MERRITT HAWKINS
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White Paper Series

Examining topics affecting the recruitment and retention of physicians and advanced practice professionals

A resource provided by Merritt Hawkins, the nation's leading physician search and consulting firm and a company of AMN Healthcare (NYSE: AMN, the largest healthcare workforce solutions company in the United States.

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Internal Medicine Recruiting Trends and Recommendations

Introduction

Merritt Hawkins is the nation's leading physician search and consulting firm and is a company of AMN Healthcare (NYSE: AMN) the largest healthcare staffing organization in the country and the innovator of healthcare workforce solutions.

As the thought leader in its field, Merritt Hawkins produces a series of surveys, white papers, speaking presentations and other resources intended to provide insight into physician supply and demand, physician compensation, practice patterns, recruiting strategies and related trends.

This white paper examines trends in the recruitment of internal medicine physicians, including current supply and demand projections, compensation in the specialty, the expanding role of internal medicine physicians and recommendations for recruiting these highly sought-after health professionals.

Internal Medicine: A Definition

Physicians practicing general internal medicine are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and care of adults from general wellness to the management of complex diseases. They, like family medicine physicians and pediatricians, are considered to be primary care practitioners.

Education and Training

According to the American Board of Internal Medicine's (ABIM) web site, "to become certified in internal medicine, a physician must complete four years of college and, typically, four years of medical school, meet the graduate medical education training (residency) requirements, demonstrate clinical competence in the care of patients, meet the licensure and procedural requirements, and pass the ABIM Internal Medicine Certification Examination."

Predoctoral Medical Education

According to ABIM, "candidates who graduated from medical schools in the United States or Canada must have attended a school that was accredited at the date of graduation by the Liaison Committee on Medical Education (LCME), the Committee for Accreditation of Canadian Medical Schools or the American Osteopathic Association."

"Graduates of international medical schools must have one of the following: (1) a standard certificate from the Educational Commission for Foreign Medical Graduates without expired examination dates; (2) comparable credentials from the Medical Council of Canada; or (3) documentation of training for those candidates who entered graduate medical education training in the United States via the Fifth Pathway, as proposed by the American Medical Association."

Graduate Medical Education (GME)

"To be admitted to the ABIM Internal Medicine Certification Examination, physicians must have satisfactorily completed, by August 31 of the year of examination, 36 calendar months, including vacation time, of U.S. or Canadian graduate medical education accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Royal College of Physicians and Surgeons of Canada or the Collège des médecins du Québec. Residency or research experience occurring before completion of the requirements for the MD or DO degree cannot be credited toward the requirements for certification. The 36 months of residency training must include 12 months of accredited internal medicine training at each of three levels: R-1, R-2 and R-3. No credit is granted for training repeated at the same level or for administrative work as a chief medical resident. In addition, training as a subspecialty fellow cannot be credited toward fulfilling the internal medicine training requirements."

Content of Training

"The 36 calendar months of full-time internal medicine residency education:

1. Must include at least 30 months of training in general internal medicine, subspecialty internal medicine and emergency medicine. Up to four months of the 30 months may include training in areas related to primary care, such as neurology, dermatology, office gynecology or office orthopedics.
2. May include up to three months of other electives approved by the internal medicine program director.
3. Includes up to three months of leave for vacation time."

Source: www.abim.org.

General Internal Medicine/Scope of Practice

According the ACP, "many internists enter into practice following completion of their basic internal medicine training. These physicians practice "general internal medicine" and are commonly referred to as "general internists." General internists are equipped to handle the broad and comprehensive spectrum of illnesses that affect adults, and are recognized as experts in diagnosis, in treatment of chronic illness, and in health promotion and disease prevention—they are not limited to one type of medical problem or organ system. General internists are equipped to deal with whatever problem a patient brings—no matter how common or rare, or how simple or complex. They are specially trained to solve puzzling diagnostic problems and can handle severe chronic illnesses and situations where several different illnesses may strike at the same time."

"Following completion of three years of training, residents are eligible for board certification in internal

medicine. General internists are capable of functioning in a number of different roles. For example, many focus on ambulatory practice and may serve as primary care physicians, following patients longitudinally for their ongoing medical care. Others may spend a majority of their time caring for hospitalized patients in the role of hospitalist (approximately over 90% of hospitalists are general internists). Many general internists care for both ambulatory and hospitalized patients in a wide variety of practice models."

General internists may practice in a variety of settings. Although internists may act as primary care physicians, they are not "general practitioners," or "family physicians," whose training is not solely concentrated on adults and may include pediatrics, obstetrics, and surgery."

Source: www.acponline.org.

Internal Medicine Subspecialties

According to the ACP, 'some internists choose to take additional training to "subspecialize" in a more focused area of internal medicine. Subspecialty training (often called a "fellowship") usually requires an additional one to three years beyond the basic three year internal medicine residency. Although physicians who have completed additional training in a particular area of internal medicine are frequently referred to by their area of subspecialty focus (for example, those who subspecialize in diseases of the heart are usually called "cardiologists"), all share the same basic internal medicine training and like general internists are also considered "internists."

- Internal medicine subspecialties include:
- Allergy and Immunology (immune system)
- Cardiovascular Disease (heart and vascular system)
    - Advanced Heart Failure and Transplant Cardiology
    - Interventional Cardiology
    - Clinical Cardiac Electrophysiology
- Endocrinology, Diabetes, and Metabolism (diabetes and other glandular and metabolic disorders)
- Gastroenterology (gastrointestinal system, liver, and gall bladder)
    - Transplant Hepatology
- Hematology (blood)
- Infectious Disease (bacterial, viral, fungal, and parasitic infections)
- Nephrology (kidneys)
- Oncology (cancer)
- Pulmonary Disease (lungs and respiratory system)
- Rheumatology (joints and musculoskeletal system)

Source: www.acponline.org

Combined Training Programs

Residency programs that combine basic internal medicine with other disciplines are available that broaden the clinical skills of trainees and usually allow completion of training in a shorter period of time than performing different residencies independently. Internal medicine combined with pediatrics (med-ped) is the most common combined program, although residency programs combined with many other specialties are available

IM and FP

What is the difference between internal medicine and family medicine?

Internal medicine is the older of these two practice areas with the practice of internal medicine resulting from the increased focus on scientific methods and training in medical education that emerged at the turn of the 20th Century. As pediatrics began to develop as a separate specialty area in the early 1900s, internal medicine continued its focus on the treatment of adult patients.

According to the ACP, "the specialty of family medicine grew out of the general practitioner movement in the late 1960s in response to the growing level of specialization in medicine that was seen as increasingly threatening to the primacy of the doctor-patient relationship and continuity of care. Conceptually, family medicine is built around a social unit (the family) as opposed to either a specific patient population (i.e. adults, children, or women), organ system (i.e., otolaryngology or urology), or nature of an intervention (i.e., surgery). Consequently, family physicians are trained with the intent to be able to deal with the entire spectrum of medical issues that might be encountered by the members of a family unit."

Both family physicians and internists see adult patients so there is an overlap in their patient base. Both have the skill sets to practice adult primary care, though today internists often use their training in adult medicine to provide care for older patients who may have multiple chronic conditions, such as pulmonary disease and diabetes.

Composition of the Internal Medicine Workforce

Internal medicine is the largest medical specialty in the U.S. and includes more than 131,000 physicians. Of these, 96,368 are in active patient care. The American College of Physicians (ACP), the specialty society for internal medicine physicians, is the second largest physician society in the United States, trailing only the American Medical Association (AMA). The chart below provides data on the current composition of the internal medicine workforce. The data include percent of internal medicine physicians in active patient care who fall into various categories (International Medical School Graduates, Board-Certified, etc.).

Internal Medicine Specialty Demographics:

Total family physicians	131,234
In Active Patient Care	96,368
International Medical School Graduates	39,469 (41%)
Board Certified	83,521 (87%)
Research	1,315 (1.4%)
Administrative/Teaching	3,262 (3.3%)
Last Year Residents	6,912 (7.1%)
Female	36,339 (38%)
Male	60,029 (62%)
45 and over	72,402 (78%)
55 and over	45,436 (47%)

Source: AMA Physician Master File

Supply and Demand Trends

The Association of American Medical Colleges periodically releases a report projecting nationwide physician supply and demand trends. In its February, 2018 report, entitled *The Complexities of Physician Supply and Demand: Projections from 2016-2030,* the AAMC estimates a shortage of up to 121,300 physicians by the year 2030. This includes a deficit of 49,000 primary care physicians and a deficit of 72,000 specialists.

In a press release announcing the report's findings, AAMC President and CEO Darrell G. Kirch, MD said, "This year's analysis reinforces the serious threat posed by a real and significant doctor shortage. With the additional demand from a population that will not only continue to grow but also age considerably over the next 12 years, we must start training more doctors now to meet the needs of our patients in the future."

As the AAMC press release notes, "As in prior projections, much of the increased demand comes from a growing, aging population. The U.S. population is estimated to grow by nearly 11%, with those over age 65 increasing by 50% by 2030. Additionally, the aging population will affect physician supply, since one-third of all currently active doctors will be older than 65 in the next decade. When these physicians decide to retire could have the greatest impact on supply".

The AAMC supports lifting the cap on funding for graduate medical education that Congress put into effect in 1997, limiting the number of physicians entering the workforce each year.

The shortage of internal medicine physicians has become a particular concern because fewer medical school graduates and medical residents are pursuing a career in general internal medicine. The chart below illustrates the problem:

Physicians Entering Internal Medicine Residencies 1951 – 2015

Year	Entering IM Residencies	Entering Subspecialty	% Subspecialty
1951 – 1960	6.989	448	7
1961 - 1970	8,782	896	10
1971 – 1980	36,837	17,110	46
1981 – 1990	47,754	30,387	64
1991 – 2000	65,207	42,069	65
2001 – 2010	69,850	51,352	74
2011 – 2015	36,303	31,989	88

Source: James E. Dalen, MD. Where Have All The Generalists Gone? American Journal of Medicine. Feb. 16, 2017

As these numbers indicate, most medical graduates who enter internal medicine residency programs go on to subspecialize, eroding the potential pool of physicians who continue to practice general internal medicine.

Many U.S. medical students and residents have expressed reservations about careers in internal medicine because of patient complexity, the practice environment and the lifestyle demands relative to other specialties. General internists also typically do not earn as high an income as specialists.

Some medical students are dissuaded from internal medicine by their experiences with elderly and chronically ill patients, who can be challenging to treat. Studies have shown that medical students' attitudes about caring for elderly and chronically ill patients decline during training. (*Source: National College of Physicians).*

The number of older adults in the United States is expected to nearly double between the years 2015 and 2030, and it therefore is likely to become more difficult to find general internists to care for this

growing population segment.

In addition to an emerging shortage of physicians nationwide, the U.S. has long experienced a maldistribution of physicians. As of July, 2018 there were 6,739 Health Care Professional Shortage Areas (HPSAs) for primary care in the United States, about double the number identified by HRSA 15 years ago. These are areas with fewer than one primary care physician per 3,500 people (3000 to one in designated "high need" areas). Over 65 million people live in a primary care HPSA and 67 percent of HPSAs are in rural areas. HRSA projects it would take over 17,000 additional primary care clinicians to achieve this ratio in the nation's 6,700-plus HPSAs.

Disparities in the supply of primary care physicians can be pronounced on a state-by-state basis, as the numbers below indicate:

Primary Care Physicians Per 100,000 Population

All U.S.		92
1.	Massachusetts	134
2.	Vermont	132
3.	Maine	130
4.	Rhode Island	116
5.	Hawaii	116
45.	Oklahoma	75
46.	Idaho	73
47.	Texas	72
48.	Nevada	70
50.	Mississippi	50

Source: AMN Physician Master File

Even states like California, which ranks 22nd nationally with 87 primary care physicians per 100,000 population, have primary care supply challenges. A study by the Robert Graham Center found that the state will need an additional 8,243 primary care physicians by 2030 (*Bloomberg Law. July 17, 2018*).

Internal Medicine Number Three in Most Demand

Each year, Merritt Hawkins releases our *Review of Physician and Advanced Practitioner Recruiting Incentives,* which tracks metrics from the more than 3,000 recruiting assignments we conduct during the 12 month period from April 1 of one year to March 31 of the next. These metrics include the types of physicians requested by our clients, average salaries being offered, and other data. Two thousand eighteen marks the 25th year we have released the *Review*. For the twelfth consecutive year, family medicine was Merritt Hawkins' most requested search assignment as ranked by the Review. However, internal medicine was our third most-requested type of physician search, the 12th consecutive year it has been ranked in the top three.

Population Growth a Demand Driver

Demand for primary care physicians, including family physicians, general internists and pediatricians, is driven in part by population growth. From 1987 to 2010, the U.S. population grew by 28%, going from 242

million to 310 million people in 23 short years, according to the U.S. Census Bureau. According to demographic experts at the University of Virginia, the U.S. population will reach 383 million by 2040, adding an additional 73 million people over three decades. But with approximately 10,000 baby boomers turning 65 each day, it is the aging of the population that is a particular driver of demand for general internists. According for the Centers for Disease Control and Prevention (CDC), patients 65 and older see a physician at two to three times the rate of younger patients.

The Role of Emerging Delivery Models

Evolving healthcare delivery models are an additional demand driver for primary care physicians such a family physicians and general internists. In the emerging population health management model, primary care-led teams coordinate care for defined population groups, such as blocks of Medicare patients, under a global payment model where the health system (and, increasingly, its physicians) assume risk.

Implementation of this model will be accomplished through inter-professional care teams, in which collaborative practice techniques will replace the current approach, where clinicians often train in silos.

Today the model is being implemented through a growing number of accountable care organizations (ACOs) that may include large medical groups, hospital systems, major employers, insurance companies and other organizations. The primary care-led team in population health management typically consists of the following:

Composition of the Primary Care-Led Team

Chief Population Health Officer/Chief Integration Officer/Chief Transformation officer

Family medicine physician or general internist

Nurse Case Manager

Physician assistant and/or nurse practitioner

Social Worker/Community Resources Specialist/Care Coordinator/Grand Aide

Primary care physicians such as family physicians and general internists top the list of most in-demand doctors in part because of their key role as quarterbacks of the delivery team. Through the patient management and care coordination they provide, quality goals are achieved within an environment of defined financial resources. Primary care physicians then are rewarded for the savings they realize, the quality standards they achieve and for their managerial role. They are the lynchpins of integrated models of care and are in demand in part for this reason.

Consolidation Driving Demand

Health system consolidation is a further driver of demand for general internists and other primary care doctors. Whereas in the past, an individual acute care facility might recruit two or three primary physicians at a time, consolidated systems may recruit 20 or 30 in order to create the primary care networks needed to treat large population groups. Instead of recruiting reactively to fill a void or to respond to demand, health systems now are recruiting proactively to meet the needs of covered lives, and, in a growing number of cases, to manage their own health plans.

The Impact of "Convenient Care"

It also is primary care physicians who are the providers of choice for evolving, non-traditional practice settings

and styles, including urgent care and retail centers, virtual patient care, concierge, quality review, Federally Qualified Health Centers (FQHCs) and others. These emerging practice settings place an emphasis on patient access to outpatient care, and they are proliferating in communities around the country. As healthcare moves to the "convenient care" model, additional family physicians and general internists will be needed to ensure patients have the ready access to care that the market now is demanding. For more information on this topic see the Merritt Hawkins' white paper *Convenient Care: Growth and Staffing Trends in Urgent Care, Retail Medicine and Free-Standing Emergency Centers.*

Internal Medicine Salary/Incentives

In our annual *Review of Physician and Advanced Practitioner Recruiting Incentives* Merritt Hawkins tracks the starting salaries our clients offer to recruit internal medicine physicians and other types of physicians. The chart below indicates low, average and high starting salary numbers for internal medicine physicians over the last several years.

Internal Medicine	Low	Average	High
2017/18	$190,000	$261,000	$465,000
2016/17	$120,000	$263,000	$450,000
2015/16	$195,000	$250,000	$370,000
2014/15	$172,000	$226,000	$325,000
2013/14	$150,000	$217,000	$350,000

As these numbers indicate, average starting salaries for internal medicine physicians have increased by approximately 20% since 2014, a further indicator of rising demand for internal medicine doctors.

It is important to note that Merritt Hawkins' physician compensation numbers reflect average salaries offered to recruit physicians, not average total physician compensation, which, in addition to salaries, may include production bonuses or other sources of income. There are various surveys that track average physician total compensation in internal medicine, and these are indicated below, with a comparison to Merritt Hawkins' average starting salary number.

Average Internal Medicine Physician Compensation As Tracked by Various Sources

Sullivan Cotter	$278,946
Integrated Health Strategies	$273,546
ECG Consulting	$259,554
American Medical Group Assn.	$258,027
Merritt Hawkins	$261,000
Hospital & Healthcare Compensation Service	$277,254
Compdata	$254,800

These total average compensation numbers can be used in tandem with Merritt Hawkins' average starting salary numbers when developing incentive programs for general internists and other types of doctors.

A Source of Revenue

Internal medicine physicians, like other types of physicians, represent a source of revenue for hospitals that balance out the costs to recruit and employ them. Merritt Hawkins' *Physician Inpatient/Outpatient Revenue Survey* tracks the net revenue that physicians in various specialties generate for their affiliated hospitals annually. The chart below indicates these numbers for internal medicine, family medicine, and pediatrics.

Annual Net Revenue Generated by Physicians for Hospitals by Selected Specialties

Internal Medicine	$1,830,200
Family Medicine	$1,493,518
Pediatrics	$655,972

Source: Merritt Hawkins 2016 Survey of Physician Inpatient/Outpatient

Internal Medicine Physicians: Practice Patterns and Perspectives

Every other year, Merritt Hawkins conducts a national survey of physicians on behalf of The Physicians Foundation. The survey tracks the practice patterns, morale levels and career plans of doctors nationwide and is one of the largest and most comprehensive physician surveys undertaken in the United States.

Below are responses to several (though not all) questions from the 2018 version of the survey that were provided by 951 internal medicine physicians.

1. What is Your Current Professional Status?

	All
Practice owner/partner/associate	23.4%
Employed by a hospital	21.4%
Employed by a hospital-owned medical group	21.4%
Employed by a physician-owned medical group	12.8%
Other	20.9%

2. Which best describes your professional morale and your feelings about the current state of the medical profession?

	All
Very positive	7.9 %
Somewhat positive	38.6%
Somewhat negative	34.8%
Very negative	18.6%

3. What is your position on concierge/direct pay medicine?

	All
I now practice some form of concierge/direct pay medicine	6.6%
I am planning to transition fully to this model	3.1%
I am planning to transition in part to this model	12.9%
I have no plans to transition to this model	77.4%

4. On average, how many hours do you work per week (include all clinical and non-clinical duties)?

	All
0-20	4.1%
21-30	4.3%
31-40	8.6%
41-50	25.1%
51-60	25.5%
61-70	17.2%

71-80	9.2%
81 or more	6.0%
OVERALL AVERAGE	**53.2 hours**

5. Of these, how many hours do you work each week on NON-CLINICAL (paperwork) duties only?

	All
0-5	18.8%
6-10	25.6%
11-15	19.5%
16-20	14.2%
21-25	8.6%
26 or more	13.3%
OVERALL AVERAGE	**13.0 hours**

6. On average, how many patients do you see per day (include both office and hospital encounters)?

	All
0-10	16.3%
11-20	54.6%
21-30	23.8%
31-40	3.7%
41-50	1.1%
51-60	0.2%
61 or more	0.3%
OVERALL AVERAGE	**17.5**

7. Which of the following best describes your current practice?

	All
I am overextended and overworked	28.0%
I am at full capacity	54.2%
I have time to see more patients and assume more duties	17.8%

8. Is any of your compensation tied to quality metrics such as patient satisfaction, following treatment guidelines, compliance, "citizenship", error rates, etc.?

	All
Yes	56.6%
No	31.6%
Unsure	11.8%

9. What percent of your TOTAL compensation is tied to such metrics?

	All
0-10	39.4%
11-20	24.9%
21-30	8.5%
31-40	1.7%

41-50	1.5%
51 or more	5.1%
OVERALL AVERAGE	**14.6%**

10. How many of your patients are affected by a social situation that poses a serious impediment to their health?

	All
All	6.3%
Many	52.7%
Some	30.1%
Few	10.2%
None	0.8%

11. On the whole, how would you describe the current state of relations between physicians and hospitals, many of which now would employ physicians?

	All
Mostly positive and cooperative	6.8%
Somewhat positive and cooperative	29.0%
Neither positive nor negative	24.6%
Somewhat negative and adversarial	29.2%
Mostly negative and adversarial	10.4%

At Capacity or Overextended

Notable among these responses is that 82% of general internists indicated they are either at capacity or are overextended, while only 18% indicated they have the time to see new patients or take on more duties. In addition, 77% of internists indicated they are either employed by a hospital or medical group or are in some other practice status, while only 23% indicated they are in independent, private practice. This compares to 33% of all physicians responding to the survey who indicated they are in independent, private practice. These numbers underline the fact that the employed physician model is particularly prevalent in internal medicine.

While the majority of general internists (56.6%) indicated that some of their compensation is tied to quality-based metrics such as patient satisfaction, a still substantial 31.6% indicated that none of their compensation is tied to quality. Of those who do have compensation tied to quality, quality metrics determine an average 14.6% of their total compensation.

It is troubling to note that 53.4% of general internists described their morale as somewhat or very negative. There are a number of reasons why many physicians, including internists, are experiencing poor professional morale, and these are explored in more detail in the analysis section of the *2018 Survey of America's Physicians: Practice Plans and Perspectives* that Merritt Hawkins conducted on behalf of The Physicians Foundation. Low levels of morale, and the increased employment of physicians by hospitals, medical groups and other facilities, speaks to the need for enhanced physician retention programs to minimize physician burnout and turnover. These topics are addressed in more detail in Merritt Hawkins' white paper *Addressing Physician Burnout and Turnover.*

It also is troubling to note that 89% of general internists indicated that some, many, or all of their patients are subject to a social condition such as poverty that poses a serious impediment to their health. The majority

of general internists (59%) indicated that many or all of their patients are subject to such a condition. These stark numbers underscore the challenges physicians face treating patients with few resources or those who suffer from drug addiction, lack of education and other social conditions that can be tied to poor health outcomes. The population health management model referenced above is an emerging method for dealing with these challenges.

Recruiting Recommendations

The recruiting market in general internal medicine today is one in which there are many more practice openings for physicians than there are doctors to fill them. The mission for facilities recruiting general internists, therefore, is finding ways to differentiate the practice opportunity from others that physicians may be considering.

Today, virtually all general internal medicine practice opportunities feature an outpatient only practice. There are still isolated cases where hospitals, medical groups or other facilities are seeking internists willing to practice both inpatient and outpatient care, but these typically are confined to rural areas. In the great majority of cases, inpatient work now is handled by hospitalists.

Call/coverage often is directed to nurses who will triage to the ED, the hospital or a central call center, while the internist may in some cases be required to take back-up call.

Generally speaking, internists being recruited today are asked to focus on the disease management of typically older, adult patients who may have health challenges such as chronic obstructive pulmonary disease (COPD), hypertension, diabetes or some combination of chronic illnesses. Adult patients with more general primary care requirements are usually handled by family physicians.

General internists also may have a role to play in team- based care, as referenced above, in collaborative care environments where patient panels are treated by a group of healthcare professionals. This model can be advanced through a patient centered medical home, an accountable care organization, or in a traditional hospital or medical group setting where the team-based approach has been implemented. Internists may find this setting attractive as it reduces the stress of caring for complex patients by involving other clinicians in the care and decision-making process and determining the treatment plan for each patient.

For most general internal medicine practices, a 40-hour week is usually required, though building flexibility in how hours are structured is one way to enhance the appeal of the opportunity. Expectations for patients seen per day will be moderate based on the types of patients seen. With older patients who have chronic problems, 18 – 22 patients at the most is a common standard. Flexibility also may include offering candidates an opportunity to practice a subspecialty.

Internists typically are offered a salary with a production bonus if their employer is a hospital or medical group, or often a straight salary if their employer is an urgent care center of a Federally Qualified Health Center (FQHC). The salary and overall incentive package should be competitive, and more information regarding current physician recruiting incentives is offered in Merritt Hawkins' 2018 *Review.*

Part-time schedules are attractive to many physicians who have family obligations, and flexibility regarding time-off for family and related personal matters when needed also is highly desired by today's candidates. The more schedule options the practice can offer the better its chances of standing out in today's market.

Ideally, the practice will be able to offer a variety of attractions, including good financials, a flexible schedule and perhaps the opportunity to do specialty work. For younger physicians, educational loan forgiveness can

be a compelling attraction.

The key is to make the practice environment – the physician's "workshop" – as appealing as possible. Hospitals, medical groups and other facilities seeking physicians cannot control their location or the number of professional sports teams or other attractions in their area. However, they can take steps to ensure that the practice conditions under which the physician will work will be as positive as possible.

This may include staffing the practice with physician assistants or nurse practitioners, allowing general internists to play a leadership role and assist in the implementation of emerging delivery models such as population health management that are built around the team-based approach to care It also could include the use of locum tenens physicians to provide physicians with more schedule flexibility or help during peak usage periods, thereby reducing stress and burnout. The use of scribes to assist with quality tracking and data entry is appealing to many physicians, as is access to specialists.

In today's market, it is important to remain objective on candidate parameters. A newly minted resident may not always not be the most appropriate candidate. The right candidate may be an older physician with a proven track record who wants to be in your community or a candidate who requires the employer's assistance in obtaining a work visa or green card. It is important to focus on practical qualities such as training, commitment, work ethic and bedside manner rather than seeking an idealized candidate from Central Casting.

The challenges inherent to recruiting general internists are unlikely to ease, but with maximum effort and a willingness to tailor the practice to the wants and needs of today's doctors, recruiting success still is attainable.

About Merritt Hawkins

Established in 1987, Merritt Hawkins is the leading physician search and consulting firm in the United States and is a company of AMN Healthcare (NYSE: AMN), the largest healthcare workforce solutions organization in the nation. Merritt Hawkins' provides physician and advanced practitioner recruiting services to hospitals, medical groups, community health centers, telehealth providers and many other types of entities nationwide.

The thought leader in our industry, Merritt Hawkins produces a series of surveys, white papers, books, and speaking presentations internally and also produces research and thought leadership for third parties. Organizations for which Merritt Hawkins has completed research and analysis projects include **The Physicians Foundation, the Indian Health Service, Trinity University, the American Academy of Physician Assistants, the Association of Academic Surgical Administrators, the Maryland State Medical Society, and the North Texas Regional Extension Center.**

This is one in a series of Merritt Hawkins' white papers examining a variety of topics directly or indirectly affecting the recruitment and retention of physicians and advanced practice professionals, including physician assistants (PAs) and nurse practitioner (NPs).

Additional Merritt Hawkins' white papers include:

- Psychiatry: "The Silent Shortage"
- Physician Supply Comparisons: Physicians by Select Specialties Practicing in Each State and Licensed in Each State but Practicing Elsewhere
- The Aging Physician Workforce: A Demographic Dilemma
- Nurse Practitioners and Physician Assistants: Supply, Distribution, and Scope of Practice Considerations
- The Physician Shortage: Data Points and State Rankings
- Physician Supply Considerations: The Emerging Shortage of Medical Specialists
- RVU FAQ: Understanding RVU Compensation in Physician Employment Agreements
- The Economic Impact of Physicians
- Ten Keys to Physician Retention
- Trends in Incentive-Based Physician Compensation

For additional information about Merritt Hawkins' services, white papers, speaking presentations or related matters, contact:

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