2018 ASCRS Physician Compensation Survey

Executive Summary

February 2020

Created by ECG Management Consultants
on behalf of the
Healthcare Economics Committee
American Society of Colon and Rectal Surgeons

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Executive Summary

Background

The American Society of Colon and Rectal Surgeons (ASCRS) is the premier society for colon and rectal surgeons dedicated to advancing and promoting the science and practice of the treatment of patients with diseases and disorders affecting the colon, rectum, and anus. One of the most significant changes for members of the society over the past 30 years has been the shift from a self-employed, small practice model to one of employment by large healthcare organizations. Increasingly, healthcare organizations are using physician compensation data obtained through third-party surveys to help inform compensation (e.g., salary, incentives, and benefits) decisions. As part of a strategic plan designed to provide value to our members, the Executive Council of the ASCRS charged the Healthcare Economics Committee (HEC) to broadly examine the current state of colorectal surgery practice and compensation.

Previous surveys that report data for colorectal surgeons have been limited by low numbers of respondents. Some surveys do not report colorectal surgery as a defined specialty, requiring extrapolation from the results reported for general surgery or surgical oncology. Furthermore, little or no information is available regarding the impact of board status, case mix, years in practice, participation in general surgery call and other factors that may influence compensation.

Purpose

The purpose of the ASCRS survey was to develop a more reliable and representative compensation and production benchmark for ASCRS members that would also provide information on surgeon demographics, practice characteristics, incentives, benefits, and other relevant factors. By surveying active members practicing in the U.S., the ASCRS had potential to engage a larger number of respondents than any other existing survey, allowing more granular comparisons.

It was anticipated that the knowledge gained would benefit members of the ASCRS in many ways.

- Benchmark compensation and productivity data will allow surgeons to evaluate the economic health of their practice.

- Surgeons negotiating an employment contract, whether as a practice leader or potential employee, will benefit from a more robust benchmark by which to set realistic productivity goals and fair compensation.
- Physician-leaders may use the data to guide the structure of compensation models, employment decisions and resource allocation.
- ASCRS strategic initiatives will be informed by the provider and practice characteristics data.

Survey Design and Methodology

Physician compensations surveys are subject to regulation under the Sherman Anti-Trust Act. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) have issued safe-harbor guidelines and will not challenge written surveys of physician compensation if the following conditions are satisfied: [1]

1. The survey is managed by a third-party;
2. The information provided by survey participants is based on data more than 3 months old; and
3. There are at least five providers reporting data upon which each disseminated statistic is based…and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.

ASCRS engaged ECG Management Consultants (ECG) as the independent third-party administrator of the Physician Compensation Survey. The survey instrument was jointly designed by the Healthcare Economics Committee and ECG, with final approval from the Executive Council. Questions were chosen to address significant gaps in existing surveys while respecting the many demands on our members' time. The survey was designed to be completed in no more than twenty minutes. Data requested in this survey represents activities from 12 months ending December 31, 2018.

ECG created a secure online survey portal and was responsible for data collection, aggregation and summarization. Further *post hoc* analysis was performed by an independent bioinformatician engaged by the HEC. ASCRS members at no time had or will have access to the unblinded data set, which is maintained in strict confidence by ECG.

Although members were encouraged to answer all questions to maximize the value of the survey, the survey was designed to allow members to decline to answer any question deemed too sensitive or for which they did not know the answer. The only required answers were those necessary to ensure compliance with DOJ and FTC requirements.

The resulting de-identified dataset is owned by the ASCRS and cannot be used by ECG or any other entity without the permission of the ASCRS. The Executive Council will control access to the raw data and be responsible for ensuring continued compliance with the DOJ and FTC guidelines.

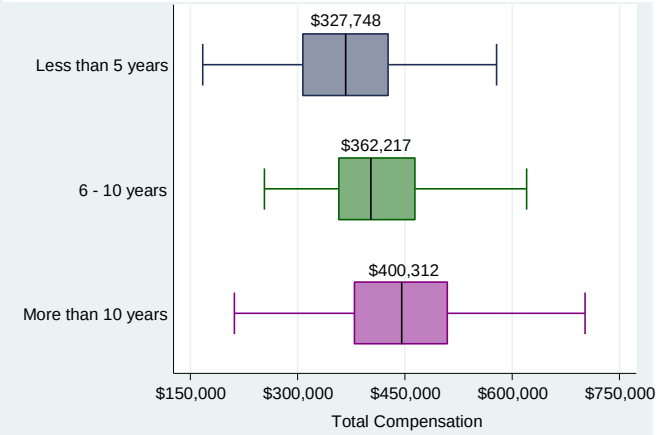
Findings

A total of 4,063 ASCRS contacts (not known to be retired or practicing internationally) were invited to participate in the survey via email. Responses were received from 811 colon and rectal surgery providers, of whom 788 were in active practice in the United States and eligible for inclusion. This 20% response rate exceeds the typical response rate of 10%–15% for similar surveys. Contacts accessed their unique survey link using a randomly generated source identification number, which acted as another measure of security.

Of the 788 eligible respondents, 479 surgeons from 283 organizations provided compensation data, making this the largest colorectal surgery compensation dataset extant. Of the 479 surgeons for whom compensation data was provided, 297 also provided work RVU data.

Compensation: Compensation was found to vary by years since completion of colorectal fellowship. We have reported median compensation with inter-quartile range for three cohorts based on years since completion of training: new practices (0-5 years), developing practices (6-10 years) and mature practices (11-30 years). Median compensation ranged from $327,748 for new practices to $400,312 for mature practices. (See **Figure 1.1**)

Figure 1.1 Total Compensation by Years in Practice (normalized* to 1.0 FTE)

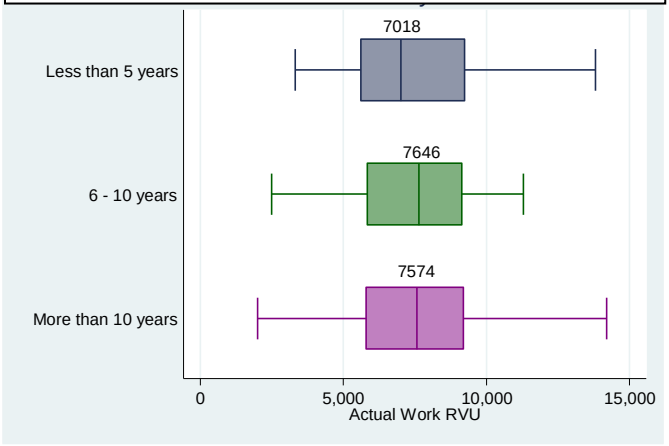


** Most respondens (96.4%) were employed full-time (1.0 FTE). For those who reported < 1.0 FTE total employment, compensation was "normalized" to the equivalent of 1.0 FTE by dividing compensation by the reported FTE.*

Productivity: Many respondents (67.6%) reported that a portion of their time was protected for non-clinical duties. Non-clinical time varied from as little as 1%, to as much as 95%, of the surgeon's contractual obligation. Assessment of productivity, as measured by work RVUs, is difficult for surgeons with contractually defined non-clinical time. It is likely that the contractual delineation of workload does not precisely reflect the actual distribution of the surgeon's activities. Therefore, Work RVU data is reported with three different methodologies.

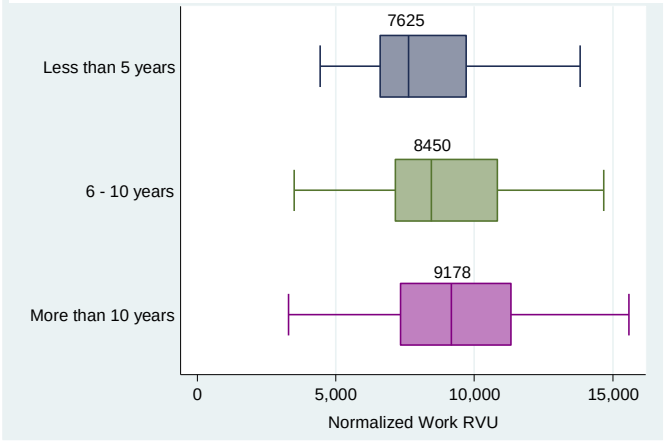
Reported Work RVUs: Median Work RVUs with inter-quartile range is shown for all respondents in **Figure 1.2**, regardless of reported clinical FTE status. Median Work RVUs increased from 7018 for new practices to 7574 for mature practices. This understates to some degree the productivity to be expected from a surgeon with full-time clinical duties because of the inclusion of data from surgeons with significant non-clinical duties.

Figure 1.2 Reported Work RVUs by Years in Practice



Normalized Work RVUs: To avoid understatement of productivity brought about by the inclusion of data from physicians with less than full-time clinical responsibilities, ECG reports productivity "normalized" to the equivalent of full-time, 1.0 FTE clinical productivity as is shown in **Figure 1.3**. This is done by dividing the reported Work RVUs by the clinical portion of the physician's time. This model assumes that a surgeon with contractually protected time produces clinical Work RVUs exactly proportional to the stated percentage of clinical time. For example, a half-time clinical surgeon (0.5 FTE clinical) is assumed to produce exactly half as many Work RVUs as a full-time clinical surgeon (1.0 FTE clinical). Therefore, the half-time surgeon's reported Work RVUs are divided by 0.5 to achieve equivalence to the Work RVUs reported by full-time clinical surgeons. In this model, the median Work RVUs increase from 7625 for new practices to 9178 for mature practices. Because many compensation models reward surgeons who exceed RVU targets (but not those who exceed their protected time), a part-time clinical surgeon is more likely to produce Work RVUs at a

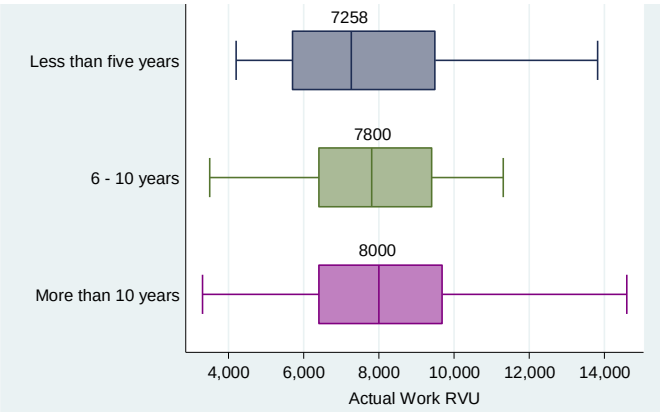
Figure 1.3 Reported Work RVUs Normalized to 1.0 FTE Clinical Work



higher rate than anticipated by the stated contractual clinical time than at a lower rate. As a result, this model likely overstates the clinical productivity for surgeons with contractually protected non-clinical time.

Reported Work RVUs for Surgeons with at least 0.8 Clinical FTE: The normalization methodology described above introduces increasing risk of inaccuracy as the percentage of clinical time decreases. Therefore, the unadjusted Work RVUs reported by only those 235 surgeons reporting both Work RVUs and a clinical FTE of 0.8 or greater is shown in **Figure 1.4**. These surgeons are working primarily as clinicians. It is likely that they are participating fully in on-call responsibilities and very likely have clinical productivity approximating that of a surgeon without protected time. While this value might understate the productivity to be expected from a full-time clinical surgeon, the potential for error is much smaller due to the exclusion of data from surgeons with less than 0.8 FTE clinical responsibilities.

Figure 1.4 Reported Work RVUs for Surgeons with ≥ 0.8 Clinical FTE



Discussion

The ASCRS 2019 Compensation Survey represents the largest survey database of compensation and productivity data for colorectal surgeons. This data is a valuable resource for members of the society who wish to evaluate the economic health of their practice, set realistic RVU production goals, allocate resources, assess a compensation model or negotiate an employment contract. Colorectal surgeons practice in an increasingly complex economic environment and there are multiple variables that impact productivity and compensation. Geographic location, case mix, payer mix, referral patterns, non-clinical responsibilities, and allocation of resources such as APP support, OR access and clinic hours must all be considered. Therefore, this data must be considered in the context of the unique attributes of a given practice. It is also important to recognize the strengths and limitations of this report which are described in **Table 1.1**.

Table 1.1 Survey Strengths and Limitations

Strengths	
Large sample size	811 surgeons responded by completing at least a portion of the survey. Of these, 788 met the inclusion criteria of surgeons actively practicing in the United States in 2018.
Definition of colorectal surgeon	Respondents were all active members of the ASCRS, 97% were board-certified or board-eligible in colorectal surgery, and respondents devoted an average of 95% of their clinical time to colorectal surgery.
Limitations	
Self-reported data	All compensation surveys rely upon self-reported data. There is no mechanism to request documentation or verification of responses. Although the survey included clear instructions and definitions, it is possible that compensation and production data provided by some respondents was inaccurate.
Incomplete data	Many respondents chose not to provide answers to the compensation questions. Of the 788 eligible respondents, only 479 provided compensation data. This limits the ability to filter by multiple variables. Even so, this compensation dataset is the largest such survey extant. Of the 479 surgeons for whom compensation data was provided, only 297 also provided work RVU data.
Normalization of data	For respondents who reported less than full-time employment, compensation was normalized (extrapolated) to 1.0 FTE. This was only required for 3.6% of respondents. However, 67.6% of respondents reported less than full-time clinical duties. Because it is likely that the contractual description of clinical responsibilities might not accurately reflect a surgeon's actual activities, any method of presenting productivity data for surgeons with protected time risks over- or under-stating what should be expected of a full-time clinical surgeon.
Differing compensation for clinical and non-clinical time	Surgeons with partial FTE designated for research or administrative activities may be compensated at a lower rate for their non-clinical time. Normalization of RVUs might result in an underestimate of compensation per RVU. The survey did not attempt to determine how compensation was determined for non-clinical activities.
Diverse practice environments	Colorectal surgeons have extremely diverse practices, making data analysis complex. Factors such as geographic location, employed vs. independent, academic vs. non-academic, full-time clinical vs. part-time, utilization of APPs, years in practice, and distribution of activities within the broad field of colorectal surgery might all be expected to impact compensation and productivity.

Bibliography

1. Statements Of Antitrust Enforcement Policy in Health Care. https://www.justice.gov/atr/statements-antitrust-enforcement-policyin-health-care#CONTNUM_49. Accessed November 3, 2019.

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Disclaimer

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