Michigan
Emergency Medicine Residency Programs

Effective Job Searching Interactive Seminar August 16, 2023

Workbook Table of Contents

SAMPLE CV

JANE GOODDOCTOR, MD
143 Pleasant Street
Greenville, NC 27835
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TRAINING & EDUCATION

2018 to 2021	Emergency Medicine Residency
2020 to 2021	Chief Resident
	East Carolina University, Greenville, NC
2017 to 2018	Transitional Intern
	Grady Memorial Hospital, Atlanta, GA
2013 to 2017	Doctor of Medicine
	Medical College of Georgia, Augusta, GA
2009 to 2013	B.A. Biology
	West Virginia University, Morgantown, WV

PROFESSIONAL EXPERIENCE

7/2020 to present	Emergency Department Physician (Per Diem)
	Greenville Hospital, Greenville, NC
7/2020 to Present	Emergency Department Physician (Per Diem)
	Pitt County Regional Hospital, Greenville, NC
7/2019 to 6/2020	Research Assistant, Department of Emergency Medicine
	Medical College of Georgia, Augusta, GA

CERTIFICATION & LICENSURE

June, 2021	Board Eligible Emergency Medicine (ABEM)
	ACLS Instructor (exp. 10/2028)
	APLS, ATLS Provider (exp. 10/2028)
	Licensed, State of North Carolina
	Licensed, State of Virginia

PROFESSIONAL ACTIVITIES

2020	Gooddoctor J. Pre-Hospital Administration of High Dosage Epinephrine.
	American Journal of Emergency Medicine; 8/5, 663-8
2019	Participator, "Composite Tissue Allograft Project"
	East Carolina University Emergency Department; Benson, N., MD
2019	Poster Presentation, "Snakebites Hurt"
	ACEP Scientific Assembly, Chicago, IL

(this section can be a catch-all for any and all activities that do and do not fit under a research and publication heading, but all must be related to the medical profession)

AWARDS & HONORS

2020 to 2021	Chief Resident, Department of Emergency Medicine East Carolina University
2019	Winning Poster Presentation "Snakebites Hurt" ACEP Scientific Assembly, 2001, Chicago, IL
2018	Nicholas Benson Outstanding Resident Award Emergency Department, East Carolina University
2017	Honors in Surgery & Pediatric Clerkships Medical College of Georgia

(include any honors, awards or scholarships earned from the undergraduate level up through residency)

PROFESSIONAL MEMBERSHIPS

American Academy Emergency Medicine
Medical Association of North Carolina
American College of Emergency Physicians
Emergency Medicine Residents Association
American Medical Association

PERSONAL

Date of Birth: July 12, 1991
Place of Birth: Akron, OH
Married to John Smith, Oncology Nurse
Children: Michael, aged 5
Interests: skiing, competitive swimming, reading

Excellent references available upon request

Along with the great cover letter, a strong CV is the best offense for dealing with the competition in any job market. Your CV is the vehicle with which you make a first impression upon a prospective employer. So what makes a CV stand out? I'll give you a hint: it's *not* the color! I get blue CVs, gray CVs, I even get pink CVs . . . I hate them all! A CV often needs to be faxed or copied. It's difficult to do that if the paper has a distinctively darker hue. Your CV should be on white paper, or, if you insist on asserting your individuality, try buff!

I receive hundreds of CVs from graduating residents every year and at least half of them throw in the biggest errors right at the top. To begin with, there's the missing MD or DO beside the physician's name. Now, assuming you worked a massive number of years to earn those two letters, why would you leave them off your CV? My other primary pet peeve is contact information printed in font so small, it requires an electron microscope to read it. Assuming you would actually like someone to contact you, why would you make that activity such a challenge? The font on any portion of your CV should be no smaller than 12 pt. That should take care of the openers!

The first section of your CV should carry the heading *Training & Education*. Since all information on your CV should be listed chronologically from the most recent backwards, the first listing under this heading is your residency. If you are a Chief Resident, include that in your residency entry. After your residency program, list your internship, then Medical School, followed by undergraduate education. Show both beginning and ending dates (7/01 to 6/04) on all entries, placing the dates in a separate column to the left side. Make sure to provide both city and state information for every institution. Don't assume everyone knows where Harvard is.

Any paid work experience comes in the next section under the heading *Professional Experience.* Once again, always work from the most recent backwards and provide location information. If you have non-medical work experience that took place between your undergraduate and residency years, and took up a significant amount of time (more than 4 months), you can add another section headed *Additional Work Experience*. Military service should go under Professional Experience if it was after medical school, and under "Additional" if not. It is important that your CV not have any gaps in time from your undergraduate years to present. Gaps raise red flags in the minds of prospective employers and responsible recruiters, sending imaginations racing in wrong directions like incarceration or rehab.

The next section covers *Certification & Licensure*. Make sure you enter the date you become board eligible in Emergency Medicine (June 2006) and which board you will take (ABEM or ABOEM). Leaving out the date makes the statement a false one, as you are not officially board eligible until you graduate residency. List all of your life saving certifications (ACLS, ATLS, etc.) with indication of either provider or instructor status. Dates of achievement are not necessary, but you can include the year it expires. List any state licenses you have acquired. If you have a state license in the works, you can list it as "pending."

The next heading deals with *Research and Publications.* List any research that is documented and, if necessary, indicate if the project is on-going, along with the names of all participants. Publications must actually be published! If you have enough entries to warrant it, you can also add another section for *Posters and Presentations*. Since most graduating residents don't have enough entries for separate headings here, I am a big fan of using a general heading of *Professional Activities* to include all of the above and any items that may not fit into the other standard categories.

Awards & Honors should be listed next and include any achieved from residency back through undergraduate school. If you are a chief resident, that is considered an honor and should be your first entry here. It is perfectly all right to list your Chief Resident status twice, once in this section and also under your residency program entry. You can also include any civic awards and don't leave out scholarships. Follow that up with a list of your *Professional Memberships* and be sure to include any offices you may have held in any organization.

If you don't have enough goodies to list in the last few categories, you can always lump them together under the heading *Professional Activities*. This is a great catch-all heading for any moonlighting, committee, research, publication and presentation participation, as well as any other professional activities you believe are worth mentioning

No CV is complete without a *Personal* section and it's the one that is most often missing on both graduating resident and experienced physician CVs. Without a personal section, you're not really a person in the mind of a prospective employer, just a list of categories. This is your opportunity to stand out from the crowd. Indicate your date of birth, place of birth, marital status; add the name of your spouse and occupation, if applicable, and the names and ages of any children. Then list any strong interests, hobbies and/or sports. I can't tell you how often I have had candidates selected for interviews because of an item in the personal section of their CV that caught the eye of a potential employer. You never know what an employer might zoom in on, but they won't zoom in on anything if you don't provide the information!

Most grads ask me how long their CV should be. I don't believe there is a hard and fast rule. The average is 2 pages, but if you've got the meat to fill more, don't leave anything out. It is not necessary to describe your training or detail your rotations, but be sure to include any volunteer medical work. Leave out your scouting badges, but include civic program participation. Use your head – what would impress a Director and what would most consider filler fodder.

Should you have an objective on your CV? Well, to be honest, most employers understand the primary objective of a graduating resident: to get a job! Objectives are essentially a limiting factor, and you should only use one if there is a practice element you must have, and will not accept a job without it. For instance, if you will not accept a position that does not allow you to use Ultrasound, or cannot consider a job that doesn't include teaching, then you have appropriate grounds for using an objective. It should be stated simply and go at the top of your CV, above the section headings.

Do not put your references on your CV. Simply place the statement "references available upon request" at the bottom of your CV. Or, if you're feeling particularly cocky, you can say "excellent references, etc." Provide a separate page for your reference list that includes the name, title, institution and contact information for each reference.

In general, your CV needs to be easy to read, with the most important information quickly found, and a bit of personal insight provided. That'll make a great first impression!

Emergency Physicians Monthly July, 2005

Covering Cover Letters

It is astounding how many CVs are sent to prospective employers without a cover letter. As a professional recruiter, less than 10% of the CVs I receive are accompanied by a cover letter! It seems most candidates assume an employer knows why he or she is sending a CV. Of course, we all know what happens when one assumes.

A strong, targeted cover letter is one of the greatest sales tools in a physician candidate's arsenal. It provides an introduction to what the CV will offer, highlights distinguishing features about the candidate, explains why that particular employer is of interest to the candidate and gives the employer reason to sit up and take notice. With the understanding that every CV should be sent with a cover letter, learning how to put one together in an effective manner is what we will try to accomplish here. This is an example of a standard cover letter from a graduating resident:

Dear Sirs,
Are you looking for a self-motivated, personable, well trained physician to work in your Emergency Department? I am an Emergency Medicine Resident graduating from the residency program at Givemeabreak University in Podunk, Iowa, and I am very interested in a job with your hospital. I have enclosed my CV and hope to hear from you shortly.
Very truly yours,
Dudley Doorong, MD

Let's say I am one of the "Sirs" (Dudley's first mistake, which we will get into in a minute). I read the first line and my answer to the question is "no." . . . end of story. CV and cover letter are flung over the left shoulder and immediately enter the circular file. Here's one of the golden rules of promotional writing: *Never open with a question*. Why? Because, the answer just might be "no!" The purpose of promotional writing is to elicit "yes" responses. A cover letter is the most commonly used form of promotional writing.

A cover letter is your first sales tool and in today's tight market, it needs to be a very effective one. To properly cover the subject of the cover letter, we'll divide it into sections:

Salutation

Not only is the old standard "Dear Sirs," or "Dear Gentlemen," horribly outdated, it is also terribly sexist! In this, the information age, it is also totally unnecessary! Find out whom you want to write to. The name of the physician in charge of the Emergency Department is available with a phone call, or a few minutes on the hospital web site. You can call the hospital Public Relations Department or the Medical Affairs Department and be blunt, "This is Dr. Michael Dooright. I would like to send some information to the physician in charge of the Emergency Medicine Department, could you please give me his or her name and exact title?" I recommend you contact the Emergency Department itself for the information, but be certain to emphasize that you are looking for the *physician* in charge. The person who answers the phone in the ED can be a unit clerk or secretary, who will probably give you the name of the Nurse Manager if you simply request the name of the "Director." Once you find out the name and title of the chief, do a little research. Maybe you went to the same medical school, or have other education or training elements in common. Any information you can dig up can be used as ammunition in your pitch.

A sure way to get your letter and CV noticed is to gain the referral of a colleague who knows the director.
If your research turns up any possible links with someone you know, explore it. The Emergency Medicine ranks, despite recent and rapid expansion, still remain a relatively small world compared to other specialties. You never know who may know whom, unless you ask the question.

Introduction

Simply put, tell it like it is. This is where you introduce yourself and the purpose of your letter:

Dear Dr. Nelson,

I am a June, 2001 graduate of the Emergency Medicine Residency Program at Maine Medical Center. I am contacting you regarding a potential position with your department.

If you were referred to this director by a colleague, that person's name should appear right up front in the introduction:

I am contacting you at the suggestion of Dr. Emerson Pike, regarding a potential position with your department. I am a June, 2001 . . . .

Pitch

This is where the sell comes in. Begin by selling your sincerity regarding your particular interest in this department and this hospital. The best pitches refer to both professional and personal motivations for your interest. This is where your research into the facility and the director comes into play. Be specific about what in that department, and that facility, attracts you to them as a potential employer. For example,

After careful research, I have selected (name of hospital) because of the high volume of vehicular trauma, and the recently opened Observation Area, both of which hold particular interest for me.
Together with your department's reputation for high patient satisfaction ratios and low patient to physician statistics, these factors provide ample motivation for my strong interest level.

Well, you get the gist. Use your own style but make sure you get your points across. Follow up with your personal reasons for wanting to be in that area. These can sometimes be as important to a potential employer as your professional reasons. Most directors are concerned with retention of their physicians, particularly newly hired graduating residents. Since over 65% are still leaving their first job within two years, the stability issue is a serious one. So, if you can demonstrate strong ties to the area, your viability as a potential candidate will rise significantly. For example,

My wife, Barbara, and I are both originally from Massachusetts and most of our family still resides in the general Springfield area. With the recent birth of our first child, Jonathan, we are determined to return to the area to put down roots and raise our family.

Use names, it makes you and your family seem more real in the mind of the reader.

What if you don't have family in the area? Go for more general attractions and reasons for your interest.

Though my husband, Jason, and I are originally from the west coast, we are interested in the Springfield area because of it's excellent public school system and proximity to the Berkshires.
As an antique dealer, Jason is particularly excited about the prospect of being so close to prime areas like Stockbridge and Lenox. We are also avid winter sports enthusiasts.

Again, the purpose is to demonstrate that you have done your homework and have real reasons for wanting to work with this institution. You aren't interested in just *any* job, but in *this* specific job, so use details and keep sincere in your pitch.

Justification

In this section you are stating why you are the right person for the job. This is where you summarize what you bring to the table. Since you've included a CV, there's no need to repeat it in the cover letter. You do, however, want to highlight what you think makes you particularly appealing to this potential employer. Refer back to the professional points in your pitch, but keep it short and sweet.

My experience as a paramedic for the city of New York along with my excellent medical school record and residency training make me an outstanding candidate for your department. I was also instrumental in the development of an Observation Area in a community hospital affiliated with my residency program, where I have been moonlighting for the past year. My references will support my outstanding record in the area of patient satisfaction as well as my ability to work well in a team.

Don't be too general and make sure not to overdo the superlatives. . . outstanding, excellent, terrific, fabulous, awesome can all make future life difficult, as you will have to be able to live up to your bio!

Declaration & Close

State your intentions. If you are going to be in the area anytime in the near future, make it clear that you would like to meet with the Director during that trip, at no expense to him or her. Most directors will make time to meet with an interesting candidate if it doesn't cost them anything to do so. Even if there turns out to be no position available at that time, encourage the meeting anyway, emphasizing that you understand the lack of immediate opening. That situation could change in a day.

Most people end a cover letter by stating their hope to hear from the addressee shortly or in the near future. Why leave it up to them? Are you doctors or are you mice? Take the initiative and don't wait for the people to call you, state when you are going to call them. Aggressive is good!

We will be in your area from Monday, Sept. 15 through Friday, Sept. 19 and I would like to schedule an appointment to meet with you on a preliminary basis. I will telephone you next week to ascertain which day that week would be most convenient for you. Or . . . .

I will telephone you next week to discuss potential opportunities with your department and to arrange a convenient time to meet.

Close with "Sincerely" and make sure to sign the thing! I marvel at how many unsigned cover letters I get. It demonstrates poor attention to detail and is actually quite rude.

A good cover letter is typed, and no longer than one page. Any longer and the task of reading the thing will seem too daunting to a busy department head. Make sure your CV is up to snuff as a few will read it first and then look at the cover letter. Don't include anything else . . . no copies of certifications or licenses or birth certificates or diplomas or green cards or library cards. With an effective cover letter and a strong CV, you won't need anything else. Snail mail, fax or e-mail all suffice, but I prefer snail mail for a first contact.

I won't promise you instant results from every one you send out, but I will promise your odds of producing a positive response will increase dramatically. Create a file for everyone you contact that includes any research results and a copy of the cover letter, so you can refer back to it when you do get the person on the phone. Remember, a cover letter must be target-specific to be effective, so don't attempt to use the same cover letter with different employers. Form letters are easily recognized and just as easily ignored.

Emergency Physician's Monthly May, 2005

SAMPLE COVER LETTER

September 1, 2020

Dr. Leroy Nelson
Director, Emergency Department
Good Samaritan Hospital
99 Hospital Drive
Washington, DC, 22222

Dear Dr. Nelson,

Introduction

I am a June, 2021 graduate of the Emergency Medicine Residency Program at Maimonides Medical Center. I am contacting you regarding a potential position with your department. *Or . . .*
I am contacting you at the suggestion of Dr. Emerson Pike, regarding a potential position with your department. I am a June, 2007 graduate of the . . . .

Pitch

After careful research, I have selected Good Samaritan Hospital because of the high incidence of vehicular trauma patients and the recently opened Observation Area, both of which hold particular interest for me, as my enclosed CV will bear out. Together with your department's reputation for high patient satisfaction ratios and low patient to physician statistics, these factors provide ample motivation for my strong interest level in a position on your staff.

My wife, Barbara, and I are both originally from the D. C. area and most of our family resides in nearby Maryland and Virginia. With the recent birth of our first child, Jonathan, we are determined to return to the area to put down roots and raise our family. *Or . . .*
My wife, Barbara, and I are originally from the west coast, but we are focusing on the D.C. area because of the excellent public school system for our 6-month old son, Jonathan, but primarily due to Barbara's career as a political lobbyist.

Justification

My experience as a paramedic for the City of New York along with my excellent medical school record and residency training make me an outstanding candidate for your department. I was also instrumental in the development of an Observation Are in a community hospital affiliated with my residency program, where I have been doing extra shifts for the past year. My references will support my outstanding record in the area of patient satisfaction as well as my ability to work well in a team.

Declaration & Close

We will be in the Washington, D.C. area from Tuesday, September 22nd through Friday, September 25th and I would like to schedule an appointment to meet with you on a preliminary basis. I will telephone you shortly to ascertain which of these days is most convenient for you. *Or . . .*
I will telephone you next week to discuss potential opportunities with your department and to arrange a convenient time to meet.

Sincerely,

James Singletary, MD
30146 East 52nd Avenue, Apt. 10B
Brooklyn, NY 44444
(718) 555-4444
JamesSing@aol.com

In Reference to References, Part I

Those of you who have attended my residency-program seminar, Effective Job Searching, are familiar with much of this information. Since most of you have not had that unique pleasure, I thought it time I shared with the rest of the class!

The purpose of a reference is to provide an honest and detailed assessment of an employee's (or trainee's) current professional skills and interpersonal skills, as well as their future prospects, to a specific, interested, potential employer. A reference can be provided in standard letter form, template evaluation format or verbally, either in person or over the phone. These days a lot of references are provided by email. These documents and/or conversations are often the deciding factor for an employer when choosing between multiple candidates. As such, people providing references must recognize the responsibility they have agreed to undertake.

As a recruiter, I have found that reference issues can even arise with the most marketable of candidates as well as the standard graduating resident. The most prevalent problems are:

- *Difficulty with gathering references in a timely manner*
- *"Cookie cutter" references so generic they could have been written about anybody*
- *Unusually short, incomplete references*
- *References lacking candidate-relationship and contact information*

The average graduating resident approaches the Residency Director, Department Chairperson and a faculty member for references. I have found that most "cookie cutter" references come from the Department Chairperson. Granted, there are those who go out of their way to pay special attention to the progress of every resident, but these administrators are the exception rather than the rule. A prospective employer may expect this reference, but a grad shouldn't expect it to be their major sales asset. The strongest reference for a graduating resident comes from the director of the residency program.

When choosing a faculty member, a graduating resident wants to select the instructor who's had the most influence upon and is the most aware of his or her growth and performance as a physician and as an individual. The fact that a member of the faculty is your favorite B-ball partner should not be a deciding factor. Choose someone who is intimately aware of your work and growth, your strong points and how you have overcome any weak points. If you are academic faculty and seeking a reference from a colleague, the same rules apply.

Neither grads nor experienced job searchers should ignore department heads and faculty from other medical departments with whom you've had positive and significant interaction. These references demonstrate your ability to work well within the entire medical community, not just Emergency Medicine, and refer to your ability to handle consults.

If you are a grad, another strong reference source is the director of any department where you have contributed a minimum of 100 hours of moonlighting. Positive commentary from an employer where you work in a paid, unsupervised capacity packs a much bigger punch than the usual faculty reference. It states that the physician has gained significant experience in the "real world" of Emergency Medicine and has weathered the transition well. Moonlighting references also help reassure prospective employers about a physician candidate's ability to achieve top contribution levels in a shorter period of time than the average grad with no paid experience.

One of my favorite candidates won a hotly-contested position on the weight of one reference. It was from the Emergency Department Nurse Manager. Out of the hundreds and hundreds of candidates I have worked with over the years, only a few have thought of the Nurse Manager when it came to reference time. A very strong consideration to any prospective employer is a candidate's ability to work well with nursing staff. A positive, detailed reference from a Nurse Manager will nip those doubts in the bud. If you have a stronger working relationship with a nurse in the department who is not the nurse manager, he or she can be an equally compelling reference and you shouldn't hesitate to use that person.

Everyone, not just graduating residents, should attempt to be more creative when it comes to choosing references. You absolutely need three, but four or five is better. Like prunes, however, 8 or more are too many unless you are going for a chairmanship. Of course, for grads the Residency Director and Department Chairperson references will always be required. More experienced physicians leaving one job for another will have to provide supervisory and colleague references, but the other two or three can be more adventurous. Don't ignore the possibility of using a personal or character reference. I'm not talking about Flo, the waitress from the Eat At Your Own Risk Diner across from the hospital. It should be someone in a position of some importance within the business sector, the community or even the clergy, who has known you for a long period of time and can speak directly to your good character. Family members don't qualify – they usually have *to say nice things.*

Next month we'll talk about how to ask someone to provide a reference, what should be in a reference and how to overcome potential reference problems.

EMERGENCY MEDICINE NEWS, February, 2009

In Reference to References
Part II: Getting Them and Other Issues

A lot of job searchers just whip up a reference list leaving out the most important step in the process. You should always ask permission before using someone as a reference, even if it is considered a moot point that they will provide one, like with a residency director or ED director. This serves two purposes: first, getting confirmation that the person is willing and happy to act as a reference and second, having the opportunity to contribute to how that reference will read. When asking someone to act as a reference for you, be clear about what areas of your performance you want that person to address. What you are actually asking for is two fold: the writing of an initial letter of reference and availability to take calls from potential employers. Ask him or her to be as detailed as possible. And, don't be afraid to ask what kind of reference you can expect. If someone is not willing to speak highly of you, he or she will usually decline to act as a reference. Request that each person put the letter of reference on departmental or other appropriate stationery. The letter can be addressed to "To Whom It May Concern," if it will be used with multiple prospective employers, but a targeted reference letter to a specific potential employer is more effective and impressive. It is essential that each person provide their full title, institution of employment, location and telephone as well as e-mail contact information for the follow-up contact which is sure to come.

If you considering multiple positions, be certain to advise those acting as your references that they will be required to respond to multiple employers. The best way to accomplish the process effectively is to provide the names of the people who will be receiving the letters and making the follow-up calls to each of your references as they come up. That way the letters can be personalized and when the phone calls come, your reference team won't be caught unaware regarding who the caller is. This level of preparation and attention to the reference process is always impressive to a potential employer. It demonstrates your attention to detail and your serious interest in their specific job.

Many graduating residents just compile a list of references with phone numbers for anyone to contact. I highly discourage this practice. You have no way of knowing what will be said. With a letter of reference in hand, you can be fairly certain the flavor of any follow-up conversation will closely resemble the content of the letter.

For graduating residents who often bring the same level of training and experience to the table, a strong reference is an essential sales tool. Grads can make the most of this sales tool by getting their reference letters to prospective employers *before* going on an interview. Candidates who submit outstanding references with a CV often get more interviews as well as more comprehensive and positive interview experiences. Strong references will heighten interest and cause an employer to go the extra mile to sell their opportunity to this individual. It also significantly decreases the time frame, at the end of the interview process, necessary for making offers and closing deals.

Currently employed physicians who are conducting a confidential job search will want to secure references from those colleagues who can be counted upon to retain confidentiality either with a current employer or from past employers or training programs. Once a formal offer has been extended by an employer and accepted verbally by the candidate, access to the current supervisor is provided and expected. Prior to offer and acceptance, no prospective employer is permitted to contact the current employer without the candidate's permission. However, emergency medicine is a small world and docs like to talk to other docs, particularly if it's about someone they might know. If you are interviewing with an employer who may know any of your current colleagues, it is well within the realm or reason that the potential employer may want to conduct an "unofficial" conversation about you. It is important to make very clear that no contact is to be allowed until you have given your permission. Failure to follow those instructions by a prospective employer that results in the loss of or interference with your current position is actionable.

The ideal reference should emphasize the physician's specific areas of growth and areas of strength. It can even address areas of weakness, highlighting successful efforts to improve and evidence of same. Equally important is a discussion of the physician's interpersonal skills, not just with colleagues, but with superiors, staff, patients and their families. It astounds me how many references concentrate on clinical skills and totally ignore the crucial area of communication skills. Another skill set that needs to be addressed is documentation. You want reference to your ability to handle coding and documentation, your computer skills and the timeliness with which you handle that responsibility. Each reference should also state the nature and length of the relationship with the physician candidate.

Finally, the reference should be obviously pertinent to the individual physician, with no evidence of a generic or "cookie cutter" approach. Generic letters of reference are more damaging than most people know. They literally say the following: "this physician was not significant enough or important enough to warrant my attention . . . no real negatives, but no real positives, either." That's hardly inspiring.

If you have negatives in your background, like a probationary period during residency, substance abuse issues or other situations that required disciplinary action, the chances are pretty strong they will come to light in a reference. Never, ever try to hide or ignore a negative. It will nearly always surface at some point and be far more damaging than if you bring it up. It is far better to deal with an issue from the *offensive* position than from the *defensive* position. You want to put any negative history on the table before a prospective employer has a chance to ask about it. This strategy puts you in a position of control over the information and you can present it in a more advantageous manner. Present the information honestly and emphasize what you learned as a result of the situation and detail the methods you used to overcome the problem. It's what we call turning a negative into a positive. You are then perceived as someone who learns from their mistakes and takes responsibility for them.

Set up an appointment with any individual you plan to use as a reference and discuss the matter with each one. Be clear that you thoroughly expect them to include the negative issue in the reference, as you would if in their position. Ask them to detail your road to improvement in the reference and to evaluate your current status as it applies to the issue. No one wants to write a lousy reference for a colleague or trainee. By conferring with them directly regarding the issue, you make their job easier. Certainly, not all negative issues can be turned into positives. I was contacted by a physician several years ago who had 14 pending malpractice judgments. A reference from the Pope wouldn't have helped that guy.

Handled correctly and responsibly, references can be one of the greatest sales tools in an Emergency Physician candidate's arsenal, no matter the level of experience. Choose your references wisely, keep some control over the content and always thank a reference for their time and contribution to your job search. A good way to do that is with a personal note. Taking the time to put pen to paper makes a far stronger impression than a verbal thank-you or a quick email.

Next month we will look at the other side of the equation; how to provide a strong, effective reference.

In Reference To References
Part 3: Writing An Effective Reference

Nothing can toss a wrench into a budding career more quickly than a lousy reference. And it's not just negative information in a reference that can do the job. A badly written reference or one providing skimpy, non-specific information can be just as damaging.

I talked to some ED hiring authorities about what they want to see in a reference letter and most weren't thrilled with the references they have been seeing lately. The director of a large, metropolitan ED (who preferred to remain anonymous) told me "Sometimes I wonder if the references I get are a snow job . . . kind of a Rodney Dangerfield 'take my wife, please!' effort to dump their less talented physicians on someone else. I get letters that have about enough real content to fill a thimble. Then when I try to follow up on the phone they either duck my calls or give me a quick 'yeah, he's real good' and hurry to hang-up. How can they justify that? We are talking about saving lives here – the physicians we hire in our ED have people's lives in their hands. If you are in an administrative position, providing accurate and detailed references is part of the job, not something you blow-off."

My questions led me to wonder if a lot of these cookie-cutter/inadequate reference problems might stem from the fact that the authors just really don't know *how* to write a reference. So, I asked a few very smart people who are in hiring positions what they want to see in a reference letter. To begin with, my team wanted to make sure the reference they received came from someone qualified to provide it. If you are approached by a colleague or a graduating resident and asked to provide a reference, you should ask yourself the following questions before agreeing to do so:

- Have I known the person long enough to provide a reference based on a reasonable length of relationship?
- Have I worked closely enough with this person to provide a reference based on a solid knowledge of the person's skills in a variety of areas?
- Do I think highly enough of this person to provide an enthusiastic reference that will be an asset in their job search?

If the answer to any of these questions is no, you should probably politely decline. Obviously, if you are a residency program director or chairperson, or the supervisor of a departing physician, you are essentially obligated to provide a reference. But even if you are providing a reference out of obligation, there is a right way and wrong way to do it. It is very important that the reference include specifics about the relationship between writer and subject, specifics about what the information they are providing is based on, and for what period of time.

Mark Alderdice, MD, a Regional Director and partner with CEP America had this to say about the source of a reference. "Reference letters, by their very nature, carry less weight the more impersonal or anonymous they are; a good reference letter establishes a relationship between the writer and the evaluator. It is best if the writer is known to the reader. Choice of references is critical in this area."

Chris Michos, MD, Chairman of Emergency Medicine at Waterbury Hospital in Connecticut could probably teach a course in reference writing. What he looks for first is a serious level of interest on behalf of the writer, a well constructed evaluation and a letter that demonstrates effort, thought, time and honest assessment. In terms of content, the areas he wants to see covered are Clinical Skills, Procedural Skills, a bit about the current position or program (volume, acuity and something that shows parity to the position the physician is applying for) interpersonal skills with patients, nursing, colleagues and consults. If there were early issues that needed to be addressed, Chris wants to know about them and how progress was made addressing those issues. In fact, when he was starting out in the business world his mentor taught him a valuable lesson about writing a reference that he follows to this day, "If asked to provide a reference, I am going to say nine good things about the person and mention one area that needed improvement. If it's all good, the reference appears unbelievable. But when you mention an area where improvement was needed and gained, it shows the person has the ability to listen and accept criticism and the good sense to act on it."

Dr. Alderdice gave me his requirements for a memorable reference letter. "I look for categorical statements such as 'one of the 5 best residents ever in this program,' or 'have worked with John for 14 years and consider him to embody the very best attributes of a physician.' Statements that are unequivocal and place the candidate clearly in the top echelon" are the ones that catch his interest.

In support of my opening statements, Dr. Alderdice had this to say about the potential backlash of a "cookie-cutter" reference: "Conversely, letters that lack any categorical statements sound like they were done by rote and are, to many readers, a red flag." He went on to say how he reacts to this kind of reference and I think his words are quite important for all to consider. "I only make follow-up calls if the reference is ambiguous or seems half-hearted. I am more likely to call someone the applicant didn't list if I get the feeling the writer is unenthusiastic. A nurse manager may be more candid than a medical director who is trying to ease a poor performer out of his department."

As you can see from these quotes, there appears to be a real consensus of opinion among the top hiring authorities in the emergency medicine arena. They are in synch regarding the value of a strong reference, and on what specifically makes a reference memorable and effective. These hiring authorities also agree upon the damage that can result from a boiler-plate type of reference letter.

To recap what constitutes a strong, effective reference letter, it is one that:

- Establishes a long-term, close relationship between the candidate physician and the reference writer with details of the working relationship and the period of time it lasted
- Establishes the current work environment of the candidate
- Provides "categorical statements" and specific details about the candidate's performance in key areas of importance including:
  clinical knowledge and skills
  communication and documentation skills
  interpersonal skills with colleagues, superiors, nursing and support staff
  interpersonal skills with patients and their families
  working relationships with outside department consults
  other outstanding abilities
- One area that needed improvement and details of how that improvement was achieved
- Enthusiasm, Enthusiasm, Enthusiasm!

If you are asked to provide a reference, or required to do so, and you want to provide a reference letter that benefits the physician in question, rather than one that could impede his or her job search, please take the time and make the effort to do it right. A reference is a serious tool for a job seeker and can't be treated lightly. The reference you provide can make the difference between your physician candidate getting a job or getting passed over.

EMERGENCY MEDICINE NEWS, **May, 2009**

Protect Your Paperwork!

Welcome to the wonderful world of identity theft, web worms and all the other high tech, low life schemes to rip you off, defraud the public and use your bona fides for personal gain.

What does all this mean to you? As a physician job candidate, your identity is surfing the country in the form of your CV. It is up to you to make sure the process is handled securely so that you fully protect your paperwork. By protecting your paperwork, you protect yourself. The first step to protecting your paperwork is controlling what information you place in it.

Numbers – these are the biggest danger. License numbers, DEA numbers, social security numbers – none belong on your CV. Someone could take those numbers and use them for nefarious purposes. These numbers are only to be provided during a credentialing process *after* you have accepted a position. No employer expects to see them on your CV and could quite possibly question your judgment should they appear there.

Your photo is also not the best thing to put on a CV, even if you're a dead ringer for Brad Pitt or Angelina Jolie! A CV is an informational piece not a portfolio. Your appearance may be an asset, but it's the kind of asset that is most effective on a site interview rather than on paper. There is also the possibility again, that your photo could be transposed for less than respectable purposes. Identity theft starts with one or two pieces of information. Sending a piece of paper through cyberspace that contains your name, address and photo could give a con man all he needs to counterfeit a drivers license or even an employee badge for a medical facility.

Contact information needs to be on your CV so that the prospective employers who receive it can actually contact you. Some candidates provide only cell phone numbers and email on their CV and even leave off their actual street address, providing the rest of their contact details only to interested parties after initial contact and conversation. That's just fine. Again, put it together: a CV that contains full contact information, license, DEA and Social Security numbers as well as a photo, is an open invitation to identity thieves. . . "take my identity, please!" It can also be used for counterfeiting prescriptions and a host of other illegal purposes and it could be all done under your name. That's not a hassle anyone needs!

The next step in protecting your paperwork is controlling where it goes and who sees it. My rule of thumb is "know who, where and why" prior to forwarding a CV. If you see a job listing that interests you, make a phone call first and establish the basics. I know most of the job hunting web sites provide the opportunity to automatically submit your CV to anyone who has listed a job posting. While it may sound like a quick and easy way to establish contact, I advise caution. Don't send your CV to anyone, unless you know beforehand, the name of the person receiving it, their title and the full name and location of their group and/or hospital, as well as a mutual understanding of the purpose behind submitting your CV. Is there a position available or is your CV being submitted for future consideration? You have the right to insist upon confidentiality prior to submitting a CV. This is especially important for those physicians who are making a job change. Confidentiality means no one sees that CV without your permission. If you are conducting a confidential job search and don't want your current employer to know about it, you have to be especially careful about protecting your paperwork. Make it clear to any prospective employer that your job search is confidential and no contact with your current employer can be permitted without your permission, and dropping your name to outsiders must be prevented. They will totally understand.

This brings up the issue of "blind ads." All the job classifieds including Annals, AAEM's job bank, our classified section here in *EM News* and the premier EM job web site, EDPhysician.com feature some job postings that provide nothing more than a box number (in the case of print ads) or email address for response. In other words, you are being asked to submit your CV to a totally unidentified entity with no way of knowing what they will do with it or even whether they will acknowledge receipt! That really makes me nervous. Blind recruitment ads have been around for a long time and I have always wondered what they are trying to hide. In my 30 years of recruiting I have established only 3 reasons for running a blind ad. First, it can be a recruiter on a CV acquisition drive. It's a nasty piece of truth but there are recruiters out there who either make-up jobs or select the one decent position they have, and run a blind job posting in order to acquire CVs they can use as marketing tools. The CVs they

collect are then used for a process known as "papering." They take the CVs and send them to every ED in a state or states in order to entice the employer to use their services. If an employer bites, the physicians are then contacted and often hounded into working with them. The second reason for running a blind ad is so that the employer can be selective and lazy – since no one who sent their CV knows who they sent it to, the employer need not respond except to those who interest them. This means your ability to follow-up on a CV submission is totally eliminated. And finally, some employers who run blind ads have stated to me that they do so to prevent recruiters from contacting them. Quite frankly, a simple sentence at the bottom of the job posting stating they will work with recruiters can prevent that. As a professional recruiter, I have always viewed blind ads as both dangerous and elitist and my advice is to avoid them.

If you are responding to a job posting from an independent recruiter, don't expect the recruiter to spill all the details before you send them a CV. Should they do so, there is nothing to prevent you from cutting the recruiter out of the equation and contacting the employer yourself. It's called protecting your bottom line! Working with a professional recruiter has many benefits but requires you to establish an understanding and relationship with that recruiter first, before submitting a CV. Does the recruiter have a deep knowledge and scope of the EM market? Does the recruiter have a strong understanding of what you are looking for and can this person produce opportunities in your geographic focus area? Personally, I don't want to waste my time with a candidate I know I can't help. You'll know once you've spoken with a recruiter for ten minutes if they are a true professional who will work with you responsibly, or if you're getting a snow-job from an unscrupulous wheeler-dealer; your gut will tell you what you need to know. A good barometer is how much the recruiter is willing to listen instead of talk!

If you can't locate a phone number to make initial contact, a good cover letter with a minimal CV can provide protection for your paperwork. You can provide a "bare-bones" CV that limits your contact information and only gives highlights of your training and experience along with a cover letter that states your intention to provide further information once you have received basic details about the position and the employer over the phone. A strong cover letter should also target a prospective employer's specific needs and present your position as a qualified candidate for the job opportunity, based on the information provided in the job posting.

Protecting your paperwork comes down to thinking before you act. A job candidate who takes responsibility for the security of their CV and identity will enjoy a more hassle-free search process.

Published: September, 2008
Emergency Medicine News

Effective Job Search Preparation
Goal Setting

Residents graduating in 2015 and any experienced Emergency Physicians planning to job search this year need to make choices now. They must choose the goals they want to pursue. Goal setting can be a mind-numbing experience if you are not accustomed to the process. Keep it simple but target-specific. Your goals for your first job search, or any job search, should fall into three categories: *Practice Profile, Location/Lifestyle,* and *Finance.*

The first item on a goal setting agenda must be deciding which of these three categories will take top priority in your job search. Once you have chosen the most important category, understand that the other two will be driven by the primary one.

If, like most Emergency Physicians, you choose **Location/Lifestyle** as your category of primary importance, you will have to settle for whatever job opportunities exist in your defined location and accept whatever income those opportunities offer. Many job seekers choose this as their primary category for reasons that might not hold-up in an interview setting: they want to be close to mountains, they want to be close to water, they love to ski, they love to scuba dive, they hate winter, they hate big cities or their dogs are allergic to humidity. All noble reasons, to be sure, but they have little to do with work and a whole lot more to do with time off. Imagine the reaction of a director who asks a candidate "why do you want to work here?" and gets the reply "because I love to ski!" Successful candidates think with a *career head* not a vacation head!

You need to be very careful about choosing this as your primary category. It can seriously limit the number of job opportunities available to you, especially if you choose a popular lifestyle area where job opportunities are scarce. Hiring authorities are looking for physicians who present the greatest chance of long term employment, so they focus on candidates with close ties to their area. The location/lifestyle category in the primary position can also be limiting financially as popular lifestyle regions don't need to provide the highest incomes to attract physicians.

So, what if you choose **Finances** as your most important category? No one will fault you for wanting to earn the most you possibly can, but you must understand that big bucks usually mean a trade-off. Employers who use income to entice physicians do so because it is usually the only carrot they have to dangle. Uncommonly high-paying jobs can mean uncommonly high risk in less than desirable areas. Sometimes a group will intentionally keep coverage low in order to keep profits high. This scenario is a high-risk option poised to provide the onset of your malpractice history. Incomes can vary dramatically from one state to the next and from one hospital to the next, even in the same town. Variables include location, patient payer mix, HMO penetration, employee-status and incentive package or partnership formulas. Make sure you've read all the fine print and evaluated the risks that accompany an offer before you make a high-income choice.

These days, however, it is also possible to reap the benefits of working with a top notch ED at a great hospital that just happens to be in what I like to call a location-challenged region. I'm referring to one of those definitely livable places that are not at the top of anyone's "I just gotta live there!" hit parade. You can expect higher regular income and some pretty impressive perks from extensive loan assistance over a 4 to 7 year period of time and hefty sign-on and retention bonuses. You can also expect very high level practice environment and quality in these jobs. If you are coming out of residency with a hefty loan debt, you might consider devoting the first 5 years of proactive to paying them off by accepting one of these positions. We're not talking mud huts here, just not San Francisco or DC or New York City. (Though a mud hut is about all you can afford on what they are paying in New York City these days!)

In case you don't know what the term **Practice Profile** means, it's the job, and nothing but the job, so help you . . . well, you get the picture. The startling truth is that less than 10% of graduating residents choose Practice Profile as their primary goal. As physicians gain clinical experience, however, it becomes more and more important. As a recruiter, I have found that most boarded physicians who are out of residency for 4 years or longer make moves based on a search for an improved practice profile. The priorities they set as graduating residents often take a dramatic turn after the first two years on the job. Most grads are woefully uninformed about what is available in

the Emergency Medicine job market and, as a result, can be easily influenced by a savvy dog and pony show or lured by an impressive dollar amount.

I would encourage every Emergency Physician to consider the ramifications of *not* choosing the practice profile as their primary goal. No matter how beautiful your surroundings or how much money you earn, if you are unhappy in your job, you will be unhappy in your life. And if *you* are unhappy, your family will be unhappy too. The best approach to goal setting is to make Practice Profile as important as Location/Lifestyle, and remain open to widening your geographic search parameters until the right job for you surfaces.

Goal setting is not a solitary cerebral exercise. It requires extensive consultation with your family so that you develop goals that meet all of your individual and collective needs. A goal is not a goal until actually written down, in detail. Chart your three-category goal list with the following headings:

1. *must* have
2. *like* to have
3. will consider
4. won't consider

As you job search, this goal chart will provide you with a strong basis for evaluating each opportunity. You may find that certain items will move around on your chart within the second and third headings so remain flexible. Once you have defined your goals and committed them to paper, you will enjoy reduced stress levels and increased excitement /anticipation levels in your job search process.

Published: May, 2006
Emergency Medicine News

Preparing For Change

It's May; the lovely month of May when nearly every senior resident begins the process of preparing to relocate to a new area, home and job. Some are bringing families, both large and small, and many are dealing with the emotional issues that make change difficult. It doesn't matter if you are going from hovel to penthouse or stranger-in-town to bosom-of-the-family, major change is major scary for most people. It means a departure from comfort zones and can manifest with procrastination, depression and other less than desirable reactions. The good news is there are some wonderful exercises and activities the whole family can do to positively prepare for change.

It all begins with visualization. If you spent any time watching the athletes prepare to compete at the Winter Olympics a few months ago, you saw skiers and lugers and bobsledders preparing their runs using visualization. It looked like they were in a virtual reality booth as they stood, eyes closed, moving their bodies with the twists and turns of the course they saw in their minds. If it's good enough for Lindsey Vonn, it works for me! This is something you can teach your kids to do and have fun with as well. Have everyone sit together in a quiet, relaxed setting with no interruptions. Beginning with the more negative aspects of the change, select one person to direct the exercise; a visual tour guide if you will. Visualize the activities involved with relocation that can spur negative emotion: taking pictures down from the walls, packing up books, wrapping treasured items for transport, saying goodbyes to friends and colleagues. The most important part of the exercise is to allow yourselves to fully feel the emotions that will surface with these visuals. Don't fight them, just let them flow. When you do these activities for real, and these emotions surface again you will be able to say, "I recognize this and I can deal with it." The negative emotions will fade far more quickly when they are expected and familiar.

Move on immediately to all the positive aspects. It's the exact same exercise except this time you visualize your new home; it can be reality or fantasy, whichever the case may be. Think of having all that extra income to apply towards a fun lifestyle. How about building a retirement account that will ensure security for your family? Your kids can visualize potential new friends, activities, sports opportunities, cool vacations. You and your spouse can visualize that new Mercedes you've been eyeing for years! Whatever makes you smile in anticipation or gives you a good dose of the "warm and fuzzies," those are the places you want to go in your head.

These exercises can be done alone or as a family. If you do them as a family, which I highly recommend, be sure to discuss what each of you experienced after each session, providing support and understanding. Don't be upset if the tears flow a bit, particularly from younger kids, it's natural and healthy. I recommend attempting this adventure more than once, as anyone who uses visualization regularly will tell you, it gets better with practice.

Another good preparatory activity is to do as much research on your new home region as possible. Get on the web and look for fun facts about your new location. Try the chamber of Commerce sites for the area, also any visitor's bureau sites. Google for photos, pull out the old Rand McNally Road Atlas and look for interesting venues in the region, places you might want to check out, national parks, anything that is within a reasonable drive for a weekend jaunt. Hit the library and see if you can find any books on the area as well. The AAA offices often have great maps and other items that may feature your new hometown. As a physician, the more you know about the hospital you are going to, the more prepared you will be to hit the ground running. Read the hospital web site page by page, then Google for press releases and new articles from the past few years. Often you will see announcements of new additions to staff with bios, community outreach programs and other news and events. This kind of research will give you a strong picture of how the hospital fits into and works within the community. Walking in the door the first day with that kind of knowledge under your hat will give you a strong advantage.

Another exercise that the whole family can participate in is "positive power listing." Start by having everyone sit around the kitchen table (there's something about kitchen tables that just work better with this kind of exercise) and each person creates a list of the things they are looking forward to. Then combine all those items onto a Positive Power List and post it where it's easily accessible. Have a pencil handy so new items can be added easily. The more concrete, positive elements you can amass, the more positive things there are to focus on. When the willies hit anyone in the family, when someone's feeling nervous or depressed, pull down the power list and get everyone positive again!

One of the most positive things you can do for yourself and your family is preparation. Handle the details of the relocation as soon as possible, leaving time to tie up loose ends as they arise. Nothing puts a downer on a move more than chaos, and chaos only happens when you don't prepare in a timely fashion. Try not to leave anything to the last minute, school enrollment, insurance, housing, transportation, and of course, licensing and credentials. Your new employer has an entire staff dedicated to assisting physicians with relocation, a section of Human Resources, often called Physician Affairs (don't get the wrong idea here – it isn't a procurement group) and they can assist you with most of the major elements of a move. If you are going to be a hospital employee, you may have already been in touch with this staff. If you are joining a group and they have not provided an area expert to work with, ask them if the hospital Physician Affairs/Services staff is available to you, and I'm sure they'll put you in touch with the right people. The key here is to ask for help if you need it.

Having moved more times in my life than I can count on all digits, I know how unsettling the process can be. I am, however, a strong believer in change. Change is opportunity and change is progress. To make the most out of change, I believe you have to confront it with positive anticipation and a whole lot of lists!

Emergency Medicine News, May, 2011

Job Searching on the Web

ACEP News January, 2013

As an emergency physician, your only reliable source for on-line job searching is via sites devoted exclusively to emergency medicine. There are plenty of them. Some have been around a long time and, some are new and upcoming. Some are hosted by contract groups and independent recruitment firms, while others are open to all job listings. Some are hosted by professional associations while others are job boards on specialty information sites. Some are the online versions of print classified ads. The most important thing is to chase the web listings in a way that produces strong results and little hassle. Let's talk about where you can find real opportunity while retaining confidentiality and safety.

Still king of the mountain (but maybe not for long) is **EDPhysician.com**. This is still the premier site for finding EM opportunity based on sheer numbers alone with over 1,500 jobs around the country. There are separate sections for Administrative jobs, Locum jobs, Urgent Care jobs, Pediatric Emergency jobs and even PA/NP jobs. There is also a section that provides the contact information for every state medical board. The style is free form though the owner, Ralph Single, MD, is restricting individual listing size to 300 words. Click on a state and jobs come up in random order. Leave the site and come back in, click on the same state and the order changes. It's easy to navigate, the actual employers are easily identified and you can email a specific listing to yourself or a friend. You will notice that the listings have reference numbers. Those are more for the site than the employer so, if you contact an employer, don't use the reference number as an identifying item. With this as with many sites, you can contact the employer/recruiter directly from the site. The email goes to the employer and is identified as a response from a specific job listing, provides your email address, a phone number (if you provide it) and the opportunity to pen a quick note from you to the employer. It is state driven and each state has a "top of the box" option for employers, that makes the same listing pop on top every time.

The Career Center sponsored by ACEP and EMRA is remaining steady with about 500 emergency physician jobs around the country. The biggest problem with this site is the cost to employers/recruiters for listing – easily the most expensive of all the sites which cuts down on usage by potential employers. The format is fairly simple, though I have often encountered technical issues on the cover page and had problems applying filters for the search. Other emergency department job listings, including those for mid-level providers, nurses and then the locum community are mixed in with the physician listings as well, requiring more targeted scanning. This is the "official job site" for the association, so don't ignore it. There is a great deal of meat here, so it is definitely worth the time and effort.

Climbing the ladder swiftly is the newer site **EDSource.com**. The first line on the "about" page states "edSource is the leading provider of emergency department news and emergency medicine news on the web." I think my friends here at EM News might take exception to that statement! This site has the appearance of a newsletter and, in fact, offers one. They copy articles from the specialty journals and other publications, listing them on the right hand side of the cover page under the heading "EM News." The problem is, when I clicked on any of the headlines my browser couldn't find and open any of the articles; I tried for 4 days in a row with no luck. They are obviously trying hard to appear "official" and Emergency Medicine friendly, also offering a series of links at the bottom of the cover page to web sites for ACEP, ABEM, AAEM, even the CDC . This is all very pretty, but I believe they would be better served putting the effort into their actual job search function and forget about all the fluff. If I want to read an article in EM News, I'll go to the EM News website. No registration is required to search the jobs; good on them! When you start the search process a map of the country comes up and you can click on individual states. Again, locum assignments are mixed in with permanent listings along with mid-level provider jobs, but they are clearly identified and easily skipped over. About 301 positions for emergency physicians were available and fairly evenly spread over the 50 states. One thing I found dicey – there's no requirement for the employer to identify themselves. The rates for advertising were pretty good and definitely competitive. Another problem with this site – there is no telephone connection available – no identification of who is in charge of the site, who owns it, who runs it and they do not respond to email requests for communication. In fact, the only email address they provide is the one to list a job. It's all a big mystery; a bit concerning, that. Still, very worth a look and one hopes they will eventually work the kinks out.

I love Elad Bicer, MD's site **EMedCentral.com**. It's a web site for emergency physicians by emergency physicians and nothing costs you a dime. Their job board is free form and very low cost to post. I've seen as many as 600 jobs posted on this board in peak season. It is so easy to maintain, edit and update your listings as an employer/recruiter. The site also has a running activity line with who is doing what and when. They provide terrific popular blogs, Questions and Answers, even feature specific emergency department and residency programs. There's something for everyone on this site including some pretty terrific jobs – and they are exclusively for emergency physicians.

If you are a member of AAEM and will only take a job with an employer who commits to the tenets of the association, the **AAEM.org** job board may be your best bet for job searching. You won't find a lot of quantity but the quality will be there. In some cases the listings are blind with no employer provided, so you have to submit your CV to the AAEM job board administrator who will then refer it to the employer. This is all quite archaic, but at least you can be fairly certain it won't end up plastered on a telephone pole in Dubuque. Obviously if you are interested in an academic job, the board at **SAEM.Org** is the place to go.

EDOpenings.com is a brand new player in the field with great potential. It is run by Melissa Moody, who has been involved with print recruitment classifieds for years. It is a fairly simple format, state driven and though very short on numbers right now, I expect it to grow rapidly. My only complaint about this site is they are set-up for physician registration on site, so that employers can click on the option "find a physician." Granted, you must have an account and log in with password to utilize the function, but as you could see from last month's piece, I am very anti-CV posting on job web sites in general. They have made a nice start and are definitely worth a look; just give them a little time to get up and running. By August when the Fall market begins, they should be a serious player.
Finally, I couldn't do a piece on this topic without pointing out the job search boards based on the ads that appear in printed Emergency Medicine monthlies like **ACEP News.** Classified Job listings in the back of that publication can also be found on line at www.imngmedjobs.com, a generalist site that gives you the option to immediately choose EM and narrow your search by job title and/or employer. The site has under 100 EM jobs but the details are there and so are some of the smaller groups and hospital employers. Even **Annuls of Emergency Medicine** gives you the option of skipping their classified pages and go straight to www.elsevierhealthcareers.com. You can filter your search by state and specialty (this is a generalist site) and there appear to be about 250 EM jobs. There are also featured employers, featured jobs and even a featured video. Worth looking into as some smaller employers tend to stick with Annuals exclusively.

The **Emergency Medicine News** job board is operated by PhysicianJobsPlus, a generalist specialty search engine owned by the publisher, Lippincott, Williams & Wilkins. The left side of the main page provides several filter categories that narrow the search by specialty, job title and category. The top filter for location and keywords doesn't seem to work well with the other filters. Once you have set filters the listings come up depending upon how you filtered. You could end up with 50 ads from one national group or none at all. There are some good jobs on this board, you just have to work a little to find them. The ads from **ACEP News** can be found at MedJobnetwork.com, by clicking on the emergency medicine specialty choice. There are less than 200 jobs listed but quite a few are individual groups and hospitals so definitely worth checking out!

As I have stated so many times, the secret to successfully using the web as your job search source is to use it often. Check back into sites of choice once a week – new stuff is being listed on a daily basis, especially during peak hiring season of September through April. Be smart when using the web. Don't put anything out there you don't want seen by the world. Contact only those employers/recruiters that have something very specific to offer you. Contact a prospective employer before sending a CV – call first if you can. Know who is going to get your paperwork and what they are going to do with it. I am advocating paranoia, just good common sense and judgment. Happy hunting!

Barb Katz is the owner of The Katz Company EMC, Inc. an EM consulting & recruitment firm. She has been writing about EM careers& teaching Effective Job Searching to EM residents for nearly 20 years.

Truth in Advertising

If you are seeking job opportunity on the web, be prepared to wend your way through duplicate listings, misleading location reports, and some ridiculously superfluous information that has nothing to do with job, location or lifestyle. For example, here's a statement from a job listing I found on the web for a position in the Midwest: "land a lunker striper in an area known to offer some of the best crappie." Yup, that's a load of crappie in my book! Then there's the group offering a job in the "Raleigh/Durham Triangle area" with a location that is actually over 50 miles away from the Triangle area. One of my favorite web job listings comes out of the Pacific Northwest: "work from home as long as you live 10 minutes away – no experience required." All you janitors who wished you'd gone to med school – here's your shot! And finally, my prime example of totally inane job advertising comes out of a listing for a job in Georgia offering the opportunity to work at a "facility on the bleeding edge of technology and an extremely modern replacement hospital in the works." Words fail me!

While these may sound funny, there's actually nothing humorous about physician candidates wasting valuable and limited time trolling through hundreds and hundreds of job listings that offer little to no real information. I'm not saying that the positions I quoted above aren't possibly worthwhile, viable opportunities. I'm saying they are being presented in such a manner that no one could discern their potential value from the information being provided.

For months when I am preparing the annual location and compensation reports for my September and October columns, a portion of my research includes viewing every job listing on every job web site that exists in Emergency Medicine. What I saw this year made it clear to me that agencies, groups and employers of all types and sizes seem to have changed their primary job listing goal from advertising opportunity to soliciting responses. If you are a graduating resident, your base knowledge of the job market in emergency medicine is probably slim to none at best. Tiptoeing through these web sites or the classifieds isn't going to help a whole lot. The biggest challenge you face is finding information – real information about a job. Details are in short shrift this year. You're more likely to get visual pictures of waving palm trees and trickling mountain streams than actual practice details. Even boarded, experienced physicians hitting the job market can become easy prey for some of these hyperbole hacks.

I've assembled some tips for reading between the lines and making sense out of the senseless:

- **Lead-ins are come-ons**. I'm referring to the top tag-line that is supposed to attract your attention. Think of the tabloids you see at the supermarket check-out line. A headline may say "Brangelina Calling it Quits." But when you get into the article you find out the super star couple is actually "quitting" their LA pad for their New Orleans mansion this summer. So when the tag line/come on says " Work and Live in Paradise" it might be referring to the tiny town of Paradise, CA at the edge of the inland town of Chico that was formerly known as Poverty Ridge. Always read the *entire* listing before considering a position.
- **Who's really advertising this job**? When reading through a job listing sometimes the pronouns can be misleading. Words like "We" and "Our," are meant to lead you to think it is the actual employer running the ad. But if you were to send your CV, it could end up in the hands of a less-than-professional recruiters (with any kind of employer or an independent) who might use it for their gain instead of yours. One notorious activity they engage in is called "papering," providing entire state(s) with your CV for marketing purposes – using you as a "Poster Boy" candidate to lure new clients and/or contracts. With this kind of ad, there is either no contact name or, if there is one, it's a fake name. Some recruiters, even good ones, use a fake contact name on all their listings. I think it's so that when an inquiry comes in, they can identify it as "a new fish on the hook." I've never understood this. One would think that if a recruiter wanted to develop a reputation, they wouldn't want to hide their name. But that's just my opinion for what it's worth. The trick here is to read the fine print which can be found in the email address and the URL if one is provided. In most cases, the name of the advertiser is quite evident. If you're not sure, call the contact number listed and say "this is Dr. (first name), what company have I reached?" If the company name doesn't ring a bell, ask what kind of firm it is. "Is this a recruitment firm or a contract group? May I please have the address of your web site so I can do some further research before calling back." Check out the web site and then, if

still interested, call back and ask to speak with the person whose name is on the job listing. If a different person comes on the phone, ask to leave a message for the first one. If they won't take the message, or if that person doesn't get back to you, you've probably got a fictitious contact person deal. Proceed with caution and don't submit a CV until you are fully informed about who it is going to and what they will do with it.

- **It's all in the details**! If the job listing is very short on actual position specification, and most are, yet there is something about it that attracts you, it's time to pick up the phone and get some questions answered before you send any paperwork. In most cases when you place an inquiry call the person on the other end of the phone is going to be far more interested in getting information about you than in answering your questions. Take charge from the start . . . "I need some actual specifications on this position before providing my information to you. Once I have those specs, I will be happy to answer any questions you may have about me." If the person on the phone can't answer practice profile questions, ask for the name and number of a hiring authority who can. It is better for you to place the call than have them call you back – protect your identity until you know exactly who you are dealing with. Have real details on all facets of the position and the employer before submitting your CV.
- **You gotta give a little to get a little**. If you call a recruitment firm, they will not be willing to tell you the name of the facility or group or give you an exact location until they have received your CV. Why? Because once they've given you all the details, you could pick up the phone and call that employer directly, thereby cutting them out of the equation, even though it was their listing and information that attracted you to the opportunity in the first place. Of course, this is unethical behavior in which no physician would ever consider engaging. Uh, well, then again. A professional recruiter will be able to give you enough practice details, compensation details and even lifestyle details for you to decide if the position is worth pursuing, without revealing who the employer is. Not so professional recruiters will try and do a sell job on you without providing any specifics just to get their hands on your CV. Take notes on the details. If, at the end of the conversation, you have some significant notes, and the position is of interest, you should be just fine submitting your CV. Once a professional recruiter has received your CV, immediate, full client disclosure should be forthcoming. Professional recruiters will guarantee total confidentiality and will not refer your CV anywhere without your permission. If they don't offer this to you verbally, insist upon it before submitting your paperwork.
- **Duplicates can be dangerous!** Understand that some employers will utilize the services of more than one recruitment firm in order to fill their opening, especially in a candidate-driven market like this one. In these cases, the first recruiter to submit a physician candidate's CV is considered the referring agent. With the way job listings are these days, you could end up contacting two or three recruiters about the same job. No recruiter "owns" a candidate. You have the right to choose who you want to represent you. Your best bet is to work with the recruiter who has the most comprehensive details about the position so, once again, make phone calls first and deliver your paperwork to the one who will provide you with the most information while having full understanding of your professional and personal goals. If you end up having more than one recruiter trying to refer you to an employer, the employer is quite likely to negate you as a candidate entirely to avoid getting involved in a bidding war. So make sure you know what recruiter is representing you with each employer and make those choices carefully.

When it comes to web job listings, stick with the best and leave the rest! Any job listing that fails to provide *real* information is probably not worth your time, it's as simple as that. Read through the sites at least once a week as new items come in on a daily basis. Stick to your quality guns and only proceed when there is some meat to the matter!

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Emergency Medicine News

Recruiters: The Good, The Bad and How to Make It Work

Last year around this time my column spent a few months focusing on how to prepare for a job search. Well, it's that time again, the season starts in August and graduating residents, as well as experienced, boarded Emergency Physicians are getting ready to jump into the market. Many will consider seeking the assistance of a professional recruiter. Being a professional Emergency Physician recruiter myself, I obviously applaud that thought. But, I also have to warn potential candidates that not all recruiters are created equal. And, even when you do find a good one, there is a right way and a wrong way to work with a recruiter.

The Good

Truly professional Emergency Physician recruiters work exclusively in the Emergency Medicine specialty and possess expert knowledge of the market place. They know the language of the specialty and can provide detailed statistics and practice information on any position they represent. Professional recruiters listen before they sell, getting to know your professional and personal needs before trying to pitch a position.

Once they have a complete picture of your search parameters and the lifestyle requirements for you and your family, they will work with you to create a marketing plan. A marketing plan details the geographic areas of the search, the position profile, and the time frame. Instead of waiting for opportunity to wander through the door, a professional recruiter is proactive, going out into the market place and searching for the best job opportunities that fit your plan. Career counseling is another benefit you get from a professional recruiter. They provide you with an honest assessment of your assets and your goals, even if the truth isn't pretty or exactly what you want to hear. A professional recruiter handles all the details and legwork, saving you both time and expense. The best have earned a reputation for ethics and performance and can be found through referral from a colleague or from a well-crafted, detailed job listing on the web or in an Emergency Medicine publication.

The Bad

Though it pains me to say it, a large percentage of physician recruiters don't merit the "professional" tag. The worst of them are actually quite easy to spot if you know what to look for. Be wary of the fast talker who tries to sell you a job before finding out what you're looking for. Look out for skeletal job descriptions that emphasize paradise and palm trees instead of the practice profile. Don't waste your time with "generalists" who don't specialize in Emergency Medicine because they will have limited knowledge of the specialty and no understanding of the unique practice criteria. Working with a less than professional recruiter can not only be frustrating and unpleasant, it can also be dangerous to your career. The worst ones use sleazy tactics to generate job interviews such as "papering." Papering is when a recruiter takes your CV and sends it to every hospital in a geographic region. This is known as an unsolicited referral and, though most hiring authorities will refuse to acknowledge them, it can become a problem if the physician contacts the employer on his/her own behalf. Employers don't want to be hassled by territorial disputes over candidates. In addition, if your CV shows up on the desk of every ED Director in one or more states, it can make you appear indiscriminate, as a lot of these Directors communicate with each other on a regular basis.

Finally, the worst part of working with a less than professional recruiter is simply that it's a waste of your time, a commodity you have very little of, especially if you're a graduating resident.

How To Make It Work

Rule number one is *protect your paperwork*. A professional recruiter will never send your CV to anyone without your permission. Establishing a winning relationship with a professional recruiter begins with establishing a mutual trust. Be honest about any negatives in your background. Turning a negative into a positive is one of the most valuable tools in a pro's arsenal. Along with mutual trust goes mutual respect. Once you've enlisted the assistance of a recruiter, you commit to prompt responses to phone calls and e-mails as well as immediate feedback on any contact with employer clients. The recruiter will also provide you with comprehensive feedback on your standing as a candidate from the client. Communication is the most important directive of the candidate/recruiter relationship. If you choose, as many job seekers do, to work with more than one recruiter, let the right hand know what the left hand is doing. Once again, employers don't want to get involved with a candidate territorial dispute, so it is up to you to keep each recruiter informed about which positions the other one is representing. If you encounter a recruiter who tells you not to let another recruiter know what jobs they are sending you to, that's a classic non-professional stance and that recruiter should be avoided. Professional recruiters *want* you to tell the

other recruiter which employers they have submitted you to, in order to prevent candidate referral disputes which can often end in the client negating the candidate all together. The rule of thumb is simple: whichever recruiter presents a position to you first, in a complete and professional manner, is the one who is permitted to submit your CV to that employer, and works with you on that position.

The biggest mistake Emergency Physician candidates make is to think that once they get an offer, they don't need the recruiter any more. There are many negotiating and closing details a professional recruiter is aware of that most candidates aren't. Don't be afraid of pressure to accept a position you don't really want; a professional recruiter would never do that. Recruitment fees are earned only when *both* parties are happy with the match. You'd be silly not to utilize their experience at the negotiating and closing phases. After all, the services are free to you; the client pays the fee.

Which brings me to the question "does a recruitment fee reduce a candidate's chances of getting an offer?" The answer is no, with rare exceptions. Employers who use the services of a professional recruiter have already committed to paying a fee for the candidate who best fits their team and their needs. The only way a fee could be detrimental would be a scenario in which two, totally equal candidates are vying for a job and one comes with a fee attached. Since we are dealing with people and not lawnmowers here, the chances of that happening are, well, exceptionally rare.

Only you can decide whether or not working with a professional recruiter will be of benefit to you. I encourage you to consider the option, especially if your search parameters are fairly broad and you could use some help defining the field. A good professional recruiter can make your job search experience a great deal easier and a lot more successful.

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Independent Contractors: What You Need To Know

The average graduating Emergency Medicine resident has little understanding of what the employment status "Independent Contractor (IC)" means. Most see it as a vaguely less than permanent position that doesn't provide job security or benefits. Well, they are kind-of right about the benefits, but the rest is sheer urban myth. So, I decided to talk to some folks who have clear and detailed understanding of the IC status, to clear up all the misconceptions.

Joe Danna, MD is the President of Illinois's ECHO, Ltd., an Emergency Physician contract management group that has been staffing Emergency Departments for nearly 30 years. All of the group physicians work as ICs and would fight rather than switch. "I started out as an IC in '81," says Dr. Danna, "with a group in Chicago. I liked the independence to create the benefit plan that was best – health, dental, vision, life, etc. – for me and my family. It may be nice when the company gives it to you, but it's nicer when you can craft your own. My biggest concern was disability. No employer can get you enough of what you need as an emergency Physician. We are most vulnerable in our working years with infectious disease, risk of personal violence, physical and mental stress, all of which take their toll." CPA and Emergency Physician group accountant, Dan Anderson of Kankakee, IL agrees. "As an employee or an IC, even one who is incorporated, you should pay the premiums for your disability out of your own pocket. If you let any corporation pay the premiums and you then collect benefits, they are taxable as income. If you pay the premiums yourself and collect the benefits, they are tax-free. In the long run, if you were to become disabled, the savings of not paying income tax on that benefit is enormous."

Understand that those employers who hire their physicians as Independent Contractors are expected to provide Malpractice coverage to their physicians at no cost to the physician. It is the only "benefit" they are legally permitted to provide. But that doesn't interfere with bonuses, incentive income or partnership shares.

Mr. Anderson says that the number one advantage of being an Independent Contractor is "flexibility! You get to choose your own path financially and for the future. First you choose your best tax position:

- A Personal Service Corporation (files federal form 1120)
- A Sub-S Corporation (files federal form 120S)
- An unincorporated self-employed-individual/SEP (files federal form 1040 with schedule C expenses)
- A single-member Limited Liability Corporation/LLC (files federal form 1040 with schedule C expenses)

As a W-2 employee, your un-reimbursed employee business expenses on Schedule A are subject to a 2% limitation of adjusted gross income. If you choose any of the tax positions listed above, your expenses are deductible dollar for dollar."

Wayne Gallops, DO a physician with ECHO, has been an IC for nearly 20 years. He believes the biggest misconception about the status is that it is not a secure position. "I believe it's the opposite; contracts for ICs read the same as those for employees, and they require strong cause for termination so you'd have to screw up big time to lose your job! As an IC, I can have the choice to set my own hours within the parameters of the group needs and scale down my hours without any penalties when the time comes for me to do so. Essentially I've aligned my interests with those of my group and the administration of the hospital and the trickle down result is patient satisfaction, streamlined and completed documentation and strong risk management. We function as a democratic group, particularly in terms of how we practice medicine and have for the past 18 years I've been here. To make the most of being an IC, I think you need to have a good accountant and a good investment counselor and a good grasp of what your needs are."

Dan Anderson also stressed the word flexibility as it applies to the area of benefits. "As an employee, you take what you are given, whether you need it or not, and it is considered part of your income. As an IC, you can shop and get only the benefits you need and deduct the premiums. As your needs change, you have the ability to change your benefits to match them. As an incorporated IC, you can have a medical expense reimbursement plan that covers everything not covered by insurance including the insurance premiums."

Joe Danna had more to say on the benefit topic. "As a young physician, when I came out of residency, I had a huge debt. I preferred to get my income upfront in cash so I could pay off those debts in the first 5 to 10 years, which I was able to do as an Independent Contractor. At that time in my career I didn't need life insurance and that sort of thing. I needed cash to pay off my loans. As an IC I had the flexibility to use the money I earned the way I needed to. In a few years as my loans were getting paid off, I also had the flexibility to create a portfolio that included life insurance vehicles and disability programs by working with a top broker. This is more important in the last ten years of your career than in the first ten. Because I am incorporated, I can buy, in pre-tax dollars, all the life insurance and other investments I need for me and my family and in doing so, decrease my taxable income. As an IC, you have the ability to maximize your investment potential that you don't have as an employee, because you choose what you need, you don't settle for what they give you."

Jill Hastings, JD, a principal with Pension Strategies, LLC out of Phoenix, AZ designs pension strategies for firms and individuals. She has worked with a number of IC emergency physicians through a group called Affilion out of Tempe, AZ and agrees that Independent Contractors have far advanced flexibility when it comes to pension and retirement program options. "You are self-employed, so instead of being at the whim of your employer, you have control because you *are* the employer. Being an IC also gives you the flexibility to change directions as your priorities change. These pensions and retirement plans provide huge tax benefits to Independent Contractors as well, so they provide not only for the future but by making annual contributions, it pays off immediately." Ms. Hastings went on to make a very important point. "The one issue I have with Independent Contractors is I hate to see people with their wonderful options do nothing. W2 employees are more apt to participate because the ground work is laid by their employer. IC's need to take the responsibility to get these opportunities rolling, but not all of them do. They don't need to know everything there is to know about investing to participate – there are lots of professionals who can help, direct and advise them to get started – they just have to tap the sources."

Finally, I asked Dan the CPA if one can be a partner in a group and still be an Independent Contractor. "Absolutely!" said Dan, "There's nothing to prevent that. Just about any group partnership structure can accommodate an IC. That's why so many Emergency Physicians *are* ICs. It keeps the group overhead low and allows partners to make financial choices for themselves."

So if you are a grad or an experienced emergency physician looking at a position that offers Independent Contractor status, there's nothing to be leery of. The job is just as secure as that of a hospital or group employee and the advantages are numerous, from higher up-front salaries to great tax and pension/retirement benefits. Many groups who use the IC status are now providing professional assistance to new physicians with establishing the best tax position for them and making the most of the advantages. This assistance is provided free-of-charge for as long as the physician needs to become comfortable and can arrange for his or her own accounting and financial representation. The key word for Independent Contractors is "flexibility." It has been my experience over the last 18 years that it's not always easy to convince a physician to try IC status, but it's darn near impossible to get an IC to change back to an employee once they have!

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SITE INTERVIEWS: EXPECT THE UNEXPECTED

"It takes a village" . . . . to hire an Emergency Physician in rural America! A few years ago, one of my graduating residents and his wife went on a site interview at an eleven-bed hospital in rural Montana. Touching down at the tiny town airfield, they were somewhat amazed to see quite a crowd gathered in front of the one-room terminal building. As they stepped off the plane, the local high school band came marching from the terminal playing a stirring rendition of "When the Saints Come Marching In." Next came the Mayor and hospital President (conveniently one in the same). The timely town festival that evening featured a Casino Night where the couple won an all-expense-paid, long weekend at the lovely Inn in which they were staying, (for which they would have to return.) While the physician interviewed at the hospital the next day, the Mayor's wife squired his spouse around the grade school where the 2nd grader most resembling Shirley Temple presented her with what felt like 42 pounds of wild flowers. The rest of the visit pretty much followed suit and the couple went home with not only a job offer, but an offer for a nearly interest-free home mortgage from the town bank, free riding lessons for the whole family and enough promotional pressure to fell a moose. Three weeks later the physician reluctantly turned the job down in favor of another, but confessed "I doubt I will ever feel this wanted again . . .we may never get over the guilt!"

At the other end of the spectrum, a physician interviewing at a major urban trauma center was made to sit on a gurney in the fast track for an hour until he was delivered to the Director's office. He wasn't offered so much as a cup of coffee or even parking validation. But when the offer came in 2 days later he jumped on it. I've had a candidate subjected to a 3-hour Mormon prayer meeting even though he was Jewish, another mistaken for a mental patient impersonating a physician, and yet another vomit all over my client in his car.

To put it short and sweet, you've got to be prepared for anything on a site interview. Some prospective employers will trot out the whole dog and pony show complete with wining and dining. Others will barely acknowledge your existence as a person. Most fall somewhere in the middle. Few have the funds for the full scale seduction of a physician. My experience has been that academic institutions conduct a more Spartan interview, often requiring more than one visit while community hospitals and academic affiliates tend to put as much emphasis on recruiting the person as the doctor.

There are, however, ways to eliminate a great deal of the unknown aspects of the experience. The most reliable is to get a complete, printed itinerary of the interview trip prior to your visit. A good itinerary will include any and all travel information as well as accommodation details, including local transportation to and from the airport, hotel and hospital. It will also list the meetings that comprise the interview: the individual's name and title, plus the time and location of the meeting. If any social activities are planned (lunch, dinner, etc.), each should be on the itinerary with the location, time and names and titles of all those attending. It's also important to find out who's going to foot the bill. Most prospective employers will reimburse the expenses for you and your spouse or significant other, but few will include air fare for the kids. Reimbursement means you submit all your receipts for travel, lodgings, meals and local transportation. Don't expect reimbursement for first class fares or that side trip to Disney World. Other employers won't pick-up expenses for first interviews while those in popular vacation areas often won't lay out a dime to meet you. If your spouse is accompanying you and is expected to be occupied with lifestyle research (area and school tours, etc.) while you interview, there should be a separate itinerary that details those activities as well.

Lifestyle research also requires some preparation. In most cases the hospital with which you are interviewing either has a relocation expert on staff or will recommend an area real estate agent their incoming physicians have had success with in the past. Call that person with your housing needs and desires so the tour can be tailored to your specific interests. Communicate with the area Board of Education to get school information and arrange visits. If you have religious requirements, make sure the area can satisfy them as well.

Even with a step by step itinerary, there is one aspect of the site interview that still leaves you flying blind – the personalities and expectations of the people who decide whether or not you get an offer. Each person you meet on a site interview will have their own agenda and particular requirements for an Emergency Physician candidate. Professional recruiters will be able to prepare you by advising which buttons to push with each interviewer. It's their responsibility, and in their best interest, to gather

that information and impart it to any candidate who interviews with their client. They will also handle all of the travel arrangements, itinerary and lifestyle research for you. If you're flying solo, however, you will have to do your own digging. Ask the hiring authority or principle contact about each individual you will meet. Try to find out where they did their training and get a practice history. Ask about their personalities and interests to see if you have any in common. Take notes and bring them with you for easy reference.

Another excellent information gathering technique is to contact the hospital's marketing or public affairs department and have them send you the latest annual report as well as any other printed information they have available. You'll often find a full staff list with small bios on key medical personnel along with a lot of other usable statistics. One of my favorite sources is the local Chamber of Commerce. What you want from them is their complete Relocation Packet. It will contain everything from demographics to weather patterns. You might have to shell out a few bucks for it, but it's well worth the expense. Don't wait until the last minute to request these materials as it can often take a week or more to get them. I'd also suggest that you review all these materials before you or the institution shell out the money for plane tickets. You just may discover from your reading that this isn't the opportunity you are looking for after all.

The more you know before you go, the more prepared you'll be to make a great impression. One other tip: if you get sick, reschedule! As one of my candidates learned the hard way, hurling on the hiring authority doesn't win big points in job competitions.

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The Right Answers

If you are actively entering the job market, you are going to get questions thrown at you from every direction. Any physician preparing to interview needs to have some answers ready to go. Here are a few of the questions most frequently asked by prospective employers and guidelines for developing effective answers.

"Why are you interested in this opportunity?"
This could easily be the first and most important question you're asked and you need to be prepared for it. Employers are looking for a response that demonstrates serious interest in their specific position and a strong reason for locating in their area. They are looking for candidates who want to make a long-term commitment to their department and will provide stability to their team. If you have family in the area, you'll want to emphasize that connection. It supports the employer's desire for a candidate to have strong ties to the community. But you also want to target the specific elements of the job that make it attractive to you. Try not to dwell entirely on "what's in it for me" things like compensation and schedule, but pick out practice elements that make the job attractive to you.

"Tell me about yourself."
Though more a command performance than a question, most candidates find themselves at a loss for where to begin on this one. Some recite their resumes verbatim while others go the Charles Dickens route with "I am born . . ." and work their way up from there. What the employer is looking for is a three to four minute overview of you as a person. Cover the highlights of family, interests and personal traits, closing with professional and personal goals. You want to present yourself as a well-rounded person with family ties and interests outside of the workplace. It is also important to demonstrate that you have established both professional and personal goals that their position will help you satisfy. It may be a good idea for you to write up your answer ahead of time and practice until it feels comfortable and familiar, and doesn't come off like a canned response.

""What are your strengths and weaknesses?"
Most Emergency Physicians I know could spend several hours extolling their strengths. Try to contain yourself. In this case you want to pinpoint those strengths that will particularly contribute to achieving the department's needs and the director's goals for the prospective employer. Weaknesses, on the other hand, can be difficult. You don't want to paint a negative picture of yourself, but you also don't want to come off as an egotistical bore. If you don't believe you really have any weaknesses, try turning a positive into a negative. Select something that most would consider to be a positive trait, but couch it as a negative. "I tend to pay a bit too much attention to detail." Or, "some colleagues have said I spend too much time with patient's families." You can be creative, but make certain it's based on an element of truth. Don't claim to pay too much attention to detail if your documentation skills are less than stellar! If, however, you have a weakness, don't try to hide it. Be up front with what it is, while also providing details on the steps you have taken, and continue to take, to overcome it. If you bring up a negative first, you can approach it from an offensive position of power as opposed to a defensive position of weakness.

"What amount of compensation are you seeking?"
This can be a tricky one and your answer should depend upon the timing of the question. If the query comes early on, your answer should be no answer at all. Let them know that you need to get all the information on the position, and complete the interview process, before you feel equipped to provide a response. If you've done appropriate research, you should have an idea of the compensation range and be prepared to handle this question at the close of the interview. Don't let yourself be pinned down to stating a specific number. It will prevent you from achieving anything higher should it be available. Feel free to discuss the compensation levels you have encountered with other interviews, but make sure you convey that your salary requirements are directly tied to the specific position. Most employers won't even address the issue until offer time anyway, but you can also answer the question with another question, "What is the range you are offering?" Understand that most salary ranges are based on experience and a graduating resident will usually achieve a starting salary at the lower end of the range.

The secret to providing winning answers is learning as much as possible about the people who are going to be asking the questions. Take the time and make the effort to do the research on a prospective position. Prepare your answers ahead of time until they feel natural and spontaneous. Make sure you go through the process for every

interview you generate, tailoring your responses to each potential employer. This is one case when one size definitely doesn't fit all!

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SITE INTERVIEW DETAIL CHECKLIST

1. How much time do you need to be there?
2. What kind of transportation will be most efficient and how much travel time will you need to allow?
3. Who pays for transportation to the interview?
4. Who pays for the hotel accommodations, if a hotel stay is necessary?
5. How do you get to the hospital from your hotel? Or to the hotel from the airport? Should you rent a car?
6. If the employer is paying for the interview trip, are they fronting the expenses or reimbursing you?
7. If they're reimbursing you, how long will it take to get your money?
8. Who will you be meeting with (both name & title), when and where?
9. What about an area tour? School tour?
10. What other expenses will the employer pick up?
11. Will there be activities that your spouse will be expected to attend?
12. Will you be expected to return for another interview?
13. Can you take home a sample contract?

A professional recruiter will handle ***all*** of the above for you.

PRACTICE OPPORTUNITY CRITERIA

THE FACILITY

- What is the ownership of the hospital; is management conducted in-house or contracted from a corporate office and, if so, by whom?
- **What is the overall financial condition of the facility?**
- What is the financial basis; profit or not-for-profit?
- How many licensed beds are in the facility?
- Is the facility a regional referral center for any specialties or procedures?
- Is the facility a teaching center? If yes, what is the university affiliation, if any; what residency programs rotate in the Emergency Department (ED) – are they university or in-house based?
- What competition (other hospitals) exists in the service area and where does this facility rank in reputation, referral and usage?
- Does the facility have definitive plans for future growth, renovation or expansion? If so, will construction effect the operations of the ED; how much and for how long?
- What specialties are not available and/or represented at the facility?
- **What percentage of the hospital admissions are generated out of the ED?**
- **Does the ED have full department status with representation on the Executive Committee or other governing board?**
- Are the rights of due process for Emergency Physicians (EPs) covered in the hospital by-laws?
- What is the relationship between the ED and administration?
- What is the relationship between the ED and the other hospital medical services?
- What is the reputation of the ED in the community?

*TIPS**: Make sure you interview with someone at the top of hospital administration (CEO, Administrator, etc.), particularly if position is with a contract group of any size***

You'll hear and learn things here that you won't from anyone in the group. Be sure to determine the status of the group's contract. . . when is it up? Will it automatically renew, require re-negotiation, or be put out for bid?

Either get the most recent hospital Annual Report or meet with the CFO or both

Get the ED's financial condition, and that of the hospital, from the person who knows the scoop.

EMERGENCY DEPARTMENT PHYSICAL PLANT

- What is the general layout of the ED and when was it built or last renovated?
- How many beds are in the ED; how are they designated and arranged?
- How many of the beds are monitored?
- **Are there enough beds to handle patient volume? If not, how many patients, on average, are seen in hallways?**
- What diagnostic equipment (radiology, ultrasound, etc.) is available for use in the ED by EPs?
- If not within the ED, where is Radiology in proximity to the ED, and do ED patients get priority usage? Does the ED have 24 hour access to a radiology tech or physician; is it in person or by tele-radiology, or do ED physicians read their own films at certain times?
- What is the average turn around time for lab results?
- Does the ED have a separate section for primary care patients (Fast Track)? Where is it and who handles the coverage? If mid-level providers like PAs or NPs, how are they supervised?
- Does the ED have a separate Pediatric section? Where is it and which physicians provide coverage? If no separate section, does the ED have special Pediatric equipment?
- **How does the triage system work and what is the average patient turn-around time?**
- How does the nurse's station function; is there one central station for both physicians and nurses or a arrangement? If so, what is it?

- How is coding and documentation handled in the ED? If it is handled by an outside billing firm, who is it and what is the collection rate?
- **Is the ED using EMR, and if so, what is the system and is it hospital-wide or only in the ED? If none, are there immediate future plans for implementation?**
- Does the ED have any special features (hyperbaric chambers, observation unit, pain management clinic, chest pain clinic, etc.)?
- Where do Emergency Physicians park? Is that area well lit, guarded and safe? What kind of security is provided in the ED itself?
- What "wind-down" relaxation and/or lounge facilities exist for ED physicians? Do nurses share it?

POSITION SPECIFICATIONS

General & Clinical

- What is the ED's designated trauma level (if any) and what cases are stabilized and transported? What facility(ies) do they transport to?
- What is the annual patient volume in the ED; how does it spread out over the year? What is the rise in census ratio over the last 5 years, and what is predicted over the next 5 – 10 years?
- **What is history of physician turnover in the department?**
- **How long has the position been open, why is it open, and how many candidates have interviewed**?
- **Have any offers been extended and why were they turned down?**
- **If the employer is a contract group, how long have they had the contract and when is it up for renewal?**
- What is the educational background and certification of the department physicians?
- How many nurses work in the ED, are they exclusive to the ED, to whom do they report and how many are CEN or ACLS, ATLS, PALS certified?
- Are Physician Assistants or Nurse Practitioners utilized in the ED, where and how?
- What responsibility does the ED cover in the region's EMS system?
- **What is the daily coverage in the ED and who provides it?**
- How many clinical hours per shift, per week and per year does the position call for?
- What is the actual length of the average shift *after* completion of documentation?
- How is the schedule determined and is there shift equity for new, in-coming physicians?
- Is there a stipend for physicians who do exclusive night/weekend shifts?
- What is the overall patient mix in the ED (% medical, % pediatric, % trauma, etc.).
- Are Psych or Substance Abuse patients handled in the ED? If yes, is there Crisis Counseling or Social Services assistance and in what capacity?
- What other, if any, support staff exists in the ED?
- **What is the average number of patients one physician sees in one hour?**
- What is the patient payer mix (% insured, % HMO, % Medicare, % self pay, etc.)?
- Does the ED have Occupational Medicine clients? If so, where are these patients seen, by whom, and at what times or the day?
- Does the ED run off-site Urgent Care or Walk-in Clinics? If so, what are the details?
- Do Emergency Physicians have any responsibilities out of the department (answering codes, death pronouncements, etc.)?
- What ED committees exist and what participation is required by an EP?
- Does the department or group adhere to a Best Practice plan and, if so, what is it's origin?
- How is patient satisfaction rated in the ED? Is there a call-back program in place?
- **Do Emergency Physicians write admit orders**? If yes, **WHY**?
  This is considered a totally outdated practice and is only done in the most rural of sites where only primary-care trained physicians can be recruited for the ED. It is a well known fact that BCEM/residency trained physicians would never consider a position that required the administrative work of outside medical services. This one is a big no-no.
- **Do Emergency Physicians "hold" patients for private physicians? If yes, how often?**
  This is another outdated practice that is not seen in EDs recruiting BCEM docs.
- Do the Emergency Physicians and their families socialize with one another? Is it encouraged?

Tips: ***An ED without computers or computers on order probably won't survive for long***

Academic

- How many clinical hours do Emergency Physicians work?
- Is there a practice/clinical track for physicians who don't wish to matriculate in academics?
- **What is the length of the average shift after paperwork?**
- **Is there protected time?**
- How is the protected time to be spent (teaching, research, etc.)?
- Does the position offer tenure or tenure track, and what are the terms?
- What are the publishing and research requirements?
- What kind of teaching is available, bedside, classroom, lecture, etc.?
- How much actual hands-on patient-care will a faculty member do?
- Does the department provide office support staff and computer support?

*Tips****: Try to get an idea of the actual faculty hierarchy as well as a feel for the amount of "university politics" you're likely to encounter.***

Academic Affiliate

- How much, if any, protected time is available and what can it be used for?
- Does the position offer a faculty appointment and, if so, at what level?
- If rotating Emergency Medicine residents, are teaching or clinical shifts available at the residency's primary site?
- What impact does the academic center have on the protocols and operations of the affiliate department?

Tips: ***Don't make the mistake of expecting the same schedule and benefits of academics. It's a clinical position with teaching, offering little, if any, protected time.***

COMPENSATION

- What is the base salary, both annually and hourly?
- What, if any, incentive income exists (production bonuses, percentages, etc.)?
- **If incentive income exists, how is it calculated and by whom; how is it paid and when?**
- What is the detailed benefit package, and does coverage require a premium contribution by the physician? If yes, how much, how often?
- **What is the value of the entire compensation package, and what increases are available at what intervals?**
- **If Fee For Service or RVU-based, how is the compensation calculated, by whom, and is there structure in place to create fairness in the disbursement of patients, and eliminate competition between physicians?**
- Is partnership offered and at what stage of employment; what does partnership mean in terms of responsibility, vote and profits; what is the formula for earning partnership and is there a buy-in?
- Is ownership an option and, if so, is there any debt that would be inherited when buying into the group?

Tips: ***Following are a list of specific benefits you should ask about. Of course, rarely will one benefit package contain everything listed.***

1. *Healthcare:* How many options are there and what is the contribution required for either single, married with no dependents or family. This category covers Hospitalization and Major Medical. It can also include Dental, Optical and/or a Prescription Plan, if available, but these can require additional contributions.
2. *Disability:* Usually only for the employee, covers long and short term. Get details of coverage and contribution, if any.
3. *Life Insurance:* Rarely requires a contribution (unless additional coverage is requested) and is usually in the amount of between 1 and 2% of annual salary.

4. *Malpractice Insurance:* Make certain you ask about **tail coverage**! Occurrence Malpractice automatically covers the tail, Claims Made does not and requires additional (and very expensive) premium. If your prospective employer does not offer tail coverage, find out how each staff member arranges theirs and if a group rate may be available. Some states only offer Claims Made, check first.
5. *Paid Vacation:* How much time in weeks and hours, and is it really paid, or is it really time you'd have off anyway? Can you take cash instead of time?
6. *Sick & Personal Days:* How many do you get annually, how are they accrued, can they accumulate and can you receive cash for unused time?
7. *CME (Continuing Medical Education):* How much time are you allotted per year and how much cash towards tuition and accommodations? Is it flexible?
8. *Professional Dues & Expenses:* This is often provided with academic and administrative positions. Get the amount cap and whether you carry any over.
9. *401K/403B Pensions:* You contribute part of your salary to a cap set by the feds; your employer may or may not "match" a portion of your $$ input.
10. *Other Pension & Retirement Plans:* Far too many options to detail here. Just make certain you get specific details on earning, vesting, penalties & payments.
11. *Incentive Bonuses:* As mentioned above, find out how the amount is calculated and upon what factors is it based, when and how is it paid.
12. *Relocation Expenses:* Will the employer cover the cost (out-of-pocket) for your move to their location and is there a cap on the amount? If you don't need to relocate, will they provide an equivalent amount as a sign-on bonus? **Always find out how relocation dollars are paid and when.**
13. *Sign On Bonus:* Now becoming popular again due to the increase of need in the market. As usual **find out how much, when it's paid and in what form**. If a sign-on bonus seems unusually high – dig deeper; it could be hidden combat pay!
14. *Loan Forgiveness*: If you have insane levels of student loans then a perk that might perk you up is the one where an employer offers to pay down your loan debt. This usually is done in increments of $20K to $25K a year and can go on for as many as 4 or 5 years, depending upon the contract you sign. In most cases, multiple payments will require a longer contract requirement. Most contract groups will not offer loan forgiveness, but direct hospital employers, particularly those in hard-to-recruit areas can be your best bet.

- I'm sure there are all sorts of other enticing tid-bits available out there, I've encountered free laundry service, scrubs and coats, sick child care on site, and a variety of miscellaneous lures (would you believe your own deer chopped into venison steaks each year)! Get details: how much, how calculated, when and in what form.
- Keep in mind***, if you're an independent contractor, the IRS allows you no benefits except Malpractice coverage*****!**

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Inclusion in "Effective Job Searching" Workbook since 1996
Updated 4/11

Sample Post-Interview Thank You Letter

Jane & Joe Gooddoctor
143 Pleasant Street
Greenville, NC 27835

December 2, 2020

George Marshall, MD, FACEP
Emergency Department Director
Good Samaritan Medical Center
Ten Medical Drive
Roanoke, VA 06779

Dear George,

Thank you for your hospitality and attention during our visit to Good Samaritan this week. Both Joe and I enjoyed meeting with you and your colleagues. John Crawford was particularly helpful with information on the hospital's history, policies and plans for the future. We also especially enjoyed the opportunity to get acquainted with your staff and their spouses at Monday night's dinner.

I am very interested in an attending position with your group. The teaching and research opportunities along with the challenging patient mix and future expansion plans fulfill my professional goals. I believe I can make a valuable contribution to these efforts with my training, enthusiasm and strong interest in EMS.

Both Joe and I are excited about relocating to the Roanoke area with its beautiful mountain scenery, friendly people and excellent schools. During the real estate tour we found a number of neighborhoods that would provide the kind of lifestyle we are seeking, at reasonable rates.

(no offer yet, want the job)

Please let me know if I can provide any further information that may assist with your decision . I look forward to hearing from you, as arranged, on Tuesday.

(have offer, still interviewing)

I will be completing my scheduled interviews at the end of next week and will be prepared to make a final decision by the 21st of December. I look forward to receiving your sample contract and to speaking with you again shortly.

(no offer, still interviewing)

I will be completing my scheduled interviews at the end of next week and will be prepared to make a final decision on all offers, including yours I hope, by the 21st of December. I would like to have a signed contract before the New Year. Please let me know if I can provide any further information.

(Have offer, want the job)

I am pleased to accept your offer of full-time employment and look forward to receiving your contract. I will review, sign and return it in the time allotted. Should any issues arise regarding the contract, I will contact you immediately. Thank you, again, for this wonderful opportunity.

Sincerely,

Doctors Behaving Badly

"I know it's a big market right now but what's up with these docs who fly in on my dime, let me wine and dine them, say they want the job, and then disappear?" asked a client recently. "Attitude! Lots and lots of really AMAZING attitude!" was the response I got from another director when I asked him to describe the physicians he's been interviewing this past season. I've written on this topic before, but once again graduating residents seem to comprise the lion's share of the bad behavior, and it's just getting worse. Most of the 2011 grads are committed to new jobs by now and the class of 2012 is getting ready to hit the search trail in a few months.

Yes indeedy boys and girls, the emergency medicine market is as ripe as a hot house tomato and all you talented soon-to-be-ex-trainees are very much in demand. But that's no reason to throw professionalism, ethics and the good manners Mom and Dad taught you in the dumpster. In hopes that the incoming graduates will be willing to up the "class quotient," in the future, the following is a recap of what's been going down this past hiring season.

Promise Them Anything But Give Them the Shaft

"This is the job for me, absolutely, no question about it, when can I start, just send me the contract . . . please leave your name and number at the beep." It appears that a number of this year's grads are trying to have their cake and eat it too. Here's the hard news: you can only accept *one* job. And once you do, you have to stick with it or get branded lousy. Again, it's a tough market out there with lots and lots of jobs, but less than 20% are terrific jobs. You don't want to start your career with a reputation for bad behavior and business ethics. If you aren't sure you want a job, be honest. They will continue to interview for as long as you continue to interview. If, on the other hand, you are really afraid of losing the offer, accept it and stick with it. Only say yes when you mean it. And what's with the Houdini act? Countless job candidates are showing up on site interviews with big travel tickets and meal expenses then disappearing into the night with nary a thank you call or word of feedback. Accepting an employer's invitation to a site interview at their expense obligates you to show up, be professional, provide references, send a thank you note and provide feedback in a timely manner. If you are issued an offer, it must be responded to, whether yea or nay, with courtesy and tact in time to meet the deadline.

Agree to the Job But Demand the Moon

Any job candidate that goes on an interview with detailed, prior knowledge of the employer's compensation package, but thinks they have the ability to demand considerably more is living in fantasy land. Yes, it's a big market and nearly everything is negotiable. But if you're a grad with no practical experience, just what is it you think you are negotiating with? If an employer has a staff or group of docs that are earning at a certain hourly level or based on an RVU percentage, why would they take the chance of ruffling all those experienced feathers just to get your tail on board? If the income isn't in your desired range on the page, don't spend their money on a site interview thinking you can dazzle them enough to pay you more than they are paying their boarded, experienced docs. Sure, you've got school loan debt; that is understood. But you can't expect to pay it all back in two years. Do some research and find out what the market will bear in your geographic area of preference. When you conduct the initial phone interview with the hiring authority, make it clear what kind of income level you require. If they can't match it, they'll say so and no one is out the price of a plane ticket. Not doing initial phone interviews with the top doc? Shame on you!

Don't Call Us We'll Call You

Repeat after me: I will return the phone calls and emails of prospective employers I have contacted and recruiters I have engaged in a prompt and timely fashion! It's just good manners and it demonstrates a level of professionalism that might make the difference between whether or not you get the offer.

What - No Whipped Cream?

The inflated sense of entitlement that seems to be permeating the class of 2011 appears to be a thing of amazement for all to see. I have heard from employers all over the country reporting incredible demands over and above even generous sign-on bonuses. My favorite, was "of course, you'll buy my house so I can move, right?" Physicians of the Emergency Medicine persuasion, please understand: the money well has a bottom, and needy doesn't mean desperate. If it's a good job, other candidates are lined up behind you waiting to jump on it without ridiculous

demands. There are some interesting perks being offered out there, but don't make outrageous demands right out of the gate. Think about proving your worth *first*, then asking for a boost.

Frankly, My Dear, I'd Rather Be In Chicago

If you or your spouse will *only* consider living in Chicago, why are you interviewing in Cleveland? One can turn down offers for all sorts of reasons, but general location is NOT one of them. The candidate who responds to an offer with "my wife won't move to (insert city here)" sounds like a wuss and leaves a very poor impression. I encourage every grad to look outside a limited site box and consider a variety of geographic locations that could potentially fulfill their lifestyle wish list, as it greatly widens the range of opportunities available to them. But if you're pretty sure you can't live there, don't interview there.

I Know I Said Yes But All's Fair In Love & Job Searching, Right?

I've lectured on this and I've written on this issue countless times but it never seems to go away. If you say yes verbally you have made a commitment. That means you stop interviewing and they stop interviewing. It means you enter into contract negotiations with the intention of coming to an agreement, the particulars of which should already have been discussed, leaving primarily the legal contract language to be signed off on. It doesn't mean that you can stall signing the contract and keep looking so you can use the job as a back-up position just in case something better comes up. If you say yes, mean it. When you do, the employer tells all other candidates that the job is filled. Should you renege, they have to start all over again. You've made an enemy and burned a bridge – not the best way to start a career. Certainly if a big surprise or two shows up in the contract that can't be ironed out, then you have every right to back out, but that's the only acceptable reason for doing so. If you get a call a month or two down the road offering what you think might be a better job, you have only one ethical response, "wow, thanks for thinking of me, but I have already accepted another position."

Look, I know there is a lot of stuff going on out there. I know that some employers are not playing fair with candidates and putting on some pretty impressive dog and pony shows to lure physicians in. It's a leap of faith on both sides. What I'm saying is play fair. Take the road less travelled and treat everyone you encounter with the same level of respect with which you expect to be treated. Try to adhere to a few simple guidelines:

Always communicate with those involved in your job search in a timely manner
Only accept site interviews with employers that you will seriously consider working for and
in geographic areas where the entire family is willing to live
Check your attitude at the door of the hospital when approaching for interviews
Think not only what your employer can do for you, but also what you can do for your employer
When negotiating an offer, put away the entitlement and base requirements on research and reason
When you accept a job verbally, it means you intend to sign a contract

Even if you interview without costing the prospective employer a dime, or just drop in for an informal look-see, follow the guidelines. You never know when you might encounter these folks again and in what circumstances. Do you want to be remembered as the doc who was rude with 'tude, the greedy Gus who couldn't get enough, Houdini's protégé, or the king of the time wasters? Or would you rather be remembered as that really nice, professional physician who would have been lovely to get then and is probably even lovelier to get now? The footprint you leave behind you is totally in your hands.

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Emergency Medicine News

Plan for the End . . . At the Beginning

Several times in the last few months I've been asked about exit strategies by relatively young emergency physicians who are seeking a way out of full-time clinical practice. And while it paints a poor picture of the specialty that so many of its practitioners are looking to leave before they reach retirement age, it also shines a glaring light on the fact that most emergency physicians don't plan adequately for retirement. To begin with, emergency physicians are like the sports stars of medicine; the average career span is around 25 years. That puts them at "retirement" age a full 10 years before they can collect social security. Other specialists work well into their 60's and even their 70s, but not so often Emergency Physicians. Call it burn-out, or whatever, the fact remains that around age 55, a great many of these docs are ready to get out of the ED. So when an EP wants to stop being an EP, but can't stop working . . . Houston, we have a problem.

A large number of these physicians, even those who are closer to retirement age, are not financially capable of retiring fully, so they must continue earning a wage. The problem is there isn't much out there for an emergency physician who no longer wants to practice emergency medicine on a full-time basis. Part time, locums, urgent care, rural medicine or even dwelling in the bowels of a cruise ship 12 hours a day for weeks at a time; that pretty much compiles the average list of opportunities. As for executive options with HMOs, Healthcare Organizations, Insurance Companies, etc., *fuggedaboudit!* You can have 2 MBAs and a long list of administrative accomplishments; it won't matter. Those companies are primarily looking for money counters and paper pushers, not good doctors with a clinical conscience.

The time to make plans for the end of your career is at the *beginning* of your career. The average graduating resident puts the majority of their focus on the immediate financial gain a position offers, and tends to ignore the retirement and pension opportunities. While it is understood that most of these physicians are coming out of residency with large school loan debt, and often have young families to care for, the future is not going to take care of itself. Planning for retirement must be pro-active and it needs to start with the first job. One of the contributing issues to this troubling trend is a tendency to attempt living at a lifestyle level one would *like* to become accustomed to before one can *afford* to. With some young docs, the purchase of expensive homes, cars, boats and other "toys" seems to take precedence over saving for a rainy day. But that's the American way of life these days isn't it? For a young physician starting out in a specialty with an early burn-out rate, this is especially dangerous.

Right about now a large number of 2008 graduating residents, as well as other emergency physician job seekers are either actively interviewing or approaching the decision making portion of their job searches. I encourage all to pay particular attention to the retirement and pension benefits being offered by the employers they are considering.

Among the small, democratic group type of employer, many have made the commitment to provide for the future of the partners by including group-made contributions into a defined retirement plan for each physician on an annual basis, some as high as $45,000 a year. The physicians in these groups are still earning good incomes, often with performance-based incentive formulas, while they enjoy the peace of mind they gain from knowing the future is being attended to. The amounts vary and are dependent upon the vote of the partners. Ask for details regarding when these contributions start (usually when you make partner), how the funds are managed and what happens to funds that have been accrued when a physician leaves the partnership.

The average hospital/healthcare corporation type of employer can't afford to pay-out high retirement contributions for their hospital-based physicians. Most of these employers contribute something to a defined retirement plan, but the amounts differ widely and the formulas can be complex, based on annual earnings and time on the job. However, these employers usually provide the opportunity to defer a percentage of your annual salary into a variety of physician-directed pension plans including 401Ks, 403Bs and others, often including a match (a donation of funds by the employer into the pension fund based on a percentage of the amount contributed by the employee.) Match percentages are not always set in stone, and are sometimes dependent upon the employer's fiscal year financial results. Most retirement plans have an age requirement for distribution. When interviewing with this kind of employer, find out what happens to the retirement monies invested for you should you leave that job before you reach retirement age. Also keep in mind that pension plans that have a match or include employer contributions of any kind, usually require a 5 year vesting period, which will have an effect on how much you walk

away with should you leave the job before becoming fully vested in the pension. Ask questions and get details. The hospital human resources department will have a benefits coordinator who specializes in these matters.

Still other employers, particularly large, national contract groups, employ their physicians on an Independent Contractor status, which means that no formal retirement or pension plans may exist at all. It can be entirely up to the individual physician to set-up an SEP (self employed pension) or other retirement account. Unfortunately, not many of the younger physicians in these positions are doing so, despite the higher cash earnings and tax perks they enjoy. It's not because these employers don't encourage them to invest for retirement. A lot of the Independent Contractor-based employers even provide professional financial counseling and assistance for their physicians at no cost. If you are considering a position with an employer on an Independent Contractor basis, ask how they help their physicians create retirement plans and what kind of professional advisors they make available.

Every employer is different and a job seeker deciding between 3 different opportunities will most likely be faced with three different retirement/pension plans. The important thing is to give the same focus to that part of the income package as you give to the base salary and incentives. And when you make a choice, make the most of it; max out your opportunities to invest in the future. By starting to take fiscal responsibility for the future early on, you prepare the way for a comfortable retirement on your own terms later on.

Published December, 2007
Emergency Medicine News

Front Money: Where Does It End?

I am working with a client in Iowa. This client is offering a first year package worth just shy of $350,000.00 and that's *before* benefits. But there's more . . . a lot more. In order to attract residency trained emergency physicians, they are also offering "front money:" $25,000.00 sign-on bonus, $10,000.00 relocation bonus, $100,000.00 in loan forgiveness (for a multiple year contract) and $20,000.00 in monthly stipends for the physician at signing. That's a guaranteed $145,000.00 *before the physician steps foot in the ED for a day's work!* Now this is not a West Texas wasteland with wads of tumbleweed blowing down unpaved streets and rattlesnake walls around the homesteads. It's not an inner city ghetto with bars on the windows and it's not a remote swamp deep in the Everglades. It is a lovely area with wonderful schools, terrific small-city lifestyle, strong economy and a very high tech medical environment. There are countless festivals, professional sports, riverfront recreation areas and cultural/historical regions. The hospital itself has won awards for patient care excellence with exceptional patient satisfaction scores.

So why do they have to lay out nearly $150,000.00 in front money to attract emergency medicine physicians? The answer is: pretty much because everyone else is doing it . . . at least all the employers that are not in San Diego, Charleston, Seattle, Boston, San Francisco or Colorado, if you get my drift.

It's a very interesting dichotomy. We are definitely in a shortage situation in emergency medicine. There are not enough hospitals in the country, not enough emergency rooms in the hospitals and not enough physicians to work in the Emergency Departments. Back in the late 90s and up until about 2006, there weren't enough good jobs for emergency physicians. Competition on top positions like the one mentioned above was fierce. But employers didn't expect physicians to pay them front money to get an interview. Now the tables have turned; and dramatically so. I wrote a column at this time last year about graduating residents' poor interview behavior; specifically walking into interviews and asking about sign-on bonuses before even taking a chair. There was one academic faculty physician who took great offense and sent what could only be described as hate-mail to my editor. But that same behavior not only continues, it has escalated. Unfortunately, I have trouble finding a great deal of fault with graduating residents who are coming out of their programs with enormous loan debt and young families, wanting to get their piece of the pie. The question at this point becomes, how long can this go on and at what point does it harm the specialty?

The large, national groups, whether corporate entities or physician owned and run, have the financial capability of putting these front packages out there, but at some point, if they have to do it for all of their sites, it becomes prohibitive. And what happens when a physician going for a job in a popular lifestyle location begins comparing notes with a colleague interviewing for the same group but in a less desirable location, and the later is getting a huge front package while he or she is barely getting a relocation bonus? Certainly the group can cite the difficulties of recruiting in less popular areas, but can they expect any candidate to accept that and not play the equity card? If they are offering jobs to physicians with the same credentials and work history (and with graduating residents that is often the case) how do they justify offering one a huge front package but not the other?

I just finished running a four part series on the positive points of looking at a rural emergency medicine practice. How do these employers in the most hard to recruit areas compete with the employers throwing everything but the kitchen sink into the mix? Obviously, if you are an employer in a highly desirable lifestyle area like the ones mentioned above, most of this is a moot point. Emergency physicians are pretty much indoctrinated into the understanding that if you want to work and live in Colorado, for instance, you pay for the privilege with lower incomes.

I found myself engaged in conversation with many different employers and physicians during ACEP Scientific Assembly back in October, regarding this growing phenomenon. Many were concerned that all this front money is not only breaking the bank, but it also doesn't necessarily buy the physician for more than a year, which puts them in the position of having to fork out the front money again. Most of these contract deals come with a one year employment contract. Though some employers hold some of the sign-on bonus for re-signing, most do not.

The truth is, *physician retention* is not the focus of most employers and, in my opinion it should be. If the practice environment and basic income status is strong, the need to recruit new physicians becomes less of an issue. Emergency physicians are the most mobile of all the specialties. It used to be that the average emergency physician took a new job every five to six years. But the depressed real estate market and economic uncertainty has put a major crimp in that trend. Physician families are often less open to relocation especially when it means removing young kids form their schools and selling a house. It makes more sense to me for employers to put a good deal of this front money into sporadic retention bonuses over say, three to five years. They could also put some effort into creating more satisfactory work environments. How about sinking some bucks into the EMR and documentation systems? Why not think outside the box a bit and create department team bonding events. People who really enjoy working together accomplish more and are less likely to leave, especially if they play together as well.

The market for emergency physicians is going to remain hot as a pistol for the foreseeable future. . . of that there is little doubt. If employers keep throwing front money at physicians, the issue of retention just becomes more problematic. I would really like to hear some ideas from all sides of this situation on what can be considered a reasonable incentive to sign-on, ideas for retention, and how we can make the entire job market more equitable for all involved. Emergency medicine is a small specialty when compared to others, and every person involved in it is susceptible to major problems should the whole shooting match go down in flames. If the current competition among employers continues to escalate, it won't be long before the fire trucks are going to start rolling.

Please contribute your thoughts and ideas either to the editor of Emergency Medicine News or to me directly. I will continue researching this issue and report back the results of all efforts later this year.

EMERGENCY MEDICINE NEWS
Career Source Column, February, 2012

True Values
Part One

True Value isn't just a hardware store; it's an essential way of evaluating a compensation package. With today's wild and wooly job market for emergency physicians, candidates are experiencing an unprecedented variety of items tossed at them from huge sign-on bonuses to free dry cleaning. It's especially difficult to sort through all of it and make sense of what has value. What is a sign-on bonus really worth in the long run; or loan payback, hourly salary, bonuses, pensions, retirement, and of course the now popular RVU? These days I find younger physicians, particularly those just coming out of residency, are more susceptible to fabulous front money and less impressed with the long term gains. In my opinion that can be a big mistake. Let's look at each category.

Sign-on Bonus

Ah, the wonderful world of short term bribery . . . to be honest, that's what sign-on bonuses are, a bribe to get you to take one job over another. Now I have nothing against financial gain, being a devoted capitalist from way back, but I like a big bang for my buck. A $30K sign-on paid when you sign a contract sounds really juicy, doesn't it? But what if I told you that the average physician blows these dollars long before they start the job and all too often, figure out in a few months that oops, the chunk of change was nice but the job really sucks! The scenario draws from the same pool of psychology as lottery winnings . . . found money blown on unimportant frivolities leading to bankruptcy; you know the story. What I'm starting to see now is a sign-on bonus structure that is spread out over time, rewarding longevity. It's more of a thank you than a please and far more valuable in the long run. You perform well, your value goes up as does your retention bonus.

Loan payback

With the average grad coming out of residency with a loan debt in the $300K to $350K range, that's a heck of a big millstone hanging around the neck. Asking employers to help with that used to be a Federal or State Underserved Area perk, but these days EM residents are adding it to their must have lists. Certainly having an employer tell you that they are going to take a third of that debt off your hands is a high value compensation item, but it all depends on how it is structured. No one except a desperate lunatic is going to offer $100K in loan payback for signing a one year contract. This is strictly a time= money deal. Expect an average of $20K-$25K a year scenario where you need to work 4 or 5 years to realize the full value. And here's the rub, you best be real sure you are going to be happy in the job because 5 years is a long time to be miserable at work! Try to get a pro-rated application of the loan payback so that if you do decide to leave before the full time commitment is up, you don't lose what you have earned up to that point. Avoid the all or nothing deal; it's too much of a gamble. Also, don't expect to see this option with a small, democratic private group. Most don't have the profit margins necessary to fund this kind of deal, even on a long term basis. And equal equity ownership groups are going to be hesitant as it was not provided for the current owners in the past. These types of groups have more profit-driven dollars to offer that can potentially be even more lucrative down the road.

True Value Part One/pg. 2

Hourly Salary

Many candidates hear the hourly and stop listening. Big mistake! Guaranteed salaries are hard to find these days and the really high ones ($225 to $300 an hour) are usually in location-challenged areas where money is the only sales tool they have to offer. It is also usually in lieu of bonus pools and RVU-driven compensation that can sometimes add up to even higher levels of earning. The bulk of employers are going with a multi-level compensation program that *starts* with a guaranteed hourly base that is supplemented with incentive earnings and benefits. These guaranteed hourlies can be shift-based with higher dollars available for nights, but the shift differential is a tired trend that is, in my opinion, on its last legs. To realize true value, look for a base that is commensurate with norms in the area and, when added into the full package, creates a strong comp figure in exchange for the work. Make sure you are not required to work an unusually high number of hours annually to earn the max income. Full time clinical in the private sector averages around 1,400 to 1,600 hours.

Benefits

These are a dying commodity. In the good old days you had paid vacations and health coverage and disability and all sorts of cool stuff that added as much as $65-$70K to your package. Now . . .not so much. If you take on a position as an Independent Contractor this category is moot – there are no benefits except malpractice coverage; end of story. As an employee, the most important benefit you want to look for is strong health care coverage for you and your family, hopefully including dental and vision and prescription options. That's where the true value lies. Disability is nice, but mostly available as hospital employee or employee of a large group. It also has to provide a serious income if you are permanently disabled and can't work. Life insurance is sometimes offered but the truth is, the levels aren't high and you can do better securing this sort of thing on your own. You can find all these on your own through ACEP at group rates, or through a good benefit agent. Paid vacations are also primarily a thing of the past, with most groups and employers working the vacation leave into the schedule. Another true value is CME stipend which should be at the $5K level each year for the private sector, without paid time to take it. Finally, that malpractice coverage is the last thing you want to ignore. Make sure it is at least $1MM/$3MM and that tail is provided, or at the very least, earned over time.

Next month we'll look at true values in the prevalent, incentive income packages and the essential pension/retirement programs.

ACEP NEWS

April 2013

True Values
Part Two of a Two-part Series

In Part one, we looked at the more standard elements of the compensation package. Now let's take a look at the more creative elements of compensation and the future building blocks of income.

Bonus pools

The hottest thing to hit emergency physician incomes in the 90s was the incentive bonus. It has now become a major portion of many overall compensation packages and highly sought by both experienced physicians and graduating residents. The concept initially was to create an avenue so that those physicians who move patients and document more efficiently, would be able to earn more than those who didn't. The situation now presents a real dilemma with no two bonus programs being alike. The variety of formulas is vast and rarely, if ever, guaranteed. The most important things a job candidate needs to look for with a bonus program are:

- the formula for earning bonus money;
- the criteria bonus money is based on . . . for instance: hours worked that pay period; productivity; patient feedback; patient complaints; departmental contribution and meeting attendance; director's discretion; a combination of all of the above;
- the formula uniform throughout the group'
- and, does the formula reward good work or does it set-up a billing competition between physicians?

Bonus income should reward the strong clinical skills and documentation abilities of physicians. It should NOT reward speed and productivity in such a manner that a slug-fest for billing ensues. That creates a dangerous environment for both patients and physicians. The best bonus packages are based on a combination of factors and are uniform throughout the group or department. Other questions to ask include how and when the bonus income is distributed.

RVUs

Otherwise known as "eat what you kill," RVU compensation started up in California and is swiftly working its way east overtaking many employers in the Texas market as well. It is quite simple: based on billings and collections over a period of time, an RVU (Relative Value Unit) is established. It could be $3.45 or it could be $32.85, it depends on the department and payer mix. Then the production of the physician is broken down into RVUs and the multiples of that equation make up the physicians earnings for the pay period. It has proven that

documentation is a key factor in this income model and often you will find scribes employed in those environments where RVU compensation is applied.
Some employers are converting their bonus pools to RVU compensation in addition to a base hourly rate for a hybrid model. Many physicians who were working in EDs back in the 90s actually remember this as "Fee For Service."
The most important thing is to find out what the range of actual cash earnings are in a chart showing hours worked and RVUs earned per physician. What is the low, the high and the average earning points? Find out the time frame for getting up and running with earnings. It can run as long as three to six months, so you must determine how to pay bills until then. Many groups establish a base hourly for the first few months and compensate additional earnings retroactively when the RVU cycle is complete. One other very important issue with this comp model is appropriateness for a graduating resident. An experienced physician needs time with the learning curve for this kind of model but it can take a good deal longer for a grad. The true value here is making sure you can keep up with the team and not be left behind the income wagon. I often advise grads to wait a few years before going for this kind of job.

Benefits

Medical benefits, whether in a hospital plan or group plan, are definitely true value and should be sought wherever you interview. Make sure they are comprehensive and include family coverage. Look for dental and vision and prescription coverage as well, though anyone will tell you that finding true value in a dental plan is next to impossible. Disability is a biggy and if you don't have it through your employer get it through a professional organization or other avenue. Disability (short and long term) are your best chance for income should anything occur that leaves you unable to work. CME is important of course and the average stipend in the private sector is $5K a year – though most academic positions provide higher levels. Paid leave is hard to find – darn near impossible in the private sector, but if you do find it, make sure other vital elements are not negated to fund it. Most employers work vacations into the schedule these days. Life insurance sounds good but it costs the employer little and really shouldn't be a factor in decision making. Most physicians find that the life insurance policies that they obtain on their own carry more value. If you take a position as an independent contractor, all of this is moot as the law prevents the employer from offering benefits other than malpractice coverage. Speaking of Malpractice coverage . . . have you seen the cost of tail lately? Do not be stunned if you are asked to earn your tail over time in smaller groups. In those states where Occurrence MP is available this is not an issue as tail is included. But if the coverage is Claims Made, the tail is separate and can be very expensive. Never assume it will be covered, always ask. And, if you must earn that coverage either as a new doc or as a partner, make sure you know the formula for doing so.

Pensions

Many employers are pulling back on pensions and contributions to same. Since so many 401Ks and 403Bs took major hits in the recession, physicians became more interested in immediate cash as opposed to controlled investing. Most employees of hospitals and healthcare systems have a pension component. In most cases the monies going into these pensions come out of the physician's earnings. The physician can also direct how these savings are invested. Look for an employer that provides a match for true value. It will be a percentage of what the physician deposits but can really add up over the years. That is another important point about pensions, the longer you stay the more valuable they become. In most cases you need to be an employee for at least 5 years before you are vested and can take the money with you when you leave. Some employers vest in percentage increments of 20% per year, so that it takes 5 years to fully vest. Find out what the specifics are before signing on the dotted line. At the very least a pension is an enforced savings plan. Any noted investment guru will always tell you to "pay yourself first" and a pension is a great way to do it.

Retirement

This is usually the last thing that most young physicians consider when evaluating a compensation package and it should be the first! This can easily be what makes the difference between retiring with a major chunk or change at 55 to 60, or working like a dog until you are 70. Ask what the group or employer is offering and, if there is a defined retirement formula, get the details. Many small, democratic groups contribute the maximum amount allowed to each physician . . . $48K a year, instead of paying up front or big annual bonuses.

That is really true value! But it is often overlooked because it is not cash in hand. Time to change your thinking and plan for the future!

Perks

I know of a group that has their own chef in the physicians lounge. I know of another that provides valet parking for their docs. Some get their scrubs and coats cleaned and others have child care centers available on campus. I once had a hospital in rural Montana offer a physician a free mortgage and discount furniture. Whatever form they take, perks are simply that . . .perks. When it comes to decision making between two great opportunities this is the last category you should focus on. Perks are the category of the least true value.

Evaluating a compensation plan can be daunting. The trick is to look at your family and decide ahead of time what your specific needs will be. Some employers will negotiate to craft a package that is best for you. Make certain that when you sign on the dotted line the package you accept is one that contains true value, not just a lot of useless coverage and empty promises!

ACEP News 6/13

The 2022-23 Emergency Physician Job Market

By Barb Katz

Two and a half years into the Covid Crisis and no doubt you are thinking the job market should be returning to normal, right? Uh, not so fast . . . the news is less than stellar. The Fall 2022 market is up 15% from last year but still lags behind the 2019 market by 47%!! Other elements of the market, however, have increased. In 2019, 63% of available jobs were with national contract groups with 53% open to primary care physicians. This season NCGs represent 73% of the open jobs and 58% are open to primary care boards.

Due to dwindling compensation information, this year's report is a combination of position availability and compensation stats where available. All compensation numbers represent salaries only – no bonuses, benefits, or front money have been included. These are all from currently available positions and annual incomes are based on 1,560 clinical hours. As usual, the breakdown is by the usual geographic regions.

The **Southeast provides 36%** of US jobs; 89% with National contract groups and 78% open to PC boards.

Alabama Average: $410K
Tennessee Average: $401K; High: $436K; *jobs in all major cities*
Florida Average: $398K; High: $467K; *lots of opportunity in major cities including Miami*
Louisiana Average: $390K
North Carolina Average: $390K
Kentucky Average: $380K; *strong opportunity in Louisville*
South Carolina Average: $370K
Arkansas Average: $360K; *opportunity in Little Rock*
Virginia Average: $360K; *opportunities in Tidewater and DC areas*
West Virginia Average: $350K
Georgia Average: $320K
Mississippi – N/A

The **West/Southwest region represent 23%** of the open jobs, 76% with NCGs and 48% open to PC boarded docs.

Texas Average: $443K; High of $484K; *huge area of opportunity in San Antonio/Austin, less in Dallas and Houston but still plentiful*
Arizona Average: $418K; High of $507K; *good options in Phoenix and southern AZ*
California Average: $417K; High: $468K; *very sparse opportunity in major cities*
Utah Average: $375K *first job opening in Utah in a decade!*
Nevada Average: $367K; *strong opportunity in the Las Vegas area*
Oklahoma Average: $360K
Colorado Average: $300K
New Mexico – 3 jobs, N/A
Hawaii – N/A

The 12 states of the **Midwest have 17%** of US jobs; 67% with NCGs and 67% accepting PC Boards.

Illinois Average: $411K; High: $432K; *a few spots in the Chicago area*
North Dakota Average: $410K
Ohio Average: $401K; *major "C" cities have very few opportunities*
Wisconsin Average: $390K
Missouri Average: $380K; *a few jobs in Kansas City and St. Louis*
South Dakota Average: $ 370K*; only rural*
Nebraska Average: $360K
Indiana Average: $360K; *good opportunity in Ft. Wayne*
Kansas Average: $354K; High: $411K

Minnesota Average: $340K
Michigan Average: $312K
Iowa Average: 293K

The **Northeastern states have 11%** of the jobs with 41% in NCGs and 37% open to PC Boards.

Massachusetts Average: $373K; High: $400K; *Boston is rife with opportunity*
New York Average: $348K; High: $430K; *lots of openings in the NYC area*
Connecticut Average: $332K; High: $400K
New Hampshire Average: $329K: High: $400K
Maine Average: $300K
Rhode Island – N/A
Vermont – N/A

The small region of **Middle Atlantic has 9%** of the jobs, 60% with NCGs and only 18% open to PC boarded physicians.

Pennsylvania Average: $350K; *moderate opportunity in Pittsburgh and Philadelphia*
Maryland Average: $343K; High: $350K; *a few jobs in the Baltimore area*
New Jersey Average: $315K; High: $375K
DC – N/A
Delaware – N/A

Finally, the **Pacific Northwest** has only 4% of the nation's jobs with only 24% at NCGs or open to PC boarded physicians.
Washington Average: $417K
Oregon Average: $336K
Wyoming: no average, but a high of $460K
Idaho – N/A
Alaska – N/A
Montana – N/A

As far as trends, the big sign on bonuses are still a thing of the pass, but I have seen one or two in seriously tough geographic locations. Some of the large, NCG groups are back to offering a monthly stipend but loan forgiveness is pretty much dead.

If you are a 2023 grad, start your job search now and be aware that there are only enough jobs for about half of your graduating class. Of course, that doesn't include the underground spots that are never advertised and require a referral or a secret password! Best of luck!

Say "No" Like A Pro

Most Emergency Physician job candidates excel at saying "yes" to an offer, but are clueless when it comes to saying "no." It's important to understand that your "no," and how you handle it, can affect your future career as much as the "yes" you give to the employer who's offer you accept.

There is a double mandate when turning down an offer of employment:

1. Leave behind a good impression as both a physician and a person
2. Leave the door open for future potential

The consequences of a badly delivered "no" can be multiple and serious. Employers put a significant amount of time and expense into the process of hiring a physician Most employers foot the bill for interviewing each and every candidate (which can range from three to eight physicians on average) including travel, hotel and related expenses. Many are also paying fees to a professional recruiter for their services. The time commitment toward reviewing CVs, conducting telephone interviews and hosting one to two day site interviews is considerable. A standard recruitment campaign can cost a potential employer between $15,000 and $30,000 on average, depending upon the number of candidates interviewed. The time expended by both director and existing staff is incalculable. Since the average Emergency Physician changes jobs 6 times in a career, the potential for burning a bridge or two in the process is quite strong. To put it in a nutshell: the director/administrator you offend this year with an unprofessional turn down, could easily be the director/administrator you want to work for at another hospital five years from now. There is also the undeniable fact that Emergency Medicine is still a small world and news of bad behavior gets around.

Unless you are completely lacking in the most minimal of social graces, you will have sent a thank-you letter to every employer with whom you interviewed. If you received an offer form that employer, you should have given them a time frame for your decision. Once you've made that decision you have an obligation to let the other employers know about it. The average experienced physician sends an e-mail. The average graduating resident does absolutely nothing. Neither is professionally acceptable. Even if you have interviewed with 25 prospective employers, each and every one, whether they have made you an offer or not, deserves the courtesy of a formal letter or telephone call. Many physicians believe that they have no obligation to contact a prospective employer they are turning down if they were referred by a professional recruiter. Indeed, that recruiter will make the initial turn-down phone call for you. If, however, you want to fulfill the two mandates listed above, it is up to you to follow-up with a phone call or letter.

Emergency Medicine is still a relatively small community in the wide world of healthcare. ED directors and physicians talk to each other. When a physician candidate has been remiss in professionalism, the word gets around. Saying "no" is uncomfortable. Few people like hearing the word and few like having to say it. But there are ways of doing so that soften the blow, and leave you looking like a pro.

If you have been made an actual offer by an employer, you need to alert them to your decision as soon as possible so they can move forward with their hiring process. Call the hiring authority and thank him/her sincerely for the opportunity and the offer. Tell the hiring authority that you have accepted another offer, and provide the details of *where* you are going and *why* you chose the offer you did. The information you provide could help that employer fine tune their recruitment process. They will be quite grateful for any feedback you can provide. Then, follow-it up with a formal letter reiterating:

1. your sincere thanks for the opportunity to interview with them
2. their kind offer
3. what you liked about their opportunity
4. the name of the employer's offer you accepted
5. the reason you chose the one you did

This letter will be filed, and you will be remembered as a professional. Once again, if you worked with a recruiter that generated offers, the recruiter will make the phone call for you, but it is still up to you to at least get that letter out.

Employers that provided a site interview, but not an offer, should also be sent a formal letter notifying them of your decision. Of course, you aren't going to thank them for an offer, but the rest of the content points should be included. Be target specific when writing them so the letters don't come off sounding like a form-letter. Use names, dates, observations, etc. to let them know you actually remember the experience.

If you are like most graduating residents and seasonal job searchers, you may have already accepted a position to start this summer, back in December or earlier in the year. If you haven't done the "pro no" process, it's not too late. Don't be shy – this is a text-book "better late than never" scenario.

Fulfilling the double mandate will make those employers feel good about you, make you feel good about yourself, and leave doors of opportunity wide open for the future.

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Consequences

I recently received this e-mail from a director in the Midwest:

Barb – can you explain something to me? Let's say a grad takes a job right out of residency with a small, democratic group. Seven months into the job the director comes up to the kid and says "we're sorry but we've found someone who will work all nights and we are going to replace you." That would be illegal or at least unethical, right?

*But this is what new grads do to us! Where are **their** ethics? Why is it OK for a new grad to dump a job after 6 months if one that pays more crops up? It just happened to us last month, which means we will have to spring huge bucks for a locum to fill in for the summer. As far as I am concerned, new grads are now at the bottom of the list for new hires. Let them get their experience and grow up somewhere else!*

This is obviously one very ticked off director and you be assured that he has ranted on this topic to anyone who will listen. Directors talk to each other and they name names. This recent grad just set his feet on the road to a rocky reputation. If you understand nothing else about your job search decisions this year understand this: there will always be consequences to your actions.

Whether the employer is a small democratic group or a big healthcare conglomerate, they invest a good deal of time and expense into the recruitment of a new physician. The interview expenses alone for one candidate can reach into the thousands of dollars. A recruitment fee in the $25K range can also be involved. The cost of recruiting can easily mount to some pretty significant numbers. Needless to say, the employer expects to recoup those costs from the services provided by the physician over a period of years. With a graduating resident, there is also an adjustment period that includes an effort towards helping that physician get their feet on the ground and even study for their boards. Most directors believe the transitional period for the average grad is six to nine months.

Over the last several years, more and more small, democratic private groups had curtailed their consideration of graduating resident candidates for their open positions. Either they hadn't the time or manpower to provide the double coverage necessary to assimilate a new grad into the practice, or they believed that most new grads were using their first jobs as stepping-stones. Now, with this highly candidate-driven market, these groups have no choice but to consider grads for their openings. Though the stats still show that about 50% of graduating residents leave their first job in two years or less, the average grad is staying longer. There is also no doubt that Emergency Physicians become more marketable once they are board certified, but what about the employers that helped get them to that point? Aren't they entitled to reap a little benefit from their efforts?

There are definite consequences to the actions of graduating residents as a result of their first job decisions. A graduating resident should be looking to spend at least 3 to 4 years at their first job, especially in this market with employers offering loan payback and big sign-ons and even stipends for multi-year contracts. If a new employer is offering $100K in loan forgiveness for a 4 or 5 year contract, guess what happens if the physician hired leaves before the end of that period? He or she will have to reimburse the employer for the portion of loans covered, that wasn't "paid for" in labor. And, if a physician gets a sizeable sign-on bonus, he or she could be on the hook for that as well if leaving before the end of the contract. Imagine what an employer would do to a grad who took $18K to $20K in stipend money *before* they started, and then left in 6 months! Have your attorneys on stand-by kids . . . this stuff is actionable!

Another consideration that most don't think about until it's too late is the issue of references. When you make a job change, your new employer is going to want references from your current employer. For a recent graduate, they will ask for residency references, but the decision to hire will be based on the reference from the current supervisor. If that reference questions the physician's motivation for a move, it sends a message to the new employer that this physician may be just as likely to pick-up and move once another carrot is dangled. You must

understand that most employers are looking for stability in their new hires. If physicians don't demonstrate stability in their background, serious doubt is cast on whether they will do so in the future as well.

If you are a graduating resident, there is absolutely nothing wrong with planning a to use the current market to set yourself up for early loan payback and a strong start with an employer who is happy to pay you all the silly money up front for a multi-year contract. But you must be ready and able to live-out the terms of that contract in order to reap those rewards and move on to the next step in your career without a falter. Make sure you read the fine print and have the backing of your family before signing on the dotted line and cashing that sign-on bonus check. Once you've done that, the commitment is cast in iron.

When you are making a decision about where you are going to plant your feet for that first job, think long and hard about the long-term issues connected to that decision. There can be good reasons for leaving a job earlier than intended. If promises are not kept, if the environment is not conducive to the practice of quality medicine, if a group loses a contract, or any situation where the physician is put in an uncomfortable or risky position is an acceptable motivation for a move. But if your motivation for an early move falls into the category of income, or less night shifts or some other reason that could be considered self-serving, be prepared to deal with bad feelings and a reputation that can follow you for a long time to come. Use your head when making choices and refrain from making your first job a short-term place to hang your hat until a "better one" comes along.

Every action has a reaction . . . a consequence. Though none of us has a crystal ball and can predict the future, you can set defined goals and map out a road to achieving them. I encourage you to make these decisions and set those goals before you send out a CV or pick up a phone. Be prepared to accept the consequences of your actions and live out the terms of your agreements; that way everyone wins.

EMERGENCY MEDICINE NEWS
The Career Source July 2012

THE PARTNERSHIP CHRONICLES

BY BARB KATZ
THE CAREER SOURCE
EMERGENCY MEDICINE NEWS
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"Defining "Partnership"
Part One: The Beginning

Ask just about any job-seeking Emergency Physician what he or she is looking for in a job and the word "partnership" is bound to surface. The problem is the term "partnership" is being bandied about as much as the term "democratic" these days, even in situations where neither really exists, and those who use it don't even know what it means.

The popular pursuit of partnership started in earnest back in the late 80s/early 90s with the backlash against national contract groups and the concept that Emergency Physicians were being badly treated by many employers. The belief was that hospitals and contract groups both large and small, were treating EPs as shift labor that were not being properly compensated for their time, qualifications and efforts. Physicians began demanding an "open books" policy and a voice in the running of their department as well as a financial piece of the pie. This debate even saw the creation of a second specialty organization, American Association of Emergency Medicine (AAEM), dedicated to the vision statement: "the ideal practice situation in Emergency Medicine affords each physician an equitable ownership stake in the practice. Such ownership entails substantive responsibility to the practice beyond clinical services." This is a wonderful goal to be sure, but not easily achieved. Over 50% of the Emergency Physicians practicing today, who are hospital employees, employees of large or national contract groups (even those that are primarily physician owned and run) as well as most Emergency Department academic faculty have no chance at this ideal. As such, there has been much discussion about a cruelly dangled banana few are capable or reaching, and raising the expectations of Emergency Physicians (particularly graduating residents) to unachievable heights. On the other hand, if ideals are never set down, how can one be expected to reach for them?

Though groups of Emergency Physicians staffing either single or multiple facility EDs as equal partners have been in existence since before the official inception of the specialty, it is only in the last ten years that the pursuit of partnership has taken such a primary role in the average job search. If Emergency Physician job seekers are going to focus on partnership, it is essential for them to understand exactly what partnership means in each job opportunity that claims to provide it. They must also be clear about when and how this partnership is earned. One of the things that have made the concept of partnership or ownership even more complex is the recent popularity of incentive compensation. Many, uninformed physicians mistakenly consider this extra income a form of partnership. Incentive compensation, such as bonus pools and hourly productivity bonuses are just that: a means of compensating a physician for his or her performance based on a variety of factors including productivity, patient satisfaction and department/hospital contribution. But it is not partnership. Possibly an even more important factor is that physicians, particularly graduating residents, are not spending the time and effort to analyze what kind of practice structure best fits their individual professional and personal needs and desires. Not everyone is cut

out to be a business owner with all the time and energy output that role requires. So, it's essential that physicians evaluate their goals as they apply to short and long term practice commitment, and understand how each opportunity they consider fits them.

There are quite a few partnership modules in existence within the groups staffing Emergency Departments today, and the principle three are:

Equal Equity Ownership,
Limited Liability Partnership
Non-equity Partnership.

Another element integral to the subject is that partnership/ownership potential is rarely, if ever guaranteed, either verbally or in a written employment contract. So why does the average graduating resident seem to believe that partnership is an immediate inalienable right not unlike that of free speech? As a professional recruiter, and residency program lecturer, I can attest to the fact that the popularity of partnership as a job market "buzz word" has led to an inflated sense of entitlement on the part of graduating residents. It's not their fault. Many grads are being led down a primrose path by a new kind of specialty folklore that tells of huge annual incomes and management roles from day one. This can result in inevitable disappointment when the promised riches don't materialize rapidly enough, and the physician starts looking for greener pastures. Hence, we have one of the factors behind the high percentage of grads leaving their first job within two years.

Any experienced Emergency Medicine group partner or owner, no matter what form that position takes, would agree that either must be *earned*, not simply conveyed on the first day of work. Earning partnership/ownership, particularly in an equity situation, not only takes years, but often a financial contribution in the form of a buy-in as well. And, since less than 50% of the jobs available this year will be with groups providing eventual partnership or ownership in any form, graduating residents with those goals should be focusing on the following:

What are the criteria for earning partnership or equity ownership . . . the specific formula? At what point does eligibility become available? And what, specifically, does partnership or ownership mean? What are the financial gains as well as the potential financial responsibilities? What is the time and energy commitment, above the standard clinical duties, required for partnership or ownership?

In the coming months I will attempt to answer these questions by defining each of the three main partnership/ownership categories, with the help of the groups that fit them through interviews with group representatives and research. I welcome any communication and opinions on this subject so feel free to contact me.

Defining Partnership
Part Two: Equal Equity Ownership

An Equal Equity Ownership group is one that provides an equal share in the ownership of the group to every physician who is invited to become a partner/owner. Not every physician who works with the group must be an owner and some may choose not to be. Why? Because as Len Nitowski, MD, FACEP, the President of the DFES group at Christiana Medical Center in Newark Delaware points out, "Not everyone is cut out to be the owner of the candy store." Dr. Nitowski is the president of a group that provides equity ownership to each full-time group member, but in the form of a corporation that gives stock to their physicians. Each member of the group is treated equally in terms of stock ownership. His group has been a template for excellence in both the academic (a highly respected Emergency Medicine residency has been in place here since the 70s) and private sector since its inception in 1969. Dr. Nitowski believes "some young doctors think ownership just means more money. Physicians must understand the level of commitment as well as the time, effort and mind-set required of an equity owner." He also objects to the term "partnership" when referring to an equity ownership model, "partnerships are legal constructions between two parties; ownership is a different animal."

Dr. Nitowski helps evaluate the job offers extended to his graduating residents. He works with each resident to examine "the fit" of the opportunity in terms of how the structure fulfills individual desires and needs. If a graduating resident is seeking security, ownership may not be the best road to take. He also emphasizes the details of group governance – who makes the decisions and how are those decisions made, and asserts that it is up to the individual to decide if he/she wants the additional responsibility, above clinical, required to be an owner. This is a self-examination Dr. Nitowski believes every physician should be doing: "what is the best practice structure for my practice style?"

So what makes a physician good equity ownership material? I heard from a number of sources on this question and they all agreed on these five traits:

1) Self confident
2) Organized with an ability to understand and handle finances
3) A contributor willing to step up to the plate and get involved
4) A decision maker and collaborator with good common sense
5) A risk taker, willing to put in the time and effort in order to reap the benefits

Arizona Emergency Medicine Specialists at Kingman Regional Medical Center in Kingman, AZ, was established only a few months ago. Dr. Michael Ward, the president of the group, along with his 3 other partners, have established clear criteria for adding new equity owners to their group: residency training in Emergency Medicine (this is an Osteopathic Emergency Medicine residency site,) and a commitment to live locally and be community-responsible. There are other physicians working for this group as employees who enjoy incentive income as well as salaries and benefits, and who have the potential for equal equity owner partnership. This is a young group, with most of the physicians only a year or so out of residency and they are all taking a leap of faith to make this group work. They have definite ideas of what sort of physician will make the best potential colleague. "We don't operate in a vacuum," states Dr. Ward. "New potential partners must understand the concept of what we do and how it affects the hospital in terms of our patient satisfaction levels, lengths of stay and left-without-medical-screening rates. We are looking for people who maintain their abilities in a teaching environment, who have common sense and a desire to be independent. The solvency of the residency program is tied directly to the success and survival or our group. We're not interested in someone who just wants a pay check." In its infancy, it will take this group a few years to establish specific buy-in/equity earning guidelines, but for right now, they are doing the job and enjoying the adventure.

Not all equal equity ownership groups are enjoying the ride. One such group in the southeast, which shall remain anonymous, is experiencing serious issues with a partner who has literally taken over the group due, in part, to a relationship with a high-level hospital administrator. This is a prime example of "power run amok" that is a direct result of group partners becoming complacent and allowing someone else to gradually take the reins. Instead of dividing responsibilities among all the physician owners, the same fellow volunteered and the rest just sat back and said "fine, less work for me," until they opened their eyes one morning and realized that their democratic group had become a dictatorship. As one of the effected partners told me, "it's easy to give the power away, but damn difficult to take it back."

Steve McIntyre, MD, business partner for Appleton Emergency Physicians at Appleton Medical Center in Wisconsin, says his group recently began further encouraging each physician to participate in committees and other hospital projects by paying the hourly rate for their time. "It's that visible involvement with the hospital that keeps a contract strong." They've even set up a fund for events that promote group visibility, and emphasize group contributions to both the hospital and community.

Understanding that all groups are not that equal or equitable, what should you be looking for in a potential equal equity ownership group opportunity?

1) a stable group with a strong relationship with hospital executives and medical staff
2) a group of physicians who are all contributing and involved with both the ED management and hospital committees and activities
3) a group that offers a well-defined path to ownership that includes:
    - defined requirements for earning an equity owner invitation

- defined time frame for equity owner invitation
- defined formula for earning and/or buying into equity ownership

4) A group that will open their books for you prior to written contract
5) A group who's members have an approach to patient care with which you can work
6) A group of physicians you feel a connection with on a personal level

I can't quote specific numbers to you for earnings or buy-ins as every group is different. I can tell you that most established equal equity ownership deals require a purchase into the accounts receivable in one way or another. Some will allow sweat equity to be a factor, others will not. Time frames will differ as much as management styles. I can urge you, however to ask detailed questions; not only of the prospective group, but of yourself. As Dr. Nitowski asks his graduating residents, "if the guy who sweeps up the candy store calls in sick, are you ready to pick up a broom?" If you aren't absolutely certain the answer to that question is yes, than equal equity ownership might not be for you. If not, perhaps a limited liability partnership is more up your alley . . . we'll cover those next month.

Defining Partnership
Part Three: Limited Liability Groups

A Limited Liability Group (LLG) refers to any group where one physician, or a minority of the physicians in the group, owns the bulk of the contract and all the other physicians work for them. In some cases, actual shares or portions of ownership may be available to physicians working in the group, but they will not equal those of the primary partners. With lesser ownership, however, comes lesser responsibility. Last month in the equal equity ownership portion of the series, we discussed owning the candy store and all the responsibility that implies. In the case of the LLG, we are referring to either owning a small portion of the candy store, or working to earn a portion of the candy store's profits with little or no repercussions from any of its potential losses. The amount of democracy and generosity with profits is actually dependent upon the majority shareholder(s).

Many of these majority shareholders began these groups with their own money, often mortgaging their homes to get them off the ground. Obviously, they feel an entitlement to the lion's share of the profits as they are the ones who took all the risks to start the group in the first place. But the recruitment of new physicians can be significantly more difficult for these owners if they are not willing to provide a vote along with a piece of the action. Incoming physicians may respect the sacrifices made by the founding partner(s), however, they feel their contributions should be rewarded as well. These groups come in all sizes, from one-to-two site groups to larger, regional groups. What any interviewing physician must know before signing on the dotted line, is the exact formula employed for earning a Limited Liability Partnership (LLP) in this kind of group, as well as any potential for future ownership.

There is a large presence of LLGs in the marketplace, but as it turned out, few were willing to go on the record and be identified in this piece. In many cases these groups were started by one or two physicians taking out a substantial loan to get the group off the ground and that loan is still being paid off. A physician being brought into the group who is subsequently made an LLP, may very well inherit a portion of the responsibility for that loan along with partnership. Once again, it is all dependent upon how those primary partners are defining partnership. For a true limited liability partnership, a new physician must:

- Be given a percentage of the actual profits above and beyond any incentive performance-based income, though it will not be an equal percentage
- Have limited responsibility, equal to the percentage of profits provided, for any unexpected overhead expenses or malpractice settlements not covered by insurance
- Be given a defined voice in the governance of the group
- Have limited responsibility, equal to the percentage of profits provided, for working extra shifts as required
- Be given full disclosure of group assets and liabilities (access to open books)

Rao Kilaru, MD, the president and principal partner of Prairie Emergency Services at Provena St. Jospeh's Medical Center in Joliet, IL, describes his LLG as a Subchapter S Corporation that distributes all the money at the end of the year, creating less incentive for physicians to purchase partnership with a buy-in. He also points out that medical practices, other than ED groups, involve a buy-in and commitment even though there is no expectation of partnership, particularly in a well-established practice.

Very, very few groups guarantee invitation to partnership either verbally or in an employment contract. Partnership, no matter what form it takes, is nearly always a potential based on the performance of the physician and the structure, stability and financial condition of the group. The time frame for invitation to LLP is group-dependent. I have seen ranges of two years to seven years. Some groups allow new physicians to earn partnership through "sweat equity," which entails working for a period of time at a lower level of income with that monetary difference considered the "buy-in." Many physicians feel that this method is no longer viable as there is risk of working for years at lower income leves and never actually being invited to partnership, or the group could lose the contract, or family issues could necessitate relocation. In short, it is a leap of faith that is becoming less and less practical. An actual "buy-in" once LLP is actually offered, makes more sense to most physicians. Buy-ins are usually based on the Accounts Receivable of the group and the percentage of ownership being offered. In addition, the liabilities assumed by that new partner should not exceed the percentage of profits. Most groups allow a new physician partner to pay off the "buy-in" over time, often without any interest assessed, so that it doesn't seriously impact income levels.

Another important factor to be considered with LLP is the opportunity to become a primary partner. In many cases, when primary partners reach retirement age, they sell their "shares" or partnership portion to the other physicians in the group. There have been cases of partners passing away and leaving their primary ownership to spouses and/or children who attempt to sell them back to the group at nearly extortive levels. Any partnership agreement needs to include specific arrangements for the death, disability and retirement of any partner either principal or limited-liability.

For those physicians who

1) want some group involvement above the clinical, but not the level required of an equal owner
2) want to have a voice in the running of the ED but not a direct position of authority
3) want to reap a portion of the profits but is happy with a smaller piece
4) are willing to shoulder a small level of responsibility and liability, but not the lion's share . . . limited-liability partnership could very well be the answer.

As usual, the most important factor for any job seeker who is interviewing with a group potentially offering a limited-liability partnership is *full disclosure*. Read the small print and make certain you understand all the details.

If, on the other hand, you are more interested in reaping some rewards from your hard work but don't want the responsibility of group administration or governance, perhaps a non-equity partnership is the thing for you. We'll talk about that next month.

Defining Partnership
Part 4: Non-Equity Partnerships

It almost sounds like an oxymoron, "non-equity partnerships," but in fact, there are many groups that fit this category. They are groups that are owned by one, or a minority of the working physicians, and make partnership available after a period of time, usually one to two years. Partnership in this case really does mean profits without responsibility, but it can also mean profits without any managerial input. Simply stated, the "quality" of the group is dependent upon the owner(s), not only their management style but their ability to attract top physicians. These principals run the gamut from unpredictable dictators to benevolent, generous leaders.

At this point I have the option of taking the low road with urban myths and legends of abuses, or the high road featuring the positive side of the non-equity partnership faction. Being fortunate enough to be well acquainted

with Dan Walsh, DO, FACEP, one of the owners and Managing Partner of Emergency Medicine Consultants of Lorain County in Ohio, I choose to take the high road. Dr. Walsh was once an original minority partner in a regional group that was absorbed by a much larger, national contract group, with whom he became a regional Vice President. About 5 years ago, Dan and his partner, Alan Starr, MD, FACEP, mortgaged their homes and all their belongings to start-up EMC of Lorain County. Since it was just the two of them, they chose the non-equity partnership format. "We offer a no liability, no responsibility opportunity to share in the profits of the organization in an on-going fashion" states Dr. Walsh. "This doesn't mean there is no input. All decisions regarding staffing levels, lengths of shifts, protocols, and the selection of physician partners are made in a democratic fashion. Financials are also shared with the physician partners."

The group runs three sites including a large, suburban medical center ED, a low-volume community ED and a new and incredibly successful free-standing ED in a fashionable Cleveland suburb that, combined, comprise over 85,00 patient visits per year.

I asked Dr. Walsh why he and Dr. Starr chose this partnership format. "After years of working in the business of Emergency Medicine, I have seen the pitfalls of management by committee. We feel this model affords the physician the opportunity to forge policy and share profitability without the liability of direct equity ownership. But, let me be clear; Alan and I are dedicated to ensuring that the entity continues as an independent, physician-owned and operated group after we retire."

On the subject of the downside to an Emergency Physician, Dr. Walsh responded, "If a physician is interested in equity ownership, he or she may have a wait. But, the possibility of achieving it is infinitely better than with large regional or national contract groups."

The subject of working as an Independent Contractor also came up as all of the EMC of Lorain County physicians are ICs, by choice. Many physicians, particularly graduating residents, are unfamiliar with this income format. "Our physicians elected to be Independent Contractors because of the tremendous tax benefits and the ability to tax-defer large amounts into retirement. It's like having your own business and that's the greatest tax advantage there is, whether you choose to incorporate yourself or not." Dr. Walsh has been adding to staff regularly due to a constant rise in census among their 3 locations, and one of the benefits he provides to his physicians is the availability of a top tax accountant to teach the unfamiliar how to make the most of being an Independent Contractor.

While this is an above average example of non-equity partnership, there are many others. There are also quite a few horror shops where physicians work as indentured servants at the whim of the owners with no say in how the department is run. For any physician who is seeking this type of opportunity, also known as "the perks without the pains," there are some important questions that need to be asked in order to avoid the bottom of the barrel jobs:

- If no equity is being conferred, what does partnership mean?
- When a partner shares in profits, how are those profits determined and distributed?
- What, if any, impact do physician partners have in the management of the ED?
- What is the employment basis – employee or Independent Contractor?
- If employee, what benefits are made available without cost to the physician?
- If Independent Contractor, are Malpractice and Tail coverage still provided to the physician at no cost? And, is there a tax advisor available for consultation?
- Will there be potential for equity ownership down the road?

As with any job search, details are the key. It is up to the physician to ask the questions and make certain they get detailed answers.

In many ways, the non-equity partnership can be a good way for graduating residents to begin their careers. It is an opportunity to experience a partnership track and learn the business of Emergency Medicine without having to shoulder the sometimes overwhelming responsibilities or equity ownership. The challenge here is to find a non-

equity partnership opportunity with a group that is focused on forging an equitable and stable work environment dedicated to quality patient care.

Next month we will wrap-up the series with comments and final thoughts from all over the spectrum of Emergency Medicine Partnerships.

Defining Partnership
Part 5: Wrap-Up

Partnerships began springing up 15 years ago, mostly as a backlash against national contract groups. Many Emergency physicians were treated badly by employers, who thought of them as shift labor and didn't compensate them fairly. As physicians began demanding open books, a voice in running the department, and a financial piece of the pie, partnerships began to look more appealing. Still, questions remain, so here are a few final thoughts on the subject:

One of the earlier participants in this series pointed out the existence of several large, regional and national groups that promise full partnership and profits but then deduct from those profits for administration, billing, malpractice coverage, accounting, physician credentialing and other "management items," leaving significantly trimmed actual earnings left over. What is particularly disturbing about this practice is that these groups own all the companies providing those services and the charges, while within the realm of reason, all bring profits back into the pockets of the primary owners, and out of the pockets of working physicians. These partners find themselves responsible for the liabilities while excessive profits are quietly siphoned off in a risk free manor.

John H. Myers, MD FACEP,FAAP, the President of Questcare Partners of Dallas, TX described the challenge of taking his group from one owner physician to 51. "It has been tough and has taken nearly three years from proposing the change to refining the operations. The financial and business issues required the physicians serving on our Board of Directors to learn to be business people as well as physicians. We now have a 13-member Board elected by the member-owners (comprised of the President, 3 at-large members and representatives from each facility) and our officers are elected by the Board." Dr. Myers believes group participation in governance and an open book policy are key items to success. As for graduating residents, "partnership has become a buzz word. Good groups don't want a 'backpacker mentality,' that is, they expect owner physicians to contribute more than merely clinical time. I believe the new generation of grads expect full disclosure and require an environment that breeds less suspicion about the nature and motives of group management."

Many of the groups, like DFES in Delaware from part two of this series, are corporations with stock ownership for their physicians. The Schumacher Group of Louisiana is steered by Kip Schumacher, MD, the principal owner and stockholder of the group, and though he has given out nearly 40% of the company to his leading physicians via stock options, he retains all liabilities. "Options are given to those physicians who show great leadership. The reason why some groups fail is that their physicians just have to show up to earn rewards, they don't have to go the extra mile, making it difficult to rid the group of dead weight. For true success everyone has to push the wagon up the hill.. Any group can be successful. It's determined by the group's leadership. Good group governance is the key."

I asked Ron Hellstern, MD, Sr. VP of Physician Executive Development for PSR, the Emergency Medicine division of MedicalEdge Healthcare Group, Inc., a practice management consulting firm in Dallas, TX, "Why do some partnerships work and others do not?" Dr. Hellstern replied with a 3 page letter, but his most emphatic point was "the biggest reason is leadership or the lack thereof. Good leadership sets the tone of the organization and helps the EM group define its mission, vision and values. A group culture that has the rank and file honoring the contribution of the leadership, just as the leadership honors the contribution of the rank and file, is essential to success. No leader can lead those who refuse to be led and/or publicly challenge the group's collective decisions. Thus, effective discipline is also an essential part of effective group leadership. 'Control' is the real test of EM group democratic rule commitment. If a majority of the members of the group cannot remove or replace the leadership of the group they are not in control of the group. The most successful EM groups I've seen (i) are led by extraordinary leaders who inspire, direct and discipline the group members (ii)) view control of the leadership

as an investment decision rather than one of status, and (iii) make compensation for clinical practice the same for everyone in the group, while keeping the question of administrative compensation separate and tied to results."

In response to the question "what should physicians look for in a contract promising potential partnership?" William Sullivan, DO, JD, a Frankfort, IL health law attorney specializing in physician employment contracts, replied, "At a minimum, a contract offering a partnership track should state the time frame within which a partnership offer will be made and should describe any "buy-in" that a new partner will be required to make. Depending on the business structure, a new partner may inherit liabilities of the other partners or of the group as a whole. In a general partnership, if the group is sued for any reason, all of the partners share in the liability even if only one partner was accused of wrongdoing. If the group's contract guarantees that the group will pay for malpractice tail insurance and the group does not have sufficient funding to do so, a partner could face financial liability if the group breaches its contract. Different business entities provide some liability protection to partners, so discussing the prospective partnership with a business attorney would be a good idea before accepting a partnership offer. An offer of partnership shows that a group is willing to make a long-term commitment to the physician. Before accepting the offer, the physician should know the risks, benefits and alternatives to partnership so that an informed decision can be made."

And Jim Shortall, head of The Paladin Healthcare Group of Hampton, NH , which provides business management services for several Emergency Medicine groups in New England, shared with me what he believed to be the essential elements of a successful group. "First and foremost, as in any business relationship no matter what the actual legal structure may be, you need to have a strong commitment from all the partners toward a common goal for the practice. This becomes the essential element in the process of building a strong, well-functioning group because it provides the compass for all decisions, both current and future, that the group will make. It's very important that new members are selected based on their ability to embrace and support that goal." Jim also listed "(i) the establishment of a strong communication system for all members, (ii) the creation of policies and procedures to create fairness and equality for all members, (iii) guidelines for voting on important matters, (iv) defined procedures for buying-in or cashing-out of the practice, and (v) the implementation of systems to deal effectively with problems when they arise." Jim emphasized that "the last important areas to be addressed are how group finances are managed and profits are distributed."

Mr. Shortall was also thorough enough to add a final thought which I think sums up those of the series, "For physicians seeking to join a group, they need to (i) make sure they understand the terms and conditions of the deal (ii) make certain all their questions and concerns are addressed to their complete satisfaction and (iii) make sure they understand and can support the common goals of the practice."

Emergency Physician groups will continue to change and evolve and grow. But it is the responsibility of all physicians looking to join a group to first know themselves in order to determine their suitability for a potential partnership in a practice.

Barbara Katz
President

The Katz Company EMC, Inc.

Barbara Katz has been working exclusively with Emergency Medicine physicians since 1991. Prior to founding The Katz Company in July of 2001, Barb Katz spent 10 years as the **Executive Director of the Emergency Medicine Division of The Cambridge Group** in both Connecticut and Virginia. Barb went on to open The Katz Company with the purpose of providing expert recruitment and consulting services to the Emergency Medicine arena, as well as affording extensive educational opportunities to the specialty's national population of residents. In June of 2007, the company relocated to Phoenix, AZ, reincorporating under the name **The Katz Company EMC, Inc**

Well known for her informative, and often provocative monthly column "**Career Source"** running in ***Emergency Medicine News*** from January of 2006 to December, 2012, she began her writing career with "**The Katz Report"** column that ran in ***Emergency Physicians' Monthly*** for 10 years. Since January of 2013, Barb has been contributing to ***ACEP NOW***. Her annual salary survey is considered the most accurate in the specialty.

Barb is the nationally recognized expert in the Emergency Medicine job marketplace. Realizing early on that the specialty's graduating residents were ill-prepared to navigate the job market, Barb created the training seminar **"Effective Job Searching."** It was first presented as a pilot program at ***East Carolina University's*** Emergency Medicine Residency program in 1995, and resulted in the highest ratings in the history of the program. The four-hour seminar is now conducted at residency programs around the country, with the contents updated annually to reflect the constant changes, new trends and developments in the Emergency Medicine arena. It has also been expanded to apply to experienced physicians and presented to enthusiastic response at the ***AAWEP*** Leadership Conference. Ms. Katz has also served as faculty at the ***Virginia ACEP*** "Careers in Emergency Medicine" conference. In 2011 she presented her seminar at **Darnall Army Medical Center's Emergency Medicine Residency** Program, made her 5th trip to the **Synergy** program in Saginaw, MI and presented to the first graduating class from the EM residency at **UC San Francisco** in September of 2011, returning every year since.

As a featured speaker for ***EMRA*** at their ***ACEP Scientific Assembly*** program "Life After Residency," Barb experienced standing-room-only audiences and rave reviews every year from 1998 to 2004 and again in 2010 and 2011, and is returning this year in Seattle. She also served as a career consultant at their annual job fair each year, providing professional career advice to individual residents. Barb has presented several programs at the ***AAEM Scientific Assembly***. Ms. Katz was afforded the honor of contributing a chapter to the ***AAEM*** textbook, **"Rules of The Road,"** as the *only non-physician faculty author*. Ms. Katz has also served as faculty for the 2004 ***Academy of Family Practitioners*** CME Program, "Emergency & Urgent Care" on the subject of the future of Family Practitioners in the world of Emergency Medicine. In addition, she was interviewed for the web-based Category One CME program, ***"Practical Reviews in Emergency Medicine"*** in the early fall of 2005 and again in 2006. Barb was asked to become a contributor to the **ACEP Young Physicians Section Quarterly Newsletter** for March of 2007. She has also been a featured contributor on the practice web site **EMCentral.com** and the **Acute Care Continuum** blog.

Barb's commitment to delivering effective job searching education to Emergency Physicians, both experienced and graduating resident, continue with new efforts. Barb has been ***faculty*** for ***ACEP Scientific Assembly***, teaching a class on CV development ***since 2008***. She has also been **faculty** for the ***Resident's Section of AAEM*** at their ***Scientific Assembly*** in **2009 and 2010**, and presented an additional program for the **Young Physicians' Section in 2010** to more rave reviews. She addressed the **Resident's Section of ACOEP** for the first time in April of 2012, and presented two programs at the **VA ACEP Leadership Conference** in Williamsburg in May of 2012. Barb was asked to join the **Workforce** and **Career Sections of ACEP**, and presented the keynote address to **Workforce** in 2014, and continues to participate to this date.

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