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Salary and Financial Planning
How can I find out about how much I should be getting paid?
Compensation and how it is dispensed is one of the most important decisions an organization makes with regard to its employees. The key resources available for salaries of the various medical specialties are often limited and held close by consulting firms. Despite this, some research will allow you to arrive at numbers that should serve as a guide.

When negotiating employment contracts with health systems or hospitals, you will hear the term “fair market value” or FMV. For academic positions, salaries depend on the specialty (i.e., thoracic, congenital or adult cardiac), the region (Western, Southern, Midwestern, Northeastern), the rank (instructor, assistant, associate, or full professor), and whether it is a public or private institution. The ranges for these are published in an Association of American Medical Colleges (AAMC) publication and are given as the 25th, median, and 75th percentiles, as well as the mean. Faculty Salary Survey Reports (AAMC login required) allows individuals affiliated with AAMC-member institutions and other AAMC constituents to access faculty salary report tables. These tables are identical to the tables in the AAMC annual report on medical school faculty salaries. The shortcoming of this report is that it is a survey. In addition, the access to this information will typically need to come from your dean, department chair, or division head, given that only member institutions have access to this data. Note, if you are fortunate to negotiate at the upper range at FMV, occasionally the hospital will have to seek outside third-party valuation to determine if the needs of the program and your skills justify your salary.

For private practice, the ranges can vary much more significantly based on whether the salary is guaranteed, productivity based, or if it includes such things as a “buy in” into the practice. Furthermore,
practices that are hospital based or hospital employed may be far different from salaries in which a private practice group is providing the salary support, especially during the early years of the contract. Additional information regarding ranges, again based by geographic region, is the Medical Group Management Association (MGMA) report. Another good resource is Medical Economics magazine. All of these have limitations in that they are survey based.

A Google search will yield a number of other websites, but not a lot of good data or information. Another option is to speak with previous graduates from your program who are dispersed around the country and ask what they are seeing for salaries in their respective region.

**What is a fair salary range in my particular region?**

Fair salary ranges often depend on what is being asked of the surgeon joining the practice. A salary for a person right out of fellowship with a general cardiothoracic surgery background will differ from a person coming to a practice with experience or special skills such as VATS lobectomy/MIS, endovascular skills, or complex/advanced/MIS cardiac experience. The range will also depend upon how the salary is structured. Built in buy-ins and guaranteed step-ups offer a different compensation scheme than straight salary based upon production. In addition, salaries that are hospital supported may vary from those offered by private practices.

Salary ranges for a region may best be obtained by talking directly to surgeons and previous year graduates to find out what they were given when they joined their respective practice. The key is to make relevant “apples-to-apples” comparisons based on practice design, call schedule, practice demands, and partnership tract.

**Where does my salary come from? How do surgeons get paid?**

The salary for those in academic medicine usually represents a composite of several sources. Typically, a private institution may have divisional or department monies set aside for the recruitment of faculty. There may be special endowment funds or programmatic development funds that support specialized faculty. In addition, private institutions that are integrated with their own hospital may have salary support directly from that hospital.

Public institutions typically receive “state dollars” that support a portion of the faculty’s salary, but these are usually small in amount relative to the total salary. In addition, there may be department or divisional funds that have been set aside over time or approved by the Dean or institution to recruit or support certain faculty. Finally, research endowments may be available to support those faculty engaged in active investigation.

How surgeons get paid, in general, is by providing clinical surgical services. Any clinical activity, such as seeing and evaluating patients in the inpatient and outpatient setting, and performing operations or procedures can usually be defined by a 5 digit code (CPT, common procedural terminology). The CPT code can also be applied to diagnostic procedural interpretation, Evaluation & Management (E&M) of patients, and for critical care services provided. These codes carry with them implied value based upon
the region of the country in which a surgeon practices and the associated assigned practice expenses represented by that region. Finally, contracts with specific payers (commercial [BlueCross/BlueShield] versus governmental [Medicaid/Medicare]) also determine at what rate those CPTs will be reimbursed. Thus, a surgeon who does a three-vessel CABG procedure using the LIMA to LAD and two vein grafts will be paid typically for CPT codes 33533 and 33518. Add-on codes such as 33508 can be used if endoscopic vein harvest was used. Occasionally, there are other add-on codes that may be applied. In general, other major procedures, such as an AVR (33405) performed at the same time will receive reimbursement at a reduced rate to represent the fact that the opening of the patient, the initiation of CPB and the closure of the patient is already represented in the first major code (e.g., 33533).

These codes, when submitted with appropriate documentation (i.e., H&P or Op Note) to the designated payer will result in payment for those services.

What are the best avenues for retirement and savings: 403B, IRA, 401K, etc.?

Most young physicians who are transitioning from a residency or fellowship program into full-time employment are faced with a daunting array of investment choices for their retirement savings. The key point is that retirement savings should receive serious and early consideration given that the most “valuable” dollar you will save are those dollars put away into tax advantaged accounts EARLY in your career. Due to the TIME VALUE OF MONEY concept, a dollar put away at age 36 is much more valuable than the dollar you save at age 56 because of the power of COMPOUNDING INTEREST.

It is recommended that you engage a Certified Financial Planner early in your career development. Most financial advisors will direct employees to use and maximize all employer-provided retirement plans. The most common plans are the 401K and the 403B plans that are employee sponsored and available to employees of either private or public for-profit and not-for-profit organizations. The IRS limits the total contribution that an individual can make to these plans, and it is advisable to put away that maximum amount. In addition, the employee should take advantage of any employer contributions (matching) that may be available. Some employers will match your contribution dollar for dollar, up to a certain percentage of your total salary. For example, if you direct $15,000 to be deposited into your employer-sponsored 401K, your employer may match your contribution; that means you will have added $30,000 that year.

Other savings vehicles include Deferred Compensation Plans like 457s. These allow you to put away a part of your salary pre-tax and allow it to grow tax free. You pay tax the money when it is withdrawn. This may be useful if your 401k or 403b contribution totals are less than the limit. Roth 401Ks and traditional IRAs are additional retirement savings vehicles that are available regardless of an individual's income.

A Practice Management Column from STS News has more information on planning for retirement.
Negotiating Contracts
How does one negotiate for more money and length of a contract in private or hospital-based non-academic practice?

Commencing a new practice can be one of the most exciting yet harrowing times of your career. Achieving the most clarity upon your contract initiation often avoids future confusion and concerns particularly when it comes to compensation and duration.

Generally, most private or hospital-based practices will provide you with a “template” contract that includes terms of compensation calculation, as well as contract duration. Interpreting this may seem daunting, but the first step is to know that every one of these contracts is negotiable.

In order to maximize your personal security you must first be on the lookout for contract term and termination clauses. These are very different. Contract term specifically relates to a fixed period of time your contract is valid until full re-negotiation is required (i.e., 2, 5, 10 years). Good private practice contracts do not have terms since upon signing you are on a specific road to partnership or dutiful employment without end. The termination clause outlines how your exit of the practice “with cause” or “without cause” is actionable. “With cause” is usually due to your inability to maintain a license to practice, where “without cause” relates to a supra-majority decision based on practice strategy or direction. Take care to avoid contracts that are short term (less than 5 years), and those that have specific volume or productivity numbers associated with termination.

Compensation calculation in your contract should be clearly outlined. Upon commencement, most practices offer a fixed salary for a period of 1 to 3 years. Practices where salary is equal among all members may choose to amortize your salary growth over time to offset the expenses related to your hire in lieu of a “buy in” involving your share of the practice’s fixed assets. Alternatively, after a guarantee period, your salary may be based on your productivity and thus based on collections, charges or wRVUs or a combination of these factors. This is often well laid out in the terms of your contract. Note that compensation usually has an inverse relationship to contract term.

Negotiating more money based on your clinical experience, the unique value you may bring to the practice or variables of augmented responsibilities (i.e., call coverage, remote geography or environmental particulars) are all valid opportunities. Further compensation augmentation may be achieved in other forms as in the following examples.

- With fixed salary contracts, it may be reasonable to request an annual escalator for cost of living or COLA (Cost of Living Adjustment).
- Negotiating increases through your benefit package at initiation of your contract is sometimes easier. This may be in the form of additional retirement benefit, life or disability insurance, time off, car/phone allowance or CME.
- You may be eligible for various incentive bonuses or expense reimbursement such as sign-on bonus or augmented relocation expenses.
- If starting a private practice contract, a longer period to full partnership usually increases acceptable starting pay.
- If you feel your offer is below market, you may use the MGMA Survey Data (Physician Compensation) as justification for more compensation.

It is always a good idea to obtain independent legal counsel when evaluating a contract.
How do I renegotiate my new contract with the hospital?

1. Have data (AAMC, MGMA data are often helpful)
2. Define your personal goals:
   a. money
   b. time
   c. research
   d. clinical
3. Decide on a compensation model that fits your level, experience, and environment:
   a. guaranteed salary model with programmatic goals (quality, volume, milestones) with minimal wRVU productivity
   b. productivity-based model (compensation based predominantly on wRVU efforts)
   c. hybrid model (majority guarantee with productivity bonus - $/wRVU over a threshold)
4. Demonstrate volumes and excellent outcomes (i.e., have your data available)
5. Demonstrate participation in medical staff leadership
6. Demonstrate civic and philanthropic involvement in the community
7. Keep all records of communication, including prior offers and contracts
8. Share thank you letters from patients and staff
9. Educate yourself on the MGMA physician compensation scale, wRVU, contribution margin (STS Workforce on Practice Management)

What are the pitfalls that I need to watch for with my contract negotiations?

Request a “letter of intent” before receiving the contract, outlining the basics of the offer. It helps ensure that you and the employer are on the same page and that verbal agreements are included in the contract. However, never move based on a letter of intent. The subsequent contract may be unacceptable or may not materialize.

Careful consideration should be given to individualizing an employment contract so it meets your specific needs, taking into account your own specific employment priorities. A generic contract may work well for one physician and not another.

Don’t hesitate to negotiate for fear of losing the offer. Ask for what you feel strongly about. The contract sets the tone for the future relationship.

While compensation is important when negotiating an employment contract, other criteria should be considered, including benefits, malpractice coverage, and future partnership potential. These can profoundly affect earnings and quality of life over several years.

Consult with senior colleagues, medical and specialty societies, and qualified legal professionals before signing a contract.

Specific information:
A contract should contain the following components. Alongside each component are important considerations and tips to avoid some of the common pitfalls.

- **Scope of work, work hours, schedule, and call duty:** The contract should stipulate the scope of work, the maximum number of work hours each week or month, and should define call duty expectations. Although employers sometimes hesitate to include specifics about the scope of
work because workload and patient volume are not always predictable, the contract should include basic expectations and estimates regarding number of procedures or patients. The contract should also include the practice’s approach to call duty and coverage. (A contract that states “call will be shared fairly” is ambiguous. A clause stating that “call will be shared equally” may be more appropriate.)

- **Restrictive covenants**: These “non-compete” agreements typically prevent a physician from working for a competitor located within a specific geographic area for a certain period of time following departure. The more specialized you are, the more geographically expanded the covenant will be. Junior faculty members should be aware of and request deletion of onerous non-compete clauses. In some states, non-compete clauses are illegal. In other states, they are enforceable only if deemed “reasonable”. Nonetheless, they still might have to be fought legally if they are in the contract.

- **Compensation**: Compensation may be structured in several ways, as a guaranteed annual salary, as a variable amount based on “production” (usually calculated from billings or collections), or as some combination. Make sure that compensation is adequate. Production or collections-based compensation formulas might be a bad deal for physicians new to practice because it takes time to build a patient base and start collecting receivables. If a production formula is used, specific details should be provided on how compensation is calculated, when you will be paid, and in what increments. These can be quite complex, but understanding your compensation based on your collections is most important. The contract should also clearly delineate terms regarding any money you might be obligated to repay, such as signing bonuses, loans, salary advances. Also, the contract should address total compensation, including malpractice premiums, coverage for malpractice claims, and health, life, and disability benefits.

- **Termination**: There are two basic types of termination provisions. “With cause” allows the employer to terminate the physician for reasons such as loss of privileges or inability to meet patient-care obligation, and “without cause” allows the employer to terminate the contract with no stated reason. In “without cause” terminations, the notice period should be long enough to allow the physician to secure other employment. If the employer can terminate the faculty member "without cause" by providing a 90-day written notice, the faculty member who decides to leave should be allowed to provide comparable notice. Beware of large disparities between the two notice periods and request a modification. Also, if the physician is permitted to initiate a without-cause termination, make sure the termination clause does not conflict with the non-compete clause.

- **"Tail" professional liability**: This refers to malpractice coverage that extends to cover lawsuits or claims that arise after the clinician has left the organization. The contract should provide details on how "tail" professional liability is covered. Most organizations cover this, but not all. Not having such coverage could make the departing faculty member less attractive to a prospective hiring organization.

A Practice Management Column from STS News has more information on gaining a power position in negotiations.
Research

How do I obtain research seed funding?
Seed funding is generally considered a resource obtained through one’s own institution as “start-up” funding for the purpose of producing the preliminary data required to apply for a grant. When looking at a prospective job opportunity, it is important to make sure the allocation of seed funding is discussed upfront and is an integral part of the negotiation. The common duration of support is 2 years, but 3 years is preferable. In the case of basic science research, it may take up to 2 years just to have enough preliminary data to submit a competitive grant application and, therefore, a third year of funding is a necessary bridge. For a basic science laboratory, the amount of support should be between $50,000 and $100,000 per year. This would be enough to hire a lab technician or a post-doctoral fellow (the latter being preferable) and still leave you with enough money for supplies or basic operating expenses. Employers may respond by saying, “Let’s wait until you get started then we’ll work something out.” It’s important to remember that you are at your greatest advantage in the negotiating process before you sign. Once you’ve committed, they have no formal obligation to fulfill a verbal promise.

Any start-up effort should be a part of a larger more established investigator’s group. This will allow you to share the resources that are already present rather than having to acquire larger and more expensive equipment or share the administrative staff that is innately required for any scientific endeavor.

If one’s prospective employer is not able to provide seed funding, there are several extramural funding sources that are available to young investigators. These grants are generally available only to applicants who are in the first 3 to 5 years of their first academic appointment.

How do I apply for my first grant?
The National Institutes of Health (NIH) defines a grant as a financial assistance mechanism providing money, property, or both to an eligible entity to carry out an approved project or activity. Grants range from small-sum 2-year funding sources to large, independent investigator-level sums lasting 5 years. In the interest of addressing the issue of “first grants” or early career grants, the focus here will be on small-sum short-term funding. This essentially excludes the traditional K- or R-level NIH funding opportunities that exist.

In becoming familiar with the variety of funding sources that are available, you will come across terms other than the traditional “grant”. Words such as Scholarship, Fellowship or Award are commonly mentioned but all mean the same thing. Essentially, they are a source of extramural funding provided for the purpose of carrying out a research project. These early career grants generally cater to applicants who are in the first 3 to 5 years of their first academic appointment. As with most grants, having preliminary data is preferred and gives greater strength to the application, but in the case of these funding opportunities, it’s not a must.
Clinical Practice

How do I start a program in my new practice that highlights my special skills?

1. Meet with all the appropriate stakeholders:
   a. Cardiology
   b. Pulmonology
   c. Vascular Surgeons
   d. Internists
   e. Family Medicine
   f. Endocrinology
   g. Gastroenterology
   h. Oncology
2. Invite the stakeholder to dinner or a lecture
3. Give Grand Rounds
4. Invite the stakeholder to view an operation
5. Share data
6. Collaborate with stakeholders on multidisciplinary program development
7. Invite an established specialist to discuss the program
8. Interact respectfully and professionally with stakeholders

What do I need to know about hospital employment: the good, the bad, and the ugly?

1. The good
   a. Stable income
   b. Work-life balance
   c. Aligned priorities with hospital – good hospitals will provide high quality resources to enhance your efficiency
2. The bad
   a. Potential for restricted strategic and clinical independence
   b. W-2 vs. 1099 wages
3. The ugly
   a. Practice future and stability tied to the stability of hospital and health system
   b. Office and clinical FTE resources managed by hospital (can be good if reasonable, ugly if not)
   c. Potential for non-clinical medical director

A Practice Management Column from STS News has more information on hospital system employment.

What is a reasonable clinical volume in years 1-3 of private practice?

Being clinically active out of training or when starting a new practice, it is of great importance to establish yourself as an independent contributor to your partners, your referring physicians, your hospital, and your patients. A high personal volume and associating yourself with supportive partners who encourage and foster your clinical growth in a protective manner is important, but this may not be
enough. If possible, you should attempt to seek out an environment where you avoid the contractual need to compete with other surgeons for cases. It is also very important to recognize that despite your prior training excellence or experience, there is great value in humility and the ability to work within the existing framework of your new practice or hospital as you get started. This pertains to adopting the familiar routine in the operating room shared by other surgeons whenever possible (i.e., cannulating, suture use) so as to minimize the variables experienced by the nursing and support staff. Scrubbing with your partners to learn their methods may be the ideal way to minimize initial technical variability and protect your outcomes as you initiate practice. Once you have established yourself, slowly refining technique to give time for the team to adapt may minimize the chances of human error from your support team and maximize your outcomes.

Though higher volumes have clear benefits, a minimum of 3-4 cases per week (about 150 cases per year) would be recommended as you start practice in a new environment. This would allow for a routine to be established by your operative team while affording you the regularity required for allowing your skills to improve. But operative volume is not the only thing that is important to your independent development. Evaluating new patients and learning when and when not to operate, managing patients in your new environment, and communicating your clinical interests and plans to nursing and referring physicians all have equal importance in establishing yourself for long term success.

**How do I best communicate with patients/referring physicians?**

Your first and best communication tool in your career will be your surgical outcomes. Consistently excellent surgical results will always outrank any other form of marketing in the long run. Never underestimate the value of patient-to-patient and patient-to-referring physician recommendations. Each patient encounter is an opportunity for you to communicate with his/her primary care provider or referring provider. A succinct but informative letter to the referring physician summarizing your impression and plan is an essential communication tool and is always appropriate after your initial consultation, at the time of a patient’s discharge from the hospital and after follow-up visits. When possible, it is good practice to speak directly to your referring physician, usually by telephone, to update the physician after performing a surgical procedure on one of his/her patients or in the case of complications.

With regard to patients, it is good practice to not only provide early postoperative follow-up, but also long-term follow-up whenever possible or appropriate. Early follow-up includes not only the usual postoperative visit, but also can be supplemented by a phone call to the patient a day or so after his/her discharge from the hospital (by yourself or one of your staff members). Long-term follow-up, depending on the need and indication can be either in person or by phone or letter. Maintaining contact with patients helps to:

1. Show your continued concern for the patient’s well-being; and
2. Maintain useful follow-up to ensure appropriate ongoing progress in the care of the patient and permits long-term outcome analysis.

**How do I balance clinical, research, and administrative time?**

As physicians become increasingly involved in leadership roles, the balance between clinical and administrative responsibilities becomes more and more challenging. Initially, few physicians relinquish
their clinical duties to join committees, further their training, lead a research project, or take on administrative duties. However, if physicians continue to ascend, administrative duties can begin to consume their schedules. There are some high-energy physicians who think that they can do it all. Unfortunately, it is not sustainable and cannot last forever. Eventually, physicians who want to pursue positions of leadership must make sacrifices, which usually mean reducing patient care delivery. It’s natural for physicians to be reluctant to relinquish patient care. While many physicians continue the balance, others may continue to advance in leadership and administration. While the decision to stop clinical work altogether may be difficult, it is typically a very gradual process with many opportunities along the way.

Contract issues
Job description, duties and protected time. The contract should spell out, in detail, the duties and responsibilities of the position including, a breakdown of how many hours the faculty member is expected to spend on specific duties such as teaching, research, patient care, and committee responsibilities. The contract also should address the resources available to allow the faculty member to perform those tasks. More importantly, how time will be protected for non-clinical activities should be addressed.

Compensation, expectations, and productivity
Academic medicine has moved increasingly toward productivity-based compensation and "quantifiable" accomplishments. Clinical productivity may be based on billings, wRVUs, patient volume, or collections. Research productivity may be based on grant amounts and number of published articles. Unfortunately, non-clinical duties, especially teaching and administrative duties, typically do not generate revenue and are difficult to quantify. A contract should delineate the ways in which these efforts will be compensated and how they will affect future salary or promotion.

Practice issues
As physicians become increasingly involved in leadership roles, both the individual and the group face important decisions about priorities, schedules, and money. To maintain harmony among the physician and the practice, the entire group must recognize the benefits of these non-clinical endeavors. The time commitment and benefits of a partner being involved in administrative duties must be recognized as worthwhile to the group, even if it means that the clinical responsibilities may not be shared equally.

How do I get out of a bad practice?
Getting out of a bad practice is a difficult situation for anyone to face, especially someone who is in the early stages of his/her career. The most important thing to remember is do not do anything abrupt or make an emotional decision. These are actions that invariably will have consequences that are not in your favor. Before doing anything, reach out to senior colleagues or mentors. Here are a few principles to help guide you through this process:

- **The grass isn’t always greener on the other side.** Starting out in general is difficult because you are used to a certain rhythm and volume in training that doesn’t always transfer to a new setting. Whatever the reason is for thinking that you’re in a “bad” job, make sure you take the time to talk to as many colleagues and friends as possible. It’s important to get their thoughts on how they see your situation and whether the things that you don’t like are part of starting out and getting settled in a new environment with new people. Frequent moves early in one’s career are
not generally viewed favorably in the long term, so please be sure a move is necessary and based on major issues.

- **Make sure you are clear about the terms of your contract.** Before thinking about getting out of your job, you need to see if you legally can do so. It’s also important to make sure there isn’t any “non-compete” language in the contract in case you are thinking of taking a job in the same area. Generally, academic contracts are pretty much the same and not very flexible when it comes to upfront negotiations; however, contracts for private jobs have much more opportunity for adjustment in order to potentially avoid problems.

- **Don’t go from bad to worse.** You may think that getting out of your existing situation at all cost is the best thing, but the worst thing you can do is make a rushed decision and land up in a worse predicament. Changing jobs for whatever reason should be a careful and methodical process. Above all, you now have the experience of having chosen a less than ideal job, so take the time to use the knowledge gained to make a better choice. Make sure you engage colleagues and friends who have your best interest in mind and lean on them for guidance and advice throughout the process.

- **Patience is a virtue.** Keep in mind that the right job for you may not be available just yet so you need to show patience. Moreover, once you have identified some opportunities it’s important to remember that it may take months or even a year before things are close to being finalized. It’s also important to remember that unlike the limitations that come with finishing training at a specific time and the prospects of not having a job after July 1, now you can make your move with greater flexibility and control.

- **Finding a job.** Using a variety of means, you can find out what’s out there; the use of recruiters, online job postings, printed job posting, and word of mouth all apply.

- **Be discreet.** If you have decided that pursuing an alternate opportunity is the correct course of action, it may be wise to keep this to yourself so as not to “poison the well” of your current job. Moreover, professionalism and confidentiality is an important virtue in your dialogue with future jobs. “Bashing” your current job may harm you. If you are determination to get out of your current situation, it’s very important not to burn your bridges or conduct yourself in a way that lets your partners or—more importantly—your referring specialists know you are intending to leave. This doesn’t mean you can’t let your partners know there are things about the practice you’re not happy about, but the premature talk or threat of leaving can have irreversible repercussions. On the other hand, at some point you have to let your partners or employer know of your intentions to leave. This doesn’t need to happen until you have an offer in hand. If you think there is any way you could be persuaded to stay, again, wait until you have an offer in hand. If you wish to stay and discuss a retention package, do so professionally and not repeatedly as this will strain your relationship between the hospital and your partners. Going on interviews may require using your vacation time in order to further keep things discreet.

- **Be prepared to explain why you’re leaving.** Everywhere you go you’re going to get asked why you are leaving. It’s important to have an answer that emphasizes how the change is what’s best for you at that point in your career and not focused on the negatives of your current situation.
Always try to leave on a good note. The cardiothoracic surgery community is a small one and going around speaking poorly about your partners/employers is not worth it in the long run. Try to leave it as though the move was out of your own best interest and not due to the environment or the people with whom you are working. If you leave, make every effort to afford your partners time to locate a replacement and avoid interruption of patient care.

**Academic Careers**

**How do I find an academic practice?**

When looking for an academic practice you should take into account varying factors, such as the type of procedures you want to perform, the desire to do clinical or basic science research, and the area of the country where you wish to live. You should try to look for a practice that appears to be committed to developing the academic career of its junior faculty and where there appears to be a need that coincides with your clinical interest. Available positions can be found on the Cardiothoracic Surgery Network ([CTSNet.org](http://CTSNet.org)), cardiothoracic journals, personal contacts, or, through the fellowship director. It is best to begin thinking about jobs at the end of your second-to-last fellowship year and send out letters in the early fall of your last fellowship year.

**How do you choose an academic niche?**

It is never too early to begin to think about a professional niche. This is critical for personal and professional promotion (nationally and within one’s institution). The niche will set the physician apart from others as an expert in a particular area of thoracic surgery. These areas may include basic science research, clinical research in defined areas such as lung transplantation or thoracic oncology, clinical trials (which may include obtaining a master in public health degree) or up-and-coming techniques such as robotic surgery. The particular niche is not important as long as it is enjoyable. It does not necessarily even need to compose the majority of one’s clinical practice so long as a specific role can be carved out.

Defining an academic niche cannot be emphasized enough. It will create job security, open up future job offers, and create an area of focus for research and writing. Succeeding in a niche requires choosing a focus that is not too broad but allows for novel and innovative research and new ideas. It also requires a lot of work in research and writing. Many physicians fail in academia because they “don’t like to write.” Most who say that they do not like to write are just not comfortable writing, and it would benefit them to take some basic writing courses. Although taking a writing course may seem annoying and embarrassing, it will benefit an academic thoracic surgeon’s career. The two most important things to remember when deciding on a professional niche are to do it because you love it not because someone told you to and commit to it and focus to succeed (i.e., additional training, mentorship).

**Who can mentor me in an academic practice?**

Finding a mentor in academic medicine is becoming more difficult as faculty are forced to concentrate more on clinical medicine and less on education. This reality means that new faculty must be creative when looking for and identifying possible mentors. The fact that many more physicians are spending less time on education also means that one may have to look for more than one mentor, a clinical and an academic mentor. The ideal mentor should be someone who has achieved at a minimum an academic rank of associate professor so that he or she can guide and advise the mentee through the promotion
process. It is also best if the mentor comes from within one’s own institution and clinical division. If that is not possible, there is nothing wrong with seeking help from surgeons in other specialties or other respected institutions. The most important thing is finding someone who wants to mentor. The mentor should also be someone who can help the mentee identify an academic niche and potential research and grant projects. The mentor and mentee should meet regularly throughout the year (i.e., quarterly) to review all clinical and academic goals and progress.

**How does my group raise my academic profile, and how do I promote my partners in academic thoracic surgery practice?**

Raising one’s academic profile is always more credible when it is not direct self-promotion. Having support from your senior partners is essential and ultimately in their best interests. This is as much the case for promoting your academic profile as it is for building your clinical practice. Assistance from your practice group with developing your academic portfolio can take many forms, such as supporting your membership applications to national societies, nominating you for committee involvement, and, most importantly, providing protected time for your academic program so that you have valuable work to publish and present. Your role in this collaborative effort is to be productive while always giving credit to your group for its support. If you are productive, you will be doing your part in promoting your group partnership. Participating in formal multidisciplinary team meetings or meeting one-on-one with colleagues remain ideal opportunities for collective promotion. A social media or website presence are additional methods to inform patients about your practice.

**Social Media**

**How can I use social media safely and effectively in a surgical practice?**

Social media engagement allows surgeons to define their own public personas, while providing education and interaction to the public. Involvement in health care social media carries potential benefits for your practice, scholarly activities, and the public we serve. It’s a way to interact with other clinicians, educate the public, and connect with advocacy groups and patients; however, it’s imperative that social media practices be cautious, deliberate, and professionally appropriate.

One of the pivotal factors leading to heightened social media engagement by surgeons has been the realization that, due to our career choice, we all have public profiles easily searchable on the internet. Many of the sites where you might be featured aren’t necessarily under your control, nor are they vetted for accuracy, such as patient rating sites. More and more patients are using web-based searches to find out information about their diseases, their potential surgeons, and the hospitals where they might choose to receive their care. Social media creates a world of opportunity in terms of creating your public persona and molding the way in which you are seen by the public. Not only can you optimize your own online profile, you can harness the opportunities to build your practice, promote your institution, report the scientific and clinical achievements of our field, improve interactions with clinicians and advocacy groups, and educate the public.
Tips and pitfalls for professional social media use

- Create your own personal identity, defining for the public how you want to be viewed and for what you’d like to be known.
- Separate your personal from your professional life. Either use dual accounts or Facebook for personal life (where online relationships require reciprocity) and Twitter for professional life (where anyone can follow you and see your posts).
- Use common sense: Never provide private health information. Do not provide specific advice to patients in terms of medical management. General education and recommendations of how to access care are great. Specific care plans are totally inappropriate.
- Be aware of your institutional policies. If no policies are in place, check out the guidelines created by the AMA and published online in 2010.
- Take time to understand your audience and be thoughtful in your postings.
- Use your network to grow your network. Strategically select the people/pages/organizations that you follow, based not only on their interests, but also on their followings. Engage stakeholders and influencers when you have important messages to share.
- Engage your audience with interesting and eye-catching content, including linked content and images.
- Recognize the permanence of your online activity. All deleted posts can be saved as a screenshot by a viewer before you delete them. Whatever you say cannot be taken back.
- Serve as a positive role model for trainees. They might already know how to use social media sites and applications, but that doesn’t mean they’re doing it professionally or appropriately.
- Participate in TweetChats that are of interest to you, such as #TSSMN (The Thoracic Surgery Social Media Network; quarterly chats in areas of general thoracic and cardiac topics), #MedEd (Medical Education chat; weekly chats on Thursdays), #LCSM (Lung Cancer Social Media; biweekly chats on Thursdays), and #IGSJC (International General Surgery Journal Club; monthly chats). The STS Workforce on Career Development also will hold TweetChats on early career issues; follow @CTSurgeryCareers and #CTSurgeryCareers.