

PLAYING *the* ODDS

Physician shortages across the country are giving today's young doctors an advantage when it comes to negotiating salaries. New physicians are landing great deals, and high-demand specialists are practically winning the lottery.

Dr DAVID NGUYEN BECAME WELL AWARE OF HIS FINANCIAL POWER WHILE STILL a resident at the Medical College of Pennsylvania.

Even before his final year working with Hahnemann University Hospital in Philadelphia, the budding gynecologist received dozens of calls from recruiters all over the country trying to position themselves for his future services.

"The phone was just ringing off the hook," says Nguyen. "They started calling a year ahead to arrange these opportunities. Even where I was practicing, there were many opportunities. But I chose not to stay there. I knew there were abundant opportunities everywhere."

An avid outdoorsman who enjoys hunting and fishing, Nguyen wanted out of the big city. He and his wife, a primary care physician, zeroed in on Appalachia, a region that not only offered the lifestyle they wanted, but like most rural areas, also faces a physician shortage.

The young couple instantly became a hot commodity and negotiated deals that not only exceeded entry-level compensation, but included perks like paid malpractice insurance.

"We set a range for ourselves and went to the upper half, not entry level," Nguyen says. "Still, with that request we had many, many offers."

The couple eventually settled on Hazard, Kentucky, where in 2005 he took a position with Appalachian Regional Healthcare, and she at nearby McDowell Hospital. Their rural location did not mean Nguyen

had to sacrifice modern medical conditions to meet his lifestyle goals, however.

"We live in a pretty remote area, yet the hospital has pretty much everything—MRI, CT—you name it, it has it," Nguyen says. "We even have thoracic and cardiovascular surgery—that is what made the final decision. I can definitely do a lot here."

Not all rural hospitals are like this, says Nguyen, recalling visits to several facilities that expected him to practice "old-time medicine with a bag." But he knew the physician shortage coupled with a little patience



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would produce an opportunity that did not require him to compromise his lifestyle, income, or professional goals.

“You really can dictate where you want to go,” Nguyen says. “If you like an area, look around.... You can always find places that meet your needs. You don’t have to compromise anymore.”

Supply and demand

Nguyen represents a new breed of doctors who are keenly aware of the nationwide physician shortage, and financially savvy enough to leverage the age-old capitalistic principle of supply and demand into a sweet financial deal for themselves.

Hospital and physician groups nationwide have come to expect this, physician recruiters say. Specialists know they are in

short supply and are asking for everything from more money to four-day work weeks and as much as 20 weeks paid vacation. What’s more—they are getting it.

The trend has prompted salary escalation in some specialties of almost 10 percent annually since 2000 as physician employers not only must pay new recruits more than ever before, but are forced to give regular raises—sometimes twice per year—to their existing physician employees to prevent them from looking elsewhere.

“Physicians are watching the salaries go up, and they are very tuned in to what the market is for their specialty,” says Kurt Scott, a physician recruiter with the Utah-based VISTA Staffing

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Solutions. “They have no issues talking to their hospital administrators or practice administrators about more money.”

Kurt Mosley, the vice president of business development for the Texas-based physician recruiting firm Merritt Hawkins & Associates, agrees “smart” doctors are leveraging the nationwide physician shortage into better deals for themselves.

“Doctors are holding the cards right now,” Mosley says. “They are more astute about what they earn, what they should earn, and what the market rate is for their services than I have ever seen in my 15 years in the business.”

Hospitals often don’t want to pay the big bucks, but usually have no choice, Mosley says. The average resident now receives

about 80 offers, so employers unwilling to pay the going rate usually see their position remain unfilled. “Sometimes we have to be very honest with a hospital that comes to us and say, ‘This offer you are giving this doctor, we don’t even want to take your money because you are not going to be successful unless you are competitive,’” he says.

Paul Smallwood, the vice president of physician search for St. Louis-based Cejka Search, says physicians usually don’t abuse their newfound power. But “at the same time there is opportunity for them to make a generous income,” he says.

Less gambling, more guarantee

Historically, hospitals lured new recruits with a combination of salary guarantee and a production bonus based on their output, Smallwood says. This management-favored arrangement ensured a doctor’s work habits were tied to his compensation.

Many physicians, however, are no longer willing to gamble with how much money they will take home, Smallwood says, and they are forcing employers to pony up a much larger guarantee.

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A Steep Climb

Between 2000 and 2004, physician earnings rose more quickly than inflation, according to the *American Medical Group Association Physician Compensation and Productivity Survey*.

SPECIALTY	2000	2004	CHANGE
Radiology (non-interv'l)	\$262,579	\$364,899	39%
Dermatology	\$198,196	\$274,014	PERCENT
Radiology (interventional)	\$306,000	\$410,250	34%
Cardiology (cath lab)	\$286,000	\$380,279	33%
Gastroenterology	\$240,000	\$308,246	28%
Hematology & Med Oncology	\$196,500	\$255,007	28%
Cardiology (general)	\$271,001	\$336,000	24%
Anesthesiology	\$255,651	\$315,300	24%
Orthopaedic Surgery	\$308,389	\$381,429	24%
Emergency Care (surgery)	\$190,179	\$230,930	21%
General Surgery	\$244,794	\$294,000	20%
Otolaryngology	\$253,746	\$303,000	20%
Urgent Care	\$147,248	\$176,353	20%
Pathology	\$211,000	\$250,000	18%
Psychiatry	\$149,581	\$177,000	18%
Urology	\$274,063	\$324,690	18%
Endocrinology	\$157,767	\$185,000	17%
Internal Medicine	\$144,264	\$169,569	17%
Pediatrics & Adolescent	\$143,468	\$169,267	17%
Rheumatologic Disease	\$160,876	\$188,260	17%
Infectious Disease	\$161,225	\$185,920	15%
Family Medicine	\$144,290	\$164,209	14%
Neurology	\$178,850	\$201,241	12%
Allergy	\$186,072	\$207,278	11%
Hypertension & Nephrology	\$193,793	\$214,751	11%
Pulmonary Disease	\$199,909	\$222,000	11%
Ophthalmology (surgery)	\$239,379	\$264,422	10%
Gyn & Obstetrics (surgery)	\$228,663	\$250,196	9%
Cardiac/Thoracic Surgery	\$389,926	\$421,620	8%

Table: Median Income. Source: American Medical Group Association.

Saving by Sharing

Giving physicians a voice in administration has solved recruiting problems and saved money for one hospital.

While many small rural hospitals are having a hard time recruiting physicians at a price they can afford, Springfield Hospital in southern Vermont is the exception to the rule.

The 69-bed community medical center located in the Connecticut River Valley just 90 minutes south of the Canadian border does not pay physicians the going national rate. Regardless, it has managed during the past two years to land an otolaryngologist, a neurosurgeon, an anesthesiologist, and a primary care doctor.

No search took longer than a year.

The secret? A total lack of ego within its administration and a willingness to allow doctors an equal partnership in making important decisions, says Tom Crawford, the hospital’s chief operating officer.

“I wish I had something that was really complex that I could sell, but it’s really all about respect,” Crawford says. “If we are going to do anything at this hospital, or change anything, we give our physicians a call and we solicit their input because we don’t want to make any decisions that make their professional life worse or frustrate them.”

Crawford would not disclose what he pays his physicians, but says it is below the median income outlined in salary surveys conducted by organizations like the American Medical Group Association.

Physicians at Springfield, however, are given significant political clout—including four seats on the hospital’s board of trustees—along with a benefit package that includes malpractice insurance, retirement contributions, a four-day work week, eight weeks vacation, and a week



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TOM CRAWFORD, THE CHIEF OPERATING OFFICER OF SPRINGFIELD HOSPITAL, SAYS THE HOSPITAL ATTRACTS PHYSICIANS BY GIVING PHYSICIANS A SAY IN ADMINISTRATIVE AFFAIRS.

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jockeying stops, Crawford says.

“We have one vanilla contract where the only things that change are the names and dates,” Crawford says. “People are looking for an opportunity to have the quality of life they want... We offer things people generally can’t put a price tag on.”

Paul Smallwood, the vice president of physician search for St. Louis-based Cejka Search, says Springfield’s approach is gaining momentum across the county.

“There have been evolutions between physicians and administrators over the years because of the stark (financial) issues that are so substantial now,” Smallwood says.

Terry Caroon, the director of physician services for Phelps County Regional Medical Center in Rolla, Missouri, says her 250-bed regional hospital has also begun offering physicians more administrative control.

“It’s a new concept,” Caroon says. Hospitals are learning that “physicians need to be in the drivers’ seat... They need to be in control, and we (as administrators) need to give them the tools to do a good job.”

Crawford says a prime example of this took place at Springfield Hospital last year when the institution decided to reduce its bed capacity and become a federally designated critical access hospital to save money.

The administration strongly supported the change, but was willing to back down if physicians disagreed, he says.

“That is the power of our medical staff,” Crawford says. “But they are so in tune with what we are doing that they voted unanimously—unanimously—to support us going critical access. I know hospitals that can’t get their doctors to decide on salt or pepper.” ■

of paid continuing medical education anywhere in the continental United States.

These perks are nice, Crawford says, but giving physicians significant administrative and political control is what seems to make the difference.

“Suppose you were going to make \$100 per day but your professional life is miserable because you don’t feel you are being treated right, someone is always breathing down your

back, and there is a hierarchy making it almost impossible to get anything done. Or you could make \$80 per day and none of that exists. What would you choose?” Crawford asks.

“We are finding that physicians are willing to choose a lower rate of pay but a better work environment,” he says.

Once recruits talk to the hospital’s staff and become convinced the administration really does stay out of the way, much of the financial

“If compensation was expected to be \$300,000, in the past they took \$200,000 guaranteed with a production opportunity for \$100,000 more,” Smallwood says. “Now they want the salary to be closer to whole.”

According to the American Medical Group Association (AMGA)—a leading industry compensation tracker—physician income in many specialty areas increased well above the inflation rate throughout the decade.

The AMGA's *2005 Medical Group Compensation and Financial Survey* indicates that in the four years between 2000 and 2004, the latest figures available, physician median income rose 20 percent or more in many specialty areas, while a select few saw increases higher than 30 percent. (See “A Steep Climb”, page 16)

Radiologists and dermatologists led the pack with median compensation increases close to 40 percent. Cardiology incomes rose 33 percent during this time span, while gastroenterology, hematology, and oncology earnings went up 28 percent. Anesthesiologists and orthopaedic surgeons saw income boosts of 24 percent, while general surgeons and otolaryngologists experienced compensation increases of 20 percent.

These trends, which medical administrators say show no signs of slowing, have placed employers in a bind.

“We have lost people over dollars, I'll admit that,” says Thomas Nantais, the chief operating officer for the Henry Ford Medical Group in Detroit. “At some point, you can only pay so much.”

Henry Ford employs some 900 physicians. Nantais, who oversees physician compensation for the medical group, says doctors—especially those in specialties like dermatology and radiology that are experiencing significant income jumps—are acutely aware of how quickly compensation

is rising nationwide.

Physicians are always stopping by his office to talk about their salary and whether more money is available, Nantais says. “Almost every day of the week I hear from a doctor who says, ‘My buddy in private practice, or my colleague who works in California, Idaho, or wherever, makes a lot more money than I do, and as a result I want to be paid accordingly.’”

Pay now or pay later

This pressure creates a Catch 22 for the medical industry.

If a hospital or medical group agrees to pay more, it creates upward pressure within its own system because boosting pay for one specialist means the group must increase compensation for all doctors in a similar specialty.

If, however, the group lets the physician walk and sell his services on the open market, the group must recruit a new specialist and likely pay top dollar anyway because doctors are negotiating in an open market where their services are in short supply but have a high demand.

If the physicians do become “free agents,” they are not inclined to settle for what they were earning in their previous positions, says Terry Caroon, the director of physician services for Phelps County Regional Medical Center in Rolla, Missouri.

“I have not had a doctor make a terribly unreasonable demand,” Caroon says, but “everybody wants just a little bit more than they are making right now.”

Decreasing availability drives up compensation, so “if you are going to attract people you are going to have to ante up,” says Joseph Bisordi, MD, a nephrologist and the chief medical officer of Geisinger Health Care System, which employs 650 physicians and operates three medical centers in Pennsylvania.

“We can't run what is otherwise a prof-

itable hospital without certain specialties, so (finding ways to pay for raising salaries) is the cost of doing business in a sense,” Bisordi says. “Hospitals are finding ways to support and attract people.”

Money, Bisordi says, is only one part of the equation. Physicians also are keenly aware they can parlay their scarceness into benefits like four-day work weeks—which are now the norm for dermatologists—limited call coverage, and extended time off, he says.

“There is a critical shortage” in radiology, Bisordi says. “You see ads for those people starting at \$350,000 out of residency with \$500,000 to \$600,000 or more a year partnership in a couple of years, and things like 10-to-20 weeks off.”

Although shortages exist in nearly every state, not all hospitals and physician groups are forced to play by these new financial rules, says Dr. Robert Johnson, the chairman of the Council on Graduate Medical Education, which assesses physician workforce trends and financing policies for both Congress and the U.S. Department of Health and Human Services.

Medical centers and physician practice organizations in highly desirable communities pay the going rate, but generally have enough applicants so they can hold the line and not add to salary escalation, Johnson says. Less sought after communities, however, don't have the same leverage, he says.

“If the physician goes to a physician shortage area, and usually that is rural, then yes, he does have a lot of power,” Johnson says. “If he wants to go to Florida, California, or New York, or if he wants to ski in Utah, he has less power.”

Rural areas are often the poorest, which makes guaranteeing income difficult, especially if they are recruiting physicians to open a private practice. To compensate,

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many state governments have teamed up with local medical centers to offer financial packages that include tuition forgiveness, loan repayment, and even mortgage subsidies to complement cash.

“Physicians are calling the shots, but in some places there are just not enough (cash) resources to support it,” Johnson says. “So what many states are doing is forgiving tuition, which is a big issue. Some are giving tax incentives.”

An open secret

Physicians do not like to talk about money. Several organizations like the American Dermatological Society, The American College of Cardiology, the American Academy of Orthopaedic Surgeons and even the American Medical Association declined requests for an interview.

Physicians who were willing to talk acknowledged compensation for many specialties is rising, but they say patient volume, not greed, is driving the increase.

Americans are aging and seeking more medical services than ever before, according to specialists. The physician shortage means doctors are doing more procedures than ever, they say, and it's the extra work that is producing additional income.

“Volume is what drives the pool of money,” says Harvey Neiman, MD, the executive director of the American College of Radiology. “You can't raise your fees...because Medicare won't pay any more and insurance companies won't pay any more. So there is only one driver that can send the numbers up.”

Modern technology allows physicians to be more efficient, which has led to increased earnings, but the physician shortage is a double-edged sword, Neiman says.

Radiologists and other specialty groups contract with hospitals to provide services.

If the group is shorthanded, the doctors have to pull night and weekend duty to compensate, which adds to their income.

“If the volume goes up and you can't find a youngster to add to the group, what do you do?” Neiman says. “You do more work and you get the volume done. That is why your income goes up.”

Santa Monica plastic surgeon Michael McGuire, MD, has heard all the jokes and he says he understands that many people believe he and his California cosmetic surgery colleagues all make more than \$1 million annually and live in beachside mansions.

Nothing could be further from the truth, he says. A few do live that kind of lifestyle, but according to the AMGA, plastic surgeons in 2004 on average made less (\$315,000 average annual salary) than neuro, thoracic, orthopaedic, and even pediatric surgeons, McGuire says.

“The *Doctor 90210* (television) shows have done a lot to make our image much worse than it should be,” McGuire says. “If you are at all halfway competent, you are not going to starve to death. But to go into this profession thinking you are going to make millions of dollars is unrealistic, and you are going to be a very unhappy individual.”

Even with today's rapidly rising incomes and many specialties that top \$300,000 in annual compensation, both physicians and medical administrators say few doctors go into medicine for the money.

“I can't imagine somebody going into medicine for the money,” says Peter Pardoll, MD, a retired Florida gastroenterologist who now runs his own medical consulting firm and coaches young physicians about their earning potential. “I saw my friends in law school making a lot more money than I was ever making, and putting in fewer hours.

“The money physicians make is nothing,”

Pardoll says. “Not with the amount of years you spend on your education, and with the responsibilities that you have. And not when you have CEOs of health care insurance companies making \$125 million with their bonuses. You think they spend 100 hours working a week? They don't.”

Even though hospital administrators like Henry Ford's Nantais are willing to say that physicians in some cases are actually “underpaid,” they also say compensation cannot continue to increase at rates that are double—and in some cases triple—the rate of inflation much longer because hospitals can't afford it.

The solution? Medical schools must increase supply by increasing student capacity—the Association of American Medical Colleges earlier this year called for medical schools to increase student volumes by as much as 30 percent in some cases. That's the only way to curb the physician shortage and stabilize salaries, Nantais says.

“We have to get back to equilibrium,” Nantais says. “At this point, we are okay, but if (physician earnings) continue to escalate beyond the rate of inflation, or what is considered to be reasonable salary increases, we probably will have a problem.” ■

John Zicconi is a free-lance writer and a longtime contributor to *UO*.