifestyles can open eyes to the possibilities of reflecting the diversity of our nation. Members of societies and fraternities tend to select candidates that resemble them, which is a comfortable choice. However, this comfort zone does not allow organizations to evolve with society. By balancing the scales, the specialty and training programs could be more appealing to the diverse communities they serve.

Over the past decade and a half, I am proud to have witnessed the acceptance of our Latin American colleagues bringing great concepts and ideas to our specialty.

Question

Women, Hispanics, and African Americans are underrepresented in our specialty and more dramatically in leadership. What is holding them back?

Kpodzo:

Not seeing examples of yourself in your field creates an inherent doubt about fitting in and being welcomed in the field. No or poor representation of minority groups on faculty and in leadership positions results in limited recruitment and retention of members of these same groups into residency programs. Men and nonminority persons in academic and in leadership positions have to first believe that these candidates are equal and that their presence in the field is necessary and valuable, and then actively mentor, recruit, and retain these trainees. This is the crux behind the hashtags #ILookLikeASurgeon, #HeforShe, and #WhatADoctorLooksLike; perhaps we need a new hashtag, such as #MajorityForMinority to help pave the way for health equity in the United States.

Armstrong:

The lack of visible role models plays an important role in students/residents even considering specialized training, such as in plastic surgery. Additionally, leaders must actively create environments that are welcoming to nonmajority trainees.

Rios:

Plastic surgery's long road to training is fraught with financial and practical barriers for Hispanics. Without role models and mentors, Hispanic students may be little able to navigate the milestones needed to become a plastic surgeon.

For the Hispanic who does become a plastic surgeon, the environment in the plastic surgery societies is not particularly inviting. As a young plastic surgeon, I felt there were "cliques" that seemed almost impossible to break into. A women's organization exists, but a "Hispanic" organization does not. Hispanic societies within our organizations could not only encourage camaraderie, but also promote our specialty to the Hispanic patients.

Phillips:

This underrepresentation is partly due to the pipeline: women were a significantly tiny minority in the boomer and older generations, and these are the age groups in leadership positions. A much more insidious issue, however, is the lack of support for women and the biological imperatives associated with aging. Fertility begins to decline at age 30 in the average population, and at age 27 in those exposed to the operating room (OR) environment. A lack of support during pregnancy and maternal/paternal leave can choke the professional growth of women as well as men who are deeply involved with their families. Surgery as a whole, and the specialty groups only slightly less so, have an atmosphere of total devotion to the patients and specialty. This is not supportive of any outside activities, including family life, and it leads to burnout, frustration, disruptive behavior, and discouragement of trainees who wish to have a balanced lifestyle. Cooperative sharing of patient responsibilities can give surgeons a better life balance without guilt. It is the responsibility of community and academic leadership to not only allow but also promote this healthy balance. As women grow in their professional development, they need to be perceived as a difference that brings a welcome, contributing viewpoint; they need to be encouraged to push themselves out of their comfort zones, to risk failure at reaching a goal, and to persevere. This means they need a mentor, sponsor, or coach—someone who listens, cares, and encourages them.

Garza:

As more surgeons from underrepresented groups are promoted to leadership roles, we will see an increase in these groups among trainees and younger surgeons. This is not a passive process; we must actively work to promote diversity. For example, having all male panelists at our national meetings sends the message to medical students and young surgeons that you must fit a certain mold to fill these roles. Instead, we should work to seek out a diverse group of surgeons to include in prominent, visible roles on stage at meetings, behind the scenes in committee membership, and in other influential positions.

Calobrace:

One aspect is the time commitment. Women in medicine have a distinct disadvantage in that during their career, having a family consumes time not only for the pregnancies but for the obligations at home. It is difficult to give extra time to leadership roles when their plate is full with work and family. Hispanics and African Americans are generally underrepresented in our specialty, and thus underrepresented in leadership roles.

There has to be a *desire* to improve diversity in our leadership. Each committee should seek as diverse a group as possible with the belief that diversity can provide improved understanding, representation, experiences, and ultimately, better outcomes.

Question

Although women can successfully negotiate for others, they often pay a social cost when negotiating for themselves, which is perceived as unlikability. How can we overcome this as a specialty?

Kpodzo:

Business aspects of medicine, including negotiation, should be taught during residency training; women should be offered additional sessions to help them negotiate from the female perspective. Leaders should learn how their biases could result in unfair assessments of women negotiating for themselves. There should be greater transparency in contracts and compensation packages being offered. When a difference in compensation between men and women is identified, there should be a leveling of base salaries and benefits for equal hours worked and other similar metrics. Starbucks, Apple, Salesforce, Intel, and Adobe have demonstrated that this is possible.

Rios:

Once female leadership becomes the norm, perhaps these biases may disappear. It is interesting to me that over 90% of our clientele in aesthetic surgery are women, yet our aesthetic society has not yet had a female president. If we encourage women to take leadership positions, we will truly gain an important insight into our most important aesthetic clientele.

Calobrace:

It is disheartening to see strong, confident women characterized by their peers as difficult, mean, or worse. We see it throughout the corporate world and in politics. These cultural biases are hard to change. Because of the need to be taken seriously, women have had to be strong in medicine and not expose their more vulnerable, gentle side. Continuing to place women in leadership roles will help to break down those preconceived, cultural biases. It takes time.

Garza:

Often women will accommodate less than ideal working situations so as not to upset people by asking for more resources. Resources should be distributed equitably, and the onus should not be on women to ask for things they should already have. Evaluating our practices from a leadership level is critical, and likability really is irrelevant.

Phillips:

This negotiation disparity is a societal issue, not just a professional or discipline-specific problem. Partly, women need to be able to accept that they may not be liked for speaking up for themselves, but they are more likely to be respected. (Is it better to be

liked and not respected?) Both aspiring men and women need to be educated about the different negotiating and leadership styles of men and women. Both men and women will be better and stronger leaders individually, and our specialty on the whole will be stronger and more productive.

Armstrong:

My perception is that if women are regarded as equal to their male counterparts, these negative perceptions tend to fall by the wayside.

Question

Is reasonable maternity leave possible, and can we as a specialty make it work?

Phillips:

We need to accept, as a profession, that we are *not* gods without needs. To ignore that basic tenet makes our flaws worse as we become stressed by not fulfilling our social needs. We need to support each other during pregnancy, child rearing, parental care, illness, or injury. At least one of these events eventually happens to all of us, and to ignore that fact and not ask for support when we need is extremely detrimental to the individual surgeon. Frank discussion as early as possible allows planning for needed coverage, explanation of benefits, and education of both parties. We must support our young colleagues as they enter their child bearing/rearing years. They are the future of our specialty, and we cannot cannibalize them. Similarly, exploration of available support systems can alleviate concern and smooth a transition back to full professional activity. The Residency Review Committee (RRC) has made new rules to recognize and accommodate these biological needs. Program directors and chiefs must make themselves aware of these rules, obtain support from their institutions, and work flexibly within the rules to support their faculty, residents, partners, and colleagues in the community. In supporting the needs of those affiliated with their institution, leaders themselves should be aware that a vehicle accident or parental ill health may make them need support in return.

Armstrong:

Maternity should be incorporated into any training program. The entire resident trainee group should be advised that if one of their colleagues happens to become pregnant, the expectation is that their coresidents will work together to manage during the time the female resident is on leave. The female resident will likely be required to minimize their vacation time during that year as a show of goodwill toward those who may have had to work more call, longer hours, etc. to account for the maternity leave.

Calobrace:

Our specialty has to be better at allowing women, or men, to work a little less than full time schedule and take time off for pregnancies and other important events. It seems surgeons are seen as weak if they want to balance life and work. We should help foster a culture that respects surgeons' dual roles as physician and spouse/parent. Both are important—trying to do it all leads to poor job satisfaction and burnout.

Kpodzo:

Reasonable maternity leave is absolutely possible. The specialty of plastic surgery needs to recognize the importance of having and raising children while balancing a professional life. A basic maternity leave of 3 months is quite reasonable, and ideally, should be followed by a transitional period of another 1 to 3 months of part-time work. Approaches to assist in off-loading some of the work and call responsibilities would include using locum tenens and physician extenders. Our specialty organizations could play a role in assisting solo practitioners in creating local groups for call coverage.

Rios:

We need to change our perspective on the negative aspects of maternity leave. We must remember that many of our aesthetic patients are mothers seeking a positive change in their lives. Our members who participate in maternity leave can certainly bring us something positive from their experience.

Question

Women are sometimes less supportive of other women than are men. How can we bring this to light and help women flourish?^{9,15}

Armstrong:

I am convinced that equal treatment among all trainees and faculty will help alleviate most, if not all, of the potential animosity.

Phillips:

In the era of women as a tiny minority, some, with aspirations of leadership, feared that the pipeline was constricted at the end: there was only room for one woman leader. Out of self-preservation, they did not support each other. Many, in their rise through the ranks, never met other women, so they did not learn collegiality. Supporting women in leadership, with luncheons, symposia, and places to meet, helps build teamwork.

Calobrace:

It is no surprise that women buy into all of the cultural biases men do. It is just like a woman seeing a bad driver in front of her, and yelling “woman driver,” as if all bad driving is by women. It is characterized as internalized oppression in the psychology world. We see it in our workplace all of the time with a large group of women working together. We do workshops and educational seminars to help raise the veil on these issues. It is important to teach women how to recognize it, and then how to avoid it. I love that there is a Women Plastic Surgeons (WPS) committee in the American Society of Plastic Surgeons and Women Aesthetic Surgeons (WAS) in the Aesthetic Society. That is the approach—women being together, working together, supporting each other, and finding that they are stronger together than apart.

Garza:

I have been fortunate in my training and early in my career to have had many female mentors who offered me guidance and support. I have turned to them for advice in all

realms—managing my patients, navigating research, and balancing family life with work. Furthermore, these women have included me in research and clinical initiatives with the aim of helping to promote my career. My experience highlights the importance of diversity of those in power.

Kpodzo:

My personal experience with other women in plastic surgery has been positive and supportive.

Rios:

Female leadership could integrate awareness and “sensitivity” training during the meetings of the women societies.

Question

What role does mentorship have in diversifying the specialty and its leadership?

Garza:

Mentors should:

- Help mentees reach their goals.
- Involve mentees in projects/activities that are going to foster that individual's growth.
- Provide an example of a practice to which the mentee can relate.
- Provide emotional support and allow for mentees to express concerns/fears that may have been similar to those experienced by the mentor.

Kpodzo:

A good mentor provides direction toward resources, information, networking, collaboration, and other opportunities. A mentor also provides guidance in career planning, demonstrates professionalism, and balances career and personal goals. For trainees, mentorship instills a feeling of belongingness in the profession, which is essential in increasing diversity within the specialty, lowering the barriers caused by unconscious bias, and grooming surgeons for leadership.

Phillips:

Mentorship is absolutely critical, especially for those who doubt their ability, discount it, or minimize it, to see their extraordinary value for what it is. Women especially need a mirror to see themselves for who they are and what they have accomplished. Minority populations suffer from intrinsic and extrinsic bias and need to be coached and encouraged to follow their stars, believe in themselves, and do their best. Eventually they will be successful.

A good mentor listens, provides both positive and negative criticism, is positive, does not take credit for what their mentee has done, advertises the mentee's abilities to others, suggests the mentee for jobs (including writing, speaking, and committee roles in the early years), and helps the mentee achieve *his or her own* goals, not the mentor's goals.

Calobrace:

A good mentorship creates an environment of role-modeling and advocacy. Mentor programs have been shown to improve job satisfaction, job retention, increased promotions to more advanced positions, improved productivity, and reduced costs in the workplace. The mentor program should try to provide mentors that will be active in their role and provide a good match for the mentee. It is helpful if the mentor is at a higher level, has more advanced experience, is a good teacher, is in a leadership position, and is able to promote those attributes in the mentee. The mentor needs to be compassionate, understanding, empathetic, and dedicated to their role.

Rios:

A good mentor listens, offers advice, shows a genuine concern, and has the mentee's best interest at heart. The relationship can be a fruitful two-way street.

Half the U.S. population is female, over 90% of aesthetic patients are females, 40% of the country is nonwhite, 18% are Hispanic, 12% are African American, and 4.5% identify as lesbian, gay, bisexual, or transgender (LGBT).¹⁶ Proper mentorship could have a profound impact on diversifying the society and improving interactions with the patients.

Armstrong:

Mentors are essential to provide support and encouragement to trainees and to young and even senior faculty. Leaders who perceive diversity as important will promote women and nonmajority clinicians in all aspects of leadership. Mentors should be more senior than their mentees, open to questions, and willing to offer serious criticism as well as strong support to their mentee.

Question

How do we account for unrecognized implicit biases that affect our perception and treatment of certain groups?

Rios:

Since implicit bias is unrecognized, our specialty needs to recognize that it exists. It may be best addressed by outside trained professionals who could analyze the society and make recommendations for overcoming existent bias to incorporate into our programs.

Kpodo:

Implicit bias not only affects current and future professionals in the field, but it also affects patient care. Open and honest discussion about implicit bias in our specialty needs to be at the front and center in our societies, not just among women and minority groups. The leadership of our societies, department/division chairpersons, and program directors need information on implicit bias and encouragement to address this issue. Tools such as the Implicit Association Test (IAT) can help all of us confront our implicit biases in areas such as age, race, gender, sexuality, and class. Assessment should be repeated to evaluate progress. Institutions should be transparent about the methodology used for the evaluation of residency candidates and faculty considered for

promotion to mitigate biases that creep in when decisions are based upon “instinct.” Institutions that improve recruitment and retention of these groups should receive positive feedback and be encouraged to share their strategies with others. Increasing the number of women and minority persons within the field will expand the opportunities for personal relationships and experiences that counter the stereotypes upon which implicit bias is built.

Garza:

We need to appoint more diverse members to our academic faculty, private hospital leadership, national organization leadership, journal editorial committees, and other organizations. There should be oversight to ensure appointments are merit based and inclusive.

Armstrong:

Exposure to a diverse workforce allows society to see and understand that there are actually very few differences between men, women, and diverse groups when it comes to medical and surgical competency.

Calobrace:

Wow, implicit bias is a challenge because it is ingrained in each individual from an early age. Usually, some level of implicit bias exists even when someone has a very open mind about diversity. It is hard to battle within oneself if unrecognized biases guide decisions every day, even with people who would consider themselves very open-minded and unprejudiced. It takes *effort* to help individuals and organizations identify and resist the impact of their biases—it is easier said than done.

Phillips:

We all need to educate ourselves, be aware of our own biases, and try to overcome them, not only for the greater good, but for our own good as a leader and human being.

Question

Does underrepresentation of lower socioeconomic groups, physical ability, and sexual orientation impact our specialty and our patients?

Armstrong:

A lack of access to health care is the primary problem for low-income patients, leading to a lack of basic medical surveillance and overuse of emergency departments for conditions that should be managed in a primary care office. Devastating medical outcomes can result for treatable conditions, such as hypertension, diabetes, and cancer. Poor and undereducated patients being treated for breast cancer are often diagnosed in later stages; those diagnosed at an early stage may not get referrals for reconstruction or understand their options for treatment. Unfortunately, many patients falling into a lower socioeconomic or educational status are black and Hispanic citizens.

Accommodations for physical disabilities have greatly improved, making access to care less of a problem, currently. Additionally, plastic surgery, as a profession, has been

more forward thinking than some professions when it comes to persons of varied genders. Gender reaffirming surgery is a growing aspect of our specialty that is a result of plastic surgeons seeking to address an issue in society that is rapidly becoming accepted by American society.

Phillips:

Getting people of lower socioeconomic groups into the medical education pipeline has been difficult, but it is improving with scholarships. Medical students' ability may not be recognized as they come through medical school. The applicant may not state, or the faculty reviewing the curriculum vitae (CV), may not appreciate that someone who works while also attending medical school is determined to succeed, even though they may not have outstanding USMLE scores. We academicians need to be sensitive to that. Sexual orientation is becoming less of a problem area, but the leadership needs to model appropriate behavior and support by educating their residents, peers, and colleagues. Underrepresentation should be a nonissue, and it is the job of leadership to assure that it is so. Physical disabilities are more problematic, as surgeons are highly educated manual laborers, and that part of our profession is difficult, if not impossible, to change.

Kpodzo:

As an African surgeon in an academic setting at an institution whose mission is to serve the underserved, I am constantly confronted with patients with limited access to care who have been turned away from other hospitals or by other surgeons. Indeed, many of these patients do not seek out care, as they believe that they will not receive it, or their primary care providers did not refer them as the result of conscious and unconscious biases, as demonstrated in the studies on disparities in access to breast reconstruction. Patients specifically seeking out a woman or a black surgeon describe feeling as though the relationship will be different and that they will be perceived differently.

Calobrace:

Our specialty and patients are impacted in ways that are hard to measure. There has been an improved openness toward sexual orientation. As the world goes, so goes our specialty. Because of that, there are regional differences. As a gay surgeon, I have been allowed to participate at the highest levels; it was harder at the beginning, but it has improved over the last two decades. It has always been my hope that my example and mentorship of other young gay plastic surgeons would foster a more accepting attitude—and I think it has. The challenge is not being a part of the “club.” I am sure women and minority ethnicities have felt some of the same exclusions. It takes conviction to step forward as an “outsider,” and it is easier with a mentor with clout. Our best hope is for courageous surgeons to take on leadership roles and help foster a new, more open environment in our specialty.

Rios:

Socioeconomic forces are probably the most important issues that prevent many first-generation Hispanic students from achieving careers in plastic surgery.

Question

What can we do to improve retention so that underrepresented groups achieve leadership positions?

Calobrace:

Mentoring improves job satisfaction and retention. Leaders who are members of an underrepresented group can serve as important mentors to their group and forge the way for others.

Kpodzo:

Mentorship, greater transparency, and equity in salaries are essential in retaining underrepresented groups in academic medicine. Statistically, a disproportionate number of underrepresented minorities come from lower socioeconomic backgrounds, and they may feel greater pressures to provide support to members of their family of origin or extended families. Given these additional pressures and responsibilities, members of these groups may choose to leave academia when faced with conscious and unconscious biases in academic politics, resulting in discouraging disparities in advancement. To retain women in the workplace, we must create a work environment that is supportive to pregnancy (including fertility treatments) and family responsibilities, allowing women to remain competitive and advance. This requires changes on a systemic level: a call and office coverage should be in place within a department for Family and Medical Leave Act (FMLA) leave situations, and last-minute child and elder care services should be available for unexpected illnesses and events. An improved benefit plan similar to the Kaiser model could be extended to provide health coverage for parents, home care assistance, and long-term care provision. Such systemic changes would benefit everyone in the workplace. At the same time, it will unburden and destigmatize women and others who carry a disproportionate share of domestic responsibilities. When combined with mentorship, these systemic changes will increase diversification of the leadership in our societies, academic medicine, and other surgical settings.

Phillips:

We must provide avenues for continued education and skills enhancement.

Rios:

Active outreach to underrepresented groups could prove to be fruitful on a short-term basis. The goal should, however, not be to fill a quota, but to truly cultivate these groups and benefit from their insight. Affirmative action for the sake of filling quotas is unproductive.

Question

In a 2015 article on “Gender Disparities in Academic Medicine” by Jennifer Waljee et al in *Plastic and Reconstructive Surgery*,² it was reported that women were less likely to hold tenure track position or engage in research, and they were less satisfied with their academic practice than men. What can be done to close the gap?

Phillips:

We studied publication rates of men versus women and their professional academic rank.¹⁷ Women have a lag in publications in their early careers, correlating with their biological imperatives, which is overcome as their careers progress. We academicians and universities need to support women in their early careers, as they slow their academic productivity while they are heavily engaged in child rearing. Women will work very hard if supported, and the academic unit, the profession, and the individual woman will benefit if this is done.

Question

The *Harvard Business Review* (HBR) published an article entitled, “Why Diversity Programs Fail.” In fact, such programs can actually worsen bias. Mentoring programs help, and the best programs mentor everyone. Can mentoring programs work in plastic surgery? And if so, how?¹⁸

Kpodzo:

Mentorship played an important role in my decision to pursue plastic surgery as a specialty. The HBR article highlights that there are fewer barriers for Caucasian men in the formation of informal mentoring relationships, which can become more formal. On the other hand, for women and underrepresented minorities, mentoring relationships require more structure and formalization, since their potential mentors may feel uncomfortable approaching their mentees informally. As a resident, I experienced this when I heard some of my male coresidents and attendings were chatting about the weekend game of golf to which I had not been invited. These are the types of informal interactions that grow into formal mentoring relationships, providing access to research opportunities, fellowship positions, and employment. These oversights may be unintentional, but over time they create and perpetuate a differential between the majority and underrepresented groups. During training, all residents should be assigned mentors, and structure provided for mentor–mentee interactions. For attendings, voluntary mentorship programs, including assistance, training, and guidance on how to best support mentees, should be offered within institutions and societies.

Calobrace:

In our specialty, plastic surgeons are by far more likely to be in solo practice compared to other specialties. We do not have to be islands alone in the ocean, vulnerable to every storm that passes. Role modeling is often the most powerful factor in a surgeon's growth. Ask any surgeon, and they will relay a story of another surgeon who made the difference in their life and career—that is mentorship. Through our organizations, we can create lifelong, continued mentorships.

Phillips:

We need to mentor *all* of our faculty, evaluating their skill sets, passions, and goals. By mentoring each as individuals, resentment of one individual over another is unlikely to develop. We need to consciously practice giving equal voice to all. Sometimes this is as simple as remarking in a meeting that the idea now supported was mentioned earlier

by an underrepresented minority. We must educate our young colleagues about what they must do to be successful in their practice, research, and leadership efforts. At the same time, we must educate ourselves to be good leaders and role models.

Armstrong:

Programs that overtly attempt to identify and promote a diversity mission may stigmatize the participants. Leaders must create a diverse workforce without having to broadcast that fact. This goal should be part of the core mission of the organization in question.

Rios:

Both mentor and mentee need to join a mentorship program with an open mind. If the mentor is going to dismiss the mentee's ideas, the program is doomed to failure. Mentors will need to be selected for specific qualities and trained on how to get the most out of the relationship. From the Hispanic point of view, I would recommend offering Hispanic and non-Hispanic mentors, or both, to the mentees. Offering only Hispanic mentors is a sign of implicit bias. An outside professional organization may be needed to guide our specialty through the process. The investment can bear fruits for the mentee, the mentor, and the specialty.

25.3 Stories from Our Midst

Question

Dr. Hultman, you were chief of a division with five women faculty at a time when you were the only male on the faculty. Why was your division unique, and what did you learn?

Hultman:

Just a few years after I had finished training, I found myself in the unlikely position of becoming Chief of Plastic Surgery at the University of North Carolina (UNC). My directive was to rebuild a program that had suffered major challenges and losses. I had no experience with finance and accounting, creating business plans, or managing people, but I was determined to recruit the best talent, based on fit, vision, passion, and potential. During my 14 years as Chief, I recruited 14 faculty members (not a coincidence, as this was my target): seven men (of whom six left) and seven women (of whom one left) ($p < 0.01$ by chi-square!), while I was at UNC. In fact, for many years in the mid-2010s, I led an all-female faculty with a male residency coordinator.

I did not set out to create a division of all women; my goal was to hire the right people at the right time for the right reasons. I wanted to hire people who brought different backgrounds and perspectives to the group, across lines of gender, sexual orientation, and race, and also geography, religion, and politics. One year, our service was notable for six Asian women as medical students, residents, and faculty. Another year, our team was represented by seven different faiths: Hindu, Baha'i, Mormon, Chaldean Catholic, Methodist Christian, Jewish, and Muslim. We had Republicans, Democrats, Green Party people, Libertarians, and Independents.

I hired an equal number of men and women, but interestingly, the conditions I (we) created at UNC most likely determined whom we retained. The men left for a variety of good reasons: promotion, leadership elsewhere, more money, or desire to pursue private practice. The single woman who left was one of my best recruits, but she and her husband seized an opportunity at a better academic medical center.

So, what were the conditions created at UNC that enhanced our ability to not only recruit but also retain our female faculty?

I could never compete on money—as a public, state-regulated institution committed to serving indigent and underinsured patients, the UNC had limited endowments, a poor payer mix, operational inefficiencies, and significant overhead. Instead, I focused on what we could offer or I negotiated what was fair and just:

- Base salaries pegged to the Association of American Medical Colleges (AAMC) median for plastic surgeons, according to academic rank.
- Variable and supplemental pay based on scholarship and clinical productivity, plus service to the university (in the form of medical directorships).
- A benefits package that was the best in the nation, in terms of health and life insurance, disability, and retirement.
- Transparency with all of the numbers: base salaries, work relative value units (wRVUs), and targets for productivity.
- Equal call and coverage of the inpatient service: no exceptions.
- Flexibility: 1 day per week for research, teaching, administration, or clinical care.
- Promotional pathways that included both tenure and clinical tracks, with some variance allowed for time to promotion.
- An FMLA leave policy that provided the full 12 weeks of time off allowed legally, with a guarantee that all resources (OR time, clinic slots, an advanced practice provider, and administrative support) be reinstated on return to work.
- Internal promotions (e.g., program director, service line director, and quality officer) based on a merit, interest, and potential.

The work to create this environment was challenging, and my efforts were rewarded eventually, but I met resistance along the way—sometimes in places where you would least expect it. Senior leaders, as far “up” as the Dean’s office, discouraged me from “allowing” 12 weeks of FMLA leave, stating it would reduce our division’s financial productivity. Over almost two decades, I had accrued over 50 weeks of sick leave, and I frequently donated this time to faculty, nurses, and staff, for legitimate medical needs—which was not popular beyond our division.

When I helped one of our female faculty members put together 4 months of FMLA-related leave to visit her husband, I was reprimanded by the new Chair of Surgery (a woman), for not being more “in control” of my faculty. This same Chair of Surgery demanded that I give up block time from one of my faculty members, who was on maternity leave, so that the Chair’s husband, a gastrointestinal surgeon, could have his own block time when he arrived (despite robust utilization of that block time by our division, while the plastic surgery attending was on leave). A quick call to the Senior Legal Counsel at UNC Hospitals confirmed that my attending was entitled to that block time, when she returned.

Due to “reverse loopholes” set up by our very own human resources (HR) department, many of my female faculty did not qualify for their performance incentive plans when they took FMLA leave to have children because their wRVU targets, which they all met on a monthly basis, were not prorated to a 9-month year. To qualify for their bonus,

these women either had to put in 12 months of work into 9 months (while they were pregnant), or they had to time their pregnancies so that their FMLA leave straddled two different academic years. I could not get this corrected.

During my time on faculty at UNC, I was given the gift of being able to build a division of plastic surgery from a faculty of two to eight surgeons, converting our residency program from a 2-year independent track to a 6-year integrated pathway, and building an office-based surgery center. I actively sought out my own mentors, and interestingly, many of them are eminently respected women in plastic surgery: Linda Phillips at University of Texas Medical Branch at Galveston (UTMB); Mary McGrath at University of California, San Francisco (UCSF); and Juliana Hanson at Oregon Health and Sciences University (OHSU). These women and others at UNC have achieved something that a gender-blind society should value: mentoring a man who in turn mentored women.

I am proud that I brought together and developed a first-class team, by providing a work space that focused on intangible benefits, like flexibility, autonomy, and respect. I remain unequivocally impressed by their professionalism, commitment to our patients, their love of teaching, and their compassion. This was truly a halcyon period in my career, which will represent the best of what I did.

Question

Dr. Kpodzo, you are an academic plastic surgeon and both an African/African American and a woman. Can you please describe mentors, experience with bias, and the changes that would help attract underrepresented groups?

Kpodzo:

I received excellent mentorship and sponsorship particularly as a medical student. All of my plastic surgery mentors were Caucasian men. My attendings and senior residents were extremely supportive and advising, and guided me during residency and fellowship. A few helped me as I went into practice. It has since become increasingly difficult to develop mentorship relationships when it becomes essential to have a mentor who can relate to my professional and personal goals as well as give guidance on navigating bias and differential treatment in the profession. I need a mentor who has navigated similar experiences and with whom it is safe to share a broad range of concerns.

I was the first black woman to complete training in my residency program. (I did not know there were still “firsts” like that.) As I have continued to progress in my career, the unicorn-factor has been magnified in many ways, leading to a sense of loneliness and isolation.

Being a surgeon is challenging for anyone. However, being a female surgeon and a black woman add further layers of frustration. The package that I come in is never what is expected when people hear “plastic surgeon.” Verbally, the message can be clear: “Are you going to do my surgery?” or “When is the doctor coming?” from a patient; or as stated by a colleague, “We really have to get you into a white coat so that you can look like an attending.” Actions can be even more explicit and hurtful. Patients hand me the meal tray when I enter the room or continue talking as if I had never entered at all. I speak to an anesthesiologist who is so focused on determining the title on my name badge that she misses all of my instructions about the case. I have combated these types of biases through the use of humor, outward shows of confidence, and by holding myself to a high level of excellence. I pride myself in the fact that each and every day I

break the stereotypes that many people hold about black women. While it is rewarding to make patients and their families, colleagues, and hospital staff aware of their biases and shatter stereotypes, it can also be frustrating, burdensome, and repetitive. My energy would be much better used focusing upon caring for my patients and advancing the field rather than asserting or defending my position.

Attracting underrepresented groups to the specialty is predicated upon creating a welcoming atmosphere. Open discussions among colleagues and leadership will signal self-awareness and interest in treating female and minority attendings equally and respectfully, promoting their professional advancement. The recruitment and retention of women and underrepresented groups, particularly in academia, will promote greater diversity of ideas and attract a more diverse group of medical students into the field.

Question

Dr. Calobrace, little has been written about the impact of sexual orientation among plastic surgeons compared with other underrepresented groups, and yet sexual orientation and gender identity receive a lot of attention in the media. Can you please describe mentors, experience with bias, and how your identity as someone who is gay impacts the perception superiors, peers, and patients have of you?

Calobrace:

When I was in medical school on the service of the Chair of Surgery, I could clearly sense he was very homophobic. I was a good student and worked extremely hard, so there was never need to reprimand me, but he was nevertheless aloof and distant. The letter he sent on my behalf as I interviewed for a general surgery residency position said, "Brad is a hard worker, and he did well on his exams. However, there is some question as to whether Brad is a 'team player.'" I knew exactly what it meant. These experiences did lead me to be a perfectionist. I just did not want to give anyone ammunition to discriminate against me. I felt less vulnerable if I was "the best." In medical school in the 1980s, there was no place for being "out"; although with my rather energetic personality and mannerisms, it was not that big of a secret. General surgery was definitely an "old boys" world, so I decided to do my general surgery residency at University of Southern California (USC) in Los Angeles to be in a more open-minded environment. Although I did not exactly talk about it, I think everyone knew I was gay, and, for the most part, was quite accepting. Many of my attending surgeons believed more than I did that I would be a part of the future of plastic surgery. If I can only tell you what it means to have someone of such respect and authority provide unconditional advocacy—that is why I believe so strongly in mentorships. Mentors have the ability to change everything for those in the underrepresented groups.

When I moved to Louisville, I felt the vulnerability and the feeling of being an outsider in a very real way. A patient and her mother wanted me to know another plastic surgeon in my community had told them that I was gay and HIV-positive, and that they should be cautious about seeing me for surgery. They were outraged and quickly came to see me for the surgery. At one point a letter sent to our society referred to me as a "malignancy in our community." That could have been because I advertised, as the letter stated, but I knew something more was at play. ("What does this gay plastic surgeon we do not even know think he is doing promoting himself in our community?") His bias

was palpable. I was fully trained, and yet I was not a part of the group. With time, all of that has changed, and today I really enjoy and respect all of my colleagues in Louisville.

Today, I travel the world sharing my experiences as a U.S. plastic surgeon. If anyone would have told me this would be my life in 1985 as I started medical school, I would have thought they were smoking crack. I thought that was not possible for a gay man. I have incredible mentors, colleagues, advocates, and friends that support me unconditionally and truly believe in me. Today, I bring my husband to all events, and he is welcomed at all turns with openness and kindness. I have been a faculty member teaching residents for the last 20 years, and I just launched a fellowship program in aesthetic surgery. It is my responsibility to mentor others, not necessarily gays, but all future plastic surgeons to help open minds and hearts to the greatness of diversity within our specialty. Only through exposure and understanding will we grow as a specialty and land on the right side of history as it relates to inclusiveness in medicine. We each have the ability to make a small difference, and I will continue to try and do my part and hope others will as well.

Question

Dr. Armstrong, you are one of the few black chiefs/chairs in any surgical division or department. Can you please describe mentors, experience with bias, and how we can create greater leadership diversity?

Armstrong:

I had several mentors starting in medical school and continuing into my professional academic career. I graduated from the Southern Illinois University School of Medicine (SIU). Training in New Orleans exposed me to a host of excellent surgeons. I had considered additional training in hand surgery since my medical school days. The encouragement and support by Dr. Swartz eventually led me to gain a position in Hand Surgery at Baylor College of Medicine/St. Luke's Episcopal Hospital program. My mentors Frederick Kessler, Michael Epstein, and a young David Netscher helped build a strong foundation for me to pursue an academic career in both plastic and hand surgery.

I started my career at The Ohio State College of Medicine in the Division of Plastic Surgery. I fashioned my style of leadership on Robert Ruberg, MD, my first boss, who was key to my early development. My "senseis" were two general surgeon chairs, Drs. Eddie L. Hoover (SUNY-Buffalo) and the late Claude H. Organ (Creighton University and The University of California, San Francisco-East Bay). Each of these giants in surgery provided concrete advice and guidance about the nuts and bolts of promotion and leadership. I owe each a tremendous "Thank You."

The only forms of bias or unfairness that I have recognized are primarily related to some persons not recognizing that I was the person that was listed for a lecture or committee. The assumption was that I was Caucasian. I simply went about my work as planned and in almost all of the cases was rewarded with enlightened pleasantness by the people that I interacted with.

Leaders must make a conscious effort to recruit and mentor underrepresented faculty and staff whether they be of a different ethnic, racial, or gender group. Treat each individual as an equal and expect the same results as one would from any other faculty member. A structured mentoring program should be a part of the organizational plan and provided in an equitable manner.

Question

Dr. Garza, you recently published a paper entitled “Pregnancy and the Plastic Surgery Resident.”⁷ You are now starting your academic career, and you just had a baby. Are there challenges that a woman plastic surgeon faces now in carrying a pregnancy, breastfeeding, and caring for a baby?

Garza:

Every new surgeon faces challenges in building his or her practice. In academics, expectations are to be clinically productive, be involved in resident education and service to the institution, participate in organized medicine, and perform research and publish. I was aware of all of these expectations as I entered my practice nearly 5 months pregnant. As a resident and fellow, I did not feel I had sufficient time, external support, or finances to start my family. It is not that I believed having a child just as I was starting my career was the ideal time—I realized there is “no right time.” Although I received support from my institution and colleagues, I harbored internal guilt about “taking time off.”

July 1 marks the start of the board collection period during which all cases performed over 9 consecutive months are to be submitted, reviewed, and some selected for the oral examination. I was concerned about completing the required minimum number of cases to be eligible for the boards before my baby's arrival.

The collection period is inflexible; I could not put the 9-month collection period on hold to accommodate the birth of my first child. To complete the 9-month collection period and maintain my eligibility, I also hoped my pregnancy went smoothly enough to allow me to operate until 38 weeks. (I operated in my 40th week before delivering.) For a prospective parent or anyone with a major life changing event, this inflexibility is daunting. A simple solution would be to make the collection period inclusive of 9 months within a year, not necessarily consecutive months. This would allow for 12-week FMLA or other leave.

In addition to the pressure of obtaining board certification, being unavailable for several weeks/months while on leave makes starting a practice difficult, when that is the time to make yourself available to patients and referring physicians to build your reputation. When returning from leave, that building phase seems to start over again. While away from work, patient care cannot be put fully on hold. Having a child can also result in a significant financial impact. Pay is often productivity based, and if productivity measures are not prorated according to time actually worked, this type of pay structure may penalize parents who take leave.

Aspects of surgery can pose occupational hazards during pregnancy. Surgeons are accustomed to standing for long periods of time, often not breaking for food, water, or rest that are essential to a healthy pregnancy. The unpredictability of a surgeon's schedule makes taking care of oneself difficult. Furthermore, exposures to infectious diseases and radiation need to be avoided.

After returning to work, there is a significant adjustment phase. Scheduling breast-feeding at home and pumping at work is challenging. It takes a significant amount of time to plan the day, transport equipment, find time and an appropriate space to pump, and preserve and transport milk. This effort takes away from time spent completing other tasks (or resting, eating, or socializing). With no dedicated break times, physicians

are used to fitting meals into 5-minute periods between cases or clinic visits. As a nursing mother, you learn to fit pumping and eating into those “breaks,” which can feel very isolating.

Although federal law requires that a nursing mother has break time to express breast milk and requires a designated area (other than a bathroom) to do so, the size of the area does not have to be proportional to the number of nursing employees. For a large hospital, this could mean a designated single room (or chair behind a curtain) for all nursing women, and the location of the designated area is not always easily accessed from the operating room. Consequently, female surgeons, hospital staff, nurses, students, and administrators find themselves pumping in locker rooms, bathrooms, conference rooms, patient exam rooms, or anywhere you can hang your hand-written “Do Not Disturb” sign.

Women have silently dealt with less-than-ideal circumstances for a long time, and we need to do better to make an already difficult task a little less difficult by dedicating a greater number of appropriately equipped spaces to breastfeeding in health care settings, meeting venues, and in public places. We need to provide actual protected time for nursing mothers to express breast milk while at work.

One of the most difficult aspects of returning to work was adjusting emotionally to leaving my child. It is not just the stress of leaving your baby each day, but realizing that everything has changed personally while nothing has changed professionally. There are the same clinical productivity measures, the same research expectations, the same number of meetings in addition to social events keeping you away from home. But now, as a parent, you take on a whole new set of responsibilities in caring for your child. Having help and support is key, which means having the finances to provide that help. These stressors affect both men and women, but when the woman surgeon is also expected to be the primary caregiver and manager of the home (because her partner also has a demanding career), the day-to-day becomes even more stressful. We must start offering women/parents in surgery more flexibility. Many women who entered academic practice early after training have told me that they transitioned to private practice to allow more flexibility and ability to participate in their children's lives. If we do not recognize the factors that lead to poor retention of female faculty and then do something about it, we will continue to lose women in surgery. In turn, we will lose these women as valuable mentors to trainees along with the care they provide to our patients.

Question

Dr. Phillips, you are chief at UTMB, you have raised four children with your surgeon husband, and you have had more than one resident go through pregnancy, even with complications. Can you please describe mentors, experience with bias, the ways in which our specialty could improve, and the keys to your success in all these areas?

Phillips:

I learned to be humble, listen to feedback as constructive criticism, and accept differing opinions as an opportunity for improvement. I learned to work within the rules, but apply them flexibly for the benefit of all parties. I learned to build consensus and lead collaboratively, working proactively before a crisis occurs. Our specialty needs to listen

to diverse opinions; we need to indulge less in expressing our own views, which may have been repeatedly stated in the same meeting or conference call.

We think well as innovators. We should not be afraid to lead the RRC and Accreditation Council for Graduate Medical Education (ACGME) in ways to support and provide safety for our residents in their early years, especially as the residency years overlap with peak fertility years. We need to provide safe environments: physically, mentally, and emotionally.

Yes, I did encounter implicit and explicit bias, but I learned that my best response was in my own work and my own efforts to be collegial and collaborative.

Question

Dr. Rios, you are a Hispanic plastic surgeon in Texas, where there is a large Hispanic population. Can you please describe mentors, experience with bias, and how your background impacts your patients?

Rios:

I was fortunate to have my father as a mentor. He was from Mexico City and did his training in the United States. I grew up along the Mexico–Texas border where the population is 90% Hispanic and 75% of the population speaks Spanish at home. My father was a strong, compassionate, and confident role model.

My General Surgery Chairman was Claude Organ, MD, a prominent African American general surgeon, and he promoted diversity in his program. He encouraged research and many of his residents published papers and did fellowships.

There were biases along my path to this profession, but my role models instilled a sense of confidence in me. I never was too concerned with anybody else's opinion about me; I knew what I had to do. I had a vision and stuck to the pathway to get there. I knew that hard work and ethical treatment of patients were the most important qualities to have as a surgeon.

I did experience a few incidents of mild racism in college, but not enough to throw me off my track. There was more good than bad in college. I chuckle at how many people seemed to have underestimated me throughout my training and career. I cannot tell you how many people cannot believe I went to Harvard when they find out. Recently, one of my plastic surgery faculty told me he would not have guessed while I was training with him how successful I would become, especially in my participation in American Society for Aesthetic Plastic Surgery (ASAPS). I responded that his sentiment was not uncommon throughout my life, and that is why I never depended on anybody's opinion to validate me. I was used to being underestimated. With my sometimes quiet demeanor, I just concentrated on the task at hand and filtered out the unimportant noise around me. Sometimes the less said is the best option.

Maintaining a calm demeanor and retaining my cultural pride has helped me be successful in the Hispanic community where I practice. I respect my patients and try to reach them halfway by utilizing Spanish in my practice. I am proud of my Hispanic culture and am not afraid to let people know.

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