Dr. Marinelli:

Hey, everybody. Welcome back for another episode of ENT in a Nutshell. My name is John Marinelli and today I have the privilege of hosting a very special episode on personal finance and investing with the founder of the White Coat Investor, Dr. Jim Dahle. Dr. Dahle, thank you so much for being here today.

Dr. James Dahle:

You're very welcome. It's wonderful to be on here and I think what you're doing with this podcast is incredible, especially with how quickly it's growing.

Dr. Marinelli:

Thank you. Yeah. Also, as a part of this special episode I'm going to have a little bit of help conducting the interview with neurotologist Dr. Doug Ruhl, who himself is a bit of a financial guru, has put considerable work into the topic of ENT litigation and I know has mentored countless residents on the topic. Dr. Ruhl, thank you for being willing to come and help out today as well.

Dr. Ruhl:

Thanks, John. I'm excited to be here.

Dr. Marinelli:

All right. Well, Dr. Dahle, I just wanted to start by saying I actually read your first book back in medical school. It was the first personal finance book I had ever read. I think I read it in two days on vacation. Through reading it, I quickly realized that a lot of these topics for a long time that I had considered being very confusing or maybe somewhat daunting, were actually quite understandable. I think immediately afterwards I went to that post you had back in October of 2017, the recommended reading list, I read pretty much every book with an asterisk by it and several others.

And I know it has significantly shaped our financial outlook, my family's as well as countless residents and friends that I have. But I also appreciate, there could be several listeners that maybe have never heard of the White Coat Investor, or heard of Dr. Jim Dahle. Could you just tell us a little bit about yourself and how the White Coat Investor got started?

Dr. James Dahle:

Sure. I think what a lot of people need to realize upfront is that I'm not a financial advisor, I'm not an accountant, I'm not an attorney and I'm certainly not their attorney or accountant or advisor. I'm just a doc who saw a big gap in the financial education of physicians, dentists and other high income professionals. We're basically coming out of our training at some point in our late 20s or 30s with no training whatsoever in how to navigate the business world, the personal finance world, the investing world. And we're being asked to take on a second job as a pension fund manager in our 401K world, we're all asked to basically manage our own 401Ks.

Yes, you can hire advisors, you can hire help. But a lot of times, that turned out to be the problem. You would go to the wrong people and you would be ripped off and you get bad advice. And so at some point in residency, I realized that every financial interaction I had ever had with a professional had gone bad. That included an insurance agent, a financial advisor, a realtor, an appraiser, a recruiter, mortgage lenders, a couple of those. And I realized if I didn't start learning this stuff on my own, I was just going to be taken advantage of over and over again.

My initial motivation to learn this stuff was purely selfish. I just wanted to quit getting ripped off. What I realized, as I started reading used books and spending time on internet forums and reading blogs was that I found this stuff really interesting too. In the same way that I love medicine, I love personal finance. After a few years I found online, I wasn't so much learning as I was teaching and I enjoyed that as well. I was an academic doc for just a few short years while I was I the military, but I loved the teaching aspect of it. I was never much into research, but I loved the teaching aspect of it.

And in 2011, about a year after I got out of the military and I started the White Coat Investor. I just loved that aspect of being able to help a lot of docs just with a few simple teachings and principles, because they had never had it before and due to their high incomes, it's made a difference in their lives of perhaps millions of dollars over the course of their career. It's been pretty rewarding. It's been a fun journey and it's been fun to get my whole family involved with it.

Dr. Ruhl:

Dr. Dahle, we appreciate all you've done to help us, in your words, get a fair shake on Wall Street. I know it's certainly made a positive impact on our lives and we're glad to share your thoughts with our community. I know that there's a lot of topics that we could cover today, but we first wanted to tackle the elephant in the room for young physicians, student loans. Similar to other specialties, the average ENT resident incurs about 150 to $250 000 in debt during their training. And I think this issue weighs heavy on the minds of residents and junior staff. Did you mind sharing with us how you would like our audience to think about student load debt.

Dr. James Dahle:

Sure. Student loans are really interesting. Some of the most recent data on them, you may be surprised about. Fewer medical students actually have student loans these days. And the percentage of docs that come out with student loan debt is actually falling. Not dramatically, but it is going down each year. Right now it stands at about 27% of medical students are coming out of school debt free. Now, the problem is the average student loan of those that have loans, is going up dramatically. What is happening is that the student loan burden is not only going up, but it is becoming more and more concentrated. While the average student loan burden coming out of a MD school might only be a couple hundred thousand dollars, I keep seeing more and more people with 400, 500, $600 000 in student loans.

And when you're looking at that sort of a debt, even if you're in a relatively well paying specialty, it is the elephant in the room. It is the biggest piece of your financial life. I think you do need to address it upfront and there's basically two approaches. The first is to get somebody else to pay it off and the second is to pay it off yourself. And depending on which of those two routes you're going down, you'll obviously tailor your plan accordingly. When I talk about those people who have someone else paying it off, it might be a contract. If you're in the military and you have HPSP contract, they like to call it a scholarship. I think it's much better termed a contract, because in reality the way it works is you get some of your money upfront and then you just get paid a little bit less later when you're an attending. But that's one way to come out with time debt instead of money debt.

But, other ways include public service loan forgiveness. If you're working in an academic medical center, you're working at a BA or some other 501C3 where you're directly employed, if you make payments for 10 years, everything else is forgiven tax free. And all those low payments you make in those income driven repayment programs while you're in residency and fellowship, essentially is the amount that's left over to be forgiven after 10 years of making payments. If you qualify for that

program, it is a great opportunity. And over the next couple of years, we're going to start seeing the first batches of really significant numbers of physicians receiving public service loan forgiveness.

On the other end of the spectrum are those who are paying their student loans off themselves. And the key here is to have an aggressive plan to keep the interest rates down as much as you can, to make big payments. And try to wipe that out within two to five years of coming out of residency, before you really get used to that attending level income and lifestyle. And that's really the key I think, is to try to live as much as you can like a resident for those first few years out of residency and get that debt taken care of, so you can move on with your life.

Dr. Ruhl:

You talked about, in your writings and podcasts, we see terms like hedonic treadmill and lifestyle habituation. Can you touch upon that as people transition from residency to early staff hood?

Dr. James Dahle:

Yeah. This is just natural, when you have more money, you tend to spend more money. And it's like that for every American, probably everybody in the world. And doctors are no exception, when we have more, we tend to spend more. But the key to building wealth is to realize that the measurement of wealth is not income, it's net worth. Meaning everything you own, minus everything you owe. In a lot of ways, a doctor coming out of training is the poorest person in the world. They've got a net worth of minus 200, or minus 300, or minus $400 000. Compared to the guy living under the aqueduct downtown, they're dramatically more poor by measurement of net worth. And I think the key is to remember that and to live your net worth, rather than your income. Whereas most doctors are tempted to live their income, rather than their net worth and because of that, they actually never acquire very much net worth.

This concept of a hedonic treadmill is just the idea that when you have more, you spend more, but it doesn't actually make you any happier, that you quickly become adjusted to your new level of spending and that it doesn't give you any additional happiness. You really have to be careful, understanding yourself and what makes you happy and carefully spending your money on those things that really make you happy. And I think the general guideline should be, to be selectively extravagant, but generally frugal. Save money on all the stuff you don't care about and when it's something you really do care about, splurge on it. For me, that tends to be outdoor equipment, for rafting or climbing or canyoning or boating, that sort of stuff. Whereas I don't seem to care nearly as much what my daily driver is, I'm still driving a 2005 with 250 000 miles on it. I just don't care. It's got a dent in the bumper, I don't plan to fix. But I'm going to have the top of the line climbing and rafting gear. Everybody's a little bit different, you just have to understand yourself and spend your money on that stuff that's actually going to make you happier.

Dr. Ruhl:

I think the next logical step, when you've tackled debt or had a [inaudible 00:09:54] plan to address the debt, is making a prudent plan for saving and investing. I want to hear your thoughts for our audience about how a resident or junior staff should think about concepts like financial independence, or the importance of investing towards their longterm financial security and life goals. Put another way, why should a young doctor care about investing for their future?

Dr. James Dahle:

It seems obvious to those of us who work in this space that at some point in the future, you're not going to be able to work. And you're going to need to live off the money you earned while you could work. That's the main reason. The greatest financial task of our lives is saving up for retirement and it takes a lot of money. Basically, you need 25 times what you spend in order to be financially independent, in order to not have to work. And if you look at what you're actually spending and multiply that by 25 you will realize that's a vast sum. Typically, a seven figure sum. Now, some of that spending goes away in retirement, obviously you're not spending on work expenses and maybe even cancel your disability insurance and your life insurance. And some of your kid related expenses go away and obviously you're not saving for college and retirement once you're already in retirement.

But you're still going to have a fair amount of expenses and you've got to have a lot of money saved for that. And the sooner you start, the more heavy lifting your money can do for you rather than it just all being brute force savings. But there's no doubt that, especially in the beginning, some of that money has to come from brute force savings. Meaning you have to carve it out of your income by not spending it and investing it. In order to be a good investor, you have to first be a good saver. In my recommendation to attending physicians is that they take 20% of their gross income and put it toward retirement. Now some of that might be in a retirement account, like a 401k, or a Roth IRA funded through the backdoor for themselves and their spouse.

But if they don't enough space in there to put 20% of their income, it means investing in a non-qualified or taxable account, which is fine as well. But the point is, you've got to put a lot of money in there. Anything else you're doing, if you're saving up for a Tesla, or you're saving up for college, you're saving up for a house down payment or you're paying off your student loans, that's all in addition to that 20%. I think a lot of people just need to be given a number like that and realize that this is a major budget item for you. This is not something you do with a little bit of money that you have left over at the end of the month. This is something you carve off the top and it just has to be a major priority for you.

And in order to get to that number, what you'll quickly realize, is that you have to keep your lifestyle in check. You can't buy a new car every three years, you can't live in a house that's five times your gross income. In order to have money to invest, you've got to keep your spending down to at least a reasonable level. The good news is, reasonable for physicians is still a very nice lifestyle.

Dr. Marinelli:

One question I wanted to ask, just related to that, when you talk about 20% and stuff. How do you cast a vision as to determining this is enough? For instance, if you look at some of the behavioral economics literature you see, there's maybe not much more happiness you buy once the income goes over about 75 000 a year. I don't know, how do you think about setting goals financially and casting a vision for that?

Dr. James Dahle:

It's a very interesting concept. It's interesting to go back to the original data on that. And what you see if you look at those studies is that happiness does not level off at $75 000 a year of income. Certainly, the rate of the increase in happiness is much higher, below $75 000 a year than it is above $75 000 a year. But it never really levels out. That's a bit of a myth with that data. The other myth with it, is that it has to be adjusted to where you live and to time. It's now several years old and it was not necessarily designed for those who live in the Bay Area. In the Bay Area, that $75 000 a year might be $110 000 a year for instance.

I think it's not entirely academically truthful to say that additional spending or additional income beyond $75 000 a year brings no happiness. Because, I think it does bring at least a little bit of

happiness, let's keep that in mind. But the truth is that it's not going to make as big of a difference as in the beginning. In the beginning, your first $50 000, $100 000 worth of income makes a dramatic difference in your life. When you're already making $600 000, another $50 000 in income is not going to make a very dramatic change in your life. That's just the way life is. And I think it's important to realize that if it's not going to make you any happier now. You might as well put it towards something that's going to make you happier later. And there is no doubt when they survey retirees, that the happiness of retirees and their satisfaction with retirement basically comes down to two things.

Number one is their health, number two is their financial situation. If you can ensure those two things in retirement, you are much more likely to have what you consider to be a happy retirement.

Dr. Marinelli:

Going off of that from a resident standpoint, you said first staff saving 20%. What about for a resident, practically speaking, what can that look like?

Dr. James Dahle:

I have really low expectations for residents. And I think that's okay. A lot of people don't realize that what you do as a resident as far as saving and investing, it's really important to get in those habits of saving and investing. But the actual amount you save, is probably not going to move the needle much. Now, it's a little bit different, I think, in the military because a resident typically makes a little bit more and an attending typically makes a little bit less. You can make more of a difference in the military, especially since you don't have as many student loans, typically. But for the most part, the amount of money you can save on an income of 50 or $60 000 a year compared to what you can save every month when you have an income of three, or four or $500 000 a year is just not very significant.

Where I think residents really need to put their focus is on a few things. Number one, learning to be a great doc. In a lot of ways, you're investing in yourself not only your future professional happiness and the care of your patients, but in your future earnings ability. Learning to be a great doc and ensuring career longevity, I think, is the number one goal in residency. But as far as financial things in residency, it's important to take care of things like disability insurance. Residents get disabled all the time. Nobody really talks about it, but this is a critical piece of insurance to get in place as an intern. Not waiting until you're an attending to do that. If anybody else depends on your income, you also need term life insurance and a lot more of it than you probably think. You probably need a seven figure amount of term life insurance, even as a resident. The good news is that stuff's pretty inexpensive. You also need to make sure you have a really good plan for your student loans, whether it's paying it back or whether it's going for public service loan forgiveness. Making sure you're enrolling in the right income driven repayment program for your federal loans.

I think those things matte a lot more than how much you save and invest. But I do think it's good to get in the habit of investing as a resident. And I generally recommend you use a Roth account to do that, but these days, there's at least one good reason for a resident not to use a Roth account. And that's because when you put more money into a tax deferred account, whether it's an IRA or a 401k or 403b, it will decrease your income which is used to calculate your income driven repayments for your student loans. Especially if you're going for public service loan forgiveness, you may not want to use a Roth account during residency. But as a general rule, because you're in a relatively low income bracket during residency, a Roth is a good place to invest.

I think that's all very important. But, probably the most important thing is to hit the ground running as an attending, with a good, solid written investment plan. Because when that money starts rolling in, you start making the big bucks as an attending and that's the money that's really going to

move the needle, you want to actually know what you're doing by the time you get there. I tell residents, have a plan for every dollar for your first 12 paychecks that you get coming out of residency. If you spend that money wisely, or invest, use it to build wealth, whatever, chances are you're going to set yourself up for a very financially successful career and lifetime.

But if you just do what comes naturally, by the time you come out of residency, you're going to have a big fat mortgage and two Teslas on car loans. And by the time the student loan payments start having to be made, there won't be any money left to make them. I think planning and insurance and student loan planning and just developing good habits is far more important in residency than how much you save.

If you're a resident and you're maxing out a Roth IRA, I think you're doing great. I would not say that a resident should expect to be saving 20% of their gross income for retirement. I think that's just probably too much, you probably have better use for the money.

Dr. Ruhl:

There was a ton of pearls that were just thrown out there. We will try to dissect some of those as we go along here, for sure. When you talk about investing, if we made that transition, you have written about and your White Coat Investor network have talked about waterfall investing or filling buckets. There's good images of pouring water into certain buckets and when that overflows, go to the next one. Can you describe what that means in general terms? I know everybody's a little bit different on maybe what order, but there's general principles with that, that I think could introduce good concepts on where people can put cash as they start increasing their income or increasing their savings rate.

Dr. James Dahle:

I think the main concept behind this idea of a waterfall, and I give credit to actually a financial advisor, Sarah Catherine Gutierrez. I think she's the first one I saw actually present it as a waterfall. But the idea is that some of your investing accounts have better tax advantages than others, is basically what it comes down to. If you have a limited amount of money, you want to make sure you're using the accounts that provide the most advantages. For example, the most tax advantaged account out there, at least for those using a high deductible health plan, is a health savings account.

A lot of people don't realize that these accounts are really investing accounts, because you don't have to take the money out at the end of the year. It's not use lose, like a flexible spending account. Anything that's still in there at the end of the year, just rolls over to the next year. And these accounts can be invested in good, solid, low cost index mutual funds, just like a 401k can. The nice thing about this account, however, is that it's triple tax free. You get a tax deduction for every dollar you put in there, just like you would in your 401k. As it grows and kicks off dividends and capital gains as you buy and sell, there is no tax consequence to that. But when you take the money out, whether now or in retirement, as long as you spend it on healthcare, it comes out totally tax free. Just like a Roth IRA money would when it comes out of its account in retirement.

Compared to a 401k or a Roth IRA, the tax advantages of an HSA are even better. It's your best investing account. If you're eligible for one, I encourage you to use it, to max it out. And that's the thing at the top of your waterfall. Next in the waterfall typically comes some of these, at least for an attending position, is usually a tax deferred account like your 401k or 403b. And you max that out next. And if you still have more money after maxing out an HSA and a 401k, then you typically move on to something like a Roth IRA for yourself and your spouse. That's another $6000 a year for anybody under 50 years old.

Eventually, if you're a really good saver and you're saving a large chunk of your income, you may max out all of your tax advantaged accounts. And at that point you're left with basically what we call a

taxable or a non-qualified or a brokerage account. And there's no limit on how much money you can put in there. At the bottom of any waterfall, you always end up with a taxable account. But in general, if you're investing, you probably have access to one or more of those tax advantaged kinds of accounts and should use those first.

Dr. Ruhl:

Where does saving for children's college fit into this? I always hear people say, well I got to make sure I put in enough for my kid's college. But it's a balance of making sure that you have enough for your future or take care of your immediate and short term, long terms needs. In your mind, how should a young physician weigh that option of when to begin that component?

Dr. James Dahle:

I think it's really fascinating. I see people saving for college while they're still in residency. They haven't even paid for their own education and they're saving for their kid's education. I think that's really noble that they love their kids that much, but I think they're a little bit screwed up that way. I think you ought to pay for your own education first. Until your student loans are gone, you probably have no business putting money in a 529.

The good news is, there are other ways to pay for college besides saving money in advance. The child can earn some money, most of us worked at least a little bit during college and before college and during the summer. The child can save some money and they can work as they go along. They can get scholarships, you can pay for some of it out of your current cashflow. You can choose a less expensive college. It's pretty dramatic the difference in price in colleges across this country. It doesn't have to all be saved up in advance, that's number one.

Number two, if you can get yourself into a good financial position, meaning you got your student loans paid off, you're at least making great progress on your mortgage. You're doing a great job saving for retirement. Now you're in a position of strength. And you can really save a lot of money for college in a hurry. For example, the 529 rules allow you to max out a 529 with five years worth of contributions upfront. You can actually put five years worth of $15 000 a year, what's that work out to be? $75 000 into a 529 in one year. And your spouse can do the same. You can put up to $150 000 all at once into a 529 to save for college. It's not like it has to be put in there every year as you go along. If you don't put it in there until your kid's 10, you can still put a whole bunch of money in there at one time. And I think that's another misconception, that this is something that has to take place earlier. Obviously, the earlier you do it, the longer compound interest has to work on that money. But it's not like it has to be done that way.

I would recommend that you definitely prioritize your own retirement and paying for your own education ahead of paying for your children's education. But at a certain point, it's something you probably want to save up at least something for, to help them not end up with the same level of student loans you had.

Dr. Ruhl:

You'd mentioned earlier, the benefits of potentially having residents consider a traditional IRA versus a Roth IRA and then staff who are more inclined to do Roth IRAs particularly a backdoor IRA. What recommendation do you have if a resident did start off with the tax benefits of a traditional IRA? Getting rid of that, to prevent problems with their backdoor Roth and generally touch upon that.

Dr. James Dahle:

Sure. A lot of complex tax planning techniques you just mentioned there that might have gone over the head of a few people. To understand what we're talking about here, you have to understand a few rules about retirement accounts. For example, a traditional IRA is a tax deferred account, when you put money in there you get a tax deduction in the amount of the money you put in there. But there are some limitations on that. If you have a retirement plan at work and you make any significant amount of money which might be just a resident with a little bit of moonlighting money on the side, you are no longer eligible to deduct that IRA contribution. And that's the issue for attending physicians, is they generally have a retirement account at work and they make too much money to deduct an IRA contribution.

That leaves them with a Roth IRA. And most attendings have an income above the limit where they can contribute directly to a Roth IRA. They have to actually fund it indirectly. Meaning, they put the money into a traditional IRA they don't get a deduction for it and the next day, they move that money to a Roth IRA. Now because they didn't get that deduction upfront, the cost to convert it to a Roth IRA is basically zero. In the end, it's just like contributing directly to a Roth IRA. But this indirect, or backdoor, contribution allows them to do so legally. And although it sounds sketchy, they call it backdoor Roth IRA, it sounds like you're doing something illegal, you're not. Congress and the IRS have both blessed this technique for funding an IRA for high income professionals. It's perfectly fine to do.

But one of the catches with it, that messes some people up is what's called the pro rata rule which says, that in the year you do a conversion, if you don't zero out that traditional IRA, meaning there's nothing left in the traditional IRA, your conversion gets prorated. Instead of it being a totally tax free conversion, you'll end up converting some pre-tax money and some after tax money. And there will be a tax cost to that conversion. You want to be careful about that. You want to make sure that IRA is zeroed out at the end of the year.

And there's basically two ways to do that. One is to just convert the whole thing and pay the taxes on it and then of course it's going to be zero. And that's a good thing to do if it's a small account, it's really easy to do and the tax cost isn't too high so you might as well. But if it's a significantly sized traditional IRA or SEP IRA or simple IRA, anything like that, then what you may want to do is roll it into a 401k first. And there's no tax cost to doing a roll over, but that clears up that pro rata issue so you can go ahead and do a backdoor Roth IRA for yourself each year.

A little bit complex there. The first time people hear that, in general, it goes right over their head. You really have to hear it about three times before you understand it. I have a tutorial on my website, if you just Google backdoor Roth IRA tutorial, it will pop right up and it will walk you through the steps of doing that and help you understand the pro rata rule. But a Roth IRA is a great place to save for retirement and it's worth taking the time to understand that.

Dr. Ruhl:

I appreciate it. I know it's a complex topic to many, but just so those listeners that it applied to them or it sparked their mind, I hope that added some clarity to that concept. Taking one big step back, I think it's important to at least mention to listeners that before doing all this, it's always to have some sort of emergency fund buffer. You don't want to be living paycheck to paycheck and have everything invested into the market that is volatile. Just make sure that concept is understood.

Dr. James Dahle:

Boy, people really learn that lately.

Dr. Ruhl:

Exactly.

Dr. James Dahle:

It's been the wildest thing about this particular economic downturn. Normally, medicine is such an insulated profession. Our incomes tend to be so stable, because hey, people need medical care in good times and bad. But it's been really surprising, I think, to a lot of docs to see not only their portfolios drop in value, but their incomes go down so much. And I've been amazed how many emails I've gotten from doctors that have been furloughed or been asked to take a voluntary pay cut of 20 to 50%. That really does demonstrate the need to have some sort of an emergency fund. Traditionally, that's three to six months of living expenses saved up in some sort of liquid safe investment, like a money market fund or a high yield savings account. A lot of docs thought their income was so stable, they didn't really need that and I think this particular downturn has taught them the hard way, unfortunately, that they probably still do need that sort of a cash buffer.

Dr. Ruhl:

Yeah. Absolutely. Talking about the accounts themselves, people always ask what should they put in the accounts. I know we can't give specific advice, but I think that listeners that ar familiar with you know the general answer to this question. But what type of funds do you recommend physicians look for to put into these accounts that we talked about earlier?

Dr. James Dahle:

Well, in general it's important to understand the difference between an account and an investment. I like to think of an account as luggage. It might be suitcase, it might be a backpack, it might be a carry on, it might be a trunk. And each of those is suitable for a different type of trip. Whereas an investment is like the clothes that goes into the luggage and any type of investment can go into any type of account. There's a few restrictions, but for the most part, that's true. And just like any type of clothing can go into type of luggage. It's important to differentiate between those two things. A 401k is not an investment, it's an investment account. What are investments? Investments might be stocks or bonds, or more likely, mutual funds. Now what a mutual fund is, is it's a group of investors that essentially pool their money together to get professional management and benefit from some scale. Their costs go down to each of them because they're taking advantage of these economies of scale. They get professional management, they get diversification, they get liquidity and they get these advantages of investing with hundreds or even thousands of other investors.

And the next question that comes up, once people realize, oh yeah, this is a good idea for me to use mutual funds is, what kind of mutual fund should I use? And there's basically two main types of mutual funds. The first type is what's called an actively managed mutual find. And in this type of investment, the manager tries to pick the good stocks and avoid the bad stocks. They do all kinds of research and they use their fancy computers and they do the best they can to avoid the lousy stocks and get those good ones. But it turns out, if you actually look at the data of how well these active managers do in picking the stocks, they don't do a very good job of it at all. It's a really hard thing to do, it turns out, to pick stocks well enough to overcome the cost of doing so.

And on average, they typically underperform the market. The market on average does better than these mutual fund managers do. A number of years ago, a few smart people said, well, it might be hard to beat the market, but it's not that hard to match the market. We'll just buy all the stocks. That's really easy to do, it doesn't take any expertise. It's pretty much guaranteed to get the market return and most importantly, it costs almost nothing to do that. And so, you don't have that drag of those costs of

managing the fund. And these types of funds are called passive funds, or more commonly, index funds. And they're available for stocks and bonds and real estate and various types of stocks and bonds and real estate. And what I recommend people do is that they take advantage of this guarantee that an index fund provides to essentially guarantee you the market return.

Now, if the market goes down, of course the value of your index fund will go down. But, when the market goes up, you will get the entire performance of the market. In the long run, I think you're much more likely to reach your investing goals if you will keep your expenses down and get that market return by using index funds. Rather than passively managed mutual funds or heaven forbid, trying to pick and choose the good stocks and bonds yourself, which I think is a pretty losing strategy the vast majority of the time for a busy professional like a physician.

Dr. Ruhl:

You've talked about uncompensated risk with stocks and also it kind of parallels with the self cleansing ability of index funds. You mentioned you buy the whole basket, if a company does poorly, it is removed from that index and the index self cleanse whether they're up and rising or the better vetted companies are in the index and it's an interesting concept that's sometimes difficult to convey to someone not familiar to that.

Dr. James Dahle:

Yeah. It's lick the backdoor Roth IRA concept. Until you hear it three or four times, it doesn't click why you should be using an index fund. But once you read a couple of books or you read a few blog posts and finally it just clicks for you and you realize, oh yeah, of course I should be using an index fund. But there's still a lot of investors out there that haven't quite figured that out yet.

Dr. Ruhl:

I get questions sometimes from people that stay what stocks should I buy? What mutual fund should I buy today? Or, I have $5000 to put it, what do I do right now? And I always them, it depends. Can you just briefly explain why answering this seemingly benign question in isolation is a disservice to them? and you've touched upon earlier the importance of crafting an investment policy statement and that can be something very simple. And you've written about that on your website as well.

Dr. James Dahle:

Yeah. I think that's exactly it, the answer to all of those questions, and they are very common questions, even I my own Facebook group or on my own forums. I have people asking those questions all the time. And the answer to that question is, you should do what your written investment plan says you should do. And of course they go, "Well I don't have a written investing plan." Well, the answer to that is, you need to get a written investment plan. Because once you have a written investment plan, it tells what you should do with any spare money you come into. Whether that's a windfall from an inheritance, whether that's money you made at work this year, whether it's money you got when you sold an investment property, whatever it might be, if you have a written investment plan, it tells you what you should do with that money, what you should invest in.

And you realize that the idea is to have a long term plan where you basically set percentages for each type of investment that you want to invest in. In my case, that's stocks, bonds and real estate. I put 60% of my money in stocks, 20% of my money in bonds, and 20% in real estate. At any given moment, if I happen to have $10 000 one month to invest, I look at which one of those is below its percentage. For example, maybe because the stock market's down, only 55% of my portfolio is in stocks. In that sort of a

month, that $10 000 is going all towards stocks. And in my plan, it would dictate that it went into a stock index fund. And so, what would I do with that $10 000? I'd put it into a stock index fund because that's what my plan says to do.

On the other hand, maybe after a year like 2019, maybe my portfolio is now 65% stocks and only 15% bonds. In that situation, if I had $10 000, I would put it into a bond index fund. And in that way, bring that portfolio back into alignment with my written investing plan. I think once you understand that concept, it really eliminates a lot of the stress from investing and trying to decide every single month, what am I going to invest in? And in reality, in the long run, having a plan is really the key to successfully meeting your goals.

Dr. Marinelli:

Yeah. I know the first time I read about rebalancing and asset allocation and whatnot, it blew my mind how simple and ingenious it was. Building off of this, I just want to touch on the topic of having a financial advisor. I've heard a wide variety of opinions on this, people saying, well it just saves me so much time, I don't have to think about it. And for them, that's very valuable. And then there are other people saying, all the time it takes me to learn enough to pick a good financial advisor, I could just do it all myself. What are your thoughts about a financial advisor?

Dr. James Dahle:

I think there's truth in both schools of thought there. And I don't think we need to necessarily be dogmatic about it. I would estimate that about 80% od physicians want and need a good financial advisor. And for those people, the greatest service I can do for them, is to connect them with somebody who gives good advice at a fair price. And that's perfectly fine. If you're that type of a person that you just don't feel comfortable doing it, or you don't want to do it, or you have no interest in this, investing is not a hobby for you, I think it's perfectly fine to use a good advisor. But you need to at least learn enough to recognize what good advice looks like and to understand what the price should be for good advice.

What does good advice look like? They should be talking about things like we've been talking about in this podcast. They should be talking about index funds and backdoor Roth IRAs and keeping costs down, et cetera. What is a fair price for investment advice? If they're going to be doing financial planning for you and if they're going to be managing your investments, you should expect to pay a four figure amount per year.

You're really not going to find anybody doing a good job for less than $1000 a year. And once you're up above about $10 000 a year, you can almost certainly get just as good or better service for less money. And I think recognizing what good advice looks like is really helpful to that 80% of the people. But the other 20%, are people that have at least enough interest in this to run the numbers and realize what paying thousands of dollars a year to a financial advisor means to their financial situation in the long run. And a lot of times doctors that run those numbers will determine that they would rather retire five years sooner than use a financial advisor. And that's really, when you run out the cost of a financial advisor, it might mean that big of a difference.

It's a significant expense in your life. If you invested that money instead of paying it to a financial advisor, you really can have significantly more money, assuming you do as good of a job managing your money as that financial advisor would have. A lot of docs, especially the do it yourself types, like myself, would rather save that money. And especially if they find it interesting anyway, can develop the discipline and develop the knowledge they need to be successful investing. I think it's fine to go either

route, in fact it's fine to switch from one route to another. For example, I've been doing my own taxes for years. But probably starting next year, my business taxes are going to be done by an accountant.

And likewise, you can go in the opposite way. A lot of people feel like starting with a financial advisor to help them draft up a financial plan and then after a few years they feel like it's on autopilot and they can handle it and they've learned a little bit more. And they go and become do it yourself investors. You're not locked in, in any way. You just need to be aware and make that decision rationally and with intention.

Dr. Ruhl:

Those that do decide to do it yourself, either forever or intermittently, find the beauty and simplicity in index funds. It makes that rebalancing and targeted investment much easier. Dr. Dahle, you touched upon it earlier about bonds and being able to rebalance either with new contributions when the market is very high or rebalancing from that generally, how should we view bonds and should that change during your investing career or during investing lifetime?

Dr. James Dahle:

Bonds have a couple of advantages. One, they act differently than stocks and they have low correlation between them. Often, when stocks go down, bonds go up or at least stay the same. There's no guarantee there of course, non-correlation is not reverse correlation. That's one benefit is, it provides that diversification a little bit of balance to the portfolio.

Then of course, there are fairly long periods of time when bonds may outperform stocks. A lot of people refer to the 2000s as a lost decade for stocks, because bond returns and stock returns were pretty similar over a 10 year period. And that happens periodically and there's really no guarantee that bonds don't outperform stocks in the long run. Those are the two main reasons people hold bonds in their accounts, but after a downturn like this one associate with the Coronavirus, people generally remember the value of bonds for a while afterward. It's only when we've had years and years of fantastic stock market returns that people start going, maybe I should have 100% stock portfolio. A lot of those people either work investing or have already forgotten what it was like to lose real money they used to have in stock market downturn.

Because the worst thing you can do is overestimate your risk tolerance and end up selling low. I did a poll in mid March. I think the market bottomed on March 23rd. And that time, I was doing a poll on Twitter as to what people thought the stock market was going to do. And guess what? 93% of people that answered that poll thought it was going to go down from there and we were at the bottom. If you thought the market was going to go down, you might have sold and ending up selling at the bottom and not capturing any of the subsequent recovery. And I think you have to be really careful about that. That can really damage progress toward your financial goals to sell low like that.

Dr. Ruhl:

Even the unique volatility now is applicable, it's timeless. We think that the story sounds different, but it rhymes, is often the thing. There will be ups and downs throughout our life.

Dr. James Dahle:

Yeah. Every bear market is a little bit unique, but once you've been through three or four of them, and you're looking around, you've got all these people doing crazy things. And you realize that you've seen this movie before and you know how it ends. You might not know exactly when it ends, but you know it's going to end and that all you really need to do to be successful is not panic sell at the bottom.

Dr. Marinelli:

I want to transition, as we're building wealth, particularly in our early years or our vulnerable years, it's essential to protect ourself. And you've touched upon a little bit with the types of insurances. I just want to jump back to that for a minute and go into the nuances, specially right now, of disability insurance. When is it appropriate, when should we get it, what should we look for? What pearls of wisdom should we have or filter should we have as we look for this?

Dr. James Dahle:

Well, I think number one is, determine if you need it. And most doctors do. If you depend on your income to live, you need disability insurance. And it not only protects your loved ones, but it protects you. And doctors do get disabled all the time, it's not uncommon at all. If you're not yet financially independent, you need to go see an independent insurance agent and buy a disability insurance policy. Now, you may have one that's adequate through your work, but a lot of times the ones you get at your work, not only are they not portable, they don't go with you if you change jobs. But their definition of disability is significantly weaker. Now, that often means you get a discount on it, but what you really need is a disability insurance policy that's going to pay if you get disabled. And the best ones as far as the definition of disability, tend to be the individual disability policies that you would buy from an independent insurance agent.

The first thing, and the main thing is if you need disability insurance, go get disability insurance. Everything else is just details. It's nice to have a policy that is specialty specific. Meaning, if you could teach, but you can't operate, it's still going to pay you. It's nice to have some extra writers on, one I recommend for everybody is called a residual disability writer. Meaning, if you're only partially disabled, or as you're coming back from a disability, it's still going to pay you something.

If you're young, you probably want a cost of living adjustment writer. If you get disabled at 35, you want that payment to go up over the next 30 years before you hit social security age. And that's what a cost of living writer does. If you're buying a policy and you're still in residency, or you're in the military and planning to get out, you might want to get a future purchase option writer, which essentially guarantees you the ability to buy more disability insurance when your income goes up without having to prove that you're still insurable.

Those are all important details, but the main thing is if you need disability insurance, get out there and get disability insurance right now. It's really sad to me to get emails from doctors who didn't do this and then became disabled, because it does happen.

Dr. Ruhl:

Touching upon that, what advice would have for somebody with a pre-existing medical condition that is perhaps unable to obtain adequate disability insurance?

Dr. James Dahle:

Well, what usually happens is, you get an exclusion. Meaning, it will not cover a disability related to your pre-existing condition. It's not that they won't sell you a disability insurance policy, but if you've had back surgery, they're probably going to exclude that. Any disability from a back issue, is not going to result in them paying you. But, if you get in a car wreck from something else, or you get cancer or you get terrible COVID and don't recover from it, or whatever it's going to pay. If you have a pre-existing condition, I still think you ought to get disability insurance, you just realize that you can't insure against that pre-existing condition.

All the more reason to get it early if you can, before you develop those sorts of conditions. It's the same thing with dangerous hobbies, if you rock climb, or if you fly private planes or you go scuba diving, that sort of stuff's going to be excluded too. The policy I used to have totally excluded any injury from rock climbing. I just always knew that, that was a risk for me if I got disabled rock climbing, it wasn't going to pay.

Dr. Ruhl:

You mentioned briefly earlier about life insurance as well. Obviously, there's many options out there. Do you mind sharing or diving a little deeper? Particularly, the nuances between term life versus whole like, I think you've written passionately about that.

Dr. James Dahle:

Yeah. If you need life insurance, what you probably need is called term life insurance. Meaning if you die during a specified term and maybe that's 20 years or 30 years or something like that, you're loved ones will receive a big fat sum of money to make up for the fact that you're not there generating money anymore. And most doctors that have someone else depending on their income need a seven figure amount of life insurance. Something between one and five million is probably a right amount. And what that allows your family to pay off the mortgage and to go to college and for your partner to live the rest of their life as though you were still there, at least from a financial perspective.

Now, when you go to an insurance agent, a lot of times they try to talk you into a different type of life insurance product. The most classic examples of these permanent life insurances is whole life insurance. This is not a policy that only lasts for a specified term. This is a policy that will pay out whenever you die. Even if you die at 95, it's going to pay out. Now, obviously, most of those people who buy term life insurance and tell their financially independent at 55 or 60 or 65, most of those people will still be living when that term ends. Most people will not get a payment from the life insurance. And because of that, the premiums for the life insurance are much cheaper than you would get for a policy that is guaranteed that it's going to pay out if you just hold onto it, like whole life insurance.

Term life insurance might be anywhere from eight to 20 times cheaper than whole life insurance. What most people need is term insurance and is dramatically cheaper than whole life insurance, why do so many people end up buying whole life insurance? And the reason why is because it's a product designed to be sold. And what I mean by that is, it pays really well to sell this stuff. A typical commission on a whole life insurance policy is between 50 and 110% of the first years premium. If this agent talks you into buying a hole life policy that you're paying $30 000 a year into, he basically got paid 30 grand to sell you that policy. Now you know why he's trying so hard to sell it to you. But that's the reason that so many of these get sold.

But, their purchase is often regretted. I polled my Facebook group of mostly physicians, who have bought whole life insurance policies. 75% of them regret it. If you look at the national society of actuary information about 80% of people who buy whole life insurance policies surrender them. And surrendering this policy's designed to be held until death, is pretty much by definition someone who wishes they haven't bought it in the first place. It's not something that you really probably need. Probably less than 1% of people, including doctors, actually need one of these policies just because most people don't have a permanent need for life insurance. At some point they're going to become financially independent and they won't need life insurance anymore.

Sometimes people realize that and they don't want to buy it. And the salesman turned to the next step and they talk about all the other things you can do with whole life insurance, besides just insure against dying late in life. For example, it develops a cash value that you can borrow against. And

they try to talk you into using it to pay for college, or using it to pay for your next car by borrowing against it, or using it to pay for retirement. But the truth is, for all these other purposes, of whole life insurance, there's usually a better financial tool available to do it. For example, a 529 is a better way to pay for college. Paying cash for your car is a better way to buy cars. Using a retirement account is a better way to save for retirement than using whole life insurance.

As a general rule, it's a product made to be sold and you should avoid it. And if an agent's really pushing it on you, you should go find another agent.

Dr. Ruhl:

To round out the big topics with insurance, I think it was in fellowship I was reading through your material and I kept hearing about umbrella insurance, that was a new concept to me. Could you briefly touch upon that and the utility of having this?

Dr. James Dahle:

Sure. Most of us know about liability insurance. As physicians, we know we can get sued at any time for any amount, by anybody for anything. And we carry malpractice insurance. We transfer that risk of getting sued to an insurance company. And yes, we pay big fat premiums for that but when you get sued, it's really nice to know that you're basically a defense witness, rather than the person who's actually going to be coughing up the money in the event that that suit is lost or settled. Likewise, in your personal life, you have some liability. Most of this is related to your auto. About 80% of the policies or 80% of the claims, even against umbrella insurance policies, are auto related.

And what an umbrella policy is, it sits on top of your auto policy as well as your homeowners or renters policy and gives you additional personal liability protection. The good news is, you can buy a million or two million or five million dollars of this for dramatically less than what you're paying for a million dollars in professional liability insurance. For example, a two million dollar umbrella policy might be $300 000. But a one million dollar malpractice policy might be 15 or $20 000. It's just dramatically cheaper and you ought to add it onto your insurance coverage.

Dr. Marinelli:

Transition again, just a little bit but, a hot topic for a lot of residents and early attendings is just the idea of home ownership and how to approach thinking about home ownership, especially as a first time home buyer. Can you just talk a little bit about your thoughts on that?

Dr. James Dahle:

I am a big fan of ownership. I like owning my job, I like owning investments, I like owning assets, I like owning my home. But the truth is, it takes about five years to break even on buying a home. And the reason why is because the transaction costs are so high. I estimate that it's about 15% of the value of the home, roundtrip to get in and out with all the closing costs, with all the realtor fees, with the things you've got to buy as you move in and fix up as you move out. It's about 15%. It takes time for the home to appreciate enough to make up for those transaction costs. And how much time does it take? Well, on average, about five years. In a rally good market, it might only take one year. In a really bad market, it might take 10 years.

But since residencies are often no longer than five years and often only three or four years, on average, most residents are going to come out behind buying their home. I have told residents for a long time, you probably shouldn't buy during residency, you should probably rent. But I don't think I've really talked a lot of people out of buying during residency. Most of them still do, it's one of those mistakes

that we all seem to need to make ourselves. But the truth is, despite everything the lending industry and the realtor industry would tell you, most people are not coming out ahead doing it. And in fact, in a really bad time when they come out of residency and can't sell it and end up trying to be long distance landlords, boy, they really become advocates for this policy of not buying a home during residency.

The other thing people get confused on is they think that just because they're renting, they have to be in an apartment. They don't realize that you can rent a home, just as nice a one you can buy in most locations. It's perfectly fine to rent during residency. Now when people come out of residency, I think they ought to wait until they are in a stable professional and personal situation. If you got twins on the way, it might not be the time to buy a home. If you're about to get married, it might not be the time to buy a home. You want to wait until things stabilize. Likewise, with the job, if you just started a new job, you got to realize that 50% of doctors change jobs in their first one to two years out of residency. Make sure that you like the job and the job likes you before you buy a house.

And what does that usually mean? That usually means six to 12 months. Six to 12 months before you're really ready to buy a house coming out of residency. I'm not a stickler that you absolutely have to save up the 20% down payment to do it, you probably have a better use for your money, whether it's maxing out retirement accounts or whether it's paying off student loans. It's okay to use a physician mortgage to do it, but what I don't want you to have to do is sell that home two years from now and take a loss on it, at least after transaction costs.

Dr. Marinelli:

Yeah. We're getting a little bit close to time, but one last question I just wanted to pitch for you. Obviously ENT, like several residencies, very busy residency and often as an early staff you're equally busy if not more. What advice do you have surrounding efficiently learning the necessary personal finance material amidst a busy residency schedule?

Dr. James Dahle:

Well, I think you have to learn this material. Just you had to learn everything else in medical school and residency. And you've got to dedicate some time to it. Now, there are some shortcuts. The cheapest way to learn this is to go get some good personal finance books, follow a good blog, spend some time on internet forums asking questions and crafting your financial plan. But there are shortcuts. At its extreme, you can go hire a financial advisor who would do a lot of this for you. They will teach you, at 200 or $300 an hour, they will teach you this stuff. A good advisor will.

In between those two ends of the spectrum, I've tried to come up with something to help doctors. That's not necessarily forcing them to learn it all on their own, but also not sending them to a relatively expensive advisor. And it's what I call our fire your financial advisor online course. It's provocatively titled and my financial advisor advertisers on my blog don't really like the title much. But what it is, it helps you to draft up your own financial plan. It's an online course, it's about eight hours. There's a pre-test and a post test and there's quizzes throughout. And with each section of it, whether it's insurance or student loans or investing or estate planning, it takes you through that section of a written financial plan. By the time you're done with the eight hour course, you've got a written financial plan that you understand, that you wrote yourself that you can modify yourself, that you can follow to success.

I think one of those three options is really what you need to do. But how can you do it in residency? Well, you've got to take advantage of podcasts and online courses like that and blogs and using the time that you do have available to you. If it's important to you, you'll learn it. I learned it in residency. I know you can too. And it's entirely possible. Many of your peers are doing it. I think saying

you can't learn just a little bit more in residency is a little bit of a cop out, because you can. You're not quite that busy that you can't learn any of this stuff, especially since the material is so much easier than what you're learning in residency already.

Dr. Marinelli:

Awesome. Any other advice you want to give the average ENT resident before we close up?

Dr. James Dahle:

I think one way to look at your career is that you have basically won a lottery. Maybe it's a 15 or 20 million dollar lottery by getting into an ENT residency. And all you have to do to collect on that lottery is stay in your career for 20 or 30 years and you will get that money. You really want to take the steps all along the way to promote longevity in your career. You don't want to burn out. You don't want to end up having to do something else or punch out early. Every time you're faced with a decision about your career, choose that path that will result in you being able to be in that career longer. I think that will make a bigger difference not only in your happiness, but in the amount of good you can do with your patients and financially. Because, the longer you can earn for, the more time you have for your investments to compound, the more money you can save, the less your money is taxed if you spread it out over more years. As you make career decisions, always make the ones that will result in more longevity in your career.

Dr. Marinelli:

Awesome. Well, I think this has been a really helpful session. We have so many questions we could ask, but I think, hopefully, this has been helpful for our listeners. We really appreciate your time and being on the podcast today.

Dr. James Dahle:

You're very welcome. It's wonderful to be here.

Dr. Marinelli:

All right. Well, that will wrap things up for today. I won't close with questions and a summary like we normally do, just being the nature of the podcast. But the only thing I will say is, in terms of practical next steps, you could go to whitecoatinvestor.com where he's got a ton of different good resources online as well as his podcast. That's freely available through numerous different mediums. I'll just remind you also to check out our website headmirror.com where each podcast is searchable by keywords. And then the content, along with our complete surgical video atlas is organized by subspecialty within ENT.

Thanks so much for listening and we'll catch you next time.