Neurosurgery
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# Privademic Model Catching on in Neurosurgery

## Emerging structures enable neurosurgeons to pursue academic activities in an essentially private-practice setting

By Bonnie Darves

Neurosurgeons who are torn between practicing in the academic setting—it's all they really know after so many years of training—and signing on with a private practice might not have to make a hard, either/or choice anymore.

The privademic model, which combines some aspects of academic practice, from research opportunities to teaching responsibility, in a private practice or community hospital setting, is becoming increasingly common in neurosurgery and other surgical specialties. The hybrid model, as it has emerged to date, typically incorporates the production-based compensation incentives that prevail in the private-practice model, with potential for participating in clinical trials and, in many cases, modest exposure to teaching residents or medical students.

The affiliation "alignment" with academic centers in privademic practices range from loose to formal, and in some privademic practices, research and clinical trial participation are conducted in an essentially standalone fashion fully outside the academic setting. In most cases, neurosurgeon compensation in privademic practices is based more on the private-practice or hospital-based model than the academic one. This arrangement can allow some "lever" capability for neurosurgeons who are attracted to the academic model but still want to be able to exercise some control over their clinical production.

The driving forces behind the privademic model are myriad. For one, while academic centers are the preferred setting for most highly complex neurosurgery cases, they're an expensive place to perform the more routine spine or functional neurosurgery procedures. Insurers are increasingly balking at absorbing the high tab, which is driving volume to community hospitals with solid, if small, neurosurgery services. In addition, reimbursement is decreasing and the uncertainty about what's ahead in the post-health reform environment is prompting a pervasive cost-containment mentality in organizations that provide so-called "big ticket" medical and surgical services.

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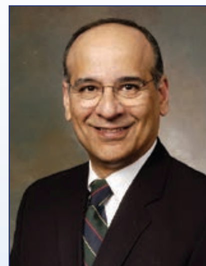
>
> - Raj Narayan, MD
>
> *Neurosurgery Chair, Hofstra North Shore-LIJ School of Medicine*
> *Executive Director, Cushing Neuroscience Institute*



What's in it for established academic centers? Essentially, by creating privademic affiliations with community hospitals and high-caliber private neurosurgery practices, the centers achieve two objectives: a presence in the community that provides a referral link back to the academic facility for complex or high-risk procedures or subspecialty neurosurgery services, and a means of tapping outside neurosurgeons to share or even out the caseload. Some large academic centers are even using an elaborate hub-and-spoke approach to linking community

continued on page 2

## IN THIS ISSUE...

Privademic Model Catching on in Neurosurgery
PAGE 1

Practice Profile
PAGE 4

Upcoming Neurosurgery Events
PAGE 5

Understand the Neurosurgeon Recruiting Timeline
PAGE 6

In Brief
PAGE 7

Crafting the Compelling CV
PAGE 8

Legal Corner
PAGE 9

Where the Jobs Are AND Neurosurgery Physician Assistant Compensation Varies Widely
PAGE 10

PA Profile
PAGE 11

Neurosurgery Positions & Featured Opportunity
PAGE 12

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# Privademic Model Catching on in Neurosurgery

(continued from Page 1)

and institutional resources, establishing a presence in multiple community hospitals.

## Draw for neurosurgeons

The privademic model's structure can vary considerably depending on the regional market and the extent to which academic centers wish to expand their reach and enable community-based neurosurgeons to participate in academic activities. For the most part, however, the model offers the potential for a best-of-all-worlds practice approach, in which neurosurgeons can keep a toehold in academia while enjoying some of the relative autonomy that private practice affords. That's the view of Raj Narayan, MD, professor and chair of neurosurgery at Hofstra North Shore-LIJ School of Medicine and executive director of North Shore-LIJ's Cushing Neuroscience Institute—a collective organization structured on a quasi-privademic practice model.

One appealing feature for the neurosurgeons who join Dr. Narayan's group, he points out, is that they have access to a full spectrum of support services. "This is a very important point for neurosurgeons. If you are in a hospital where you have significant depth of expertise, it's good for the patient and for the surgeon's peace of mind," he said. "You know that your anesthesiology, radiology and interventional people are all excellent, so if you get a difficult case or in a complicated situation you always have others you can count on to help you out." In addition, Dr. Narayan notes that many neurosurgeons who either don't do research or don't want to conduct a lot of research themselves appreciate being affiliated with an organization that operates a robust research center.

In his group, some neurosurgeons are more academically oriented—they're predominantly doing research, publishing papers, and "trying to push the envelope," Dr. Narayan explains. Others are primarily clinically oriented, and focused on doing the cases. Many of the neurosurgeons in both camps are involved in teaching, to varying degrees. "It's a very rich environment, intellectually," he adds. "What we have here is basically a neuroscience institute on steroids."

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>
> **- Ania Pollack, MD**
>
> *Neurosurgeon, The Clinical Neuroscience Institute | Dayton, Ohio*

"We have a very big tent here, so there is the ability in our organization for physicians to find a niche," said Dr. Narayan, whose group includes 20 neurosurgeons and numerous neurosurgery and neurology subspecialties. "If you want to do predominately clinical work, there's a space for you. And for neurosurgeons who want to want to do significant amount of academic work, there's a place for them, too." North Shore-LIJ Health System, based in Manhasset, N.Y., is arguably the country's largest healthcare system after Kaiser Permanente; it operates a hub-and-spoke model that includes 17 regional hospitals, employs approximately 2,500 physicians, and has an additional 5,000 voluntary medical staff members.

Despite its extensive outreach into and presence in the community, the North Shore-LIJ neurosurgery department and all of its affiliated subspecialties operate under a single financial umbrella, which Dr. Narayan considers a big plus because that obviates some of the conflicts that can occur when a case essentially "straddles" two subspecialties. "What that does is take away the turf issues in terms of who is looking after the patient and what treatment the patient gets," he said. "So if a patient comes in with an aneurysm, the endovascular specialist and the open neurosurgeon discuss the case and decide what is best for the patient–and that's what the patient gets."

## Model boosts full-services center trend

For Ohio neurosurgeon Ania Pollack, MD, the privademic model offered an opportunity to incorporate her strong academic background and interests with a privademic environment that, in her view, represents the way of the future. Two years ago, Dr. Pollack, whose practice focuses on brain-tumor and skull-base surgery, helped develop a new dedicated neuroscience institute at 900-bed Miami Valley Hospital in Dayton, Ohio, a community medical center that is affiliated with Wright State University.

"I do think that the privademic model–especially in the context of the comprehensive neuroscience institute–is the model of the future for our field, and I wanted to be involved in creating this kind of program," she said, "because I am a builder, not a follower." Although she was concerned that she'd miss being in a purely academic environment—Dr. Pollack did her residency and fellowship at Northwestern University in Chicago—her academic appointment at Wright State University enables her to keep the pulse on that setting.

The 2 ½-year-old endeavor that Dr. Pollack helped start is a prime example of the privademic movement's promise. The Clinical Neuroscience Institute recently launched an accredited neurology residency program and will soon apply to start one in neurosurgery. And she personally is building the neurologist-oncology service from the ground up. "It's very exciting to be part of this–and it's also an exciting time in neurosurgery, I think," Dr. Pollack said, because the comprehensive neuroscience center approach is, in her view,

continued on page 3

the way that care will be delivered in the future.

"High quality care has to be delivered in the community, too, and built up there—so that much of the more routine care can be provided there and the academic centers can handle the complex cases," she said. "When you consider that approximately 80% of cancer care is provided in the community, not at academic centers, the emerging privademic approach makes sense. Not every patient can go off to MD Anderson for treatment." The privademic model also affords myriad opportunities for both clinical and research collaboration, she noted, and that's where the model likely will find its longer-term hold.

"In the future, I think the market will demand not only high quality of care in neurosurgery but also a more comprehensive and multidisciplinary approach to disease treatment," Dr. Pollack said. "That's what a true privademic model is, and that's what centers like ours are trying to deliver."

For example, expanding the research base into the community holds promise for moving cutting-edge evidence-based protocols into the standard of care sooner—across the board. That's been a longstanding issue in medicine generally, when academically developed best practices take too much time to gain a foothold in everyday community practice.

This emerging blending of academic and community resource allocation and knowledge-dissemination is one key objective of the privademic practice that's been developed at Loma Linda University in Southern California. The eight-neurosurgeon group has its hub at the university but also operates four satellite clinics in the community, where neurosurgeons see patients and either care for them in those offices or in affiliated community hospitals where they take call. Complex cases are referred as appropriate to the university location.

In a recent development, neurosurgery residents are now rotating through the community clinics as well. And in a somewhat unusual arrangement, formerly purely academic neurosurgeons have moved in to the community setting to practice.

To the extent feasible, all of the Loma Linda neurosurgeons allocate their clinical and academic time to suit their interests—and are supported in doing so. "If the department chair or one of the neurosurgeons wants to his practice in a certain direction, and can demonstrate good cause and financial viability, he can do so," said Kevin Hockenson, Department of Neurosurgery Administrator at Loma Linda. "We also have several physicians who work in a hybrid model with .7 FTE at Loma Linda and .3 FTE with Kaiser or other facility."

Loma Linda University operates a second hospital in Murrieta, where several of the group's neurosurgeons house their clinical procedure practice, but that location "is more like a private practice setting," Mr. Hockenson notes. "This setting provides a good experience for our residency program, however, so that the residents can get a sense of what private practice looks like."

One draw for neurosurgeons who join the Loma Linda organization is that they can effectively "dial up" their clinical volume as desired and as their stamina permits, to increase their income. "This enables them to earn a private practice salary yet still be part of an academic institution where they can teach or do research—or perform the more complicated cases that can't be done at the community hospital," Mr. Hockenson said. "It's the best of both worlds, in a sense, but these surgeons do have to work very hard to keep up their productivity."

## Privademic practice realities

If the privademic model sounds like mostly pleasure and relatively little pain, that's not exactly the case, of course. While physicians in many privademic practices do retain the ability to carve out their clinical and academic activities and schedules as resources, circumstances and infrastructure permit, there are realities and inherent constraints.

For one, privademic neurosurgeons may have high clinical productivity expectations—any practice, after all, has to meet its expenses to stay afloat. If the privademic practice is relatively small, call duty could be heavy as well. In addition, most privademic practices, of necessity, have a less varied caseload than academic centers, from the standpoint of complexity, because many community hospitals are simply not equipped to handle major cases that may require a multidisciplinary approach from the start and in the OR.

Further, while the privademic model might possess certain inherent flexibility, it's not necessarily an environment for mavericks who prefer a lot of autonomy. "In privademic practice, it is a team approach," Dr. Pollack stresses. "You respect each other's interests and commitments to different things—but we all take call, and we all participate in both clinical and academic activities." Typically, most neurosurgeons will be more heavily weighted toward one or the other, but an exclusive research focus isn't feasible. "If you want one day for research and four for clinical care, that might work. But if you want five days in a lab, the privademic model is not for you," she explained. "If you want a lot of protected time for research, you will need a substantial grant."

While the privademic model is positioned to expand considerably in the years ahead, it's still in the experimental stages on some levels—and market and health reform factors will affect how well these groups and their traditional counterparts fare over time. For that reason, neurosurgeons are well advised to thoroughly research the organizations they are considering, and to have a legal professional review the contracts.

"It's important to check out the practice's resources, as well as the financial structure and foundation, to ensure that it's solid," Dr. Pollack advises. "It's also key to find out how much of your compensation will be productivity based and to obtain details, in writing, on how much protected time you will have to pursue academic activities."

*Bonnie Darves is a Seattle-based independent healthcare journalist and editor of Neurosurgery Market Watch.*

PRACTICE PROFILE

# Setting a High Bar

## Unusual philosophy, patient-focused culture underpin innovative Colorado practice

By Bonnie Darves

In some ways, the story about how High Mountain Brain and Spinal Surgery Center was established seven years ago makes perfect sense in the context of its current culture and its practice philosophy. David W. Miller, MD, who trained at the Cleveland Clinic Foundation, did his fellowship in Pittsburgh, and pursued his Gamma Knife training in Stockholm, didn't go looking for a practice that would be a good fit for him but rather for an opportunity to do it right—from scratch.

"I actually cold-called the hospital CEO and asked him if he'd like to have a neurosurgeon," recalls Dr. Miller, whose Glenwood Springs. Colo., practice is affiliated with Valley View Hospital. "I wanted a place where we could build our own culture—one that removed the negatives of my prior experiences and incorporated the positives." He also wanted to find a hospital big enough to do both brain and spine, and that also had good-quality subspecialty support and primary care—a criteria combination that Valley View met handily.

*David W. Miller, MD, founder of High Mountain Brain and Spinal Surgery Center, visits with a post-op patient at Valley View Hospital.*

Starting a practice and a hospital neurosurgery program from scratch was no small feat, Dr. Miller acknowledges, but the result has been worth the effort. The medical community has welcomed him openly, and the hospital has fully supported the practice in providing needed equipment and technology. He and his staff have created a patient-focused practice philosophy and environment that do far more than pay lip service to what's become an almost clichéd term these days. High Mountain's front-office and clinical staff extend don't just welcome new patients but also take the time to find out about their lives, before the patient meets with Dr. Miller and his physician Assistant, Nick Armano, PA-C.

"Every individual in this office takes a personal interest in the patient—to learn about their families and what impact their condition or treatment has or will have on their lives," Dr. Miller explains. "It's not, 'Mrs. Smith is an L-4/5 disc herniation.'"

This sounds like a simple thing on the surface, but it's powerful in the context of neurosurgery services, Dr. Miller and Mr. Armano concur, where patients are understandably inclined to be, well, a tad nervous. "People are terrified to see neurosurgeons. And I think Nick's job and my job are made easier because by the time we see them," Dr. Miller says, "they're much calmer, and they already feel like people have an interest in them. And that goes a long way toward establishing rapport and trust."

The culture of embracing the whole patient also figures in the way High Mountain Brain and Spinal Surgery Center conducts the new-patient intake history and examination. It's anything but the rushed checklist-style process Mr. Armano experienced in previous employment settings—when he often saw as many as 40 patients a day and, of necessity, was relegated to what he describes as "one-sided discussions." In a hands-on and engaged session that could run an hour or more, he and Dr. Miller try to consider treatment plans in the light of the patient's "real life"—their vocational and recreational demands (or hopes), and how a prospective procedure might affect the big picture.

Dr. Miller cites a recent example of a patient whose history, examination and imaging results suggest that he needs surgery urgently. But in discussion, it turns out that the man's child is undergoing chemotherapy. "The last thing that he needs is to have surgery right now, so we came up with an alternative plan," he recalls, that might help alleviate symptoms until the patient's family life was on a better footing.

continued on page 5

Another practice differentiator, Dr. Miller admits willingly, is that he's not always inclined to recommend surgery as the first option. "It's a fundamental approach we take that isn't necessarily true of most surgeons: We honestly try to find some nonsurgical way to help the patient first," Dr. Miller says, and then move on to surgery if or when it's needed or warranted.

## Engaged patients, ideal setting help

High Mountain provides fairly comprehensive neurosurgery services, with a focus on complex spine, tumor (brain, spine and pituitary), and trauma surgery—with extensive use of minimally invasive treatment. The patient demographics largely account for the procedure volumes and breakdown. The practice is situated in a quasi-resort setting—40 miles, respectively, from Aspen and Vail—and it's a premier skiing and fishing destination. The patient population also includes ranchers and agricultural workers, and the vast majority of the patients are physically active and generally fit. "It's a nice population to treat," Dr. Miller notes, because the patients tend to be motivated to get well and do well.

"The average patient we have doesn't need to be coaxed into activity," Dr. Miller says. In fact, it's often quite the opposite, Mr. Armano reports—trying to encourage patients to take it easy after surgery—to hold off on hitting the slopes or returning to rollerblading—so they can heal without problems. "When I go to conferences and talk about our patients and their post-op activity levels, people are often somewhat shocked," he says. "For example, we have an 80-year-old who skied 50 days last year after he had his fusion, and one patient who's 102 and is still skiing!"

Another benefit for Dr. Miller's practice is that the hospital is a Planetree facility, which by design offers highly personalized patient-centered on care in a homelike, healing environment in which all care is delivered with the objective of ensuring that patients and their care team are in partnership regarding care planning and decisions. "Having and promoting that philosophy of care does make a big difference to our patients—and our patients tell us that over and over again," Dr. Miller says, quipping that when his surgery patients come back for their six-week visit, often they're "still talking about the massage they received before they went back for surgery."

*Nick Armano, PA-C, credits the extensive patient intake session, in part, with the neurosurgery practice's consistently high patient satisfaction rankings.*

Now that the practice is well established, functioning as he had hoped and intended, and busy, Dr. Miller is setting his sights on growth. The next step is to bring in another neurosurgeon who shares his practice philosophy, and then, ideally, broaden the range of services available. "It's really a great referral community here, so there is plenty of opportunity to expand the practice."

## UPCOMING U.S. NEUROSURGERY EVENTS/CMEs

American Academy of Neurological & Orthopaedic Surgeons 38th Annual Scientific Meeting
❑ June 13 - 14
Memphis, Tennessee

Minimally Invasive Neurosurgery (MINS)
❑ June 13 - 14
New York, New York

2014 New England Neurosurgical Society Annual Meeting
❑ June 26 - 28
Brewster, Massachusetts

2014 Cerebrovascular Complications Conference
❑ June 26 - 29
Jackson Hole, Wyoming

The 32nd Annual Symposium of the National Neurotrauma Society
❑ June 29 - July 2
San Francisco, California

ISIS-International Spine Invention Society
❑ July 30 - August 3
Orlando, Florida

Scoliosis Research Society: 49th Annual Meeting & Course
❑ September 10 - 13
Anchorage, Alaska

NASS-North American Spine Society
❑ November 12 - 15
San Francisco, California

## UPCOMING INTERNATIONAL CMEs

49th Annual Rocky Mountain Neurosurgical Society Meeting
❑ June 14 - 18
St. Andrews by the Sea
New Brunswick, Canada

IMAST 21st International Meeting on Advanced Spine Techniques
❑ July 16-19
Valencia, Spain

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

# Understand the Neurosurgeon Recruiting Timeline

## When is the right time to start recruiting—or applying—for a neurosurgery position?

By Katie Cole

It's clearly too late to start recruiting for a replacement neurosurgeon after one leaves, but when should a practice start? With the average search for a neurosurgeon now taking in excess of nine months, the general advice is: the sooner the better.

Whether you are looking for a neurosurgeon to join your practice or you are a neurosurgeon looking for a practice opportunity, time, due diligence, and accessibility are essential for both parties during the entire recruitment process. Practices want to identify the best, long-term fit for their group—a neurosurgeon who will help establish and reinforce a strong reputation in the community.

Neurosurgeons also want a good fit, as it's logistically challenging—and not much fun for families—to constantly move practices and relocate, possibly across the country.

In that context, let's look at the timeline specifics. Many neurosurgeons start positions in the summer because that's when fellows and residents finish their training. Even experienced neurosurgeons typically have contracts that end in the summer, which is why that season constitutes the majority of hiring activity. Fellows and residents typically start looking for positions the summer prior to completing their training, so approximately one year before they are available. They typically engage in phone interviews and make site visits through the later summer and in to the fall, and most identify a few contenders before the end of the year.

If the neurosurgeons haven't already signed by the end of the year, they generally have narrowed their search, and are either in negotiations before spring or make their final

continued on page 7

GLOBAL NEUROSURGERY PROGRAM

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decision and sign before spring starts. Most new positions filled by residents and fellows start in June, July or August.

### Start the conversation early

If your organization anticipates a neurosurgery need, the sooner you can start speaking with potential candidates the better your chances for identifying the best fit. If you have a position you hope to fill starting in the summer, keep in mind that there is considerably more competition then—which means that you should start reaching as soon as possible.

Whether your need occurs because you must replace a neurosurgeon who is leaving or retiring, or because of increased community need, it's advisable to start recruiting a minimum of six months before the clinical need will occur. If you have the flexibility, in the current market a window of nine to 12 months would be ideal. It's also important to anticipate and build in the time required to identify candidates, set up phone interviews with key department personnel, and coordinate first and second round interviews and site visits. And remember: Contract negotiations can take one to two months, at a minimum, even after both parties have confirmed mutual interest.

The best way to guarantee the best fit for your practice is to start speaking with quality candidates immediately on receipt of their CVs. Even if several people within the department need to review the CVs, the sooner you contact interested candidates, the greater your chances of hiring the best neurosurgeon for your group. Oftentimes, organizations let weeks go by before candidates are contacted, and neurosurgeons lose interest and begin pursuing other options.

### When should candidates start looking?

If you are a resident or fellow, the best time to start looking for a new position is at least one year before you complete your training. If you are seeking an academic position, you can start your search even earlier, 18 months or more before you will be available to start. Private and hospital-employed practices typically have a more urgent clinical need, so they will speak with potential candidates six to 12 months prior to their neurosurgery opening.

If you have a very specific type of opportunity you are seeking, either restricted geographically or by sub-specialty, you can start looking sooner to start getting a feel for the marketplace. It may be too early to actually set up conversations with potential groups, but you can start seeing what is available that offers the type of practice or environment you are seeking. That will give you a sense of what is currently open and what may be offered as you get closer to your availability.

If you are an experienced neurosurgeon already in a practice setting, start looking for a position at least six months before your contract will end. Although you have limited time for visits already if you are in a busy practice, do try to get a feel for what you are looking for six to 12 months before you actually plan to leave.

As you speak with potential groups, your search will evolve, and you will gain clarity about what is important to you in a practice opportunity. At that point and you can identify two or three key practices and make the time to visit as soon as you can.

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

## IN BRIEF

## CNS Expands Global Education Outreach

The Congress of Neurological Surgeons has launched an ambitious, broad-scale initiative to enable neurosurgeons in developing countries to access up-to-date neurosurgery education via the Web regardless of where they practice and the resources available to them. Called the CNS World Wide Webinar Program, the offering—a philanthropic project targeting neurosurgeons in 36 economically underdeveloped countries—includes education in cerebrovascular, epilepsy, pediatric and neuropathology topics, among others.

The program will allow neurosurgeons no-fee access to the education through the CNS Webinar Library, at http://w3.cns.org/university/webinar/www.asp.

## AMA Issues Guidance on Employment Issues

In response to the overwhelming shift toward hospital and health system employment of both specialists and primary care physicians—nearly two thirds of U.S. physicians are opting for employed positions–the American Medical Association has developed a new document to identify and address some of the problematic areas that have arisen in wake of the mega-trend. Some employed physicians are reporting issues with economic interests intervening in care patterns, vague or inordinately punitive performance metrics tied to compensation, and employment termination disputes.

The "AMA Principles for Physician Employment" looks at such issues as compensation structure clarity, conflicts of interest, medical decisionmaking and referral decision restrictions, and peer- and performance-review considerations. To obtain a copy, go to http://www.ama-assn.org/ama/pub/news/news/2012-11-13-ama-adopts-principles-physician-employment.page.

# Crafting the Compelling CV

## Neurosurgeons searching for an opportunity should avoid cutting corners in such an important document

By Bonnie Darves

In the physician job-search realm, there's an inordinate focus these days on keeping supporting documents brief and rendering them in an almost clipped concision. The rationale, so the argument goes, is that we're all too rushed and too information-overloaded to read anything longer than roughly a page.

Although there's some wisdom in that, it's probably even wiser to avoid going overboard—or "underboard," as the case may be—with the physician curriculum vitae (CV). The cover letter is a candidate for a solid one-pager, but the CV should be much more expansive, advises James Tysinger, PhD, vice chair for professional development in the University of Texas Health Science Center in Austin. "It's very important to end up with a CV document that reflects your experience," he says. "What I usually see, instead, is that physicians go overboard in the cover letter and then omit key details in their CVs—because they've heard some myth that CVs should be a single page."

> **"It's very important to end up with a CV document that reflects your experience. What I usually see, instead, is that physicians go overboard in the cover letter, and then omit key details in their CVs—because they've heard some myth that CVs should be a single page."**
>
> **- James Tysinger, PhD**
> *University of Texas Health Science Center*

Dr. Tysinger, who has counseled job-seeking physicians for nearly two decades and frequently makes presentations on preparing associated documents, cites the example of a physician's application he encountered recently. The physician was eyeing a department-chair position, but his CV was only a single page. "That clearly doesn't provide enough detail for someone who is going for a senior faculty position," he says, adding that a department considering such an application would likely expect the CV to run at least three pages—possibly longer. It is generally expected, Dr. Tysinger notes, that any physician who is applying for an academic position will submit a highly detailed CV.

Neurosurgeons who are just starting a job search and may be sending out their CVs broadly initially might consider writing two versions—a condensed two-page "highlights" CV and a four- to five-page document to send as a follow-up when more detail is requested or when the opportunity is one that they're highly interested in pursuing. For example, the detailed version should include a complete description of clinical activities and teaching experience, with a focus on any experience that's above and beyond what a typical resident might have accomplished.

In any event case, the neurosurgeon who crafts Version 1 and Version 2 should make it clear to recipients that both a condensed and complete version are available. The shorter version might omit all but recent articles in high-profile peer-reviewed publications, for example, while alluding to the availability of the complete list on request. Another option is to create an addendum to list invited presentations, in-progress work or pending patents, research projects and non-peer reviewed publications, among other less crucial information.

Following are other tips for producing a compelling CV:

**List all positions and experience chronologically, but lead with the titles first rather than the dates.**

Prospective employers will be more interested in what you've done and the leadership roles you have assumed, than what the actual dates were. That detail can be included at the end of the line, as in: Chief Neurosurgery Resident, Metropolitan Medical Center—2013-2014. Use the same detail-first, dates later convention in listing degrees, certifications, licenses, professional society memberships and honors or awards.

**Do include specifics of above-and-beyond and extracurricular appointments and activities.**

For neurosurgeons just out of training, it's important to include details of committee participation, special assignments (such as patient safety improvement initiatives or curricula development) and professional society involvement. Prospective employers are also interested in knowing about community service or volunteer work, even if it's not directly related to medicine.

**Ensure consistent formatting throughout.**

It's a minor detail, perhaps, but inconsistent formatting can be annoying to the reader/recipient. So, if you bold clinical positions or use a colon to introduce a list or incorporate a dash between dates, rather than the words "for" and "to," do so throughout the document.

**Choose a highly readable font and font size.**

You may be partial to fancy serif fonts such as Baskerville or some of the newer-looking "blocky" fonts such as Copperplate, but it's best to reserve those for other kinds of non-professional documents. Stick with either commonly used sans-serif fonts like Arial or Calibri, or the standard Times Roman serif font. Also ensure that the chosen font is large enough—at least 11-point type—so that potential reviewers with aging eyes don't have to pull out a magnifying glass to get through the document.

## LEGAL CORNER

By Roderick J. Holloman

**Q: I have been offered an opportunity to practice in a setting and structure that would be roughly 80% clinical duties and 20% academic—a combination of teaching and research. This position is exactly what I am looking for, and I am very interested. However, there is one significant concern right now: The productivity benchmarks for a bonus, as the organization's contracts are structured, appear to be based purely on physicians who are in 100% clinical positions. I do not want to lose this opportunity, but I would prefer that my productivity be evaluated on an apples-to-apples basis. How should I address this with the prospective employer?**

A: This is a very important consideration, understandably, but it needn't turn into a deal-breaker for you. One relatively simple way to resolve the issue would be to structure the productivity-bonus structure to reflect your actual expected work breakdown.

In other words, you could propose that your productivity be measured against 80% of the median productivity of your colleagues who are working 100% clinical time. If the employer is unwilling to structure your compensation in this manner, you could propose an alternative approach—that you receive a monthly teaching/research stipend (e.g. $2,500 per month). The stipend could be structured to make up for what you stand to "lose" because of the time your academic responsibilities will consume, thereby reducing your clinical productivity.

**Q: I have just received an employment contract for a combined academic/clinical position that I would like to accept. The issue is that the contract is somewhat abbreviated, and does not specify my call schedule, my weekly work schedule or the allocation of my time among my expected research, clinical and administrative duties. Should the contract absolutely include these items?**

> "One relatively simple way to resolve the issue would be to structure the productivity-bonus structure to reflect your actual expected work breakdown."

A: Yes, at a minimum it should the breakdown of your time allocation by percentages (e.g. 80% clinical time, 10% administrative time and 10% percent for your research activities. Additionally, if you have a preference for the campus or practice locations where you will practice, your contract should specify these details.

Other items that should be included in the contract include:

- Annual vacation allowance and any related conditions
- Any restrictive covenants (such as a prohibition against working for a local competitor for a specified period following the termination of the employment
- The basis for termination of employment, and the number of days of advance notice required to terminate without cause
- Benefits, such as insurance, retirement plan offerings and fringe benefits

**Q: The job market for my particular neurosurgery sub-specialty is not the best at the moment. I have been offered an opportunity with a teaching hospital that includes good compensation and benefits, but the problem is that I do not want to teach. This is my only offer at present, and suffice it to say that I do not want to scare off the employer by noting my preference not to teach. How should I play this?**

A: If you are absolutely certain that you do not want to teach, I would strongly suggest that you continue your search for employment. I mention this because while you may reconcile yourself to teaching for a while, eventually your lack of enthusiasm for this component of the position (unless you change your views) will likely become apparent. And it makes no sense to have your "job record" tarnished by lackluster performance in any area.

However, if an undefined period of unemployment is not an option, you should discuss your preferences with the department chair. First, ask what your specific teaching duties will be. Then, suggest that while you are amenable to teaching, you think you could add more value in other areas, such as clinical productivity and/or research. Be prepared to make a concrete suggestion in this regard, so that it might be viewed as a win-win.

*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 be reached at 202-572-1000 or rjholloman@hollomanlawgroup.com.*

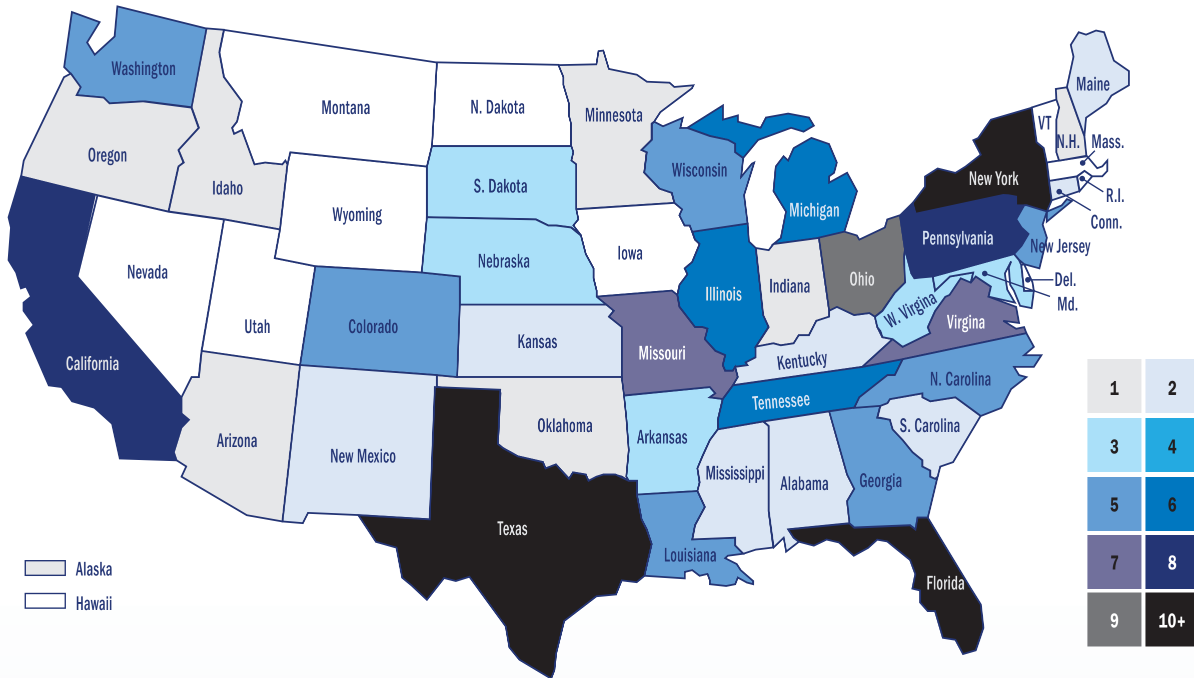
**CONTRIBUTORS WANTED!**

**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**

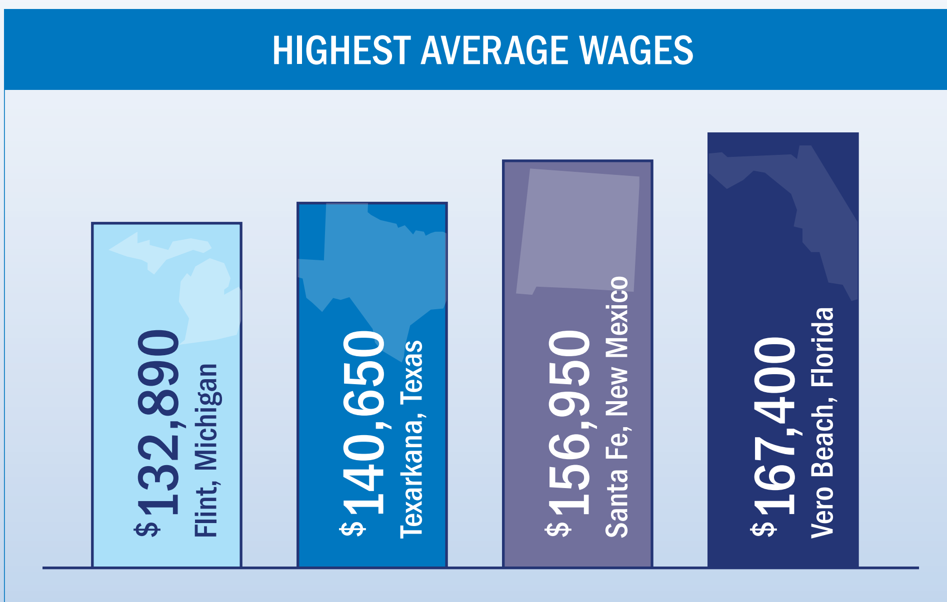
## Where the Jobs Are

### A snapshot of states where neurosurgery positions are currently available




Sources: Harlequin Recruiting, American Association of Neurological Surgeons, Career MD, New England Journal of Medicine, Journal of Neurosurgery, Academic Keys, MedCareers, and PracticeLink

## Neurosurgery Physician Assistant Compensation Varies Widely




Physician assistants (PAs) have long played a role in neurosurgery practices, and are considered a vital component of the surgical team in many practice settings–private, privademic and traditional academic. But as the services delivery model changes and the neurosurgeon shortage shows little sign of abating in the near term, neurosurgical PAs, particularly those with substantial experience, are in increasing demand in the marketplace. They're also commanding higher salaries in certain markets.

Recent data from the U.S. Bureau of Labor Statistics, published in a May 30, 2014, Becker's Hospital Review article, identified the following four areas–some of them a bit surprising–in the country where neurosurgery PAs earn the highest average wages, compared to their counterparts in other regions:

Vero Beach, Florida – $167,400
Santa Fe, New Mexico – $156,950
Texarkana, Texas – $140,650
Flint, Michigan – $132,890

A recent survey by the website Indeed.com also demonstrated the neurosurgical PA compensation variations that can occur in a single market. In the New York City area, the salary range for neurosurgery PAs ranged from a low of $111,000 to a high of $176,000.

*– Bonnie Darves*

# PA PROFILE

## Joe Hlavin, M.S., PA-C

### Current

Neurosurgical Physician Assistant, The Texas Brain and Spine Institute, Bryan, Texas; and program director for the Texas A&M Health Science Center Postgraduate Physician Assistant Residency in Neurosurgery

### Career Path

Since becoming a neurosurgical PA in 1992, Mr. Hlavin has combined clinical practice with training neurosurgical PA residents. He has held numerous leadership positions as a PA liaison to the American Association of Neurological Surgeons (AANS). A former president of the Association of Neurosurgical Physician Assistants, he also founded and heads the Senior Clinicians Society. He is currently a director of the SW conference for the American Association of Surgical Physician Assistants.

### Up Next

Completing a Ph.D. in human resource development at Texas A&M, which he will use to support his career expansion into such areas as leadership and change management in healthcare and neurosurgery practice.

"My ultimate goal is to work within a hybrid system to create a position that enables me to train, lead and still maintain a part-time clinical practice," Mr. Hlavin said. "My goal in pursuing the doctorate degree is to push my boundaries to encompass a leadership role in PA training."

### Why He Chose Neurosurgical Practice

"It's an exciting field that's constantly changing with the rapid clinical and technology advances," he said. "I enjoy the mix of surgical and clinic practice that neurosurgical PA practice provides, and it has been exciting to watch how our field has become more recognized as our patient care roles and scope have expanded. I also love teaching PAs and watching them develop—it's very gratifying when your residents graduate and move into the field."

### Advice to PA colleagues

"If you want to expand your career and become involved in management, look for opportunities to become more involved in hospital and clinic leadership roles. There's always a place for PAs who are willing to do this work," he said. "There are also opportunities on the clinical side, particularly for neurosurgical PAs who are interested in improving neurosurgery teams and care continuity, especially now, when patients are becoming more involved in the care they receive."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- 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

### New York City Area Neurosurgeon Opportunity

A private practice in the New York City area is seeking a BE/BC neurosurgeon to join its group. The practice has preference for a candidate with fellowship training in either spine or neuro-oncology. The incoming neurosurgeon will take call at two hospitals, both in the Brooklyn area.

The incoming neurosurgeon can choose between a hospital employed or group employed position. The call and schedule are flexible, however, the practice seeks a neurosurgeon who ideally would take call or clinic four days a week. The group does mostly general neurosurgery, and it is an all-adult practice, with an emphasis on spine, both trauma and elective. Both facilities are level I trauma centers.

The group is offering a competitive salary plus full benefits, with a productivity-based incentive. The group also has academic affiliations with many of the New York City universities, and adjunct faculty appointments are possible for the incoming neurosurgeon.

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