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Wellness

Control versus Choice in Deciding Career Pathway in Plastic Surgery: The Perfect Ratio

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Background: The decisions and components of a career in medicine have changed. Historically, a career selection was often a decision between joining an institution or academic center versus the fiscal risks associated with private practice. This created a relatively simple risk versus reward equation: those in private practice made more money if it went well. The medical landscape has changed immensely, and priorities and remuneration have morphed, including concerns about promoting and sustaining well-being.

Methods: The authors performed a systematic review of scholarly databases to identify relevant resources to the topic of study. Additionally, the authors relied on their own cumulative experience in the field, including the work of Dr. Wayne Sotile of the Sotile Center for Physician Resilience.

Results: The first installment of this article proposes a new model in opposition to the current standard of "risk versus reward" where the tradeoff is instead "control versus choice," where autonomy is the new risk.

Conclusions: The five components that make up the majority of the ingredients in a plastic surgery career are clinical practice model, administrative duty, corporate support, academic involvement, and per diem or retainers. Much of finding or developing a practice model that suits the individual is figuring out an acceptable ratio of these ingredients. Inherent to this process is how much authority one has versus instituted control of any form, from hospital to university to insurance company. *(Plast Reconstr Surg Glob Open 2024; 12:e6240; doi: 10.1097/GOX.0000000000006240; Published online 17 October 2024.)*

INTRODUCTION

The conversation of career evaluation and the decision process for plastic surgery graduates have shifted in recent years, bringing to light new issues in selecting career choices after training. So, why an update? What has changed over the years? Historically, a career selection was an issue of deciding between risk and reward. A single provider private practice was heavy on entrepreneurial risk in terms of time and investment, with the potential for greater fiscal reward. Conversely, entering a closed system like academics, Veteran's Affairs (VA), or Kaiser minimizes risk, limiting the reward.[1,2] Now, concerns about promoting and sustaining well-being have never been higher, changing the equation. Recent studies have reported that early career physicians have the highest rates of depersonalization, lowest career satisfaction, and highest work/home conflicts. Satisfaction in one's workplace is crucial to resilience, whether a physician prefers to be independent in decision-making, or operating in a more controlled institution.[3–5] American Medical Association data show that the percentage of physicians in private practice fell from 60.1% in 2012 to 46.7% in 2022.[6] This is a seismic shift away from private practice in medicine as evidenced by the Great Resignation.

Recently, job options including the VA, academics, single or multispecialty groups, and solo practice have begun to resemble each other. Academic practice is no longer dictated by scholarly activity, but by relative value unit (RVU) production, with academic rank no longer solely dictating salary.[7,8] The core mission of academics—education and research—is still there; the key is finding how to pay for it, moving a private practice salary model into academia. Conversely, private practice is now a source of

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many publications, often as a form of direct advertising.[9] A comparison of workforce data from 2012 to present shows a shift toward group employment, causing considerable overlap in work environment, forcing physicians to rethink career choices.[10]

Deciding between control or choice has the ability to influence the short- and long-term factors in a career, including surgical procedures performed, patient populations treated, allocation of resources, and work hours. Instead of defining positions based on practice categories, we now have to consider the fact that many academic positions are group specialty practices affiliated with a university. In fact, there may now be more control of your practice in a closed system than in private practice, in which practice is often dictated by insurance coverage. A closed system is unburdened by these fiscal decisions, which end up dictating much of private practice, allowing paradoxical increase in choice.

The control versus choice equation has entered into all facets of the career path, influencing electronic medical records and the drive not to treat, but to code and chart. The amount of time and money invested in this has radically altered how much control physicians have in their practice. The majority of the care team does not meet at the bedside, rather at the computer in this "tick box" era, which further enhances billing and, thus, clinical income.[11–13] This forces physicians to decide what comes first: coding or clinical presence?

Across the country, we see older doctors retiring earlier from their practices, and younger doctors choosing to work in big medical corporations or institutions. Instead of opening their own practice, younger physicians are opting for positions offering long-term security, such as in large-scale systems, doing research in facilities, or working in tech.[14] The issues of why people went into private practice are addressed similarly with moving into a closed system; people want more time and flexibility. As we recognize the value of work-life balance, flexibility becomes tantamount, and the restraint of academic practice becomes less appealing. A new, untested model in private practices is selling out to private equity, which would require relinquishing any future control.

Much of finding the practice model that suits you is figuring out an acceptable ratio or blend, of the five ingredients that comprise a career in plastic surgery. The categories stem from sources of income, because the stark reality is that a majority of the decisions made in medicine can be traced back to the money.[15] There are no longer, large enough reserves available within academic centers or large groups to support non-income productive practice. There is an awareness that some in the group will be clinically productive and others in the group may do research or a less remunerated subspecialty, but the long-term goal is to have a viable group with an understanding that team members may have some income sharing.

CLINICAL PRACTICE

Although seemingly self-explanatory, this model can easily become convoluted in the current healthcare system. There are multiple measures of clinical income, including RVU collections and market share, which affect how your income is calculated. Direct clinical collections make more sense in a cosmetic private practice, yet an RVU model would be more fitting at an inner-city institution. Given the location, a hospital may have government support for unreimbursed care or favorable Medicaid contracts for facility fees. With Medicaid physician fees lagging significantly behind Medicare and commercial insurance remuneration, in this instance, it is best to combine facility fees with overall income so that the enterprise can then cover a dollar per working relative value unit.[16]

Takeaways

Question: How have shifting priorities affected the factors that dictate decision-making in terms of career choice for plastic surgeons?

Findings: Control over working environment has intrinsic effects on physician career satisfaction and well-being. Every type of practice model has a different distribution of strengths, and physicians should analyze these carefully in order to better align with their long term career goals.

Meaning: Career paths for plastic surgeons are often a balancing act between the amount of control and the amount of choice in the different types of practice model.

Why would this be so? A hospital employer will always sell out its employed physician remuneration rates in preference for better hospital facility rates as it retains control over the workforce, allowing the institution to negotiate with physicians, whose worth they have decided. As a hospital system has little vested interest in supporting anything other than maximally remunerating operating room time, cosmetic surgery or injectables are irrelevant to support this salary line. Currently, the salaries offered to attract full-time plastic surgeons are out of context with the potential to earn that salary line through clinical production. The higher average salary levels are set by market norms created by risk-tolerant plastic surgeons in private practice. So, the employed surgeon currently gets rewarded based on no risk. Yet, this model is unsustainable long term, and salaries will inevitably decrease for the employee. In the D.C. area, average plastic surgeon income is $430,000.[17] A conservative model of 2.5 times collective to salary requires a clinical productivity of $1,075,000; add a supporting middle-level provider and that is $1,250,000 of gross production. In this market, the most common reconstructive cases reimburse $1000–$2000. This would require approximately 780 cases to cover yearly expenses, a productivity figure that is virtually unattainable. Also, considering the number of referring physicians needed to feed this system, there are seldom enough other doctors in the same group to maintain flow.

RVU is often a measure for productivity, with remuneration of multiple RVUs calculated by a set rate such as a multiple of the Medicare conversion rate along with a geographic practice cost index to account for changes in practice costs based on area. The Physician Fee Schedule conversion factor is set at $33.89 for the calendar year of

2023, with the rate set to decrease in 2024 to $32.74, a decrease of 3.4%. With the decrease in resources and the inability to multitask or do concurrent surgery, there is a finite limit to clinical productivity.[18–20] Complicating this model of performance-based pay is using patient satisfaction as a determinant of Medicare reimbursement or institutional pay. A factor of performance often measured is patient satisfaction, which includes subjective metrics, like parking or food services. Bundling these factors with surgical outcomes can erode an RVU model.[21] Lopez et al[22] proposed applying the congruence model to surgeon compensation modeling to help employers understand how different forces work together to shape performance outcomes and ultimately to determine compensation methods relevant to the value-based system physicians work in. Compensation in this model aims to incentivize and reward employee behaviors that are key to a business's success, which can have variable effects on clinical outcomes.[22]

ACADEMICS

In the past, the significance of being an academic surgeon was tightly held in the bastions of institutes of higher learning. As when pharmaceuticals transitioned to direct-to-patient advertising, there is now direct-to-patient academic advertisement. Today, the general populous is just as likely to see your references as your peers. This has not been lost on some of the most entrepreneurial of our specialty. Conversely, academics as a scholarly pursuit, rather than academic advertisement, is significantly undersupported. A model of tenure and advancement, publish or perish, is going extinct. In 2016, 25.2% of surgery faculty appointments were on a tenure track, and 63.4% of surgery faculty appointments did not offer tenure.[23,24] The percentage of full-time MD faculty in clinical departments that were either tenured or on the tenure track decreased from 57% in 1985 to 42% in 2004.

Evidenced by the growth in the *Plastic and Reconstructive Surgery* journal, our contributions to clinical research could not be stronger or of better quality.[25] Yet, a proportion of it could now be considered academic advertising, a way to ethically drive business. The sparse amount of financial support for plastic surgery research offered by contemporary academic institutions is surprising.[20] Academic medical center revenue instabilities force physicians to generate their own income.[26] This means the source of academic position remuneration is clinical rather than a classical model of endowing chair based on a combination of clinical, research, teaching and institutional "citizenship." The threats to the future of the academic model include indirect medical education, alternative credentialing like the Cosmetic Surgery Board, and funding decreases. There was once a move toward bundled payments that would further empower any employer institution rather than academic institutions. If pay for performance is incorporated, academic institutions will become further undersupported. Depending on location, the sicker, less compliant, and more difficult patient populations ensure further financial instability. In general, there is just not enough money in grants from the National Institutes of Health or medical philanthropy.[27]

These considerations become even more important when considering the implications of sex and changes in career/home expectations on a surgical career. Career choice and family values make for a complex decision matrix. As young people consider having families, the current landscape of academic medicine may leave many surgeons unmotivated to enter the academic culture, which is often not welcoming to the personal side of starting a family.[28] Intuitively, one might think that the consideration of having a family might taint the attractiveness of an academic career, given its inherent, multiple roles. On the other hand, experience indicates strongly that the structure and resources of working for an institution are appealing to many young physicians when planning a surgical career. Indeed, the average age of surgeons across the board in academics was found to be slightly younger than those in private practice, with a median age of 53 versus 56 years. Private practice has held the allure of a higher degree of flexibility and choice, and an estimated 90% of plastic surgery residents eventually go into private practice. However, the stresses and complexities of private practice can be daunting, and burnout is documented more commonly in private practice.[29] The days of private practice bringing home guaranteed millions are over. In fact, a study from 2018 that examined lifetime career earnings of surgeons in academic medicine versus private practice actually found that plastic surgery had one of the smallest disparities, averaging around 2% difference. It is hard to get yourself started—with private practice overhead costs estimated to be around 60%–70% of charges, only the highest performers will obtain the money everyone thinks a plastic surgeon will receive. Additionally, a survey of members of the American College of Surgeons found that those in academic medicine have higher career satisfaction and are less likely to experience burnout or depression.[28,29]

In order for the field to continue evolving, people are needed in all practice models to provide representative viewpoints of patient issues and outcomes. Currently, given our value-based model in academics and the burgeoning complexities of establishing and maintaining a private practice, the spectrum of choice versus control will likely remain a complex matrix.[28]

CORPORATE

The role of corporate speaker, consultant, or investigator has always been a common pathway for notoriety in plastic surgery. What comes first: being a laser expert or being given all the lasers first? There are currently plastic surgeons who make as much in corporate support as from their academic clinical practices. A 2009 survey found that nearly 84% of physicians had some form of financial interaction with manufacturers of drugs, devices, biologicals, and medical supplies. Nearly 20% received reimbursements for attending meetings or continuing medical education events, and around 15% received payments for professional services.[30] A recent study published in *Plastic*

and Reconstructive Surgery found that 1% of plastic surgeons received more than 50% of the corporate payouts. The Sunshine Act made corporate support of physicians public knowledge, requiring reporting of any payments more than $10.[30] With this law, there has been a rise of direct-to-consumer advertising, as well as increased marketing to payers. One aspect of corporate support that can significantly underwrite academic interests is supplanting direct costs of manpower to do the research and the cost of travel to disseminate it. In essence, corporate funding acts as academic support.[31] Companies therefore increasingly rely on clinical research professionals, or "medical scientific liaisons," to market products to a broad range of audiences. These reactive changes may undermine the goals of the act in its essence by encouraging a form of undue influence.

ADMINISTRATION

With the growing complexities of medicine, the market for administrators has also grown.[32] The requirement of taking on administrative responsibility falls on many physicians across work settings, resulting in added work in lieu of income-generating clinical opportunities.[33–35] Large institutions assign busy roles to individuals to meet their agenda (ie, credentialing, promotion, and diversity). These administrative duties often infringe on personal time, headaches that fill after-hours time for many surgeons.

On the other extreme, a two-person private practice probably has 5–10 hours/week in administrative commitment. That is 20% of the working year devoted to non-income–generating, equity-building, or cost-saving pursuits, a large commitment of time for which the hourly remuneration is essentially unrecoverable. In large organizations, there are a portion of administrative heavy roles: program, clinical, medical directorships, or chairmanships. The time for these needs to be benchmarked to allow for a reduction in clinical volume of, say, 0.2–0.5 full-time employees to be successful.

Consider medical legal or insurance adjusting as an administrative role. Expert witness court testimony reimburses at an average rate of $555 per hour.[36] However, doing this work requires a certain credibility and the ability to tolerate a degree of persecution at the hands of opposing counsel. It is ultimately difficult to make a worthwhile living off of this. There is a ceiling to income generated from this source, as states limit medical legal income to a percentage of overall income. For example, Maryland law precludes doctors from testifying in medical malpractice cases if they devote more than 25% of their professional activity to expert testimony and related activities.[37] We would include insurance adjuster, peer-to-peer reviewer, and independent medical examiner in this same category, due to the off-hour nature of the work and decreased risk, compared with surgical practice.

PER DIEM/RETAINER

As the environment of the emergency room or on-call services has changed to primary care for the uninsured, so has the value of emergency coverage as a practice builder, as patients can research which surgeons to see, and an insurer-driven panel redirects patients upon discharge. Essentially, taking emergency room call is no longer helpful in practice building, with the exception being a source of immediate surgical care with direct charges. Certification of hospitals for trauma level and need for comprehensive services has driven physician coverage support. We have, as a specialty, relied on other specialties for driving charges or call reparation. In the D. C. market, some hospitals pay $2000/night for coverage. One must follow the money and realize there is a reason that call is remunerated, be it low pay, high volume, or difficulty completing cases because of operating room resources.

The relationship between off-hours call and physician burnout is well-established. Taking night or weekend call increases odds of burnout by 3%–9% for each additional night or weekend spent on call.[38,39] Anecdotal experience suggests that nights on call serve as a vital variable for physician and family well-being: small changes can make large differences in resilience, well-being, and overall satisfaction with work/life integration.

CONCLUSIONS

The landscape of medicine has changed dramatically in recent years, impacting how plastic surgeons practice. The perspective shift of "risk" versus "reward" to "control" versus "choice" requires careful consideration of priorities, which is discussed in depth in our companion article.

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DISCLOSURES

The authors have no financial interest to declare in relation to the content of this article. Dr. Sotile is one of the foremost experts on physician resilience and has written numerous peer reviewed articles and books on the subject, in addition to being the founder of the Sotile Center for Physician Resilience. As such, he was invited to comment on this subject by the primary authors, Dr. Steven P. Davison and Dr. Gregory Evans. Dr. Steven Davison is the President of DAVinci Plastic and Reconstructive Surgery.

REFERENCES

1. Mims KY. Uncharted territory: plastic surgeons in private practice navigate financial uncertainty during the COVID-19 pandemic. Arlington Heights, IL: American Society of Plastic Surgeons; 2020. Available at https://www.plasticsurgery.org/for-medical-professionals/publications/psn-extra/news/uncharted-territory. Accessed July 31, 2023.
2. Zbar RIS, Zbar D, Canady JW. Downstream impact for plastic surgeons in the United States from the "No Surprises Act." *Plast Reconstr Surg Glob Open.* 2022;10:e4202.
3. Dyrbye LN, Varkey P, Boone SL, et al. Physician satisfaction and burnout at different career stages. *Mayo Clin Proc.* 2013;88:1358–1367.

4. Canivet C, Choi B, Karasek R, et al. Can high psychological job demands, low decision latitude, and high job strain predict disability pensions? A 12-year follow-up of middle-aged Swedish workers. *Int Arch Occup Environ Health*. 2013;86:307–319.
5. Simonds GR, Sotile WM. *The Thriving Physician: How to Avoid Burnout by Choosing Resilience Throughout Your Medical Career*. Gulf Breeze, FL: Huron Consulting Group; 2018.
6. Kane C. Policy research perspectives: recent changes in physician practice arrangements: private practice dropped to less than 50 percent of physicians in 2020. Chicago, IL: American Medical Association; 2021. Available at https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf. Accessed August 2, 2023.
7. Khullar D, Kocher R, Conway P, et al. How 10 leading health systems pay their doctors. *Healthc (Amst)*. 2015;3:60–62.
8. Hsiao WC, Braun P, Yntema D, et al. Estimating physicians' work for a resource-based relative-value scale. *N Engl J Med*. 1988;319:835–841.
9. Hammond JB, Armstrong VL, McMullen K, et al. Aesthetic surgery research funding: where does it come from and to whom does it go? *Aesthet Surg J*. 2021;41:1473–1480.
10. Kane C. Policy research perspectives: recent changes in physician practice arrangements: shifts away from private practice and towards larger practice size continue through 2022. Arlington Heights, IL: American Medical Association; 2021. Available at https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf. Accessed August 2, 2023.
11. Pierpont GL, Thilgen D. Effect of computerized charting on nursing activity in intensive care. *Crit Care Med*. 1995;23:1067–1073.
12. Kittinger BJ, Matejicka A, 2nd, Mahabir RC. Surgical precision in clinical documentation connects patient safety, quality of care, and reimbursement. *Perspect Health Inf Manag*. 2016;13:1f.
13. Reyes C, Greenbaum A, Porto C, et al. Implementation of a clinical documentation improvement curriculum improves quality metrics and hospital charges in an academic surgery department. *J Am Coll Surg*. 2017;224:301–309.
14. Davison SP, Clemens MW. The job search. In Korman JM, HM Furnas (eds.), *Business Plast Surg*. World Scientific Publishing: 2010:3–27.
15. Reuter JA. *The Financing of Academic Health Centers: A Chart Book*. Washington, DC: Commonwealth Fund; 1997.
16. Congressional Budget Office. The prices that commercial health insurers and Medicare pay for hospitals' and physicians' services. 2022. Available at https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf. Accessed August 2, 2023.
17. Plastic Surgeon Salary in Washington, DC. Available at https://www.ziprecruiter.com/Salaries/Plastic-Surgeon-Salary-in-Washington,DC. Accessed July 31, 2023.
18. Blau JA, Marks CE, Phillips BT, et al. Disparities between operative time and relative value units for plastic surgery procedures. *Plast Reconstr Surg*. 2021;148:638–644.
19. Wang TY, Nelson JA, Corrigan D, et al. Contribution of plastic surgery to a health care system: our economic value to hospital profitability. *Plast Reconstr Surg*. 2012;129:154e–160e.
20. Massarweh NN, LeMaire SA, Merkow RP. Preserving an academic mission in the face of clinical productivity targets: where is the academic surgeon's carrot? *Ann Surg*. 2020;271:223–224.
21. Geiger NF. RN. On tying Medicare reimbursement to patient satisfaction surveys. *Am J Nurs*. 2012;112:11.
22. Lopez J, Offodile AC, Shenaq D, et al. Plastic surgeon financial compensation-incentivization models in surgical care delivery: the past, present, and future. *Plast Reconstr Surg*. 2021;148:1415–1422.
23. Walling A, Nilsen KM. Tenure appointments for faculty of clinical departments at U.S. medical schools: does specialty designation make a difference? *Acad Med*. 2018;93:1719–1726.
24. Lin LO, Barker JC, Khansa I, et al. A primer for success as an early career academic plastic surgeon. *Plast Reconstr Surg Glob Open*. 2022;10:e4066.
25. Leonardo J. PRS hits impact factor record high for fifth time in six years. Chicago, IL: American Society of Plastic Surgeons; 2022. Available at https://www.plasticsurgery.org/for-medical-professionals/publications/psn-extra/news/prs-hits-impact-factor-record-high-for-fifth-time-in-six-years. Accessed July 31, 2023.
26. Evans G. Georgetown University grand rounds. [Presentation.] 2020.
27. Hu Y, Edwards BL, Brooks KD, et al. Recent trends in national institutes of health funding for surgery: 2003 to 2013. *Am J Surg*. 2015;209:1083–1089.
28. Shah AR, Haws MJ, Kalliainen LK. Factors affecting women's success in academic and private practice plastic surgery. *Plast Reconstr Surg*. 2018;141:1063–1070.
29. Balch CM, Shanafelt T. Combating stress and burnout in surgical practice: a review. *Adv Surg*. 2010;44:29–47.
30. Richardson E. The Physician Payments Sunshine Act. Available at https://www.healthaffairs.org/do/10.1377/hpb20141002.272302/. Accessed July 31, 2023.
31. Ahmed R, Lopez J, Bae S, et al. The dawn of transparency: insights from the physician payment sunshine act in plastic surgery. *Ann Plast Surg*. 2017;78:315–323.
32. Fairchild DG, Benjamin EM, Gifford DR, et al. Physician leadership: enhancing the career development of academic physician administrators and leaders. *Acad Med*. 2004;79:214–218.
33. Berenson RA, Ginsburg PB, May JH. Hospital-physicians relations: cooperation, competition, or separation? *Health Aff (Millwood)*. 2007;26:w31–w43.
34. Sullivan EE, Ellner A. Strong patient-provider relationships drive healthier outcomes. 2017. Available at https://hbr.org/2015/10/strong-patient-provider-relationships-drive-healthier-outcomes. Accessed July 31, 2023.
35. Tevis SE, Kennedy GD. Building relationships with hospital administrators. In: Wang T, Beck A, eds. *Building a Clinical Practice. Success in Academic Surgery*. Cham: Springer; 2020:115–127.
36. Mangraviti JJ, Wilbur KJ, Nasser Donovan N. Expert witness fee study. 2021. Available at https://seak.com/expert-witness-fee-study/#:~:text=The%20average%20hourly%20fee%20for,all%20medical%20experts%20is%20%24555. Accessed July 31, 2023.
37. How Maryland's new 25% rule in medical malpractice claims affects health care providers. Available at https://www.tydingslaw.com/news-insights/how-marylands-new-25-rule-medical-malpractice-claims-affects-health-care-providers. Accessed July 31, 2023.
38. Balch CM, Shanafelt TD, Dyrbye LN, et al. Surgeon distress as calibrated by hours worked and nights on call. *J Am Coll Surg*. 2010;211:609–619.
39. Shanafelt TD, Balch CM, Bechamps GJ, et al. Burnout and career satisfaction among American surgeons. *Ann Surg*. 2009;250:463–471.