Original Article

NASPAG Pediatric and Adolescent Gynecology Surgery Compensation Survey

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A B S T R A C T

Introduction: Over the last decade, the field of pediatric and adolescent gynecology (PAG) has rapidly expanded on the basis of a need for this specialized training to care for children and adolescents with gynecologic concerns. There are 18 PAG fellowship programs within the United States and Canada. Since 2017, which marked the beginning of the American Board of Obstetrics and Gynecology (ABOG) Focused Practice Examination in PAG and PAG Maintenance of Certification program, there has been a growing recognition of this specialty, given the unique population served. However, there is a paucity of information related to compensation in PAG. As the field has grown and more PAG fellow graduates are sought by children's hospitals throughout the United States and Canada, there is an urgent need to ensure that salary is equitable for these specialty PAG providers given the unique skills acquired during fellowship training, beyond that of obstetrics and gynecology (OBGYN) residency. This initial survey aimed to focus on compensation for PAG surgeons in the United States.
Objectives: To survey NASPAG PAG surgeons in the United States about current benefits, practice metrics, and compensation
Methods: A 15-question anonymous survey was sent to PAG surgeons in the United States in February 2022, with 3 reminders sent by email to engage voluntary participation. The survey aimed to understand practice characteristics, current compensation, and relative value unit (RVU) benchmarks. Descriptive statistics were utilized. Compensation means and quartiles were calculated in U.S. dollars for the following categories: assistant professor, associate professor, and full professor. The compensation mean was also calculated for private/hybrid and instructor categories.
Results: Among 255 eligible members, 88 completed the survey, for a participation rate of 34.5%. Sixty-three point six percent reported having completed a PAG fellowship, whereas one-third reported specializing in this area with no fellowship available at the time. Three-fourths reported having achieved ABOG Focused Practice PAG certification. Most providers were academic (75%) and working full time (82.9%). Among academicians, most were assistant professors (48%) and on the non-tenure track (50.6%). RVU benchmarks varied, with 40.2% reporting OBGYN generalist targets and only 18.3% reporting PAG-specific targets, despite most physicians practicing only PAG (62.5%) and less than 30% practicing PAG plus some adult OBGYN. Salary support varied, with 57% employed by a hospital. Incentives were common, with most receiving a bonus at the end of the year (52.9%). As expected, full professors reported higher mean compensation ($345k) as compared with less senior colleagues ($248k and $302k for assistant and associate professors, respectively). Private practice/hybrid practitioners reported compensation ($251k) similar to that of assistant professors ($248k). Only 2 instructor-level physicians completed the survey. The mean number for this level is skewed and is not a reliable predictor for this academic level. Quartiles could not be calculated for this category.
Conclusion: This is the first survey addressing compensation in the field of PAG in the United States. There is an ongoing need to collect this information to prepare PAG fellow graduates for the job market. Additional surveys, including an understanding of the compensation landscape in Canada, are needed in the future to address specific questions related to compensation for those who have less than 50% clinical time.
Key Words: Compensation, Salary, Pediatric and adolescent gynecology, Equity

Background

The North American Society for Pediatric and Adolescent Gynecology (NASPAG), established in 1986, is the flagship society for pediatric and adolescent gynecology (PAG) surgeons in the United States. This organization's mission areas include focusing on improving the health of girls and adolescents through clinical care, education, and research. The advocacy committee has grown robust over the years as well, focusing on advocacy concerns not only related to patient care but also for providers. The NASPAG board, executive directors, current president, and past presidents are frequently engaged in important topics to gain an understanding of the current state of the field and future opportunities.[1] Compensation for obstetrics and gynecology (OBGYN) has been a longstanding discussion. Many nationwide surveys have attempted to address compensation for the specialty, as well as subspecialty areas within the field. Historically, obstetrics providers have been compensated more than gynecology providers, a function of the current health care reimbursement model within the United

Conflict of Interest Statement None

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States, set by the Centers for Medicare & Medicaid Services (CMS).[2] This is a system built on current procedural terminology (CPT) values and the International Classification of Diseases (ICD), now in version 10 since its inception.[2] Previous research has established CPT value differences among procedures performed in males vs similar procedures in females, resulting in lesser reimbursement for clinicians and surgeons caring for women and girls. There has been an additional compensation differential noted related to gender, with female surgeons typically earning compensation equal to 82% of what male surgeons make.[3] Furthermore, the dichotomy of the reimbursement model has led to fewer gynecologic specialty surgeons and an increase in care gaps.[3] PAG is a newer specialty within OBGYN, and specialty care gap concerns exist, primarily on the basis of geographic location.

Over the last decade, the field of PAG has rapidly expanded on the basis of a need for this specialized training to care for children and adolescents with gynecologic concerns. There are now 18 PAG fellowship programs within the United States and Canada.[1] PAG is the newest subspecialty field within OBGYN and as of 2017 has taken steps toward specialty recognition with Focused Practice certification in PAG through the American Board of Obstetrics and Gynecology (ABOG).[4] The same year, a Maintenance of Certification program was launched in PAG.[4] Growing recognition of this field has occurred, but more work is needed to address health care gaps for this PAG population. Given the paucity of PAG providers in North America, access to PAG health care for patients needing these providers is clearly impacted. As more PAG fellow graduates are sought by children's hospitals throughout the United States, there is an urgent need to ensure that salary is equitable for these specialty PAG providers given the unique skills acquired during fellowship training, beyond that of OBGYN residency. Having an understanding of the current workforce in this field plus an understanding of compensation for this specialty will be important to attract future providers to the field. This initial survey sought to understand the current compensation for PAG surgeons in the United States.

Methods

A 15-question anonymous survey was sent electronically by NASPAG to PAG surgeons in the United States in February 2022, with 3 reminders to engage voluntary participation to understand practice characteristics and total compensation. PAG surgeons were asked to fill out the survey voluntarily if they identified as U.S. PAG surgeons. The survey also inquired about relative value unit (RVU) benchmark tools utilized by providers at their institutions and the type of RVU assignment made for their clinical work target at the 50th percentile. Additionally, employment and benefits structure were assessed, although this information was not linked to total compensation to minimize loss of confidentiality. Descriptive statistics were utilized. Compensation means and quartiles were calculated in U.S. dollars for the following categories: assistant professor, associate professor, and full professor. The compensation mean was also calculated for the instructor and private/hybrid categories.

Questions

1	What RVU benchmark does your institution use to be considered performing at the 50%
2	Do you know if you institution uses a particular tool in order to come up with an RVU benchmark?
3	What is your practice type?
4	If you are academic, what is your rank?
5	Are you part time or full time?
6	If academic are you tenure track or non-tenure track?
7	What is your current salary?
8	If you are further in your career at this time, can you recall your salary when you first started in the field of PAG?
9	Have you completed a fellowship in PAG?
10	Have you obtained your specialty certification in PAG through ABOG?
11	Do you do all PAG or some PAG and some OBGYN?
12	How is your employment structured?
13	Who supports your salary?
14	Do you have any type of incentive plan?
15	Do you have certain benefits included as part of your compensation package?

Fig. 1. U.S. pediatric and adolescent gynecology (PAG) surgery compensation survey questionnaire.

Table 1
Employment Characteristics of U.S. Pediatric and Adolescent Gynecology (PAG) Surgeons

Employment	*N*	%
Academic	66	75
Private practice	9	10.2
Hybrid practice	13	14.8
Fellowship trained	56	63.6
Not fellowship trained	16	18.2
Fellowship not offered at time of training	16	18.2
PAG Focused Practice certified	66	75

Results

Among 255 eligible members, 88 completed the survey questions (Fig. 1), resulting in a participation rate of 34.5% (Fig. 2a). Most U.S. PAG surgeons (63.6%) reported having completed a PAG fellowship, whereas one-third reported specializing in this area with no fellowship training available at the time (Table 1). Three-fourths reported having achieved ABOG Focused Practice PAG certification (Table 1). Most providers were academic (75%) and working full

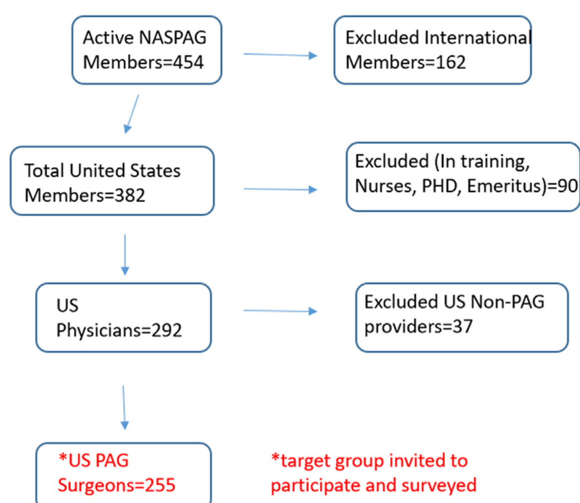

Fig. 2a. North American Society for Pediatric and Adolescent Gynecology (NASPAG) survey participation.

Table 2
Academic Levels of U.S. Pediatric and Adolescent Gynecology (PAG) Surgeons

Academic rank	*N*	%
Instructor	2	2.4
Assistant professor	40	47.6
Associate professor	23	27.4
Professor	10	11.9

Table 3
Relative Value Unit (RVU) Target Source Reported by U.S. Pediatric and Adolescent Gynecology (PAG) Surgeons

RVU source	*N*	%
MGMA	17	22.7
AAMC	10	13.3
Sullivan Cotter	14	18.7
None	19	25.3
Other	15	20

Table 4
Relative Value Unit (RVU) Target Number Reported by U.S. Pediatric Adolescent Gynecology (PAG) Surgeons

RVU target	*N*	%
OBGYN generalist level	33	40.2
PAG-specific level	15	18.3
Hybrid	21	25.6
Pediatric level	2	2.4
Fee for service	11	13.4

Table 5
Compensation by Practice and Academic Rank for U.S. Pediatric and Adolescent Gynecology (PAG) Surgeons

Practice type	*N*	Mean salary, U.S. dollars (SD)	Range, U.S. dollars
Full time	73	276,918.10 (62,606)	145,000–500,000
Part time	15	183,800 (59,780.79)	100,000–300,000
All PAG service	48	263,830 (55,825.50)	100,000–415,000
Some PAG service	27	292,839.50 (79,732.96)	145,000–500,000
Instructor	2	329,150 (100,197) full time NA part time	258,300–400,000
Assistant professor	40	248,076 (49,529.79) full time 179,200 (49,529.79) part time	190,000–350,000
Associate professor	23	302,251.50 (70,388.71) full time 185,000 (91,469.48) part time	150,000–500,000
Professor	10	345,0751 (43,560.38) full time 211,500 (75,660.43) part time	300,00–415,000
Private/hybrid	13	251,250 (66,493.29) full time 174,500 (49,675.61) part time	145,000–350,000

Table 6
Pediatric and Adolescent Gynecology (PAG) Academic Specialty Quartiles for U.S. PAG Surgeons

Academic level	Assistant professor	Associate professor	Professor
Quartile	**U.S. dollars ($)**		
<25th	190,000	150,000	300,000
25th	226,250	268,000	315,750
Median	240,000	300,000	337,000
75th	250,000	340,000	377,004
90th	350,000	500,000	415,000

time (82.9%) (Table 1). Among academicians, most were assistant professors (48%) and on the non-tenure track (50.6%). Only 3 (3.5%) individuals reported being tenured, and 10 (11.9%) individuals were at the professor level (Table 2). RVU benchmarks varied, with 40.2% of providers given OBGYN generalist RVU number targets and only 18.3% given PAG-specific RVU number targets, despite most practicing only PAG (62.5%) (Tables 3 and 4). Among those participating in the survey, less than 30% reported practicing PAG plus some adult OBGYN. Salary support among PAG providers varied, with 47% remarking that they were employed by a hospital, 34% employed by a medical school, 17% in group practice, and 1.1% self-employed. Incentives were common, with a slight majority receiving a bonus at the end of the year (52.9%), some reporting call pay (14.8%), and others reporting an incentive for performing at greater than 50% RVU (17.4%). As expected, providers reported an increase in salary from when they started their PAG position (mean = $181,022.90) to their current salary (mean = $276,918.10). Additionally, full professors reported higher mean compensation ($345k) compared with less senior colleagues ($248k and $302k for assistant and associate professors, respectively (Table 5). Private practice/hybrid practitioners reported compensation ($251k) similar to that of assistant professors ($248k) (Table 5). With only 2 instructors reporting, this mean number is likely skewed and is not a reliable predictor for this level. Interestingly, among those focusing their practice in PAG solely, compensation was 10% less than those doing some PAG and some adult OBGYN (Table 5). Salary quartiles were calculated in U.S. dollars for the assistant professor, associate professor and professor levels (Table 6, Fig. 2b-4).

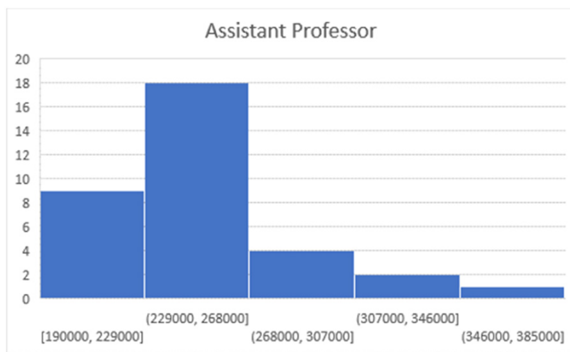

Fig. 2b. Quartiles for the pediatric and adolescent gynecology (PAG) surgeon assistant professor level (U.S. dollars).

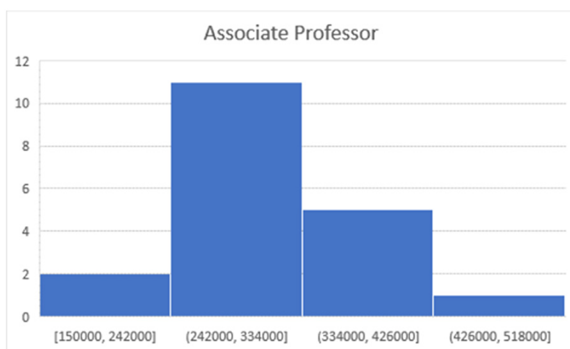

Fig. 3. Quartiles for the pediatric and adolescent gynecology (PAG) surgeon associate professor level (U.S. dollars).

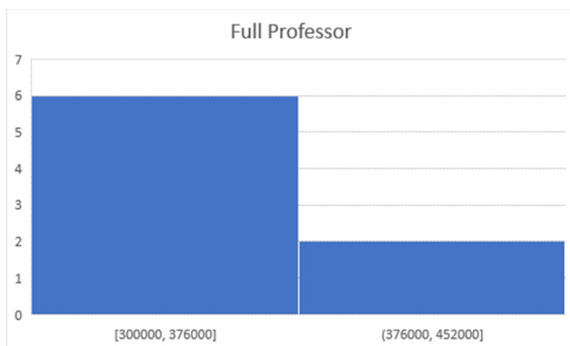

Fig. 4. Quartiles for the pediatric and adolescent gynecology (PAG) surgeon professor level (U.S. dollars).

Discussion

Although these compensation numbers are the first to have been established in the field, it is important to move toward an understanding of the value assigned to the PAG specialty compared with what providers are compensated. As a specialized field within OBGYN, PAG surgery providers should be looked at carefully and compared with other gynecologic surgery subspecialties in several categories: years of specialty training, value-based care added, rarity of the specialty, and level of compensation. Consideration should be made for compensating those with additional training, beyond residency training, more than providers without this additional specialized training.

Not many papers exist in the literature to inform gynecologic surgeons regarding compensation. However, 1 paper focusing on minimally invasive gynecologists (MIGs) looked at compensation on the basis of a survey of MIG fellow graduates in 2015.[5] This was an international survey and included data from MIGs surgeons in 8 countries, although most (93%) were from the United States. Most were practicing at academic institutions (61%) and were at the assistant professor level (66.4%). They did assess locations and years of experience as they related to compensation. Academic surgeons with 3 years of experience reported a mean salary of $208,743. Although they assessed benefits as part of compensation, they did not specifically look at RVUs.[5]

Whereas this study is more recent, similar concerns related to compensation and reimbursement have been discussed in gynecologic oncology since 1996.[6] Using a federal register from 1995, researchers Goff et al compared work RVUs and total reimbursement among 24 groups of gender-specific surgical procedures. Groups were matched as closely as possible, and procedure examples were utilized to compare, included staging for ovarian cancer vs testicular cancer. They discovered that male-specific procedures were reimbursed more than female-specific procedures in 19 (79%) of cases and ranged from $2-$621 more. Furthermore, they assessed whether gynecologic procedures were undervalued. They noted that a general surgery exploratory laparotomy (CPT code 49,000) had a total RVU assigned of 17.18 at the time, whereas the RVU assigned to laparotomies for gynecologic reasons ranged from 11.9 to 16.5.[6] Additionally, RVU reimbursement was noted to vary by state of practice in this study.[6]

No studies currently exist on compensation for PAG. As medical systems move toward value-based care, quality of care and care value are important aspects to address. Pediatric surgery subspecialties have also focused on these issues, with 1 document recommending that children with complex surgical concerns, such as malignancies or congenital anomalies, be sent to surgeons in pediatric centers, where these problems could be best managed by teams.[7] These were primarily derived from expert opinion, although evidence of improved outcomes does exist in several cases.[7] For instance in 2013, a study was undertaken to assess a surgeon's degree of specialization in children and associated outcomes. The researchers included hospital discharge data from 1998 to 2007 among children 18 or younger in the fields of otolaryngology, neurosurgery, cardiothoracic surgery, pediatric general surgery, orthopedic surgery, and urology. Mortality and length of stay were noted to increase with decreasing quartile of pediatric subspecialization in all surgical specialties.[8]

Quality of care has been a focus for the PAG specialty, too. A few specific examples related to quality of care for children and adolescents with gynecologic conditions have been reported in the literature. These examples address specifically ovarian torsion and mullerian anomalies. One study in the United Kingdom noted that ovarian sparing rates increased when a gynecologist was involved in the management of benign ovarian tumors and masses.[9] Furthermore, a paper published in 2019 focused on a cohort of 245 cases of torsion and the ovarian salvage rates. At this single institution, salvage rates soared at 94%, and most cases (87%) were performed by pediatric and adolescent gynecologists.[10] This is very different from the nationwide

outcomes related to ovarian and adnexal torsion, which are reported to be as high as 78% for oophorectomy after a diagnosis of torsion[11] currently, which has not changed since a study that looked at the nationwide sample using the KID database from 2000 to 2006 and with reported oophorectomy rates at 58%.[12] Other studies have also demonstrated that oophorectomy rates are higher among children under 11 years, those with public insurance, and those with complex health conditions.[13-15] Finally, PAG patients with congenital anomalies of the reproductive tract face similar disparities of care. Reproductive tract anomalies affect 7% of women, with complexities ranging from duplication to agenesis. Many papers have focused on outcomes related to the management of various conditions, especially given the obstetric risks they pose later on in life.[16-19] NASPAG and American College of Obstetricians and Gynecologists (ACOG) committee opinions currently address diagnosis and management of Mullerian anomalies and reinforce the importance of ensuring surgical management is performed by a provider who has specific training or expertise, as this is what ensures the best outcome.[16,17,20-22] With the classification system also changing recently, the complexity of these conditions has been highlighted as important to understand from the point of diagnosis.[23] These studies provide evidence that PAG provider input in clinical care makes a difference in outcomes for this population of children and adolescents.

This is a complex process for the health care system, let alone a new medical specialty. The steps mentioned above are in line with schools of thought focused on health care pathways and ensuring timely access to care to the right specialist. According to a recent bioethical paper, the health care system has done poorly with delivering health care in a fair and just manner thus far.[14,24,25] For instance, there is a critical need to look at current RVU surveys from all sources and to ensure there is a standardized manner in which the data are captured, there is relevance to current medical practice, considerations are made for value-based quality of care factors, gender equity is maintained. and specialties and subspecialties are defined appropriately for the work that they do. This ultimately will help us prepare future clinicians and surgeons for fair market reimbursement and compensation in gynecologic fields, including PAG, as these factors drive many decisions as residents decide field of practice on completion of residency.[26] These factors could also drive decisions as far back as medical school in terms of student choice to pursue a surgical specialty. These factors include compensation, work-life balance, job market, and long-term patient follow-up.[25,27-29]

There are some relevant limitations to point out in this particular compensation study. First, we acknowledge that there is some inherent recall bias related to surveys. Second, this was an initial look at compensation for the field, and although the participation rate was moderate, it would be ideal to capture more participants in the future. This could help better understand the data captured and avoid large skews that exist, as was the case for the instructor level. We were unable to compare years of practice as well, which might have allowed for comparisons from year to year and to evaluate for annual cost of living adjustments. Practice models were heterogeneous, which could impact compensation reported by providers. Total compensation was assessed by this initial survey among U.S. PAG surgeons and not linked to practice location, bonus structure, benefits, or performance metrics to minimize loss of confidentiality. The time frame from the starting salary point to current salary was also not assessed to minimize loss of confidentiality. These data were meant to be as de-identified as possible to encourage participation; therefore, compensation was not tied to geographic location. With time and comfort with participation in such surveys in the future, it might be possible to increase PAG surgeon participation rate. Finally, this initial survey did not address compensation in Canada for PAG surgeons.

Conclusion

This is the first survey addressing compensation in the field of PAG. There is an ongoing need to collect this information to prepare PAG fellow graduates for the job market, including aiding with employment decisions and negotiation and to ensure equity. Future surveys could aim to address specific questions related to compensation for those who have less than 50% clinical time. Additional surveys, including an understanding of the compensation landscape in Canada for PAG surgeons, are also needed.

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