Are you happier if you reap what you sow? A commentary on compensation and morale among current reproductive endocrinology and infertility specialists

The nature of our educational journey results in reproductive endocrinologists rarely being exposed to practice outside of academia before venturing into the "real world" after their fellowship. Many of us have had the luxury of college guidance counselors to help steer us toward medical school, followed by well-orchestrated application, interview, and match processes for obstetrics and gynecology residency and reproductive endocrinology and infertility (REI) fellowship. The match seems stressful and arbitrary, but this gripe fades when faced with what comes next. Following fellowship training, there are a broad range of opportunities and no clear guidance as to how to attain the ideal job that leads to personal career-long contentment. This choice is unique to each individual and has many confounding variables, but the article by Stadtmauer et al. (1) in this issue of *Fertility and Sterility* attempts to identify common themes among reproductive endocrinologists, which lead to higher morale and job satisfaction.

This study presents the results of a late-2019 cross-sectional, web-based survey of 370 board-certified reproductive endocrinologists on professional satisfaction, compensation, age, and gender disparities as an update to a similar survey conducted in 2016 by the Society for Reproductive Endocrinology and Infertility (1, 2). The demographic results of the survey highlight a paradigm shift in gender representation in our specialty. For example, merely 5 years ago, only 38.1% of survey respondents were women, compared with 48.4% of the respondents identifying as women in the current study, with gender ratios shifted dramatically across age groups (1, 2). Women outnumbered men by >3:1 among those younger than 40 years; in contrast, most reproductive endocrinologists aged >51 years were men. As expected from an initially male-dominated field, this indicates that there are now more women in the field and that the gender gap is closing. However, women and men were represented slightly differently based on the setting and number of hours worked per week. On average, women worked 46.7 hours per week, whereas men worked 50.6 hours (8% difference; $P = .04$), and more women than men reported working in academic settings.

In a big step toward equality, when the years of experience and practice setting were assessed, salaries were not significantly different between the sexes or in terms of race (1). The starting salaries were similar between private practice settings and academia. However, the salaries in private practice settings significantly increased until approximately 10 years after fellowship and then plateaued, presumably because when many physicians share profits, the compensation would be dependent on patient population and volume. On the other hand, salaries in academia remained nearly stagnant over the course of time. Overall, the mean annual salaries were 86% (median, 70%) higher for REIs in private practice settings than for those in academic settings. Moreover, with ≥10 years of experience, those working in a private practice group had mean earnings roughly twice as much as academicians (an increase of 109%). Interestingly, after 10 years of experience, the difference between the mean and median for private practice physicians was significant ($320,997), whereas the difference between the mean and median for academicians was only $41,600. This could indicate a significant right-sided skew toward a limited number of private practitioners earning substantially more (the highest earner earned $5 million in a study). Therefore, after 10 years of private practice, the median (a better comparison) earning was 43% more than that in academia, not more than double as indicated by the mean.

As one would expect after seeing the discrepancy in compensation, it was more common for a provider to leave academia to join a private practice setting (27% of respondents) than it was to leave a private practice setting to join an academic setting (8% of respondents). Of people working in private practice settings, 82% of respondents considered their compensation to be fair, whereas only 53% of those in academia reported that they felt fairly compensated. Although the reasons for the discrepancies in perceptions of compensation fairness are not addressed in the current study, it leaves room to consider whether the differences in the perception of fairness can be explained by salary alone. Research in economics has suggested that the levels of happiness do not typically increase with income once a certain salary is achieved (3). However, with increased emphasis on salary transparency in our field, the adage "compare and despair" may be at play. Another possible reason for the discrepancies in the perceptions of fairness may be related to differences in how compensation packages are allocated. Academicians may have lower base salaries, which are offset by excellent health care and retirement benefits, and may be undervalued. Academicians may also spend time differently, with teaching roles, research, and other academic responsibilities reducing their time spent on revenue-generating patient care. In many cases, academicians may not be monetarily reaping what they sow because academic endeavors may be undervalued. What is high-quality research and training the future generation worth, and, if monetized, where would that additional compensation come from? On the other hand, in addition to more time spent on patient care, doctors in private practice settings may be more focused on and connected to how their work affects the bottom line of their business, thus influencing their business behavior and take-home pay.

Employee morale was also addressed in the study by Stadtmauer et al. (1). Practitioners who worked in private practice group settings reported the highest morale, whereas those in solo private practice settings reported

the lowest. Overall, private practice physicians reported higher morale than academic physicians. Morale increased with compensation and decreased with hours worked; 50 hours per week was the turning point, with those who worked <50 hours per week reporting significantly higher morale than those who worked more. Morale was unrelated to the in vitro fertilization cycle and surgical procedure volume. Women reported lower morale than men, even when accounting for practice type, work hours, and compensation. Interestingly, but not surprisingly, morale was high, regardless of the practice type or sex, once the physician received a very high compensation. The group with the lowest morale across the board included women in academia who worked >50 hours per week. This accounted for 25% of the survey respondents, raising the following questions: what more can we do to increase morale for this population? To what extent does recognition of the critical role that academicians have in teaching and research influence morale? Do some reproductive endocrinologists in academic environments feel like another cog in the wheel, or are they satisfied monetarily reaping lesser than what they sow, given the unique rewards of academia, such as intellectual stimulation and mentorship?

Not elucidated by the current study is the effect of the element of control that REIs can have over their work-life balance. Presumably, practice owners have more control over day-to-day activities, hours worked, and in a high-volume market, compensation. However, the spectrum of job opportunities available today is strikingly different from that of opportunities available, for instance, 20 years ago. With fewer solo practices, many large group practices opening high-volume satellites, and more academic programs being bought or managed by large conglomerates, the face of REI is a changing landscape. Despite salaries increasing by 29% on average compared with the salaries 5 years ago, morale has decreased since then, which raises the following question: do individuals across the board now have less control over their day-to-day activities? Another question for future evaluation is whether the growing proportion of nonequity partners in private practices has similar morale scores compared with owners. Despite considering all these factors, REI remains a high-morale specialty. When asked if they would choose REI again, 91% of the survey respondents answered yes.

It makes sense that work-life balance is a strong contributing factor for happiness among reproductive endocrinologists because those who work less hours make more money and those who have more control, such as those who are equity partners in a group private practice, report the highest morale. Despite being the top 1% of earners in the world, a large percentage of REIs felt that they were not fairly compensated, presumably because of "compare and despair" with their colleagues. Beyond changing the system, there may be room for us to adjust our perceptions of fairness by gaining back some element of control and rewarding productivity in areas that previously were only based on tenure, such as traditional academic settings. With increasing emphasis on workplace equality and financial transparency, our field must navigate how to remain a high-morale specialty in this changing landscape of medicine.

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