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IN THIS ISSUE...

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Compensation Increases Continue for Surgical PAs and NPs

By Bonnie Darves

Surveys that track surgical physician assistants' and nurse practitioners' compensation report a bright, if somewhat mixed picture. Overall, surgery specialized advance practice clinicians (APCs) have seen their annual earnings increase between 1% and 6%, depending on the survey, subspecialty and region, and in a development that portends well for the future, the ratio of APCs to physicians is on the rise. As that occurs, demand for APCs will likely rise in tandem.

Following are highlights from the most recent compensation surveys published by the American Medical Group Association (AMGA), the Medical Group Management Association (MGMA) and the Neurosurgery Executives' Resource, Value and Education Society (NERVES).

- AMGA. The group's 2019 Medical Group Compensation and Productivity Survey posted median compensation of $124,294 for surgical PAs across specialties, and $113,502 for NPs. The survey included 1,934 NPs and 1,961 PAs.
- MGMA. In its 2019 report based on 2018 data, the MGMA reported a median of $120,386 for surgical PAs and $114,339 for NPs. Increases over 2018 report medians were 1.09% for PAs and 3.88% for NPs. The survey included 602 surgical NPs and 534 PAs.
- NERVES. This neurosurgery-specific survey showed significant compensation gains for PAs and NPs in its most recent Socio-Economic Survey, based on 2018 data: PA median compensation increased 6.2% to $120,000; and NP compensation was up 5.7% to $112,000. The survey included 269 NPs and 264 PAs.

Supply and demand plays key role in APC compensation

The ratio of supply to demand is always a key determinant in clinician earnings across the healthcare spectrum, and recent shifts in that ratio suggest that PAs and NPs will continue to see annual compensation increases—of approximately 2% annually in most markets and more in regions and subspecialty areas where advance practice clinician (APC) supply is tight, sources predicted. In the PA and NP surgery sector, groups are slowly but steadily increasing the ratio of ACPs to surgeons, part of the growing trend toward expanding APC scope and exploring ways to incorporate APCs in care teams to increase overall practice efficiency. MGMA found, for example, that the ratio of APCs in single-specialty surgical practices increased from 0.53:1 in 2017 to 0.55:1 in 2019.

One of the key APC compensation drivers in the years ahead, in surgical specialties as well as primary care, will be the looming physician shortage, according to Andrew Hajde, CMPE, assistant director of association content for the MGMA. "Groups are expanding the use of PAs and NPs in general, across the board, but compensation will also be driven by increases in retiring physicians and the growing physician shortage," he said. "The Association of American Medical Colleges predicts a physician shortage of 122,000 by 2032, so there will be a huge push for more NPs and PAs to support physicians."

This prediction is underscored by recent figures from the U.S. Bureau of Labor Statistics, which projects that the number of U.S. PAs will grow 31% from 2018 to 2028—far faster than the average (around 7%) for all occupations.

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Compensation Increases

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Mr. Hajde, who spent two decades managing surgical and medical subspecialty groups, predicts that the current national push toward reducing PA oversight burdens and the state-by-state legislative developments that are expanding PA practice scope and autonomy, will have a major effect on how groups structure care teams and delivery.

"The recent passage of North Dakota's House Bill 1175 that gives PAs more autonomy and the California bill that expands PA prescribing [Senate Bill 697] are huge developments that enable PAs to work more autonomously and reduce the supervisory burden for surgeons and other physicians," he said. "It would be great to see more of these developments across the country—sooner rather than later—so that groups can use PAs more efficiently."

Wayne Hartley, MHA, chief operating officer for AMGA's consulting practice, concurs with Mr. Hajde's assessment. He also thinks such developments will boost both surgical practice efficiency and, over the medium term, PA salaries as well. "As more states expand scope of practice for both PAs and NPs so that APCs can see more patients without direct supervision, I think we'll see more consistent compensation increases in the surgical specialties," Mr. Hartley said. He added that the increased trend toward greater subspecialization in the surgical physician specialties, which is being mirrored in the APC sector accordingly, will also drive compensation increases.

These trends, as they take hold in the PA sector, "may also shift revenue generation and productivity for surgical practices," according to Mike Radomski, a NERVES senior officer who is CFO and vice president for finance with the Mayfield Clinic in Cincinnati, Ohio. He added that the NERVES survey found, for example, that PAs produce work resource value units (wRVUs) at twice the rate of NPs—1,550 versus 703. Further, while NPs generate collections at approximately 35% of their compensation, for PAs that rate is 75%, he noted.

"The recent passage of North Dakota's House Bill 1175 that gives PAs more autonomy and the California bill that expands PA prescribing are huge developments that … reduce the supervisory burden for surgeons and other physicians. It would be great to see more of these developments across the country—sooner rather than later."

– Andrew Hajde, CMPE, Medical Group Management Association

Mr. Hajde added that physician groups appear generally grateful for this loosening of restrictions and anxiously await legislation that will continue the trend. (See the update on the American Association of Physician Assistants' national Optimal Team Practice initiative in this issue.) "If this occurs, I think we'll see [PA to physician] ratios increase and continued expansion of APC use in general," he said.

"In my experience, in the past some payors had rules that limited scope of practice for specialty APCs, although much progress has been made on this in recent years," Mr. Hartley said. "The market generally accepts APCs, especially due to the focus on cost management."

Cardio specialties top earners

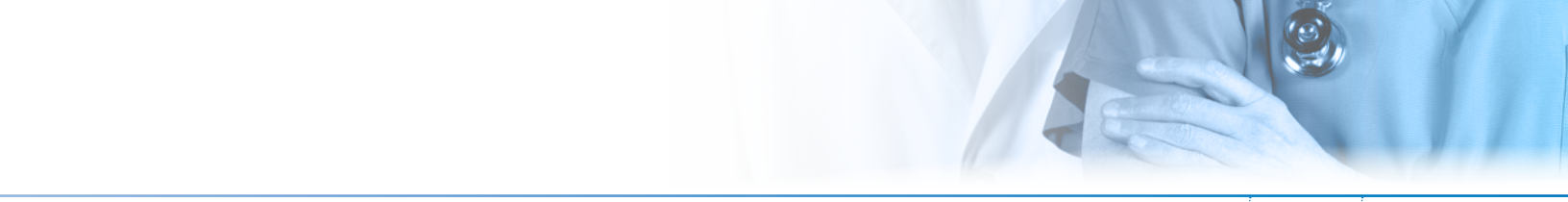
Not surprisingly, PAs and NPs who work in cardiac surgery retained their top spot on the compensation scale. The AMGA survey reported a median of $154,159 for cardiovascular PAs and $141,339 for cardiothoracic PAs. Median compensation for NPs in those two specialties was $117,330 and $120,612, respectively.

In the MGMA survey, the median compensation for cardiothoracic PAs was $144,817 and for orthopedic surgery PAs, also a top earning specialty, the median was $126,675.

In the AMGA survey, trauma surgery NPs had median compensation of $123,944, the highest compensation for any surgical NPs. In other large subspecialty categories, median compensation was $121,396 for general surgery PAs and $109,639 for NPs; $121,019 for neurosurgery PAs and $111,598 for NPs; and $128,139 for orthopedic surgery PAs and $114,066 for NPs. In otolaryngology, PAs had median compensation of $118,731 and NPs, $109,428.

The lowest-earning APCs clustered in some of the smaller surgical specialties, per AMGA survey figures. NPs in pediatric surgery, urology and vascular surgery had median compensation of roughly $107,000. Among PAs, the lowest median compensation—in the $110,000 to $115,000 range—was seen in bariatric surgery, gynecological oncology and orthopedic sports medicine.

The trend toward PA certification and subspecialization is particularly pronounced in the hospital practice setting, where many surgical PAs practice, according to 2018 data



from the National Commission on Certification of Physician Assistants. Today, more than 40% of certified PAs practice in hospitals. The report also found that 48% of certified PAs earn between $100,000 and $140,000, while only 15% earn more between $140,000 and $160,000.

Percentile and regional compensation data illustrate hiring practices

Although median compensation numbers, and their increases (or declines, if rare) year over year, provide a good picture of what's going on with APC salaries in general, the percentile ranges that surveys report help APCs better determine what their compensation will be based on experience. Generally speaking, APCs who are new to practice will earn in the 20th to 40th percentile of the compensation range, while highly experienced PAs or NPs might see income in the 70th to 90th percentiles—depending on their specialty and market factors in the regions where they practice.

The AMGA survey, for example, reported a wide spread for surgical specialty APCs across the board. In that survey, 20th percentile compensation was $106,225 for PAs, compared to $166,595 at the 90th percentile. For NPs, those figures were $100,206 and $147,342, respectively. This suggests that highly experienced PAs, particularly those with broad-ranging procedure skills and/or or deep subspecialization, may be able to command significantly higher compensation in the marketplace than their less experienced counterparts, some sources observed.

Overall, although specific skill sets and experience are important in setting compensation, it's worth noting that the salary data reported in major surveys and local market conditions still significantly influence the final compensation that APCs earn, in much the same way that survey data still largely dictates physician compensation. In the AMGA survey, of the 147 medical groups that disclosed their salary determinants, 82% used market salary data in setting salaries, while only 20% cited budget as a determinant. In terms of PA and NP incentive and discretionary compensation unrelated to productivity, patient satisfaction was the key factor, at 75% of AMGA's reporting groups, followed by clinical quality outcomes, used by 60% in determining additional compensation.

In terms of movement toward solidly incorporating productivity measures in PA and NP compensation structures, Mr. Hartley noted that such structures are still more common in primary care APC practice than in the surgical specialties. "We see some productivity-oriented models for primary care APCs who manage their own panel. With that exception, most APCs are on base-salary or base-plus-production models," he said. "Quality goals are slowly entering formulas but do not constitute a significant component of pay for most APCs." He added that establishing timely and accurate quality reporting for physicians has been the priority for most groups but acknowledged that there's a recognition that "these issues need to be worked out for APCs, too."

On the regional front, the MGMA survey found a somewhat pronounced compensation spread. PAs in the Western region had median compensation of $135,025, compared to $112,826 in the Southern region. Median compensation for both NPs and PAs in the Midwest was essentially flat compared to the prior year, at $108,401 and $118,439, respectively, Mr. Hajde observed. In the Eastern region, median compensation was $110,822 for NPs and $118,689 for PAs. "Regionally, we don't necessarily see the same compensation patterns for APCs that we see with physicians, and it's interesting to us that there's not more alignment," he said. "This suggests that what's going on in the regions has more to do with supply and demand issues."

On a final positive note, sources interviewed for this article concurred that the job market is bright for surgical APCs. At AMGA, for example, the annual AMGA Medical Group Compensation and Productivity Survey has included growing numbers of PAs and NPs, Mr. Hartley observed. "Over the past several years, our sample size for surgical PAs (and other APPs) reported into the survey has grown," he said. "I think that reflects growth in hiring and more interest in market-based data for nonphysicians. We've also seen more subspecialties reported for APCs."

"Over the past several years, our [survey] sample size for surgical PAs and other APPs has grown. I think that reflects growth in hiring and more interest in market-based data for nonphysicians."

– Wayne Hartley, American Medical Group Association

Ms. Darves, a freelance healthcare writer and editor based near Seattle, is editor of Surgery PA Market Watch and Neurosurgery Market Watch.

Optimal Team Practice PA Initiative Gaining Traction

By Bonnie Darves

A long-sought mechanism for removing some of the burdensome administrative aspects of physician oversight in PA practice has begun to move forward, as states enact aspects of the American Association of Physician Assistants' proposed Optimal Team Practice (OTP) legislation. North Dakota in April 2019 became the first state to approve OTP, which permits PAs to practice without having either an agreement or a specific relationship with a physician.

The North Dakota law states that PAs, like other healthcare professionals, may now collaborate with, consult with, or refer patients to healthcare team members based on the patient's condition, the standard of care, and the PA's education, experience and competence. Practices, rather than state law, may dictate the degree of collaboration between PAs and overseeing physicians.

"This legislation [H.B. 1175] will go a long way in expanding access to high-quality care for the people of North Dakota, enabling PAs to practice without unnecessary administrative burdens," said Jonathan E. Sobel, DMSc, MBA, PA-C, AAPA's president and board chair. "This landmark move to Optimal Team Practice demonstrates that legislators recognize the PA profession as a solution to some of their toughest healthcare challenges."

As envisioned by the AAPA, OTP occurs when PAs, physicians, and other healthcare professionals collaborate to provide quality care without the stringent administrative constraints that have governed physician oversight of PAs and required sometimes onerous oversight relationships. The AAPA's OTP initiative supports the following regulatory and administrative changes:

- Eliminating the legal requirement for a specific relationship between a PA, physician or any other healthcare provider order PAs to practice to the full extent of their education, training and experience.
- Creating a separate majority-PA board to regulate PAs or add PAs and physicians who work with PAs to medical or healing arts boards.
- Authorize PAs to be eligible for direct payment by all public, government and commercial insurers.

The enactment of OTP legislation paves the way for other states' efforts to move forward, and several states are in various stages of developing associated regulations. The benefits of OTP for PAs are obvious, but physicians also stand to benefit from less stringent PA oversight arrangements, according to AAPA officials. Under OTP, physicians would not be directly responsible for care that PAs provide on their own, when the physician is not involved in that care, potentially reducing physicians' liability exposure.

In addition, practices could form healthcare teams on a case-by-case basis, allowing physicians to work with different PAs on different cases. Further, OTP enables physicians to provide collaborative care with PAs with fewer constraints when the PAs are employed in hospitals and health systems, or other corporate structures that use staffing companies. The latter could significantly affect how surgical PAs practice and enable more flexibility in arranging pre- and post-operative care.

Last spring, West Virginia enacted OTP-based legislation governing direct physician oversight. S.B. 688 eliminated the requirement

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HOW THE NORTH DAKOTA OTP LEGISLATION WORKS

North Dakota's H.B. 1175, which may become a model for other states, makes the following changes regarding PA practice:

- Removes the requirement that PAs have a written agreement with a physician if they practice at licensed facilities (e.g., hospitals and nursing homes), facilities or clinics with a credentialing and privileging process. It also applies to physician-owned facilities or practices.
- Removes references to "supervision" and allows PAs to collaborate with members of the healthcare team as practices choose.
- Permits PAs to own their own practice, provided the PA practice obtains approval of the North Dakota Board of Medicine. The law requires that PA practice owners with fewer than 4,000 hours of experience must have a collaborating physician.
- Removes references to physician responsibility for the care that PAs provide.
- Makes PAs directly responsible for the care that they provide to patients.

"These changes are needed for our profession and for our patients. This bill allows PAs to practice where they are needed most and take the administrative burden off our physician colleagues. The North Dakota Academy of PAs, along with our bill sponsors, all contributed to the success of this legislation," said Jay Metzger, PA-C, president of North Dakota Academy of Physician Assistants.

When to Talk About Salary in a Job Interview

By Katie Cole

Many physician assistant candidates, when speaking to me about a prospective opportunity, ask me how much the job pays as their first question. Before they ask about call requirements, the schedule, the patient case mix, or what surgeons they will be working with, PAs want to know what the salary is. Of course, this is one of the most important aspects of any job search, and PAs understandably want to rule out any jobs that aren't in an acceptable compensation range. However, by focusing entirely on salary considerations first, candidates might be limiting the field of potential job offers—from the standpoint of both quantity and dollar amount.

Most candidates think that starting the discussion with the salary details upfront is a more effective way to proceed. But by doing that, they might discount positions that would be great fits based on salary alone—even if there might be opportunities for the employer to increase the salary to an appropriate range. Once the potential employer likes you and believes that you'll be a good fit for the practice, you're in the best position to negotiate compensation. After you have met with the practice administrators and the surgeons, and they've all been impressed by your skills, attitude, personality and potential fit, your monetary value can be justified based on more than just your CV.

There is a fine line between not wasting your time or the potential employer's time. Basically, it makes sense to eliminate positions that would pay significantly lower than your requirements or even what you are currently earning, while you continue to seek competitive offers. Get a basic idea of what you're worth and what the market is paying, in the geographic location as well as specialty. Then you'll have a baseline—and a better sense of your competitive salary range based on your personal education, training and experience. Try to get an approximate range of the compensation level you're seeking, ideally before you respond to an email or call a recruiter.

To get the most offers and the highest salary amount, it can be more effective to wait until after the first interview before discussing compensation. For example, if you're interested in the opportunity, request a shadowing experience with prospective colleagues—and then wow them. This is a great way to increase your negotiating power when the time comes to review an employment offer. And if you sense that the practice or hospital is anxious to have you join the team, keep the recruiter in the loop and consider letting that person help handle the negotiations.

Ms. Cole is a Denver resident and publisher of Surgery PA Market Watch and Neurosurgery Market Watch.

SURGERY PA AND NP JOBS

Tucson, AZ: *Hospital Employed - Endovascular Neurosurgery PA/NP*
Greenville, NC: *Hospital Employed—Transplant Surgery PA/NP*
Long Island, NY: *Private Practice—Neurosurgery PA*
Trenton, NJ: *Hospital Employed—Neuro-ICU PA/NP*
Albuquerque, NM: *Hospital Employed—Cardiothoracic Surgery PA/NP*
Macon, GA: *Private Practice—Neurosurgery PA/NP*
Greenville, NC: *Hospital Employed—Orthopedic Trauma Surgery PA/NP*
Raleigh, NC: *Academic-Neurosurgery PA/NP–100% outpatient*
Greenville, NC: *Hospital Employed—Cardiothoracic Surgery PA/NP*
Atlanta, GA: *Private Practice—Neurosurgery PA/NP*
Los Angeles, CA: *Hospital Employed—Cardiothoracic Surgery PA/NP*
Philadelphia, PA: *Hospital Employed—Cardiothoracic Surgery PA/NP*

OTP Gaining Traction

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for PAs who work in hospital settings—approximately 50% of the state's PAs currently work in hospitals—to have structured practice agreements with specific physicians in order to practice. The legislation requires a practice notification, via a written notice, that a PA "will practice in collaboration with one or more physicians in a hospital in the state of West Virginia," with the appropriate licensing board.

In other recent PA-oversight developments, two states, California and Idaho, added PA representation to their medical boards, bringing the total to 20. Eight U.S. states now have separate PA boards.

Bonnie Darves is a Seattle-area freelance writer. She serves as editor of Surgery PA Market Watch and Neurosurgery Market Watch.

Spotlight on ENT Surgery PA Practice

PAs in the Field Enjoy Broad Practice Scope, Patient Relationships

By Bonnie Darves

What the ENT physician assistant specialty lacks in size—only an estimated 1% of U.S. PAs are in ENT—it makes up in scope. Many PAs in the specialty enjoy broad diversity of practice and the opportunity to perform numerous procedures that affect the senses, thereby helping to improve patients' quality of life.

"One thing PA students are constantly surprised by is the depth of our subspecialty—the fact that we work in head and neck surgery, and with issues affecting voice, hearing, smell, taste and sleep. It's such a broad array," said Kristi Gidley, PA-C, MSHA, president-elect of The Society of Physician Assistants in Otorhinolaryngology/Head & Neck Surgery (SPAO-HNS) and executive administrator of the Department of Otolaryngology at the University of Alabama Birmingham. "We have a good specialty that's very procedure based, and we work with wonderful physicians." The field also encompasses a blend of primary and urgent care, in addition to surgical care, Ms. Gidley notes, so it's a good choice for PAs who seek an expansive practice and an opportunity to increase their skills over time.

For the most part, the SPAO-HNS, which has approximately 450 members including PAs and nurse practitioners, focuses its advocacy efforts on initiatives that the American Association of Physician Assistants supports. "We would like everyone in the field to be able to work efficiently and at the top of their license," Ms. Gidley said.

The organization's primary objective, however, is to ensure ample learning and skills-enhancement opportunities for ENT PAs and NPs. The SPAO-HNS's annual "ENT for the PA-C" conference, for example, provides extensive CME opportunities. The program encompasses both core and advanced learning tracks, surgical skills practice in a simulation laboratory, and an entire day of hands-on workshops. "Our program offers in-depth learning opportunities for both experienced PAs and those new to our field," Ms. Gidley said. The 2020 conference is set April 2-6 in San Francisco.

Although ENT is a small subspecialty, it's characterized by a robust job market—and there are plenty of opportunities to practice in a wide range of settings, Ms. Gidley observed. "At every advanced practice meeting I go to, I hear that the market is booming—and fortunately, that is driving increases in both compensation and practice scope," she said.

In November, Surgery PA Market Watch reached out to several ENT PAs to find out drew them to the field, what they do in their daily practice lives, and what makes their work gratifying. Here are their perspectives.

Trina Sheedy, MMS, PA-C

Head and Neck Surgical Oncology

University of California Francisco at San Francisco

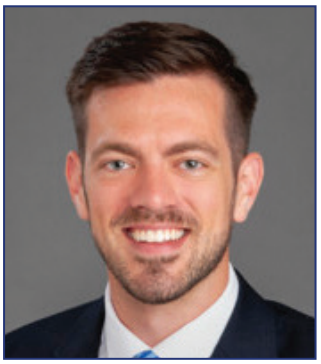
How did you end up in the field? I choose to be a PA because I wanted to work in healthcare but didn't want to go to med school! The path to be a physician seemed too long and daunting. I really liked the idea of having independent practice while working as part of a team, and I appreciated the flexibility to change specialties. I also saw PA practice as an opportunity for a more favorable work-life balance.

What do you do, and what's most gratifying about your practice? Currently, my role includes a combination of independent practice and physician support all within our outpatient clinic. I have an independent clinic one day per week where I see new patients, follow-ups, post-ops and survivorship-type patients. I closely support two ablative surgeons and our facial plastic reconstructive surgeons. With these physicians, I do "shared visits" with them in clinic.

I was drawn to this position because I worked as a medical assistant prior to PA school in the head and neck surgery department and really came to love this patient population. Not only is any cancer diagnosis life-altering, but head and neck cancer changes the way a person communicates and interacts with his or her family, friends, and society in general. The things that make us ourselves like our appearance and the sound of our voice can be forever altered by their cancer and treatment.

Developing relationships with patients is the most gratifying aspect of my practice. Due to the nature of head and neck cancer, we follow these patients for many years. Not only is it meaningful to see them through their treatment—to be with them through literally the hardest time in their lives—but it's very gratifying to see them recover and do well in their "new normal" state.

What about ENT practice do you think PAs in other practice/specialty areas might find surprising? Probably how procedure-heavy it is. There is so much room for independent practice and in-office procedures. ENT PAs perform flexible laryngoscopy, nasal endoscopy, nasal/skull base debridements, nasal and oral cavity biopsies, skin biopsies, cerumen removal, myringotomy and more—on both adult and pediatric patients. Interpretation of diagnostic tests is also constant whether that be audiograms, polysomnography, or imaging.



Kevin Shefferly, PA-C, Masters of Science in Management

Piedmont Ear, Nose & Throat Associates
Winston-Salem, North Carolina

How did you end up in the field? I grew up in a "medical" family—my mother, father and sister are all in medical fields. During my second year in college, my father, who is in emergency medicine, urged me to consider PA practice because of the direction medicine has taken. I also was attracted to the fact that I had the flexibility to switch between specialties and that I'd probably have better work-life balance as a PA than as an MD.

ENT was appealing, even though it represented only about 3% of the PA curriculum, and I found that I loved it. So I decided to do a fellowship and really enjoyed the experience and the diversity within the practice. I also like the fact that it's a highly visual field—I'm not very interested in labs.

What do you do and what's most rewarding about your practice? There's so much that's gratifying, but I especially enjoy all the procedures we do—and ENT PAs do a ton of them—and the scope that's possible in our field. For example, I was the first in our practice to do dexamethasone injections, and I recently went to the OR to learn how to put ear tubes in kids. As one of two PAs in the practice, I have the opportunity to work with 12 different surgeons, which means I'm always learning something new.

At the same time, there's a lot of autonomy in ENT practice, and I think PAs can play a unique role in serving as patient advocates because we're able to spend a lot of time with them.

How would you counsel PAs who want to come into the field? It's important for students and new grads to keep in mind that the world of ENT PA practice is so small that they have to take advantage of the electives and make connections, ideally while they're still students, with practicing PAs. That's really the best way to go to figure out what you want to do. And a lot of us are ready to counsel grads—I'd be excited to be approached to provide some help!

On the potential downside, being in ENT involves a long learning experience because the field is so varied. I think that, realistically, it takes at least three years to be able to handle your own patient load.

Brittany Gunville, MS, PA-C

Otolaryngology, Head & Neck Surgical Oncology
Stanford Health Care, Palo Alto, California

How did you end up in the field? I chose to become a PA because I enjoy providing care for patients and enjoy the diagnostic aspect of medicine. I knew I wanted to specialize in ENT before I knew I wanted to become a PA. My sister is deaf, so I was always drawn to the inner-ear anatomy; however, I fell in love with head and neck oncology during my first job. ENT encompasses so many of the basic senses—smell, taste, hearing and sensation. Any deficit in any of these senses can dramatically impact a person's life.

What do you do in your daily practice life? I currently practice in head and neck surgical oncology in a large academic institution and have been in the field for the past five years. My scope includes evaluating and treating new cancer patients and handling routine visits for cancer surveillance. I was drawn to the opportunity because I enjoy working with head and neck cancer patients; they are some of the strongest people I know.

What do you find most rewarding in your practice? The most gratifying aspect of my practice is being able to help people through their cancer journey. From the time of diagnosis, through treatment, to survivorship. As PAs, we are patients' lifeline to understanding their diagnosis and their treatment, and all the different steps that their treatment entails.

What about ENT practice do you think PAs in other practice/specialty areas might find surprising? ENT practice is much more than ears and vertigo. The incidence of HPV related head and neck cancer, for example, is on the rise. Education is key, including patients and providers, to identifying early signs and symptoms.

What advice would you give to other PAs or recent graduates about planning to pursue a career in ENT and structuring their job search? Gain experience now, by volunteering or shadowing. There are so many subspecialties of ENT that people are not familiar with that are fascinating and can help patients with their ability to do basic tasks that bring so much joy to their life—such as eating, tasting and communicating.

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ENT Surgery PA Practice

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Nabilah Ali, PA-C

Physician Assistant, Cedars Sinai Medical Center Otolaryngology
Los Angeles, California

How did you end up in the field? During college, I worked in cancer research and had the opportunity to collaborate with PAs, MDs and NPs. What appealed to me about PA practice was the strong foundation that we get—and the flexibility in the field to choose a specialty and even make a change if you want.

What do you do and what's most gratifying about your practice? My favorite thing about my practice—I'm a first assist in the OR and I also do inpatient rounds and consults—is that it's truly an ongoing learning experience, every day. We're doing robotic surgery, and we're now using special loupes that allow you to see more of the small areas that were difficult to view before.

Working in a tertiary center also means that I go to all the tumor boards, and I also get to be part of many different teams—so I end up having a good understanding of all that's going on with the care of the patient. I also have the somewhat unusual opportunity to interact frequently with PAs in other specialties outside ENT, so that's gratifying even if it's not a day-to-day experience.

And when I'm in the OR, I'm sometimes working with up to 12 people—it's really a beautiful dance.

How would you counsel PAs who want to come into the field? I love working with new grads and my advice to them (and to others already in the field) is this: Whatever specialty you're thinking about, go and try it! I think PAs are sometimes hesitant to check out several different fields—or other fields if they're already in practice.

It's also important for new grads to really reach out to practicing PAs. There's a lot of camaraderie in our field, I've found, and there truly are people out there who are willing to help you get started or make a change in your career.

If you're interested in ENT, plan on a long learning curve, because it really takes two to three years to gain proficiency. We do hire new grads in our practice, and they start out in the outpatient clinical side and slowly work their way into the OR.

Cheryl Dawn Tioaquen, PA

Otolaryngology Physician Assistant,
Ear, Nose & Throat Institute
Johns Creek, Georgia

How did you end up in the field—and what does your practice look like? I've been fortunate—I joined this group fresh out of PA school. Prior to PA school, I worked in the hospitals as a respiratory therapist. I'd never thought about doing ENT as a career, but I knew I wanted to grow in medicine and work in a specialty field. Considering my background and expertise already with the pulmonary side, I knew that adding the "ears, nose, and throat" aspect would be a great addition for me.

My role includes assessing and coming up with a plan for the patients, performing procedures including cerumen removal, nasal endoscopies, laryngoscopies, nasal cauterizing, I&Ds, and even giving botox injections for wrinkles. In the surgery aspect, although the PAs in our practice aren't utilized in the OR as a first assist, we still support our surgeons by performing the pre-operative exams and paperwork, assessing patients post-op, and taking call after hours.

What do you find most rewarding in your practice? What's most gratifying is getting to know my patients and seeing the great results on their follow-up visit. A lot of the time, they become frequent fliers because we treat many common ailments. They'll come in for treatment of sinus infection, and then they'll come back to talk about their sleep apnea or get their ear wax removed. Our patients also love bringing in other family members, so I get to know them on a personal level.

What about ENT practice do you think PAs in other practice/specialty areas might find surprising? They might be surprised by just how hands-on the ENT field is. We do more than just deal with ear, tonsil and sinus infections. We also manage patients with allergies, obstructive sleep apnea and dizziness, for example. It's is also an involved field, with a lot of collaborative work because the team includes speech therapy, physical therapy and audiology—and even (lucky for me in my clinic) infectious disease.

How would you counsel PAs who want to come into the field? My advice to other PAs or new grads would is to really consider this field. I feel that in PA school, ENT didn't get enough credit because it blurred into emergency medicine and primary care. It's also a lot of hands-on work, so there is never a dull moment.

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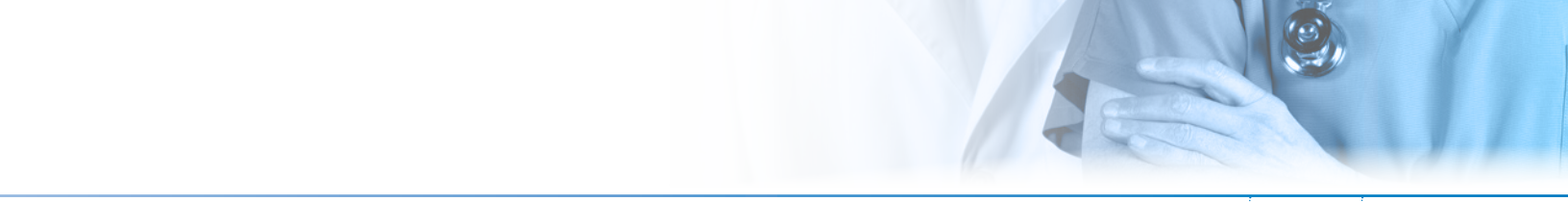

FEATURED OPPORTUNITY

Atlanta Neurosurgery Practice Seeks Surgery-Experienced PA/NP

A private neurosurgery group in Atlanta, Georgia, seeks a neurosurgery PA or NP to join its practice. The practice prefers a candidate with neurosurgery, orthopedic or other surgery experience. The practice requires at least 1 year of experience post graduating from a PA or NP program. The practice currently has five neurosurgeons and five advance practice providers.

The incoming PA or NP will work with several different neurosurgeons within the practice. Call will be 1:4 for the incoming APP. The APP will have a mix of clinic and OR responsibilities, at approximately 50% clinic and 50% OR. Clinic duties include a mix of seeing new patients, returning patients and post- op patients.

The case mix will be mostly spine with some general neurosurgery. Polaris Spine & Neurosurgery is Atlanta's premier comprehensive spine care center, and the practice is the second outpatient surgery center in the country to offer robotically navigated spine surgery. The practice will provide competitive compensation, PTO, paid holidays, a 401(k) option and a great work environment.

SURGERY PA EVENTS

Sanger Heart and Vascular Institute Cardiovascular Symposium
❏ January 24
Charlotte, North Carolina

5th Annual Conference: Practical Urology
❏ January 30 - February 1
Los Angeles, California

Introduction to Gamma Knife Radiosurgery Training Course
❏ February 3-6
Miami, Florida

Mayo Clinic Interactive Surgery Symposium 2020
❏ February 2-7
Waikoloa, Hawaii

Physician Assistants in Orthopaedic Surgery (PAOS) Winter Symposium
❏ February 14-16
Phoenix, Arizona

Florida Academy of Physician Assistants (FAPA) 2020 Winter Symposium
❏ February 21-23
Kissimmee, Florida

ENT for the PA-C Annual CME
❏ April 2-6
San Francisco, California

APACVS 39th Annual Meeting
❏ April 15-19
Miami, Florida

2020 AANS Scientific Meeting
❏ April 25-29
Boston, Massachusetts

AASPA 20th Annual CME Meeting & Surgical Update
❏ October 15-18
Tampa, Florida

ENT Surgery PA Practice

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As you would with any job you're considering, find out what the practice can offer you in regard to what you want in a job—the schedule, call requirements, and the role and responsibilities. Also find out about the benefits including the CME bank and PTO. It also never hurts to ask to shadow, so that you can get a feel for the workflow, the practice environment and the staff and providers.

If you're a new grad, definitely make sure that the practice provides adequate support, resources and guidance because if you're working in any specialty, it's at a level higher than what we're taught in PA school. As Ms. Frizzle from the Magic School Bus once said, you need to "Take chances, make mistakes and get messy!" to work in ENT.

LEGAL CORNER

Getting Out When an Employment Arrangement No Longer Suits

By Bonnie Darves

Andrew Knoll, MD, JD

In this regular column, Surgery PA Market Watch speaks with health lawyers about contract issues and other trends related to provider compensation and performance. In this article, physician and attorney Andrew Knoll, MD, JD, a partner with the Syracuse, N.Y., firm Cohen Compagni Beckman Appler & Knoll, PLLC, who specializes in physician and provider contracts, discusses issues that can cause problems when an employment arrangement goes sour.

Q: As advanced practice clinicians increasingly find themselves in hospital- or health system-employed arrangements, they're finding that factors outside their control might change what was a good job into a less desirable one—especially in the case of mergers or acquisitions. How can clinicians protect themselves if the entity they join hooks up with or is consumed by one that they really don't want to work for-whether for personal/ethical or professional reasons?

A: They can't; they're essentially chattel. Welcome to the new business of medicine. Unfortunately, there is nothing that can be done to protect the physician or advance practice providers. That is why I now concentrate on the exit strategy when I review a contract. If the job goes in a direction you don't like, your best option is to quit.

If you want to have more control, you could go with a private group rather than a large entity—but the latter are becoming fewer in the evolving marketplace. The bottom line is that, at least from the standpoint of employment contracts, there's nothing special about a physician or a highly specialized PA. When you enter the workforce, you're an employee. For the most part, you get to do what your employer tells you to do, until the day you don't like it anymore. And then you give notice and quit.

Q: So, are all aspects of an initial employment contract still valid when another entity purchases or merges with the practice that employed the PA or surgeon? For example, what happens if the original employer promises A and B in terms of resources, technology, equipment or other support, and the new entity wants to scale back?

A: It's very common these days for provider employment agreements to include a provision that permits the employer to assign the agreement to a successor entity without need for the employee's consent. If that's the case, the contract continues as it's written. If not, then the employment relationship becomes one "at will," and the original contract terminates. In that case, A and B go away as promises, and the new employer can scale back any way it wishes.

Q: Well, it looks like this leaves us with that exit strategy you mentioned. How easy or hard is it to sever the relationship—and what can advance practice clinicians do to make it less hard should they decide to leave?

A: For example, if the contract can be terminated on 90 days' notice, there's no tail and no restrictive covenant, it's easy to part ways. You simply give notice and look for a job. On the other hand, if it can't be terminated except at the end of a two- or three-year period, there's a 60-mile restrictive covenant (and you grew up in the town and all your family is there), and the malpractice tail coverage costs five figures—it's typically about three times the amount of the annual malpractice premium—you might be in a tough situation.

So, in today's day and age of big health systems and non-negotiable contracts, negotiate the best you can on the exit-strategy criteria such as tail coverage, restrictive covenants and notice period. Then, if the place moves in a direction that you don't like, you can leave.

CONTRIBUTIONS WELCOMED!

Help shape Surgery PA Market Watch by contributing opinion articles that address issues affecting surgical APC practice or that provide guidance on career matters. We also seek ideas for articles on topics of potential interest to our readers.

To discuss an idea or to propose a coverage topic, please contact Surgery PA Market Watch editor Bonnie Darves at **425-822-7409** or **bonnie@darves.net** or publisher Katie Cole at **303-832-1866** or **katie.cole@harlequinna.com**.