



Profiles in Plastic Surgeons' Practice Transitions

By Karen Zupko

Sorry, I didn't call you back last week, Karen. I was climbing mountains in Nicaragua."

That was the message that New Orleans plastic surgeon John Church, MD, left for me after my call requesting an interview.

What a perfect message and precursor to the fascinating, motivating, and instructional conversations I've had with nearly a dozen plastic surgeons who have transitioned from active practice—and one who returned to recreate a practice.

The surgeons interviewed for this article are living proof that the predictors of successful aging I found in various articles are accurate. Those qualities are, in order: optimism, wisdom, resilience, self-efficacy, low perceived stress, low level of depressive symptoms, exercising, writing, computer use, and regular socialization.

One surgeon commented, "Practice transition is a euphemism for retirement." Well sort of. For many physicians, the word and concept of "retirement" has a negative connotation. In my conversations, I found no one sounding old, bored, tired, or defeated. Retirement usually means an ending—for some surgeons, the transition was a wind down to retirement.



John Church, MD, enjoying his retirement mountain climbing.

When Should Surgeons Transition or Retire?

"Before you have to," was the unanimous opinion of those interviewed. Bill Mullis, MD, long time partner at Charlotte Plastic Surgery, summed it up this way: "I would never want to put one of my partners in the position of saying it was time for me to go because of clinical reasons. Imagine the personal anguish that would cause them. And, what a personal blow to receive that feedback."

Although there is no required age to put down your scalpel, it is interesting that other professions do have mandated "finish lines." For example, Pope Paul VI decreed that bishops retire at 75. Air traffic controllers have a mandatory retirement at 56; pilots must retire at 65 and fire fighters at 57. Supreme Court justices in three states must retire at 70, while US Supreme Court appointments are for life.

If you're looking for detailed trends in plastic surgeons' retirement ages, read *The Ageing Surgeon* by Edward Luce, MD which appeared in PRS, March 2011. His article shows research indicating that 39% of plastic surgeons retire between 65 and 74. Of course, the growing trend toward non-invasive treatments means that trading injectables and lasers for the OR can extend one's profitable practice years. On the other hand, surgeons who faced significant losses in the 2007–2008 economic down turn, but now see their retirement accounts swelled with post election profits, may decide to head for the exits a bit earlier.

2003 ASAPS President Franklin DiSpaltro, MD, who retired at 67 in 2007 shared that, "When you feel your tolerance for the behavior of the operating room staff is waning, and on the occasion where your hands may be one step behind your thought process, it's time."

When Dr. Church was asked if making the decision to leave practice was hard, he laughed and said "NO!" and added, "Leaving on top when both the practice and I were healthy was important."

Jim Wells, MD, ASAPS past president, retired in 2016 at 75, after 42 years of practice. In discussing his decision to stop practice, Wells says, "I was blessed with good health. But I am not one of those doctors who said, "Gosh, I wish could've done one more operation.



Jim Wells, MD, culls through old patient charts from his storage facility.

"Now a public member of Long Beach Memorial Hospital's board of directors and a member of the philanthropic board, staying involved at an institution where he served three times as chief of the medical staff was important. Dr. Wells reports, "We recently had a group of surgeons from Japan, and taking them on the tour of the ORs, I can honestly say, I don't miss operating."

Planning is the Key to Success

A gerontologist friend of mine used to say, "Retiring from medicine, without retiring to something, is risky." Often he quipped that golf didn't count because rarely after the first year did one's handicap improve.

None of surgeons interviewed fell into the golf trap or made a knee jerk decision to quit. All demonstrated talents for planning for life post practice. And, each reported being happily married and gave their wives credit for a smooth transition.

Dr. Mullis, speaking on the subject of retirement planning at a recent Southeastern Society for Plastic and Reconstructive surgery

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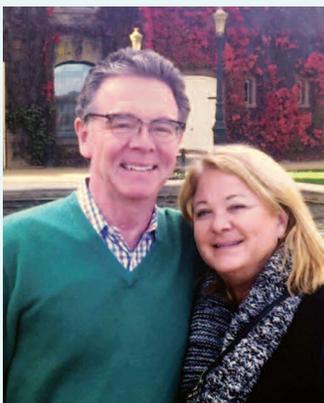
From Surgeon to Hospital Executive to Surgeon, Jim Moore, MD, has come full circle

From a solo practice in Athens, Georgia, Jim Moore, MD, transitioned to becoming a senior VP and chief medical officer of his hospital. He felt prepared for the position, after holding seats on the hospital board and serving as chairman, as well as eight years in key medical staff leadership positions; Moore at 60 was ready to try something new. That was in 2012. Yet, just three years later he was in back in practice. The hospital installation of an EMR and the surrounding politics resulted in Dr. Moore explaining: "That experience wasn't what I had signed up for," prompting his decision to resign.

After a several month sabbatical, he and wife Susan, who is a nurse, opened a new practice with a full service med-spa.

"My heart, I found, is in being a plastic surgeon," he says. "And, it was fun starting a new practice having had experience." Moore who will turn 65 in May found that there is such a thing as patient loyalty. "Look, when you depart, patients move on and find other doctors. I didn't know what to expect."

"My breast reconstruction patients from years back returned; we'd been through a lot together. I heard things like 'I need you doc' and 'We're glad you're back.' And, it wasn't just reconstructive patients either—"My returning



Dr. Moore has simplified his practice, opting out of Medicare and Medicaid and no longer seeing trauma cases. He and his wife Susan, who works in the practice and is shown here, are targeting his retirement at age 69.

patients were from across all service lines including injectables. When you reflect, it is nice to know that you really did have an impact on people's lives."

Looking back, he says that his time in administration has contributed to his consultation style. "I'm a much better listener—I find that I focus more on the patient's goals and less on the technical issues of scheduling. I feel more relaxed."

Dr. Moore's new practice is edited—having opted out of Medicare and Medicaid—he has a very limited insurance profile. "I focus on facial aesthetics, breast, and body surgery. Past breast reconstruction patients are seen for removal and replacement of implants—no new primaries. And, no trauma."

The full service med-spa offers the services of an aesthetician, top line laser treatments as well as Coolsculpting and injectables.

When he asked if he has pegged a new retirement date, Dr. Moore reports that he and Susan, who works in the practice have arbitrarily settled on 69. He feels if he wants to slow down further, the options that the med-spa services offers are a nice transition. And, that it allows greater flexibility for time off.

meeting, offered these five financial planning tips to surgeons of all ages:

1. Stay married to your first spouse—if at all possible.
2. Get your kids through college as quickly as possible.
3. If you are 50 or older, do not build a new house. A female surgeon recently added, "And for heaven's sake do not build an ASC!"
4. Avoid buying expensive assets that do not appreciate in value such as cars, planes, and boats.
5. Get out of debt as fast as you can.

Most everyone, surgeon or not, who I've shared these rules with agrees. All of the surgeons seemed comfortable with the organization of their financial and investment decisions.

Assuming the financial affairs are in order, winding down your practice and deciding what to do with your time become two major issues. The "retiring from practice" choices are interesting.

Perhaps Dr. Church in New Orleans had the most interesting strategy. "I tried retirement out. I started out taking afternoons off, four days a week. And, then I took Fridays off. Next, I went to three days. I figured that if I couldn't keep myself busy and from going nuts with that much free time, stopping practice altogether wouldn't work." (Clearly, he was a surgeon who could manage his overhead.)

Dr. Mullis, a well-known rock and roll enthusiast, experienced chest pain while dancing with wife Linda at a Platter's concert in 2004. The pain was a due to a 95%

blockage. It was repaired with stents and he was back in action. "But that was a wake up call," he said. "There is more to life than dying with your boots on in the OR."

Like Dr. Church, Dr. Mullis began to practice on a reduced schedule, leaving Thursdays at noon, and returning to the office on Monday. If you are organized, Dr. Mullis advises you can keep this schedule and operate. It's one of the advantages of being in a group. Because he'd been practice for 25 years and the hospital and his group agreed, there was no call obligation.

Winding down a solo practice, says Dr. Wells, is almost more work than starting one. He advises contacting your state medical association and professional liability carriers for checklists. Solo doctors have the burden of

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Turning in your DEA license too soon is a mistake, Dr. Church, learned the hard way. In order to participate at the university, you need a DEA license. When you check the box on a form that you turned it in with no place to indicate you did so voluntarily, alarm bells seem to go off. After dealing with the bureaucracy and paperwork, he regained that license and the ability to participate at Tulane.

arranging for record storage and retention according to state regulations, as well as disposing of drugs, and ending all service contracts for phones, software, copiers and other leases. Regardless of your practice type you'll need to notify the state board, the DEA and Medicare and any other plans you participate in.

TIP: The 66 page guide *The Doctor is Out: A Physician's Guide to Closing Practice* developed by the North Carolina Medical Board is one resource that makes this easier.

7 Key Questions to Help You Plan

"The longest journey begins with a single step" is a Chinese saying with relevance to you if you are in your late 50s or older. The time to plan is now, with an eye to the future.

The almost-60 surgeon who told me last weekend about his office building, OR and recovery center blueprints—with no succession plan in place—clearly needed to stop and ask himself these questions. Also, being a doctor, he should have known that saying you want to practice for another 10 years doesn't necessarily mean you get to do so.

1. Have you done a check with your advisors, lawyer, estate planner, investment advisor, insurance broker and accountant as a team?

Having them all sit down and provide different financial perspectives and tax issues is often instructive. And, you will make better



Cleaning out years of journals is a big task.

decisions than if you tried to make thoughtful choices between cases or exam 2 and 3.

Don't make the mistake of thinking your office real estate is your retirement plan. Remember 2007–2008. And, your price may seem inflated to buyers. Real estate's illiquidity seems oft forgotten.

2. What does your spouse think? His or her age and stage in life may influence some decisions and the timing. You may be ready to retire, but he or she may not. Remember Henny Youngman's advice, "Promise to take your spouse for better or for worse, but not for lunch!" As Dr. Mullis said, "the house is hers."

3. Realistically assess the benefit of thoughtfully recruiting a like-minded associate or successor, as I like to call them. Someone to cover 50% of the overhead after awhile would be a positive for most solo surgeons. And, look at your options to practice part time. Can you afford to ease out?

4. If you were to retire within the next six months, what your routine would be like? After the initial travel is completed and the long postponed fun is over, then what? And, what about year three?

5. What will fill the void of patient gratitude and being good at what you do? Sure there are practice hassles but there are plenty of rewards too.

6. Anything left on your professional "to do" list?

7. Does your legacy matter? David Brooks asked the question at a talk I attended: Have you been so busy working on your resume, that you've neglected your eulogy? It's a pertinent question.

Learn from Karen Zupko
In-Person at
The Aesthetic Meeting!

TEACHING COURSES:

Friday, April 28, 2:00–4:00pm

111 Relationship Marketing: What It Means and How to Put It in Action

Friday, April 28, 4:30pm–6:30pm

214 Successful Principles for Non-Surgical Services: Fast Track Your ROI

Saturday, April 29, 9:00am–4:30pm

S13 Skills for Successful Patient Coordinators

Sunday, April 30, 9:00am–11:00am

S16 Patient Coordinator Alums

Sunday, April 30, 12:00pm–1:00pm

S17 Financial Management for Spouses and Surgeons

Sunday, April 30, 2:00–4:00pm

419 Managing and Developing Your Most Valuable Practice Asset

Monday, May 1, 2:00–4:00pm

613 Reading Prospective Patients More Effectively and Improving Scheduling Results

PRACTICE CHANGERS:

Monday, May 1, 12:30pm–12:45pm

Online Leads Expire!

What To Do With All that New Found Free Time?

Not surprising, the retired plastic surgeons I spoke with share an artistic bent. Jim McDonough, MD, a retired plastic surgeon in Asheville, NC, shares his beautiful photographs daily on Facebook with an adoring group of "likers," including me. His abilities as a sculptor and potter are equally as impressive. Phil Stone, MD creates exquisite wood art pieces. Jim Wells, MD reports that he has rekindled an interest in music and is once again taking drawing lessons. Dr. Mullis reports his wife Linda encouraged him to try sculpting. She approached a women's sculpting group about letting him join. After some debate they voted him in. "When I was able to demonstrate how to do a nose, everyone was impressed," he told me.

As for volunteer activities, Dr. Church enjoys supervising the residents' aesthetic clinic at Tulane. It's rewarding and the young

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surgeons are “awesome smart.” However, Dr. Church says there is some small satisfaction when supervising in the OR: his decades of experience allow him to say, “I wouldn’t do that.”

Turning in your DEA license too soon is a mistake, Dr. Church, learned the hard way. In order to participate at the university, you need a DEA license. When you check the box on a form that you turned it in with no place to indicate you did so voluntarily, alarm bells seem to go off. After dealing with the bureaucracy and paperwork, he regained that license and the ability to participate at Tulane.

Dr. Church described the benefits of having started mountain climbing when he turned 50. It has taken to him eight countries in central and South America. Now in his 70s, his climbs are not as rigorous as those done in his 50s, but provide a challenge, camaraderie, and great sport. Speaking of sport, Dr. Church must be one of the few surgeons who didn’t play golf, but who took it up late in life with clubs given to him by Gus Colon, MD, who was in his call group.

Of the surgeons interviewed only Dr. DiSpaltro and wife Val have relocated from their original home state. Having moved to Palm Beach Gardens, Florida, they live on street with five surgeons from N.J. who were interconnected with three from St. Barnabas medical staff.

Bill Mullis makes the point that there is no reason to be bored. “There are plenty of medically related charitable organizations that can use your help, and residents’ clinics. Plus all sorts of meaningful volunteer and online educational opportunities.”

Karen Zupko, President of Karen Zupko & Associates, Inc., is an internationally sought-after speaker, author, and practice management consultant. For more than 30 years, she has been advising and educating plastic surgeons on management and marketing issues, including group practice issues, personnel, billing, technology, coding, and practice expansion.

For more information on the Aging Surgeon Program, please visit <http://agingsurgeonprogram.com>

Avoid Choosing the Wrong Investment Firm

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When Beauty is Not Fleeting

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reaching impact on the self-esteem of patients, we have watched with equal amazement the evolution of breast reconstruction remove, with no less diligence, the heartache of amputation and create in its place a fair contender to nature’s own hand. Dr. Pat Maxwell, globally recognized for pioneering many significant innovations that have raised the bar for the post cancer woman, credited recent advancements with offering more specific choices for women, based on body type, and, therefore, yielding unprecedented outcomes in the recreation of the breast.

As recently as January of this year, options expanded with the FDA approval of the Natrelle Inspira Soft Touch implant. This gave access to implants with three levels of cohesive gel in this line allowing surgeons to make decisions that are very specifically aligned with patient goals and desired outcomes.

As a researcher who has pushed the envelope for improved strategies for restoration of women after the trauma of disease, I have long recognized that many of the hurdles the post cancer woman faces are the result of an accelerated aging process resulting from the hormonal impact of treatment. We have moved well beyond breast reconstruction to embrace a suite of tools that, in their totality, recreate the full picture of health and vitality so critical to the reinvention

process often referred to as “moving on.”

As we redefine beauty on individual terms we acknowledge not only the right of choice, but, also the power to create and recreate ourselves over many stages of life. This process of reinvention, whether manifested in a single or multi-dimensional approach, has long been a defining element of a well lived life. It encourages one past the barriers of hurtful experiences and beyond the fears many hold when considering the passage of time.

As we learn to embrace and combine our unique perspectives and approaches with the deep-rooted needs of the patient, we co-create not only the curve of a face or the shape of a breast, but the path of the future for the one who will undertake the journey. So, as we push the bar for meaningful changes to alter once firmly held limitations, we applaud Christie’s return to the pages of SI, and look to see when the natural curve of the reconstructed breast will appear on a runway angel destined for the Victoria’s Secret walk knowing beauty is found in all forms of life’s experiences, and that we are closing the once unyielding divide in our interpretations.

Tamarin Lindenberg is a healthcare executive and behavioral researcher with a specific focus in medical aesthetics. She leads an investment fund for early stage ventures in medical aesthetics. www.hittiinc.com