ASMBS Compensation and Practice Style Survey, 2023

R. Wesley Vosburg, MD, FACS, FASMBS, DABOM
Mount Auburn Hospital
Harvard Medical School
Cambridge, MA
rvosburg@mah.harvard.edu

Alan Saber, MD, MS, FACS, FASMBD, DABOM
Newark Beth Israel Medical Center
Rutgers NJ medical School
Newark, NJ
saber6231@gmail.com

Paul Severson, MD, FACS, FASMBS
Cuyuna Regional Medical Center
University of Minnesota Medical School
Crosby, MN
seversonpas@gmail.com

Teresa LaMasters MD, FACS, FASMBS, DABOM
UnityPoint Clinic Weight Loss Specialists
West Des Moines, IA
teresa.lamasters@gmail.com

Introduction:

The American Society for Metabolic and Bariatric Surgery (ASMBS) released a paper in 2013 on physician compensation and practice models [1]. This survey-based project gave physicians a frame of reference for employment negotiations. At the time of the original paper as well as today, national benchmark data on metabolic and bariatric surgeon salary data is inadequate. Regional variations in salary and a multitude of employment circumstances makes interpretation of the data difficult for individual surgeons to apply to their specific circumstances.

It can be challenging for surgeons to maintain overhead for a structured program that meets the Metabolic and Bariatric Surgery Quality Improvement Project (MBSAQIP) requirements for accreditation. The trend for surgeon employment continues to grow and it was decided that after 10 years the original survey would be updated.

This version was intended to give up-to-date salary information for MBS surgeons who have different employment types including models in private practice or with hospital employment at both academic and community settings with and without teaching service. We additionally sought to gather data on race, gender and ethnicity as it relates to salary trends nationally. There has been growing numbers of MBS surgeons who have administrative leadership roles. We wanted to evaluate the average stipend amounts for site directors, medical education roles, division chiefs and department chairs. Data on non-MBS general surgery coverage was also collected with annual and nightly rates for surgeons providing this service. Data on obesity

medicine board certification, focused practice designation in MBS, years in practice, as well as others were included in this update.

Methods

The original compensation and practice style project from 2013 utilized two different surveys for employed and private practice surgeons. We elected to merge all questions into one universal survey to distribute to MBS surgeons (Appendix A). Questions were pertinent to surgeons' 2022 calendar year salary.

Utilizing SurveyMonkey (Palo Alto CA) the data was collected electronically. An initial email and reminder email that contained a link to the survey were sent directly to all 2,344 ASMBS regular members (surgeons) via emails on file with the ASMBS. Links to the survey were also posted on ASMBS social media platforms and via the online DocMatter community (San Francisco, CA).

Anonymous survey data was exported into STATA 17 (StataCorp LLC, Texas, USA) for statistical analysis. It was analyzed graphically for distribution. Summary statistics were created for related groups of variables. T-tests were used for comparing continuous outcomes with dichotomous variables and ANOVA was used for comparing continuous outcomes with categorical variables (more than 2 variables).

Surveys were excluded if the respondent did not work full time or incompletely answered the survey.

Results

Demographics:

657 responses were received for this survey. Responses missing a total salary number or that were incomplete were excluded from analysis. A total of 465 survey responses were included in final analysis.

Demographics data on age revealed the most common age group was surgeons in the 41-50 year old group with slightly less responses from the 31-40 and 51-60 age ranges. (Table 1).

Age range	Observations	Percentage
31-40	146	31.4
41-50	155	33.3
51-60	126	27.1
61-70	36	7.7
71-80	2	0.4
Total	464	100

Table 1: Respondent age.

Data on gender revealed that most respondents were male (77.4%, 360/465). Female was the next most common answer at 20.4% (95/465). “Prefer not to answer” and “Prefer not to self-describe made up 2.1% of responses. Ethnicity data is showed in table 2, with 63.0% self-identifying as white.

Race / Ethnicity	Observations	Percent
American Indian or Alaska Native	2	0.4
Asian	22	4.7
Asian Indian	44	9.3
Black or African American	14	3.0
Central American	2	0.4
Chinese	3	0.6
Cuban	4	0.8
Filipino	5	1.1
Hispanic or Latino or Spanish Origin of any Race	24	5.1
Japanese	1	0.2
Korean	3	0.6
Mexican, Mexican American, Chicano	4	0.8
Native Hawaiian or other Pacific Islander	2	0.4
Other Asian (Pakistani, Cambodian, and Hmong, etc.)	3	0.6
Other Caribbean	3	0.6
Puerto Rican	4	0.8
Some Other Race	8	1.7
South American	1	0.2
Spaniard	3	0.6
Vietnamese	0	0.0
White	298	63.0
Prefer not to answer	23	4.9

Table 2: Ethnicity data

Primary practice location data was received from 46 states and Washington DC. 27 States had 5 or more responses and allowed for state-level data inclusion. Surgeon years of experience revealed responses of up to 31-40 years in MBS practice. The most frequent category was 5-10 years in practice (Table 3).

Years in practice	Observations	Percent
0-4	102	21.9
5-10	116	25.0
11-15	71	15.3
16-20	64	13.8
21-30	92	19.8
31-40	20	4.3

Table 3: Years of practice experience for respondents.

69.9% of responses came from surgeons whose practices were made up of greater than 50% MBS (Table 4).

Percentage of practice dedicated to MBS	Observations	Percent
< 25%	43	9.3
25-50%	97	20.9
51-75%	129	27.7%
76-100%	196	42.2%

Table 4: Percentage of practice made up of MBS

Practice type was divided into 7 categories and is displayed in table 5.

Practice type	Observations	Percent
Employed, community practice WITH teaching	117	25.2
Employed, community practice WITHOUT teaching	134	28.8
Employed, academic practice, with teaching	115	24.7
Employed, private practice	35	7.53
Owner / partner, private practice	56	12.0
Military	5	1.1
Other	3	0.7

Table 5: Respondent practice type.

13.3% of surgeons reported that they were certified by the American Board of Obesity Medicine (ABOM). 22.7% of surgeons had a focused practice designation from the American Board of Surgery in Metabolic and bariatric surgery (FPDMBS). 72.7% of surgeons did a fellowship in MBS.

69.3% of surgeons had a medical weight loss program associated with their practice and only 7.5% stated that they derived income directly from it.

64.7% of surgeons that responded took non-bariatric, surgery call in 2022 and 48.7% were paid additionally for it.

Income results:

From all 465 national surgeon responses it showed the following for total income from 2022.

This included any compensation from base salary, bonuses, administrative positions and others.

For private practice owners and partners, it was collections minus overhead (Table 6).

	Mean	**5%**	**25%**	**Median**	**75%**	**95%**
All	$569,458	$300,000	$403,000	$500,000	$650,000	$1,020,000
Employed, community practice with teaching	$577,318	$325,000	$432,000	$511,000	$675,000	$1,000,000
Employed, community practice without teaching	$587,785	$335,000	$440,000	$547,488	$650,000	$1,096,000
Employed, academic practice, with teaching	$524,912	$300,000	$375,000	$450,000	$610,000	$950,000
Employed, private practice	$422,438	$250,000	$325,000	$400,000	$500,000	$785,000
Owner / partner, private practice	$716,986	$250,000	$380,000	$550,000	$800,000	$2,000,000
Military	$239,193	$125,000	$168,000	$200,000	$350,000	$352,966

Table 6: Mean and percentile data for gross 2022 salary for MBS surgeons (including all forms of compensation for the year).

An analysis of compensation models demonstrated that the most common employment category was “base salary with an RVU productivity-based bonus” (48.6%). The next most common categories were “base salary only” (13.6%) and “productivity only based on RVUs without a base salary” (13.1%) (Table 7).

Compensation model	Observations	Percent
Base salary with RVU productivity-based bonus	226	48.6
Base salary only	63	13.6
Productivity only based on RVUs with no base salary	61	13.1
Base salary with non-productivity-based bonus	30	6.5
Productivity only based on collections minus cost (no base salary)	25	5.4
Base salary with collections-based bonus	23	5.0
Productivity based on RVUs plus incentive (no base salary)	17	3.7
Other	14	3.0
Base salary with billing-based bonus	6	1.3

Table 7: Frequency of compensation models in respondents.

114 surgeons reported they were the MBS site director for their program. 11 said they were fellowship directors and 13 were residency program directors. 39 division chiefs and 17 department chairs were included. 95 people said they did “other administrative work”

The median compensation for these positions are reported in table 8.

Title	Mean	5%	25%	Median	75%	95%	Obs.
MBS site director	$31,493	$5,000	$15,000	$25,000	$50,000	$75,000	144
Fellowship director	$20,000	$5,000	$10,000	$25,000	$30,000	$40,000	11
Residency director	$43,864	$15,000	$20,000	$30,000	$50,000	$150,000	13
Division chief	$39,872	$5,000	$10,000	$25,000	$50,000	$120,000	39
Department chair	$75,588	$5,000	$25,000	$50,000	$150,000	$150,000	17
Other administrative work	$42,947	$5,000	$10,000	$25,000	$55,000	$150,000	95

Table 8: Mean and percentile earnings for administrative positions of MBS surgeons. Obs = observations.

Subgroup analysis:

Surgeon gender

Female surgeons were found to make significantly less money in 2022 than male surgeons in this study. There was an average decrease of $136,391 in mean annual full-time gross / total salary for females vs. males (p=0.0002, difference -$136,391, 95% CI: -$206,976 to -$65,806) (Table 9). Most female respondents were in an employed model (88.4%), in community (57.9%) or academic settings (30.5%). Base salary with RVU based incentive was the most common

compensation model (52.6%) and base salary only was the next most common (19.0%). 57.9% of female surgeons said they took non-bariatric surgery call.

	Mean	5%	25%	Median	75%	95%
Male	$592,139	$310,000	$425,000	$524,500	$695,000	$1,500,000
Female	$455,748	$235,000	$350,000	$430,000	$525,000	$1,452,002

Table 9: Mean and percentile total annual income for male vs female surgeons.

Impact on specialty board distinctions

There was no significant difference in average salary for surgeons who did a bariatric surgery fellowship, had an ABOM certification or FPDMBS from the American Board of Surgery. In terms of years of practice, there were significantly lower salaries in surgeons who were in years 0-4 of practice vs those in years 11-15, 16-20 and 21-30. Surgeons in the 5-10 year experience group had significantly lower salaries than the 11-15 and 16-20 groups. Practice year 11 and beyond did not show any significant difference in annual salary between experience groups. The percent of practice time spent to MBS showed that the only difference between groups was for surgeons in group 25-50% vs 76-100%.

Employment type

Employment type showed an interesting finding. When all 7 groups of employment type were compared in univariate analysis private practice owner / partner was the only group that was significantly different than some of the other groups (employed academic, private practice

employed and military). The remaining 6 groups (excluding private practice owner / partner) were not significantly different in terms of mean salary.

Due to private practice owner / partner being an outlier from the other groups in terms of salary the data was divided into that group and a second group including the other 6 practice types. Salary results from employed surgeons (non-private practice owner / partner) is included in table 10.

	Mean	**5%**	**25%**	**Median**	**75%**	**95%**	**Observations**
Total	$549, 258	$300,000	$405, 772	$500,000	$649,000	$970,000	409
Base	$433,709	$275,000	$360,000	$420,000	$500,000	$700,000	297

Table 10: Employed surgeon salary mean and percentile values. Total is total compensation for 2022 with all sources of income included. Base is the base salary only for surgeons with that employment model before any incentive or additional pay is added.

High percentage of practice dedicated to MBS

The data outside of this section refers to all surgeons who responded to the survey regardless of the percentage of practice time dedicated to MBS. Subgroup analysis was conducted on those surgeons who practices were 50% or greater MBS. This resulted in 325 responses. 129 surgeons' practices were 51-75% MBS (39.7%) and 196 were 76-100% MBS (60.3%).

	Mean	5%	25%	Median	75%	95%	obs
All	$593,456	$300,000	$410,000	$525,000	$700,000	$1,050,000	325
Employed, community practice with teaching	$593,785	$345,871	$436,125	$553,000	$706,000	$1,500,000	80
Employed, community practice without teaching	$604,735	$300,000	$454,022	$550,000	$700,000	$1,100,000	94
Employed, academic practice, with teaching	$543,987	$298,000	$390,000	$450,000	$680,000	$1,040,750	77
Employed, private practice	$433,146	$289,817	$325,000	$405,000	$500,000	$785,000	26
Owner / partner, private practice	$778,052	$250,000	$380,000	$550,000	$820,000	$2,000,000	42
Military	$256,991	$125,000	$162,500	$275,000	$351,483	$352,966	4

Table 11: Percentile data on gross 2022 salary results for MBS surgeons whose practice is 51% or more MBS (including all forms of compensation for the year).

A significant difference was found on univariate in mean salary between surgeons with a high percentage of bariatric surgery making up their practice (>50%) vs surgeons with lower percentage of practice dedicated to MBS (<50%). The higher percentage of practice dedicated

too MBS group had an average salary that was $79,706 higher, p=0.014, 95% CI: $16,562 to $142,850.

Geographic salary responses by state.

Data by state was included for the employed surgeon groups in table 12. Florida, Illinois and South Carolina were the 3 states with the highest median salary. Kentucky, Arizona and Michigan were the 3 states with the lowest median income. The median income for Florida was higher than the 75th percentile for Kentucky (lowest and highest income states). (Table 12)

	Obs.	mean	5%	25%	median	75%	95%
Alabama	6	$468,000	$260,000	$298,000	$525,000	$600,000	$600,000
Arizona	7	$515,509	$294,569	$399,000	$430,000	$750,000	$780,000
California	19	$614,526	$200,000	$390,000	$543,000	$750,000	$1,500,000
Connecticut	9	$513,889	$50,000	$365,000	$497,000	$725,000	$870,000
Florida	30	$696,636	$335,000	$461,235	$675,000	$835,000	$1,400,000
Georgia	15	$533,953	$168,000	$360,000	$450,000	$725,000	$1,200,000
Illinois	17	$535,281	$250,000	$400,000	$610,000	$630,000	$777,777
Indiana	9	$572,428	$425,000	$468,000	$550,000	$700,000	$750,000
Kansas	7	$515,545	$289,817	$425,000	$545,000	$600,000	$649,000
Kentucky	11	$580,909	$125,000	$340,000	$415,000	$620,000	$1,200,000
Maryland	6	$491,333	$270,000	$350,000	$501,500	$605,000	$720,000
Massachusetts	14	$443,049	$235,000	$370,000	$431,500	$500,000	$680,886
Michigan	15	$506,376	$325,000	$377,000	$430,000	$600,000	$960,000
Minnesota	7	$509,731	$180,000	$325,000	$523,000	$556,000	$920,000
Missouri	8	$586,389	$275,000	$420,559	$467,500	$810,000	$1,020,000
New Jersey	13	$531,450	$300,000	$400,000	$450,000	$583,000	$1,000,000
New York	34	$589,349	$269,315	$362,000	$552,500	$740,000	$1,151,807
North Carolina	15	$617,572	$400,000	$410,000	$538,495	$850,000	$1,100,000
Ohio	20	$599,564	$330,000	$435,000	$537,500	$730,000	$1,050,000
Oklahoma	5	$439,200	$396,000	$422,000	$435,000	$450,000	$493,000
Pennsylvania	21	$517,253	$350,000	$440,000	$500,000	$564,000	$775,000
South Carolina	7	$572,937	$472,562	$475,500	$560,000	$630,000	$748,000
Tennessee	12	$438,880	$310,000	$387,500	$442,500	$497,500	$554,128
Texas	26	$543,035	$350,000	$405,772	$488,000	$620,000	$770,000
Virginia	10	$536,706	$200,000	$412,067	$521,500	$700,000	$790,000
Washington	9	$467,349	$240,000	$385,000	$475,000	$542,000	$683,634
Wisconsin	8	$523,500	$375,000	$460,000	$499,000	$597,500	$700,000
National	409	$549,258	$300,000	$405,772	$500,000	$649,000	$970,000

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Table 12: Response for gross 2022 income by state and for the nation for employed surgeons where at least 5 responses or more per state existed. Obs. = observations.

Private practice owner / partner data is included in table 13. It was reported separately from the other 6 categories of practices due to being significantly different than several of the other groups.

Mean	5%	25%	Median	75%	95%	Observations
$716,986	$250,000	$380,000	$550,000	$800,000	$2,000,000	56

Table 13: Private practice owner / partner salary range for the nation.

Effects of COVID-19 pandemic on income

Two-tailed t-test revealed no significant difference in mean gross salary between surgeons who said their salary was impacted by the COVID-19 pandemic and those who said it was not (p=0.659). The degree to which surgeons who said their practice or salary was impacted by the pandemic also did not show a statistically significant difference in terms of gross salary between groups (10% or less, 20%, 30%, 40%, 50% and >50%)

RVU data

72% of surgeons reported that their compensation model was at least partly RVU based. 222 surgeons reported on total work RVU generation. The median number of wRVUs generated was 8,850. (Table 14)

	Mean	5%	25%	Median	75%	95%	Observations
Total wRVUs generated	9,447	4,500	6,700	8,850	11,250	15,300	222

Table 14: Total wRVUs generated from 2022 by mean and percentile.

For surgeons with a base salary and RVU incentive model the following data was found for RVU threshold to start making incentive pay. (Table 15). We did not receive enough answers on the dollars per RVU that were earned above the surgeon's RVU collection threshold to report on it for this subgroup.

	Mean	5%	25%	Median	75%	95%	Observations
RVU Threshold	7,429	4,600	6,071	7,000	8,300	12,000	167

Table 15: Mean and percentiles of RVU threshold values over which surgeons would make incentive dollars above their base salary.

Surgeons who reported no base salary data and dollars per RVU were collected for a single threshold. Data collected on additional threshold tier levels for RVU based incentive pay was not adequate to include in analysis. (Table 16)

	Mean	5%	25%	Median	75%	95%	Obs
Baseline dollars per RVU	58	44	54	60	63	68	62
Threshold for additional dollars per RVU	6,450	850	4,550	6,500	8,900	10,600	19
Second tier dollars per RVU	58	20	54	62	65	73	17

Table 16: For surgeons without a base salary – baseline dollars per RVU, threshold for second tier of RVU earnings and second tier dollars per RVU. Obs = observations.

Call compensation

64.7% of surgeons (301/465) responded that they took non-bariatric surgery call which included trauma, acute care surgery or other. 48.7% indicated that they were paid specifically for this non-bariatric surgery call as part of a base salary or additional compensation. 51.3% said they were not compensated for it. Annual non-bariatric surgery call totaled an average of $46,336. 128 surgeons reported that they were paid per night of non-bariatric surgery call. The average nightly compensation was $1,052 (Table 17).

	Mean	5%	25%	Median	75%	95%	Obs
Annual non-bariatric call compensation	$46,336	$5,000	$15,000	$35,000	$60,000	$150,000	146
Nightly non-bariatric call compensation	$1,052	$400	$580	$1,000	$1,273	$2,000	128

Table 17: Non-bariatric call compensation data for MBS surgeons for the year and per night on call

Multi-factor analysis of sex, experience, administrative roles and race on earnings

Due to the potential for confounding effects when multiple factors were in place for an individual we performed a linear regression analysis on salary which included sex, years of experience (more or less than 10), holding an administrative role, percent of practice dedicated to MBS (> or < 50%) and race (white or not-white). The results of this analysis showed that when holding the other factors constant, sex (p=0.006), years of experience (p=0.004), and holding an administrative role (p=0.000) each were each individually associated with higher income that

was statistically significant. Race was not associated with a statistically significant difference in income. Higher percentage of practice dedicated to MBS was not significantly different.

Conclusions

Practice patterns revealed that the most common setting for MBS surgeons in the US today is an employed model with a base salary and incentive compensation based on RVU threshold. This trend is similarly noted from the first iteration of the ASMBS compensation and practice survey from 2013. The median level at which an incentive pay begins to be generated has increased since that time from 6,200 to 6,500 RVUs per year. The median total salary for MBS surgeons in 2022 who were not private practice owners or partners was found to be $500,000. This is an increase from the previous median salary for non-private practice owner / partner physicians in 2013 of $360,000. Private practice owner / partner salaries were noted to be higher with mean salary of $550,000. This is up from 2013 which was reported to be $490,000.

This survey included responses from 465 surgeons which is a large increase from 216 in the original practice pattern and salary publication. The additional responses allowed us to generate more accurate mean and percentile tables for not only salary by employment type but also location (state) as well as stipend information for administrative leadership positions. To our knowledge this is the first publication with such information. It should be helpful for negotiations when surgeons assume these important roles.

State level data was included to provide individualized results to geographic regions. There was a large difference in states with high median compensation vs. states with low median compensation. This difference was calculated to be $260,000 per year between the highest (Florida) and lowest (Kentucky) states. Differences in compensation by state did not appear to coincide with 2022 annual cost of living patterns (Table 18) [2].

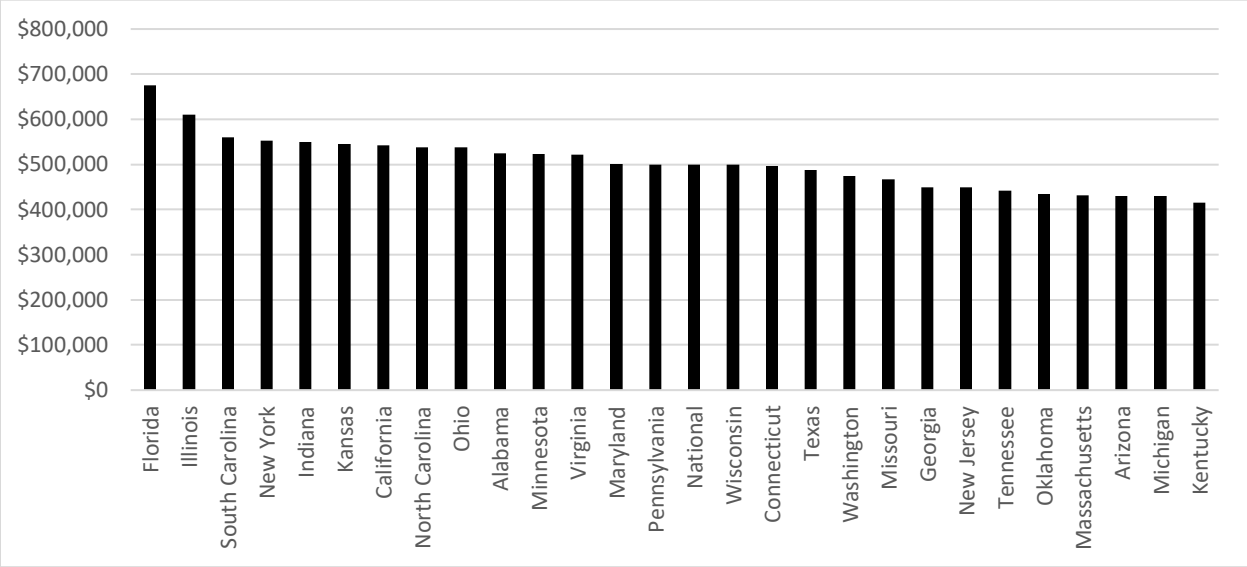

Table 18: Median salary for non-private-practice owner / partner physicians by state.

There was a large pay discrepancy noted based on surgeon gender. No causal relationship can be drawn from this retrospective review directly. One theory we evaluated was that perhaps more males had paid leadership positions vs. females. This turned out not to be the supported. Univariate analysis on gender with or without leadership roles was not statistically significantly different between males and females ($p=0.51$). We also wondered if the male population sampled had more years of experience than the female group. However, There was no significant

difference in the proportion of females to males in the 0-4 years in practice group compared to the entire cohort (p=0.20). There was a significant difference in the proportion of males vs females in the 11+ year of experience group which had a higher proportion of males (59% vs 52%, p=0.048). It is hard to say if this association may have an impact. Employment type and compensation models were similar between male and female surgeons. Both groups showed the employed model in community or academic practice to be the most common. Base salary with RVU collection threshold followed by base salary only were the most common compensation models in both groups. Multivariate linear regression analyses also confirmed gender as an independent predictor of salary. Further study in this area is warranted.

Mean salary was found to be significantly lower for surgeons who were early in practice (0-4 years) or age 31-40 (lowest age range). This may reflect why there was no significant difference in salary based on presence or absence of a fellowship in MBS. It is possible that surgeons later in practice did not have the option for fellowship training when they completed residency. Surgeons who had a higher percentage of practice dedicated to MBS were found to have a significantly higher average salary in univariate analysis. This difference did not hold true in multivariate analysis.

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Placed on ASMBS Website _____.

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Drs. Vosburg, Saber, Severson and LaMasters each contributed to the conception and design and acquisition of data, interpretation of data including statistical analysis, drafting and revising of this article for important intellectual content, and final approval of the version to be published.

Works Cited

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Appendix A (survey questions)

In order to learn how demographics impact income, we would like to know a little more about you.

What is your age in years?
- 31-40
- 41-50
- 51-60
- 61-70
- 71-80

What is your race / ethnicity? (select all that apply)
- American Indian or Alaska Native
- Asian
- Asian Indian
- Black or African American
- Central American
- Chinese
- Cuban
- Filipino
- Hispanic or Latino or Spanish Origin of any Race
- Japanese
- Korean
- Mexican, Mexican American, Chicano
- Native Hawaiian or other Pacific Islander
- Other Asian (Pakistani, Cambodian, and Hmong, etc.)
- Other Caribbean
- Puerto Rican
- Some Other Race
- South American
- Spaniard
- Vietnamese
- White
- Prefer not to answer

What is your gender?
- Male
- Female

- non-binary / third gender
- Prefer to self describe
- Transgender
- Prefer not to answer

Over the past 12 months have you worked full time?

- Yes
- No

Did you complete a fellowship in minimally invasive or bariatric surgery?

- Yes
- No

Do you have a Focused Practice Designation in Metabolic and Bariatric surgery from the American Board of Surgery (ABS)?

- Yes
- No

How many years have you been in practice?

- 0-4
- 5-10
- 11-15
- 16-20
- 21-30
- 31-40
- 41+

How would you describe your PRIMARY employment?

- Employed - at an academic hospital, with teaching
- Employed - at a community practice, with teaching
- Employed - at a community practice, withOUT teaching
- Private practice - employed
- Private practice - owner or partner
- Militray
- other

What percentage of your practice is bariatric surgery?

- < 25%

- 26 - 50%
- 51 - 75%
- 76 - 100%

In which state is your current PRIMARY employment located?

What was your total gross annual income for calendar year 2022 (this includes salary, directorships, incentives, call pay, bonuses and stipends)?
This is the same as BOX 5 on your 2022 W-2 (Medicare wages and tips)
This amount should NOT include overhead or expenses for surgeons in private practice models

(Please enter a number without a dollar sign and without commas, spaces or decimals,
for example $350,000 should be reported as "350000")

Was your reported 2022 salary decreased due to the effects of COVID-19 pandemic (eg. OR closure, decreased referral base, etc.)

- Yes
- No

Approximately what percentage of your clinical activity in 2022 decreased from the effects of COVID compared to pre-COVID times?

- 10% or less
- 20%
- 30%
- 40%
- 50%
- >50%

By what percentage was your 2022 salary decreased from the effects of COVID compared to pre-COVID times

- 10% or less
- 20%
- 30%
- 40%
- 50%
- >50%

Did you receive part of your 2022 compensation from any of the following?
If so please sect the 2022 income generated in US dollars from that source.
Metabolic and Bariatric Surgery site director

- Fellowship director
- Residency director
- Division chief
- Department chair
- other administrative work

Did you take non-bariatric surgery call in 2022? (This can include trauma and/or acute care surgery)

- Yes
- No

Were you paid for the non-bariatric surgery call you took in 2022?
(may be negotiated into your base salary or as additional compensation)

- Yes
- No

Please estimate on average your total non-bariatric call compensation for 2022?

How much were you compensated per night of non-bariatric surgery call?

Please enter a number without a dollar sign and without commas, spaces or decimals, for example $1,000 should be reported as "1000"

Are you certified by the American Board of Obesity Medicine (ABOM)?

- Yes
- No

Do you have a medical weight loss program associated with your practice?

- Yes
- No

Do you derive compensation directly from the medical weight loss program? (Not including downstream revenue for patients that move to surgery)

- Yes
- No

Was any of your 2022 compensation RVU based?

- Yes
- No

How would you describe your compensation model?

- Productivity only based on RVUs (no base salary)
- Productivity based on RVUs plus incentive (no base salary)
- Productivity only based on collections - costs (no base salary)
- Base salary with RVU productivity based bonus
- Base salary with NON-productivity based bonus
- Base salary with billing based bonus
- Base salary with collections based bonus
- Base salary only
- Other

If you have no base salary: Please enter the baseline dollars per RVU of your lowest tier, leave blank if not applicable.

If you have no base salary: Please enter the threshold of RVUs to make it to the next tier leave blank if not applicable.

If you have no base salary: Please enter the dollars per RVU of your second tier leave blank if not applicable.

If you have no base salary: Please explain additional tier thresholds for RVUs and compensation per RVU
leave blank if not applicable.

Please enter the total number of work RVUs you generated in the last year (if known)