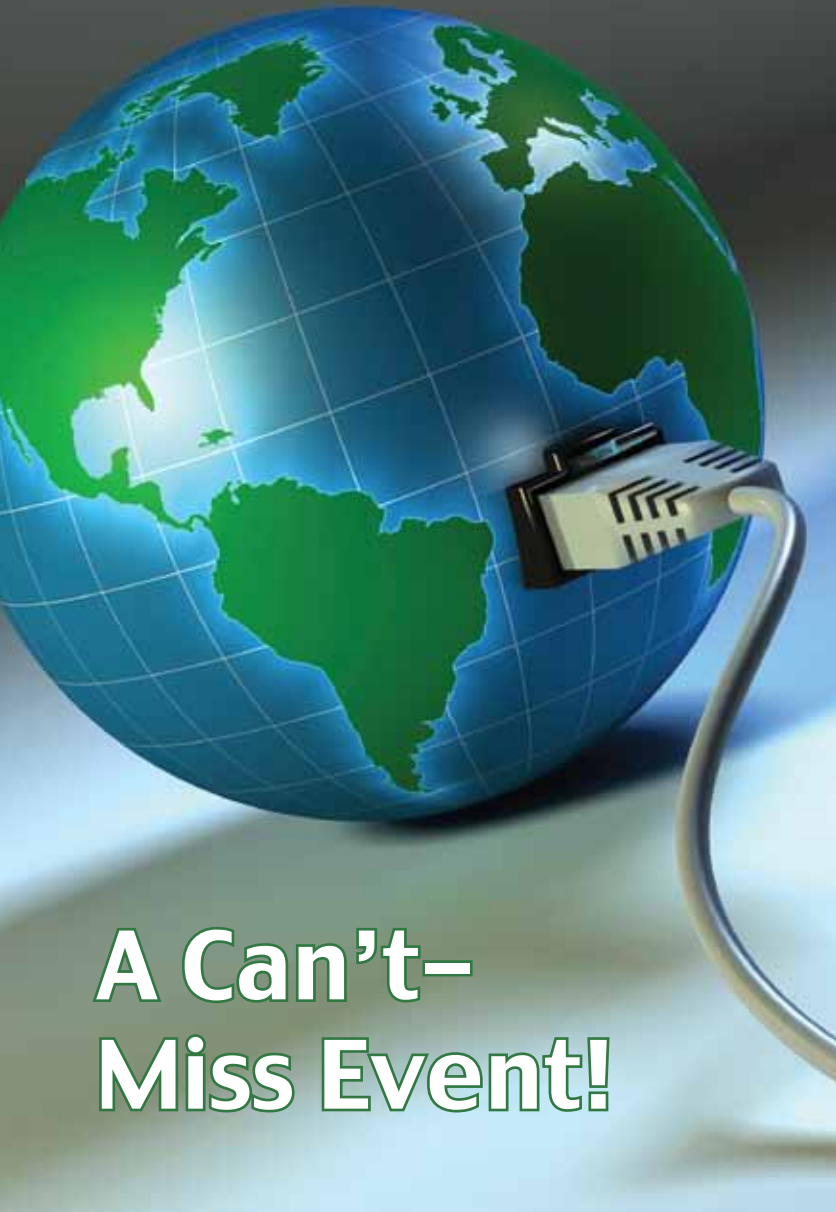


The Pulse

Fall 2010

NAPR 2010 Fall Log-In...



A Can't-Miss Event!

Have you registered for the 2010 Fall Log-in yet? If not, why not? Have you wanted to send your recruiters to “the NAPR School of Healthcare Recruitment” but haven’t wanted to spend the extra dollars for the additional expenses like hotel, airfare, meals, and time out of the office? If you answered yes then here’s your chance to have your whole office attend and save.

NAPR will be presenting six topics during the week of September 27 - October 1, 2010. One area a day for five days, just 60 minutes a day, from the comfort of your own office. Just \$499 per site, YES that’s right – only \$499 per site, no matter how many individuals at that location participate.

Monday will focus on sourcing. During “**Sourcing Candidates From All Perspectives**” the attendees will learn how to use and find candidate sourcing options specific to the attendees’ recruiting niche.

Tuesday will offer two sessions with a short break in between. The first session, “**Cold-Calling and Pre-Qualifying**,” will provide the attendee a variety of techniques to use to source and qualify prospects. The beginner recruiter and the seasoned professional will benefit by gaining some practical applications to use when qualifying prospective candidates. The second session, “**Presenting and Behavioral-Based Interviewing**,” will help you start putting some of these skills to use in real-life scenarios and opportunities to participate in role plays. This session will be highly interactive. Please note it is recommended you take both courses offered on Tuesday for the best result.

On Wednesday learn how to “**Hang Your Dirty Laundry from a Flagpole — Overcoming Objectives**.” This session will focus on ways to overcome the common objections given by clients and candidates in regard to the placement process.

Thursday brings our new course “**Preparing for the Interview**.” During this session attendees will be taught the goals and objectives of the interview, learn how to ensure a successful interview, including coaching both sides, understanding the entire process, and appreciating how the spouse and family factor into the equation.

Friday’s session, “**Closing — Bringing It All Together**,” will provide attendees the basic closing skills needed to enhance their interview-to-placement ratio and also to provide the beginner recruiter with the fundamentals needed to understand the closing process and sequence.

For more information or to register [click here](#).



NAPR is Networking...



That's right NAPR now has a page on Facebook and we want you to be our friend. You will get updates on the latest industry trends, association news, convention information and much more right to your wall. Plus you'll receive "friends-only" promotions. Be the first to know when online registration to our meetings and conventions have opened and see what our speakers are going to talk about. It's easy to join — just click the icon above, register (if you aren't already a Facebook member) and then "like" our page.

Two easy ways to make sure you are. Follow us on twitter!

1.) The Careers Page a great page to showcase positions. To start following us all you have to do is simply click <http://bit.ly/d5dABu>.

2.) The News Page is a great way to make sure you haven't gotten away or that you haven't missed anything. On this page we will tweet about the latest happenings in the industry and association. We will, as with Facebook friends, send you the news first with a tweet from us when convention registration is live, exclusive insight from our speakers as the tweet with us about their upcoming presentations, and much more.



To follow us on the News Page simply click <http://bit.ly/aO8dqF>.

Start following us today! You won't want us to get away!

2010-2011 NAPR Board of Directors

PRESIDENT.....Pat Doyle-Grace, CPC-PRC
Cejka Search/MRA
314-236-4466

PRESIDENT-ELECT..... Patrice Streicher
VISTA Staffing Solutions, Inc.
414-427-7250

VICE PRESIDENTAnne Folger
Health Future, LLC
541-618-7240

SECRETARY/TREASURER Jim Stone
The Medicus Firm
972-759-0331 x225

IMMED. PAST PRES. Tammy Jamison
Lehigh Valley Health Network
610-969-0211

OTHER BOARD MEMBERS

Sandi Buchanan.... Carolinas HealthCare System
704-355-5030

Susan Masterson TeamHealth
865-293-5270

Marty Osinski American Medical
Consultants, Inc.
305-254-8808

Wanda Parker..... The HealthField Alliance
203-778-3333

NAPR SERVICES, INC. Brenda Lewis
B.E.L. Associates, Inc.
814-382-6007

INTERNET/WEBSITE Jo-Ann M. Toldt, CPC-PRC
TeamHealth
856-686-4351

ETHICS CHAIR..... Jane Born
Born & Bicknell, Inc.
561-322-3011

EDUCATION CHAIR..... Craig Fowler
Pinnacle Health Group
404-591-4221

EXECUTIVE VICE PRESIDENT Bill Kautter, CAE
222 S Westmonte Dr Ste 101
Altamonte Springs, FL 32714
407-774-7880 • 800-726-5613
Fax: 407-774-6440
bkautter@napr.org

What's Hot in Physician Recruitment? Ethics are Still Number One!

By Pat Doyle-Grace, NAPR President, and Jane E. Born, Chairperson, NAPR Ethics Committee



Do you believe the best way to rise to the top in physician recruitment is to be ethical? Do you fully practice what you believe? To paraphrase Jon Hunstman, author of *Winners Never Cheat*, "Honor, fairness, honesty and respect are values as old as time and still hold true today. You don't need to compromise your core values to become a financial success. If you're a leader or aspire to be a leader in any field it is critical to focus on values that the modern world often tramples. The message is sweet, simple and clear: stick to your beliefs staunchly, even if it costs you in the short term, because character, integrity and long-term results are what really count."

At NAPR Headquarters, we receive inquiries regularly from our members regarding ethics. Our members have questions and seek direction on a myriad of ethics topics. Therefore, we are excited to put together a series of articles focused on the

hottest ethical issues our members face today. The first article will be featured in our Winter newsletter. It will address "procuring cause" versus "first in."

We welcome all inquiries and thank you for your active participation in NAPR. Active membership through active participation helps all of us! The Ethics Committee of NAPR is comprised of our peers in physician recruitment. As President of NAPR I work closely with our Chairperson of Ethics, Jane Born. We both find it incredibly rewarding to be part of a group of such fine and dedicated people in our industry who volunteer their time to help in upholding our Code of Ethics. NAPR states that its Code of Ethics is "practical but strict" based upon excellence, honesty, fairness, peer review and reasonable industry standards. NAPR and its members are committed to ethics. It is first in our slogan. But, our commitment is not just an abstract, high-sounding term, empty of meaning with NAPR. Unlike other associations, our Code of Ethics "has teeth." NAPR offers its members recourse. We believe that no member should have an unfair advantage over another. As members, we agree to report any violations of the Code of Ethics; however, we are judicious

in reporting of issues, bearing in mind that there are always two sides to every story. The root of the issue can sometimes be poor communication, or misunderstanding.

It seems no matter how far all of us have come in today's sophisticated and technologically advanced society, the most important values are the ones we learn from childhood. However, the simple truth is that doing good business is like being a good listener, everyone agrees that it is very important; however, not everyone always does it. Why? Because many people do not stay focused on their core values. Can one thrive in a complex, fast-paced, competitive recruitment industry? We believe it's possible if one emphasizes self-discipline, cooperation, and responsible business practices. As NAPR members we choose an environment of mutual respect and shared responsibility. We strive to be the highest achievers among all other physician recruiters. We covet our high standards of professional conduct and defend what we believe. Integrity does matter, and always will.

It's our honor to serve you. We are proud of our members. As a member in good standing of the National Association of Physician Recruiters, you represent the best and brightest in physician recruitment today; and hopefully, inspire others to do good business as well!

**Unlike other associations,
our Code of Ethics
"has teeth."**



Primary Care in Medical Education: The Problems, the Solutions

By Scott Harris, reprinted with permission from the AAMC Reporter, March 2010 edition

People often reference medical education's hidden curriculum—a set of unwritten lessons about practicing medicine that professors impart to their students. But despite its name, at times the hidden curriculum is anything but.

A large number of observers inside and outside academic medicine believe a big part of the hidden curriculum in undergraduate and graduate medical education (GME) discourages students—passively and not so passively—from pursuing a career in the primary care specialties.

But many medical schools and residency programs have made firm commitments—some new, some longstanding, and some largely under the national radar—to raising interest in primary care. Primary care is generally defined as family medicine, internal medicine, and pediatrics, although it is the adult-oriented specialties for which the problem exists most pointedly, physician workforce experts say. In the 2009 Main Residency Match, 3,703 U.S. allopathic senior students matched to an internal or family medicine residency program, compared with 4,617 in 2000 and 5,020 in 1996. According to AAMC data, all primary care practitioners entering general practice after residency are down from 8,162 in 2000 to an estimated low of 6,757 in 2007. The Council on Graduate Medical Education (COGME) claims that all primary care physicians currently comprise 35 percent of practicing physicians, but that number is rapidly declining because of increased retirements and fewer new doctors to replace them. Recent COGME studies show that fewer than 20 percent of all U.S. medical students are choosing primary care specialties.

Low interest in primary care is nothing new, however, and has root causes that extend far beyond the halls of medical school. Familiar systemic issues of lower compensation and high administrative burdens for primary care practitioners versus those in other specialties undoubtedly play a major role.

For Naseem Helo, now a third-year medical student at Loyola University Chicago Stritch School of Medicine, the hidden curriculum came into full view during a family medicine clerkship at an academic

medical center he declined to identify.

"The program director discouraged me from entering primary care," said Helo, who plans to pursue radiology. "He stated that students have too much debt to enter a profession that does not realistically compensate physicians."

There are schools, however, that have established a commitment to eliminating this climate of negative reinforcement. Since 1970, the University of Massachusetts Medical School (UMMS) has made it a priority to increase the number of primary care practitioners in Massachusetts. According to school data, about half of all UMMS graduating classes enter general primary care practice after training.

"Culturally, we try to discourage this phenomenon of primary care bashing," said UMMS Dean Terry Flotte, M.D. "We have developed survey tools that ask how students get their attitude about primary care. But most of our efforts in this area are not structured. It starts with me and the chancellor embracing the primary care mission, and pointing out how central it is."

It is widely known that primary care practitioners are relatively poorly compensated in the current fee-for-service payment system, which tends to reward tests and procedures over so-called "cognitive services" such as patient consultations. This, in turn, hampers a doctor's ability to pay back student debt, which now averages about \$156,000 for each medical school graduate, according to the AAMC. "Students realize that it is impractical to enter a profession where the compensation cannot cover student debt," Helo said.

"Students also feel a sense of entitlement, that being a physician defines them as a person that will have a good salary. Students want to see their hard work, sweat, and tears pay off financially, and that can often guide students away from primary care."

Some medical schools are offering help on this front as well. The Commonwealth Medical College (TCMC) in Scranton, Pa., which matriculated its first class in 2009, used philanthropic donations to provide scholarships totaling \$80,000—\$20,000 per year—to its 65-member charter class. At UMMS, the Learning Contract serves

as a major incentive for students. Created through an agreement with the state government, the contract defers two-thirds of a student's tuition payments and forgives it entirely for completing four years of primary care service in Massachusetts.

"It's removing one of those obstacles to primary care," Flotte said. "People don't choose their specialty based on debt alone, but having a lower debt burden can be enabling."

"For practicing primary care doctors, large administrative obligations and the short-duration, high-volume patient visits required to remain financially stable can mean an undesirable practice model. Many primary care practitioners who serve on medical school faculty observe that this clinical reality cannot help but seep in to the classroom environment."

"Rank-and-file family doctors are short-changed in terms of time," said David Deci, M.D., a family medicine practitioner and director of the office of medical student education at the University of Wisconsin School of Medicine and Public Health's family medicine department. "They shoulder the bureaucratic burden of the entire system. It's not the fun stuff. It's the referrals and pre-certifications and all the other things that come along with bringing people through the system."

From a literally more concrete perspective, clinical training facilities for primary care are often less well-appointed (and thus less impressive to some students) than others. This can be a function of the simple fact that primary care practice is a relatively low-tech operation, medical educators said.

"Modern medicine is enthralled with high-tech measures," Deci said. "We're all drawn to bells and whistles. The contribution that can be made through a long-term relationship with a patient needs to be shown as well. When you're working with an elderly patient with multiple conditions and diseases, and you manage to keep him out of the hospital for two years, you've made a great contribution. But it's harder to demonstrate that than it is to show the value of removing a tumor with gamma knife surgery."

Continued on page 6

Who's Going to Take Care of Us? Surgery, Primary shortages endanger access to services

The passage of national health care legislation is an occasion for celebration, but the party may be short-lived unless serious attention is devoted to a growing concern: The nation's need for more physicians, especially in primary care and general surgery.

Some recent headlines highlight this issue:

- "Health law may worsen family doctor shortage"
- "Health reform's next challenge: Who will care for the newly insured?"
- "Medical Schools Can't Keep Up: As Ranks of Insured Expand, Nation Faces Shortage of 150,000 Doctors in 15 Years"

One of the essential steps to ensuring that the physician workforce can grow is to end the cap on new residency positions imposed by the Balanced Budget Act of 1997. Because of this legislation, the number of Medicare-funded graduate medical education (GME) positions has been frozen for 13 years, despite the nation's growing population and the imminent explosion in demand for health care services as the Baby Boom generation enters retirement. AMA staff continue to work with lawmakers to address this concern.

Surgery leaders are calling for an end to the residency cap "as the first step in addressing the current and projected shortage of general surgeons" ("Commentary: The Case for Expanding General Surgery Residencies," *Academic Medicine*, May).

Similarly, the authors of a recent book, *The Coming Shortage of Surgeons: Why They Are Disappearing and What That Means for Our Health* call for adjusting the cap as well as shortening surgery training and using technology to increase productivity (JAMA book review, April 28).



Like surgery, primary care faces an uncertain future—one that could have significant implications for the health of Americans. Low reimbursements and a mounting tide of paperwork and documentation are just two reasons that many US medical school graduates forego a career in primary care. To help address these concerns, the AMA is working with Congress to fix the Medicare reimbursement formula for physicians, and is rolling out a new technology and practice management service that promises relief to overburdened doctors.

To stay up-to-date on these and related topics in medicine and medical education, be sure to subscribe to the AMA's free e-mail newsletter, the GME e-Letter. For more information and to sign up, see www.ama-assn.org/go/gmenews or e-mail us at gme@ama-assn.org.

NAPR
National Association of Physician Recruiters
Ethics, Education, Services

2010 Fall Log-In

September 27 - October 1, 2010

IF YOU'RE LOOKING TO RECRUIT INTERNISTS, SUBSPECIALISTS, AND HOSPITALISTS . . .

ADVERTISE IN OUR AWARD-WINNING PUBLICATIONS



ACP HOSPITALIST

Winner of a 2010 Silver ASHPE Award.

ACP INTERNIST

Honored with a 2010 Silver EXCEL Award for General Excellence Among Newspapers by Association Media & Publishing.

ANNALS OF INTERNAL MEDICINE

The most cited internal medicine journal in the world.

AND COMPLEMENT WITH OUR WEB SITE!



Call 800-523-1546 for space reservations or media kits:
Margaret Gardner, ext. 2768 • Maria Fitzgerald, ext. 2667
Ryan Magee, ext. 2557

www.acponline.org/careers



Primary Care in Medical Education...

Continued from page 4

UMMS makes a deliberate effort to ensure that primary care clinical sites include cutting-edge technologies such as teleconferencing and electronic health record systems. "We work hard to develop innovative primary care residency sites," Flotte said. "We try to make those teaching sites attractive. What we want is to have our faculty be happy in their work environment. We have built a new, state-of-the-art clinic with high-end IT infrastructure and teleconferencing capabilities. Students and residents who work there can still participate in grand rounds. It makes a really big difference in morale, and it makes the facilities in our own system that much more valuable."

Within academic medicine, students and faculty members have long observed that rivalries (friendly and otherwise) are common among specialties of all stripes, with each specialist believing his or her profession to be superior. And with most modern faculties consisting mainly of subspecialists, combined with the larger systemic factors of compensation and practice climate, primary care educators often find

they are underrepresented in medical education, and the longstanding debates that take place there.

"Medical education is all about context," said Jeffrey Borkan, M.D., Ph.D., professor and chair of the department of family medicine at Brown University's Warren Alpert Medical School and the president of the Association of Departments of Family Medicine. "There can be an inherent bias because of who the trainers are and where the education happens. U.S. academic medical centers and medical schools tend to be in urban areas and have a predominance of specialist and subspecialist physicians, providing care in tertiary and quaternary hospital settings. Primary care and primary care physicians and educators can be underrepresented in these settings, even though present in the broader community and country."

Several schools are making concerted efforts to reverse this trend by exposing students to primary care doctors and more traditional primary care practice environments throughout the continuum of medical edu-

cation.

During GME, most primary care residencies take place in hospitals or similar inpatient settings, where interaction with community practices is limited. This leads many resident internists to consider hospital medicine rather than general primary care. In 2007, 10 percent of internists entered hospital medicine compared with 4 percent in 2002, AAMC data show.

"Internal medicine residencies are based very intensely in the hospital," said Justin Weis, M.D., a third-year internal medicine resident at the University of Rochester Medical Center. "It gives you a narrow or absent view of primary medicine. The real work of practice happens in the clinic, but most residents just don't see this. Being a hospitalist is a natural progression from an internal medicine residency. To go into clinics, it's a much bigger wall to get over."

The expansion of regional branch campuses has provided fertile ground for training primary care doctors in a more

Continued on page 7

Primary Care in Medical Education...

Continued from page 6

representative setting. H. David Wilson, M.D., dean of the Kansas University (KU) - Wichita School of Medicine regional campus, said the comparatively rural location of most branch campuses allows exposure to a more conventional version of general practice.

"Our students get away from an environment where there is a super-specialist on every hallway," Wilson said. "It gets them into the real world where they have contact with practicing doctors and community physicians. Regional campuses can put students in a one-on-one situation. They see the local doctor as a very important person in a rural area, and a highly respected member of the community."

Wilson said that about a third of all KU medical students spend their final two years in Wichita, which has partnerships with three hospitals and many doctors' offices across the state. On average, 21 percent of KU medical graduates enter family medicine, Wilson said.

During TCMC's development, leaders recruited community physicians to not only serve as faculty members, but design the school's curriculum, sit on the admissions committee, and even interview applicants.

The TCMC curriculum heavily reflects that emphasis on primary care. First-year TCMC students spend their first three weeks shadowing a general internist, and are assigned to a patient with a chronic illness, who the students then track throughout their time in medical school. There are small-group research projects on primary care-related topics. In years three and four, students rotate through branch campuses in the smaller cities of Wilkes-Barre and Williamsport.

"It's about assisting with patients and learning from them," said Janet Townsend, M.D., the school's founding chair of family medicine and community health. "It's an immersion experience. They will be living the life of a community physician much more than in basic block rotations. It includes time in the office, and they get to round on patients who went to the hospital. From the beginning through the end, they are learning how physicians work in the community."

Although it is too early for data, Townsend said the school intends for 50-60 percent of all graduates to enter primary care.

Academic medicine is also working to address the disparities and shortcomings in the health care system that play their own role in discouraging interest in primary care. Duke University School of Medicine has created an intricate web of community partnerships that treat patients in their own neighborhoods and even provide in-home doctor visits and other primary care services. So far, Duke officials say the program has improved health outcomes in the greater Durham, N.C., area, while reducing costs by keeping patients out of emergency rooms. Many other academic health systems receive grants and form partnerships to test and study new models of care delivery that could one day bring more balance to the system.

For example, at the University of Cincinnati College of Medicine, Gregory W. Rouan, M.D., associate chair for education in the college's internal medicine department, is collaborating with a team of researchers from the AAMC, the Society of General Internal Medicine, and the American College of Physicians to study and disseminate information on different clinical innovations taking place in academic medicine, including the patient-centered medical home, a more coordinated model of care in which primary care providers are officially recognized as the central manager of a patient's health.

A recent survey of academic medical centers administered by this group found that faculty clinics are increasing their use of health IT, phone, and e-mail to coordinate and provide patient care, and 88 percent of survey respondents had fully or partially implemented evidence-based protocols in their practices. And of course, there is the ongoing health care reform debate.

Though the prospects of national reform legislation are currently uncertain, a series of federal regulations could result in up to a 6 percent payment increase for primary care services. Lawmakers are expected to increase the annual payment ceiling for participants in the National Health Service Corps, which provides debt relief to doctors who serve in rural areas, from \$35,000 to \$50,000, to keep up with debt levels.

According to AAMC Chief Advocacy Officer Atul Grover, M.D., Ph.D., changes in the larger health care system—such as a move toward managed care in the 1990s—can have a major influence on the medical education environment. Grover added that

the current model is, on many levels, simply unappealing to students. "In 1995, interest in family medicine and other primary care professions jumped up. The changes were in the economics and the marketplace," Grover said.

"Everyone believed managed care would change things and primary care doctors would make more money because of their prominent role in that model. We were told if we wanted to be employed, we should not subspecialize. But of course, that didn't happen. "Today, there is some uncertainty over how primary care is evolving, and what the role of the physician will be," Grover continued.

"The current delivery system is often unappealing to people. Part of that goes back to reimbursement, because physicians see more patients in smaller blocks of time so they can keep practices afloat. With new models like the team-based medical home, as long as you are paying fairly, that might increase the attractiveness." Sometimes, however, simple explanations—and solutions—can also be effective.

In the 2009 AAMC Graduation Questionnaire, which is completed by all graduating medical students, role model influence was named as the top factor affecting specialty choice behind only the content of the specialty and its fit with personal interests. "I encourage my faculty to be the best physicians possible," said Wisconsin's Deci. "In that way, you'll be a role model. I share with learners the breadth of experience that I have, the kinds of care I have provided, and how all of that sustains me in a lifelong career in medicine.

But you have to know yourself. You have to know what you want. We certainly need surgeons and radiologists, too. So be true to yourself. What students have a hard time with is the outside negativity." Weis, the third-year Rochester resident, agreed. "Finding that somebody you want to emulate is crucial."

Copyright © 1995-2010 Association of American Medical Colleges, 2450 N Street, NW, Washington, DC 20037-1126 U.S.A. All rights reserved.

ACGME Releases Proposed Duty Hour Standards

In June, the Accreditation Council for Graduate Medical Education released its draft standards for resident physician duty hours, with a proposed effective date of July 2011.

<http://acgme-2010standards.org/>

These changes, which were prompted by a report of the Institute of Medicine in December 2008, are outlined in a NEJM article by members of the ACGME duty hours task force.

<http://content.nejm.org/cgi/content/full/NEJMs1005800>

The AMA “commends” the ACGME “for its thoughtful work toward ensuring excellent resident education, improving patient safety and quality, and balancing the many views on resident duty hour standards. The AMA supports these goals while also encouraging appropriate flexibility for residents in different medical specialties and training levels.”

Other organizations joined the AMA in recognizing the ACGME’s work in this regard. The Association of American Medical Colleges, for example, expressed “praise” for the ACGME’s new standards, and “applauds the council task force for paying special attention to the time on duty, supervision, and workloads of first-year residents, the least experienced and most vulnerable of trainees.” Similarly, four leading organizations in neurological surgery called the standards “a win-win for both residents and patients.”

In the national media, Pauline Chen, MD, writing in the *New York Times* (June 24), pointed out that the standards look beyond the metric of hours worked to the critical concern of appropriate supervision and “the thoughtful and deliberate presence of great teachers.” A physician commentator in *Forbes* (June 29) concedes that the proposed standards are a step in the right direction but argues that the “larger systemic problem” is whether or not “the new hours are sufficient to meet educational needs.”

The AMA reviewed the proposed standards to assess their potential impact on graduate medical education and patient care and submitted a formal response to the ACGME in August. Through mid-July, the ACGME had received more than 600 comments on its draft standards for resident physician duty hours. The majority of comments were in response to the standards for maximum duty period length (225), supervision (111), and maximum in-hospital on-call frequency (65).

As is obvious, this issue continues to arouse passionate debate. One surgeon, writing in the *Archives of Surgery*, put it bluntly: “It is time to grow up and stop whining.” He was not referring, however, to the current crop of surgical trainees but to the “dinosaurs” who “doggedly . . . cling to the past.”

In contrast, one regular correspondent to the AMA’s GME e-Letter stated, “Limits on working hours for trainees are dangerous. They will endanger the patients of those doctors when those doctors are no longer in training and no longer ‘protected.’”

“The sick patient does not care about the doctor’s sleep hygiene. The sick patient wants the doctor to be there If you have a shift mentality, you won’t be there, and you’ll not get the experience. But even worse, if you are absent when your future patient needs you, even when you are tired and no longer a resident, you will be a lousy doctor.”

For the latest news and updates on duty hours and other graduate medical education issues, be sure to subscribe to the AMA’s free GME e-Letter. E-mail meded@ama-assn.org for more information.

CLASSIFIEDS

RECRUITER – LIVINGSTON, NJ

Alpha Physician Resources, a physician practice management company specializing in emergency medicine, is seeking a Recruiter. The medical group we represent, Emergency Medical Associates (EMA), is highly regarded in its field.

This position will be responsible for recruiting physicians, physician assistants, and nurse practitioners for our client hospitals. Your responsibilities will include, but are not limited to, developing and implementing recruitment strategies, sourcing candidates, screening and interviewing qualified candidates, scheduling interviews with medical directors, negotiating compensation packages, traveling to recruiting conferences, and coordinating resident dinners.

Candidates must have a Bachelor’s degree; 2-3 years of recruiting experience in healthcare required, physician recruitment experience preferred. Must be proficient with Microsoft Excel and Word, have excellent organization skills with attention to detail, the ability to work in a client driven, fast-paced environment and be able to work and make decisions independently.

We offer a competitive salary and top-notch benefits including Medical, Dental, Prescription, Life Insurance, Long-term Disability, and 401(k). If you are interested in this opportunity, please forward your resume, including your salary requirements to Beth Gehring by email ~ jobs@alpha-apr.com or by fax to 973-740-1395. No phone calls please. Alpha Physician Resources is an equal opportunity employer.

For rates and deadlines to place your classified ad in a future issue of the NAPR newsletter, please contact Elaine York at eyork@kmgnet.com or 407-571-1135.

Extend your reach



In building the best team, you want to place physicians who are productive in their current positions and are open to bigger challenges. Here, you'll reach a unique audience of active and passive job seekers.

Tailor a recruiting solution to your specific needs and budget:

- *JAMA*
- *Archives Journals*
- Combo Buys
- Online Only

For details, contact us or visit our Web site.

Classified Advertising
American Medical Association
800.262.2260 • 312.464.5909 fax

classifieds@ama-assn.org
www.jamacareercenter.com

Medical School Enrollment Increases to Meet Growing Physician Demand

By Sarah Mann reprinted with permission from the AAMC Reporter, November 2009 edition

U.S. medical schools continued to expand enrollment this year to meet the increasing demand for more doctors, according to new AAMC data.

Enrollment grew by 2 percent this year, with just less than 18,400 students entering medical school this fall. Since 2002, 57 medical schools have boosted their enrollment by more than 10 percent.

Two forces contributed to the increase in enrollment, according to AAMC President and CEO Darrell G. Kirch, M.D. Four new medical schools—Florida International University Herbert Wertheim College of Medicine; The Commonwealth Medical College in Scranton, Pa.; Texas Tech University Paul L. Foster School of Medicine; and the University of Central Florida College of Medicine—enrolled a total of 189 students. In addition, 12 existing medical students expanded their class sizes by at least 7 percent.

“U.S. medical schools are really stepping up in order to keep the pipeline of new physicians flowing so that all Americans have access to health care,” Kirch said.

The number of medical school applicants remained stable, with 42,269 applicants in 2009, compared with 42,231 in 2008.

Kirch noted that medical school enrollment will continue to increase next year, when a new medical school, the Virginia Tech Carilion School of Medicine, is expected to seat its charter class. Moreover, three other schools are currently in the formal stages of development: Central Michigan University School of Medicine, Touro University College of Medicine in New Jersey, and Hofstra University School of Medicine in New York.

Additionally, an increase in the number of people sitting for the Medical College Admissions Test (MCAT)® could be an early indicator that applications are likely to increase in 2010.

“The 2010 applicant pool is following a similar path compared to this time last year, and we continue to be very hopeful the pool will increase given the

3 percent increase in MCAT examinees,” said Gwen Garrison, Ph.D., AAMC director of student and applicant studies.

While Kirch lauded the enrollment increase as a necessary step in warding off a national physician shortage, he noted that this move will only be successful if there is a corresponding rise in graduate medical education (GME) slots. The AAMC Center for Workforce Studies has predicted a shortage of 124,000-159,000 physicians by 2025. As of late October, the perceived high costs associated with the Resident Physician Shortage Reduction Act, which would increase the number of Medicare-supported residency positions by 15,000, made it unlikely that the act would be included in final health care reform legislation. None of the health care reform bills currently before Congress would increase GME slots, but would redistribute about 1,000 unused residency positions. According to AAMC estimates, the shortage reduction act would add about 40,000 new physicians over 10 years, while redistribution would add about 3,000.

“The very bottom line is that our medical schools in the U.S. are working hard to meet the demand for more physicians,” Kirch said. “We are advocating strongly for increases in the funding for residency training positions because if we don’t, we face the possibility of very significant physician shortages.”

It is unlikely the economic downturn had an effect on 2009 applications because applications were submitted between June and September of last year, before the decline in U.S. and global stock markets.

“I think that even with the economic downturn, there is still the fact that medicine is a very compelling career,” Kirch said.

Kirch added that medical schools have increased efforts to provide scholarships to students to address rising tuition and student debt and continue to attract top students.

The applicant data revealed good news for black medical school students

and applicants, traditionally among the most underrepresented in the medical field. Black applicants rose 4 percent compared with 2008, and black enrollees are at their highest point since 1999, representing 7 percent of all new medical students.

“We are certainly glad to see a rise in the applicant pool and more African-American enrollees,” Garrison said.

Among Hispanic and Latino populations, applications decreased about 1 percent from 2008, with 3,061 applicants. Applications from American Indians decreased about 5 percent to 379 from 400 in 2008, while enrollees decreased to 153 from 172 last year. The number of both white and Asian American students who applied and enrolled increased slightly from 2008.

Female applicants were down slightly to 20,252 this year from 20,360 in 2008, while male applicants increased from 21,870 last year to 22,014 this year. Although male enrollees outnumbered female enrollees by 52 percent to 48 percent, Kirch noted that the number of female enrollees has steadily increased since 1992.

The academic quality of applicants continues to be high, with the average MCAT exam score and undergraduate grade point average remaining relatively unchanged from last year. The percentage of applicants who had experience with research or who had volunteered in a medical or clinical capacity remained about the same over last year, while the percentage of applicants with nonmedical community service experience increased slightly.

Copyright © 1995-2010 Association of American Medical Colleges, 2450 N Street, NW, Washington, DC 20037-1126 U.S.A. All rights reserved.

If recruiting top physicians is important to you, advertise in the source that's important to them.

Physicians across many specialties consistently rate the *New England Journal of Medicine* (NEJM) as an essential journal.¹ They read it. They cite it. They trust it. And they click on it. In fact, in a recent independent blind survey, NEJM was ranked #1 as a source of job leads, both in print and online.² Which is why you should advertise with NEJM, both in print and online, at NEJM CareerCenter (nejmjobs.org).



The NEW ENGLAND
JOURNAL of MEDICINE

NEJM CAREERCENTER
Where Physicians Find Jobs.

Please contact us for more information: Phone: (800) 635-6991 E-mail: nejmjobs@nejm.org Website: nejmjobs.org

¹2007 Essential Journal Study, The Matalia Group ²"2008 How Physicians Search for Jobs," an independent, blind study conducted by Zeldis Research Associates, Inc.



AAMC Pleased More Medical School Graduates are Matching to Primary Care Residencies

AAMC (Association of American Medical Colleges) President and CEO Darrell G. Kirch, M.D., issued the following statement on Match Day results released this afternoon by the National Resident Matching Program (NRMP) for U.S. medical school graduates and the primary care specialties:

"The AAMC is extremely encouraged that more graduating U.S. medical students this year chose primary care for their residency training. The increases for family medicine, internal medicine, and pediatrics in this year's Match are welcome steps in the right direction for improving our health care system and our nation's health.

Many factors go into a new doctor's choice for residency training. An AAMC survey last fall indicated that nearly 50 percent of U.S. medical schools had instituted or were considering programs or policies to encourage interest in primary care. We believe the results of this year's Match demonstrate that the nation's medical schools are making progress in their efforts to encourage more new doctors to pursue careers in primary

care. A strong primary care system is an essential part of good medicine.

As U.S. medical schools continue to increase enrollment to meet physician workforce needs, it is crucial that we lift the cap on Medicare-supported residency positions so future graduates can complete their training. By making this important investment, we can ensure that all Americans have access to the high-quality health care they deserve."

The Association of American Medical Colleges is a not-for-profit association representing all 133 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians. Additional information about the AAMC and U.S. medical schools and teaching hospitals is available at www.aamc.org/newsroom.



Retaining Physicians Long-Term

Keep “Recruiting” Physicians Long After Their Start Date

By Andrea C. Santiago,
Director of Communications,
The Medicus Firm

Recruiting physicians is challenging under any circumstances, particularly in the current economic environment. Recruiting physicians to smaller towns or even rural areas can, at times, be an even greater challenge, and signing the physician is only half the battle of physician staffing. Another key factor to maintaining a successful physician staff is retention, which can be even more difficult in some areas than in others.

On August 9, the *Washington Post* ran a story about the primary care physicians in one rural community in Virginia. Many physicians, like the family physician highlighted in the story, are initially drawn to jobs in rural areas due to the monetary incentives offered from the government for working in an under-served area. The majority of a physician’s student loans can be reimbursed, or “forgiven” after working in a medically underserved community for a few years after training, usually three to five years.

But what happens after the three years? In the *Washington Post* story, the young doctor seems ready to bolt on the last day of her third year. But she also has many reasons to stay, and her new colleagues continually try to help her realize the long-term potential for a satisfying life in a (very) small town.

Do you have a retention plan for your physicians? Below are a few tips utilized by hospital systems when trying to retain physicians.

1.) **Physician satisfaction surveys** — some hospitals utilize surveys to help analyze their physicians overall satisfaction with their careers and lifestyle. The surveys help the hospitals identify what they’re doing right, and where they can improve. Also, they can plan ahead for possible turnover — if a physician indicates they are very dissatisfied, the hospital can work with the physician while also making plans to recruit if needed.

2.) **Mentoring** —by pairing up the new physician with another physician in the community, especially someone who has similar interests, you can help the new physician form ties in the civic community and in the medical community as well. In the *Post* story, the young doctor’s mentor was a physician who had lived in the area for a very long time, so she can help the newcomer get more involved.

3.) **Retention bonuses** — some hospitals offer substantial retention bonuses to help physicians stay a bit longer even after their government/student loan benefits have been maximized. For example, if the government tenure requirement runs out in 3 years, the hospital may offer an additional bonus two years later, and then maybe another

one down the road to keep the physician there long enough to the point where he or she will have made a life there and want to stay indefinitely.

4.) **Community involvement/networking, etc.** — this may also fall under the mentor’s responsibility, but everyone can help the newer physicians get involved in local events, politics, hobbies, and social groups. In the *Post* article, colleagues even went so far as to set up the physician on a date with a man from a nearby town.

Jim Stone, managing partner of The Medicus Firm, and executive committee member of the NAPR, states, “Even when the employer, hospital, community, and colleagues do everything right to create a great work environment, where the physician can be productive, well-compensated, and satisfied with his or her practice, there is no guarantee a physician will stay.” He adds, “It may sometimes be difficult to compete, particularly for younger, single physicians who are very dependent on high-tech gadgets, EMR, and other cutting-edge technology that rural practices may not always be able to offer.”

That’s not to say a strong retention rate cannot be achieved in smaller communities, or anywhere. The recent boom of technology on the business/communications side of medical practice, such as social media, smartphones, and EMR, could make the differences between metro practices and rural practices even more pronounced. Therefore, implementing a proactive retention plan for newer physicians will be even more crucial than ever, to help your practice remain competitive as compared to other employers trying to recruit your physicians away from your hospital system, or away from the community.

The *New England Journal of Medicine*.

Physicians read it.

Click on it.

Trust it.

And consider it essential.

Advertisers love NEJM because it is the leading source for medical information among physicians. Physicians rank it among the top three essential journals in 12 specialties.¹ And NEJM was recently ranked #1 as a source of job leads — both in print and online — in an independent, blind study conducted among physicians.²

All of which explains why NEJM regularly publishes significantly more recruitment pages than its closest competitors. It's where physicians find jobs.

Please contact us for more information:

Phone: (800) 635-6991

E-mail: nejmjobs@nejm.org

Website: nejmjobs.org

Which is why you should advertise in it.



The NEW ENGLAND
JOURNAL of MEDICINE

NEJM CAREER CENTER

Where Physicians Find Jobs.

¹2007 Essential Journal Study, The Matalia Group ²"2008 How Physicians Search for Jobs," an independent, blind study conducted by Zeldis Research Associates, Inc.

Email over

One Million

Health Professionals



MMS INC.
1-800-MED-LIST®

Email delivery like no other.

Double-permissioned emails and state-of-the-art delivery infrastructure give MMS an unsurpassed 97% deliverability. Visit us at www.mmslists.com or call 1.800.MED.LIST today to see how we can help you deliver.

☀ Promote your jobs to more than 100,000
PracticeLink.com visitors each month!



PracticeLink®

Search Firm Job Posting

The #1 physician recruitment solution.



“I have made more than twenty placements through PracticeLink. I feel I’m getting a full return on my investment with the leads I have received.” — Neal Fenster, Enterprise Medical, St. Louis, Missouri

Search firms can reach PracticeLink’s thousands of active job-seekers

- **Post your jobs online**, and they’ll be accessible on PracticeLink.com and our partner websites. Reserve as many job slots as you need; there are plans to fit every budget.
- Seamless integration of **onTrack RMS** tracks your PracticeLink candidate responses
- **Social media integration** allows physicians to share your jobs

Also: An improved physician job search experience, integrated physician career content and more!

For more information, call Sarah Armstrong
(800) 776-8383 ext. 254



Brand your firm to **PracticeLink Magazine's** 80,000 job-seeking physicians.

For more information, call
Laura Connelly or Diane Lewis
(800) 776-8383 ext. 255

Physician recruitment is a challenge. Let PracticeLink make it easier.

WELCOME NEW MEMBERS

ACTIVE MEMBERS

Alliance Medical..... Adam DeaneBath, ME

Baptist Health
South Florida.....David Schubert Miami, FL

Beck-Field &
Associates, Inc..... Bob OverfieldSelma, TX

Choate Consulting Wendy Brown Brookfield, CT

Healthcare Recruitment
Counselors..... Brian Torchin.....Philadelphia, PA

North County
Health Services..... Cynthia BekdacheSan Marcos, CA

Primary Care Physicians
d/b/a Jena Medical
Family Practice..... David Yoon Orange City, FL

Professional
Employment GroupPatrick Brennan.....St Louis, MO

RAD DoxiFindRich Smith, Jr..... Thomasville, GA

ReKam Healthcare
Solutions, Inc.Rebecca Smith Riverton, WY

RosmanSearch, Inc.....Beth Dery Pepper Pike, OH

Supplemental Health
d/b/a Supplemental
PhysiciansAdrian Campos.....Park City, UT

University Health
Systems of Eastern NC...Beverly Walker.....Wilson, NC

VENDOR MEMBERS

ZirMed, Inc.Jim Lacy.....Louisville, KY

Physician Relationship Management for Microsoft Dynamics CRM



CRM software that allows you to:

- Organize Your Contacts
- Track Recruiting Opportunities
- Log Recruiting Activities from MS Outlook
- Capture Expenses by Candidate, Opportunity & Category
- Manage Candidate Information including copies of CV's and Interview Comments
- Organize Candidate Site Visits
- Coordinate On-boarding Activities
- Works with your MS Outlook
- Provide Management Reports

For More Information or
to Request a Demonstration,
contact us at
1-877-330-3368 or
www.softsolgrp.com/prm

SOFTWARE SOLUTIONS
GROUP, INC.

Save the date!
*Your first resource for physician recruitment
meeting in the "Second City."*

2011 NAPR
Annual Conference
Palmer House Hilton
Chicago, IL
April 7-9

ENJOY
PLAY RECRUIT