

Neurosurgery Compensation Update

Compensation Rising, but Sustainability of High Starting Salaries in Hospital-Employed Sector Prompts Concerns

By Bonnie Darves

All of the major national surveys that track neurosurgeon compensation reported increases over the past year, to varying degrees. The 2015 NERVES (Neurosurgery Executives' Resource Value and Education Society) survey, the most comprehensive and detailed in the industry with 692 participating neurosurgeons, found an overall compensation

whose pediatrics practice base is 75% or greater of total patient services.

The compensation increase in neurosurgery was pretty much across the board, regardless of practice type, with hospital-employed neurosurgeon compensation topping the charts. MGMA, for example, found a spread of a \$792,256 (hospital/health system-owned) median to

"Today, compensation is still driven a lot by productivity, and while that will still be important in the future, it will become less important as we move toward value-based metrics."

— Thomas Dobosenski, President, AMGA Consulting



hike of 3.2%, to a median of \$692,000. The American Medical Group Management Association (AMGA) reported a more modest increase—1.2%—to \$736,924 median, for its 456 participants.

The Medical Group Management Association, whose annual Physician Compensation and Production Report survey findings are often used as a benchmark generally in setting physician-compensation structures across specialties, pegged the median at \$772,914 in its 2016 report, up about 3% from \$747,066 last year. That survey included 338 neurosurgeons.

In pediatric neurosurgery, the AGMA 2016 Medical Group Compensation and Productivity Survey reported median compensation of \$778,853 among the 16 participating groups, two-thirds of which are large multispecialty practices. The NERVES survey reported a median compensation of \$554,000 for neurosurgeons

\$706,740 for physician-owned practices. That's little surprise, specialty-sector observers maintain, and continues the trend seen in recent years.

"Hospital-employed neurosurgeons continue to lead in compensation, and our perception is that hospitals simply have a greater amount of resources available to employ neurosurgeons—so they can compensate at a higher level, at least currently," said Michael Radomski, CPA, who chairs the NERVES survey and is chief financial officer of Mayfield Clinic Brain & Spine in Cincinnati. "Whether that will change remains to be seen, but overall, the neurosurgeons whose compensation was highest on average were either hospital employed or practicing in small groups."

Thomas Dobosenski, president of AMGA Consulting, also questions whether the hospital-employed compensation differential will persist, given the market conditions that are generally producing downward pressure on neurosurgery

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Neurosurgery Compensation Update

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reimbursement. Neurosurgeons leaving training who are enticed to consider the top-paying offers should look well beyond the current dollars to determine whether such compensation levels are attainable over the medium term and sustainable over the longer term, he cautioned.

“It’s one thing to get the high compensation you’re looking for at the time, but what neurosurgeons really need to find out is what’s the sustainability of that compensation over time?” Mr. Dobosenski observed. “They need to ask how affordable the neurosurgery compensation plan is within the organization—can they afford to continue paying at that level long term?” To determine that, the prospective joining neurosurgeon would have to know how financially healthy the employing entity is, from the standpoint of its operating margin, position in the marketplace and relationships with payers. In his view, a healthy nonprofit organization would generally need a 3% to 5% operating margin to sustain a high compensation levels in a costly service such as neurosurgery. “If the margin is coming in at 1%, I think a neurosurgeon would have to think long and hard about joining that organization,” Mr. Dobosenski said, at least from the standpoint of a high starting salary being sustainable.

Regional compensation differences see little change

The other non-news, which all three surveys found, is that regional compensation differences in the specialty—some of them quite wide—persist in neurosurgery as they do in many other specialties. Here’s how those numbers played out in median neurosurgery compensation, where figures are available:

- **AMGA:** Southern—\$751,999; Northern—\$811,250; Western—\$695,274; Eastern—\$647,563
- **MGMA:** Midwest—\$850,000; Southern—\$750,718; Western—\$736,838; Eastern—\$683,822

The NERVES survey found similar rankings, with highest compensation in the South, followed by the Midwest, East and West regions. “This is consistent with recent history,” Mr. Radomski observed.

for physicians’ services, but in situations where demand outstrips supply or recruiting challenges drive up compensation, what constitutes FMV can fluctuate significantly. (See chart for how those MGMA findings stacked up.)

MGMA Median Regional Compensation by Practice Type		
	PHYSICIAN-OWNED	HOSPITAL/HEALTH-SYSTEM-OWNED
MIDWEST	\$667,930	\$871,172
EASTERN	\$502,941	\$770,649
SOUTHERN	\$707,410	\$785,387
WESTERN	\$822,542	\$771,389

On the regional level, a more detailed look at the MGMA compensation findings uncovers some interesting differences, according to David Gans, MSHA, who is a senior fellow in industry affairs for the organization. Most notably, the median-compensation spread between practice types in all regions except the West was substantial, with hospital/health system-owned practices paying higher levels in most cases.

“I think what we’re seeing is that in the hospital environment, there’s greater opportunity for cross subsidy, from the standpoint that the neurosurgery services are needed to support the mission of the organization,” said Mr. Gans, who has long been involved in the MGMA survey. “And it’s entirely possible that in intensely competitive areas, you will see hospitals pay more for a service—whether it’s neurosurgery or family practice—than could be sustained by other physician practices in the region based purely on their [payer] contracts.”

Mr. Gans noted that hospitals must abide by the federal regulations that stipulate that they cannot pay more than fair market value (FMV)

Michael Heaton, a partner in the Indianapolis accounting firm Katz, Sapper & Miller, which conducts the NERVES survey on an independent basis, concurs with Mr. Gans that the physician-supply issue in neurosurgery is a key factor driving up entry-level compensation. “We continue to have a supply issue not just in neurosurgery but in almost all specialties, and it’s putting a lot of upward pressure on starting salaries,” Mr. Heaton said, adding that the pressure is particularly intense on the hospital-employed realm. Overall, the NERVES survey found a major difference between hospital-employed and private-practice median neurosurgeon compensation, at \$916,000 and \$794,000, respectively.

Looking beyond the dollar sign

Like Mr. Dobosenski, Mr. Heaton thinks that neurosurgeons considering positions at the top of the compensation range should ask probing questions about the sustainability of the promised income given the pressures on hospitals today. “I think that sometimes candidates who are evaluating opportunities

are not asking the right questions about the hospital-employed positions,” he said, such as what the organization’s market position is and whether the practice is the optimal size for the organization and market. Neurosurgeons also should try to discern whether the needed financial and operational infrastructure exists to support the practice over the medium term.

“It’s not just about the practice’s economics and the compensation they’re [currently] offering,” Mr. Heaton said. “Candidates need to know how the practice is positioned in the marketplace and what its relationships are with payers, and health systems, in the case of private practices.” In particular, he advises neurosurgeons to ask where the hospital or the practice’s leadership sees the organization in five to 10 years, to ensure the group is equipped to weather the reimbursement challenges ahead. “It’s also important for candidates to keep in mind that there are independent neurosurgery groups out there that are doing very well,” he added, financially and competitively. Generally, neurosurgery has been slower to move to the employed model than many other specialties, research has shown.

Todd Barnes, MBA, the longtime administrator of the neurosurgery and neurology departments at the University of Oklahoma Health Sciences Center, urges neurosurgeons starting out to be particularly wary of compensation guarantees from hospitals that seem too good to be true.

They just might be—from the standpoint of what happens a year or two down the road, Mr. Barnes observes. As such, neurosurgeon candidates should focus more on the longer-term financial earnings potential, if they’re likely to stay in the region under consideration for several years, he advises.

“We’re seeing some hospitals offering neurosurgeons starting salaries of \$700,000 to \$800,000 right out of training, where a group in that region might offer closer to \$550,000 to \$600,000. What neurosurgeons need to know about the high compensation guarantees,” Mr. Barnes points out, “is what happens to that compensation in the second or third year.” For example, he has heard of situations in which young neurosurgeons find that the productivity (in work relative value units or WRVUs, the typical measure) required to sustain their initial compensation levels after the guarantee ends just aren’t feasible, for clinical, logistical or volume reasons.

“The neurosurgeon could end up earning \$150,000 less in year two or three,” Mr. Barnes said. In addition, he cites situations in which inordinately high starting salaries are accompanied by very high call demands, such as one in two or one in three days, and is not compensated separately but instead is part of the base compensation. “I think it’s important to remember that call pays can add up to six figures annually, so neurosurgeons should make sure they’re looking at the complete picture of potential

compensation, including call, both initially and over the mid-term,” he said, when they compare offers.

Mr. Radomski also supports the longer-term view approach to evaluating practice opportunities. Neurosurgeons should understand that if they join a private practice or an academic group, they might receive a lower starting salary, he acknowledges, but might also have the potential for higher compensation than their hospital-employed counterparts five years down the road and more income potential from nonclinical activities. However, many young physicians don’t look that far ahead, which presents a challenge to hiring practices that must compete with high starting salaries, he points out.

“I think it’s a matter of balancing expectations, so that neurosurgery residents coming out understand that although they come in at an entry-level salary, that compensation could ramp up pretty quickly as they become more experienced or when they become an owner,” Mr. Radomski said. For instance, the NERVES survey found that neurosurgeon compensation from ancillary services and other non-direct patient care sources made up 20% of total compensation last year—and many neurosurgery practices are expanding such services.

Following are other key findings from the NERVES survey of potential interest to job-seeking neurosurgeons:

- The 2015 NERVES report included participation from 90 practices and 692 neurosurgeons, compared to 96 practices and 580 neurosurgeons in 2014, and 63 practices and 415 neurosurgeons in 2013.
- Based on a specialty definition of greater than 50% of their services, spine specialists lead at a median compensation level of \$774,000 followed by vascular, cranial, functional, pediatric, general, pediatric cranial and other neurosurgeons.

“I think that the neurosurgery call-pay marketplace has found its high-water mark. We see a lot of contracts renewing at the same numbers.”

— Michael Heaton, Partner, Katz, Sapper & Miller

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Neurosurgery Registry Emerges As Forerunner in Quality-Measurement Movement

By Bonnie Darves

In an evolving healthcare environment with an intensifying focus on measuring care quality and demonstrating the value – to patients, payers and, potentially, policymakers – of that care, specialties such as neurosurgery can find themselves in a visible and somewhat vulnerable position. Many procedures neurosurgeons perform are both high-cost and high-risk, and until recently quality-measurement tools and methodologies that have predominated have been too generic to be either useful or applicable in neurosurgery, putting the specialty at risk for non-meaningful and possibly inaccurate “valuation” of surgical services.

The QOD, a collaborative effort of the American Academy of Neurological Surgeons (AANS) and other neurosurgery organizations, operates as a continuous clinical registry for neurosurgical procedures and practice patterns. To date, the registry has collected and analyzed data on nearly 40,000 patients who have undergone lumbar, cervical and cerebrovascular procedures, and in February 2016 implemented reporting for deformity-associated procedures. A module for brain tumors is forthcoming. (See sidebar.) The QOD recently expanded its scope to encourage other specialties, such as radiology, pain

“This is a grass-roots effort, and the QOD needs neurosurgeons who are willing to lend their expertise or who are just eager to help.”

– Kimon Bekelis, MD



Fortunately, two recent developments are changing that picture. On the governmental level, the Centers for Medicare & Medicaid Services (CMS) established the Qualified Clinical Data Registry (QCDR) reporting option that now enables specialty groups to create and report what they deem as relevant quality measures.

On the specialty level, a pioneering effort begun in 2012 to create a national neurosurgery-specific repository of meaningful data on the efficacy and outcomes of surgical procedures has been enormously successful. Despite its brief existence, the Quality Outcomes Database (QOD), formerly known as the National Neurosurgery Quality and Outcomes Database, has emerged as a leading clinical registry, positioning neurosurgery ahead of the curve in the health reform-driven push to demonstrate care value.

management and internal medicine, to contribute relevant data to the registry.

In addition to helping neurosurgery establish risk-adjusted national benchmarks for procedures’ quality and cost, the QOD also enables neurosurgery practices and hospitals to analyze morbidity and outcomes in near real time—a benefit that retrospective clinical trials cannot deliver because of the unavoidable time lag.

“We all strive to produce the best outcomes for our patients, but it’s difficult to see how we perform without comparisons to other physicians and other patients. The QOD is a powerful tool for enabling neurosurgeons to gauge efficacy and identify where improvements might be warranted,” said Kimon Bekelis, MD, a cerebrovascular/endovascular fellow at Thomas Jefferson University Hospital in Philadelphia and an Instructor at The Dartmouth Institute for Health Policy and Clinical

QOD: By the numbers

Following are the most recent (August 2016) participation and patient numbers for the Quality Outcomes Database, formerly known as the National Neurosurgery Quality and Outcomes Database (N2QOD).

LUMBAR:

Total contracted sites = 83
Total active sites = 72
Total patients in registry (screened) = 27,318
Patients—registry accrual = 23,491
Participating states = 32
3-month follow-up = 75.3%
12-month follow-up = 67.3 %

CERVICAL:

Total contracted sites = 53
Total patients in registry (screened) = 10,240
Patients—registry accrual = 8,592
Participating states = 32
3-month follow-up = 77%
12-month follow-up = 68.6 %

CEREBROVASCULAR:

Total contracted sites = 12
Total patients in registry (screened) = 828
Patients—registry accrual = 499
30-day follow-up = 57.4%

DEFORMITY*:

Total active sites = 38
Total patients enrolled = 389
Patients—registry accrual = 320
3-month follow-up = 74.9%
12-month follow-up = 59.5%
*Rolled out in February 2016

Practice. “An important component of the registry is the research that comes from these numbers.”

In the coming years, the QOD data will help facilitate multi-center trials and cooperative

clinical studies, noted Dr. Bekelis, who has co-authored articles on the registry and is the AANS Young Neurosurgeons Committee liaison to the QOD. He has led research projects on outcome predictive modeling, comparative effectiveness and resource utilization. The registry will be hugely beneficial to the neurosurgery specialty as CMS and other entities increasingly require and rely on patient outcomes data to structure reimbursement, Dr. Bekelis added.

The QOD is chaired by Robert Harbaugh, MD, the director of Neuroscience Institute at the Penn State Milton S. Hershey Medical Center and the Penn State College of Medicine who has played a key role in the registry's development and growth. Vice-chair Anthony L. Asher, MD, co-medical director of the Carolinas Healthcare System Neuroscience Institute, has also been

instrumental in furthering the registry. "Without the support of the former and the unyielding dedication of the latter, this endeavor would not have been possible," said Dr. Bekelis. He added that AANS staff, physician volunteers and statisticians have provided significant support. "They've put a tremendous amount of work into this and have turned it into one of the premier clinical registries in the country," said Dr. Bekelis.

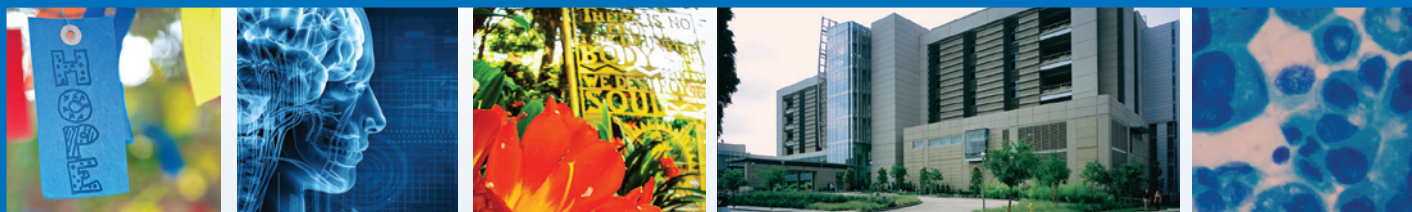
Participation opportunities abound

Although the registry is well established, QOD's leadership would like to see the participant base increase in the years ahead, particularly in the academic sector. Dr. Bekelis urges young neurosurgeons whose organizations or practices are not involved in the registry—which is open to practices of all

sizes and types—to consider leading such efforts. "Any size practice can participate in the registry, but effective participation really requires an institutional commitment. And that's where young neurosurgeons might play an important role as they move into their careers," Dr. Bekelis said.

He added that QOD involvement opportunities are also plentiful on the national level, where there's an active committee structure representative of all neurosurgery subspecialties. "This is a grass-roots effort, and the QOD needs neurosurgeons who are willing to lend their expertise or who are just eager to help," he said.

For more information on the registry, go to www.neuropoint.org/NPA%20N2QOD.aspx.



NEUROSURGICAL ONCOLOGY FELLOWSHIP

The Division of Neurosurgery at City of Hope, is now accepting applications for our Neurosurgical Oncology Fellowship Program for the 2018-2019 academic year (non-ACGME). The fellowship is a one-year program that offers comprehensive training in advanced brain and spine tumor therapy in a multidisciplinary environment. City of Hope is a National Cancer Institute-designated comprehensive cancer center located just northeast of Los Angeles.

Our focus on basic research keeps us on the cusp of big discoveries. We are the only cancer center in the country that is injecting cancer-killing immune cells directly into the brain to treat patients with advanced brain tumors — in an effort to produce a more potent response. And we were the first research institution in the world to use neural stem cells in patients with glioblastoma.

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To apply, interested candidates completing neurosurgical residencies within the U.S. should send a letter of application and curriculum vitae to:

Mike. Y. Chen, M.D., Ph.D., Fellowship Director
City of Hope
Division of Neurosurgery, MOB 2001A
1500 E. Duarte Road, Duarte, CA 91010
mchen@coh.org



Neurosurgeon Mentorship: Thoughts on Seeking, Sustaining It

The value of having a good mentor is perhaps most palpable when neurosurgeons are approaching a major decision—like choosing a first practice opportunity—or dealing with a crisis in which the physician's personal and professional lives intersect in a challenging way.

To explore the realm of mentorship, including how to find a mentor and maximize the relationship for person and mutual benefit, Neurosurgery Market Watch spoke with two neurosurgeons who have long been involved in mentorship activities.

Deborah Benzil, MD, FAANS, is a neurosurgeon with the multi-specialty group CareMount Medical, in Mount Kisco, N.Y. and a partner in the consulting firm Benzil Zusman, LLC. She also teaches socioeconomic education courses for physicians at Columbia University, covering issues of importance as they transition to practice.

Julie Pilitsis, MD, PhD, FAANS, is chair of the Department of Neuroscience and Experimental Therapeutics at Albany Medical Center and professor of neurosurgery at Albany Medical College in New York. Involved in mentorship activities for the AANS, Dr. Pilitsis is a former chair of Women in Neurosurgery.

What does a solid mentorship relationship look like?

Dr. Benzil: The core of a good mentor relationship is that it should be mutually beneficial, and it should evolve over time. It's also got to be open—the two parties have to be able to talk about the good things and the bad things, and young neurosurgeons need to be open to receiving critical but constructive feedback. Good mentoring should reach the point pretty quickly where the mentor is not just a role model but someone you can interact with honestly and who can be honest with you—for example, if the mentor thinks your surgical skills are great but you need to work on how you talk with patients' families.

Young neurosurgeons should keep in mind that they might need more than one mentor, depending on what they want to do. For example, I have mentored neurosurgeons on women's issues that arise in our field, and I have mentored neurosurgeons on leadership development.

What are some of the barriers, perceived or actual, to young neurosurgeons seeking mentorship or guidance?

Dr. Pilitsis: I think that sometimes residents are reluctant to ask questions about clinical matters that are important to them or that they're struggling with, because they're possibly concerned about revealing what they don't know. In other cases, residents might be reluctant to approach an attending or potential mentor because they think the person is too busy.

In fact, young neurosurgeons will find that most of their senior colleagues are more than willing to help—that they just need to reach out. Because in fact, we want to hear more from our younger colleagues and to be available to them for counsel. That's something we're working on as a professional organization (AANS) through our leadership and with our established resident mentorship program—finding ways to draw attention to the need for more formal mentorship activities in residency programs generally.

What key advice would you give neurosurgery residents and fellows on finding mentors or working with mentors, or seeking guidance from attendings?

Dr. Pilitsis: If you're trying to evaluate potential opportunities or explore practice settings, start by reaching out to someone [an attending] in your program you're comfortable with, and ask questions. Even



Julie Pilitsis, MD



Deborah Benzil, MD

if that neurosurgeon can't answer all of your questions, about practice settings particularly, that faculty member likely can direct you to, or facilitate a connection with someone they know who can help.

Young neurosurgeons working with mentors also need to learn how to “manage up.” After you meet with the mentor or engage in an exchange, and the mentor offers to help,

AANS Mentorship Program Helps Meet Residents' Needs

The AANS has developed a robust resident mentor program in which trainees who make the request will be paired with a more senior neurosurgeon, based on the kind of assistance they're seeking, to the extent possible, based on the young neurosurgeon's responses to a survey. In most cases, mentees will work with neurosurgeons who are outside their program and possibly geographic area as well.

For details, go to: www.aans.org/Young%20Neurosurgeons/Residents/Resident%20Membership/Resident%20Mentoring%20Program.aspx.



send a thank-you e-mail message reminding the neurosurgeon of the encounter. If it's appropriate, consider following up through the senior colleague's secretary or assistant, to reiterate the request. That way, the [mentor/senior] neurosurgeon sees that the matter is important to you.

Finally, residents need to make themselves available to their mentors or attendings when those neurosurgeons have time to work with them. As a mentor, one thing that drives me nuts is when I tell "mentees" what works for me, and they say they're too busy at that time. It's important to be very respectful of your mentor's time, and it's fair to assume that your mentor is always busier than you are.

Dr. Benzil: Ideally, neurosurgery residents would start trying to find a potential mentor relatively early in training, by first identifying a faculty member who appears to have the capacity and willingness to be a mentor.

Then, you can approach the physician indirectly or directly.

Indirectly, you might just start a somewhat casual conversation with Dr. X about what you think you do well and where you might need to improve—and then ask for the attending's perception of your work or what you have stated. As you start to get feedback, you could expand the discussion—for example, by saying, "Dr. X, I know that you have a family and school-age children. Would you be willing to talk about the challenges of balancing that?" Hopefully, over time that interaction will grow and become deeper.

Directly, you could just be very straightforward: Ask to set an appointment, and then directly ask the neurosurgeon to function as your mentor. To be politically correct, though, in the case of approaching a less senior attending, there might need to be

some caveats. You could say, "I think that our program director and department head are great, but it's my impression that for an actual mentoring arrangement, you and I might be a very good match. Would you be willing to serve in that role?"

How has your mentor—or mentors—been instrumental in your own career development?

Dr. Pilitsis: They've been helpful in many ways, but I remember two conversations very vividly. I called one of my medical school mentors when I was exploring fellowship options, because I felt I needed guidance from someone who was "distant" from my own program.

In another situation, when I took a first practice opportunity and it wasn't working out very well, my mentor from residency was invaluable in helping me get through that period and move forward.

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- Starting salaries varied considerably depending on specialty, as follows: vascular (\$549,000), spine (\$514,000), cranial/skull base (\$492,000) and pediatric (\$479,000).
- Practice-funded professional development costs have a median value of \$10,000.
- Practices planning to recruit physicians and/or advanced practice clinicians in the next year increased from 60% to 65% in 2015.
- Only 12% of neurosurgery practices surveyed have been approached by a health system regarding employment.

Another area where job-seeking neurosurgeon candidates should be asking more questions in reviewing compensation involves how well a prospective practice—whether it's private, academic or hospital/health system owned—

or there aren't any plans for making adjustments, neurosurgeons should be wary," he said. "Today, compensation is still driven a lot by productivity, and while that will still be important in the future, it will become less important as we move toward value-based metrics."

Call pay hits 'high-water mark'

A key factor in neurosurgeon compensation—call pay—is ostensibly undergoing a shift. As recently as five years ago, call pay for procedure-intensive specialties such as neurosurgery might have varied substantially from one hospital to another, or one region to another. But those differences are fewer now, most sources agreed, as such data becomes nationally reported and readily accessible. Call

"Our perception is that hospitals simply have a greater amount of resources available to employ neurosurgeons—so they can compensate at a higher level, at least currently. Whether that will change remains to be seen."

— Michael Radomski, CPA, NERVES survey chair and CFO, Mayfield Clinic

is prepared to function in a world where care quality is becoming a key factor in reimbursement. In particular, as government payors move toward quality-based incentives and penalty structures, and all payors gravitate toward risk-based or bundled payment models, neurosurgery practices must be equipped to perform under those constraints, Mr. Dobosenski maintains.

"I think the question neurosurgeons should ask is this: When was the last time the practice modified or adjusted the way it pays its physicians based on healthcare reform? If it's been 10 years,

pay rates have inched up over the last five years, but the daily rates as high as \$3,000 that were reported anecdotally, if rarely, appear to be going away, some interviewees suggested.

The NERVES survey, with its large participant base, provides a reliable barometer of call-pay trends. In the 2015 NERVES survey, median call pay at Level 1 trauma centers was \$2,425. Although that's up 33% from five years ago, per NERVES survey data, Mr. Heaton doesn't think that annual increases going forward will be as high. "I think that the neurosurgery call-pay marketplace has found its high-water mark,"

Working Hard for the Money

The continued uptick in neurosurgeon compensation is surely good news, but there's another side to the picture that's worth mention: Overall, neurosurgeons are working harder for the compensation they earn than they were a few years ago, some surveys found, yet others saw little change or a decline, as measured by work RVUs (WRVUs), the most commonly used productivity measure.

Following is the short take on how the surveys' productivity data panned out:

- MGMA: median WRVUs totaled 9,366 in the 2015, up only slightly from 9,252 last year, but well above the 2012 median of 8,689.
- AMGA: median WRVUs came in at 9,446, a 7% increase over last year. The most productive neurosurgeons were in the Southern region, where median RVUs hit 10,918, versus 9,735 in the Eastern region, 7,644 in the West and 8,712 in the Northern region.
- NERVES: WRVUs dropped by 5.2% from last year, continuing a trend seen for the last four years.

he said. "We see a lot of contracts renewing at the same numbers. And it's a self-fulfilling prophecy to some extent—because people pay for call based on the survey findings."

Ms. Darves, a Seattle-area healthcare writer, is editor of *Neurosurgery Market Watch*.

SEEKING NEUROSURGEONS TO JOIN GROWING NEUROSCIENCE INSTITUTE IN SOUTHWEST OHIO

Premier Health

Premier Health in Dayton, Ohio, seeks four neurosurgeons with expertise in complex spine, spine, and vascular neurosurgery, as well as general neurosurgery with an interest in trauma. The Division of Neurosurgery is seeking neurosurgeon(s) who are interested in having a robust clinical practice, teaching opportunities, program building, and research and device development. The neurosurgeons would join an existing practice of four neurosurgeons, which is a part of a rapidly growing Comprehensive Neuroscience Institute with divisions in neurosurgery, interventional neurology, neurocritical care and neurology.

The primary admitting hospital is Miami Valley Hospital, a state-of-the-art, 974-bed Level I Trauma Center and designated Primary Stroke Center. Premier Health Partners also comprises three other area hospitals, for a total of nearly 1,900 beds. The health system is affiliated with Wright State University, which offers support/protected time for basic science research interests, medical student and residency teaching opportunities, and collaboration with engineering for device development. Miami Valley Hospital is a teaching hospital for numerous residency programs, including general surgery, neurology and orthopedics. It offers many teaching opportunities, with the primary goal of establishing a new neurosurgery residency program.

Hospital & Practice Highlights:

- Busy cranial and spine clinical practice opportunity with call cover
 - Miami Valley Hospital currently runs 3-4 Block ORs with neuro-team coverage 5 days per week specifically for neurosurgery
 - 20 bed neuro-ICU with 24-hour neurocritical care service
 - Mid-level practitioner support
 - Stryker and Stealth Navigation
 - Varian TrueBeam at MVH
 - 3T MRI
 - Epic electronic health record (EHR) system
 - Academic appointment at Wright State University Boonshoft School of Medicine
 - Program building and leadership opportunities, including the eventual development of a neurosurgery residency program
 - Neuroscience and Engineering Collaborative Research Building currently under construction on Wright State University campus
 - Protected time for research including basic science, translational and clinical. New neurosurgery lab at Wright State University (*only 15 minutes from Miami Valley Hospital*) with countless opportunities to conduct research and network with others
 - Collaborative support from the Chair of Neurology & Brage Golding Distinguished Professor and Chair of Research in development of multi-disciplinary approach to patient care and cutting-edge research
 - Synergies with engineering department create opportunities in bioengineering, biomechanics and new-instrument development
 - 2 ROSA neurosurgical robots
 - Competitive compensation and relocation
- Contact Eric J. Sedwick, MBA, CPC, System Director
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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**

UPCOMING U.S. NEUROSURGERY EVENTS/CMES

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Complex Spine Surgery: Innovations in Practice

☐ November 11-12
Las Vegas, Nevada

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☐ November 11-13
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SVIN: Society of Vascular and Interventional Neurology Annual Meeting

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Brooklyn, New York

Pediatrics Craniomaxillofacial Surgery

☐ November 18-20
Phoenix, Arizona

Principles of Operative Treatment of Craniomaxillofacial Trauma and Reconstruction

☐ December 3-4
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☐ December 5-8
Orlando, Florida

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Global Spine Conference

☐ May 3-6
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LEGAL CORNER



Looking at Neurosurgeon Non-competes, Quality Clauses

In this new series, Neurosurgery Market Watch speaks with health law specialists about contractual issues and trends related to neurosurgery compensation and performance. In this article, physician and attorney Anthony Knoll, MD, JD, a partner with the Syracuse, N.Y., firm Cohen Compagni Beckman Appler & Knoll, PLLC, who specializes in physician contracts, offers a perspective on restrictive covenant clauses that hospitals, health systems and other hiring entities use to prevent physicians who leave the practice from providing their services to nearby “competing” practices for a specific time period.

He also talks about the relatively new trend toward connecting quality-metrics performance and annual compensation in employment contracts.

Q: In an environment in which some states are moving away from enforcing restrictive covenants—or “non-competes,” as they’re frequently called—and the health services marketplace is changing rapidly, how prevalent and how important are these agreements? How should neurosurgeons view such clauses in the overall context of a contract?

A: We’re still seeing these clauses, and they’re not going away. Physicians should consider them enforceable from the standpoint, at least, of the cost—in money and time—to

defend themselves if they leave a practice and the employer decides to launch a lawsuit to enforce the agreement.

For the most part, these restrictive covenants are still structured to prevent the departing physician from practicing within a certain radius of the hospital or practice—which might be 30 miles in a rural area, 10-15 in a suburban one or just a few miles in an urban area. Most are fairly standard and relatively reasonable, but I occasionally see something unreasonable, like a 50-mile radius in a suburban area.

However, we’re seeing some shifts in these clauses in certain urban areas that neurosurgeons should be aware of. In some markets where a lot of consolidation has occurred and health systems are gobbling up smaller hospitals, for example, the restrictive covenant, rather than spelling out a geographic distance will instead cite a specific competing hospital or health system. It might state: within two years of leaving the practice, the neurosurgeon cannot work for health system Y or hospitals A, B or C. Others I’ve seen might restrict the surgeon from going to a particular large health system, but not to smaller hospitals or systems in the same urban area.

Of course, this isn’t a scientific sample, but it’s interesting because it’s something we weren’t seeing before—these clauses tended to be pretty vanilla. And the fact

that these are cropping up might mean that non-competes matter more now than they did five years ago. It’s a byproduct of this mega-merger trend.

Q: To what extent are quality-metric performance clauses that affect actual compensation showing up in employment contracts, and should neurosurgeons be concerned about them?

A: Organizations are trying to move in this direction, but in my opinion, it’s hard to draft objective, consistently fair criteria. My general feeling about this is that if the neurosurgeon gets a bonus out of it, it’s found money. What we’re not seeing very much of is potentially punitive quality structures—that the surgeon is going to make \$500,000 a year, but 10% of that amount is at risk based on the surgeon’s performance in, say, five particular areas. What we are seeing, with few exceptions, is that physicians’ performance on quality measures might increase compensation but not lower it.

I think this is a tough area for practices and hospitals. They’re trying to use a mechanism and some objectivity so that when the hospital is going to allocate a pile of money [for quality performance] to a group, there’s some defensible way to give more of the bonus money to the stellar surgeons who perform well and have a great reputation with patients and colleagues than the ones who are just scraping by. But the differentiation I’ve seen to date is pretty minimal, which is why I advise physicians not to get overly concerned about these clauses in terms of their compensation. Psychologically, if you’re not betting on it, you’re not going to worry about it.

“Other [non-competes] I’ve seen restrict the surgeon from going to a particular large health system but not to smaller hospitals or health systems in the same area.”

What Residency Doesn't Teach You...



By Daniel M. Aghion, MD

A few years ago, I wrote about the silent struggle that residents and fellows face within their own programs to ensure that they come out with adequate training, sound clinical decision-making ability and the other skills we need to become capable neurosurgeons.

"Somehow," I wrote, "it seems to work out."

Here's how. During my fellowship year, I found myself asking over and over, where do I want to work? With whom do I want to work? What kind of practice do I want to be a part of? Most of those questions fell on deaf ears, as I soon realized that truly, only I can answer those questions.

I quickly realized that the type of person we are, the type of physician we will be, and even how we treat our patients was determined far before medical school, long before chief residency, and well before fellowship—with all of our predispositions and biases that existed before we embarked on this prolonged journey.

So, now the decision became much more clear. I had to find good people to work with, physicians who did the right thing, and surgeons who were happy doing what they were doing. And I had to find all of this in a desirable location. This was the challenge before me.

I started exploring. Bombarded with slide shows and recruiting people, it was difficult for me to easily decipher what really mattered. Did

management, to cite key ones—also required close examination.

Then there was the financial due diligence, which I found the most challenging because it entails concepts such as income guarantees, compensation structures, overhead-to-revenue ratio, physician productivity and ownership/partnerships. On the purely business side, in today's environment neurosurgeons considering opportunities also need to look at managed care contracts, balance sheets and cash-flow statements, accounts receivable, audit history and malpractice claims. And then there was restrictive covenants and tail insurance to consider. I felt like I had to get an MBA just to understand some of the lingo.

Wait a minute, I thought. Why hasn't anyone mentioned this to me before? Did I miss a lecture on this? If we work so hard to get to this point, shouldn't we be more prepared? Most importantly, I wondered why the entire business and financial realm of where we were all headed wasn't stressed more in training. It's no wonder that 50% of neurosurgeons change jobs within the first two years of graduating residency. We think we know what to look for, but in fact, many of us haven't the slightest idea. We're at risk of being swayed by money, instrumentation, case complexity or even our partners.

In this shifting healthcare industry and as a neurosurgeon focusing on spine, I wondered where I fit in the changing marketplace. I found that I had more questions than answers. Then, the phone rang.

It was a friend, someone I had trained with, calling to speak with my wife. What she said was simple: "I know what he's looking for; just come check out my job." That's all it took. The next weekend my wife and I were on an airplane on the first of many visits. People were happy. They were real. They were honest and friendly. They had created their niche by

"There is a lot to neurosurgery outside of patient care, yet most of what really matters is not covered in your typical residency or fellowship program."

The issue was identifying the information on which to base my answers. Who could tell me what things were really like once our training is over, and who would teach me how to prepare for that? Showing up to the OR as a resident or fellow and pulling up the pre-op films was easy. But how did we get to this point? What was the decision making process to allow access for this patient to the OR? How would I be able to translate seemingly obvious judgments from just a few patient experiences? Surely, everyone must be happy in his or her current position, or on his or her current track, and with the people they work with, I presumed. Otherwise, why would they still be working there?

I want to be part of a small practice, a multi-subspecialty practice or a solo practice, or did I want to become a hospital employee?

Researching details about practice location, partners, hospital affiliation, community needs, call requirements and family needs, is painstaking but important. And the list went on. Doing my due diligence, I investigated matters such as: Does the group have enough patients to support a new physician? How many new patients per year does the practice attract? How many patients does it lose? I also looked into whether the prospective group had a marketing plan, and what steps it would take to direct patients my way. The more logistical issues—call coverage duties and division of

taking excellent care of their patients, by doing the right thing. They resisted the temptation of “cookbook medicine” and remained true to their principles. This was nothing advertised, nothing in a PowerPoint presentation. It was just a feeling that I had.

As you make your way into the confusing market, I hope that some of the things I learned ring true for you and help in this amazing opportunity with which we have been so fortunately blessed. We shouldn't be afraid to ask questions, even though this process can make us extremely uncomfortable. There is a lot to neurosurgery outside of patient care, yet most of what really matters is not covered in your typical residency or fellowship program.

Love what you do—and be good at it. Care for each patient as if they are your own family members. Trust a friend, and maybe look for that unadvertised job. That is what residency doesn't teach you. That is what we hope we have silently learned and come to appreciate as the world is moving forward around us. Each patient experience, each encounter is a chance to make a difference for that person, that family, and the world.

Dr. Aghion is a neurosurgeon at Memorial Regional Hospital and The Memorial Neuroscience Institute in Hollywood, Fla. He specializes in complex spine disorders.



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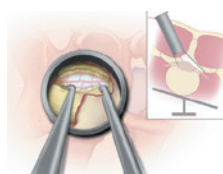
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The Private-Practice Neurosurgeon Personality: Do You Have It?

By Katie Cole



Many neurosurgeons today opt for hospital-employed opportunities, or opportunities that presumably encourage and support work-life balance. The vacation-time conversation is one that comes up frequently in neurosurgeons' first interviews, and surely during second looks.

However, not all neurosurgeons either seek or are cut out for the reasonably predictable practice life. I often encounter what I would call the traditional "private-practice personality." This mindset is exhibited by neurosurgeons who want the conventional private practice model, and are willing to work hard and receive the financial rewards for putting in long hours weeks on end. And in fact, many private practice opportunities today do offer income potential of well over \$1 million annually. But that comes with the understanding that the incoming neurosurgeon will consistently work hard enough to achieve above the 90th percentile in productivity, per the major surveys.

This arrangement and expectation, in my experience, involves far more than just doing cases efficiently and caring for a high volume of patients. The other prerequisites are traits and activities that many neurosurgeons prefer to avoid: Ease with marketing your services to the community and other specialists, and these days, to the primary care community in particular.

Whether you are starting a practice from scratch in a new practice, with or without hospital support, or you are walking in to an existing practice but are responsible for bringing

in your own patients, you will be expected to do some degree of marketing. To create and sustain a steady patient load, you are required to court primary care doctors and put yourself out there to the community where you practice. This can include making local medical staff presentations, distributing brochures on your services and practice, and keeping referring physicians in the communication loop by sending them letters about every patient contact you make. In some practices, neurosurgeons might be expected to essentially "cold call"

A private-practice neurosurgeon's success is largely dependent on personality, and how much networking and marketing the physician is willing to do, in addition to managing a high case volume. This doesn't mean taking out billboards or recording radio advertisements, but it does mean a lot of hand-shaking and courting referring physicians. The online patient community is growing daily, so neurosurgeons who take the private-practice route should be able and willing to market the practice on the Internet, and be accessible online to patients and referring physicians.

"A private-practice neurosurgeon's success is largely dependent on personality, and how much networking and marketing the physician is willing to do, in addition to managing a high case volume."

prospective referral sources. All of this entails a willingness to put yourself out there and be highly visible in the community.

These expectations do not appeal to many neurosurgeons seeking jobs today. Most neurosurgeons I encounter seek a flexible schedule, ample vacation time and a clear-cut compensation contract that outlines specifically how much they will earn year to year. If you are actually more inclined toward the private-practice life—you want to perform and earn over the 90th percentile and are willing to put in the hours and effort—such opportunities are available to ambitious neurosurgeons.

Neurosurgeons of the past have a reputation for working 80-hour weeks, not taking vacation, and wanting to operate into their seventies. While some in the field think that this personality and practice model no longer exists, neurosurgeons today can still find private-practice positions that offer ample financial reward for hard work, if they have the traits and skills required to build referral networks and maintain active relationships with referring physicians.

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

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IN BRIEF

Spine Society Finds Little Employment Shift

A recent survey conducted by the North American Spine Society, which included 455 respondents who are either neurosurgeons or orthopaedic surgeons, indicates that spine surgeons aren't leaving private practice in droves, as some industry watchers have suggested. The survey found that 64% of the surgeons remain employed by private practices, and that 81% of respondents have not changed their practice setting in the past five to seven years.

Regarding medical technology-associated purchasing, 26% of respondents indicated that they retain full control over such purchases, and 47% cited having "influence" in such decisions.

In other findings, participants report increasing involvement in accountable care organizations (ACOs)—23% are involved now—and 31% indicated that their group or health system plans to make the requisite modifications to participate in the Centers for Medicare & Medicaid Services' mandatory alternative payment models in the future.

AANS Supports CDC TBI Surveillance System

In August, the American Association of Neurological Surgeons submitted a position statement in support of the U.S. Centers for Disease Control's proposed Traumatic Brain Injury Surveillance System and the associated tracking activities. In the statement, AANS supported the CDC's proposed enhancement of TBI tracking to include not only TBI incidence, morbidity and mortality, but also trends in TBI and the effect of preventative measures.

The AANS and Congress of Neurological Surgeons cited their strong support for the CDC's plans to expand the focus on TBI related to youth sports and recreation, and both indicated their intent to play a supporting role in the endeavor.

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FEATURED OPPORTUNITY

Central California Private-Practice Opportunity

A thriving private practice in central California is seeking a BE/BC neurosurgeon. This is a unique opportunity for the incoming neurosurgeon to have an ownership position in the hospital as well as the surgery center. This position is a traditional private practice employment model, and there is also a partnership track for the incoming neurosurgeon.

The group has preference for a candidate with a spine fellowship or equivalent experience, and the practice will encompass general neurosurgery but will be spine dominant. At

this time, the practice is considering only candidates with 2 to 4+ years' experience.

Call for the incoming neurosurgeon will be 1:4. This is a very well-established private practice, and the group has several offices in central and southern California.

The location in central California currently has two neurosurgeons in the practice, both of whom are experienced with fellowships in spine and are board certified. The practice enjoys a strong collegial spirit, and the physicians and support staff focus on

patient care and believe in a team-oriented practice style.

The practice will offer a very competitive guarantee and partnership track with no buy-in. There is tremendous income potential, particularly with the ownership component in the surgery center and hospital. The city is one of the 10 largest cities in California. The town offers more clear days annually than the majority of cities in the U.S., and is known for its long-lasting mild autumns and warm springs.