Neurosurgery
MARKET WATCH™

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Looking for Leadership Opportunities

Even in early career, neurosurgeons will find numerous outlets for boosting their leadership credentials

By Bonnie Darves

Young neurosurgeons who've survived the specialty's notoriously grueling training program have developed some leadership skills of necessity, through teaching the residents behind them and assuming roles assigned them by attendings or department chairs.

The notion of leadership, in terms of both actual requirements and potential opportunities, takes on an entirely different dimension when neurosurgeons move into practice, however. Not only are they at the helm in the OR, but in many cases practices also expect their incoming neurosurgeons to take on operational or managerial responsibilities within the organization, or to direct activities at the hospital level on the practice's behalf.

In short, if young neurosurgeons expect they'll be waiting a while to be tapped on the shoulder and asked to take a leadership role, that's no longer the case, maintains John Liu, MD, co-medical director of the spine center at Cedars-Sinai Medical Center in Los Angeles. "Especially with this changing economic climate, young neurosurgeons need to gain leadership skills early on, and they'll find many opportunities today in their practices and at the hospital," says Dr. Liu, who also serves as director of the facility's neurosurgery residency program and is vice chair of spine services. They might serve as clinical director of practice operations within a mid-sized group, Dr. Liu explains, or asked by their chair to take a key committee position within the hospital.

"In either case, they'll learn about issues that practice leaders or hospital administrators are concerned about," Dr. Liu says. "They'll also develop awareness of the economic trends coming down the line—things they typically didn't learn about during training—to better position themselves for larger leadership roles later."

Dr. Liu also urges neurosurgeons to take advantage of group learning opportunities, such as management training or leadership workshops, presentations and courses that may be offered at hospitals, conferences, universities or online.

Formal leadership training is valuable, but there's something to be said for pursuing seat-of-the-pants opportunities as well. That's what happened to Steven W. Chang, MD, a neurosurgeon at Barrow Neurological Institute in Phoenix, Ariz. Not long after he completed his training there, the group tapped him to serve as clinical director of a new satellite clinic.

"I was hesitant initially to take the director position, but it ended up being a wonderful, enjoyable opportunity to not only improve my leadership skills but also to gain a better understanding of referral patterns and the local macro- and micro-economics that affect our organization," says Dr. Chang. "The lesson in this is that if you're flexible, leadership opportunities will present themselves early in your career. Even if it's something you didn't 'sign up' to do, you'll grow professionally if you accept it."

"…If you're flexible, leadership opportunities will present themselves early in your career. Even if it's something you didn't 'sign up' to do, you'll grow professionally if you accept it."

– Steven W. Chang, MD
Barrow Neurological Institute

Business training, education position neurosurgeons for advancement

For Gavin Britz, MD, MPH, formal education both within and outside of medicine has provided a solid foundation for the leadership roles he has taken on within Duke University—as director of the Duke Cerebrovascular Center and the associated fellowship program. "To position themselves for leadership positions early on, neurosurgeons

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Leadership Opportunities

(continued from Page 1)

also need a grounding in the business side--in healthcare in general and health economics in particular," says Dr. Britz. "A basic neurosurgery residency doesn't train you in those areas."

To the latter end, Dr. Britz is now pursuing an MBA, a learning experience that is proving especially eye-opening for him. "The MPH has proved very helpful. But what I am discovering in the business courses is that it's a very different way of thinking, compared to what I experienced in training," observes Dr. Britz, who completed his training a decade ago. "Before, I used to think in terms of coming in and doing a case. Today, especially if you want to be in leadership, I think that it's important to also understand the inner workings of the hospital, and the health system at the local and national levels. And the business courses have been very invaluable in that regard, enabling me to look at my work differently, as part of the total environment of care delivery."

Neurosurgeons who are eyeing leadership roles but don't want to pursue a business degree can instead opt for standalone courses, Dr. Britz advises, such as accounting or practice management fundamentals, and coding classes. "This approach is a lot less demanding than a degree, and it's still a good way to equip yourself for leadership roles."

At the other end of that spectrum, young neurosurgeons can boost their leadership credentials by serving as an educational resource for others, advises Hatem Abdo, MD, director of Central Maryland Neurosurgical Associates, LLC, in Baltimore. "I think it's very important for young neurosurgeons to get involved in educational activities at the hospital—by giving lecture to hospital staff members and nurses, and by making presentations to patients and consumers as well," he says, adding that such experiences offer a simple way for neurosurgeons to gain exposure within the medical community while improving their own leadership skills.

"Neurosurgeons sometimes assume that other physicians [in different specialties] have a basic understanding of brain tumors, for example, or the rationale for ordering certain diagnostic tests, but that's not necessarily the case," Dr. Abdo says. "These experiences also help neurosurgeons build self-confidence--and often boost referrals as well."

On the less-visible front, neurosurgeons joining mid-sized or large practices may discover minor leadership opportunities that help them develop their business skills and position them for larger roles down the line, Dr. Abdo observes. Practices often look for newly trained neurosurgeons to oversee insurance disability cases, for instance, or to run the call schedule.

Professional organizations: Actively seeking 'young talent'

In both the clinical and healthcare industry realms, neurosurgeons will find ample opportunities to "grow into" future leadership roles, according to Brian Gantwerker, MD, president of The Craniospinal Center of Los Angeles. When he was starting his private practice three years ago, Dr. Gantwerker essentially "offered himself" to the hospital, to peer review surgical cases and serve on committees where his expertise might be beneficial.

"I think that we take certain leadership skills with us from our training—we've learned to delegate and presumably have developed basic organizational skills. But it's important to keep looking for ways to improve on those skills," says Dr. Gantwerker. "In my case, because I was going out on my own, it was particularly important to seek opportunities to help prepare me for the leadership role I was heading into."

In that regard, he observes, organized medicine, from professional societies such as the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), to national and state medical associations, remains an under-utilized resource for gaining skills. Such organizations are not only open to placing young neurosurgeons in leadership roles, Dr. Gantwerker observes, "they're actively seeking our involvement, especially in outreach, and in initiatives involving and patient care and advocacy."

The AANS and CNS may offer opportunities on membership committees or in national policy activities, for example, while state medical associations are often eager to involve neurosurgeons in a variety of initiatives. "There are so few of us that neurosurgeons often aren't involved in organized medicine, but our skills and perspectives are definitely needed, and seeking leadership opportunities is a good way to ensure that neurosurgery's interests are represented," Dr. Gantwerker says. "Besides, I think that we can learn a lot from our colleagues in other specialties."

Tips for boosting leadership potential

The neurosurgeons interviewed for this article offered strategies that their younger colleagues can employ to tap early-career opportunities and prepare themselves for larger leadership roles later. Here are a few:

- When asked to assume an expanded role or a new responsibility in your practice or hospital, simply say "yes."
- Look for opportunities to serve on hospital committees or participate in institution-wide clinical initiatives.
- If you see an unmet need in your organization, offer to either address it personally or to convene a task force to devise a long-range solution.
- Ask your superiors and more established colleagues for suggestions on how you can add value to your practice beyond performing procedures.
- Get involved in professional societies and medical associations at the local, state and national level. Help out where there's a need, until you find a niche to boost your leadership credentials.

Bonnie Darves is a Seattle-based freelance healthcare writer and editor of Neurosurgery Market Watch.

IN BRIEF

‘July phenomenon’ not found in neurosurgery

The notion that the July arrival of new residents at teaching hospitals leads to an increase in medical errors, complications or higher patient mortality, especially in procedure-intensive specialties, has long been debated. But the data collected to date on what’s been called “the July phenomenon” have been inconsistent, and little data exists about neurosurgery.

Because of the “high stakes” in neurosurgical treatment and procedures, it might be expected that morbidity and mortality would increase when new residents come on the scene. However, a new report published in the September issue of *Neurosurgery* suggests otherwise. In their review of the National Inpatient Sample database from 1998 to 2008 on cases involving non-traumatic hemorrhage, central nervous system (CNS) trauma, CNS tumor, and hydrocephalus, Weaver et al did not find higher rates of complications or mortality for patients treated in teaching hospitals during the month of July versus other months in the year.

Valuing non-clinical work poses challenges

As the dynamics of medical practice and healthcare delivery continue to shift, neurosurgeons, like their colleagues in other surgical specialties, find themselves assuming an ever-broader range of roles outside of clinical care—from medical directorship positions to administrative responsibility, and from consulting to oversight of inpatient programs in such areas as patient safety or health information technology (HIT) .

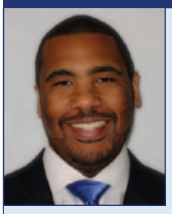
Figuring out how to appropriately and fairly established the fair market value of such work without running afoul of federal laws poses considerable challenges, especially in fields such as neurosurgery where physician time is both highly valued and restricted. In a recent article in AANS Neurosurgeon (Vol. 21, No. 3) co-authors Nicholas Bambakidis, MD, and Mark Ray Hoeprich, MD, provide a detailed overview of methods being used to set compensation for nonclinical work, laws that govern such arrangements and recent (albeit scant) data on median nonclinical compensation.

The authors found that while surgical specialists are compensated at a higher rate than their primary care peers for directorship positions--$150/hour versus $110/hour, respectively, according to a 2011 Medical Group Management Association report—small differences existed when the number of discrete responsibilities were calculated. Surgical specialists in directorship roles with six to 10 responsibilities earned a median of $40,000 annually, while their colleagues with 16 or more responsibilities earned only $10 more (median of $50,000).

The authors concluded that translating neurosurgeons’ nonclinical work into specific economic value is an area that requires further evaluation and improved methodology.

LEGAL CORNER

By Roderick J. Holloman



Q. After two years of employment receiving a guaranteed base salary, I am now receiving a productivity-based compensation model measured by wRVU productivity. I am concerned that the billing staff members are not particularly well versed, and that as a result there will be coding errors or, worse, omitted codes—leaving me under-compensated. How should I approach this sensitive issue?

A. This is indeed a sensitive issue, as you do not want to voice your concern in a manner that belittles or offends your staff, which could result in your coding being “unintentionally” compromised. Presumably there is a practice manager or department chair to whom you can communicate your concerns discreetly.

If so, schedule a closed-door meeting to articulate your concerns. Also ensure that you keep track of your procedures to cross reference them against the information coders are submitting on your behalf.

Upon finding the first discrepancy, you should raise the issue diplomatically with the person responsible for the coding to resolve it at that level prior to escalating it to the practice manager (or department chair in the case of a hospital employer). If the issue is not readily resolved, you may need to approach the hospital chief financial officer or practice equivalent to raise your concerns.

Q. I have a somewhat unusual problem regarding my current negotiations with a practice I hope to join. As part of my employment, I would receive compensation for oversight of my physician assistant. However, the assistant has yet to be hired, and the preliminary agreement states that it is “to be determined” when this assistant will be hired. How should I approach this situation?

A. You can resolve this issue by ensuring that your contract stipulates a date by which the assistant must be hired and the compensation for the oversight. For example, “on or before January 1, 2013, Employer shall employ a physician assistant who shall assist Physician in his/her practice. As compensation for oversight of the assistant, Physician shall receive…”

Author’s note: *Roderick Holloman is the principal of The Holloman Law Group, PLLC, a national healthcare law firm. He welcomes readers’ questions and can reached at 202-572-1000 or rjholloman@hollomanlawgroup.com.*

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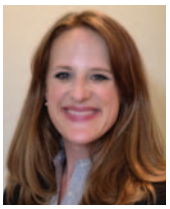
Changing Jobs: Why Many Neurosurgeons Make a Move in Early Career

By Katie Cole



After medical school, residency and perhaps a fellowship, young neurosurgeons are understandably anxious to start their first job. During training, so many decisions are made for them that the first position represents the one decision graduates can make based on their own individual criteria.

So why do so many neurosurgeons—the accepted statistic is that more than 30% neurosurgeons will change jobs once their first contract is up—make a shift? The reasons are myriad and multifactorial.

For one, numerous considerations emerge (and possibly compete) in evaluating a first job: location, salary, employment model, advancement opportunities and practice/institution infrastructure, to name just a few. As such, "getting it right" the first time is challenging.

So how can neurosurgeons better ensure that their first job out of training is a realistic choice for the long term? Essentially, the first step is to take a broad view. For example, personal and family preferences figure prominently in the first position neurosurgeons accept out of training, and those preferences may understandably vary considerably from one neurosurgeon to the next. However, many neurosurgeons choose their first position based primarily on a single overshadowing factor, such as location or salary, and don't take other, less reflective factors into consideration. That narrow focus may translate into a poor job fit for the long term.

Second, during the final year of residency or a fellowship, neurosurgeons have limited time availability for making site visits. On average, neurosurgeons may only have time to visit between three and six practices. And they may make a decision based on two or three competing offers.

Of course, once the basics of an opportunity are evaluated, there are numerous additional factors that cannot be determined until the neurosurgeon is actually on the job. For instance, practice dynamics and personalities may be generally in alignment—or, at the other end of the spectrum, mired in conflict. Likewise, discord may exist with the other neurosurgery groups in the community, or there may be political battles within the department or group itself. Or there may be funding, procedure-volume, or payer/reimbursement issues that are difficult to identify or predict.

Interestingly, however, those business factors usually aren't the main reason that neurosurgeons relocate after their first position. Rather, it's more often because the neurosurgeons failed to evaluate a job considering their big-picture lifestyle outside of the practice environment. In short, it's easy to be impressed with a high salary or ideal location, but if the job fails to meet other important factors in the neurosurgeon's lifestyle and family as a whole, it will ultimately not be a successful match.

When young neurosurgeons select their first job they are anxious to begin their career, and many don't consider issues that may not be relevant then but will be extremely important later--such as community amenities and good school systems. Another issue that neurosurgeons without children may fail to consider is whether the practice location offers a safe, family-friendly environment and a sense of community.

Following are other possible reasons neurosurgeons cite for leaving their initial post-training opportunity:

- Proximity to an international airport, to make business and family travel easier
- Competition, market saturation or insufficient community need for their services
- Contractual issues: RVU or volume expectations (or guarantees) that are not sustainable long term, or failure to attain partnership in the initially outlined time frame
- Limited or no opportunities for upward mobility

Of course, there is no perfect practice situation, which means that personal flexibility and adaptability, and a willingness to evolve with the job, are crucially important to long-term success. At the same time, it's equally important to consider "permanent" evaluation factors, such as the community compatibility and culture, location proximity to family, and the culture and personalities of the other neurosurgeons in the group, to increase the chances of making a good job choice the first time around.

Ms. Cole, a Denver resident, is publisher of Neurosurgery Market Watch.

Bucking the Trend

Atlanta group clings to its private-practice roots, philosophy

By Bonnie Darves

As healthcare delivery shifts in tandem with health reform changes and a volatile reimbursement picture, it's little wonder that many neurosurgeons and even groups are opting for hospital or health system employment. But for some private practices that have painstakingly—and successfully--carved out their niche, the appeal of independence proves more compelling than the enticement of what might be deemed a more "secure" arrangement.

Atlanta Brain and Spine Care fits that bill. The five-surgeon group, the region's largest private neurosurgery practice, is more than a holdout. It's intentionally "bucking the trend," says the group's secretary and treasurer, Regis Haid Jr., MD. "We recognize that there's a tendency in our specialty toward working for hospitals. But we feel that we can deliver more cost-effective value outcomes, using our model. The majority of neurosurgery practices are either pure private practices or directly affiliated with the hospital. We're trying to mix the model."

At first glance, ABSC, which specializes primarily in spine care, looks like a traditional private group. The neurosurgeons are compensated on productivity, and the practice maintains a strong, mutually beneficial relationship with the hospitals it serves. But there are a few interesting wrinkles. For one, ABSC serves a single large hospital system, Piedmont Healthcare, despite operating in a city with multiple systems and more than a dozen inpatient facilities. And within that system, ABSC neurosurgeons perform procedures at a single facility, Piedmont Hospital, rather than working at multiple facilities.

"Working with only one hospital system, the one we consider the best in the area, is an elective choice we've made," Dr. Haid said. "Essentially, we've decided to be monogamous." The unusual affiliation model is more cost-effective and efficient operationally, Dr. Haid maintains, and in his view enables ABSC to "bring value to the system and help them be more productive."

Regis Haid Jr., MD, center, with his colleagues at Atlanta Brain and Spine Care—from left, David Benglis Jr., MD, Steven Wray, MD, Gary Gropper MD, and Roger Frankel, MD.

To that end, ABSC serves as a consultant to the health system, actively assisting Piedmont in managing its neurosciences services. The group shares outcomes information and certain details on services costs and margins, Dr. Haid explains, to help the hospital craft its strategic plans.

In addition, in a somewhat unusual arrangement, ABSC assumes management of two Piedmont-employed neurosurgeons, who are "embedded" in the hospital. "A lot of neurosurgeons want to work for a hospital now. But we know how to run the practice, and manage the surgeons, to avoid duplication of services, control costs and provide value," he said. "This works out well for all of us."

ABSC is renowned in the physician practice industry and has been recognized by the Medical Group Management Association for running a very tight, well-oiled operation, largely under the direction of its crackerjack administrator, Carla Patterson, CPA.

Within ABSC, the group employs a management approach focused largely on equality but also on flexibility. All of the neurosurgeons share overhead and CME costs equally, and likewise, call is shared equally, regardless of how much the individual neurosurgeon chooses to work in any given week. Some neurosurgeons choose to work less than their colleagues, and the group adjusts accordingly. "We think we provide quality of life for the surgeons. If one of them wants to take a week off a month, we accommodate that," Ms. Patterson explains.

"Different surgeons, at different times of their lives, have different needs." says Dr. Haid, who spends considerable time traveling on AANS business, teaching and developing resident courses. "That's why we allow some flexibility in our system."

While acknowledging that his group's independent status poses challenges in the current economic and national health policy environment, he is unequivocal about what he perceives as the advantages of remaining independent—for the neurosurgeons and ABSC's staff. "We have decision-making autonomy about our hours, our services, and who we hire and fire. We also decide how much we pay our employees and how much vacation we give them," he says. "So I think that our staff members are loyal to us, in a way, I think, that people aren't necessarily loyal to institutions."

Neurosurgery
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A Mentoring Guide for Academic Physician Leaders

By Francine Gaillour, MD

If you are an academic medicine faculty member, the role of "mentor" is frequently included in your role description. How do you know whether you are doing that job well? Perhaps the only hint you'll receive that indicates it is not going well is your frustration that your junior colleagues are not showing the improvement you hoped for.

On the flip side, perhaps you are a junior faculty member who wants to excel and are waiting for promotion to associate professor. Or you are wondering if you'll ever get the "go-ahead" to run your own research program—and wishing you had a better mentor who could accelerate your career.

This topic of mentorship comes up so frequently that I have provided here the outline I've used with physician clients in academic organizations who are expected to mentor their junior colleagues.

The Mentoring Relationship is Key to Future Leadership

First, you likely have the makings of a good mentor, but you're not tapping into your full repertoire. One client in academic research took his mentor role very seriously, but initially looked at his role narrowly, limiting himself to helping his research fellows write grants. While he himself had built a prestigious program, he took for granted that junior faculty naturally knew what to do to build their own programs.

Over time he learned to expand his mentorship to teaching fellows and junior faculty the important steps involved in developing a comprehensive research program. Later on, he also took on the task of improving his own leadership skills and ensuring that his team developed theirs as well.

Another physician I counseled was frustrated because she hadn't been advanced to associate professor after several years at her institution. Furthermore, she was not receiving clear guidance from her assigned mentor about the milestones necessary to get there. One critical piece of advice I offered her early on: Don't be passive as a protégé. Be *proactive* and seek out your assigned mentor; and ask for specific guidance on the issues most critical to you.

> **"Don't take it as a personal affront if you do not have expertise in all areas; it is a rare academic physician who does."**

Rating Yourself Using a Mentoring Guideline

For both of these physician clients, I offered a simple "Mentoring Topics" outline they could use as a foundation for achieving desired outcomes from the mentoring relationship. Look at the mentoring relationship in academic medicine as the means to achieve one singular goal: ***Equipping junior faculty to excel in their current role and grow as future academic leaders.***

Mentors are encouraged to go through the chart below, scoring themselves on each topic using the key provided at the bottom of the chart. Regardless of your level of experience or interest in a particular topic, ensure that your junior faculty attain the requisite competency over time.

If you can't provide specific guidance, point your protégé to a resource who can--whether that's another faculty member or an outside coach. Don't take it as a personal affront if you do not have expertise in all areas; it is a rare academic physician who does.

Protégés should go through the list and note of the importance and priority of each area. Ideally, you and your mentor should review these areas together.

Mentoring Topics for Academic Leaders

If you are a mentor, rate yourself between 1 and 4 as follows for each topic:

1. I do not have experience in this area and would not feel comfortable mentoring.
2. I have experience in this area, but it is not among my favorite topics to mentor on.
3. I have experience in this area, but I have not thought about mentoring on this topic.
4. I have experience in this area and have successfully mentored others on this topic.

Clinical Excellence

My junior faculty member is improving Clinical Skills and Demonstrating Clinical Excellence as a practitioner as measured through clinical outcomes, peer review and patient-satisfaction metrics.

My Rating

Clinical Leadership

My junior faculty member is effectively leading his/her Clinical Team or Research Team, engaging the team in a collaborative manner as measured by employee-satisfaction metrics, recruitment and team-project milestones.

My Rating

Program Development

My junior faculty member is learning how to develop a research program in health reform/his field of expertise by demonstrating proficiency in bench/lab techniques, accuracy in data gathering and reporting, and creative thinking in long-range plans. He/she can be a respected and independent program leader at some point.

My Rating

Presenting and Collaborating

My junior faculty member is learning to present his/her work in national and international forums, through publications and speaking, and to connect with potential collaborators who can stimulate and enhance her/his work.

My Rating

Grant Writing

My junior faculty member is becoming adept at writing grant proposals that have a high probability of being funded. Her/his writing skills are improving to the point that he/she can assume 90% of the grant-writing task,

requiring only polish from senior faculty. The faculty member's writing style and skills are at a post-graduate level.

My Rating

Ethical Behavior

My junior faculty member demonstrates ethical conduct, respectful behavior and collegiality toward administrative staff, peers, junior and senior faculty. He/she is scrupulous in relationships with outside vendors or pharmaceutical companies, identifying and openly disclosing potential conflicts of interests, and removing himself/herself from any situations of impropriety.

My Rating

Marketing and Fundraising

My junior faculty member is becoming proficient in and actively participates in marketing and promoting her/his clinical or research program to the community or outside donors. The faculty member is visible, engaging the organization's advocates and energetic promoters of the research area for the purposes of recruitment and fundraising.

My Rating

Teaching

My junior faculty member is adept at teaching medical students and residents within his/her area of expertise.

My Rating

Career Development

My junior faculty member understands the agreed-upon milestones and timeline for advancement with our academic organization. He/she has a professional development plan in place to gain requisite leadership, business and communication skills. He/she understands opportunities available within and outside the organization.

My Rating

Take a look where you rate yourself highest. On at least five of the eight topics, you should score a 3 or 4. Examine where you rate yourself a 2; if your experience is deep, but you don't feel comfortable as a mentor, obtain outside input to help identity where your reluctance may lie. Where you rated yourself a 1, find the appropriate mentor, coach or resource for your junior team members.

The outline above is just a starting point for academic leaders and their junior faculty. Physicians in academic practice likely will identity additional topics for inclusion in their formal mentoring relationship.

Dr. Gaillour is a Seattle-based executive coach, consultant and leadership strategist who works with physicians on healthcare transformation. For more information, go to www.PhysicianLeadership.com.

UPCOMING U.S. NEUROSURGERY EVENTS/CMEs

CNS Annual Meeting
❏ October 6-10
Chicago, Illinois
***Meet us there! Booth #725

IntraCranial Stent Meeting
❏ October 8-10
Madison, Wisconsin

74th Annual Meeting of the American Academy of Neurological Surgery
❏ October 17-20
Cape Cod, Massachusetts

Neurorehabilitation Summit
❏ October 25-26
Rochester, Minnesota

2012 AANS/ CNS Section on Pediatrics
❏ November 27-30
St. Louis, Missouri

NANS- North American Neuromodulation Society 16th Annual Meeting
❏ December 6-9
Las Vegas, Nevada

12th Annual Symposium on Current Concepts in Spinal Disorders
❏ January 31– February 2
Las Vegas, Nevada

64th Southern Neurosurgical Society Annual Meeting
❏ February 20-23
Sarasota, Florida

Neurosurgical Society of America Annual Meeting
❏ April 7-10
Sea Island, Georgia

UPCOMING INTERNATIONAL CMEs

EANS Annual Meeting
❏ October 24-27
Bratislava, Slovakia

International Society of Pediatric Neurosurgery
❏ November 1-2
New Delhi, India

XXII European Stroke Conference
❏ May 28-31 2013
London, United Kingdom

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

NEUROSURGERY POSITIONS

HOSPITAL EMPLOYED	ACADEMIC	LEADERSHIP
Colorado	Wisconsin *(Spine)*	Nebraska
Virginia	Michigan *(Spine)*	New York
Tennessee	Kentucky *(Pediatric and Spine)*	
Kentucky	Wisconsin *(Neuro-Intensivist)*	
New York	Georgia *(Pediatric)*	
Massachusetts	North Carolina *(Skull Base)*	
Michigan	New York	
Indiana	Nebraska	
Pennsylvania *(Spine)*		
Ohio		
South Dakota		

PRIVA-DEMIC	PRIVATE PRACTICE	HOSPITAL GUARANTEE
Wisconsin *(Spine)*	New York	Florida
Pennsylvania *(Spine)*	Maryland	California
North Carolina	Virginia *(100% Spine)*	New York
New York	California	Texas
Kansas	Wyoming	
Michigan		

- For more information on these positions, or if you are interested in hiring a neurosurgeon for a permanent position, please contact ***info@harlequinna.com.***
- If you have locums assignments available or are interested in locums positions, please contact Aaron Risen at The Surgeons Link at ***aaron@thesurgeonslink.com***

FEATURED OPPORTUNITY

Neurosurgery Chief position

University in Nebraska is seeking a BE/BC Chief of Neurosurgery. The current chief is retiring, and the incoming neurosurgeon will transition into the chief position as the current chief moves toward retirement.

The university's neurosurgery department is developing a comprehensive Neuroscience Institute model with an academic foundation in collaboration with the region's largest community-based health system. This is a unique opportunity to be in on ground floor of the institute's development.

Academic experience and interest is required, and previous leadership experience in an academic setting is preferred. Fellowship training is also required, along with current professor status, a proven record of academic success and a demonstrated ability to oversee all aspects of department management.

Current department faculty are dedicated to fostering superior clinical, teaching and research achievement. The chief position will be very hands-on, and will involve teaching medical students and general-surgery residents. Currently, no neurosurgery residency program exists.

The position will offer competitive compensation, salary guarantee and intramural funds for research endeavors, as well as a relocation allowance, sign-on bonus and tuition remission.

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