

Out of 525 invitations 283 (54%) responses were returned.

The median age of respondents was 40-49 years (37%) with 22% below 40 years and 40% age 50 or above. 68% of respondents were male. 62% have been in clinical practice for 10 or more years, 23% for at least 25 years and 16% for less than 5 years.

15% (36) of respondents were Chief of pediatric otolaryngology at their institution (7 with endowed chairs and 5 are department chairman/chairwoman). Academic rank among those with an academic affiliation were 33% assistant professor, 40% associate professor, and 27% full professor.

The entire United States was well represented.

66% of respondents are fellows in AAP and 58% fellows in ACS.

101/257 (39%) of respondents were 10 years or less into their first job out of fellowship and reported a median starting base salary of \$250,000 with 13% receiving >\$300,000., Estimated median total pay including bonuses and sign-on expenses was \$275,000.

Student debt had a left sloping curve with 64% of respondents completing training with <\$100,000 in debt (32% had no debt). Conversely 9.1% of respondents have >\$250,000 in student debt at completion of training. However, when factoring in combined debt with their spouses, only 55% had a debt <\$100k and 17% had >\$250k with 5% >\$350k.

The majority (88%) of respondents are not participating in loan forgiveness programs, with Federal Loan repayment program being the most common forgiveness program used (8%).

58% of respondents practice in the same location since completion of fellowship. 30% are in a second practice location, 9% in a 3rd and just 3% have had more than 3 unique practice locations since completing fellowship.

Practice style is chosen for a variety of reasons with geographic location (72%), a desire to teach (60%), academic opportunities with resident presence (53%), current partners in the group (56%), and an ability to sub-specialize (47%) representing the most common factors.

Only 41% of respondents had an attorney review their initial contract before signing. 90% engaged in none or minimal negotiations before signing the contract. The most commonly negotiated factor was first year compensation with research time, academic/meeting expenses, and support (both clinical and academic) representing the most common additional factors negotiated at the initial contract. 45% of respondents have further negotiated salary or other compensations since starting their current job while 32% of respondents have negotiated non-monetary compensations such as vacation, research time, support, maternity/paternity leave since starting their current job.

Interestingly, 49% of respondents have sought additional structured training in leadership, finance or teaching skills since finishing their fellowship. 25% of respondents hold a secondary educational degree, (17 MPH, 7 PhD, 16 MBA and 23 other).

45% of respondents were in a practice that afforded partnership (ie/ same benefits as other members, full participation in incentive pool, finished paying any “buy-in”). Of those, 30% made “partner” at the end of the 1st year, 24% at the end of the second year, and 6% not until after their 5th year of employment.

83% hold their primary appointment under the Department of Otolaryngology or Pediatric Otolaryngology while 17% are in the Department of Surgery, and 10% hold a joint appointment in Pediatrics.

36% of respondents work in groups without adult otolaryngology partners. The most common arrangement (35%) is a group of 5-10 pediatric otolaryngologists while 8% are the only pediatric otolaryngologist in their practice.

Having advanced practice providers was very common. 75% of respondents have nurse practitioner (NP) colleagues in their practice, the majority (51%) having 1-2.

55% of respondents have physician assistant (PA) colleagues in their practice, with the most frequent arrangement also being 1-2 PAs in the practice (55%).

84% of respondents are Full time (1.0FTE), 12% are between 0.8-0.99FTE, and 4% are part time (0.5FTE or less). The median for average of hours worked each week (accounting for all clinical and non-clinical activities) is 51-60 hours. 11% of respondents work more than 70 hours per week while 7% work <40 hours.

18% of respondents report that they had reduced workload since starting their current position. Interestingly, respondents reported doing so most commonly before age 50 (48% of the time), between 50-55 (19% of the time), and after age 60 (29% of the time). In addition, the majority of those who reduced their workload did so by only <5%.

The majority of respondents (46%) hope to retire at age 65-70, with an additional 28% looking to retire between ages 60-65 and <10% preparing to retire before age 60. About 8% plan to die on the job! (no plans to retire), Luckily 77% of respondents feel on track financially to retire when desired.

Most respondents see patients and operate at more than one location (55%). Of these, 52% went to an off-site location with an ambulatory OR, 78% went to a satellite office without an OR, and 44% went to a free-standing satellite OR (32% were going to more than one satellite location).

The most common breakdown reported regarding acuity of Pediatric Otolaryngology practices was that 50% of the patient load is made up of uncomplicated children needing uncomplicated procedures, 20-30% is composed of complicated children needing uncomplicated procedures and 20-30% are children requiring complicated procedures.

60 % of practices are made up of >40% uncomplicated children needing uncomplicated procedures while 70% of practices are made up of >20% complicated children needing uncomplicated procedures and 60% of practices are made up of >20% children needing complicated procedures.

Most doctors schedule 16-20 children in a typical half day with <5% scheduling >30 children in a half day session.

Templates typically allow 15 min for new patient visits, and 10-15 min for follow up patients, and 10 min for post op patients. 40% of respondents utilize PA/NPs to enhance their clinical volumes adding 5-10 additional patients in a typical half day with this support. It is not typical to utilize residents/fellows to specifically enhance clinic volumes

Respondents report that no-shows and same-day cancellations are a real issue, impacting half day clinic visits by an average of about 4-5 patients per day.

A majority of respondents (54%) see children in at least 16 ½ day office sessions per month, with 75% participating in at least one multi-disciplinary clinic per month. A typical month includes 8-12 ½ day OR sessions (or 4-6 full OR days) at the main hospital, and 2-4 ½ day OR session (or 1-3 Full days) at a surgicenter or satellite OR each month. Clinic time and OR time held roughly a 1:1 weighted average.

The majority of respondents report seeing a mean of 80 new patient visits each month (between 41-120) , with a median of about 65 surgeries each month (most commonly between 51-75).

The most common models for support staffing were:

- Sharing a personal surgery scheduler between 1-4 providers and not having a personal clinic scheduler or a Departmental surgery scheduler.

- Office-shared PNP or PA between 1-6 providers

- 1/3rd of practices did NOT have an RN (when present, shared between 3-4 providers)

- 70% of practices did NOT have a shared LPN (when present, shared between 3-4 providers)

- 78% of practices employed MA's typically shared among 3-4 providers

- Office managers were employed in 94% of practices, most typically shared with the whole group

- A shared Triage nurse was present in 60% of practices, typically shared with the whole group

- Administrative assistant/Secretary shared between 3-6 providers.

- Most do not have a Research Assistant but when present they were typically shared with >10 providers.

The median income for practicing medicine in the responding group is \$447,081 with 40% making between \$350,000-\$500,000 while 25% make <\$350k and 35% make >\$500k (20% making >\$600k).

There remains a gap between male and female Otolaryngologists. The mean salary for male Pediatric Otolaryngologists was \$462,000 while the mean salary for female Pediatric Otolaryngologists was \$415,000 a gap of \$47,000.

This gap appears mostly explained by age differences within the specialty.

AGE	30-39	40-49	50-59	>60
	60%M/40%F	67%M/53%F.	70%M/30%F.	82%M/18%F

Compensation by age group

30-39	\$379K
40-49	\$479K
50-59	\$473K
>60	\$438K

Age group by gender

	30-39	40-49	50-59	>60		
Females.	28%	39%	23%	10%.	=.	100%
Males	19%	37%	23%	21%.	=.	100%

32% of respondents were female and 68% of respondents were male

So it is pretty clear that a higher proportion of the female respondents were in the youngest age group and that the youngest age group had a distinctly lower compensation level when compared to the other age cohorts.

It would take a focused survey design to tease out the factors that may contribute to gender differences in compensation (clinical productivity measures; straight salary vs incentive eligible job choices; effects of child-bearing/child raising; academic rank/responsibilities.

There were also geographic differences noted. Pediatric Otolaryngologists practicing in the Midwest earned a mean of \$507,000 compared to \$453,000 in the Western states, \$444,000 in the Southwestern states, \$425,000 in New England/Mid-Atlantic states and \$423,000 in the Southern states.

As would be expected, Academic rank also showed differences in compensation. Chiefs of Pediatric Otolaryngology averaged \$521,000, Professors (non-chiefs) \$478,000, Associate Professors \$463,000, and Assistant Professors \$391,000. Those with an Academic Affiliation but no rank averaged \$541,000 while those with no Academic Affiliation were compensated at a mean of \$442,000.

The most common compensation agreement appears to be a base salary making up about 80% of compensation with a productivity bonus making up 20%. Only 15% are on a “straight salary” (no productivity bonus).

RVU generation as a basis of calculating a productivity bonus is the most common model (62% of those who get a productivity bonus) and the mean RVU generation reported is 7001-8000.

When RVU targets are not met, 1/3rd have no consequence while 1/3rd suffer a financial penalty and 1/3rd get counselled or lectured.

Academic productivity incentive/bonuses were present in about ½ of practices but resulted in <5% of total compensation in 77% of cases when available.

Incentive bonuses for documentation, cost-containment, community service or medical missions are exceedingly rare and minimal when present.

Supplements for performing administrative duties for the practice, hospital or school are provided to 40% of respondents but almost always (90% of the time) make up <10% of total compensation.

20% of respondents engage in occasional medical malpractice reviews at minimal financial remuneration.

40% of respondents get paid something for providing after-hours or trauma call at their hospital but it typically (86%) accounts for <5% of total compensation.

Ownership in a surgicenter or medical office building is enjoyed by 23% and, when present, averages about 10% of total compensation.

Additional benefits that are provided as part of employment to >70% of respondents include:

- Malpractice coverage
- Meeting travel allowance
- Medical organization dues
- Disability insurance
- Life Insurance
- Pre-tax retirement plan
- Matching retirement plan contribution
- Medical licensing fees

<20% of respondents receive:

- Tuition reimbursement
- Long term care insurance
- Medical equipment allowance
- Auto allowance

Pre-tax retirement contributions combined between employer and employee averaged \$40,000 with 10% contributing >\$65k and 27% contributing <\$25K.

403b was the most common vehicle for retirement funding (70%) followed by HSA and 401K accounts. <10% participate in a pension-profit-sharing plan.

We appear to be good at saving for retirement with additional Post-tax dollar contributions towards retirement exceeding \$20k by 44% while only 27% contributed <\$5000.

61% of contracts include a geographic non-compete clause. 43% allow termination without cause. 80% of respondents report no prohibition against expert witnessing or industry consulting. Half of respondents reported being allowed to moonlight.

The majority of respondents reported 40-60% of their patient population being covered by either Medicaid or Medicaid managed care. 20% had <30% Medicaid while 39% had >50%. Only 2% reported having more than 10% indigent care (no coverage) and 10% reported having more than 10% enrolled in high deductible HSA plans.

The most typical breakdown was:

Medicaid (or Medicaid/HMO) 50%

Commercial insurance 20%

HMO 20%

Tricare 5-10%

Indigent care/Self pay <5%

Future growth of our specialty with respect to work-force related expansion over the next 5 years was interesting and should be balanced with our Pediatric Otolaryngology Fellowship graduation rates and the anticipated retirement estimates reported above.

38% of respondents anticipate adding one net MD

29% of respondents anticipate adding two net MDs

14% of respondents anticipate adding 3 or more MDs to their practices

19% do not anticipate a change in the number of practicing otolaryngologists

Only 1% reported anticipating a decline in pediatric ENT in their practice

66% anticipate adding one or more additional advanced practice providers (NP/PA) within the next 5 years.

33% expect to add one APP

19% expect to add two APPs

15% expect to add 3 or more APPs

Of those who employ APPs 58% are compensated on a salary from the hospital or medical school independent of the physician's clinical practice while 35% are paid by the clinical practice and 1/3rd of those are able to earn a productivity bonus.

While the majority (60%) of respondents were not privy to expenses of his/her practice, of those that were, overhead averaging 50% excluding physician salaries was reported by the majority.

In regard to physician on-call duties, only 30% of pediatric otolaryngologists reported being paid a specific stipend for taking call. 28% for covering facial trauma call, and 37% reported other specialties in their hospital were receiving additional stipends for call responsibilities.

The majority (65%) of respondents are responsible for covering only 1 hospital while on call while 19% cover 2 locations, 7% cover 3 locations, and 4% cover 4 or more hospitals. 4% reported only covering patient phone calls, without a primary hospital call responsibility.

On-call burden averaged 5 nights a month (1 in 6 night call) with 18% averaging 2 or fewer nights per month (1 in 15) and 8% more than 10 nights (1 in 3). 74% only cover children while on call leaving ¼ to cover adults and children on their call nights.

The majority of respondents have primary coverage while on call; 86% have resident coverage, 28% have fellow coverage, and 23% have PA or PNP primary coverage while on call. Daytime calls tend to be triaged by a member of the nursing staff acting as a triage nurse (51%) or have a primary nurse triage line (19%). 39% of respondents reported getting >7 patient-related messages daily to respond to while 30% get <3.

Paid time off for vacation is typically 20 days, with 6% getting 2 weeks or less and 26% receiving 5 weeks or more.

Paid academic leave is typically 10 days with 17% getting 3 weeks or more and 31% getting 1 week or less.

Sick leave allowance is usually < 10 days, FMLA was > 30 days. Maternity/Paternity leave is typically >30 days.

62% of respondents have protected research, teaching, or administrative time. Usually this is allotted at either 2 (30%) or 4 (26%) days each month. 15% of respondents reported >4 days per month for academic/research time. This time was not contingent on meeting minimum volume or revenue metrics in 90% of cases. In addition this time is not factored into compensation unless impacted through salary support via a grant or stipend (12%), or as a compensation point system (17%).

Electronic health record (EHR) is nearly universally utilized; 63% of respondents used EPIC, 17% CERNER and 20% utilize another EHR in the office while 68% use EPIC and 26% use CERNER in their primary hospital.

The top five issues most concerning to pediatric otolaryngology respondents include:

1. Reimbursement levels for what we do
2. Creating a separate certification process for Advanced Pediatric Otolaryngology
3. Maintenance of Certification
4. Long term workforce issues in Pediatric Otolaryngology
5. Advocacy efforts at the state and national level

On a scale of 0 (not at all burned out)-100 (ready to quit tomorrow), some degree of Burn-out at the present time or in the past was reported in about 78% of pediatric otolaryngology respondents with an average score of 22. Most (63%) report relatively low levels (<30), however, there were 10% of respondents at a level 41-50, 7% at level 71-80, and nearly 6% of respondents considered themselves burned out to the level of considering quitting.

The majority of respondents (57%) reported re-thinking work/life balance and priorities in response to their feelings of burn out. 28% reported changing work schedule and/or vacation allotment, and 20% reported changing work focus (more or less clinical, admin, or research). 19% had not initiated any changes in response to feelings of burnout.

59% of respondents report being extremely or very satisfied with the value of his/her membership in ASPO, while 6% are not or extremely not satisfied.

The most common suggestions for improvements include:

1. Continue gathering this information and publish/distribute these results
2. Engage the younger members more in the organization
3. Pursue more diversity in presenters/moderators with emphasis on more complex topics
4. Do not pursue Pediatric Sub-specialty certification
5. Have ASPO support local and regional education efforts by members
6. Make the survey shorter