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## Hospitalist Recruitment and Retention Challenges in Rural Communities

*Source: Kenneth G. Simone, DO, SFHM, president  
and founder of Hospitalist and Practice Solutions,  
a hospital medicine practice management  
consulting firm.*

Rural communities are typically challenged to both recruit and retain physicians due to myriad factors. These challenges may be a consequence of geography, economics, culture, education, technological resources, and health care resources (i.e., hospital bed capacity, practice scope of service, lack of specialists, lack of advanced medical technology, professional isolation, etc.). Many of these factors affect the spouse/significant other and children as well as the physician candidate. Thus, it behooves the recruiting entity to create a comprehensive recruitment and retention plan targeted to all family members.

Geographically, rural communities are often far removed from their suburban and urban neighbors. Consequently, access to economic opportunities and cultural offerings are often lacking. Rural communities often lack the educational resources larger communities enjoy, putting these smaller communities at a disadvantage. These limitations may be critical factors in a candidate's decision-making process. Furthermore, low population patterns in rural areas make it more costly for communities and businesses to provide critical services, raising the cost of living. If the job pay (for the candidate and/or significant other) is not commensurate with the high cost of living it may be a deterrent to successful physician recruitment and/or retention. These and other factors place rural communities at a recruitment disadvantage to its larger neighbors.

While rural communities face many challenges, they offer alternative opportunities and lifestyles. For example, rural communities are less densely populated than suburban and urban counterparts. Consequently, there tends to be less pollution, noise, and crime. Many rural areas offer mountains, coastlines, and lakes. Its residents may have access to vast acres of land and the opportunity to live on the water, mountain, or in pastoral communities. These rural communities may allow access to outdoor recreational activities (such as camping, hiking, hunting, fishing, boating, water and snow skiing, horseback riding, bicycling, etc.). Recruiters should be intimately aware of the unique aspects of the recruitment community.

Rural hospitals tend to have a quaint feel, reflective of their community. Many hospital employees know each other and may even live in the same neighborhood. Physicians know their patients personally more often than not. Frequently physicians run into their patients when off duty while grocery shopping, dining, or attending a play, to name a few examples. This can help physicians feel a connection with the community; on the other hand, it can be stifling for some. The candidate must be made aware of this small-town atmosphere before they are brought to town for an interview and before they are hired.

The 2011 AHA Rural Hospital Survey reported that 13.7 percent of critical access hospitals and 41.2 percent of rural hospitals utilize hospitalists. Hospitalist use more than doubled in these institutions between 2005 and 2009. Furthermore, hospitalists care for more than half of the inpatients in the majority of rural hospitals utilizing these

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doctors. Even in the face of gaining popularity, rural communities have experienced unique challenges recruiting and retaining hospitalist physicians. Hospitalists tend to practice in suburban and urban communities due to the nature of their job. These physicians rely on referrals from primary care providers (PCPs) and specialists. The patient base within the community must be large enough to support the referring physicians as well as the hospitalist practice. Smaller, more rural communities don't tend to have the physician base, never mind the patient base, to support a hospitalist program. Furthermore, the (potential) referral network may not be interested in relinquishing a portion of their salary to a hospitalist program (i.e., give up their inpatient income) due to small patient panels. Consequently, it's difficult for hospitalist practices to flourish due to a low inpatient census.

While many hospitalists are successfully recruited into large urban institutions, some are particularly interested in practicing in smaller hospitals. Hospitalists seeking smaller institutions tend to gravitate toward rural and suburban communities as the majority of small hospitals are located in these areas. As a general rule, the smaller the bed size (50 beds or fewer) the greater the likelihood that it's located in a rural community. Consider that the medical staff size in rural hospitals is typically smaller than in larger communities. There may be fewer specialists and less backup for hospitalist providers in these smaller institutions. Night call frequency may be greater than in large hospitals due to a smaller pool of physicians with which to share call. Medical resources and technology are usually limited in these rural areas. As a result, the hospitalist physician may be viewed as the go-to person and the responsibilities and expectations placed on them may be quite high. While some hospitalists thrive in this type of environment, many

physicians shy away from such a medical community, or once recruited, become overwhelmed by the limitations of this rural lifestyle.

Some hospitalists choose to work in critical access hospitals. These hospitalists are charged with stabilizing the patient within three days of admission and either discharging them or transferring them to another institution. These physicians manage complicated patients with multiple problems requiring an extended stay in the hospital less often. Additionally, the hospitalist's exposure to critically ill patients may be limited, as frequently these patients are transported from the field to facilities capable of managing both the patient's acute illness as well as extended needs (thereby passing the local critical access hospital). This phenomenon may serve as a recruitment impediment for some hospitalists because they feel they are less challenged while others believe they will lose their clinical skills if not regularly caring for critically ill patients. On the other hand, although critical access hospitalists may have limited clinical exposure and opportunity in some respects, they have a wide range of responsibilities placed upon them because of their small medical staff size and limited resources. In addition, the number of hospitalist providers is often smaller, placing greater responsibility upon these physicians. Consequently, these hospitalists must possess excellent triage skills, must work well independently, and must be able to multitask. These factors may limit the candidate pool, creating barriers to recruitment.

Rural hospitalists who work in institutions with a small bed capacity typically perform a broad spectrum of services to subsidize their income. For example, hospitalists may perform treadmill stress testing; pulmonary function testing; and/or invasive procedures (i.e., thoracentesis, paracentesis, central line placement, etc.). Some rural hospitalists

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cover the emergency department when they're on call; others work in outpatient clinics as part of their schedule. Many rural hospitalist practices must get creative to successfully fund the program. It takes a special candidate to fill this type of position. Hospitalists must possess a wide range of skills and be willing to provide services outside the realm of inpatient medicine. Most hospitalists expect to focus primarily on inpatient medicine, which is why they went into the specialty. Thus, the recruitment pool will be smaller for this type of program.

Rural hospitalist programs may proceed in a different direction to obtain program subsidy. The hospitalists may be expected to provide added value services for the hospital in return for financial support. These added value services may include participating on the Code Team and/or Rapid Response Team. The hospitalists may be required to serve on medical staff committees, chair departments, participate in medical staff initiatives (i.e., evidence-based clinical guideline development), and provide educational in-services to hospital non-physician staff. Some hospitalist candidates may become disillusioned with their non-clinical responsibilities resulting in either recruitment or retention challenges. While the previous statement is true, what I find in my consultative experience working with rural programs is that recruitment and retention challenges are more common when the hospitalist does not feel supported (professionally or financially) by hospital administration.

Hospital administrators in rural institutions are often reluctant to provide appropriate subsidies to their hospital medicine program. Their resistance may be based in their failure to realize the broader benefits (i.e., medical staff/community stabilization, patient retention within the local community, etc.)

a well-funded program provides. A high-functioning hospitalist program is often the best recruitment (and retention) tool an administrator has to recruit PCPs and specialists into the community. Hospitalist program leaders are frequently required to justify why their program requires considerable financial support. Rural hospital medicine programs frequently require significant subsidies as a consequence of its low ADC, payor mix, need for a disproportionate amount of hospitalist providers compared to patient encounters/net income (for coverage purposes), etc. Accordingly, hospitalists may face an uphill battle advocating for their hospital medicine program, which may result in job dissatisfaction and retention problems.

It is not unusual to see a disproportionate number of foreign doctors (including hospitalists) working in rural America. Historically, international medical graduates (IMGs) have been attracted to rural communities, as many IMGs have geographic employment limitations due to their visa status. For example, a J-1 visa requires physicians to return home to their country for two years after residency training unless they agree to practice in designated underserved areas for three years. Thus, IMGs have been recruited to work in these difficult-to-recruit, underserved areas. While this phenomenon creates a recruitment advantage for rural areas it does not necessarily lead to stability within its physician community. In many instances, once IMGs fulfill their visa commitments, they move on to suburban or urban locations. This creates turnover and a potential physician shortage (if the hospitalist program was built around these physicians) in rural areas that may already be experiencing recruitment challenges. Hospitalist turnover may also create an unstable environment within the referral network especially if these physicians have

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Be sure to check out the recruiter home page (<https://recruiters.nejmcareercenter.org>) for additional recruiter resources, including recruitment studies and an archive of RPT.

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We'll be giving away two copies of this book! Two winners will be chosen at random from the correct responses we receive via email by 5 p.m. EST on Monday, Dec. 17, to the following question:

**According to a 2010 AHA survey (based on 2003–2010 data), what region in the United States is showing greatest hospitalist growth?**

- A. Northwest
- B. Midwest
- C. Northeast
- D. Southeast

Send your response to [resourcecenter@nejm.org](mailto:resourcecenter@nejm.org).

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**ACP/Internal Medicine**  
**April 11–13, 2013**  
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[im2013.acponline.org](http://im2013.acponline.org)

**Association of Program  
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**PROMOTIONAL NOTES/NEWS**
**Early Closing Dates for NEJM Issues!**

As a courtesy, we want to remind you that the closing dates for the *New England Journal of Medicine* are at least one day earlier for the next several weeks during the holiday season. Below, you will find the issue and closing dates for the weeks affected by the earlier deadlines.

Issue	Line/Fractional Close*
Dec. 6	Nov. 15
Dec. 13	Nov. 21
Dec. 27	Dec. 6
Jan. 3	Dec. 12
Jan. 10	Dec. 18
Jan. 17	Dec. 26

\*Closing dates for full-page ads are generally seven days prior to the materials' due dates. Please call the NEJM Recruitment Advertising Department for more details.

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to come back into the hospital and provide inpatient services due to hospitalist shortages. The instability may lead to job dissatisfaction and exodus of the referral network (from the rural community).

The introduction of the H-1B visa has further compounded the recruitment problems in underserved rural communities. The H-1B visa does not require a physician to return home or work in an underserved area for three years. This has prompted many IMGs to work in suburban or urban locations that are not underserved. As a result, underserved areas are now recruiting fewer IMGs. Hospitalist programs considering recruitment of IMGs should be aware of how visa status affects the placement of these physicians.

In summary, rural communities are challenged to successfully recruit and retain hospitalist physicians. The challenges may be related to work, family, visa status, and

educational, financial, and geographical considerations. The recruiting entity must identify candidates who are confident in their skills because rural hospitalists rely much more on clinical judgment and procedural skill sets than in suburban and urban hospitals where there is greater availability of specialists and medical technology. Furthermore, the candidate must be receptive to other challenges associated with rural hospital medicine programs, including daytime staffing and scheduling nuances and a potentially demanding on-call schedule. The candidate must also be aware of the economic stressors on small hospitals that constrain their ability to offer competitive compensation and practice resources. It behooves the recruiting entity to identify the attractive characteristics of their community and match them to the ideal candidate. The recruiting institution should engage consultants who have proven experience working within rural communities. ■



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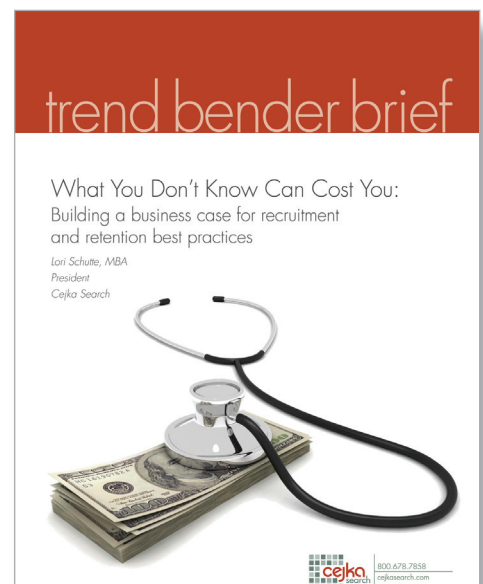
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