

The Business of Academic Plastic Surgery

L. Scott Levin, M.D.

Philadelphia, Pa.

Background: Given the changes in health care economics and the changes in increasing rates of uninsured and undercovered patients in the United States, the revenue stream for all physicians, and particularly those in academic medical centers, is subject to fluctuations that make it difficult to fund the missions of education and research. Often, academic plastic surgeons are required to use clinical revenue to supplement efforts in research and education. A large margin on clinical revenue that was present perhaps 10 or 20 years ago has been eroded by many socioeconomic factors, making it difficult to provide optimal training in academic environments for our residents.

Methods: In an attempt to ascertain “best in show,” a survey was sent to 89 plastic surgery programs that requested information regarding faculty salaries, relative value units, National Institutes of Health support, ancillary revenue support for taking call, and the number of faculty within individual programs.

Results: Fifty-three programs responded with completed data.

Conclusion: The following practices directly contribute to stable financial environments: external support for call coverage, recruitment support, and gain sharing associated with health system profitability. Coverage agreements with outside facilities can be lucrative if properly negotiated. Paid medical directorships for administrative/clinical oversight are helpful. Payor mixes with high percentages of commercial, managed care, and self-pay (aesthetic) and low percentages of Medicaid are beneficial. Practices with a healthy mix of aesthetic surgery add strength. (*Plast. Reconstr. Surg.* 126: 303, 2010.)

The “business” of academic plastic surgery is critical to the success of the specialty across the missions of education, research, and clinical care. Often, division chiefs or department chairs have been asked: “Do you know anybody in your program that would be good to join our group practice or academic institution as a young faculty person or a new partner?” Although the majority of plastic surgery residents who finish their training gravitate to the private arena, the need for committed academic plastic surgeons is more important than ever, as divisions struggle with financial and autonomy issues.¹

Clearly, the pathway for autonomy and financial solvency as outlined by the Association of Academic Chairmen of Plastic Surgery leadership is moving toward achievement of departmental status.² We not only need to attract the best and the brightest plastic surgery residents into either integrated, combined, or independent programs, but we need to prove to them that academic plastic

surgery can be professionally fulfilling in all of the subspecialties within plastic surgery and be a lucrative and rewarding career.³ With changes in economic policy and diminished reimbursement for reconstructive surgery, academic surgery in all specialties is at a crossroad. The margin no longer exists where academic plastic surgery programs can fund the missions of education and research on the clinical enterprise alone.

Accordingly, we hope to use these data to deepen our individual and collective understanding of where programs exist in relation to peers, and understand how other programs are able to improve their financial health (e.g., receiving reimbursement for being on call, obtaining a higher percentage of indirect funds coming from the dean for National Institutes of Health grants). By establishing data points, and collating data, information can be used to strategically provide leverage within an institution to move toward departmental status.² Furthermore, the information may help make adjustments to the programs.


From the University of Pennsylvania.

Received for publication July 14, 2009; accepted October 28, 2009.

Copyright ©2010 by the American Society of Plastic Surgeons

DOI: 10.1097/PRS.0b013e3181dbc0af


Disclosure: *The author has no financial interest to declare in relation to the content of this article.*



CLINICAL PRODUCTIVITY & COMPENSATION

	AVERAGE	MEDIAN
Average WRVUs per surgeon	7,009	6,800
Average Collections per surgeon	\$699,814	\$600,608
How many surgeons in your program	5	5
Collections/WRVU	\$98	\$91
Average Compensation of surgeons (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only)	\$364,463	\$349,745
Compensation as % of Receipts	58%	53%
Comp/WRVU	\$53.50	\$49.75
Starting salary for hires out of fellowship (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only)	\$219,061	\$220,000

Fig. 1. Clinical productivity and compensation. *WRVU*, work relative value unit.



EXTERNAL SUPPORT

Do you receive any revenue as part of shared profitability with your hospital and/or SOM? (i.e. ASC)?	11 of 51 (23%) report receiving some form of support.
Payment for call coverage?	16 of 51 (33%) report receiving payment for call coverage.
Please provide a listing of any medical director type revenue/stipends received (i.e. Trauma Call= \$50,000/yr/MD for 3 MDs; Director of X = \$25,000/yr, etc.)	29 of 51 (57%) report receiving medical directorships.

13

Fig. 2. External hospital support. *SOM*, State Operations Manual; *ASC*, ambulatory surgical center.

METHODS

A survey was distributed to better understand the financial scorecard of the members of the Association of Academic Chairmen of Plastic Surgery (Figs. 1 through 3). The purpose of this “Association of Academic Chairmen of Plastic Surgery survey” of divisional/department finances was to

understand how academic centers are performing in areas of physician income, endowments, and institutional support. By analyzing these data, insight will be gained as to whether or not academic plastic surgery, as we know it now or have known it in the past, is sustainable. These data will also be used as a platform for advancing critical dialogue



Fig. 3. Practice expenses, hospital costs, and additional revenue. *NIH*, National Institutes of Health.

between department chairmen and division chiefs and hospital and health system leadership in plastic surgery.

On January 17, 2008, the Association of Academic Chairmen of Plastic Surgery leadership requested members to participate in a survey to evaluate multiple financial parameters in academic institutions in the United States specific to clinical productivity, physician compensation, and numerous criteria that affect these data points (e.g., external funds flow from ancillary support from the hospital from medical directorships sharing profitability with the hospital) (Figs. 1 through 3).

RESULTS

Fifty-three programs responded with completed data. Response rates to mailed surveys when published in medical journals are approximately 60 percent.⁴ There were 10 programs that attempted to provide data for the survey. Some were small divisions, and some were in a state of flux and had no or only one faculty member. For this reason, these programs were excluded from the total data analysis. Data included aggregate clinical productivity, compensation, average relative value units per surgeon, collections per surgeon, collections per work relative value unit and average compensation to surgeons, compensation as percentage of re-

ceipts, compensation per relative value unit (Figs. 3 and 4), and the starting salaries for nonfaculty members.

The following results directly contribute to stable financial environments: external support for call coverage, recruitment support, and gain sharing associated with health system profitability. Coverage agreements with outside facilities can be lucrative if properly negotiated. Paid medical directorships for administrative/clinical oversight are helpful. Payor mixes with high percentages of commercial, managed care, and self-pay (aesthetic) and low percentages of Medicaid are beneficial. Practices with a healthy mix of aesthetic surgery add strength.

DISCUSSION

Strategies for optimizing “financial position” include negotiating for external support (46 percent of our programs receive money for call coverage, recruitment support, and/or gain-sharing profitability). Negotiate to get paid for administrative/clinical oversight by means of medical directorships (51 percent of our programs receive this type of support). Increase aesthetic surgery cases. Seek and carefully evaluate coverage agreements with outlying facilities. You may actually earn more providing that coverage than spending a busy day at your hospital. Does it make sense to transition to a hos-

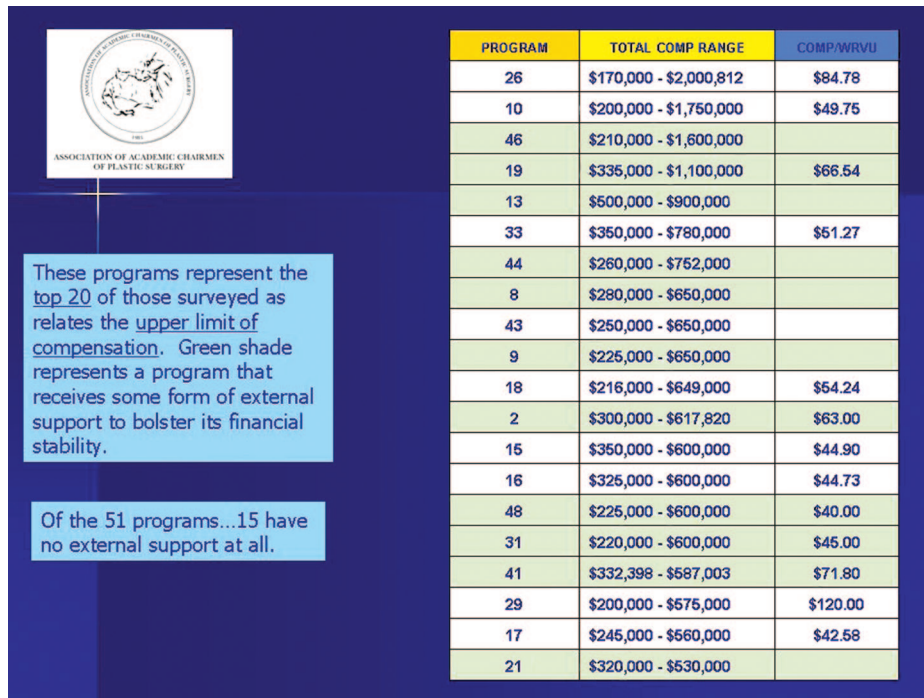


Fig. 4. Compensation for 20 programs.

pital-based clinic? This would alleviate the costs of the clinic and some indirect expenses associated with it. There are also risks of losing patients because of increased exposure to deductibles and payments. If you are in a hospital-based clinic, negotiate to get some of the indirect expenses you own covered (i.e., nursing/midlevel, transcription, file clerk; 40 percent of our programs in hospital-based clinics receive such support). Negotiate growth of faculty with your hospital/health system. The health system needs to be invested in your growth, and in some cases it benefits them more than you. Get the system to invest in the costs of recruitment and covering deficits associated with new hires.

Patients typically arrive in the operating room through the clinic. Increasing your time in the clinic will generate work relative value units and receipts as you increase your caseloads. It is not unusual for a surgeon to spend 2 full days per week in the clinic. Invest in personnel who optimize your net collection rate to be consistently approximately 95 percent to ensure that you are collecting all you are entitled to collect. Closely examine the expense structure/overhead of your practice to reduce personnel expenses whenever possible.

There were several areas of discrepancy between divisions in terms of compensation for surgeons, support from health systems, and National Institutes of Health funding. Collectively, these data will be

important to generate ideas for sustenance of academic plastic surgery as we go forward in the future.

This is the first attempt to reflect national data in support of academic plastic surgery programs. The programs represented in the survey include a very high percentage (53 of 89). The data represent a critical mass of information that reflects the best practices in many institutions throughout the United States. Subsequently, strategies to improve fund flow to a division or to a department and ultimately to surgeon compensation will result in faculty satisfaction with academic surgery as a career choice. Furthermore, training programs now have data that suggest sources of revenue that are available that were not considered or were not requested. Academic plastic surgery, with their strength in reconstruction surgery that includes the management of craniofacial trauma and hand emergency, do have significant strength and importance in any health system, often because of small faculty size compared with other divisions or departments such as orthopedics, general surgery, or neurosurgery. Plastic surgery has had difficulty acquiring the resources that are necessary to sustain its academic surgery missions, including research, education, and optimization of patient care. These data will allow chiefs and chairmen of divisions and departments to have objective data that can be used to negotiate improving financial health, which will ultimately and positively

impact on resident education and quality of training for our residents.

L. Scott Levin, M.D.

Department of Orthopaedic Surgery and
Department of Surgery
Division of Plastic Surgery
University of Pennsylvania
2 Silverstein
3400 Spruce Street
Philadelphia, Pa. 19104
scott.levin@uphs.upenn.edu

REFERENCES

1. Krieger LM, Lee GK. The economics of plastic surgery practices: Trends in income, procedure mix, and volume. *Plast Reconstr Surg.* 2004;114:192–199.
2. Guyuron B. Academic plastic surgery: Division or department? *Aesthet Surg J.* 2008;28:594–595.
3. Addona T, Polcino M, Siver L, Taub PJ. Leadership trends in plastic surgery. *Plast Reconstr Surg.* 2009;123:750–753.
4. Asch DA, Jedrzeski JK, Christakis NA. Response rates to mail surveys published in medical journals. *J Clin Epidemiol.* 1997; 50:1129–1136.

Recent Supplements in *Plastic and Reconstructive Surgery*[®]

- Body Contouring Surgery after Massive Weight Loss (January 2006)
- Consensus Recommendations for Soft-Tissue Augmentation with Nonanimal Stabilized Hyaluronic Acid (Restylane[®]) (March 2006)
- Current Concepts in Wound Healing (June 2006)
- Semipermanent and Permanent Dermal/Subdermal Fillers (September 1, 2006)
- Advances in Breast Augmentation (December 2006)
- Temporary Dermal and Soft-Tissue Fillers (November 2007)
- Craniofacial Trauma (December 2007)
- Silicone Breast Implants: Outcomes and Safety (December 2007)
- Advances in Facial Rejuvenation: Botulinum Toxin Type A, Hyaluronic Acid Dermal Fillers, and Combination Therapies—Consensus Recommendations (May 2008)
- Advances in Pediatric Plastic Surgery (online, July 2009)
- Evidence-Based Patient Safety Advisory for Ambulatory Surgery (October 2009)
- Advances in Reconstructive Microsurgery (online, December 2009)