

Training & Practice Update

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Geriatricians and Compensation Front Page

United States medical school graduates (USMDs) are choosing specialties other than primary care and geriatrics. The table below compares selected specialties by the percent of their trainees who are USMDs, the percent of filled first year fellowship positions, and private practice compensation.

The low number of USMDs entering geriatrics training will influence the quality and availability of physicians with in-depth training to care for older adults. The ratio of geriatricians to Americans 75 and over will change from 4.7 geriatricians/10,000 population in 2000 to 1.6 geriatricians/10,000 population by 2050. This change in ratio is due to the dramatic increase in the number of older Americans while the number of geriatricians stabilizes at around 8,000. The majority of geriatricians (71% or 8,272 of the 11,719 certified) were certified when a practice pathway was an option for certification. Now the only way a physician can become a geriatrician

is to complete a geriatric medicine fellowship program. However, only a small number of USMDs are enrolling in geriatric medicine fellowship programs.

Physicians graduating from U.S. medical schools in 2007 owed an average of \$138,608 for their education. Fifty one percent of these graduates said that salary expectations were a moderate or strong influence in determining their specialty.¹ Indeed, geriatric medicine which has the fewest percent of USMDs enrolling in training programs, also has the lowest median salary among U.S. specialties (Table 1). General internal medicine physicians who train fewer years than geriatricians have a higher median practice salary. The costs associated with extra years of geriatric training do not translate into additional income,² and are affecting medical student's career choices.

Table 1. USMDs and First Year Trainees in Selected Residency and Fellowship Training Programs and Private Practice Salary

| Specialty | % of Residents or Fellows who are USMDs | % of Filled First Year Positions | 2006 Median Salary once in Private Practice [†] |
|---------------------------|---|----------------------------------|--|
| Orthopedics | 97% | 98% | \$425,000 |
| Urology | 95% | 70% | \$357,605 |
| Dermatology | 95% | 99% | \$335,899 |
| Radiology (non-invasive) | 90% | 96% | \$426,345 |
| Emergency Medicine | 85% | 99% | \$250,030 |
| Gastroenterology | 69% | 94% | \$406,345 |
| Pediatrics | 69% | 97% | \$174,353 |
| Psychiatry | 62% | 94% | \$185,957 |
| Neurology | 57% | 86% | \$220,000 |
| General Internal Medicine | 50% | 97% | \$177,059 |
| Family Medicine | 47% | 94% | \$164,021 |
| Geriatric Psychiatry | 33% | 48% | N/A [*] |
| Geriatrics (FM+IM) | 32% | 54% | \$161,888 |

Sources: JAMA GME Tables, 2006-2007, September 5, 2007.

[†]MGMA Physician Compensation and Production Survey: 2007 Report Based on 2006 Data³

^{*}Data not reported due to insufficient responses

Geriatricians and Financial Compensation

Compensation for Academic Faculty

Instructors and assistant professors in geriatrics have considerably lower compensation than their colleagues in family medicine and internal medicine, but once they become associate professors their salaries are similar (Table 2).

Overall academic geriatrician's salaries are competitive with other non-procedural specialists, but are not competitive with physicians in procedural practices. These findings are consistent with what was reported in the October 2004 Training and Practice Update using compensation data from 2002-2003.⁴

Table 3 presents combined median salaries of assistant, associate, and professor ranks from AY 2005-06 to AY 2006-07. During this time academic geriatricians' salaries increased by 2.8%, but the combined ranks salary of academic geriatricians was lower than internal medicine or family medicine faculty for both years. Similar increases occurred for pediatrics (2.1%) which has a comparable salary to geriatricians and for urology (2.7%), however, urology median salaries are \$120,000 more than geriatricians.

Table 2. Medical School Faculty Total Compensation* 2006-2007 (Median Dollars)

| Practice Areas | Instructor | | Assistant Professor | | Associate Professor | | Professor | | Chief | |
|--------------------------------|------------|---------|---------------------|---------|---------------------|---------|-----------|---------|-------|---------|
| | Count | \$ | Count | \$ | Count | \$ | Count | \$ | Count | \$ |
| Orthopedics | 73 | 211,000 | 609 | 315,000 | 369 | 394,000 | 285 | 388,000 | 31 | 475,000 |
| Urology | 33 | 80,000 | 262 | 231,000 | 186 | 304,000 | 185 | 325,000 | 30 | 352,000 |
| Dermatology | 40 | 203,000 | 254 | 197,000 | 127 | 222,000 | 116 | 232,000 | 19 | 262,000 |
| Radiology (non-invasive) | 168 | 109,000 | 847 | 281,000 | 410 | 311,000 | 455 | 330,000 | 87 | 351,000 |
| Emergency Medicine | 243 | 189,000 | 1,107 | 202,000 | 349 | 214,000 | 142 | 229,000 | 33 | 267,000 |
| Gastroenterology | 63 | 158,000 | 470 | 200,000 | 337 | 232,000 | 335 | 255,000 | 53 | 313,000 |
| Pediatrics | 134 | 116,000 | 944 | 132,000 | 404 | 150,000 | 317 | 181,000 | 47 | 198,000 |
| Psychiatry | 265 | 138,000 | 1,355 | 144,000 | 612 | 160,000 | 629 | 196,000 | 72 | 182,000 |
| Neurology | 135 | 102,000 | 916 | 134,000 | 563 | 169,000 | 584 | 203,000 | 36 | 219,000 |
| General Internal Medicine | 603 | 135,000 | 1,880 | 142,000 | 692 | 160,000 | 430 | 197,000 | 48 | 225,000 |
| Family Medicine | 164 | 125,000 | 1,302 | 142,000 | 489 | 160,000 | 279 | 181,000 | 16 | 182,000 |
| Geriatrics – Internal Medicine | 33 | 107,000 | 237 | 131,000 | 94 | 165,000 | 71 | 197,000 | 26 | 231,000 |

Source: AAMC Data Services⁵

*Total salary without benefits

| Department | Percent Change 2005-2006 to 2006-2007 | 2005-2006 (Median \$) | 2006-2007 (Median \$) |
|--------------------------------|---|--------------------------|--------------------------|
| Orthopedics | +6.0% | 333,000 | 353,000 |
| Urology | +2.7% | 263,000 | 270,000 |
| Dermatology | — | —* | 213,000 |
| Radiology (non-invasive) | — | —* | 303,000 |
| Emergency Medicine | +5.6% | 195,000 | 206,000 |
| Gastroenterology | +4.7% | 215,000 | 225,000 |
| Pediatrics | +2.1% | 141,000 | 144,000 |
| Psychiatry | +3.3% | 152,000 | 157,000 |
| Neurology | +3.9% | 153,000 | 159,000 |
| General Internal Medicine | +4.1% | 146,000 | 152,000 |
| Family Medicine | +3.4% | 145,000 | 150,000 |
| Geriatrics – Internal Medicine | +2.8% | 141,000 | 145,000 |

*In 2006/07 Dermatology was divided to excluding Mohs Surgery and Dermatology-Mohs Surgery; Diagnostic Radiology was divided into Interventional and non-Interventional. Source: AAMC Data Services^{5,6}

| Practice Area | 2002 | 2003 | 2004 | 2005 | 2006 | % Change from 2002 to 2006 | % Change from 2003 to 2006 |
|------------------------------|-------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| | Median (\$) | Median (\$) (% Change 2002 to 2003) | Median (\$) (% Change 2003 to 2004) | Median (\$) (% Change 2004 to 2005) | Median (\$) (% Change 2005 to 2006) | | |
| Orthopedics | 364,060 | 385,000 (+5.8%) | 383,697 (-0.3%) | 415,347 (+8.2%) | 425,000 (+2.3%) | +16.7% | +10.4% |
| Urology | 294,337 | 344,038 (+16.9%) | 335,731 (-2.4%) | 336,364 (+0.2%) | 357,605 (+6.3%) | +21.5% | +3.9% |
| Dermatology | 262,782 | 280,121 (+6.6%) | 298,115 (+6.4%) | 321,180 (+7.7%) | 335,899 (+4.6%) | +27.8% | +19.9% |
| Radiology (non-invasive) | 348,774 | 395,501 (+13.4%) | 399,195 (+0.9%) | 419,148 (+5.0%) | 426,345 (+1.7%) | +22.2% | +7.8% |
| Emergency Medicine | 211,709 | 215,859 (+2.0%) | 221,679 (+2.7%) | 243,449 (+9.8%) | 250,030 (+2.7%) | +18.1% | +15.8% |
| Gastroenterology | 321,023 | 351,614 (+9.5%) | 368,733 (+4.9%) | 384,015 (+4.1%) | 406,345 (+5.8%) | +26.6% | +15.6% |
| Pediatrics | 153,098 | 158,867 (+3.8%) | 161,331 (+1.6%) | 167,158 (+3.6%) | 174,353 (+4.3%) | +13.9% | +9.7% |
| Psychiatry | 159,444 | 161,344 (+1.2%) | 180,000 (+11.6%) | 185,690 (+3.2%) | 185,957 (+0.1%) | +16.6% | +15.3% |
| Neurology | 185,666 | 190,973 (+2.9%) | 211,094 (+10.5%) | 216,199 (+2.4%) | 220,000 (+1.8%) | +18.5% | +15.2% |
| General Internal Medicine | 154,756 | 159,252 (+2.9%) | 166,420 (+4.5%) | 174,664 (+5.0%) | 177,059 (1.4%) | +14.4% | +11.2% |
| Family Medicine without OB | 150,267 | 152,478 (+1.5%) | 156,011 (+2.3%) | 160,729 (+3.0%) | 164,021 (+2.0%) | +9.2% | +7.6% |
| Geriatrics—Internal Medicine | 146,016 | 155,276 (+6.3%) | 160,340 (+3.3%) | 162,977 (+1.6%) | 161,888 (-0.7%) | +10.9% | +4.3% |

Source: MGMA⁷⁻¹⁰

Compensation for Geriatricians in Private Practice

From 2002 to 2006, increases in compensation for private practice physicians ranged from 9.2% to 27.8% (Table 4). In that same time period salaries of private practice geriatricians increased 10.9%; from \$146,016 to \$161,888. However, salaries actually dropped slightly (-0.7%) from 2005 to 2006. In the last five years geriatricians had the lowest median salary or next to lowest salary among all physicians.

Geriatricians in private practice earned about \$17,000 more than their academic colleagues in 2006 (\$161,888 versus \$145,000) or a 10.4% difference.

Discussion

In October 2004, we reported on financial compensation for geriatricians in academic and private practice using data from 2002-03. Not much has changed over the intervening 3 ½ years. While salaries have increased, the median salary of combined ranks for academic geriatrics was \$130,000 in AY 2002-2003¹¹ and is \$145,000 in AY 2006-07: it remains one of the lowest for academic physicians during both time periods. The median salary for geriatricians in private practice was \$155,276 in 2003 and is now \$161,888, again, one of the lowest compensated specialties for both time periods.

Geriatricians depend mainly upon Medicare for payment, which provides lower rates of reimbursement for office based primary care than private payors in many regions.² Also, even with the Centers for Medicare and Medicaid (CMS) implemented increases for evaluation and management (E&M) services, the gap in compensation between primary care and procedural specialists continues to widen.¹²

In 2002-03 there were 321 graduates of geriatric medicine fellowship programs and that declined to 304 graduates in AY 2005-06.¹³ The small number of geriatricians as well as other specialists with training in caring for older adults limits the availability of expert chronic care to the oldest and most frail Americans. Even with the significant contributions of nurse practitioners, physician assistants, and other health care professionals, the expected need for geriatric expertise, which will greatly increase over the next 25 years, will not be met.

Financial disincentives pose a large barrier to entry into the field of geriatrics. In 2007, the average medical school debt was \$138,600 and salaries for geriatricians are low compared to other medical specialists. The April 2008 Institute of Medicine report: *Retooling for an Aging America: Building the health care workforce* outlines recommendations for enhanced training, loan forgiveness, and compensation increases for physicians providing geriatric medicine services.²

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The Status of Geriatrics Workforce Study National Oversight Panel

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