Neonatology Job Search: Looking Beyond the Dollar Signs

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Abstract

After about a decade of graduate and postgraduate medical training, many long hours, and personal sacrifices, perhaps carrying significant debt, you are about to land that long-awaited first job out of fellowship. Coming from the perspective of a fellow's salary, attending salaries may look like the Promised Land. Starting salaries in neonatology vary from region to region and by type of practice, but the once wide gap between private practice and academic salaries has shrunk in recent years, just as job descriptions have blurred in both venues. Although starting salary is important and often sets the baseline for future raises, there are many factors beyond salary that will influence your lifestyle, career opportunities, job satisfaction, and lifetime finances. This article is intended to educate graduating fellows and other junior faculty or recent graduates about a myriad of factors that should be considered, along with base salary, when negotiating your first (or subsequent) position out of fellowship.

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Introduction

Medical training is a long and winding road toward employment and financial security for you and your family. Looking for your first job out of fellowship is an exciting but often stressful time, coupled with personal, family, and professional opportunities and demands that may pull you in different directions. Little in medical school, residency, or fellowship training prepares a graduating fellow or a recent graduate/junior faculty for negotiating that first job contract. This article is intended to help you think broadly about what is important to you personally and professionally as you embark on the job interview journey and help you consider the factors beyond base salary that can substantially influence job satisfaction, career advancement, and your professional and financial future.

Completion of fellowship training is a time to take stock of what really matters to you. Consider the items in Table 1, add to this list if something meaningful to you is missing, and then rank your top five priorities in life. These will help you focus on the career opportunities that will be most fulfilling at this stage in your life. Remember that the order of your priorities is likely to change over time, so this is an exercise you should complete about every 5 to 7 years.

Fellowship training offers a smorgasbord of learning experiences in clinical care, research, teaching, and leadership skills development. Seeking a job after fellowship typically necessitates narrowing your focus and

Abbreviations

CPT: Current Procedural Terminology
RVU: relative value unit

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Table 1. Determining Your Top Priorities

- Immediate family (spouse, children)
- Being close to extended family
- A satisfying career as a clinician
- Opportunity to teach/impart knowledge
- Discovery/influencing the health of many through research
- Affluence
- Health/fitness
- Community service
- Adventure/travel
- Religion/spirituality
- Sports/hobbies
- Art/music
- Leisure time/flexible hours

a certain amount of introspection. *What are you passionate about* (Table 2)? You will have a satisfying career if you are doing something that speaks to that passion, makes you excited to go to work most mornings, and allows you to come home feeling like you have made a difference. *What are you good at?* People tend to be happy when they do something at which they excel. This means acknowledging your strengths and weaknesses. Burnout happens when you are in the wrong job at the wrong time in your life; set yourself up for success by finding a job that plays to your strengths.

Table 2. Determining Your Passion

- Direct patient care and building relationships with your patients' families
- Research and discovery of new knowledge
- Teaching the next generation
- Improving processes of care and patient outcomes
- Changing policies that impact health care delivery on a local or global scale

Choosing a Practice Venue

For most trainees, the major considerations that drive that first employment decision are (1) geography and (2) the type of practice venue. Family, personal, and lifestyle choices may limit the job search to a particular part of the country (to large metropolitan cities versus smaller cities in less populated states). Chosen career paths with emphasis on clinical care, teaching, or research often steer trainees toward a faculty position at an academic medical center or affiliated hospital or toward a hospital-based employee position or private practice. It is notable that in recent years the lines between academic and private practice have blurred, salary differentials have narrowed, and many job descriptions in academic and nonacademic settings overlap.

Academic Versus Private Practice

There was a time when choosing between academic and private practice neonatology meant very different career paths. The phenotype of the academic neonatologist certainly includes, but is no longer restricted to, the physician-scientist who devotes significant effort to basic or clinical research. Today, many academic faculty are clinician-educators that devote their full effort to providing clinical care and teaching medical students, residents, and fellows. Full-time clinical faculty jobs with minimal teaching responsibilities have also become more common as academic centers form affiliate relationships and provide professional services in community hospital neonatal intensive care units (NICUs). Similarly, some national and local physician groups offer career opportunities with significant teaching responsibilities, or involvement in clinical, quality, or health services research.

At one time, an academic job meant earning a fixed salary, typically based on academic rank, whereas a job in the private sector meant being self-employed and charging a fee-for-service, such that your income was determined by your clinical collections and administrative overhead. Today, fee-for-service neonatologists are on the endangered species list. Neonatologists, including those in the private sector, are often employed and salaried by the hospital system for which they work or by one of several large national physician groups. The complexity of contracting, billing, and collections, intensifying demands to lower costs, the requirements for continuing medical education, quality improvement participation, adoption of expensive information technology, and the changing health care landscape has resulted in a migration from independent, private practice to employment by large group practices or multispecialty physician groups that perform the business contracting and billing functions of the practice, pay physician and staff salaries, and determine bonuses. This model may also apply to neonatologists in some academic practices, where the faculty are employed by a multispecialty group practice. A fixed salary is no longer the only income model in academic practice. Many academic faculty earn a base salary as reflected by time in rank, but also have moonlighting opportunities doing extra night or weekend call and participate in an incentive plan that may incorporate a bonus based on (1) clinical productivity (relative value units [RVUs] or collections), (2) academic productivity (grant funding and manuscripts published), and/or (3) service (excellence in teaching and administration). According to the Bureau of Labor Statistics, only one fourth of all doctors are self-employed and this percentage is even lower (and a moving target) in

neonatology and other predominantly in-patient–based subspecialties.

So how does one choose between academic or private practice? If your passion is research and discovery, and your career vision is that of an National Institutes of Health-funded physician-scientist, the choice is fairly straightforward. Outside of an academic medical center, it is difficult to replicate this environment, the required research infrastructure, space, equipment, mentors, collaborators, and protected time to launch, and nurture a career as an investigator. If your strengths and passion are in the clinical and teaching realms, your options are less restricted, and the factors discussed in the rest of this article can be used as a guide to finding the best possible job fit.

Practice Size and Level of Care

Although most Accreditation Council Graduate Medical Education–approved fellowships in Neonatal-Perinatal Medicine are situated in academic centers with large NICUs providing care to the most complex and critically ill patients, many jobs in neonatology are in smaller community hospitals where the sickest patients or those needing medical or surgical subspecialty services are stabilized and then transported out. An important factor in your choice of a job out of fellowship is the spectrum of patients and diseases you will care for in that venue. Some early career neonatologists will be happy to never be responsible for another infant with congenital diaphragmatic hernia on extracorporeal membrane oxygenation, whereas others will be frustrated by having to transport to another facility patients with problems for which they demonstrated competence during their fellowship training. Some jobs in academia and private practices offer a mix of level II and level III care with options to focus on one or the other. Some practices include coverage of the newborn nursery. *Does the patient population match your skill set and interests?* The practice venue and the patient care mix can also have bearing on your salary if your income is tied to RVUs or billings, because lower-acuity patients generate lower RVUs and reimbursements.

NICUs also vary tremendously in terms of number of beds, average daily census, delivery volumes, and staffing models. Be sure to understand the staffing model and not just focus on the number of beds or average daily census. A 100-bed NICU that is covered daily by five neonatologists may feel more manageable than one with 36 beds covered by a single neonatologist doing a 24-hour shift without residents or nurse practitioners. The staffing model may include residents and fellows and necessitate the incorporation of bedside and didactic teaching in the daily workflow as well as trainee evaluations and feedback. The model may also include neonatal nurse practitioners, NICU hospitalists, or physician assistants who work as a team under the supervision of an attending neonatologist or who work somewhat independently seeing lower-acuity patients. The patient-to-provider ratio, the range of medical and surgical problems cared for (ie, patient acuity), and the experience and skills of the nursing and respiratory care staff are more likely to dictate the pace and stress of the workday than the number of patients on your service. Make sure to understand the staffing model at night and on weekends and not just during the weekday. Although you, as the attending neonatologist, are medically responsible for the patients under your care, it may be reassuring to know there is another neonatologist or other subspecialist readily available to consult about a complex or unstable patient. In a smaller unit, you are more likely to be the only attending during the better part of the day with fewer opportunities to discuss patient care issues with an experienced colleague.

It is important to inquire about patient outcomes for key neonatal morbidities and if the practice belongs to an external benchmarking group like Vermont Oxford Network, Pediatrix, the National Institute of Child Health and Human Development Neonatal Network or Children's Hospital Corporation of American. It is also helpful to ask about the competition for neonatal services in town and relationships between the groups and hospitals that are competing for market share.

Practice Climate and Culture

Your professional colleagues are among the most important factors in long-term job satisfaction or disgruntlement. Although it is always challenging to understand group dynamics during an interview (when everyone is on their best behavior), it is important to try to meet as many of your future colleagues one-on-one, as well as in a group setting, such as at an interview dinner, sign-out rounds, or a clinical care conference. Beyond the number of professional colleagues in the group, be sure to ask about how long they have been there and if there is any anticipated turnover in the next 2 years. Ask about seniority, because you may not want to be the only junior person in a group where everyone is nearing retirement age and hoping to cut back on night call. Find out if the group socializes outside of work, because this may tell you something about camaraderie. Spend time with the most recent person to join the group and find out about their transition to the practice. Unless you stay where you trained, you will bring new ideas and new approaches to

patient care and clinical processes. *How adaptable are you? How open to change are they? Are you the first new partner to join the group in a decade?* Ask about how the group has dealt in the past with maternity/paternity leave and family or personal illness, because this speaks volumes about relationships and the personality of the group.

Be sure to inquire about relationships with hospital administration, nursing leadership, and other subspecialties, such as ophthalmology, radiology, cardiology, and, if relevant, pediatric surgery and anesthesiology. Relations with obstetrics and maternal-fetal medicine are particularly important; the size and stability of that service will directly impact NICU volumes and potentially your income. Does the hospital support social workers, case managers, pediatric pharmacists, nutritionists, lactation specialists, physical, and occupational and speech therapists? Do the physicians, nurses, and essential support staff work well as a team? Spend time on patient care rounds to observe these dynamics first hand. If possible, meet with hospital administration and get a feel for the value placed on perinatal care and the NICU service relative to overall institutional strategy and goals.

In academic practice, get a sense of whether your colleagues truly value what you bring to the group. If you are a physician-scientist, is research and discovery valued by the group, even if most of your future colleagues are not directly involved in research? Are there large pay differentials between those who do predominantly clinical time and those who spend most of their time in the laboratory? If you are a clinician-educator joining a highly academic practice with a strong research portfolio, is there evidence your contributions will be appreciated and valued? What is the pathway for promotion for those without grants and numerous peer-reviewed publications? How is the workload distributed among the various team members with different strengths and interests? Does the division leadership and department Chair value everyone's contributions?

Time Distribution and Clinical Responsibilities

It is important to understand the distribution of your effort whether you are a full-time clinician in private practice or are intent on an academic career with a major research focus. There are as many ways to calculate clinical effort as there are neonatology practices. Academic programs typically assign a percentage of effort to the domains of clinical, research, and academic time (which includes teaching and unfunded scholarly activities). A full-time academic clinician-educator may have clinical responsibilities for the equivalent of 5 to 8 or more months per year. Clinical effort for a K awardee with 75% research effort might translate to as few as 6 weeks or as many as 12 weeks of clinical time. Be sure to clarify the number of weeks of clinical time and how and where your clinical time will be spent. *Will you be solely based in a high-acuity level III or IV NICU or is some time allocated to level II or level I care?* Will you spend all your time at the primary NICU, or will you have clinical responsibilities at an affiliated community hospital? What is the commute time and level of support for patients in the affiliate hospitals? Are there clinical responsibilities for a follow-up clinic or a consultative service for high-risk mothers? Is that part of, or in addition to, your NICU weeks?

The duration of a clinical service block ranges from 2 to 4 weeks in most academic practices, allowing for continuity of care and assessment of trainees on a NICU rotation and blocks of uninterrupted time for academic pursuits, especially research. Private practice schedules tend to be more evenly distributed throughout the year, with coverage in 1- to 7-day-long stretches, depending on the availability of skilled hands at night with days off scattered throughout the week or month. Be sure to ask what are the expectations for your off-service time. For the physician-scientist, this answer is self-evident. For the full-time clinician or clinician-educator, expectations vary significantly from on-site presence and participation in teaching conferences, meetings, administrative or quality improvement projects to days completely free of any work responsibilities.

Night Call

After salary, night call is perhaps the factor that most influences employment decisions. Few job applicants need to be coached to ask about night and weekend coverage and whether night call is in-house or from home. Although both models still exist in academic and private practice, an increasing number of NICUs have moved to in-house 24-hour coverage by a neonatologist, including programs that train residents and fellows. Some states mandate 24/7 presence of a board-eligible or -certified neonatologist. It is important to ask how many physicians are in the call pool. In some practices, it is possible to "buy-out" or age out. Is the call distributed equally and included in your base pay, or do individuals have the option to do more or less call for more or less pay? What is the staffing model at night and on weekends? If you are attending a delivery, is there another skilled provider to address urgent patient care needs? How many weekends will you work and for how many patients are you responsible? If the NICU accepts outborn babies, what is the configuration of the transport team? Do you have

additional transport call or extracorporeal membrane oxygenation call responsibilities?

Administration and Infrastructure

As a fellow it may be difficult to envision how much an efficient or inefficient administrative infrastructure will impact your life, your hours, and your livelihood. *Will you have access to a secretary to support your clinical and professional activities? Will you have an office for clinical and academic work?* Be sure to inquire about the NICU's electronic medical records and computerized physician order entry systems. Does the system work well for the unique patient population of the NICU? Is the system integrated with the hospital laboratories, pharmacy, and nursing documentation? An efficient system can make documentation and billing a lot easier and order writing a lot safer. On the contrary, lack of a system or use of an adult-oriented system may reflect limited resources, other priorities, or a hospital that is slow to adopt new technologies. In addition, ask about information technology support services for the clinical workstations and for personal computers used for business purposes.

Fellows rarely concern themselves with billing and documentation, but these activities will impact your life whether you are in private or academic practice. Some physicians are responsible for their own Current Procedural Terminology (CPT) coding and must be familiar with the required documentation to justify the use of a bundled critical care versus weight-based code. Under- and overcoding are both considered fraudulent and can have serious consequences beyond the impact on revenue. Other practices hire professional coders who submit bills in your name based on your documentation. Still others rely on NICU electronic medical record programs with built-in CPT code features. You should make time to learn the basics of neonatology CPT coding and some of the business aspects of neonatology as part of your fellowship training. The AAP Perinatal Section Workshop each April in Scottsdale is an excellent way to get a crash course on coding and practice management.

Inquire about how the administrative responsibilities of the practice are shared among the group. Who takes care of credentialing, contracts, negotiations with the hospital, day and nighttime scheduling, and updating policies and procedures? If your goal is to obtain funding to support your research, make sure you are free from these administrative duties.

Research Support

For an aspiring physician-scientist, the keys to success are committed mentorship by an established investigator in your chosen field of research, protected time for research (that means limited clinical and teaching time and avoidance of administrative duties until you are well-established), and a robust institutional research infrastructure (cutting-edge core laboratories and technology, a knowledgeable grants office, an accredited animal care facility, an efficient institutional review board review process, access to biostatistical support, access to a rich clinical database or a funded Clinical & Translational Science Award. A critical mass of investigators and a collaborative research environment is more important than the square footage of your laboratory. Inquire about the success rate for other young investigators in your department. If no one has been successful in getting a K award or converting a K to an R, you might want to keep looking.

There may not be much room for salary negotiations for a budding academic physician-scientist. You may be encouraged to spend a year or two in the rank of Instructor (generally at a somewhat lower salary) before promotion to Assistant Professor and the start of your tenure clock. This is often a wise choice, particularly for those without an MD, PhD. Think of it as a well-funded post doc position. Starting your tenure clock before writing a successful K award and publishing several first authorship articles will put enormous pressure on you to achieving R-level funding and sufficient productivity to earn promotion with tenure. Understand the promotion process at your institution and meet at least annually with your Division Chief and/or Chair to make sure you are on track to achieve promotion and tenure.

On the flip side, research start-up funds may be an important area for negotiation. You are likely to be asked for a list of the resources you will need to support your research program; this list will be used to determine your start-up funds. Spend time on this task and talk to colleagues and mentors about what you will need and what it will cost to hire a technician or clinical research coordinator, pay for biostatistical support or animal care costs, purchase supplies and equipment, and pay for core laboratory charges. How large a start-up package you will need depends on the type of research you want to do and the established research infrastructure of the institution and department. Make sure all the major equipment items you will need are in place and understand the operator cost of using them. Animal costs and per diem expenses vary enormously from one medical school to another. Do your homework. Most importantly, make sure you understand the sources of funds for the portion of your own salary that is not grant-supported. Your protected time is always the most expensive part of the physician-scientist start-

up package. If you are given 75% protected time for research, 75% of your salary and fringe benefits must be covered and is generally considered part of your start-up package. This amount (typically as much as $450,000 over 3 years) may or may not be spelled out in the offer letter and may come from a departmental or divisional development fund, from the dean's office, from the academic program support of your Division Director or Chair, or may be embedded in your start-up package. It is obviously important to clarify this. The leadership will find it refreshing that you understand the size of the investment the institution is making in you.

There should be clear expectations of the timeline for acquiring extramural funding. It is likely to take 2 to 3 years to obtain a K award and 4 to 5 more years to secure R01 funding. K awards are excellent mechanisms to ensure mentorship and research protected time (mandatory 75% research effort), but these awards typically do not cover 75% of a neonatologist's salary or all of your research expenses. You will still need those start-up funds to pay for supplies and part of a technician salary. Make sure to discuss the gap between K award funding and the costs of running your laboratory with your K award mentor, your division director, or the research vice chairperson. Be clear about your options if your grant applications are unsuccessful after 3 years; after 5 years. *If you are hired on the physician-scientist (tenure) track, what are the consequences if you do not meet the criteria for promotion on the tenure track? Can you switch tracks and assume more clinical responsibilities or is it an up-or-out policy?*

Office Space/Laboratory Space

Having a dedicated space to conduct your academic work will be critical to your success. For those seeking a basic science position, you will need to understand how laboratory space is distributed at your institution, the possible locations, and options for expansion as your funding and laboratory grow. It might be reasonable, even optimal, to have bench space within the research laboratory of your primary mentor. Expansive laboratory space in a location isolated from research collaborators and mentors or core laboratories may not be in your best interests. On the other hand, private office space, no matter how small, with a computer, a phone, etc, where you can think and write is essential.

Salary, Bonuses, and Benefits

Starting salary is a justifiably important factor in your job search; everyone wants to feel valued, and your salary is one tangible way for your institution or group to express that they value your contributions and work effort. It also serves as a basis for comparison between positions. But it is not the only factor and should be considered in the context of other financial and nonfinancial benefits, your workload, and expectations and equity issues. The following example is illustrative. A neonatology colleague accepted a position that offered a substantially higher salary than another job opportunity only to find out later that she was the lowest paid in the group, and the others had cut deals to be paid extra for night call, whereas her call was built into her base salary. It did not help that she was the only woman in the group. Needless to say, she left a few years later, selling her home at a loss and taking a lower-paid position where finances were more transparent and equitable. She is happy in her new job.

Salary discussions and negotiations are often uncomfortable for some young physicians; this is particularly, but not exclusively true for women, who are much less likely to negotiate for a higher salary than men. If the direct approach is uncomfortable, ask about how salaries are determined (seniority, employee versus founding partner, academic rank, RVUs or billings, clinical service time), the sources of revenue (clinical income, grants and contracts, funds transfers from hospital or medical school, philanthropy), and opportunities for raises and moonlighting to supplement your starting income. *Can you expect an annual cost of living increase, what impact does a promotion or assumption of new administrative responsibilities have on your salary, what happens if you do or do not acquire external research funding during the set expectation period?*

Salaries in private practice vary from state to state, with the size and level of NICU care and size of the group. If your income depends on what you bill and collect, adding a new partner or nurse practitioner who is paid from practice revenues may reduce your call but also impact your take-home pay. Changing market forces, payer mix, and referral patterns may immediately impact your salary in a fee-for-service practice; academic practices and salaried group practices are not immune to these factors, but the direct impact on the employee is likely to be limited to no annual raise or bonus.

Salaries in academic practices are typically benchmarked to a national or regional standard. Although there may be some wiggle room, these benchmarks and the salaries of others in the group at the same academic rank often define the salary range. You can look up the 25th, 50th, and 75th percentile salary benchmarks for academic neonatologists in that region of the country from a number of sources, including Association of Administrators in Academic

Pediatrics – Medical School Pediatric Faculty Compensation and Productivity Survey (www.aaapeds.org), often used by pediatric departments. The American Medical Association Salary Survey Guidebook and the Association of American Medical Colleges Report on Faculty Salaries provide academic physician salary ranges and can be purchased on line for a fee or may be available in your library. The Medical Group Management Association produces a compensation survey of private practice and academic physicians by specialty and by region, also available for purchase. Merritt Hawkins & Associates also publish data on physician compensation models. Use these resources (see Reference section) as a framework for negotiations and to educate yourself on fair and reasonable compensation.

Remember that salary is only part of the financial package that will determine your disposable income. Benefits are a critical part of your overall compensation. Most academic practices offer excellent benefits packages. Benefits are more variable in private practices. Although not an exclusive list, Table 3 includes several benefit categories to consider.

There are also expenses that may be borne by your employer or may be the responsibility of the individual or group practice. Be sure to understand who pays for your malpractice insurance and, in the unfortunate event that you are named in a malpractice claim, who covers the legal fees and looks out for your interests. *Are there parking fees?* This is a common expense at academic medical centers born by the employee. *Is there a billing or overhead tax or do you need to cover the salary of your office manager who performs these business functions for the practice?* These taxes can be as high as 25% to 30% of collections. Understand how this expense is covered and how it may impact your compensation.

Do not forget about personal taxes. As an employee of a group practice or university, state (if applicable) and federal income taxes are typically withheld. As an independent contractor, you will need to make quarterly payments. You may also need to pay a self-employment tax of 15.30% (roughly the equivalent of the combined contributions of the employee and employer under the Federal Insurance Contributions Act tax). This rate includes 12.4% for social security and 2.9% for Medicare. The social security portion of the self-employment tax only applies to the first $110,100 of income (for the 2012 tax year). There is no limit to the amount that is taxable under the 2.9% Medicare portion of the self-employment tax. If you do not have a tax advisor or accountant, now is a good time to get one.

Moonlighting and bonus payouts can have a substantial bearing on your total compensation. Ask about moonlighting and extra-pay opportunities within the practice, such as night or weekend call or coverage at a community hospital NICU. Inquire about a signing bonus. These are more common in some parts of the country than others and may help with a move to a more expensive housing market or cover a loss on your current home sale.

Table 3. Benefits Categories

1. Health insurance, dental, vision, and prescription drugs plans
2. Life insurance, disability insurance
3. Retirement (employer/employee) contributions to a 401K, 403B, IRA match
4. Pretax flexible spending accounts for health care and dependent care
5. Vacation time and sick leave policies
6. Maternity/paternity leave policies
7. Tuition benefits for children, spouse, self; is this a pre- or post-tax benefit?
8. Student loan repayment: Your institution may have an internal program that offers student loan subsidies or may have an excellent track record of sponsoring research faculty for an NIH loan repayment program.
9. Housing or mortgage assistance: forgivable or a low-interest/no-interest loan to help with a down payment on your house
10. Moving expenses (typically up to 1-month salary)
11. CME funds for membership dues, travel, and registration for meetings, computer hardware and software, books and journal subscriptions
12. Library services and access to electronic journals
13. Licensing fees, credentialing fees, and board examination expenses
14. Childcare options and supplements
15. Stock options, buy-in/buy-out plans

IRA=individual retirement account; NIH=National Institutes of Health; CME=continuing medical education.

Find out about bonuses, incentive plans, and profit-sharing plans. Ask about stock options, if relevant. If there are annual bonuses based on clinical or academic productivity, ask how the amount is calculated, if overall department or institutional margin can wipe out a profitable year for neonatology, and what the typical bonus pay has been in past years for physicians with a similar effort distribution and job description as yours. If you have a start-up package and receive institutional development funds, you may or may not be eligible for incentive pay.

Licensing and Credentialing

An additional factor to consider as you transition into your first job is that the credentialing and medical licensure process can be unpredictable and prolonged. Even if you and your department are completely on top of your paperwork, unexpected delays may arise. You should inquire what would happen if you are not credentialed for clinical work by your start date, specifically if you will be paid.

Summary

This article provides an overview of what you should consider when negotiating your first job contract. Your choice of practice venue will depend on your priorities and on your personal and professional goals. Make sure to seek advice from colleagues, faculty, and mentors: most will be eager to provide advice and help you avoid the mistakes they may have made and facilitate your successful transition from trainee to professional colleague.

Suggested Reading

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Salary Information

Trainees and Early Career Neonatologist (TECaN) website, "Navigating the Salary and Benefits Waters" (http://www2.aap.org/sections/perinatal/tecan/Tsalary.html)

Merritt Hawkins & Associates produces a publication offering an overview of common physician compensation models.

The Association of American Medical Colleges produces a report on academic physician salaries and ranges and breaks that information down into categories such as teaching, research, and patient care. Some program directors or department chairs may allow you access to their copy, or it can be purchased online.

Educational Perspectives: Neonatology Job Search: Looking Beyond the Dollar Signs

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