DOCTOR'S CROSSING
CARPE DIEM PODCAST
TRANSCRIPT

# EPISODE 71 3 Myths About Getting Into Pharma

## With guest Dr. Marjorie Stiegler

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MS: "A hematologist, an OB-GYN, a dermatologist like yourself all increased their salaries when they took their first pharma job. And they are moving from hours that are extreme and unpredictable to what's basically a 40-hour work week that has a lot of flexibility."

HF: Welcome to The Doctor's Crossing Carpe Diem podcast. If you're questioning your career in medicine, you've come to the right place. I'm Heather Fork, a former dermatologist and founder of The Doctor's Crossing. As a master certified coach, I've helped hundreds of physicians find greater happiness in their career, whether in medicine, a nonclinical job, or something else. I started this podcast to help you discover the career path that's best for you and give you some resources and encouragement to make it happen. You don't need to get stuck at the white coat crossroads. So, pull up a chair, my friend, and let's carpe that diem.

Hello, hello, and welcome back to the Doctor's Crossing Carpe Diem podcast. You are listening to episode number 71. We have a very special guest today to help us do some myth busting around applying for nonclinical jobs. Our myth busting is going to be focused around what's required to land a nonclinical job, transferable skills and compensation. I'm very excited to have my dear friend and colleague Dr. Marjorie Stiegler here to help us.

Dr. Stiegler is an anesthesiologist who currently works as the Executive Medical Director in Medical Affairs for a big pharma company. She's also a speaker, branding expert and a coach for physicians who want to transition into industry. In addition to all the hats she wears, Marjorie hosts the excellent podcast The Career Prescription.

I'm always impressed by how much Dr. Stiegler does for other physicians. My guess is she doesn't need a lot of sleep. Marjorie has a number of online courses that she offers, including one on how to transition into pharma called The Industry Insider. I'll have a link to this course in the show notes, as well as her contact information.

Although our conversation is going to be through the lens of pharma, the myths we're going to be busting are applicable in many nonclinical areas. I'm very honored to welcome Dr. Marjorie Stiegler to the podcast. Hey, Marjorie, how's it going?

MS: It's great. Thank you for having me, Heather. Good to be with you.

HF: This is wonderful. I have to say I am a big fan of your podcast. I love how focused you are. You tell us in advance what we're going to learn. You teach us very well in a very efficient manner, and then we get to move on with our day. There's not a lot of fluff.

MS: Thank you so much. That's really very kind. I do try to keep it tight because yeah, people are busy and I know a lot of people have many questions. I try to focus the podcast around people's questions. Just get the answer and move on. Yeah, thank you.

HF: You're very, very welcome. And today I love this topic that you came up with, which is busting some myths that physicians often have when they're thinking of applying for a nonclinical job or transitioning. Before we dive into these myths that we're going to be busting, I'd love to have you tell the listeners a little bit about you.

MS: Sure. I think like all doctors, when you ask me that question, I want to tell you my CV. I'm an anesthesiologist by training. I trained at Mass General and then I went out to California, to UCLA, where I spent five years on the faculty. And then I moved to North Carolina where I spent another five years on the faculty at UNC Chapel Hill. And actually, I still have a faculty appointment there.

But about five years ago, everything's in five, it's about five years ago. I was just thinking about my three-to-five-year plan and I was not really sure that anything I saw around me really appealed to me. I was very happy in academics and I really love anesthesiology, but I didn't want to be a department chair. It wasn't clear to me what was next for me.

And while I was sort of feeling receptive, an opportunity came along to consider a role at one of the pharmaceutical companies nearby. I'm in a research triangle. There's a lot of them. And I thought, "I don't know anything about this. It might be very different. It might be something I don't like." It's certainly scary, but also an amazing opportunity to really learn an entirely different side of healthcare in a way that I didn't know already. And I figured if I didn't like it, worst case I would just quit and go back. But as it turns out, I loved it. And here I am still several roles and promotions later, really, really enjoying the way I get to make a contribution for patients as a medical director.

HF: Are you doing any type of active practice?

MS: Oh, great question. I had been up until COVID. As an anesthesiologist our schedules for surgery, I had transitioned away from the OR at UNC because a big academic institution had to schedule things in a way that wasn't really compatible with my work. But my company did support me to work a day a week in the operating room if I wanted to. So, I partnered up with a surgeon, who's a neighbor of mine.

And I did that, taking care of elective outpatient cases, a couple of days a month. And when COVID struck, by the nature of the fact that it was just a single physician practice, we didn't have PPE. Nobody did, but we definitely didn't have PPE. We didn't really know what to do about testing. And we didn't have the infrastructure that a large institution does to be sure that we were coming back online in a safe way. I just felt like I would take a pause until all that dust settled. But now that it's been a two-year pause, I think it's unlikely that I will go back.

HF: How do you feel about closing that door?

MS: It's mixed feelings. I love anesthesiology and I look back on all of that very fondly and I would do it again, but I think about patient safety and I think to myself, "It's been such a long time. If I were the patient, I don't think I would want somebody like me coming in and taking care of them." I would need to be doing a re-entry back into full-time practice if I were going to pursue that. But I don't think I am, because I'm quite happy with what I'm doing now.

HF: Yeah. I'm curious if you compare the joy and the fulfillment that you got as an anesthesiologist to the joy and fulfillment that you get in your current role in pharma, how do you compare them?

MS: Wow. That's such a great question that's making me think really deeply. I think the difference is in clinical medicine, things are one-on-one and you can have that satisfaction in a given day of having done any number of things. For an anesthesiologist that might be helping somebody in their labor and delivery or C-section, and then there's a baby at the end and that's so very joyous. Or it can be just sort of a routine surgery that goes well and everybody's happy and has a smooth day or when you can literally save someone's life when they come in in trauma. Those kinds of things are on a day to day and on a one-to-one basis.

Working in industry is different because those types of encounters obviously don't happen on the day to day. We don't have the same emergencies. But the impact on patients, when you can bring a medicine that solves a problem that millions of people have, that's enormously gratifying. It's maybe more of the cadence instead of every day piece of joy. It's just an overall general feeling of good, meaningful contribution.

HF: Thank you for answering that. I love getting to hear someone like yourself who's been in both worlds compare and contrast them because we often get really trapped into thinking that once we prepare for this career to care for patients, that's it, we die with our boots on. But we're lifelong learners. And I think part of job satisfaction is growing and learning. And that stagnation of clinical care, I'm not saying it's that way for everybody, but it's a risk. It can often impede the joy that comes from caring for patients. So now you're doing it in a different way.

MS: Absolutely. And I am a very curious person. I mean, it sounds cliche to say we're lifelong learners, but I am, I like to do different things. That's part of what's been the driving force behind the several businesses that I've started and things like that. I like to learn and do new things. And for me, although it's kind of ambiguous and it's out of my comfort zone, I like that. That's my personality. Not everybody does like that. And then they don't need to do it, but for me, I wanted to learn new things. I wanted to do new things.

HF: I think that's one reason why you are so generative. You're always creating things and doing things. That's just a part of you, like you said. Would you like to dive into these myths that you would like to bust for our listeners today?

MS: Sure. I picked these three because I get probably, on a slow day, five messages and on a busy day, sometimes 15 or 20 messages a day from our colleagues asking me questions about transitions into pharma specifically. And there are three questions or misconceptions that are just ubiquitous. Everyone has them. I've tried to in my own podcast answer them so I could just direct people that I don't have to be a broken record, but it would be great for us to address them all together here on your show too.

HF: All right. Well, what's the first one that you'd like to bust?

MS: The first one is prior experience is not needed. This is a very common perception. Most people understandably believe that prior experience is needed because almost every job description says that it is. But this is aspirational.

The key is really in understanding what's an entry level physician job in the organization. And sometimes that requires a little bit of savvy and kind of reading between the lines. Sometimes it can be clear from the job title. For example, within pharmaceutical or medical device companies, an associate medical director is an entry level position. A vice president is obviously not. And so, some people get the impression that they could come into a company at a very high level like that, that's not going to happen because you don't understand the business and the work.

But an associate medical director sounds like it could be a senior role, but it isn't. It's an entry level role. And so, something that's entry level by definition does not require prior experience. And the job posting might say that they want a couple of years up to two to three years or something like that of prior experience. But again, that's just their aspiration. If a person had been an associate medical director for three years, they'd probably be looking to move on by now to get a promotion and move up.

I think that's the number one myth. Don't let that hold you back. You're never going to find a job description that says, "Hey, no experience needed, come on down." It's not going to read that way. But when you know how to read between the lines and identify

the right ones, then you'll know what you're an appropriate candidate for. And then it's just a matter of learning how to position yourself in a way that makes you a desirable candidate to the hiring manager or to the recruiter.

HF: I have to say amen Marjorie. Everything you said is so spot on and I hope everybody heard it. And if you didn't, go back and listen again, because sometimes it takes a bit for this to settle in. You don't need this experience that sounds like it's required when you look at the job description. And that job title is really helpful. And then going to the qualifications part and seeing what it says there.

And as I mentioned in the intro of the podcast, this is not just for pharma. This is for utilization management. This is also for medical writing, physician advising. Most of these companies expect to onboard you and train you.

MS: Absolutely, absolutely. They do. And it's really, really robust. A lot of these companies will expect for the first four to six months of your employment to be mostly you learning rather than you being a contributor really in an independent way. That's very common. It's standard.

HF: You're making this distinction of associate medical director. That would be the most entry level?

MS: Well, it varies from company to company. The titles are not always the same. This is something we really address in Industry Insider for that reason. Because you can sometimes determine by title, but then also sometimes by things in the job description. For example, if the job description mentions that you'll be managing a team, it's probably not an entry level role. You'll be managing a team.

What you're looking for is the job opening on that team. That team that's below the person. There are multiple ways besides just a job title, but certainly anything that says senior, or VP or chief medical, that's in a large company, I suppose a startup could be a little different, but in a major company, that's absolutely not an appropriate role to be applying for. And if anything, you probably won't even be seen, your resume won't be seen. But if it is, a person would realize that you don't know anything about the industry, or you would realize you're not an appropriate candidate for it.

It's really important to match yourself well. That prevents you from rejection or just no response at all. And the reason that's important is because that's discouraging. If you're applying for lots of things and nobody's ever calling you back and you're feeling terrible, then you may want to just give up. But if you're just doing it wrong, you just need help. You just need a little help to do it right and then you'll have success.

HF: Right. You don't want to develop a complex and get discouraged. We want to have some of those wins. I like that you're bringing out being strategic versus just throwing spaghetti and praying that someone will contact you.

MS: Some people say that it's really just a matter of perseverance and applying as much as you can. And I don't take issue with the perseverance part. You definitely need that. And I don't take issue with applying a lot if you need to. Many of my students get jobs very, very quickly. And so, I don't know that you need to apply a lot, but you do need to apply strategically. And then you might need to apply a lot. But the first order of business is to apply strategically.

HF: I agree. And I've seen it work often. Would you like to take us to myth number two?

MS: Sure. This is very common. Physicians often have a considerable amount of debt for medical school and from residency in their relatively lower salaries. And so, it's a really common concern that the compensation won't be adequate and they'll have to take a really significant pay cut. And usually this is more rooted in "Will they be able to pay their bills, including their loans?"

I think this also comes from people Googling. They'll Google "How much does a medical director make?" And I tried that myself this morning and I saw some answers as low as $70,000 and some as high as $150,000. But this is considerably lower than the market norm, even for an entry level position in pharma. Considerably lower. That's entirely outside the range of what a person can expect to make. And I know many, many of my students actually had pay raises. They're moving into an entry level role and they actually earn more than they did as a physician clinically.

Another piece to keep in mind. This is a little bit of an aside, but when you are coming at an entry level role, you're at the bottom. You're only going to go up and your

compensation will also go up. But for many physicians, once you're out of residency or you made partner or whatever is the structure in your group, that's kind of it. You're sort of at the ceiling. There's not much more to go. That's something to keep in mind as well. Very often, if you do find yourself having a temporary pay cut, it's temporary. Now I have had one person who is an extremely highly paid specialist. She made a million a year. That person is going to take a pay cut.

HF: That person probably is okay with a pay cut.

MS: I don't mind sharing it. I'm an anesthesiologist and we're a well-paid specialty. And when I made my transition, I earned the same. I didn't take a pay cut at all, but I also didn't get a big huge boost. But if that gives people a sort of range or a sense for what the earning is. It's not what you see online.

And the reason for that is that industry has an entirely different compensation structure. Salary, I don't want to call it a small part, but it's just a part of the compensation structure. And the total amount that you would earn in a year has a lot to do with other factors. And this can include bonuses. It can include stock. It can include all kinds of generous company programs and contributions. And so, it's really something where even if you knew the base salary, you would want to add a multiplier on that because that's not what you'd expect to earn.

HF: For our listeners. Would you like to give some guidance on what the range can be?

MS: Sure. For most large companies, I do have some small ones, but I have a database now of a very good number of physicians who have transitioned in. And their entry level total compensation in both large and small companies is usually in the mid $300,000. So, $350,000-ish. Now some people earn less and some earn more, but I think most people can probably keep the lights on with that amount of money. I hope that people will feel reassured that the compensation is good.

HF: Yeah. And I can corroborate that. I've seen ranges a little bit lower sometimes if they're starting at a contract research organization where they might start in the mid twos, but then as you mentioned, there's a lot of added bonuses, sometimes stock options and different things that can bring that up into the threes.

And you're right. I have a number of physicians who go up in salary, even some that aren't just primary care when they take these positions. And you also have to add in the extra time when you're a physician that's not compensated. If you really broke it down to an hourly rate it could be an even bigger increase. You could even stay lateral, but because of the time differential potentially you could still go up.

MS: I think that's an important point. Your point in primary care is a great one. A handful of students come to mind. A rheumatologist, a hematologist, an OB-GYN, a dermatologist like yourself all increased their salaries when they took their first pharma job. That to me it's amazing.

HF: That's amazing. Yeah.

MS: And they are moving from hours that are extreme and unpredictable to what's basically a 40-hour work week that has a lot of flexibility. In most places, if you needed to take a portion of your afternoon off to go to the dentist or go to your kindergartner's poem reading or whatever, it would be fine. It's totally fine. It's just an entirely different work environment.

HF: And that has huge value. That can be priceless. And it's what so many physicians are looking for. Before we go to the third myth, we're going to just take a short break and then we'll be back to talk about transferable skills.

If you are applying to a nonclinical job, it's a great idea to convert your CV to a resume. A well-crafted resume helps recruiters see why you are the right person for the job. My resume kit is a downloadable PDF that walks you step by step through creating an impressive resume of your own. You'll have everything you need, including templates and a bonus on writing a winning cover letter.

To get immediate access to this kit that I use with my coaching clients go to doctorscrossing.com/resumekit or simply go to The Doctors Crossing website and hit the products tab at the top of the page. Now back to our podcast.

All right. We're back with Dr. Marjorie Stiegler and we're talking about some different myths around transferring into nonclinical jobs. And this third myth that we're busting has to do with transferable skills.

MS: Yes. I know Heather in your work you have heard this before. And the first thing that comes out of the mouth of so many of our colleagues is, “Oh, I don't know how to do anything else. I'm just a doctor.” Have you heard that phrase a bunch of times?

HF: If I had a penny for every time I've heard that I would be a multi-multimillionaire.

MS: Yes. It's so common. People come and they say, “I don't know how to do anything. I'm just a doctor.” And then they look at these job descriptions and they think to themselves, “I don't have any of that stuff.” You don't have some of it because as I mentioned, it's written in an aspirational way and no manager actually expects to find anybody that has all of that.

But the other thing, it's not a secret, but this is the reality. You do have these things, but industry uses a different language to describe them. So, you don't recognize when you're looking at the job description that you do have that and you can demonstrate that or you haven't thought enough about your day to day to realize all of the skills that you are putting to use in your encounters with other clinicians, with patients and just in the way in which you make clinical decisions and manage everything that you have to triage and prioritize and address in a given day. People lump that all together and say “I’m just a doctor.” And it's so much more.

HF: I know it's heartbreaking that that's how we see ourselves. And it is a common phenomenon. And that's why when I made my resume kit, I had this section on transferable skills, the skills builder, it was called, “You're not chopped liver.” Don’t undervalue yourself.

And I like that you bring out that we have all these skills we're using on a day-to-day basis, but because they're so natural for us, we don't identify them as skills. That's a great exercise just to go through your day and say, “What exactly am I doing?” And see if you could match some of those skills to a job description. All these different things that you're doing, like analyzing, evaluating guidelines, interacting with others, building

relationships, resolving conflict. I know you have many of these that you see in the job descriptions, but if you go and underline in that job description what you see and then go back and really think about your day, you'll see that there's a really great match.

MS: Absolutely. And as you know, because I'm an affiliate with you, I've seen your resume kit. And I think it's really, really helpful to start looking at the things that you already have on paper in a different way to think about them in a way that makes for an industry friendly resume. But this probably sounds nebulous to a lot of listeners. So, I'll get into a couple of examples if that's helpful.

HF: Yes, that would be great.

MS: One of the things to know is healthcare is obviously all about teamwork. We don't operate in a vacuum and you are interacting most likely with office staff, with nurses, with technicians and other support staff, as well as probably other physicians during the day. And really regardless of your practice environment, just by being the physician in the group, you're sort of de facto the leader. People will look at you that way, even if they don't report to you. And they're in a different functional line. We call it multidisciplinary. They're in a different discipline than you or interprofessional. They have a different degree than you, but you are by default the leader and you are influencing and communicating and really setting the direction for what's going to get done in a day or what the plan is for the patient. And you do that literally every day without thinking about it at all.

Industry doesn't use the same terms. They call this matrix leadership and sometimes cross-functional leadership. You're reading the job description and you're like, “Oh, demonstrated abilities in matrix leadership. I don't have that.” But you do. You just don't know that you do because you don't recognize the words and you haven't thought about what you're doing on the day to day in that regard.

And another example is publishing. Now not everybody is in academics, but most people, obviously in medical school and residency, you're familiar with the idea that you do a little research, you present an abstract and ideally this results in a manuscript. And in pharma, in medical devices, biotech, that's a large part of the work. It’s to present science.

And so, if you have personal experience with that process from the ideation of the study to creating the design, executing it and then presenting the results. If you are familiar with that from end to end or even a part in the middle, this is exactly a skill that would be used in pharma, but they call it something different. In the industry, it's called evidence generation or sometimes data dissemination.

And I always thought the phrase, and I still think the phrase evidence generation is a funny one. But when you think about it, that's what everybody does. You have an idea. You have a hypothesis and then you have to go out and get the answers. You have to go out and design a study that gives you the data that generates the data. That is the evidence generation.

It's a funny phrase and you would look at it and not recognize it for what it is, but it just means clinical research. And so, this is something that we really again get into in Industry Insider because there are so many of these examples where your listeners, I hope right now are having like a light bulb moment of, "Oh yeah. I can see now. Even if I don't have those, I've got something in my pocket that meets the skills." You really have much, much more than you think. I guarantee everyone listening has more than they think.

HF: Yes, those are fantastic examples. And it makes me think back to medical school when we were learning a new language.

MS: Yes.

HF: I remember when I was presenting and I said this 49-year-old, blah, blah, blah, who had a heart attack. And the attending corrected me and said, myocardial infarction. We did it in medical school so we can do it again in a new career.

MS: Yes. But the thing is really for your listeners and for your clients, you have to do the work to be able to decipher these job descriptions. I've just given a few nuggets here and it will vary by company and it will vary by role. But that's part of the work that you need to do in order to have that strategic application.

You've got to understand what those words mean so you can figure out what you have and position it in such a way that connects the dots. Because the person on the other side who is looking, it's true what they say, they're going to look at it for seven seconds. They're not going to sit there and ponder, "I wonder if this person's skills might be able to be applicable. Let me think about that." They're not going to do that. That's your job as the applicant. And sometimes that requires inside help. It requires somebody like you or like me to be able to do that translation and help somebody through that work.

HF: Yeah. It's a process. That's one way to really make yourself stand out from someone who really hasn't had that mentorship.

MS: Absolutely.

HF: Well, this has been really wonderful. I love busting myths because they are roadblocks. And when you bust them, you kind of create this forward momentum.

MS: Yes.

HF: How can folks find out about you and also, if they're interested in your Industry Insider course? I'll definitely link to it in the show notes.

MS: Yeah. Yeah. I have my own website, which it's a dinosaur, it's so old. It's my self-name. It's marjoriestieglermd.com. People can come there to find me. They can find my podcast The Career Prescription on any of the major directories. It's on iTunes, Apple or Spotify or Google Podcast. Whatever you're using, you can find The Career Prescription there.

And then for people who just want to dive right in to learn some stuff. If you go to courses.marjoriestieglermd.com, you'll find my entire library. Some of them are CME accredited. It's all well worth checking out. And I would love to have people be in touch. I have contact forms on my website and so forth. And as I mentioned, people do ask me questions all the time. I should probably also mention, I don't answer all the time.

HF: You can't.

MS: It's the courses. I have a podcast. I do the coaching. I really don't. It would be a full-time job for me to sit there and answer everything that comes my way. So, I can't, but I do love to be connected to people. I like to hear their stories, I like to hear their questions because then I can use that on a subsequent podcast episode, which is probably much better than me just texting them back.

HF: Yeah. Check out her podcast, there's really a wealth of information on there. She does them weekly and you can get so much of what you need to know just right there. But then if you want the next level, check out her courses and the other things that she all offers.

Thank you, Marjorie. This has been a lot of fun. I look forward to having you back on the podcast and as always, I'm kind of cheering you on and watching all the things that you're doing. So, thank you again for being so helpful to other physicians.

MS: Thank you, Heather. That's so kind and so generous of you to say. I really appreciate the opportunity to come on and be on your podcast. And I'll certainly come back again.

HF: Wonderful. All right. Thank you again. And guys, don't forget to carpe that diem and I'll see you in the next episode. Bye for now.

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