Trends in Physician Compensation Among Medical Group Management Association Member Practices: Compensation Growth Trend Slows Slightly

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Physicians in Medical Group Management Association (MGMA) member practices continued to enjoy increases in compensation and production from 1999 to 2000. However, the rate of increase was generally lower than it was from 1998 to 1999. In most instances, greater pay was achieved by increases in production. Physicians generally had increased pay in 2000, but the rate appears to be stabilizing.

These findings are based on data from the *MGMA Physician Compensation and Production Survey: 2001 Report Based on 2000 Data*,[1] an annual survey conducted by the MGMA. Continuing a trend that started in 1998, primary care physicians as a whole enjoyed compensation increases of 2.27% from 1999 to 2000. This increased pay was coupled with only a 0.4% increase in production (measured as gross charges) over the previous year's levels. The rate of increase in compensation was smaller than the increase from 1998 to 1999, when primary care physicians saw compensation increases of 3.39%. Moreover, although production levels increased significantly in the 1998 to 1999 time period, average production levels for primary care physicians remained virtually unchanged from 1999 to 2000.

Specialist physicians also enjoyed relatively healthy increases in compensation in 2000, with an average increase of 4.3%. This rate of increase is lower than that in 1999, when specialists had a 6% increase in compensation over their levels in 1998. Percentage change in specialist physician production was largely consistent with this change in compensation, with specialist physician production increasing by 4.83% in 2000 from 1999 levels.

The *MGMA Physician Compensation and Production Survey: 2001 Report Based on 2000 Data* is based on the survey responses of 960 MGMA member medical practices, representing 30,584 physicians and midlevel providers. The survey of MGMA member practices has been conducted annually since 1987. Data are reported for 87 physician subspecialties and 13 midlevel provider specialties. The report contains sections on physician compensation, benefits, and productivity, as well as summary tables for selected specialties. Data examined in this article include the following:

- Compensation and production levels for primary care (Figure 1) and specialist (Figure 2) physicians for 1996 through 2000
- Percentage change in compensation and production levels for primary care (Figure 3) and specialist (Figure 4) physicians for 1996 through 2000
- Median compensation and production levels for selected specialties for 2000, as well as the 5-year trend (Table 1)
- Median compensation for selected specialties by group type (Table 2 and Figure 6)
- Operating costs as a percentage of total net medical revenue for 1990 through 2000 (Figure 5). (Operating cost data were obtained from the *MGMA Cost Survey: 2001 Report based on 2000 Data*.[2])
- Compensation by geographic section (Table 3 and Figure 7)
- Compensation by years in practice (Table 4 and Figure 8)
- Compensation by specialty and gender (Table 5)

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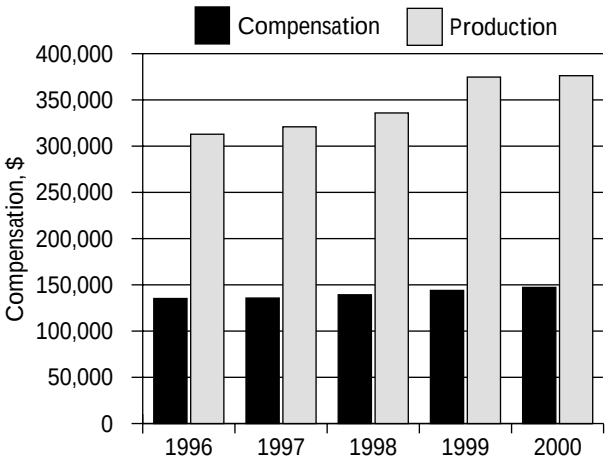

Figure 1. Median compensation and production for primary care physicians, 1996–2000. (Data from MGMA physician compensation and production survey: 2001 report based on 2000 data. Tables A and B: Median compensation and production for selected specialties, 1996–2000. Tables 1 and 15: Median compensation and production for hospitalist physicians. Englewood [CO]: Medical Group Management Association; 2001. © 2001 Medical Group Management Association.)

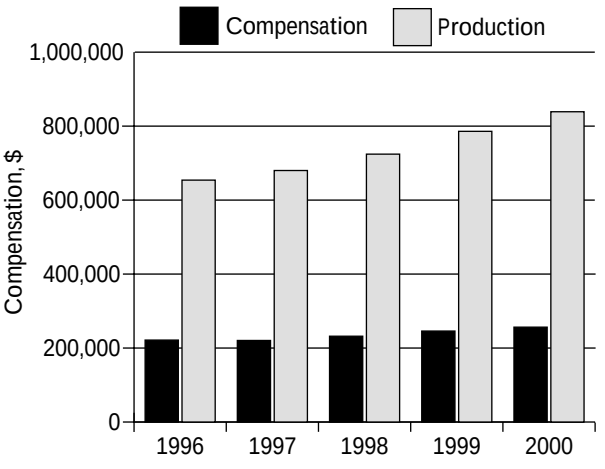

Figure 2. Median compensation and production for specialist physicians, 1996–2000. (Data from MGMA physician compensation and production survey: 2001 report based on 2000 data. Tables A and B: Median compensation and production for selected specialties, 1996–2000. Englewood [CO]: Medical Group Management Association; 2001. © 2001 Medical Group Management Association.)

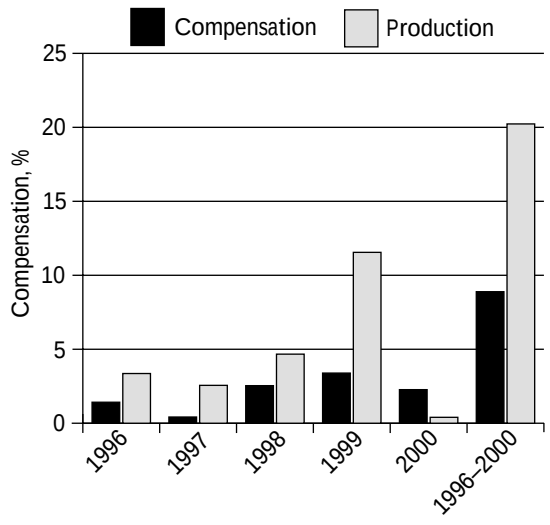

Figure 3. Percentage change in compensation and production for primary care physicians, 1996–2000. (Reproduced with permission from MGMA physician compensation and production survey: 2001 report based on 2000 data. Tables A and B: median compensation and production for selected specialties, 1996–2000. Englewood [CO]: Medical Group Management Association; 2001. © 2001 Medical Group Management Association.)

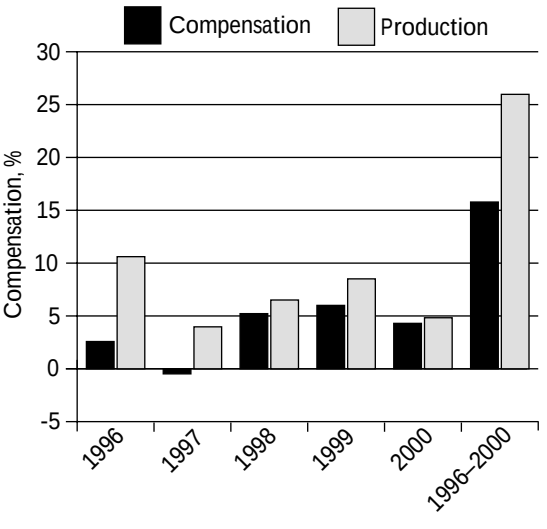

Figure 4. Percentage change in compensation and production for specialist physicians, 1996–2000. (Reproduced with permission from MGMA physician compensation and production survey: 2001 report based on 2000 data. Tables A and B: Median compensation and production for selected specialties, 1996–2000. Englewood [CO]: Medical Group Management Association; 2001. © 2001 Medical Group Management Association.)

Table 1. Median Compensation and Production for Primary Care and Selected Physician Specialties

	Median Compensation 2000, $	Change in Compensation 1999–2000, %	Change in Compensation 1996–2000, %	Median Production 2000, $	Change in Production 1999–2000, %	Change in Production 1996–2000, %
All primary care	**147,232**	**2.27**	**8.89**	**376,187**	**0.4**	**20.23**
Family practice (without obstetrics)	145,121	2.56	9.58	366,892	–1.06	19.69
Internal medicine (general)	149,109	2.55	6.5	367,738	–0.95	17.87
Internal medicine (hospitalist)	151,013	1.46	NA	343,961	14.93	NA
Pediatric/adolescent medicine	141,676	–0.93	7.3	406,985	5.01	22.79
All specialties	**256,494**	**4.30**	**15.78**	**823,883**	**4.83**	**25.97**
Anesthesiology	280,353	14.54	17.92	698,778	8.59	35.64
Cardiology (invasive)	365,894	7.61	3.43	1,447,063	6.72	23.65
Cardiology (noninvasive)	300,073	7.66	21.42	1,074,378	4.33	30.67
Dermatology	213,876	2.30	17.66	780,159	14.81	32.77
Emergency medicine	198,423	6.30	10.24	455,043	–1.64	22.02
Gastroenterology	281,308	6.35	25.37	1,158,324	9.56	45.27
Hematology/oncology	258,403	1.27	35.61	491,946	–5.23	11.69
Neurology	175,143	–1.71	8.58	544,380	–4.56	20.52
Obstetrics/gynecology	223,207	1.91	2.6	744,759	–1.4	17.83
Ophthalmology	236,353	7.56	15.01	1,077,329	15.8	32.78
Orthopaedic surgery	335,646	5.11	8.11	1,178,291	4.4	16.55
Otorhinolaryngology	235,415	–0.22	3.91	988,416	–0.7	25.37
Psychiatry	156,486	3.02	14.67	310,471	10.57	21.5
Pulmonary medicine	195,557	1.74	15.69	613,350	12.56	34.87
Radiology (diagnostic, noninvasive)	298,824	–5.15	10.92	1,021,782	–7.11	30.62
Surgery (general)	245,541	3.79	9.92	945,341	1.93	28.73
Urology	301,772	12.26	35.79	1,086,174	11.3	50.63

NA = not available.

Data from MGMA physician compensation and production survey: 2001 report based on 2000 data. Tables A and B: Median compensation and production for selected specialties, 1996-2000; Table 1: Physician compensation (all specialties); Table 15: Physician gross charges (technical component excluded). Englewood (CO): Medical Group Management Association; 2001.

FIVE-YEAR TRENDS IN COMPENSATION AND PRODUCTION

Trends related to physician compensation and production levels over the 5-year period from 1996 through 2000 continue to reveal the increased effort required to earn additional income. **Figure 1** and **Figure 2** show median compensation and production levels for primary care and specialist physicians during this 5-year period. Both figures show gradual increases in compensation levels, generally combined with more aggressive increases in production levels. This trend also is reflected in **Figure 3** and **Figure 4**, which illustrate the percentage change in primary care and specialist physician compensation and production during the same 5-year period. For primary care physicians as a whole, compensation increased from 1996 through 2000 by 8.89%, but

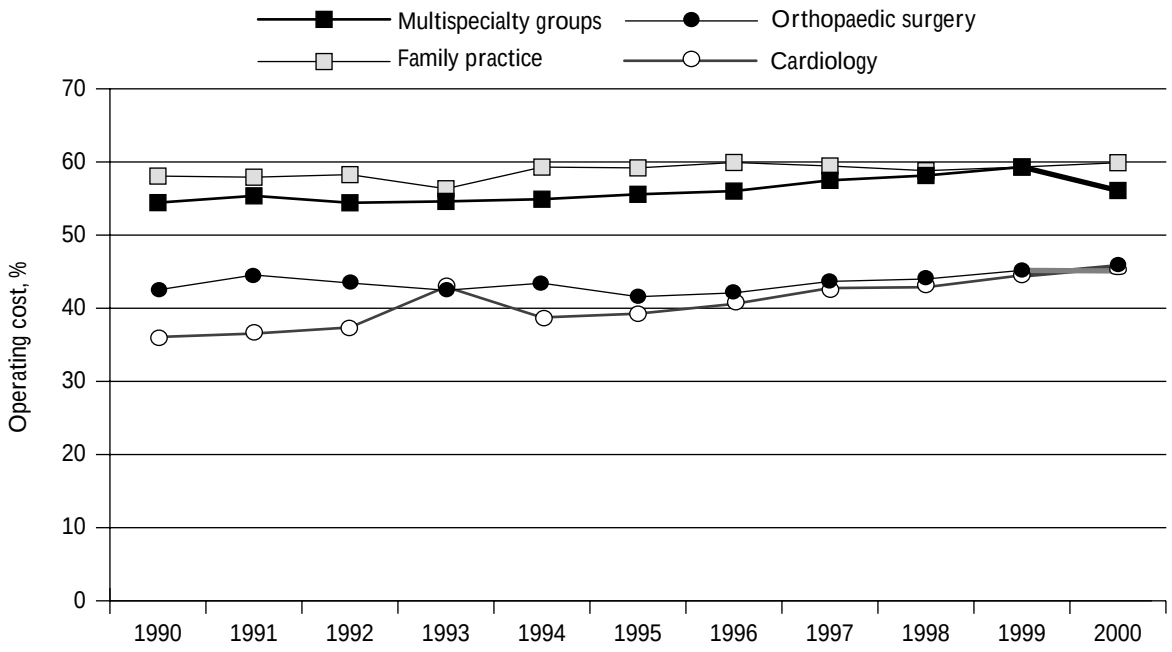

Figure 5. Operating cost as a percent of total medical revenue, 1990–2000. (Reproduced with permission from MGMA cost survey: 2001 report based on 2000 data. Graph 4. Englewood [CO]: Medical Group Management Association; 2001. © 2001 Medical Group Management Association.)

it took an increase in production of 20.23% to achieve this increase in pay (**Table 1**). The disparity between compensation and production increases was also significant for specialists, whose 25.97% increase in production from 1996 through 2000 yielded only a 15.78% increase in compensation during the same period.

Data presented in Table 1 also reveal the same overall trends in compensation and production levels over the same 5-year period for selected medical and surgical specialties. There are several possible reasons why production generally rises at a rate greater than that of compensation, including decreases in reimbursement due to managed care arrangements, continued downward pressure in governmental and private payer reimbursement rates, and increased operating costs associated with the infrastructure necessary to practice medicine in today's complex business and regulatory environment. These factors, combined with the relatively strong national economy and shortages of skilled labor in many regions during most of the 2000 survey period, may have helped further increase practice operating costs. Some of these changes may have abated somewhat with the economic reversal in the second half of 2001. The changing economic climate, coupled with significant changes in Medicare reimbursement in 2002, may result in significant downward pressure in compensation levels in coming years.

PRIMARY CARE PHYSICIAN COMPENSATION

General Considerations

Primary care physician compensation and production levels may be moving back toward a trend seen in the early to mid 1990s, when hospitals, physician practice management companies, and medical groups were engaged in a primary care "buying frenzy." During a 3-year period ending in 1996, the percentage increase in compensation levels for primary care physicians exceeded the percentage change in production. However, as indicated in Figure 3, this trend was reversed in 1996, after which time there was a more typical relationship between increases in compensation and production (ie, percentage increases in production significantly exceed those in compensation) for primary care physicians. Although the relationship between compensation and production levels in primary care specialties reversed itself once again during the 1999 to 2000 time period, only time will tell whether this reversal is an aberration or the beginning of an underlying trend.

Winners and Losers

Specific changes in compensation and production for primary care physicians from 1999 to 2000 (Table 1) include the following:

- Internal medicine (general)—in 2000, median

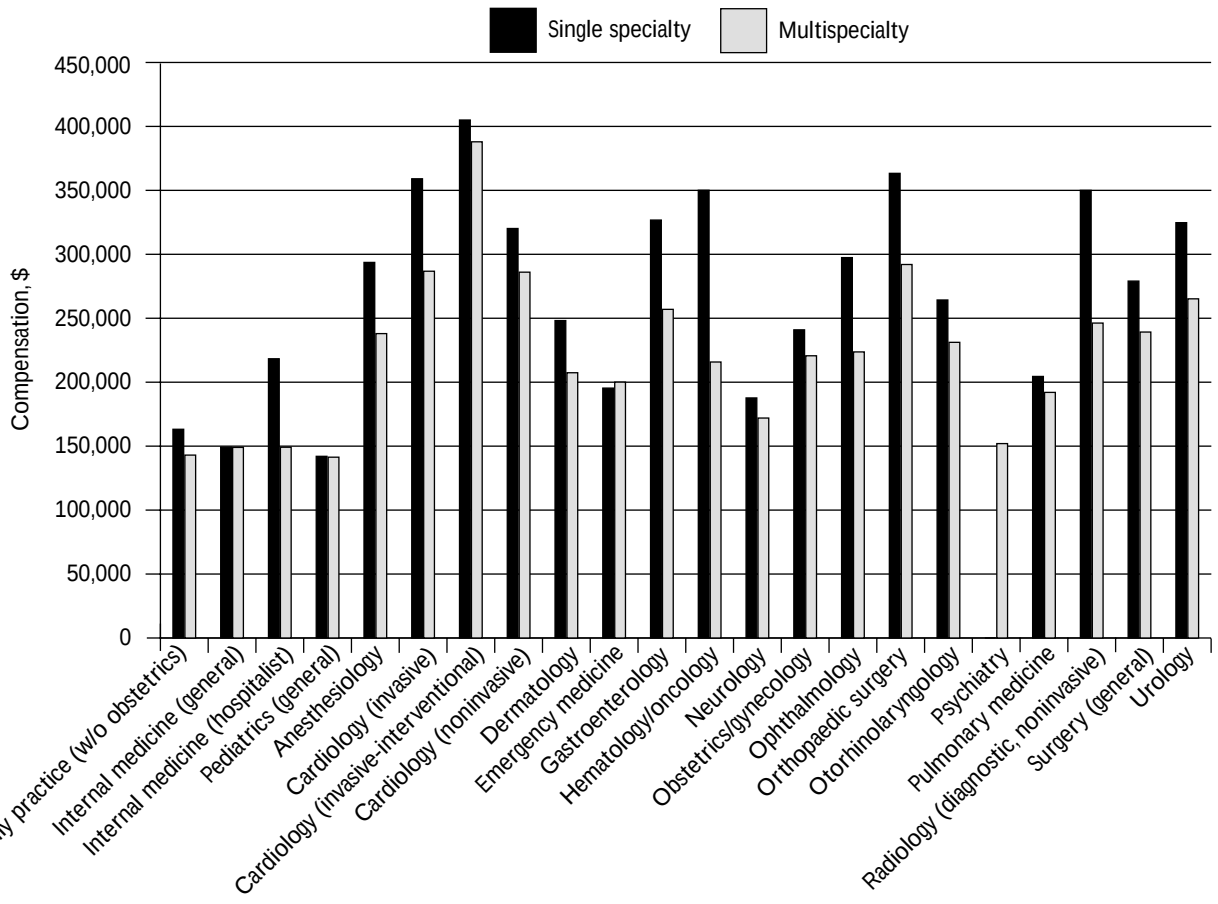

Figure 6. Median compensation by group type and physician specialty, 2000. w/o = without. (Data from MGMA physician compensation and production survey: 2001 report based on 2000 data. Table 2: Physician compensation by group type. Englewood [CO]: Medical Group Management Association; 2001. © 2001 Medical Group Management Association.)

compensation was $149,104 for general internists, up 2.55% from 1999 levels. During the same period, production in this group was relatively stable, showing a modest decrease of less than 1%.

- Internal medicine (hospitalists)—a 1.46% increase in compensation was accompanied by a 14.93% increase in production. This significant increase in production may be a sign of the increased familiarity with and resulting use of these hospital-based providers.
- Pediatrics/adolescent medicine—median compensation in 2000 was $141,676, down by approximately 1% from 1999 levels. In striking contrast, production increased 5.01% in this group during the same time period.

Hospitalist Compensation

The trend toward the use of hospitalist physicians that started several years ago continued unabated in 2000. These physicians generally had compensation levels that were slightly higher than those of their general internal medicine counterparts ($151,013 versus $149,109). Hospitalist compensation in 2000 increased by 1.46% from 1999 levels. However, the 2000 median production for these physicians is lower than for their general internal medicine counterparts ($343,961 versus $367,738). Nevertheless, as stated previously, the production levels for these physicians increased significantly (14.93%) from 1999 to 2000. The increases in production levels may be due, at least in part, to the greater familiarity with and reliance on this hospital-based practice. Medical groups are increasingly using hospitalist physicians as a means both to provide quality care and to enhance patient access to providers in outpatient settings.

SPECIALIST PHYSICIAN COMPENSATION

General Considerations

Although physicians in most medical and surgical

Table 2. Median Compensation for Primary Care and Selected Physician Specialties by Group Type, 2000

	Median Compensation, $	
	Single-Specialty Groups, $	Multi-specialty Groups, $
All primary care	**150,630**	**146,713**
Family practice (without obstetrics)	163,197	143,000
Internal medicine (general)	149,271	149,012
Internal medicine (hospitalist)	218,317	149,150
Pediatrics (general)	142,045	141,371
All specialties	**286,365**	**212,118**
Anesthesiology	293,664	238,000
Cardiology (invasive)	359,050	285,605
Cardiology (invasive-interventional)	405,000	387,962
Cardiology (noninvasive)	320,179	286,033
Dermatology	248,192	207,398
Emergency medicine	195,389	200,066
Gastroenterology	326,780	258,990
Hematology/oncology	350,058	215,791
Neurology	187,692	171,976
Obstetrics/gynecology	240,938	220,659
Ophthalmology	297,419	223,682
Orthopaedic surgery	363,309	292,032
Otorhinolaryngology	264,285	231,171
Psychiatry	*	152,000
Pulmonary medicine	204,500	192,033
Radiology (diagnostic, noninvasive)	350,000	246,237
Surgery (general)	279,060	239,218
Urology	324,748	265,185

*Insufficient responses to report.

Data from MGMA physician compensation and production survey: 2001 report based on 2000 data. Table 2: Physician compensation by group type. Englewood (CO): Medical Group Management Association; 2001. © 2001 Medical Group Management Association.

specialties also enjoyed increases in compensation levels in 2000, median levels in a few specialty areas—particularly diagnostic radiology and neurology—actually decreased from 1999 to 2000 (Table 1). Compensation in most other medical and surgical specialties increased from 1999 to 2000, although the rate of increase differed significantly, ranging from slight (1.27%) in hematology/oncology to substantial (14.54%) in anesthesiology. In several specialties the percentage increase in compensation was greater than the associated increase in production.

Winners and Losers

Table 1 provides compensation and production information for several medical and surgical specialties, including the following:

- Anesthesiologists—median compensation for anesthesiologists in 2000 was $280,353, reflecting a 14.54% increase over 1999 levels. Production levels for anesthesiologists during this same time period increased by 8.59%.
- Invasive and noninvasive cardiologists—these specialists also experienced healthy increases in compensation levels, even though a decrease had occurred the previous year. In 2000, median compensation for invasive cardiologists was $365,894 (a 7.61% increase from 1999 levels) and for noninvasive cardiologists was $300,073 (a 7.66% increase from 1999). In both cases, production increased at a much less dramatic pace (6.72% for invasive cardiologists, 4.33% for noninvasive cardiologists).
- Gastroenterologists—the increase in compensation levels for gastroenterologists was a healthy 6.35% for the period from 1999 to 2000; there was also a concomitant increase of 9.56% in production. Median compensation for gastroenterologists in 2000 was $281,308.
- Urologists—physician compensation levels in urology also increased significantly from 1999 to 2000 (12.26%); there was an associated 11.3% increase in production levels.
- Neurologists—physicians in neurology were less fortunate, facing a decrease of 1.71% in compensation.
- Diagnostic radiology—of all physician specialties, diagnostic radiology fared the worst, with a 5.15% decrease in compensation over the prior year.

Many factors most likely influence changes in physician compensation from year to year. One such factor is the generally steady increase in practice operating costs over the past decade, which reflects the changing business and regulatory environment of health care as well as the changing economic climate. **Figure 5** shows operating costs for medical group practices for multispecialty and select single-specialty (ie, family practice, orthopaedic surgery, cardiology) groups from 1990 to 2000 as a percentage of total net medical revenue.

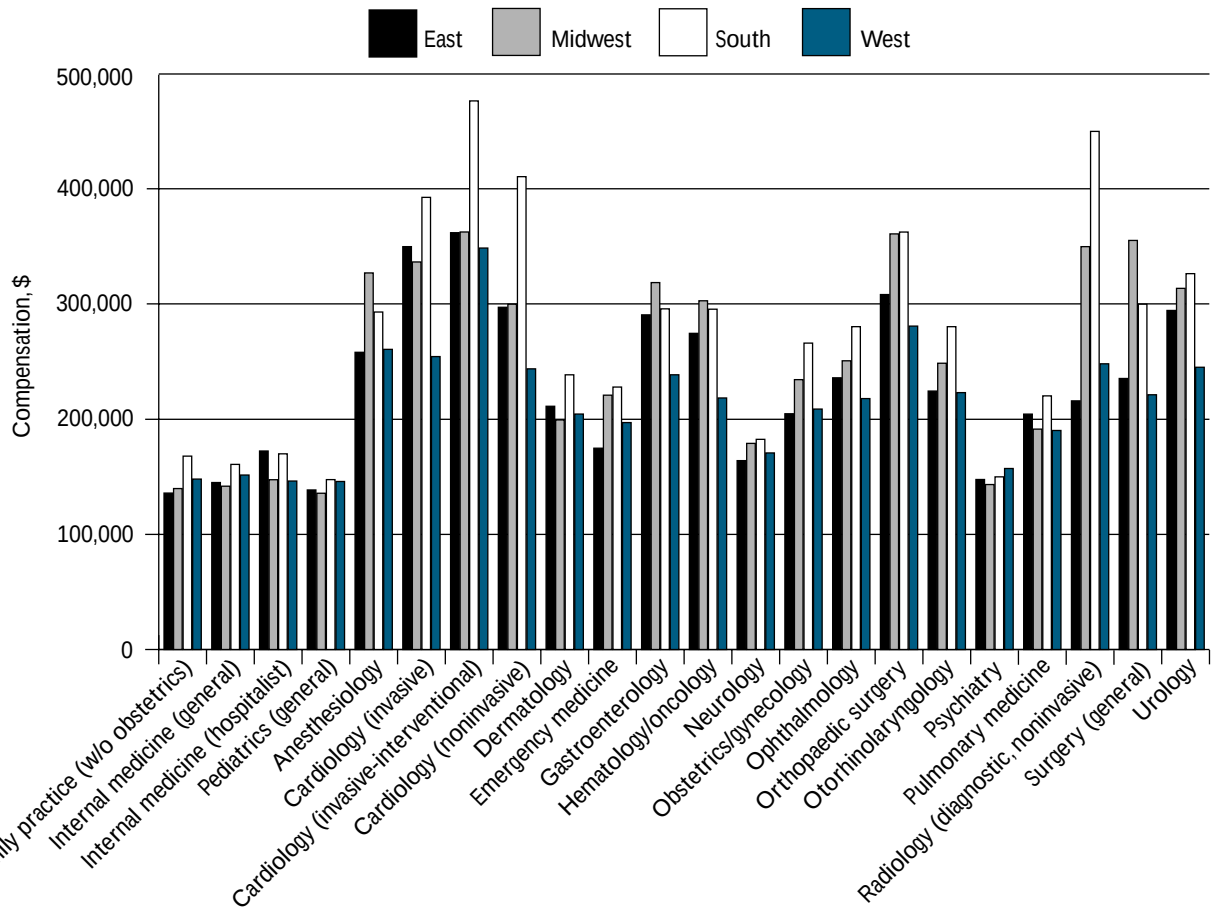

Figure 7. Median compensation by geographic region of the United States, 2000. w/o = without. (Data from MGMA physician compensation and production survey: 2001 report based on 2000 data. Table 3A: Physician compensation by geographic section for all practices. Englewood [CO]: Medical Group Management Association; 2001. © 2001 Medical Group Management Association.)

Although the overall trend has a number of peaks and valleys, practice operating costs have generally increased during this time period. There have been a few decreases in percentages over time (eg, a 3.2% decrease in costs for single specialty family practice groups during the 1999–2000 time period), but—in an age of declining reimbursement—even slight increases in operating costs will generally need to be made up by increased work levels or the creation of new revenue streams.

The changes in compensation levels for some specialists, including cardiologists, gastroenterologists, and orthopaedic surgeons, may be supported by practice diversification activities designed to capitalize on new revenue streams (eg, nuclear camera procedures, endoscopy suite development, ambulatory surgical center investments). Despite changes in reimbursement levels, many specialties have capitalized on and invested in new treatment and service delivery models that may provide benefits of a service delivery and financial nature.

OTHER FACTORS INFLUENCING COMPENSATION

Practice Setting

Figure 6 and **Table 2** summarize compensation levels in selected specialties for physicians in single-specialty and multispecialty groups. For the most part, physicians in single-specialty groups fared better than those in multispecialty groups. This finding typically results from many causes, including higher operating costs associated with multispecialty enterprises and at least some degree of income-spreading among primary care and specialist physicians to promote group cohesiveness and other goals.

The higher pay levels in single-specialty practices may also result from the efforts of many single-specialty

Table 3. Median Compensation by Geographic Region of the United States (All Practice Types), 2000

	Median Compensation, $			
	East	Midwest	South	West
All primary care	**139,510**	**143,258**	**160,000**	**149,410**
Family practice (without obstetrics)	135,901	139,835	168,000	148,061
Internal medicine (general)	145,064	141,878	160,823	151,573
Internal medicine (hospitalist)	172,451	147,501	170,000	146,359
Pediatrics (general)	138,610	135,760	147,599	145,972
All specialties	**240,000**	**285,070**	**286,330**	**236,550**
Anesthesiology	258,207	327,157	293,198	260,759
Cardiology (invasive)	350,000	336,692	392,813	254,489
Cardiology (invasive-interventional)	362,100	362,733	476,606	348,775
Cardiology (noninvasive)	297,329	300,000	410,799	243,834
Dermatology	211,320	199,464	238,648	204,551
Emergency medicine	174,889	220,953	228,014	197,146
Gastroenterology	290,727	318,776	295,957	238,674
Hematology/oncology	274,668	302,965	295,650	218,524
Neurology	164,093	179,076	182,586	170,768
Obstetrics/gynecology	204,800	234,454	266,193	208,881
Ophthalmology	236,033	250,824	280,479	217,997
Orthopaedic surgery	308,375	361,071	362,679	280,960
Otorhinolaryngology	224,520	248,710	280,461	223,178
Psychiatry	147,704	143,321	150,000	157,254
Pulmonary medicine	204,500	191,462	220,351	190,281
Radiology (diagnostic, noninvasive)	216,000	350,000	450,123	248,209
Surgery (general)	235,461	255,396	300,000	221,314
Urology	294,566	313,761	326,534	245,206

Data from MGMA physician compensation and production survey: 2001 report based on 2000 data. Table 3A: Physician compensation by geographic section for all practices. Englewood (CO): Medical Group Management Association; 2001.

groups to diversify their sources of practice income. Many single-specialty groups in cardiology, gastroenterology, orthopaedics, and ophthalmology are increasingly looking to new technologies and delivery models (eg, heart hospitals, endoscopy suites, ambulatory surgical centers). These services are becoming important components of full-service medical practices. Of course, although physicians in single-specialty groups may garner higher wages for their efforts, physicians in multispecialty practices—particularly specialists—enjoy the built-in referrals of the multispecialty setting. Moreover, many specialists prefer multispecialty groups for various nonfinancial reasons, including enhanced contracting, access to patients, convenience, practice culture, quality of care, and other tangible and intangible benefits.

Geographic Location

As in the past, median physician compensation levels tend to be higher in the southern United States (**Figure 7** and **Table 3**). This pattern generally conforms with the overall penetration of managed care throughout the United States. Physicians in the eastern and western United States have the lowest levels of compensation, primarily because of increased managed care penetration in these regions, an abundance of physicians in certain specialties, and relatively lower reimbursement rates. These trends possibly also reflect, to some degree, differences in the cost of nonphysician labor and in other operating costs in different regions of the nation. Interestingly, whereas median compensation levels for primary care physicians vary significantly

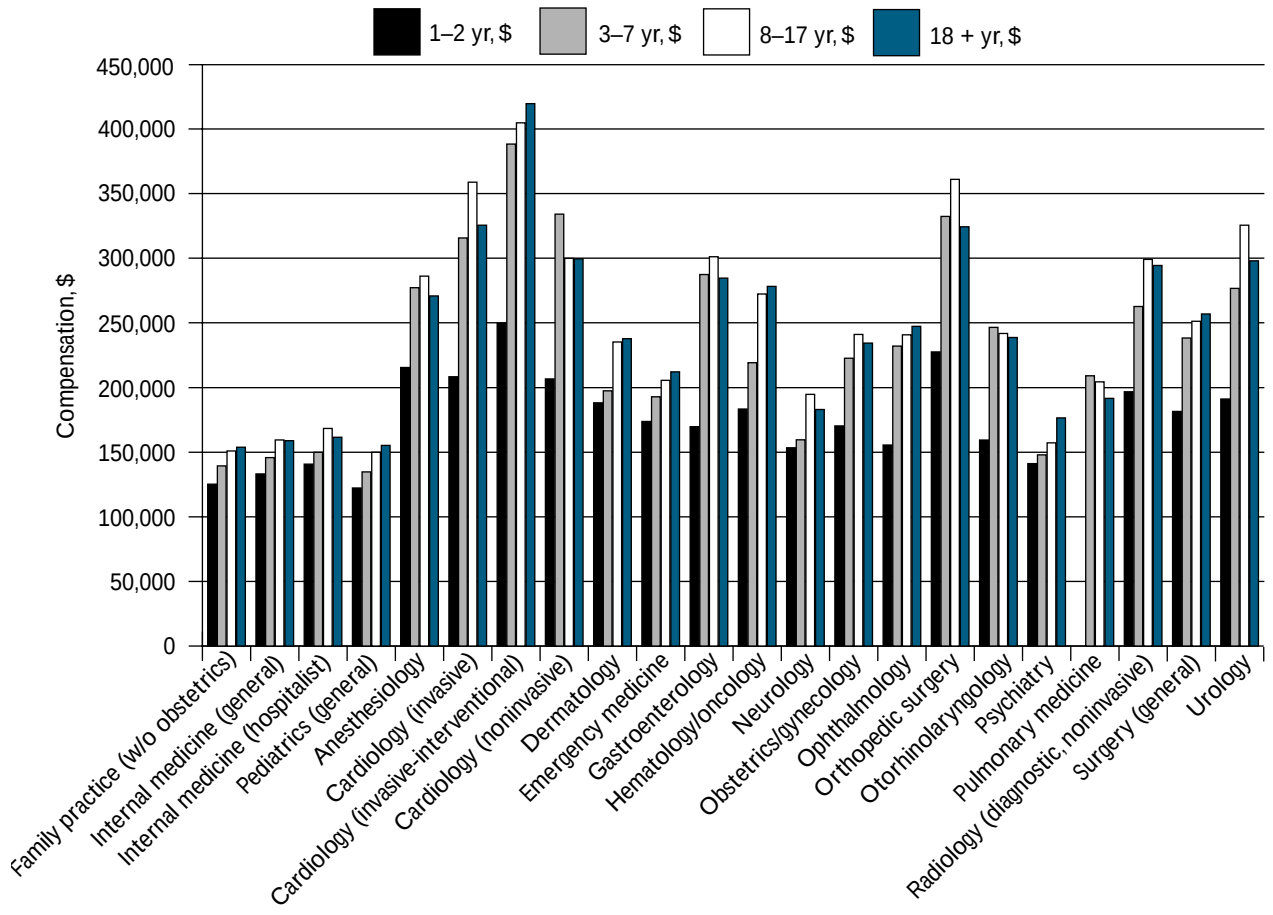

Figure 8. Median compensation by years in practice, 2000. w/o = without. (Data from MGMA physician compensation and production survey: 2001 report based on 2000 data. Table 7B: Physician compensation by years in specialty. Englewood [CO]: Medical Group Management Association; 2001. © 2001 Medical Group Management Association.)

between midwestern ($143,258) and southern ($160,000) regions, the differences in median pay levels for specialist physicians between these 2 regions is almost insignificant ($285,070 midwestern, $286,330 southern).

Years of Practice

Compensation by years of practice tends to show a rather steep increase after completion of an initial 1- to 2-year period of associate physician status. **Figure 8** and **Table 4** show median compensation levels in 2000 by years of practice for primary care and selected specialties. In all medical and surgical specialties, associate physicians in their first 1 to 2 years of practice received significantly lower levels of compensation than physicians with more years of experience. This disparity is not unexpected, because most medical groups have a 2- to 3-year partnership track, with new physicians working to build a practice. Moreover, although there were significant differences in the compensation received by a group's junior and most senior partners, these differences were still significantly smaller than those between associate and partner physicians.

Average compensation for primary care physicians in their first 1 to 2 years of practice was $129,897. In comparison, average compensation in 2000 for primary care physicians with 3 to 7 years of practice was $141,247, with 8 to 17 years of practice was $155,036, and with 18 or more years of practice was $156,430. Similar trends characterized specialist compensation. Average compensation for specialists with 1 to 2 years of practice in 2000 was $186,241. This level compares with an average compensation of $244,722 for specialists with 3 to 7 years of practice, $258,207 for specialists with 8 to 17 years of practice, and $243,300 for specialists with 18 or more years of practice.

Table 4. Median Compensation for Primary Care and Selected Specialties by Years in Practice, 2000

	Median Compensation, $			
	1–2 Years	3–7 Years	8–17 Years	18+ Years
All primary care	**129,879**	**141,247**	**155,036**	**156,430**
Family practice (without obstetrics)	125,293	139,430	151,000	153,890
Internal medicine (general)	133,218	145,854	159,522	158,950
Internal medicine (hospitalist)	140,800	149,967	168,427	161,611
Pediatrics (general)	122,340	134,794	150,000	155,302
All specialties	**186,241**	**244,722**	**258,207**	**243,300**
Anesthesiology	215,620	277,373	286,330	270,999
Cardiology (invasive)	208,444	315,882	359,050	325,754
Cardiology (invasive-interventional)	250,000	388,566	405,000	419,857
Cardiology (noninvasive)	206,755	334,310	300,100	299,715
Dermatology	188,260	197,565	235,355	237,907
Emergency medicine	173,834	192,936	205,665	212,228
Gastroenterology	169,776	287,578	301,345	284,801
Hematology/oncology	183,460	219,312	272,500	278,393
Neurology	153,460	159,629	194,809	183,102
Obstetrics/gynecology	170,391	222,783	241,195	234,500
Ophthalmology	155,601	232,185	240,909	247,456
Orthopaedic surgery	227,662	332,560	361,252	324,529
Otorhinolaryngology	159,465	246,661	241,947	238,839
Psychiatry	141,217	147,982	157,289	176,583
Pulmonary medicine	*	209,195	204,500	191,714
Radiology (diagnostic, noninvasive)	196,817	262,829	299,284	294,584
Surgery (general)	181,597	238,433	251,396	257,043
Urology	191,223	276,850	325,751	298,182

*Insufficient responses to report.

Data from MGMA physician compensation and production survey: 2001 report based on 2000 data. Table 8B: Physician compensation by years in specialty. Englewood (CO): Medical Group Management Association; 2001.

These data reflect the general life cycle of compensation levels in most groups, with physicians at the outset or in the twilight of their careers generally receiving lower levels of compensation. The decreases experienced by the most senior specialist physicians are likely the result of various factors, including the addition of new and younger physicians to medical groups (thus diluting the established practices of more senior physicians) and the increased use of productivity-oriented compensation methods in group practices.

Certainly, these underlying trends may shift somewhat in the next few years as medical groups compete for a limited number of physicians in some specialties. The emphasis on primary care physicians that marked the early to mid 1990s has resulted in a shortage of physicians in some medical and surgical specialties, as well as more intense competition in many parts of the country to fill vacancies in these specialties. As a result, some practices are offering higher starting salaries and developing creative part-time or slow-down strategies to retain senior physicians (who would otherwise retire) in certain specialties (eg, cardiology, rheumatology, gastroenterology).

Gender

Table 5 presents median compensation for female and male physicians in primary care and selected spe-

Table 5. Median Compensation for Primary Care and Selected Physician Specialties by Gender

	Median Compensation, $		Gender-Based Differences	
	Male	Female	$	%
All primary care	**152,939**	**127,500**	**25,439**	**19.9**
Family practice (without obstetrics)	150,364	125,386	24,978	16.6
Internal medicine (general)	153,193	129,791	23,402	15.3
Internal medicine (hospitalist)	159,628	145,000	14,628	9.2
Pediatrics (general)	152,531	123,097	29,434	19.3
All specialties	**271,782**	**194,400**	**77,382**	**28.4**
Anesthesiology	293,377	237,680	55,697	19.0
Cardiology (invasive)	345,737	280,941	64,796	18.7
Cardiology (invasive-interventional)	405,000	300,350	104,650	25.8
Cardiology (noninvasive)	320,362	227,422	92,940	29.0
Dermatology	247,975	180,930	67,045	27.0
Emergency medicine	196,585	163,336	33,249	16.9
Gastroenterology	300,000	265,000	35,000	11.7
Hematology/oncology	311,133	234,443	76,690	24.6
Neurology	185,148	152,062	33,086	17.9
Obstetrics/gynecology	246,021	204,007	42,014	17.1
Ophthalmology	273,313	219,549	53,764	19.7
Orthopaedic surgery	348,820	335,000	13,820	4.0
Otorhinolaryngology	254,971	194,800	60,171	23.6
Psychiatry	145,745	141,263	4,482	3.1
Pulmonary medicine	197,573	190,281	7,292	3.7
Radiology (diagnostic, noninvasive)	350,000	271,700	78,300	22.4
Surgery (general)	264,766	194,023	70,743	26.7
Urology	313,719	201,560	112,159	35.8

Data from MGMA physician compensation and production survey: 2001 report based on 2000 data. Table 9: Physician compensation by gender. Englewood (CO): Medical Group Management Association; 2001.

cialties. In 1999, male physicians on average made 14.7% more than their female counterparts in primary care disciplines and 21.1% more than their female counterparts in medical and surgical specialties, which translated to an average difference in compensation of $22,316 for primary care physicians and $54,042 for specialists. This trend continued in 2000, when male primary care physicians, on average, made 19.9% more than their female counterparts ($152,939 versus $127,500). The gender difference for specialist physicians was even greater at 28.4% ($271,782 versus $194,400). The gender gap continues to be present even in obstetrics and gynecology, a specialty in which female physicians are often viewed as having greater access to patients. In 2000, male obstetrics/gynecology physicians had median compensation levels of $246,021, compared with a median of $204,007 for female obstetrics/gynecology physicians, reflecting a difference of 17.1%.

The disparity between male and female compensation levels may result from several factors, including differing desires concerning work schedules and income needs. Practice groups are also increasingly turning to production-based compensation schemes to accommodate differing physician lifestyle preferences. Although such systems promote greater flexibility, physician autonomy, and choice, these benefits frequently carry an associated financial cost.

MIDLEVEL PROVIDER COMPENSATION

Midlevel providers include nurse practitioners, primary care and surgical physician assistants, certified registered nurse anesthetists, optometrists, and psychologists. As with physicians, compensation levels for these providers have generally stabilized, with only slight increases (in most cases) from 1999. As a whole, median compensation levels for these providers increased 1.41% in 2000, representing a slight decrease from the 2.3% increase from 1998 to 1999. Physician assistants working in primary care were the greatest winners in 2000, with a median compensation of $64,815, representing an increase of 7.83% over the prior year. This increase in pay level most likely results from the fact that such providers functioned more as true providers of some primary care services and thus had independent billing authority, as opposed to functioning in a physician extender capacity.

FUTURE TRENDS IN PHYSICIAN COMPENSATION

An assessment of historic trends reveals that physician compensation continues to rise but, in most cases, only when accompanied by increases in production or work levels. More recently, increases in pay levels appear to have stabilized somewhat. This trend may result from several reasons, including difficulty in sustaining the workload necessary to achieve significant increases in compensation and the combined pressures of increased operating costs and declines in reimbursement.

For many specialties the near-term prospects for increased compensation may rest in the willingness of physicians and their medical groups to invest in practice-building strategies that will diversify and increase revenue streams. As pay rates for professional services continue to face pressure from public and private payers alike, many medical groups will look to new technologies and business strategies to enhance practice revenues. Given medical education practices in recent years, which have resulted in fewer physicians being trained in some specialties, and the inevitable forces of supply and demand, historic trends related to compensation levels may become distorted. The dearth of physicians in some specialties may mean that physicians at midcareer will feel increased pressure either to accept lower pay levels as group practices compete to hire new physicians or to accept appealing financial packages designed to retain senior physicians in badly needed specialties. Together, these factors will continue to affect the underlying trends for physician compensation in the United States in the years ahead. **HP**

REFERENCES

1. MGMA physician compensation and production survey: 2001 report based on 2000 data. Englewood (CO): Medical Group Management Association; 2001.
2. MGMA cost survey: 2001 report based on 2000 data. Englewood (CO): Medical Group Management Association; 2001.