2025 SURVEY SUBJECT:

Call and Compensation

THE 2025 OTOLARYNGOLOGY WORKFORCE

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY®

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American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS)

American Academy of Otolaryngology–Head and Neck Surgery,
The 2025 Otolaryngology Workforce

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY®

THANK YOU

This work is dedicated to all readers whose lives this may shape so we may better serve our patients. A special thanks to those members who completed these surveys. Without you, none of this would be possible.

American Academy of Otolaryngology–Head and Neck Surgery

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HOW TO CITE FIGURES AND TABLES

When citing figures from this document, please use the following format:

Figures: Figure [number], [Title], from *The 2025 Otolaryngology Workforce*, published by the American Academy of Otolaryngology–Head and Neck Surgery, 2025.

Tables: Table [number], [Title], from *The 2025 Otolaryngology Workforce*, published by the American Academy of Otolaryngology–Head and Neck Surgery, 2025.

Example:

Figure 1.5, "Response Time or Living Distance Mandate," from *The 2025 Otolaryngology Workforce*, published by the American Academy of Otolaryngology–Head and Neck Surgery, 2025.

LIST OF FIGURES

BACKGROUND

As our Academy members are likely aware, our Workforce and Socioeconomic Task Force was given new life in 2021 under the leadership of Drs. Denneny and Yanagisawa. Since then, and with your help, we have been able to shed light on important elements of our workforce, ranging from practice benchmarking to changing workforce patterns, and describing how these might affect patient care. Thank you again to all who have taken the time to participate in these surveys. A lot of work goes into this production, and our CEO, Academy staff, and workforce task force members deserve our thanks.

Scholars in our field continue to add to the body of literature on our workforce, giving a more nuanced understanding to workforce patterns and patient access. We thank them for their efforts as well. Our subspecialties have also taken interest in their workforces, and we look forward to ongoing partnerships with them since our Academy has the mission to bring all subspecialties together as otolaryngologists. Moreover, the infrastructure and institutional knowledge we've gained over these last four years will aid us all as we explore access gaps to optimize patient access.

Why does our workforce matter? Optimizing our workforce means being accessible to patients with the skillsets they require. Understanding these factors on a macro level and filling any gaps are the first steps towards optimal patient care. Importantly, this process also focuses on practice-related issues, so we can have fulfilling careers. Patient care is further improved as a derivative of this focus.

After publishing the *2022* and *2023 Otolaryngology Workforce* reports, we needed time to reflect on what we had learned, engage stakeholders, and plan a cadence for these reports moving forward. To those ends, our sights are on a larger report next year, but, given the dynamic nature of the job market and three-year-old compensation data, we wanted to publish a shorter report this year strictly on compensation. We were lucky to be joined by our colleagues in the Board of Governors who had executed a call survey earlier this year, which provides a more nuanced understanding to this important topic. Your participation in these surveys was the best we've had and allowed us to describe call and compensation in ways/environments we couldn't before.

We hope you find the information gathered here useful. As always, feel free to reach out any time to me or other task force members for your questions and thoughts.

Sincerely,

Andrew J. Tompkins, MD, MBA
Chair, Workforce and Socioeconomic Task Force

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METHODOLOGY

BOG Call Survey

The Board of Governors (BOG) Call Survey was drafted by BOG leadership and distributed to U.S.-based, actively practicing Academy members through a Survey Monkey survey platform. The survey ran from February 12, 2025 through April 15, 2025. Email reminders were sent for survey completion.

The CSV file was downloaded to a secure network in May 2025 for the data analysis. The survey had 739 responses. No duplicate entries were identified, and all identifiable information was deleted and the file saved on a secure server. The original CSV was then deleted.

The only data modification was performed in the practice setting column. Here, the "Hospital employee" and "Nonacademic hospital" categories were combined into one category of "Nonacademic hospital," since the "Academic medical center" category was available to those fitting that practice setting. 26 "Other" practice settings were reclassified, either into their own category ("Hybrid" being one example) or into established categories, where obvious and appropriate.

Not every respondent responded to every question. When analyzing each question or combination of questions, blank/no responses were excluded. This allowed us to capture data from partially completed surveys for any question that was answered. Where relevant, we attempted to be transparent about the number of responses for the question analyzed.

Compensation Survey

The compensation survey questions were created by the AAO-HNS Workforce and Socioeconomic Task Force and distributed to both Academy members as well as past members through a Survey Monkey platform. The survey ran from July 2, 2025 through August 13, 2025. Reminder emails were sent weekly to those having not completed the survey.

The CSV file was downloaded to a secure network in August 2025 for the data analysis. No duplicates were identified on name or email verification, after which all identifiable data were deleted. The original CSV was deleted. One response provided no data and was deleted from the analysis. Where possible and obvious based on the description, "Other" categories in the career status column were placed into other career status categories, though, because of the survey logic, they did not answer any questions beyond intake demographic data. This process revealed the following counts:

- **2** *International Member*
- **2** *Resident-in-Training*
- **3** *In Industry*
- **5** *Administrative Only*
- **8** *Fellow-in-Training*
- **14** *Other*
- **73** *Retired*
- **1,583** *Physician in Active Practice (Full or Part-Time) in the U.S./Territories/Military Overseas*

Notably, our actively practicing physician responses were 30% higher compared to the 2023 Otolaryngology Workforce.

After a group discussion and review, 39 "Other" practice environments were reclassified, and new categories

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of Locums and Academic/Private Split created. Not every respondent responded to every question. When analyzing each question or combination of questions, blank/no responses were excluded. This allowed us to capture data from partially completed surveys for any question that was answered. Where relevant, we attempted to be transparent about the number of responses for the question analyzed.

Where free text responses were provided for compensation specifics, best attempts were made to create a table for each practice setting. Data that were collected included hospitals covered, payment amounts converted to daily payment rates (averaged if different amounts for different hospitals), and other payment caveats such as whether payment was for just otolaryngology call, facial trauma, or both.

Where income amounts were described, if median or 25th/75th percentiles did not fall cleanly on an income boundary of the ranges provided, the midpoint of the range was used in which that data point fell and rounded to the nearest thousand dollars. For example, if the median fell within the $25,001-$50,000 range, the median selected was $38,000.

GLOSSARY OF TERMS

Advanced Practice Provider(s)	APP(s)
American Academy of Otolaryngology–Head and Neck Surgery	AAO-HNS
AAO-HNS Board of Governors	BOG
Multispecialty Group	MSG
Single-Specialty Group	SSG
Veterans' Affairs	VA

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CALL

Taking call is a necessary element of patient care. However, call represents a unique challenge to the provider, as it can disrupt normal clinical duties, take added time away from family, and lead to more general exhaustion and burnout. We hope the BOG Call Survey and Compensation Survey benchmarking will help otolaryngologists navigate these waters and achieve an ideal balance between these factors.

The respondent breakdown for the BOG Call Survey may have over-sampling of nonacademic hospital environments and under-sampling of solo practitioners when compared to the current compensation survey as well as the last two workforce reports (Figure 1.1). The over-sampling may also be due to combining practice environments "Hospital employed" and "Nonacademic hospital" for the analysis. We show a similar trend of academic employment with younger age cohorts (Figure 1.2) compared to prior workforce surveys.

Hospital on-call coverage is provided by most otolaryngologists, with near universal call coverage in institutional environments and a slight decline in private practice environments (Figure 1.3). These differences are likely explained by mandated hospital coverage for most of the respondents, but less frequently in private environments (Figure 1.4).

Over 90% of respondents had some form of response time or living distance requirement for being on call (Figure 1.5). One quarter of respondents must respond to calls and perform an in-person evaluation within a certain time, and one third of those surveyed must comply with callback response times, living distance mandates, and in-person evaluation times (Figure 1.6). Regarding driving times, approximately 50% of participants reported that their longest reported driving distance for a hospital they take call for was 16-30 minutes, while approximately 10% must drive 46-60 minutes (Figure 1.9).

Most survey participants in private practice provide on-call coverage 4-8 days per month, with a median of 5 days per month (Table 1.1). Physicians in academics reported slightly fewer on-call days each month. The number of days on-call for those in private practice did not vary significantly based on age. In contrast, older practitioners at academic centers reported fewer on-call days. 43% of all respondents reported taking call one week at a time, whereas 36% are on-call one day at a time. Providing on-call coverage one day at a time was more common in private practice (41%), while week-long call blocks were reported by 54% of those working in academic settings (Table 1.1, Table 1.2, and Table 1.3).

More than 40% of practitioners provide on-call coverage for only one hospital. However, nonacademic hospital physicians had a larger tendency to only cover one hospital while on call (Figure 1.7). Interestingly, a larger number of hospitals covered did not always correspond to an increased likelihood of being paid for call. We see a trend towards a higher likelihood of pay with more hospitals covered in academic and private settings, but the opposite appeared to be the case in nonacademic hospital environments, where more hospitals covered translated to lower likelihood of call payment (Figure 1.8).

While maxillofacial trauma and pediatric airway emergency coverage was roughly twice as common in academic settings (Figure 1.10 and Figure 1.11), a substantial percentage of private and nonacademic hospital otolaryngologists serve in these capacities as well. The shifting of practice environments over time has the capacity to affect willingness or capability to provide this type of care in all communities and is worth tracking into the future.

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Along similar lines of available coverage, we see over 80% of responding otolaryngologists across practice settings receive transfers from hospitals that do not have otolaryngology on-call coverage (Figure 1.12). While this would seem to imply a lack of necessary care in many communities, a more thorough analysis is required to understand access gaps – especially given the nature of our field as subspecialists.

Most respondents from academic medical centers have resident on-call coverage, whereas nearly 90% of respondents in private practice or nonacademic settings do not (Figure 1.13). In addition, over 75% of all respondents do not have any APP on-call coverage, regardless of practice setting (Figure 1.14). Conversely, the roughly 20% who do have APP call help in some capacity may speak to an expanding APP role in otolaryngologic care and lessening of call burden. This too should be tracked over time to monitor trends.

Most otolaryngologists in all practice settings do not believe their professional responsibility is to provide on-call coverage if they are not reimbursed. These sentiments were stronger in private practice than in institutional settings and did not differ greatly with age (Figure 1.15 and Figure 1.16). Greater than 85% of practitioners employed in a private single- or multispecialty group practice have this opinion, whereas 65% and 70% believe this in academic and nonacademic hospital settings, respectively.

Half of otolaryngologists that responded to the BOG Call Survey stated that they were paid for call, which is slightly higher than the 44% across all practice settings in the Compensation Survey (Figure 1.17). Call compensation appears to be much more common in private practice settings, something consistently shown in prior workforce reports and in the current Compensation Survey. Most private practice otolaryngologists receive compensation for call, whereas 62% and 74% of otolaryngologists in nonacademic and academic settings do not.

Unsurprisingly, receiving compensation seems to be driven by multiple factors, as noted in Table 1.5, Table 1.6, and Table 1.7. Each setting will be unique in this regard and present different opportunities for fair treatment and compensation. When receiving compensation for call, most otolaryngologists receive compensation by a flat daily rate, or a flat daily rate plus collections from direct patient billing (Table 1.8).

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BOG CALL SURVEY DEMOGRAPHICS

FIGURE 1.1:

Practice Setting of BOG Call Survey Respondents

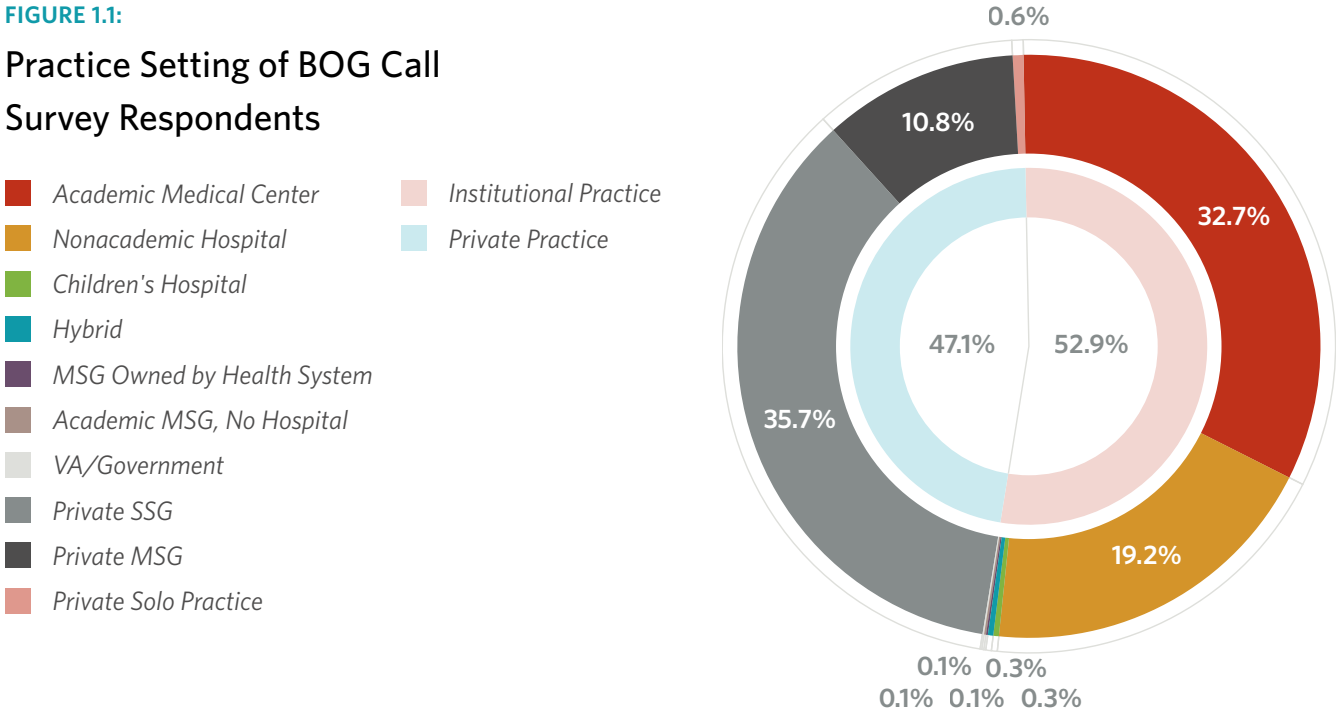
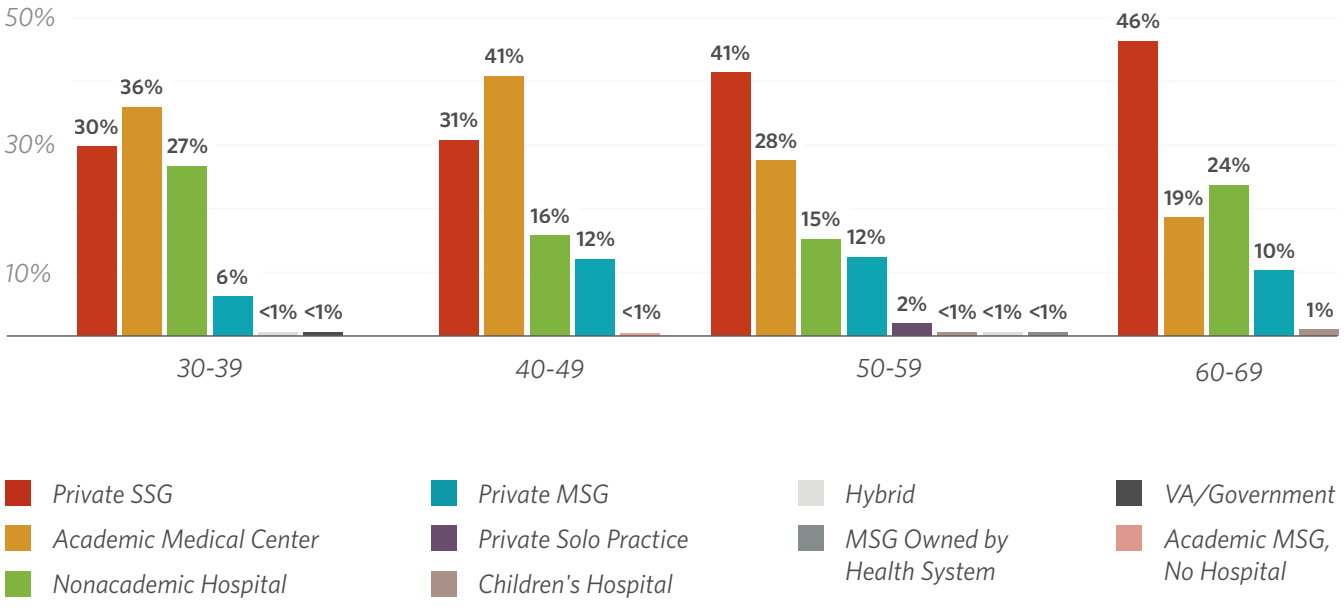


FIGURE 1.2:

Practice Setting by Age (Decade)



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CALL COVERAGE

FIGURE 1.3:

Hospital Call Coverage by Individual or Group by Common Practice Settings

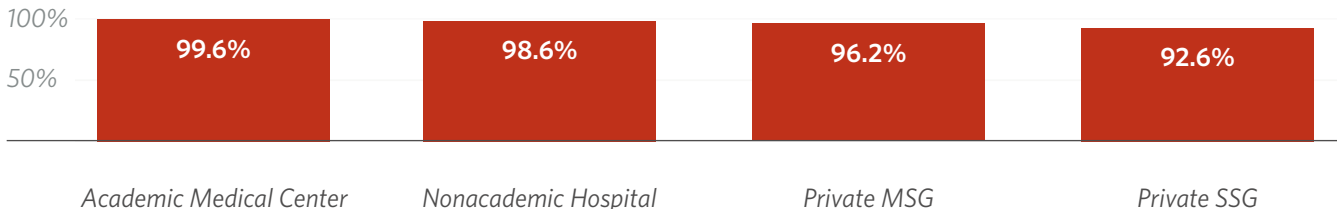

FIGURE 1.4:

Mandated Call Coverage by Common Practice Settings

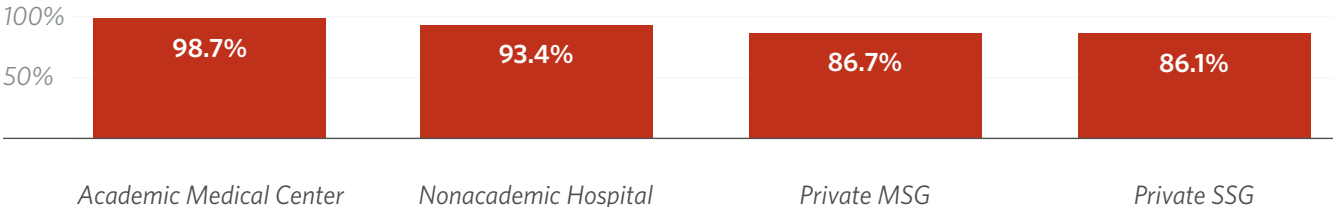

FIGURE 1.5:

Response Time or Living Distance Mandate

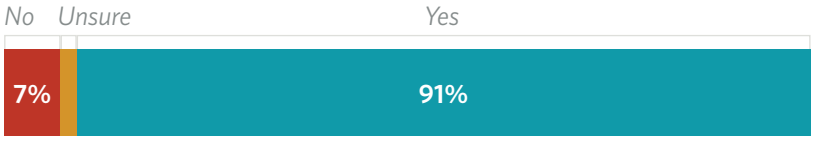

FIGURE 1.6:

Time and Distance Mandates for Call, When Present

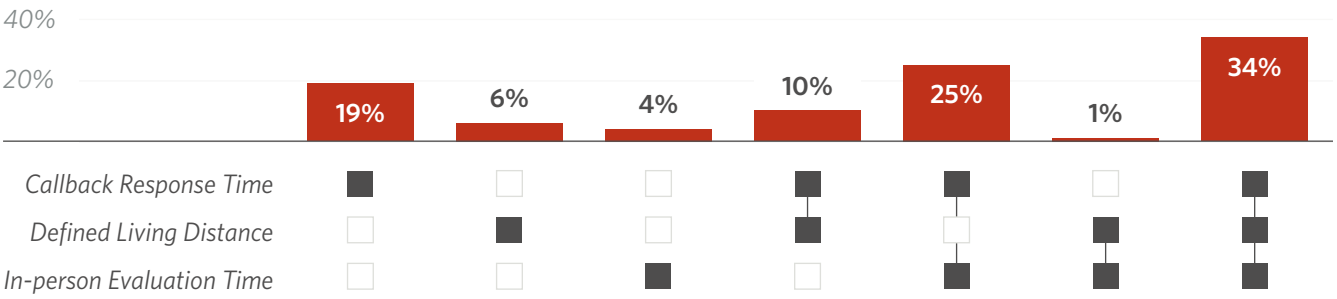

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TABLE 1.1:

Coverage Days per Month by Individual and Age (Decade)

Decade		*All Practice Locations*	*Academic & Children's Hospital*	*Private Practice*
30-39 *(Count: 158)*	*25th %*	*4*	*3*	*4*
	Median	*5*	*4*	*5*
	75th %	*7*	*6*	*7*
40-49 *(Count: 240)*	*25th %*	*3*	*3*	*4*
	Median	*5*	*3*	*5*
	75th %	*7*	*6*	*7*
50-59 *(Count: 202)*	*25th %*	*3*	*2*	*4*
	Median	*5*	*4*	*5*
	75th %	*7*	*5*	*7*
60-69 *(Count: 91)*	*25th %*	*4*	*2*	*4*
	Median	*6*	*3*	*6*
	75th %	*8*	*6*	*8*

Counts listed are for all practice locations

TABLE 1.2:

Call Blocks Used in Private Practice

Call Blocks	*Percent*
One day at a time	**40.9%**
One week at a time	**34.5%**
One weekday at a time, one weekend at a time	**13.1%**
Variable	**3.2%**
2 to 6 day blocks	**2.6%**
Mon-Thurs and Fri-Sun blocks	**2.2%**
Other	**3.4%**

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TABLE 1.3:

Call Blocks Used in Academics

Call Blocks	Percent
One week at a time	53.9%
One day at a time	31.0%
One weekday at a time, one weekend at a time	6.9%
2 to 6 day blocks	2.6%
Variable	1.7%
Mon-Thurs and Fri-Sun blocks	0.9%
Other	3.0%

FIGURE 1.7:

Number of Hospitals Covered Simultaneously for In-Person Call by Common Practice Types

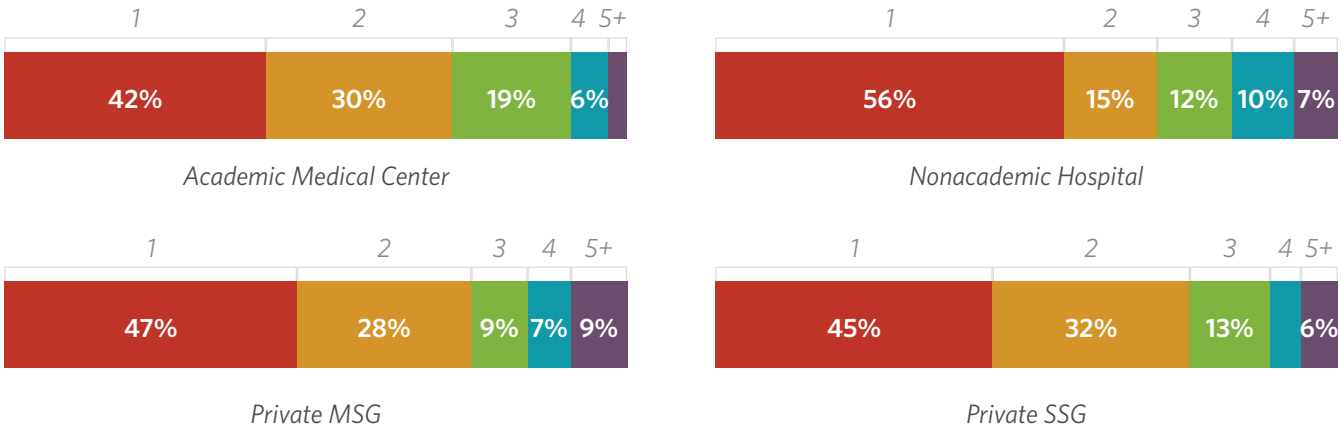

FIGURE 1.8:

Hospitals Covered for In-Person Call by Whether Paid for Call and Practice Setting

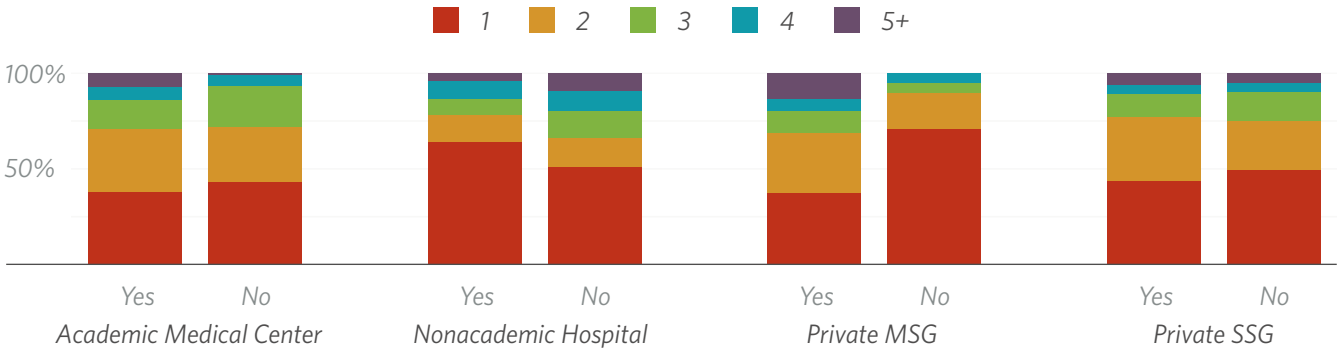

FIGURE 1.9:

Longest One-Way Driving Distance to Covered Hospital

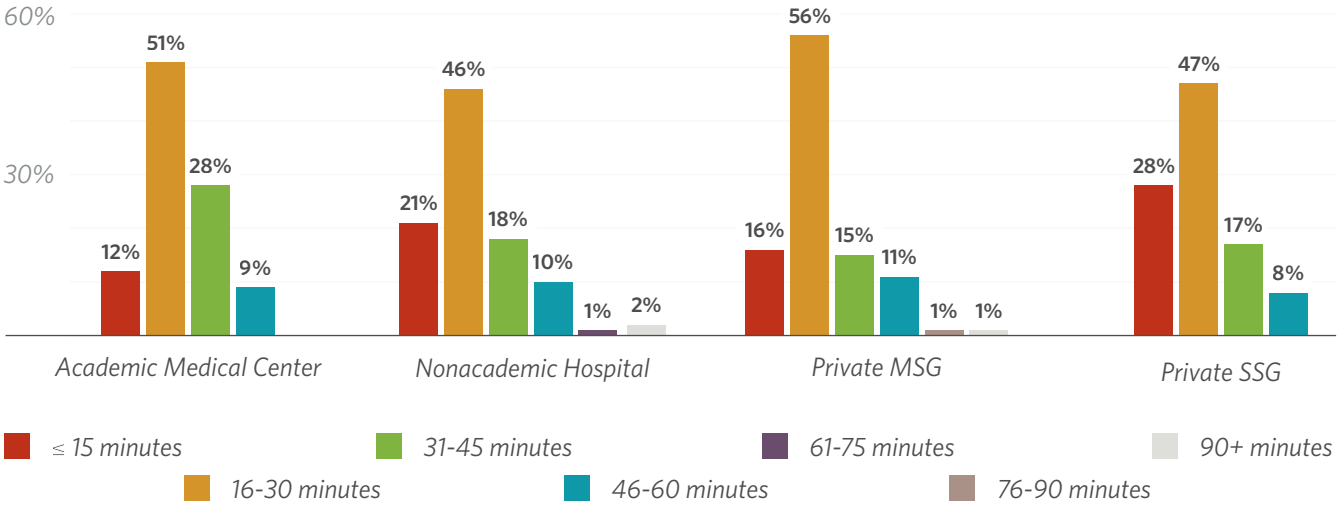

FIGURE 1.10:

Maxillofacial Trauma Coverage by Common Practice Types

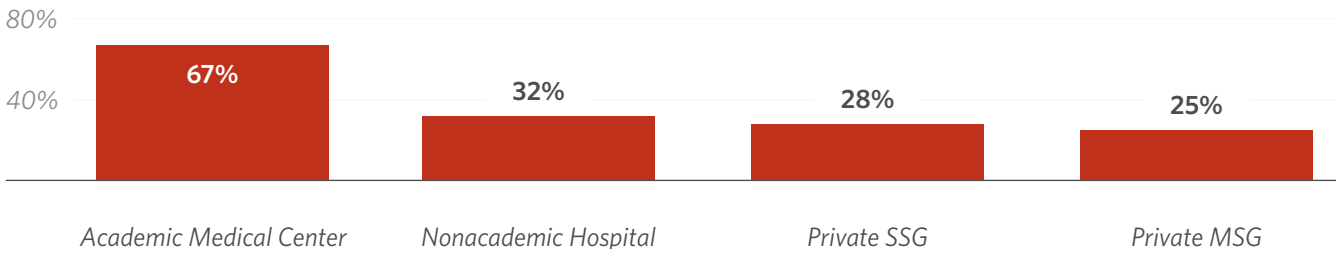

FIGURE 1.11:

Pediatric Airway Emergency Coverage by Common Practice Types

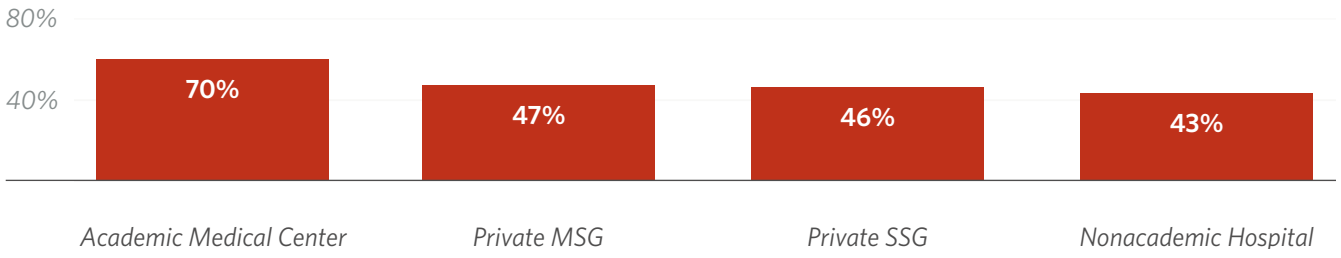

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FIGURE 1.12:

Hospitals Without ENT Coverage Resulting in Transfers by Common Practice Types

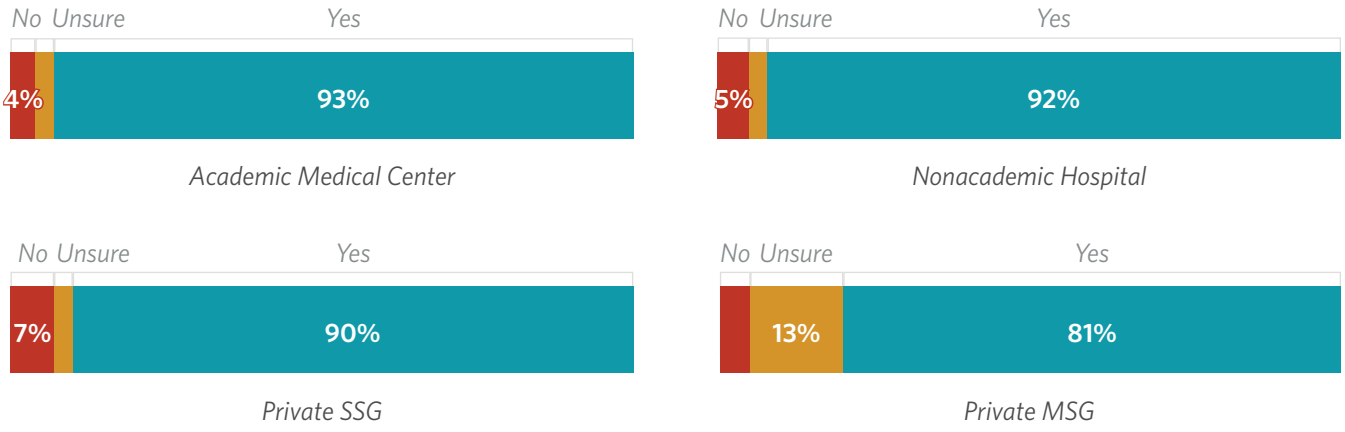


TABLE 1.4:

Reasons Not Taking Call

No Call Reason	Count	Percent
Not mandated	15	60%
Senior physician	5	20%
Don't have the expertise required	3	12%
Another group hired/got contract	3	12%
Refusal to pay	3	12%
Other	2	8%

Sum of percentages > 100 because of multiple responses

CALL ASSISTANCE

FIGURE 1.13:

Resident Call Coverage by Common Practice Types

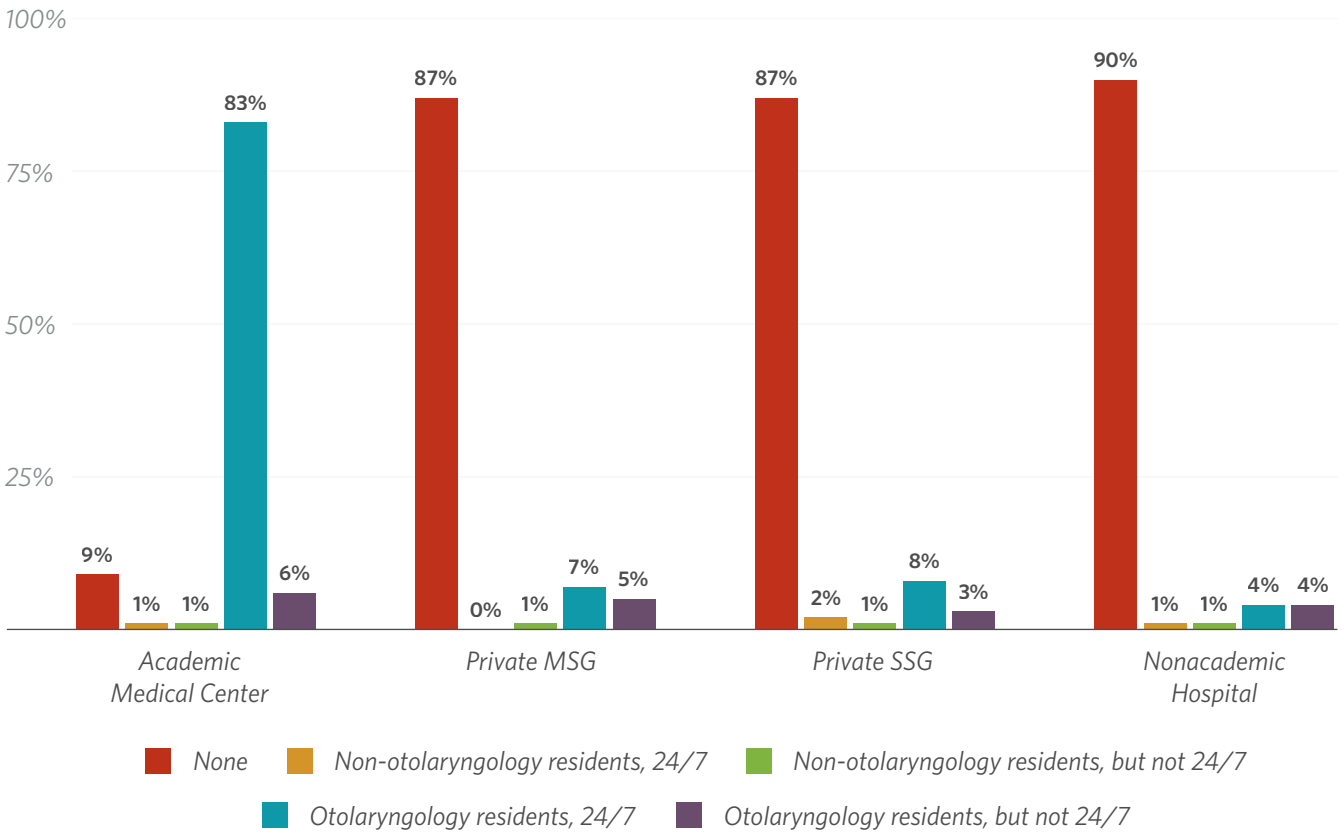
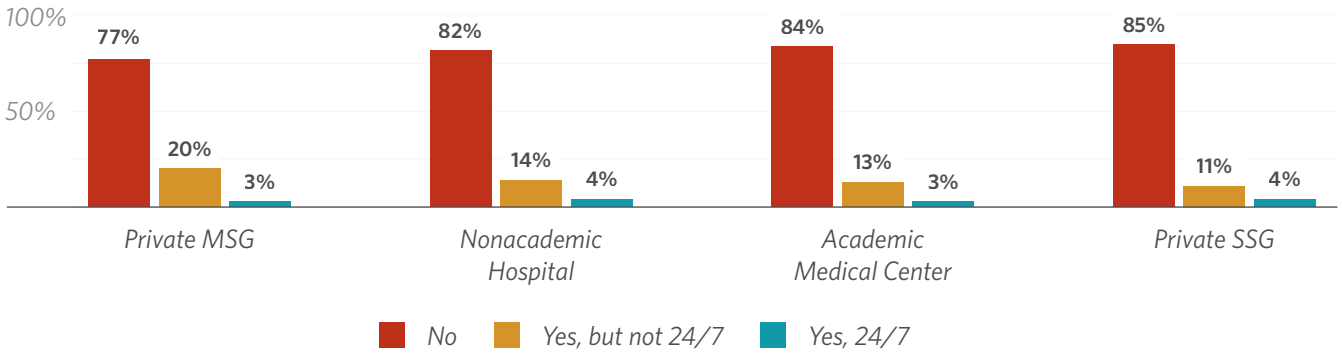


FIGURE 1.14:

APP Call Coverage by Common Practice Types



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CALL REIMBURSEMENT

FIGURE 1.15:

Professional Responsibility to Provide On-Call Coverage Without Reimbursement at Hospital(s) Where I am a Member of the Medical Staff by Common Practice Types

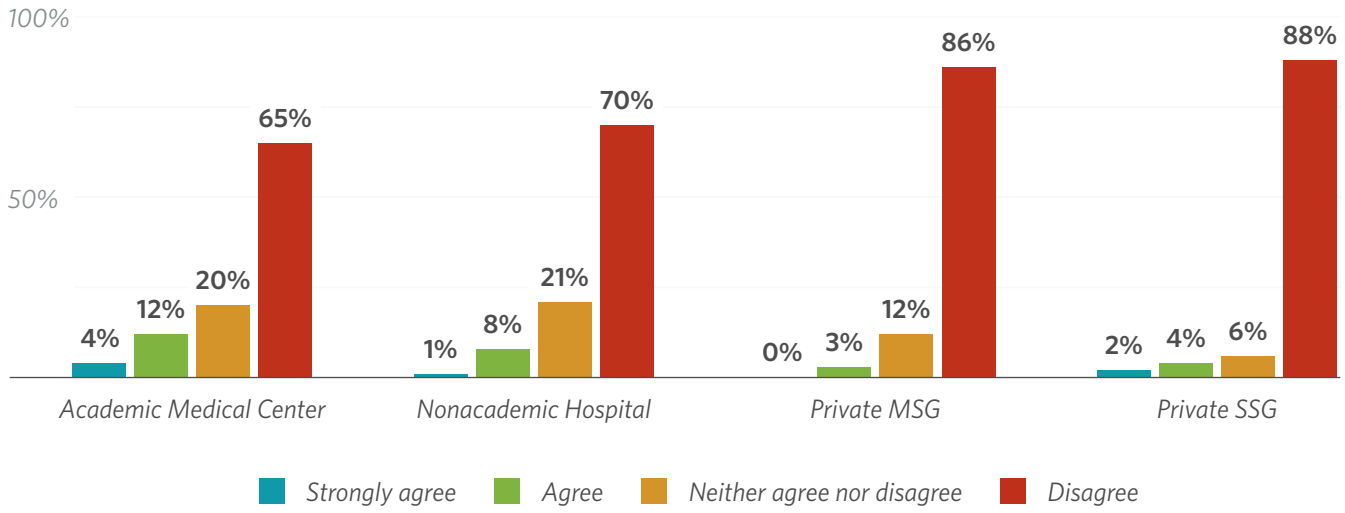

FIGURE 1.16:

Professional Responsibility to Provide On-Call Coverage Without Reimbursement at Hospital(s) Where I am a Member of the Medical Staff by Age (Decade)

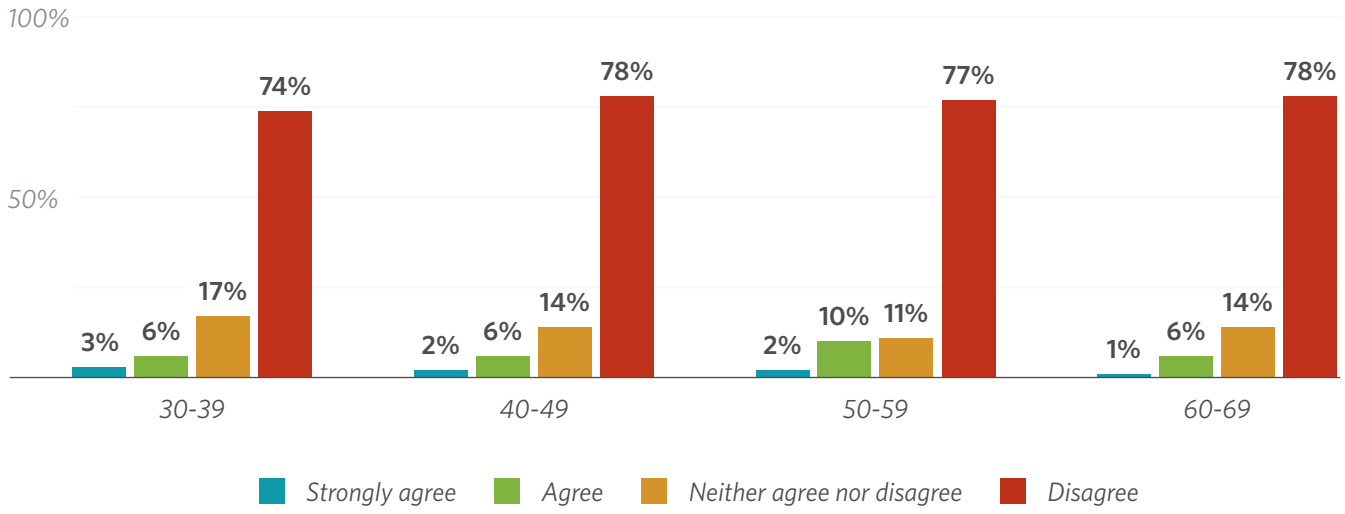

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FIGURE 1.17:

Call Reimbursement by Common Practice Types

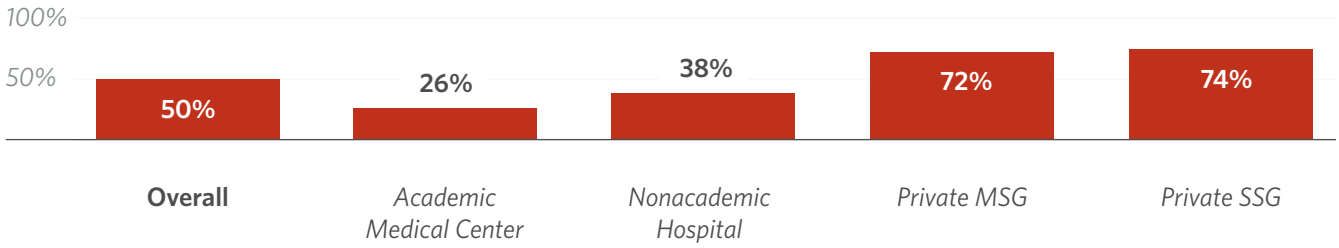

TABLE 1.5:

Reasons for Reimbursement

Reimbursement Reason	Count	Percent
Negotiated reimbursement between group and hospital	268	75%
Everyone on staff is reimbursed	63	18%
Hospital employee with negotiated contract	52	15%
Other	20	6%

Sum of percentages > 100 because of multiple responses

Total Responses: 355

TABLE 1.6:

Leverage Factors for Obtaining Call Pay

Leverage Factor for Call Pay	Count	Percent
Only ENT provider(s) available/willing to provide on-call coverage	252	74%
ENT coverage required for trauma level designation	164	48%
Unique skills/services offered by your practice	101	30%
Downstream revenue generated by my clinical activities	81	24%
Other	36	11%

Sum of percentages > 100 because of multiple responses

Total Responses: 339

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TABLE 1.7:

Reasons for No Reimbursement

Non-reimbursement Reason	Count	Percent
Requirement to be on Staff	183	52%
Work in Academic Medical Center	175	50%
Don't have leverage	175	50%
Never requested	41	12%
Refusal to pay	12	3%
Other	11	3%
Part of employement contract	7	2%

Sum of percentages > 100 because of multiple responses

Total Responses: 350

TABLE 1.8:

How Call is Compensated

How are you reimbursed for on-call services?	Percent
Flat rate for each day of call	44.9%
Flat rate and direct patient billing	43.7%
Hourly rate	2.9%
By wRVUs	0.9%
Hourly rate and direct patient billing	0.6%
Flat rate per week	0.6%
Flat rate for each day of call (if activated to come in)	0.6%
Other	6.0%

COMPENSATION

Demographics

Compared to prior workforce surveys, we showed a modest decline in the average age of practicing otolaryngologists (Table 2.1). This might be a reflection of workforce trends or the 30% higher sampling in this iteration. The breakdown of otolaryngologists by sex seems stable overall, but women constitute over a third of the workforce in the youngest cohort (Figure 2.1).

We saw similar practice pattern changes over time as the BOG Call Survey revealed, when compared to the 2023 Otolaryngology Workforce. We saw continued declines in solo practice, general increases in academic medical center employment, declines in private SSG representation, and a rise in nonacademic hospital employment (Figure 2.2). The most notable recent changes across both current surveys were the slight declines in academic medical center employment and rise in nonacademic hospital employment in the 30-39 age cohort (Figure 2.3). Nonacademic hospital environments seem to be in the most need, based on prior surveys and sites of locum tenens work. They also have the highest average clinical compensation. Whether these needs and pay are driving these shifts are worthy of future inquiry.

This survey was also the first that showed greater than 50% of otolaryngologists in institutional settings, though we should note that the survey sample is more representative of Academy members, which may differ from the total population of otolaryngologists. Fellowship training among practicing otolaryngologists is still just above 50% (Table 2.3), and is expectedly higher in academic settings (Figure 2.4). Nonacademic hospital employment is now the third most common practice environment, and future areas of interest might include the effect this (and fellowship training) is having on tertiary referrals, new training centers, and patient access.

2024 Clinical and Ancillary Compensation

We were able to show some clinical income differences across economic regions, though this analysis did not control for other relevant factors such as practice environment, age, productivity, or cost of living (Figure 2.6). Insurance mix and how concentrated insurance markets are in these regions can also dictate income and are worthy of future inquiry.

Nonacademic hospital practice environments again showed a higher median clinical income and higher base than other practice environments. Notably, otolaryngologists in all practice settings have seen substantial median increases in clinical income from 2021 (2022 Otolaryngology Workforce) to 2024 (current survey). All settings saw steady median clinical income growth between 2021 and 2024, except for private SSG practices, which showed stable median clinical income between 2022 and 2024.

Due to the concentration of fellowship-trained physicians and responses, we could only compare clinical income by fellowship in academic environments. There appear to be significant differences, with rhinology at the high end and laryngology at the lower end (Figure 2.8). Interestingly, this did not correlate with patients seen per day (2023 Otolaryngology Workforce) or mean clinical hours worked per week (2022 Otolaryngology Workforce) by fellowship in academic settings. Clinical income may therefore be more heavily driven by procedures per patient, relative work RVUs, and, to some degree, payer mix.

Similarly to 2023 Otolaryngology Workforce, we see the peak earning decade in the 50s and lowest earning

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decade in one's 30s (Figure 2.9). Again, we saw median clinical income increases reported across all decades compared to 2022 clinical income (2023 Otolaryngology Workforce). While we again showed clinical income differences by sex, two notable findings emerged. Firstly, the peak median income decade was in one's 40s for women (Figure 2.10). Secondly, while male and female clinical income rose across all age groups in academic practices, it rose more in the male cohorts between 2021 and 2024 (Figure 2.11). This topic remains of interest, and underlying drivers of these disparities might be elucidated through more multifactorial analyses and case studies.

A separate analysis was performed on the top clinical income quartile, earning more than $650,000 in 2024. While this was not the multifactorial analysis done in 2022 Otolaryngology Workforce, we highlighted some potential drivers of higher clinical income (Table 2.5). Unsurprisingly, the 50s age bracket had a greater preponderance of high income earners. The 2022 Otolaryngology Workforce showed that this decade is where peak productivity was reached in terms of patients seen per day, which may explain the higher income. Practice settings that showed a tendency towards higher income were private SSGs and nonacademic hospitals, whereas there was a tendency away from higher income in academic settings. Again, males stood out as having a higher tendency towards high income. Fellowship training generally did not appear to make a significant difference. The stand-out economic region that seemed to have a high income tendency was the Mideast.

Regarding clinical income stability, something that we have consistently shown is less downside risk of income variation in academic and nonacademic hospital settings (Figure 2.12). Further inquiry into why downside risk differs across practice settings seems warranted. Consistent with prior reports, we again showed a higher incidence of ancillary income collection in private practice settings (Table 2.6). Still, about one fifth to one quarter of otolaryngologists in institutional settings collected ancillary income in 2024. Ancillary income amounts were also higher in private practice settings (Figure 2.13), which likely reflects the options available to those practices. Interestingly, we saw lower risk of ancillary income declines year over year compared to clinical income (Figure 2.14).

2024 Call Compensation

Consistent with the BOG Call Survey, we showed that otolaryngologists who are in institutional settings are slightly more likely to take call (Figure 2.15). These percentages differ somewhat from our last two surveys, most notably with academic otolaryngologists reporting a higher likelihood of call in the current survey. Private practice physicians appear to have more flexibility with respect to only being on call for their practice, with solo practitioners showing the most discernment for what entity call is provided for and the lowest likelihood of taking call (Table 2.7).

Despite the above facts about solo practitioners, when they took call, they took some of the highest amounts of call days per month (Table 2.8). Nonacademic hospital physicians were closely behind them, followed by other private practice physicians, and academic physicians taking the least number of call days per month. This finding was also consistent with the BOG survey. Among the largest practice settings, the median rate of needing to physically go in to the hospital while taking call was lowest among solo practitioners, which was consistent with the 2022 Otolaryngology Workforce (Table 2.10). While not shown graphically, 4-9% of physicians in the major practice environments go in nearly every time they are on call. Interestingly, over half of those physicians were not compensated for call. The overall percentage of otolaryngologists being compensated for call was 44%, and compared to the rates described in the 2023 Otolaryngology Workforce it appears physicians across different

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practice environments are being paid for call at higher rates (Figure 2.16). We showed slightly lower rates for being paid for call in private settings and higher rates in institutional settings compared to the BOG survey, though in both surveys private practice physicians were more likely to be paid for taking call. As noted in the BOG survey, some of these covered facilities are potentially very far away (Figure 1.9). What the above few paragraphs speak to is a significant, uncompensated call burden for many otolaryngologists.

Some practice environments seemed to have a better correlation with being paid for call the more one had to physically go in while on call, which was strongest in solo practice (Table 2.11). Academics and private MSG environments seemed to have little correlation between these two factors.

When paid for call, most otolaryngologists were paid a flat rate on the basis of time, though more diverse payment methods were available to institutionally-based otolaryngologists (Table 2.12). This was the first survey where we started to dig into the reality of call compensation. It appears that when otolaryngologists are paid for call the ranges were fairly similar, with the exception of academic settings which had lower compensation (Figure 2.17).

We did our best with the open-ended responses to ascertain what the daily payment rates were. Your comments were extremely helpful and will help us to craft better questions in the future. After reading through the hundreds of responses it became clear that in order to describe daily call reimbursement accurately on a per facility-day basis we need to be more clear in our question about what direct coverage means (some took this as taking phone calls only), what kind of call one is paid for (ENT versus facial trauma), and other modifying factors, such as payments only after certain call thresholds are met. Due to these discoveries, we decided to describe daily call payment in the most broad way possible in this iteration, creating average daily rates without any control for facilities covered, modifying factors, or type of call taken. However, we tried to color these statistics by providing context below each practice environment. When call compensation was received, daily call compensation rates seemed to be higher in private practice environments (Figure 2.18). Your responses have helped us to craft better questions in the future to get more specificity on this topic.

Locums Compensation

Our rationale for including specific locum tenens compensation information in Table 2.13 is due to the critical dearth of data in this area and how this lack of information impacts our members. While our sample size was limited, responses tended to coalesce around similar numbers. A few items are worth keeping in mind regarding understanding the "market rate." First, locums companies charge the covered entity more than what the physician is paid. Second, work performed by the locums physician is revenue-generating for the covered entity. Therefore, daily locums rates may best describe the market rate for call coverage in situations where the above two factors are perfectly offsetting. With these facts in mind, the daily payment rates prior to any hourly consideration (Table 2.13) are markedly higher than the daily call compensation rates described in Figure 2.18. With or without consideration for hourly compensation beyond the daily rate, the extrapolated annual pay is also markedly higher than median clinical income in any practice setting. One would expect higher annualized pay given the inherent demand for services for those entities seeking locums work and the limited number of physicians willing to perform this work.

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DEMOGRAPHICS

TABLE 2.1:

Average Age (Mean and Median) of Practicing Otolaryngologists

Mean	Median
49.5	48

TABLE 2.2:

Sex of Practicing Otolaryngologists

Sex	Percentage
Male	74.9%
Female	24.8%
Other	0.3%
Total	100%

FIGURE 2.1:

Practicing Otolaryngologists by Sex and Age (Decade)

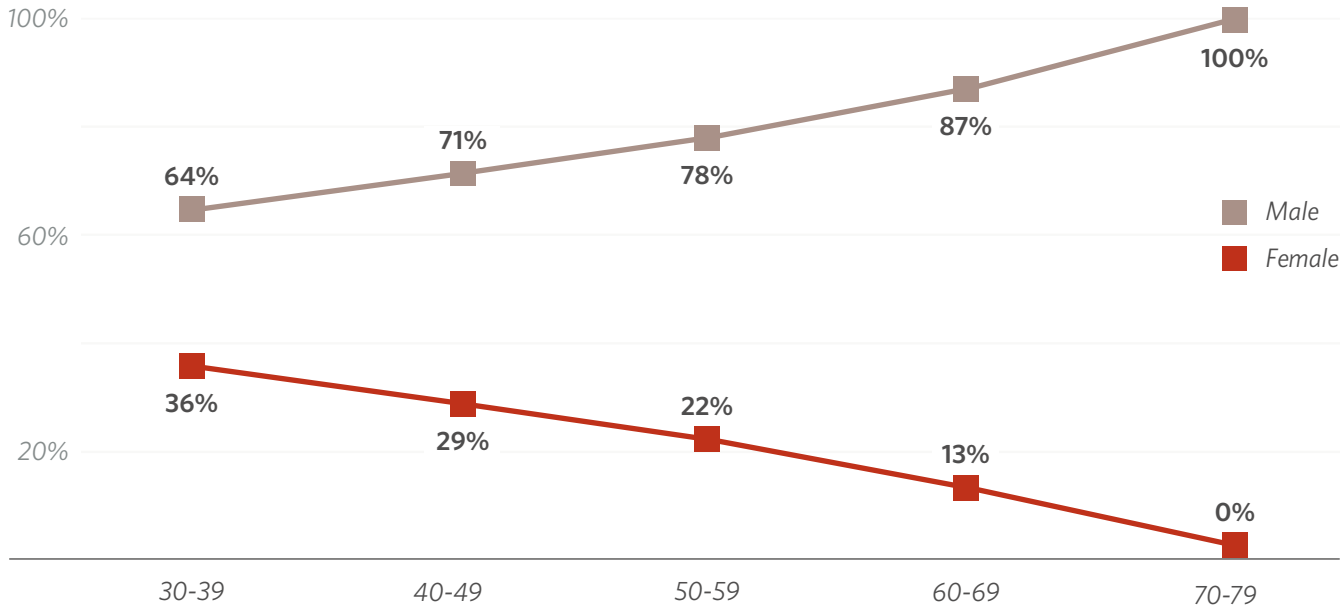

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FIGURE 2.2:

Practice Settings of Practicing Otolaryngologists

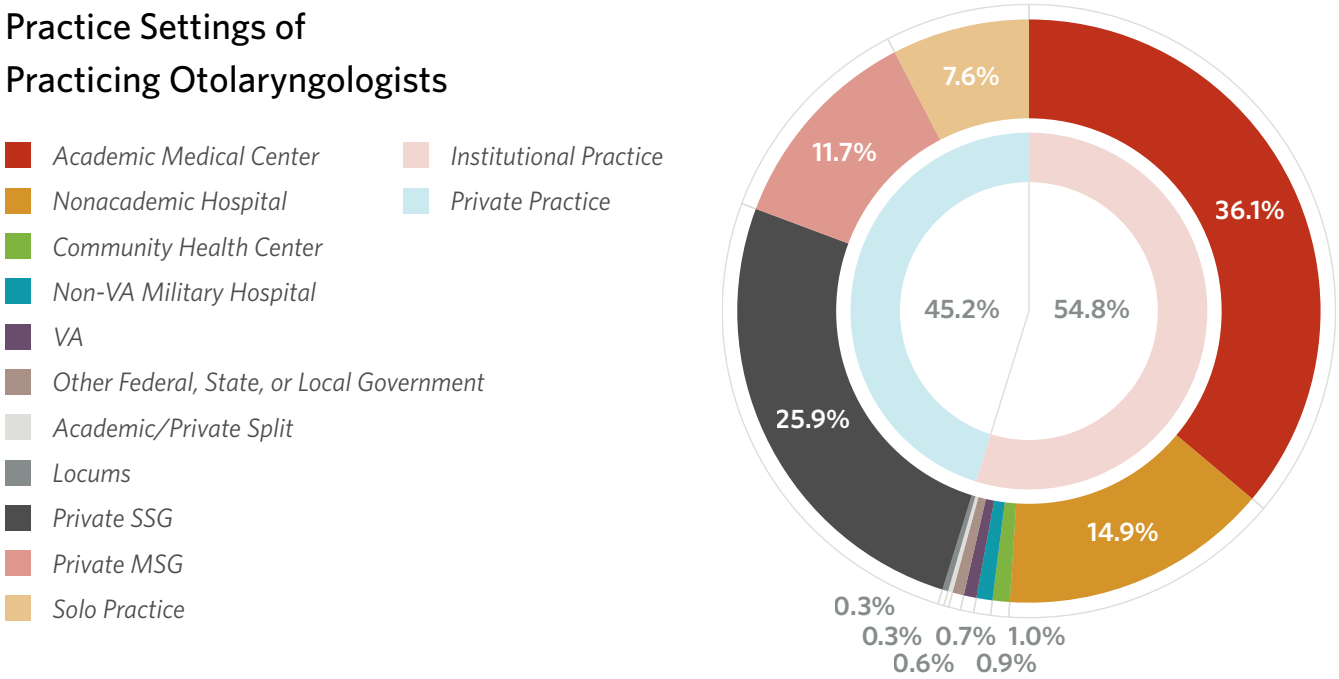

FIGURE 2.3:

Practice Setting by Age (Decade)

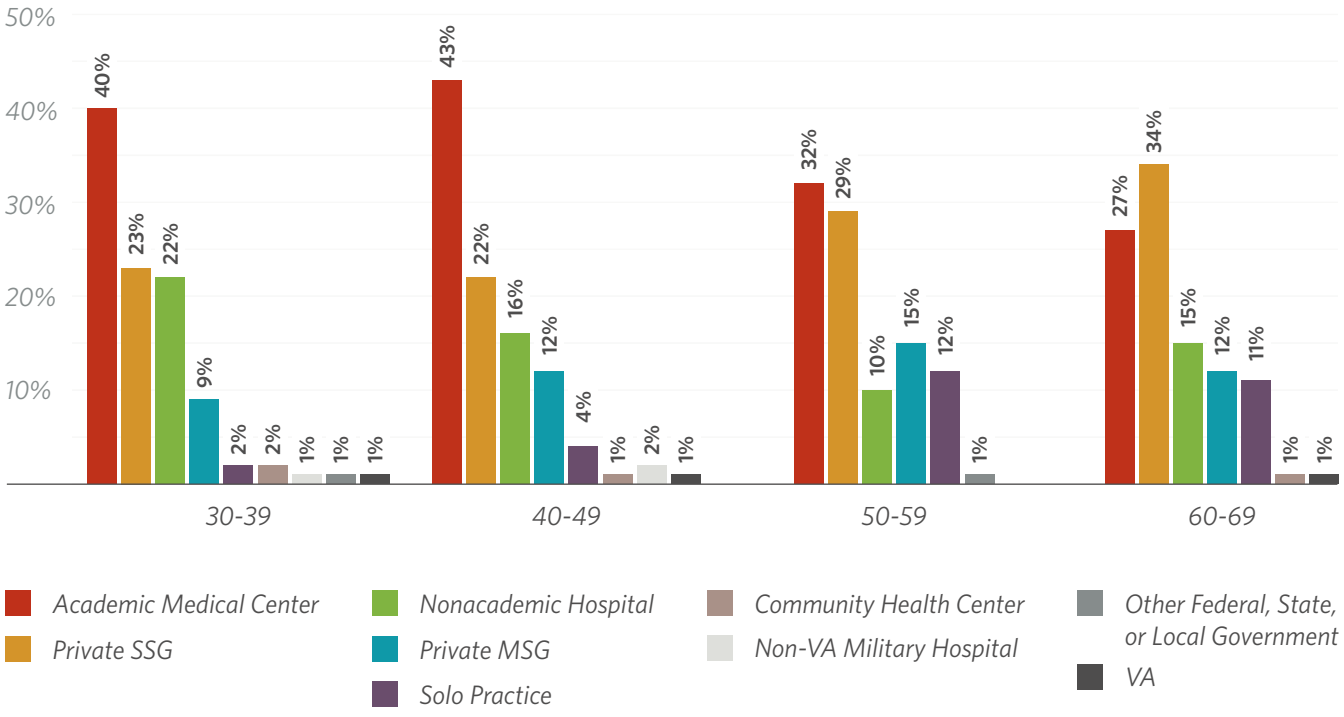

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TABLE 2.3:

Fellowship Training Among Practicing Otolaryngologists

Yes	*No*
53%	47%

TABLE 2.4:

Fellowship Training of Fellowship-Trained Respondents

Fellowship Type	*Count*	*Percent*
Pediatric Otolaryngology	*193*	**23.3%**
Head and Neck Oncology	*188*	**22.7%**
Facial Plastic and Reconstructive Surgery	*121*	**14.6%**
Laryngology	*91*	**11.0%**
Rhinology	*87*	**10.5%**
Neurotology	*85*	**10.3%**
Otology	*28*	**3.4%**
Sleep Medicine/Surgery	*10*	**1.2%**
Endocrine Surgery	*10*	**1.2%**
Allergy	*7*	**0.8%**
Craniofacial and Skull Base Surgery	*7*	**0.8%**
Overall	**827**	100.0%

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FIGURE 2.4:

Fellowship Training by Practice Setting

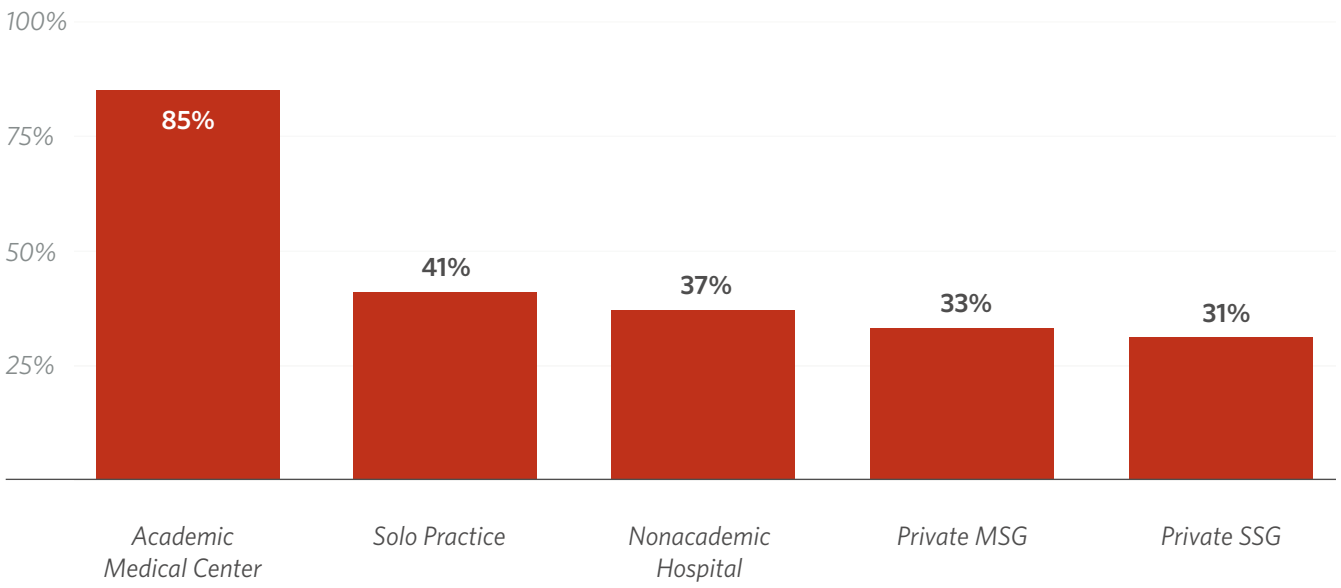
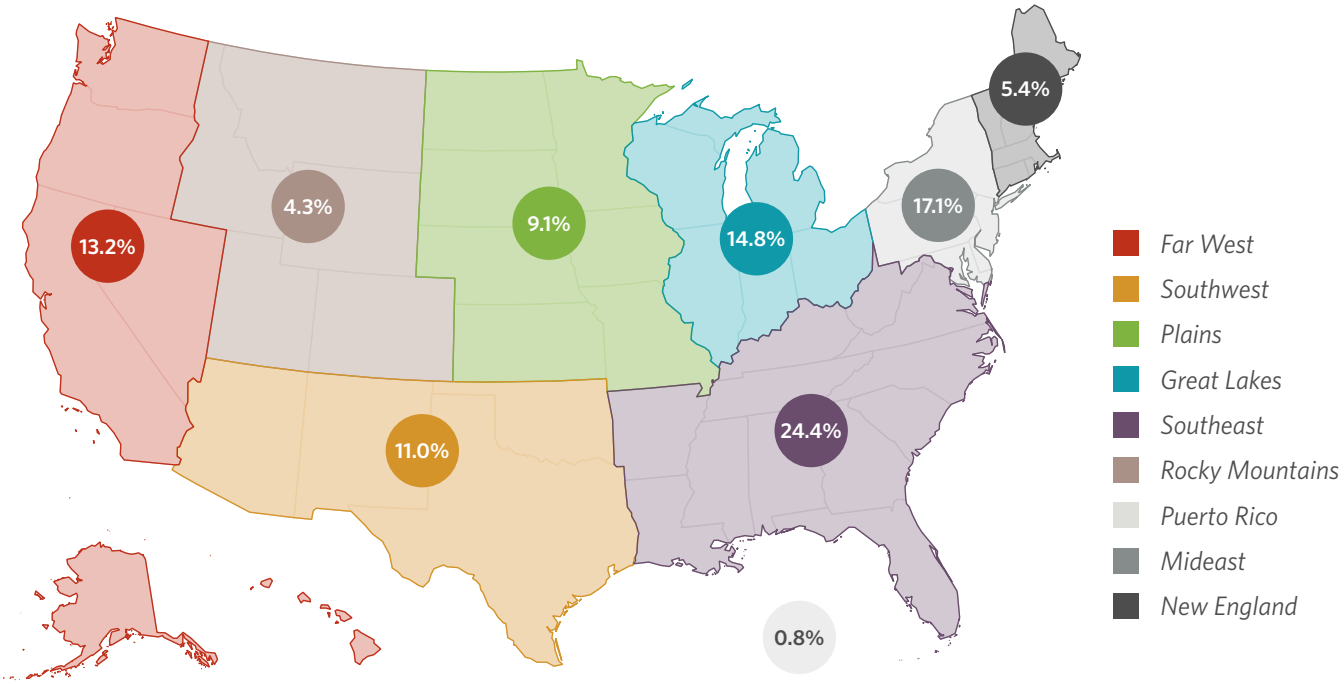


FIGURE 2.5:

Practicing Otolaryngologists by Economic Region



2024 CLINICAL AND ANCILLARY COMPENSATION

FIGURE 2.6:

2024 Clinical Income by Economic Region (Median, 25th/75th Percentile Shown)

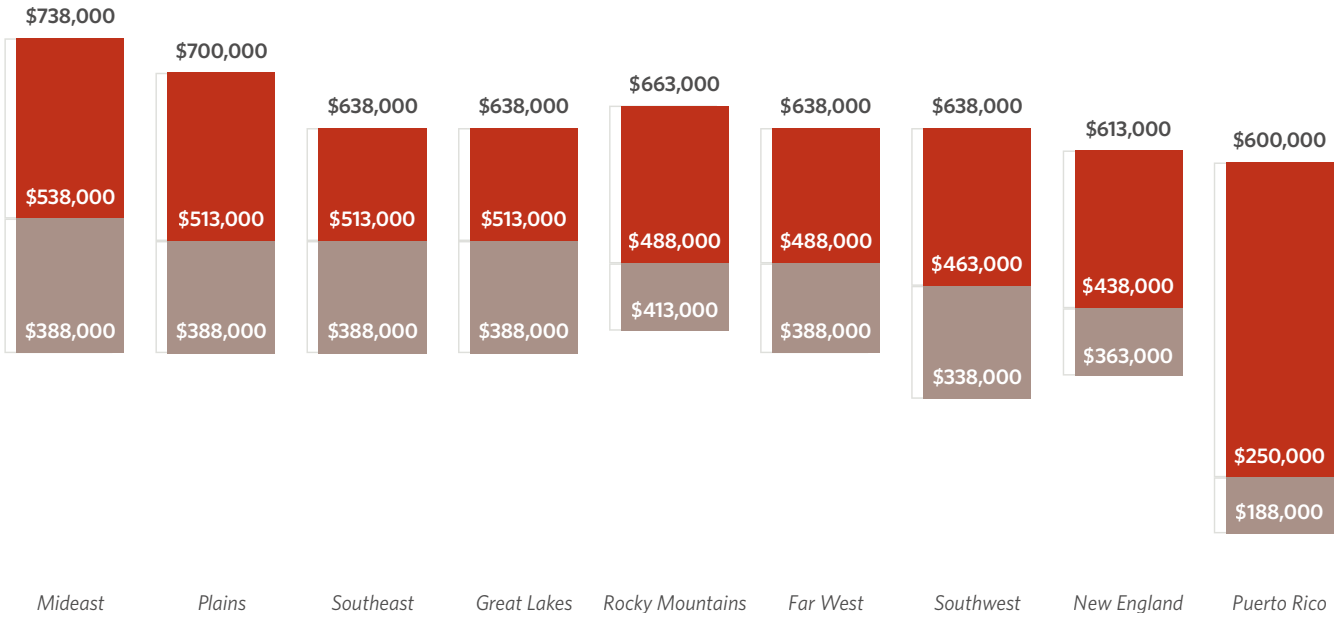


FIGURE 2.7:

2024 Clinical Income by Practice Setting (Median,25th/75th Percentile Shown)

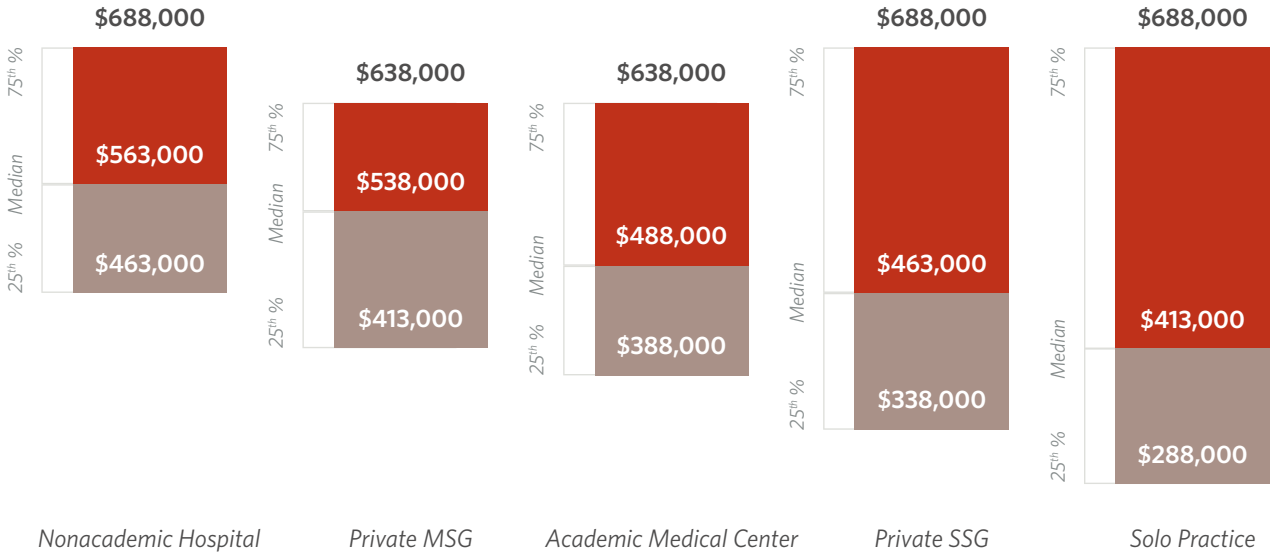


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FIGURE 2.8:

2024 Clinical Income for Academic Practice by Fellowship (Median, 25th/75th Percentile Shown)

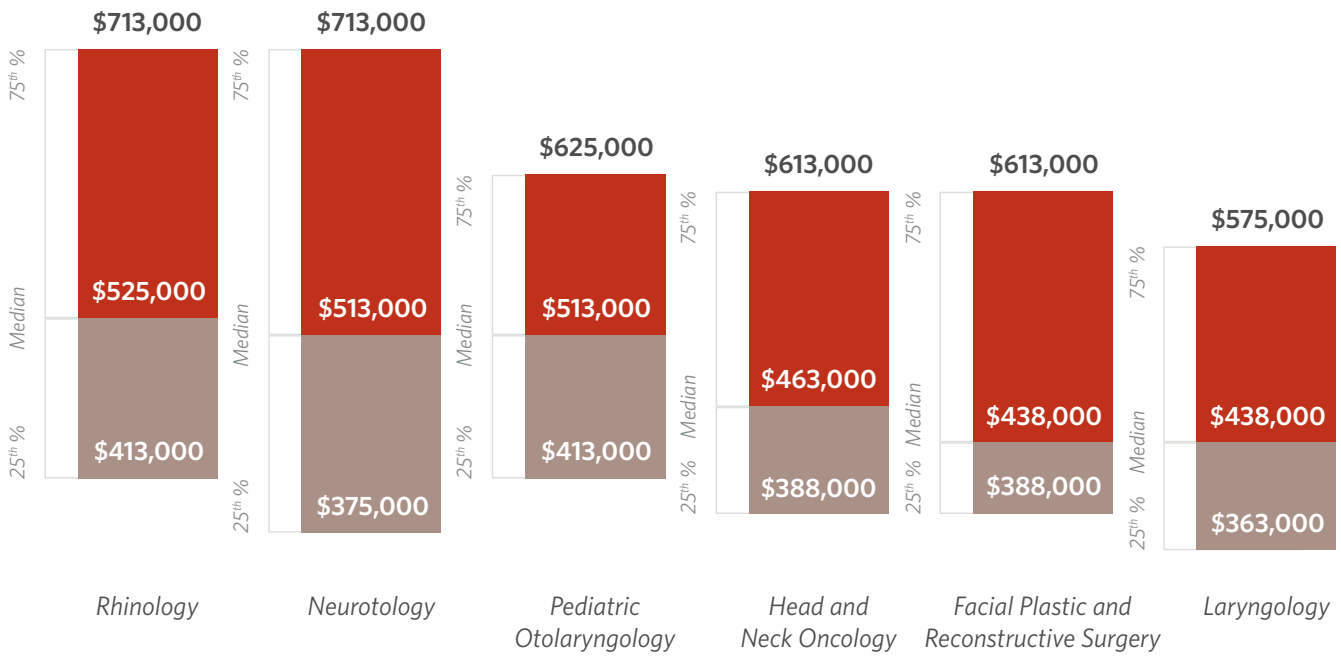

FIGURE 2.9:

2024 Clinical Income by Age (Decade) (Median, 25th/75th Percentile Shown)

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FIGURE 2.10:

2024 Clinical Income by Age (Decade) and Sex (Median, 25th/75th Percentile Shown)

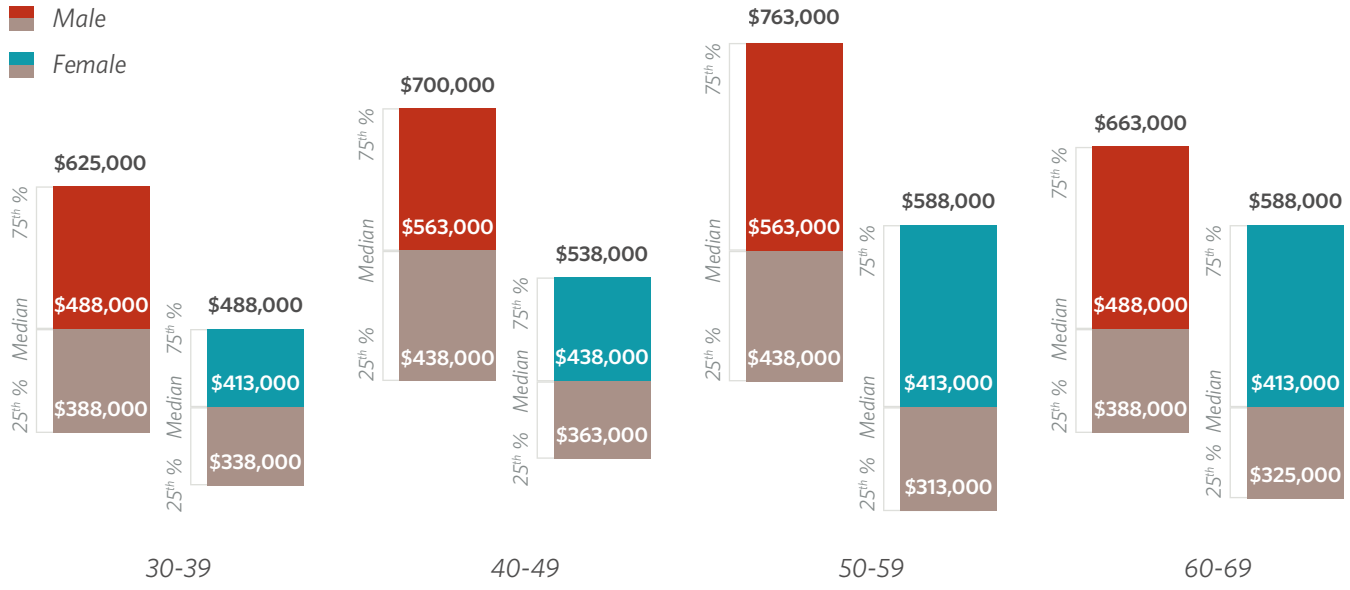

FIGURE 2.11:

2024 Clinical Income by Age (Decade) and Sex in Academics (Median, 25th/75th Percentile Shown)

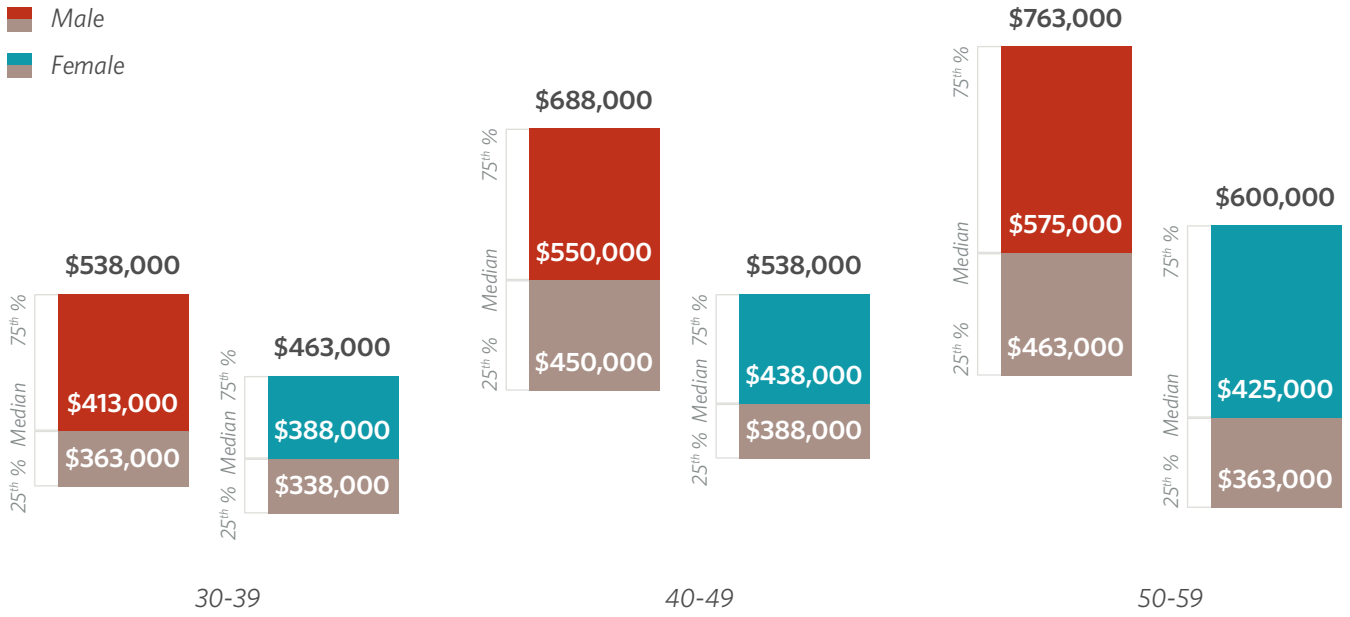

TABLE 2.5:

High Earners (>$650,000 Clinical Income) vs All

Age (Decade)	All	High Earners
30-39	21.4%	**15.5%**
40-49	33.5%	**33.3%**
50-59	23.3%	**30.5%**
60-69	17.8%	**17.3%**
70-79	3.4%	**3.3%**
80-89	0.5%	**0.0%**

Practice Setting	All	High Earners
Academic Medical Center/ Medical School	36.1%	**32.6%**
Private SSG	25.9%	**29.3%**
Nonacademic Hospital	14.9%	**17.2%**
Private MSG	11.7%	**10.9%**
Solo Practice	7.6%	**8.3%**
Community Health Center	1.0%	**1.0%**
Non-VA Military Hospital	0.9%	**0.3%**
VA	0.7%	**0.0%**
Other Federal, State, or Local Government	0.6%	**0.3%**
Locums	0.3%	**0.0%**
Academic/Private Split	0.3%	**0.3%**

Sex	All	High Earners
Male	74.9%	**88.0%**
Female	24.8%	**11.7%**
Other	0.3%	**0.3%**

Fellowship	All	High Earners
Yes	52.8%	**53.8%**
No	47.2%	**46.2%**

Economic Region	All	High Earners
Southeast	24.4%	**21.8%**
Mideast	17.1%	**23.3%**
Great Lakes	14.8%	**13.4%**
Far West	13.2%	**12.4%**
Southwest	11.0%	**9.9%**
Plains	9.1%	**9.6%**
New England	5.4%	**4.3%**
Rocky Mountain	4.3%	**4.6%**
Puerto Rico	0.8%	**0.8%**

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FIGURE 2.12:

2024 Clinical Income versus 2023 by Practice Setting

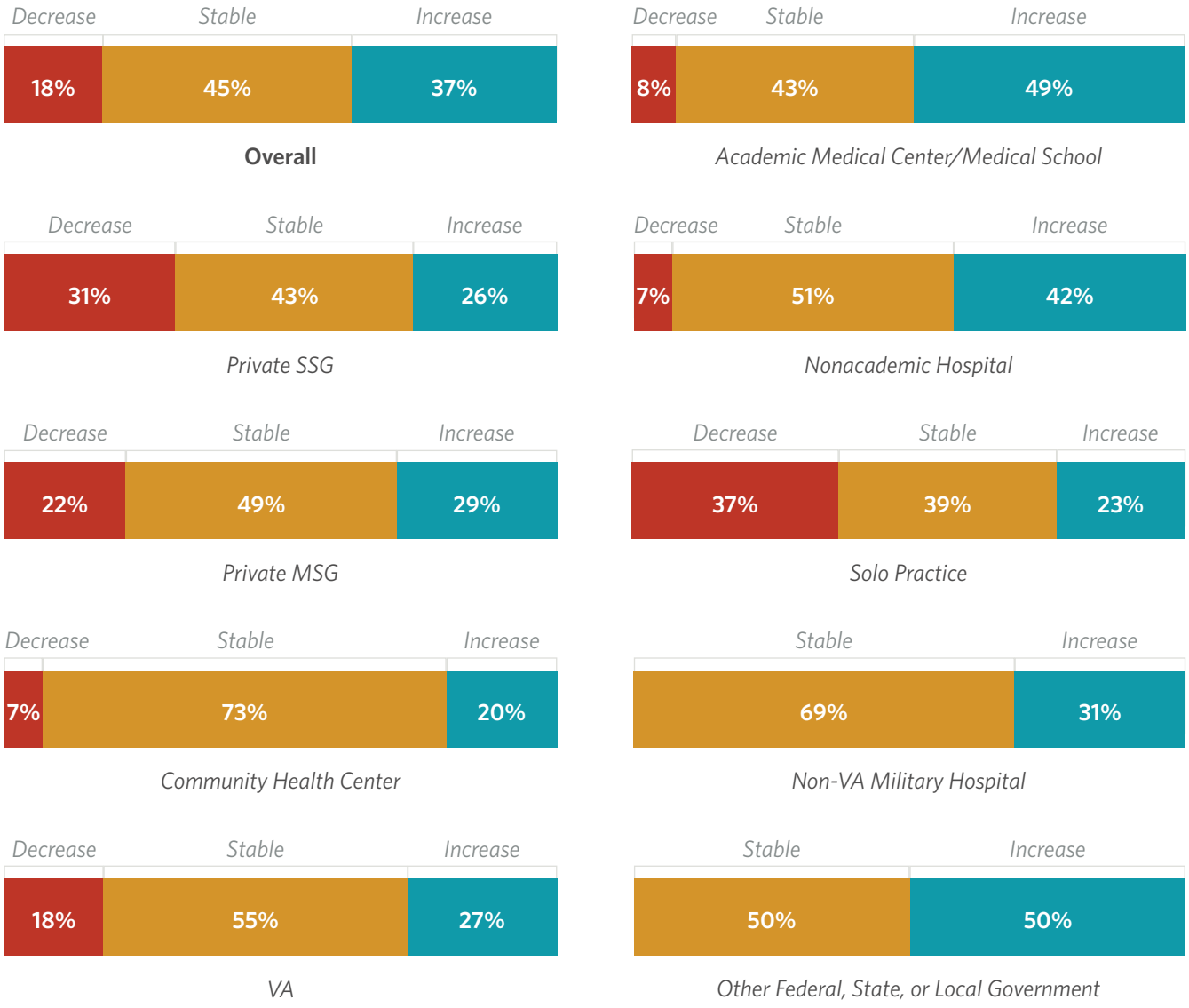

TABLE 2.6:

2024 Ancillary Income Receipt by Practice Setting

Practice Setting	*Yes*	*No*
Private SSG	*77%*	*24%*
Solo Practice	*57%*	*43%*
Private MSG	*42%*	*58%*
VA	*27%*	*73%*
Nonacademic Hospital	*26%*	*74%*
Non-VA Military Hospital	*23%*	*77%*
Academic Medical Center/ Medical School	*22%*	*78%*
Community Health Center	*20%*	*80%*
Other Federal, State, or Local Government	*20%*	*80%*
Overall	**42%**	**58%**

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FIGURE 2.13:

2024 Ancillary Income by Practice Setting, When Received (Median, 25th/75th Percentile Shown)

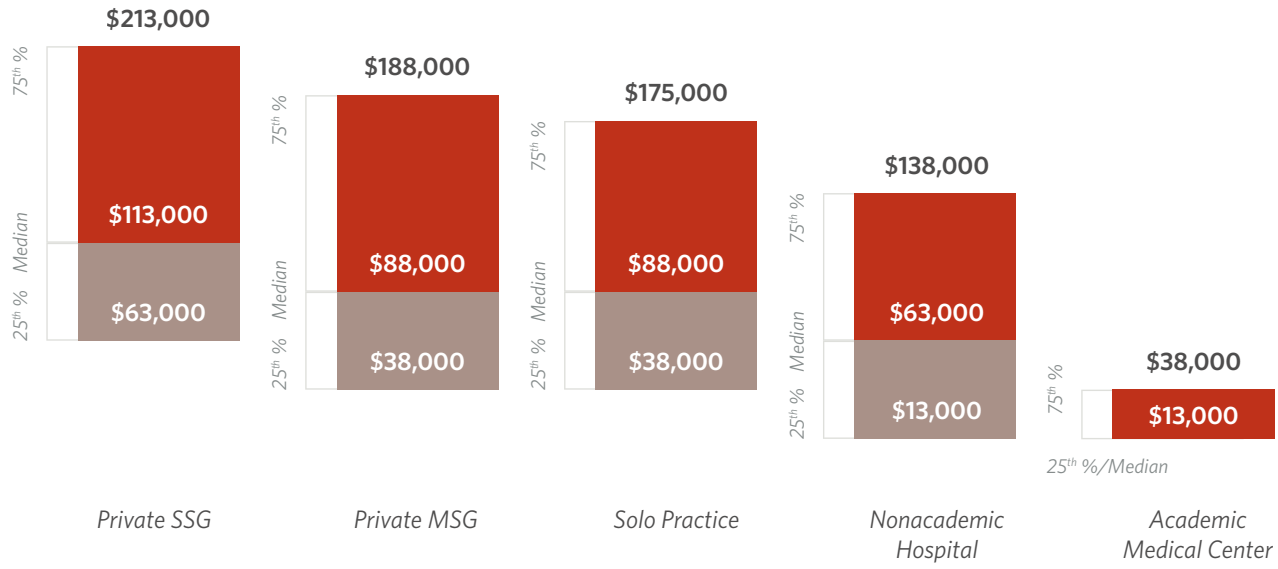
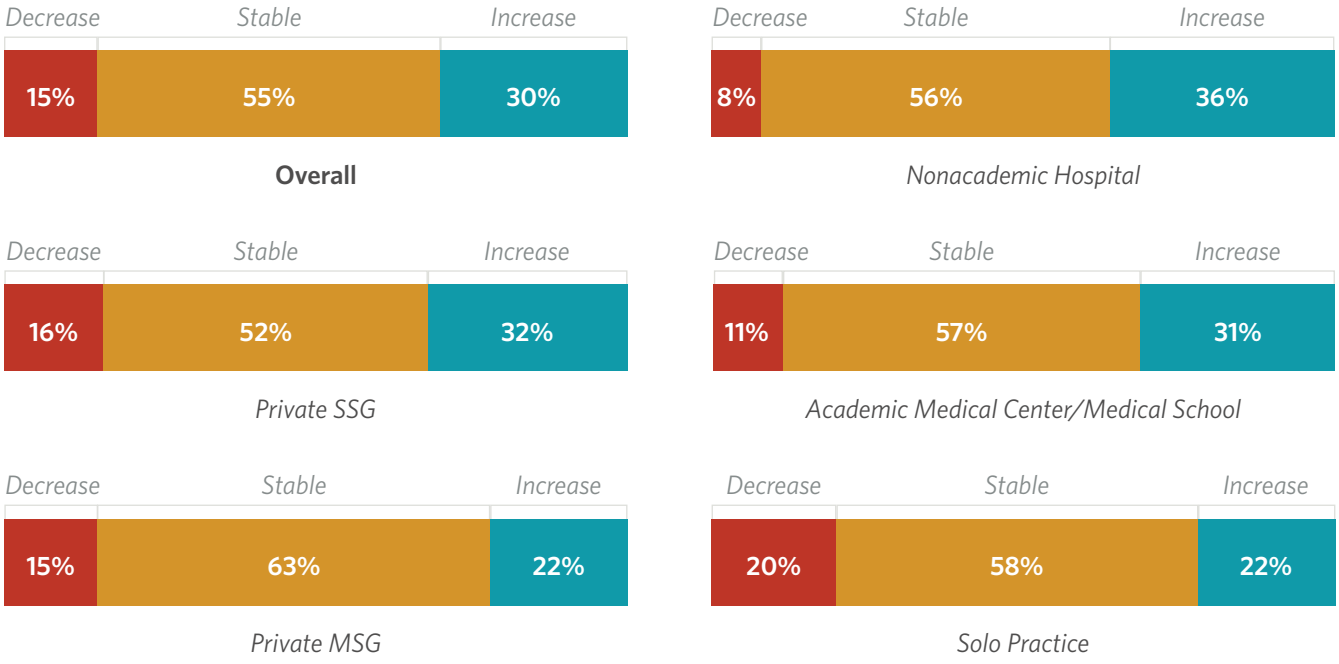


FIGURE 2.14:

2024 Ancillary Income versus 2023 by Practice Setting



2024 CALL COMPENSATION

FIGURE 2.15:

Otolaryngologists Taking Call in 2024 by Practice Setting

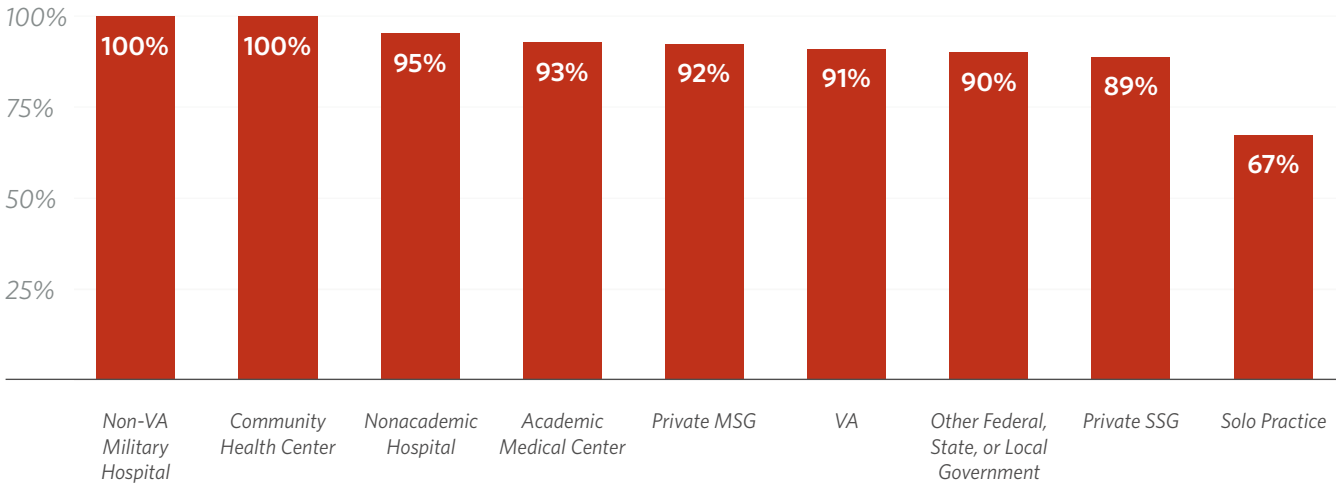


TABLE 2.7:

Entity Taken Call for in 2024 by Practice Setting

2024 Practice Setting	*My practice/ patients and hospital patients*	*My practice/ patients only*
Non-VA Military Hospital	*100%*	*0%*
Academic Medical Center/ Medical School	*98%*	*2%*
Nonacademic Hospital	*98%*	*2%*
Community Health Center	*93%*	*7%*
Private MSG	*93%*	*7%*
VA	*90%*	*10%*
Private SSG	*80%*	*20%*
Solo Practice	*64%*	*36%*
Overall	**91%**	**9%**

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TABLE 2.8:

Average Call Days Per Month, When Taking Call

Practice Setting	Count	25th %	Median	75th %
Community Health Center	15	7	9.5	15
Solo Practice	75	5	7	30
Nonacademic Hospital	218	5	7	10
Private SSG	352	4	6	9
Private MSG	164	4	6	8
VA	10	4.5	5	9.5
Non-VA Military Hospital	13	4	5	7
Academic Medical Center	504	2	4	7

TABLE 2.9:

Average Facilities Directly Covered While on Call, When Taking Call

Practice Setting	Count	25th %	Median	75th %
Community Health Center	15	1	1	1-2
Solo Practice	75	1	1	1-2
Nonacademic Hospital	218	1	1-2	2-3
Private SSG	350	1	1-2	2-3
Private MSG	164	1	1-2	2-3
VA	10	1	1	1-2
Non-VA Military Hospital	13	1	1-2	2-3
Academic Medical Center	507	1	1-2	2-3

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TABLE 2.10:

How Often Needing to Go in When on Call

Practice Setting	Count	25th %	Median	75th %
Community Health Center	15	11-20%	21-30%	31-40%
Solo Practice	75	0-10%	11-20%	31-40%
Nonacademic Hospital	218	11-20%	21-30%	41-50%
Private SSG	349	0-10%	21-30%	41-50%
Private MSG	163	11-20%	21-30%	41-50%
VA	10	0-10%	0-10%	21-30%
Non-VA Military Hospital	13	11-20%	21-30%	35%
Academic Medical Center	507	11-20%	21-30%	41-50%

FIGURE 2.16:

Otolaryngologists Paid for Call in 2024 by Practice Setting

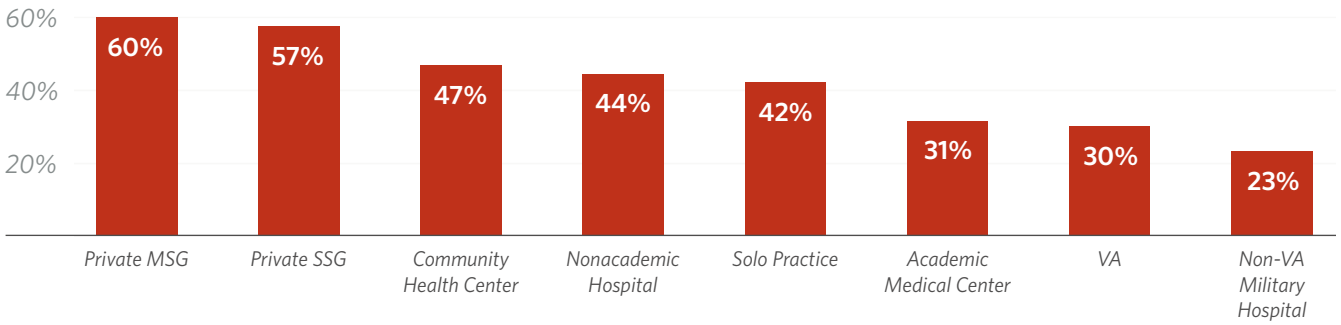

TABLE 2.11:

Dependency of Paid for Call versus Percent Go-In Rate

Practice Setting	Compensation	Count	25th %	Median	75th %
Academic Medical Center	No	346	11-20%	21-30%	41-50%
	Yes	160	11-20%	21-30%	51-60%
Private SSG	No	147	0-10%	0-10%	21-30%
	Yes	202	11-20%	21-30%	51-60%
Private MSG	No	64	0-10%	21-30%	40%
	Yes	99	11-20%	21-30%	50%
Nonacademic Hospital	No	122	0-10%	11-20%	31-40%
	Yes	96	11-20%	21-30%	41-50%
Solo Practice	No	43	0-10%	0-10%	11-20%
	Yes	32	11-20%	21-30%	70%

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TABLE 2.12:

Methods of Call Payment by Practice Setting, When Paid for Call

Method of Call Payment	Academic Medical Center (Count: 160)	Nonacademic Hospital (Count: 97)	Private SSG (Count: 200)	Private MSG (Count: 98)	Solo Practice (Count: 32)
Flate Rate based on Time (Day/Month/Year)	*78%*	*69%*	*96%*	*81%*	*100%*
By Consult/ Procedure/RVU	*16%*	*25%*	*11%*	*18%*	*6%*
Flat Rate if Beyond Contracted Amount	*6%*	*20%*	*3%*	*7%*	*0%*
Flat Rate if Activated to Come In	*7%*	*8%*	*2%*	*3%*	*6%*
Included in Employment Contract	*16%*	*16%*	*5%*	*7%*	*0%*

Percentages >100% due to multiple combined methods utilized

FIGURE 2.17:

2024 Call Compensation by Practice Setting, When Received (Median, 25th/75th Percentile Shown)

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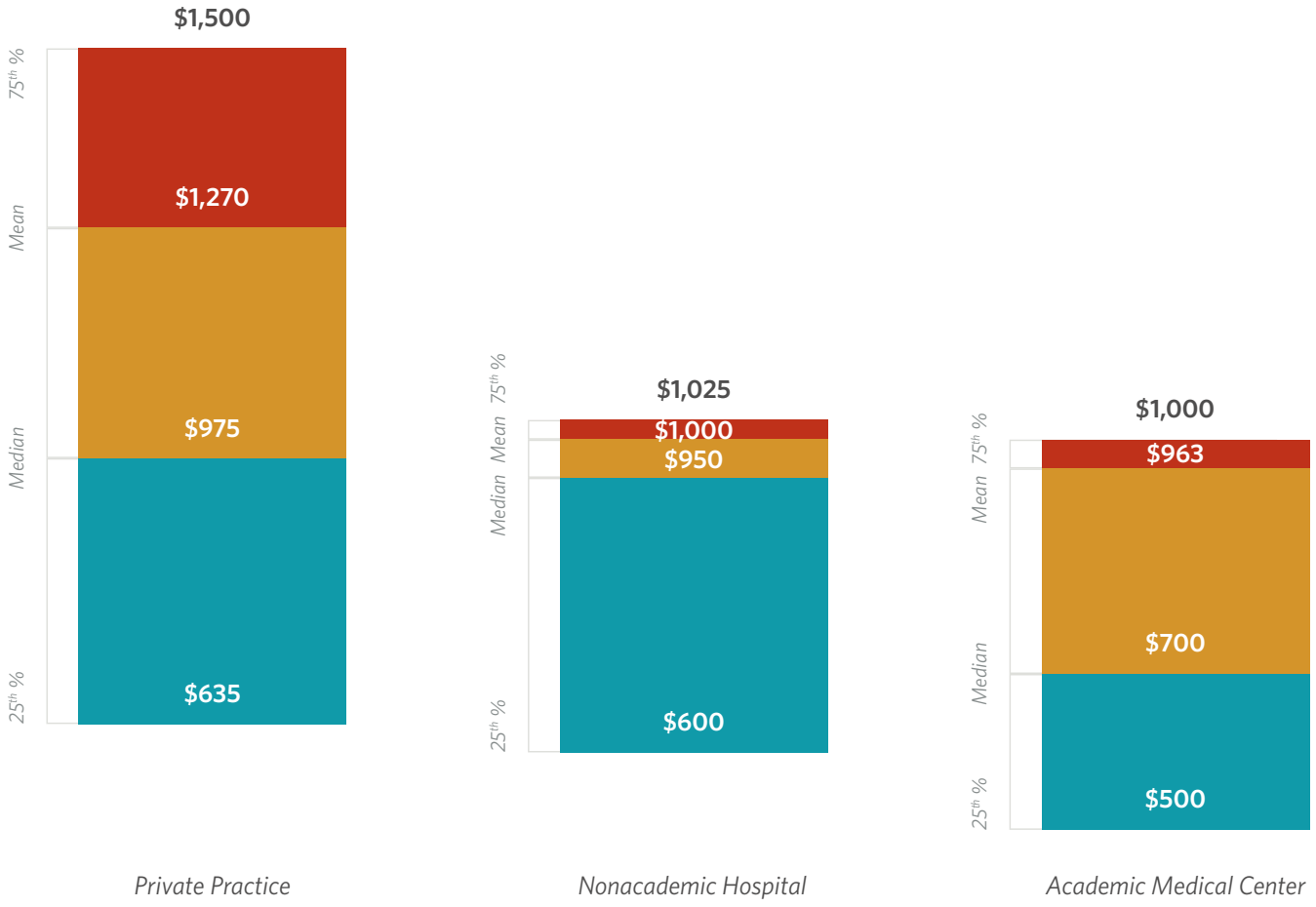
FIGURE 2.18:

Daily Call Compensation Rate by Practice Setting (Median, Mean, 25th/75th Percentile Shown)



Noted in the free responses were the following:

Private Practice

- 11/140 providing daily coverage amounts stated that pay also included facial trauma coverage
- 11/143 specified that they covered unpaid facilities

Nonacademic Hospital

- 3/42 responses stated that any facility covered was unpaid
- 10/42 responses clarified pay was only received if exceeding a certain number of call days
- 2/42 specified the daily rate included facial trauma coverage
- 10/39 specifying daily rate amounts stated additional money was offered when activated

Academic Medical Center

- 10/49 responses alluded to the fact that main facility was not paid while outside/sister facility was
- 2/41 daily rate responses clarified pay was only received if exceeding a certain number of call days
- 5/41 daily rate responses were offered additional money based on wRVU or per consult/activation
- Hourly rates provided varied widely

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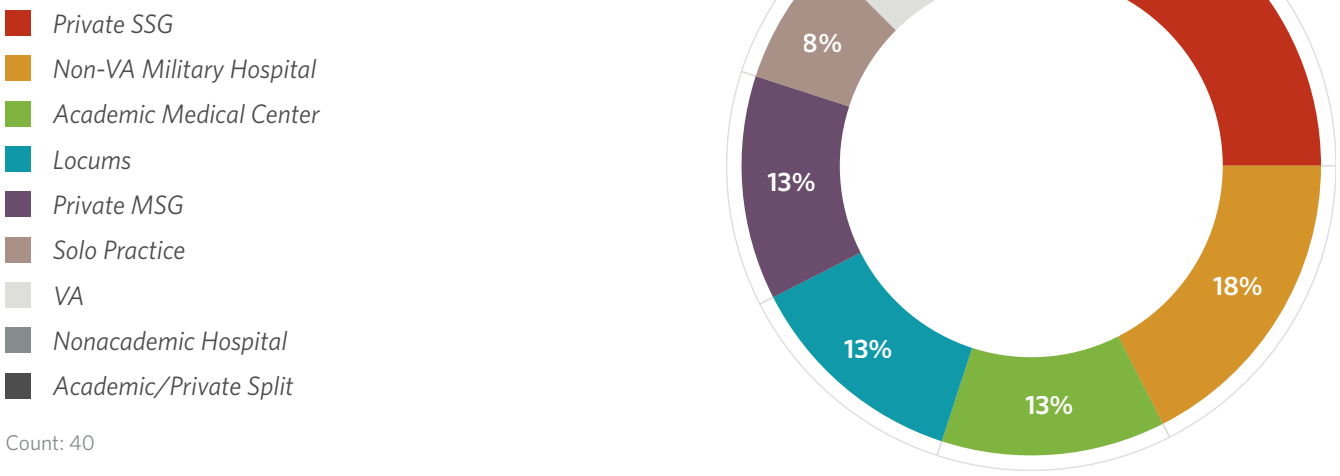
LOCUMS COMPENSATION

FIGURE 2.19:

Otolaryngologists Doing Locums Work by Primary Practice Setting



Count: 40

TABLE 2.13:

2024 Locums Compensation

	Count	25th %	Median	Mean	75th %
Overall Daily Rate	36	$1,800	$2,000	$2,036	$2,250
Daily Rate with Additional Hourly Trigger	18	-	$1,925	$1,950	-
Daily Rate without Additional Hourly Trigger	13	-	$1,950	$2,100	-
Hourly Comp after Hourly Trigger	23	-	$225	$240	-

Most Common Hourly Trigger for Extra Compensation	4 hours

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LOOKING FORWARD

The BOG and AAO-HNS Workforce and Socioeconomic Task Force surveys on call and compensation provide otolaryngologists with needed updates on these topics. We hope the data described here enable more informed decision-making as we move toward our next iteration of our workforce survey next year.

Moving forward, we hope to identify areas of concern related to disability and professional fulfillment. We will elaborate on patient access more comprehensively, identifying areas in need and wait times. This will introduce a different framework for patient care delivery, but if we are to be leaders in this space – which I believe we are – we must comprehensively appreciate access from the patient's perspective and know where their demand is highest. We will strive to attain a regular cadence for these surveys and reports, and we will make attempts to engage our subspecialty partners to coordinate and avoid survey fatigue. As some have already done, please come to us with ideas and areas of inquiry. Harnessing your insights will prove invaluable as we move forward with this project.

As I reflect on what we've been able to accomplish these last four years, I appreciate even more the need to unite all subspecialties under the Academy's umbrella. In short time, we've developed strong institutional knowledge, adapted processes for faster turnaround, and have engaged with multiple subspecialties and stakeholders to produce a high value product for our members. We found success in including non-current Academy members in our compensation survey, which may have been instrumental in increasing our response rate and will hopefully bring more of us back as engaged Academy members. We can accomplish more by working together.

Again, a great many thanks to Dr. Shah and the Academy staff highlighted in this report. The BOG and task force members who devoted their time to this report deserve our thanks as well, as do each of you who participated. Your time and willingness to participate in these surveys have made these reports possible. We are excited for what the future holds, particularly as we uncover opportunities to optimize patient care and our careers in medicine.

Sincerely,

Andrew J. Tompkins, MD, MBA
Chair, Workforce and Socioeconomic Task Force

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APPENDIX 1: BOG CALL SURVEY QUESTIONS

QUESTION 1: Do you or your group provide hospital on-call coverage services?

Yes or No

QUESTION 2: Is on-call coverage mandated by your hospital?

Yes or No

QUESTION 3: If the time and/or distance is mandated, please check all that apply:

- *Must respond to calls within a defined time period*
- *Required to provide an in-person evaluation within a defined time period*
- *Must live within a defined distance from the facility*
- *Other (please specify)*

QUESTION 4: How many days a month do you or your group provide on-call coverage?

Response options 1 – 31

QUESTION 5: How many days do you personally provide on-call coverage?

Response options 1 – 31

QUESTION 6: Do you take call:

- *One day at a time*
- *One week at a time*
- *One month at a time*
- *Other (please specify)*

QUESTION 7: Do you have resident on-call coverage?

- *Otolaryngology residents, 24/7*
- *Otolaryngology residents, but not 24/7*
- *Non-otolaryngology residents, 24/7*
- *Non-otolaryngology residents, but not 24/7*
- *No*

QUESTION 8: Do you have advanced practice provider on-call coverage?

- *Yes, 24/7*
- *Yes, but not 24/7*
- *No*

QUESTION 9: Who gets the first call?

- *Advanced practice provider*
- *Resident physician*
- *Attending physician*

QUESTION 10: Are you reimbursed for the on-call services that you provide?

Yes or No

QUESTION 11: What are the reasons that you are not reimbursed for on-call services? (check all that apply)

- *Work at an academic medical center*
- *I am a member of the U.S. military*
- *Is a requirement to be a member of the hospital medical staff*
- *Do not have the leverage required to negotiate a reimbursement agreement*
- *Never requested to be reimbursed*
- *Other (please specify)*

QUESTION 12: What are the reasons that you are reimbursed for on-call services? (list all that apply)

- *Everyone on the medical staff is reimbursed for on-call coverage*
- *Negotiated reimbursement agreement between practitioner/practice and hospital*
- *Hospital employee with negotiated contract*
- *Other (please specify)*

QUESTION 13: If you have a reimbursement agreement for on-call services, what factors provided you with the leverage to negotiate that agreement? (list all that apply)

- *The only ENT providers available or willing to provide on-call coverage*
- *The downstream revenue generated by my clinical activities at the hospital*
- *Unique skills/services offered by your practice (e.g., pediatric airway)*
- *Otolaryngology coverage required for a level I or II trauma center for quality designation*
- *Other (please specify)*

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QUESTION 14: How are you reimbursed for on-call services?

- *Flat rate for each day of call*
- *Hourly rate based on amount of time in the hospital seeing consults or performing non-elective surgery*
- *Flat rate and direct patient billing*
- *Hourly rate and direct patient billing*
- *Other (please specify)*

QUESTION 15: How many hospitals do you or your group simultaneously provide in-person on-call coverage to?

1, 2, 3, 4, or 5+

QUESTION 16: What is the longest average one-way driving distance to a hospital that you can provide in-person on-call coverage for?

- *15 minutes or less*
- *16-30 minutes*
- *31-45 minutes*
- *46-60 minutes*
- *61-75 minutes*
- *76-90 minutes*
- *90+ minutes*

QUESTION 17: Do you provide on-call coverage for maxillofacial trauma?

Yes or No

QUESTION 18: Do you provide on-call coverage for pediatric airway emergencies?

Yes or No

QUESTION 19: Are there hospitals in your area that are "uncovered" by otolaryngology, requiring you to care for patients that are transferred from hospital to hospital?

Yes, No, or Unsure

QUESTION 20: What are the reason(s) you do NOT provide on-call service to hospital(s). (Choose all that apply)

- *Not mandated by the hospital*
- *I do not have privileges at a hospital*
- *I have a nonsurgical practice*
- *I do not have the expertise/skills to provide on-call coverage (e.g., neurotologist)*
- *I am a senior physician*
- *Other (please specify)*

QUESTION 21: As a physician, it is my professional responsibility to provide on-call coverage without reimbursement at the hospital(s) where I am a member of the medical staff.

- *Disagree*
- *Neither agree or disagree*
- *Agree*
- *Strongly agree*

QUESTION 22: What is your practice setting?

- *Private single-specialty group*
- *Private multispecialty group*
- *Nonacademic hospital*
- *Hospital employee*
- *Academic medical center*
- *VA/Government*
- *Military*
- *Other (please specify)*

QUESTION 23: Where do you practice in the US?

- *Northeast*
- *Mid-Atlantic*
- *Midwest*
- *South*
- *West*
- *Alaska/Hawaii/ Puerto Rico/US Territory*
- *Other (please specify)*

QUESTION 24: What is your age range?

- *Under 30*
- *30-39*
- *40-49*
- *50-59*
- *60-69*
- *70+*

QUESTION 25: What is your gender?

- *Woman*
- *Man*
- *Transgender*
- *Non-binary*
- *Non-conforming*
- *Other (please specify)*

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APPENDIX 2: AAO-HNS 2025 COMPENSATION SURVEY QUESTIONS

QUESTION 1: What is your current age?

Response options: 25-99 in increments of 1

QUESTION 2: What is your sex?

Male, Female, or Other

QUESTION 3: Which of these career pathways best describes you for calendar year 2024?

- *Physician in active practice (full- or part-time) in U.S./territories/ military overseas*
- *Resident-in-training*
- *Fellow-in-training*
- *Retired (completely) from practice*
- *In industry*
- *Administrative only*
- *International member of the AAO-HNS*
- *Other (please describe)*

** Selections besides "Physician in active practice" bring respondent to final "thank you" page*

QUESTION 4: What best describes your primary practice setting?

- *Solo practice*
- *Private, single-specialty (primarily) otolaryngology group*
- *Private, multispecialty group*
- *Academic medical center/medical school*
- *Nonacademic hospital*
- *Community health center*
- *Veterans Affairs (VA)*
- *Non-VA military hospital*
- *Other federal, state, or local government*
- *Other (please specify)*

QUESTION 5: In which state do you primarily practice?

Drop down of 50 states, territories, and DC

QUESTION 6: Have you completed a fellowship?

Yes or No

QUESTION 7: (If "yes" to Question 6) Type of Fellowship

- *Allergy*
- *Craniofacial and Skull Base Surgery*
- *Endocrine Surgery*
- *Facial Plastic and Reconstructive Surgery*
- *Head and Neck Oncology*
- *Laryngology*
- *Neurotology*
- *Otology*
- *Pediatric Otolaryngology*
- *Sleep Medicine/Surgery*

QUESTION 8: Estimate your clinical income (including bonus) in 2024 for only the practice of otolaryngology (not call or ancillary income). Please include all income from fees, salaries, retainers, bonuses, employer retirement contributions, and deferred compensation. Do not include investment income from medical related enterprises independent from your medical practice, dividends, and other returns from investments in medical related enterprises such as laboratories, imaging centers, ambulatory surgery centers, real estate, or and fringe benefits you may have received.

Drop down in $25k increments, $0-$1M+

QUESTION 9: How did your total clinical income in 2024 compare with 2023?

Stable, Increase, or Decrease

QUESTION 10: Did you receive any medically-related ancillary income in 2024? This would include income from consulting, surgery center ownership, hearing aids, allergy, real estate, etc.

Yes or No

QUESTION 11: (If "yes" to Question 10) Please estimate your total ancillary income for 2024.

Drop down in $25k increments, $0-$1M+

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QUESTION 12: (If "yes" to Question 10) How did your total ancillary income in 2024 compare with 2023?

Stable, Increase, or Decrease

QUESTION 13: In the 2024 calendar year, did you take any call (for your practice, hospital, both, etc.)?

Yes or No

QUESTION 14: (If "yes" to Question 13) For what entity did you take call in 2024?

My practice/patients only or My practice/patients and hospital patients

QUESTION 15: (If "yes" to Question 13) How many days per month did you take call in 2024, if averaged over the year?

Drop down from 0-31

QUESTION 16: (If "yes" to Question 13) How many facilities did you cover directly, on average, when taking call in 2024?

- *0*
- *1*
- *1 or 2*
- *2*
- *2 or 3*
- *3*
- *3 or 4*
- *4*
- *4 or 5*
- *5*
- *5 or 6*
- *6*
- *6 or 7*
- *7*
- *8*
- *9*
- *10*
- *>10*

QUESTION 17: (If "yes" to Question 13) On average, how often would you have to go in to see patients when taking call in 2024?

Drop down 0-10%, 11-20%, ... 91-100%

QUESTION 18: (If "yes" to Question 13) Were you compensated for call in any fashion in 2024?

Yes or No

QUESTION 19: (If "yes" to Question 18) How were you compensated for call? (Select all that apply)

- *Flat rate by day/week/month (time)*
- *By consult/procedure/wRVU*
- *Flat rate beyond contracted amount*
- *Flat rate if activated to come in*
- *Included in employment contract*

QUESTION 20: (If "yes" to Question 18) Please estimate your total call compensation only for 2024.

Drop down 5K increments to 100k, then 10K increments to 250k, then >250k

QUESTION 21: (If "yes" to Question 18) Please share any compensation specifics (per hospital amount, activation amount, hourly compensation, etc.) you can:

Open-ended response

QUESTION 22: Did you perform any locums work in 2024?

Yes or No

QUESTION 23: (If "yes" to Question 22) Please share compensation details for your locums assignments (payment per day, payment for call-backs, after-hours hourly rate, etc.).

Open-ended response

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2025