

Step 2: Choosing a Career

*Your business is not to see what lies dimly at a distance,
but to do what lies clearly at hand.*

– T. Carlyle

There are six tasks to accomplish in fourth year:

Step 1: Write your CV. Document what you have done thus far.

Step 2: Choose a career. Choose wisely: this decision is for the rest of your life.

Step 3: Schedule your fourth year based upon your career.

Step 4: Write a personal statement

Step 5: Complete ERAS

Step 6: Interview and choose a residency.

Step 7: Squeeze the last juice from this orange you call medical school (See Step 3)

Step 8: Clean up details: i.e., take step II of the boards. (See Step 3)

Step 9: The Match

This chapter will focus upon some general principles useful in choosing a career.

I. GENERAL CONSIDERATIONS

A. The best decisions are made when relaxed. Do not put undue pressure on yourself. The answer will come to you in due time if you continue to search for it. As you go through this process, remember the following:

1. It is normal to be conflicted about what to do. Each career has attractive elements. This does not make you aimless or uncommitted. You just need more information.
2. There may be more than one right answer for you.
3. Where two choices are indistinguishable, they are the same. Choose one, and go on. It is likely that you would have been equally happy with either choice.
4. There are worse things in life than having to choose between two challenging, exciting careers.
5. If you really don't know, you need more information. Use section II to help you acquire the best information.

B. Choose the decision for you, not someone else. "Bad faith" is the belief that you do not have control over the decisions in your life. It is damaging because when you believe you have no control, you begin to lose responsibility for your actions, and other things/people start to control you. Words such as "have to," "must" or "luck" are

evidence of bad faith. All you have to do in life is die; everything else is completely under your control, and the results of the decisions you make (or do not make) are your responsibility. If you do not make these decisions, someone or something else will make it for you. This career decision is for the rest of your life. Like other life decisions (i.e., who you will marry), it is too important to leave to chance or the opinion of others. You are not just making this decision for a 25 year-old student; you are making a decision for a 50 year-old physician (you in 25 years). If you do not own this decision, other people will own the decision for you.

1. Choose what you want to do, not what residency you think you can get into. You have come too far to sell-out now. Go get what you want. If you are not sufficiently competitive for a particular residency, then work on becoming more competitive. It may take an extra year to do some research or clinical training, but it is worth it if that is what you want to do.
2. Don't let the promise of prestige influence you. In the eyes of the public, some careers are more prestigious than others. Most of your life will be spent with your patients or alone in your office, not at cocktail parties. It is far more satisfying to be happy in your day-to-day work than to be impressive at the country club. Remember that people who are unhappy with their prestigious jobs rarely last in them. An ex-neurosurgeon impresses no one at a cocktail party.
3. Honors. A career is not a certificate for a job well done while in medical school. Do not get the two mixed up. Some specialties are so competitive that you will have to be at the top of your class or have a great board score to get the spot. The converse is not true: just because you are at the top of your class or have outstanding board scores does not require you to choose one of these competitive careers. The decision is not about how you did in the last three years, it is about what you want to do with the next 40 years of your life.
4. Friends, family and significant others.
 - a. Just because your mother was a radiologist does not mean that you have to be a radiologist, even if she wants you to do so. The 99% of your life spent when your mother is not around is more important than the 1% you are with her at family holidays.
 - b. Orthopedic surgery may be popular amongst your friends, but after graduation, your friends will be nowhere to be found. You will find little solace from your friends' opinions when you are alone in your orthopedic practice.
 - c. If your spouse wants you to make a lot of money, reassure him that the best way to do so is to choose a career in which you are happy. See Proverbs, "Find a man diligent in his business, and he will sit before kings." A disgruntled heart transplant surgeon makes no money if he is bad at it. You will be bad at whatever you are unhappy doing.
 - d. If your family wants you to choose a career with a good lifestyle, reassure them that the best lifestyle is one in which you are happy at work, so that you do not bring bitterness and angst home to them.
5. Residents and Faculty Mentors. Residents and faculty who have been important mentors for you will recruit you to their specialty. They have a vested interest in getting you to do their specialty (i.e., they may want you in their department, or they may simply wish to boost their department's prestige by the number of students choosing their department). Remember, it is you that must live with your

choice, not them. They understand that you must make a choice; if they are true mentors, they will respect your choice.

6. Other classmates. Everyone wants to be special; it is tempting to choose a career that not everyone is doing (or can do) to prove your uniqueness. Over the last three years, you have been forced (at least implicitly) to compete with your fellow classmates. It will be tempting to choose a career that allows you to escape this competition.

a. Don't dismiss a career in pediatrics just because the students in your class whom you respect the least have declared their desire to do it. This decision does not lump you into this cohort of the worst students: after graduation, they will be long gone.

b. Don't forgo a career in ophthalmology because other classmates with higher class ranks have chosen it. You are not competing against them any longer, you are choosing a career. Do not let other classmate's choices intimidate you from a profession.

C. Choose your residency based upon the character of the career, not the character of the residency training. The residency will last a few years, the career will last a lifetime.

1. Residency will be over before you know it. Do not be deterred because the field you enjoy requires a five-year instead of a three-year residency.

2. Choose your career based upon what you see yourself enjoying for its duration. Some careers are exciting at first, but become monotonous later. You may love the thrill of the ER or OR now, but will you still find the same thrill when you are a 50 year-old physician.

D. Do not be swayed by sample bias. Take the time to look at what the field involves, not necessarily the experience you have had doing clerkships.

1. A bad team, a bad attending, or a busy month may sway your opinion against a career. Conversely, a charismatic team or attending may make a field seem more attractive than it is. Look closely at what the physicians in your field do. Can you see yourself doing this in 20 years?

2. Academic bias. Most of your experience with a career will be in the academic setting. Realize that the private practice career in the same specialty may be very different from what you are experiencing. If you are certain that academics is for you, then what you see is what you get. If on the other hand you think that private or community-based practice is a possibility, take the time to look at what the career looks like in private practice.

3. Inpatient bias. Most of your clinical experience will be on the wards even though most physicians have a practice that is predominately in the ambulatory clinics.

E. Money. All medical careers will allow you to live comfortably, but remember that comfortable is a relative term: your standard of living is likely to catch up with your income (it will always seem like you need more money). Financially productive physicians are those who receive enjoyment and fulfillment from their careers: they are less apt to seek fulfillment in purchasing expensive cars, boats, and vacations. Remember too that time is always more important than money. For example, given the choice

between jail time and a substantial fine, people always choose the monetary fine. You are likely saddled with large student loans, and the prospect of having these paid off as soon as possible is attractive. You will not always have loans, however; you will always have the career that you choose. Mid-life crises happen to people who have lots of money, but little fulfillment in their lives. The result of a mid-life crisis is always a new car and a new marriage; both of which rarely result in more fulfillment, they just reduce the total amount of money. The most pressing concerns are those that are most readily apparent to you: those of the 25 year-old man with \$120,000 in loans. Try to make your decision of the 35, 45, 55, and 65 year-old man who has to live with your decision.

F. Lifestyle. Integrate lifestyle into your choice, but do not let it dictate your choice. By their nature, some careers will require you to be on-call at unpredictable hours (i.e., trauma surgery, obstetrics, etc.). Do not be deceived, however: every field will give you some latitude in defining your job description. If you do not want to be on call, almost all specialties allow you to choose a job that requires little or no call. You may get paid less, but the sacrifice of money for time may be worth it to you. The point is that you, and not your career choice, will dictate what your job description will look like. Once again, do not be a slave to bad faith: you have control over your lifestyle.

1. Time off for family. Remember that the best thing you can do for a healthy family life is to come home having spent the day being fulfilled, and not beaten down, by your career. Enjoyment of your personal life and free-time will be augmented if you are fulfilled by your career. The opposite is also true, regardless of how much free time your career provides.
2. No call. After finishing medical school and residency, call may seem an onerous feature that you want to avoid. Keep in mind, however, that call for the attending academic physician or the private community physician will be very different (and likely less taxing) than call for a training physician.
3. Liability. Do not let the lawyers choose your career for you. High-liability professions (surgery, ob-gyn, emergency medicine) usually have insurance proportional to their potential liability. Good physicians have the lowest risk of liability. You are likely to be the best if you are doing a career you enjoy.
4. Burnout potential. Burn-out is not a function of too much work, it is a function of lack of fulfillment out of proportion to the amount of time and energy invested. Seek a career that fulfills you and burn-out will never be an issue. Remember that thrilling things rarely sustain fulfillment; making a difference in peoples' lives (and being able to see that difference) usually does.

G. Up-front difficulty. Some careers seem so vast and onerous at first-blush (general surgery, internal medicine) that you will be tempted to believe that you will never be able to do that career. No one likes feeling out of control, and with the limited knowledge you possess at this stage of the game, it will be tempting to choose a career that you feel you can get your arms around at this stage of your life. Remember, however, this decision is not for what you will do now, but what you will do for the rest of your life. See these vast careers as a good video game: no one enjoys a video game you can master in the first hour of playing it. It loses its appeal if you know you can always win. If you relish the thought of doing the same limited area (which some people do) for the rest of your life, one of the subspecialties if for you. If you like the thought of a continual challenge in your career, then one of these (at first blush) intimidating careers may offer you the

challenge that you will enjoy ten years down the road. These careers are like golf: no one enjoys golf the first time they play it: it is too difficult to be good at it the first time out. Over time, however, you develop proficiency in the game, and there is a certain satisfaction that comes with mastering the ultimately difficult game. Over time you will develop mastery and the uncomfortable feeling of being out of control will abate. The key point is that you choose the career not based upon how intimidating it appears and not based upon your ability now, but instead based upon what you will enjoy doing after several years of doing it.

IV. A Method for Choosing Your Career

A. Do not stress. How can you read the handwriting on the wall when your back is against the wall? Not knowing your career does not mean that you are aimless and uncommitted. It simply means that you need more information. Structure your fourth year so that you can acquire this information. Do not be concerned if you change your mind between now and then; this is normal.

B. Narrow it down to two choices as soon as possible. This will allow you to do as many rotations in these two areas as possible. It will also allow you to focus your efforts on researching these choices. Your first two rotations in fourth year should be in these two fields.

C. If you are still on the fence come August, prepare to enter the more competitive of the two residencies. The competitive residency application process begins earlier in the year and involves scheduling more interviews. It is possible to start the ophthalmology interview process and then change to internal medicine half way through the process. It will be next to impossible to do the reverse.

D. Make your final decision not based upon what is attractive in each of the careers, but instead based upon what you do not want to give up. Choosing a career is like choosing a spouse. Of the many people you will date, each will have likeable attributes. No one person is likely to have every attribute, however, and so you will have to give up something. Each person will have something you value, but one person will have something that you cannot see yourself doing without for the rest of your life. That is your spouse. The same is true for your career. You may enjoy the thrill of the operating room during surgery and the challenge of figuring out a complicated multi-system case in internal medicine. Both are attractive, but you cannot have both. Which of the two can you not do without? Use the Friday 5 PM test to decide. Imagine that at 5 PM on a Friday, as you are leaving the hospital, you are told of an interesting surgical patient going to the OR. Will you stay for the case? Now imagine a complicated internal medicine case with interesting physical findings rolls in the door. Will you stay to evaluate?

E. Choose a career for what it is, not for what it is not. You will be able to negotiate the logistics of your career (call, salary, etc.; see above), but you will not be able to change the character of the career. If you love patient care, do not think that you will be able to be “the radiologist who sees patients.” Your employer will expect a radiologist to read films, not see patients. The ER doctor is expected to see patients quickly, not to do full internal medicine work-ups in the ER. You can do the extra tasks (seeing patients, evaluating complicated work-ups) but you will do so on your own time. Like a spouse, love your career for what it is; don’t try to change her.

F. Do not plan on doing two residencies (i.e., I'll do internal medicine now and come back and do radiology residency later). Residency is harder than you think, and it is unlikely that at the end of the first residency you will be opting to re-enlist in another. Even if you do, you will be substantially less competitive. Why? Your second residency program will not receive as much money to compensate you. Each hospital training program receives two types of funding from Medicare for each resident it employs. Direct Medical Expenditures (DME) funding essentially pays your salary (\$40,000); Indirect Medical Expenditures (IME) funding (\$120,000) is paid to the hospital under the presumption that they will be less efficient in making money because they are training you. You see none of the IME dollars, but it matters to you because IME funding is given only for the resident's first training program. The program that accepts you for your second residency will receive no IME funds for you, making you substantially less competitive when compared to another fresh-out-of-med school applicant for whom they will receive the funds.

V. ACADEMIC CAREERS

A career in academic medicine may seem daunting at first since people who do it are quick to tell you how miserable it is. It is true that academic physicians get paid substantially less than private practice physicians and that there is most cases pressure to publish scientific studies and obtain grant funding. The discrepancy in pay is across the board, but much more pronounced in high-paying specialties (see below). As a rule, academic physicians get paid between 1/3 to 1/2 as much, but it is also true that they have to deal with substantially fewer headaches. Malpractice insurance is paid by the university, and malpractice as a whole is much less frequent. There are residents that do most of the work, and while they know less, they tend to be more compulsive in checking details than the average physician. There are also a multitude of consultants and colleagues to assist the academic physician. The fact that the physician is not treating the patient for profit makes for a more altruistic motive when facing the jury. At this stage in your career being successful at publication seems impossible, but that is because you have not been trained to do it yet. The people who fail do so not because they are unlucky (as the academic physician would have you believe) but because they are uninterested in doing it. The person uninterested in scientific research should not do academics, because he will ultimately not be good at it. There is a role for clinician educators, and if teaching is what you like to do this may be the career for you.

Promotion is the key in academics, since this defines how long you stay in the academic center and your pay. Most academic physicians receive a base pay that is somewhere between \$80,000 and 150,000 depending upon the rank and the specialty. On top of that the physician receives a percentage of what he bills for as part of his practice. Non-clinical physicians may receive a higher base salary with the expectation that they will ultimately cover that difference with grant funding (see below).

The ranks in academics (with national average base pay) are: Clinical Instructor (\$80,000), Assistant Professor (\$85,000), Associate Professor (\$100,000), Professor (\$120,000) and then various levels of Professor (Professor level 1, level 2, etc.). All faculty with whom you have worked have an appointment at least at the level of Instructor. Progressing to Asst. Professor is

very easy; progressing to Assoc. Professor is much more difficult as it is an implicit message that this is someone the center wants to keep around for a very long time. Promotion is based on time spent in academics (usually at least 3 years for Assoc. Professor; at least 8 years for Professor), publications, service to the center, national reputation, and most importantly grant funding. As a physician receives a grant, some percentage of that money goes to support his salary. Another large percentage (upwards of 40%) goes to the university to support overhead; these are called indirect costs. The physician who brings in many grants in essence pays for his own salary, and the university makes 40% of each grant. You can see why grant funding is so important to the university.

Tenure is a very big deal, since the tenured physician (like a “made man” in the mob) is untouchable: he cannot be terminated from the University without a gross violation of codes of conduct. The premise of tenure is that it protects academic freedom: a physician scientist cannot be terminated because of the results or topic of his research. Obviously, the university does not want tenured physicians that they would not otherwise want to keep around; the potential for “dead wood” is high. In most centers, there are two tracks for academic physicians (the ranks are the same): tenure track and non-tenure track. The non-tenure track is for most clinical physicians since grant funding is much less of their reason for existence. To the university, the fully grant-funded physician is who they want to tenure. If the guy brings in money each year and pays his own salary, why not keep him around? So brass tacks: publications do not get you promoted or tenured, grants do. Ultimately publications are important only to the extent that they predict grant funding. For physicians who do engage in the tenure track, there is a scary consequence. At the seven-year mark, a committee will meet to decide if this physician is worthy of tenure. If not, he must leave the university. The non-tenure track physician can stay on as long as the dean sees fit, but he can be fired at any time.

The bottom line is that academics is for anyone who wants to do it; it is not just for those who are the smartest. Again, “Find a man diligent in his business, and he shall sit before kings.” (Or was it deans?). It has great potential for enjoyment, as the intellectual environment is stimulating and the chance to empower student physicians is fulfilling. The patient population at university settings is usually the underserved (since private practice physicians make no money on these people), and this too can be rewarding if you see this as your calling. If you think you want to enter an academic career, you should start telling people (every person you meet) that now. Choose your residency at an academic center, and latch on as soon as possible with a mentor who can teach you how to research and how to teach. Publication at this stage is not important: you will be picked up in an academic center not based upon what you have published, but instead based upon your potential for ultimately bringing in grants. At all times in your career, remember this: deans do not care what you have done in the past, they only care what you can do for them now. If you want to do academics for teaching only, then aggressively pursue the goal. Learn to teach well by pairing yourself with a teaching mentor. To avoid bitter disappointment, however, you have to know that this choice means that you will likely never make as much money as your private practice colleagues, and you will statistically not advance as high or as fast as your research colleagues.

VI. PRIVATE PRACTICE CAREERS

Private practice careers are so varied that it is impossible to describe the different permeations here. A few key points in making this decision are worth describing, however. The private practice physician derives his salary from billing, and billing is contingent upon three things: 1) Patient volume, 2) Patients who have insurance, benefits, or will pay, and 3) Documentation of the service provided. If you are missing one of these, money does not come in, and the practice is finished. Keep in mind that there is substantial overhead: paying malpractice, renting office space, paying office workers, billing officers, etc. is expensive. Coming up with this up-front capital is almost impossible for the neophyte physician who has student loans, and for this reason, nobody starts a practice solo anymore. Usually, physicians will latch on with a group practice or be hired by a hospital or HMO who will absorb most of these costs up-front and guarantee a salary (i.e., independent of what he bills) for the first two years with the hope that the physician will generate money for them when he is established. This means of course that the private practice physician (who hoped to escape the politics of academics) is now saddled with a tax that he must pay to the group that hired him, and must be a slave to some extent to their political machine.

Usually, however, all of this works out: the physician becomes established in a group practice and ultimately becomes a partner, which means that other neophyte physicians now pay a tax to him. The downside to private practice is the drudgery of paperwork and dealing with insurance companies; for if you do not document, you do not get paid. The other downside is the lack of intellectual stimulation that comes with working with scientific colleagues, students and residents. Skills decline, and there is a constant pressure to stay current on the recent advances in medical care. The other downside is that private practice will always gravitate towards paying patients; caring for the underserved is possible, but always at your financial expense.

One last thing, the tests do not stop after graduation from medical school. In each specialty you will be required to take certification tests every five to ten years. The academic physician is at a natural advantage, since it is likely that he has heard the newest therapy discussed as part of the incessant rounds and conferences that are a part of his daily work. The private practice physician must have the discipline to stay current with the medical literature. This requires time, and time in private practice is money. The discrepancy in pay between academic medicine and private practice is in some part neutralized by these hidden expenses.