Episode 5 Top 3 Nonclinical Job Sectors with Dr. John Jurica

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HF: Hello, hello and welcome to The Doctor's Crossing *Carpe Diem* Podcast. A while back I was talking with one of my physician coaching clients about what he might want to do if he left family practice. He made me laugh when he quipped, 'I only know about the jobs I learned on Sesame Street!' I thought that was really funny and it also captured the reality of exploring non-clinical career options. It can seem like a big black box.

Well, today, I have a wonderful guest who's going to help me open up this black box for you and go over some of the most common non-clinical careers. He's one of my favorite podcasters. I recommend him all the time to my clients and creative resources for positions in transition as well as just an all-around great guy. If you've already guessed Dr. John Jurica, you are right.

John is a Board-Certified Family Practice Physician and founder of The Physicians' Non-clinical Careers podcasts where he interviews physicians from a wide variety of non-clinical careers. I highly recommend you check out his podcasts. He also created a membership site, The Non-Clinical Career Academy which has over 17 on-line courses in it and at the end of this podcast he's going to share a very special offer for you related to this academy. You don't want to miss it. Without further ado, it is my pleasure to introduce to you, my friend and colleague, Doctor John Jurica. Hey John! How's it going?

JJ: It's going really well Heather. It's nice to talk to you and I'm looking forward to this.

HF: Yes, me too. I'm very honored to have you. I'm a big fan of your podcasts and want to thank you for all you do for physicians to help them in this difficult period when you're questioning your career.

JJ: It's interesting and I think we have a mutual admiration society here Heather, because you are one of the first people I heard about and found when I was looking into non-clinical careers back four or five years ago so it's great to be on your podcast. I'm glad you created this, it's fantastic.

HF: Thank you. Well, it's fun to have you and I'm sure I'll be having you back down the road. So, today we're going to be talking about three sort of big buckets of non-clinical options, and then we're going to drill down on them in more detail. Which are the three that you wanted to talk about John?

JJ: So, this is not based on any particular science but it is based on, let's say, some of the questions I get on the Facebook group that we might talk about in a minute and the type of guests I've had, and so forth. One is huge, just because there's a lot of opportunities in it, and that's Pharma. And then the second one is very popular because it's got a low barrier to entry and that's Utilization Management and Benefit Management and I think the third one is Medical Writing. Again, because there's many different opportunities and so many different ways that you can be a Medical Writer. Those are the three that I would probably start with.

HF: I think that's great and I have to say that those are the three most common areas I've seen my clients going into, for the reasons that you mention. And as we both know there are a lot of others because you've interviewed, I think close to 170 episodes on your podcasts, so you've interviewed the whole spectrum. We just want people to know that there are many more than we're talking about but we're just focusing here today on these three big buckets. Which one would you like to start with John?

JJ: I guess I'd like to start with, I would say, industry. I say pharmaceutical industry. We usually lump in the medical device and biotech and maybe some other things, but we'll call it the pharmaceutical industry to keep it simple.

HF: And would you like to break down pharma a little bit for us because it is its own big black box and I think it's confusing to people.

JJ: It is in fact, it's still somewhat confusing to me although I'm getting better at understanding what the options are. But it is huge and so I guess the way I look at it after talking to a few guests that have been working in pharma and medical devices, there's like, I think, four major big areas.

So, if you think about pharma, you think about doing studies and research - Phase 2, 3 4. Phase 1, I guess, as well. And so, the one big part is the research and development, so that's where the scientists tend to fall. And then the other big part is what is called Medical Affairs, which is kind of a nebulous term so it doesn't really help us to know what people do there. But we can talk about that.

The third big section is clinical safety and pharmacovigilence which we can get into in a little bit and I think there's also the regulatory affairs department which I am probably the least familiar with that piece.

So, I think those are the four major – I mean, do you feel like there is something I'm missing at this point?

HF: I think you hit the main ones and one way I heard it described was more of a Sesame Street description which was - there are the makers, the people who make the drugs; the marketers, the people who are selling and marketing them and the regulators who keep people safe and look that everything's done properly for the FDA. And in the middle of that, the medical affairs is sort of at the hub and connects these different parts and that's just another way I heard of thinking about the different parts of pharma.

JJ: Yeah, I think that's correct, it kind of helps put in perspective kind of what they do and each of them have multiple roles within them. So, just because of that it's just a large pool of jobs out there but I think when someone is looking for a job and they're considering pharma, they have to kind of figure out which area they really want to focus on.

HF: Right, and I think the areas that I've seen my clients go into the broad categories would be, one - drug safety, which is also pharmacovigilance. Two, - being a medical monitor, overseeing the clinical trials. Medical affairs and then the medical science liaison position.

JJ: Yes, those are very, I think those are the most common positions that I also deal with. I've interviewed MSLs. I've interviewed one medical monitor. A couple of medical affairs people and then I've interviewed a couple – they get kind of higher up in the pharmaceutical industry where they started in, I think the clinical development side and moved up to larger, lets say, geographic areas covering different therapeutic classes and then ultimately became a CMO.

So, it's like when there's positions in any industry where a physician can end up being sort of an executive level position and that's usually what a CMO is doing.

HF: You're right. There's a lot of movement in pharma which is helpful because once you get in, there's a lot of opportunity. Would you like to say, maybe just a brief little description for each of those four categories? Starting with drug safety?

JJ: Yeah, drug safety. That is generally, I think it can relate to both during the clinical trials themselves but mostly relates to monitoring the safety side-effects, adverse reactions

and so forth after a drug has been released and is being used. I guess that would be either a formal Phase 4 study or just reports from the field in terms of adverse effects and things like that.

The thing about this, I think most of these positions do require some residency and more extensive training but I've actually seen that there are some positions where they don't have to be licensed, for whatever reason. So they have the clinical, a little bit of clinical. They understand how to track and monitor and identify adverse reactions and then try to scientifically evaluate whether they're related to the drug or the device itself but they don't necessarily have to be licensed because they don't really do anything directly with patients. So that can be helpful for some.

HF: You're absolutely correct and you make a really good point is that within this category of drug safety there's a spectrum of what the different jobs will require and there are foreign medical graduates and those who haven't finished residency who don't have a license or certification who can get these jobs in drug safety. It's a certain level of physician and then there are others where they do specifically require the board certification and license or a certain number of years of clinical experience.

JJ: Yeah, and one of the things that occurs to me is that sometimes even though you might not have a lot of clinical experience, if you do have some research background, like maybe as an undergrad or even in graduate school or maybe you were doing something as a side gig or something to make some money while you were in medical school or maybe you served in an IRB or something, that can help you get into this kind of job. I think also the medical monitor position, that can be helpful. So you have to kind of gear your background to what you might be more apt to land in terms of a job in the pharma industry.

HF: Now that's a good point. Even if you have a little bit of something that helps show interest in pharma that's very helpful. I have had a couple of clients who've gone into drug safety. One without any prior pharma experience and the other just had a few things that she was doing on the side. I like to encourage physicians that this is a good pharma position if you've had no, or a little bit of pharma experience, because they're really looking for your clinical knowledge and ability to analyze information.

JJ: Absolutely. I think that kind of applies to some of the other major categories of pharma as well. We didn't talk about a CRO but I look at it - which is a Contract Research Organization - which I kind of lump under the research and development side although there seems to be some overlap. But the reason I bring that up is because again those are the medical monitors for most CROs which is like a third party that supports the

pharmaceutical companies. It's not really a pharmaceutical company itself but they also seem to attract physicians who although they may have extensive clinical experience, if they don't, any kind of scientific background or IRB background or research background will help with those positions as well. Has that been your experience?

HF: Yes, and you make a really good point of mentioning the CRO which is the Contract Research Organization and these are companies, some are small, some are large that will run the clinical trials for the big pharma. Your Amgen, your Roche, your Novartis, maybe don't want to do their clinical trials, and this is a good entry point for physicians because the jobs are usually a little bit less competitive than getting into big pharma.

JJ: Ok, yeah that makes sense. I see when there are these third parties, they're trying to connect the resources to the companies and so they usually have cast a wider net in terms of finding eligible physicians to do those kinds of jobs.

HF: Yeh, do you want to touch upon a little, just a little bit more about the medical monitor position?

JJ: Yes. From what I understand, I had one guest that ended up, he actually was looking for an MSL position for, I don't know, a year or two and he ended up going into a medical monitor position. He loves it. And basically, when there is a study being done and you have individual, I guess primary investigators out in the field, you know, they're collecting patients. There might be an ortho study or a cancer study or something and you have multiple principle investigators out there that are feeding patients and following the protocols and the study parameters, where you have to have somebody from the company or from the CRO going out and tracking and making sure that they're crossing their Ts and dotting their I's and so the medical monitor goes out and helps facilitate the studies.

Make sure things are being done right, brings information back to the home company – whether it's the CRO or the parent – and just be that go-between and address issues that arise as they come up. Make sure that the study continues in a reasonably speedy way in as much as possible and again I think it's similar type of knowledge of basic science and clinical medicine and being able to communicate between the various parties.

HF: Now, that's an excellent description. I think it's similar in terms of some jobs will hire you without experience. I had a call where a recruiter was looking for an emergency medicine physician in Dallas to be a medical monitor and they were willing to train. So when it's specific like that, they may take you on without any experience. Other times,

they might be looking for someone who has actual clinical trial experience and is in a certain specialty. So there is a wide range and then it also varies between whether a license or board- certification are required or one or the other of those.

Let's go to something you know very well which is the medical science liaison.

JJ: Yes, of all the pharma jobs I'm familiar with, this is the one that seems the most common in terms of interest by physicians because in many cases has that lowest barrier to entry.

Even maybe less than a medical monitor. If you have a foreign medical grad that comes here, doesn't match in a residency or someone goes to med school but they weren't able to complete a residency or just chose not to, there seems to be a significant number of positions open to those physicians with the medical degree that don't have a license or don't have residency training. That doesn't mean there aren't MSLs out there that have some extensive training but the MSL position is a position, it's an educational position.

It's a role that I think falls under the medical affairs division and it is a role where they communicate and bring scientific literature and education out to the field to do what they call *key opinion leaders* or influencers – they have other terms and they educate them about the drugs or the therapeutic class and how to use the drug and what's being observed with the drug and the study results. And they also take information back from the influencer to the company about things that they have observed with their patients. It kind of parallels a sales position but there is no sales involved in this at all. It's strictly educational.

The MSL is able to discuss new studies that are coming out. Something that's not published or other observations and sometimes the MSL will serve also as a resource both inside the company with the sales part of the company or with others, teach them about the drug. Because they become pretty much the expert facing outward from the company to the public and to physicians that are using the drugs.

HF: That's another excellent description John, thank you. And I know from my clients, often they have interest in this position until they hear that there's a lot of travel, they're often going out to key opinion leaders and might be on the road four days a week and it does pay, typically, a bit less than the other ones we're discussing. Sometimes that can also be a barrier.

JJ: Absolutely, yeah. I've heard that too and I know of some that have been able to minimize that to some extent. Meaning, if you're in a big city and they need you in a big city, your territory could be just part of a county or part of a city and your travel basically means getting in the car and visiting key opinion leaders.

Now, if you're in a small company that has large territories – I had one guest that her territory included California and Hawaii - it sounds like it might be fun but she got pretty worn out pretty quickly. Getting on a plane every other week to go to Hawaii or Oregon or California. And you can do that even from a different area so the further out you are and the more remote, the more travel there's going to be.

HF: One thing for people to keep in mind is if they're able to do this job for a couple of years, I have seen physicians who then advance to another position where they were more home-based or remote so they didn't have to keep [traveling]. If you can hang in there for a couple of years!

JJ: Yeah, I've heard people that then became sort of, they moved up the chain. Maybe they were more of a supervisory position over other MSLs and that allowed them to do more work from home. I think a lot of these, basically you're working from home when you're not on the road. And so you can work it to your advantage if you just get a little bit creative. But yeah, you really have to consider the travel, especially if you have a family and those concerns.

HF: Alright, so let's just touch briefly on the medical affairs which, again I like to think of as the hub that connects these different parts of the makers and the marketers and the regulator.

JJ: Yeah, medical affairs. So, I think, to me, it's a little more vague. They definitely are involved with taking the drug that has been approved and getting involved in disseminating it, communicating about it, providing regulatory support and they're the ones I think that generally interact with the MSLs, for example, so they have a little bit more management in their working.

They interact too with the pharmacovigilence and so it's a little more, I don't know how to describe it, it's just less concrete to me and less specific and I think in medical affairs the jobs can be quite different depending on the company, the drug or the medical device and there's different levels in medical affairs. There's Medical Directors and I've heard different terms. Medical Advisers I've heard. Then you get up into more of the leadership level in terms of communicating with the various other sections. So, I don't know what your experience has been with the medical affairs.

HF: My general impression that it's harder to get this job at an entry level because you do need a good knowledge of these different parts of pharma. I'm seeing it more as for some physicians who either have a lot of clinical trial experience or have already been in pharma.

JJ: Yeah, I would agree. That's what I've been told as well.

HF: Now we can go to the next category and I just want to let the listeners know that we will be talking about compensation but we'll do that after we've done the three areas and give you some guidance on that. How about going to the utilization management bucket John?

JJ: Now, this is interesting to me. My background in UM was originally was as a physician advisor in the hospital side many years ago when this whole UM thing developed mainly because DRGs were implemented and we started getting bigger and bigger insurers and they had to control their costs and so I'm including things that involved hospitals, third parties. I'm including benefit management which is more outpatient.

I guess case management is another sort of version of this, but mainly I'm talking about the utilization management and benefit management that we see, like I see in the Facebook group. Most of those physicians are doing remote benefit management. Going through speaking with physicians or with offices or surgery centers. These are outpatient mostly but about imaging, about procedures, things like that. Making sure that the patients meet the criteria. And basically, it's part of a revenue cycle process of trying to keep the costs down and make sure that patients are getting the care they need but not the care that they don't need.

HF: Exactly, and within that, we would also include, I'm assuming, the health insurance companies.

JJ: Yeah, so some of them do that themselves. I had a guest who worked for Optum 360. So, that is a company, a separate company that provides UM services for hospitals and health systems but on behalf of United Healthcare. So, it's a subsidiary. And then there's all the other 3rd party, you know, UM and benefit management providers out there, some of them are fairly small but there are a lot of them. They come up quite often in the Facebook group. And then there's those that are just based at hospitals for the in-patient side of utilization management.

HF: For our listeners, to put these in three broad UM categories, does it work for you to have the health insurance category - with the medical directors, say working for Aetna, BlueCross, or Cigna, that's one group. And then physicians who are doing benefit management for a third party company, such as eviCore or Magellan, and then the Physician Advisor category as the third area?

JJ: Yeah, that makes sense. One of the other things, the terms I've heard as I was doing some of my background and maybe you have a little more clarity than I do on this but

there's what are called IROs also that are Individual Review Organizations, or **Independent Review Organizations (correct)** which – I don't know if that's the same as a Benefit Management Company or an actual other level of review that can be brought in when there's a questionable case.

HF: That's a really good question and they, I like to see them as sort of in between the health insurance and the benefit management because they're doing some of both. They're looking at the medical care and they're also looking at things like CT scans, imaging studies but more closer to health insurance because those are usually their customers, their clients.

JJ: Right. So, they work usually for them. Now, from my experience, these various companies usually do ask that there be some specialty, you know, that you're working in. But on the other hand, I've talked to people even though their companies are looking for a particular specialty, there seems to be a lot of flexibility and there's generally some formal training. You don't really have to have experience doing UM in the past. You don't necessarily have to have any certification and when they're in a bind, they'll pretty much expand who they'll accept for a given role unless it's a very niche role.

HF: Yes and that's a nice area because you don't need to have that experience and sometimes physicians will have done chart review on the side while they're still in clinical practice so they're getting some experience doing the kind of work that they would be doing for a health insurance company and sometimes for a Benefit Management Company or IRO, and that can be a good way to see if you're even interested in this work before you ever leave or make a big leap.

JJ: Yes, I think it brings up a good point too because as we look at what we're talking about today, we're going to talk about pharma, UM and medical writing. We're kind of going from pharma where there isn't a whole lot of opportunity to do part-time work generally like in the roles that we've talked about to the UM where there might be some and it's often remote and you can do some chart reviews based on almost a case rate, and then when we get to the writing, then the sky's the limit in terms of flexibility.

So, I think it's a good view of different opportunities for physicians depending on their personalities and preferences.

HF: Exactly, and from talking to physicians on your podcast, what have you seen about how they like this work and there often comes up that question of, doing those peer to peer calls, where they're having to talk to their colleagues and question their treatment plans?

JJ: Yeah, that's something that comes up, and actually that was my own experience when I started working as a part-time physicians' advisor at my hospital, was almost like moonlighting, to make some extra money.

I was like, Oh gosh, here we go, I'm going to talk to these doctors and they're not going to want to hear from me and they're going to yell at me and really the accomplished UM physician advisors that I've spoken with and that really enjoy their jobs is they look at it differently. They look at it as, Look, I'm here to educate the physician. I'm going to call the physician, or the office, talk to somebody and say, You know what? What you've documented here just doesn't meet the criteria. You need to document something more. So, I'm calling you to find out what's really going on with this patient. Is there something that justifies what you're requesting and I'm going to help you to do that documentation? So, if you look at it more that way. Most people that take a job like this don't really look at it as sort of a conformational thing.

HF: And I think the companies also provide training often and help you listen in on these calls and get comfortable while you're doing them. Some physicians have even told me that they feel good about the calls when they can really help a physician get what they need and want by maybe just getting an x-ray or putting in some documentation that was missing. So it's not just no, no, no you can't have this. It's, Let me see how I can help you.

JJ: Yes, and things do change over time and you know we don't all keep up on every little bit of research that's done and new protocol evidence-based approach and you know some things change and then as a UM physician you'll explain, well there is a step that now is considered more appropriate, and why don't we do that first, as you said.

I think it's very popular too, because it's the barrier is lower in terms of what the background is and the extent of your experience and some people occasionally find themselves in a position where they just are in a big hurry. I don't think they should be in a hurry when they're going to change jobs but they just feel like they are and they can usually research this and prepare for it and find a job in a reasonable length of time as opposed to some other transitions that I've seen.

HF: Yes, it's definitely something to try out if you have any interest and different ways to do that. Let's just touch briefly upon the physician advisor role which, as you mentioned, it can be in the hospital setting but it can also be remote.

JJ: Yes, because when this started, we didn't have EMRs and EHRs. So now that we do, we can access almost all the information remotely. So, I see the majority of the positions

that my guests have taken have definitely been remote. There are times when the hospital wants somebody on-site for that kind of UM review and get to know the medical staff but even there, many hospitals are using the remote physician advisers.

HF: Can you just give a little description about the physician advisor? You mentioned it before, but just maybe repeat, what is the physician advisor actually doing?

JJ: Well, depending on which of these specific roles they're doing, they're receiving a referral from a nurse who usually does the initial review of whether it's a procedure or admission to the hospital or admission to an observation unit or a test that's being done. And it's already failed that level so it's going to the physician. The physician's going to review the medical record, the report that the UM nurse has provided, and then decide, first of all, just on the face of it if this should be approved or not.

Now they have to follow the guidelines that are provided by the employer which are pretty standard I think across the industry. They pretty much mimic what Medicare and other entities have created. And then at that point, if they feel it hasn't met, then they actually need to communicate with somebody about whether or not this really should proceed.

HF: My understanding, I've had a number of physicians in these roles, is that the physician advisor hat when they're in the hospital system can be – there can be a lot of hats they wear – they can even be dealing with physicians who might not be documenting properly or having issues with EMR. They can be bringing down new initiatives. Can be involved in trying to create projects where they're capturing information about people or bouncing back to the emergency room.

So, it can be very broad-based, whereas, in the remote positions, it seems much more focused on determining the in-patient versus observation status, when people are coming into the emergency room. And also the level of care too. Is that your understanding?

JJ: Yes, absolutely. In fact, I have a good friend who has been a UM Physician Advisor for years at the hospital where I used to be the CMO. In addition to interacting with physicians, he also does teaching of physicians so they know what the guidelines are. He also runs a weekly long stay case meeting, where it's a multi-disciplinary team and they're looking at the cases that are staying longer than expected. He also gets on phone calls with an administrative law judge. If something gets denied by Medicare so he's having a discussion with someone from the MAC. So it gets a little more diverse I think in the hospital setting than what you might be doing in terms of a remote position.

HF: Yeah and I think they're changing the term now to call them Medical Directors because the PA people often think that PA is referring to a Physician Assistant. But it's a really interesting one to look at if you like to stay in a hospital setting, not be clinical, but you're good at interacting with diverse people and managing conflict too!

JJ: They often overlap and work collaboratively – can I say that word - collaboratively with other people like the other people in the clinical documentation improvement because that kind of relates to the medical record and whether they meet the criteria and also the quality improvement so there's a little bit more overlap and it kind of overlaps to the term, as you said because the physician advisor is seen not so much as a leadership role and some of these do get into that management leadership.

HF: Alright, excellent. Now, would you like to talk about the category of medical writing? And we can also put medical communications in here which is often within pharma industry or a CRO as separate?

JJ: Yes, this is another one that I don't know numbers-wise if there's an equal number of people in medical writing as in, let's say, the whole pharma industry but there are certainly lots of different jobs. It takes a special person, someone who likes to write obviously but just to keep it short, the way I think of it is on one hand you have technical writing and that – you mentioned the CRO – and I believe that CROs sometimes employ the technical writers. You've got journalistic writing.

I talked to a guest who spent 10 years attending national conferences in his specialty and basically writing reviews of those for what used to be called throwaway journals but they're just the society and association journals and he did that and made a living for 10 years writing. I know, it's kind of incredible. Then he went back to clinical if you can imagine that!

HF: Oh, that's a story!

JJ: We don't recommend that, right? And you've got all the educational type of writing, whether it's education for patients or education for physicians. You've got the promotional type of writing, which is what you mentioned, the medical communications, which oftentimes involves working for an agency as well as working directly for a pharmaceutical company or medical device. And then I also like to throw in the category of editor, so it's very common for a medical writer to end up sort of moving up to an editor position. They're not always called editors. They might be called medical directors of an agency or something but there's a lot of options there.

And the other thing to keep in mind is that with writing, you can either be a freelance writer and you can pretty much do all of the things that I've just mentioned or you can be an employed medical writer and in some situations, you're more likely to be employed than to be freelance. And if you freelance of course, you have to know a little bit about running a business, because that involves …

HF: You eat what you kill in freelance. Eat what you write.

JJ: Yeah, is that your experience? I've talked to someone who was a CME Medical Writer who ended up getting employed by a CRO as a technical medical writer but I don't know, I've had the occasion to talk to a lot of writers and the thing is it takes a lot of discipline, self-discipline. There's deadlines, if you're a freelance writer especially, and even if you're not and so you can have more flexibility if you are freelance, you can travel and write from anywhere. But if you're working for a company that you have to show up 9-5, then that's obviously a totally different situation.

HF: I think you did a great job at describing a very complex area because you're right, it's everything from the more regulatory research-based scientific writing at one end, into the educational, CME, patient information content and then to topical health news, things that are more contemporary, and you're right, it has the freelance component or has the employ component.

I've seen people go back and forth. They might start out as a freelancer, which is the way to establish your portfolio and once they have their portfolio then it's easier for them to get hired as an employed physician and after being employed for a bit, they might decide to go as a freelancer.

JJ: Right. Exactly. I think people do kind of skip around, they look for the next best opportunity. Maybe they've got tired of being completely based on their own schedule and go to one that's got a little more structure to it, maybe pays a little better, and then move up to become an editor or medical director. But I've talked to many people. I've really enjoy it and I have done it for a long time.

HF: It's great for a certain personality type, as you mentioned. Discipline, possibly more introverted, able to meet deadlines, and likes to work independently. One area that I just wanted to mention briefly which is copywriting and it's something that we don't really hear about for physicians but I believe it's going to be an up-and-coming area because there's so much web content that's being produced. Whether it's a physicians' website, a hospital website and they're having to reach readers in a more engaging way and copywriting is writing information with the audience in mind so you're using language and

imagery that makes it very accessible and there aren't - I only know of one physician who is a copywriter that I just saw on the internet - however, with so many businesses going remote and also people creating their own businesses and physicians doing this as well, there's really a need for those who can write informational content in a way that's engaging and it's a special skill that you either – you can be trained into it but it's for I think people who like to be a bit more creative in their writing. So, I put that out there for some physicians who are considering writing and like to use their creative talent too.

JJ: Now would some of that fall into like the marketing spheres that we were talking about?

HF: Yes, it definitely can. It's really in part of medical communications as well, or any communications. But I think it's taking on a whole new dimension as there is so much content being put out on the internet that needs to grab the attention of audiences because it's becoming more and more of a crowded field, hence your content can't just be dry and informational, it has to be very accessible.

JJ: That's absolutely true. I was actually just thinking about that because I read some writers, medical writers, CME and so forth and they do a good job but it is very dry and nowadays everybody only has this short attention span and the skill to be able to be a copywriter that writes in an interesting and engaging way is extremely important.

HF: Absolutely. You can't just put it out there and expect people to read it anymore. Now, anything else you want to say about medical writing or medical communications?

JJ: Well, I guess I would say one thing. The American Medical Writers' Association as a resource, it's pretty much, everyone that I've talked to always mentions that. There's a lot of different resources and so you would want to check that out. And the only other thing I would say is that I purposely left book authors out of this particular topic. Most book authors don't make a living writing books, they usually use it as a way to sort of support what they're doing in other things but there have been many physicians that I've encountered that have written really awesome books but they're usually lucky if they break even on the cost of publishing it most of the time.

HF: That's right, and it can be a good platform. It can help you with being known and being someone who is known as an expert in your area, so that's helpful. Alright, so those were our big categories of pharma, utilization management, medical writing/medical communication.

We also just want to mention that there are many other areas we haven't talked about such as informatics with the EMR, consulting, life insurance, disability. There's healthcare administration, working for the FDA or the CDC. Working in public health,

teaching, and some of the things that could be considered more of a side gig. Which are, doing the chart review, expert witness, freelance consulting. Also doing teaching/writing as a side gig.

And then we've also seen physicians getting into coaching, whether it's health, wellness, obesity coaching, career coaching, different things. And a great place to find out about a lot of these areas – oh I didn't even mention investment banking or finance or some of these other areas – is John's podcast. Because you get to hear physician stories for these different areas.

Today we really couldn't go really into the depth of how do you get into these jobs? What's the day-to-day like? Requirements? All these other things, but you will find a lot of the specifics on his podcast and I'll also be adding on new episodes on my podcasts with interviews with this kind of information.

Alright John, we want to talk about compensation. Would you like to give some guidance? Will we go back and forth on that?

JJ: Well, let me just say a general thing that people are concerned when they're leaving clinical medicine that the compensation isn't going to be there and I guess what I would say is these companies are hiring physicians because they need physicians, they need hat expertise, the education, the training, the perspective, plus physicians are probably the best employees they'll ever hire because they're so accountable and responsible because that's what we're taught from Day 1.

And you're usually going to get a salary that is commensurate. Not necessarily with, let's say, a high paid surgical specialty but especially if you can consider the hours, and the lack of call, the lack of liability. So maybe you're making 250 as a super-busy family physician and you're going into UM or something and might make between 150 and 200 or whatever that might be. To me, that's an equivalent salary and most of the time you're going to have an opportunity to make something near what you make clinically unless you are, like I said, very highly paid. Otherwise they wouldn't be able to recruit anybody except for people that aren't working.

HF: Yeah, and it's true, a lot of physicians especially in primary care are pleasantly surprised. I've had a couple of clients recently in primary care who, their salary increased and they're very happy with the benefits and the work hours. What I have seen is that in the benefit management area, the entry-level, there tends to be around 150 to 220K-ish and that varies a bit. Within health insurance, it's usually a little bit higher. The lower end around 180K and I've seen it go up to around 300K for that entry-level position.

One thing to remember is there's often bonusing which can be pretty regular. There can be stock options which enhance that package for you and in pharma that's the range I've seen too – between 180K and the 300Ks. So, things usually settle out around the mid-range of 220, 240K-ish. But there's a lot of upward growth once you get in, especially if you're getting stock options, so you can get up in the 300Ks, even sometime the 400Ks, depending on the company. Is that what you've been familiar with John?

JJ: Yeah, I would say that obviously if you're a freelance whatever, writer, consultant, depends on what you're producing and there's probably only so much you can make as a freelance writer. But I would say like in the pharma which is a huge chunk of healthcare system in this country, very similar to the hospital setting, particularly as you get into the leadership positions, when you work in a corporation like that we had matching on our 401K, or I guess it was really a 403B, we had deferred compensation. Once I got to the VPMA and CMO level and the salaries there and I think at those levels in the pharmaceutical company, we're talking well over 300,000, easily, with more experience.

Now that wouldn't be your first year in that position. So you have an opportunity in these kind of roles to really make a decent income. Again, without the kind of headaches we're used to in clinical medicine.

HF: And that's a good point because it's helpful to calculate your actual hourly rate when you're factoring in call time, answering emails, doing charting at night because that is your true hourly rate. And when you compare that to what you've been making in an employed position with a company where you might start at 8 am and stop at 5 pm. It's a very different picture.

JJ: Yes, absolutely.

HF: One thing I would just add about medical writing is that it tends to be a bit lower than some of the other non-clinical positions with an average entry level, if you're employed, around 100 - 120k and that can go up. I have talked to some freelancers - let's talk about being employed first – employed physicians who are making higher than that, and especially if they're in pharma (as writers) the compensation can be in the mid-100s up to 200, eventually higher. And in medical communications, I think there's a lot of upside potential there. For freelancing, I've heard it's difficult to get started - the average income is around 75 -150K when a freelancer is working for themselves. Some will sub-contract. They'll get big enough to have sub-contractors under them and can make 200k or over that if they have other people helping them.

JJ: Yeah and at that point they're into like a small business type of thing so, you know, if you're going to be a freelancer, you're going to be doing your own thing anyway. Why not leverage it as you can?

HF: Absolutely. Alright. I know we're probably a little over time here but there is so much great content I wanted to get your guidance on. I think you did a wonderful job,helping out here. Now I had mentioned earlier that there was a special offer you were going to give to the listeners. Can you tell us about that?

JJ: Yes. For those that don't quite know what The Non-Clinical Academy is. It started out as individual courses – I have a course for MSLs, people seeking an MSL job, and several jobs for seeking a job in the hospital - but it became apparent to me that I have a pretty broad audience that isn't necessarily dedicated to one particular non-clinical career so I started by creating 12 courses, there's now 17. I put them into a membership site so that they could just go in there at their own convenience and access the courses that they thought were the most appropriate for them.

There's courses and other things like how to look up the salary for a hospital-based physician and things of that nature. But in any event I was trying to think of how I can let people get a glimpse of using it and I had the ability on the platform that I use to provide a $1 entry but it didn't give me a choice to do it for a day or a week.

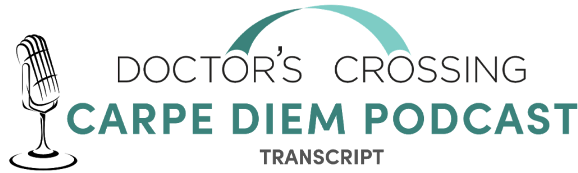
So, if you go to nonclinicalphysicans.com/joinNCA – which is for the non-clinical career academy – and put in the coupon code TRIAL, you can actually have a whole month of access for $1 and just check it out. See if there's courses in there that might be useful to you and maybe that'll help get you started if you're on this journey and you're at the beginning stages.

nonclinicalphysicians.com/joinnca Coupon Code : TRIAL

HF: I don't know how someone could not take you up on that offer John! That is really generous, and I will definitely put this in the show notes for this episode which will be on my website so you can take advantage of it.

Alright John, any last words to physicians out there who are trying to figure this all out?

JJ: Well, let's see. One last bit of advice here about a book that I wanted to mention when we were talking about the pharmaceutical companies because there was a book written by a physician in the UK, and this is not an affiliated link or anything, this is just something I came across about three months ago and I thought, this is an awesome resource.



So, it's called ***A Doctor's Guide to Careers Outside the NHS,*** which is the National Health Service. His name is Paul Hercock and you can get that on Amazon and if you are looking in 'industry', it really has a lot of information and I'd say 95+% of it is applicable to the US as well as the UK and Europe.

https://www.amazon.com/Beyond-Ward-Doctors-Careers-Outside-ebook/dp/B079SD1XQZ

So that's one last bit of advice I would give and I would just encourage people that are following your podcasts and have worked with you or thinking about it or just looking at non-clinical careers to just keep the faith. Physicians are awesome at what they do. You're all great, you know, employees. You're great people. I consider physicians to be sort of one big happy family and I just encourage everyone not to get discouraged and keep moving forward with your new career if that's what you want to do.

HF: Those are beautiful words John, and we do have a lovely community. Reach out for help. I see physicians all the time, wanting to help each other just because someone else helped them and because they care. So, thank you, thank you John, this was really, really excellent. We'll make sure to link to these resources that you mention, including the book, and I look forward to listening to more of your podcasts.

JJ: That's awesome Heather, it's been my pleasure, I always enjoy speaking with you and I hope you continue to do a podcast for a long time.

HF: Alright, thanks so much John.

Okay guys, as you know, till next time, don't forget to *Carpe* that *Diem*! Bye for now.

[00:47:48]

END OF TRANSCRIPT