

Neurosurgeon Compensation: Major Surveys' Findings Reflect a Constantly Shifting Marketplace

By Bonnie Darves

When neurosurgery practices and healthcare organizations that employ neurosurgeons are assembling their compensation packages, they turn to the national surveys for benchmarking data and go from there to adjust for several factors. Those range from supply and demand, to local market conditions and payor mix, to their own resources and overall revenue streams.

However, the major national surveys that cover neurosurgery—produced by the American Medical Group Association (AMGA), the Medical Group Management Association (MGMA), and the Neurosurgery Executives' Resource Value and Education Society (NERVES)—sometimes experience potentially considerable variations in their respondent bases from year to year. That can translate into substantial differences in compensation findings from one survey to the next, not just one year to the next.

For example, this year, one major survey found median neurosurgery compensation flat, while others reported increases of 5% or more compared to the previous year. For that reason, many organizations, in neurosurgery

The following table shows the median neurosurgeon compensation findings from the largest and most recent national surveys:

Median Neurosurgeon Compensation by Survey	
NERVES Socioeconomic Survey—2017 report	\$749,000
AMGA 2018 Medical Group Compensation and Productivity Survey	\$800,000
MGMA 2018 Physician Compensation and Production Survey	\$821,691
SullivanCotter 2017 Compensation and Productivity Survey	\$725,985

The differences among survey methodologies and respondent bases can make direct survey comparisons challenging, especially in an environment characterized, increasingly, by

“We do a lot of work creating physician compensation plans, and I can't remember the last time I created a plan on a strictly regional [data] basis. Most organizations want to focus on the national numbers, which are a bit more stable...”

— Wayne Hartley, AMGA Consulting



and numerous other specialties, tend to look at multiple surveys to get a broader sense of the compensation trends before designing or adjusting compensation packages.

group mergers and acquisitions. There's also a sense that hospital employment of neurosurgeons, and the competition among organizations to hire more specialists at

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Neurosurgeon Compensation

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whatever compensation rates the market requires, to improve their bargaining position with payors, is having an inflationary effect. Many industry observers claim that the rush to expand specialty services might be driving up compensation to possibly unsustainable levels.

“Even the academic centers are starting to merge with non-academic centers, so there’s some movement afoot to create larger organizations that can compete more effectively,” said Fred Horton, president of AMGA Consulting. These larger entities are

neurosurgeons who are seeking a first or subsequent opportunity should understand that many other factors that surveys track can and likely will affect what they get paid ultimately. These range from the type and size of practice, to practices’ patient volumes and demographics.

The NERVES (Neurosurgery Executives’ Resource Value and Education Society) survey is the largest and most comprehensive of the national compensation surveys that cover the specialty. As such, the survey is a reliable barometer of not only compensation

attributes that largely to supply-and-demand factors, as exemplified by the brisk recruiting environment. “Recruitment continues to be a major activity—79% of practices reported that they’re planning to recruit physicians and/or advanced practice clinicians in the next year,” Mr. Radomski said. That’s up from 77% in 2016, he added.

In other upticks, NERVES the survey found increased collections of 4.5% for neurosurgery groups, and an increase of 7.7% in surgical cases compared with 2016 data.

For young neurosurgeons, the NERVES survey provides highly sought but hard to find information on neurosurgeon starting salaries nationally. The report provided a breakdown by subspecialty, as follows:

“Recruitment continues to be a major activity—79% of practices reported that they’re planning to recruit physicians and/or advanced practice clinicians in the next year.”

– Mike Radomski, NERVES



NERVES—Starting Neurosurgeon Salaries	
Vascular	\$577,000
Spine	\$550,000
Cranial/skull base	\$526,000
Pediatrics	\$499,000

also eyeing potential benefits from operational efficiencies and higher volumes, so that they can maintain profitability in an environment where physician compensation commands a large portion of the budget.

Those post-merger operational gains have been slow in coming, but groups in the surgical specialties are starting to move beyond integration pains to turn their attention to financial and logistical issues where efficiencies will pay dividends, such as payor contracting, physician productivity and revenue management. All of this means that neurosurgeons who seek top-earning positions should expect pressure to produce and to manage patients as efficiently as possible, several sources stated.

Looking beyond the basics

Although survey-reported median compensation is an important metric,

and productivity trends but also of how neurosurgeons’ annual practice patterns break down, by subspecialty and other factors. The recent survey included 96 practices and 815 neurosurgeons, a slight increase over last year’s participation.

The NERVES report found, not surprisingly, that spine surgeons had the highest median compensation, at \$796,000, followed by vascular, cranial and functional. Based on the specialty definition of “greater than 50% or services provided,” adult services neurosurgeons had median compensation of \$755,000, compared to \$648,000 for pediatric general services.

Overall compensation was up 5.5% from the previous NERVES survey’s findings, and starting salaries “continue to trend upward,” according to Mike Radomski, a NERVES senior officer who is CFO and vice president of finance at the Mayfield Clinic in Cincinnati. He

Of all the surveys, the MGMA’s found the largest year-over-year change in neurosurgery compensation. In the 2017 report, median neurosurgery compensation was \$719,805. The AMGA survey, by comparison, found compensation in neurosurgery virtually flat, given that the 2017 reported median compensation of \$799,266.

Regional differences less important now

What’s interesting is that the traditional geographic breakdowns—the large surveys divide the country into four regions for the purposes of tallying regional compensation, equating roughly to East, West, South and North—are becoming less meaningful over time in the surgical specialties, several

sources noted. Nick Fabrizio, PhD, FACMPE, a principal consultant with MGMA's consulting practice, sees more significant compensation differences between rural and urban/suburban areas rather than from one geographic region to another—regardless of the specialty.

“In some cases, we’re also seeing more significant compensation differences from state to state than region to region, which is a relatively new finding,” Mr. Fabrizio said.

In the 2018 MGMA survey, in the physician specialties, the difference in compensation from the highest-paid state to lowest ranged from \$100,000 to \$270,000—a far larger spread than from region to region. In neurosurgery, that regional spread from lowest to highest median compensation was less than \$70,000.

Wayne Hartley, MHA, chief operating officer for AMGA's consulting practice, thinks that the regional compensation differences are blurring primarily for two key reasons. Today, hiring practices and healthcare organizations are recruiting nationally and they're also using national survey benchmarks rather than regional data as the starting basis for their compensation structures.

“We do a lot of work creating physician compensation plans, and I can't remember the last time I created a plan on a strictly regional [data] basis,” he said. “Most organizations want to focus on the national numbers, which are a bit more stable than regional ones. Typically, we apply the national stats, but we might build in cost-of-living [differential] in compensation plans for places like New York or Los Angeles.”

That doesn't mean that the regional compensation differences are going away in neurosurgery or other surgical specialties, Mr. Hartley observed, but rather that employers aren't using them as the key basis for setting compensation. In the AMGA survey, for example, median neurosurgery compensation in the Western and Southern regions was very close, at \$800,563 and \$802,255, respectively. The Eastern and Northern regions

NERVES Survey's Nuanced Findings

The annual NERVES survey, the most detailed of the national surveys, is the most representative of the practice environment in that it gathers and reports on some market and operational factors that might affect compensation but for which data is not widely available. It was conducted by the independent accounting firm Katz, Sapper & Miller.

Following are some of those findings:

Call pay down slightly. Call pay, a significant factor in neurosurgeon compensation with the median daily overall rate, was \$1,680. That compares to the prior year's median of \$1,700. Trauma call pay varied significantly by level, in some cases. Level 1 median was \$2,250, Level 2 was \$2,100, and Level 3 was \$1,575.

Non-competes are prevalent. New neurosurgery recruits should expect a non-compete/post-employment restriction provision in their employment agreement, as 77% of neurosurgery practices that participated in the survey include such language.

Quality program participation on rise. A majority of practices, 67%, reported that they participate in Merit-based Incentive Payment System (MIPS), the Medicare quality payment program.

Practices expand investments. The survey found that one third of responding practices have physician investors in outside ambulatory surgery centers (ASCs) or specialty hospitals. One third of practices also reported that they invest in Accountable Care Organizations (ACOs).

came in at a median of \$767,211 and \$817,898, respectively. The regional range widens at the lower and higher ends of the earnings spectrum, however, as the table below shows:

AMGA 20th Percentile	Eastern	Western	Southern	Northern
	\$603,655	\$492,390	\$585,111	\$600,639
AMGA 80th Percentile	Eastern	Western	Southern	Northern
	\$1,146,001	\$1,164,467	\$1,019,385	\$1,095,500

In the MGMA survey, regional neurosurgery compensation was highest in the West, at \$737,805, and lowest in the East, at \$784,793. The South and Midwest came in at \$805,738 and \$837,350, respectively. NERVES did not provide a breakdown, but Mr. Radomski noted that the South and West had the highest and lowest median compensation, respectively, with the East and Midwest taking the second and third spots.

Group ownership matters

The continued trend toward consolidation of practices—less in neurosurgery than in many other specialties but a factor nonetheless—combined with the rapidly increasing move toward

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hospital or health system employment of surgeons, is making compensation differences among practice settings somewhat harder to track these days. At the same time, most of the national surveys' findings demonstrate that where neurosurgeons practice can have a considerable effect on their compensation.

The NERVES survey provides a more detailed view of these differences than the other surveys. That report found a wide spread among practice types, with median compensation of \$873,000 for hospital-employed neurosurgeons, followed by \$822,000 for neurosurgeons in private practice. Neurosurgeons in academic practice had median compensation of \$664,000.

AMGA, which reports on income variations by group size and whose participant base tends to include larger organizations, found the highest median neurosurgery compensation, \$844,000, in groups with 50 to 150 physicians. For those who practice in groups with 150 to 300 physicians, median compensation was \$831,580, followed by \$780,000 for neurosurgeons practicing in groups with more than 300 physicians.

The MGMA survey found the smallest spread across various practice types.

In physician-owned practices, median compensation was \$837,354, compared to \$819,210 for hospital-owned practices. In pediatric neurosurgery, the median compensation was \$703,951 for neurosurgeons practicing in hospital-owned groups, just slightly lower than the overall median of \$716,918 for all pediatrics neurosurgery practices.

Other compensation-influencing factors

The persisting shortage of neurosurgeons continues to affect compensation in the upward direction, especially in difficult-to-recruit-to areas, all sources agreed. In the productivity arena, the survey findings found that neurosurgeon production is either stable or slightly increasing, as measured by work relative value units (wRVUs).

The AMGA survey reported median annual wRVUs of 9,594, a negligible increase of 29 wRVUs over the previous year's report. "So basically, you have flat productivity and flat compensation," Mr. Horton said, "but we saw some interesting data at the 80th and 90th percentile." At the 80th, he said, wRVUs decreased by 267 annually compared to last year, and at the 90th,

by 869. This is noteworthy, Mr. Horton added, because "neurosurgery is definitely a specialty that continues to be paid mainly on productivity."

As such, Mr. Horton advises neurosurgeons at all career stages but especially those starting out to try to get a global sense of the productivity picture in any practice opportunity they're considering. They should ask what the targets are and whether new neurosurgeons have been able to achieve those targets once they have acclimated and gotten up to speed.

Perhaps even more important, neurosurgeons should ask how well they'll be supported operationally in meeting productivity expectations. "If I were a young surgeon I'd want to know what the organization is focusing on operationally to help me get to target productivity levels," Mr. Horton said. "That also helps you determine whether the organization, especially if it's an independent practice, has staying power."

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Ms. Darves, an independent writer based in the Seattle area, is editor of Neurosurgery Market Watch.

FEATURED OPPORTUNITY

Georgia Practice Seeks Endovascular Neurosurgeon

A well-known, premier private practice in central Georgia seeks a BE/BC endovascular neurosurgeon to join their practice. The practice has its own surgery center, and physical therapy and IOM. The practice includes six neurosurgeons with full PA support.

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Practice trauma call would be 1:6 or 1:7, with endovascular call will most likely be 1:10. The practice seeks a dual-trained endovascular neurosurgeon and will consider either experienced candidates or 2019 fellows.

The practice has a bi-plane room undergoing renovations to add state-of-the-art equipment. An approximate estimate of the endovascular vs. general neurosurgery work for the incoming neurosurgeon would be 50/50. There are two

hospitals associated with the practice, both working to become Level I stroke centers. The practice will provide a competitive salary and full benefit package, and a traditional partnership track with no buy-in requirement. The desirable community, about an hour from Atlanta, features low living costs, excellent schools, and access to many cultural and year-round recreational opportunities.

Employment or Private Practice? What Young Neurosurgeons Need to Know About Compensation Structures

By Angie Caldwell, CPA, MBA and Kristy Diederich, MHSA



Angie Caldwell
CPA, MBA

After they complete their lengthy, arduous residencies, and for many, an additional fellowship, newly trained neurosurgeons are understandably eager to secure their first jobs. One of the first, and most important, career choices neurosurgeons will need to make is whether to choose employment or private practice¹. It is important to understand the long-term impact of pursuing either, but it is not necessarily a clear-cut choice.

Often, many questions arise: How much should I expect to be paid? What do the compensation terms mean? How do I compare different compensation structures? As today's neurosurgeons are practicing in a broader range of positions, they must be aware of the wide-ranging recruitment strategies and compensation structures, which also can take many forms. Understanding all components of both employment and private practice models is critical to making the best decision.

Dissecting the employed compensation model

Increasingly, hospitals and health systems are looking for ways to expand their market footprints by creating better physician-alignment structures. For younger physicians, employment has become the top practice choice. According to the 2018 Medscape Young Physician Compensation Report, 85% of all physicians aged 40 or younger are employed.

Hospitals and health systems typically use the following primary compensation structure components when recruiting new residents and fellows. Other contractual components may be included, depending on the needs of the hospital.

Base salary. Most employed-physician compensation models today include a base salary, or a fixed amount of money paid to a physician by an employer in return for work performed. Base salaries typically do not include benefits, bonuses or other potential compensation from an employer.

To recruit newly trained physicians, hospitals or health systems typically offer a guaranteed base salary for the initial one to two years of employment. This salary is primarily determined through the study of prevailing local market compensation and national compensation surveys conducted by organizations such as the Medical Group Management Association (MGMA), SullivanCotter and Associates, Inc.

productivity is by using work relative value units (wRVUs). A wRVU is a unit of measure that reflects the time, amount of effort and technical ability required to accomplish a particular service or procedure⁴. A production bonus is most often structured by multiplying a pre-determined conversion factor by wRVUs in excess of a pre-determined wRVU threshold.

In addition, quality metric-based bonus structures are becoming increasingly popular with the push toward value-based care. To receive a quality bonus, physicians must achieve targets or thresholds relating to clinical quality, patient satisfaction and/or physician engagement. SullivanCotter's 2017 Physician Compensation and Productivity Survey Report found that the

“Both employment and private practice arrangements have pros and cons, but all neurosurgeons should understand the different compensation structures and, ultimately, their ramifications for them personally, professionally and financially.”

(SullivanCotter) and the American Medical Group Association (AMGA). Hospitals and health systems reference these annual surveys as one means to assess whether they are offering a compensation structure that is of fair market value² and commercially reasonable³. The concepts of fair market value and commercial reasonableness are critical to the determination of compensation for an employed physician. We will explore these concepts further in a future Neurosurgery Market Watch article.

Production and quality bonuses. Beyond the base salary compensation, productivity and/or achieving certain quality metrics are key components of employed-physician contracts. The most common way to measure

mean quality incentive payment was 9.8% of a surgical physician's total compensation.

Call-coverage compensation. Call coverage can be another component of compensation, if it's not included in the base salary. But determining the actual value of call pay can be challenging. According to SullivanCotter's 2016 Physician On-Call Pay Survey Report, the median call pay for neurosurgeons ranged from \$62.50 per hour at non-trauma centers, to \$83.33 per hour for trauma coverage at designated trauma centers. Not only can amounts paid for call vary from facility to facility, but amounts can vary depending on what is included in the call service. For

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Employment or Private Practice?

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example, a neurosurgeon may be responsible for inpatient calls or multiple facilities.

Further, call compensation may be impacted by a hospital's medical staff bylaws, which might describe the call requirements for each specialty providing call coverage to the hospital's emergency department. For example, the bylaws might indicate that each physician will provide call coverage pro rata with the other physicians in the call panel at a minimum specified number of days per month.

Understanding private-practice compensation models

The shift away from traditional private practice in all specialties is driven by both healthcare market dynamics, such as declining reimbursement and regulatory pressures, and physician preference. However, many new physicians join private practices seeking more autonomy and control. Private practice compensation structures typically include the following primary components. Other contractual components may be included, depending on the needs of the practice.

Initial-salary contracts. When a neurosurgeon, whether newly trained or already in practice, joins a private practice, the compensation is typically straight salary or a salary with some potential for bonus compensation. This allows the physician to gradually ramp up productivity, while building up his or her patient panel.

Sharing profit/loss. Following the initial contract period, the neurosurgeon might then be offered partnership or ownership. This might involve a single buy-in into the practice or a gradual stepwise contribution until full partnership or ownership is reached. Once the physician contributes the full buy-in amount, the profit/loss is shared in one or more ways:

- Equal share to every physician partner
- Straight productivity-based compensation
- Productivity bonus in addition to an even-standard compensation for each partner

- Cost-center compensation (i.e., a net collections and overhead expenses allocation model)
- Any combination of the above

Many times, partners choose their model depending on the practice environment and the number of physicians in the group. For example, equal pay for every partner could lead to some physicians bearing a larger work load than others, as there is little incentive to enhance productivity on an individual basis. Conversely, in a purely productivity-based compensation model, each partner is highly motivated to increase productivity, possibly creating competition between partners.

Call-coverage compensation. Private practice compensation arrangements might also include the consideration of call coverage. A hospital may contract with a private practice

to provide coverage for its ED patients and its inpatients. The private practice, in turn, passes through all, or a portion of, the daily call rate to the physician for providing coverage.

The decision to seek employment or private practice will no doubt be one of the greatest choices a neurosurgeon makes in her or his career. Both arrangements have pros and cons, but all neurosurgeons should understand the different compensation structures and, ultimately, their ramifications for them personally, professionally and financially. Choosing the right practice type with the right group is important not only for neurosurgeons' income but also for their future success.

Ms. Caldwell is a principal for healthcare consulting and valuation services at PYA, P.C., in Tampa, Fla.

Ms. Diederich is a senior consultant with the firm.

Resources

Deborah L. Benzil, Edie E. Zusman.

Defining the Value of Neurosurgery in the New Healthcare Era, *Neurosurgery*, Volume 80, Issue 4S, 1 April 2017, Pages S23–S27.

The Employed Neurosurgeon: Essential Lessons, *Neurosurgery*, Volume 80, Issue 4S, 1 April 2017, Pages S59–S64.

2018 Medscape Young Physician Compensation Report

2018 MGMA Physician Compensation and Production Survey

2017 SullivanCotter Physician Compensation and Productivity Survey Report

2018 AMGA Medical Group Compensation and Productivity Survey

2016 SullivanCotter Physician On-Call Pay Survey Report

Footnotes

1. For the purpose of this article, the term private practice means either a solo practitioner, or practitioner not employed by a corporate entity, such as a hospital or health system.
2. Fair market value (FMV) is defined as the price at which the property or service would change hands between a willing buyer and a willing seller, neither being under a compulsion to buy or sell and both having reasonable knowledge of the relevant facts (IRS definition).
3. An arrangement that is commercially reasonable appears to be a sensible, prudent business arrangement, from the perspective of the parties involved, even in the absence of any potential referrals (The Department of Health and Human Services definition).
4. Work RVU amounts are based on the resource-based relative value scale (RBRVS), which is used by the Centers for Medicare & Medicaid Services. The Specialty Society RVS Update Committee (RUC) works with national medical specialty societies to provide relative value recommendations to CMS annually. The RUC uses a survey that is issued to qualified healthcare professionals to determine physician work.

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LEGAL CORNER

Employment Contracts Become More Standardized, but It's Not All Bad

By Bonnie Darves



Andrew Knoll, MD, JD

In this regular column, Neurosurgery Market Watch speaks with health lawyers about contract issues and other trends related to neurosurgery compensation and performance. In this article, physician and attorney Andrew Knoll, MD, JD, a partner with the Syracuse, N.Y., firm Cohen Compagni Beckman Appler & Knoll, PLLC, who specializes in physician contracts, discusses the trend toward boilerplate contracts as hospital or health system employment of neurosurgeons increases, and a few quasi-positive developments.

Q: You mentioned that physician employment contracts have become much more standardized in recent years. What's driving that, and what does it mean for the neurosurgeon who is evaluating potential practice opportunities?

A: What we're seeing is that as hospitals and health systems increasingly employ physicians, they're moving toward standardized language and terms in the body of the document and using lots of exhibits to address the details for specific specialties. In part, this is a way to simplify matters. If a health system has 4,000 contracts out there, it's much easier to control things if the contracts generally use the same language.

So what neurosurgeons might see is that the key details referenced are included in the exhibits—as in, “compensation is per Exhibit A” and “work assignment is per Exhibit B.” The employers do that for good reason, because the things that might be negotiable—if there's any wiggle room at all, and there might not be—will be in the exhibits.

While the basic terms of the contract are more generalized now, on the plus side, these contracts tend to be generally fair and reasonable, even if they're slanted toward the employer. That's because if they put something in there that's over the top, and the hospital or health system is constantly recruiting, they don't want to receive 100 calls from 100 lawyers complaining about the same unreasonable provision. It's better to just adjust the [contested] provision to make it fairer or more reasonable than to say no to people.

Q: How is this contract-language standardization trend affecting key issues like call duty, which is near and dear (or dreaded, as the case may be) to neurosurgeons?

A: What we're seeing is an attempt to retain flexibility on the part of the employer. For example, I haven't seen a contract that clearly specifies call requirements in several years. The provision tends to say something like “you will take call in equitable rotation with other physicians” in the group, or that “call will be dictated by your division.” The latter wording is especially common in academic departments.

What this language generally says is “we'll give you reasonable assurance that we won't treat you any worse than anyone else here, but we won't be specific.” So you aren't likely to see a provision stating that call will be 1:3 or 1:4, and there's a logic to that. If the organization loses a neurosurgeon or one goes out on disability, for example, they don't want to be held to a specific ratio while they try to address the situation.

When I press on this issue, employers say that they have no intention of burning out their physicians but have to retain flexibility to protect themselves.

Q: In this environment where specialty groups are merging or being snapped up by large organizations, what should neurosurgeons look for in contracts that might affect their ability to move on if they don't like the direction the group is taking?

A: This can be a challenging area, with regard to decisions regarding a potential sale or merger, depending on the situation. Basically, what's been occurring is that a certain type of assignment clause has become very common. It says, essentially, that while the physician is not permitted to assign the contract to another physician (understandably), the employer retains the right to assign the physician's employment contract to any successor in the event of a merger or if another entity purchases the group's assets.

On another note, there have been some interesting developments in non-compete clauses that might benefit physicians. Rather than stating that the physician may not leave to join another organization within a certain radius of the employer—say, 10 or 20 miles—we're seeing contracts that state specific competitors, as in “you may go anywhere you want provided you do not work for competitor A or competitor B.”

This opens up an interesting question, in this era of mega-systems whose facilities might spread across hundreds of miles: Would a restrictive covenant be enforceable if a neurosurgeon practicing in midtown Manhattan wanted to move to a competing organization's hospital that's at the outer end of Long Island—where the patients likely would not follow the physician?

I haven't seen any case law in New York that actually upholds a restriction that involves a practice 100 miles away from the employer, but these non-competes would be understandably

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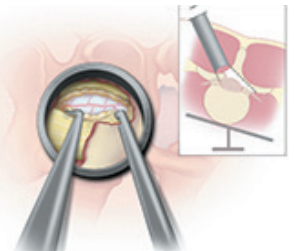
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This fellowship is for students who have completed at least two years of medical college and requires them to take one year off from their academic schedule.

GLOBAL HEALTH NEUROSURGERY FELLOW

This one- or two-year position in East Africa, for a fully trained neurosurgeon, entails evaluating patients, performing surgery, and training local surgeons and medical staff, as well as ongoing research together with FIENS and Weill Cornell Medicine Neurosurgery.

ENDOSCOPIC SKULL BASE FELLOWSHIP

This 3-month position helps fill the need many neurosurgeons in training have for in-depth exposure to advanced minimally invasive techniques. Participating fellows will observe cases in the operating room and be involved in research projects including clinical reports and cadaveric dissection in the Weill Cornell Medical College's advanced Surgical Innovations Laboratory for Skull Base Microneurosurgery.

**For more information and
application instructions, visit
weillcornellbrainandspine.org/fellowships**

Eyeing Offers? Don't Ignore the Benefits

By Katie Cole



It's easy to focus your job hunt on salary alone. However, benefits are very important to factor in the job decision making process. Compensation is usually the first, or one of the first, questions prospective candidates ask about any neurosurgery job opportunity. Yet, there are so many other factors, including benefits, that have a significant impact on the overall job opportunity and how satisfied you will be long-term with your job choice.

It's critical for candidates to evaluate the entire compensation package and have a very good understanding of exactly what benefits are being offered. In today's healthcare environment where so many neurosurgeons are choosing to be employed, or smaller practices are being bought out or merging with larger health systems, it's also crucial for employers to offer strong benefit packages to be competitive when trying to attract surgeons.

Standard benefit plans typically offer medical and dental coverage, and usually life insurance, disability, (paid time off) PTO, retirement (either a 401(k) or, less frequently, pension plan), CME, licensing fees/ professional dues, and malpractice. Sign-on bonus, paid relocation, and tuition reimbursement are also commonly offered by many hospital systems. Hospital systems in

more rural, hard-to-recruit-to areas often offer stipends during training as well, to candidates finishing their residency or fellowship who have signed but won't start working for another six months or longer.

Benefits can be negotiable to some extent, as with salary, and this is something candidates sometimes overlook when they just focus on the compensation amount. Hospitals are often capped off in what they can offer in cash compensation by either fair market value (FMV) regulations or a requirement to meet Medical Group Management Association (MGMA) or American Medical Group Association (AMGA) benchmarks. For these reasons, negotiating additional benefits can be a way to increase a compensation offer if the hospital is unable to increase a salary or guarantee a certain dollar amount.

Other options that some hospitals and medical groups are offering, or that can be negotiated, are often non-qualified retirement plans (restoration plan, fixed-percentage contribution of salary, or supplemental contributions). This is a good option for neurosurgeons, as they have higher compensation than most other specialists and surgeons. Typically, however, qualified retirement contributions for physicians are limited by the statutory cap (\$270,000 in 2017) and deferrals by the federal limit (\$18,000 in 2017).

Other options for additional benefits that might exist and can be valuable include long term care insurance, sabbatical, pre-

paid legal/malpractice claim services, and wellness programs. Another quasi-benefit that might be negotiated can be a more flexible work schedule.

According to a recent SullivanCotter and Associates report, many organizations offer multiple medical plan options; PPO/POS most commonly, followed by HMO/EPO plans. High-deductible plans continue to rise in usage. Most organizations require a contribution for physicians and dependents. Typical cost sharing is an 80-20 employer-employee split, with a 70-30 split for dependents. Dental coverage is also typically provided, with typical cost sharing of a 70-30 employer-employee split or a 65-35 split for dependents.

Compensation, salary and income guarantees are important factors in making your job choice. However, it is so important to consider the entire package, including a comprehensive understanding of the benefit plan being offered as well as what could possibly be negotiated, before declining or accepting a potential offer.

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Ms. Cole is a Denver resident and publisher of Neurosurgery Market Watch.
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*"Attracting and Retaining Physicians Through Benefits," accessible at: <https://www.sullivancotter.com/attracting-and-retaining-physicians-through-benefits/>

Legal Corner

(continued from Page 8)

intimidating to a young neurosurgeon who encounters one. On the positive side, a recent [New York] appellate decision refused to uphold a restrictive covenant like that because

it involved an organization with multiple sites over a broad geographic area.

At the very least, neurosurgeons who are considering practicing in a state that permits

this non-compete restrictive covenants should seek legal advice on the contract and get a sense of the legal climate there regarding such clauses.

UPCOMING U.S. NEUROSURGERY EVENTS/CMES

Global Health in Neurosurgery 2018

☐ November 4-5
New York, NY

Microsurgical Approaches to Aneurysms and Skull Base Diseases 2018

☐ November 15-17
Jacksonville, FL

4th Annual International Spinal Deformity Symposium (ISDS)

☐ November 30- December 1
New York, NY

American Epilepsy Society (AES) Annual Meeting

☐ December 1-3
New Orleans, LA

47th Annual Meeting of the AANS/CNS Section on Pediatric Neurological Surgery

☐ December 6-9
Nashville, TN

Mayo Clinic Radiation Oncology: Current Practice and Future Direction

☐ January 7-11
Kauai, HI

Spine: Base to Summit

☐ January 18-21
Vail, CO

2019 Winter Clinics

☐ February 24-28
Snowmass Village, CO

UPCOMING INTERNATIONAL CMES

The 7th Annual Dandy Meeting

☐ October 12-14
Cabo San Lucas, Mexico

► For more info regarding any of these events, or to post your upcoming CME or neurosurgery event, please contact info@harlequinna.com.

Neurosurgery Fellowships

Swedish Neuroscience Institute (SNI) at Swedish Medical Center in Seattle, WA, is seeking qualified physicians (MD/DO) for one- or two-year fellowships for academic years 2019 and 2020.

SNI offers advanced clinical training with the following neurosurgical fellowships:

- **Complex and Minimally Invasive Spine Surgery**
- **Vascular Neurosurgery (Combined Open/Endo)**
- **Endoscopic Cranial & Skull Base Surgery**
- **Functional Neurosurgery**

Additionally, SNI offers fellowships in:

- **Interventional Spine**
- **Clinical Neuroscience Research**

Physicians currently in residency or that have completed residency are eligible to apply. Candidates must qualify for licensure in the State of Washington. Preference will be given to board eligible applicants. If interested, please submit a current CV and two letters of recommendation to the program coordinator:

susan.thomas@swedish.org



<http://www.swedish.org/services/neuroscience-institute/fellowships>

IN BRIEF

AANS Weighs in on Device Safety

The American Association of Neurological Surgeons recently provided comments on the FDA's Medical Device Safety Action Plan currently in development, recommending that the FDA continue the Medical Device Reports (MDRs) program while enhancing the voluntary mechanism enabling individual physicians to directly report device safety concerns to the FDA.

Preliminary plan work and accompanying language suggested that the current system is too reliant on individual clinicians to take the requisite steps to report incidents that might signal a device safety issue. The letter stressed that AANS and CNS encourage members to submit MDRs when appropriate and argued that individual physicians are uniquely qualified to provide such data to the FDA.

CDC Issues TBI Pediatrics Guidelines

The Centers for Disease Control and Prevention (CDC) has issued an evidence-based clinical guideline for the diagnosis and management of concussion or mild traumatic brain injury (mTBI) of any cause in children. Previous guidelines covering mTBI have been consensus based and some have focused narrowly on sports concussion or only on adults.

The guideline calls for conservative use of imaging; comprehensive assessment of patients' risks for sustained recovery, including a history of mTBI or other brain injury and post-injury symptom severity; and provision of specific instructions on return to activity.

The guideline was published in the Sept. 4 issue of JAMA Pediatrics.

Harlequin Recruiting
PO Box 102166
Denver, CO 80250

NEUROSURGERY POSITIONS

GENERAL NEUROSURGERY

Brooklyn, NY: *Hospital Employed, Trauma*
Cincinnati, OH: *Private Practice*
Bakersfield, CA: *Private Practice, Ownership in Hospital and Surgery Center*
Hattiesburg, MS: *Physician-Owned Clinic*
Tucson, AZ: *Private Practice, Vascular*
Kingsport, TN: *Hospital-Based Private Practice*
Gastonia, NC: *Hospital Employed*
Fort Wayne, IN: *Hospital Employed*
San Antonio, TX: *Academic/VA*
Brooklyn, NY: *Private Practice, Spine/ Cranial Trauma*
Danville, CA: *Private Practice, Cranial*

Farmington, NM: *Hospital Employed, Spine/ General Neurosurgery*
Salina, KS: *Hospital Employed*
Las Vegas, NV: *Private Practice, Cranial*

PEDIATRIC NEUROSURGERY

Philadelphia, PA: *Private Practice*
San Antonio, TX: *Academic*

ENDOVASCULAR

Macon, GA: *Private Practice*
Charlottesville, VA: *Hospital Employed*
Fresno, CA: *Private Practice*
Reading, PA: *Hospital Employed*

SPINE

Long Island, NY: *Private Practice*
Martinsburg, WV: *Academic*
Dayton, OH: *Private Practice/Hospital Employed*
Reno, NV: *Private Practice*
Albuquerque, NM: *Academic*
Reading, PA: *Hospital Employed*
Knoxville, TN: *Hospital Employed*
Houston, TX: *Academic*
San Antonio, TX: *Academic*

CHIARI

Long Island, NY: *Private Practice*

► For more information on these positions, or if you are interested in hiring a neurosurgeon for a permanent position, please contact katie.cole@harlequinna.com or call (303) 832-1866.

CONTRIBUTORS WANTED! Neurosurgery Market Watch welcomes submissions of articles of potential interest to practicing neurosurgeons. We are particularly interested in opinion articles about how trends occurring in the neurosurgery marketplace or in the health policy arena might affect the practice environment.

To discuss a potential idea, please contact Bonnie Darves at 425-822-7409 or bonnie@darves.net