



SURGICAL TRANSITIONS RESOURCE GUIDE:

Several Female Perspectives on Transitioning Through
Medicine

Association of Women Surgeons Clinical Practice Committee

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Introduction: Transitions

Seldom does a path in one's life follow a smooth straight course. Bumps, u-turns, roadblocks and fast curves are inevitable. Possessing the tools to handle them safely with minimal collateral damage is the key to success. This document was created to assist in giving tips for transitioning through the stages of training and moving between various forms of practice. Additionally, it helps to define the types of practice, benefits and drawbacks of each and how our authors maneuvered the course.

Medical School to Residency – Lisa Reid

The transition from being a medical student to becoming a surgery resident is a pivotal point in a young surgeon's career. Having the right tools, and knowledge where to get good advice are the keys to success. These tools include having a good mentor, a support system of family and/or friends, and maintaining good physical and mental health.

After students spend 4 years acquiring basic medical knowledge and honing their clinical skills, residency is the opportunity to care for patients as a physician.

Interns are protected by senior residents and attending surgeons who are there to answer questions, and to validate or dispute appropriate management of patients. Surgery residency involves not only learning how to operate, but also how to diagnose and treat surgical problems, and manage patients in the peri-operative period. Knowledge of surgical technique is gained in the operating room, and on the floors you learn how to manage an array of issues to include TPN, nasogastric tubes, a hypotensive patient, and how to recognize surgical emergencies. Finding a mentor early on will help with guidance through residency and with career planning.

Medical school is demanding mentally and physically and prepares you somewhat for the rigors of residency, though there are new challenges that arise. The surgery rotation for most students is anywhere between 6-12 weeks. A surgery residency is at least 5 years of the same long hours dealing with oftentimes very sick patients, and figuring how to work as a part of a surgical team. The intern year oftentimes does not involve a lot of operating, and it takes time to figure how things work at each institution. There is a general awareness that it is a time for others to see what you are capable of. It is hard to find personal time to accomplish even basic needs such as eating and sleeping, much more to find time to spend with partners, family or friends. It may be hard to make weddings, funerals or other family gatherings due to call schedules, and just being exhausted from working. Resident burnout has been increasingly recognized by ACGME, and it appears that resident suicide rates are going up. It is important to remember to take care of yourself. Exercise and sleep are vital.

As I look back on my own experience, I think I did a pretty good job with maintaining a workout schedule and taking care of my physical health. I was not as good at maintaining friendships as I could have been, and wish I had made more of an effort to attend family gatherings that I missed because I felt too tired or was post call. I have been fortunate to be able to re-establish most of these meaningful relationships as friends and family appreciate the demands of surgery residency. I also struggled with feelings that I had to do more than average to prove that I was as good as my male counterparts. Looking back now I would tell my resident self that it was not necessary.

The transition from medical school to residency can be accomplished smoothly with attention to maintaining good physical and mental health, maintaining a good support system to include family and friends, and seeking out and accepting advice from mentors.

Training Environment to Practice - *Chantal Reyna*

I have always believed there is a song for everything. We use music to motivate ourselves through life, whether it is at the gym, during rounds, in the operating room, driving home or relaxing. For that reason, I have chosen a song to accompany each section, as music may express the feelings had during this transition.

“A Change is Gonna Come” sung by Sam Cooke. Throughout the years, we always look ahead to end. Most of us use the short term goals within the final purpose to feel we have accomplished something (end of internship, end of second year etc.) until we can finally say, “Im done. I have finished my training and ready to head out on my own.” This is a remarkable achievement, and it is a sensation worth cherishing. However, about 3 months into “our own” we realize that education and training never end. There are many things we have yet to learn and for which we may feel unprepared. The change from residency/fellowship to practice is one we yearn for and one we all must face.

“A whole new world” sung by Brad Kane and Lea Salonga in Aladdin. Starting out in practice is exhilarating with many unexpected and welcomed benefits. The shadow overlooking your shoulder is gone, but a new one lands: personal responsibility. This sensation occurs instantly with the first patient visit and the realization that you are the one making the final decisions. However, this is a blessing. It encourages personal growth and establishes independence. Your unique style of care is created. You are no longer at the beck and call of those above you. You make your own template and create your own schedule. It is the first time in ages that you have control over your life. The gym, hobbies and weekends become feasible. In residency, I had an attending who told me “nothing before 9am.” As resident, I found this frustrating as I would be done with rounds and ready to go, only to have to wait for another hour or so before starting that case. From the post training side, I found that I understand the desire to start at 9am; in fact, I have integrated this into my practice. It turns out that not all surgeons are morning people; I am definitely one of that category. Not only is there a change in practice but changes in your own life as well. Many people move to a completely new location for their first job out of training. I moved to the Midwest with no family or acquaintances. This allowed me (as well as others) to find new friends, new activities, and occasionally a new self. This change facilitates your experience of a new world, full of wonderful possibilities.

“Unintended Consequences of Love” by Bonnie Raitt. The feeling of not being a trainee is wonderful, but then you realize people are asking you questions about billing, coding, templates and your mind is blank. We are all trained for the practice of medicine but not the business of it. One of the biggest complaints I hear from recently graduated residents and fellows is no one taught them anything about medicine being a business. As trainees, we are sheltered from this aspect, for good or bad. However, once you are on your own, these are things most of us (even in academic practice) will have to face, from attending a mandatory institutional class for proper billing to paying out of pocket for a billing and coding course. No one discussed how to incorporate yourself if you decide to start your own practice. In addition, as a trainee you show up when clinic started and saw the patients as they arrived. But how did

those patients know when to show up? Who decided when and where? It turns out that the answer is now you. Most trainees don't realize that someone has to set up times that allow for efficient flow of new patients and established patients. A consideration most of us never had. This then leads to the question, "How do I run an efficient clinic?" The answer: ancillary staff. Sure that sounds like an easy answer, but how do you effectively work with ancillary staff? Do you have a medical assistant? A nurse practitioner? Physician assistant? Nurse Navigator? What are these things? As a resident, I had never heard of an NP, PA or nurse navigator. As a fellow, I started to know of them, but not how to utilize them. I didn't know the importance of this support system until I started my practice, and even then I didn't know how to use them effectively. It takes some trial and error to create a smooth work flow, so be patient and kind to all those involved. Have an open mind and listen to suggestions from the staff and those who came before you. Now that you have seen all these patients, in your new template with your awesome ancillary staff, you order images, schedule surgeries and set up follow up appointments. Establishing an organized method of following these items up is critical. It may be having a datasheet or a log or whatever else might be helpful. Typically starting from day one, have a plan or keep a running list. I find having an excel spreadsheet has been the most effective as well as a color coded calendar my staff and I can access; one common point to facilitate communication between the team. Yes, it is a team. Finally, between the clinic, the OR, and the paperwork, when is there time for the new you? Many still struggle with the work-life balance and prevention of burnout. People will sacrifice their sleep and personal time to write manuscripts, dictate notes and do cases. While basking in the freedom of your new life, be aware the pitfalls of becoming overworked too quickly. When you start, your template plate will be empty and you will feel the need to fill it with new patients. I encourage you to follow your pre-established template as to not set the expectations too high to start. You will become busy faster than you think. Take the time to re-evaluate your clinic and work flow. Pitfalls, burnout and stress easily overwhelm you if you do not prepare yourself and make yourself a priority. Don't let the consequences of the change overwhelm the benefits.

"Friend Like Me" sung by Robin Williams in Aladdin. Remember that you are not the first person to have gone through the change from resident/fellow to autonomous surgeon. With that in mind, the others who have treaded the path before you have a few words of advice. Mentors: they are critical. However, do not only choose mentors in your own specialty but across all disciplines if you can (pathology, radiology, oncology, etc.) Being able to call someone at any time provides you with a sense of comfort and confidence while caring for patients. In addition, you may copy some of your mentors' technique and style, so it may behoove you to take some sample notes (de-identified, HiPPA compliant notes, of course) to create your own templates. Start working on these about 6 months before leaving to allow time to ask questions or change templates over time. Granted, even after being on your own, these notes and dictations may change as your style evolves. In fact, your style will change. Your practice will change; that's why it's practice. You are constantly learning and improving (or at least you should be) and you will see this as time goes on. Don't be scared; be prepared. Most of us throughout training have spoken to countless physicians while receiving consults; but by the time we end our training we hate the pager as well as consults. In practice, learn to love the consults, love the referrers (I can't say love the pager...I'm not sure I ever can). The conversations you have with these

providers will be drastically different than the ones you had in training. If you are in a training program where the attendings receive outside referrals (i.e. a separate private clinic), ask to observe their practice and note their interactions and discussions with other physicians. The art of communication between a referrer and surgeon has been lost in training. Before completing residency/fellowship, establish a plan to communicate with your referrers. How will you meet them? How will you follow up with them after you see a patient? Some of us are lucky to have physician liaisons to assist introductions and help grow a new practice. Sometimes you are your own liaison. Communication with referrers after you have seen their patients can help increase and set referral patterns. A simple phone call, thank you notes or letters with a copy of your H and P is a good start. Keep a list of those who refer patients as you see them and set aside some time at the end of the week to call, thank and update them on your mutual patients. No one teaches you how to build a practice or how to communicate, so you might have to take the initiative to learn. In addition to sample notes and referral interactions, ask about clinic templates. How do your attendings schedule patients? How long for each visit for a new patient compared to an established follow up? Obtain blank templates for clinic times, so you can work on your own before you leave. As important as it is to discuss issues which arise after your practice begins, it is also important to have a job in the first place. As such, here are some tips for the job interview. You may still be paying off debt for residency or fellowship applications, but the good news is most places will cover some of your expenses for the interviews. Remember they are trying to woo you. Yes, I know that you need a job, but you have the skills and expertise that they need. You should be courted.

While interviewing, I used the acronym **CLEAR**, which I heard during a fellows' conference and share with anyone going on interviews.

Clinical-What are the clinical expectations, support staff, etc?

Leadership-Are there leadership opportunities (if desired)? Who is the leadership you will be working with or under? What is the hierarchy?

Education- Are there educational opportunities, i.e. medical students, residents, fellows (if desired)? Are there any community lectures or activities in which to participate (a good way to meet physicians and patients)?

Administration- Is there dedicated administrative time? Do you have any administrative assistance?

Research- Are there research opportunities or support staff? An established database?

Most of these may not apply in a completely private practice, but they can be tailored as needed. Lastly, once out in practice you will have to obtain Continued Medical Education (CME) credits and keep track of it. Ask about CME time away and any funds that may be provided. One thing I learned is to record my cases, notes and CME credits as soon as it happens to prevent using personal time to back log them. Remember, many of us have gone through this transition and we rely on the aid of others. Find mentors and friends to guide and support you through this new part of your life.

"A Change is Gonna Come" sung by Adam Lambert. As the song "A Change is Gonna Come" was

first sung by Sam Cooke and later by a variety of artists including Aretha Franklin and Adam Lambert, the transition from training to practice has been done by others before you. It is the same song, but different each time. The time will come for training to end and your independence to blossom. We all look forward to that day, with excess enthusiasm combined with hesitation. The important thing is we all want it and are ready for it. You have had years of training to get you to this point and it is time to use your skills and knowledge to help the rest of the community. Throughout this time remember there are changes, evolutions, freedoms, and unexpected consequences. The good news is that others have come before you and survived, and so will you. You have friends, mentors and family to help ease the transition from trainee to surgeon. Good Luck.

Academic to Private Practice – Robin Williams

When starting practice 22 ½ years ago, I never dreamed that I would transition through multiple practice types throughout my career. I started my career as an instructor at Meharry Medical College. I honestly thought that I would be at Meharry for a long time. As my clinical practice began to grow, it became clear to me that what I loved most about the practice of medicine was the interaction with the patient and assisting her/him to achieve optimum health. Many of my extracurricular activities encompassed patient advocacy, especially for breast cancer patients. I was no longer happy wearing multiple hats of clinician, assistant professor, medical student clerkship coordinator. Enters transition #1: from academic to private practice.

There was some trepidation for making this move, the main fear being would I be successful enough to pay for the expenses related to private practice in addition to assuring that I would have an adequate income. I had saved enough money early in my career that I felt that I would be solvent for at least a year to a year and a half as the practice continued to grow. Fortunately, I had joined a practice which allowed me to practice expense free for six months; after that we equally shared expenses. The practice did well; I even eventually became the managing partner. By this time, the practice had acquired a satellite location. However, life was ever evolving. One partner was getting closer to retirement and the other partner had become increasingly involved administratively with one of the community hospitals and had the opportunity to become involved full-time. I was totally entrenched in the world of private practice and still had plenty of room to grown. We ultimately decided to disband the practice. Enters transition #2: from group practice to solo practice.

The transition to solo was not difficult. Having served as the managing partner for a few years with the group practice, I had already acquired some of the skills necessary to run a solo practice. The satellite location for the former group practice became my primary base. So as not to lose my referral base from the previous practice, I subleased an office a couple of blocks from the previous main practice location. To provide the structure for the daily operations of the practice, my mother wrote a comprehensive policy and procedure manual that covered everything from how to turn the phones over to and from the answering service to professional conduct in the office. I hired a consultant to assist with human resources. It was so important to be able to hire the right people and prevent attrition. I also contracted with a company to manage payroll. Due to the faith that I had in my staff, we discontinued outsourcing of billing and brought it in house. The biggest advantage of having a solo practice is that you run it exactly as you would like. There is no consensus agreement between partners; there are no multiple meetings. The final decisions are yours. One intimately learns the anatomy of a practice when solo. The biggest con, as evidenced by the description above, is that it becomes very time consuming. It becomes difficult to maintain balance. From a business standpoint, there is little negotiating power with insurance companies because the volume of one surgeon cannot compete with the volume of multiple surgeons in a group practice.

When the economy took a turn for the worse in 2008, solo practice became even more difficult. There were times when patients would elect to defer surgery unless absolutely necessary.

Although I could see the writing on the wall, I tried to persevere. How could I let go of an entity in which I had poured so much of myself? I was very proud of my practice. While I was persevering, I developed hypertension and financially, I began to bleed. I had to make a change. Other surgeons around me had already begun making changes. I was one of the two remaining solo surgeons at my hospital. That other surgeon had decided to join a growing surgical group in town. I began to explore options. One of my goals had been to streamline my practice to breast only. I thought this might be the perfect time to seek joining a breast only group. When I made the initial inquiry of one of the larger breast groups in town, there was no opening. A couple of months later, however, I received a phone call that they were now looking to add a surgeon. Enters transition #3: solo practice to hospital system employed.

Presently, I am an employed physician practicing breast only. The quality of my life has improved vastly. The pros are:

- 1) Less administrative responsibility
- 2) Resources available that may have been less accessible previously
- 3) Financial stability
- 4) Reasonable hours/more vacation time
- 5) Time to become involved in as much or little hospital committee work as I would like

The main con is that sometimes decisions are made without physician input. Also as an employee, our salary is partly volume dependent. Salary negotiating skills are required, especially when you are being quoted fair market values. It is important to know your value.

Robin's tips

- 1) There does not have to be a straight path to ultimately achieve your goal.
- 2) Do what makes you happy.
- 3) Position yourself financially early in your career to allow freedom to make changes later.
- 4) Have a good support system (at work and at home)
- 5) Do not be afraid to take positions of leadership. Those skills may become useful for a future transition.
- 6) If one of your staff has a good idea for change of operations, be willing to listen and possibly incorporate the change.

Private Practice to Academic Practice – Susan Hoover

One does not purposely make suboptimal life decisions. In this regard, a sensible surgeon is no different from any other sensible person. One makes the best decisions one can with the information one has at the time. Experience teaches that it may be of less value than one thinks to attempt to meticulously chart the optimal path for one's entire life or career. Things happen. Information changes. And if we are to move forward at all, we do just as we have been taught to do in the surgical theatre when unexpected findings arise--we adapt, we choose the best course we can, and we move on and overcome. This is in fact all, and also the best thing, one can do. And it is, and will be, enough.

If you're anything like me, when you're on a flight, particularly a dreadfully long and packed flight in coach, monitoring the little screen in the seatback is especially comforting. The tiny little plane icon shows exactly where I am on the map. It never veers an inch from the line of the flight path. It even shows me what cities I'm passing over, how far away my destination is and exactly how much longer until I get there. But I read somewhere once that an airplane is pointed off course more than 90% of the time. It's the constant readjusting of the route along the way that enables the pilot to get the plane there on a seemingly perfect route. I think this is true for a career in surgery as well. At least my own flight path as a surgeon seems to make the case. This is my story in brief. I hope you may learn something from it.

As I navigated through general surgery residency, I kept an open mind about where my plane would land. I was recruited to plastic surgery and transplant. But after spending several months on the service of a prominent breast surgeon and being at the institution where the first national breast fellowship just started, I elected to chart my course in breast surgery and have no regrets in that regard. I loved the patient population, the surgeries and the fact that I could follow my patients long-term. When it came time to choose where I would practice, I thought I would go into practice in one city and stay there for my entire career, much like my father, who was a cardiovascular and thoracic surgeon. That thought turned out to be the farthest from the facts as they ultimately played out. Instead, I found my destinations to be composed of 4 cities and 5 moves across 3 states—the math seems funny, but it adds up as you will see.

When it finally came time to decide what type of practice to pursue, academia came to me mainly due to extenuating circumstances. On the day I was to sit for my general surgery boards during the year of breast fellowship, my father lost his battle with a rare cancer. Needless to say, that was a dark time as I lost the person with whom I was closest in my life and who served as the quintessential example of what I had hope my practice and care of patients would one day be. My daddy. My mentor. My trusted advisor was now gone. Instead of interviewing and seeking employment opportunities, I found myself in the midst of the grieving process while pushing forward to learn as much as I could in fellowship as I knew I had only this one opportunity to hone my knowledge base and skill set as the foundation of the years of practice to come. So, it

turned out that I approached the Division Chair of Surgical Oncology where I was training and simply asked if I could stay on as a junior faculty member, and he said ‘yes’. I had proven myself during the prior 5 years of residency there and despite the personal hardship in fellowship, I managed to be the same reliable individual my faculty teachers had come to know during residency, so it worked-out for all involved. I had a job and didn’t have to stress to scramble to find something last minute, and they had a junior faculty member they knew, trained and trusted. Little did I know then that my surgical career as I know it today would be single handily orchestrated by that little, 3-lettered word, ‘yes’, as I sat across from the division chair that day.

Three years I spent there developing my operative and patient management skills as a junior faculty. In the process, I made it my mission to teach the residents that rotated on breast to be the best breast surgeons they could be in the limited time they had on service. I wanted to make sure they would graduate with the skill set to perform breast surgery and manage the ever-changing landscape of breast patient management without doing a breast fellowship. As it turned out, this dedication to my goals to teach in the best way I knew how ended in my being honored with the Faculty Teaching Award by the Chief Residents—an honor not previously bestowed to a junior faculty member so early in their career. I blossomed in academia from the perspective of teaching and passing on all that I had learned from my excellent surgical mentors. Simply put, when you enjoy something, you tend to excel at it. I decided I wanted to make a career in academia. I felt I could have the most impact there, contributing to the training of future generations of breast cancer and general surgeons. I felt it was my calling. And it’s proven to be. I’ve taught, learned a lot myself, and made great friends and colleagues along the way. After a few years of staying where I’d trained, I found my wings to be a bit tethered and was ready to fly to new uncharted territory. I had an opportunity to work at a National Cancer Institute designated cancer center—an opportunity I could not refuse. Despite thinking that I would stay in one place to practice, this was a chance for a budding breast surgeon to make a career move that would allow me to be unknown to anyone around me at work and to prove myself without the fall-back of my mentors and teachers from residency and fellowship. This move would also be a pivotal one, as you shall shortly see.

In my new position, I found a wealth of academic opportunities that awaited me, very different than my previous employment. As a new member, I was the one with experience from a different institution, which served a significant purpose for the new institution to learn from my experience and to add something new and fresh to the mix. I was afforded the opportunity to join research groups, serve on national breast cancer panels and serve as director of different programs within the cancer center. I think some of these types of opportunities did not come my way previously because I had stayed where I trained and maybe it’s just me, but I felt as though I was looked upon as the “super-fellow” without really ever breaking into the faculty niche—my colleagues still viewed me as their trainee and not a “grown-up” surgeon, or at least that’s what I perceived at times. So in my new found position, I was really on top of the world and recall waking up each day incredibly excited to see what the new day at work held for me. I

was teaching residents and fellows, my true love, and building a very successful and busy practice. I really felt as though I had arrived at that place I would call my final work-home forever—I couldn't ask for anything more.

Like I said though, things can change. The stars sometimes align in such a way that circumstances lead to new beginnings, again. After 3 years at the cancer center, there began many internal changes, one of which was a split from the university's training programs, which meant that teaching residents was disappearing from the fabric as I knew it. At the same time a friend was whewing me from a far to join him in practice. He had been semi-pestering me for a long time to take the leap and try private practice. I finally caved. The teaching opportunities at the cancer center had essentially ceased and the work-load increased to a degree that I found myself essentially in private practice but on an academic salary. Suddenly, the opportunity to maybe increase my salary in private practice and pay-off student debts became quite attractive.

I took the plunge. Moved 1000 miles. And assumed my new role in private practice. Looking back, it was both the wrong move for me and the right move for me, rolled into one. I recall sitting at my desk in my very nice private office within days of getting there and thinking, 'I've made a huge mistake'. I felt immediately isolated and sorely missed the teaching of others and the camaraderie of my academic colleagues across the cancer center. All the involvement in research, national panels, and any chance at teaching were pulled out from under me—by my own undoing. I hadn't realized how much I enjoyed the overall atmosphere of the academic setting until I found myself devoid of it. On the other hand, I have always believed that opportunities come my way for a reason and to make the most of them. As such, I tried not to overthink the move to private practice. I just went with the flow and figured if all this ended up being was a detour flight path, how bad could it really be? In that way, I made the very most of my experience in private practice. I was able to take on a skill set of breast ultrasound and breast stereotactic guided core biopsies that would not have been afforded me in academia. We developed a boutique practice with in-house mammography, genetic counseling, and all minimally invasive techniques available to our patients from needle biopsy to partial breast irradiation techniques. We drew patients from the tri-state area and delivered premier care to our patients. From this standpoint, private practice was the *crème de la crème*. Who wouldn't want to be in a setting where all quintessential services were available to patients under one roof with the autonomy and the independence as the practitioner to call the shots. That being said, that sense of freedom did not come without a price. It can have its own snares and traps, as I learned. There was hiring and firing of staff, paying the bills, fixing office equipment, making sure the landscaper was keeping the premises looking top-notch, purchasing in-office equipment, calling the plumber when the plumbing went on the blink, making sure payroll was on budget (we were responsible for 13 employees and their families—if we didn't pay, 13 families would be affected!)...to just name a few. It ultimately became apparent to me that my venture into private practice had served its purpose and had played out. I wanted to return to academia.

I had never really stopped and thought about how hard it might be for someone to make this kind of move—from private practice into academia. Unlike some professions, I don't think there's much of a revolving door when it comes to moving from private back into academic practice—it's kind of a one-way ticket usually. If you leave academia, it's very hard to convince academia to take you back years later. Unless you have something they don't have, and really want. Turns out, I did. And that allowed me to make the unusual jump back into academia. I brought as my dowry to this new marriage a skill set that was marketable and that most academic surgeons didn't have—my acquired skills of minimally invasive procedures such as ultrasound and stereotactic guided needle biopsies, partial breast irradiation techniques, building of a successful practice, to name a few. As I mentioned, it all works out as it's supposed to. All these newly acquired talents made me very attractive to my newest destination—a hybrid practice at this country's top cancer center. So I moved again.

My background positioned me well to function in this Center's growing network of community based practices. It was a kind of hybrid, academic/private practice set-up. I think these are going to be more and more common as academic centers seek to cover the bottom line by throwing out the dragnet and making their expertise obtainable to areas far and wide. For me, this jaunt was worth the ride as it landed me back in my home state, and it was nice to be surrounded by academic colleagues again. I was allowed the autonomy to build practices for the Center in the greater metropolitan area using the local hospital resources and conveniences for patients that lived in those communities. The delivery of care mimicked that of the main Center but allowed the patient the comfort of being in their suburb close to home—we brought academic practice to their living rooms. I was able to offer patients all the options available at an academic center while being able to still deliver the personal touches I did in private practice. It was truly the best of both worlds. Like anywhere though, things are never perfect. Building these successful suburban centers was easier said than done. In essence we were the front-line for the Center to negotiate our way into very locked-down referral patterns. Many of the community private physicians felt threatened by the establishment of the Center's satellite offices. Paving a new way of referral patterns to the Center was not easy—many a slammed door in the face was experienced first-hand when making personal visits to referring physician's offices to educate the medical community about our presence and services. With persistence and alleviating the community of their misguided fears, the practice took off and served what it had intended—to just be another option for patients and referring physicians in the local communities. After achieving these goals and helping build these satellite centers, I reflected on my varied career as a surgeon. I realized that although I had no regrets of all my moves and experiences along the way, I still lamented my exodus from my favorite place to work, which was my second place of employment. On a whim, I inquired if there was a spot open for me—there wasn't. But several months later, there was. Soon thereafter I found myself back at the place I wish I'd never left many years before. This was the one spot that met all my needs as a surgeon. The academic foundation of science, research and teaching with the boutique-like atmosphere and delivery of care of private practice—a combination in which I thrive as a surgeon and in which I feel that my

patients receive the care I wish to deliver.

To me, what may on the outside seem like a straight line academic career has been anything but. I've had a foray in private practice. I've been in a hybrid academic-private practice. And now I've found my home back in true academic medicine. At each step though, I feel like I made the right choice at the time, and it's worked out well. I don't think I'd do anything differently knowing what I did at the time. There are ups and downs with any move and with any job choice. The key is to plan as carefully as you can, learn what you can from the good and the bad, continue to help your patients and those around you. Your story is your own. May it turn out as well and as fulfilling as mine has so far.

Military to Civilian Practice - T. Salewa Oseni and Marion Henry

There are many reasons why women make the change from military to civilian life perhaps more than can be covered in this paper. The reasons are usually multifactorial with a combination of family commitments, deployments, life and professional goals that make continued active duty challenging for women with surgical careers. A common theme however, is that frustrations of being in the military starts to outweigh the enjoyment and advantages of being in the military. However, there are two natural points when transition is always considered. The first is when one's military obligated time commitment is over and the other is retirement. At the end of obligated service a surgeon can choose to continue their surgical career in the military for a certain time period or transition to civilian life. The amount of time one has left until a 20 year retirement certainly weighs into this decision. It is wise to really look at all the financial implications of getting in or getting out. The second time point is if and when you come up for retirement. Once again this is a natural time point to consider staying in the military or moving on to civilian service.

PROS

The biggest benefit to transitioning from military to civilian practice is the ability to make long terms plans regarding your career and life. This may be more challenging in the military because at any given time or at least every 3-4 years you will move to a new duty station or have your tour of duty interrupted by deployment. This may limit your ability to do certain things especially those that require long term commitments such as research projects. A reality of a military surgical career is deployments and the push to be administratively involved in hospital and leadership committees that have minimal impact on your practice. With civilian practice either of these becomes a personal choice. There are fewer turnovers of support and ancillary staff so there is good continuity and less ongoing training.

CONS

The biggest downside that comes with transitions is uncertainty regarding income. To a certain extent part of the unintended benefit from active duty is steady income that is largely unaffected by ebbs and flows in patient volume and legislature such as the Affordable Care Act. A much greater awareness and understanding of billing and coding issues is required once you enter into civilian practice. Similarly, the need for a more detailed understanding of business plans and management may be required if you are going to start your own practice or join a group.

TIPS

What kind of practice do I want?

-If unsure, start by applying broadly. The military model is essentially an employed model with certain limitations. Unless stationed at a large military center it is likely that you are doing some amount of general surgery and a majority of your cases may not be in your area of

specialization. As you transition, the first question should be what kind of practice do I want? Private vs. employed, solo vs. group, academic vs. community, general surgery vs. specialization? If unsure about which of these is of particular interest, start broadly with your search and then narrow your focus as you determine what would suit you better.

Timing

Planning is essential to having a smooth transition, so start early. Take your time to really look around and see what different types of jobs exist in your specialty, what the going rates for salary are, where things may be opening up soon. Part of this process also includes making yourself a desirable candidate once you determine the kind of practice you want. Perhaps there are certain skills that are now required which were optional during training such as robotics. Having a two year plan gives you the opportunity to acquire additional training courses if so desired. Also, if it is the right position they may be willing to hold the spot for you. Additionally, the separation process from the military can take quite a while. Do not underestimate the time this requires. Finally, remember the adage: *It is always better to be running toward something rather than running away.*

Networking

Most jobs are advertised, however some are not. It is very important to maintain connections with people in the civilian medical world because they are an invaluable source of information. This includes former mentors, colleagues you trained with, contacts through meetings and associations. In the military, due to the nature of what we do, we tend to be very insular and typically engage with other military surgeons. Attending conferences is very important. Use these meetings as opportunities to stay abreast in your field, and to network.

Support

This will be a very significant change and getting as much support as you can is important. Talking to trusted friends and colleagues provides an invaluable source of advice. The AWS is a great resource with so many women who are willing to be mentors or just offer advice if necessary.

Recommendations

The decision to transition from a military practice to a civilian one remains an incredibly personal choice. Evaluating where you are in your career what you want out of your career and whether you can achieve this while staying in the military is certainly a driving factor. Lastly, there is a lot of discussion about “burnout” among surgeons in civilian practice. Similarly, there is definitely a component of “burnout” among military surgeons. All of these factors drive your decision making. However, if this transition is made with clear goals and a well thought out plan, it is likely that you will be happy with your decision either way.

Clinical Practice to Administration - Mary Maniscalco-Theberge

My practice of medicine and surgery has always been driven by an inner voice to “do the right thing.” It is the compass that has guided my life. As a surgery resident, we accepted responsibility for everything that went on with our patients. “Resident” was the perfect term to describe us, as we lived at the hospital, 120-140 hours a week, in an effort to control everything.

Switch frame to being a new attending. Initially, I operated in the mode that I needed to be there all the time resulting in the nurses challenging me to allow them to do their job. Additionally, as the most junior member of the Surgery team, I was assigned committee duty. My assignment as the Department of Surgery’s representative to the hospital Quality Improvement / Risk Management Committee retrospectively was defining for my career. This was an incredible learning experience. As a surgery resident, I had gained a lot of knowledge about how to treat individual patients and their diseases; working on this committee, I gained knowledge about the influence of the system on that care. The lessons I learned not only improved my individual practice and understanding of teamwork, but it also demonstrated how changing the system could facilitate the best care of patients. Working on this committee also increased my understanding of different medical specialties.

Medicine is a team sport, and learning how improve teamwork, allowed me to understand that a good system gives providers the tools, resources, and staff needed to provide the best patient care.

By supporting the system to “do the right thing”, the system can facilitate individuals operating to their greatest potential. If each individual team member operates to their greatest potential—then the system ROCKS and great care is provided.

Seeing the impact that this committee had on the practice of medicine inspired me to stay involved in hospital committee work. Changing my focus, I looked at committee work as an opportunity, rather than a chore. Staying engaged, preparing for meetings, and actively participating resulted in my selection for leadership positions and accepting the leadership roles allowed me to impact the system to “do the right thing.”

This natural transition to leadership positions impacted my clinic, my service, and my department. My experience resulted in a recruitment to the Veterans Health Administration’s Office of the Medical Inspector (OMI). OMI provides the country’s largest health care system a rapid response investigation team. Leading OMI investigations provided me the opportunity to

“do the right thing.” OMI’s work results in reports with conclusions and recommendations that improve health care delivery to Veterans across the system.

Throughout this time, I also stayed clinically active. Staying connect to patients not only provided inspiration, it also kept me in touch with the impact of policy changes on the provider, guiding my efforts “do the right thing.”

Pros/Unintended benefits

Transitioning to administration allows impact on an entire health care system to “do the right thing.” Taking a lead in administrative roles facilitates your efforts to set-up systems that allow healthcare providers to function at their greatest potential, improve job satisfaction, and improve team function. These efforts result in happy employees who are more engaged and empowered to take ownership to improvement the care of patients.

Another unintended benefit of an administrative transition is much of work is scheduled. Scheduling results in developing some semblance of a life, I knew on most nights when I would arrive home.

As in investigator, my travel exposed me to incredible, smart people “doing the right thing,” restoring my faith in our system. It also allowed me the opportunity to mentor and develop the next generation.

Cons/unintended consequences

Engaging in an administrative practice gives you less time to see patients.

As caring for patients is what inspires me, if it is the same for you, I recommend finding a way to stay clinically active. My clinical practice resulted in more work, but made all my other work worthwhile, and a remained constant prompt to “do the right thing.”

Not being engaged in daily clinical activity creates a bigger challenge to stay on top of new clinical developments.

You attend a lot of meetings.

It is lonely at the top.

Tips/how would have done differently

I recommend getting involved on hospital committees, for example: quality improvement and patient safety. These are natural committees for a surgeon. Our morbidity and mortality conferences teach us to do critical analysis of our care and practice, these skills are translatable to quality improvement and patient safety. Serve on a committee, prepare for meetings, contribute, ask engaging questions, and improve your knowledge base. Be the best you can be, take classes: leadership, communication, writing, and know what you are talking about.

Seek a mentor to help guide you.

Engage your fellow employees, embrace that you are there to help them reach their greatest potential. Everyone has a role to play; the roles are different, equally important, and needed to “do the right thing.”

The one thing I might have done differently was not to wait to be recruited for leadership positions, instead put yourself out there. Although a title was never as important to me as getting the “right thing done,” officially accepting administrative leadership roles puts you in the position to shape change.

Recommendation why to consider transition

Getting involved in administration allows you to influence the practice of medicine, resulting in ensuring the best possible care of patients. It will allow you the stimulation to continue to grow, and share your experiences to improve the system.

You will be in a position to inspire others to join a great profession. There is no greater honor or privilege granted anyone, than when patients put their lives in our hands. Making the system “do the right thing,” ensures you are worthy of that trust.

Conclusion: Transitions

“Change is the only constant in life” –Heraclitus

Throughout the course of becoming a surgeon, one transitions multiple times from education to training to a variety of practice types. Some changes happen with eager anticipation such as medical school to residency; some occur because either situations change or people do. Hopefully the stories told and the advice given will provide some comfort and guidance for the many transitions encountered throughout a medical career.