



## CRAFTING A SUSTAINABLE MODEL FOR PHYSICIAN RECRUITMENT AND RETENTION

Using a six-point cycle developed and implemented by The Coker Group as a strategy for recruiting and maintaining a stable medical staff, readers of this report will be prepared to implement a sound medical staffing program to meet the short- and longer-term needs of their service area.

By Kay Stanley, FACMPE, Coker Group

## Table of Contents

Introduction .....	4
Understanding the high cost of attrition .....	5
I. Anticipating — Decreasing supply, increasing demand.....	7
Planning for Medical Staff Development.....	9
Conducting a Community Needs Assessment .....	9
Analyzing and Using Results of the CNA .....	10
II. Recruiting — Attracting physicians using a proven course of action. ....	10
Following the rules.....	10
Using available resources.....	11
Understanding the competition .....	14
Presenting your position favorably.....	14
Offering an appealing compensation and benefits package .....	16
III. Matching — Hiring for complementary work style, culture, and values.....	16
Interviewing candidates.....	16
Evaluating skills and work styles.....	17
Using assessment tools.....	17
IV. Retention — Holding on to physicians through mentoring, coaching, and practice support .....	18
Providing ongoing guidance and training .....	19
Respecting needs and providing tools for working .....	19
Building relationships between administration and clinical positions .....	20
V. Monitoring — Examining satisfaction levels through periodic interviews and meetings with individuals and groups, to maintain a high functioning environment.....	21
Ask: What are we doing right? What are we doing wrong?.....	21
Instituting a Physician Relations Program to assist with monitoring physician satisfaction .....	21
VI. Recovering — How lessons learned from exit interviews can drive improvements .....	22

Taking inventory and effecting change..... 22

Conclusion..... 22

# Crafting a Sustainable Model for Physician Recruitment and Retention

By Kay Stanley, FACMPE, Coker Group

## Introduction

Physician supply is decreasing at a time when the demand for quality healthcare—along with the number of aging patients—is increasing. Hospitals and health care systems are experiencing an increase in physician attrition rates that is expected to grow through 2020. Physicians leave the workforce through retirement, mortality, disability, and career change. A growing consensus is that over the next 15 years, requirements for physician services will grow faster than supply—especially for specialist services and specialties that predominately serve the elderly.<sup>1</sup>

According to the U.S. Department of Labor, in 2000 there were approximately 598,000 physicians working in the United States. Seventy percent were in office-based practices and 20 percent held hospitals-based positions. The rest worked in veterans' hospitals, public health services, and in other government positions. The Labor Department projects that overall physician employment will grow about 10 to 20 percent by 2010.<sup>2</sup> Many of the physicians who are completing their training<sup>3</sup> and entering practice, as well as those who are weary of carrying the burden of practice ownership, are expressing a high level of interest in employment by hospitals or large group practices. Staffs are also strained by a growing percentage of physicians who are choosing to practice part-time. While only 13 percent practiced part-time in 2005, 19 percent reported being part-timers in 2007.<sup>4</sup>

---

<sup>1</sup> Physician Supply and Demand: Projections to 2020. US Department of Health and Human Services Health Resources and Services Administration, Bureau of Health Professions, October 2006. Accessed 2/9/2009. Available at <ftp://ftp.hrsa.gov/bhpr/workforce/PhysicianForecastingPaperfinal.pdf>.

<sup>2</sup> Abdo, W., Broxterman, M., Physician employment trends, Physician's News Digest. Accessed 2/9/2009. Available at <http://www.physiciansnews.com/business/604abdo.html>.

<sup>3</sup> Note: Almost 24,000 physicians complete their training through programs of graduate medical education (GME) each year. Before completing residencies and fellowships, new physicians must earn a four-year college degree and complete four years of medical education. Four out of five physicians completing GME are graduates of United States medical schools. Most are graduates of schools of allopathic medicine, which annually graduate approximately 15,000 to 16,000 MDs. This number has been relatively stable since 1980, and the baseline projections assume that the U.S. will continue to graduate approximately 16,000 MDs per year through 2020. Schools of osteopathic medicine graduate approximately 3,000 DOs per year, and the baseline supply projections assume that this number will steadily increase to approximately 4,000 per year over the next decade. (Source: Physician Supply and Demand: Projections to 2020. U.S. Department of Health and Human Services.)

<sup>4</sup> Physician & Healthcare Executive Surveys: Physician Retention Survey. [http://www.merritthawkins.com/pdf/20007\\_Physician\\_Inpatient\\_Outpatient\\_Revenue\\_Survey.pdf](http://www.merritthawkins.com/pdf/20007_Physician_Inpatient_Outpatient_Revenue_Survey.pdf). Accessed 12/29/2008.

Physicians in increasing numbers are choosing one of two alternative tracks: employment by hospitals, on the one hand, or separation from and competition with hospitals, on the other. In any case, hospitals must take aggressive steps to react to the dwindling supply of physicians. Consider this statement: If the estimates are 40 percent of physician recruitment is for the hospital employment track, and your health system does not have an employment entity, then the supply of eligible physicians to recruit to your market has decreased 40 percent while demand, in most geographical areas, is increasing. Due to the number of physicians who desire to be employed, non-employing entities have a 40 percent smaller recruitment supply pool (i.e., fewer candidates to choose from) than organizations that employ physicians.

If your organization is struggling to retain physicians, it is worth trying to find out why they are leaving. A 2006 Physician Retention Survey conducted by Cejka Search and The American Medical Group Association identified some of the most common reasons a physician voluntarily resigns from a practice:<sup>5</sup>

- 51 percent cited a poor cultural fit with the practice;
- 42 percent relocated to be closer to their own or their spouse's family;
- 32 percent sought higher compensation;
- 22 percent left to find a better community fit;
- 17 percent pointed to an incompatible work schedule;
- 17 percent cited excessive call requirements.

## Understanding the high cost of attrition

How important is this physician attrition to hospitals? Physicians affiliated with hospitals generate an average of \$1.54 million in revenues per year per physician for the institutions, according to a 2007 survey by Dallas physician recruiting firm Merritt, Hawkins & Associates. According to Joseph Hawkins, the firm's CEO, the survey underscores the central role physicians play in the health care delivery system. "The physician's pen is still the most powerful tool in healthcare," Hawkins notes. "Patients are not admitted to the hospital or discharged, tests ordered, or procedures performed without a physician's signature. Hospitals depend on doctors to drive patient care, which in turn drives revenue."<sup>6</sup>

The income lost after a physician's departure, the ensuing recruiting costs, and the new physician's startup expenses can easily top \$200,000, according to an article "Estimates of costs of primary care physician turnover," in the *American Journal of Managed Care*.<sup>7</sup>

---

<sup>5</sup> Note: Methodology: The Cejka Search and AMGA 2006 Physician Retention Survey was distributed in December 2007 to 300 AMGA member medical groups. All survey responses (43) were compiled for this survey (a 15 percent response rate). These 43 responding groups collectively represent a population comprised of 14,705 physicians of whom 2,604 (19 percent) were practicing part-time, as defined by the responding group.

<sup>6</sup> <http://www.merrithawkins.com/pdf/2007-mha-revenue-survey-release.pdf>. Accessed 12/29/2008.

<sup>7</sup> Buchbinder, S.B., Wilson, M., Melick, C.F., Powe, N.R., Estimates of costs of primary care physician turnover. *American Journal of Managed Care*. 1999; 5(11):1431-8. Accessed 2/13/2009 at <http://www.ncbi.nlm.gov/pubmed/10662416>.

Physician employers can hardly stand the cost of turnover in times of tight money and stiff competition for talent and skills.

This paper presents a six-point plan to combat deficient medical staffing for the long term, and explains how you can craft an enduring model for recruiting and retaining a medical staff to meet the ongoing demands of the market.

The six-point physician recruitment and retention program is illustrated in Figure 1.

**Figure 1**



## I. Anticipating — Decreasing supply, increasing demand

The numbers don't lie. The story is about "disappearing docs." Our health care system is experiencing a shortfall that will manifest itself over the next few years and significantly stretch our systems and providers. "Since 1980, the US population has increased more than 33 percent, while the number of new doctors graduating from medical school has stayed constant, creating shortages in primary care and other specialties," says a Cejka Search report. "The changing profile of the typical American medical group will be influenced to a great extent by the retirement of predominantly male, Baby Boomer physicians and the emergence of the Millennial generation workforce, which is equally comprised of male and female physicians."<sup>8</sup> The shortfall can be attributed to the aging of the physician workforce (with its associated decrease in hours worked), the increasing number of female physicians (who tend to work fewer hours and retire earlier than their male counterparts), the lesser work effort of physicians who are employees, the tendency of younger physicians to place a greater emphasis on personal time, the increasing frequency of early retirement, and the limited hours that residents are permitted to work.<sup>9</sup> Ironically, in the 1980s and 1990s, many predicted a physician glut.<sup>10</sup> Most previous workforce analyses used unmodified population forecasts from the Census Bureau, which have proved to be low, and, therefore, the resulting projections of physicians per capita were excessively high. Indeed, this error accounts for approximately 25 percent of the physician surpluses that were previously predicted.<sup>11</sup> The predictions today are that the nation will have a shortage of 85,000 to 200,000 physicians in 2020 unless action is taken soon to increase the number from 25,000 physicians who graduate from United States medical schools annually.<sup>12</sup>

The J-1 visa waiver program for international medical graduates (IMGs) offers a critical source of health care providers to community health centers and other locations in rural communities and underserved areas. If all IMGs currently in primary care practice were removed, one out of every five "adequately served" non-metropolitan counties would become underserved and the number of rural counties with no primary care physicians would rise from 161 to 212. The American College of Physicians cautions that the nation should not rely on international medical graduates alone to solve the shortage of primary care physicians in the United States given the need for medical personnel in the home countries of some of these physicians.<sup>13</sup>

---

<sup>8</sup> Physician & Healthcare Executive Surveys: Physician Retention Survey.  
<http://www.cejkasearch.com/surveys/physician-retention-surveys/2008>. Accessed 10/8/2008.

<sup>9</sup> Cooper, R.A., Getzen, T.E., McKee, H.J., and Laud, P. Economic and demographic trends signal an impending physician shortage, Health Affairs, Accessed 2/9/2009 at <http://content.healthaffairs.org/cgi/content/full/21/1/140>.

<sup>10</sup> Kallenberg, G, Riegelman, R, Hockey, L., "Waiting for the Doctor Glut, or is the Calvary Really Coming?"  
<http://www.springerlink.com/content/m405133707867706/>. Accessed 10/9/2008.

<sup>11</sup> Cooper, et al., Economic and demographic trends signal an impending physician shortage, Health Affairs, Accessed 2/9/2009 at <http://content.healthaffairs.org/cgi/content/full/21/1/140>.

<sup>12</sup> Physician & Healthcare Executive Surveys: Physician Retention Survey.  
<http://www.cejkasearch.com/surveys/physician-retention-surveys/2007/2007-physician-retention-survey.htm>.  
Accessed 10-6-2008.

<sup>13</sup> Creating a New National Workforce for Internal Medicine, American College of Physicians, A Position Paper—2006.  
Accessed 3/6/2009 at [http://www.acponline.org/pressroom/ref\\_primecare.htm](http://www.acponline.org/pressroom/ref_primecare.htm).

More recently, Physicians' Foundation 2008<sup>14</sup> survey of approximately 12,000 physicians nationwide that included more than 800,000 data points found "An overwhelming majority of physicians—78 percent believe that there is a shortage of primary care doctors in the United States today. Additionally, 49 percent, or more than 150,000 practicing doctors said that over the next three years they plan to reduce the number of patients they see or stop practicing entirely." About 11 percent of respondents said they plan to retire in the next one to three years. More than 13 percent said they plan to seek a job in a non-clinical health care setting, which would remove them from active patient care. More than 10 percent said they would seek a job unrelated to health care.

The broader purpose of the survey is to suggest how the state of physician morale, and the position of today's doctors vis à vis the current medical practice environment, may affect access to physician services and, by extension, overall quality of care in the United States. The physicians' perspective is essential to the health care debate and can have drastic implications for the number of physicians available to see patients. Either it will influence a motivated workforce and encourage a new generation of quality physicians, or it will generate widespread discontent that could jeopardize the quality of our medical workforce.

Capacity is a major issue in the shortage factor. From the responses received from physicians in all 50 states and the District of Columbia, The Physicians' Foundation report indicates that the majority of physicians (63.4 percent) work 51 hours or more per week while 38 percent work 61 or more hours a week. Over 90 percent said that the amount of time they spend on non-clinical paperwork has increased in the last three years. Over 60 percent spend at least 11 hours per week on non-clinical paperwork duties. Sixty-three percent said that the growing volume of non-clinical duties they face has caused them to spend less time per patient. Over 70 percent see either a "moderate need" or an "urgent need" for more primary care physicians in their areas. Close to 90 percent said it is either "very difficult" or "moderately difficult" to recruit physicians to their practices, further suggesting that excess physician capacity is minimal. Fifty-three percent said they have had to close their practices to certain categories of patients as a response to cost/reimbursement or time issues. The shortage of physicians in rural areas will present an even greater challenge than for metropolitan areas, as fewer and fewer physicians who are entering the medical profession are choosing a rural location for their practice. The most common reasons doctors give for avoiding rural areas include professional isolation, income reduction (more rural patients are uninsured), lack of physician (e.g. medical library, electronic health records and computerized order entry, Medical Imaging PACS system, physician dining area and lounge, Medical Staff Office, Nationally accredited CME Program, Free Parking, inclusion in the physician directory, etc.) and cultural amenities, and fewer employment opportunities for other family members. Unless these issues are addressed, physician **maldistribution** will continue to be a problem.<sup>15</sup> The disparity in physician supply for rural areas may become more severe as the number of female physicians entering the medical profession increases. Research indicates female physicians are less likely to choose a rural location for their practice than their male counterparts.<sup>16</sup> One explanation for the historically low percentage of women in rural practice is the difficulty of meeting the needs of male spouses of physicians in rural areas.<sup>17</sup> Male spouses of physicians face greater problems

---

<sup>14</sup> The Physicians' Foundation, The Physicians' Perspective: Medical Practice in 2008, Survey Summary & Analysis, Accessed 12/29/2008 at [http://www.physiciansfoundations.org/usr\\_doc/PF\\_Survey\\_Report.pdf](http://www.physiciansfoundations.org/usr_doc/PF_Survey_Report.pdf).

<sup>15</sup> Abdo, W. and Broxterman, M. Physician employment trends, Physician's News Digest. Accessed 2/9/2009 at <http://www.physiciansnews.com/business/604abdo.html>.

<sup>16</sup> Cronin, D., "What's Happening with Georgia's Physician Workforce Shortage?" Progress Notes, September 2008.

finding employment than female spouses, as they're more likely to seek employment, or full-time employment.

To meet the upcoming challenges of supply and demand, a hospital must develop a clear strategy to recruit physicians in order to both serve the community and increase its profits. And the first part of the plan must address medical staff development.

### **Planning for Medical Staff Development**

A medical staff development plan quantifies physician need in a geographic area, establishes hospital recruitment priorities in the context of community need, and addresses related issues such as medical staff organization, physician practice location, service line development, overall physician retention strategies, as well as other alignment initiatives.

The planning method uses both quantitative input, such as physician-to-population ratios, and qualitative input, including physician interviews and steering committee discussions. The plan should factor in changes in health care delivery and medical practice, such as the difficulty in getting specialist physicians to agree to emergency call. Many physicians who in the past volunteered their time as on-call specialists at hospital emergency rooms now are demanding to be paid. This is due primarily to the increase in uninsured ER patients, fewer specialists to share the on-call load, greater liability risks in the ER, and a desire for a more balanced life.

Also, the plan should focus on the renewed interest by physicians in employment opportunities. While it may seem obvious, a plan will only succeed if the organization is both committed and prepared to make changes. Therefore "buy in" is necessary in all stages of the planning process.

Characteristics of successful medical staff development and recruitment initiatives include:<sup>18</sup>

- Making it easy for physicians to join the staff and begin to practice;
- Offering a variety of practice settings;
- Considering nonphysician clinicians;
- Providing a high-productivity environment;
- Redefining physician categories;
- Adjusting productivity assumptions;
- Encouraging the medical staff to review and, where necessary, update their structure and bylaws.

### **Conducting a Community Needs Assessment**

The first stage in instituting a medical staff development plan is executed by performing a community needs assessment (CNA).

---

<sup>17</sup> Abdo, et al.

<sup>18</sup> Lifton, James. Seven Steps to Successful Medical Staff Development Planning. Accessed 10/14/2008 at [http://www.trusteemag.com/trusteemag\\_app/jsp/articledisplay.jsp?dcrp](http://www.trusteemag.com/trusteemag_app/jsp/articledisplay.jsp?dcrp) .

A hospital can offer certain financial benefits to a physician as an incentive for relocating his or her medical practice into the hospital's Geographic Service Area,<sup>19</sup> when there is documented objective evidence of a community need for the recruited physician's specialty in the community. A community needs assessment of the physicians in a hospital service area provides an efficient, defensible, and affordable solution to physician needs planning. A formal physician staffing survey as part of the CNA should be completed every two to three years by an independent entity and in compliance with all federal rules pertaining to physician recruitment.

Information necessary for a CNA can be gathered by a survey or by live interviews of physicians and hospital administrators, as long as the same questions are asked in each interview. The survey may be expanded to include community members, hospital board representatives, and key employers in the market.

A CNA (see Figure I-2, CNA) requires the cooperation of the hospital in providing necessary data and working with physicians to assist in completion of the opinion survey. [Figure I-2 Physician Community Needs Analysis]

### Analyzing and Using Results of the CNA

The survey results—and any underlying trends they uncover—should then be considered, along with the thoughts and needs of existing medical staff, department managers, and the community (the latter can be assessed by using focus groups). Reported wait times for existing practitioners should also be considered. Although these indicators may not ultimately affect a search list, they might determine timing or priorities.

## II. Recruiting — Attracting physicians using a proven course of action.

After community needs are determined, recruitment is the second point on the medical staff recruitment and retention cycle.

How do you attract talented physicians to your area and keep them to maintain a competitive advantage? This is, and will be, a constant and costly battle. Where do you start?

### Following the rules

The Internal Revenue Service (IRS), U.S. Department of Health and Human Services (HHS), and the Centers for Medicare and Medicaid (CMS)—through the Stark Laws—impose regulations governing how physician recruitment must be conducted and the conditions under which recruiting incentives may be offered. State health agencies also have some impact on physician recruitment. Although not required by Federal statutes, many states still have Certificate of Need regulations.

Physician recruiters and hospitals should be familiar with these laws and regulations. Regulations may vary, but in recruiting physicians private practices are required to:

- demonstrate a need in the community for a new physician;
- provide a guaranteed salary or income that is “reasonable;”

---

<sup>19</sup> Per Stark II, Final Definition, Geographic Service Area (GSA) is defined as the area composed of the lowest number of contiguous postal zip codes from which the hospital draws at least 75 percent of its inpatients. For rural hospitals, the GSA can be at least 90 percent of inpatient admissions.

- make a written agreement with the physician that is approved by the recruiting hospital board; allow the physician to obtain privileges at other hospitals, in addition to the recruiting hospital;
- require that the physician see Medicare patients;
- not tie incentives to requirements that the physician refer patients to the hospital.

### Using available resources

A good sourcing strategy is a necessary piece of the puzzle for physician searches. It begins with determining what type of people you need and then deciding the best way to reach them. Working through an in-house recruiting function is one approach. Another approach is to use an external recruiting firm. A firm typically uses one of three basic fee structures:

- **Contingent** – typically the fee is paid at the fulfillment of the assignment, based on a percentage of the hired candidate’s first year cash compensation, with most falling in the 15 percent to 25 percent range. In contingency search, there is no exclusivity in the arrangement; the client is free to use other search firms or source candidates on its own. Contingent search tends to be less oriented toward candidate assessment and more about getting résumés in front of the client. “Headhunting” is an idiom often associated with this approach.
- **Retained** – typically, the fee is paid in installments based on time intervals or deliverables. Like contingency, the fee is based on the hired candidate’s first year cash compensation with most falling in the 25 percent to 40 percent range. The arrangement is generally exclusive so that if the client finds and hires the candidate outside the efforts of the search firm, the fee remains due and payable. The process is highly structured, hands on, and much more collaborative than contingency. The client will be exposed to fewer résumés and candidates.
- **Consultative** – the fee is based on the time the consultant devotes to the project. The same process is used as the retained approach in terms of collaboration, structure, and hands-on touch. The client has the potential to receive the same quality service that the retained firms provide, with a possibility for significant reduction in fees because the client only paying for the consultant’s time, and the position may be filled sooner than expected. The client may disengage the consultant without the financial penalties that often accompany the retained model.

Whatever recruitment model is selected, it is imperative to define what opportunities exist, as well as expectations, whether recruiting for a new position or one that already exists.

Typically a recruiter will begin the process by asking a set of questions to the clinic regarding the specific opportunity. The questions and items to consider in Table II-1 below provide a profile that will prepare the way for a successful search for a single position.

**Table II-1**

Questions/Other Considerations	Comments
1. Timeframe for filling this position?	
2. Why does the need exist? <ul style="list-style-type: none"> <li>a. If it is because a physician left the group, identify reason for physician’s departure.</li> <li>b. Do you want to call and speak to former physician?</li> </ul>	
3. Who are the decision makers?	
4. Does the practice/hospital already have a contract developed for this opportunity? <ul style="list-style-type: none"> <li>a. If not, template will need to be finalized and submitted to physician recruiter before beginning the search so as not to delay closing a candidate.</li> <li>b. The contract should spell out employee benefits, i.e., malpractice, health insurance, CME, vacation, sick leave, disability, etc.               <ul style="list-style-type: none"> <li>i. Will need copy to send to candidates; have all questions answered regarding both contracts <i>prior</i> to site visit.</li> </ul> </li> <li>c. Contract cannot include a non-compete clause.</li> </ul>	
5. Will the new physician be eligible to be on a partnership track? If so, what are the conditions? <ul style="list-style-type: none"> <li>a. Typically 18-24 months</li> <li>b. Components of buy-in already defined               <ul style="list-style-type: none"> <li>i. Depreciated value of assets</li> <li>ii. No Good Will</li> </ul> </li> </ul>	
6. What is the compensation structure for a new physician? <ul style="list-style-type: none"> <li>a. Employed by group? If so, has salary been established?               <ul style="list-style-type: none"> <li>i. Present MGMA range for specialty</li> <li>ii. Bonus/incentive structure</li> </ul> </li> </ul>	

<ul style="list-style-type: none"> <li>b. What happens after first year?</li> <li>c. Independent contract from day one? <ul style="list-style-type: none"> <li>i. Projected income</li> </ul> </li> <li>d. Is there an established salary in mind?</li> </ul>	
7. What is the age of the practice?	
8. Hours of operation—Monday through Friday? <ul style="list-style-type: none"> <li>a. Extended hours or Saturday operations?</li> </ul>	
9. What is the practice volume? <ul style="list-style-type: none"> <li>a. Patients per day?</li> <li>b. Hospital consults?</li> <li>c. Average wait time to get an appointment?</li> <li>d. If specialist, referral base?</li> </ul>	
10. Call coverage	
11. Gross charges for current and prior year	
12. Net Collection percentage <ul style="list-style-type: none"> <li>a. Is billing and collections function managed in house or outsourced?</li> </ul>	
13. Payer Mix <ul style="list-style-type: none"> <li>a. Medicare</li> <li>b. Medicaid</li> <li>c. PPO</li> <li>d. BCBS</li> </ul>	
14. How stable, financially speaking, is the clinic? (fair, good, excellent)	
15. Request CVs of existing physicians in the group	
16. Tour clinic facilities <ul style="list-style-type: none"> <li>a. Square footage; number of exam rooms</li> <li>b. Take note of age and condition of furnishings, equipment, computerization, EMR, etc.</li> </ul>	

The recruitment initiative should also list the qualifications necessary for the position, including training, years of experience, and other indicators of whether the candidate would be a good fit for the clinic or the patient population served by the clinic.

### Understanding the competition

The existing and anticipated shortfall of physicians has already created stiff competition among healthcare providers across geographic locations. Allan Fain, director of medical staff development for Wellmont Health System in Kingsport, TN, says, “What this means is—physicians will probably have 200 bona fide job offers anywhere they want to go. And the specialists, because there are so few doctors, they’ve got their choice of anywhere in the country.”<sup>20</sup> The competition is especially heated for cardiologists, gastroenterologists, and oncologists because fewer new practitioners are coming into the system. For example, in 2008 fewer than 800 cardiologists completed their training and were ready to begin practicing, compared to nearly 1,200 in 1994.<sup>21</sup> Meanwhile, millions of aging baby boomers require predictable needs for specialty medical care as they reach their 50s and 60s. The competition, therefore, is on the local, state, and national level, as specialists can expect to receive hundreds of offers.

### Presenting your position favorably

Because of stiff competition, you must present your practice opportunity favorably, responding to the physician’s prospective needs and presenting a longer-term view of what the practice and the community offer. During the next several years, there will be important trends in the medical industry that will affect the careers and future earning power of most physicians practicing in the United States. In order to maximize their fullest potential, physicians will have these trends in mind before entering the job market.<sup>22</sup> Adequate compensation is certainly one component, but clinical autonomy and control over their time and work environment tend to be more important over the long term. As younger physicians move into the medical industry, expect quality of life to become an increasing consideration.

An independent study conducted for the *New England Journal of Medicine* reports that physicians rank location as the top reason they accept a position. Family considerations and the type of practice setting tied for second place. Although compensation is considered only the fifth most important reason for choosing their current job among all respondents, physicians 41 and older place it at the top of their lists.<sup>23 24</sup>

---

<sup>20</sup> Hayes, S. C., “Physician shortage fuels local recruiting efforts,” Timesnews.net, [http://www.timesnews.net/print\\_article.php?id=9008860](http://www.timesnews.net/print_article.php?id=9008860). Accessed 12/9/2008.

<sup>21</sup> Ibid.

<sup>22</sup> Abdo, et al.

<sup>23</sup> “How Young Physicians Search for Jobs, Zeldis Research Associates, April 2004. Accessed 2/12/2009, [www.medicuspartners.com/pdfs/HowYoungProfessionalsSearchForJobs.pdf](http://www.medicuspartners.com/pdfs/HowYoungProfessionalsSearchForJobs.pdf).

<sup>24</sup> Note: Survey based on the following data: Sample: 2,000 total, consisting of physicians in practice five years or fewer. Source: Random selection, AMA physician file; Usable responses: 486 (24.9% response rate).

These factors will also be the basis for their satisfaction and retention. If these needs are ignored, you risk hiring the wrong physicians, who in turn may lose money for your practice, whether they stay or go.

Following are some examples of ways to present the benefits of your area to appeal to potential recruits:

- Northeast**      The Northeast region includes many intellectual centers and urban areas, and is steeped in historic, cultural, and outdoor diversions to satisfy a broad spectrum of tastes and interests. Physicians who are attracted to the Northeast are most likely from the area, educated there, and have family nearby. At the community level, focus on school systems and nearby colleges and universities, and be prepared to provide detailed information about each community in the service area.
- Southeast**      The Southeast includes beautiful landscapes, including warm Atlantic beaches, Florida's Gulf Coast, the Blue Ridge Mountains, and many prominent golf courses created by some of the world's greatest golf architects. Many areas in the Southeast also offer low costs of living. At the local level, highlight the benefits of living in hospitable small towns with access to urban areas and cultural diversions, warm weather, and the many outdoor activities available most of the year.
- Midwest**        Physicians raised in the Midwest, or those seeking a less hectic lifestyle may seek the benefits of living in the Midwest. Less expensive than the Northeast and West Coast and less stressful, many areas of the Midwest feature an open and casual approach to everyday living that may lure physicians seeking to migrate from the larger coastal cities.
- Southwest**      The Southwest's year-round outdoor activities, economic growth, and lower taxes compared to most other areas of the country are appealing to many physicians. The Southwest offers many culturally-appealing larger cities, but includes many suburbs, small towns, and remote rural areas that provide diverse opportunities for work in close proximity to a huge variety of recreational opportunities.
- West**            Gorgeous weather, the beaches of California, and the mountains and deserts of Utah, Nevada, Colorado, and other western states provide many attractive recreational opportunities. Many physicians will also appreciate the family-friendly atmospheres of many of the West's smaller cities and towns.
- Northwest**      The perfect location for a balanced lifestyle, with access to beaches and mountains, as well as highly-regarded metropolitan areas. Vibrant and sophisticated cities like Seattle and Portland are nestled between the Cascade and Olympic Mountain ranges along Puget Sound. Likewise, the Northwest offers many attractive rural communities for those who seek a slower pace. The Northwest offers a variety of options for living, with each community possessing a unique identity and character. For the outdoor enthusiast, even urban areas feature attractive parks and gardens and offer outdoor opportunities including golf, kayaking and canoeing, fishing and clamming, and hiking. The Northwest offers access to skiing, snowboarding, river rafting, hiking and some of the most scenic parks in the U.S.

## Offering an appealing compensation and benefits package

Can small organizations compete against larger ones in recruiting physicians and vice versa? The answer is yes. The key is to focus not only on the attractive aspects of your location, but also on the benefits that the organization offers.

One key “benefit,” is, of course, salary and other direct financial compensation. Surveys from the Medical Group Management Association and other sources offer up-to-date data for compensation ranges. These resources are invaluable in setting comparable standards for hiring and employment. When offering a compensation package, state the base salary, if any. For incentive compensation, define terms, include formulas, and provide realistic sample calculations. Establish whether your practice’s new physician will be paid for productivity. If so, is the formula based on collections, charges, relative value units (RVUs), profitability, or some combination of these? The agreement should state whether the new physician will be eligible for participation in pay-for-performance programs, or if there is the potential to earn bonuses for areas such as patient satisfaction or good physician citizenship (serving on committees, for example). The agreement should also state whether the new physician’s compensation method can—or will—change during the term of employment.

In an independent survey sponsored by the *New England Journal of Medicine* entitled “How Young Physicians Search for Jobs,” three out of four respondents said that malpractice insurance is the most important benefit. The signing bonus and CME time allowance were the second and third most important benefits, respectively. The remaining key benefits were, in order, disability insurance, education loan forgiveness, relocation expenses, CME expenses, and sabbatical eligibility.<sup>25</sup>

## III. Matching — Hiring for complementary work style, culture, and values

Recruiting the best physician begins with evaluating your practice’s needs and the identifying the attributes of your ideal candidate. Before the first interview, you should prepare thorough answers to the following questions:

1. What qualifications and qualities do we need in a physician? Describe duties to be performed, work schedules, and locations. Outline the required skills or necessary credentials. Identify characteristics or conditions that will fit with the current culture and values.
2. What does our practice offer to a physician? Describe the community and what it has to offer, the types of patients and cases in the practice. Identify strengths of the professional colleagues, the staff, and the support that is available.

## Interviewing candidates

The first discussions with viable candidates should be for at least an hour by phone (or in person, if practical). The conversation should focus on drawing out the candidates to learn as much as possible about them, such as background, training, etc.—and what they want in a job—as possible. Then, you should describe your practice, including its setting and culture and what you have to

---

<sup>25</sup> “How Young Physicians Search for Jobs,” Zeldis Research Associates. Accessed 2/11/2009, available at [www.medicuspartners.com/pdfs/HowYoungProfessionalsSearchForJobs.pdf](http://www.medicuspartners.com/pdfs/HowYoungProfessionalsSearchForJobs.pdf)

offer. It is important to consider, both in your questions and answers, generational differences that can affect values, attitudes, and behaviors at work. These differences are often displayed in communication style, dress, work processes, and even the definition of work. The information that you gather should enable you to assess how well each candidate will probably fit with your practice, and whether to continue in the recruitment process with the candidate.

### **Evaluating skills and work styles**

An organization must assess a candidate's compatibility with the organizational culture. This includes both the philosophy of care and clinical process, and the business philosophy, including financial goals and cost-containment or utilization requirements. During the interview process you should provide clear and complete information about workplace conditions, responsibilities, and expectations. The interviewer must carefully explain the management process, such as how decisions are made and how productivity expectations are determined and measured. The series of interviews should encompass requirements for administrative duties, including authorizations, referrals, follow-ups, and reporting.

Specialist recruits that join the organization should have practice styles, productivity, and skill levels that are compatible with those of the primary care physicians and other specialists. Flexibility and ability to work well with others are desirable traits as well. Since you are recruiting for the long term, it is important to define expectations beforehand so there are few surprises on both sides after the physician arrives.

The physician should receive a clear picture of the patients and cases that the practice will see. Although the practice may change or physician's priorities may change over time, it is important to establish accurate expectations in the beginning to avoid misunderstandings. A practice can't really do much if a physician's personal choices change over time, but it can change how it presents itself and how, when, and if changes are made.

### **Using assessment tools**

A systematic approach to physician recruitment should include the use of some assessments tools. Hiring the right physicians for your organization will never be an exact science, yet human resource tools can greatly increase the odds of hiring the right people and retaining them once hired.

How valuable would it be to know the answers to the following questions before you make a hiring decision?

What will this person be like to manage?

What will they be like as a manager?

How will they behave in a crisis?

What are they like under time pressure?

What role(s) will they excel in or struggle with?

When your hospital or practice invests in an expensive piece of equipment, you receive a manual containing instructions for operating it, maintaining it, and troubleshooting. But when you invest in human capital through your physicians and employees, you do not receive a similar manual.

Assessments can help fill this information gap, by revealing the human characteristics that make each of us unique. Assessment tools aid in identifying personality traits of potential hires. The same information is significant for training and management purposes.

Assessments are a primary predictor of job success. They can have greater relevance than factors such as age, experience, training, and other particulars that employers use to make human capital decisions. Assessments can help you match employees to the work they do. When the match is good, performance often exceeds expectations.

The price you pay when hiring a person unsuited to a position can be enormous, in terms of time, training, money, and other resources. When you focus on understanding and measuring core competencies, behaviors, and interests of candidates to ensure they fit the job, you're more likely to:

- Avoid costly hiring mistakes;
- Hire top performers;
- Put the right person in the right job the first time;
- Identify and develop leadership skills.

Building your physician team and solving your human capital management challenges are fundamental to your success. Add measures based on established assessment tools and you will see your growth in your organization's morale—and performance.

#### **IV. Retention — Holding on to physicians through mentoring, coaching, and practice support**

Forty-six percent of physicians who leave a practice are most likely to do so within the first three years, according to the 2006 Physician Retention Survey.<sup>26</sup> Cycle Four in the enduring physician employment model is designed to help you retain physicians for a long tenure.

Why do physicians change jobs? The reasons are plentiful, but physicians most frequently cite:

- An unstable organization;
- Limited professional growth opportunities;
- Office politics/work culture issues;
- Demands that make it difficult to balance between work and personal lives;
- Patients, cases, and career choices;
- Location and lifestyle;
- Compensation.

---

<sup>26</sup> Valancy, J. "Recruiting and Retaining the Right Physicians," *Family Practice Management*, October 2007, Vol. 14, No. 9, pages 28-33. Accessed 11/21/2008 at <http://www.aafp.org/fpm/20071000/28recr.html>.

## Providing ongoing guidance and training

These issues are so important and so varied that they're best dealt with by instituting a mentoring and coaching program. The program should be designed to help physicians early in their careers to navigate these hurdles and frustrations, in the process making an individualized effort to retain them in your organization and the profession.

Regarding mentoring, the Cejka survey report states the following:<sup>27</sup>

- 95 percent of respondents believe that mentoring increases retention and 56 percent assign a mentor to newly recruited physicians.
- Groups who assign mentors are strongly committed to mentoring as a retention strategy, with 83 percent somewhat or very likely to expand it.
- The use of mentors is expected to become more widespread; 62 percent of respondents who do not currently have a mentoring program say that they are somewhat or very likely to start one.

Mentoring is when someone who's very experienced in a profession provides support and counsel to another, less experienced, professional. For example, an experienced physician might mentor a physician entering practice by offering one-on-one guidance on personal development. A successful mentoring relationship allows dialogue between two autonomous practitioners on a voluntary basis. It is also open and confidential, which enables young practitioners to voice concerns and frustrations without fear.

Mentors meet with new physicians to talk through any impediments or problems that are obstructing personal and professional development. For their part, neophytes are encouraged to speak up about any obstacles and explore potential remedial action with the mentor. This is constructive reflection, and the physician sets the agenda. Both personal and educational issues may be discussed.

## Respecting needs and providing tools for working

In addition to mentoring, physicians require a great deal of support from their employers in providing their work infrastructure. As a profession, physicians' desire is to take care of patients (and this is, to a major extent, what their training focuses on), but they need the support of a strong operational structure from which to provide care and make sound decisions. Employers who seek to retain their physicians must:

- Keep commitments made during the recruitment stage;
- Put the physician in the best position to be successful;
- Provide practice development support;
- Ensure satisfaction with the hospital's services;

---

<sup>27</sup> Physician & Healthcare Executive Surveys: Physician Retention Survey.  
<http://www.cejkasearch.com/surveys/physician-retention-surveys/2007/2007-physician-retention-survey.htm>.  
Accessed 10-6-2008.

- Recognize the representative role the CEO and administrative team plays to the physician—you are the hospital;
- Develop a strategy for practices., e.g. customized plans to help strengthen the relationship with each practice based on their needs over the next 12 months, etc.;
- Define physician relations activities. This could include approaches to better align with each practice by uncovering unique concerns of each physician and the individual practice strategies. This is a global issue that applies to every practice;
- Develop and maintain tools to track and monitor physician/practice issues and opportunities;
- Track physician/practice issues and concerns to point of resolution and beyond;
- Establish and implement a response policy for responding to physicians after identification of an issue or opportunity (e.g., 72 hours to communicate next steps or resolution);
- Involve physicians in hospital development strategies through committees, input, advisory groups, active seeking of opinions, etc.; Institute and ensure a service mindset from department directors and underscore its relevance through training;
- Develop a service recovery process to proactively address issues that will invariably arise, in an effort to be responsive to physician and office staff needs
- Develop a service recovery process to correct or make up for mistakes for physicians and their staff to know what to do to address an issue. This is a global issue that applies to every practice;
- Provide local CME and other educational opportunities for physicians and office staffs (CEUs);
- Develop continuing education sessions for recruiters and other hospital staff members on physician sales; e.g., attaining a better understanding of the needs of physicians and their office, ways to relate to physicians, support their progress and help the practice to thrive;
- Conduct a “where can we improve?” survey for the physician 9-12 months after they begin employment;
- Interview those physicians who leave to find out why and consider suggestions they have made for improvement(s).

### **Building relationships between administration and clinical positions**

Retention efforts begin with recruitment, including the period between signing and the start-up date. Each new hire should have a structured orientation. It should be individualized and specialty-specific, and include introductions to key department managers and medical and administrative staff. All new physicians should have a group orientation that is more conceptual and philosophical, where the organization’s strategic plan is presented and physicians’ issues and concerns are discussed. Spouses could be included for part or all of this portion of the orientation.

Mentoring and support initiatives that foster retention help to include the physician and his or her family in the organization and in the community. The organization that markets the physician to the community drives volume to the hospital and embraces the physician through the practice building years.

## **V. Monitoring — Examining satisfaction levels through periodic interviews and meetings with individuals and groups, to maintain a high functioning environment**

Closely associated with the retention and support phase are the efforts that examine and monitor levels of satisfaction. Periodic surveys are one tool. Developing a structured plan of action for a physician relations program and implementing it are ways to achieve and maintain a smooth program. Planning is the first (and maybe easiest) step; implementing and maintaining a consistent program is the tough part.

### **Ask: What are we doing right? What are we doing wrong?**

Communication plays an important role in physician satisfaction and retention, and of course is also crucial to the operation of the medical staff at large. Three steps to positive relationships are: 1) involving the players in committees, advisory groups, etc.; 2) inducing dialogue and soliciting input; and (3) responding to suggestions, requests, and complaints with action. Effective communication starts with administration and physicians sincerely seeking the best for each other. Setting up a planned program for two-way communication that includes periodic visits by hospital physician services representatives during the early months and years of a new physician's hire will help to establish the healthy dialogue that is necessary to maintain satisfaction through consistent attention to and resolution of issues.

Measuring results by using survey mechanisms at predictable periods, such as after 9 to 12 months, and annually thereafter, are among the ways to be certain you are getting important feedback about issues and concerns. Once dissatisfactions are revealed, interviewing for specifics, following through with solutions, and monitoring solutions over the long term are the primary means for maintaining communication and ensuring loyalty and stability.

Long term results should be measured through tracking mechanisms that document issues and the status of resolutions.

### **Instituting a Physician Relations Program to assist with monitoring physician satisfaction**

Although it is essential for the communication channels to be open across the administrative staff, the reality is that channels sometimes get clogged. Hence a physician relations program can be a valuable conduit for monitoring and maintaining physician satisfaction. The program, which encompasses the overall initiatives related to physician services, should start when the physician signs and be active through the start date to facilitate a smooth transition and establish a sound foundation for the new practice.

The program should outline various stages of the strategies and activities, as customized for the practice, and establish ongoing actions. These include growing beyond issues and concerns with the hospital to advance towards greater collaboration and partnering efforts between the practices and hospital. The program should, in part, focus on strategic opportunities, including potential joint ventures. Using simple software tools data can be entered and report issues and concerns by department (see Figure V-1, Data Entry and Figure V-2, Issues and Concerns by Department). The

report identifies the physician, date of call, specialty, issue, problem solving, resolution, follow-up actions, the physician relations representative, and the person that was contacted about the issue. A compiled report is likely to reveal patterns by department and identify problem areas.

The physician relations program will apprise administration of problems and provide regular progress reports feedback. Useful communiqués such as newsletters and bulletins can help disseminate current information and are easily referred to. Announcements and reminders of meetings and events planned for the benefit of physicians are especially important and should be communicated through shared calendars and other means (e.g., email, IM, bulletin boards, etc.). Reminders and announcements should be sent or posted multiple times to ensure that they're not overlooked by physicians and their staffs.

## **VI. Recovering — How lessons learned from exit interviews can drive improvements**

### **Taking inventory and effecting change**

An exit interview should be part of the exit process. It is crucial to assess both what you are doing well and what you can improve in all stages of physician employment, including the recruiting and hiring process. This is a good opportunity to learn about weaknesses and to strengthen the practice through new policies, or to simply do a better job communicating and resolving problems. It can also help you identify your organization's strong areas, which you can emphasize when recruiting. When change is needed, have the courage to make it in order to avoid future conflict and loss. With stiff competition for a diminishing supply of physicians, your organization can ill afford the price of turnover.

It is important to note that sometimes physicians leave for positive reasons, to change career directions to pursue other interests, or to reduce their work load, and sometimes to retire. Exit interviews from positive departures are also valuable for gaining vital information about the organization and the cultural environment, as well as recommendations and other input.

In the case of a negative departure, a single exit interview should be assessed in context. Just because a physician complains about issues or faults an organization does not mean that there is a pervasive problem, and just because a physician says something should be changed, does not mean it should (or could). In other words, you cannot please everybody, and there are often good reasons why you should not try.

### **Conclusion**

Recruiting and employing high-quality physicians that are a good match for the practice is the ideal goal. A concerted effort is needed to sustain a positive relationship—which is a key to physician retention. This begins during the recruiting process, and continues when you negotiate an employment agreement that is fair to both parties. Another key to building and maintaining a productive and committed medical staff is getting your new physicians off to fast starts by providing what they need during the crucial first few months of employment. When you add to this ongoing support through mentoring and proper staffing, consistent performance monitoring, and accountability, you can greatly increase your physician retention rate—and the overall productivity of your practice.

