Opinion: Private Practice Considerations

-Jenny Woodbury

While many residents preview the life of an academician during their training, only about 20% of anesthesiology residents choose to stay within the academic practice environment. For those interested in becoming a clinical anesthesiologist in community practice, acquisition of knowledge to navigate this job sector can be uncertain and intimidating. This opinion piece is to offer introductory perspectives and considerations if private practice is an appealing career path after graduation.

Private practice is a blanket term for the cohort of physicians who serve the patients outside of an academic...
institution, and within anesthesia, they deliver the majority of anesthetics in the United States. While some private practice physicians do diversify their roles to include business management, administrative duties (such as reviewing cases and QI reports, joining hospital committees and leadership, etc.), industry-based research, or society leadership (such as joining the medical board, national and local societies, consulting, etc.), their time is dedicated to offering clinical services and support within community hospitals, free-standing surgical centers, and clinical offices.

Typically, private practice groups determine their staffing needs approximately 6-18 months in advance. The timeframes depend on a variety of factors, but not limited to, planned retirements, changes in facility contracts, and historic lead-time from prior recruitment efforts, including the timeframe to obtain medical licenses and credentials. Thus, initial conversations are enlightening for understanding a practice’s staffing needs as well as culture, but proceed tactfully. Recruiters are helpful first contacts, but they can also create a layer of difficulty in obtaining accurate or meaningful information. In more competitive markets, a direct physician contact is preferable.

Private practice are mostly permutations of each other, but it is important to prioritize and understand the importance of these areas: where do you want to live, who is delivering the anesthesia, where will you be practicing, what type of cases are you responsible for, how are you getting paid, what is the benefit package, and what is the group culture.

LOCATION: This is mostly a personal preference, but one thing worth considering is balancing higher salaries for quick debt repayment. Additionally, states that do not collect state income tax can save you $30,000-40,000 a year.

STAFFING MODEL: The practice environment can be any or a combination of anesthesiologists, certified registered nurse anesthetics (CRNAs), anesthesia assistants (AAs), residents, and other students. The number of MD-only practices available in the country is diminishing. Unless these groups contract with a locum company, bring on part-time help, or have built-in staffing flexibility, call schedules may be demanding or vacation time difficult to arrange. Cases are performed personally, and breaks are dictated among the in-room staff.
Care team models can vary from medical direction to medical supervision. For the purposes of this article, the distinction involves staffing, but there are important billing considerations involved. A quick breakdown: anesthesiologists oversee up to 4 rooms run by CRNAs or AAs with medical direction. It assumes that the anesthesiologist will be able to 1) perform a preoperative evaluation and exam, 2) offer a plan, 3) participate in the most demanding portions of the anesthetic, 4) ensure that the plan is being performed by an anesthetist, 5) monitor the case in frequent increments, 6) remain physically available for emergencies or critical portions of the case, and 7) evaluate the patient postoperatively. When the staffing model requires overseeing more than 4 concurrent rooms or the anesthesiologists cannot perform the 7 areas listed above, for simplicity, it is medical supervision.

**PRACTICE LOCATIONS & CASE TYPES:** Every practice group has a different approach to their business model. When interviewing, ask for a copy of the day’s schedule. It offers information about the group’s scheduling process and its business practice.

The schedulers, who can be anesthesiologists or non-clinical employees, assign anesthesiologists by location, surgical case, surgeon, surgical group, or any combination of this. Some groups desire fellowship-trained individuals while others hire strong generalists, or they desire a combination of both. Based on skill sets and future practice interest, it is important to ask what types of cases need coverage as well as determine whether the desired types of cases are available (e.g. cardiac, pediatrics, etc).

The schedule sheds life on the overall relationship within a medical community. A private practice group that works with multiple hospitals, ambulatory surgical centers, and clinical offices for many years likely has a long-term vision and strategy to overcome fluctuations in cash flow.

**PAYCHECK & BENEFITS:** The paychecks are directly correlated to the productivity of the group; however, the pay depends on the group structure, incentive system, and disbursement of funds (partners, contract management group, shareholders, etc). However, the basic question is whether the contract agreement is for a 1099 (independent contractor) or W2 (salaried physicians). Within the contract, a description of the following should be addressed: benefits coverage including retirement funds, health/dental/vision insurance, disability coverage; malpractice coverage; relocation assistance; and, moving expenses.

Malpractice coverage is a topic of its own. Optimally, the group should offer event-based insurance, which covers the physician at any time a suit is filed as long as the event occurred when coverage was active, or tail insurance, which provides coverage for events that occurred while the physician had coverage after the claim-based insurance has expired or been terminated.

**PRACTICE CULTURE:** One of the hardest things to understand is a practice culture. This includes understanding the on-boarding process, allocation of vacation time, practice decision patterns (determination of partnership tracks, practice guidelines, etc), support for adverse patient outcomes, and management of crises (COVID). Speaking to multiple individuals including those who have left the practice can shed light on a group’s strengths and weaknesses.
Clarification on seniority and partnership track is very important. Based on the group’s hierarchy, the years leading to becoming a partner may be hard, unrewarding, and long days with a fraction of the senior partners’ pay. Additionally, the future direction of the group may change frequently depending on the group’s goals, financial structure, and external stressors (consolidation of medical groups, payor reimbursements, etc). If the partnership track exists, the buy-in may be costly, up to 20-30% of the annual pay. Anesthesiologists who are hired to work with large hospital groups (such as Kaiser, Mayo Clinic, etc) or an employee of a contract management group may find their groups more democratic and pay directly proportional to one’s productivity. The trade-off is corporate or hospital leadership may impose change upon the group.

Final Words: Lastly, even with ample amount of preparation, the first or second job immediately out of residency or fellowship may not be the ideal or perfect job. In other specialties, the assumption is that 50% of recent graduates will switch jobs within a year. As for my journey immediately after fellowship, my private practice job offered the balance and lifestyle I desired for myself and my family; however, the pandemic and personal circumstances changed over a year. The great job no longer met the dynamic changes that occurred within my family. It is okay to switch jobs and change one’s career trajectory; however, do so gracefully: leave on good terms and maintain relationships. These connections may be beneficial to you again in the future. Every position you apply for will request references, and those will come from former coworkers.

RECRUITMENT

A million thanks to the residents and faculty who helped make this virtual recruitment season a success. We couldn’t have done it without all of you! The residency leadership team hosted virtual interview days where applicants met with our program leadership, our chair, and an interview team. Each team consisted of one resident and two faculty members. For the third year in a row, to reduce affinity bias and allow for a more equitable approach, these teams asked standardized questions about clinical experiences, resilience, and teamwork. Applicants also had the opportunity to attend virtual socials with the residents, grand rounds, and research talks. In addition, this year we launched our ambassador program which gave applicants the opportunity to connect one on one with a faculty, resident, or fellow outside of the standardized interview day. We are getting a lot of positive feedback and are excited for match day!

We have MUCH TO LOOK FORWARD to as the winter months turn to spring:

Moonlighting

The operating rooms have been busy – especially with all the absences due to illnesses and leaves. Thank you for all the work you’re doing taking care of our patients and each other! The residency leadership team is working with our class reps to establish Saturday moonlighting in the Mount Zion ORs. Our goal is to have this up and running for CA2s and CA3s who meet criteria at the start of the new academic year. There is a chance that it
will be available sooner. We will send out details once we have the rules and pay structure solidified. In addition, we plan to allow CA3s the opportunity to do moonlighting shifts in the Surgical/Trauma ICU at ZSFG. More details to come on this as well.

The Ted Eger Resident Lounge at Parnassus
The residency leadership team has been working to re-establish a space for a resident lounge. Special thanks to Dr. Michael Gropper, Dr. Judith Hellman, and Maelani Atken for finding and dedicating Dr. Eger’s office to the residents. As you all know, Dr. Eger was a pioneer in the field of anesthesia. He was also an endless advocate for resident education and research. He started the Western Anesthesia Resident Conference (WARC) as a way for trainees to showcase the work they were doing. His legend lives on today. The lounge is located just down the hall from S455. It features a locked door, a sofa, and computers. We hope to have it ready for use this Spring.

AEDs
Following this recent surge and now decline in COVID cases, we look forward to moving our protected anesthesia education days (AEDs) back to in person. Many thanks to the faculty who work alone in the ORs on Wednesdays (most of them overscheduled) so that the residents can have this dedicated protected time. And special thanks to Dr. Michael Gropper for allowing the department to financially support this endeavor. We look forward to seeing people in person again!

Career: Becoming a New Attending

-Sarah Cotter

The first few months as a new anesthesia attending can be overwhelming and stressful. It has been great to be able to work with a wonderful and amazing group of residents at UCSF. You are all fantastic, which I personally can vouch for! I do not have a lot of rules but here are some pointers to consider when you are taking the plunge into a new career as an attending.

Do:

- Expect that your first few weeks as a new attending will be even more exhausting than your first few weeks as a new CA-1. There is a lot of responsibility, and a lot to learn. Be patient with yourself.
- Get to know your residents, your nursing colleagues, and your technicians. When you build rapport with your teammates, a lung transplant at 4 AM feels a little less terrible. It is really important to remember peoples’ names, and something about them. This goes a long way.
- Recognize that although we all think “real life” starts with the end of training, there’s still a lot of career ahead of you. It may well be that the first job you take out of residency or fellowship isn’t your forever
job. That’s okay. Pay attention to what drives you and what feels meaningful, and be willing to change your mind.

- Go into cardiac. Just kidding! But seriously, consider it :)
- Keep our numbers. Call us, any time, any day – for case advice, for career advice, for a check-in.

Don’t:
- Ever be afraid to ask for help. I called an overhead STAT my first week as a new attending at UCSF. I still have to ask people how to get to certain ORs (OR 1 had me wandering in circles for hours). The ability to ask for help demonstrates that you are trustworthy, that you know your limits, and that you prioritize safety above ego. This is imperative.
- Quit on a bad day. (This applies to just about anything in life, jobs included)
- Conflate money with value.
- Forget what it feels like to be the low man/woman/person on the totem pole. Engage medical students. Not so long ago you too had to hover awkwardly in the OR while it felt like everyone else around you had busy, important jobs to do. People usually don’t pick medical specialties because they love the subject matter. They pick specialties because they meet someone who they want to be like. Be the person someone wants to become.
- Underestimate the utility of a quick TEE. Call your friendly cardiac anesthesiologist and we’ll always be happy to swing by and help!

I am always here to help. Please do not hesitate to reach out for advice in career choices or if you just want to chat!

Well-being: Managing Mistakes & Resiliency

- Denise Chang

Mistakes are inevitable in our careers. The first step to a resilient career in anesthesia is to accept this fact. We are not perfect all the time, the circumstances we work under are usually not ideal, our patients frequently do not come to us with precisely diagnosed and simplistic problems, and our execution of well thought out anesthetic plans depend on fallible equipment and at times, unreliable support staff.

I made at least two medication errors during residency and witnessed several more. My first medication error as a CA-1 was the worst one, because I hadn’t even realized it occurred until hours after the fact. I had given a patient 150mg of IV ketamine instead of 30mg. Somewhere between my intention and my actions, a mistake occurred that resulted in a patient experiencing an unintended, negative outcome. I was confused when returning my box and reconciling my narcotics and ran to my attending in tears thinking my short-lived 2 month anesthesia career was over.
I will always be grateful to this particular attending who gently grounded me and made me look at the forest, when I was focused on this one particular flaming tree. She reassured me that “this is not the only time you will make a medication error” (accurate prediction #1), and asked me “what contributed to this error and how will you prevent it from happening again?” (role model behavior #2, seeing as I made a dilution and used the same size syringe and wasn’t diligent about checking my labels when giving medications). As I was quick to learn, debriefing with a trusted colleague can address both the emotional processing and the systems improvement aspects of a mistake.

As the pediatric QI champion, I continue to see world-class anesthesiologists make mistakes that are sometimes preventable, but most of the time a result of systems errors or miscommunication. When we discuss standard of care—and in the personal court of my own judge and jury of being able to sleep at night—I think, would the care of this patient had been better if someone else was the anesthesiologist? What could I have done better to learn how to anticipate challenging actions fraught with potential missteps before the mistake happened? What could the system have taught me?

Because intention + action = outcome, I examine all these parts separately. Were my intentions truly correct—did I want that good outcome enough to be as diligent or as thoughtful with my intention as I should have been, as if I were literally treating a family member or friend or colleague? Were my actions in line with the best information, equipment, preparation under the circumstances? If yes to both, then learn from this mistake and move on. I am reminded of this particular painting, Warships in a Heavy Storm by Ludolf Bakhuysen. At first glance, these ships are struggling and you wonder if they will even make it, but look closely and you will realize that these ships are built to weather storms—the hulls are designed for adverse weather conditions, the sailors are experienced. Similar to these ships, we as physicians are meant to journey through our mistakes, to learn and to grow. Don’t waste a mistake by not letting it become an opportunity to become wiser or to prevent others from suffering similar mistakes. And finally, this last piece on our own resilience, we need to be kinder to ourselves and realize, our best is good enough—it is all that we can offer.

Technology: Tips and Tricks in APeX Anesthesia

-Dylan Masters & David Robinowitz

We are really excited to offer up some tips and hidden gems from APeX. If you didn’t know, there are actually a number of people and a whole APeX Anesthesia committee working behind the scenes to keep things working, up to date, and improving!
Today, we’re going to review some **TOOLS** to help make a common resident task, keeping **ACGME case logs** up to date, easier. In future issues of this newsletter, we plan to cover APeX Macros and other topics in more detail, so stay tuned, or ask us in the OR!

When I used to chart my case logs as a resident, I would pull up “My Cases” over the date range I needed. This method was tough, because lots of data wasn’t there, and selecting a large date range tends to slow down the program. Luckily, there’s been some help, especially from Priya Ramaswamy, our informatics fellow, to make this process easier. As a resident, you can run a **Report in APeX** that shows all your OR procedures and contains all the important details the ACGME case log form needs, such as date, age, ASA, surgical procedure, anesthesia procedure notes (neuraxial, A-line), neuromonitoring, SedLine use, etc.!

To access this, within APeX reports interface:

1. **Epic menu → Reports → My Reports**
2. Search for the “**My Anesthesia Encounters (Resident) – Last 90 Days**” report.

Now, did you notice if you chart every OR case you do perfectly, at the end of residency, you would still be a couple sections short of completing your **minimum ACGME requirements**? Yes, I’m talking about non-OR items like regional blocks, pain consults, and labor epidurals. You’ll notice ACGME requires a minimum of 20 pain evaluations (acute or chronic), 40 “vaginal deliveries” (separate from epidural section), and 40 peripheral nerve blocks. To easily view your consults and bedside procedures, again with the Apex reports interface:

1. **Epic menu → Reports → My Reports**
2. Use the “**AN My IP Consult/Procedure Notes Last 90 Days**” report.

Any catch to these reports? Well, these reports pull only UCSF data, so cases from ZSFG or the VA don’t appear. What if you need more than 90 days of data? Well, probably best to **update your ACGME logs more frequently**, but you can also log into [residash.ucsfmedicalcenter.org](http://residash.ucsfmedicalcenter.org), and in the **Surgery section** you can find a **similar log of all cases you were logged into**, though without as good formatting.

**Why hasn’t this process been automated** to pull directly from APeX into ACGME? We wish, and have discussed this, but so far the answer from the ACGME is no – maybe someday!

**Need more help** or screen shots to help you find these data? We’ve added an updated guide specific to this topic to the “**Anesthesia Guides**” area of the **Anesthesia Learning Home Dashboard (LHD)**. You see this dashboard every time you log in to the Anesthesiology SVC. Did you know you can also press “**F1**” at any time while logged into APeX Anesthesia, and a **pop up window** will appear showing the middle column (the Guides and Tipsheets)?
Community: Life Before Anesthesia

Check out the UCSF Residency Instagram page @UCSFAnesthesia for social events, faculty features, resident spotlights, and more about what the department is up to both in and out of the OR. Recent faculty features include Dr. Art Wallace and Dr. Stephanie Lim!

Dr. Wallace

What are your hobbies outside of work? I do a lot of stuff. I build RC aircrafts, fly, scuba dive, develop medical devices, work on artificial intelligence, ski, sail, walk my dogs, play the piano (badly), build stuff, write books, invent, and spend time with my family.

Advice for residents: I think it is important to read every day. It is really, really hard when you finish a day in the OR to study but if you read an hour a day by the end of the year when boards come up you will have studied 365 hours.... Next, it is important to have staff show you how to do every technique. It is hard once you are an attending to develop new skills. It is vastly easier to learn from every attending so that you have done every technique in anesthesia. Sort that what you are told into “personal opinion” or “established by randomized trials.” You will be told many things that are personal opinion as revealed fact, question those things. If something seems to not make logical sense or not be physically possible, study it, investigate it, do research. When I was in medical school, my girlfriend developed terminal cancer. She enrolled in a clinical trial at the NCI and was put in the control group. I called the oncologist to ask about being in the control group. I asked if the therapy worked. “We have no idea.” I said, “This therapy has been around for 30 years, how can you not know if it works?” “We don’t know.” “Why do you give it?” “It makes the patient think we are doing something. Don’t worry, she’ll be dead by Christmas….” Apart from the horrific bedside manner, which you should avoid at all costs because patients and families will remember your words for the next 40 years, you should not provide care that you have no idea if it works. One of my major life goals is to never have to say that to a patient. I want to know what works, and what does not. Medicine should provide the best care possible for patients. That goal requires research, education, and compassion, you should strive to accomplish those goals.

Dr. Lim

What are your hobbies outside of work? My interests outside of work mostly evolve around my two boys: age 7 and 9. Some weekends are about cheering my son at his swim meets. Other interests include food and wine, travel, financial management and investments.

Advice for residents: Work hard and learn the most during those training years. Also don’t forget to take care of yourself, and it is never too early to start investing.
To learn more about other faculty - like Dr. Mike Bokoch, Dr. Odi Ehie, Dr. Anne Donovan, and more - please visit our Instagram Page.

Chief’s Corner:

-Ashley Oliver, Sherry Liou, & Elan Krojanker

First off, **congratulations to everyone for finishing the ITE**! Whether it was your first or your last, it's a big accomplishment. You all have also successfully made it halfway through the academic year (as well as through another variant surge)!

**Class of 2026!**

In other news, we have officially finished **recruitment season 2022**! With all your help, we interviewed incredible applicants and are eagerly awaiting Match Day in March.

**Special Thanks…**

We appreciate every single one of you for your flexibility throughout this academic year. Many of you have stepped up in HUGE ways to help cover each other, particularly over these past few months. To everyone who has taken on an extra call shift or who has agreed to last minute (often same day) site and rotation swaps, we could not be more grateful for your good humor and big-picture attitude. We don’t take either lightly or for granted!

**Speaking of socials….**

We know that everyone has been looking forward to in-person gatherings, and we will be able to resume **First Fridays** in March! We are also planning a very special First Friday for April, which may or may not be on one of our APD's fancy renovated backyards (more info to come!). In the meantime, please continue to be conscientious while gathering amongst yourselves. Wearing masks and/or staying outdoors is critical to keep one another as safe as possible. It also allows us to continue to advocate for social events that are certainly some of the best parts of residency.

**Shout Outs**

- Special thank you to **Kit, Sivan** and the **CA-1 class** for organizing and hosting a post-ITE pizza party!

- Thank you to everyone who showed up and participated in our first **residency-wide virtual Movie Night** (Danny Lazzareschi for the movie suggestion, Jannot and Serena Smith for getting snacks and assembling snack packs). If you’d like to plan an upcoming movie night (outside?!), please get in touch with Ashley!
Congratulations to everyone on finishing the ITE! With the help from our amazing fellows, we organized many review sessions in January to hone in on high-yield topics and commonly missed key terms. Fellows from Critical Care Medicine, Pediatric, Cardiac, OB, Regional, and Chronic Pain Medicine led these evening sessions. These zoom sessions were recorded and made available to those who were unable to attend.

We are working with Dr. Gropper, Dr. Sullivan, Dr. Turnbull, and the rest of the leadership team in bringing back RESIDENT MOONLIGHTING! Moonlighting was paused due to the pandemic, and we hope to reinstate these extra clinical opportunities for residents interested in further expanding their experiences. Stay tuned for updates, requirements, and how you can sign up over the upcoming months.

Special Thanks to the following for contributing to this newsletter: Jenny Woodbury, Kristina Sullivan, Sarah Cotter, Denise Chang, Dylan Masters, David Robinowitz, Ashley Oliver, Sherry Liou, Elan Krojanker, & Jannot Ross.

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