Life after fellowship: private practice versus academics—the low down

A gastroenterology career has different pathways in which physicians pursue their vocation. Historically, private practice, industry, and academics have been common paths. Recently, physicians' academic careers have received increased attention because of a finite or reduced number of jobs and limited funding of positions, which are signs of our economic times.

In the last 2 decades, there has been mounting pressure on academic physicians to generate more of their salaries through patient care, thus reducing time for research and/or teaching.[1,2] What are the options available to graduating fellows? What are the pros and cons of academic versus private practice? Drs Singh, Giardiello, Singhal, and Badreddine attempt to answer theses questions by giving us some reasons to choose one path over the other.

Reem Sharaiha, MD, MSc
The Fellows' Corner Editor
Advanced Endoscopy Attending Physician
Division of Gastroenterology and Hepatology
New York Presbyterian Hospital–Weill Cornell Medical Center
New York, New York, USA

REFERENCES

1. Borges NJ, Navarro AM, Grover A, et al. How, when, and why do physicians choose careers in academic medicine? A literature review. Acad Med 2010;85:680-6.
2. Spiro HM. A perspective on careers in academic medicine. Arch Intern Med 1989;149:969-72.

WHY A CAREER IN ACADEMIC GASTROENTEROLOGY?

Each year, my (V.K.S.) fellowship program dedicated one session to career planning. During one of these sessions, one of our senior faculty members remarked, "If you want to do clinical work 100 percent of the time, then choose a career in private practice. However, if you want to do something else for even 20 percent of your time, whether it is research, teaching, lecturing, administration, health policy, et cetera, then choose a career in academic gastroenterology. We are all busy, so pick your career on what it is you enjoy doing or find fulfilling and don't think too hard about the money."

Simple enough words, but the decision to choose a career in academia versus practice continues to leave many senior gastroenterology fellows with persistent indigestion. With mounting educational debt, increasing time spent pursuing specialty and subspecialty training at apprentice pay levels, and growing families to support in an era of economic uncertainty, it is difficult for many to imagine the economic feasibility of pursuing an academic career.

We hope to convince some of you that a career in academic gastroenterology is a viable option. Notice we say "some of you," because academia cannot generate positions or careers for everyone, nor should it. We need far more hard-working and well-trained gastroenterologists in practice to serve the digestive health needs of the majority of the American public. Some gastroenterology trainees have expended the effort, taken the time, and demonstrated a genuine interest in going beyond the standard Accreditation Council for Graduate Medical Education training requirements to make academic contributions. We want to convince these trainees that an academic career is the right choice. We have known many fellows who trained at the highest levels, acquired strong research skills, had work published in high-impact journals, and then took practice jobs, to the chagrin of their mentors, particularly given that so many of these fellows appeared to have a genuine interest in academic careers. Although more can be done by academic centers, funding agencies, and the general health system to promote academic careers among fellows, there are still several reasons that an academic career should and will remain an attractive option for the appropriately trained and interested senior fellow.

First, although, historically, salaries have been low in academic gastroenterology, they are not as poor as many senior fellows believe. Salaries have improved for academic gastroenterologists, especially because many divisions have implemented additional compensation for clinical productivity. The median gastroenterology faculty salaries for assistant, associate, and full professors in 2011 to 2012 were $252,000, $287,000, and $324,000, respectively.[3] The median salary for all gastroenterologists, according to the Medscape 2013 physician compensation survey, was $342,000.[4] In addition, academic gastroenterologists have opportunities for salary enhancement from royalties on

0016-5107/$36.00
http://dx.doi.org/10.1016/j.gie.2013.11.028

patents and books, consulting, invited lectures, endoscopy workshops, and so on. Also, *starting* salaries, especially in many American urban centers where everyone seems to want to live, are nearly equal between academic and practice positions. Academic institutions typically offer fairly generous faculty benefits including contributions to retirement savings plans (403b), tuition remission for dependents, and lower cost healthcare premiums. The primary driver of the higher incomes in private practice is ownership of an ambulatory endoscopy center (AEC). The challenges and opportunities for AECs were reported recently in *Gastrointestinal Endoscopy*.[5] Despite the fact that AECs are associated with lower costs than hospital endoscopy units, the revenue of these units likely is going to be under serious pressure in the near future because (1) Medicare and private insurance reimbursement continue to fall, (2) mid-level providers increasingly perform "bread and butter" procedures such as EGD and colonoscopy, (3) colon cancer screening shifts from colonoscopy to stool-based assays or CT colonography, and (4) the American hospital lobby pushes to stifle the cherry-picking of well-insured patients by AECs. The expansion of AECs is regulated in 36 states that have legislated certificate of need programs in order to control healthcare facility costs. In addition, Medicare does not currently require that AECs submit information on the cost and quality of care they provide, but this was recently recommended by the Medicare Payment Advisory Commission.[6] This will likely expose for-profit practices, such as unnecessary endoscopic procedures or shorter intervals for screening colonoscopy, which may result in further decreases to AEC reimbursement.[7,8] The trend toward consolidation between practices to achieve greater efficiency and the gradual shift of many practicing gastroenterologists to salaried positions in hospitals is a bellwether for the future of AECs. Although many will argue that these pressures will negatively affect academic endoscopy units as well, we think the effect will be less pronounced because academic faculty are salaried, they tend to perform a wider variety of specialized non-endoscopic procedures (manometry, impedance, capsule endoscopy, breath testing, liver biopsies, peritoneoscopy, etc), and they have more favorable terms in negotiating payments from insurance companies and state healthcare commissions because they tend to form the safety net of care for the uninsured and underinsured.

Second, the opportunity to subspecialize and become an expert in a particular area is a compelling reason for an academic career. Part of our (V.K.S.) motivation for an academic career was the desire to not see every possible gastrointestinal or liver disorder in clinic or spend endoscopy blocks doing general endoscopy. We like a subspecialty referral practice offering a bit of control over not only the diseases we manage but also over our time. In addition, academic gastroenterology allows for performing procedures that are not routine in private practice. For example, EUS is a procedure commonly referred to tertiary-care centers because most practices do not want to invest in equipment for a money-losing and time-consuming procedure. For a practice with a 1-hour procedure slot, it might be financially more sensible to perform 3 or 4 colonoscopies instead of 1 EUS.

The third reason that an academic career should remain an attractive option is the opportunity to take part in the research and development enterprise. The only way medical care improves is through research and development. The growth of the overall economy and gross domestic product of nations is directly proportional to the vitality and productivity of its scientists and engineers. Although public grant funding is at an all-time low, we would argue that grant support has been in the hands of relatively few academic gastroenterologists and, historically, a fair share of research, particularly clinical research, has been supported by industry and private philanthropy. Some argue that academic faculty members are doing increasing clinical work, almost proportional to private practitioners without the private practice pay, which compromises their research efforts. We argue that this is a phenomenon in institutions that deviate from their academic missions. It is important for senior fellows to realize that protected time for research is essential and should be negotiated into contracts. Academic medicine continues to abound with opportunities for producing meaningful research, particularly for junior investigators, through professional society[9] as well as within-institution career development and start-up grants. Protected time, coupled with the assistance of fellows, residents, and medical students, can allow a faculty member to be productive in clinical research.

Fourth, the practice of gastroenterology does not occur in a vacuum—it requires high-level consultation and assistance from surgeons, diagnostic and interventional radiologists, pathologists, and pain specialists. There is truth to the statement, "you are only as good as your weakest link." In academic settings, you are surrounded by consummate practitioners in the medical specialties with whom you constantly interact. This not only makes your job easier but allows you to provide the best care for your patients. This is not replicated in most practice settings, and this is probably the reason patients with complicated problems typically are referred to tertiary-care centers. Many senior fellows certainly find leaving the ivory tower for practice difficult for this reason.

Fifth, but not least, an academic career affords one the wonderful opportunity to train and teach the next generation of practitioners in the art and science of gastroenterology. Even as a junior faculty member (V.K.S.), I have found it extremely fulfilling to mentor trainees and students in clinical and research work. Although teaching and mentoring are not typically compensated and do not prominently figure into decisions regarding promotion, many faculty continue to take part in these activities because of the inherent satisfaction derived from serving