Neurosurgery MARKET WATCH™

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Neurosurgery Compensation Update

Incomes Flattening but Stable, Yet Signs Point to More Leveling, Possible Declines

By Bonnie Darves

First the sort of good news: Despite the struggling economy and the incessant wrangling on Capitol Hill about reining in healthcare costs, compensation in most of the highly specialized surgical fields, including neurosurgery, continues to increase, if in small increments.

The general trend in neurosurgery, however, is toward a flattening in income. This became more pronounced this past year, when one of the leading national compensation-reporting organizations, the Medical Group Management Association (MGMA), reported stagnant compensation; and another, the Neurosurgery Executives' Resource Value and Education Society (NERVES), found a slight, but noticeable drop in income over the past year—this after several previous years of consistently rising incomes. (See sidebar.)

"Even with the tightening of the belt in ancillary services and revenues, the specialties are not necessarily slowing down too much in compensation. And with neurosurgery, we haven't seen as big a slowdown as we might have expected, with the continuing revenue squeeze on the surgical specialists," said Brad Vaudrey, MBA, CPA, a principal with the Minneapolis firm Sullivan, Cotter and Associates, Inc., which produces the annual physician compensation survey for the American Medical Group Association and provides tailored compensation programs for healthcare organizations.

"This correlates with what we're hearing as far as reimbursement is concerned. We've seen decreases in the actual net collection [revenues] number, even though there's an increase in demand for the surgical specialties such as neurosurgery," Mr. Vaudrey observed. The AMGA average median compensation increase for last year was roughly 2% across all specialties, he added, compared to 4% for primary care.

Here's the other news: The factors that affect neurosurgeon compensation are about to undergo what some industry watchers predict may be the most substantial shift in decades. Health reform, the emergence of accountable care organizations (ACOs) and the movement toward Medicare bundled payments for high-dollar services portend a more volatile reimbursement picture.

That shift might not affect neurosurgeons' incomes in the near term, particularly as more patients come on to the coverage rolls with health reform. But it's fair to say that the reimbursement uncertainty is front of mind for neurosurgery practice administrators, along with the potential effects of the consolidation occurring in neurosurgery and other specialties.

"Part of what's driving the leveling off in compensation may be the trend toward hospital-based employment of neurosurgeons—which could be evening out the [income] spread," said Hiroshi Nakano, CEO of South Sound Neurosurgery in Puyallup, Wash., near Seattle. The former chair of the NERVES survey committee, Mr. Nakano speculates that these market factors could result in neurosurgeons coming out of training starting at a relatively

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>
> **- Hiroshi Nakano**
> CEO, South Sound Neurosurgery, and NERVES board member

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Neurosurgery Compensation

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higher salary than they would have a few years ago, compared to their more experienced colleagues. Simultaneously, more experienced neurosurgeons who are "looking for a soft landing" from running a practice might see their compensation decline in the move to hospital employment.

"The median compensation for neurosurgeons had been growing steadily for five years, until 2011, so clearly market factors are playing a role in the flattening," Mr. Nakano said, noting that in 2008, the NERVES survey reported a median compensation of $651,000. The NERVES survey, which last year included 464 neurosurgeons in 71 practices, is considered a highly reliable indicator of the nuances driving neurosurgeon compensation.

Market, governmental forces affecting compensation

Todd Evenson, MBA, the director of data solutions for MGMA who has worked on the compensation survey for several years, views the neurosurgery compensation picture as "relatively stable." But he, too, predicts that the consolidation occurring in the specialty sector as hospitals acquire practices and employ neurosurgeons, and the regulatory and policy forces affecting reimbursement, will drive change in the next few years.

"Specialists have been in a world of production-based compensation for many years, but it's important to remember that groups align their compensation models to the prevailing reimbursement models," Mr. Evenson said. So as Medicare reimbursement gets squeezed—bundled payments are already reducing reimbursement for certain neurosurgical procedures—and ACOs distribute money across a spectrum of providers, practices will have to adjust accordingly.

Neurosurgery services demand and market factors in specific geographic regions are also contributing to the leveling off in compensation that the surveys show. In the big picture, one NERVES survey finding is particularly telling: Productivity, as measured by annual work RVUs, has declined overall in recent years (see sidebar). "Until 2009, RVUs were rising every year, and the assumption was that as compensation was leveling off, neurosurgeons were working harder to keep their incomes up," Mr. Nakano said, referring to survey findings.

Mr. Nakano points to another indicator of current and anticipated shifts in neurosurgery services volume—a perceptible hiring slowdown. "We ask respondents about their plans for recruiting over in the next 12 months, and there's been a consistent decrease in recent years—from 78% in 2007 to 70% in 2011," he observed. "That's probably due mostly to the fact that the market is consolidating, but it's definitely affecting compensation."

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HOW THE COMPENSATION NUMBERS STACK UP

Three of the leading entities that track neurosurgeon compensation and productivity, in the form of work relative value units (w-RVUs), report their data in annual publicly available surveys. Following are some of those surveys' key findings:

Neurosurgery Executives' Resource Value and Education Society (NERVES) Socio-economic Survey: 2011 report based on 2010 data

Median compensation: **$715,764**, down slightly from $730,530 in the 2010 survey. For neurosurgeons in their first five years of practice, regardless of practice setting, the median compensation was $679,677, compared to $513,464 in 2009.

Median annual work RVUs: **10,776** in 2011, up slightly from 10,062 in 2010 but down considerably from 11,167 in 2009.

Also of interest: In percentage of cases by type, the NERVES survey found that cranial is going up steadily—from an average of 24% in 2007 to 34% last year.

Medical Group Management Association (MGMA) Physician Compensation and Production Survey: 2012 Report Based on 2011 Data

Median compensation: **$740,702** in 2011, compared to $741,897 in 2010. For academic neurosurgeons, the median compensation was $468,188.

Median annual work RVUs: **9,421** in 2011, versus 10,772 in 2010.

Also of interest: In 2011, specialists in single-specialty practices were compensated $2.28 less for every work RVU they generated than specialists who work in multi-specialty settings.

American Medical Group Association (AMGA) 2012 Medical Group Compensation and Financial Survey Report Based on 2011 Data

Median compensation: **$656,250** in 2011, up 4.9% from the prior year.

Median annual work RVUs: **9,261** last year, with productivity highest in the Southern region—at 10,873 compared to 8,808 in the Eastern region.

Also of interest: Surgical specialties saw an average compensation increase of 3.4% in 2011, compared to 4.0% for primary care specialties and 2.8% for other medical specialties.

Compensation Update

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Market forces, particularly robust competition and softening demand, are affecting neurosurgery services nationally but are particularly palpable in the Northeast, where neurosurgeon compensation and productivity have stagnated or declined, especially compared to the South. To Richard Nesto, MD, executive vice president and chief medical officer at the 520-physician Lahey Clinic in Burlington, Mass., the large multi-specialty practice's recent experience in neurosurgical services is a case in point.

"Our neurosurgery volume has been flat, and has not grown at all in recent years. We're surrounded by academic medical centers—five or six within 25 miles—all with neurosurgery departments and some with dedicated neuro-ICUs," he said, noting that Lahey employs seven neurosurgeons. "It's a very crowded market for a highly specialized area."

That produces two factors, in Dr. Nesto's view: Stiff competition for high-quality neurosurgeons among these competing hospitals, but a potentially volatile volume and revenues picture for any individual institution. "The volume is chopped up by a lot of sites, so there's not a lot of neurosurgery growth in this area—and there won't be. So this is not a place where someone out of training will come," he said, "because they're not going to make hay and build high volume over time."

Dr. Nesto points out that one of the clinic's neurosurgeons moved to a competing practice a while back in search of higher volume, but didn't achieve his objective. "He isn't doing any more volume there than he was here. Our neurosurgeons earn a market-acceptable rate, one that's fair for the region. But there's not a lot of room for [compensation] growth because demand is adequate but not increasing," he said.

He noted that Lahey Clinic moved from a purely salaried model two years ago to one that offers an additional 10% incentive pay potential, based 50% on productivity and 50% on a combination of other factors such as service, care quality, outcomes measures and patient satisfaction.

Greener Pastures: Do They Exist?

Jeffrey Holden, Lahey Health's vice president for

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ASK THE RIGHT 'MARKET' QUESTIONS BEFORE YOU COMMIT

In a heavily procedure-based specialty such as neurosurgery, it's very important for physicians who are coming out of training and evaluating opportunities to get a clear picture of the market for their services in the areas they're eyeing. But often, young neurosurgeons don't ask enough questions to ascertain whether a facility, program or practice can not only ensure the procedure volume the neurosurgeon would like but also provide a foundation for growing the practice.

Aaron Hajart, MS, senior director of administration for the Neurological Institute of New Jersey in Newark, and a board member with the Neurosurgery Executives' Resource Value and Education Society (NERVES) in Charlotte, N.C., cautions that neurosurgeons could be setting themselves up for disappointment at the least, and possibly failure from the standpoint of being unable to sustain a viable practice.

"We're seeing a lot of neurosurgeons go into new jobs or employed situations where the [services] don't exist already—and being told that the volume is there," Mr. Hajart said. "But the reality is that no one can build a program in six or 12 months. So we're seeing many neurosurgeons looking for a new job less than a year or two into their first practice position because, for example, they're only getting 60 to 100 cases a year."

There's no surefire way to avoid getting into a situation in which the practice doesn't live up to either the hiring entity's promises or the neurosurgeon's expectations. But asking pointed questions—about the facility's positioning, marketplace demographics and practice resources—can help. Mr. Hajart proposes the following as "must-ask" questions for neurosurgeons evaluating opportunities in programs that don't have a long track record:

- What do you view as your deficiency areas [in the practice or program] that might affect a neurosurgery practice, and what are your plans for addressing them?
- Does your hospital have and support my sub-specialty area? For example, if the hospital is recruiting for spine, are orthopedic musculoskeletal services available? Or if it's recruiting for a functional neurosurgeon, does it have neuroelectrophysiology and pain management services in house?
- Do you have the equipment I need to do my job, or the ability to obtain that equipment? "The point is to think through all of the things you will need to build a successful practice for yourself," Mr. Hajart explains, "and find out if they're available—or if there are near-term plans to add them."
- How many neurosurgeons in my specialty area are in practice in your region? It's important to look beyond the facility's case volume, to the larger marketplace and the trends in that marketplace, Mr. Hajart observes, that might limit a new neurosurgeon's ability to build a practice.

"What you really need to know is this: How many people like me are there in this area, and is there enough services demand to support another neurosurgeon in my specialty?" he said.

Resident Profile

Krystal Tomei, MD, MPH

Current: Chief resident, University of Medicine and Dentistry of New Jersey, New Jersey Medical School, Neurological Surgery Program

Up next: A pediatric neurosurgery fellowship at Barrow Neurological Institute, Phoenix. Hopes to work in a pediatric hospital setting ultimately, while retaining the ability to also hold privileges at an adult facility so that she can follow patients into their adult years.

Why she chose neurosurgery: It was actually my childhood dream—I started thinking that I wanted to be a brain surgeon when I was 11. I had a cousin who had a TBI, around the same that I decided that, hey, the human body is pretty cool. I started by trying to understand more about what happened to my cousin, and somehow I've never wavered. I think my parents are still surprised, because there's never been a physician in my family on either side.

Once you start doing your clinical rotations people tell you to keep an open mind, and I tried to. At one point, when I had already done trauma and plastic surgery, I remember thinking, 'if I don't like neurosurgery, I am totally screwed.' But of course I loved the field!

It's interesting now, because it feels like the days drag and yet the years fly by.

Professional involvement: I joined the American Medical Students Association during medical school, and that was my first exposure to organized medicine. I learned that health policy is not the same as politics—that it's gratifying to take a role beyond caring for your own patients, to try to improve the system and the care of patients you'll never see. It's been inspiring to see how many physicians see the value in that role.

I stayed involved with the AMA, and then got involved in the neurosurgery organizations. They welcomed me with open arms because they don't often have residents who are willing to spend that extra time. So they've actually created ways for me to stay involved, and I now sit on AANS and CNS joint guidelines committee and am a member of the CNS Quality Improvement Work Group. It's been a real learning experience, and I see enough value in this that it's been worth using my vacations and some weekends I'd have otherwise had off to do the work.

Advice to neurosurgery resident colleagues: At some point in neurosurgery you will hit a low you've never hit in your life, when you are beyond exhausted and your patient isn't doing well, and you've made a mistake—and we all do.

And the last thing you should do when you hit that low is to say, 'I wish I would have done x.' Instead, say to yourself, 'This sucks, but I couldn't picture myself doing anything else—and it can only get better from here.'

As for planning your career, as you start to look at fellowships and practice options, make a wish list of what you want in both your fellowship training and your future career. And when you start to evaluate fellowships, don't forget to start thinking about what you want in your future practice. Your fellowship should be just another step in that direction.

– By Bonnie Darves

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IN BRIEF

Neurosurgeon shortage: IOM alerted

Getting a handle on how a specialist shortage will play out in the U.S. healthcare services marketplace is difficult for policymakers and patients alike, but the recent numbers in neurosurgery make the case fairly clearly: There are more than 5,700 hospitals that serve more than 311 million Americans, yet only an estimated 3,689 board-certified neurosurgeons are in practice today.

That ratio will worsen soon, the Society of Neurological Surgeons predicts, as an additional 30 million Americans receive healthcare benefits under health reform and the baby boomers hit the Medicare rolls in full force over the next five years.

That was the message Ralph G. Dacey, Jr., MD, the society's president, delivered to the Institute of Medicine in December 2012, referring to the "supply-demand mismatch that will become even more acute" with the again of the population.

Dr. Dacey urged the IOM to both recognize the protracted education and training pipeline for the specialty—up to 18 years for some sub-specialists—and press for additional financial support for graduate medical education to increase the number of ACGME-accredited training spots. "Replenishing the neurosurgical workforce is no easy task," he told the IOM.

CNS launches new education foundation

The Congress of Neurological Surgeons recently announced the launch of a new foundation to support the development and ongoing support of educational initiatives in neurosurgery practice. Called the CNS Foundation, the entity will focus not on research but rather on practice enhancement initiatives, particularly in the areas of practice guidelines and international education that will advance the specialty in the future.

Specific details on the foundation's mission and activities will be announced in the coming months.

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▸ For more information, contact Katie Cole at ***(303) 832-1866*** or ***info@harlequinna.com***.

UPCOMING U.S. NEUROSURGERY EVENTS/CMEs

Neurosurgical Update: Interactive Review by Case Management
❑ February 16 - 17
Coral Gables, Florida

Annual Meeting of the AANS/CNS Section of Disorders of the Spine and Peripheral Nerves
❑ March 6 - 9
Phoenix, Arizona

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

Rocky Mountain Neurosurgical Society
❑ June 16 - 21
Maui, Hawaii

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

CNS MOC Board Review Course
❑ March 9 - 10
Phoenix, Arizona

Pain Bi-Annual Meeting
❑ April 26
New Orleans, Louisiana

81st AANS Annual Meeting
❑ April 27 - May 1
Cleveland, Ohio

UPCOMING INTERNATIONAL CMEs

British Association of Spinal Surgeons Annual Meeting
❑ March 13 - 15
The Halls, Norwich

International Society for the Advancement of Spine Surgery
❑ April 2 - 5
Vancouver, B.C., Canada

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

WLNC (World Live Neurovascular Conference)
❑ May 29 - 31
Istanbul, Turkey

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

What to Expect During a Site Visit

By Katie Cole

After a neurosurgeon considers a job opportunity and speaks with either administrators or other neurosurgeons at the prospective practice, the site visit usually follows. This is the exploratory part—the neurosurgeon meets with the administrators and other physicians, tours the office and associated hospitals, and gets a feel for the location and community.

A site visit serves as a mutual interview for both the neurosurgeon considering the opportunity as well as the facility considering hiring the neurosurgeon, and is typically is the first face-to-face encounter for both parties. To ensure that it is time well spent, both parties should adequately prepare for the visit.

The site visit is an essential part of evaluating a physician opportunity, for all involved. But it's important to remember that regardless of how heavily recruited the neurosurgeon is, the site visit proceedings are also an interview—and an important one. The facility showcases what they have to offer, and the neurosurgeon promotes himself or herself.

Neurosurgeons often are so focused on evaluating the location and facility that they may almost forget that they're still being interviewed. During the visit, neurosurgeons are expected to not only elaborate on training and experience, but also respond to questions involving behavioral and compatibility issues.

Because the site visit almost always involves travel, the extended encounter gives both parties a chance to get to know each other not only at the facility but also in social situations such as dinners. In short, while neurosurgeons' credentials and training are important, demeanor and working congenially with staff are also essential aspects of making a good impression.

What to expect

Most site visits include one to two full days of interviews and meetings with hospital administrators and other physician leaders, as well as the neurosurgeons involved in the hiring group. A visit often can be scheduled at either the beginning or end of the week, to allow an extra day for the neurosurgeon (and possibly the spouse as well) to tour the area and perhaps meet with real estate agents to tour neighborhoods and properties.

Hospital administrators involved in the interview vary considerably from one visit to another. A neurosurgeon can expect to meet with individuals ranging from the hospital CEO, to the vice president of operations, to the practice management director and, invariably, the hospital recruiter. Physician leaders are typically included in the itinerary, and it is important to meet with as many neurosurgeons as possible to see if there is a clinical and personality fit for both the candidate and the group.

The visiting neurosurgeon typically is provided with an itinerary of the site visit, including the names and titles of the hospital staff and all confirmed travel arrangements, including air ticket information, rental car information, and hotel accommodations.

"While neurosurgeons' credentials and training are important, demeanor and working congenially with staff are also essential aspects of making a good impression."

If it is determined after the first visit that there may be a mutual fit, typically a second look is scheduled to confirm details of the opportunity. This includes going over the compensation and the technical aspects (such as available and needed equipment). The discussion also typically involves confirming call, and negotiating the salary and other benefit and incentive details.

During training, the average neurosurgeon can only visit with four or five facilities because the final years of training or fellowship already consume most of a neurosurgeon's available time. For neurosurgeons who are already working, it may be difficult to request time off to visit another facility.

Before making the visit, research the area, the demographics and payor mix, any obtain as much information as possible about the opportunity and the community. Also check out the hospital or group's website, and get a grasp of the facility's programs and services.

After the site visit

After the visit, review the key points covered. The visiting neurosurgeon should have a good understanding of the opportunity. Ensure that all important questions were covered during the visit—not only the clinical aspects but also the prospective compatibility among the physician colleagues, and whether the community meets the neurosurgeon's needs. Look for red flags; and it goes without saying that the impressions of the visiting neurosurgeon's spouse are important.

After the visit, if there is mutual interest in moving forward, the neurosurgeon should convey his or her interest almost immediately to key personnel involved in the interviews, as that might not have come across during the visit. A thank-you letter, carefully crafted and sent either by email or traditional mail, is appropriate. If the neurosurgeon is interested in the position, he or she should be sure to let key personnel know. Even if the opportunity is not a good match, the neurosurgeon should still send a timely thank-you letter—one that indicates that he or she will be continuing the job search.

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

LEGAL CORNER

By Roderick J. Holloman

Q: I am being heavily recruited to relocate to an underserved area by the CEO of the local hospital. He has expressed a willingness to employ me directly or to offer a one-year income guarantee to supplement my practice should I elect to establish one or join an existing group of surgeons. I have long wanted my own practice, but I am concerned that with medicine's current state, an independent practice might not be a good idea. What do you think?

A: The "prognosis" depends on the practice's projected payor mix, now and in the coming years as the patient base ages. If, for example, your primary practice payor would be Medicare, I would advise you to strongly consider becoming a hospital employee and table discussion of your own practice until the viability of such a practice is established.

My recommendation is due in large part to the likelihood of decreased Medicare reimbursements and increased overhead expenses—the result of which would be working longer hours for reduced compensation. If you are persuaded that joining a private practice, as an employee or a shareholder, is a better option, aggressively negotiate for a longer income guarantee.

Private practices often cannot absorb losses to the degree that a hospital can, and if your practice isn't profitable by the second year, you may find yourself in a vulnerable position. The situation could be especially problematic if your contract contains a restrictive covenant limiting your ability to practice in the catchment area.

Q: I am professionally frustrated. I was recruited with three other neurosurgeons, to establish a neurosurgery program at a regional hospital. Unfortunately, the hospital has been less than accommodating despite our repeated requests for institutional support and backing.

Although I earn a very good salary, I am considering submitting my resignation and finding another opportunity, as I fear that my skills are being quickly compromised. However, my contract contains a non-compete clause. Is it enforceable in light of the hospital's failure to provide the support it promised per my contract?

A: I sympathize with your untenable situation. However, I strongly encourage you to stick it out until you secure employment elsewhere, as it is uncertain where your subsequent employment would take you or how long you would be unemployed, and therefore without opportunity to utilize your skills. That situation could foster further frustration (especially when coupled with the income loss).

Regarding the non-compete, if it is indisputable that the employer has failed to provide the resources reasonably necessary, you may be able to reach a resolution that includes waiver of the non-compete.

Generally, such a restrictive covenant is written so that it operates as an agreement independent of all others. As such, even a material breach of the employment contract would not render the restrictive covenant void. Therefore, you should consider consulting an attorney to review your contract and discuss your options. Each state treats restrictive covenants differently, and your state may have a solidly established, public policy against the enforcement of non-compete agreements.

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.

Compensation Update

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financial services, cites an anecdotal indicator of the marketplace shifting and volatility that's occurring in many of the specialties: Many of Lahey Clinic's former residents—the practice trains 145 across several specialties—who have taken hospital-employed positions elsewhere in recent years are calling to inquire about potential openings at Lahey. "Many of the residents go out there, but then want to come back and be part of the organization a few years later," Mr. Holden said, presumably because they suspect a shakier reimbursement picture.

"I think they view this is as a 'safe' place, because, like Mayo, we've been doing this [large group practice] model a long time, and we're very experienced at it," Dr. Nesto added.

Both he and Mr. Holden concurred that the overall earnings picture for specialists, including neurosurgeons, remains bright, especially as the baby boomers move into Medicare in growing numbers. However, they also agreed that physicians should become more cognizant of forces—such as bundled payments and outcomes performance payments (or reductions)—that challenge practice leaders and administrators as they structure compensation plans.

"Those factors just aren't on young physicians' radars," Mr. Holden said. "And while neurosurgeons are well paid and will continue to be pretty well paid, they need to understand that the [reimbursement] base for what practices get paid is shrinking."

Aaron Hajart, MS, senior director of administration at the Neurological Institute of New Jersey in Newark, a large academic program affiliated with the University of Medicine and Dentistry of New Jersey, concurs with Mr. Holden thinks that it behooves young neurosurgeons to obtain a basic grasp of the market forces affecting neurosurgery before they start interviewing. "What we see here is that many neurosurgeons come in knowing the [compensation] figure they want, but they don't really understand the factors affecting compensation," he said.

Bonnie Darves is a Seattle-based freelance healthcare writer.

NEUROSURGERY POSITIONS

HOSPITAL EMPLOYED

Virginia
Colorado
Ohio
Kentucky
Texas
Tennessee
Mississippi *(2014)*
Boston, MA
Wyoming
Philadelphia, PA
Indiana
Wisconsin
Ohio *(Spine)*
Arkansas
Washington *(Neuro-Endovascular)*

LEADERSHIP

Nebraska
Wisconsin

PRIVA-DEMIC

Pennsylvania
North Carolina
New York
Wisconsin *(Spine)*
Brooklyn, NY *(Spine)*
Ohio *(Neuro-Oncology)*
Pennsylvania *(Endovascular)*
Pennsylvania *(Skull Base)*

ACADEMIC

Wisconsin *(Neuro-Interventional)*
Kentucky *(Pediatric)*
Nebraska
North Carolina
Florida *(Pediatric)*
Tennessee *(Functional)*
Detroit, MI *(Spine)*

PRIVATE PRACTICE

Long Island, NY
Colorado *(Spine)*
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Kansas
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Nevada
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- 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 any locums assignments available, or if you are interested in locums positions, please contact Aaron Risen at The Surgeons Link at ***aaron@thesurgeonslink.com***

FEATURED OPPORTUNITY

Academic Spine Neurosurgery Department Opening in Wisconsin

A Wisconsin teaching hospital seeks a BE/BC neurosurgeon to join its neurosurgery department. This position will be a spine neurosurgeon position, although it will incorporate general neurosurgery as well, and the position will be fully employed by the health system and will incorporate a full-scope departmental role.

Spine fellowship or equivalent experience is preferred, and experience with all types of spine procedures, including complex spine, is also preferred. The department also has preference for a candidate with leadership experience or interest in pursuing leadership in academics, as the opportunity is structured to enable the incoming neurosurgeon to move relatively quickly into a leadership role. Rank will be commensurate with experience.

The incoming neurosurgeon will receive full support from the facility and the community. Call will be 1:6 for the incoming neurosurgeon. There is also a full support staff, including NPs and PAs, who also take call. The facility is consistently rated a Top 100 institution in the nation. The incoming neurosurgeon will receive a very competitive salary and a full menu of benefits.

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