



Assessing Your Practice Options

What You Want

The first step in the process of beginning your career as a practicing cardiologist in a chosen (sub)specialty practice is knowing what you want from work. You must then realize that different work environments present different challenges. For example, you might be an electrophysiologist (EP) in a small group, or an EP in a large multi-specialty group cardiology or internal medicine group. Each setting has different implications for:

- call coverage (general subspecialty only);
- "narrowness" of practice;
- research;
- income potential;
- risk for competition;
- business development;
- financial investment;
- camaraderie;
- political environment; and
- perceived prestige in community.

Types Of Opportunities Available - Generally

There are three basic types of environments in which you might work: academic, clinic practice, or group practice (whether hospital supported or not).

Each has trade offs; no one situation is perfect. The goal is to find the situation for which you are best suited. Furthermore, what you consider to be an advantage or a disadvantage is a function of *your own preferences*.

When deciding what is most important for you, you should be able to prioritize the attributes that matter most to you, recognizing that some overlap. For example, in an academic setting, you will have a controlled environment with assistance from fellows and residents, but you may have a lower overall salary. Or, small EP-only groups may share call in rotation with other EPs in the area for general call if there are enough in the community. On the other hand, some mid-size multi-specialty cardiology groups do not have enough EPs to warrant EP-only call so you may end up in a mixed general cardiology call rotation. Each position is different.

Implications of Different Cardiology Settings

Cardiologists practice in a variety of settings from narrow subspecialty practices to fully integrated "heart practices." You should consider both the **degree of specialization** you want and the **amount of control** over your own practice you need to determine what type of setting is best suited for your practice.

In evaluating your options and settings, decide both what you do want and what you do not want. Remember that what you do not want can often be clearer than what you do want and can be an equally good place to start. Define your 'ideal' practice as best as you can to determine what you are looking for. This will minimize the time spent in the search process because you will be able to eliminate certain situations at the outset.

Implications of Different Settings

Generally, the larger and fuller service the practice is, the lower the individual requirements to build your own practice and the greater the predictability of your income and the economics of the practice. Also, with more physicians and overall greater size comes additional regulation, which tends to mean both professional management and an established hierarchy. In such a setting, you may find your individual voice is "lost." Thus, if control over your own practice is paramount, this may not be ideal for you.

Consider the issue of call coverage. Call coverage is a necessary evil for most, if not all, cardiologists. Logically, you would think that a larger group would reduce the individual amount of call coverage. Depending on the practice location and style however, this may not be the case. Many larger groups become large by covering a number of facilities, the coverage of which may not be concurrently possible. As a result, these larger groups must maintain and implement multiple call schedules, particularly where they cover multiple facilities, thereby increasing the amount of call for each practice member. Likewise, when you add in a mix of cardiology subspecialists who are not equally interchangeable, you can see that the call schedule often functions like small spinning tops that grow or contract within some parameter (geography to be covered, subspecialty, etc.). On the other hand, in areas of dense population, some groups are large but they retain only a few facility bases. Focusing on depth of coverage, rather than breadth of coverage, they are able to limit the call responsibilities.

Economic Options of Cardiology Practices

Compensation Factors

Compensation levels for cardiologists vary too widely to provide an exact estimate. The variety is due to a range of factors including the need for new cardiologists in particular areas, the cardiologist's area of specialization (or subspecialization), the employment situation (multi-specialty group, exclusive hospital contract, etc.), and the particular personality types the employers' feel they need. Furthermore, the laws of supply and demand become very important and play a key role in the situation. Lately, this has been an enormous factor impacting compensation.

Specific factors related to you and your employment opportunities include:

Candidate Factors
• Board certification in cardiology
• Fellowship or "special" training
• Special or unique talents and skills, number of cases done, etc.
• How "hot" the specialty is at the time
• Geographic limitations flexibility
• Attractiveness as a candidate (personality, training, amenability to practice demands, likelihood of "fitting in," etc.)
• Number of similar candidates available, interested in position
• Candidate's ability to promote the practice/hospital (special talents, personality, reputation in the area, etc.)
• Special or unique talents and skills

Employer Factors
• Desirability of the practice location
• Level of competition in that (sub)specialty generally and in the employer's specific area
• Employer's reputation locally and nationally
• Employer's market share and growth potential in the practice's service area
• Number of potential candidates for the position
• Employer's need for your particular cardiology talent (and reasons for the need)
• Degree of cardiology subspecialization required
• Co-ownership and/or advancement terms and opportunities

Compensation is a two-way street in which both the prospective practice and the candidate arrive at a mutually agreeable salary based on a number of considerations. Regardless of distribution, a practice only has a certain amount of funds to allocate for a new associate. On the other hand, a practice cannot really change its physicians, location or much else about itself very quickly. Many times, as the demand for associates increases all it can (realistically) change is the compensation offered and its track to co-ownership. If a high guaranteed salary is important to you, then you may have to give up some bonus potential, an employer paid disability insurance policy, or other benefits. Alternatively, you might be offered a great compensation package only to find either that your salary will not increase much per year or that the buy-in terms are oppressive or not offered at all. Co-ownership is not always a spelled out part of the deal, and it is not always automatically based on the time served as an employee.

Basic Practice Economics

Average Gross Income per Cardiologist

Gross Income Range (Common)		
Cardiovascular Surgery	\$500,000	\$950,000
Electrophysiology	\$650,000	\$1,200,000
Interventional Cardiology	\$600,000	\$1,000,000
Invasive Cardiology	\$600,000	\$1,000,000
Non-Invasive Cardiology	\$400,000	\$900,000
Internal Medicine (no cardiology fellowship)	\$250,000	\$450,000
* These figures vary substantially throughout the country, based on geography and services rendered.		

How Cardiologists Make Money

Procedures form the majority of income for most cardiologists. In fact, the Evaluation and Management ("E&M") services often make up about 10% of the proceduralist's collected income. Thus, a focus on both what you would do and how you would make money in practice are important criteria in determining income opportunities.

Average Net Income

Practice Gross (collected) and Net (physician) income vary widely with extreme variation in ranges dependent upon practice style, philosophy, age of physician and type of practice. Some cardiologists in some regions will make two to three times the income of their local peers, depending largely on what they own, how medically aggressive they are (including how much actual cardiology versus internal medicine they practice), how hard they are willing to work (especially in terms of days during the week and time off). Another important factor is how willing they are to innovate and to assume risk in purchasing equipment, developing labs, and bringing on a wide range of professional talent. (Remember that the payors in the same regions tend to pay the providers relatively the same amounts.) Therefore, effectiveness of billing and collecting aside and assuming the care rendered is medically necessary, differences in offers of compensation and earning potential may be due to practice "style," meaning one group takes more time off (thereby earning less) and another group simply works more.

Associate Economics

Generally, there is an enormous range in what associates are offered, due to the laws of supply and demand. However, when considering "salary," remember also consideration for the other elements of compensation (insurances, benefits, paid expenses, vacations, etc.). Nevertheless, the following are average candidates' starting salaries:

Associate Base Pay	
Specialty	Starting Salary Ranges
Cardiovascular Surgery	\$200,000 - \$250,000
Electrophysiology	\$250,000 - \$400,000 *
Interventional Cardiology	\$260,000 - \$400,000
Invasive Cardiology*	\$250,000 - \$375,000
Non-invasive Cardiology	\$200,000 - \$325,000
General Internal Medicine	\$135,000 - \$150,000

* This is possibly higher than expected due to the laws of supply and demand and there being less of these trained.

If you have specialized training that the practice recruiting you sees as a benefit, (such as echo or nuclear certification) then you may be offered a higher compensation level. As large cardiology practices develop and grow, they commonly recruit more specialized cardiology talents.

Cardiology continues to subspecialize. To a large extent, this subspecialization is driven by technology, as the research tools now available were only imagined a few years ago. Adding to this great growth in subspecialization is the aging population and the overall increased attention on fitness. This increased subspecialization works two ways for you. On the one hand, existing cardiology groups and hospitals seek this subspecialized talent as a marketing tool to enhance their images or to ensure a competitive advantage. On the other hand, with this technology becoming more widely available, even smaller groups are seeking EPs and you will have to evaluate if they can support you in the long term, and/or if the community is growing sufficiently in the interim.

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