Chapter 2
Choosing the Right Job—How to Find the Right Fit, What Should I Look For?

Prashant Sinha

The experience of choosing a job as a surgeon is incomprehensibly complex. There are an increasing number of post-residency fellowships, an increasing demand for jobs with an expected 20% growth between 2012–2022, changing competency requirements, and increasing marketplace competition. The era of one job for a lifetime is gone, over 50% of physicians change jobs within the first 2 years [1], and practice patterns are rapidly changing. It is this incredible diversity that makes practicing surgery today, and for the foreseeable decades, more variable but also more personalized than ever before. What this means for your first or next job is that the more you look, the closer you get to ideal. A good job should find a match with an individual that sets realistic constraints and prioritizes their expectations with honesty. This chapter on choice should appeal to a diverse group of job seekers, and I will strive to provide tools to inform that choice as much as possible.

As background, I have lived my adult life in the US Northeast, not straying very far or for very long. My training and practice is and has been predominantly in academic

P. Sinha, M.D., F.A.C.S. (✉)
NYU Langone Medical Center,
530 First Ave, Suite 6C, New York, NY 10016, USA
e-mail: prashant.sinha@nyumc.org

D.B. Renton et al. (eds.), *The SAGES Manual Transitioning to Practice*, DOI 10.1007/978-3-319-51397-3_2

medical centers, but I have deviated out of academia for a community practice, and I have practiced in fields outside of clinical medicine including finance, web development, and medical device development and have enjoyed every bit of it. I am not advocating for my particular choices though, as they reflect only my interests; choices should never be imposed on you when job seeking.

I presume that as job seekers, you will have chosen a specialty or focus in surgery that suits you well. Specific specialties will provide constraints of their own, particularly when a field requires regionalized referrals to a large medical center—transplant, surgical oncology, endocrine, and pediatric surgery for example. Beyond specialty, life circumstances will place particular constraints on choice, and it is very important to respect those constraints rather than ignore them. A prominent transplant surgeon told me that he started his job based on geography, and has never regretted it. It allowed him family stability and family support while he began his career, and subsequently allowed him to loosen geographic constraints when his family's needs changed. He changed jobs (and geography) twice since, each change fulfilling a specific career goal. Prioritize life constraints before choosing a job. Salary, predictability of hours, benefits, research, teaching, community or regional presence, commute, growth opportunity, and opportunities in unrelated or tangential fields; these are all different considerations among many more that can shape your future career or careers.

Salary is only one driver of choice, but one that is highly variable and highly subjective. Once a threshold is crossed, the value of salary may be secondary to other constraints. Most people will understand the drivers of and range of salary as they start their search within a given specialty and geography. As a general statement however, the Department of Labor and Statistic reports that the median general surgeon pay is $367,885 in 2015. There are significant variations depending on fellowship training, geography, and years of experience. The first year of practice in any setting is expected to generate a loss on the professional side. Most every entity,

faculty practice, private practice group, and hospital employment, has a mechanism to manage this loss. Hospitals, for example, offset the employment overhead through new inpatient admissions, by pooling overhead costs with other surgeons, and by providing income guarantees to allow time for practice building. It is often for this reason that many contracts include a 1–3-year term for renewal allowing a mechanism to assess practice building and to manage the risks of a poorly performing surgeon. If income concerns are a top priority, choosing to practice in a large medical center will usually provide the most clinical volume stability with the least financial risk. Large medical centers recognize this and can afford to reduce salary commensurate with their stability and reputation. They count on longevity, productivity, and other factors like outcomes and academic contribution as metrics to increase salary. Surgeons that choose to diversify their practices can benefit from increased income and not always with significant increase in risk. Diversification may include combining high volume ambulatory procedures with more complex inpatient procedures. Alternative income strategies could also include investment into physician owned practices, or ambulatory care centers when allowed by law. Physicians that add administrative job duties within a hospital or large group practice have diversified their talents and income stream. Low-level administrative duties do not add income, but with progressive experience or targeted management training, physician leaders within a hospital or healthcare network are highly valued and can be compensated accordingly. Some private practice surgeons have used their creativity and entrepreneurship exceedingly well to add revenue. I personally know a few business-minded private practice surgeons that concurrently pursue medical device development while maintaining a hospital affiliation for referrals and continue to pursue scholarly activity through their professional society. Some have invested time and money in hobbies or fields entirely outside of medicine. Maintaining an efficient clinical practice can provide a solid financial base for almost anything, particularly when all

aspects of the finances and clinical volume can be controlled as in private practice.

The next several sections will discuss the various venues for practicing surgeons, private practice, academic medicine, institutional medicine, and community hospital medicine. This will be followed by a concluding section summarizing the various aspects of these different types of practices and the types of personalities that are drawn to those types of practice.

Private Practice

It is still possible to have a successful private practice, even as a solo practitioner, but it is important to have a full understanding of what it entails. The private practitioner still exists in surgery in many parts of the country both urban and rural, although the overall trend has been toward employed positions. The pressures that have driven practitioners away from a solo practice into group or hospital owned practices are significant, mostly poor growth in reimbursement relative to office costs. A new requirement to switch to electronic medical records systems has unfortunately added to overhead costs. And, with overall payments decreasing relative to inflation, workloads have increased causing surgeon fatigue. However, the satisfaction of managing all aspects of a private practice can be very gratifying due to practice efficiency, capturing more of the gross income and actively control workload. The net income difference in private versus employed group employment has decreased though, and the ability to capture patient market share can be harder with managed care contracts, while benefits such as personal healthcare costs have increased. A decision to enter a private practice should weigh these issues particularly when an arrangement is being made to work at a hospital or ambulatory clinic. It will be important to understand how surgeons currently work at the facility that will support your surgical procedures, and also to understand how a hospital would view your entry into

the market. You should understand whether your entry creates competition primarily or whether your entry comes with added skills that are not currently or readily available. There is a trend toward hospital acquisition of physician practices, particularly mature ones that serve patients that may choose between several hospitals. Hospitals make money with inpatient stays and referrals to inpatient services or ancillary services that are hospital owned. If possible, learn about any recent physician practice acquisitions before choosing to enter the market independently.

Three of my friends have nevertheless chosen the private practice route, and each of these has taken slightly different routes. The first, a plastic surgeon, freshly out of fellowship, currently practices in three locations—a rented office timeshare in a cosmetic practice of an acquaintance, an ambulatory surgery center, and its affiliate hospital. He has chosen to define the scope of his practice to 10% cosmetic surgery with a well-established group as a contractor, and the remainder as reconstructive work focused primarily on breast oncology within a tertiary medical center with a cancer center and an affiliated ambulatory surgery center. His wife has become the business manager, and they have a wonderful work–life balance even if work is ever present in the background; that balance comes from the freedom of controlling their own workload. They have some risk as a solo practice, but these have been mitigated by having multiple relatively independent sources of revenue, and professional friendships that have allowed for mutually beneficial cross-coverage of patients. As time passes, his value in his community and his preferred hospital has continually increased leaving him with various opportunities—offers for practice buyout, transition to hospital employment, and requests for additional services. Next, an orthopedic hand surgeon chose to leave an academic practice where he was also a fellowship program director in order to build a better practice than the medical center provided, and one that clearly had need in the community. The process of starting the practice took a year of planning including a research

phase, wind-down phase at the medical center, and a transition into practice phase. He hired a new fellow that he had personally trained, rented space in a building owned by an existing orthopedic practice with minimal clinical overlap, and is using a free EMR to keep overhead costs down. The loss of significant income as he transitions his practice has been mitigated by having had 15 years of local community presence and savings behind him and a family willing to ride out the change with him. Before he announced his intent to leave the medical center, his practice was ready to start business in case his leaving did not proceed well; it worked out well with an agreeable transition period. His long-term plan is to grow the practice into a multisite facility as a route to his own retirement and as a lasting legacy to the community in which he has practiced. The third example, a bariatric surgeon, had joined a stable general surgery practice out of fellowship and used it to build a successful bariatric practice—this surgeon was also his senior partner's prior resident. When the senior partner retired, he had to decide on selling or staying. Having had a good trajectory and an office staff already accustomed to the increased overhead in managing a high volume bariatric clinic practice, this surgeon hired a newly graduated fellow and a physician assistant. At the same time he completed a successful negotiation with a competing nearby hospital willing to help provide growth through larger and better facilities, a new referral pathway that would allow practice growth, and a 3-year proposal for practice purchase. This savvy surgeon understood his market value to a competitor hospital and allowed himself to be "bought" by his competitor as the market dynamics changed. He and his new hospital gained as his former affiliate lost. Local laws can also dramatically affect local market conditions, and these are particularly important to pay attention to. For my three friends above, the longest in private practice had an ambulatory procedure suite within his office, but the other two could not build office or ambulatory procedure suites due to increased regulatory oversight over their creation and maintenance.

If starting a private practice is daunting or a finding a partner is difficult, then the benefits of private practice can also be had through joining a solo or small group practice. Any more than three practitioners usually becomes a more complex organization requiring a management tier and likely a senior/junior partner structure; the partner or managing tier is typically a time-tenured or high volume member that collects a higher salary and/or has an equity stake in the practice. In most established private practice settings, there should be a strong pre-existing relationship to a hospital and or ambulatory surgery facility. Similarly, there should be strong ties to referring physicians and these relationships must be respected and maintained in the manner set by the practice. Similarly privileges in the operating suites may imply negotiated on call coverage that is either accounted for in the private practice or may be an additional requirement. Joining a private practice is very much akin to joining a family; much can be learned by spending a day or more at the practice to watch how it conducts its business. It is vital to understand whether you will be adding growth or replacing a member, and to the extent possible to understand the business rationale for hiring an additional member. Relative to joining a faculty practice in an academic medical center, there is much greater transparency in understanding your own value and contribution to a small private practice group. A private practice group is also more sensitive to variations in the local market, and requires a particularly good working relationship with your peers as the risks are shared. A smart private practice group should help new hires with clinical and networking support early to reduce potential risks early in the relationship.

Whether you choose to start your own private practice by taking call in a hospital and building a referral base, or join a small private practice, make sure you have a good grasp of what it takes to manage a business. Recognize that it can take a good year of planning to put in place an office space, EMR, contracts with insurers, credentialing at hospitals or ambulatory surgery centers, and establishing a relationship with

referring physicians. A good lawyer or firm with experience in contracts for private physician practices is worth the seemingly exorbitant cost.

The choice to start or join a private practice requires a detailed understanding of running a business, managing staff, negotiating contracts, managing cash flow, and local market dynamics. It provides for professional independence, centers around patient care, and allows the practice to cater to a particular referral base or patient populace. Long-term patient relationships are formed, and strong professional relationships with referring physicians are required. It therefore tends to attract those with strong business management skills and a focus on patient care. For those unwilling to put any portion of their income at risk, those that foresee a potential job change for their spouse or partner, and those that need the stability of a large institution or benefits that come with institutional backing, private practice is not the right fit. If teaching and research are important, this is not the environment to find those opportunities apart from some teaching as a part of hospital privileging requirements or as part of a professional society.

Academic Medicine

Our medical education curriculum has been structured to provide a basis for both clinical medicine and research, and as such prestige for medical schools and universities comes from a hybrid of clinical reputation and research funding and often colors our perception of our own future in medicine. Few surgeons are uniquely gifted to conduct both basic science and clinical medicine; however, many do partner with basic scientists and statisticians to collaboratively conduct translational and outcomes research in a wide variety of fields. Consider that NIH funding as of early 2000 to medicine departments contributed about 28% of NIH awards to a medical school and correlated strongly with the NIH rank for that school while only 4.8% of NIH grants went to surgical

departments of which general surgery took the largest share [2]. Further consider that more recently in the decade ending in 2013, surgical NIH funding decreased 19% with a proportional tripling in outcomes research funding [3] and you understand what a rarefied opportunity Academic Surgery is. For those individuals trained in this environment, jobs are highly competitive, geographically sparse and have pressures exemplified by the phrase "triple threat"—excellence in teaching, research, and clinical medicine. The barriers to entry for those trained outside of this environment are much higher. Fortunately, any motivated young surgeon that makes their way into academia is well equipped to conduct clinical and outcomes research with relatively little training in comparison to bench and translational research. The other unspoken truth is that clinical surgery has a highly valuable contribution to the bottom line in any hospital including the most prestigious of academic medical centers. A productive clinician may survive in an academic environment without significant academic contributions through excellent outcomes and a regional reputation that draws referrals. Conversely, a surgeon that is either not clinically productive or fails to provide the latest advances in surgical care does not have longevity.

There are not many headhunters with postings for jobs in academia. Many of these positions are filled through word-of-mouth, often through a network of fellowships, and through the social networks of mentors and leaders in academia. Fellowships often provide a path to the "academic circuit" of publications, national meetings, posters, podium presentations, book chapters, committees, and the like. While this path is not necessarily an equal opportunity endeavor, it does select individuals that can thrive in academia. Simply having a track-record of excellent teaching is not sufficient; however, the ability to combine a reputation as an educator with another pillar of academia is highly desired and is a hallmark of those that have patience and well-developed cognitive skills needed to lead cutting edge clinical care. Taking time to develop a highly technical skill such as laparoscopic

liver surgery requires an investment of time and likely money (or personal debt) and may be a path into academic medicine, but again requires time spent on the national or international meeting circuit, and must be combined with publications and other scholarly activities. A technical skill can be highly desirable but may also become a commodity with time, such as laparoscopy and bariatric surgery. Furthermore, a highly technical skill may require casting a wide net geographically to find a regional medical center to support the procedure and attract patients.

Publish and get on the circuit; those two activities will put you on the roadmap and will focus your thinking. At the same time, accept the constraints of regionalized medicine. Have a realistic discussion with your family and partner, decide on what priority to give geographic constraints if any, and carve out a finite timeline for developing a reputation—don't let the pursuit of entering academic medicine last more than a typical fellowship timeframe of 1–3 years. That timeframe should also result in scholarly activity presented in meetings. Remember that with the constraints of academic medicine, your particular talents should fit in well with a few centers that either have a reputation in your interests or have committed to developing that interest. Mentorship is very important—researchers with a proven track-record during protected time in residency will often gain active guidance in finding an academic job or be recruited. Mentorship should be actively sought as a trainee or junior attending builds their interests and reputation. Mentors help guide development and greatly aid in finding and choosing a job in academia. For most others that are interviewing, it is important to spend time independently researching an institution as much as possible in advance, and to obtain information from fellows, residents, and any others. To the extent it matters, it will be valuable to understand what expectations are placed in terms of teaching commitments, publishing, clinical volume and protected time, and the particular cultural quirks. An academic job should also support several areas of interest for a given applicant, but will also require various amounts of

clinical work. Questions should be focused on the tools needed to facilitate areas of academic interest and research—grant writing resources, core facility support for statistics, clinical trials, tissue banking, etc. If a commitment is made by the medical center to support a new procedure or new research techniques, particularly if capital equipment and labor resources are needed, then these should be included in the hiring contract and carefully reviewed. These are not common scenarios for junior surgical attendings but may arise when an established and talented individual is interviewing or recruited from one academic center to another, or from a highly regarded nonacademic institution into academia.

A job in academia is highly rewarding to those individuals that strive for that "triple threat" of patient care, teaching, and research. This environment is at the forefront of scientific breakthroughs and innovative approaches to care. It attracts a diverse group of patients and with them a diverse and at times challenging set of diseases and disorders, fulfilling to a surgeon interested in a broad exposure. With that type of clinical exposure, all types of research including clinical outcomes, innovative therapies, and systems of care and quality become productive and meaningful endeavors.

Institutional Practice

There is a world of opportunity to those academic-minded individuals that have not found a job at their preferred academic medical center, or that are primarily concerned with cutting edge patient care at a large hospital. These large institutional hospitals without associated medical schools are regional magnet hospitals that are known for advanced therapies and excellent patient outcomes, and even research. These institutions have typically developed clinical expertise in a few areas that may be nationally or even internationally known, have built operational excellence, and may even bring in substantial research funding. Recently, some institutions

have become large conglomerates seeking to control both tertiary care centers and ambulatory care centers and physician practices across a given region. This network building serves to capture more patients within the network and create bargaining power with insurers, and hopefully improve care delivery (think Kaiser Permanente). Similar to academic medical centers, there is a large hospital affiliated practice with a well-established business unit that provides billing and administrative support, malpractice, and benefits. With a stronger focus on clinical medicine, and more of a business-minded focus, there may be less room for negotiation of salary, less influence of academic contributions to your value, but better benefit packages, more clinical flexibility, and improved call coverage. These institutions proudly market their accomplishments, and broadly publish their long-term goals and vision; it will be very important to think about your own alignment with those stated goals. Institutions competing in a region may employ surgeons to help with expansion when certain competencies (i.e., robotic liver surgery) are needed to compete with other institutions, or to develop a cutting edge therapy, or to fill a vacancy in a well-developed practice.

The interviews for jobs in these types of institutions are more likely to have been posted or have been sent to a recruiter to find particular types of candidates. A job may have the hybrid feel of a private practice job and an academic medical center. Important questions include the clinical productivity requirements, single versus multisite practice locations, and the frequency of rotating through those sites. Salary and increases in salary may or may not be negotiable, but can be significantly better than an academic medical center depending on the region. Generous fringe benefits can at times supplant a salary raise, while operational excellence makes focusing on clinical care easy in this type of setting. Compared to a private practice, however there are likely more restrictions on the scope of practice, and in how a practice can be developed. Having management skills can be leveraged within these institutions as their complex

structure depends on good leadership. Similar to private practice, it is advisable to understand your own worth to the institutions goals and to plan your personal growth with the institutional vision. If a choice has to be made between an academic medical center and a nonacademic institution, benefits and resources that are available for clinical or research work are useful to compare and contrast. The culture of an institution is often set in the preceding decade, but it is very important to ask specifically about culture, shared values, and areas of change. The broader market in healthcare can subtly or dramatically force both academic and institutional centers to change the way they support clinicians and researchers. Major recent trends include increasing scrutiny in the granting and the maintenance of tenure in academia, in broadening racial diversity in the faculty, and in improving access to family support for an increasingly female workforce and in bending the cost curve. I myself have become increasingly engaged in the discipline of value-based medicine as an academic area of development alongside acute care outcomes, and advanced endoscopy. Heavy financial pressures on even very strong medical centers have placed increasing pressure on the individual clinician to become more cost conscious. Actively assessing what is on the mind of your future institution will give you a glimpse of your future within it.

In summary, institutional medical centers provide the closest clinical comparison to academic medical centers and have a central motivation on providing high volume, high quality and cutting edge clinical care. They care as much about their brand as an academic center, and may even have expertise in conducting research to rival the best academic medical centers. Compared to private practice, there is less schedule or practice flexibility, but a greater number of fringe and healthcare and retirement benefits. Salary as a private practitioner versus employee may or may not be competitive depending on the dominance of the institution on the overall local market; it may be better to join a dominant institution than to fight for market share.

Hospitals

Many hospitals do not fit into the model of institutional or academic medical center, but serve as the central focus of most surgeons. Hospitals can be fairly general or can be focused on specialties such as a cancer-focused hospital, a heart and vascular hospital, or hospital that has an associated ambulatory surgery center disease-focused on breast oncology. A disease or specialty-focused hospital can be a very rewarding place to work owing to operational efficiency. A community hospital may provide financial stability compared with private practice, while supporting lower volumes or lower complexity cases compared with a more urban setting. Choosing a hospital to work in should reflect your life priorities and how you conduct business at the hospital depends on your mode of employment; do you thrive with productivity targets, or would you rather work at your own pace. The preceding sections may already give a good flavor of what to expect in terms of employment by a hospital. This section will review many of the points made already and help the reader evaluate employment within a hospital. There are various models of employment that can be drawn up. There are a few basic parts that are combined in various ways. I will use my own experience as illustration.

I decided for various reasons to find a job within commuting distance for a year while I decided on my long-term goals. I found a job posting by a placement agency and very quickly found myself in a small community working in their local 100-bed hospital with five operating rooms and with a partner that was hired just before me. Before I moved back to an academic medical center, I knew that I would miss the more relaxed pace of performing community surgery as a hospital-employed surgeon, and I learned about my individual value to the hospital as a surgeon. Finally, more important than all of the benefits and salary models to be discussed below, the key to a successful practice is to have peers that are trustworthy and easy to work with.

I received a base salary for 2 years to allow for practice building. At the time, it was a significantly higher amount by

almost 50% than the salary being offered by an academic medical center. After the 2 years, my compensation would switch to a base salary plus work-based compensation. The base would change based on the prior years income and additional payments would come from RVUs. Work Relative Value Units (wRVUs) are a unit of measure that is used to calculate physician payment for a specific procedure performed. RVU models are commonplace and take into account the complexity of the cases performed. A surgeon may decide to pick a volume/complexity mix that works well. A more complex case requires more work and generates more RVUs and inpatient management time while an ambulatory setting may allow easier, high volume low RVU cases. The number of RVUs is ultimately multiplied by a base payment that accounts for regional cost of living, your specialty, and perhaps additional amounts to reflect productivity. Because the formulas can be confusing, I asked that quarterly reports of my RVU work be provided along with the associated income as if I were on that model, while I developed my practice. The models are for the most part fair and are calculated by various agencies to help hospitals recruit and retain physicians. Some RVU models do not use a base level of salary but tiers to reflect different amounts of work; at the first tier, the RVU payment multiplier is lowest, rising for the next tier(s). Other payment models can use billing or collections and sometimes employers will pool those payments for a group of physicians to allow for practice variations and differences in productivity. If your salary is based on billing or collections, and you change jobs, there may be a large amount of money that will be pending (accounts receivable) as you wind down and it is best to discuss how and to whom this amount will be distributed once you leave and the money arrives. RVU models can be advantageous in some settings with a poorly insured patient populace as the wRVU for a surgeon does not depend on how much is actually collected.

Benefits should be available including healthcare, provisions for retirement contributions or even an employer match, malpractice coverage, CME funds or meeting and travel funds. New equipment purchases for specialty

procedures, office space, physician extender support, discounted disability, and life insurance can also be part of a benefits package. Generally speaking, the larger the hospital the better the benefits, and while my hospital provided a very nice office space and excellent staff, there was little in the way of CME funds and no budget for physician extenders.

Loan repayments are not common but exist in underserved or critical access hospitals, and through the uniformed services as well as eight governmental agencies: National Institutes of Health; Food and Drug Administration; Centers for Disease Control; Alcohol, Drug Abuse, and Mental Health Administration; Health Resources and Services Administration; Agency for Health Care Policy and Research; Agency for Toxic Substances and Disease Registry; and Indian Health Service. For the eight governmental agencies, most will not support clinical surgery but may support related research, with the exception of the Indian Health Service. I know of surgeons in the Indian Health Service and in the Army and Navy; each of them has had challenging but gratifying experiences and careers. Both military and nonmilitary services are run with specific requirements and promotions as well as duty obligations. These will be discussed in a later chapter. Major additional benefits beyond loan repayment include exposure to global health and the ability to directly contribute to underserved populations, paid leave, travel benefits, and retirement benefits. Outside of these special government agencies, it may be worthwhile to ask about loan repayment from a prospective hospital employer in an underserved or rural area.

Malpractice coverage comes in two flavors, occurrence based and claims made. Private practice physicians will need to purchase this independently, but this is important to understand for any surgeon, particularly if there is any job or location change. Occurrence-based coverage allows you to change jobs or location and still be covered for the care delivered before the change. Claims-made coverage requires the purchase of a "tail" policy to allow coverage for any claims that arise after you leave. The individual surgeon may pay for this; however, it is common to negotiate this coverage with either the previous employer or the new employer.

Summary

Ultimately, there are more choices and more benefits available to surgeons today than there has been in the past. While payments have decreased and have become bundled, and administrative burdens have increased, a surgical career remains highly gratifying, and can be tailored to suit an individuals needs. There is no perfect job, and compromise is key while understanding the various modes of employment. I again emphasize that priorities should be given to personal needs, whether that is a salary goal, work–life balance, research, teaching, high complexity, low complexity, geography, service, or loan repayment. Some of the best advice comes from peer networking and mentors whether formal or informal, and meetings at professional societies. Some of the best job opportunities come from the same. Many of the concerns in choosing a job in various environments are listed here and hopefully each describes the atmosphere of that environment well. Choose based on your own research and ask important questions of your future employer and future peers. Remember that your needs may change or evolve over time, and in no way should you feel tied to one job for life. Finally, any job that you take will benefit from your own hard work, keeping in mind that the first several years require patience and extra dedication so that your expectations come to fruition.

References

1. United States Department of Labor. Occupational Outlook Handbook, 2008–09 Edition. Available at www.bls.gov (accessed October 5, 2016).
2. Ozomaro U et al. How important is the contribution of surgical specialties to a medical school's NIH funding? J Surg Res. 2007;141(1):16–21.
3. Hu Y et al. Recent trends in National Institutes of Health funding for surgery: 2003 to 2013. Am J Surg. 2015;209(6):1083–9.

http://www.springer.com/978-3-319-51396-6

The SAGES Manual Transitioning to Practice

Renton, D.; Nau, P.; Gee, D.W. (Eds.)

2017, XI, 249 p. 6 illus., 2 illus. in color., Softcover
ISBN: 978-3-319-51396-6