RECRUITING PHYSICIANS FOR RURAL SETTINGS

Search Committees Should Consider Strategies Tailored to Today's Labor Market

BY BRIAN McCARTIE

Approximately 50 million Americans live in communities without access to primary health care, according to the National Health Service Corps (NHSC).[1] The NHSC has designated more than 3,000 health professional shortage areas (HPSAs), providing assistance to these communities, including scholarship programs for physicians in training who have signified a willingness to serve them.

HPSAs notwithstanding, many other U.S. communities could be designated as "underserved" because they have less-than-ideal coverage of primary care medical services and, especially, of specialty care. In many predominantly rural counties throughout the United States, single-specialty medical groups and multi-specialty groups struggle to hire the providers they need. Rural hospitals often work diligently to attract physicians, especially in sought-after specialties, to their communities to open solo practices.

Despite the professional and lifestyle attractions of major metropolitan areas, it is possible to bring well-qualified physicians to rural areas. Success in the recruitment of physicians to rural areas depends on three factors:

- An effective and realistic assessment of the characteristics desired in the physician
- The tailoring of opportunities to reflect the needs of realistic candidates
- Effective recruitment strategies

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A Realistic Assessment

What can an organization realistically expect when recruiting a physician to a rural location? Competence is realistic; it should never be necessary to sacrifice quality to bring a physician to a rural setting. It is important to examine every qualified candidate to see if he or she might be a "fit," however, rather than screening people out immediately because they do not meet certain criteria.

A community (or a medical group serving it) searching for a physician would probably view as ideal a young person who could conceivably practice there for 30 or more years. However, a more realistic candidate might be an urban physician who is 10 years away from retirement and seeking a change in lifestyle.

An international medical graduate (IMG) may be the best-qualified applicant in some searches. Although many rural communities welcome immigrant physicians, others tend to be less tolerant. If an IMG were to accept a position in a less tolerant community, the local hospital should take an active leadership role in educating the community about the realities of today's medical labor market. In some specialties, such as gastroenterology and pulmonology, as many as 50 percent of the physicians graduating from U.S. residency programs are from other countries. And, typically, these residents are the "cream of the crop" of their countries' medical graduates.

In addition, it is helpful to educate local residents about the outstanding quality of care that IMGs can offer and to emphasize the fact they usually have trained in the United States and have developed strong command of English.

The education process should begin as soon as a search has concluded with a decision to bring one or more IMGs to a rural area with a population unaccustomed to physicians from other countries and cultures. The first step in this pro-

cess should be communication with local leaders about the decision. Civic group officers, business leaders, physicians, members of the clergy, school administrators, newspaper editors, and other local leaders should share the responsibility of educating the community about what the doctor will be able to offer patients. By putting their support behind the physician and commending his or her expertise to the community, local leaders can help make the transition positive for both the new physician and his or her patient base.

In cases where it appears that strong candidates for a position will be IMGs, the recruiting organization should note that on October 1, 2003, the federal government lowered the cap on H1-B visas—which cover physicians, skilled technical workers, and other professionals—from 195,000 to 65,000. Many IMGs have green cards (permanent resident status) or have become American citizens. However, it is common for IMGs who are under visa restrictions to (after using J-1 visas for training) use H1-B visas to begin working in the United States. Some of these physicians could be affected by the new H1-B restrictions. (Physicians who are renewing H1-B visas and those working at academic institutions are exempt from the lowered H1-B cap). Also, according to *American Medical News,* it is possible, but not certain, that physicians applying for jobs in underserved programs under state-sponsored programs such as "Conrad 30"* will be exempted from the cap.[2] In any case, the visa cap may be increased again in 2004 if labor market conditions indicate the need, which is likely.

Tailoring Opportunities

Practice, location, and compensation are the three primary things most physicians cite when seeking new opportunities.

Many practice characteristics may appeal to some physicians, but not others. For example, many rural medical opportunities, especially in sought-after specialties, are in solo practice. Some physicians prefer the solo practice environment, and so may consider rural opportunities for this reason.

In metropolitan areas, specialists typically find much of their time is devoted to procedures. In rural areas, however, even specialists often spend time handling general clinical work. Some specialists may like the idea of having broader responsibilities and a closer relationship with patients, as opposed to striving to squeeze as many procedures as possible into each working day.

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Where can these rural-practice-friendly physicians be found? In locating them, one strategy is to target recruitment efforts on cities near the rural practice opportunity. Although there is no guarantee that a doctor there would like a different practice environment—hoping perhaps to give up long commutes and spend his or her free time fishing, hunting, and horseback riding—it is possible. Recently, Cejka Search found a Baltimore physician who was ready to give up city life and accept an opportunity in rural Pennsylvania.

Particularly in family practice and obstetrics/gynecology, some institutions specialize in training physicians for rural practice. Recruiting from these institutions can be an effective strategy.

It is also useful to consider longer-term approaches to rural medical coverage. For example, if the local high school principal reports that he or she has two graduating seniors with the credentials, the desire, and the ability to pursue medical careers, community leaders should engage in a dialogue with these students regarding their potential willingness to practice in their home community. Although they will have a minimum of 10 years of undergraduate preparation, medical school, and residency work to complete, such students could eventually help improve local accessibility of care. Providing them with community-based educational grants, or loans that would be forgiven if they returned home to practice, can be strong enticements to ensure that they do so.

It may be possible as well to work with medical schools in the region to identify existing medical students who might wish to practice in rural areas. Cultivating a relationship with such a student early on can be beneficial. He or she might be brought in for a visit, to meet with and observe local physicians in their practices and to get to know the community. If the student should seem ready to commit to practicing in the community after completing a residency, the community could offer him or her a monthly residency salary supplement to help with living expenses during postgraduate training.

It is important to remember that, no matter where they come from, entry-level physicians will need and desire mentoring once they begin practice. Finding such opportunities could be a challenge for a new physician in solo practice in a rural area. Recruiting organizations seeking to

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*Conrad 30 is a federal program under which a state can allow as many as 30 IMGs to practice in underserved areas once their U.S. residencies are finished ("More U.S. Jobs for IMGs as J-1 Visa Waivers Increase," *American Medical News,* December 2, 2002).

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bring a new residency-program graduate to work in a rural setting will find it useful to have working relationships with nearby teaching hospitals and with specialty groups in nearby cities. These relationships can then be discussed with candidates as suggested methods of meeting their professional networking and mentoring needs.

Effective Recruitment Strategies

In every physician recruitment process it is critical to address family concerns, which are the most frequent deal-breakers in recruitment processes. When recruiting a physician with a family to work in a rural setting, the recruiting organization must consider the fact that the location may be a significant change for the candidate's family.

When a candidate physician comes to the community to meet with local hospital administrators, local physicians, or practice search committees (if the opportunity is in an existing medical group), his or her spouse should be included as part of the process. If the spouse is a professional, every attempt should be made to identify potential local career opportunities for him or her. And whether or not the candidate's spouse has a career, other personal concerns will apply. Real estate agents, local school administrators, and others should be included in the interview process to provide both the candidate and spouse with in-depth information about local housing options, schools, and other similar matters.

During the interview process, recruiters should take care to discuss all aspects of the physician's feelings (and those of his or her family members) about relocating to a rural area; this will make it clear whether the candidate is truly ready to make such a change. Interviewers should ask the physician whether he or she is also interviewing in other locales, and, if so, where. If the candidate includes other rural areas on his or her list, that is an indication of serious interest in practice in a rural setting.

Most rural community leaders and hospital and practice administrators realize that if the community is to attract and keep high-quality medical providers, it must be competitive in the compensation it offers. Rural community members can work together to make local practice financially attractive. It can be useful to offer, in return for a commitment to remain in the community for an established period of time, special mortgage rates, coverage of relocation expenses, repayment of educational loans, and other incentives. In cases where a group practice is conducting the search, its recruiters should communicate to each candidate the practice's internal incentives and partnership opportunities.

A recent issue of *American Medical News* profiled a young osteopathic physician who had opened the only primary care practice in Grandview, TX.[3] The county's economic development commission gave Jennifer Weatherly, DO, a $20,000 package that included rent subsidies and repair of the parking lot in front of her office. Local officials told the newspaper that they hope Dr. Weatherly's practice will help attract businesses to the town, which is located about 35 miles south of Fort Worth. Thus, investment in a physician candidate has the potential to pay off in a variety of ways for a community. □

NOTES

1. National Health Service Corps, "About NHSC," which can be found at www.nhsc.bhpr.hrsa.gov/about. The corps is part of the U.S. Department of Health and Human Services.
2. "Visa Cap Likely to Hurt Rural Clinics," *American Medical News*, November 10, 2003, available at www.ama-assn.org/amednews/2003/11/10/prsf1110.htm.
3. "Doctor Gets Tax Break for Settling in Rural Community," *American Medical News*, August 18, 2003, available at www.ama-assn.org/amednews/2003/08/18/bisbo0818.htm.

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