



ASCRS

**American Society of
Colon and Rectal Surgeons**

2018 ASCRS Physician Compensation Survey

Final Report

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

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I. Executive Summary

A. 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.

B. 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.

C. 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.

D. 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)

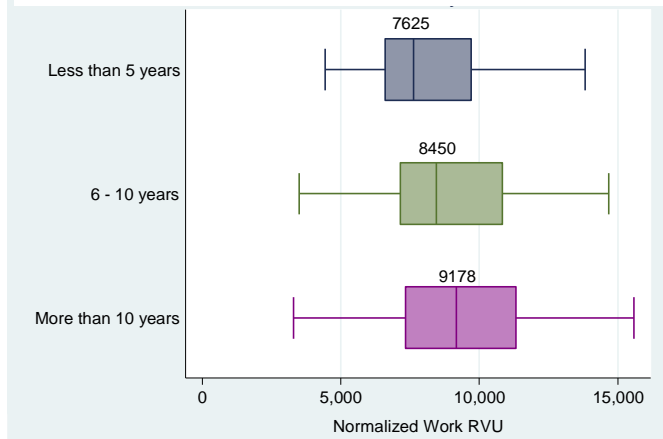


* Most respondents (96.4%) were employed full-time (1.0 FTE). For those who reported < 1.0 FTE total employment, compensation was “normalized” to the equivalent of 1.0 FTE by dividing compensation by the reported FTE.

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.

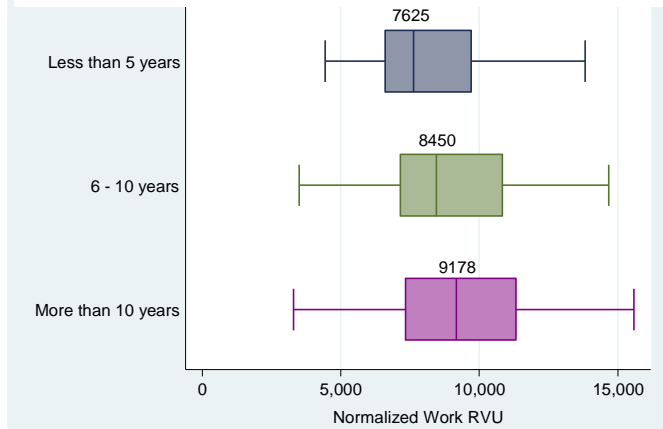
Reported Work RVUs: Median Work RVUs with inter-quartile range is shown for all respondents in **Figure 1.2**, regardless of reported clinical FTE status. Median Work RVUs increased from 7018 for new practices to 7574 for mature practices. This understates to some degree the productivity to be expected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

Figure 1.3 Reported Work RVUs Normalized to 1.0 FTE Clinical Work



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

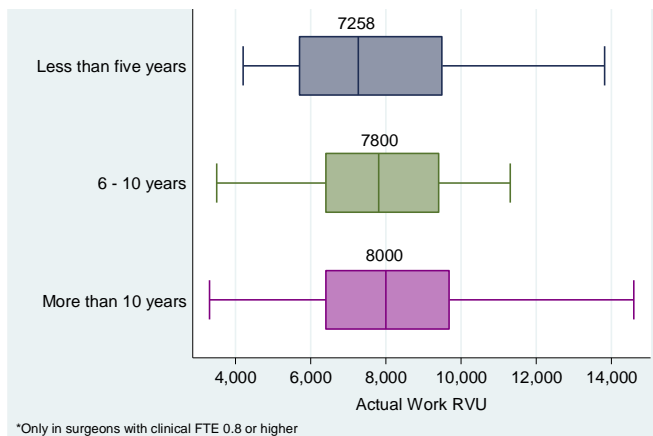


higher rate than anticipated by the stated contractual clinical time than at a lower rate. As a result, this model likely overstates the clinical productivity for surgeons with contractually protected non-clinical time.

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



E. 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.
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F. 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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II. Colorectal Surgery Physician Profile

This section summarizes demographic data from the 674 physicians who actively treated colon and rectal surgical patients in 2018, including those physicians who were hired into their current positions in 2018. A review of this data shows that the average colon and rectal surgeon was male and had 12.9 years of clinical colon and rectal surgery experience (i.e., years since completion of colon and rectal surgery residency) and 14.5 years of general surgery experience (i.e., years since completion of a general surgery residency). Nearly all the reporting colon and rectal surgeons (90.2%) were currently board certified in colon and rectal surgery. The greatest proportion of colon and rectal physicians (45%, n=296) were employed by an academic entity (academic health system, university/medical school, or faculty practice plan), 28% of physicians indicated they were in a private practice or independent medical group, and 21% reported they were employed by a community hospital/health system. Approximately 58% of the colon and rectal surgeons worked in practices that also employed advanced practice providers (APPs), and 90.3% of these surgeons provided some level of APP supervision.

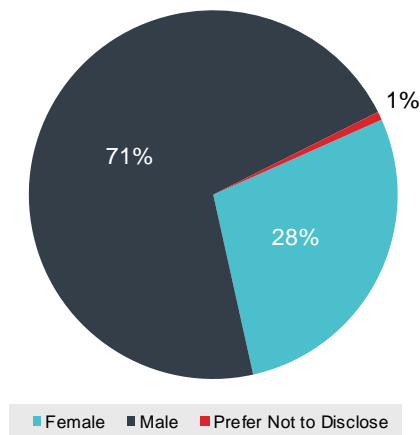
Not every physician responded to every question in this section, resulting in varying sample sizes. Further, throughout this report, responding colon and rectal surgeons are often referred to as physicians and/or colorectal surgeons.

A. Colorectal Surgeon Demographics

1. Gender

A majority (71%, n=479) of the 674 responding physicians were male and 28% (n=190) were female; this division is illustrated in figure 2.1. Less than 1% of the respondents (n=5) preferred not to disclose gender information.

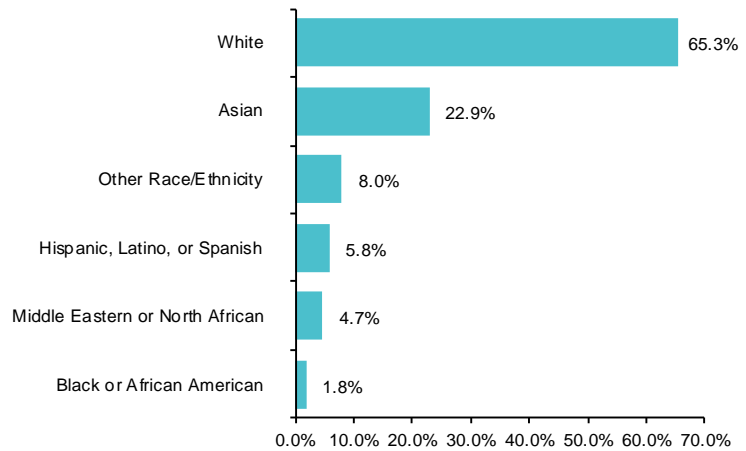
Figure 2.1: Percentage of Physicians by Gender



2. Race

Of the 674 responding surgeons, 33% (n=224) indicated they prefer not to disclose race information. Figure 2.2 reports that of the 450 surgeons who provided race information, 65% identified as White, 23% identified as Asian, 8% chose Other Race/Ethnicity, 6% identified as Hispanic/Latino/Spanish, 5% reported as Middle Eastern or North African, and 2% identified as Black or African American.

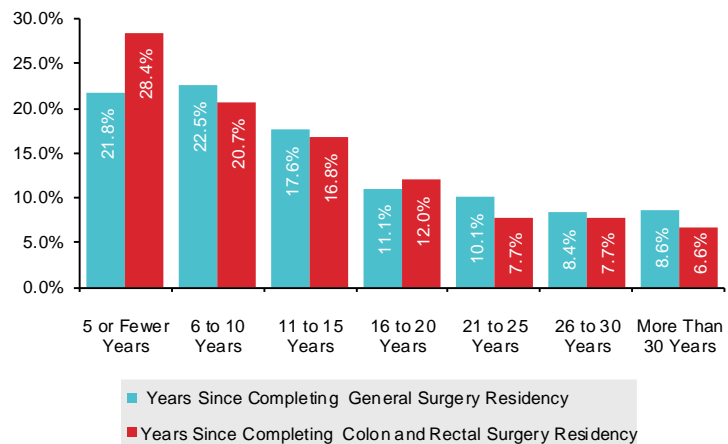
Figure 2.2: Percentage of Physicians by Reported Race



3. Years of Experience

For the average responding physician, it had been 14.5 years since completion of their general surgery residency (n=524) and 12.9 years since completion of their colon and rectal surgery residency (n=517). In aggregate, approximately 44% of physicians reported it had been 10 or fewer years since completion of their general surgery residency and nearly half of physicians reported it had been 10 or fewer years since completion of their colon and rectal surgery residency.

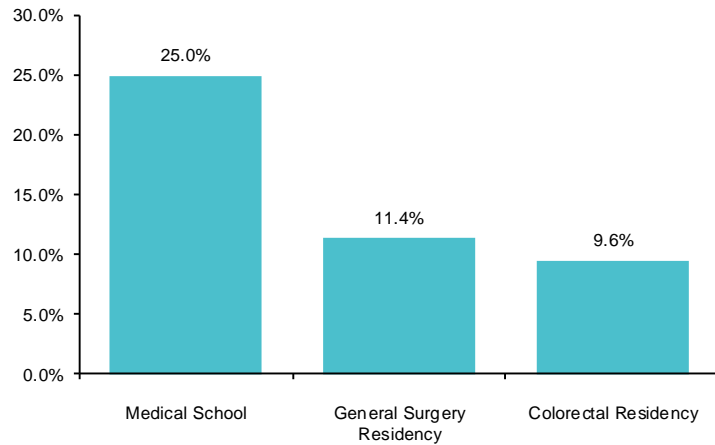
Figure 2.3: Percentage of Physicians by Years of Experience in General Surgery and Colon and Rectal Surgery



4. Education Outside of the United States

Of the 272 physicians who responded to this series of questions, 25.0% reported they completed medical school outside of the United States (n=68), 11.4% reported they completed their residency in general surgery outside of the United States (n=31), and 9.6% completed their residency in colorectal surgery outside of the United States (n=26).

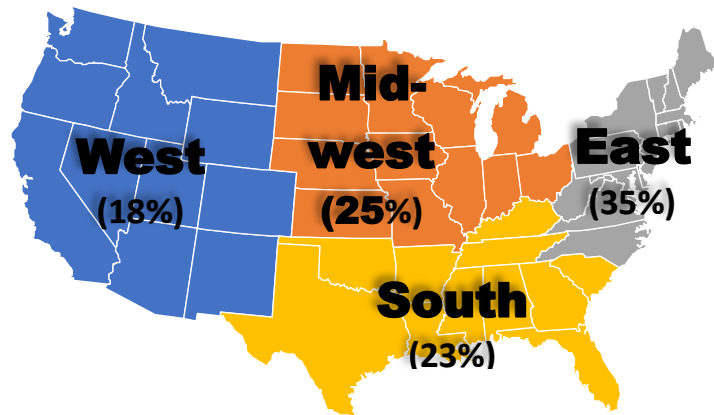
Figure 2.4: Percentage of Physicians Educated Outside of United States



5. Region

The distribution of the 670 responding colon and rectal physicians by region was well balanced, with each region representing between 18% and 35% of the data set, as shown in figure 2.5. Specifically, the East region contained the largest proportion of physicians at 35% (n=233). The Midwest region represented 25% (n=166) of physicians, the South region represented 23% (n=153), and the West region contained the remaining 18% (n=118). Forty-six states, the District of Columbia, and Puerto Rico were represented in the physician responses; only Mississippi, Rhode Island, South Dakota, and West Virginia were not represented.

Figure 2.5: Percentage of Physicians by Region



Note: Figures may not be exact due to rounding.

6. State of Residence

Approximately 80% of the 670 responding colon and rectal surgeons resided in 20 states, with about 25% of physicians living in New York, California, or Florida. Fourteen states each had fewer than five physicians represented in the survey. Table 2.1 highlights the states with at least 20 responding physicians.

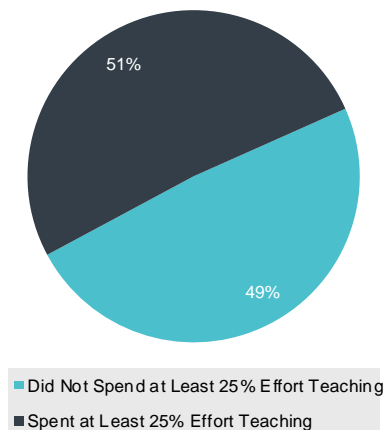
Table 2.1: Responding Physicians by State (Select States)

State	Number of Physicians	Percentage of Physicians
New York	63	9.40%
California	60	8.96%
Florida	47	7.01%
Pennsylvania	43	6.42%
Ohio	42	6.27%
Massachusetts	32	4.78%
Illinois	31	4.63%
Texas	30	4.48%
Virginia	22	3.28%
New Jersey	21	3.13%
Michigan	21	3.13%
All Other States	<u>258</u>	<u>38.51</u>
TOTAL	670	100.00%

7. Teaching Effort

Just over half (51%) of the 256 colon and rectal physicians who provided information on teaching activities stated that they spent at least 25% of their effort in didactic teaching and/or teaching in a clinical setting, as shown in figure 2.6.

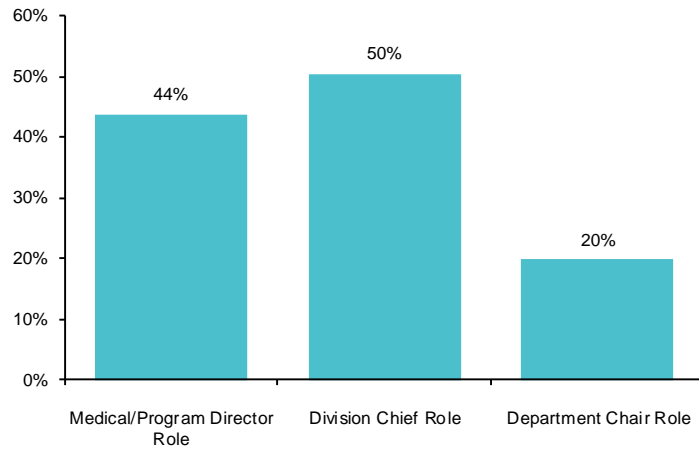
Figure 2.6: Percentage of Physicians Who Spent at Least 25% of Effort Teaching



8. Administrative Roles

Approximately 33% (n=222) of the 664 responding colon and rectal surgery physicians indicated they held one of the following administrative roles within their organization: medical/program director, division chief, and/or department chair. As shown in figure 2.8, of the 222 physicians who reported having at least one administrative role, 50% indicated they hold the title of division chief (n=112), 44% reported a role of medical/program director (n=97), and 20% indicated they hold a department chair position (n=44). On average, these 222 physicians report holding 1.1 administrative roles.

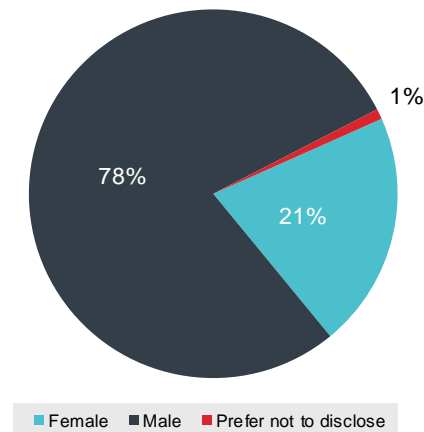
Figure 2.7: Percentage of Physicians in Administrative Role(s) by Title



9. Administrative Roles by Gender

Of the 222 colon and rectal surgeons who provided data on the administrative roles they held at their organization, 78% (n=174) were male. This is slightly higher than the 71% of male colon and rectal surgeons (479 of 674) in the larger data set.

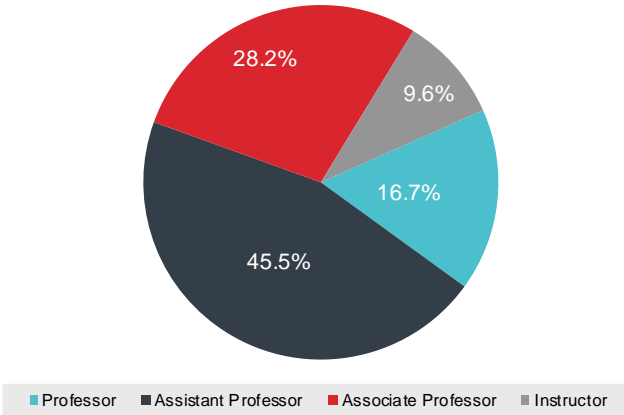
Figure 2.8: Percentage of Physicians in Administrative Roles by Gender



10. Academic Rank

Of the 664 responding colon and rectal physicians, 468 (70%) reported that they held an academic rank of professor, assistant professor, associate professor, or instructor. Of this cohort, 45.5% reported they held the rank of assistant professor, 28.2% were associate professors, 16.7% reported they held the title of professor, and 9.6% were instructors.

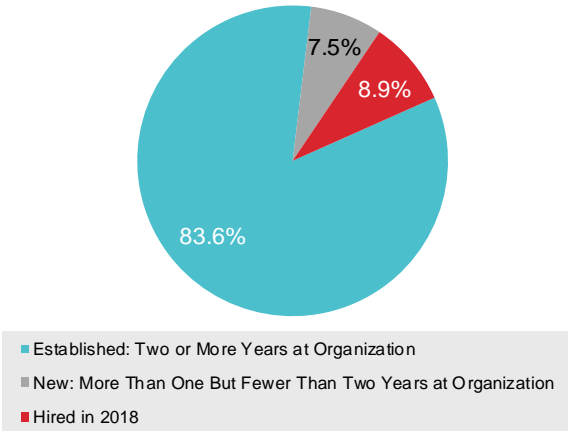
Figure 2.9: Percentage of Physicians Holding a Faculty Appointment by Rank



11. Tenure at Organization

Of the 664 responding physicians, 555 (83.6%) were considered established (i.e., they had spent two or more years at the organization), 50 (7.5%) were considered new (i.e., they had spent more than one but fewer than two years at the organization), and 59 (8.9%) reported they were hired in 2018. Data for newly hired physicians (i.e., those who reported they were hired in 2018) is summarized in the New Hire Starting Salaries and Hiring Incentives section of this report.

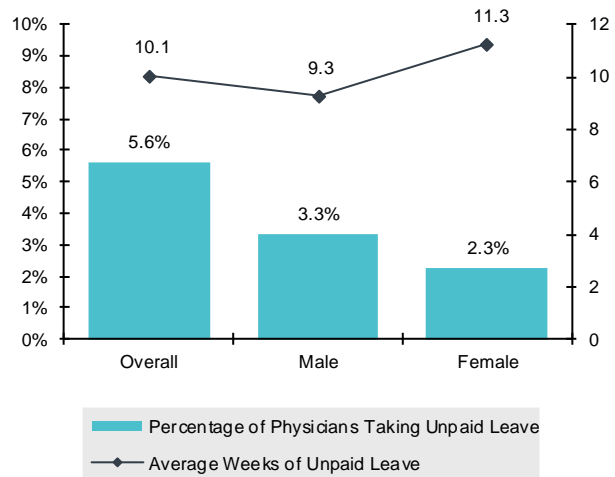
Figure 2.10: Percentage of Physicians by Tenure at Organization



12. Unpaid Leave

Overall, only 5.6% of the 661 responding colon and rectal surgery physicians reported taking unpaid leave in 2018. Of those that took unpaid leave, the average time off was 10.1 weeks. Male physicians taking unpaid leave represented 3.3% of responding physicians (or 59% of the 5.6%); female physicians were 2.3% of responding physicians (or 41% of the 5.6%). Female physicians took an average of 11.3 weeks of unpaid leave, which was 2 weeks longer than the average weeks of unpaid leave taken by male physicians (9.3 weeks). This data is presented in figure 2.11

Figure 2.11: Percentage of Physicians Taking Unpaid Leave and Average Weeks of Leave

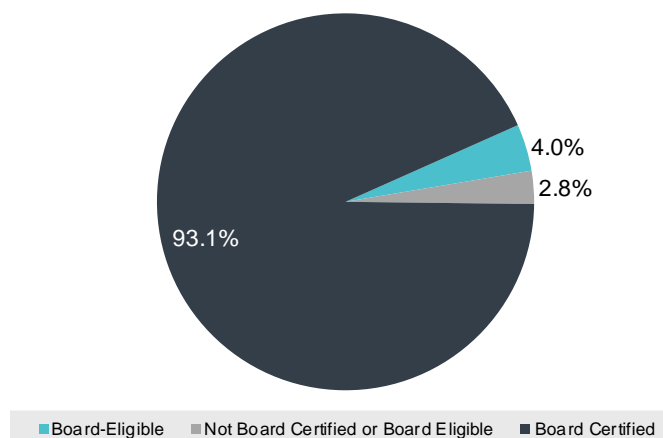


B. Colorectal Surgeon Clinical Demographics

1. General Surgery Board Certification

Nearly all physician respondents (93.1%, n=671) were board certified in general surgery, 4.0% were board eligible but not board certified, and 2.8% of physicians were not board certified or board eligible.

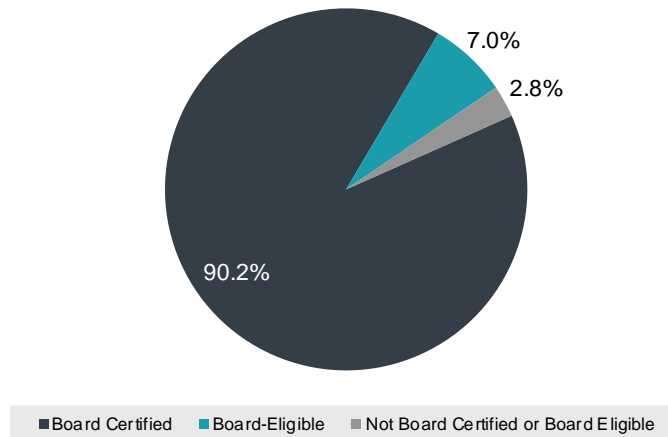
Figure 2.12: Percentage of Physicians by Board Certification in General Surgery



2. Colon and Rectal Surgery Board Certification

As shown in figure 2.13, the majority (90.2%, n=605) of colon and rectal physicians were board certified in colon and rectal surgery, 7.0% were board eligible but not board certified, and 2.8% were not board certified or board eligible.

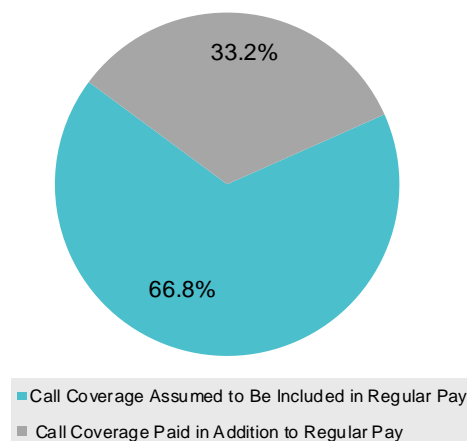
Figure 2.13: Percentage of Physicians Board Certified in Colon and Rectal Surgery



3. General Surgery Call Coverage Requirements

Only 38% (n=219) of the 570 responding physicians were required to take general surgery call. Of this cohort, 214 provided additional details about their call coverage arrangements. These physicians averaged five nights per month of required general surgery call; the median number of nights was four. As depicted in figure 2.14, approximately two-thirds (n=143) of physicians responded that they were not paid for taking general surgery call, as it was considered part of their standard work expectations (i.e., call coverage compensation was assumed to be included in regular pay). One-third of physicians were paid (in addition to regular pay) for taking general surgery call.

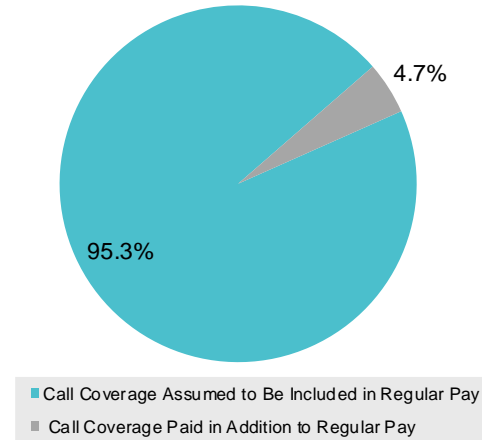
Figure 2.14: Percentage of Physicians Required to Take General Surgery Call by Payment Status



4. Colon and Rectal Surgery Call Coverage Requirements

Approximately two-thirds of the responding physicians reported they were required to take colorectal surgery call (n=386). Of this cohort, 380 provided additional details about their colorectal surgery call coverage arrangements. These physicians averaged nine nights per month of required call; the median number of nights was seven. As depicted in figure 2.15, approximately 95% (n=362) of physicians responded that they were not paid for taking colorectal surgery call, as it was considered part of their work expectations

Figure 2.15: Percentage of Physicians Required to Take Colorectal Surgery Call by Payment Status

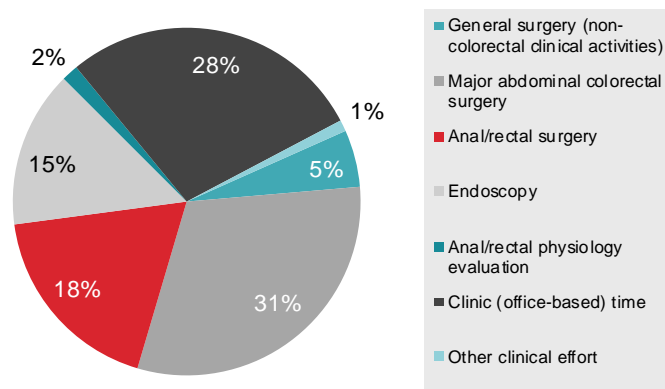


(i.e., call coverage compensation was assumed to be included in regular pay). Only about 5% of physicians were paid (in addition to regular pay) for taking colorectal surgery call.

5. Clinical Activities

Among those physicians who provided information regarding both the years since completion of their colorectal surgery residency and their distribution of clinical effort, the average physician reported 31% of their clinical time was spent performing major abdominal colorectal surgery and 28% of their clinical effort was performing duties in the clinic/office setting, as illustrated in figure 2.16. Additionally, 18% of clinical effort was spent performing anal/rectal surgery and 15% was spent performing endoscopies.

Figure 2.16: Distribution of Clinical Effort Among Colorectal Surgeons



6. Clinical Activities by Years Since Colorectal Surgery Residency

Table 2.2 summarizes the distribution of clinical effort among colorectal surgeons by years since completion of their colorectal residency. Physicians with 5 or fewer years since completion of their colorectal surgery residency generally spent more time performing general surgery, anal/rectal surgery, and anal/rectal physiology evaluation compared to physicians with greater years of experience. Time spent in major abdominal colorectal surgery generally increased with experience (until the 16-to-20-year mark). Clinical effort in endoscopy continued to increase with years of experience, and clinic (office-based) time fluctuated.

Table 2.2: Distribution of Clinical Effort Among Colorectal Surgeons by Years Since Colorectal Surgery Residency

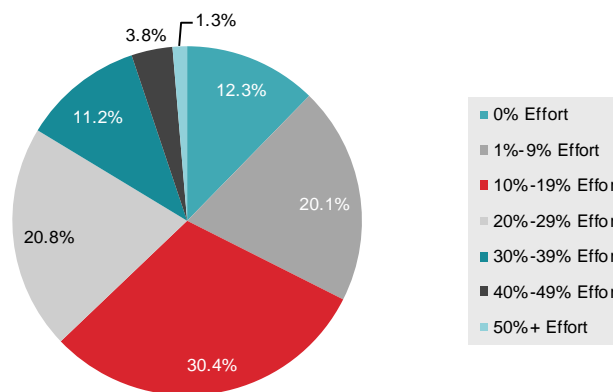
Clinical Activities	5 or Fewer Years	6 to 10 Years	11 to 15 Years	16 to 20 Years	21 to 25 Years	26 to 30 Years	More Than 30 Years
General surgery (non-colorectal)	7.7%	5.1%	4.1%	3.8%	6.8%	3.0%	3.8%
Major abdominal colorectal surgery	31.9%	32.1%	33.1%	31.0%	27.8%	29.6%	21.3%
Anal/rectal surgery	19.0%	18.3%	18.5%	19.1%	16.1%	17.9%	16.6%
Endoscopy	11.7%	12.4%	14.7%	15.1%	15.9%	20.3%	25.2%
Anal/rectal physiology evaluation	1.6%	1.6%	1.5%	1.6%	1.0%	1.4%	2.0%
Clinic (office-based) time	27.3%	29.6%	26.3%	28.4%	31.8%	27.1%	29.1%
Other clinical effort	<u>0.7%</u>	<u>0.8%</u>	<u>1.9%</u>	<u>1.0%</u>	<u>0.7%</u>	<u>0.6%</u>	<u>2.0%</u>
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Note: Figures may not be exact due to rounding.

7. Clinical Effort in Endoscopy

The distribution of clinical time spent in endoscopy varied from 0% to 60%. In aggregate, 12.3% of physicians reported they spent no time in endoscopy (0% clinical effort), while only 1.3% reported spending 50% or more of their time in endoscopy. The largest cohort of physicians (30.4%) reported spending between 10% and 19% of their clinical time in endoscopy.

Figure 2.17: Percentage of Physicians by Time Spent in Endoscopy



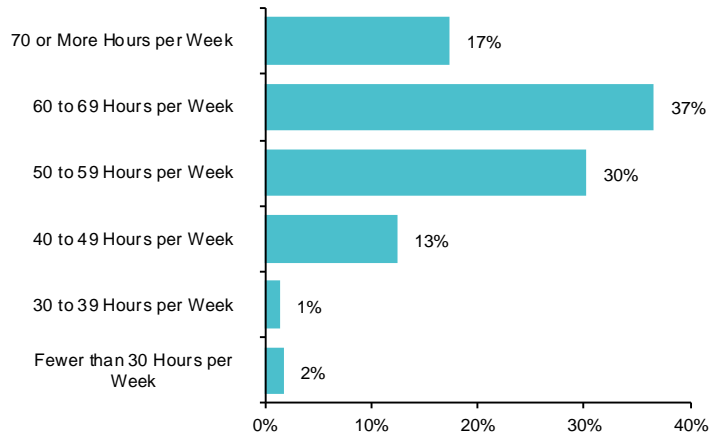
8. Hours Worked per Week

A total of 568 physicians reported the number of clinical and nonclinical hours worked per week (excluding vacation, sick days, continuing medical education, other paid time off, and call), the details of which are shown in figure 2.18.

The median hours worked per week was 60 hours, and the average number of hours worked per week was 57.4. When reviewing the range of hours worked per week, the largest cohort of physicians (37%) worked 60 to 69 hours per week.

Approximately 84% of physicians reported working at least 50 hours per week.

Figure 2.18: Percentage of Physicians by Clinical and Nonclinical Hours Worked per Week

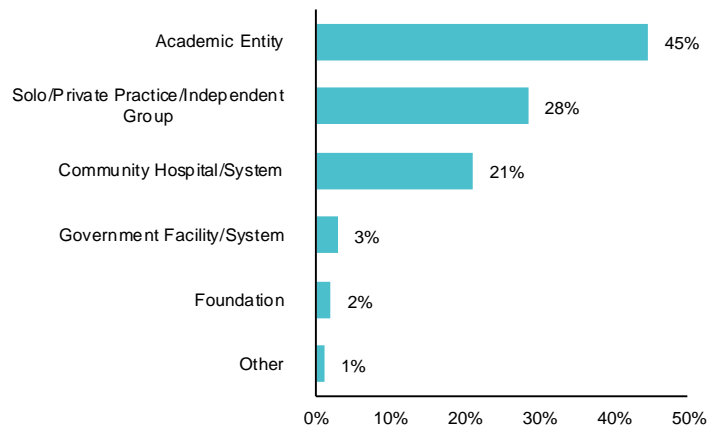


C. Colorectal Surgery Practice Demographics

1. Practice Ownership

Physicians were asked to report the type of organization that employed them/their practice. The greatest proportion of colon and rectal physicians (45%, n=296) were employed by an academic entity (academic health system, university/medical school, or faculty practice plan), 28% of physicians indicated they were in a private practice or independent medical group, and 21% reported they were employed by a community hospital/health system. The remaining physicians were employed by a federal or government facility/system (3%), a foundation (2%), or some other type of organization (1%).

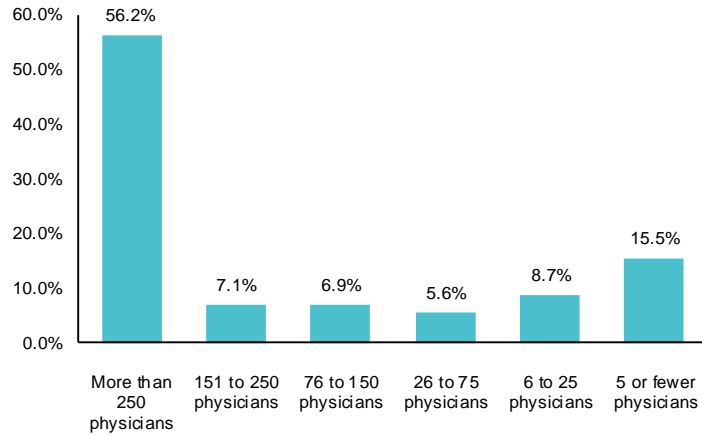
Figure 2.19: Percentage of Physicians by Practice Ownership



2. Size of Practice/Group

A total of 664 physicians provided information on the size of the practice/group that employed them, as illustrated in figure 2.20. More than half (56.2%) of the responding physicians reported they practiced in a medical group of more than 250 physicians (n=373). Physicians who practiced in a group of 5 or fewer physicians represented 15.5% of the data set (n=103).

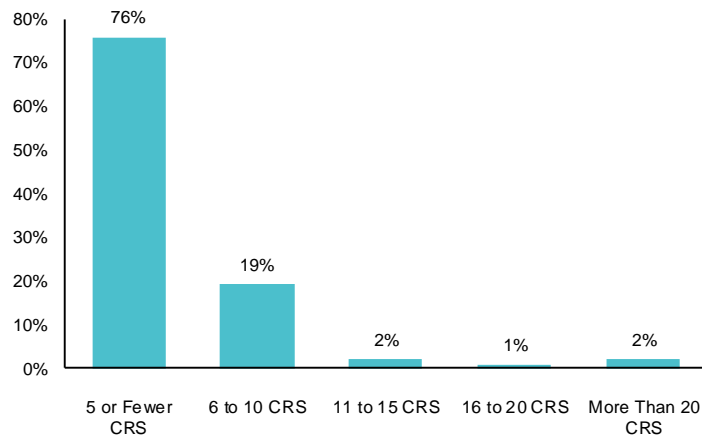
Figure 2.20: Percentage of Physicians by Size of Practice/Group



3. Number of Colon and Rectal Physicians in Practice/Group

The group of 664 physicians also provided information on the number of colon and rectal surgeons in the group/practice to which they belonged. Most physicians (76%) worked in groups with 5 or fewer colon and rectal surgeons (n=504). Only 5% of physicians were part of practices with greater than 10 colon and rectal surgeons (n=33). The average number of colon and rectal surgeons in a group was 4.2 physicians, and the median number of colorectal surgeons was 3.0.

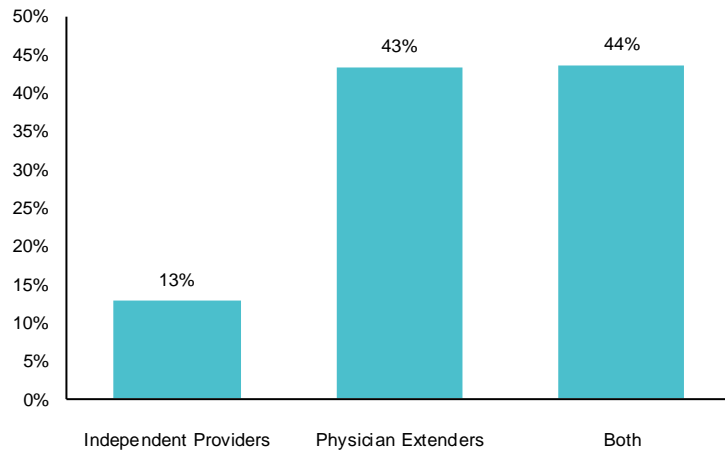
Figure 2.21: Percentage of Physicians by Number of Colorectal Physicians in Practice/Group



4. Employment and Utilization of APPs

Approximately 58% of the 662 colon and rectal surgeons who provided information regarding their practice's use of APPs indicated that the practice employed these providers (n=383). Of this cohort, 380 provided additional details regarding how APPs were utilized within their practice, with 44% reporting APPs were utilized both as physician extenders and as independent providers (n=166), as depicted in figure 2.22. In addition, 43% of physicians (n=165) reported that APPs functioned only as physician extenders, and 13% of physicians (n=49) reported APPs functioned only as independent providers.¹

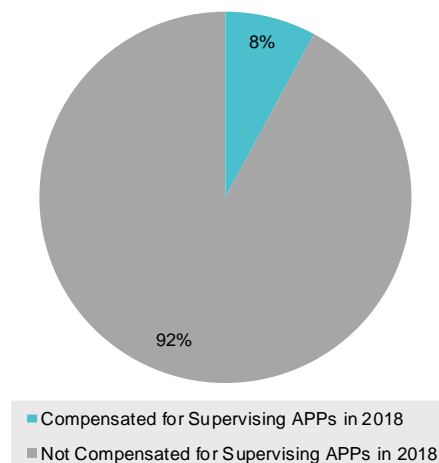
Figure 2.22: Percentage of Physicians Indicating Their Practice's Utilization of APPs



5. Payment for APP Supervision

A majority (90%) of the colon and rectal surgeons whose practices utilized APPs stated that they spent some time personally supervising these providers in 2018 (n=345). This cohort was asked additional details about APP supervision, with 341 physicians responding. As summarized in figure 2.23, only 8% of these colorectal surgeons were compensated for supervising APPs (n=27).

Figure 2.23: Percentage of Physicians Compensated for Supervising APPs

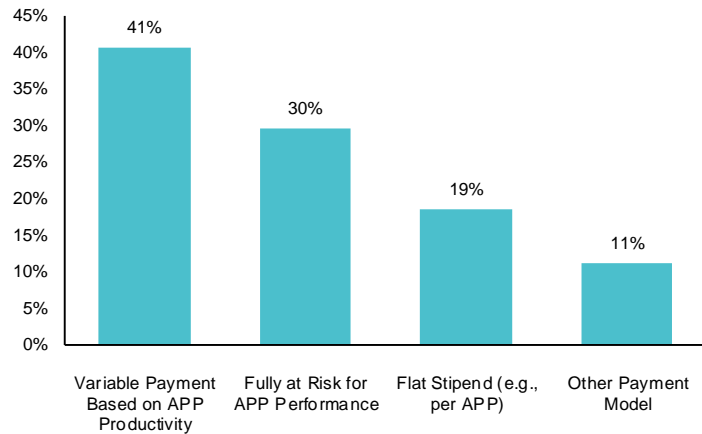


¹ APPs that function as independent providers typically have their own patient panel and bill under their own ID, while APPs that function as physician extenders typically bill for services rendered incident to a physician.

6. APP Supervision Payment Methodology

All 27 colorectal surgeons who reported they were paid for supervision of APPs provided the method by which that payment is based. Approximately 41% of physicians reported that payment was variable based on APP productivity, 30% reported they were fully at risk for APP performance (i.e., revenue less expenses determines amount available for physician stipend), 19% of physicians were paid a flat stipend, and 11% reported another payment model.

Figure 2.24: Percentage of Physicians by APP Supervision Payment Methodology

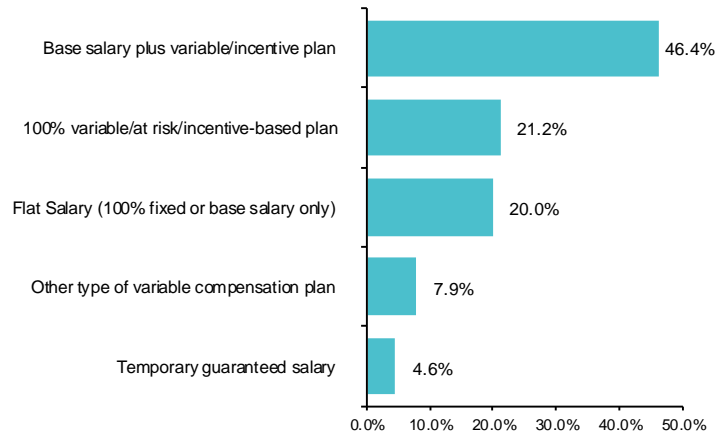


D. Colorectal Physician Compensation Plan Design

1. Compensation Plan Type

Approximately three-quarters of colorectal surgeons reported they were compensated under some type of variable/incentive-based compensation plan. Specifically, almost half (46.4%) of colorectal surgeons reported they were paid under a base salary plus variable/incentive plan, as depicted in figure 2.25. Those physicians who were paid under a 100% variable plan represented 21.2% of responding physicians, while 20% of physicians reported a flat salary plan. In addition, 7.9% of physicians reported they were paid using another type of variable compensation plan, and 4.6% reported they were paid under a temporary guaranteed salary plan.

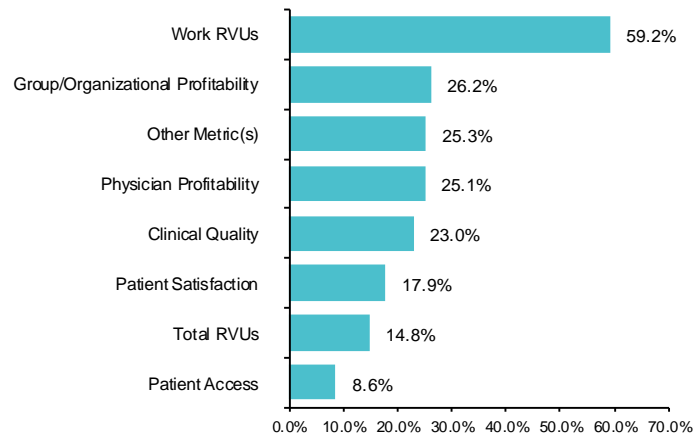
Figure 2.25: Percentage of Physicians by Type of Compensation Plan



2. Variable Compensation Incentive Components

Of the colon and rectal surgery physicians who reported being paid under some type of variable compensation plan, 431 also reported the metrics/components included in their plans. These physicians reported an average of 2.0 metrics were included within their incentive plans, with the most prevalent metric being WRVUs, as reported by 59.2% of physicians. After WRVUs, the following four metrics each had over 20% of physicians reporting: group/organizational profitability (26.2%), other metrics (25.3%), physician profitability (25.1%), and clinical quality (23.0%). Figure 2.26 summarizes the various incentives utilized in colorectal surgeon compensation plans.

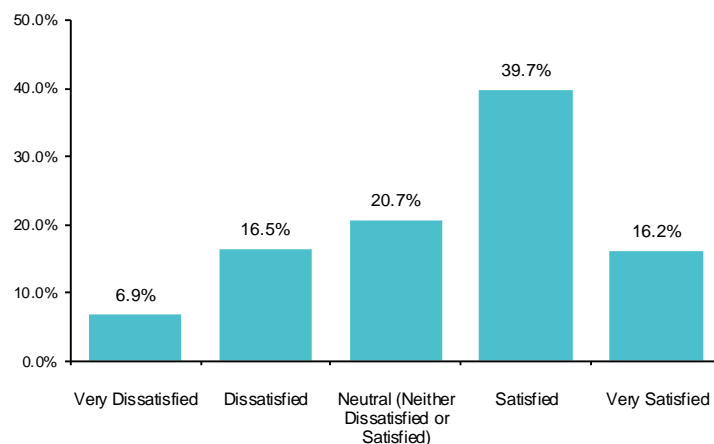
Figure 2.26: Percentage of Physicians by Plan Incentives



3. Physician Compensation Plan Satisfaction

Physicians were asked to rate their satisfaction with their 2018 compensation model—specifically, the survey asked, “how satisfied are you that your current compensation model fairly rewards the work you perform?” Responding physicians were twice as likely to be satisfied or very satisfied with their plan than dissatisfied or very dissatisfied. As illustrated in figure 2.27, the largest proportion of physicians (39.7%) reported they were satisfied that their compensation model fairly rewarded the work they performed. Less than 7% reported being very dissatisfied.

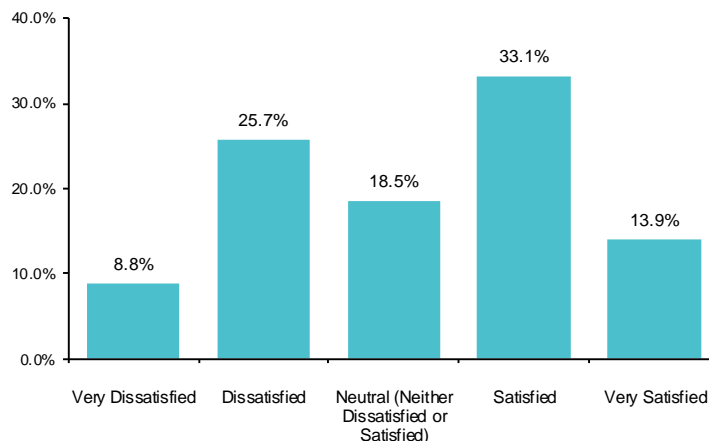
Figure 2.27: Percentage of Physicians by Satisfaction with Compensation Plan



4. Physician Satisfaction with Compensation Level

In addition to the question regarding satisfaction with their compensation plan, physicians were also asked to rate their satisfaction with their aggregate amount of compensation. Specifically, the survey asked, “how satisfied are you that the total amount of compensation fairly rewards the work you perform?” Fewer physicians were very satisfied (13.9%) or satisfied (33.1%) with the total amount of compensation earned than were very satisfied or satisfied with their compensation model. As illustrated in figure 2.28, about one-quarter of responding physicians reported they were dissatisfied with their total amount of compensation earned.

Figure 2.28: Percentage of Physicians by Satisfaction with Amount of Compensation



5. Relationship Between Type of Plan and Satisfaction with Compensation Plan

A total of 568 physicians submitted information about their type of compensation plan as well as their satisfaction with their plan. In analyzing the relationship between these two variables, figure 2.29 illustrates that the largest portion of physicians who reported they were dissatisfied (30%) or very dissatisfied (11%) with their compensation plan are paid under a flat salary plan. The highest levels of satisfaction were seen among those physicians who were paid under a base plus variable plan (50% were satisfied/very satisfied) or a 100% variable plan (51% were satisfied/very satisfied).

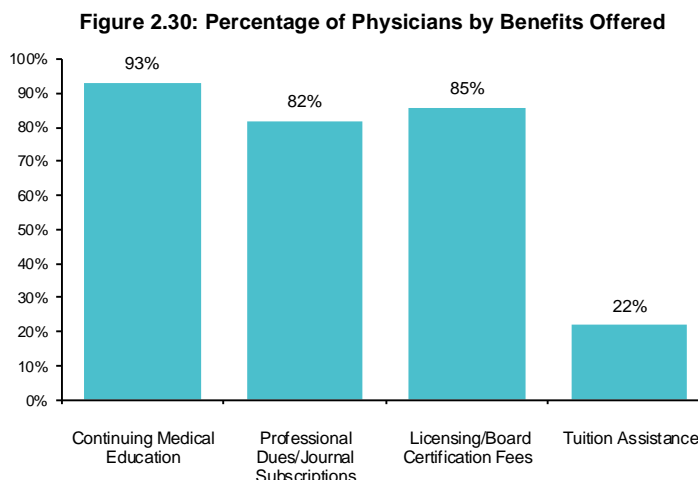
Figure 2.29: Physician Satisfaction by Compensation Plan



E. Colorectal Surgery Physician Benefits

1. Benefits Offered

A total of 467 colon and rectal physicians reported information regarding the fringe benefits that comprised their overall compensation package, including some or all of the following: continuing medical education (93% of physicians), professional dues/journal subscriptions (82%), professional license/board certification fees (85%), and/or tuition assistance—either for themselves or dependents—(22%). This data is illustrated in figure 2.30



2. Fringe Benefit Annual Allowances

Colon and rectal physicians who reported being offered specific benefits were also asked to report the annual amount of these benefits. As summarized in table 2.3, the average annual benefit amount for continuing medical education, professional dues and journal subscriptions, and licensing/board certification fees was \$3,672; \$1,425; and \$1,168, respectively. Of those physicians providing information on the annual value of tuition assistance, the average amount was \$18,500.

Table 2.3: Annual Value of Fringe Benefits

	Count	Average	Minimum	Median	Maximum
Continuing Medical Education	361	\$3,672	\$100	\$3,000	\$15,000
Professional Dues/Journal Subscriptions	285	\$1,425	\$100	\$1,000	\$10,000
Licensing/Board Certification Fees	282	\$1,168	\$100	\$1,000	\$10,000
Tuition Assistance	36	\$18,500	\$1,000	\$10,000	\$80,000

III. Colon and Rectal Surgery Physician Compensation and Production

The final colon and rectal surgery physician compensation and production data set, after data validation and the evaluation for outliers, includes data from 479 colorectal surgery physicians. ECG evaluated each metric for outliers; if compensation was identified as an outlier, the physician’s record was marked as such and removed from the compensation and production data set. To our knowledge, this survey represents the largest national compensation and production data set uniquely addressing the needs of colorectal surgeons available in the industry.

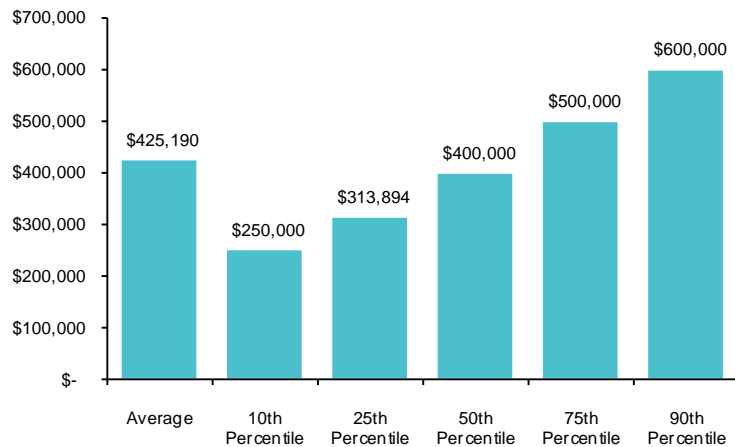
To calculate comparable compensation and production data, we used ECG’s proprietary survey methodology. In doing so, each physician’s total compensation was recalculated to a 1.0 total FTE, and production data (e.g., net professional collections, WRVUs) was recalculated to a 1.0 clinical FTE. Further analysis of compensation and productivity data was performed by a team of independent bioinformaticians.

A. Total Compensation

1. Colorectal Surgeon Compensation

In aggregate, 479 physicians from 283 organizations have compensation data in the final survey data set. The median total compensation for colon and rectal surgery physicians was \$400,000, and the average compensation was \$425,190.

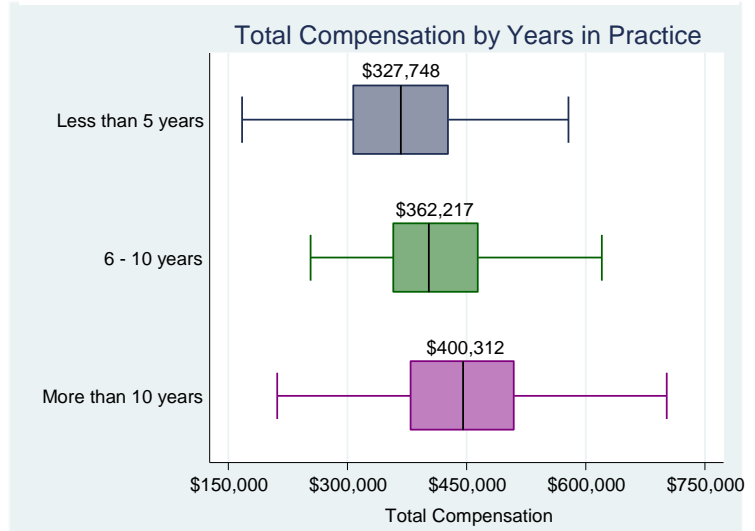
Figure 3.1: Colorectal Surgeon Compensation Benchmarks



2. Compensation by Years in Practice

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 3.2)

Figure 3.2 Total Compensation by Years in Practice (normalized* to 1.0 FTE)

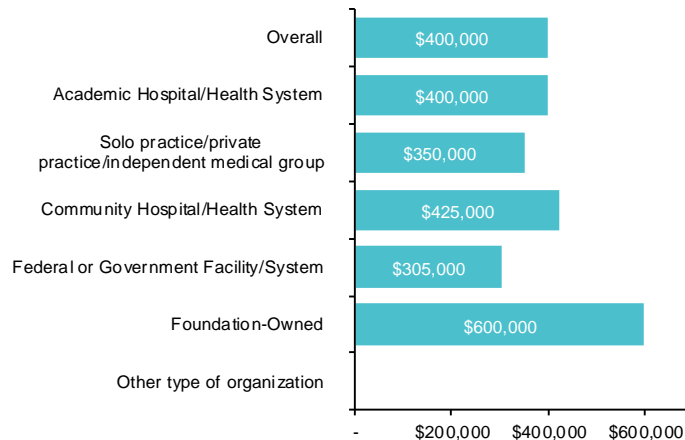


* Most respondents (96.4%) were employed full-time (1.0 FTE). For those who reported < 1.0 FTE total employment, compensation was "normalized" to the equivalent of 1.0 FTE by dividing compensation by the reported FTE.

3. Compensation by Ownership Entity

Colon and rectal surgery physicians working in a foundation model had the highest levels of median compensation at \$600,000, as shown in figure 3.3, but represented only nine physicians. The largest proportion of colon and rectal surgery physicians were employed by an academic hospital or health system entity, with median earnings of \$400,000. Median compensation for physicians in solo/private practice/independent medical groups was \$350,000.

Figure 3.3: Median Compensation by Ownership Entity

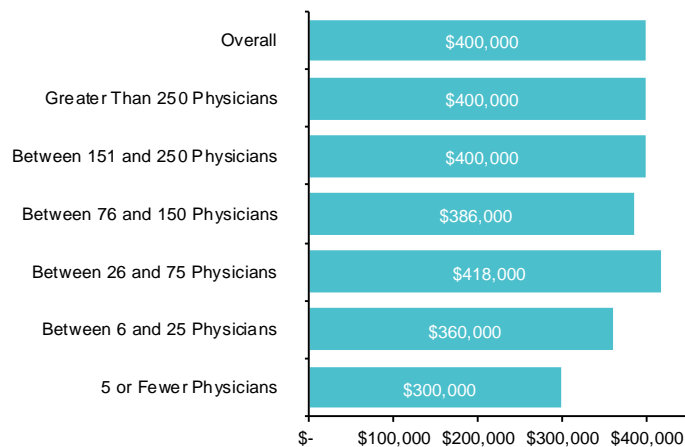


Note: Minimum sample size not met for reporting data for “other type of organization.”

4. Compensation by Size of Practice/Group

Figure 3.4 shows that colon and rectal surgery physicians practicing in groups of 26 to 75 physicians earned the highest median compensation at \$418,000. The median compensation for physicians practicing in groups of 5 or fewer physicians was the lowest in the survey at \$300,000. The largest cohort of physicians were practicing in groups with more than 250 physicians, where the median compensation was \$400,000.

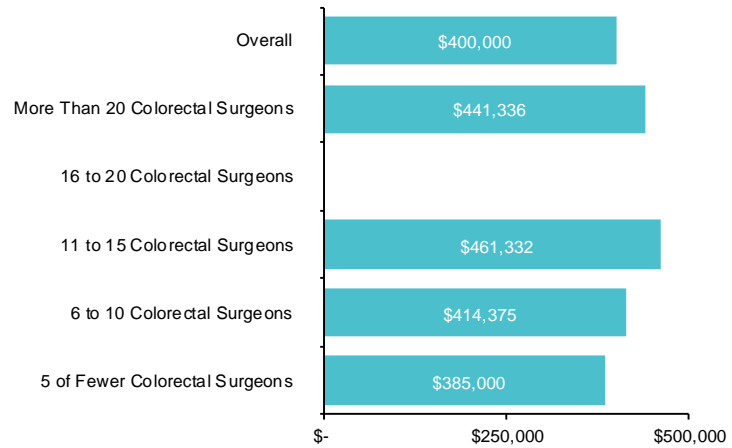
Figure 3.4: Median Compensation by Size of Practice/Group



5. Compensation by Number of Colorectal Surgeons in Group

Physicians practicing in groups with 11 to 15 colorectal surgeons earned the highest levels of median compensation at \$461,332; however, this cohort consisted of only 10 physicians in the data set. The largest proportion of reporting physicians practiced in groups of 5 or fewer colorectal surgeons, where the median earning was \$385,000. Physicians in groups of 6 to 10 colorectal surgeons reported median compensation of \$414,375, as shown in figure 3.4.

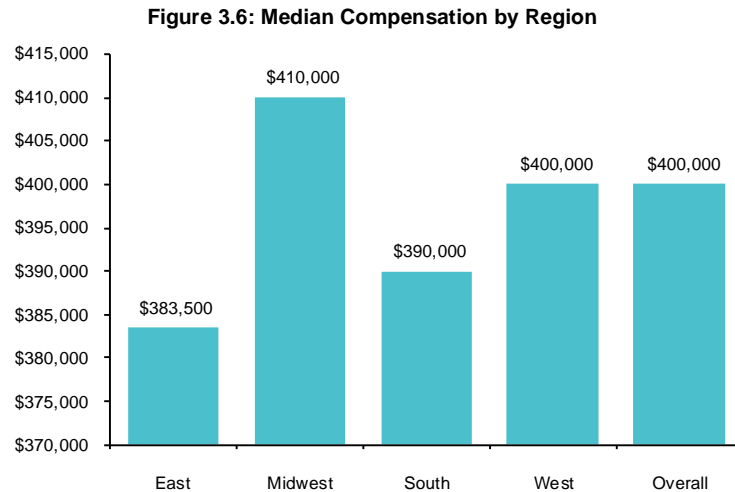
Figure 3.4: Median Compensation by Number of Colorectal Surgeons in Group



Note: Minimum sample size not met for reporting data for "16 to 20 colorectal surgeons."

6. Clinical Compensation by Region

Compensation is variable by region, as figure 3.6 shows, with colon and rectal surgery physicians who responded from the Midwest region reporting the highest median levels of compensation at \$410,000, followed by the median compensation of \$400,000 for physicians in the West. Colon and rectal surgery physicians in the East and South regions reported earning less than their counterparts in the Midwest and West, with median compensation of \$383,500 and \$390,000, respectively.²



² The states within the regional designations are as follows:

East: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Virginia, and West Virginia

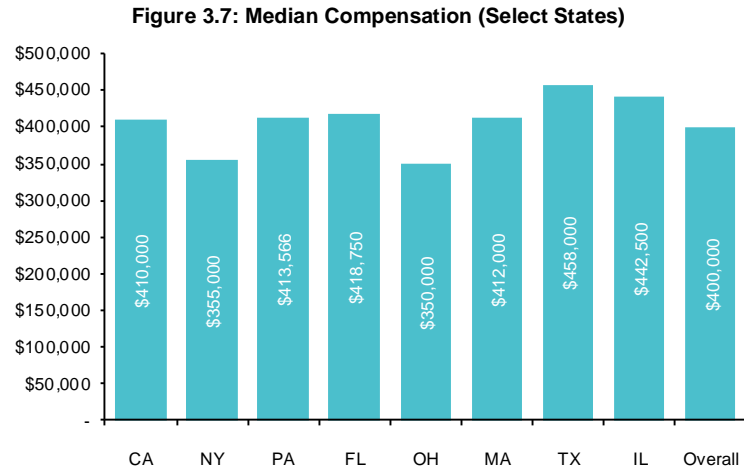
Midwest: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin

South: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, Oklahoma, Puerto Rico, South Carolina, Tennessee, and Texas

West: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming

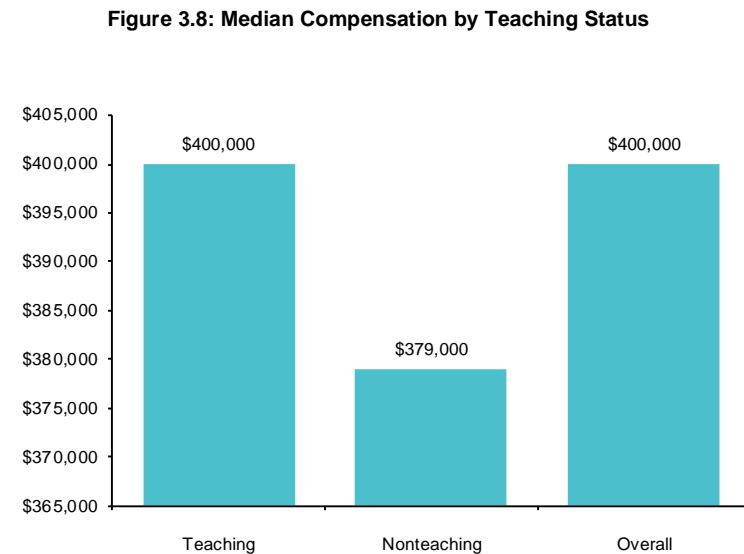
7. Compensation by State

The minimum sample size requirements of five physicians from five unique organizations were achieved for reporting state-specific compensation benchmarks in 31 states. Approximately half of the colon and rectal surgery physicians in the compensation data set practiced in eight states, which are shown in figure 3.7. Within this cohort of states, colon and rectal surgeons in Texas earned the highest median compensation at \$458,000, and only physicians in New York (\$355,000) and Ohio (\$350,000) earned less than the overall median across all surgeons (\$400,000).



8. Compensation by Teaching Status

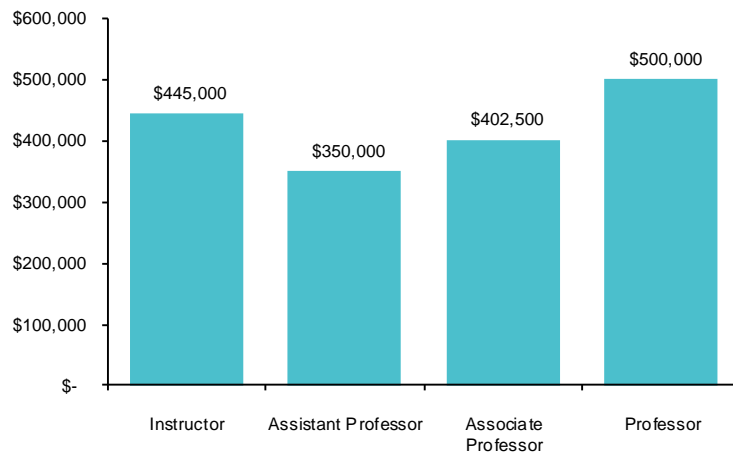
Colon and rectal surgery physicians who identified as having an academic affiliation reported median compensation of \$400,000, which was approximately 6% higher than their colon and rectal surgery peers who reported no academic affiliation, as illustrated in figure 3.8. Earnings for colon and rectal surgery physicians not affiliated with a teaching program were \$379,000.



9. Compensation by Academic Rank

Of the 349 physicians who provided academic rank, 42% identified themselves as assistant professors, with a median compensation of \$350,000. Associate professors made up 30% of the physicians who provided an academic rank and had a median compensation of \$402,500. Professors comprised 18% of these reporting physicians and had a median compensation of \$500,000.

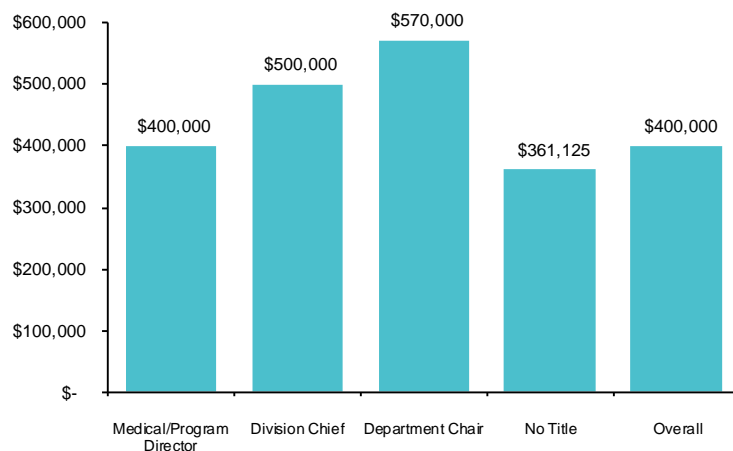
Figure 3.9: Median Compensation by Academic Rank



10. Compensation by Title

Approximately 36% of the physicians in the compensation data set indicated they held either a medical/program director, division chief, or department chair title. As shown in figure 3.10, those colorectal surgeons who held the title of department chair earned the highest median compensation at \$570,000. Division chiefs earned median compensation of \$500,000, and medical/program directors had median compensation of \$400,000.

Figure 3.10: Median Compensation by Title



11. Compensation by Type of Compensation Plan

As displayed in figure 3.11, colon and rectal surgery physicians who were paid under a 100% variable/incentive-based plan reported earning the highest levels of median compensation at \$450,000. Physicians with a base salary plus a variable component reported earning a median compensation of \$397,500. Colorectal surgeons who have a flat/fixed salary reported median compensation of \$380,000.

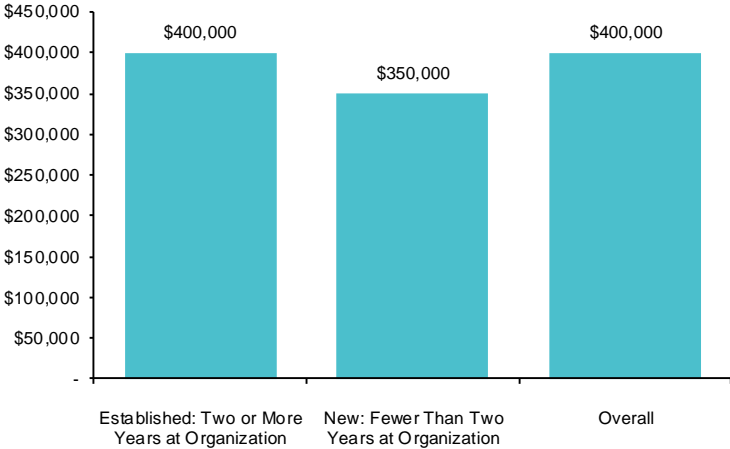
Figure 3.11: Median Compensation by Type of Compensation Plan



12. Compensation by Tenure at Current Organization

Established colon and rectal surgery physicians who had worked within their current organization for two or more years earned a median compensation of \$400,000, while new physicians who had worked for less than two years (but more than one year) within their current organization earned 13% less, at \$350,000. Figure 3.12 illustrates these differences.

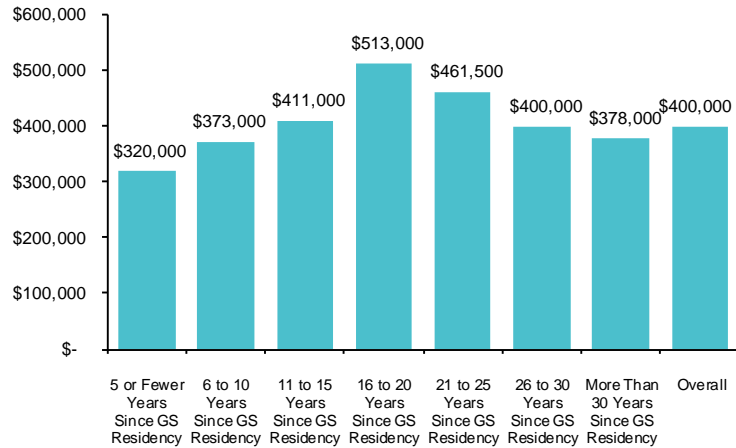
Figure 3.12: Median Compensation by Tenure



13. Compensation by Years Since Completion of General Surgery Residency

The median compensation levels for colorectal surgeons increased with years of experience and peaked at median earnings of \$513,000 for those physicians who had been in practice for 16 to 20 years since completion of their general surgery residency. Earnings then decreased as years of experience increased. The largest cohort of physicians fell between 6 to 10 years of practice since completion of their general surgery residency, with median earnings of \$373,000, as depicted in figure 3.13.

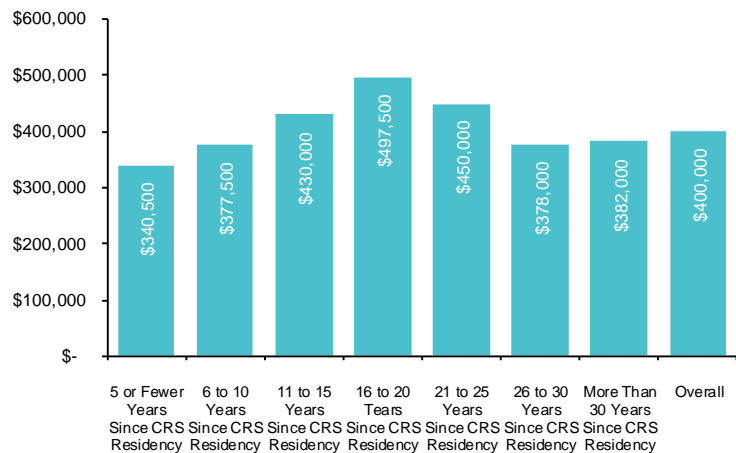
Figure 3.13: Median Compensation by Years Since Completion of General Surgery Residency



14. Compensation by Years Since Completion of Colon and Rectal Surgery Residency

As in the previous section, median compensation for colorectal surgeons increased with years of experience and peaked at median earnings of \$497,500 for those physicians who had completed 16 to 20 years of practice since completion of their colon and rectal surgery residency. Surgeons with 5 or fewer years of practice since completion of their colon and rectal surgery residency reported earnings 32% less than those with 16 to 20 years of experience. The largest cohort of physicians reported 5 or fewer years of practice

Figure 3.14: Median Compensation by Years Since Completion of Colon and Rectal Surgery Residency

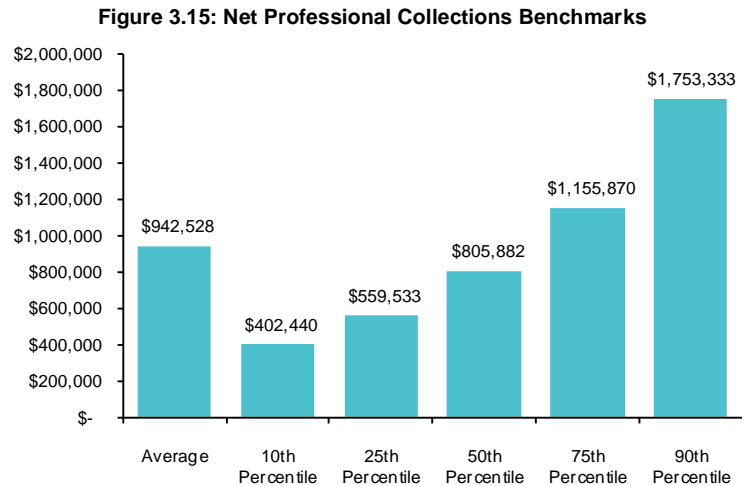


since completion of their colorectal surgery residency, with median earnings of \$340,500, as depicted in figure 3.14.

B. Production Metrics

1. Net Professional Collections

A total of 255 physicians from 176 organizations reported net professional collections data, with a median of \$805,882, as shown in figure 3.15. Total net professional collections equal total cash collections received from patients and third-party payers for the physician's professional services provided to all patients.



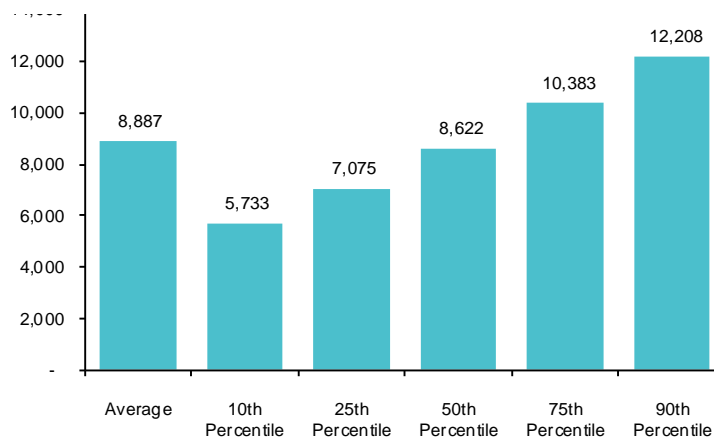
2. Work RVUs

In aggregate, 297 colon and rectal surgery physicians from 203 organizations submitted WRVU data. Reported WRVUs included personally performed clinical activities with adjustments for modifiers and excluded WRVUs attributed to providers supervised by the physician (such as nurse practitioners, residents, etc.).

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 four different methodologies

To avoid understatement of productivity brought about by the inclusion of data from physicians with less than full-time clinical responsibilities, ECG reports productivity benchmarks “normalized” to the equivalent of full-time, 1.0 FTE clinical productivity as is shown in Figure 3.16. 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. The median WRVUs by this methodology was 8,622. This method of reporting may overstate production because of the normalization process. For example, a surgeon with 0.5 Clinical FTE by contract, may be producing more than half as many Work RVUs as a full-time clinician. This would result in an over-statement of Work RVUs when normalized.

Figure 3.16: WRVUs Benchmarks Normalized to 1.0 FTE Clinical Work



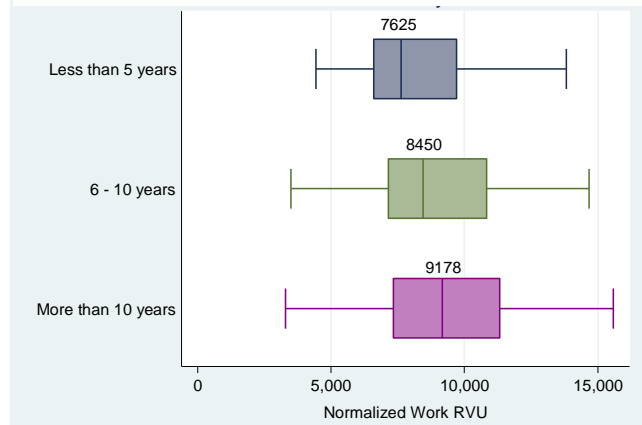
The median reported Work RVUs with inter-quartile range is shown for all respondents in 3.17, regardless of reported clinical FTE status. That is, these are the actual Work RVUs produced, without adjustment by “normalization.” Median Work RVUs increased from 7018 for new practices to 7574 for mature practices. This model 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. This method reflects the finding that Work RVUs increase as a practice matures.

Figure 3.17: Reported Work RVUs by Years in Practice



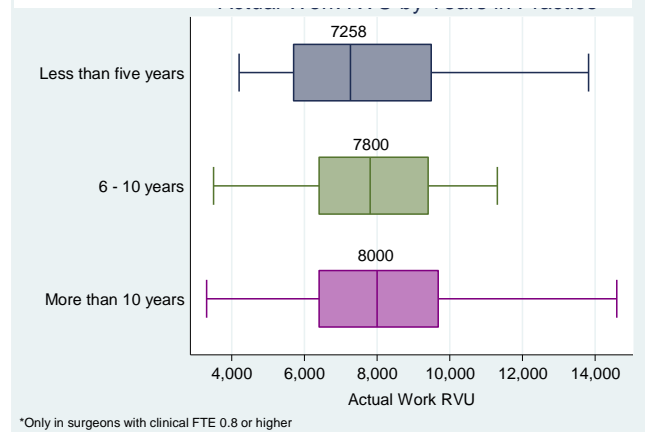
Figure 3.18 shows the reported Work RVUs depicted in Figure 3.17 normalized to 1.0 FTE Clinical Work, using the methodology described for Figure 3.16. With this adjustment, the median Work RVUs increase from 7625 for new practices to 9178 for mature practices. Because many compensation models reward 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 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.

Figure 3.18 Reported Work RVUs Normalized to 1.0 FTE Clinical Work



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 3.19. 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 3.19 Reported Work RVUs for Surgeons with ≥ 0.8 Clinical FTE



Compensation-to-Production Ratios

1. Compensation per WRVU

In aggregate, the median clinical compensation per WRVU³ was \$47.40 and the average was \$50.02, as shown in figure 3.20. Compensation per WRVU was calculated only for those physicians who reported WRVUs to the survey (297 physicians from 203 organizations).

Figure 3.20: Compensation per WRVU Benchmarks

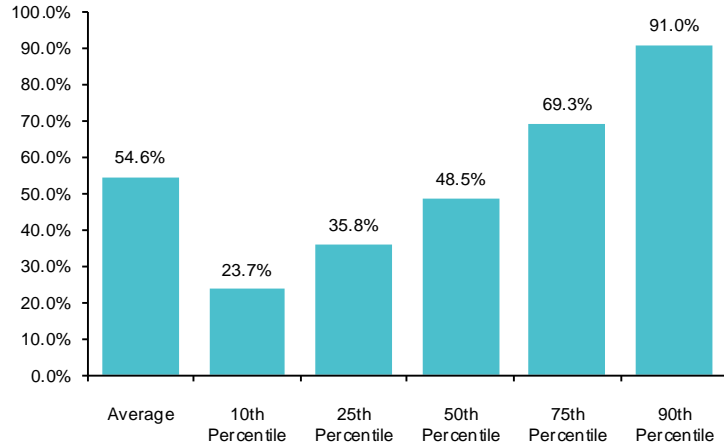


³ This ratio is calculated by dividing each physician's normalized compensation by their normalized WRVUs. This objective measure of compensation relative to productivity is measured by only the work component of the WRVU system and is widely considered a better indication of compensation per unit of production because it measures just the compensation for physician work effort and excludes the practice expense and malpractice components.

2. Compensation as a Percentage of Net Professional Collections

Compensation as a percentage of net professional collections was calculated only for those physicians who reported net professional collections (255 physicians from 176 organizations).⁴ In aggregate, the median clinical compensation as a percentage of net professional collections was 48.5%, as shown in figure 3.21. The higher this percentage is, the greater the proportion of collections being used to provide physician compensation.

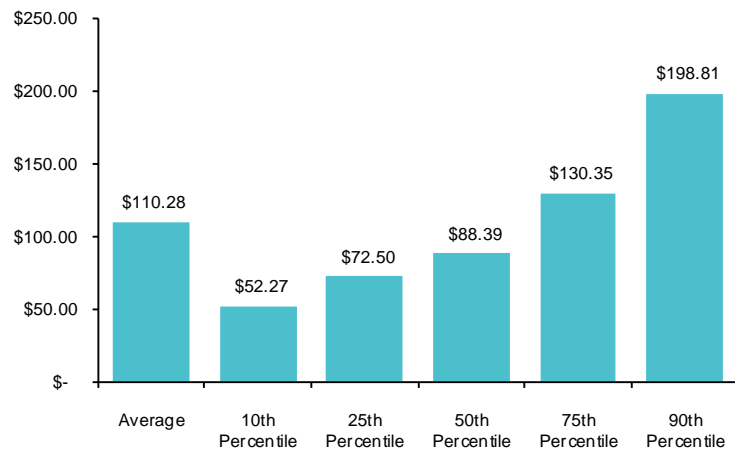
Figure 3.21: Compensation as a Percentage of Net Professional Collections Benchmarks



3. Net Professional Collections per WRVU

Net professional collections per WRVU were calculated only for those physicians who reported net professional collections and WRVUs to the 2018 ASCRS survey (156 physicians from 123 organizations). In aggregate, the median net professional collections per WRVU were \$88.39, as reported in figure 3.22. This ratio provides an objective measure of the actual payments for total professional medical services (for only the physician work effort component of the WRVU).

Figure 3.22: Net Professional Collections per WRVU Benchmarks



⁴ Total net professional collections equal total cash collections received from patients and third-party payers for the physician's professional services provided to all patients.

IV. New Hire Starting Salaries and Hiring Incentives

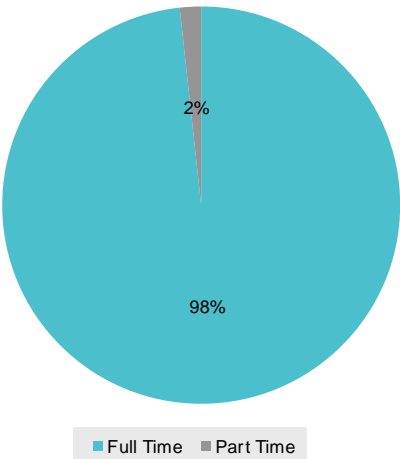
This section contains data on colon and rectal surgery physicians who were hired in 2018. Information requested from new hires included data on the employment status of the offer they accepted and the types and values of hiring or recruitment incentives included in their employment offer or contract and starting salary. The two most common types of hiring incentives received were a signing bonus, reported by 68% of new hires, and relocation assistance, reported by 62%. The median annual starting salary was \$330,000 for full-time new hires, which is 28% lower than the median clinical compensation reported by colon and rectal physicians hired prior to 2018.

A. Employment Status and Starting Salaries

1. New Hire Employment Status

A total of 58 colon and rectal physicians reported they were new hires in 2018, with 98% (n=57) indicating the offer they accepted was for a full-time position and 2% (n=1) indicating they accepted a part-time position, as shown in figure 4.1.

Figure 4.1: Percentage of New Hires by Employment Status



2. New Hire Starting Salaries

New hire colon and rectal physicians were asked to report their annual starting salary, which includes only the base (or guaranteed/fixed) component of compensation; performance bonuses or other variable compensation (including any hiring incentives) were not included in this amount. Table 4.1 presents relevant statistics for the 53 full-time new hires who provided their annual starting salary. Median compensation for these physicians was \$330,000, and average compensation was \$353,755.

Table 4.1: Percentage of New Hires by Employment Status

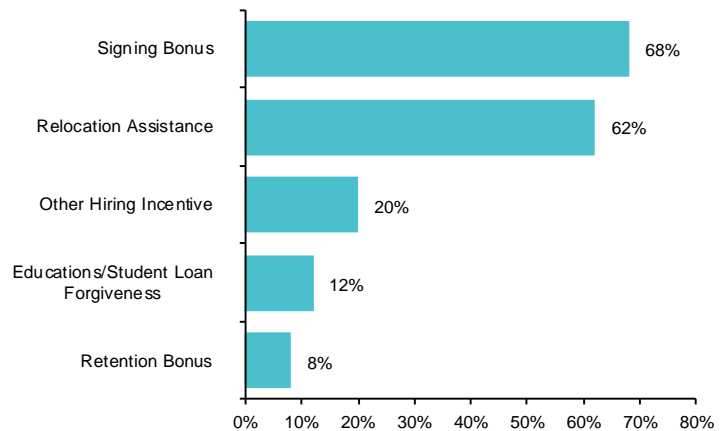
Statistic	Full-Time Physicians (N=53)
Average	\$353,755
Minimum	\$125,000
10th Percentile	\$250,000
25th Percentile	\$280,000
50th Percentile	\$330,000
75th Percentile	\$400,000
90th Percentile	\$461,200
Maximum	\$800,000

B. Recruitment Package Benefits

1. Hiring Incentives for New Hires

New hire physicians were asked to report the various hiring incentives that comprised their recruitment package, with 50 of the 58 new hires providing this data, as shown in figure 4.2. The two most common types of hiring incentives received were a signing bonus, reported by 68% (n=34) of new hires, and relocation assistance, reported by 62% (n=31).

Figure 4.2: Percentage of New Hires Receiving Hiring Incentives



2. New Hire Signing Bonus Incentive

Of the 34 new hires who reported receiving a signing bonus, 30 provided the actual amount of this incentive, valued at an average of \$25,250 (see table 4.2). The median annual signing bonus was \$25,000. Details regarding a length-of-service requirement were provided by 25 new hires. The average years-of-service obligation for these new hires was 2.4 years.

Table 4.2: Signing Bonus Hiring Incentive

Signing Bonus Value	
Average	25,250
Median	\$25,000
Minimum	\$5,000
Maximum	\$50,000
Average	\$25,250

3. New Hire Relocation Allowance Incentive

Of the 31 new hires who reported receiving a relocation allowance, 28 provided the actual amount of this incentive, valued at an average of \$12,054 (see table 4.3). The median annual relocation allowance was \$10,000. Details regarding a length-of-service requirement were provided by 9 new hires. The average years-of-service obligation for these new hires was 2.6 years.

Table 4.3: Relocation Allowance Hiring Incentive

Relocation Assistance	
Average	\$12,054
Median	\$10,000
Minimum	\$1,000
Maximum	\$25,000
Average	\$12,054

* * * * *

Disclaimer

The 2018 ASCRS Physician Compensation Survey is published by the American Society of Colon and Rectal Surgeons (ASCRS) and is a compilation of information provided solely by participating physicians. The information published in this Survey was developed from historical information and does not include any projected information. Neither ECG Management Consultants nor ASCRS has verified the accuracy, completeness, or suitability of any information provided here, and ASCRS does not recommend, encourage, or endorse any particular use of the information reported. ASCRS make no warranty, guarantee, or representation whatsoever and assumes no liability or responsibility in connection with the use or misuse of this Survey.

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