



WEALTH PLANNING FOR THE MODERN PHYSICIAN

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FROM ACADEMIA TO INNOVATION: REDEFINING PAIN MEDICINE WITH DR. PETER STAATS (PART 1)

David Mandell:

Hello, this is David Mandell, host of the podcast. Thanks for joining us today. We've got a really interesting guest, a doc who we're going to learn a lot from. So let me tell you about Dr. Peter Staats, and then we will get into it. Okay. So, Peter's got a pretty significant bio, and as we go through these two episodes, you're going to hear that, but I'm going to go through a basic bio that he uses for different speaking. He's a globally recognized leader in pain medicine, neuromodulation, and vagus nerve stimulation. As the founder of the Division of Pain Medicine at Johns Hopkins University, he was the first academic anesthesiologist to implant neuromodulation devices, developed a unified theory in pain that provided the foundation for integrative care, trained future leaders in the field, and conducted numerous research trials leading to new strategies in pain medicine. Dr. Staats has authored nearly 600 scholarly works, including articles, book chapters, and 14 books. And his latest text, *Vagus Nerve Stimulation*, was published in November of 2024.

He's been president of the World Institute of Pain, the North American Neuromodulation Society, the American Society of Interventional Pain Physicians, and several other organizations. And he's the former Lifetime Achievement Award winner from ACIP, ASPN, and NANS, some of those organizations, the Trailblazer Award from the World Institute of Pain, and the Legacy Award from the NAPA Pain Conference. So, a lot there, and that's just a piece. So, Peter, we're pleased to have you. Thanks for being here.

Dr. Peter Staats:

David, it's an honor to be with you. Thanks so much for having me.

David Mandell:

Excellent. So, we've got a lot to talk about, and that's why I wanted to do this over two episodes. And the bio that I just read makes reference to some of that. There's academic medicine, there's involvement with medical societies. Not even in there is work with industry and some of the things you've done there and your personal practice. So, we're going to get to all of that, but I'm going to start with the first question I asked every doc who comes on this program, which is where'd you grow up? What made you become a physician? And specifically, for you, anesthesiologist and pain medicine, how'd you gravitate into that specialty?

Dr. Peter Staats:

A lot of it's by chance. I grew up in Hawaii, and Hawaii was a very integrative society. They're influences from Asia, from the Philippines, from the West. And so, I had somewhat of a unique background growing up. I also was blessed to have a father who was very much an academic psychologist who challenged me to think about things differently than everybody else thinks about things. Don't accept status quo. How can we do something a little bit different and advance science forward? Went to medical school at Michigan. I planned on being an orthopedic surgeon. And for me, I think it was happenstance that I did a rotation with a very famous orthopedic surgeon who had a bad night on call, and I asked him a stupid question, and he answered a stupid answer that made me think, well, maybe orthopedics isn't for me.

My next rotation was anesthesia, and it was somewhat magical how we could use a drug to put someone asleep, waking them back up, do a nerve block and make them have surgery without feeling anything. And I was very interested in critical care. So I went to Johns Hopkins, which at that time was the top critical care program in the country, not really thinking anesthesia, but thinking critical care, and then stumbled into this field of pain, which nobody was really doing at that time.

David Mandell:

Yeah, and we'll talk about it probably there, definitely were there in the early days. So, you mentioned your father, psychologist. I think you and I talked that he was also an inventor. Obviously, he was an open thinker, someone who wanted to think about what hasn't been done rather than how it's always been done. So, you mentioned a little bit about that, but if you could tell us a little bit more about his influence and how you now, looking back, think that how that influenced you in your practice and in your career.

Dr. Peter Staats:

So, my dad would've been known for two main things, but he did a lot of other things. He developed the only unified theory in psychology and tried to figure out how do the behaviorists and the cognitive people interact to have an approach that's looking at the same problem that we can actually have a theoretical orientation to understand human behavior. And prior to him, and just for reference sake, there were the cognitive psychologists who said, "The only thing that matters is the mind." And there were the behaviorists that said, "The only thing that matters is behavior." And my father was the guy who said, "Well, it's a little more complicated than that. The mind drives behavior. Behavior affects the mind." There was Pavlovian conditioning and operant conditioning. And he was the person who said that the two are intertwined, that for something to function as a reinforcer, it needs to elicit an emotional response, which was very different than how all the behaviorists had thought and all from the classical conditioning or operant conditioning side.

It was a very unique way of looking at the problems that I think made a big difference and had a big impact on me and how I think about problems. He also invented things like timeout. So, one of the most utilized approaches in child development, seven billion kids have been trained with timeout as part of what they do, invented token economies, and first to say that physicians can function as reinforcers of patients. So, he really did have a broad influence on my thinking about pain and other areas of medicine.

David Mandell:

Yeah. Well, as I know, and as we'll talk about, again, thinking outside the box and maybe integrating different ideas is going to come up in your career. It's going to come up in what we're going to talk about. It's funny that we've sort of segued into this, and I'll come back to it a couple times because this is on this podcast, as you know, career is very important as what we're talking about, but also finance. So as you started your training, let's go back to that, because we'll then get to your first academic vision, but back in your training, and then you can even comment, we'll come back to it later as you started to work and make money and do some things, what was your interest in business of medicine, finance, investing, that kind of thing? Was it on the scale, "I'm interested in science and I don't care about all that stuff. I hope it works out," to, "No, I am interested. I read the Wall Street Journal. I've always had this business piece of my mind, too." Where were you on that scale?

Dr. Peter Staats:

Look, it's varied over the years transparently. Early on, I was a pure scientist, and I took over a division. I was the youngest division chief at Johns Hopkins. I took over a division of pain medicine when really the only things that the pain physicians were doing was epidural steroid injections and sympathetic ganglion blocks, and there were not a lot of therapeutic options for people at that time. I immediately became very interested in spinal cord stimulation and intrathecal therapy and petitioned the dean to allow me to do surgery at the hospital. And it was A, partly because of my academic interest in this, but it was also partly the finances.

I probably got the only MBA in history by chance. I was running this division. They were telling me I was losing money, and I said, "There's just no way I could be losing money. There's just no way with the volume of patients we're doing and the types of surgery we're doing. I know the bills that they're going out." So I took a class in accounting, and then I took a class in marketing, and then I took a class in contracting, and I took all these different classes just because I needed to learn how to run a division to make it financially successful and not be told by my boss that I'm not making money. And somewhere along the way, they decided they're going to have an MBA

program, and I had taken just about all the classes because I needed the knowledge.

So, I got my MBA really by chance and not by plan of having an MBA, but I needed the information that was within an MBA. And fortunately, while Hopkins didn't pay me a lot, they did allow me to take classes on things to make me a better doctor. So that prompted me to be more interested in the finances because I had to know it. And then at a certain point, I had three kids that needed to go to school and planning for them. I wasn't going to make it on what I was making at Hopkins. Even my wife was a practicing physician, we weren't going to make it on the Hopkins salary. So, I became more interested in the financial side of things and started, or worked with one of my former fellows to create a robust pain practice that was acquired by private equity, became the chief medical officer of that private equity group. And finances are really important in running a large practice. So, I don't think money is my focus, but it's nice to have it.

David Mandell:

Yeah, right. Well, yeah, you've mentioned a bunch of things, and we're going to go backwards and can come forward. So just so the listeners and those of you on YouTube watching our pretty faces, so you got the MBA while you were in practice. This is when you're in the early years when you were at Hopkins doing academic medicine, you started taking the classes, and then eventually they rolled out an MBA program when you said, "Hey, I already did the classes. I should get the degree." That's the timing, correct?

Dr. Peter Staats:

That's pretty much what happened. It was early on during my Hopkins career. I was taking a class here, a class there, and I was constantly taking a class when they announced that they had an MBA program, and I had met a lot of the criteria for the MBA and grandfathered me in on a lot of these classes, and I had a couple more classes to take, which I did. But yeah, it was a very good experience for me.

David Mandell:

Great. So, let's spend a couple minutes just talking about your time at Hopkins, meaning there are folks watching this, listening to this who are in academic medicine. I know there are folks who listen to this who are fellows and residents and maybe thinking about that. So, given that, it sounded like you were there training yourself and then you took the job, so you stayed home essentially, is that right, out of your training?

Dr. Peter Staats:

Well, look, there were really good people around me.

David Mandell:

Yeah, great.

Dr. Peter Staats:

Raja taught me all about reflex sympathetic dystrophy, and I can't say I taught myself this. He certainly taught me this. I had some other attendings that I learned what not to do from. I had the neurosurgery department who, on the one hand, were very supportive of me and helping me, training me, and learning how to do these implants and do surgery. On the other hand, this was a time when neurosurgeons were the only ones doing implants, and there was a little bit of conflict that was created because I was an anesthesiologist doing surgery at the world's greatest hospital, and that created a conflict for some of them. But when I showed them and I showed the dean and I created a pathway that required a certain skillset working with the institution that I was competent, they embraced me and supported me.

The day I got my privileges, Don Long, who was the chairman of neurosurgery, came to me, found me, and said that if I ever needed help, just to call him. So, he didn't want me to have it, but when I got it, he was glad that I was the guy to get it.

David Mandell:

And so, obviously Hopkins, a terrific reputation throughout medicine, I'm sure in certain fields, especially. So, from a career point of view, looking back now

that you've been in private practice for a long time, now you have that perspective. Again, thinking about residents, fellows who might be listening or those in private practice, what are some of the pros and cons in your view of academic practice? What success factors? What advice would you be giving someone who says, "Yeah, I think I want to go into academics rather than be in private practice." What are some lessons learned from that time of your career?

Dr. Peter Staats:

Well, I think academics gives a young physician a platform to speak from. It allowed me to do things that I may not have been able to do at other places. I had time for writing, and I wrote a new theory of pain that provided a foundation of understanding the psychological, behavioral, and interventional, which is what I did, and not be antagonistic to the other areas, but to be embracing of the other areas. I think that was accepted more because I was a Hopkins guy. I did the first clinical trial on intrathecal ziconotide, which is now pre-alt, and got published in JAMA the results of that. And that was the first new drug that was made for pain in probably 25 years at that point. They came to me because I was at Hopkins at the time and I was interested in this and I was an academic guy.

I had incredibly smart people that I was working with and I invented Qutenza Patch. That wasn't all me. There was a lot of basic science going on in the neurosurgery department that was related to this. I was working with the neurology group who they recognized that we could make an area numb with capsaicin, and I worked with really, really smart people and I had time to do things at that area. At that time, salaries were relatively poor, but it was okay with me because I didn't really need money. I wasn't looking for money. I was looking to change the world in some small way. But after I'd been doing it for a number of years, I started to hit some walls. There may be a secretary that you didn't like, but you can't fire them because they're not either the bureaucracy there.

I loved my secretary, so if she's watching this, I love my secretary. I'm speaking more as an in principle, but there were things that you had to do because it was that way. And I eventually left mostly because I wanted to do it my way.

And I found that in private practice, I was the decider, so to speak. My partners and I, I don't mean just me, but my partners and I would meet together and we would decide. And if we needed more resources, we would get more resources, but it was a very different stressor. It was 60 patients a day. We were working really, really hard.

David Mandell:

I want to interrupt you, Peter, because I want to get there to the private practice, but just to sum up what you're saying.

Dr. Peter Staats:

Yeah. So, if a young physician is interested in doing things differently, it can give you a great platform. If you're interested in teaching, it gives you a great opportunity to teach. And I was blessed by having some of the great, great students that I could teach from medical school through fellowship and other attendings that we shared knowledge together. So yeah, I think a little time was another, and good, smart people with academic interest. Those were all really powerful things, but you didn't get paid as well.

David Mandell:

That's right. Yeah.

Dr. Peter Staats:

And I recognized that and I was okay with that.

David Mandell:

Yeah. So yeah, I think if you ask most physicians, especially private practice, the biggest resource that they don't have, that they wish they had more of was time. So, the fact that you had that, and I'm sure you were still busy and had a lot of things going on, but that you had the time to pursue some things that you probably couldn't if you were seeing more patients, and we'll talk about that piece in a minute. And I do understand, and it makes sense, a large institution. I mean, one thing is a large practice of 10, 20, 30, 40 docs. Another is an institution that has 10,000 students running around in all the

different parts of the university and hundreds of staff members. And that could be beneficial because like you said, you'll get opportunities, especially if you're at a top-notch organization or a university that you wouldn't get on your own. But I can see that being something that over time might get a little bit frustrating. And so, you were there, it looks like Hopkins for over 10 years, right? I mean, 15?

Dr. Peter Staats:

Probably closer to 14 years, something like that.

David Mandell:

Yeah. Yeah. And then the next move was to what? A private practice that you were a partner coming in at, an existing practice that you joined, something new. What was it like, your last days at Hopkins? Think about that, going back, what was your thinking, what was the ideal or what were you shopping around for or what were you envisioning as you made that big leap because that was a big change?

Dr. Peter Staats:

Well, a big part of it was finances at the time. And one of my fellows was doing very well in New Jersey, a single practitioner, but drowning, I think, in the workload. And so, we had a very good relationship, and he brought me in as a full partner from day one, and together we built something that was, I think, very special, but I gave up some academics when I did that initially, initially. So...

David Mandell:

That seemed like an easy transition in that you knew the person already.

Dr. Peter Staats:

I did.

David Mandell:

You trained them. So, there was a trust level, there was a comfort level both on the person, also their academic and their clinical ability, et cetera. I wonder, maybe you know this or not, just being this, doing this, and having colleagues, that seems like another big benefit of being at a good institution and being in academics is you're going to train people that maybe you'll end up jumping out with at some point. Meaning, does that happen in your view regularly? You see people who have fellows and residents, and they ended up joining them for whatever reason, but that's where they end up is working with people that they trained. Have you seen that before?

Dr. Peter Staats:

Yeah, I've seen that before. It doesn't always work out though. I think... I was talking to my friend Tim Deere about this at one point many years ago, and he said, "You're one of the few guys who actually was able to do it after being in academics for so long to jump into private practice and then be very successful in private practice," because it's a different mindset." You got to be willing to say, "Okay, I'm in the OR at 7:00. I've got five cases to be done by 7:30, and then I got my implants, and I got all these things to be done," and you've got to be highly efficient.

David Mandell:

Yes.

Dr. Peter Staats:

Academics was not that way. Academics was much more of fill up the schedule, and you didn't really have to do a lot of work. And the pressures, if anything, were the opposite. So, if you wanted to hustle cases through the nursing staff at a big academic institution, be it pain or any other area, they kind of slow down around 2:00 or 3:00, and they're not really hustling to get everything done. In the private world, everybody's incentivized to get things done. They get to go home when the cases are done. They don't have to stick around until 5:00. If we're done at 3:00, they get to go home. So, everybody's

equally incentivized to get the cases done, which was a very different mindset than being in an academic institution.

David Mandell:

Interesting.

Dr. Peter Staats:

And I'm sure there are variances that doesn't hold in this academic place. So, I'm not trying to besmirch this, but this is where it was 30-some years ago for me. It was I got credit for filling up the OR schedule, not so much for how much I did during that OR schedule.

David Mandell:

Yeah, exactly. And that makes sense. That tells me what I think what it would be, but I also thought it was just interesting that you joined a fellow because it just meant to be like, God, if you're in a good place, there's probably going to be a lot of smart people who come through. And if the goal was to jump out, and I understand your point, which is not that many people can do it successfully, you've got a roster of all these docs that you've trained. And even if it's not them that you join, they're a call you can make, you can trust their judgment, "Oh, here's another practice in town that I know is needing somebody." It gives you an instant, I guess, network and not just a network of people you know, but actually people you trained. So, that's pretty powerful.

Dr. Peter Staats:

It's like a year-long interview of sorts in that they got to see how I work and I got to see their ethics and for a year's period of time. And this is probably beyond the scope of what you want to talk about here. There's probably nothing more important than understanding the ethics of the people that you're joining. Far and away, the way pain doctors get in trouble is they look at the number, they look at, we're going to make a million dollars a year, but they don't really dive deeper on how they're doing the billing or the percent of the practice that's opioid management, or what percentage of that practice is from urine toxicology, and are they doing that billing correctly? And man,

people get into deep, deep trouble from just a superficial look, really important to dive deeper and understand what you're getting into.

David Mandell:

Yeah, I want to come back to that for a second because I think that's a really important point and it is completely relevant to this topic, but I want to switch and then come back to the private practice. And I want to talk about two things and then we'll come back to the practice. One is your role in medical societies and groups like that. And then two is industry and even the patent that you were involved with and all that kind of thing.

Find part 2 of this episode in episode 6.11., coming out February 4, 2026.