THE CHANGING LANDSCAPE IN ACADEMIC PHYSICIAN RECRUITING

An Examination of Evolving Physician Recruiting Trends and Practices in Academic Medicine
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Change is endemic throughout the healthcare system today, even in academic medicine where tradition often enjoys particular consideration and respect.

One example of changing practices and perspectives in academic medicine is evident in how academic facilities approach physician recruiting. For years, the general approach to recruiting has remained relatively static. The traditional approach features a search committee that oversees an often lengthy and ponderous recruitment process with a great deal of medical school/university involvement. In practice, these often are “evaluation committees” rather than true search committees, in that they passively review the qualifications of candidates who have been surfaced, rather than actively participating in the search for said candidates.

In addition, the prevalent practice among academic institutions has been to offer standard incentive packages that treat all physicians equally. Salaries have been reasonably similar across entire departments, though this practice has been increasingly challenged as clinical outreach programs have become a more common feature of academic medicine search programs today. This often causes a more diverse range of responsibilities from faculty to leadership positions that must be commensurate with compensation packages to stay competitive in today’s marketplace.

Even candidate parameters have been fairly uniform. In the past, standard parameters have included a requirement that the candidate come with grant funding already established and have a minimum number of publication credits. Candidates also have typically been required to possess a baseline of experience in academics, with a minimum of professorial rank from another institution and a pedigree in training. While this practice is time-tested and has merit, as faculty roles within teaching facilities have become more diverse, expectations regarding candidate parameters and required skill sets have not kept pace.

A Growing Physician Shortage

Mindsets are changing, however, in part due to the growing shortage of physicians. According to the Association of American Medical Colleges (AAMC), the United States will face a deficit of some 91,000 physicians by the year 2020, including 45,000 primary care physicians. A study by the Robert Graham Center published in November, 2012 in the Annals of Family Medicine projects an additional 52,000 family physicians will be needed by the year 2025 to keep up with growing patient demand. Over 20 medical specialty societies have projected physicians shortages in their areas, as have over 20 state medical societies. The physician shortage is being driven by a variety of factors, including a growing and aging population, changing physician practice patterns, advances in medical technology, physician retirements, and the anticipated influx of 30 million patients who will obtain insurance as a result of the Affordable Care Act. For an in-depth look at physician supply and demand issues, see “Health Reform and the Decline of Physician Private Practice, a white paper completed by Merritt Hawkins for The Physicians Foundation.
Growing Medical School Enrollment

In response to the physician shortage, AAMC committed in 2006 to increasing U.S. medical school enrollment by 30 percent by 2015. In 2002, there were 125 medical schools in the United States. As of late March, 2012, the Liaison Committee on Medical Education (LCME) had granted full, provisional, or preliminary accreditation status to 12 new medical schools, bring the total number to 137. A May, 2012 AAMC report (“Results of the 2011 Medical School Enrollment Survey”) reflects the recent robust growth in the academic sector. Findings from the report include:

*First-year medical school enrollment in 2016-2017 is projected to reach 21,376, a 29.6 percent increase above first-year enrollment in 2002-2003. This comes close to reaching the 30 percent targeted increase by 2015 that the AAMC called for in 2006.

*Of the projected 2002-2016 growth, 58 percent will be at the 125 medical schools that were accredited as of 2002. New schools since 2002 will experience 25 percent of the growth, and the balance (17 percent) will come from schools that are currently in LCME applicant or candidate school standing.

*More than half (56 percent) of the 2002-2016 enrollment growth has already occurred, with 2,850 of the projected 4,888 new slots already in place as of 2011.

*Of schools surveyed in 2011, 43 percent indicated they had targeted increases or planned to target increases in enrollment to specific population groups or to meeting the needs of underserved communities.

*Combined M.D. and D.O. enrollment at current schools is projected to reach 26,709 by 2016-2017, an increase of 37% compared to 2002-2003.

Of particular concern to medical schools surveyed is their ability to maintain an adequate supply of preceptors, as is revealed in the following finding from the report:

*The supply of qualified primary care preceptors concerned 74 percent of medical schools, while 53% indicated a concern with the supply of qualified specialty preceptors.

It could be added that the Chair of the Department of Medicine or the Department of Surgery today typically needs a different skill set and a broader bandwidth than did these titles 20 years ago, due to the increasing complexity of today’s healthcare environment, a topic discussed at more length below.

An Increasingly Challenging Environment

Health reform, as represented by the PPACA and concurrent market forces, is creating critical challenges for all types of healthcare providers and institutions. Academic medical centers are not exempt from these challenges; in some cases are at the tip of the spear. The shift toward
preventive medicine and increased access for the newly insured will likely fall on academic medical centers, a trend underlined by the fact that 40 percent of the sickest patients are seen by only six percent of the nation’s hospitals – most of them being academic medical centers. This causes the faculty treating these complex patients, as well as the medical centers themselves, much strife assuming public quality reporting measures are implemented as expected.

Consider that, on average, among every 1,000 patients seen by a physician in the US, eight are admitted to a hospital, one is admitted to an academic medical center, and the rest are treated as outpatients or in the provider’s office. On first consideration, these numbers suggest a limited role for academic medical centers. Unfortunately, this is a common mistake made by policy makers and could not be further from the truth. Academic medical center in-patients will demand the highest ratio of residents-to-beds, because they are treating the sickest patients with the most complex cases. This makes traditional physician to population ratios, still the most common source for medical staff planning, inept and inaccurate.

Academic medical centers are facing a number of other key challenges, including:

* Medicare cuts
* Price transparency
* Community benefit reporting
* Penalties for readmissions
* Value based purchasing

* Medicaid voluntary expansion
* State exchange implementation
* Adequate patient coverage levels
* Loss or reduction of DSH payments

These and related challenges are causing academic medical centers to practice “financing under fire,” in the words of Joanne Conroy, Chief Healthcare Officer of the AAMC. Though academic medical centers tend to change generationally, these challenges are occurring at an unprecedented pace.

While all of these issues are of importance, perhaps the most important is acquiring the talent needed to keep academic medical centers true to their teaching and clinical mission, a topic addressed below.

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The “Talent Drain”

As has been observed in nursing, provider shortages can lead to a “talent drain” away from academic practice and toward the private sector. Today, a proliferating number of delivery systems, including Accountable Care Organizations (ACOs), hospital systems, large medical groups, corporate settings and concierge practices are vying with academic centers for the same limited pool of physicians. In addition, many academic medical centers today lose current faculty and/or candidates to their own clinical partners or affiliates. While on paper it shows that such providers have remained within the system, it is often the academic medical center’s leadership and/or faculty that pays the price.

As candidates now come at a premium, renewed focus is being given to the personal goals and requirements of each candidate. The transition to ACOs and other models built on physician/hospital alignment, and increasing market pressures on private practices, are fueling the growing trend toward hospital ownership of many practices and the employment of physicians who previously were independent. The consulting firm Accenture projects that by 2013, only 33
percent of the nation’s physicians will be independent (see chart below)

Independent Physicians as a Percent of Total Physicians

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2005</th>
<th>2009</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>57%</td>
<td>49%</td>
<td>43%</td>
<td>33%</td>
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</table>

Many of these physicians have clinical appointments with a local academic institution that are based on proximity, even though their practices are not overtly academic in nature. They may host residents and oversee some clinical sessions, but many are not conducting research, publishing and are not lecturing. Academic institutions are now employing more physicians than they historically have and are beginning to segment different positions within individual departments based upon the role they truly need (clinical, research, teaching, etc). Their recruitment process is beginning to evolve accordingly. However, many academic medical centers are still challenged. Ironically, while they are often the best suited to employ physicians to better serve the community; they usually have little experience doing so.

With more opportunities to choose from, candidates are less willing to compromise on salary for positions that are clinical in nature, compelling academic institutions to become more competitive with their non-academic counterparts. One indicator of the number of practice opportunities physicians today have to choose from is provided by Merritt Hawkins’ survey of final-year medical residents. In the 2011 survey, final-year residents were asked how many times they have been approached by recruiters about job opportunities. Close to half (47%) said they had been solicited by recruiters over 100 times (see chart below)
### How Many Times During Your Training Were You Contacted About Job Opportunities?

<table>
<thead>
<tr>
<th>Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 100</td>
<td>47%</td>
</tr>
<tr>
<td>51-100</td>
<td>31%</td>
</tr>
<tr>
<td>26-50</td>
<td>11%</td>
</tr>
<tr>
<td>11-25</td>
<td>9%</td>
</tr>
<tr>
<td>0-10</td>
<td>0%</td>
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Source: Merritt Hawkins 2011 Survey of Final-Year Medical Residents

Academic physicians who do not have the opportunity to augment their incomes through conventional means (i.e., grants, speaking fees, etc.) and are expected to see the same patient volumes as their colleagues in non-academic settings, are requiring more competitive income levels, or they are often gravitating to positions which offer income levels that are commensurate with the work that they are performing and the revenue that they are generating, even if these positions are outside of academia.

For positions that are purely or primarily clinical in nature, search committees are becoming less prevalent and the medical school or university is becoming less involved with recruitment, in order to promote efficiency. Recruitment of such “clinical workhorses” is increasingly being left to department heads and department administrators. Given that fewer people are engaged in these recruitment projects, offers are being made in a far narrower timeframe than was seen in the past. Again, this is a necessary reaction to a market in which candidates have multiple offers to choose from and where quick response times are critical. Unfortunately, without guidance from an experienced recruitment consultant, talent acquisition responsibilities are often shifted to leadership with limited or no experience in a recruitment process that excels in today’s market.

These trends are not isolated to positions that are mostly clinical in nature. Recruitment strategies for positions with a more significant academic component are transitioning as well. For clinical leaders, those who are partly or heavily involved with research, and physicians offering didactic instruction, the recruitment process is evolving as the landscape continues to become progressively more competitive.

Candidates pursuing these positions and high-level leadership positions are becoming increasingly impatient with long, cumbersome recruitment processes. Often, the academic recruiting process follows a familiar course: at least four candidates must be considered, three must be interviewed (often more than once), and then a subjective evaluation occurs that is frequently based on subjective impressions or anecdotal discussions. There often are no systematic, objective processes or criteria in place that would allow the search committee to make a timely selection, even one where the first candidate is accepted without subsequent candidates being considered, if this is the appropriate course.
Incremental processes and slow communication are often interpreted as a lack of interest, even when the interest level may be quite high. Recruitment committee members, while dealing with the daily challenges of their primary responsibilities, are being forced to respond in more concise timeframes and come to decisions quickly – tasks which can be a great challenge when trying to coordinate telephone conferences, personal meetings, and interviews across multiple calendars. Similarly, financial incentives are becoming far more competitive than they have been in the past. Over just the last three years, Merritt Hawkins has seen base salary offers in academic centers increase by 10 to 35 percent. True academicians are highly sought-after and are rewarded accordingly.

Survey of Academic Physicians

Merritt Hawkins gathered data regarding the strategic priorities of academic facilities during the November, 2012 AAMC annual meeting that underscores some of the trends referenced above. A non-scientific survey of meeting attendees revealed the following:

*Physician recruitment was ranked the top priority for 2013 by 77% those surveyed, followed by funding (76%) and diversity (69%).

*Competition with the private sector was ranked as the most challenging factor in physician recruiting by 58% of respondents, followed by geographic location (55%) and uncompetitive incentives (53%).

*Networking with staff was the most frequently cited physician recruitment method as cited by 77% of respondents, following by networking with residency programs (69%) and journal advertising (63%).

*100% of those surveyed indicated they have physician recruitment needs. 63% described their needs as ongoing but not urgent, while 37% described their needs as growing in urgency.

*54% of respondents indicated they recruit physicians using in-house resources while 46% indicated they use the help of recruiting firms.

CONCLUSION

Academic medical centers remain at the center of the healthcare ecosystem. This has been seen for decades, primarily as they generate the medical workforce on which the nation depends. Today, however, and in the future, they will also have more control over the clinical delivery of services and will truly reflect the full spectrum of the healthcare market. Some academic medical centers have embraced these changes, while others are still working through how they will respond to today’s shifting landscape.

Though practices in academic physician recruiting continue to evolve, certain fundamentals have not changed. Successful recruitment in academic centers still is based on an objective evaluation of the institution and the opportunity that includes an appraisal of both strengths and weaknesses. Well defined candidate parameters, a robust candidate sourcing system, an understanding of the
academic structure as it differs from other delivery models and an interview process that involves both the candidate and his or her spouse/significant other remain essential, proving that tradition still has its place.

Merritt Hawkins/ Department of Academics

Merritt Hawkins’ Department of Academics is dedicated to assisting academic medical facilities in the recruitment of faculty, clinical, research and leadership physician positions nationwide. Over the last decade, we have been engaged to conduct hundreds of academic search assignments for a wide range of positions, including Chancellor/Vice Chancellor, Dean/Associate Dean/Assistant Dean, Chairman/Vice Chair, Chief, Division Director, Program Director, Fellowship/Residency Director, Professor, Associate Professor, Assistant Professor, Chief Scientists and many others. Merritt Hawkins serves as a single source for the recruitment of key academic talent in leadership, faculty, and clinical roles.

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