

# The Economics of Private Practice versus Academia in Surgery

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**OBJECTIVE:** Residents often make career decisions regarding future practice without adequate knowledge to the realities of professional life. Currently there is a paucity of data regarding economic differences between practice models. This study seeks to illuminate the financial differences of surgical subspecialties between academic and private practice.

**DESIGN:** Data were collected from the Association of American Medical College (AAMC) and the Medical Group Management Association's (MGMA) 2015 reports of average annual salaries. Salaries were analyzed for general surgery and 7 subspecialties. Fixed time of practice was set at 30 years. Assumptions included 5 years as assistant professor, 10 years as associate professor, and 15 years as full professor. Formula used: (average yearly salary) × [years of practice (30 yrs – fellowship/research yrs)] + (\$50,000 × yrs of fellowship/research) = total adjusted lifetime revenue.

**RESULTS:** As a full professor, academic surgeons in all subspecialties make significantly less than their private practice counterparts. The largest discrepancy is in vascular and cardiothoracic surgery, with full professors earning 16% and 14% less than private practitioners. Plastic surgery and general surgery are the only 2 disciplines that have similar lifetime revenues to private practitioners, earning 2% and 6% less than their counterparts' lifetime revenue.

**CONCLUSIONS:** Academic surgeons in all surgical subspecialties examined earn less lifetime revenue compared to those in private practice. This difference in earnings decreases but remains substantial as an academic surgeon advances. With limited exposure to the diversity of professional arenas, residents must be aware of this discrepancy. (J Surg Ed ■■■■-■■■. © 2018 Association of Program Directors in Surgery. Published by Elsevier Inc. All rights reserved.)

**KEY WORDS:** private practice, academia, surgery, finance, lifetime salary income, economics

**COMPETENCE:** Practice-Based Learning and Improvement

## INTRODUCTION

From the inception of one's medical education, students are exposed mainly to academic practitioners.<sup>1</sup> Medical schools and the majority of residencies are staffed predominantly by academic surgeons and there is often little to no exposure to private practice. Since people often do what they know, it is logical that surgical residents would make career decisions based off the careers of their mentors who may be from only one professional arena. This can be problematic as the world of private practice is substantially different from academia. From a fiscal standpoint, the popular belief in the surgical community is that on average academic surgeons earn less than their private practice counterparts and further some studies demonstrate that up to 50% of academic surgeons are dissatisfied with their compensation.<sup>2-5</sup> There is in actuality a paucity of literature analyzing the income differences between academia and private practice. This is important to parse out as with the debt that most medical students incur as well as the continuing political changes to the health care market, income consideration is very relevant and may even factor into or drive career choice. Thus we sought to illuminate the economic differences and determine the financial benefits or forfeitures that exist between each surgical subspecialty in academia versus private practice. Our hypothesis was that private practice surgeons would make significantly more than academic surgeons in all specialties examined.

## METHODS

The principle outcome was to evaluate differences in lifetime salary income between private practice and academic practice of surgeons in general surgery and seven different subspecialties: cardiothoracic/thoracic, pediatric, plastic, vascular, trauma/critical care, transplant, and surgical oncology.

The abstract was presented as a podium presentation at the 13<sup>th</sup> Annual Academic Surgical Congress in Jacksonville, Florida; 2018.

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Data was collected from the Association of American Medical College (AAMC) and the Medical Group Management Association's (MGMA) 2015 reports of average annual salaries for academic practice and private practice respectively.<sup>6</sup> Several assumptions were necessary to calculate total lifetime salary. Total time of practice was set at 30 years and expected years of research during residency and fellowship training were included as per current trends (Appendix A). An average salary of \$50,000 was calculated for research and fellowship years. For academic practice, we presumed 5 years as assistant professor and 10 years as associate professor before advancement. Time to promotion was chosen through a combination of subjective clinical experience and Warner et al.'s work that showed promotion to associate professor took on average  $5.3 \pm 3.2$  years and  $8.7 \pm 5.3$  years from associate to full professor.<sup>7</sup> Lastly, it was assumed that obtaining the title of full professor meant completing 2 years of research regardless of subspecialty.

The following formulas were used to calculate lifetime revenue:

$$\text{Assistant Professor: } TAR = (AaYS) [30 - (F + R)] + [50,000 (F + R)]$$

$$\text{Associate Professor: } TAR = AaYS*5 + \{(AbYS) [25 - (F + R)] + [50,000 (F + R)]\}$$

$$\text{Full Professor: } TAR = [AaYS*5 + AbYS*10] + \{(AcYS) [15 - (F + R)] + [50,000 (F + R)]\}$$

$$\text{Private Practice: } TAR = (AdYS) [30 - (F + R)] + [50,000 (F + R)]$$

where TAR is total adjusted revenue, AaYS is assistant professor average yearly salary, AbYS is associate professor average yearly salary, AcYS is full professor average yearly salary, AdYS is private practice average yearly salary, F is years of fellowship training, and R is years of research during residency. The above calculations were performed for general surgery as well as each of the seven subspecialties examined. All results are reported in US dollars.

## RESULTS

### Private Practice

The highest earning subspecialty in the private sector, by yearly salary, is cardiothoracic surgery making \$717,987. Surgical oncology had the lowest annual salary of \$396,169 followed by general surgeons making \$429,923 (Table 1).

Cardiothoracic surgeons had the highest lifetime revenue of 18.2 million dollars, followed by pediatric surgeons earning 16.6 million dollars (Table 2). The lowest lifetime revenues were in surgical oncology (10.5 million dollars) and general surgery (12.9 million dollars).

### Academic Practice

The highest annual salary across all academic appointments is seen in cardiothoracic surgery, making \$448,900,

\$606,600, and \$716,100 as an assistant, associate, and full professor, respectively (Table 1). The lowest annual salary is earned by surgical oncologists, earning \$299,400, \$351,100, and \$399,000 as assistant, associate, and full professor, respectively. This same trend is witnessed in calculations for lifetime revenue with cardiothoracic surgeons (\$11.5 million: assistant professor, \$14.6 million: associate professor, and \$15.7 million: full professor) earning the largest lifetime revenues across all appointments followed by pediatric surgeons (\$11.3 million: assistant professor, \$12.9 million: associate professor, and \$14.6 million: full professor) (Table 2). The lowest lifetime revenues are witnessed in surgical oncology (\$8.0 million: assistant professor, \$8.7 million: associate professor, and \$9.6 million: full professor) followed by trauma/critical care (\$9.8 million: assistant professor, \$10.6 million: associate professor, and \$11.3 million: full professor).

### Private Practice versus Academic Practice

Across all surgical subspecialties, private practitioners earn a higher lifetime revenue than academic surgeons (Table 2). The largest difference is witnessed in vascular surgery and cardiothoracic surgery with private practice surgeons earning 16% and 14% more than their academic full professor counterparts respectively. Trauma/critical care surgery follows closely, with full professors earning 13% less. The smallest differences in lifetime revenue are seen in plastic surgery and general surgery with a difference of only 2% and 6%, respectively between full professors and private practitioners.

## DISCUSSION

The current environment that medical students and surgical residents are exposed to is primarily within an academic realm. There is limited exposure to the private practice environment within the curriculum and as such, residents may make future career decisions without adequate knowledge or appropriate exposure to the realities of professional life. This lends itself to a preordained segregation of surgeons through training experiences, with residents graduating from academic programs pursuing careers in the only practice environment they've had meaningful exposure to.<sup>1</sup> It also appears that the number of surgeons employed by hospitals versus private practice have been increasing since 2000; in 2009, 68% of surgeons worked at a hospital and 32% were in private practice.<sup>8</sup> The fiscal implications of choosing a career in academics rather than private practice is substantial and for many, this may be unknown information. Occupational factors that may correlate with lifetime satisfaction also are important drivers for career choice; private practitioners have increased flexibility, workplace control, and influence on practice structure. However, with

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