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Obstetrics/Gynecology: Supply, Demand, Compensation and Recruiting Trends

Introduction

Merritt Hawkins, the nation's leading physician and advanced practitioner search and consulting firm, produces a series of surveys, white papers, speaking presentations and other resources intended to provide insight into various healthcare staffing and recruiting trends.

Topics for which Merritt Hawkins has provided data and analyses include physician compensation, physician practice metrics, physician practice plans and preferences, rural physician recruiting recommendations, physician retention strategies, physician visa requirements, and the economic impact of physicians, among a variety of others.

This white paper examines supply, demand, compensation and recruiting trends in obstetrics and gynecology (OBGYN).

What OBGYNs Do

Obstetrics and gynecology is a broad and diverse medical specialty that may include surgery, management of the care of pregnant women, gynecologic care, oncology, and primary health care for women.

According to Dr. Val Vogt, MD, of the American College of Obstetrics and Gynecology (ACOG), "Most OB/GYNs are generalists and see a variety of medical conditions in the office, perform surgery, and manage labor and delivery. Office practice consists of providing women with preventive examinations and other primary care and identifying gynecologic problems. OB/GYNs typically evaluate infertility, abnormal uterine bleeding, leiomyomato, pelvic masses, pelvic organ prolapse, abnormal Pap smears, pelvic pain, endometriosis, breast disorders, and urinary incontinence."



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Examples of minor office procedures that OBGYNs may perform include colposcopy, endometrial biopsy, Pap smears, and vulvar biopsy. Office ultrasound is performed for both obstetrics and for gynecologic conditions.

Some OBGYNs provide primary care services to their female patients, in addition to the typical gynecologic procedures. Examples of outpatient procedures include laser surgery, diagnostic laparoscopy, operative laparoscopy such as laparoscopic ovarian cystectomy, tubal ligation, diagnostic and operative hysteroscopy, and endometrial ablation.

Inpatient surgical procedures include hysterectomies performed vaginally, abdominally, and laparoscopically. Other examples of inpatient procedures include abdominal or laparoscopic myomectomies. Obstetrical procedures include cervical cerclage, dilation and curettage, amniocentesis, Cesarean section, circumcision, and forceps and vacuum deliveries.

“The specialty of OB/GYN covers a variety of health care for women. As such, an OB/GYN can perform primary care, have continuity of care, and provide surgical services,” according to Dr. Vogt.

EDUCATION AND TRAINING

OBGYN education and training includes the following steps:

Step 1: A Bachelor's Degree

Undergraduate focus on a pre-medicine track to prepare for medical school with courses in anatomy, chemistry, biology, genetics, and physics.

Step 2: Medical School

To enter medical school, college graduates must score high on the Medical College Admission Test (MCAT), a program of the Association of the American Medical Colleges. Taken electronically, it contains four sections dealing with physical sciences, verbal reasoning, writing, and biological sciences (www.aamc.org).

For the first two years of medical school, students complete science courses and learn medical terminology and practices. In the third and fourth years, they complete hands-on training at a clinic or hospital. A rotation in obstetrics and gynecology is part of this clinical experience in medical school.

Step 3: OBGYN Residency

Medical school graduates must complete a four-year residency in obstetrics and gynecology to gain experience in preventive and primary care, patient diagnosis, and surgical procedures. For resident OBGYNs, responsibilities and duties increase each year, with long hours spent at the hospital or clinic responding to unexpected emergencies, such as births, at all hours of the night.



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Step 4: Licensure and Certification

All physicians, including OBGYNs, must become state licensed, and must the United States Medical Licensing Exam (USMLE). For certification through the American Board of Obstetrics and Gynecology (www.abog.org), applicants must pass two board exams. The first exam is a lengthy written exam, taken immediately after completing residency. Upon passing it, physicians must practice in women's health care before taking an oral exam given by a panel of professors.

OBGYN Subspecialties

There are four primary subspecialty fellowships in OB/GYN, including:

***Gynecologic Oncology**

Gynecological oncologists treat cancer of the reproductive organs, such as ovarian and cervical cancer.

***Reproductive Endocrinology and Infertility**

Reproductive endocrinologists are infertility specialists. They diagnose infertility problems and develop treatment plans. Many offer in vitro fertilization (IVF) procedures.

***Maternal Fetal Medicine**

Maternal-fetal medicine specialists treat high-risk pregnancies. They specialize in the health of the mother and the baby, and may also oversee complicated or high-risk deliveries, such as the vaginal delivery of a baby in the breech position.

***Female Pelvic Medicine and Reconstructive Surgery.**

Female pelvic medicine specialists and reconstructive surgeons focus on injuries to and disorders of the pelvic floor and related structures. They may treat incontinence, provide pelvic floor physical therapy or perform surgery to repair prolapsed pelvic organs.

These fellowships run three years following completion of the initial four-year core residency program, with one of the fellowship years committed to research. Other fellowships are available in genetics and pediatric and adolescent gynecology.

Practice Styles and Settings

Approximately 90% of OB/GYNs are generalists and begin practice after completing a four-year residency in OB/GYN. Private practice typically consists of office hours two to four days a week, surgery one to one



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and one half days a week, and management of labor and delivery. Generalists most commonly practice in small or large groups. A small number of OB/GYNs are in solo practice. Call is usually dependent on practice size.

Below is a brief history of one of the world's oldest medical arts.

HISTORY OF OBGYN

Gynecology

Gynecology as a branch of medicine dates back to Greco-Roman civilization, if not earlier. In the early and mid-19th century, physicians became able to successfully perform a limited variety of surgical operations on the ovaries and uterus. According to writers at the web site OBGYN North, "The American surgeon James Marion Sims and other pioneers of operative gynecology also had to combat the violent prejudice of the public against any exposure or examination of the female sexual organs. The two great advances that finally overcame such opposition and made gynecologic surgery generally available were the use of anesthesia and antiseptic methods. The separate specialty of gynecology had become fairly well established by 1880; its union with the specialty of obstetrics, arising from an overlap of natural concerns, began late in the century and has continued to the present day."

Obstetrics

Obstetrics had for a long time been the responsibility of female midwives, in fact, *Obstetrix* was the Latin word for midwife and it is thought to derive from *obstare*, to "stand before", because the attendant stood in front of the woman to receive the baby. In the 17th century, European physicians began to attend on normal deliveries of royal and aristocratic families; from this beginning, the practice grew and spread to the middle classes. In 1668 it was a physician who pioneered primary suturing of the perineum after delivery, "cleansing .. with red wine then applying three or four stitches." Then in the 20th century, medical schools changed the practice from midwifery to obstetrics, according to OBGYN North. "In 1827, fetal heart tones were auscultated for the first time. The invention of the forceps used in delivery, the introduction of anesthesia, and the discovery of the cause of puerperal ("childbed") fever in 1847 with the introduction of antiseptic methods in the delivery room were all major advances in obstetrical practice. By the early 19th century, obstetrics had become established as a recognized medical discipline in Europe and the United States. Prenatal care and instruction of pregnant mothers to reduce birth defects and problem deliveries was introduced about 1900 and was thereafter rapidly adopted throughout the world. The first epidural for labor anesthesia was given in 1901 and oxytocin was first synthesized for labor augmentation in 1953. Beginning with the development of hormonal contraceptive pills in the 1950s, obstetrician-gynecologists have also become increasingly responsible for regulating women's fertility. With the development of amniocentesis, ultrasound, and other methods for the prenatal diagnosis OBGYNs have been able to detect potential birth defects. At the same time, new methods for artificially implanting fertilized embryos within the uterus have enabled obstetrician-



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gynecologists to help previously infertile couples to have children. The first successful in vitro fertilization was performed in 1978.”

With the new age of safe childbirth, the main focus for maternity care is now the quality of the birth experience for the woman and her partner. Services are encouraged to provide choice, including home or hospital delivery, epidurals, or water births.

SUPPLY AND DEMAND

Physician shortages are projected to be widespread throughout the United States and will include both primary care physicians and specialists such as OBGYNs. According to the Association of American Medical Colleges (AAMC), there will be a deficit of up to 122,000 physicians by 2032, including a deficit of up to 55,000 primary care physicians and an even larger deficit of up to 67,000 specialists.

The shortage cuts across specialty lines and includes a deficit of OBGYNs. The American College of Obstetricians and Gynecologists (ACOG) reported in 2017 that half of U.S. counties lack a single obstetrician-gynecologist. Those areas are home to more than 10 million women, many of whom may need OB-GYNs for primary care.

By 2020, there will be up to 8,000 fewer OB-GYNs than needed, according to ACOG, and the number may rise to 22,000 by mid-century.

The shortage creates particular challenges for women in rural areas as over half of rural women live more than 30 minutes away from a hospital with perinatal services, a distance that can be life-threatening in an emergency. According to the Merritt Hawkins' study *The Physician Workforce in Texas*, 147 Texas counties have no OBGYN.

The OBGYN shortage is not limited to rural locations, however. Merritt Hawkins' *Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates* tracks the time it takes to schedule a well woman appointment with an OBGYN in 15 top metropolitan areas. These are areas in which the ratio of physicians per population (including OBGYNs) is relatively high. Below are average OBGYN appointment wait times in several of this metro areas.

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Average OBGYN Appointment Wait Times/Select Metro Areas

City	Days
Philadelphia	51
Seattle	49
Boston	45
Atlanta	39
Portland	28
Average/top 15 metros	26.4

Source; Merritt Hawkins Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates. 2017.

As these numbers indicate, even in areas with a high ratio of physicians per population, accessing an OBGYN can be difficult.

The Merritt Hawkins survey also looked at the rate at which OBGYNs in top metro markets accept Medicare and Medicaid payments (see chart below).

OBGYN Medicare and Medicaid Acceptance Rates 15 Top Metro Areas

City	% Accepting Medicare	% Accepting Medicaid
Atlanta	25%	35%
Dallas	55%	15%
Miami	70%	25%
Houston	55%	35%
Detroit	80%	45%
Average/top 15 metros	72%	55%

Source; Merritt Hawkins Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates. 2017.

These numbers indicate that access to OBGYN services is further limited by the fact almost half of

OBGYNs in the major markets surveyed do not accept Medicaid patients, while over one quarter do not accept Medicare patients.

Part of the problem is tied to the fact that the supply of physicians in all specialties is growing slowly, due the cap Congress placed on funding for physician graduate medical education in 1997.

The number of first-year OBGYN residency positions grew by less than 200 between 1992 and 2016, according to the American Association of American Colleges (AAMC), despite the fact that tens of millions of people were added to the population during that time.

In addition, many OB-GYNs are nearing retirement: their average age is 51, and they tend to retire beginning at 59, according to the AAMC. Some may consider leaving in part because of their specialty's high likelihood of being sued. In fact, nearly two out of three OB-GYNs face legal action at some point, the highest rate of all specialties, according to a 2018 report. Long hours, midnight dashes to the hospital, and stressful emergencies all contribute to the burnout that can lead OB-GYNs to cut back on — or leave — their practices.

Compounding the shortage is the growing number of OB-GYN residents who pursue subspecialty training. In 2000, only 7% sought subspecialty training, but by 2012 it had risen to 20%. (*Columbus Dispatch, August 28, 2016*).

“Because OB-GYNs are among the least compensated of all surgical specialties, an increasing proportion of residents pursue fellowship training in highly specialized areas where reimbursement is higher,” says William Rayburn, MD, associate dean of obstetrics and gynecology at the University of New Mexico Health Sciences Center and author of the 2017 ACOG report referenced above.

Below is a snapshot of the current OBGYN workforce:

OBGYN Workforce Demographics

Total OBGYNs	43,555	
In Active Patient Care	36,061	
International Medical Graduates	5,180	14%
Board Certified	30,180	83%
Research	157	<1%
Administration/Teaching	739	2%
Last Year Residency	1,164	3%
Female	20,883	58%
Male	15,178	42%
55+	15,439	43%



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Source: American Medical Association (AMA) Physician Master File. 2019.

As these numbers indicate, the majority of OBGYNs in active patient care today are women. Nationally, 82% of doctors matching into OBGYN residency programs today are women and in ten years women will represent over two-thirds of all active OBGYNs. A significant number of OBGYNs (43%) are 55 years old or older, the majority of them male. A wave of retirements can be expected in the specialty with retiring male doctors largely replaced by younger female doctors.

Many patients express a preference for female OBGYNs, and the influx of women into the specialty has allowed many patients to access female OBGYNs.

However, it has had an inhibiting effect on total FTEs. Women physicians on average work fewer hours than men and see 12% fewer patients, according to the 2018 *Survey of America's Physicians* conducted by Merritt Hawkins on behalf of The Physicians Foundation.

In addition, women tend to have shorter medical careers than do men. According to the University of Michigan's *Intern Health Study*, almost 40% of female physicians scale back their practice hours or quit medicine altogether within six years of residency. The study showed 22.6% of women doctors were not working full-time, compared to 3.6% of males, within six years of completing training. The gap between men and women physicians expands for those with and without children. 30.6% of women doctors with children were not working full-time within six years of residency compared to 4.6% of male doctors with children. (*Why women leave medicine. Association of American Medical Colleges News. October 1, 2019*).

One reason for this the relatively high rate of burnout among women physicians caused, in part, by their dual responsibilities as professionals and mothers. Studies show that female physicians take on an average of 8.5 hours more work at home each week than do male physicians. Married male doctors with children spend seven hours longer at work and spend 12 hours less per week on parenting or domestic duties than do female doctors (*Why women leave medicine. Association of American Medical Colleges. October 1, 2019*).

According to the *Survey of America's Physicians*, 78% of physicians sometimes, often or always experience feelings of burnout. The burnout rate is higher for female physicians (84.8%) than it is for male physicians (74.1%), according to the survey.

How Many OBGYNs Are Required Per 100,000 Population?

There are a variety of sources that indicate the number physicians in various specialties required to serve a population of 100,000 people, including ratios compiled by the Graduation Medical Education National



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Advisory Committee (GMENAC), which now are 40 years old, ratios compiled by academic researchers Hicks and Glenn, and ratios compiled by the consulting firm Solucient.

However, the most recent of these ratios of which Merritt Hawkins is aware were developed by the late Richard “Buz” Cooper, M.D., a nationally recognized expert in physician supply and utilization studies based at the University of Pennsylvania. Dr. Cooper’s ratios are “demand-based” and reflect the number of people required to economically sustain a medical practice by specialty based on historic usage patterns nationally, regionally and at the community level. We believe these are real world numbers and are the most current and useful of the most commonly referenced physician-to-population ratios.

According to Dr. Cooper, on a national level, a population of 100,000 people can support 14.0 OBGYNs, or one OBGYN per approximately 7,150 people. This is a general number and is likely to vary depending on the economic, social, and health profiles of particular populations.

Ratios from various sources are listed below.

Suggested OBGYNs Per 100,000 People/Variou Sources

GMENAC	Hicks & Glenn	Solucient	Dr. Richard Cooper
9.9	11.1	14.1	14.0

Obstetrics/Gynecology Sees a Bump

As a result of the trends outlined above, Merritt Hawkins has seen an increase in the number of OBGYN searches we are engaged to conduct.

The number of OBGYN searches Merritt Hawkins conducted increased by 25% from 2018 to 2019, as OBGYN moved into the third spot on our list of most requested specialties as ranked by our 2019 *Review of Physician and Advanced Practitioner Recruiting Incentives*. This is the highest spot OBGYN has occupied on this list.

It should be noted that both male and female OBGYNs today express interest in a “controllable lifestyle” and are less inclined to be on call, giving rise to the use of “laborists” whose sole function is to attend deliveries in the hospital.

OBGYN COMPENSATION

The competitive nature of OB/GYN recruiting is reflected in rising starting salaries. The chart below illustrates the increase in starting salaries for OB/GYNs over the last six years as tracked by Merritt Hawkins’ 2019 *Review of Physician and Advanced Practitioner Recruiting Incentives*.



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Average Starting Salary/OBGYN

	Low	Average	High
2018/19	\$200,000	\$318,000	\$475,000
2017/18	\$200,000	\$324,000	\$550,000
2016/17	\$170,000	\$335,000	\$700,000
2015/16	\$210,000	\$321,000	\$500,000
2014/15	\$140,000	\$276,000	\$450,000

Source: *Merritt Hawkins 2019 Review of Physician and Advanced Practitioner Recruiting Incentives*

As these numbers indicate, the average salary offer for OBGYNs as tracked by Merritt Hawkins' data has increased by 15.2% since 2015, signaling increased competition for OBGYNs nationwide.

Compensation for OBGYNs can vary by region. Below are average regional starting salary numbers for OBGYN:

OBGYN Starting Salaries by Region

Northeast	Midwest/Great Plains	Southeast	Southwest	West
265,000	\$326,000	\$325,000	\$265,000	\$327,000

Source: *Merritt Hawkins 2019 Review of Physician and Advanced Practitioner Recruiting Incentives*

Listed below are average compensation numbers for OBGYNs as tracked by various other sources. Note that Merritt Hawkins tracks average starting salaries while other sources track total gross compensation physicians would report on their tax returns.

Average Compensation/OBGYN

Sullivan Cotter	\$376,087
Integrated Healthcare Strategies	\$365,549
MGMA	\$347,719
AMGA	\$340,388
Merritt Hawkins	\$318,000

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In addition to a starting salary, OB/GYNs typically are offered a signing bonus (see chart below).

OBGYN Signing Bonuses

Low	Average	High
\$3,000	\$30,115	\$100,000

Physician contracts today also usually feature a relocation allowance, CME allowance, paid health and malpractice insurance, health insurance and a 401k or other retirement vehicle.

RECRUITING RECOMMENDATIONS

As demand for OBGYNs has increased, so has the difficulty of recruiting these specialists. Hospitals, medical groups and other healthcare facilities that are seeking OBGYNs should prepare to commit the required effort, flexibility, responsiveness and resources required to be successful in today's challenging market.

Like other physicians, OBGYNs today put a premium on schedule flexibility, particularly given the fact that so many are women and may have dual professional/child rearing responsibilities. This is obviously a particular challenge in smaller communities with few OBGYNs available to share call. Utilizing locum tenens physicians to expand coverage can be an option in these situations. If there is no way to address the call schedule it may be necessary to offer financials higher than the average compensation numbers listed above.

The OBGYN starting salary numbers we are seeing as of 2020 are usually in the \$320,000 to \$350,000 range, though there are always outliers that pay more or less, given their geographic location or other factors. The compensation package also may include a significant level of educational loan repayment, an incentive that is somewhat more common in OBGYN search than in some other specialties. The average educational loan repayment amount for all specialties as tracked in Merritt Hawkins' 2019 Review of Physician and Advanced Practice Recruiting Incentives is \$101,571.

A favorable OBGYN practice opportunity will feature a balance in volume so that OBGYNs can maintain both their OB and GYN skills without being overwhelmed. Many younger candidates today consider having access to a robot to be a mandatory part of an attractive practice opportunity.

It is important to come to the market with a competitive opportunity rather than coming in low and hoping to negotiate from there. Most OBGYN candidates are scheduling multiple interviews and virtually all of them are receiving extremely competitive offers. They often are not of the mindset that they need to back and forth with negotiations, because in many cases they already have offers that meet the majority of their requirements.



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Flexibility on candidate parameters is particularly important for healthcare facilities seeking OBGYNs. Though female OBGYNs often are the first preference of patients, each candidate, male or female, should be considered based on their individual merits. A male candidate with a positive, empathetic bedside manner and strong communications skills may be more successful than a female candidate who lacks these skills. The same can be said for older candidates or those just completing residency. Begin with the skills and personal qualities you wish to see in a candidate rather than preconceptions about appearance, age, national origin or gender.

Conclusion

As with all difficult searches, it is important in OBGYN search to be flexible, creative, and committed to quick turnarounds, accommodating the schedules of candidates, responding with information as needed, and making an offer as soon as an appropriate candidate is found. Know the market, know what is needed to be successful, and execute the search with the maximum amount of commitment and efficiency as possible.

About Merritt Hawkins

Established in 1987, Merritt Hawkins is the leading physician search and consulting firm in the United States and is a company of AMN Healthcare (NYSE: AMN), the largest healthcare workforce solutions organization in the nation. Merritt Hawkins' provides physician and advanced practitioner recruiting services to hospitals, medical groups, community health centers, telehealth providers, and many other types of entities nationwide.

The thought leader in our industry, Merritt Hawkins, produces a series of surveys, white papers, books, and speaking presentations internally and also produces research and thought leadership for third parties. Organizations for which Merritt Hawkins has completed research and analysis projects include **The Physicians Foundation, the Indian Health Service, Trinity University, the American Academy of Physician Assistants, the Association of Academic Surgical Administrators, and the North Texas Regional Extension Center.**

This is one in a series of Merritt Hawkins' white papers examining a variety of topics directly or indirectly affecting the recruitment and retention of physicians and advanced practice professionals, including physician assistants (PAs) and nurse practitioners (NPs).

Additional Merritt Hawkins' white papers include:

- ❖ Physician Supply Considerations: The Emerging Shortage of Medical Specialists
- ❖ Physician Emotional Intelligence: Going Beyond "A-Type" Personalities
- ❖ Ten Keys to Enhancing Physician/Hospital Relations: A Guide for Hospital Leaders
- ❖ Rural Physician Recruiting Challenges and Solutions



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- ❖ Psychiatry: “The Silent Shortage”
- ❖ NPs and PAs: Supply, Distribution, and Scope of Practice Considerations
- ❖ The Physician Shortage: Data Points and State Rankings
- ❖ RVU FAQ: Understanding RVU Compensation in Physician Employment Agreements
- ❖ The Economic Impact of Physicians
- ❖ International Physicians and Immigration Requirements: An FAQ
- ❖ The Growing Use and Recruitment of Hospitalists
- ❖ Staffing and Recruiting Considerations in Emergency Medicine

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