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Not the Last Word

Not the Last Word: Orthopaedic Surgery Is Lucrative (But Evidently Not Lucrative Enough)

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Orthopaedic surgeons, according to a recent Medscape survey [13], earn on average more than physicians in every other field, often by a wide margin. Nevertheless, a majority of orthopaedic surgeons reported dissatisfaction with their income, more than most other specialties.

Of course, a survey like this could be tainted by bias: The disgruntled, after all, are more likely to participate. Nonetheless, because the bias likely applies across the board, the relative differences in happiness may be meaningful.

If so, why exactly are orthopaedic surgeons so unhappy?

Maybe we can blame character—that orthopaedic surgeons are just money-grubbers. But a genuine gold-digger does not spend 4 years in medical school followed by at least 5 years in residency digging for gold; the opportunity cost is too high. Also, orthopaedic pay, however plush it may be, is not in the same league as that of Wall Street finance or even the upper echelons of legal practice.

The reported dissatisfaction among orthopaedic surgeons is more likely based on ordinary themes that are pinching everybody; they just happen to pinch orthopaedics particularly hard.

For one, orthopaedic surgeons may feel slighted by the distribution of wealth in their field. For example, a USD 1600 payment for a joint replacement seems fine until it is measured against the total payments for the procedure (often USD 30,000 or more). In such light, USD 1600 seems meager and unjust. Other areas in medicine do not have this problem: Primary care physicians may receive only USD 35 for swabbing for strep infection, but nobody seems to be getting rich on sore throats, so the far lower fee rankles far less.

Another related point is the variation in pay among orthopaedic subspecialties. For instance, spine specialists can earn millions more than general orthopaedic surgeons [7]; and the few with close ties to industry can collect tens of millions of dollars [5], if not more [6]. Orthopaedic surgeons all too frequently discover that a colleague of seemingly similar talent earns substantially more. That realization can make the well-paid feel poor. If HL Mencken's description of a rich man—"somebody who earns more than his brother-in-law" [14]—is correct, then we can define a poor doctor as somebody who earns less than a classmate from residency. Given the skewed distribution of earnings in orthopaedic surgery, "poor" doctors will be found quite often.

Digging a little deeper, the dissatisfaction could be less about the levels of pay than about its trajectory. For example, in the decade 1996 to 2005, the inflation-adjusted Medicare fee for a knee replacement fell more than 4% annually [1]. This is psychologically distressing on its own merits, but there is another issue: Small but unrelenting pay cuts drive one to work ever harder, perhaps to the point of acrimony. That

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is because many people use last year's income as an anchor, the basis for identifying a fair target income for the coming year [11].

With a target income in mind, the response to slight cuts in fees is an attempt to "make it up on the volume." This urge to work a bit harder when fees are cut seems to go against the classic economic Law of Supply, a tenet that asserts that when prices fall, producers produce less (and vice versa). Yet the exact opposite has been seen: From 1996 to 2005, when the inflation-adjusted Medicare fee for a knee replacement fell 41%, the number of knee replacements nearly doubled [1]. (This trend, of course, does not prove that income targeting was responsible, but it is curious that the total amount spent on professional fees per surgeon remained remarkably constant.) Maybe the reported unhappiness reflects a sense of running in place, working harder for no gains at all.

Granted, the cuts in fees have affected all specialties, but an equal percentage cut has the greatest net effect on those collecting the most; moreover, the threat of future cuts may be most stressful for those at the top of the income scale [8].

In the end, even people who fully understand that money does not buy happiness [6] can be subject to irrational dissatisfaction. Thus, while our leaders are justified to rail against proposed cuts to surgical fees [12], a nuanced approach to advocacy might promote greater happiness. Income equality and stability may be more important than absolute earnings.

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As happiness researchers, we were intrigued by Dr. Bernstein's analysis of dissatisfaction within the lucrative field of orthopaedic surgery, with cuts in surgical fees spurring surgeons to perform more and more procedures in an effort to maintain their incomes. We agree with his assessment that "a nuanced approach to advocacy might promote greater happiness" than simply focusing on fighting cuts to surgical fees. While it is true that decreases in income reduce well-being relatively more than increases in income benefit well-being [2], the best data suggest that once US household income reaches USD 75,000 per year, additional income ceases to increase the extent to which people laugh, smile, and experience enjoyment on a typical day [9]. Simply advocating for higher salaries may produce returns in happiness, but only for people on the lowest rungs of the pay scale—say, medical residents.

If working harder to earn more money fails to pay off in happiness, what is to be done? First, surgeons (and others) who have long since soared past the USD 75,000 income mark are better off trading some of their money to buy time [4]. Money can endow people with the freedom to transform the way they spend their time, from outsourcing dreaded tasks (such as housecleaning) to turning down drudgery at work (yet another knee replacement) in favor of more personally rewarding activities. And yet research shows that people who earn more money do not spend their time in happier ways on a day-to-day basis [10]. Thus, although a six-figure income provides a great deal of potential happiness, this potential may often go unrealized.

Even worse, thinking about money can draw us away from activities most likely to provide happiness. When individuals are merely reminded of money, they become less inclined to help others [16], but helping others offers a reliable route to happiness [15]. This suggests that people might get more happiness from their money by using it to benefit others. In one experiment, we sent one of our graduate

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students out with a stack of USD 5 and USD 20 bills [3]. She gave the cash to passersby in the morning and asked them to spend it by the end of the day, with a catch: half were told to spend the money on themselves, and half were told to spend the money on someone else. When called back that evening, those told to spend their money on someone else reported significantly greater happiness than those told to spend the money on themselves. Oddly enough, one of the best ways to feel better about making less money can be to decrease your income even more—by sharing it with someone else. Rather than focusing solely on how much money we make, a shift in mindset—from thinking not about how much we should make but how we are using what we already have—can pay off in greater happiness.

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Dr. Bernstein's discussion of income, lifestyle, and job satisfaction explores the long debated topic of "quality versus quantity," in this case quality of life versus quantity of cases and income. In doing so, he recognizes the natural desire of high earning professionals, including orthopaedic surgeons, to maintain, if not increase, their financial status, and the conflict that has arisen as reimbursement has gone down. The perceived inequality among subspecialist and different geographic locations only heightens this sense of frustration, as Dr. Bernstein so clearly points out.

Fundamentally, the practice of orthopaedic surgery has evolved to the point that the concept of "private practice" barely exists among current residents, most of whom anticipate working for a hospital system or joining a multispecialty group. There is no question that as we seek the stability and financial safety of these larger organizations there is a loss of "independence" and clear limitations placed on how we practice the "art" of medicine. For example, compliance with electronic medical record "meaningful use" requirements, as defined by CMS, may be forced upon us by linking it to our base or bonus pay, and while this may be irritating to us as individuals, it is important to the success of any group or institution we are part of, making it a necessary "evil."

Hospitals and health care systems have been financially "coerced" during the last decade by insurance providers, both public and private, and as a result have had to continually meet demands relating to documentation, billing, and electronic medical records. As noted above, these institutions must then somehow persuade physicians to behave in certain ways, often significantly changing individual patterns of practice. As a result, the idea of "private" practitioners, with no direct alignment with these entities, presents an unacceptable financial risk, and thus, the move to direct employment of physicians.

It is well understood that failure to meet expectations results in dissatisfaction. As a new generation of orthopaedic surgeons enters the workplace, they do so understanding the need to remain responsive to the changing demands of healthcare systems, and that the salary they obtain will likely be lower than that of previous decades. For the current generation, in its 50s and at the peak of its earning power, it will be difficult to adjust its expectations relating to future growth. Ultimately, our perception of our profession and our private lives is based on our expectations. With that understanding, we should consider the words of the financier and philanthropist David Rubenstein: "What do most people say on their deathbed? They don't say, 'I wish I'd made more money.' What they say is, 'I wish I'd spent more time with my family and done more for society or my community.'"

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