The Professional Approach to Physician Recruitment and Retention

by
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ABOUT THE AUTHOR

Nelson Tilden began his health care career in 1966. In over twenty years, he has administered a 175 bed rural hospital, was Executive Vice President and later President of the Kansas Hospital Association, was a regional administrator of a nine rural hospital system, and since 1983 has served as a full time physician search consultant. He now operates his own firm in the Kansas City suburb of Overland Park, Kansas.

Tilden has a Master's Degree in Hospital Administration, and a Ph.D. in Management. He has authored several articles and two books, and has taught health economics at the university level. He has presented seminars and workshops on physician recruitment and retention in cities from coast to coast. He is the founder of a highly regarded recruitment and retention training program designed to teach health care organizations to conduct their own recruitment programs.

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FOREWORD

The process of physician recruitment was never purported to be simple or inexpensive, but the rewards of a completed "search" compared with the "quick fix - send me a black bag" recruitment routine are evident and long-lasting. This is a "how to" book, designed to assist you in better understanding solid physician recruitment, which will ultimately lead to the retention of a good physician.

How does one learn the techniques required to carry out successful recruiting? Trial and error is a common way, but the economic consequences of a failed recruitment effort may be very high. Clearly paying a professional firm to do the search does not add much to your knowledge of physician recruitment. How then are you to learn?

Nelson Tilden has a curious ethic in this day and age. He takes more pleasure in teaching people to be self-sufficient and to recruit independently than he does in keeping clients dependent upon his considerable recruiting skills. He has spent over twenty years as a hospital administrator, state hospital association executive, and regional administrator for a not-for-profit hospital system.

Today Dr. Tilden heads a very successful physician and executive search firm. His deep sensitivity to physicians and other health care providers permits him to function with credibility and integrity in a field that is not well known for either attribute. In this book, he freely shares what many

recruiting firms would consider to be valuable trade secrets.

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PREFACE

THE SPECIAL CHALLENGES OF RURAL RECRUITING

In general, the techniques used for physician recruiting are similar whether the recruitment takes place for a rural setting or an urban/suburban one. There are, however, a few crucial differences which could spell the difference between success and failure of your recruiting campaign.

Philosophy of Medicine

The first difference is to realize that the physician who wants to enter a rural practice may have a somewhat different philosophy of practicing medicine than his/her urban counterpart. The rural physician may tend to be more comfortable with the prospect of practicing with fewer medical resources to fall back upon. Especially in the very young physician, you may encounter a lack of self confidence medically, which comes from (1) lack of experience and (2) some anxiety about practicing away from all of the available resources experienced in the residency setting. The older physician may be more concerned about the lack of coverage or time away from the practice, when considering a rural practice.

The rural physician needs to have an acute awareness of his/her limitations since the rural practice often requires

functioning in medical areas where the urban physician might refer to a nearby specialist. Some people feel that the rural primary care physician needs to be more of a holistic generalist than a similar urban physician.

In recruiting in rural areas therefore, one important ingredient in screening, interviewing and selecting a physician is an understanding of the candidate's philosophy of medicine, as well as the person's level of comfort about the environment in which the practice will take place. It is important to give the candidate a highly realistic view of what the practice will be like, and to get an assessment of the level of confidence the candidate has with his/her medical ability to function in that environment.

Social/Cultural Environment

The second major difference between urban and rural recruiting lies in factors related to the social/cultural environment. Obtaining a close match between candidate (and family) and the practice opportunity is one of the primary issues related to retention. It is a fact that most residency programs are urban-based. During the long residency process many spouses become "urbanized", if they weren't already from an urban area. If the candidate under consideration is not from a rural area, or has no obvious rural connections, you will want to be very deliberate in your process, or else the risk of a short rural

medicine tenure is great. Even if the physician and/or spouse has a rural background, it is necessary in the interview process to assure that the rural environment is truly desired by both physician and spouse. This needs to be an in-depth discussion because a "successful recruitment" is not really a success if the physician cannot adapt to the rural practice, and decides to leave.

Rural recruiting requires a good deal of discussion with the candidate and spouse. Understanding the medical philosophy, level of confidence, and knowledge of medical limits is more important in rural than urban recruiting. Understanding the life style wishes of a candidate is also more important because life style is being found to be of more importance all the time to younger physicians. A key ingredient in successful recruiting is to fight the tendency to sign up "a good looking doctor" and hope for the best. Remember that as difficult as recruiting seems to be, recruiting mistakes tend to be very costly ones in terms of time, money and even medical reputation.

INTRODUCTION

This book is intended for those charged with the responsibility of recruiting one or more physicians to a clinic, hospital, or other medical practice. As can be discerned from the Preface, there are subtle differences in the recruitment process depending on whether the practice site is urban or rural. These differences are minor in nature and the methods outlined in this book are applicable in either setting.

This book will provide detailed "how to do it" information on the techniques, strategies and activities needed to carry out a successful program of physician recruitment in any setting. It contains practical suggestions which have been shown to facilitate the recruitment process. In other cases, it will talk about things to avoid, pitfalls to watch for which can be very costly in terms of recruiting time and money.

Importantly, this book deals with an approach to recruiting which admittedly is not the fastest method of obtaining a physician. Recruiting "a doctor" is not all that difficult, but finding the "right" doctor for your particular situation is normally much more time consuming, and in the long run, is the only activity worthy of your time and effort. The right doctor is the one who is matched in a number of ways to your practice opportunity. Such a physician is the one who ends up staying in your community on a long term basis. Short term "quick fix" types of recruiting can end up being very costly in terms of

medical image, and perhaps even in terms of medical malpractice. Even the need to re-start the recruitment activity after the termination of the wrong doctor is accompanied by considerable financial burden and emotional trauma.

Successful recruiting usually takes more time than has been initially allotted for the project. Usually the effort required to carry out the recruitment project is understated, as is the cost. The rewards of careful recruiting and perseverance are very tangible and the benefits of recruiting a carefully matched doctor to your community are valuable beyond measure.

Good luck!

Chapter One

INTEGRATING RECRUITMENT INTO THE MANAGEMENT STRUCTURE

If you are reading this book, you probably have an interest in, or responsibility for, the recruitment of physicians for your community, medical clinic or hospital. You may already have been given the responsibility to recruit a physician and may not be entirely clear on how to start the task.

Regardless of how you have reached the point of being interested in physician recruitment, some determination has likely been made that another physician is needed. The determination may have come about through a formal study conducted by a consultant. more likely, however, the decision was more informal and was based on a consensus of several people, ranging from the hospital board, clinic members or a community committee.

Unexpected or Crisis Recruiting

The decision to recruit often comes quickly, as with the death or retirement of one or more physicians. Even in the case of a retirement, the loss is often sudden and unexpected, because not all retirement decisions are lengthy, well thought out processes. Even if the retirement was planned, it may not have been communicated to the people who would need to act upon that

knowledge. A retirement announced suddenly, like an unexpected death, often causes recruitment to take on the form of a crisis activity.

Planned Recruiting

Recruitment activity may also be precipitated by a planning study at the hospital. The study could show a declining market share and competitive inroads by a nearby, competing hospital. Inter-hospital competition is not new, but it is certainly more evident today, as hospitals compete for fewer admissions by physicians. often recruitment decisions are made which reflect the need for the revenue a new specialty would produce, especially if that activity pre-empts the ability of a competing hospital to recruit a similar physician.

Another typical scenario would be for the hospital administrator or clinic manager to realize that the average age of the medical staff is such that recruitment will become necessary at some point, hopefully some time away.

Another reason to recruit is the realization that the recruitment promises of the existing physicians are not producing the needed results. While one physician recruiting another is probably the most ideal situation, and generally the fastest method of recruiting, it is not unusual for physicians to accept the responsibility for recruiting, only to find that the amount of time they had allocated for the activity was totally

inadequate. Time is a most precious commodity for physicians, and patient-time has a way of coming before their recruitment time.

Occasionally, you may encounter physicians who accept the responsibility to recruit, but whose hearts are not really in it. Their own practice may not be as consistently busy as they would like, or they are not convinced that an additional physician is necessary at this time, or perhaps for any number of reasons feel threatened by the addition of a new physician. These are special situations and must be handled very carefully, even if everyone in town except that physician realizes the need to proceed with the recruitment. We will talk later about the need for the involvement and cooperation of the existing medical staff in the recruiting effort.

Another common scenario is for the hospital management or board to look toward recruitment to help solve an economic problem of the hospital. The loss of a physician on the staff has immediate and sometimes dramatic financial consequences for the hospital. Generally in a smaller community the loss of a physician is immediate cause for the initiation of recruitment activity. A single physician can generate activity which produces from $150,000 to more than $500,000 on the bottom line.

The foregoing should not be seen as an unhealthy phenomenon. It has been rightly said that "doctors have patients, and hospitals have doctors". The economic viability of a hospital is directly tied to the activity of the medical staff. Remaining

"in the black" in one sense is a hospital's most basic function. Beyond that survival function, however, a hospital needs to maintain a competitive edge in order to remain a vital force in the medical delivery system of the area. Lack of physician recruitment over a period of time would almost certainly mean the decline of the institution.

Occasionally the impetus for recruitment may come from the Chamber of Commerce or other civic organization. The reason for this in a rural area often relates to the distance many people drive to see the doctor. The doctor becomes one of the drawing cards which ultimately benefits the gas station, the grocery store, and all the retail shops in the community. A town without a physician is at a distinct economic disadvantage.

The hospital is not the only health care provider which relies on the physician. Recruitment is often necessary to meet the needs of nursing homes, home health agencies, the public health department and the schools. Not infrequently, these institutions play a direct role in stimulating the initiation of physician recruitment. Even if they have not taken the lead, it is important to take their needs into account when planning for a recruitment program.

We have seen that a variety of reasons may account for the recognition of the need to begin a physician recruitment program. These reasons run the gamut from recruitment being the luxury of a specialist not present before, to the very survival of the hospital itself.

Unless the community is fortunate enough to be able to recruit without conducting an organized recruitment campaign, a planned approach to recruitment is necessary to assure that the medical capacity and image of the community will not decline or decay.

In organizations which view physician recruitment as an integral part of the management process, there has likely been a deliberate decision to resist the temptation to look at recruitment as a sporadic activity, one to be initiated whenever the need is perceived. These organizations realize that recruitment takes a considerable amount of time to accomplish. Indeed, if you consider the establishment and maintenance of contacts with the various sources of candidates, it is virtually impossible to conduct recruitment in a short period of time.

Whether or not an organization makes the decision to rely heavily upon outside recruitment firms, it should plan on spending considerable time doing long range planning for the development of the medical staff. If it decides to do its own recruiting it needs to adopt the view that recruitment should be an on-going activity and be prepared to carry out a set of organized techniques such as will be described in this book.

Chapter Two

THE FEASIBILITY OF BEGINNING A PHYSICIAN RECRUITMENT PROGRAM

As we saw in Chapter One, there are many ways in which the decision can be made to recruit a physician. There are many different groups which might initiate the activity and not uncommonly, the group first recognizing the need does not communicate the need to other directly affected groups. As an example, sometimes the need is recognized in a hospital board meeting, without the presence or active involvement of the medical staff. Sometimes a civic group will take the lead, and again may not think to bring the existing physicians into the decision-making process. Often a physician group will decide to add an associate without communicating to the hospital, or with the community physician recruitment committee which may exist.

Isolated decisions to recruit in a smaller community generally lead to problems in the recruitment activity. What is needed is the recognition that recruitment is a community-wide process, and that communication is necessary in order that all affected parties understand the need for recruitment, and more importantly, development a COMMITMENT to the physician search.

The feasibility of the recruitment depends totally on the commitment of the parties affected by it. The three most directly affected groups are the hospital, the existing medical staff and the community. If any one of these three

groups is not committed to the recruitment, the effort is in real danger of failing in spite of the most skillful or well conducted campaign. The reason is this: During the recruitment process, which will be discussed in more detail later, one of the critical points is the visit of the physician and spouse to the community. During that visit, the candidate will be evaluating many things and the evaluation of most importance is whether there are any indications that he or she is not wanted.

Many otherwise excellent opportunities to recruit have been foiled when the candidate learns during the visit that one or more of the physicians in town are opposed to the search, or are even lukewarm in their attitude toward it. The psychology of feeling wanted and needed is an important element in the way a new physician candidate views a potential practice opportunity.

Physician Cooperation

One of the key essential ingredients in planning any type of physician recruitment is the consideration of how to secure the active cooperation of the medical staff. Long experience has taught that moving ahead with recruitment without cooperation usually complicates the search at best, and at worst, causes it to end in disaster.

The worse scenario is for a board or administrator to make a decision to add additional physicians without consulting the existing medical staff. Generally, this occurs because it is

felt that one or more of the medical staff will oppose a search which is felt to be needed. The underlying assumption is that if there is going to be opposition, why not ignore the opposition and just move ahead. Having witnessed several instances where the board or administrator has moved ahead without medical staff cooperation, the author feels it is a clearly better choice to slow down the recruiting process and deal with the opposition rather than to simply ignore it.

There is one overriding reason why medical staff opposition must be dealt with, and hopefully changed to cooperation or at the very least, neutrality. A great deal of weight is placed by potential physician candidates on the psychological climate of the practice opportunity. During an on-site visit, it is especially important for a new physician to feel that he/she is really wanted and needed in the community. Indications to the contrary are usually fatal in the recruitment process. Candidates especially have their antenna out for the attitudes of other physicians. It is a rare candidate who will have a positive impression of an opportunity if the medical staff environment is hostile. In some cases, candidates are lost even if they feel the medical staff is indifferent or neutral.

As we have stated elsewhere, new physicians bring into their new practices some level of anxiety about how they will be accepted and how they will fit in with the rest of the physicians. They need to feel that the other physicians actively want them to succeed, and are willing to assist them in that

process through consultations, referrals or simply comradeship.

Securing Cooperation

The only way the author knows to secure the cooperation of the medical staff in a recruitment effort is through open and frank dialogue. Sometimes this may be politically difficult, or difficult for any number of reasons. Whatever the reason, however, discussions should be initiated and continued until there is an understanding between the parties.

In most cases, the reasons for a physician's reluctance to recruit can be worked through and the perceived threat can be diminished or resolved entirely. Often a physician can feel that the new physician will be competing directly, and that his/her income will be adversely affected. In actuality, the bottom line result is usually an expansion of the service area, with little or no effect on the existing physicians. In many cases, all of the physicians benefit from the addition of new physicians because of the improved medical image and capacity of the entire medical community.

It is sometimes true that the perceived need for recruitment by the community, hospital board or administration is not shared by one or more of the existing staff, and that discussions are not fruitful in gaining cooperation. In this case, a decision must be made on the feasibility of continuing that search in the face of physician opposition. If a decision is made to proceed

with the recruitment, it will affect the type of physician personality you will need to find. A physician would need to be found who is very self-confident, self-reliant, and willing to buck some opposition for some period of time. While difficult, it is possible to recruit under such circumstances although it predictably will be a slower process.

In summary, the medical staff has a vital interest in the recruitment of additional physicians. They will have insights into the need for recruiting which should be pursued. Bringing them in very early in the discussion process is a wise strategy, and usually goes far toward securing their cooperation.

Commitment to recruiting includes the understanding of the need for recruitment, the expressed support of the effort, hopefully verbally, and the decision to take concrete steps to implement the decision to recruit. Part of that commitment relates to the time, effort and money it takes to successfully conduct the search.

The Costs of Recruiting

There are two major elements required to conduct a physician recruitment campaign: time and money. We will concentrate on the time element in the next section. The financial requirements of the recruitment process are generally quite substantial. Unfortunately, this is not understood until the process is well underway in many cases.

There are two kinds of expense associated with the recruitment process. The first relates to activities connected with identifying candidates, screening and telephone interviewing them, along with whatever background investigations are felt to be necessary. The second set of expenses is incurred in the process of having candidates and spouses visit your community.

There are some possible guidelines as to what to expect in the way of recruiting expenses. These expenses will vary according to the length of your search and the methods you use to identify candidates. If you decide to use a direct mail approach to practicing physicians and residents in a several state area surrounding your own, it will cost several hundred dollars for every 1,000 physicians you contact. If you use only a telephone campaign, some estimates run as high as 500 to 700 calls to generate enough candidates.

The second set of expenses related to the on-site visit of the physician and spouse is also directly proportional to the length of the search and the number of candidates who visit your community. Generally, on-site visits are one to one and one-half days in length. With airfare, rental cars, motel and food expense, one visit can easily range from $500 to $1,000. Again depending on the attractiveness of your practice opportunity, it can be necessary to invite as many as six to eight physicians to visit before a mutually perceived match occurs.

Some estimates of the total costs of conducting a typical search have ranged from $20,000 to a recent estimate by the

Medical Group Management Association of $34,000. These costs include some factoring in of labor expense for the people involved in the recruitment activity.

As you are considering the feasibility of conducting a physician recruitment campaign, it is very important to have a realistic notion of the considerable expense connected with this activity. If you are involved with an organization which is forced to try to conduct the recruitment at the lowest possible cost, at least be aware that most successful recruitment projects end up spending $20,000 to $30,000 in the process.

Compensation Packages

A frequently overlooked item when considering the feasibility of a search is the compensation package. This is the financial incentive for a candidate to consider your practice opportunity. Without it, the best recruitment campaign may be doomed before it gets started. A key to understanding this concept is to recognize that the same physician candidate you are trying to recruit is probably a candidate for several other practice opportunities. Where recruitment for rural areas is concerned, the physician is still very much in a seller's market. Therefore, it is essential that you offer a total package, including compensation that is at least competitive on a national basis, and perhaps even a bit better.

The basic ingredients of a compensation package include (1)

an annual income guarantee for the first year, and (2) a number of fringe benefits such as malpractice insurance paid, hospital and medical insurance paid, moving expenses paid, and time off during the first year for vacation and continuing medical education.

Before discussing each of these components of the compensation package, it should be stressed that the package does not necessarily become a gift to the physician. Most physicians simply want assistance with getting started for the first few critical months, and are very willing to offset the value of the package against revenue received. In this method, the client advances 1/12 of the annual guarantee each month, less the amount in receipts from the physician's practice. When breakeven occurs, the advance can continue to be offset against earnings, or the total amount of money advanced to date can be put into a loan and paid back over a convenient period of time.

The annual income guarantee is very simply a way of protecting the new physician from some unexpected event in the first year which could prevent the physician from earning the expected amount of money. Guarantees are almost never paid in total, and are simply a way of assuring a new candidate that this practice is actually viable. If the feasibility of the new practice has been established, including the projections of patient volumes, there should be no reason for a guarantee to come in to play, except as a way to calculate the monthly advance in the beginning.

Some clients may feel that the income guarantee is unnecessary because the practice opportunity is so obviously attractive. In reality, the psychology of offering the guarantee is the important part, along with the competitive need to present a comparable package, equal to or better than that offered by competing clients. A physician seeing a practice opportunity without an income guarantee may not choose to investigate the opportunity further. The physician may feel, "this client must not be very sure that there is a viable practice here because they are afraid to offer a guarantee".

There is a long list of possible benefits to offer as part of the compensation package, but as long as the basic ones listed above are offered, candidates will generally not select against you on the basis of compensation. These benefits are almost always offset against income, which again places them in the category of an advance. Other benefits which could be added include life insurance, disability insurance, pension (usually after a waiting period), professional dues, an automobile, country club memberships (rarely), ability to become a partner in a group after a waiting period, a book or publication allowance, assistance in setting up the office, and many others. The important aspect of the compensation package is to realize that you need a package that puts you at least equal to others the physician is considering. As long as your package is competitive, the rest of the opportunity has a chance to "sell" itself to the candidate.

One variation of the advance loan/payback mechanism described earlier deserves mentioning. One attractive option to having the physician pay back income and benefit advances is to forgive a percentage of the advance for each year the physician remains in the community. If 1/5 of the advance is forgiven each year for five years, you have provided a positive incentive for the physician to remain in your community.

Search Fees

In your study of your need to recruit and the methods you will use to accomplish the recruiting, you may well decide to seek help from a professional recruiting firm. About 25% of all physician recruiting done in the U.S. is done through firms. These firms charge professional fees for their work. The fees are paid in essentially two ways, either during the search effort or after the physician is under contract.

The first type is called a "retained search firm", while the latter is called a "contingency firm". The total fee charged should be comparable for either type of recruiting firm. The main difference lies in the way it is paid. A later section will deal with other differences between the two types of recruiting firms.

The amount of money you should budget when considering the use of a recruiting firm is relatively predictable, although it will certainly vary somewhat from firm to firm. A good rule of

thumb is to count on a professional fee of between $15,000 to $20,000, plus out-of-pocket expenses of 15% to 25% of the professional fee. If you are considering the use of a firm, it would be wise to ask several for a proposal, including an estimate of fees and expenses.

As you are considering the feasibility of your own search effort, it is important that you take into account the time required of management/clinical personnel. Should the time demands reduce the earning capacity of physicians, for example, you will want to take that into account in your thinking.

Length of the Recruiting Effort

Earlier, it was mentioned that occasionally the recruiting effort gets started because of the sudden loss of a physician. Often that results in the feeling that you need to find a replacement "right away". Sometimes it also leads to a quick decision to hire a professional recruiting firm with the expectation that a professional can produce quick results. As one who has been involved with physician recruiting for some years, it has been this author's experience that the client occasionally gets lucky and finds the physician quickly, and occasionally the professional firm will be able to produce quickly, but these instances are the exception and not the rule.

Successful recruiting is a long term activity, and as such, should be an integral part of a long range planning process.

When approached in that way, recruitment becomes a planned, deliberate process with the time built in to permit a systematic approach to recruiting. One year in advance is the minimum necessary in most cases, because of the cyclical nature of recruiting.

The great majority of residents graduate on June 30 each year. Some graduate at other times, but those are too rare to count on. Therefore, if you are planning to recruit from the ranks of residents, you should count on recruiting heavily between September and February at the latest. Some recruiters begin working with residents earlier than September, but few residents are seriously considering practice opportunities that early. The exception is the resident you have identified at an earlier stage of training, or who may be a native of your area. Such a resident should be contacted at a much earlier time, to get a head start on others who will be presenting competing practice opportunities.

Physicians who are currently practicing are recruitable all year around, and the only seasonality to their move would relate to the transfer of children to another school with as little trauma as possible. This generally means that people like to get settled prior to September, whenever possible. One time consideration to keep in mind with regard to the practicing physician is that there is often a several month period between the time a physician is recruited, and when he/she can be ready to move to a new location. Closing down a practice can often

take six months or more.

Military physicians are also recruitable all year around, although in a majority of situations there is some seasonality involved. Military physicians are often recruited into the military to do a residency, or are recruited immediately following the residency. In either case, the physician usually starts in the summer, and will therefore end his/her military obligation in the summer. Recruiting can occur at any point, as with residents, but the actual start of practice will frequently be in the summer.

From the foregoing it can be seen that recruiting has a great deal of seasonality involved. If one begins the recruitment process in the spring, the residents and military candidates will virtually all be committed to practice opportunities. It could well be the following summer before a new physician will start to practice unless an in-practice physician can be found. That means, from the time a decision is made to recruit until the physician is able to begin practice, it is possible to have a time lapse of as much as eighteen months.

It has been said that not more than 10% to a maximum of 20% of recruited physicians come from other than those completing a residency. Translated into length of search terms, that means, your chances of finding someone from other than a residency are quite low, and that the seasonal factor will strongly come into play. That being the case, you have a great incentive to plan well ahead for your recruitment campaign.

The Dangers of Getting Desperate

All too often, recruitment campaigns find themselves in situations where the physician is urgently needed. This is unfortunate. When a physician leaves with little notice, you don't have the luxury of doing advance planning. Your main concern may be to protect the practice from scattering to the winds. You may feel pressure to recruit faster than you know the process is likely to take. One of the temptations will be to "sweeten" the compensation package to make it more attractive. Another may be to turn to a professional firm, thinking that you may be able to buy your way out of a bad situation. Trying to "buy a physician" through an abnormally lucrative compensation package is a short-term solution full of dangers. You might be able to entice a physician on a one-year basis, but unless the practice opportunity is a good match for the physician in non-monetary ways, that physician will probably be gone shortly after the guarantee expires. In such a situation, you have gained little in the short range, and worse, you have perhaps damaged your reputation with your patients. Patients are not attracted to an institution with revolving door physicians. Future candidates may also look at your situation more cautiously if you have had excessive turnover.

The desperation hiring of a professional firm is not especially a danger unless you have adopted the "hired gun" attitude that since you have paid someone to recruit, the problem

is no longer yours, it is "theirs". A good professional firm will be careful not to let you think it works miracles. The professional firm cannot create a physician or go to the warehouse to get one. It must go through the recruitment process much the same as you would. The professional firm may well have contacts and the knowledge of recruiting sources to assist in the process, but unless the firm happens to be able to produce a candidate who matches your specifications in the first few weeks or months of the search, the chances are good that the seasonal cycles will come into play, and the search will still be a year long.

There are several good reasons to hire a professional firm, but being desperate for a physician in a short time frame is a poor one. Some would say that the contingency firm might be best suited for such a circumstance. If they fail to produce a candidate which is suited to your position, you haven't gained anything time-wise, but at least you haven't spent a great deal of money.

In summary, recruiting takes a great deal of time in most cases. That fact should be taken into account in your study of the feasibility of conducting the recruitment campaign. The longer you have taken to plan your recruitment, the better your campaign will tend to be. You will have the time to seek the quality physician who matches your opportunity, and who will be most likely to stay and become a long term asset to your community.

Chapter Three

EVALUATING WHAT YOU HAVE TO OFFER

What you will be offering a physician is generally called a "practice opportunity". A practice opportunity has several facets, and its overall attractiveness will determine how well you compare with the many other opportunities "your" candidate will be looking at.

It is necessary to fully understand the various parts of the practice opportunity because in your recruiting phase, there are certain predictable questions you will be asked by candidates. If you have not thought through some of these issues, you may lose the interest of the physician before you have a chance to "sell" the candidate on your strong points.

The first set of issues can be called the "professional" concerns. In no particular order of importance, some of these are:

1) The type of practice (solo, group, partnership, employed, etc.)
2) What is the nature of the "competition"?
3) What will be the expected referral patterns?
4) What are the expected patient volumes?
5) What kind of call coverage is available?
6) If another physician has left this position, what was the reason?

7) Age and specialty of other physicians

The second set of issues we would call "financial concerns". Some of these include:

1) Minimum income guarantee
2) Payback requirements
3) Benefits provided, which could include any of the following:
    a) Malpractice insurance
    b) Health and accident insurance
    c) Life insurance, usually term
    d) Disability insurance
    e) Dental insurance
    f) Vacation during the first year
    g) Time off for Continuing Medical Education
    h) Journal/book allowance
    i) Moving expense
    j) Professional membership dues
    k) Office rent subsidy or other office operating subsidy
    l) Assistance in obtaining loans

Another series of issues we could term "facility concerns". In this area we need to know the things about the physician's office and the hospital that will be of the most interest to a physician candidate. Under the office issues, some things of interest will be:

1) How is the office equipped?

2) Is the facility well laid out and functional?

3) What are the hours of operation?

4) Are there sufficient personnel?

5) Is the clinic well located?

6) How well maintained is the clinic and are there expansion/improvement plans?

7) Is the financial report in good shape?

Under the concerns about the hospital, some would be:

1) Is the hospital financially viable?

2) What is the Medicare-Medicaid load?

3) What is the bad debt situation?

4) How many beds does the hospital have?

5) How well equipped is it?

6) Are the personnel well trained? Are there adequate numbers of personnel?

7) What services are offered? What services can be obtained on a mobile basis?

8) What is the average daily census?

9) What outpatient services are offered?

10) What is the medical credentialing process?

The last set of issues might be termed, "community or geographic area" concerns. Some of these are:

1) What are the geographic advantages in terms of location?

2) What are the demographics of the area in terms of age breakdown and other population related issues? Is the area growing?

3) What are the unique selling points of the community and area?

You may think of other issues which will be of importance to a physician considering your practice opportunity. It is important to analyze your situation carefully in order to be able to market your strong points and understand where you may not look as good to a physician candidate. In the next chapter we will be taking up some of the things physicians are looking for in an opportunity, and you may think of additional items for your practice opportunity evaluation.

Chapter Four

UNDERSTANDING WHAT PHYSICIANS LOOK FOR IN A PRACTICE OPPORTUNITY

There are several major items of significant concern to any physician who is evaluating a practice opportunity. An understanding of these will help you market your opportunity as you work with the prospective candidate. The relative importance of these items will vary from physician to physician, but to some degree each will be important.

These issues could be roughly assigned to two major categories: Personal concerns and professional concerns. In looking at the personal concerns, there is one factor which deserves special attention. Until fairly recently it was assumed by the public, as well as by physicians themselves, that the physician would work long and irregular hours. That assumption "came with the territory". The physician's home life was clearly secondary to his/her professional demands, and to consider it otherwise would be to challenge the physician's dedication to the profession.

Today there is a new ethic becoming apparent among younger physicians. It is an ethic which places a much higher priority on having a life-style which allows for time with the family and time for pursuits other than medicine. It is an ethic which does not denigrate the role of medicine, but seems to strive for a balance between the professional life and the personal one.

In interviewing many younger physicians, it is clear that the new life-style concerns are not superficial or temporary. These concerns rank very high on the physician's list of priorities, and will be very important as a candidate begins to consider your opportunity. If your opportunity is one that resembles the old, traditional model, you may be looking for the proverbial needle in a haystack. In recruiting terms, the needle may be there, but the search may be long and expensive.

What then are the things a physician looks for to satisfy <u>personal</u> goals? Some of them are:

1) Adequate time for personal concerns
2) Access to shopping and dining
3) Good schools
4) A suitable church
5) Attractive housing
6) Access to cultural and recreational activities
7) Availability of people in the same age group, especially other professionals

The following are a number of items which physicians look for to meet their <u>professional</u> goals:

1) The potential to do high quality work
2) The availability of quality office facilities, equipment and personnel
3) The availability of quality hospital facilities, equipment and personnel
4) The presence of professional colleagues for call

coverage, support and assistance

5) Access to subspecialty physicians for referrals
6) Ability to obtain appropriate hospital medical staff privileges
7) Access to quality continuing medical education
8) Ability to transfer critical patients to a higher level facility quickly and safely

In addition to the personal and professional goals listed above, the physician will also have an important set of goals which could be termed "financial" in nature. The physician will have concerns which could be called "start-up" concerns and he/she would also have on-going or "long term" concerns.

Start-up Financial Concerns

A physician just beginning a new practice may have some rather large indebtedness, stemming from years and years of educational time, where the income was small to nil. Such a physician will have an understandable concern about what sort of financial help you are willing to offer on a start-up basis.

The initiation of any physician practice carries some risk with it, from the physician's point of view. What most physicians look for is some type of minimum income guarantee which tells the physician that he/she will have a base income, irrespective of the patient load generated. Such guarantees are almost always moot, because unless there is a much smaller

population to be served than anticipated, the guarantee should be met without too much difficulty.

The guarantee is a "psychological must" for your compensation package, even though your opportunity is so attractive that its earning ability is completely obvious. If you don't offer a guarantee, the candidate may wonder whether you are confident that the practice is capable of producing the necessary volumes. Beyond that, the giving of a guarantee is so established in recruiting circles that an opportunity without a guarantee is not given much consideration by candidates, irrespective of the attractiveness of the situation otherwise.

Remembering that you are in competition with other practice opportunities, you also need to remember that the physician will be looking at financial packages that include some benefits, such as were discussed in the last chapter. The provision of these items helps assure a physician that you are aware of his/her initial financial needs.

Long-Term Financial Needs

On a longer term basis, a physician will be vitally interested in whether the practice will produce reasonable income levels within a definable period of time. In other words, you need to be able to discuss the prospects for the reasonable development of a good practice in a two to four year time frame. If the physician cannot visualize a suitable practice in that

period of time, you are not likely to be able to recruit that physician.

Sometimes a physician's financial goals are tied to the ability of his/her spouse to work. You should determine early in the recruiting process whether the spouse has a desire to work, and whether there is a reasonable opportunity for work to be obtained.

An attitudinal item many physicians look for is whether the community, hospital, clinic is willing to be aggressive about marketing the new physician's practice. How will the message about the new physician get out to the public? Most physicians are concerned about how fast they can build a practice, and are looking for assistance in that area.

In summary, it is important to know what physicians are looking for in the way of a practice. You should tailor your presentation to touch on these items. In so doing, you will be putting your community and your opportunity in its best light.

Chapter Five

GETTING STARTED

By the time you reach the point of beginning the actual recruitment process, you will have come a long way. You will have achieved an understanding of the search effort and the commitment necessary from a number of parties, as we discussed earlier. You understand the costs, the length of time you are likely to work on this project, and you have the support of the medical community, as well as the community at large. Let's get on with the actual steps of recruiting.

Choosing the Recruiter

If you are the person responsible for the success of the search, you have two options: Do the work yourself or delegate it to another person. Use care in deciding whether you have the time to carry out the entire activity. It will probably take more time than you think it will.

It is important to the success of the search to have one person who is responsible for coordinating the entire search effort. If you have delegated that function to a subordinate, give that person the necessary authority to carry out the process of coordinating contacts with prospective candidates. That is not to say that others will not be involved in interviewing and

socializing with the candidate, but it is reassuring to the candidate to be communicating with the same person throughout the process.

Deciding on the Position Prerequisites

The very first task in the recruitment process is to get all the principles involved in the search to agree on just exactly what it is that you are looking for in the way of a physician. This innocent-sounding step is a very important one in the search process. If there is no precise agreement on what qualities the candidate needs to possess, there is no way all parties will agree on whether a given candidate is the one you are looking for. This can lead to all kinds of frustration and costly starts and stops during the search. The only way to avoid problems is to get everyone involved to sit down and come to a consensus about the details of the Prerequisites Statement.

One ingredient in the Prerequisites Statement is deciding on the level of certification. Do you require board certification, or board eligibility, or will something less suffice. This item largely is dependent on the completion of a residency program. Generally a candidate who has completed a residency will be board eligible. This means that the person has completed the academic and/or practice requirements, and is therefore eligible to take the exams in order to become board certified.

A second item relates to the type of physician who will fit

into your practice situation. The two types of physicians are allopathic (those graduating with an M.D.) and osteopathic (those graduating with a D.O.). There are communities which historically had all M.D.'s on the medical staff, and there are those which have likewise had only D.O.'s. In those situations, the choice is usually quite clear and is based on the historic makeup of the physician complement. In towns where both kinds of physicians are to be found, the Prerequisites Statement can perhaps be neutral, and the recruitment of either type will be equally acceptable. This is the best situation, and the one which will make the recruitment process the easiest and fastest. There are many situations, however, where referral patterns, or the specialty of the new physician, or a host of other factors which can dictate that one or the other type of physician is preferable in that situation. Either way, it is <u>essential</u> that all concerned are in agreement on this item.

Another item relates to the sex of the physician. Very much like the last item, acceptability of a male or female may be largely determined by historic precedent. This is an area that is rapidly changing with the increasing numbers of women entering medicine. In many communities today, this is a non-issue. That is to say, the acceptability of a woman physician is not even questioned. Indeed, in many communities, there is the feeling that recruiting a woman might provide a competitive advantage. Again, whatever the history or the prevailing sentiments, it is essential to have all parties reach a consensus on this issue.

Another issue relates to whether the candidate need be an American born physician, trained in the United States, or whether a foreign born person would fit the situation. This latter category includes two variations. The foreign born person who is a FMG (Foreign Medical Graduate), or a foreign born person who is a graduate of an American medical school and residency. A further variation is the foreign born person who attends a foreign medical school and then comes to the United States for the residency. As in our earlier decisions about the Prerequisites Statement, this is an area needing full discussion and agreement.

Sometimes the age of the candidate comes into play. This is an area with legal ramifications, and you will not want to discriminate against an older person in your recruitment activities. That is not to say, however, that your search activities cannot emphasize the age of a physician who will best meet the needs of the community. It is not a foregone conclusion in many searches that the new physician be a young person. There are many situations where the age and experience of an older physician make that kind of candidate highly attractive.

Your profile should be fairly clear about personality requirements of the candidate. By knowing the people with whom the candidate will have to work, agreement can usually be reached quickly concerning the type of personality that will fit in your situation. This is an item frequently overlooked, and often with bad consequences. There is a tendency to emphasize a candidate's

professional qualifications and work history, to the detriment of factors related to the cultural, social and personality fit of the physician and spouse. It can readily be seen that adjusting to a new community is more a factor in the selection than are the technical qualifications. Generally when a physician leaves town, it is because of a social incompatibility rather than a problem with professional credentials. If this is so, you should be clear about the importance of this item in the Prerequisites Statement.

One thing to remember about the Prerequisites Statement is that it is an internal document, and is not for outside publication. This document is a guide to your recruiting, which should remain confidential. If it should become public, you may spend considerable time explaining to candidates why you aren't considering someone with a certain qualification.

Preparing the Position Profile (Appendix A)

This document is the public document. It is a concise description of the practice opportunity, and is sent to potentially interested physicians who will be identified in your recruiting efforts. It is often a two page document with the following headings:

1) The type of physician sought (i.e.: "A physician specializing in Pediatrics")
2) The location of the practice opportunity

3) A description of the medical opportunity

4) A brief summary of the compensation package

The first of these items is self explanatory. The second is a description of the location. This is generally five or six paragraphs in length, and provides not only a geographical description, but provides key information about attractions in the area. This topic generally covers schools, churches, recreational activities, cultural attractions and anything else that will give the candidate a feeling for your community and area.

The description of the professional opportunity will give the candidate a sense of how easily he/she can expect to get started in your community. You should discuss the service area in some detail, and generalize on the present and future need for the services of the candidate. If you can provide some historic data related to that specialty, so much the better. This topic can discuss the office space situation, if that is especially attractive, and always discusses the type of legal structure (group, solo, employed, etc.) the candidate can expect. Sometimes the availability of equipment in the clinic or hospital is especially attractive, and if so, may be mentioned. In summary, your goal here is to portray the professional opportunity in an attractive, yet realistic, light.

The last item is a key one -- the matter of compensation. This topic may not be at the top of the list of things a potential physician candidate will be interested in, but it is

not far down the list! In this section, you will be giving a very general description of what you are offering for compensation. It is generally sufficient to say that you are offering a very attractive or competitive annual income guarantee and a benefits package which is spelled out. We will talk in much greater detail later about the whole subject of compensation. For our purposes here in writing the Position Profile, you can be fairly general, as long as you give enough information to interest the person.

Chamber of Commerce Information

While this is not considered as part of the Position Profile, it is an important part of the information package which you will send to interested candidates. There are two fundamental things a prospective candidate wants to know. One is about the professional opportunity, including compensation, and the other is locality. Spouses particularly want to know early on, just where is this place? Your own experience will probably confirm that the attractiveness of the location to the spouse often outweighs the attractiveness of the opportunity to the physician. Therefore, to give the most attractive presentation of the community and area, Chamber of Commerce brochures are often sent along with the Position Profile. If your hospital has produced a promotional piece, by all means send that. Keep in mind that first impressions are crucially important, and that the

first information you send can "make or break" a candidate's interest.

Targeting the Search (The Research Phase)

Now that you have all the necessary materials you will provide to candidates, the next step is to decide where you will target your recruiting effort. A general rule is that you will want to recruit as close to home as possible. That is to say, try to find candidates as close to where they will practice as possible. Failing that, you can move in larger and larger concentric circles until you find the physician you are seeking.

Some people have a theory that the great majority of the physicians are recruited from an area not further than two states away in any direction. Others say that residents in particular generally stay within 75 or 100 miles of their residency site. Both of these probably have validity, but only as generalities, and only as they apply to the statistical probabilities of recruiting. These theories do support the idea of recruiting as close to home as possible, at least in the early part of the search. You should not ignore the possibility that a resident from your home state may be taking a residency in a distant location, and may be planning on returning home to practice.

The first step in "targeting the search" is to choose the states you want to recruit from first. I would normally suggest an area including the six or seven closest states to your

location. Once this is done, the next step is to learn the names, addresses and telephone numbers of the residency training programs in those states pertaining to the specialty you are recruiting. A good source of these names is found in Appendix B.

Next, you should determine what military installations exist in the recruitment area. In this particular source of potential candidates, you may want to expand your area beyond the six or seven state recruitment area since military physicians are placed at installations having no relationship to their home state. Since not all military installations have hospitals or medical clinics large enough to support full-time physicians, you must first determine those installations which do have recruitable physicians. A starting source of military installations is shown in Appendix C.

The last major bit of targeting you need to consider is how to obtain the names of physicians already established in a practice situation in the recruiting area. There are a number of commercial firms which specialize in providing names of practicing physicians. These firms come in two varieties: those that are franchised by the American Medical Association to rent you a list of names, and those that obtain the names from other sources such as the Yellow Pages. The AMA franchise firms have extensive lists of physicians on their computers, and have the ability to computer-sort the names to suit your needs. For examples, you can order names by specialty, by age, by type of physician (M.D. or D.O.), by year of medical school graduation,

as well as other categories. Under your agreement with these firms, you can obtain the names for a one time mailing only. Of course, if you obtain the names for the purpose of making phone calls only, there is no restriction on the usage. The restriction is intended for those who would make a number of mass mailings to these physicians. A partial listing of firms dealing in mailing lists is found in Appendix D.

Another source of names is the directory produced by many medical groups. Specialty societies (i.e.: American Academy of Ophthalmology) often produce a membership directory which can be obtained by calling or writing the organization. Medical groups organized on a geographic basis (i.e.: The Missouri Medical Association) produce membership lists that can be obtained. Such lists are heavily weighted toward those physicians already in practice, as opposed to residents, and are good sources of potential candidates.

Beginning the Recruiting Phase

Once your search has been targeted, it is time to actually begin the process of identifying the names of specific candidates for your position. In one way or another you will need to obtain the names of residents from someone in the residency program. There are three good sources: The Program Director, the Directors secretary, or the Chief Resident of the program. To expedite the process, you should explain your need briefly to the

person you are talking with and ask for the names of residents who are not yet committed to a specific opportunity. Some programs are excellent about sharing this information, and some are not cooperative at all. Usually the person who is most likely to be cooperative is the Chief Resident. As a last resort, you can attempt to learn the name of a resident in the program and ask that person about uncommitted classmates.

Using the names of individual residents you have obtained, you have two options: you may call them directly on the phone, or you may elect to send a letter and descriptive information about the practice opportunity, and the follow up with a phone call. In either case, your aim is to bring to the attention of the potential candidate some information which will hopefully be of interest in the process of choosing a practice site.

Another strategy which is useful with resident recruiting is to send a flyer to residency programs for placement on the bulletin board. The flyer is a general statement of the opportunity, and gives a phone number to call for additional information.

A frequent strategy to reach physicians already in practice is to make a "mass mailing", generally to the physicians' homes. A personal letter is sometimes sent which outlines the general details of a practice opportunity, and again, invites any interested physician to respond. Sometimes a postal card return is employed, but more often the physician is asked to call, requesting more information. In lieu of the personal letter is

the "Dear Doctor" letter containing the same information. People experienced in direct mail seem to feel that the response rate is much better if the letter is personally addressed, albeit by word processor!

Another approach, using the same list of names you would use in mass mailing, would be to begin making "cold calls" to the physicians on the list. There are firms who believe that this is the best method of all. The general tone of the conversation is that "We have an excellent practice opportunity in blank town, and we wondered if you might know of anyone who might be interested in knowing more about such an opportunity." The problem with this approach, in the author's opinion, is that a large number of calls must be placed in order to reach a very few physicians. You must first get through a secretary or receptionist who is often extremely protective of the physician, and often will not let you talk with the doctor without knowing the reason for your call. If you say you are recruiting a physician, that usually is the kiss of death. You can be assured you will not talk with the physician.

The second reason the author feels why direct phone calling of in-practice physicians is unproductive is that your chances of timing the call to coincide with a physician's decision to look an other practice opportunities is very low. Unless you happen to call at just the right time, the physician will have either not reached the decision to move or will have made the decision some time previously and has several opportunities under consideration. In

other words, the "window of opportunity" to attract an already practicing physician is quite small in terms of the time a physician is open to hearing about your practice opportunity.

One way of extending your chances of hitting the "window of opportunity" is to consider some form of advertising. All medical journals will sell advertising space. You can place an ad, spelling out your opportunity. A physician who is not ready to make a decision to move today may read the journal next week or next month, and be interested in your opportunity. Therefore, you may want to consider determining the name of the specialty journal pertaining to the search at hand, and investigate how you can put an advertisement in the journal.

A less productive recruiting opportunity exists with academic physicians, but nonetheless one which should not be over looked. Many physicians become teachers in residency programs for a few years, and then begin to yearn for a practice which is more clinical in nature, and which may pay substantially more income. These are attractive candidates when they can be located because they are fully up-to-date in medical education, and also because their level of salary expectations will not be quite as high as an in-practice candidate. Recruiting from this source generally takes the form of learning who the faculty members are, and making a direct recruiting call. A good strategy might be to take the indirect approach of describing the opportunity, and asking if they know of anyone who might be interested.

In the final analysis, recruiting is a numbers game.

Somewhere there is a physician who is ideal for your opportunity, and your responsibility is to make the number of contacts needed to expose the opportunity to the right person. That person might be the second person you call, or the one thousand and second. Persistence is the trait most needed for success.

Chapter Six

SELECTING THE RIGHT CANDIDATE

In the last chapter, we discussed the various means of contacting physicians. You may do it by phone, through the mail, through advertisements, through word of mouth or by other means. When you have the names of potential candidates, the work of screening, interviewing and selecting the right candidate begins.

Screening

The first step used by many recruiting firms is to provide a potentially interested candidate with written information about the practice opportunity and Chamber of Commerce material about the town and area. This information also generally includes brochures, if available, on the hospital and other medical care facilities in the town.

After giving the potential candidate a few days to receive and read the information, a telephone call is placed to the physician. This call is a screening call which has two purposes. First, you want to learn the level of interest in the opportunity on the part of the physician. Secondly, if there is some level of interest, you want to determine that the physician meets your preset criteria. If either or both of these purposes is not met, the physician does not become a candidate for further

consideration.

Interviewing

After determining a level of interest and general qualifications, an in-depth phone interview is held. Again, there are two general purposes of this interview. The first is to fully explain your practice opportunity to the physician. This includes information about the practice setting, the size of the service area, projected practice volumes, information on other members of the medical staff, and very importantly, information on the competitors to the new practice. The physician will want details of your compensation package. If you are offering a first year package, he/she will want to have some idea of how fast you anticipate the practice will grow and reach a break-even point. If previous physicians have been in the position for which you are recruiting, a potential physician will be interested in that person's volumes and earnings. During this interview, you should also be prepared to discuss details about the locality. This would include information about schools, churches, shopping, recreational opportunities, social and cultural opportunities, and any other information pertinent to your area.

The second part of the in-depth phone interview is to get a detailed description of the physician's professional credentials. Beyond simple items such as dates and locations of all level of

education, dates and locations of all previous employment, board certification or eligibility, etc., you will want the physician to give you a detailed word-picture of himself/herself. This would include their own perception of their medical strengths and weaknesses, a detailed list of the procedures they will want to do, a self-assessment of their ability to deal with patients, families, peers and paraprofessionals. Although this may seem to lack objectivity, most physicians will talk enough on these points to give you a clue about their interpersonal relationships.

Toward the end of the interview, you will be getting a strong feeling about the possibility of the physician's match with your opportunity. If you are getting that kind of indication, there is no substitute for simply asking enough questions, and conversing with the physician until both of you can make a determination of interest and compatibility. Sometimes you will have to ask straight forwardly if the physician is sufficiently interested in the practice opportunity and the geographic area to pursue his/her candidacy further.

During the interview, you will have tried to obtain as much information as possible about the spouse, since you realize that the spouse will play a very large part in the decision. If you have a chance to talk with the spouse personally, that opportunity should not be missed. Frequently, the spouse may be more candid about their level of interest than the physician is. Not infrequently, a spouse may act in the role of screening

potential job opportunities, and may be your primary contact. In some cases, a physician will severely downplay the role of the spouse in the decision-making process. It is generally a mistake to be put off by that attitude, and not attempt to pursue the interests of the spouse.

At this point with many candidates you may feel comfortable with the match, but it is clear that the physician is only considering your opportunity among many others. If you feel strongly enough about wanting this particular physician, you will want to extend an invitation to visit your community in order to sell the opportunity firsthand. Extend the invitation on the phone, confirmed with a letter. We will discuss the details of preparations for the visit in a later section.

Preliminary Credentialing

Once you have proceeded far enough into the recruiting process to have a visit scheduled, you will want to do some preliminary credentials verification to assure that you have a legitimate candidate. With a resident, it is usually sufficient to call the residency director for a reference. Normally, you will get a positive indication of competency and an indication of the candidate's personality, if you pursue that point. With a physician already in practice, you will want to verify the licensure with the state licensing agency, along with the accuracy of any other credentials given to you by the physician.

You should also contact one or two previous locations (usually you will not be able to contact a practicing physician's current community) to obtain information about the physician. A hospital administrator, director of nursing or medical record person can usually give you a good reference.

The On-Site Visit

The on-site visit is in some respects the most important ingredient in the recruitment process. No matter how good your recruitment techniques up to that point, your ability to recruit all hinges upon a successful on-site visit. A short document called, "Preparing for the Physician Visit" is found in appendix E.

The purpose of the on-site visit is to gain a better understanding of the quality of the match between the candidate and your opportunity. At the same time, it must be remembered that this candidate is likely to be comparing your opportunity to several others, and therefore, an element of "selling" the opportunity to the candidate and spouse is very much present.

The better organized the visit, the better impression you are likely to give the candidate. There are several elements in an organized approach which need to be structured prior to the visit. One is to have a "Greeting Committee" set up to meet the candidate and spouse, and to be involved in the activities of the visit. The Greeting Committee might be three or four couples

representing different community interests, and who have been selected for their ability to present the community and the professional opportunity at its best. Often the committee will be headed, or at least coordinated by a health care professional, usually a hospital or clinic administrator or a physician with an interest and skills in physician recruitment. The committee ought to meet in advance of each physician on-site visit, and develop a specific visit plan for the upcoming visit.

The Greeting Committee will develop a visit agenda, hopefully with the input of the visiting physician. It is a good idea to call the candidate to see if there are specific things he/she would like included in the visit agenda. These might include a realty tour, a talk with school faculty or administration, a talk with the banker, a look at recreational facilities or churches in the area. Building into the visit these desires of the candidate helps assure that the best possible perception of the community will be obtained.

Following the development of the agenda, including spouse activities, it is a good idea to send the agenda to the candidate, along with a letter confirming the visit date and time, motel and travel arrangements, and any other details which the candidate will need to know.

The fact that you developed an agenda, and made every effort to carry it out will make a smooth visit more likely. There are some do's and don'ts that you might also want to consider:

<u>DO</u> 1) Something special to differentiate your

opportunity from others. Put some flowers with a welcoming note in the motel room, or some special thing such as an invitation for the children, if any, to attend some special event.

2) Allow some free time for unstructured touring.

3) Put your best foot forward, but maintain a sense of realism about the community and opportunity.

DON'T

1) Overwhelm the candidate in the early stages of the visit with a big reception. Meeting too many people too quickly is frequently overwhelming to many candidates.

2) Use a large welcoming committee, or one that is largely older or younger than the candidate.

3) Oversell. You want the candidate to get a fair picture, albeit as attractive as possible, so as not to get a distorted view that could lead to later problems.

Keep the visit short. A full day or a day and a half will be sufficient, particularly for the first visit. In most cases, a follow-up visit is required before "inking the contract".

Making The Offer

There is one large difference between physician recruiting and other professional recruiting. You normally don't have the luxury of interviewing on-site with several physicians in a short period of time, and choosing from among those candidates. This process works well with other professionals in most cases but not with physicians. There are still too few physicians who have too many opportunities for you to have that luxury.

Therefore, it is generally good judgment to accept the first physician who comes along who is a complete match for your

opportunity. There may not be another one in the near future, and you generally cannot take the chance that you will lose a completely qualified candidate in the hope that a better one will come along. That is not to say you have to take the first one that comes along! We talked much earlier about setting criteria, and developing a profile of a fully acceptable candidate. When that physician comes along who meets all or most of your criteria, and you are satisfied that this physician would be acceptable, offer a contract.

The offer should contain all the ingredients you will have discussed with the candidate during the visit, including the compensation package. Offers can be negotiated, but the important thing at this stage is that the physician knows in a very concrete way that you want him/her. It is important that the recruiting team not simply assume that the physician will know that he/she is wanted. A contract in hand will be a psychological advantage for you when the candidate visits other competing practice sites.

Visit Follow-up and Closing the Contract

Immediately following an on-site visit, a letter should be sent to the candidate and spouse thanking them for taking the time to look at your opportunity. If appropriate, ask them in the letter to seriously consider accepting your offer. In addition, other letters from various members of the greeting committee would be

in order. Again, do something a little extra such as ordering a three month subscription to the local newspaper for the candidate. Birthday or Christmas cards are also appropriate. After extending the offer, you will be in a difficult position with respect to other candidates since you will not want to lose them if your initial offer is rejected. It is therefore very important to extend your offer with a short time frame for acceptance. Many people feel that a candidate should be given thirty days to decide on the offer. Since the candidate is sometimes in such a strong supply and demand situation, there are no hard and fast rules in this area.

Putting a time limit on the offer will depend on whether you actually have other candidates that you could potentially lose. From the physician's point of view, they will generally delay a decision as long as possible, in the hope that a better offer will come along. While that may be normal and human, it is often not in your interest to permit the offer to stay open indefinitely.

Until the offer is accepted or rejected, it is vitally important to remain in frequent contact with the candidate to reinforce your interest, and to try to answer any questions that might arise from other visits your candidate is likely to be making to other opportunities.

The exception to the immediate offering of a contract to the first completely acceptable candidate comes when you have more than one who can visit within a short period of time. In that

case, the candidate should know that there are additional candidates, and that you will be extending an offer soon to one of them. In that case, where a candidate has left town without an offer, and you now want to make one, you might invite the physician back for a follow-up visit, and extend the offer at that time.

As you can see there are not many rules in this area of extending the contract. You don't often have total control since the physician is usually in a seller's market. A general rule would be to extend the offer with as short an acceptance period as you feel is prudent, and continue to communicate with the candidate until a decision has been reached.

Chapter Seven

RETENTION STRATEGIES

You will spend a great deal of time, money and energy in the recruitment of a physician. It makes good sense to spend a little more effort in trying to assure that the recruited physician stays in your community once he/she is there. It is almost amazing to recruiting professionals that so much effort goes into recruiting, and typically so little goes into retention. There seems to be an assumption that once a physician arrives, the battle is over. That might be true if the statistics did not show that there is a substantial amount of relocation during the first three years of a physician's practice.

The All-Important First Year

Getting off to a good start is crucial in most endeavors in life. It is especially so in the effort to retain physicians. All the options the physicians had when he/she chose your opportunity are still out there. A disgruntled physician can readily move in the early years before many patient ties are built. Therefore, it makes sense to conduct some deliberate retention activities to help assure that your recruit does not become unhappy to the point of moving.

The first item to consider is a good orientation to the new practice opportunity. Don't assume that the physician will gradually get to know where everything is located, who the support staff are, or even who his/her professional colleagues are. Plan a specific orientation which covers these points, and anything else the physician may wish to learn about.

The Buddy system

A good way to accomplish the orientation is to adopt a buddy system, where a fellow physician shows the new person around, introducing him/her to the rest of the medical staff, and to office personnel when appropriate. The buddy system works well for community introductions and social integration. The same "buddy" need not be used for all introductions or events, as long as there is coordination of effort among or between orienting physicians.

Introductions to the rest of the medical staff are vital. A new physician will need to build a practice and will rely to some extent on referrals from other physicians. A new physician can be disillusioned quickly if he/she feels that no referrals are occurring, and the reason is that other physicians are not aware of the presence of the new physician in more than a passing way. Introductions to the hospital staff are also very important. A new physician will have a much better opinion of the opportunity if hospital personnel are responsive, friendly, and call him/her

by name. The physician's efficiency is also enhanced by a good hospital orientation. This also includes the responsibilities of medical staff membership, such as attendance at meetings, chart completion expectations and protocol for scheduling procedures.

Follow-up Communication

A common mistake which is frequently made is to assume that a new physician is integrated into the practice situation after the first few days or weeks. The "new" doctor is not new any longer, and therefore is just another member of the staff. It is important to remember that the new physician will feel new in many respects for a considerable period of time. During this time, misunderstandings and "silent" conflict can arise which are not brought out into the open.

It is important to carry out a deliberate communications session, often on a quarterly basis, where the new physician's progress is discussed. Such items as compensation, record keeping, social progress, and others should be discussed. The area of compensation, particularly, can cause problems which may not surface until the physician is aggravated enough to leave the practice. Often these problems represent misunderstandings going all the way back to the hiring date. If the misunderstanding can be caught early enough, it can be dealt with simply. Left unattended, it can escalate into a major problem.

Developing the "We" Feeling

Retention depends a great deal upon the instilling of a "we" feeling into the new physician. A new physician needs to become a part of the organization as quickly as possible. Part of the process can be speeded up by a planned approach to teaching the history, traditions and customs of the community, clinic and hospital. Whether through the buddy system or through informal social functions, one or more members of the medical and/or administrative staff need to assure that some sense of history and tradition is imparted.

Conclusion

The best possible retention technique is careful matching of the candidate to the opportunity during the recruitment process. Careful attention to compatible backgrounds and personal goals will go far toward assuring that the new physician will feel at home and be easily integrated into the professional and social settings.

MSCI
Medical Search Consultants, Inc.

Appendix A

POSITION PROFILE

SPECIALTY: General Ophthalmology

LOCATION: (City), (State) is an attractive, progressive and friendly community of 11,000 located in southeastern (State). (City) residents talk about the quality of life in their community -- excellent schools, including a two-year community college, active churches, excellent recreational opportunities, good shopping, and the lack of big-city crime, pollution and congestion problems.

(City) is less than two hours from the lake resort areas of northeastern (State) and the famous Lake of the Ozarks. It is two hours from (City) and from (City), both offering the advantages of a major metropolitan area.

PRACTICE OPPORTUNITY: There is an outstanding opportunity in (City) for an ophthalmologist wanting a rural practice, but who also wants to associate with an excellent, small multi-specialty clinic and hospital. The clinic has eight physicians, representing family practice, internal medicine, general surgery, orthopedic surgery and urology. In addition, there is a smaller family practice clinic in (City) with two physicians. The hospital is one of the finest of its size anywhere. It is progressive, well managed, financially sound and responsive to physician needs.

The hospital has 97 beds, a 7 bed ICU and 4 bed recovery. There are three operating suites with an additional OR for ophthalmology under construction. The hospital has outstanding ancillary services including ultrasound, nuclear medicine and CT scanning. The hospital and clinic are prepared to purchase all necessary equipment for the office and hospital practice of ophthalmology.

The new ophthalmologist can expect referrals from all (City) physicians and will have a good practice in a short period of time. There are five optometrists in (City) who can support the addition of an ophthalmologist.

SERVICE AREA

The southeastern (State) service area offers an unmatched professional opportunity. There are currently three ophthalmologists serving a population of 250,000 people, and no ophthalmologist currently services (City), with a service area of 20,000 plus.

COMPENSATION PACKAGE:

There are several options open to a new physician with respect to affiliation with the existing multi-specialty group, with the hospital, or practicing independently.

This opportunity includes a highly attractive first year income guarantee plus a full package of benefits including:

. Malpractice insurance paid

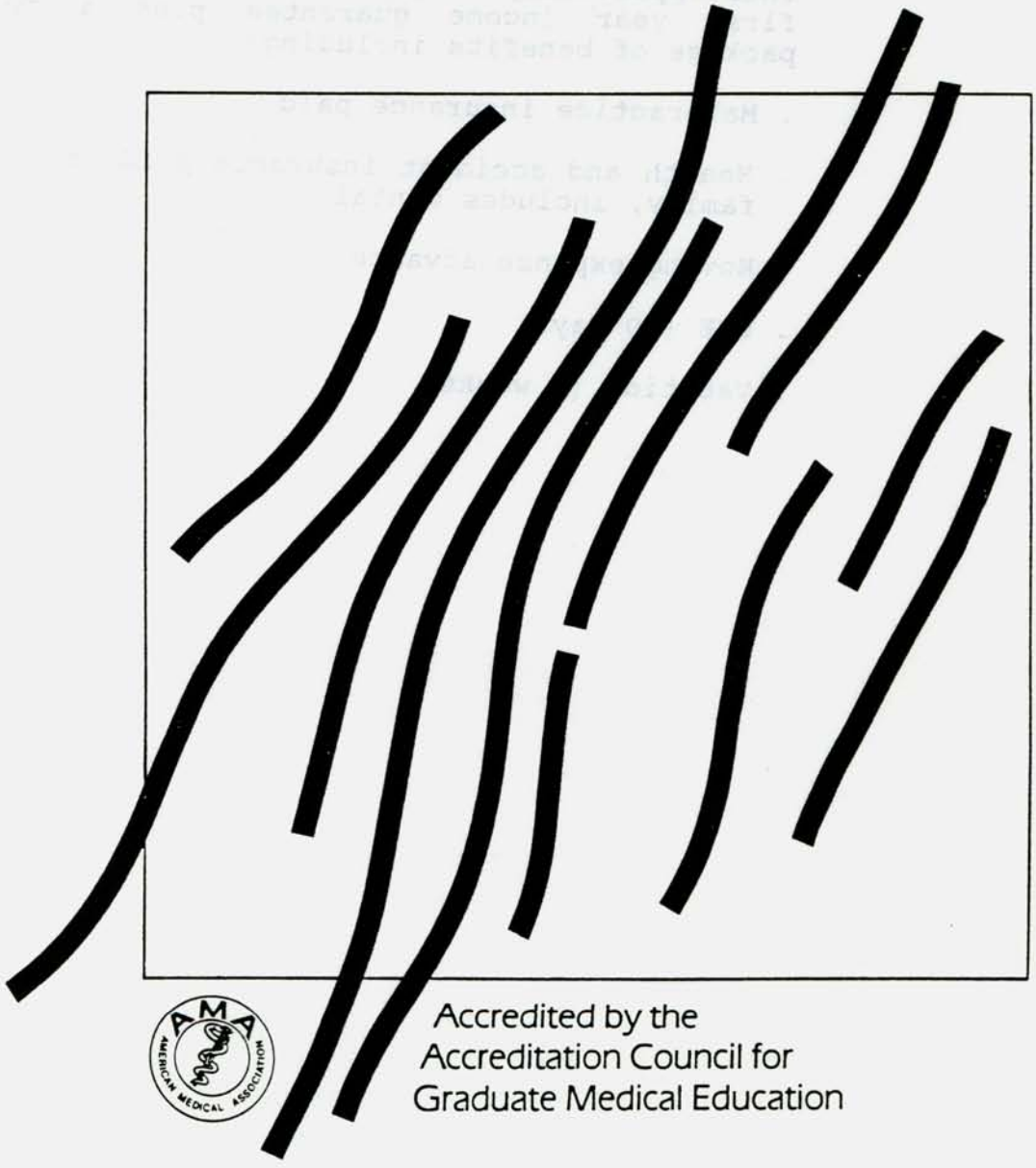
. Health and accident insurance paid for family, includes dental

. Moving expense advance

. CME (10 days)

. Vacation (4 weeks)

1986-1987 DIRECTORY OF RESIDENCY TRAINING PROGRAMS



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ACCREDITED PROGRAMS IN ANESTHESIOLOGY

MICHIGAN cont'd

Detroit

Children's Hospital of Michigan Program
Children's Hospital of Michigan
Program Director:
Marvin R Jewell, MD
Children's Hospital of Michigan
3901 Beaubien St
Detroit MI 48201
Length: 1 Year(s); Total Positions: 7 (PGY1: 0)
AN 9,000; CNP 200

Sinai Hospital of Detroit Program
Sinai Hospital of Detroit
Program Director:
Eli M Brown, MD
Sinai Hospital of Detroit
6767 W Outer Dr
Detroit MI 48235
Length: 4 Year(s); Total Positions: 21 (PGY1: 0)
AN 18,172; CNP 1,400

Southfield

Providence Hospital Program
Providence Hospital
Program Director:
Francis C Wong, MD
Providence Hospital
16001 W Nine Mile Rd
Southfield MI 48037
Length: 4 Year(s); Total Positions: 8 (PGY1: 2)
AN 14,550; CNP 950

MINNESOTA

Minneapolis

University of Minnesota Program
University of Minnesota Hospital and Clinics
Hennepin County Medical Center
Program Director:
Joseph J Buckley, MD
University of Minnesota Hospital and Clinics
420 Delaware St, S E
Minneapolis MN 55455
Length: 4 Year(s); Total Positions: 23 (PGY1: 4)
AN 21,000; CNP 1,500

Rochester

Mayo Graduate School of Medicine Program
Mayo Graduate School of Medicine-Mayo Clinic
Rochester Methodist Hospital
St Marys Hospital of Rochester
Program Director:
Alan D Sessler, MD
Mayo Graduate School of Medicine
200 First St, S W
Rochester MN 55905
Length: 4 Year(s); Total Positions: 44 (PGY1: 4)
AN 60,000; CNP 23,000

MISSISSIPPI

Jackson

University of Mississippi Medical Center Program
University Hospital
Program Director:
David L Bruce, MD
University of Mississippi Medical Center
2500 N State St
Jackson MS 39216
Length: 4 Year(s); Total Positions: 14 (PGY1: 0)
AN 10,000; CNP 51

MISSOURI

Columbia

University of Missouri Medical Center Program
Univ of Missouri-Columbia Hosp and Clinics
Program Director:
G W N Eggers, Jr, MD
University of Missouri-Columbia Hospital and Clinics
3 N 15
Columbia MO 65212
Length: 4 Year(s); Total Positions: 18 (PGY1: 2)
AN 6,500; CNP 200

Kansas City

St Luke's Hospital Program
St Luke's Hospital
Program Director:
E E Fibuch, MD
St Luke's Hospital
44th and Wornall Rd
Kansas City MO 64111
Length: 4 Year(s); Total Positions: 10 (PGY1: 2)
AN 12,592; CNP 1,800

St Louis

Barnes Hospital Program
Barnes Hospital
Program Director:
William D Owens, MD
Washington Univ School of Medicine, Dept of Anesthesiology
660 S Euclid Ave
St Louis MO 63110
Length: 4 Year(s); Total Positions: 45 (PGY1: 1)
AN 29,000; CNP 150

St Louis University Group of Hospitals Program
St Louis University Hospitals
Cardinal Glennon Children's Hospital
St Louis Regional Medical Center
VA Med Ctr-John Cochran Division
Program Director:
John F Schweiss, MD
St Louis Univ School of Medicine, Dept of Anesthesiology
1325 S Grand Blvd
St Louis MO 63104
Length: 4 Year(s); Total Positions: 16 (PGY1: 3)
AN 22,750; CNP 600

NEBRASKA

Omaha

Creighton University Program
St Joseph Hospital
Program Director:
John L Gordon, MD
Creighton University, Dept of Anesthesiology
601 N 30th St
Omaha NE 68131
Length: 3 Year(s); Total Positions: 4 (PGY1: 0)
AN 6,922; CNP 410

University of Nebraska Program
University of Nebraska Hospital and Clinics
Program Director:
K Reed Peters, MD
Univ of Nebraska Medical Center, Dept of Anesthesiology
42nd and Dewey Ave
Omaha NE 68105
Length: 4 Year(s); Total Positions: 14 (PGY1: 0)
AN 5,166; CNP 325

NEW HAMPSHIRE

Hanover

Dartmouth-Hitchcock Medical Center Program
Dartmouth-Hitchcock Medical Center
Program Director:
Allen J Hinkle, MD
Mary Hitchcock Memorial Hospital
2 Maynard St
Hanover NH 03756
Length: 3 Year(s); Total Positions: 14 (PGY1: 0)
AN 9,000; CNP 1,600

NEW JERSEY

Hackensack

Hackensack Medical Center Program
Hackensack Medical Center
Program Director:
Harvey J Hatchfield, MD
Hackensack Medical Center
22 Hospital Pl
Hackensack NJ 07601
Length: 3 Year(s); Total Positions: 9 (PGY1: 0)
AN 10,117; CNP 325

Livingston

St Barnabas Medical Center Program
St Barnabas Medical Center
Program Director:
Norman J Zeig, MD
St Barnabas Medical Center
Old Short Hills Road
Livingston NJ 07039
Length: 4 Year(s); Total Positions: 6 (PGY1: 0)
AN 16,978; CNP 300

Long Branch

Monmouth Medical Center Program
Monmouth Medical Center
Program Director:
H Lawrence Karasic, MD
Monmouth Medical Center
300 Second Ave
Long Branch NJ 07740
Length: 4 Year(s); Total Positions: 16 (PGY1: 5)
AN 12,200; CNP 552

New Brunswick

U M D N J-Rutgers Medical School Program
Middlesex General-University Hospital
Program Director:
Sanford L Klein, D D S, MD
U M D N J-Rutgers Medical School
Academic Health Science Ctr, C N 19
New Brunswick NJ 08903
Length: 3 Year(s); Total Positions: 12 (PGY1: 4)
AN 10,000; CNP 150

Newark

U M D N J-New Jersey Medical School Program
U M D N J-University Hospital
Program Director:
Wen-Hsien Wu, MD
U M D N J-New Jersey Medical School
100 Bergen St, Med Science Bldg
Newark NJ 07103
Length: 4 Year(s); Total Positions: 31 (PGY1: 6)
AN 5,000; CNP 600

Paterson

St Joseph's Hospital and Medical Center Program
St Joseph's Hospital and Medical Center
Program Director:
Anna Stanec, MD
St Joseph's Hospital and Medical Center
703 Main St
Paterson NJ 07503
Length: 4 Year(s); Total Positions: 15 (PGY1: 0)
AN 8,240; CNP 954

▶ Information Not Provided PGY1 = Positions Open to Applicants with No Previous Graduate Medical Training ★ Shared-Schedule Positions Available
An = *Total Anesthetics*, CNP = *Consultation on Nonsurgical Patients*

Army Medical Facilities

Northeastern United States

Maryland

Kimbrough U.S. Army Community Hospital,
Fort Meade, Maryland

Kirk U.S. Army Health Clinic,
Aberdeen Proving Ground, Maryland

Massachusetts

Cutler U.S. Army Community Hospital,
Fort Devens, Massachusetts

New Jersey

Patterson U.S. Army Community Hospital,
Fort Monmouth, New Jersey

Walson U.S. Army Community Hospital,
Fort Dix, New Jersey

New York

Ainsworth U.S. Army Health Clinic,
Fort Hamilton, New York

William Lordan Keller
U.S. Army Community Hospital,
West Point, New York

Pennsylvania

Dunham U.S. Army Health Clinic,
Carlisle Barracks, Pennsylvania

Washington D.C.

Walter Reed Army Medical Center,
Washington, D.C.

Southeastern United States

Alabama

Fox U.S. Army Community Hospital,
Redstone Arsenal, Alabama

Noble U.S. Army Community Hospital,
Fort McClellan, Alabama

U.S. Army Aeromedical Center and
Lyster U.S. Army Community Hospital,
Fort Rucker, Alabama

Georgia

Dwight David Eisenhower
Army Medical Center,
Fort Gordon, Georgia

Martin U.S. Army Community Hospital,
Fort Benning, Georgia

U.S. Army Health Clinic,
Fort McPherson, Georgia

Winn U.S. Army Community Hospital,
Fort Stewart, Georgia

Kentucky

Col. Florence A. Blanchfield
U.S. Army Community Hospital,
Fort Campbell, Kentucky

Ireland U.S. Army Community Hospital,
Fort Knox, Kentucky

Louisiana

Bayne-Jones U.S. Army Community Hospital,
Fort Polk, Louisiana

North Carolina

Womack U.S. Army Community Hospital,
Fort Bragg, North Carolina

South Carolina

Moncrief U.S. Army Community Hospital,
Fort Jackson, South Carolina

Virginia

DeWitt U.S. Army Community Hospital,
Fort Belvoir, Virginia

Kenner U.S. Army Community Hospital,
Fort Lee, Virginia

McDonald U.S. Army Community Hospital,
Fort Eustis, Virginia

Midwestern United States

Colorado
Fitzsimons Army Medical Center,
Denver, Colorado
U.S. Army Community Hospital,
Fort Carson, Colorado

Illinois
U.S. Army Medical Department Activity,
Fort Sheridan, Illinois

Indiana
Hawley U.S. Army Community Hospital,
Fort Benjamin Harrison, Indiana

Kansas
Irwin U.S. Army Community Hospital,
Fort Riley, Kansas
Munson U.S. Army Community Hospital,
Fort Leavenworth, Kansas

Missouri
General Leonard Wood
U.S. Army Community Hospital,
Fort Leonard Wood, Missouri

Southwestern United States

Arizona
Raymond W. Bliss
U.S. Army Community Hospital,
Forth Huachuca, Arizona

New Mexico
McAfee U.S. Army Health Clinic,
White Sands Missile Range, New Mexico

Oklahoma
Reynolds U.S. Army Community Hospital,
Fort Sill, Oklahoma

Texas
William Beaumont Army Medical Center,
El Paso, Texas
Brooke Army Medical Center,
Fort Sam Houston, Texas
Darnall U.S. Army Community Hospital,
Fort Hood, Texas

Western United States

Alaska
Bassett U.S. Army Community Hospital,
Fairbanks, Alaska

California
Silas B. Hayes U.S. Army Community Hospital,
Fort Ord, California
Letterman Army Medical Center,
San Francisco, California
Weed U.S. Army Community Hospital,
Fort Irwin, California

Hawaii
Tripler Army Medical Center,
Honolulu, Hawaii
U.S. Army Health Clinic,
Schofield Barracks, Hawaii

Washington
Madigan Army Medical Center,
Tacoma, Washington

U.S. MEDICAL FACILITIES

USAF Hosp Beale
Beale AFB CA 95903

USAF Rgn Hosp Carswell
Carswell AFB TX 76127

USAF Hosp Dyess
Dyess AFB TX 79607

USAF Hosp Ellsworth
Ellsworth AFB SD 57706

USAF Hosp F.E. Warren
F.E. Warren AFB WY 82001

USAF Hosp Griffiss
Griffiss AFB NY 13441

USAF Hosp K.I. Sawyer
K.I. Sawyer AFB MI 49843

USAF Hosp Malmstrom
Malmstrom AFB MT 59402

USAF Hosp McConnell
McConnell AFB KS 67221

USAF Hosp Pease
Pease AFB NH 03801

USAF Hosp Vandenberg
Vandenberg AFB CA 93437

USAF Rgn Hosp March
March AFB CA 92518

USAF Rgn Hosp Minot
Minot AFB ND 58705

USAF Hosp Plattsburgh
Plattsburgh AFB NY 12903

USAF Hosp Whiteman
Whiteman AFB MO 65301

USAF Clinic Peterson
Peterson AFB CO 80914

USAF Hosp Cannon
Cannon AFB NM 88101

USAF Hosp England
England AFB LA 71301

USAF Clinic McGuire
McGuire AFB NJ 08641

USAF Clinic McChord
McChord AFB WA 98438

USAF Clinic Pope
Pope AFB NC 28308

David Grant USAF Med Cen
Travis AFB CA 94535

U.S. MEDICAL FACILITIES

USAF Hosp Hill
Hill AFB UT 84056

USAF Clinic McClellan
McClellan AFB CA 95652

USAF Hosp Tinker
Tinker AFB OK 73145

USAF Clinic Brooks
Brooks AFB TX 78235

USAF Rgn Hosp Eglin
Eglin AFB FL 32542

USAF Hosp Patrick
Patrick AFB FL 32925

USAF Clinic
Los Angeles AFS CA 90009

USAF Hosp Columbus
Columbus AFB MS 39701

USAF Med Cen Keesler
Keesler AFB MS 39534

USAF Clinic Lowry
Lowry AFB CO 80230

USAF Clinic Randolph
Randolph AFB TX 78150

USAF Hosp Little Rock
Little Rock AFB AR 72099

Malcolm Grow USAF Med Cen
Andrews AFB DC 20331

USAF Clinic Norton
Norton AFB CA 92409

USAF Med Cen Scott
Scott AFB IL 62225

USAF Hosp Barksdale
Barksdale AFB AR 71110

USAF Hosp Blytheville
Blytheville AFB AR 72315

USAF Hosp Castle
Castle AFB CA 95342

Ehrling Bergquist USAF
Offutt AFB NE 68113

USAF Hosp Fairchild
Fairchild AFB WA 99111

USAF Hosp Grand Forks
Grand Forks AFB ND 58201

USAF Hosp Loring
Loring AFB ME 04750

U.S. MEDICAL FACILITIES

USAF Rgn Hosp Sheppard
Sheppard AFB TX 76311

USAF Hosp Williams
Williams AFB AZ 85224

1 AES
Pope AFB NC 28308

375 AAW
Scott AFB IL 62225

USAF Clinic Bolling
Bolling AFB DC 20332

USAF Hosp Dover
Dover AFB DE 19902

USAF Clinic Kelly
Kelly AFB TX 78241

USAF Hosp Robins
Robins AFB GA 31098

USAF Med Cen Wright-Patterson
Wright-Patterson AFB OH 45433

USAF Hosp Edwards
Edwards AFB CA 93523

USAF Clinic L.G. Hanscom
L.G. Hanscom AFB MA 01731

Wilford Hall USAF Med Cen
Lackland AFB TX 78236

USAF Hosp Chanute
Chanute AFB IL 61868

USAF Clinic Goodfellow
Goodfellow AFB TX 76908

USAF Hosp Laughlin
Laughlin AFB TX 78840

USAF Hosp Mather
Mather AFB CA 95655

USAF Hosp Reese
Reese AFB TX 79489

USAF Clinic Vance
Vance AFB OK 73701

USAF Rgn Hosp Maxwell
Maxwell AFB AL 36112

57 AES
Scott AFB IL 62225

USAF Hosp Altus
Altus AFB OK 73523

USAF Clinic Charleston
Charleston AFB SC 29404

U.S. MEDICAL FACILITIES

USAF Hosp Kirtland
Kirtland AFB NM 87117

USAF Hosp Wurtsmith
Wurtsmith AFB MI 48753

USAF Hosp Bergstrom
Bergstrom AFB TX 78743

USAF Hosp Davis-Monthan
Davis-Monthan AFB AZ 85707

USAF Hosp George
George AFB CA 92392

USAF Hosp Holloman
Holloman AFB NM 88330

USAF Hosp Langley
Langley AFB VA 23665

USAF Rgn Hosp MacDill
MacDill AFB FL 33608

USAF Hosp Mt. Home
Mt. Home AFB ID 83648

USAF Hosp Nellis
Nellis AFB NV 89110

USAF Rgn Hosp Shaw
Shaw AFB SC 29152

USAF Hosp Academy
Academy AFB CO 80840

USAF Hosp Homestead
Homestead AFB FL 33030

USAF Hosp Luke
Luke AFB AZ 85309

USAF Hosp Moody
Moody AFB GA 31601

USAF Hosp Myrtle Beach
Myrtle Beach AFB SC 29577

USAF Hosp Seymour Johnson
Seymour Johnson AFB NC
27531

USAF Hosp Tyndall
Tyndall AFB FL 32401

U. S. NAVY

Base Hospitals

	Phone	Known Specialties
CALIFORNIA		
Camp Pendleton Naval Hospital Camp Pendleton, California 92055	619/ 725-1304	
Commander Larry H. Johnson, MC, USN Program Director, Family Practice		FP
Naval Hospital 8750 Mountain Blvd Oakland, California 94627	415/ 633-5001	OPHTH
Naval Hospital Park Boulevard San Diego, California 92134-5000	619/ 233-2411	OPHTH
FLORIDA		
Naval Hospital Jacksonville, Florida 32214	904/ 777-7314	
Charles McLaughlin, M.D., USN Program Director Department of Family Medicine		FP
Naval Hospital Pensacola, Florida 32512	904/ 452-6611	
D. Vertrees Hollingsworth, M.D. Department of Family Practice		FP

U. S. NAVY

Base Hospitals

ILLINOIS

Naval Hospital 312/ 688-2251
Great Lakes, Illinois 60088

Naval Base 312/ 688-2045

Health Care Operations Division 202/ 653-1723

Dr. Miller

MARYLAND

Naval Hospital OPHTH
Bethesda, Maryland 20814

SOUTH CAROLINA

Naval Hospital 803/ 525-5301
Beaufort, South Carolina 29902

Naval Hospital 803/ 743-5670
Rivers Avenue
Charleston, South Carolina 29408

Commander R. B. Peterson, MC, USN FP
Program Director, Family Practice

TEXAS

Naval Hospital 512/ 939-2684
Corpus Christi, Texas 78350

WASHINGTON

Naval Hospital
Bremerton, Washington 98314

Vincent H. Ober, M.D. FP
Program Director, Family Practice
Department of Family Medicine

PHYSICIAN LISTINGS

can be obtained from the following firms:

	Phone
Business Mailers, Inc. 640 North LaSalle Drive Chicago, Illinois 60610	(312) 943-6666
Western Union Electronic Mail, Inc. P.O. Box 1037 McLean, Virginia 22101	(1-800-336-3337)
American Business Lists, Inc 5707 South 86th Circle P.O. Box 27347 Omaha, Nebraska 68127	(402) 331-7169

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P H Y S I C I A N
V I S I T

M S C I

Medical Search Consultants, Inc.

10950 Grandview, Suite 458
Overland Park, Kansas 66210

PREPARING FOR THE PHYSICIAN VISIT

Generally speaking, a community has only a single opportunity to evaluate and make a positive impression on a visiting physician and spouse. During that brief visit, your goal is to present your community in the most favorable, yet realistic light. More specifically, you want to provide the kind of information and impressions which will make the physician want to settle in your community, or at least, place your community high on the list of those to be seriously considered.

Therefore, first impressions are vitally important.

Will you give the impression of being well organized and professional? Will you have a ready response for most predictable questions about:

* the compensation package
* available real estate
* the school system
* churches
* shopping
* office space
* other physician acceptance and support
* recreational, social and cultural opportunities?

The successful recruitment of a physician will depend on the answers to these questions, along with other impressions.

The following are suggested key activities which have proven successful in the past:

1. Organize the recruitment/reception committee to include 5 to 7 couples of various ages who represent different facets of the community:

   * financial
   * educational
   * medical
   * administrative (hospital or clinic)
   * religious, social, cultural leaders
   * real estate representatives
   * other

2. Develop a plan to be used with each visiting physician. Be certain to specifically invite the physician's spouse/fiance. Determine in advance (in a personal phone call if possible) their interests and schedule important community contacts.

3. Compile a general, well-organized visit agenda and mail to the candidate prior to the departure. You will need to modify this for each visit. Here's an example:

DAY ONE

* arrive for an informal lunch with the recruitment committee
* brief tour of community
* tour of hospital and/or clinic
* social event (5 to 7 couples), including as many of the medical staff and spouses as possible
* set up agenda for spouse's activities for the next day. (This might include an escorted visit to the schools, the realtor, site of community interest).

DAY TWO

* medical staff breakfast
* a visit to the office site
* realty tour (if appropriate)
* lunch with appropriate medical associates
* negotiations (if appropriate)
* free time for physician and spouse
* final meeting with one or more members of the recruitment committee
* departure

If you are interested in the candidate, IMMEDIATE FOLLOW-UP IS ESSENTIAL!

Send personal letters from various members of the recruitment committee expressing your interest.

Phone the candidate and spouse to give updated information on their status.

Send local newspaper and community information.

Send hospital updates, house bulletins and newsletters.

Answer any questions the couple asked which you did not have the answers to at the time of their visit.

Send a sample contract for review.

Very importantly, if you want that physician and spouse to join your staff, offer the candidate the position.

Don't be afraid to follow-up frequently "just to stay in touch". Occasionally the decision-making process is longer than you would like. If a month or more goes by without contact, the physician might assume you have lost interest.

Set specific dates and deadlines for decision-making for both the candidate and the administration.

Keep in mind, other communities are competing with you for this same physician. Therefore, the effort it takes to present an organized approach may well set you apart from other practice opportunities open to the physician.

Finally, be prepared to do something special which might set you apart from other communities the physician will be looking at. A fruit basket or a bouquet of flowers in the motel room could be the kind of personal touch you might wish to give the prospective physician.